Communicare | Health
Primary & Community

COMMUNICARE USER GUIDE

V23.2

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Introduction

Get started using Communicare, a digital care solution for rural and remote health services.

Communicare is an electronic medical records database for primary health care providers who service a defined community, such as Aboriginal Medical Services, and for entities that provide preventative health care, such as Community Health Centres.

Communicare's emphasis is on preventive and managed health care. It provides a comprehensive recall system and can be used as a recall only system, recording only medical information required to produce recalls.

Communicare provides reports for individual patients and community-based reporting, such as coverage of the target population for preventive health care procedures. Other features include:

- A patient register with multiple patient names and history of patient addresses for a patient
- Medical records by patient
- Automated recalls based on age, sex, date of preceding events and patient conditions
- Explicit support for the following classes of information:
    - Admissions
    - Conditions
    - Acute and chronic medication
    - History items
    - Immunisation
    - Procedures
    - Referrals
- Recording of qualifiers and test results
- Statistical analysis
- Information grouped into medically significant categories (topics)
- Service recording
- Prescribing, including generic prescribing
- Progress notes
- Specific features for Aboriginal cultural beliefs, eg facility to designate a patient name as Nyaparu or similar term

About Communicare

Use the **About** window to display copyright, version, licence and other technical information about Communicare.

To display the About window, select **Help > About**.

Installing Communicare clients

Windows users with the required administrator permissions can install or upgrade Communicare clients.

The Communicare server is installed by Communicare Support at your site. You can install online clients on other computers that connect to the Communicare Server. The server and client must be on the same local network.

If you have an external service provider who manages your IT infrastructure, organise for them to install the Communicare client.

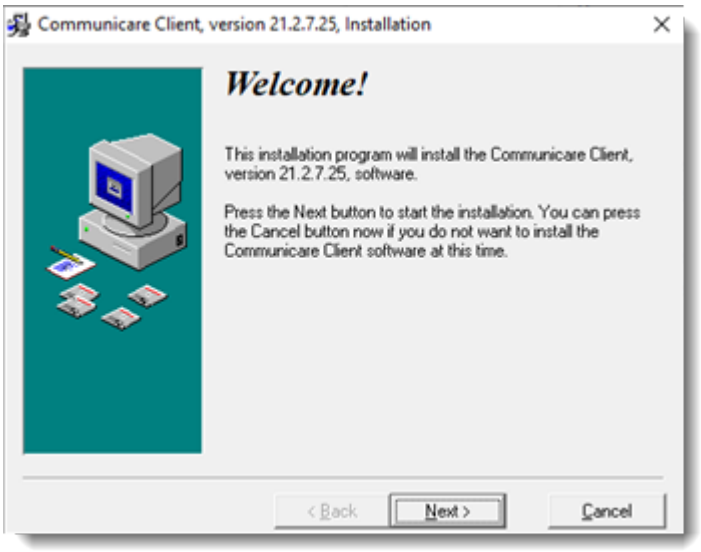
To install Communicare clients you must be on the same network as your Communicare server. You can't be working remotely, unless you are on a Remote Desktop Server.

To install a Communicare client:

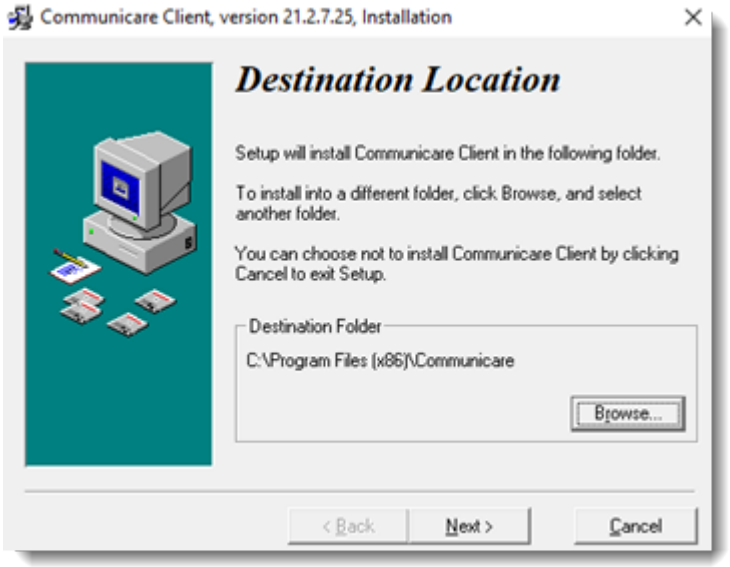
1. Right-click `\\Communicare_Server_Name\Install\CCare\Setup.exe` and select **Run as Administrator**.

> **Tip:**
> If you aren't sure of your Communicare server name, request it from your IT Team or Communicare Support.

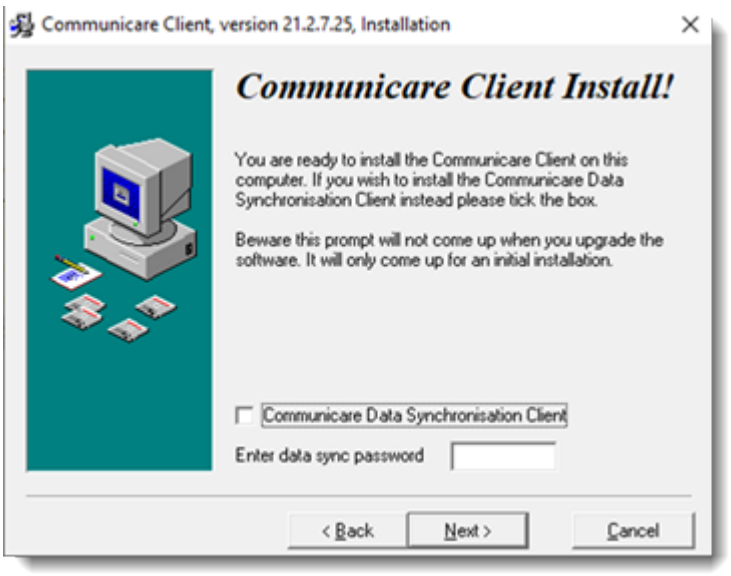
2. If there is a prompt, click **Run**.
3. In the **Welcome** window for the Communicare client, click **Next**.



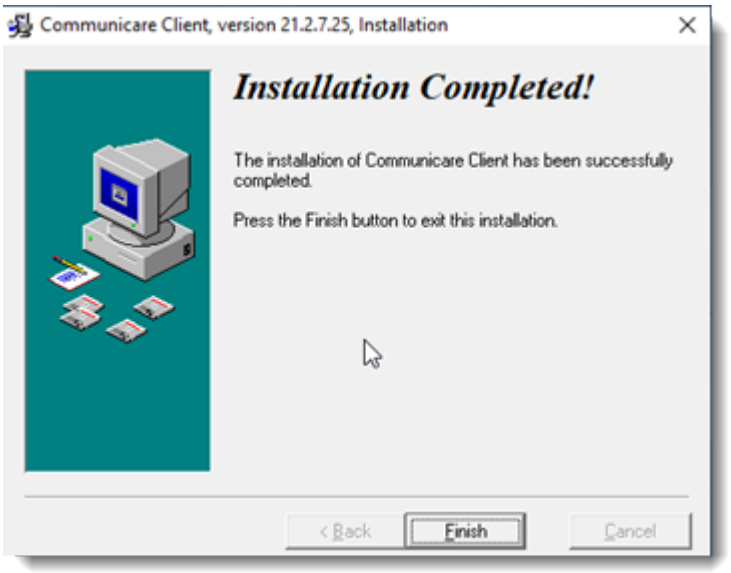
4. In the second **Welcome** window, click **Next**.
5. In the **Destination Location** window, accept the default installation location of `C:\Program Files (x86)\Communicare` and click **Next**.



6. If you are installing the offline client, set **Communicare Data Synchronisation client** and enter the Data Synchronisation installation password provided by Communicare Support. Alternatively, click **Next**.



7. In the **Important Information** window, read the information and click **Next**.
8. In the **Electronic End User License Agreement** window, click **Next** to agree to the End User License Agreement.
9. The installation begins and a progress bar is displayed. Installation will take up to 10 minutes. When the installation is finished, the **Installation Completed** window is displayed. To complete the installation, click **Finish**.



10. Communicare will offer to start. If you want to start using Communicare now, click **Yes**.

Communicare is installed to the location you selected and a Desktop shortcut is created automatically.

Upgrading Communicare clients

When the Communicare Server is upgraded, you must also upgrade the Communicare clients to the same version.

> **Tip:**
> Between Communicare versions, if a new immunisation is released, details about the immunisation are posted on the User Portal. Raise a request with Communicare Support to have your Immunisation Vaccine dataset updated, which will also update vaccine codes and formats that have been added to the AIR.

To upgrade a Communicare client:

1. Ensure that no users have Communicare open on the computer.

   > **Tip:**
   > Restart the computer before upgrading so that all Communicare clients for all users are closed.

2. Right-click `\\Communicare_Server_Name\Install\CCare\Setup.exe` and select **Run as Administrator**.

   > **Tip:**
   > If you aren't sure of your Communicare server name, request it from your IT Team or Communicare Support.

3. Click **Yes** in any pop-up windows.
4. In the **New Version Available** window, click **OK**.
   The set up files are downloaded from the Communicare server. The installation then proceeds and updates the Communicare client.

After the Communicare client is updated, Communicare opens automatically at the **Communicare Login** window.

Starting Communicare

Start Communicare as you would for any Windows application.

To start Communicare:

Double-click the  Communicare shortcut on your desktop, or run *`Communicare installation home`*`\Communicare.exe`.

Logging in to Communicare

Read the disclaimer and log in using your unique credentials. What you see in the Communicare application and database is restricted based on your log in credentials.

You will sign in to Communicare using either your Microsoft Windows credentials or specific Communicare credentials provided to you by your Communicare Administrator. You cannot log in if your username is inactive.

> **Note:**
> You should never share your log in details with anyone. Actions such as adding, changing and viewing data are recorded in the database by username, workstation, time and so on. This allows very good traceability and accountability. If you tell other people your password, they may impersonate you and their actions will be recorded as if they were your actions.

To log in to Communicare:

1. Read the disclaimer, and the important and warning information. Click **MIMS End User Licence Agreement** to read the EULA.
   If you have a licensing issue or wish to review your licensing agreement, contact Communicare Support.
2. If single sign-on is enabled for your health service using Windows Active Directory integration, your Microsoft Windows username and password are automatically included in the Login window. Click **Accept** to log in.
3. If instead of single sign-on, Communicare-specific credentials have been provided to you:
   a. In the **Username** field, enter the username provided to you.
   b. In the **Password** field, enter the password provided to you.
   c. Click **I Agree**.
   d. If your administrator set that you need to change your password, the **User Maintenance** window is displayed.
   Enter the password that was supplied to you, and a new password and click **Save**.

You are logged into Communicare.

If you had to reset your password, Communicare closes. Run Communicare again and log in using your new password.

When the offline version of Communicare (Data Synchronisation Client) is started, both the **Sync Download current as of** and **Sync Upload current as of** date and time are displayed:

- **Sync Download current as of** is the time at which the backup that was downloaded completed on the server. Data in that backup and available on the offline client is current from when the backup started, which may be an hour or more before the time displayed.
- **Sync Upload current as of** is the time that data was last successfully sent to the server. Uploaded data is available as soon as it has been processed by the server.

> **Tip:**
> If you have any trouble logging in, contact your local Communicare Administrator.

Communicare is automatically locked after 15 minutes of inactivity by default. To continue using Communicare, login again with the same password you used originally.

Unlock Communicare

Depending on where you are working in Communicare, if there has not been any activity detected for a defined period, Communicare may be locked automatically to keep you and your patients safe.

Communicare is automatically locked after 15 minutes of inactivity by default.

To continue using Communicare, login again with the same password you used originally.

Changing your password

You may be required to change your Communicare password when you first login or may change it later.

If you are required to change your Communicare password when you first login, you will be prompted to do so. Otherwise you may change your password as required.

In Communicare V23.1 and later with Firebird 4, passwords must meet the following requirements:

- Be at least 8 characters and contain no more than 255 characters
- Include at least one letter
- Include at least one number
- May include special characters

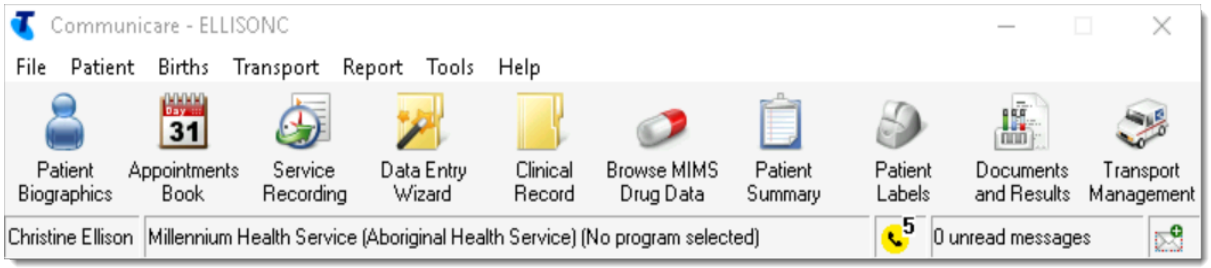
To change your Communicare password:

1. In Communicare, select **File > Change Password**.
2. In the **User Maintenance** window, in the **Old Password** field, enter your existing password.
3. In the **Password** field, enter your new password and again in the **Confirm Password** field.
4. Click **Save**.

Communicare closes. When you next log into Communicare, use your new password.

Main Toolbar

When you first open Communicare, you see the main toolbar and menu from which you access the different features in Communicare.



Tip:
Click a button to access that feature.

At the top of the Communicare toolbar window, the current user is displayed, below which is the menu bar. The menu bar largely duplicates functions performed by buttons. However, it also contains some infrequently used functions and functions that should be used with care, such as the capability to record the death of a patient.

Below the menu bar are the main Communicare toolbar buttons. The majority of Communicare's actions are performed using these buttons.

Note:
Some of these buttons will not be visible because of customisations made to your System Parameters.

Table 1. Main toolbar buttons

Button	Description	Module
Patient Biographics	Add patient records or view or amend patient details	Biographics *(on page 811)*
Appointments Book	Open the Appointments *(on page 54)* booking window.	Appointments *(on page 811)*

Table 1. Main toolbar buttons (continued)

Button	Description	Module
Service Recording	Record or display information about consultations and other services *(on page 86)*.	Service Recording *(on page 811)*
Data Entry Wizard	Use the Data Entry Wizard *(on page 165)* to add clinical items for multiple patients.	Data Entry Wizard *(on page 811)*
Clinical Record	Open a patient's Clinical Record *(on page 112)*.	Clinical Records *(on page 811)*
Browse MIMS Drug Data	Browse the MIMS Pharmaceutical Database *(on page 271)*.	Clinical Records *(on page 811)*
Patient Summary	Print a Patient Summary *(on page 533)* for the current patient.	Report Administration *(on page 811)*
Patient Labels	Print Patient Labels *(on page 532)* for the current patient. Especially formatted for letters, notes and sample bottles.	Report Administration *(on page 811)*
Documents and Results	Open Documents and Results *(on page 302)* to review electronic results and documents.	Investigations *(on page 811)* Electronic Documents *(on page 811)* Document Scanning *(on page 811)*
Transport Management	Open the Transport Services *(on page 81)* or Transport Management *(on page 82)* module, depending on which is enabled	Transport Management *(on page 811)* Transport Services *(on page 811)*

Tips

Navigating Records

Many Communicare forms display lists of records and use the same data navigation buttons, which are described here.

For example: 

The function of each of these buttons is as follows:

- Go to the first record in the list or set of records.
- Go to the previous record in the list or set of records.
- Go to the next record in the list or set of records
- Go to the last record in the list.
- Add a new record to the list.
- Delete the currently selected record.

-  Edit / change the currently selected record.
-  Confirm the changes made to the database.
-  Cancel the changes made.

Shortcut Keys

Use the listed keys and key combinations as shortcuts.

Any window

Use the following keys and key combinations from any window.

Table 2. Shortcut keys from any window

Action	Keys
Open Help to a page related to your location in Communicare	`F1`
Close the current, active window	`ALT+F4`
Call Request Remote Assistance *(on page 974)*	`CTRL+F2`

Communicare main window

If you have the rights, use these shortcuts when the main window is active, that is, it is the only window open or you have any of the following windows open: **Appointments**, **Service Recording**, **Clinical Record**.

To use shortcut keystrokes to the main menus, press `ALT` to underline the control letters in the menus, then press the required letter to open the menu. For example:

- Press `ALT+F` to open the **File** menu
- Press `ALT+F+T+P` to open the **Patient Group Maintenance** window, which is equivalent to selecting **File > Reference Tables > Patient Groups**

Table 3. Shortcut keys from the main Communicare toolbar

Action	Keys
Open Patient Search from which you can open  **Patient Biographics**	`CTRL+B`
Open  **Documents and Results**	`CTRL+D`
Open  **Drug Browser**	`CTRL+I`
Open Patient Search from which you can print  **Patient Labels**	`CTRL+L`
Write a new intramail message	`CTRL+M`
Open the **Intramail** window	`CTRL+O`
Open Patient Search from which you can open a  **Clinical Record**	`CTRL+R`
Open the **Scan Document** window from either the main toolbar or clinical record	`CTRL+S`

Table 3. Shortcut keys from the main Communicare toolbar (continued)

Action	Keys
Open the **New Letter** window from either the main toolbar or clinical record	`CTRL+W`
Open the **Automated Recall Types** window	`CTRL+ALT+A`
Open the **Address Book** from either the main toolbar or clinical record	`CTRL+ALT+B`
Open the **Clinical Item Type Maintenance** window	`CTRL+ALT+C`
Open the **Providers** window	`CTRL+ALT+P`
Open the **Qualifier Type Maintenance** window	`CTRL+ALT+Q`
Open the **Reports Search** window	`CTRL+ALT+R`
Open the **Session Templates** window	`CTRL+ALT+S`
Open the **Query Builder**	`SHIFT+CTRL+Q`
Open the **Load a query** window	`SHIFT+CTRL+S`
Open the **Communicare Templates** editor	`SHIFT+CTRL+T`

Clinical Record

Use the following keys and keystrokes within the Clinical Record.

Table 4. Shortcut keys in the Clinical Record

Action	Keys
Open the **Drug Browser** to select a medication for a prescription or medication order	`F9`
Go to the current progress note on the **Progress Notes** tab	`F10`
Open the **Clinical Terms Browser** and add a clinical item	`F11`
Add a manual recall	`F12`
If a medication order exists, open the **Administer and Supply Medication** window	`CTRL+F9`
Open the **Drug Browser** to select a medication to add to medication history	`SHIFT+F9`
Open the **Add Investigation Request** window and request an investigation	`SHIFT+F12`
If you have the Medication View right, jump to the **Medication Summary** tab	`SHIFT+CTRL+F9`

Service Recording

Use the following keys in the **Service Recording** window.

Table 5. Shortcut keys for Service Recording

Action	Keys
Filter the display	`F3`
Refresh the screen. **Tip:** Do this regularly.	`F5`
Record a patient's arrival	`F6`
Record the time a service started	`F7`

Table 5. Shortcut keys for Service Recording (continued)

Action	Keys
Record the time a service ended	`F8`

Appointments

Use the following keys and keystrokes in the **Appointments** window.

Table 6. Shortcut keys for Appointments

Action	Keys
Book the selected appointment	`CTRL+ENTER`
Cancel the selected appointment	`F2`
Cancel a whole session	`SHIFT+F2`
Refresh the appointment book	`F5`
Cancel Last Patient mode	`ESC`

Patient Search, Biographics

Press `ALT` and any underlined letter to go to that field or control. For example:

- Press `ALT+b` to move the cursor to the **Date of birth** field
- Press `ALT+m` to move the cursor to the **Medicare** field
- Press `ALT+e` to add a new patient

Entering Dates

In most situations, use one of these approaches to enter dates in Communicare:

- In a date field, type the date in that window's required format, usually dd/mm/yyyy
- Select the required date from the calendar

> **Tip:**
> If you are unsure of an exact date, such as a date of birth, use an approximate date that will be most accurate. For example:
>
> - If you know only the month and year, enter the day as the 15th of the month, `15/mm/yyyy`. Any error is at most half a month.
> - If you know only the year, enter the 1 July, `01/07/yyyy`. Any error is at most half a year.

Refresh Rates

Different modules in Communicare are refreshed automatically at set intervals.

You can also refresh a window manually at any time, using one of the following options:

- Press F5
- Click  **Refresh**
- Click **Refresh**

Table 7. Refresh Rates

Window	Automatic Refresh Rate (in seconds)	Description
Service Record List	60s or 120s	The service record list is automatically refreshed every minute if either the Service Recording window or the main Communicare window is the top level window and the Service Recording window has been idle for at least 10 seconds. If these windows are in the background, the service record list is refreshed every two minutes.
Progress Notes (historical notes)	60s	When two or more providers are working simultaneously in a clinical record, progress note changes are listed in the left pane in each of the other records every 60s when the changes are automatically saved and refreshed.
Private Billing Administration	30s	

Communicare Demo

Communicare Demonstration

You can download and assess the latest demonstration version of Communicare from the Communicare website.

To download the demo:

1. Log onto the User Portal at Communicare User Portal with your username and password. If you don't have an account, click **Create an account** and register.
2. In the **Product Updates** tab, click **Latest Version & Demo Downloads**, review the information and follow the instructions.
3. When the download is complete, run `CCDemo.exe` and follow the prompts in the installer.

Feature Demonstrations

You can also download a video demonstrating the new features in each release from the User Portal, Training website.

Tip:
To make sure you understand all the changes to Communicare, before upgrading check the release notes and feature demonstrations for each release between your current version and the version to which you are updating.

Demonstration Data

The demonstration version of Communicare contains sample data that you can use to test the functionality of Communicare. This section includes sample data that can be used to test specific modules.

Logging On

If you are using the demonstration version of Communicare, you can log in using any of the following users, no password is required.

Table 8. Demonstration acounts

Username	User Group	Provider	Role
ELLISONC	Doctors	Christine Ellison	General Medical Practitioner
NORRISD	Registered Nurses	Dianne Norris	Registered Nurse
HOLLINGSW	Health Workers	William Hollings	Aboriginal and Torres Strait Islander Health Worker
ADMINISTRATOR	System Administrator	Administrator and impersonates others	System Administrator

Organisations

Table 9. Demonstration organisations

Name	Uses
Millennium Health Service	Default organisation Has a HPI-O for use in CDA Documents

Encounter Places

Table 10. Demonstration encounter places

Name	Uses
Eastern Branch Clinic	Has a HPI-O for use in CDA Documents Associated with a NASH Org Certificate for My Health Record use
Millennium Health Service	Default Encounter Place Has a HPI-O for use in CDA Documents Associated with a NASH Org Certificate for My Health Record use
Northern Branch Clinic	Has a HPI-O for use in CDA Documents Associated with a NASH Org Certificate for My Health Record use
Western Branch Clinic	Has a HPI-O for use in CDA Documents Associated with a NASH Org Certificate for My Health Record use

Providers

Table 11. Demonstration providers

Name	Uses
Christine Ellison	Default Provider Has a HPI-I for use in CDA documents and My Health Record Access. Has Medicare provider number
William Hollings	Has a HPI-I for use in CDA documents and My Health Record Access
Diane Norris	Has a HPI-I for use in CDA documents and My Health Record Access
Molly Ayers	Has Medicare provider number
Jacob Barbour	Has Medicare provider number

Patients

Use the following demonstration patients to test different aspects of Communicare, where:

- IHI - the patient has a valid number and you can send and receive CDA documents for the patient (the standard format for eHealth Messages in Australia)
- My Health Record - the patient has a test My Health Record that you access
- MeHR - the patient is registered for MeHR in the NT
- Medicare - the patient has a valid Medicare number
- DVA number - the patient has a valid DVA number
- NCSR - the patient exists in the National Cancer Screening Register

Table 12. Demonstration patients

Name	IHI	My Health Record	MeHR	Medicare	DVA	NCSR
Vera Ashley Smith	✓	✓				
Martin Evan Brown	✓	✓	✓			
Theresa May A'Kay	✓	✓				
Avocado Connected			✓			
Celeb Adelaide Suzanne			✓			
Dot Diaz				✓		
Craig Duncan				✓		
Nicholas Lassiter				✓		
Alexandra Elmore				✓		
Frank Aldridge				✓		
Lucas Baird				✓		
Leo Armstrong				✓		
Joshua Baxter				✓		
Billie Baxter				✓		
Cheryl Hunt				✓		
Leroy Hunt				✓		

Table 12. Demonstration patients (continued)

Name	IHI	My Health Record	MeHR	Medicare	DVA	NCSR
Lexie Hunt				✓		
Aldo Hunt				✓		
Lincoln Polish					✓	
Tom Clock					✓	
Alan Gardener					✓	
Kaitlin Rivera						✓
Chantelle Mcdonald						✓
Anna Lau						✓

NCSR test integration

To connect to the NCSR:

1. On the **File > System Parameters > System** tab, set **NCSR Integration**.
2. On the **File > System Parameters > Web Services** tab, in the **National Cancer Screening Register (NCSR)** section, enter the following credentials:

   Table 13. Demo - NCSR credentials

Field	Value
URL	`https://fhirtest.emerging.com.au`
Certificate	*NCSR NASH org demo certificate*

For more information, see Enable NCSR integration *(on page 791)*.

> **Tip:**
> Use the demo patients who are enabled in the NCSR test environment described in Table 12: Demonstration patients *(on page 27)*.

Demonstration licence extension

Demonstration licences are valid for 3 months. If your licence expires and you still need the Demonstration version of Communicare, contact Communicare Support to discuss your options.

Help

Communicare provides the following help resources.

- Help in the product, responsive to the window you're in:
  - Select **Help > Communicare Help**
  - Press F1 in any window
  - Click Help when available
- Communicare Knowledge Centre

- Communicare User Portal
- Communicare Support

Audit Logs

User activity in Communicare is logged.

Logged activity includes:

- Logging on and off
- Changing user credentials, for example, password
- Changes to users and user groups, including when a system right is added or removed from a user group
- Clinical record access and actions:
    - Printing and previewing
    - Deleting clinical items
    - New adverse reactions
    - Reviewing or reassigning verbal orders
    - Delegating NCSR access
    - Consenting to My Health Record upload
- Opening **Documents and results** window:
    - Viewing results
    - Viewing documents
- Administrative actions:
    - Accessing and reviewing patient biographics
    - Marking a patient as deceased or reinstating the record for a patient marked as deceased
    - Deleting a patient record
    - Merging patient records
    - Changing a service record

If you need to review activity logs for an audit, for example for medico-legal investigations, contact Communicare Support.

Exit

Exit Communicare as you would for any other Microsoft Windows application. Either:

- Click Close
- Select **File > Exit**

The Communicare application shuts down on your computer workstation. If Communicare is running on a network, the application continues to run on the server and other computer workstations.

Administrative

Add and manage patients, manage appointments and manage transport.

Patients

Communicare uses the term *Patient* to refer to the clients of a health service.

All patient-related activities start by selecting a patient, either from the **Service Recording** window or from the **Patient Search** window.

Biographics

Biographics

Personal information about a patient is recorded in patient records in Communicare. Use the Patient Biographics window to add, edit and review patients' personal information.

Click  **Patient Biographics** to display patient search *(on page 42)* and add or edit a patient's information.

Personal information is divided into the following groups, displayed on separate tabs:

- **Personal**
- **Social**
- **Administration**
- **Identifiers** - if enabled
- **Additional** - if enabled, custom fields unique to your Communicare installation

After a particular type of information is set in patient biographics, it can't be edited except by users with Patient Edit system rights included in their user group *(on page 842)*.

Although most fields are optional in Communicare, some demographic information may be required by government bodies.

Biographics - Personal

Record personal patient information on the **Personal** tab. All patient records require at least one name and one home address. For most health services, all other data is optional. However, for some large health services you may be required to provide more information.

Table 14. Biographics information - Personal tab

Field	Description
Sex*	Ensure you set a patient's sex if you want to generate sex-based recalls automatically. Changing a patient's sex does not affect existing recalls or create new recalls. If new recalls appropriate to the new sex are required, either delete the patient and add the person as a new patient or manually adjust the recalls already generated. Choose from the following options: • `Female` - sex at birth was recorded as Female. Coded as 'F' or '2'. • `Male` - sex at birth was recorded as Male. Coded as 'M' or '1'. • `Indeterminate` - sex at birth was recorded as Indeterminate. Coded as 'D' or '3'. • `Intersex` - sex at birth was recorded as Intersex. Coded as 'I' or '3'. • `Not Stated` - sex at birth was recorded as Not Stated. Coded as 'N' or '9'. • `Unknown/Inadequately described` - sex at birth is currently unknown or inadequately described. Coded as 'U' or '9'. If sex is not set, it can be added by anyone with access to biographics. **Note:** Some external bodies do not yet recognise sexes other than Male or Female. For example, AIR uploads and Medicare card verification fail if a patient has a sex that is neither Male nor Female. In Communicare, recall rules and qualifier definitions have been adapted to allow rules to be set up for patients with a recorded sex other than Male or Female.
Date of Birth*	Ensure you provide an exact or approximate date of birth if you want to generate age-based recalls automatically. If you don't know the exact date of birth, enter an estimate and set **Estimated**. Changing a patient's date of birth does not affect existing recalls or create new recalls. If new recalls appropriate to the new date of birth are required, either delete the patient and add the person as a new patient or manually adjust the recalls already generated. A date of birth is not generally required. However, to receive ePrescriptions, the patient must have a date of birth specified. If the date of birth is not set, it can be added later by anyone with access to biographics.

Table 14. Biographics information - Personal tab (continued)

Field	Description
Gender*	(Optional) If this option has been enabled for your health service, if a patient's gender is different from their sex at birth, select a gender from the list. The default gender values are: • `Brotherboy` • `Cisgender` • `Gender non-binary` • `Other` • `Questioning` • `Sistergirl` • `Transgender Female to Male` • `Transgender Male to Female` Gender values can be customised for your health service. These values can also be captured in the `Gender Information` clinical item.
Pronouns*	(Optional) If this option has been enabled for your health service, set the pronouns by which a patient prefers to be referred. The default pronouns are: • `He/Him/His` • `She/Her/Hers` • `They/Them/Theirs` Pronoun values can be customised for your health service.
Names - **Forenames** and **Family Name**	(Required) Provide at least one family name for a patient. You can enter multiple names for a patient, but they must have only one preferred name. The patient's preferred name is used throughout Communicare, except in the following areas where the Medicare name is used instead: • Prescriptions • Pathology and Radiology requests • Billing documents • Verify Medicare details and IHI number If the given names are not set, they can be added by anyone with access to biographics.

Table 14. Biographics information - Personal tab (continued)

Field	Description
Indigenous Status	Leave blank or select one of the following options: • Aboriginal but not Torres Strait Islander - patient is of Aboriginal but not Torres Strait Islander origin. Coded as 'T' or '1'. • Torres Strait Islander but not Aboriginal - patient is of Torres Strait Islander but not Aboriginal origin. Coded as 'T' or '2'. • Both Aboriginal and Torres Strait Islander - patient is of both Aboriginal and Torres Strait Islander origin. Coded as 'T' or '3'. • Neither Aboriginal nor Torres Strait Islander - patient is of neither Aboriginal nor Torres Strait Islander origin. Coded as 'F' or '4'. • Not applicable - a non-patient of some description, for example, Unidentified. • Not stated/inadequately described - patient has declined to state their Aboriginality or the response is inadequately described. Coded as '9'.
Addresses	Provide a home address for a patient. At least a **Locality** is required. To receive ePrescriptions, the patient must have an address specified in at least **Line 1**.
Contact details	Provide phone numbers and an email address where available. From the **Prescription Format** list, select the format in which this patient would like to receive their prescriptions. This format will be set automatically when a prescriber finalises a medication. Select from: • `Printed Prescription` • `SMS ePrescription` • `Email ePrescription` • `Printed ePrescription Token` If no option is selected, the prescriber must select a format for each prescription. **Tip:** Patient's must have a IHI number to receive ePrescription tokens.
Identification numbers	• **Patient ID** - internal identifier for a person automatically generated by Communicare. • **IHI Number** - current Individual Healthcare Identifier assigned to the patient. Communicare validates a patient's IHI automatically using their Medicare number or DVA number. For more information, see Individual Healthcare Identifiers (IHI) *(on page 632)*. The text colour is dependent on the validation status. • **MRN** - an extra search term you can enter to help you find the patient. Required for WACHS. • **MeHR** - for patients in the Northern Territory, the MeHR identifier, validated against the MeHR repository when the biographics are saved.

Table 14. Biographics information - Personal tab (continued)

Field	Description
Medicare	Enter the patient's Medicare details if known. If electronic claiming is enabled for your service, to verify the patient's Medicare details with Services Australia, click **Check Card Online**. The most recent, saved, Medicare verification status is displayed in the **Medicare** pane: • `Unknown` - never validated. To verify the patient's Medicare details, click **Check Card Online**. • `Valid` - the Medicare details were valid at the date shown in the **Last Validated** field. • `Error` - Communicare could not connect to Services Australia. The date of the previous check is shown in the **Last Validated** field. **Tip:** Out-of-date or incomplete Medicare information is highlighted in yellow. The following information must be included in the biographics for an OPV check to occur: • Name • Date of birth • Sex • Medicare card number or reference number
CentreLink	If the patient holds a CentreLink card, enter the CentreLink number and select the card expiry and type of card from the following options: • HCC - Health Care Card • No card - leave the other CentreLink fields blank • Pension • Seniors - Commonwealth Seniors card
DVA	If the patient holds a DVA card, enter the DVA file number found below their name (this is different to the card number). Also select the card expiry and the type of card from the following options: • Blue • Gold • Green • No card • Orange • Unknown File no. • White
PBS Safety Net	If a PBS Safety Net card has been provided to the patient by a pharmacist, enter both the number and expiry date. Out-of-date or incomplete Safety Net information is highlighted in yellow.

*If no value is recorded for this field, `Not recorded` is displayed throughout Communicare, including in the following locations:

- Patient Banner *(on page 120)*
- Patient Search *(on page 42)*
- Letter Writer *(on page 319)*
- Patient Summary *(on page 533)*
- Investigation results *(on page 309)* & matching *(on page 309)*
- Service Recording *(on page 88)* & Select Service *(on page 94)*

Biographics - Social data

Record demographic and next-of-kin information on the **Social** tab. Depending on the configuration for your health service, some of these fields may be compulsory.

Table 15. Biographics information - Social tab

Field	Description
Additional kin information	Add names of family members, their status (either Live-in or Deceased) and relationship to the patient. If the family member is a patient of your service, in the **Name** field, click **...**Ellipsis and select their name from the database. Otherwise, type the relative's details. The status of a family member who is linked to another patient record is updated automatically if their death is recorded. If the **Structured Contacts** system module is enabled for your Communicare installation, record the following kin information. If the family member is a patient of your service, click **Link** and select their name from the database. Otherwise, type the relative's details. • **Inactive** - determines whether the kin is active or not • **Title** - kin title (mandatory) • **Given Names** - kin given name (mandatory) • **Family Name** - kin family name (mandatory) • **Relationship** - kin relationship to the patient (mandatory), for example, `Aunt` • **Contact Role** - kin role (mandatory), for example, `Nearest Relative`. This entry must be unique across all kin for the current patient, except if the value is `Other`. **Tip:** Set to `Emergency Contact` to add this person's details to the **Emergency contact** fields and to include in the emergency contact data objects in the letter writer. • Address Line 1 - address of the patient kin • Address Line 2 • Locality - kin locality • Home Phone - kin home phone number • Work Phone - kin business phone number • Mobile Phone - kin mobile phone number • Email - kin email address • Inactive date - if the kin is inactive, enter the date from which this applies • Preferred Phone - preferred phone option, Home, Work or Mobile For structured contacts, active kin are displayed in bold and listed before inactive kin.

Table 15. Biographics information - Social tab (continued)

Field	Description
Birth Plurality	Indicate whether the patient was part of a multiple birth. Select the number of births arising from a single pregnancy including the patient. If you select `Singleton`, **Birth Order** is set to **Singleton or first of a multiple birth** and disabled.
Birth Order	If a patient was part of a multiple birth, select the patient's birth order.
Emergency contact	Specify the name, phone number and relationship of who to contact in an emergency. If the **Structured Contacts** system module is enabled, these fields cannot be edited. Kin added to **Additional kin information** with a **Contact Role** of `Emergency Contact` are displayed here and are included in the emergency contact data objects in the letter writer.
Usual GP (external)	If your organisation is not the usual GP for the patient, specify the person or a practice who is. To select a GP from your address book, click  Ellipsis.
Family members on same Medicare card	A generated list of all family members on the same Medicare card as the patient, which cannot be edited.
Skin	If applicable, select a skin type from the list relevant to your patients or region.
Preferred Language	Select the patient's preferred language from the list. By default, English, supplementary codes and languages used by other patients in the system are shown. To list all available languages, click **All Languages**. The descriptions come from Australian Standard Classification of Languages, ABS Catalogue No. 1267.0. This set includes an extensive break down of Aboriginal languages.
Spoken At Home	As for the Preferred Language, select the language spoken by the patient at home.
Country of Birth	Select the patient's country of birth. Required for WACHS. By default, Australia, supplementary codes and countries used by other patients in the system are shown. To list all available countries, click **All Countries**. The descriptions come from Standard Australian Classification of Countries, ABS Catalogue No. 1269.0.
Place of Birth	Enter the locality of birth.
Marital Status	Select the ABS Registered marital status, Catalogue No. 1286.0. This classification is not the same as Social marital status, mentioned in the same document. It groups de facto and registered marriage together as Married. Required for WACHS.
Residential Status	Select the patient's residential visa status. Required for WACHS.
NDIS Status	Select whether the patient is eligible or registered for the National Disability Insurance Scheme, or the status of their application.
NDIS Number	For registered NDIS recipients, record their NDIS number.
Occupation	Enter the patient's occupation.

Table 15. Biographics information - Social tab (continued)

Field	Description
Interpreter Required	Set if the patient requires an interpreter. Required for WACHS.
Interpreter Language	If the patient requires an interpreter, the required language or language group.

Biographics - Administration

Record administrative information about the patient on the **Administration** tab.

Table 16. Biographics information - Administration tab

Field	Description
Administration Notes	Record any relevant notes. Do not record sensitive information in this section.
Pop-up Alert Notes	Record alerts to be displayed in a pop-up window in Appointments, Service Recording and the Clinical Record. Do not record sensitive information in this section.
Patient Status	Select the patient status for the current health service. By default, the status is set to `Current Patient`. Select from: • Banned 30 days • Banned 60 days • Current Patient • Fictitious Patient • Non Patient • Past Patient • Transient Patient
Current Group Memberships	Set the groups to which the patient belongs. Click **Advanced** to review the dates on which a patient joined or exited a group. For more information, see Group Memberships *(on page 48)*. For information about adding a group, see Patient Group Maintenance *(on page 865)*.
Registered for CTG Co-payment Relief	Set if a patient is Aboriginal and/or Torres Strait Islander and is registered for Close-The-Gap co-payment relief. If set, prescriptions can be marked for CTG co-payments for this patient.
Registered for PIP	Set if your health service is a patient's usual care provider, is Aboriginal and/or Torres Strait Islander, is 15 and over, and you have registered them with *Practice Incentives Program Indigenous Health Incentive*. Under the PIP IHI, your health service receives incentive payments for patient registration and preparation and review of some care plans. For more information, see https://www.servicesaustralia.gov.au/apply-for-practice-incentives-program
Special Checkbox & Special Lookup	If Special options are set up for your service in System Parameters - Patient *(on page 819)*, they are displayed in these fields. These options are relevant to your own situation and can be used as selection criteria in your reports.
Special Patient Check	If the **Special Patient Check** is enabled in System Parameters - Patient *(on page 819)*, set if you have completed the **Patient Check** for this patient.
Existing File	Existing paper file identifiers or numbers for a patient, their encounter place and whether this is their primary encounter place. Each patient can have multiple file numbers with different file numbers stored against each eligible encounter place within the current organisation. An encounter place is eligible if it has been marked as a record-storage place.

Table 16. Biographics information - Administration tab (continued)

Field	Description
Private Patient	Shows the person responsible for the patient's account, by default the patient. To add a person other than the patient who is responsible for paying the account, click **Manage Payer(s)**. To view previous transactions, click **Transaction History**.
Virtual Health Monitoring	If your health service is integrated with virtual health monitoring, such as My Care Manager, and this patient is being monitored, set the patient's monitoring status in Communicare. Choose from: • `Active` - the patient is being monitored • `Inactive` - the patient is not being monitored • `Suspended` - the patient is normally monitored, but monitoring is suspended. This can be for various reasons, such as, the patient is in hospital care, is away from home, and so on. For more information, see Virtual health monitoring *(on page 803)*.
Information Sharing Consent	Record the patient's consent to having documents uploaded to their My Health Record. See My Health Record Upload Consent. (To register the patient for My Health Record, see Registering patients with MHR *(on page 54)* for more information.) If you have a single database in your organisation used by multiple health services, record the patient's consent to information sharing. For more information, see Information Sharing Consent *(on page 41)*.

Biographics - Identifiers

Identifiers from external systems or clinics are recorded on the **Identifiers** tab. Edit these identifiers if required.

If on **File > System Parameters**, **Patient** tab, **Enable Extended Identifiers** is enabled, edit external identifiers from external systems or clinics.

Biographics - Additional

If the **Additional** tab has been enabled for your site, use it to record additional information about the patient.

If extra custom fields are enabled for your Communicare installation, they are displayed on the **Additional** tab. For example:

- Australian South Sea Islander Status
- Funding Source
- Religion

If you require additional custom fields, contact Communicare Support. Communicare's Professional Services team will scope and implement this feature as a separate, paid service.

Changing Biographics

You can update a patient's existing data, including their Medicare details, and add new patient names and patient addresses to a patient record.

If you belong to a user group *(on page 842)* with the Patient Edit system right, you can also update a patient's sex, date of birth and preferred name.

Updating patient biographics

To change a patient's biographics:

1. Click  **Biographics** wherever it is displayed, or on the **Patient Search** window, click **Change Details** after performing a search.
2. In the **Change Person Details** window, update the required fields.
   Fields where information is missing are highlighted in gold.

   > **Tip:**
   >
   > It is useful to keep a history of addresses associated with a patient, so that when they move it is easier to locate them and their relatives.
   >
   > For new addresses, in the **Addresses** pane, always click +Add and add a new address rather than amending an existing address. If you do need to correct an existing address, edit the address and click **No** when asked if the patient has moved to a new address.
   >
   > To view previously recorded addresses, in the **Addresses** pane, click Back.

3. Click **Next** to step through the tabs and update information as required.
4. Click **Save**.

Reviewing Biographics

Review patients' biographic data regularly and particularly after patient records have been merged.

A patient merge removes all review details and patient biographics. See Patient Merge *(on page 51)* for more details.

To review a patient's record:

1. Click  Patient Biographics.
2. Enter the name of the patient whose record you want to review.
3. Double-click the required patient in the list.
4. Update any details.

   > **Note:**
   > It is useful to keep a history of addresses associated with a patient, so that when they move it is easier to locate them and their relatives. For new addresses, always click + Add and add a new address rather than amending an existing address. If you do need to correct an existing address, edit the address and click 'No' when asked if the patient has moved to a new address.

5. Click **Review & Save**.

Any changes to the biographic data and the username of the reviewer and date of the review are saved. Reviewer details and date are displayed in the **Review** section at the bottom of the **Personal** tab when the biographics are next opened.

Printing Blank Biographics Forms

To print a blank biographics form for a new patient to fill in:

1. Select **Help > Forms > Blank Biographics Form**.
2. In the PDF viewer, select **Print**.

Medicare details

Communicare performs validations to check that a patient's Medicare details are correct.

Patient Biographics

In the **Change Person Details** window, on the **Personal** tab, the Medicare verification status is displayed.

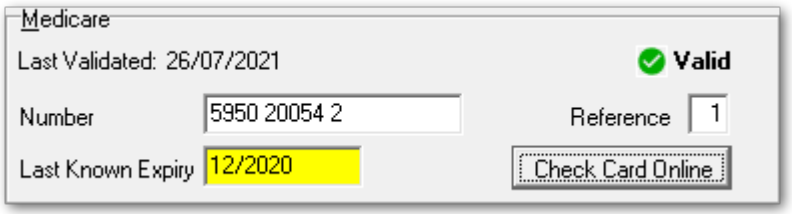
The most recent, saved, Medicare verification status is displayed in the **Medicare** pane:

- Unknown - never validated. To verify the patient's Medicare details, click **Check Card Online**.
- Valid - the Medicare details were valid at the date shown in the **Last Validated** field.
- Error - Communicare could not connect to Services Australia. The date of the previous check is shown in the **Last Validated** field.

> **Tip:**
> Out-of-date or incomplete Medicare information is highlighted in yellow. The following information must be included in the biographics for an OPV check to occur:
>
> - Name
> - Date of birth
> - Sex
> - Medicare card number or reference number

You can manually check the Medicare details of a single patient in their patient record:

1. Click **Patient Biographics** to open the patient search, and enter the patient's name.
2. Double-click the required patient or select the patient and click **Change Details**.
3. On the **Change Person Details > Personal** tab, in the **Medicare** section, click **Check Card Online**.



The patient's Medicare card number is sent to Services Australia using OPV and is validated against the details that Medicare holds.

In the **Service Recording** list, patient search, or other patient lists, for patients whose Medicare Card details are incorrect or incomplete, a  green card icon with a red slash through it is displayed. For patients with a valid Medicare card or whose details have been verified with Services Australia but with suggestions, no icon is displayed.

Information Sharing Consent

Health Services have access to any information they have recorded internally. If you have a single database in your organisation used by multiple health services, you can also share information recorded by other health services with the clients' consent.

Certain basic information (such as name and address) is always shared in order to facilitate patient lookup and basic file administration. Additionally, MBS claims made for patient services will be visible across all health services regardless of the consent process. This allows a health service to ensure that a claim has not already been made by another health service prior to performing a service.

To record information sharing consent, the following modules *(on page 811)* must be enabled for your organisation in File|System Parameters|System tab:

- Information Sharing Consent Maintenance
- Information Sharing Consent Recording

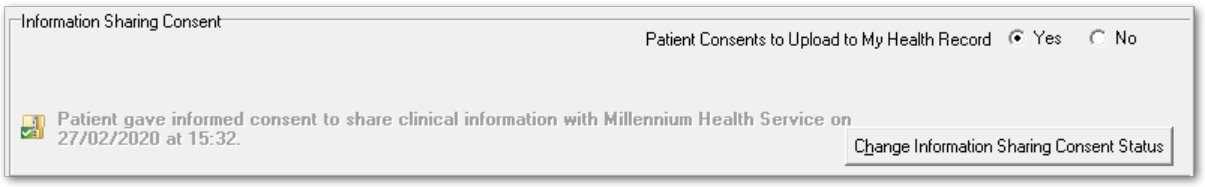
The user must also belong to a user group *(on page 842)* with the following system rights:

- Information Sharing Consent Maintenance
- Information Sharing Consent Recording

To record a patient's information sharing consent:

1. Click  Patient Biographics and open the patient's record.
2. On the **Administration** tab, click **Change Information Sharing Consent Status**.
3. In the **Information Sharing Consent** window, select from the following options:
    - `Sharing Clinical Information with Health Service Name not yet proposed` - you will have access to the common data plus any clinical information recorded by your health service and will be able to view and update information, within the constraints of your normal access and viewing rights.
    - `Declined proposed sharing of Clinical Information with Health Service Name` - you will have access to the common data plus any clinical information recorded by your health service and will be able to view and update information, within the constraints of your normal access and viewing rights.
    - `Give Consent to share Clinical Information with Health Service Name` - you will have access to any information recorded by your health service and clinical information recorded by any other health service within your organisation.
    - `Withdraw Consent to share Clinical Information with Health Service Name` - you will not have access to clinical information recorded by other health services.
4. Click **Close**.
5. In the Password required window, in the **Password** field, enter your Communicare password and click **OK**.

If consent was granted, the time and date are recorded on the **Administration** tab.



Patient Search

Use the patient search to select and work with the patient's record, or create a new record.

Patient search is displayed whenever it is necessary to identify a patient in Communicare, for example, when you open **Patient Biographics**, **Appointments**, or **Clinical Record**.

Before you add a new patient to Communicare, you should first do a thorough patient search to ensure that you don't already have a record in Communicare for that patient. See Adding a New Patient *(on page 45)* for more information.

Communicare uses the information you type into the patient search fields to produce a list of matching patients. Search by entering the following information:

- Patient name:
  - Search for both family name and given name in either order
  - For children, if you can't find a child, search with a given name of Baby Of to identify children who were entered before being given a name
- Date of birth - search by date of birth to identify patients whose surname has changed
- Medicare number
- Patient unique identifiers, **Patient ID**, **CentreLink No.**, **DVA No.**, **HPN** - deceased patients are automatically included in these search results
- Other patient identifiers - MRN, IHI
- Extended identifiers - for enterprise customers, to search using identifiers from external systems or clinics, first enable **Enable Extended Identifiers** on the **System Parameters > > Patient** tab

Use the following guidelines:

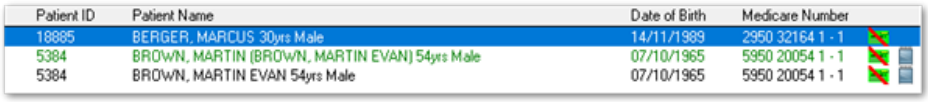
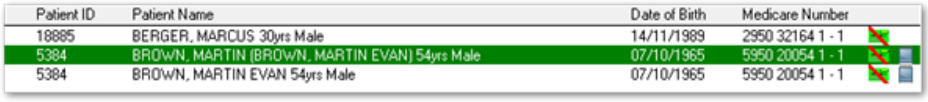
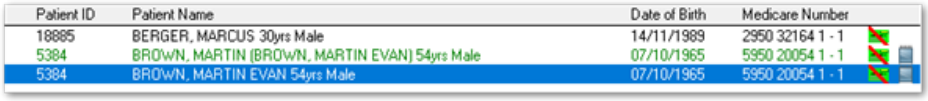
- The more information you provide, the more precise the search results are
- To display results as you type, set **Search automatically**. Results are refined as you add more information
- To enable Communicare to attempt to match search terms based on pronunciation, set **Phonetic search**
- To search by any other criteria stored in the database, click **Advanced**.
- To search on multiple criteria, on **System Parameters > Patient** tab, deselect **Single Field Patient Search**.
- Deceased patients are not included in the search results unless you set **Include deceased** or search by patient unique identifiers.

Results

- When you select a patient, the patient details panel summarises information from the patient record. Use this information to check that you have found the correct patient record.
- If the details panel is highlighted in gold, the patient has a clinical item in the specified group.

- The search returns all results that include your search term, including both preferred names and any aliases if they meet the search criteria, meaning that you can have more than one result for a single patient. If a record matching the search term is an alias, it is identified by colour in the search results. For example, a preferred name and an alias are returned for Martin Brown, using the search "MAR BRO" and displayed in the following ways:

Table 17. Patient search results with aliases

Description	Example
Aliases are listed in green text, preferred names are listed in black text	
When selected, an alias is displayed with white text on a green background	
When selected, preferred names are displayed with white text on a blue background	

- A green card icon with a red slash through it is displayed near the end of a patient's record if their Medicare Card details are incomplete. Click **Change Details** to complete the Medicare details. See Changing Biographics *(on page 38)* for more information.
- A notes icon is displayed at the end of a patient's record if there are notes entered on the **Administration** tab.

To open a patient record, double-click the patient name or click **Select Patient**. Once a patient has been selected, they remain the current patient until a new patient is selected. All patient information displayed and patient-specific reports are for the current patient. The name of the current patient is displayed prominently, usually in the title bar, with other identifying information for the patient, such as preferred name, age and so on.

Faster search

If you have a very large database, to speed up patient search:

1. In the **Patient Search** window, deselect **Search automatically**.
2. Type the details of the patient you would like to search for, with as much detail as possible.
3. Use the up or down arrow to move to the required patient in the list.
4. Press Enter to make a selection and open the patient record, or click **New Patient** to add a new patient record.

Advanced searching

Use the advanced search to compile a list of specific patients, based on any information stored in the database, including demographics. Any existing report that includes the Patient ID can be used in the search window. For example, to list all patients who live on a particular street, run Patients Search by Street Name; to list all patients in a particular age range, run Patients Search by Age.

To use advanced search:

1. In the **Patient Search** window, click **Advanced**.
2. In the **Load a patient query** window, select the patient query you want to run and click **OK**. See Patient Query *(on page 533)* for more information.
3. In the **Report Parameters** window, enter the required parameters and click **OK**.

Results

All patients whose record includes the specified parameters are listed. Double-click a patient to open their record.

To return to the regular Search window, click **New Search**.

EMPI Patient Search

If the EMPI Search module is enabled, you can search for patients from integrated systems. Click **New Patient** to go to the EMPI search window.

Using EMPI Patient Search

If the EMPI Search module is enabled, you can search for patients from integrated systems and include their existing details in a new clinical record in Communicare.

Before your health service can use the EMPI search, the following prerequisites must be met:

- EMPI Search module is enabled
- In **File > System Parameters > Web Services**, the EMPI Search path is configured

If the EMPI search is enabled for your health service, when you attempt to add a new patient, Communicare searches integrated systems for that patient and shows the matching results from the EMPI patient search.

To add a new patient when EMPI Patient Search is enabled:

1. Click  **Patient Biographics** to display patient search.
2. In the **Patient Name** field, enter the new patient's name.
3. If no matching patient results are returned, click **New Patient**.
4. In the **EMPI Patient Search** window, enter the new patient's information, including at least the given and family name.
5. Click **Search**. To return fewer matches, add more patient information and click **Search** again.
6. Select the patient in the list and click **Copy and Create New**.
7. If your patient is not found, click **Ignore and Create New**.
8. In the **Add New Person** window, complete any missing patient details.
9. Click **Save**.

Details from the EMPI, including preferred language, are imported into the Communicare patient record.

If custom fields are configured, they are added to the **Addtional** tab.

Browse For Duplicate Patient Records

Use **Browse For Duplicate Records** to locate all patient records that could be duplicates, based on name, sex and date of birth.

The following business rules apply:

- All patient names are considered when matching names but only the surname and the first initial are used to match. The surname needs only to be a fuzzy match (e.g. "FILIPS" = "PHILLIPS", "WALIAMS" = "WILLIAMS", "DELL" = "DELIA", etc.). Patients with no first name are included if the surname has a fuzzy match.
- Patients are only excluded by sex if each patient has a different sex - if one or both have no sex recorded, they are included.
- Patients are only excluded by date of birth if each patient has an age that differs by more than 2% either way. This effectively means that for a patient who is 50 years old, the search includes other patients who are up to one year older and one year younger; for a 25 year old this is narrowed to six months older or six months younger.

For information about how the merge is accomplished, see Patient Merge *(on page 51)*.

To find and merge duplicate records:

1. Select **Patient > Browse For Duplicate Records**.
2. In the **Browse For Duplicate Patient Records** window, the potential duplicate records are listed in the top and bottom grids. Click  Next to step through the records.
3. If you have checked the records and agree that two records are duplicates, ensure that the record you want to keep is in the top grid and the record that you want to merge into it is in the bottom grid and click **Merge the patient selected below into this patient**.
4. In the **Confirm** window, click **Yes**.

The records are merged.

Not all duplicate records will be identified. If you know of two records that are definitely duplicates, but have not been identified, use Patient Merge. See Patient Merge *(on page 51)* for more information.

Adding a New Patient

When a patient first makes contact with your encounter place, and before you provide a service to that patient, add a patient record.

Communicare Administrators can customise how addresses are recorded in the System Parameters and add extra localities in Locality maintenance.

All patient records require at least one name and one home address. All other data is optional. Use the same process to record addresses in urban, rural or remote areas.

To add a new patient:

1. Click  **Patient Biographics**.
2. In the **Patient Name** field, enter the name of the patient.
3. Check that the patient isn't listed and doesn't already have a patient record.
   Try the following searches:
   - Search with the family name and given name in either order to identify patients where the patient's name was originally entered incorrectly in reverse
   - Search by date of birth to identify patients whose surname has changed
   - For children, search with a given name of `Baby Of` to identify children who were entered before being given a name
4. Click  **New Patient**.

5. From the **Sex** list, select the patient's sex. Ensure you set a patient's sex if you want to generate sex-based recalls automatically.

> **Note:**
> Some external bodies including Medicare and the Australian Immunisation Register do not yet recognise sexes other than Male or Female.

6. In the **Date of Birth** field, enter the patient's birth date. Ensure you provide an exact or approximate date of birth if you want to generate age-based recalls automatically. If you don't know the exact date of birth, enter an estimate and set **Estimated**.
7. In the name fields, enter the patient's names:

    a. In the **Forenames** field, enter the patient's given names.
        - For named newborn babies, record their given names.
        - For an unnamed newborn baby, use the mother's given name in conjunction with the prefix `Baby Of`. For example, if a baby's mother's given name is Fiona, record `Baby Of Fiona`. If a name is subsequently given, record the new name as the forename and retain the newborn's family name.
        - For unnamed newborn babies from a multiple birth, use the mother's given name plus a reference to the multiple birth and birth order. For example, if the babies' mother's given name is Fiona and a set of twins are to be registered, record `Twin 1 of Fiona` for the first born baby, and `Twin 2 of Fiona` for the second born baby. For other multiple births, use the following naming convention:
            - Twins - use `Twin`, for example, `Twin 1 of Fiona`
            - Triplets - use `Trip`, for example, `Trip 1 of Fiona`
            - Quadruplets - use `Quad`, for example, `Quad 1 of Fiona`
            - Quintuplets - use `Quin`, for example, `Quin 1 of Fiona`
            - Sextuplets - use `Sext`, for example, `Sext 1 of Fiona`
            - Septuplets - use `Sept`, for example, `Sept 1 of Fiona`

    b. In the **Family Name** field, enter at least one family name.

8. From the **Indigenous Status** list, if applicable select the aboriginality of the patient.
9. In the **From** field, enter the date from which the address applies.
10. If the address, phone number and Medicare number are the same as that of the last opened and saved patient, to copy these details to the current patient, click  Use last patient's details.
11. In the **Line 1** field, enter the first line of the address, usually house number and street name.
    1 The Street.
12. In the **Line 2** field, enter the second line of the address, related to the first line. This line is usually blank.

> **Note:**
> Do not record separate addresses on line 1 and line 2 or use the address fields to record other information.

13. In the **Locality** field, start typing the locality, then select it from the list of preferred localities. If the required locality isn't displayed, set **All Localities** to select from all Australia Post localities.

> **Tip:**
> The selected locality provides the state and postcode, so you don't have to enter them.

14. Set one or more types of address, for example `Home`.
    Ensure that you set `Home` only for an address where the patient lives. A home address cannot be a P.O. Box. If only a mailing address is known, record the mailing address and also include a separate home address with only a locality specified. If the home address is genuinely unknown, set `Home` and select a **Locality** of `Other / elsewhere`.
15. Click **Add** and complete steps 11-14 for any other types of address, for example Contact and Mail.

> **Tip:**
> Use the arrow buttons to scroll between the addresses.

16. In the **Phone** field, record the patient's home phone number if available.
17. In the **Contact Details** section:
    a. In the **Work Phone** field, record the patient's work phone number.
    b. In the **Mobile Phone** field, record the patient's mobile phone number.
    c. If the patient doesn't have a phone, set `Patient has no phone`. If you set this option, any existing numbers are cleared from the phone number fields and the fields are disabled.
    d. In the **Email** field, record the patient's email address.
    e. From the **Preferred Contact** list, select how the patient prefers to be contacted or their preference not to be contacted. '
    `No Contact` is a patient opt-out of direct marketing material. It is not intended to prevent contact being made with a patient where a clinician is following-up on medical treatment. If a patient requests no contact, the extent to which this is respected should be governed by your privacy practices and discussed with the patient and their provider.
18. Set the identification numbers, Medicare, CentreLink, DVA and PBS Safety Net information where applicable. In the NT, see MeHR eRegistration *(on page 774)* for more information.
19. Click **Next** to step through the other tabs. Provide any applicable information.

> **Tip:**
> - A person is a current patient by default. If the person is not a current patient, set the patient status, including non-patient on the **Administration** tab.
> - If you want to provide additional kin information on the **Social Data** tab, the **Structured Contacts** system module must first be enabled for your Communicare installation.

20. Register the patient with My Health Record if required: click **My Health Record Registration**. See Registering patients with MHR *(on page 54)* for more information.
21. Click **Save**.
22. If the **Is patient already on the system?** window is displayed, all existing patients with similar sounding names, similar dates-of-birth and of the same sex are listed. Check the list carefully to ensure that you don't create a duplicate patient record in the database.
    - If the patient is on the list, select the patient and click **Yes**.
    - If the patient is definitely new to the health service, click **No**.

The patient record is added to your database.

It is useful to keep a history of addresses associated with a patient, so that when they move it is easier to locate them and their relatives. For new addresses, always click **+** Add and add a new address, rather than amending an existing address.

If you do need to correct an existing address, edit the address and click **No** when asked if the patient has moved to a new address.

Patient Status

Use **Current status** to indicate a person's primary relationship to your health service.

Current status is used in reports and analysis to accurately select only the appropriate people. For example, a **Recalls Due** report would normally be targeted at only current patients.

A person's status may be any one of the following:

- **Current Patient** - those who currently make use of the health service and whose information is thought to be up-to-date.
- **Transient** - those who make use of the health service on a temporary basis, and whose information may or may not be up-to-date.
- **Banned 30 days** - those who are disallowed from using the health service for 30 days from the date of banning.
- **Banned 60 days** - those who are disallowed from using the health service for 60 days from the date of banning.
- **Past Patient** - those who no longer use the health service and whose information is not thought to be up-to-date.
- **Fictitious Patient** - fictitious patients do not exist and are used for training purposes.
- **Non Patient** - people recorded in the system who are not patients. Non-patients are not included in most reports and are excluded from recalls, unless **Patient status** is set to **Non Patient**. If a non-patient becomes a patient of your clinic, ensure that you change their status to **Current Patient**. Examples of non-patients include:
    - People attending group activities, such as children attending Earbus
    - Patients who don't attend the service for their primary care, such as patients attending the dental service but who attend another clinic for their chronic disease
    - Anonymous needle exchange patients
    - HACC carer

A person can belong to only one status group at any one time.

To set the current status of a patient, in the Biographics record, go to the **Administration** tab, and from the **Patient status** list, select the required status.

To view a person's status history, click **Advanced**. For more information, see Group Membership *(on page 48)*.

When a person's death is recorded, the system automatically exits them from their most recent status group so that deceased people are automatically excluded from status-based reports.

Automatic Patient Status Change

Each day, the Communicare database is checked and one of the checks is to automatically adjust a patient's status if there has been a change. For more information about the rules by which a status is automatically changed, see Automatic Patient Status Change *(on page 933)*. The status of non-patients is never updated automatically.

Group Memberships

Use the **Group Membership** window to review the dates on which a patient joined or exited a group.

Normally it is not necessary to access this window. However, you might want to access the window to review or change details. For example, review the history of when a patient joined and exited a care program. A group may be joined and exited any number of times.

To display the **Group Memberships** window, on the **Administration** tab of a patient's biographics, click **Advanced**.

The details of all groups that a patient has ever belonged to are listed in the top pane. The details displayed for each group are:

- **Group** - the group's name, for example, `Current Patient`
- **Group Type** - the group's type, for example, `Patient Status`
    - **Continuous** - if a group type is continuous, after a patient is added to the group, they may move to other groups of the same type, but may not exit until death. Consider the `Patient Status` group type for example. A patient may start as a Temporary patient, become a Current patient, then a Past patient, then perhaps a Temporary patient once more. The patient is always a member of one Patient Status or other.
    - **Unique** - if a group type is unique, a patient may belong to only one unique group at a time. Consider again the `Patient Status` group type for example. Clearly, a patient cannot be a Current Patient and a Past Patient at the same time.

When you select a group, the dates on which the patient joined or exited the group are displayed.

If required, you can edit the following information:

- **Date Joined** - can be changed, but may not be before birth or after death.
- **Date Exited** - can be changed for group types that are not **Continuous**
    - Exit dates are adjusted automatically for Continuous membership group types to ensure there are no gaps. Communicare overwrites any changes you make to the exit date of a Continuous membership group type.
    - When a death is recorded, all groups are automatically exited on the date of death.

Deleting a Patient

You can delete fictitious patients from Communicare.

Note:
Duplicate patient entries should be merged rather than deleted. Deleting real patient records distorts statistics that may be required in the future. The delete function deletes the current patient record and all clinical items, service records and everything else related to the patient. It is an extreme measure and should not normally be required.

To delete a fictitious patient record:

1. In the main menu, select **Patient > Delete**.
2. Enter a name and select the patient record you want to delete.
3. In the **Delete Patient** window, type `DELETE`.
4. Click **OK**.

The patient record is permanently deleted.

Duplicate patient checks

When a patient is added to Communicare, a series of checks are done in an attempt to identify and prevent duplicate entries.

> **Important:**
> Ensure that each patient has only a single entry in the database.

When you enter a patient's details into the patient biographics window, Communicare checks the database and displays a list of patients with similar details. If a record matches your new patient, do not add a new record. Instead, continue with one of the listed patients by making a selection from the list.

Communicare attempts to match patient records based on the sound of the family name, the first initial of the first forename, and approximate date of birth.

To determine which patients may not be added to the database, additional tests are done on the exact family name, the start of the first forename, exact date of birth and the patient's IHI number. If Communicare does not allow you to add a new patient record because it is identified as a duplicate, but you are sure it is not a duplicate, check that all names are complete (including any middle names), and the date of birth is specified for both the patient you are attempting to add and the one the system claims is a duplicate. You cannot add a patient with the same IHI number as an existing patient; however, if one or both of the patients do not have an IHI number, you can add the new patient.

Recording the death of a patient

In Communicare, record when a patient dies. Deceased patients are excluded from many reports but will continue to be included if not marked as deceased.

To record a patient's death, you must belong to a user group with the `Clinical Records` system right.

All saved changes to a patient's deceased date (and therefore their deceased status) are logged to the database for auditing purposes.

To record the death of a patient:

1. Select **Patient > Death**.
2. In the **Patient Search** window, search for and select the patient.
3. In the patient's record, from the **Date of death** calendar, select when the patient died. If you don't know the exact date, select an approximate date and set **Date uncertain**.
4. From the **Cause of death** list, select a category. The list is based on the NT Coroner's report of common reasons for death (2017).
5. In the **Comment** field, add any other pertinent information.
6. From the **Death Notification Source** list, select how you were notified of the death of the patient.
7. From the **Death Verified** list, after verifying that the patient is dead, select `Yes`.
8. In the **Contributing factors** section, add any contributing factors if required:
    a. In the first row, from the list select a contributing factor, for example, `Smoking`.
    b. Click ✚Add. A new row is added at the top of the section. From the list select a contributing factor, for example, `Age`.
    c. Repeat step b until all factors are recorded.
9. Click **Save**.

The patient is recorded as deceased and does not appear in patient searches unless you set **Include deceased**.

Correcting Mistakes

If a patient is incorrectly marked as deceased, you can reverse the record.

To reinstate a patient:

1. Select **Patient > Death**.
2. In the **Patient Search**, set **Include deceased**, enter the full patient's name and select the patient.
3. In the patient's record, delete any contributing factors, comments, death notification source, verification, or cause of death.
4. Delete the date of death.
5. Click **Save**.

The patient is now no longer marked as deceased.

Patient merge

When a patient has been recorded twice in Communicare, use patient merge to combine the two records.

If the patient has been recorded more than twice, the merge can be used repeatedly to reduce the number of duplicate records one at a time.

During the merge, data is moved from the source patient's record into the destination patient's record, then the source patient record is deleted. In situations where data from the source patient also exists in the destination, the source data is discarded. For example, if the two records have different Medicare card numbers, the number from the destination patient is retained and the number from the source patient is discarded.

The following merge rules apply:

- Biographics information:
    - The earliest recorded date of birth is always retained.
    - If the date an address was added for the source and destination patients is different, both addresses are retained and the most recent address is made current. If the date an address was added is the same for the source and destination patients, only the destination address details are retained and made current.
    - The source patient's group memberships are discarded. To determine if any group memberships need to be manually added to the merged patient record, review the source patient's group membership history in the patient record: on the **Administration** tab, click **Advanced**.
    - De-duplication numbers and brackets, for example, `Fred Smith [1]` that may have been added by import programs are removed. Similarly, `CAUTION: POTENTIAL DUPLICATE` warnings are also removed.
    - The Patient ID of the source patient is removed from the system when the merge is complete.
    - If either the source or destination patient's biographic data had been confirmed as reviewed, i.e. the username of the reviewer and date of review was recorded in the biographics, this information is discarded during the merge.
    - For virtual health monitoring, the monitoring status of the destination patient is maintained and the status of the source patient is discarded.
- Clinical information:
    - If the same recall exists in the source and destination patients, the earlier recall is deleted and the later one is retained. In other words, where recalls are duplicated in the two records the recall is effectively moved to the later recall date. The only exception to this rule is if a recall has a comment. Commented recalls are never deleted.

    - NCSR alerts - alerts for the source patient are moved to the destination patient. If alerts exist for both the source and destination patient, whichever alert is the most recent is retained.
    - Other clinical data is combined, which may result in some duplication of information. The priority of the merge is to combine data from both sources with no loss, it is better to have a little duplication than to possibly lose valuable data. For example, if a procedure has been performed once but recorded in both patient records there will be duplicate entries.
- Medications:
    - Regular and once-off (either prescription or medication order) medications belonging to the source patient are moved to the destination patient.
    - Prescription IDs are updated and where there are duplicates, all but the latest regular medications with the same product, form, and pack combinations are stopped.
    - Medication requests and medication groups:
        - Inventory records are moved from the source patient to the destination patient
        - Medication requests are stopped and then moved from the source patient to the destination patient
        - Medication group numbers are recalculated
        - Medication group version records are moved from the source patient to the destination patient
        - If a medication request is part of a consolidated order, the consolidated order items are moved from the source to the destination patient. The consolidated order shows a status of `Error`.
    - Medications are listed on the **Medication Summary** and on the **Detail** tab of the destination patient.
    - The **Medication Summary** lists only the latest regular medication for a patient.
- Invoice information:
    - Invoices generated against the source patient are changed to the destination patient, with the default payer of the destination patient remaining the same. If the default payer of the source patient is the source patient themself, the default payer is changed to the destination patient. Otherwise it will remain the same.

If you are completing a routine audit of your records, you can browse for potential duplicates. See Browse For Duplicate Patient Records *(on page 44)*.

After you have identified the records that you want to merge:

1. Select **Patient > Merge**.
2. In the **Patient Merge** window, click **Select Source Patient**.
3. In the **Select the patient to move data FROM** window, search for the patient record, select it in the list and click **Select Patient**.
4. In the **Patient Merge** window, click **Select Destination Patient**.
5. In the **Select the patient to move data TO** window, search for the patient record, select it in the list and click **Select Patient**.
6. In the **Patient Merge** window, click **Merge Source into Destination**.
7. In the **Confirm Patient Merge** window, type `merge` and click **OK**.
8. Click **OK** and **Close**.

The patient records are merged.

Important:
Review all patient details after merging to ensure that everything is correct and up-to-date.

Errors can occur for a variety of reasons. When an error occurs, carefully read the error message and consider what it means and what needs to be done to resolve it. If you need assistance, contact Communicare Support *(on page 973)*.

You may encounter the following errors:

- `Address 'From' date may not be before date of birth.` - the source patient has an address record that is before the date of birth of the destination patient, so when the records are merged it appears as though we knew his address before he was born! Typically, this error occurs when an adult's record is being merged into a child's record, which would not normally be necessary. If the merge is still required, manually edit the **address from** dates in the source patient to be consistent with the date of birth (or date of death) of the destination patient.
- Patient status history may also be inconsistent in the same way as above. If this is the case we recommend you contact Communicare Support for advice before attempting to edit the patient status history.
- The source patient has a Centrelink card and number but the destination patient has `No card` specified - Communicare will leave `No card` alone but attempt to put the card number into the destination patient, causing an inconsistency that the database will report. Consider which is the correct data and manually edit the destination patient details before attempting to merge the patients.

Patient alert

If an alert is added to a patient's biographic information, a pop-up alert is displayed when the patient's record is opened.

Each time a user logs in to Communicare, the pop-up alert is displayed once in the following situations:

- When an appointment is made
- When a service record is created
- When the patient's clinical record is opened
- When a patient with a booked appointment arrives and is checked in

If the user logs out and logs back in again, the pop-up alert is again displayed once.

To add a pop-up alert to a patient record, in the patient's biographics record, go to the **Administration** tab, and in the **Popup alert notes** field, enter an alert.

When the **Patient Alert** window is displayed, you can take one of the following actions:

- To update the alert, in the **Patient Alert** window, **Message** field, enter new information and click **Keep with changes**.
- To close the alert if it is still relevant as-is, click **Keep without changes**.
- To remove the patient alert because it is no longer relevant, click **Delete**. The alert is removed from the database for all users.

Background Work window

The background work window is displayed when Communicare is busy and you must wait for the described background process to complete before proceeding with other actions.

For example:

Usually the process will be communicating with a third party such as Medicare's HI Service *(on page 632)* or the NT MeHR *(on page 824)*, and the wait is for data transfer to complete before saving a record or allowing one to be opened. The window may provide the option to cancel the process if required.

Registering patients with MHR

If the My Health Record Assisted Registration module is enabled in System Rights and you belong to a user group with the My Health Record Assisted Registration system right, you can register patients with My Health Record.

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Note:
My Health Record Registration is not available for offline clients.

To register patients with MHR:

1. In the Patient Biographics, click **My Health Record Registration**.
   The patient's IHI number is validated with Medicare if they have one.
2. If the following conditions are met, the **My Health Record Assisted Registration** window is displayed.
   - The current organisation has an HPI-O and associated NASH PKI Certificate for Provider Organisation, for My Health Record access.
   - The current organisation has a Medicare certificate for HI Access (Department of Human Services PKI Site Certificate) (**File > System Parameters**, **Web Services** tab).
   - The HI Service is enabled.
3. Complete the **Opt in Information Sharing** options.
4. Complete the **Identity Verification Code Delivery Method** fields.
5. From the **Identity Verification Method** list, select how you've verified the patient's identity.
6. Ensure that the patient consents to the information sharing and set the **Declaration**.
7. Click **Send Registration Details to My Health Record**.

When registration is complete, **Patient Consents to Upload to My Health Record** is set to **Yes**.

Appointments

Use Communicare appointments to book future appointments and record services provided without an appointment, for example, walk-in patients.

Note:
A standard activation fee applies. For more information, contact Communicare Support *(on page)*.

View appointments by provider for a specific date, by all dates or just for today. This provides easy analysis of workloads over time, either by the practice or for an individual provider.

Once an appointment has commenced (patient arrival), it becomes a service record. If required, service records may be entered without an appointment to facilitate walk-in patients and other reporting requirements.

Working with the Appointment Book

Use the **Appointment Book** to add sessions, book and change appointments, and check patient's in.

To open the **Appointment Book**, in the main toolbar, click  **Appointments Book**.

Sessions

Sessions with a type of *Weekly* are inserted automatically. As you open up booking days in the future, you may need to add new sessions into which you can book appointments, or you may need to add additional sessions at any time.

You can view only those appointment sessions created from templates with an Encounter Program to which you have access. Similarly, when adding Appointment sessions, only templates with Encounter Programs you have access to, or no Encounter Program specified, are available. For more information, see Appointment Session Templates *(on page 910)*.

You can insert a session with a type of *Manual* for any day. *Weekly* sessions can be inserted manually only for the day of the week for which they have been defined.

To insert a session into the appointment book:

1. In the **Appointment Book**, click  **Insert**.
2. In the **Session Templates List**, select the session you want to insert.
3. Click  **OK**.

The session is added to the **Appointment Book** unless it was not possible to insert the session because of overlaps between Providers or Facilities and so on. Repeat this process for all sessions that you want to add, including any walk-in sessions.

You can now add appointments.

> **Tip:**
> For walk-in sessions, add the patients to the **Service Recording** window was they arrive. For more information, see Adding walk-in patients to a service *(on page 62)*.

If your provider needs time set aside without any patient bookings, that is not already included as a provider planned absence, select a timeslot and click  **Reserve**. If the provider no longer needs this time set aside, select the reserved timeslot and click  **Unreserve**.

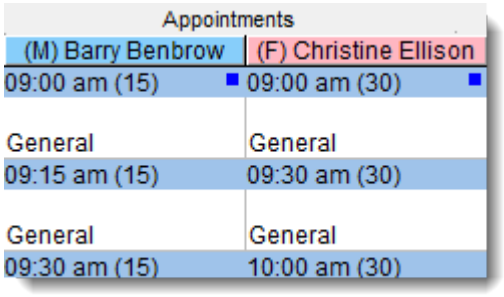
If you need to cancel a session, or part of a session:

1. In the **Appointment Book**, reschedule any appointments. See Cancelling and rescheduling appointments manually *(on page 59)* .
2. If you are cancelling part of a session, select the first appointment you want to cancel and click **Split** and in the **Confirm** window, click **OK**.
3. In the **Appointment Book**, click in the part of the session or the session that you want to cancel and click **Cancel Session**.
4. In the **Session Cancellation** window, type `session` and click **OK**.

The session or part of session is removed from the appointment book.

Booking appointments

The appointment book provides a one-day view. The sessions for a provider are listed in a single column. Each cell in the column is a single appointment timeslot. Different providers may have different length appointments, so times may not be aligned across the grid.



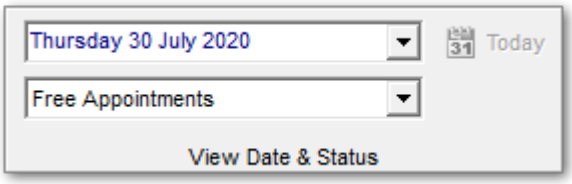
In this example, Dr Benbrow's appointments are 15 minutes long, while Dr Ellison's appointments are 30 minutes long. The time of the appointment and its length are displayed in the blue banner for each timeslot.

> **Tip:**
> Appointment timeslots during public holidays and planned absences are not displayed. Instead, a single cell is displayed giving details of the holiday or absence so that you can see why no appointments are available and when a provider will be back from leave.

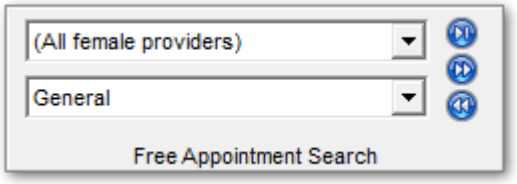
To book an appointment:

1. In the **Appointment Book**, if you have multiple sites, in the **Filter Place & Mode** pane, select a mode and place. This is important when multiple sites or separate waiting rooms are used. If you select an Administrative Encounter Place, appointments at all Service Encounter Places that belong to it are displayed.
2. If your health service books appointments from more than one workstation, to update your display to the latest appointment details, click **Refresh** or press F5.
3. Search for a free appointment slot:

- To search for a free appointment for today or a specific day, in the **View Date & Status** pane, select **Free Appointments**. The Appointment Book displays only free appointment timeslots.



- If there are no appointments available today, or for the selected date, to search for the next available appointment:
  a. In the **Free Appointment Search** pane, select which providers (all, female or male) and the type of appointment the patient requires.



  b. Click Play to go to the first day with available appointments.
  c. If there are no suitable appointments on that day, click Forward to go to the next day with available appointments or Back to go to a previous day with available appointments.

> **Tip:**
> To return to today's appointments, click **Today**.

4. If the patient requires a double appointment, select two adjacent timeslots and click **Merge**.

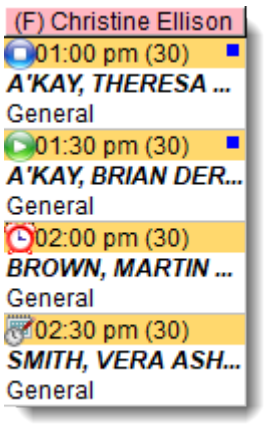
> **Tip:**
> If you later need to make this timeslot two single appointments again, select it and click **Unmerge**.

5. Select a free appointment timeslot and click **Book** or press CTRL+Enter.
6. In the **Select patient to book appointment** window (Patient search), enter the name of the patient for whom you're booking, select that patient in the list and click **Select Patient**.
   If you are booking for a new patient, first search for any existing record, then click **New Patient**.
7. The appointment is summarised in the **Appointment Details** window. Complete any extra booking information and click **Save**.
   For more information, see Appointment Details *(on page 58)*.

The selected patient is booked into the appointment timeslot.

Checking a patient in

In the Appointment Book, you can manage the appointment lifecycle: you can check in a patient when they arrive for their appointment and then monitor the progress of that patient through their appointment.



In this example:

- Vera's appointment is booked but she has not yet arrived
- Martin is checked in and is waiting
- Brian is seeing a provider (service in progress)
- Theresa has seen a provider and the service finished

Having already booked an appointment, to check a patient in when they arrive:

1. In the appointment book, select the patient.
2. Click **Check In**.
3. In the **Service Record** window, the date and time of arrival are automatically listed. Record any other information as required, including setting the priority. For more information, see Service Record - Detail *(on page 99)*.
4. Click **Save**.

The patient's status is changed to Waiting.

The other appointment status changes occur automatically when the service is started from the service record and the clinical record is closed.

To open a patient's biographic information from the appointment book, select the patient's appointment and click **Biographics**.

To view a list of all upcoming appointments for a patient, click **Services** and search for the patient. Deselect **Future Only** to view all appointments.

To take payment when a service is finished and the patient returns to reception, in the **Service Recording** window, double-click a patient and select **Edit Service Details**.

Appointment Details

When booking an appointment, after you have selected a timeslot and the patient, the **Appointment Details** window is displayed.

The patient's name and appointment information is displayed. You can't edit the appointment date or time here. Instead, click **Cancel** and move or reschedule the appointment.

To complete appointment details:

1. If you need to view or update the patient's details, click Biographics.
2. If required, in the **Booking Comment** field, add booking information. This is displayed as a service message in the **Service Recording** window. For example, the urgency of the appointment.
3. If required, in the **Operator Initials** field, enter your initials. If no initials are entered, the login username is instead recorded. If initials are entered, both the login username and the initials are recorded.
4. If you want to make this a double appointment, set **Append next timeslot**. Communicare merges this timeslot with the next if it is available.
5. If required, from the **Appointment Type** list, select the type of appointment. If you are booking an appointment from the **Incoming Referral Details** window, you must select an appointment type.
6. In the **Booking Requirements** list, set any booking requirements and type any comments.
   When the Transport Management module is enabled, any Transport requirement is replaced with the Transport Management *(on page 859)* functionality. To add a transport requirement with the relevant information from the appointment booking, set **Transport Management**. To display the transport requirements for the patient, select the blue **Transport** link.
7. Click **Save**.

Cancelling and rescheduling appointments manually

You can cancel or reschedule one or more patients' appointments in the **Appointment Book** at any time before the consultation starts.

In Communicare V21.1 and later, you can enable patients to reply to an SMS appointment reminder to confirm or reject the appointment. Patient replies are recorded in the **Appointment Book** and **Service Recording** windows. For more information, see SMS reply status *(on page 75)*.

To reschedule an appointment, you can either:

- Drag an appointment to a new timeslot, which cancels the original appointment
- Add a new appointment, then cancel the first appointment
- Queue the original appointment for rescheduling then add the rescheduled appointment. Using the reschedule queue allows the booking to be added to another session slot with the booking comments and requirements carried forward from the original booking. This is the best option if you want to cancel multiple appointments.

To cancel appointments:

1. In the **Appointment Book**, select the appointment you want to cancel.
   To select multiple appointments, press SHIFT + click.
2. Click **Cancel** or press F2.
3. In the **Appointment Cancellation** window, from the **Reason** list, select the reason for cancellation.
   If you select **Queue for rescheduling**, the patient is added to the reschedule queue. If you selected multiple patients, this is the only option available.
4. In the **Comment** field, add any other information. For example, `Provider sick`.
5. Click **OK**.

If you cancelled multiple appointments for rescheduling, a cancellation report is displayed. Print this out and use it to help ensure you reschedule all patients. The report cannot be printed later.

If you queued the patients for rescheduling, you can now reschedule the appointments.

Rescheduling appointments

If you cancelled appointments and queued the patients for rescheduling, you can reschedule the appointments.

Booking comments and requirements are copied from the original booking.

Appointments are listed in the reschedule queue until the original date and time of the appointment has passed. After that date and time, these appointments are still stored in the database but are not listed in the reschedule queue.

To display a list of appointments that were not rescheduled before the original date and time of the appointment has passed for follow up with patients who may still require an appointment:

1. As an administrator, select **Reports > Appointments > Reschedule Queue Details**.
2. Set a start date of any past date.

To reschedule appointments:

1. In the **Appointment Book**, select the next appropriate available appointment timeslot and click  **Reschedule**, or right-click and select **Reschedule From Queue**.
2. In the **Appointment Reschedule Queue** window, select the patient who you want to add to this timeslot. Details from the cancelled appointment are copied to the new appointment.
3. Click  **Select**.
4. In the **Appointment Details** window, add any required details and click  **Save**.

The appointment is booked with its original booking details and the cancelled appointment is removed from the reschedule queue.

Patients booked from the reschedule queue are no longer counted in the patient cancellation numbers. Those not rescheduled are included in the cancellation numbers with a reason of `Queue for rescheduling`.

Appointment timeslots

A timeslot is the period in which an appointment is booked. Timeslots can be of any duration.

Timeslots have the following characteristics:

- Number - controls the order of the timeslots within a session. Timeslot numbers are initially multiples of ten to facilitate easy insertion of new records.
- Start time - calculated by the system.
- Duration of the timeslot in minutes.
- Reserved - timeslots that can not be booked. Reserved timeslots are useful for breaking up a session to allow some free time.
- Release - time in minutes before which the timeslot can not be booked. For example, a 10AM timeslot with a 120 minute release cannot be booked before 8AM. Use release times to ensure that sessions are not completely booked too far in advance.
- Merged - consecutive timeslots may be merged to create a longer appointment time.

Use the Appointment Timeslot Template *(on page 916)* window to specify how the timeslots within an Appointment Session should be arranged.

Appointment session

An appointment session is the period of time for which a Provider and Facility are allocated to provide services. Sessions are normally divided into timeslots.

A Session has the following characteristics:

- Provider - who will provide service during the session.
- Appointment Facility
- Appointment Session Type
- Start Time - when the session starts
- Duration - how long the session lasts
- Last Walkin - the number of minutes before the end of the session that walk-in patients will be accepted into the session
- Default Timeslot Duration - how long timeslots normally last.
- Appointment Session Status
- Encounter Program - restricts the visibility of the session to those with access to the assigned Encounter Program

Appointment Session Status

Session Status is used to indicate the condition of sessions and session templates.

The status may be one of the following:

- Normal - the session or template operates normally.
- On-Hold - the template is ignored by the system. Use this status when setting up new templates that are not yet finalised.
- Cancelled - the session and all of its timeslots have been cancelled.

Appointment Session Insertion

The **Session Templates List** is displayed when you insert a session into the **Appointment Book**.

Sessions with a type of *Weekly* are inserted automatically. As you open up booking days in the future, you may need to add new sessions into which you can book appointments, or you may need to add additional sessions at any time.

You can view only those appointment sessions created from templates with an Encounter Program to which you have access. Similarly, when adding Appointment sessions, only templates with Encounter Programs you have access to, or no Encounter Program specified, are available. For more information, see Appointment Session Templates *(on page 910)*.

You can insert a session with a type of *Manual* for any day. *Weekly* sessions can be inserted manually only for the day of the week for which they have been defined.

To insert a session into the appointment book:

1. In the **Appointment Book**, click  **Insert**.
2. In the **Session Templates List**, select the session you want to insert.
3. Click  **OK**.

The session is added to the **Appointment Book** unless it was not possible to insert the session because of overlaps between Providers or Facilities and so on.

If there are errors in the **Template Application Log**, analyse the information and select a different session to insert.

Patient Appointment and Service History

From the **Appointment Book** or clinical record, use the **Service List** window to view a list of all upcoming appointments for a patient, and a patient's appointment and service history.

To view a list of all upcoming appointments for a single patient, including cancelled appointments, click  **Services** and search for the patient.

The **Service List** window is also displayed when an appointment is booked if the patient already has other appointments booked.

To view all appointments for the patient, including past appointments, deselect **Future Only**.

To book another appointment for the patient, click  **Book Appointment**.

To print a reminder slip for the patient, click  **Print all future appointments**.

Walk-in patients

Walk-in patients are those who arrive without an appointment. That is, they just walk in.

Add these patients to the **Service Recording** window.

Adding walk-in patients to a service

Add walk-in patients to a walk-in session, or if this session is very busy, or you don't have a dedicated walk-in session, add walk-in patients to a general session.

Patients are listed in the **Service Recording** window in priority order. The priority is determined by:

1. Priority - where 1 is the highest priority and 3 is the lowest. Exact priorities are determined by your organisation:
    - By default, all walk-in patients for a dedicated walk-in only session are assigned a priority of 2.
    - By default, walk-in patients in a General service are assigned a priority of 3.
    - By default, booked patients are assigned a priority of 2.
2. Sequence date:
    - For a booking that hasn't yet started, the booked time
    - For a patient who has arrived, the arrived or check-in time. If your organsiation has a grace period set and the patient arrives late for their appointment, the priority for their appointment may be lowered.
    - For a service that has started, the start time
3. Encounter number: two services with the same priority and sequence date are listed in the order created

> **Tip:**
> To apply basic triage to walk-in patients, ensure you set both the Priority and Service message when you enter a Service Recording. Develop standard service messages suitable for your encounter place.

To add a walk-in service:

1. In the Service Recording *(on page 86)* window, click Add.
2. In the **Add Patient to Service Recording** window:
    a. In the **Patient Name** field, enter the patient's name.
    b. Select the required patient from the patient list.
    c. Click **Select Patient**.
3. In the **Session Selection** window, select the required session from the sessions available today at your encounter place and click **Select**.
   If a walk-in session isn't available, it has either not started or has not yet passed the last walk-in time available. The number of patients waiting for the session and the scheduled end time of the session are listed.

   > **Tip:**
   > If you see a patient for an emergency on a public holiday or outside of hours when the practice is otherwise closed and there are no sessions available, click **Extra**. The encounter is recorded as a service of type `Extra` with no session. If you open a clinical record directly rather than from the **Service Recording** window, the encounter is always recorded as a service of type `Extra`.

4. In the **Service Record** window:
    a. In the **Providers** list, ensure that the Provider is correct.
    b. In the **Priority** list, select a priority for the patient. This determines the order in which patients will be seen if the provider is working from the top of the list.
    c. In the **Service message** field, enter supporting information for the priority. For example, `URGENT, head wound`.
    d. Check the other information for this patient.
5. Click **Save**.

Patients are listed in the **Service Recording** window in priority order. Providers can use this list as a guide to determine in which order to see patients, and open patient clinical records from the list.

If you added the walk-in patient to a General session, they are added to the end of the bookings, unless you have changed their priority. If you changed the walk-in patient's priority to the same or higher than the booked patients (generally a priority of 2), they are added to the Service Recording list before the next booked patient.

If a selection is cancelled, you can record the service without a session, as an Extra service. Extra services do not have a provider or encounter place assigned automatically. Set or change these manually.

Simultaneous Check-In

The **Simultaneous Check-In** window is displayed when checking in a patient who has more than one appointment today. It allows patients with multiple appointments to be efficiently managed through services with multiple providers.

Check-In

If patient has other bookings for the same Encounter Place, on the same day as the current record, when you check the patient in the **Simultaneous Check-In** window lists all appointments.

To check the patient in for all appointments:

1. Select all appointments in the list.
2. Click **Save**.

The arrival time for all selected bookings is set to that of the current record and the status of the patient is changed to *Waiting* for all appointments.

The service for each appointment then starts and ends as normal.

Withdrawal

You may want to withdraw a patient from some or all appointments on the same day. For example, a patient has three services booked for morning and three for the afternoon. The patient leaves before completing all the morning appointments but will return for the afternoon appointments

To withdraw the patient, for example, from the morning sessions:

1. In the **Service Record**, select the patient and click  **Withdraw**.
2. In the **Service Record** window, click  **Save**.
3. In the **Simultaneous Check-In** window, select all morning appointments for example, from which the patient is withdrawing.
4. Click  **Save**.

The patient is withdrawn from the selected appointments and any walk-in services at the same encounter place.

Appointment Cancellation Reason

Use the **Appointment Cancellation Reason** window to indicate a broad reason category for an appointment cancellation.

Comments can also be added to give a more detailed reason if required.

These are the defined cancellation reasons:

- Did not attend
- Rescheduled
- Queue for rescheduling
- Cancelled by patient
- Cancelled by service

Online Appointment Booking

Online appointment booking systems allow patients to find an available provider and appointment time slots 24 hours a day, without the need to interact with the health service to book an appointment.

Note:
A standard activation fee and additional charges apply. For more information, contact Communicare Support *(on page)*.

The `Online Appointment Booking` module allows external online appointment booking services, such as HealthEngine, to interface with Communicare so that appointments can be booked online. When this module is switched on, Communicare exposes the appointments book for enabled providers' session types, respecting the program rights associated with appointments.

Note:
This functionality is not available in the Communicare offline client.

Setup required

1. Contact Communicare Support to discuss online booking options.
2. Turn on the Online Appointment Booking module in **File > System Parameters**.
3. Select the program rights available for online bookings in **File > System Parameters > Appointments**.
4. Allow online appointment bookings for your organisation in **File > Organisation Maintenance**.
5. Set up the providers who will participate in online appointment bookings in **File > Providers**.
6. Set up the session types that will allow online appointment bookings in **File > Appointments > Session Types** and allow online bookings for these new online session types.
7. Ensure that the required appointment session templates have online session types attached in **File > Appointments > Session Templates**.
8. Insert the online session into the appointment book.

Communicare Support can now install the HealthEngine Appointment Connector. When this step is complete, you will be able check that the sessions that you made available for online bookings are displayed on your HealthEngine website.

Appointment Book report

Use the **Appointment Book** report to print the appointments book in a format that can be used in an emergency as a paper appointments book. It is also useful when reviewing the setup of the appointments book.

The visual layout of the report is similar to the appointment booking form, but is a list rather than a grid. One Provider is printed per page. Each cell of the report includes:

- Start Date/Time
- Duration
- Status
- Provider
- Appointment Session Type
- Facility
- Patient name
- Patient phone - this will be either the patient's Mobile Phone No, Home Phone No, or Work Phone No in that order. If the patient has no phone number recorded it will say `No Phone`.
- Booking comment
- Requirements

Cancelled sessions are automatically excluded from the report.

SMS Messages and Reminders

In Communicare V21.1 and later, you can send appointment reminders to patients using Telstra Health's SMS gateway (TH Messaging) and a new interface.

Note:
A standard activation fee and additional charges apply. For more information, contact Communicare Support *(on page)*.

Send SMS messages or reminders directly to individual patients from their biographics or clinical record, or SMS multiple patients automatically or manually.

Patient Privacy

All sites using SMS must be aware of the current direct marketing and privacy laws.

- Users must opt in to receive SMS messages.
- Users can opt out at any time to stop receiving SMS messages.

> **Tip:**
> If patients do opt out, on **Patient Biographics > Personal** tab, from the **Preferred Contact** list, select `No Contact`.

- Ensure that you document and manage these requirements.

For more information, see Office of the Australian Information Commissioner.

Enable SMS

To configure Communicare to send SMS with Telstra Health's SMS gateway (TH Messaging), enable the module and assign system rights to user groups.

Telstra Health's SMS gateway (TH Messaging) does not store message content. It passes along the complete message details using software components on both the Telstra and Telstra Health networks. The Message ID, sending phone number and receiving phone number are the only data that is stored on the server.

> **Tip:**
> You can continue to use the existing `SMS Feature` module until you exhaust your Burst credit. You should then swap over to the new SMS `Communications` module.

To enable SMS:

1. Request the new SMS Communications feature from Communicare Support. They will send you the contract forms and after you return the signed forms, set up your TH Messaging account.
2. Enable the module:
    a. Select **File > System Parameters > System** tab.
    b. In the modules list, set **Communications**.
    c. Click **Save**.
    d. Contact Communicare Support for today's security code. In the **Enter Authority Code** window, enter the code and click **OK**.
3. Assign access rights:
    a. Select **File > User Groups**.
    b. In the **User Group Maintenance** window, select the user group that you want to allow to create and manage SMS appointment reminder templates.
    c. On the **System Rights** tab, set **SMS Administration**.
    d. In the **User Group Maintenance** window, select the user group that you want to allow to send SMS appointment reminders.
    e. On the **System Rights** tab, set **SMS Messaging**.

f. Repeat steps a-e for all groups that will manage or use SMS appointment reminders.
g. Click **Save**.

After the Communications module is enabled:

- In the patient record and clinical record, when you click **Send SMS**, the Communications module is used.
- In the **Tools** menu:
  - **Send Bulk SMS** uses the Communications module
  - **Manage SMS Appointment Reminders** requires both Communications module and SMS Administration user right
  - All other SMS menu items that were previously available are hidden if SMS Feature is not enabled.

Users with the SMS Administration user right can now set up the SMS appointment reminder templates *(on page 68)* for group SMS appointment reminders for your health service.

Send direct SMS messages

Send SMS messages to individual patients from their biographics or clinical record.

If you have the Communications module or the SMS Feature module enabled and your user group has the SMS Messaging system right, you can send a direct SMS message to a patient from their clinical record or their biographics.

Tip:
An SMS cannot be sent to a patient if in the patient record, **Personal** tab:

- In the **Mobile Phone** field, there is no phone number listed
- **Patient has no phone** is set
- In the **Preferred Contact** field, No contact is selected

If both modules are enabled, the Communications module uses Telstra Health's SMS gateway (TH Messaging) to transmit SMS messages.

Remember:
Do not send confidential or sensitive information using SMS.

To send a direct SMS message to an individual patient:

1. In the clinical record or patient's biographics, click **Send SMS**.
2. In the **Send SMS Message** window, the patient's mobile phone number is displayed. The mobile number cannot be edited here.
3. In the **SMS Message** field, enter a message. The message is restricted to 320 characters.
4. Click **Send SMS**.

A new SMS Message clinical item is created in the clinical record on the **Detail** tab.

The status of the SMS message is displayed in the **SMS Send Status** field, initially with a status of `Pending`. The SMS message is sent when the `CCareQueue_Communications` service next runs. The message status in the clinical item is updated automatically when confirmation is received that the message has been sent or has failed.

Restriction:
You cannot delete the record of an SMS sent from Communicare, including from the **Detail** tab.

Send individual SMS using Burst

To send an SMS message to an individual patient using Burst:

1. In the clinical record, click **Send SMS**.
2. If you have sufficient credit to send a message, the **Send SMS** window is displayed with the patient's mobile phone number. This cannot be edited from the **SMS** window.
3. In the **Message** field, type a message. The message is restricted to 160 characters.
4. Click **Send SMS**.

A new `SMS Message` clinical item is created in the clinical record on the **Detail** tab. The **SMS Send Status** in the clinical item is updated automatically when confirmation is received that the message has been sent or has failed. If a phone number is invalid, the following message is displayed: `Send Failed (Phone number is not valid)`.

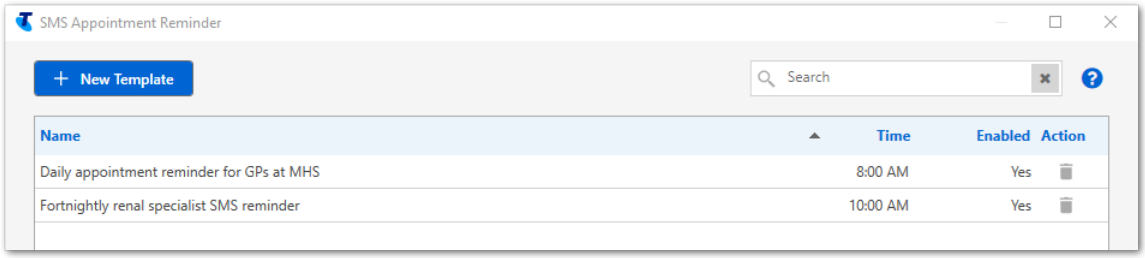
Restriction:
You cannot delete the record of an SMS sent from Communicare, including from the **Detail** tab.

SMS reminder templates

Use SMS appointment reminder templates to compose and schedule the SMS messages that are sent to individual patients automatically, depending on appointments and other filters.

To set up and manage SMS reminder templates, the `Communications` module which uses Telstra Health's SMS gateway (TH Messaging), must be enabled and you must belong to a user group with the `SMS Administration` system right.

To display the **SMS Appointment Reminder** window, select **Tools > Manage SMS Appointment Reminders**.



The **SMS Appointment Reminder** window lists all SMS reminder runs that have been scheduled for your health service. The time at which the reminder is scheduled to run is also listed.

Tip:
Before you create new templates, plan your templates to reduce the number of duplicate SMS messages sent to individual patients.

To search for a particular template, in the **Search** field, enter a word or phrase that appears in the template name.

To set up a new SMS reminder template, in the **SMS Appointment Reminder** window, click **New Template**. For more information, see Create SMS template *(on page 69)*.

To delete an SMS template that is no longer required:

1. In the **Action** column of the required template, click Delete template.
2. In the confirmation window, click **Yes**.

Create SMS template

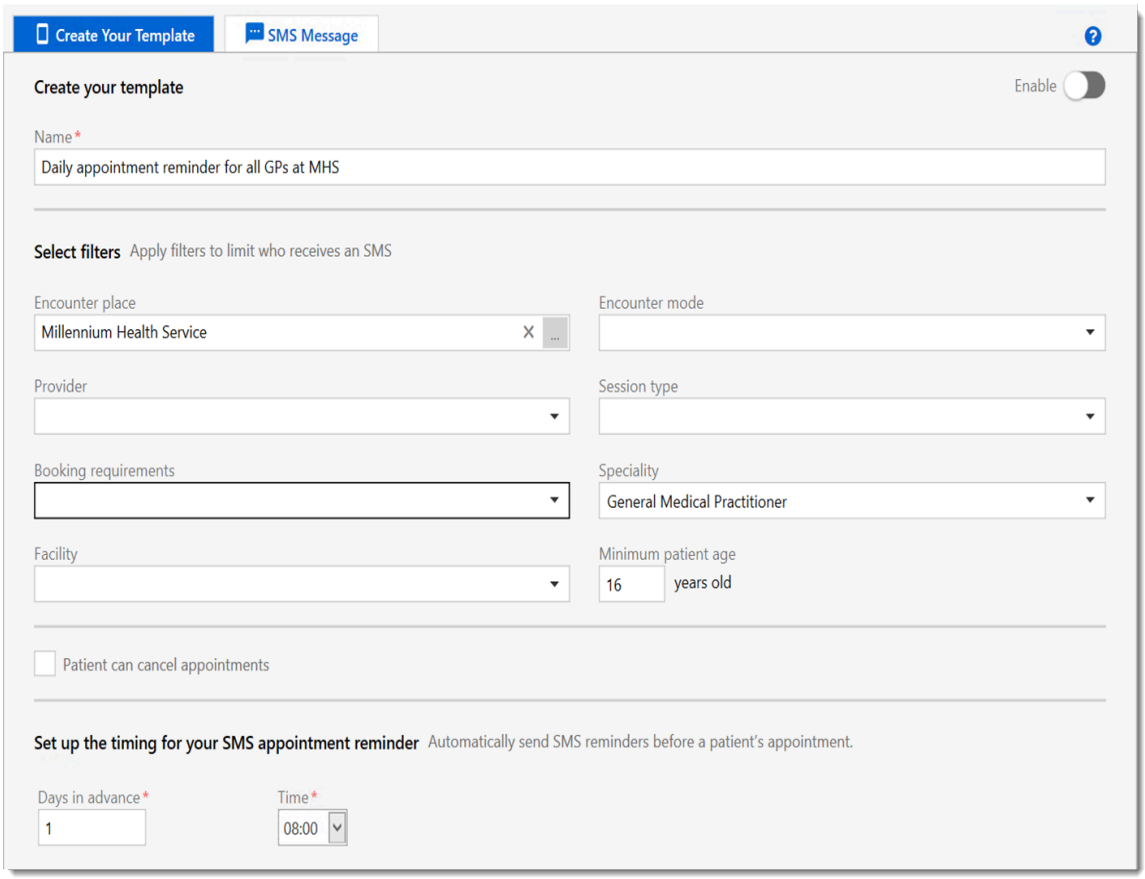
Add an SMS appointment reminder template for each different appointment reminder and frequency that you want to send.

To set up and manage SMS reminder templates, the `Communications` module which uses Telstra Health's SMS gateway (TH Messaging), must be enabled and you must belong to a user group with the `SMS Administration` system right.

Reminders can be sent up to 28 days before a patient's appointment.

To set up a new SMS reminder template:

1. Select **Tools > Manage SMS Appointment Reminders**.
2. In the **SMS Appointment Reminder** window, click **New Template**.



3. On the **Create Your Template** tab, in the **Name** field, enter a descriptive name for the template.
4. Optionally, add one or more filters to limit the recipients of the appointment reminder. Reminders are sent only for those appointments that meet all of the criteria you specify.

- In the **Encounter place** field, click the  ellipsis and in the **Select an Encounter Place** window, select the encounter place for which you want to send SMS appointment reminders and click **OK**.

  All enabled encounter places are listed. For grouped encounter places, if you select the parent encounter place, SMS appointment reminders are also sent to the dependent encounter places.
- If you want to restrict the SMS reminder to appointments only assigned to a particular encounter mode, from the **Encounter mode** list, select that mode.
- If you want to restrict the SMS reminder to appointments only for a particular provider, from the **Provider** list, select that provider. Only active providers are listed.
- If you want to restrict the SMS reminder to appointments for patients only attending a particular session, from the **Session type** list, select that session.
- If you want to restrict the SMS reminder to appointments only with a particular booking requirement, from the **Booking requirements** list, select that requirement. Booking requirements *(on page 58)* are set in the appointment.
- If you want to restrict the SMS reminder to appointments only assigned to a particular speciality, from the **Speciality** list, select that speciality.
- If you want to restrict the SMS reminder to appointments for a particular facility, from the **Facility** list, select that facility.
- If you want to restrict the SMS reminder to patients of a particular age and older, in the **Minimum patient age** field, enter an age in years. All patients who are this age or older will receive an SMS appointment reminder.

5. To allow patients to cancel appointments automatically by replying `N` or `No` (by default) to the appointment reminder SMS message, set **Patient can cancel appointments**.
6. Set up the timing for your appointment reminder. By default, the reminder is scheduled for 8am, 1 day before the booked appointment.

   a. In the **Days in advance** field, set the number of days before the booked appointment that this reminder is sent.
   Reminders can be sent up to 28 days before a patient's appointment. If you do set a 28 day reminder, appointments scheduled for a time of day after the reminder is sent will not receive a reminder because they are more than 28 days in the future. Schedule the reminder to run at the end of the work day or use a 27 day reminder limit.

   b. In the **Time** field, enter the time at which you want the reminder to be sent.

7. On the **SMS Message** tab, in the **SMS Template** field, enter a message.
   For more information, see Compose SMS message *(on page 71)*.
8. On the **Create Your Template** tab, set **Enable**.
9. Click **Save**.

Your new template is listed in the **SMS Appointment Reminder** window.

If you enabled the template, the template is run at the next scheduled time by `CCareQueue_Communications` and SMS messages are sent using Telstra Health's SMS gateway (TH Messaging), to all patients who meet the criteria specified in the template. The template does not consider any user, system or program rights.

Note:
`CCareQueue_Communications` is run once daily at the time specified in the appointment reminder template. Any appointments booked after the appointment reminders have already been sent will not receive a reminder.

For example, if *Daily appointment reminder* is run 1 day in advance at 8am, for any appointments booked after 8am on the day before the appointment, patients do not receive a reminder.

A new `SMS Message` clinical item is created in the clinical record of each recipient, on the **Detail** tab. The status of the SMS message is displayed in the **SMS Send Status** field, initially with a status of `Pending`. The SMS message is sent when the `CCareQueue_Communications` service next runs. The message status in the clinical item is updated automatically when confirmation is received that the message has been sent or has failed, or if the patient has replied.

Restriction:
You cannot delete the record of an SMS sent from Communicare, including from the **Detail** tab.

Patients can reply to their appointment reminder SMS.

- If you set **Patient can cancel appointments**, a negative response from a patient cancels their appointment. A confirmation of the appointment or no reply are indicated in the **Appointment Book** and **Service Recording** windows.
- If you did not set **Patient can cancel appointments**, replies from the patient are recorded in the **Appointment Book** and **Service Recording** windows. Cancel or reschedule appointments manually.
- Replies from the patient are recorded in their clinical record on the **Detail** tab.

Compose SMS message

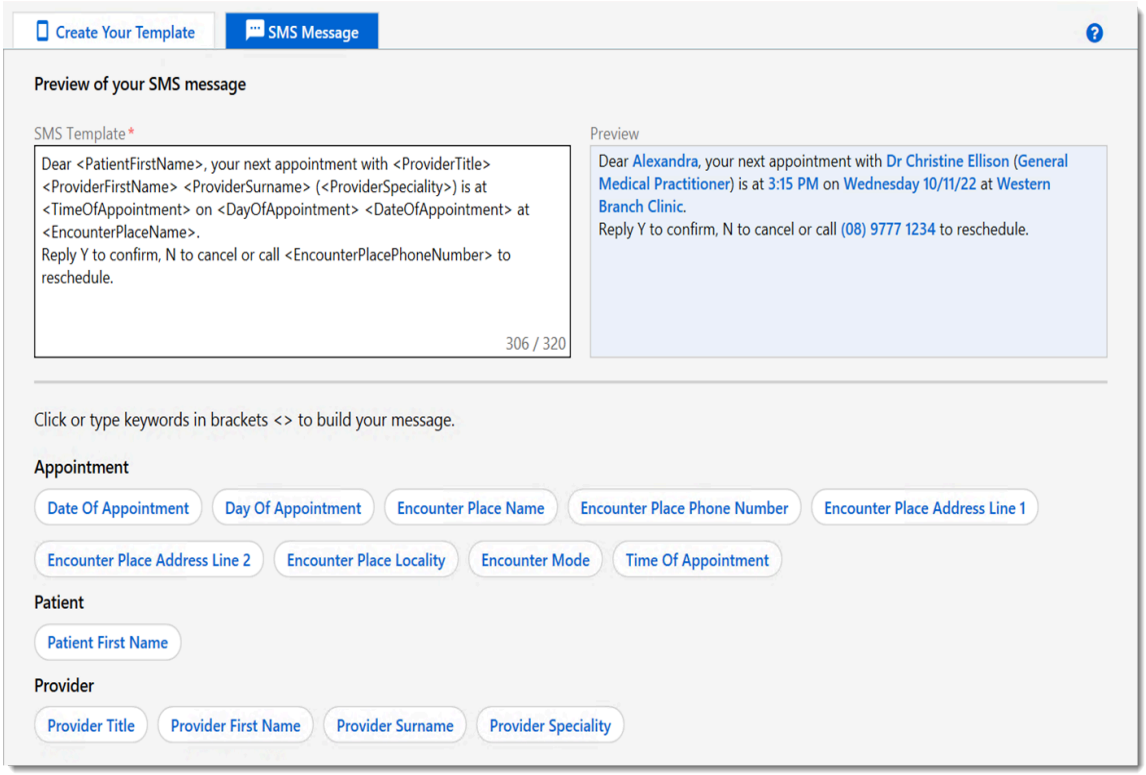
Compose and preview the SMS message sent to patients when an SMS appointment reminder template is run.

To set up and manage SMS reminder templates, the `Communications` module must be enabled and you must belong to a user group with the `SMS Administration` system right.

First, specify the scheduling details on the **Create Your Template** tab.

To compose an SMS template message:

1. Select **Tools > Manage SMS Appointment Reminders**.
2. In the **SMS Appointment Reminder** window, click **New Template**.



3. On the **SMS Message** tab, in the **SMS Template** field, enter a message of up to 320 characters. Typically your message will be a combination of free text and keywords. Keywords are substituted with real details when the message is sent.

> **Tip:**
> To add a keyword, click the keyword you want, or type it in angle brackets `< >`. Keywords are case sensitive. Remember to add spaces around your keywords. If the keyword you type is incorrect, it won't be substituted with example text in the preview.

   The word count is a combination of free text and the text of each keyword and does not account for the text that will be substituted for the keywords. If you exceed 320 characters in the **SMS Template** field by adding a keyword, the count is highlighted in red.

4. Review the SMS message in the **Preview** field. The preview is updated as you type or add keywords and shows example text substituted for the keywords, highlighted in blue.
5. To check your template settings and enable the template, return to the **Create your template** tab. For more information, see Create SMS template *(on page 69)*.

When the template is next run at the scheduled time, this message is sent to the patients who meet the criteria specified in the template.

Keywords are substituted with details from the patient record, the appointment book, the provider settings and the organisation settings.

Send bulk SMS messages manually

In Communicare V21.1 and later, you can manually send SMS messages to multiple recipients using Telstra Health's SMS gateway (TH Messaging).

The `Communications` module must be enabled and you must belong to a user group that has `SMS Messaging` system rights assigned.

To send messages to multiple recipients, Communicare first runs an SMS batch-specific report. Select from:

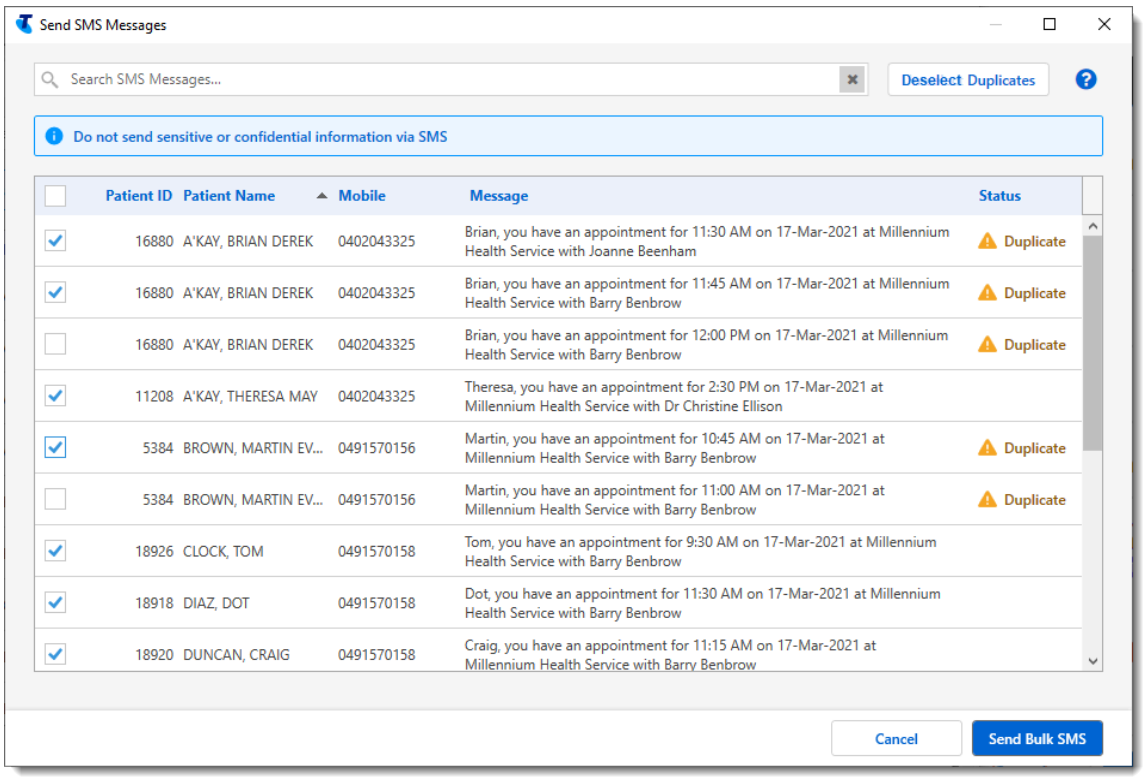
- **SMS Appointment Reminders** - shows all patients with appointments for a selected encounter place between two dates. To send reminders for a single day, enter that date in both the **First date to report** and the **Last date to report** fields. Appointments that have been cancelled or started are excluded.
- **SMS Patient Group Members** - shows all patients belonging to the selected patient group. Enter a message of up to 160 characters.

Only patients with a valid mobile phone number included in their record will receive the SMS. The following patients are excluded:

- Patients where **Preferred Contact** is set to `No Contact`.
- Deceased patients
- Fictitious patients

To manually send SMS messages to multiple recipients:

1. Select **Tools > Send Bulk SMS**.
2. In the **Select an SMS query** window, select the required query, for example, **SMS Appointment Reminders**, and click  **Preview SMS**.
3. In the confirmation window, click  **Yes**.
4. Enter the required values in the fields for the selected report and click **OK**.
   For example, to send SMS appointment reminders for tomorrow, in the **Report Parameters** window, in the **First date to report** and the **Last date to report** fields, enter `tomorrow`. Limit SMS messages to patients with appointments at your encounter place or with a specific provider if required.
5. In the **Send SMS Messages** window, all patients who meet the search criteria are listed. Select all patients to whom you want to send an SMS.



Patients can be listed multiple times. For example, if they have multiple appointments at an encounter place with one provider or separate appointments with several providers. If there is potentially more than one SMS message for a patient, **Duplicate** is displayed in the **Status** column.

Tip:

- To select all patients, set the selection box in the heading.
- For a patient with duplicates, to automatically select only the first listed message, click **Deselect Duplicates**. If a patient has appointments with separate providers, only the first appointment for the day is selected. If you want to send multiple reminders, one for each provider, also select these messages in the list.
- To find a particular patient, in the **Search SMS Messages** field, enter the patient ID, name or phone number. Results are refined as you type.

6. Click **Send Bulk SMS**.

A new SMS `Message` clinical item is created in the clinical record of each recipient, on the **Detail** tab. The status of the SMS message is displayed in the **SMS Send Status** field, initially with a status of `Pending`. If a phone number is invalid, the following message is displayed: `Send Failed (Phone number is not valid)`.

The SMS messages are sent when the `CCareQueue_Communications` service next runs. The message status in each clinical item is updated automatically when confirmation is received that the message has been sent or has failed.

Details of the SMS batch are displayed in the **Reports > SMS > Batch Report Details**.

Restriction:
You cannot delete the record of an SMS sent from Communicare, including from the **Detail** tab.

SMS replies

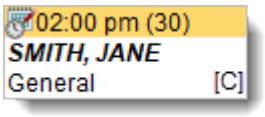
Patients can reply to an SMS and depending on the configuration of your system, confirm their appointment or cancel it automatically.

SMS reply status

If you use SMS appointment reminders, with Telstra Health's SMS gateway (TH Messaging), the status of SMS messages is recorded in the **Appointment Book** and **Service Recording**.

If patients can reply to the SMS, their response is recorded and changes the SMS status. If patients can automatically cancel an appointment, their booking is removed.

In the **Appointment Book**, the abbreviated status of the SMS replies for all patients are recorded in the timeslot for each appointment. When you select a timeslot, the status of the SMS reply for that patient is displayed on the **SMS appointment reminder** tab.



In the **Service Recording** window, the status of the SMS replies for all patients with an appointment are displayed in the **SMS Status** column. When you select a patient, the status of the SMS reply for that patient is displayed on the **SMS appointment reminder** tab.

Table 18. SMS reply statuses

Appointment Book	Service Recording	SMS appointment reminder tab	Description	Action
`[S]`	`Sent`	`Appointment Reminder SMS Sent`	An SMS appointment reminder for this appointment has been sent to the patient, but no reply has been received. If a patient replies with anything other than the expected response of `Y` or `Yes`, `N` or `No` (by default) or adds extra text, the status remains as `Sent`.	Depending on your processes, follow up with the patient or no action is required.
`[C]`	`Confirmed`	`Appointment Confirmation Received`	An SMS appointment reminder for this appointment has been sent to the patient, and the patient has replied with `Y` or `Yes` and confirmed the appointment.	No action is required.

Table 18. SMS reply statuses (continued)

Appointment Book	Service Recording	SMS appointment reminder tab	Description	Action
[R]	Rejected	Appointment Rejection Received	An SMS appointment reminder for this appointment has been sent to the patient, and the patient has replied with N or No and declined the appointment.	Depending on your processes, either reschedule the appointment with or without patient input, or cancel the appointment. If automated appointment cancellation is enabled, the booking disappears. View the SMS status in the clinical record or **Report > SMS > Appointments Cancelled by SMS**
[*blank*]	*blank*	*blank*	No automated SMS was sent or the batch failed	

Note:
Only the first response is received by Communicare. For example, if a patient replies N to an SMS reminder and then changes their mind and responds Y, the second response is ignored.

Tip:
To view any previous statuses or replies, double-click **SMS Send Status**.

Clinical record

The patient's reply is also recorded in their clinical record. To display the reply, on the **Detail** tab, select the SMS Message clinical item. Details of the SMS are displayed in the **Qualifier** pane:

- **SMS Phone Number**
- **SMS Send Status** - when the patient has replied, displays Replied (*reply from patient*), for example, Replied (Yes). If the patient includes text other than the expected response, it is recorded here. Other statuses are:
  - Pending - the SMS has not yet been sent
  - Sent Successfully
  - Send Failed - the SMS was not sent and an error is displayed

SMS reports

Use **Report > SMS** reports to monitor SMS messages:

- **Appointments Cancelled by SMS** - lists appointments automatically cancelled
- **Batch Report Details** - lists patient and SMS details for a particular batch
- **Batch Report Summary** - lists numbers of SMS messages sent and whether they were successful

Appointments cancelled by SMS

If you are using automated SMS appointment reminders with Telstra Health's SMS gateway (TH Messaging), patients can automatically cancel their appointment by replying to an appointment reminder by SMS and rejecting the appointment.

If you aren't using automated SMS appointment reminders at your health service, but would like to, contact Communicare Support to find out how to activate it.

Patients who receive an SMS appointment reminder sent from Communicare because their appointment fits the criteria specified in an SMS appointment reminder template with **Patient can cancel appointments** set, can reply to the SMS and cancel an appointment up until the time that the appointment starts.

By default, patient's who reply `N` or `No` to the appointment reminder SMS message cancel their appointment. If patient's add other text, the appointment is not cancelled.

> **Tip:**
> Add a line to your appointment reminder templates explaining to patients that they must only reply with `Yes` or `No` so that their responses can be recognised by Communicare. If you find that many of your patients reply with other responses, ask Communicare Support to also configure alternative confirmation or rejection responses.

If a patient receives multiple appointment reminders before replying, the latest appointment in the day for which the reminder is sent is cancelled.

> **Note:**
> Only the first response is received by Communicare. For example, if a patient replies `N` to an SMS reminder and then changes their mind and responds `Y`, the second response is ignored.

When a negative SMS reply is received from a patient:

- A reason of `Cancelled by patient` is recorded and a cancellation comment of `Cancelled by SMS Reply` is added to the Service List
- The appointment is removed from the appointment book and service recording
- Linked incoming referrals are updated
- Transport management linked with that appointment is updated and the comment `Cancelled by patient` is added

To display a list of appointments cancelled by SMS, run **Report > SMS > Appointments Cancelled by SMS**.

SMS Batch Reports

You can add new local SMS batch reports to be used to send SMS messages to patients as required. Either request a new custom SMS batch report from Communicare or create it yourself.

To request a new custom report:

1. In the Communicare User Portal - Help and Support tab, request support.
2. Provide the following information:
    - Purpose of the report, for example, Recalls Due
    - Additional filters required, for example, Recall type, date range (of appointment), patient age range, patient sex filter, Indigenous status, and so on
    - Preferred name of report
    - Output, the final SMS wording of no more than 320 characters

When you receive the SMS batch report XML file from Communicare Support, import it into Communicare.

To import the custom SMS batch report:

1. Select **Tools > Send Bulk SMS**.
2. In the **Select an SMS query** window, click **Import**.
3. Select the XML file on your computer and click **Open**.
4. Set **Public**.

The imported report is listed in the **Select an SMS query** window.

> **Tip:**
> SMS Bulk reports do not show in the Communicare **Reports > SMS** menu, only in the **Tools > Send Bulk SMS** menu.

Creating a new SMS batch report

To create a new local SMS report:

1. Select **Tools > Send Batch SMS**.
2. In the **Select an SMS query** window, right-click on a report and select **Copy and Edit SQL query**.
3. In the **Query Name** field, enter a name for report.
4. To prevent accidental use of the report while it is in draft, deselect **Public**.
5. If required, from the **Viewing Rights** list, select a viewing right. For example, `Maternal & Sexual Health`.
6. The `SMS Messaging` system right is required to run SMS batch reports. By default, `SMS Messaging` is assigned to the report. If any other system right is selected, from the **System Rights** list, select `SMS Messaging`.
7. Edit the SQL. You must include the following information:
    - An output attribute on the parameters set to XML, that is `<PARAMETERS OUTPUT="XML">`
    - The following output field names (use field aliases) in exactly the following order:
        - `PATID` - an integer field
        - `PATIENTNAME` - a string field
        - `MOBILENUMBER` - a string field
        - `TEXT` - a string field
8. To test your SQL, click **Preview Query**.
9. When you are satisfied with the SQL, set **Public** and click **Save**.

You can now use the report to send a custom SMS batch.

System and viewing rights

To run SMS batch reports, users require the `SMS Messaging` system right.

When a report is run, the current user's viewing rights and program rights are respected in the output.

> **Important:**
> To avoid unintentionally excluding some or all recalls, batch SMS Reminders for clinical procedures must be run by a user with the required viewing and program rights. Similarly, users running the report may have records excluded if their user group does not have the appropriate program rights.

For example, a user runs **Tools > Send Batch SMS >** *custom recall SMS batch*, then selects cervical screening recalls and the due date. If the user does not belong to a user group with the `Maternal & Sexual Health` viewing right, the output will not display any records.

SMS Messaging Using Burst

Set up SMS messaging so that your health service can send SMS messages to patients using Burst.

You can send messages to individuals or groups, including:

- Appointment reminders - `SMS Appointment Reminders` provides a standard reminder which is set by Communicare and cannot be edited
- Patient group messages - custom messages of no longer than 160 characters sent to patient groups
- SMS batch reports - if configured, use SMS batch reports to send SMS messages, for example, recalls

Note:
Patients who do not have a mobile phone number in the **Mobile Phone** field in their patient record, or who have `No Contact` set in the **Preferred Contact** field are excluded from SMS messaging and report results.

Configuring Communicare to send SMS Messages

To configure Communicare to send SMS Messages:

1. Create a request to have Communicare Support configure Communicare and your SMS messaging account. You will receive an email with the SMS website login details. Support will enable the `SMS Feature` module in Communicare.
2. Allocate the `SMS Messaging` system right to the relevant user groups.

Adding credit to your SMS account

You must add credit to your SMS account before you can send any SMS messages.

To add credit to your account:

1. In Communicare, select **Tools > SMS Top-up**.
2. Log into the SMS account website using the account name and password details provided to you by Communicare Support.
3. Follow the directions and top up your SMS credit.

Sending Batch SMS Messages using Burst

An SMS can be sent to a list of patients using templates maintained by Communicare or custom, local SMS batch reports.

You can send SMS messages to multiple patients. Appointment reminder reports used with the `SMS Feature` module are distributed by Communicare. The `SMS Appointment Reminders` template is maintained by Communicare and is not editable.

Important:
Do not send confidential or sensitive information using an SMS Message.

To send SMS messages to multiple patients using Burst:

1. Ensure Communicare is configured for SMS messaging *(on page 79)*.
2. Select **Tools > Send Batch SMS - Burst**.
3. Select **SMS Appointment Reminders**.
4. Click **Preview SMS** and in the confirmation window, click **Yes**.
5. In the **Report Parameters** window, set values that limit who you send the SMS to. For example:
    - **First date to report** - tomorrow
    - **Last date to report** - tomorrow
    - **Appointment Place** - Millennium Health Service
    - **Provider** - Christine Ellison
6. Click **OK**.
7. The **Send SMS Messages** window lists the messages to be sent and the patient name and number. Review the messages to be sent and deselect any messages you do not want to send. Note the following:
    - The traffic light icon in the bottom left corner of the SMS Batch window shows you if you have enough credit to send the messages. The icon is:
        - Red if you do not have enough credit to send the messages. **Send SMS** is disabled. Click **Top-up Credit** to add more credit. See SMS messaging *(on page 79)* for more information.
        - Yellow if you do have enough credit but it is within 50 units of your current limit.
        - Green if you have credit for 50 more messages than you are about to send.
8. Click **Send SMS**.

There is a delay between when a message is sent and when confirmation is received.

When the messages are sent, SMS Message clinical items are created for each patient who has been messaged. The Clinical Items can be found on the **Detail** tab of the Clinical Record and show the message, mobile number, date and time the message was sent, and the message status. The message status is one of the following:

- `Pending` - awaiting confirmation that the message was sent successfully
- `Sent Successfully` - the message was sent successfully
- `Send Failed` - the message failed to send and an error message is displayed

Restriction:
You cannot delete the record of an SMS sent from Communicare, including from the **Detail** tab.

Sending SMS messages to group members

You can send custom SMS messages to members of a specific group, such as `Young Mothers Group`.

Important:
Do not send confidential or sensitive information using an SMS message.

To send SMS messages to group members:

1. Ensure Communicare is configured for SMS messaging *(on page 79)*).
2. Select **Tools > Send Batch SMS**.
3. Select **SMS Patient Group Members**.
4. Click **Preview SMS** and in the confirmation window, click **Yes**.
5. In the **Report Parameters** window:

    - In the **Message to send** field, enter your message to the group, up to 160 characters long
    - From the **Patient Group** list, select the group you want to message
6. Click **OK**.
7. The **Send SMS Messages** window lists the messages to be sent and the patient name and number. Review the messages to be sent and deselect any messages you do not want to send. Note the following:
    - Any messages that are longer than 160 characters are truncated to 160 characters. Hover your mouse over the message to see the message that will be sent.
    - The traffic light icon in the bottom left corner of the SMS Batch window shows you if you have enough credit to send the messages. This will be:
        - Red if you do not have enough credit to send the messages. **Send SMS** is disabled. Click **Top-up Credit** to add more credit. See SMS messaging *(on page 79)* for more information.
        - Yellow if you do have enough credit but it is within 50 units of your current limit.
        - Green if you have credit for 50 more messages than you are about to send.
8. Click **Send SMS**.

There is a delay between when a message is sent and when confirmation is received.

When the messages are sent, SMS Message clinical items are created for each patient who has been messaged. The Clinical Items can be found on the **Detail** tab of the Clinical Record and show the message, mobile number, date and time the message was sent, and the message status. The message status is one of the following:

- `Pending` - awaiting confirmation that the message was sent successfully
- `Sent Successfully` - the message was sent successfully
- `Send Failed` - the message failed to send and an error message is displayed

Restriction:
You cannot delete the record of an SMS sent from Communicare, including from the **Detail** tab.

Transport

Communicare offers two ways of managing transport services.

Use either:

- Transport Services *(on page 81)* - a simple data collection module where drivers can record numbers of clients picked up and dropped off from various places.
- Transport Management *(on page 82)* - a comprehensive booking and management system, integrated into the appointments book.

Transport Services

Use **Transport Services** to record the number of clients picked up and dropped off from various places.

To use this functionality, the `Transport Services` module must be enabled and your user group must have the `Transport Services` system right.

To add a transport entry:

1. In the Communicare toolbar, click  **Transport Services**.
2. In the **Transport Services** window, from the **Date** calendar, select the date to which the service applies.
3. To add drivers, journey distances and journey times:
    a. In the top pane, click ✚Add.
    b. From the **Transport Driver** list, select the driver. The list of drivers contains all providers who have been designated as Transport Drivers. For more information, see Providers *(on page 917)*.
4. To add stops to the journey:
    a. In the lower pane, click ✚Add.
    b. From the **Pick-up / Drop-off Place** list, select a stop. This list contains all places that have been designated as transport stops in the address book. For more information, see Search for an address *(on page 335)*.
    c. In the count columns, enter a number for how many passengers, male and female, were picked up and dropped off. Add any patients who were scheduled to be picked up, but did not attend to the **DNA** column.
    d. Repeat steps a-c for all stops.
5. Click ✔**Save**.

Transport Management

The **Transport Management** module enables you to plan transport arrangements and track their outcomes.

> **Note:**
> A standard activation fee applies. For more information, contact Communicare Support *(on page)*.

Similar to appointments, transport requirements are booked ahead of the required date, and must be associated with a patient. There are two types of transport requirements:

- Arranged with patient's knowledge
- Arranged without patient's knowledge

When a transport requirement is completed, there are several completion statuses:

- Patient did not attend (only valid for requirements arranged with patient's knowledge)
- Patient could not be found (only valid for requirements arranged without patient's knowledge)
- Transport Provided
- Refused by patient
- Cancelled by patient
- Cancelled by service
- Patient transport by other means
- Appointment rescheduled

Transport requirements can be arranged from the following locations in Communicare:

- In the Communicare toolbar, click  **Transport Management**.
- When booking an appointment, click **Transport**.
    - The comments field in the appointment requirements grid is copied to the **Comments** field in the transport requirement.
    - The user's initials are added to the **Operator Initials** field

    - The pick up place for the transport requirement is set to the patient's home address
    - The drop off place is set to the encounter place of the appointment
    - The drop off time is set to the time of the appointment
    - The requirement arrangement is set to **Arranged with patient's knowledge**.

  If you cancel an appointment with an associated transport requirement generated by the appointment booking, you are prompted to also cancel the associated transport requirement.

- In the Clinical Record toolbar, click  **Transport**. The transport requirement is automatically linked to the current patient, and is set as **Arranged with patient's knowledge**.
- When creating a referral using a clinical item, for example, `Referral;dentist`, click  **Add Transport Requirement**.

  Information included in the referral is transferred to the transport requirement automatically, including patient details. The drop off date and time for transport also default to the appointment date and time on the referral. If changes are made to the referral after the transport requirement is added, the transport requirement is not updated, and vice versa.

  The default values depend on whether it is a From or To referral:
    - For From referrals:
        - Pickup place defaults to the patient's home address
        - Dropoff place defaults to the current encounter place
    - For To referrals:
        - Pickup place defaults to the patient's home address
        - Dropoff place defaults to the Organisation on the referral

Services

When you arrive, start or finish a service and there is an unresolved transport requirement for the current patient, you are prompted to resolve the transport requirement. You can enter a transport provider, and determine the completion status for the requirement, or leave it unresolved if necessary.

Transport Requirement List

Use the **Transport Requirement List** window to view the list of the transport requirements for patient pickups and dropoffs, and add, edit or cancel transport requirements.

To display the **Transport Requirement List** window:

- In the Communicare toolbar, click  **Transport Management**
- When booking an appointment, click **Transport**

By default, active transport requirements for today are displayed, ordered by time. Filter the list of transport requirements in the following ways:

- To expand the list to a particular date range, select the required dates in the **From** and **To** calendars.
- To view all transport requirements for the selected period, including those that have been resolved, deselect **Hide Inactive**.
- Sort the records either by pick up or drop off date and time. Set **Pickup** to order the records by the pick up date and time. Alternatively, set **Dropoff** to order by drop off date and time.

To add a new transport requirement, click Add. For more information, see Transport Requirement Maintenance *(on page 84)*.

To edit a transport requirement:

1. Select a record and click Edit.
2. In the **Transport Requirement Maintenance** window, update the required details.

To cancel or complete a transport requirement:

1. Select a record and click Cancel.
2. Select a cancellation reason and click **OK**. The cancellation reasons available are dependent on the arrangement type.

Print Transport Requirements

You can print a report of all the active transport requirements for a given day for drivers or those who cannot access reports.

To print the transport requirements for a given day:

1. Click **Print Transport List**.
2. In the **Date to Report** field, enter the required date.
3. The report includes all drivers by default. If you want to generate the report for a particular driver, from the **Transport Driver** list, select the driver you want to print the list for.
4. Click **OK**.

A list of all of active transport requirements for the specified day and driver is displayed. To print the report, click Print.

Transport Requirement Maintenance

Use the **Transport Requirement Maintenance** window to add or modify transport requirements.

To add a new transport requirement:

1. Open the **Transport Requirement Maintenance** window using one of the following methods:
   - From the **Transport Requirement List**, click Add and select a patient.
   - In the patient's clinical record, click **Transport**
   - When creating a referral using a clinical item, for example, `Referral;dentist`, click **Add Transport Requirement**.
2. In the **Transport Requirement Maintenance** window, set an arrangement option. The arrangement option affects the possible completion options. Select either:
   - **Arranged with patient's knowledge** - if the patient was unavailable for pickup, the transport cannot be resolved with `Patient could not be found`, instead it must be resolved with `Patient did not attend`
   - **Arranged without patient's knowledge** - if the patient was unavailable for pickup, the transport cannot be resolved with `Patient did not attend`, instead resolve it with `Patient could not be found`
3. From the **Transport Driver** list, select a driver. The list of drivers contains all providers who have been designated as Transport Drivers. For more information, see Providers *(on page 917)*.

4. In the **Other transport requirements** section, review any other active transport requirements for the current patient to avoid clashes.
5. From either the pickup **Date/Time** calendar or dropoff **Date/Time** calendar, select a transport date and then edit the pickup or dropoff time.

> **Tip:**
> Typically, specify only a dropoff date and time for pickups to provide the transport driver with more flexibility. A transport requirement may have both a pickup date and a dropoff date, however you will be prompted to confirm that there is enough time between the two entries.

6. In the **Pickup** section, click either **Encounter Places**, **Address Book** or **Patient's Home** and select a pickup address.
7. In the **Dropoff** section, click either **Encounter Places**, **Address Book** or **Patient's Home** and select a pickup address.
8. In the **Comments** field, enter any other relevant information for the driver.
9. Click **Save and Schedule a Return** if the patient will be returned to their pickup address after their appointment, or **Save** if transport is required only one-way.
10. If you created a return journey, enter the return journey dates and times and save. To provide the transport driver with more flexibility, for return journeys, specify only a pickup time.

The new transport requirement is added to the **Transport Requirement List**. Print if required.

Rescheduling cancelled transport requirements

You can easily reschedule transport requirements that have been cancelled for any of the following reasons:

- Patient did not attend
- Patient could not be found
- Refused by Patient
- Appointment rescheduled

To reschedule a cancelled appointment:

1. In the **Transport Requirement List**, deselect **Hide Inactive**.
2. Double-click the cancelled appointment that you want to reschedule.
3. In the **Transport Requirement Maintenance** window, click **Carry Forward**. The details of the transport requirement, except the date and time, are copied to a new transport requirement.
4. Select a new pickup or dropoff **Date/Time**.
5. Click **Save**.

Setting a transport requirement to complete

You can set the status of a transport requirement from either the **Transport Requirement List** or the **Transport Requirement Maintenance** window.

To complete a transport requirement in the **Transport Requirement Maintenance** window:

1. In the **Transport Requirement Maintenance** window, for the **Completed Status**, set an option.
2. Click **Save**.

The completed item is set to inactive.

Encounters

Open a service recording for patient interactions and add clinical items, record progress notes, prescribe medications, review investigations, write referrals and manage recalls.

Encounters

Record patient encounters in Communicare using any one of the following methods.

- Service Recording *(on page 86)* - best suited to health services that employ a receptionist. Allows each patient consultation to be tracked from the moment the patient arrives until the service is complete.
- Clinical Record *(on page 112)* - best suited to health services that do not employ a receptionist and do not wish to record waiting times. Record attendance in a special attendance item and qualifiers.

Note:
Both methods satisfy OATSIH Service Activity Report (SAR) requirements.

Service Recording

In Communicare, a service is where a patient interacts with a service provider. In general, it means to have a consultation with a health care provider, that is, a Doctor, Nurse, or Healthworker.

One service can relate to any number of clinical items, services and billing claims. For example, a child may see the doctor and have a check up, be given one or more immunisations and receive a prescription.

All patients entering the clinic are recorded in the service recording window and their progress is monitored throughout the duration of their visit. A history is created that can be displayed for any day or any provider.

To view or record a consultation, click  **Service Recording**.

Service records can be added, deleted and changed using the Navigator Buttons *(on page 21)* at the top of the window.

Refreshing the Service Record List

As the day progresses, records are added, completed, removed, and so on. The service record list is automatically refreshed every minute if either the Service Recording window or the main Communicare window is the top level window and the Service Recording window has been idle for at least 10 seconds. If these windows are in the background, the service record list is refreshed every two minutes. This will ensure the list you are viewing is the most up to date.

To refresh the window manually, click  Refresh, or press F5 as often as required.

Sorting the Service Record List

To sort the Service Record List by Patient Name, Start/Withdraw time and the Encounter Place and Mode, click the required column header.

To return to the default ordering, click **Reset Ordering**.

Medicare Claim Form

To print the Medicare Assignment Form for Medicare Bulk Bill claims and Patient claim report for Private claims, click  Claim Form.

Only those items set in the Service Record window are printed.

For Medicare claims, if the Provider has a valid number, these details are also printed. If the first provider has no Provider number, the next provider's number is used.

The button is disabled if no claim has been submitted for the service.

Printing Service Lists

To print a service list, click  Services. See Quick Print Services *(on page 575)* for more information.

Service Status

The status or progress of a service is indicated by the following icons.

Table 19. Service status icons

Status Icon	Description
	An appointment was booked
 Waiting	The patient has arrived and an arrival time recorded
 Started	The service has begun and a start time recorded
 Paused	The service was paused
 Finished	The service finished and a finish time was recorded
 Withdrawn	The patient left before the service started and a withdrawal time was recorded
 Cancelled	The appointment was cancelled

The patient list may also show the following information:

Table 20. Patient list information

Icon	Description
	Some information is attached to the service and this service cannot be deleted. The information can be a clinical item, prescription, adverse reaction, result, investigation request, progress note, lock conflict, Medicare or private billing claim, birth notification, patient documents, and so on. If there isn't an icon, no information has been recorded for the service yet.
	There are notes entered on the **Administration** tab of the patient's biographics. Double-click the icon to view the notes.
	Medicare Card details are incomplete. To complete the Medicare details, click  Biographics. See Changing Biographics *(on page 38)* for more information.

Medicare claim status

The Medicare claim status is also displayed in  **Service Recording** window for each service.

-  Claimed - a claim has been made for this service. Services that have a claims with a status of `Sending for Processing (128)` also display this icon.

  > **Tip:**
  > For claims with a status of `Sending Claim for Processing`, if you open **Service Record > Medicare** tab, the claimed items are selected but no icon is displayed. Claims with this status are also listed in a patient's clinical record: click  **Claims** to display the **History of MBS Items** window.

-  **Unclaimed** - a claimable service has not yet been claimed.
-  **Not claimable** - the service has been marked as not claimable.

Recording a Service

For each patient encounter, record a service.

Recording services from the Service Recording window

To record a service from the **Service Recording** window:

1. To open the **Service Recording** window, click  **Service Recording**.
2. When a patient arrives, if they have an appointment booked, click  **Check In**.
3. If the patient is a walk-in or you are not using appointments, click  **Add** and select the patient.
4. In the **Session Selection** window, select the walk-in session or click **Extra**.
5. In the **Service Record** window, set **Medicare** to bulk bill the patient, or **Private** otherwise.
6. From the **Providers** list, select a provider.
7. Enter encounter place and mode information. If a default provider, mode or place has been set on the main toolbar (see Preselecting the Provider *(on page 111)*), these details are already entered.
8. Click **OK**.

The patient status is changed to *Waiting*.

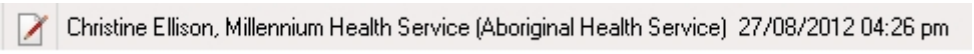
By default, the date of service is today. You may not have details of patient arrival unless waiting times are being recorded for your particular mode and place.

Recording services by opening the Clinical Record

Whether or not your health service books appointments, or records waiting times, opening a clinical record starts a service.

To record a patient's arrival in the clinical record:

1. Click  **Clinical Record** on the main toolbar and select the patient.
2. If the provider, mode and place (see Preselecting the Provider *(on page 111)*) are set and there is no other service recorded for the patient today, the clinical record is displayed and the service starts.
3. If there is a service already recorded today, in the **Select Service** window:
    - If you want to continue an earlier service, select that service and click **Yes - Open selected service**. If you are an additional provider, your name will be added to the service.
    - If this service is clearly another service provided independently of any earlier service, click **No - Start new service**.
4. If all the necessary details haven't been provided, in the **Provider, Place and Mode selection** window:
    a. From the **Provider** list, select your name.
    b. From the **Place and mode** list, select your encounter place and mode.
    c. To save these details on this computer, click **Remember These Details**.
    d. Click **OK**.

In the clinical record, the status bar at the bottom displays details of the current service, including provider. 

You can now enter details of your service, such as clinical items, medications and so on.

If you want to change or add providers:

1. Double-click the current service details.
2. In the **Service Record** window, on the **Detail** tab, select the required providers.
3. Click **Save**.

Ending a service

To end a service, close the clinical record and complete the followup tasks.

To end a service:

1. In the clinical record, click Close.
2. If there are any prescriptions that have not been finalised or printed, a **Confirm** window is displayed.
    - If you want to finalise or print the prescriptions:
        a. Click **Yes**. The **Finalise Prescriptions** window is displayed.
        b. Finalise the prescriptions or print the medications as required. For more information, see Finalise Prescriptions *(on page 240)*.
    - If you don't want to finalise the prescriptions, click **No**.
3. If you use medication requests and the latest non-cancelled request was stopped today and a pickup location isn't set, or there is a pickup location set but a medication request has never been created, a **Confirm** window is displayed.
    - If you want to create a medication request for the patient:
        a. Click **Yes**. The **Medication Requests** window is displayed.
        b. Add a new medication request as required. For more information, see Medication Requests *(on page 244)*.
    - If you don't want to create a medication request, click **No**.
4. In the **Service exit** window, click **Yes - This service is now complete**. Alternatively, if you want to pause the service because the patient will now see another provider, click **No - Patient will see another provider**. See Service Exit Dialog Form *(on page 95)* for more information.
5. If you are registered with Medicare and online claiming is enabled for your health service, on the **Medicare** tab of the **Service Record** window:
    - If the policy of your health service is to have a receptionist process Medicare claims, click **Save**.
    - If you want to submit Medicare claims yourself, check that the **Default Claiming Provider** is correct, select the relevant Medicare items and click **Claim now**. For the current service, you can add or change providers by clicking the yellow triangle or double-clicking on the current service details (see above).

    For more information about sending a claim to Medicare, see Submit a claim to Medicare *(on page 100)*.

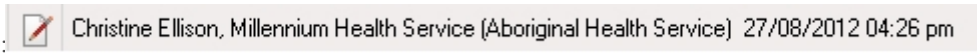
The service is complete and you can start another service.

> **Tip:**
> If you don't ever submit Medicare claims and don't want to see the Medicare tab when you close a service record:
>
> 1. Select **File > Providers**.
> 2. In the **Providers** window, double-click your name.
> 3. In the **Provider** window, deselect **Show Medicare Claim Tab?**.
> 4. Click **Save**.

Recording services for a previous day

If required, you can record services for a previous day for a service provided to a patient by you.

To record services for a previous day:

1. Click **Clinical Record** on the main toolbar and select the patient. A service for today is generated.
2. Double-click the current service details in the status bar. For example: 

3. In the **Service Record** window, in the **Date of service** calendar, select the correct date of the service.
4. Click **OK**.

You can now enter clinical information for that service, which are recorded in the patient's Progress notes with the date you selected.

You can also record services for a date prior to today in the Service Recording window, but you cannot enter clinical information if you use this method.

Editing clinical information for a service

If you are the provider who recorded a service, you can edit the clinical information.

To enter clinical information for an existing service:

1. Click **Clinical Record** on the main toolbar and select the patient.
2. On the **Progress Notes** tab of the clinical record, in the contact list in the left pane, drag the service you want to edit to the service details pane on the right.
3. In the **Select a different service** window, click **Yes - Open Selected service instead of current service**.

Communicare exits today's current service, so the old service can be opened. The old service is opened and you can now update details in the old service.

When you close the clinical record, in the **Service exit** window, if you aren't providing a service today, click **Ignore - No service has been provided**.

Recording the length of the service

Communicare records how long each provider spends on a service. The time spent providing a service is recorded next to each provider. For example, one provider spent 30 minutes with a patient whilst another spent only 5 minutes with the patient on the same service. If you do not manually add or change the time, Communicare records the time that the clinical record was open in that provider's name automatically.

Recording Telehealth Consultations

Use one of these encounter modes to record telehealth services.

Table 21. Telehealth service encounter modes

Encounter Mode	Consultation Delivery	Description	Included in reports	Automated patient status updates?
Telehealth Video	Video conferencing	Use to record services where the contact between the Communicare provider and the patient was using video conferencing.	nKPI and OSR	Yes

Table 21. Telehealth service encounter modes (continued)

Encounter Mode	Consultation Delivery	Description	Included in reports	Automated patient status updates?
Telehealth - Provider	Telephone or by another device such as a computer, with or without video	Use to record remote telehealth consultations during the COVID-19 pandemic.	nKPI and OSR	Yes
Telehealth - Recipient	Facilitator only	Use where a consultation happened between a provider elsewhere and a patient, such as between a specialist and patient at a hospital, and the Communicare provider only facilitated the contact by providing a room and remote conferencing equipment.	nKPI and OSR	Yes
Telephone	Telephone	Use to record a clinical consultation performed over the telephone between the Communicare provider and the patient.	nKPI and OSR	Yes

For information about adding encounter places, see Editing Encounter Places *(on page 872)*.

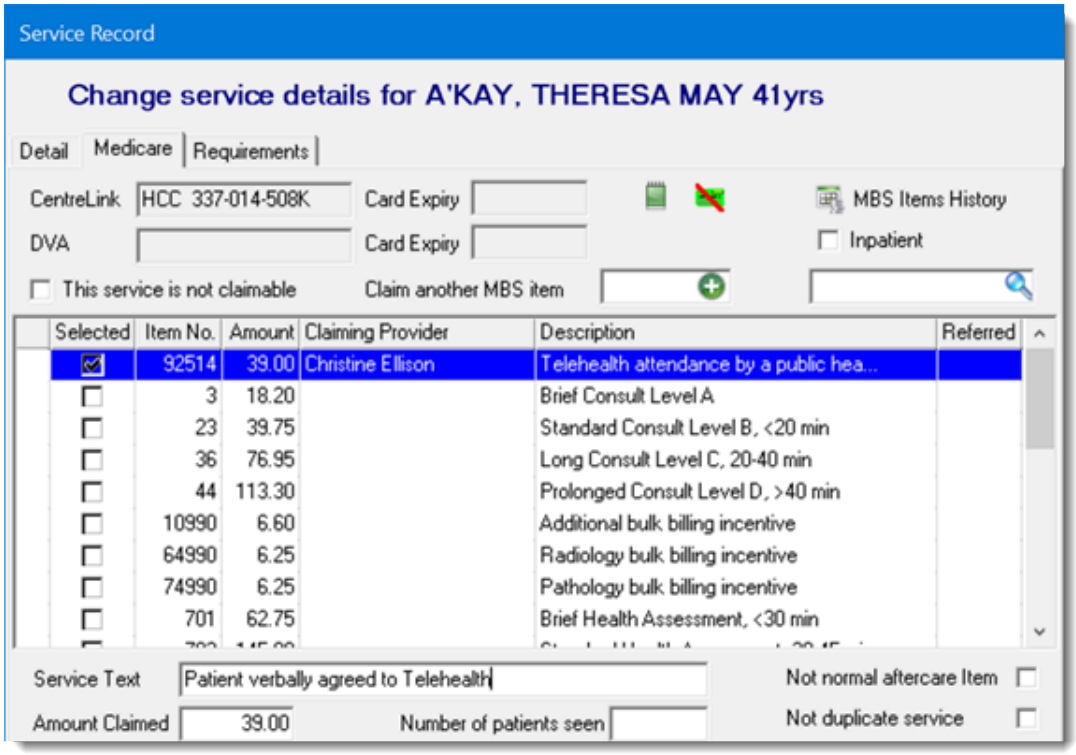
Assignment of benefit for Telehealth

You need your patient's agreement, or the agreement of a responsible person for the patient, to bulk bill telehealth items before Services Australia will pay the Medicare benefit.

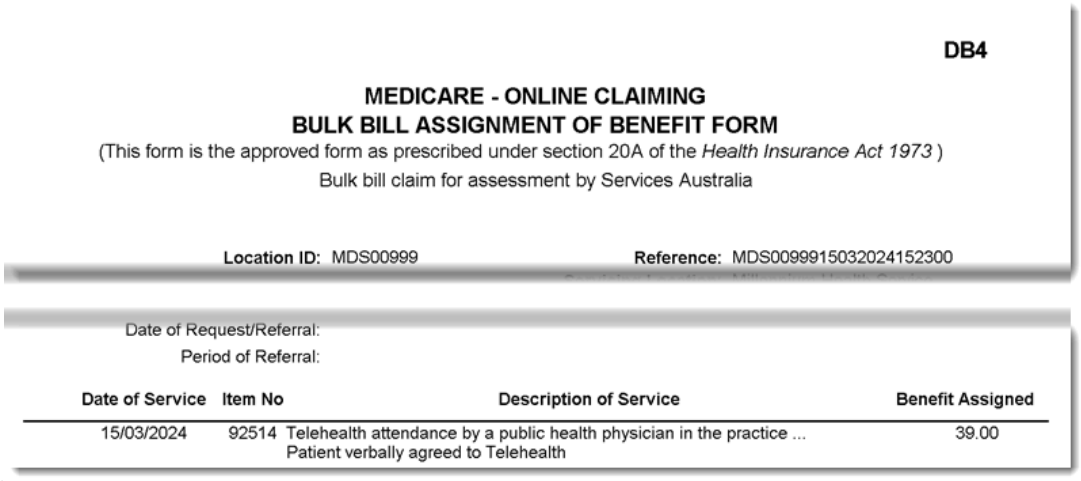
You must either:

- Get patient agreement in writing or by email for telehealth services. For more information, see https://www.servicesaustralia.gov.au/assignment-benefit-signature-requirements-and-exemptions?context=23366#email.
- Get verbal agreement from your patient during the telehealth consultation and record that agreement.
    1. Ensure that the DB4 *(on page 839)* option is set in **File > Organisation Maintenance**.
    2. During the telehealth consultation, get verbal agreement from the patient for the assignment of benefit and explain that you'll fill in the **Patient Signature** field.

3. On the **Service Record > Medicare** tab, in the **Service Text** field, type `Patient verbally agreed to Telehealth`.



4. The service text is added to the automatically generated Bulk Bill Assignment of Benefit (DB4) form.



5. Send the DB4 form to your patient electronically.

For more information, see https://www.servicesaustralia.gov.au/changes-to-mbs-items-during-coronavirus-covid-19-response?context=20#requirements.

Pandemic response

During a pandemic, ensure that you log on to the Communicare User Portal weekly and take the following steps:

- Download and install the latest MBS updates
- Check for new ICPC-2 PLUS clinical items and advice on creating pathology requests
- Download new reports.

Note:
Reports are generic and will only work if the descriptions of clinical items, test requests and incoming results are consistent with the logic explained in each report. For example, for COVID-19 lab test results must contain one of the following terms to be included in the reports: COVID, CORONAVIRUS or CORONA VIRUS. If you use these reports, ensure that you review them after items are used, tests are requested and results have arrived. Raise a support request if the data you require is not included in the report.

Service Selector

When you open the clinical record for a patient or add a service recording, and a service has already been provided for that patient today, those services are listed in the Service Selector window.

From the **Clinical Record**, if required, open and edit an existing service:

- To edit the service, double-click it or click **Yes - Open selected service**
- To start a new service for the patient, click **No - Start new service**

From the **Service Recording** window, if required, update the details of an existing service:

- To update a service, double-click it, or click **Yes - Update selected service**
- To create a new service, click **No - Add new service**

Starting a Service

Every time you open a clinical record, a service is started. You have the option of keeping the service or not when you close the clinical record.

To capture statistics for OATSIH Service Activity Reporting, Communicare does not allow anything to be recorded or edited on a person's clinical record until you have defined the service, that is, who provided the service and what date the service was provided.

To define a new service, open a clinical record, either directly or in Service Recording.

Starting a service from Service Recording

To start a service from Service Recording:

1. In the main toolbar, click  **Service Recording**.
2. In the list, double-click a patient who is already queued and click **Open Clinical Record**.
3. If the patient has a status of `Waiting`, click **Yes** to confirm that you want to see the patient now.

If the patient is not already listed, first add them:

1. In the main toolbar, click  **Service Recording**.
2. Click  Add and select a patient.
3. Select a session.

4. Select a provider, place, mode details (if not already defined - see Preselecting the Provider *(on page 111)*) and date and click **Save**.
5. Double-click the patient and click **Open Clinical Record**.

The service is started and you can record clinical items.

Starting a service from the Clinical Record

Open a Clinical Record to automatically start a service for today using the provider, place and mode already selected. If you do not have these details preselected you will see a form requesting these details (see Provider\, Mode\, Place Selection *(on page 111)*).

To start a service from the Clinical Record, on the main toolbar, click  **Clinical Record** and select the patient.

Editing a service

When revisiting a clinical record on a particular day, do not start a new service unless the patient has left and returned for a different reason. You should normally select the existing service.

To add more details to an existing service (for example, to complete progress notes *(on page 137)* at the end of the day or record a home visit):

1. In the **Service Recording** window, double-click the required patient.
2. Click **Open Clinical Record**.
3. In the **Select Service** window, select the required service and click **Yes - Open selected service**.
4. On the **Progress Notes** tab, today's services are listed on the service pane on the right.
5. Double-click the item you want to edit, update it and click **Save**.
6. Close the service.
7. Select the required Medicare option.

Closing a Clinical Record

To complete a service, close the clinical record.

When you close a clinical record you perform one of the following actions:

- Complete the service
- Pause the service so it can be completed by another provider
- Close the service without providing a service and record your access in the database. Unless you opened an existing service or booking (when you opened the clinical record) your service comment is also ignored. No patient or consultation details are sent to MHR or MeHR.

Completing a service

When you complete a service, service details are sent to MHR or MeHR where enabled and selected.

If your health service is integrated with Medicare, you can submit an electronic claim when you close a service.

To complete a service:

1. In the Clinical Record, click Close.
2. If there are any prescriptions that have not been finalised or printed, you are prompted to finalise the prescriptions. To finalise the prescriptions:
    a. In the **Confirm** window, click **Yes**.
    b. In the **Finalise Prescriptions** window, select the prescriptions and the required medication request and print options and click **Finalise**. For more information, see Finalise Prescriptions *(on page 240)*.
3. If you use medication requests and the latest non-cancelled request was stopped today and a pickup location isn't set, or there is a pickup location set but a medication request has never been created, you are prompted to create a medication request.
    - In the **Confirm** window, if you want to create a medication request for the patient:
        a. Click **Yes**. The **Medication Requests** window is displayed.
        b. Add a new medication request as required. For more information, see Medication Requests *(on page 244)*.
    - If you don't want to create a medication request, click **No**.
4. In the **Service exit** window, in the **Service message** field, enter a comment about the service to be displayed in the **Service Record** window.
5. If you want to upload service records to MHR, set **Send Event Summary to My Health Record** and **Send Shared Health Summary to My Health Record**. If the patient has consented to sharing information with MHR, these options are set. See My Health Record Summary Documents *(on page 98)* below for more information.
6. For NT patients, if you want to upload their service records to MeHR, set **Send to the MeHR**. If the MeHR to My Health Record Transition *(on page 811)* module is enabled, and you want to upload service records to MHR, set **Send Event Summary to MeHR** and **Send Shared Health Summary to MeHR**. See MeHR *(on page 97)* below for more information
7. Click **Yes - This service is now complete**.
8. The **Service Record** window is displayed. The service message from step 3 is displayed on the **Detail** tab.
9. If Medicare claiming is enabled, on the **Medicare** tab:
    - If reception handles payment and claims at your health service, click **Claim later**.
    - If you submit claims yourself, select the relevant Medicare items and click **Claim now**.

The service finishes.

If you finalised any prescriptions, they are assigned a script number. If you chose to print any prescriptions or medication requests they are printed to your default printer.

If sharing with MeHR is enabled, the Current Health Profile for the patient and a Medical Event Summary for the consultation are sent to the MeHR.

If sharing with MHR is enabled, a Shared Health Summary and an Event Summary for the service are sent to MHR.

In the **Service Recording** window, the service has a status of `Finished`.

Pausing a service

If you have completed your contact with a patient but they will be going on to see another provider, you can pause a service.

To pause a service:

1. In the Clinical Record, click Close.
2. If there are any prescriptions that have not been finalised or printed, you are prompted to finalise the prescriptions. To finalise the prescriptions:
    a. In the **Confirm** window, click **Yes**.
    b. In the **Finalise Prescriptions** window, select the prescriptions and the required medication request and print options and click **Finalise**. For more information, see Finalise Prescriptions *(on page 240)*.
3. In the **Service exit** window, in the **Service message** field, enter a comment about the service to be displayed in the **Service Record** window.
4. If you want to upload service records to MHR, set **Send Event Summary to My Health Record** and **Send Shared Health Summary to My Health Record**. If the patient has consented to sharing information with MHR, these options are set. See My Health Record Summary Documents *(on page 98)* below for more information.
5. For NT patients, if you want to upload their service records to MeHR, set **Send to the MeHR**. If the MeHR to My Health Record Transition *(on page 811)* module is enabled, and you want to upload service records to MHR, set **Send Event Summary to MeHR** and **Send Shared Health Summary to MeHR**. See MeHR *(on page 97)* below for more information
6. Click **No - Patient will see another provider**.
7. The **Service Record** window is displayed. The service message from step 3 is displayed on the **Detail** tab.
8. If Medicare claiming is enabled, on the **Medicare** tab:
    - If reception handles payment and claims at your health service, click **Claim later**.
    - If you submit claims yourself, select the relevant Medicare items and click **Claim now**.

The service is paused.

If you finalised any prescriptions, they are assigned a script number. If you chose to print any prescriptions or medication requests they are printed to your default printer.

If sharing with MeHR is enabled, the Current Health Profile for the patient and a Medical Event Summary for the consultation are sent to the MeHR.

If sharing with MHR is enabled, a Shared Health Summary and an Event Summary for the service are sent to MHR.

In the **Service Recording** window, the service has a status of `Paused` with a count in minutes of how long the service has been paused.

MeHR

If the MeHR module is enabled and the patient is registered with MeHR, choose whether to send details of this consultation to the MeHR.

Send to the MeHR is disabled if there is a new `Confirmed Pregnancy` or `Antenatal Check-up` clinical item recorded against the service. Instead, in the `Confirmed Pregnancy` clinical item, if **Send Antenatal Report to MeHR** is set, the information is sent to MeHR (see MeHR Antenatal Reports *(on page 779)* for more information).

If MeHR to My Health Record Transition *(on page 779)* is enabled, the option to send information to the MeHR will not be available if the patient has a My Health Record or the provider has access to the My Health Record.

If the MeHR to My Health Record Transition *(on page 811)* module is turned on and the patient has an MeHR but not a My Health Record, **Send to the MeHR** is replaced with **Send Event Summary to MeHR**, and **Send Shared Health Summary to MeHR**. These options create My Health Record documents as normal, but send them to MeHR.

My Health Record Summary Documents

To upload summaries to My Health Record, the following requirements must be met:

- My Health Record Access is enabled in System Parameters *(on page 810)* and in User Groups *(on page 842)*
- HI Service is enabled in Organisation Parameters - General *(on page 835)*
- Current Organisation has a valid HPI-O
- Current Provider has a valid HPI-I
- Current Patient has a valid IHI

If these criteria are met, and the patient consents, a Shared Health Summary and an Event Summary for a service are generated when a service is complete.

The **Shared Health Summary** and **Event Summary** options are set if:

- The patient has consented to sending documents to the My Health Record, that is, in Patient Biographics *(on page 30)*, **Patient consents to My Health Record uploads** is set. If the patient has not yet given consent or has declined consent, these options are not set.
- For Shared Health Summaries, both:
  - The patient has consented to upload documents (or if the Mehr to My Health Record Transition *(on page 811)* module is enabled, the patient has not declined consent to upload documents)
  - Data that will be included has been recorded or amended (for example, an immunisation has been recorded, a summary clinical item added, a current medication stopped, and so on)

If My Health Record Access is enabled in both System Parameters *(on page 810)* and in User Groups *(on page 842)* but one of the other conditions is not met, a **My Health Record Help** button is displayed instead of the **Shared Health Summary** and **Event Summary** options.

Changing to a Different Service

If you were part of a past service, you can edit that service.

On the **Progress Notes** tab of the clinical record, you may swap to edit a previous contact note if you were part of that past service.

To change to another service, you can drag and drop any of the contact or service headers onto the current note. Dragging a contact header will attempt to change to that contact's note. If you drag a service header the system will check to see if the current provider is a part of that service before changing to that contact's service. Communicare will check to see if you have the appropriate permissions before changing to that contact note. If you are not part of the past service, you will not be able to switch to edit that provider's note.

Service Record

Use the **Service Record** window to set the provider and encounter place and mode, record billing details and set any requirements.

The **Service Record** window is organised into the following tabs:

- Detail *(on page 99)*
- Medicare *(on page 100)*
- Private *(on page 107)*
- Requirements *(on page 109)*

Service Record Defaults

The following rules determine the default values used when creating a new service record:

- If a specific provider is selected in the main toolbar, the selected provider is the default.
- If **(No provider selected)** is selected on the main toolbar, no provider is selected for the service.
- If a specific place and mode is selected on the main toolbar, the selected place and mode is the default.
- If **(No place and mode selected)** is selected in the main toolbar, no place and mode is selected for the service.

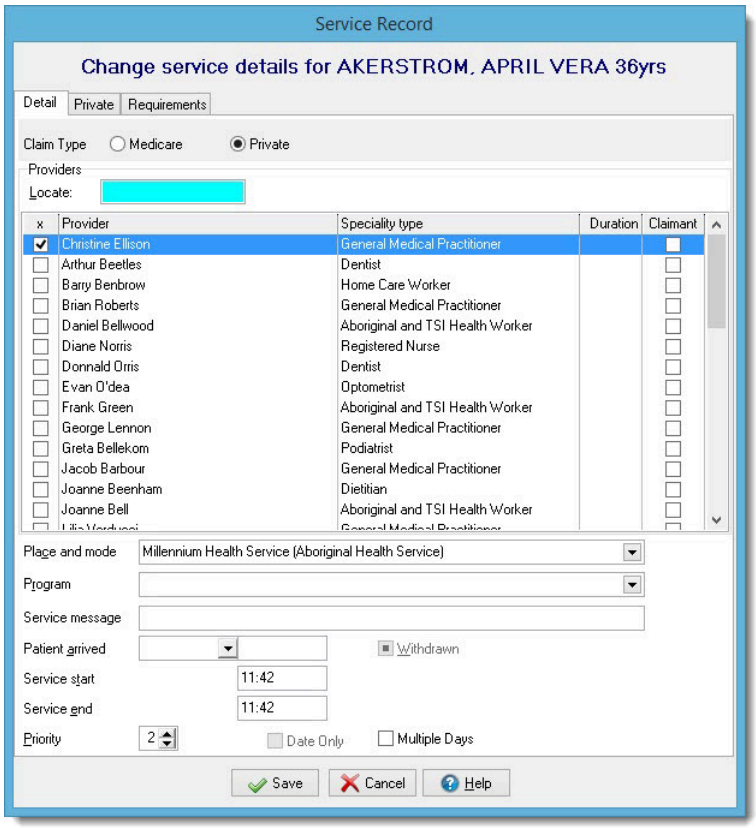
Health Care Home (HCH)

The patient HCH Tier details are displayed next to patient banner only if the patient is registered for HCH and the HCH Tier is recorded.

Service Record - Detail

Use the **Service Record > Detail** tab to set the provider and encounter place and mode.

You can also set the type of billing and service details for the patient on this tab.



- **Claim Type** - type of the billing, either **Medicare** or **Private**. The type of claim selected determines which billing tab is displayed, either **Medicare** or **Private**.
- **Providers** - the healthcare service providers
- **Duration** - displays the time the provider had the clinical record open. Edit the length of the service in the **Duration** field if required.
- **Claimant** - set the claimant in the Providers list. By default, the claimant is the first provider added to the service with a provider number for the encounter place of the service, with GPs taking priority over other speciality types.
- **Encounter place** - the encounter place of the service. For example, Millenium Health Service.

- **Encounter mode** - the encounter mode of the service. For example, Aboriginal Health Service.
- **Patient arrived** - the time the patient arrived.
- **Withdrawn** - set if a patient arrives, but then leaves before a service can start. The start time records the time the patient withdrew.
- **Service start** - the time the clinical record was opened and the service began, or the time the patient withdrew. To reset the service record status, delete the start time.
- **Service end** - the time the service was completed. To reset the service record status, delete the end time.
- **Priority** - set to change the order in which patients are to be seen, if the case is urgent or your health service uses grace periods.
- **Date Only** - if your service doesn't record start and end times, set to record the date instead.
- **Multiple Days**- when a service ends on a day later than the day the service started, set to record the date as well as the time that the service ended.
- **After Hours**- if the service is by date only, set to record an out-of-hours service. This is set automatically for days when there are no clinic hours.

Service Record - Medicare

When a service is completed or paused, a Medicare claim can be submitted either by the provider or reception.

Note the following:

- To submit Medicare claims, the `Electronic Claims` module must be enabled for your health service and you must belong to a user group that has the `Billing` system right.
- You can submit a claim only for patients whose Medicare details are complete. If Medicare details are incomplete, expired or missing, the  Incomplete Medicare Details icon is displayed.
- MBS 10990 or 10991 - Communicare automatically adds MBS 10990 or 10991 items to claims for clients under 16 or who have a valid Centrelink Card. Your Communicare Administrator can change the item to be claimed on Organisation Parameters - Medicare Claims *(on page 837)* or disable the feature.
- After Hours MBS Item Claims - claims for items 3, 23, 36 or 44 are changed to items 5000, 5020, 5040 or 5060 respectively automatically when the service is on a Sunday or public holiday, is before 8:00am or after 1:00pm on a Saturday or after 8:00pm on a weekday or the service is marked as 'after hours' for a date only service. The Public Holidays reference table must be kept up-to-date for this feature to work correctly.
- If there multiple claiming providers, make a separate claim for each provider.
- An offline client can only claim a service that has been entirely created offline.
- If enabled, if you want to batch a claim with other services for the same patient from the same provider and same encounter place, select **Batch claim**. You cannot create a batch service if the service is not started, if there is no claimant provider selected, if the service is withdrawn, or if the service is not claimable. There can be only one active batch claim for a patient per provider per encounter place. You can submit the claim from any of the services that are batched together. Multiple providers are not allowed for batch services.

In the **Service Record** window, you can also decide whether an item is Not normal Aftercare Items *(on page 442)*, Not duplicate service *(on page 443)* or Not part of a multiple procedure *(on page 443)*.

Submit a claim to Medicare

If your health service is integrated with Medicare, you can submit an electronic claim either when you close a service if you are the provider, or later if you are a receptionist or claims manager.

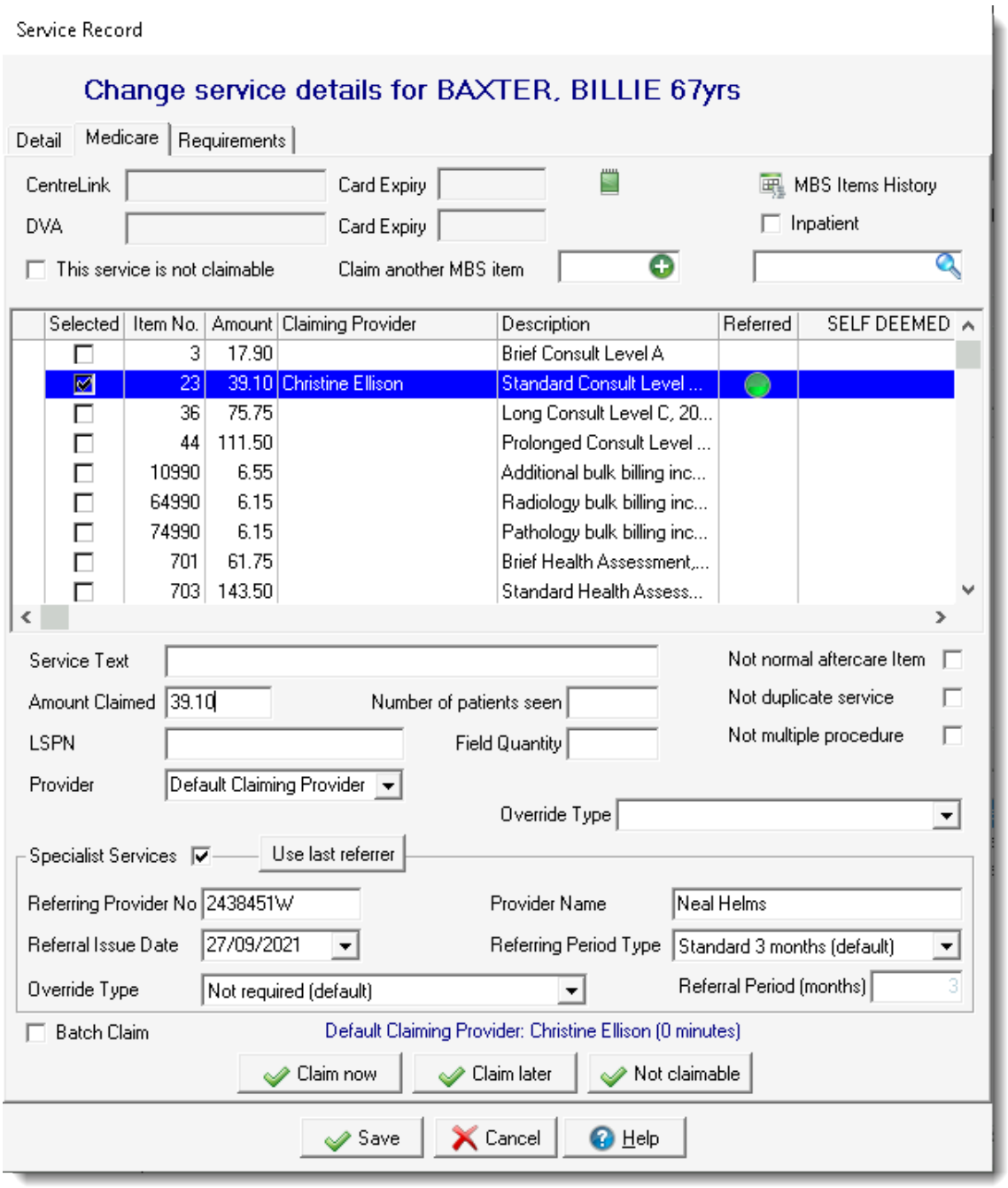
If the service is not claimable, set **This service is not claimable** and click **Save**, or click **Not claimable**.

Select an MBS item and then add the details for that specific item. You can set a different provider for each item.

> **Tip:**
> If a clinical item used in the service is linked to an MBS item for your site, the item is selected automatically.

To submit a Medicare claim:

1. Open the **Service Record** window.
    - If you are the provider and you are submitting the Medicare claim:
        a. In the Clinical Record, click Close.
        b. Click **Yes - This service is now complete** or **No - Patient will see another provider**.
    - If you are the receptionist:
        a. Click  Service Recording.
        b. In the **Service Recording** window, double-click the patient for whom you want to submit a claim.



2. In the **Service Record** window, on the **Medicare** tab, check that the provider listed as **Default Claiming Provider** is correct (listed above the **Claim now** button). If the provider is incorrect, on the **Detail** tab, select the correct provider.
3. Review the information that relates to all items claimed.
    - To view or edit administration notes related to the claim, click Admin notes.

> **Tip:**
> This is useful for doctors to add claim notes for the claims administrator.

    - If enabled, to claim the items as an Inpatient Service, select **Inpatient**.

4. To display previous items that have been marked for claiming for this patient, whether they have been paid or not, click **MBS Items History**.
5. In the list of items, select an item. Most common MBS items are listed.
    - If the item you want to claim is not listed, either:
        - If you know the number of an item which is not listed, in the **Claim another MBS item** field, enter the number and click Add.
        - Search for an item:
            a. Click Search.
            b. In the **Search MBS Items** field, enter a search term. For example, `pregnancy`.
            c. In the list, select an item and click **Select**. The item is added to the list in the **Service Record** window and is selected.
    - If you want to claim an item more than once, right-click the item and select **Add this MBS item again**.
    - If you want to claim an item that does not have a simple fee (such as a home visit), right-click on the item and select **Display the derived fee description for this MBS item**. Using the description, fill in the details required (for example, amount claimed, number of patients seen, and so on).
6. Below the list of items, select the details that apply specifically to the selected item:
    - In the **Amount Claimed** field, if the amount you want to claim for this item is different to the default, enter the correct amount.
    - If this item was provided by a location-specific provider, such as an x-ray machine, in the **LSPN** field, enter its number.
    - From the **Provider** list, select the provider who is claiming the selected MBS item if different from the default provider listed above the buttons.
    - You may need to provide other information specific to your health service in the other optional fields, including:
        - **Service Text**
        - **Number of patients seen**
        - **Field Quantity**
        - **Self Deemed**
        - **Override Type**

      For more information about these fields, see Education guide - Medicare Online data elements
    - If the item being claimed requires details of a referring provider, select the item, select **Specialist Services** and do one of the following:

      Note:
      Referral details are only included once for each claiming provider, so select only one item per specialist claiming provider.

        - Complete the specialist's and the referral details
            - To add details of the last referring provider for the patient, click **Use last referrer**.
            - If the referral has a custom referral period, from the **Referring Period Type**, select `Non-standard` and enter the referral period in the **Referral Period** field.
        - From the **Override Type** list, select an override type:
            - `Lost` - do not provide any referring provider or referrer information.
            - `Emergency` - do not provide any referring provider or referrer information.

- `Hospital` - also set **Inpatient** which includes the Hospital Facility ID *(on page 872)* for the encounter place in the claim. Do not provide any referring provider or referrer information.
- `Referral Provider Details will be submitted` - include a referring provider number and submit the referral separately.

> **Tip:**
>
> If **Specialist Services** is selected and details are complete, a green dot is displayed in the **Referred** column for the claim item. If it has been selected, but some details are missing, a yellow dot is displayed.

- You can also set whether an item is Not normal aftercare items *(on page 442)*, Not duplicate service *(on page 443)* or Not multiple procedure *(on page 443)*.

7. Repeat steps 5 *(on page 103)* - 6 *(on page 103)* for each item, changing the provider if required.
8. When you are confident that the items to claim are correct, click **Claim now**.
   If you have MBS incentive items set for your organisation or encounter place, for eligible patients you are automatically prompted to also include the incentive item appropriate to your region. In the **Confirm** window, click **Yes**.
9. In the **Bulk Bill - Electronic Claims** window, review the bulk bill details and click **Accept**.

The patient's clinical record is closed.

The claim is queued to submit electronically to Medicare Online when `CCareQueue_ServicesAustralia` next runs.

If you submitted a claim incorrectly, correct it as quickly as possible. See Correcting Medicare Claims *(on page 106)* for more information.

In the **Service Record** window, on the **Medicare** tab, next to each item claimed there is an icon showing its status. These icons are also displayed when you open the **Service Record** from the **Online Claiming** window:

- Claim sent or claim pending
- Claim rejected
- Claim paid

Check details of Medicare claims on **File > Online Claiming > Bulk Bill Claims** tab. For more information, see Bulk Bill Claims (Online Claiming) *(on page 423)*.

Daily Medicare Tasks

Each morning, check the Medicare claim status for the previous day's encounters.

The Medicare claim status for each encounter is displayed in the **Claims Status (Online Claiming)** window. Select **File > Online Claiming > Bulk Bill Claims** tab.

Table 22. Medicare tasks by status

Claim Status	Description	
Error: Claim not sent - please retry	There was an error and the claim wasn't submitted to Medicare	Resubmit the claim

Table 22. Medicare tasks by status (continued)

Claim Status	Description	
Claim waiting in queue Claim sent - Awaiting processing Claim processed - Awaiting Payment	One or more of the claims for the service are in progress	No action required if the transmission date is within the previous week Contact Medicare Australia if a claim is still in progress after a week
Claim paid by Medicare Australia	All claims are paid or processed awaiting payment By default, paid claims are not displayed	No action required
Claim partially paid by Medicare Australia	Some claims are paid and the rest have been rejected	Click **View Medicare Australia Report** and read the report. Fix the problem in the claim: 1. In Service Recording or Biographics, open the claim details. 2. Make the required changes, then either: ◦ To resend the claim, click **Claim Now**. ◦ Deselect the items that are not claimable and click **Save**.
Claim rejected - View Report	All claims have been rejected	Click **View Medicare Australia Report** and read the report. Fix the problem in the claim: 1. In the **Claims Status (Online Claiming)** window, click **Reset Bulk Bill**. 2. In Service Recording or Biographics, open the claim details. 3. Make the required changes, then either: ◦ To resend the claim, click **Claim Now**. ◦ If the claim can't be resent, click **Not Claimable**.
Claim discarded	When a rejected claim is retransmitted, the original claim is discarded	No action required

Associated Reports

To display the reports associated with Medicare:

1. Select **Report > Search Reports**.
2. In the **Reports Search** window, in the **Search** field, enter `medicare`.

When required, generate a list of patients whose Medicare details are incorrect, run **Report > Patients > Invalid Medicare Details**. Send this list to Medicare Australia who can provide the correct numbers and other details.

At a convenient time run the Payment Report for all claims. This may take some time depending on the number of claims currently awaiting payment.

See Reports *(on page 453)* for more information.

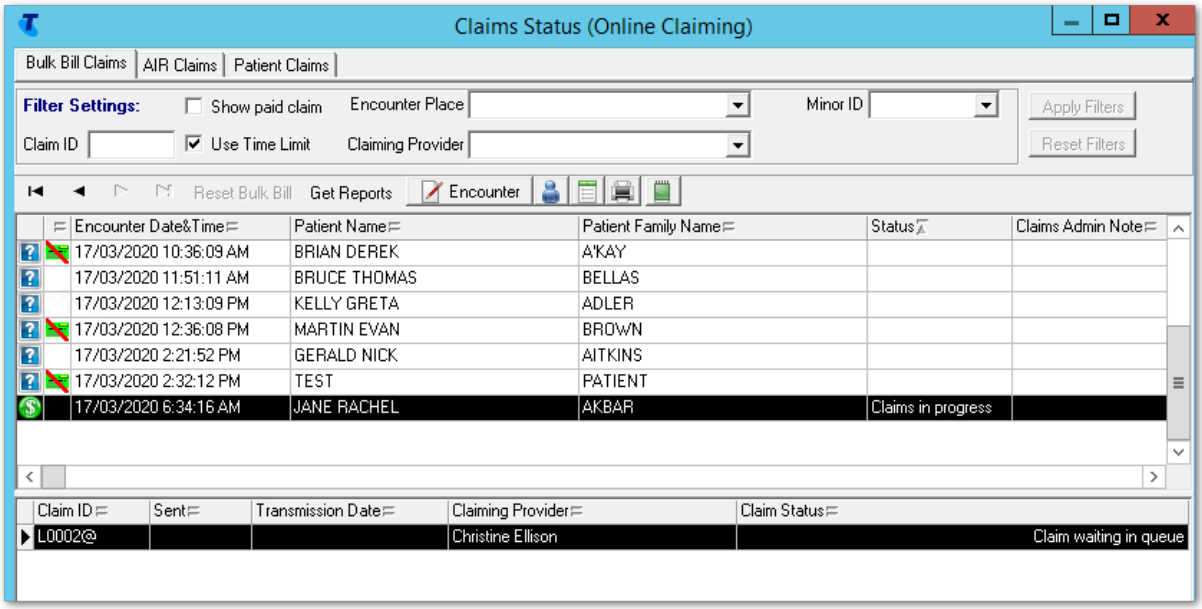
Correcting Medicare Claims

If you mistakenly submit a claim to Medicare, depending on the status of the claim in Communicare, you may be able to revoke if you act quickly.

Depending on the status, you can either:

- Revoke the claim - preferred method, requiring quick action
- Have Medicare intercept the claim
- Have Medicare reverse payment of the claim

Check the status of the claim for the patient in the **Claims Status (Online Claiming)** window. To display this window, select **File > Online Claiming > Bulk Bill Claims** tab.



Revoking the claim

If you submit an incorrect Medicare claim and the claim has either of the following statuses, revoke it by making the claim non-claimable:

- Status of Claims in progress, `Claim Status of Claim waiting in queue`
- Status of Claims in progress, `Claim Status of Claim sent - Awaiting processing`

To revoke the claim:

1. In the encounter list, select the required encounter.
2. Click **Encounter**.

3. In the **Service Record** window, **Medicare** tab, click **Not Claimable**.
4. To confirm that you want to revoke the claim and make it non-claimable, click **Yes**.

Result: The claim is revoked and removed from the encounter list in the **Claims Status (Online Claiming)** window. You can now submit a claim for the correct Medicare items.

To submit the claim again:

1. Click  **Service Recording**.
2. From the **Service Recording** window, double-click the service record of the patient for whom you want to claim. Adjust the filters as required.
3. In the **Service Record** window, **Medicare** tab, deselect **This service is not claimable**.
4. Select the correct Medicare items.
5. Click **Claim now**.

Intercepting the claim

If you submit an incorrect Medicare claim and in the **Claims Status (Online Claiming)** window, the Claim Status is `Claim processed - Awaiting Payment`, immediately ring Medicare eBusiness on 1800 700 199 and ask them to intercept the claim before it is processed.

If Medicare is able to intercept the claim, it is deleted by Medicare and its status remains in `Pending` in Communicare.

To resubmit the claim:

1. After the 7 day period where the claim is locked, select **File > Online Claiming > Bulk Bill Claims**.
2. In the encounter list, select the required encounter.
3. Click **Reset Bulk Bill**.
4. Click **Encounter**.
5. In the **Service Record** window, **Medicare** tab, select the correct items.
6. Click **Claim now** and submit the correct claim to Medicare.

The claim is prioritised and is submitted electronically to Medicare Online immediately.

Reversing the claim

If your Medicare claim has already gone through to Medicare and has a Claim Status of `Claim paid` by Medicare Australia, complete the following steps:

1. Ring Medicare eBusiness on 1800 700 199 and ask them to reverse the payment.
2. Repay Medicare for the amount of the claim.
3. Submit a support request asking for Communicare Support to set that specific paid claim to unpaid in Communicare.
4. If required, correct your accounts so that an incorrect amount isn't reported. For help with correcting your accounts, submit a support request.

Service Record - Private

Check the Private Billing items claimed on the **Private** tab.

To display the **Private** tab, at the end of a service, on the **Detail** tab, set the **Claim Type** to **Private**.

To generate an invoice for Private Billing items, enter the following details:

- **Bill To** - a list of all the Billing Types recorded under **File > Reference Tables > Private Billing > Billing Types**.
- **Reference** - record an external reference number to be displayed on the invoice for the claim.
- **Payer** - select the payer for the service. By default, the patient is added as the payer if they are 15 years or older. To add a new payer to the list, click **Add Payer** and select a payer from the list of existing Individual or Organisation payers. If the Billing Type is Individual, the payer is added from the Payer Management *(on page 451)* or the Address Book.
- **Contact Details** - displays the contact details of the selected payer in read-only mode. For organisations, **Attn:** is displayed with the contact details of a contact person if recorded in the Address Book.
- Fee items - a list of fee items recorded in the Fee Schedule under **File > Reference Tables > Private Billing > Fee Schedule**. The **Amount** column displays the amount associated with the selected **Bill To** item.

  To find an item:
  - **Find Item** - search for fee items by item code or the description.
  - **Claim another item** - to add the same item again, click  Add.

- Enter the following details for each selected fee item:
  - **Inpatient** - if you want to claim the items as an inpatient service, set **Inpatient**.
  - **Service Text** - comments for the selected fee item.
  - **Number of Patients Seen** - the number of patients seen for the selected item.
  - **Override Type**
  - **Not normal aftercare item** - set if this is not a normal aftercare item.
  - **Not Duplicate Service** - set if this is not a duplicate service.
  - **Not multiple procedure** - set if this is not a multiple procedure item.
- **Specialist Services** - if the item being claimed requires details of a referring provider, set **Specialist Services** and enter the following information.

  Tip:
  Click **Use last referrer** to add the details of the last referring provider for that patient.

  - **Referring Provider No** - the provider number of the referring provider.
  - **Referral Issue Date** - the referral issue date.
  - **Provider Name** - the referring provider name.
  - **Referring Period Type** - the referring period type, `Standard 3 months` by default.
  - **Override Type** - if referred services were provided without referral from another health professional, select an override type.
- Enter payment details:
  - **Total Amount** - the sum of the schedule fees for all selected fee items, calculated automatically.
  - **Payment Method** - the preferred method of payment for the service. The default payment method of `Account` is overwritten by the default payment method of the payer.
  - **Amount Paid** - the amount paid by the payer. If the patient pays the full amount of the invoice, click **Pay in Full**. The total amount is added to the **Amount Paid** field automatically. If the total amount changes, click **Pay In Full** again to update the value in the **Amount Paid** field.

> **Note:**
> If Amount Paid is `0.00`, the **Payment Method** must be set to `Account`. If the Amount Paid is greater than `0.00`, the **Payment Method** cannot be set to `Account`.

- **Balance Due** - the amount not paid yet by the payer. That is, the difference between the total amount and the amount paid.
- **Total MBS Amount** - the total of the selected MBS item fee. If any of the selected fee items don't have an MBS item fee, `Derived` is displayed, otherwise the total MBS amount is displayed
- **Gap Amount** - the difference between the Fee Schedule item fee and the MBS item fee. If there are no linked MBS items, both the total MBS fee and the gap are 0.00. If any of the selected Fee Items don't have an MBS item Fee, `Derived` is displayed, otherwise the gap amount is displayed.

To create an invoice or receipt for the selected payer and fee items, click **Invoice / Receipt**. In the **Confirm** window, check that the amount paid and the claiming provider are correct. If the claiming provider is incorrect, click **No** and on the **Detail** tab, correct the claimant. To create the invoice, on the **Private** tab, click **Invoice/Receipt** again.

After the invoice is created, the **Private Billing** tab becomes read only. If you need to make any further changes to the invoice after it has been created, for more information, see Private_Billing_Administration *(on page 449)*.

To save the Service Record details without creating an invoice, make sure there is no value for **Amount Paid** and click **Save**. If the amount paid is greater than `0.00`, an invoice is created.

To view the history of all the transactions for the patient, click **Transaction History**.

Service Record - Requirements

Select a requirement to display an exclamation mark icon in Service Recording.

Maintain the list of requirements at **File > Reference Tables > Requirements**.

Service Record Filter Selections

Use the **Service Record Filter Selections** window to determine which service records are displayed in the **Service Recording** window.

To display the **Service Record Filter Selections** window, in the **Service Recording** window, click  **Filter**.

You can refine the services displayed by service progress, claim status, date, provider, place, mode and speciality.

Select the type of service records to display. Click the status buttons to change the patients displayed, for example, to view only those patients waiting and currently in consultation. Select from:

-  **Booked**
-  **Waiting**
-  **Started**
-  **Paused**
-  **Finished**

-  **Withdrawn**
-  **Cancelled**

To display services for dates other than today, select a date in the calendar.

To display finished appointments displayed based on their bulk bill claim status, set **Claim Status** and select from the following statuses:

-  **Claimed** - a claim has been made. Claims that have a status of `Sending for Processing` are included provided they meet the other filter criteria.
-  **Unclaimed** - a claimable service has not yet been claimed. This filter will include claims which are unclaimable, which will appear with no status icon.
-  **Not claimable** - the service has been marked as not claimable.

You can limit services to those for a specific provider or select (all providers) to show consultations for all providers. It will not filter services that do not have a provider yet.

You can also restrict the services displayed to a particular Encounter Place. Select an Administrative Encounter Place to show services from all Service Encounter Places that belong to it.

Use speciality filters to limit the display to only those services that have a provider with the chosen speciality or specialities. It will not filter services that do not have a speciality yet.

To include services for fictitious patients, set **Include Fictitious Patients**.

To include services for deceased patients, set **Include Deceased Patients**.

Service Record status

The status or progress of a service is indicated by the following icons:

-  indicates that an appointment has been booked.
-  indicates that the patient has arrived. An arrival time has been recorded.
-  indicates that the service has begun. A start time has been recorded.
-  indicates that the service has beeen paused.
-  indicates that the service has been finished. A finish time has been recorded.
-  indicates that the patient left before the service was started. A withdrawal time has been recorded.
-  indicates a cancelled appointment.

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Provider Mode Place Selection

The **Provider, Mode and Place and Program** window is displayed when you open a clinical record and Communicare is unable to identify the provider and mode-place for opening the clinical record.

If you want to be able to change the clinical record, identify yourself as a provider.

If a default is set, the default will be used to identify the user as a provider.

The program selection is optional but should be used whenever a service is part of a defined program.

Data Entry Wizard

This form always appears after first selecting the Data Entry Wizard. This is to confirm not only the details of the provider, mode and place but also the date of the services to be recorded.

Preselecting the Provider

You can set the Provider, Encounter Place, Encounter Mode and optional Program used for all future services.

If your username is linked to a provider name, you cannot change the default provider name. However, you can still change provider names by editing service record details.

To change these settings:

1. Double-click the status bar under the main tool bar.
2. Edit the required settings.
3. Click **Close**.

> **Note:**
> These settings are independent from the filter in the Service Record Filter Selections *(on page 109)*.

Medicare Assignment Form

You can print patient and service details to a Medicare form ready for signing.

The form can be printed on preprinted forms or plain paper. You will need permission from Medicare Australia to use plain paper forms.

To print a Medicare Assignment Form for any patient:

1. In the **Service Recording** window, in the service list, select a completed service with a status of *Finished*.
2. Click  **Claim Form**.

For details on updating MBS items, see Medicare Benefits Schedule Import *(on page 879)* and Medicare Benefits Schedule Shortlist *(on page 878)*.

Medicare Assignment Form Type

Preprinted, tractor-fed form

The printer settings used for the Medicare Assignment Form are:

- Paper Size = Custom
- Length = 214.0 mm
- Width = 227.0 mm
- Left margin = 13.0 mm
- Right margin = 13.0 mm
- Orientation = Portrait

Refer to your Windows documentation for details on how to specify printer stationery.

Plain paper

If you have permission, print a plain paper Medicare Assignment Form to any general use printer.

The Medicare Assignment Form prints to the top half of plain A4 landscape paper. Alternatively, you can insert A5 paper sideways.

Online claiming

If Medicare Online Claiming is enabled for your site, print two Medicare Assignment Form prints to plain A4 paper: one for the patient and one for the site.

No form is submitted to Medicare Australia.

Organisation settings

To check or change the organisation settings for your site:

1. Select **File > Organisation Maintenance**.
2. In the **Organisation Parameters** window, double-click your organisation.
3. On the **Medicare Claims** tab, check or change the settings.
4. Click **Save**.

Workers Compensation

In WA, record workers compensation interactions using the WorkCover clinical items.

During a service, in the **Clinical Terms Browser**, search for the `workcover` keyword and use the following clinical items to record workers compensation activity:

- **Admin;certificate;workers comp** - use to record in Communicare that you have completed the First, Progress and Final Certificates of Capacity. For more information, see https://www.workcover.wa.gov.au/resources/forms-publications/health-provider-resources/#Certificates.
- **Admin;workers comp report**
- **Advice/education;workers comp**
- **Check up;workcover**

For more information, see WorkCover WA.

Clinical Records

The clinical record comprises all clinical information recorded for a patient in Communicare by your health service. It includes clinical items and recalls.

To access clinical records, click  **Clinical Record** or select **Patient > Clinical Record**.

The **Clinical Record** has three main tabs which display the summary, the progress notes and the details of a patient's record.

Common toolbar

The buttons described in the following table are visible regardless of which tab is selected.

Table 23. Main Toolbar

Button	Secondary Link	Description	Module	User Group System Rights required
Clinical Item		Add a clinical item		Clinical Records
Medication		Use to access prescribe, administer, supply or add medication history. Select from the following options.	Prescribing *(on page 223)* Medication View *(on page 811)* Medications management *(on page 811)*	
	Add Medication	Use to prescribe medications or create medication orders.	Prescribing *(on page 223)*	Prescribing - Full Prescribing - Once Off/ Short Course
	Add Medication History	Use to add medications prescribed by other services.	Medication View *(on page 811)*	Medication History
	Administer & Supply	Use to administer and supply medication orders.	Medications management *(on page 811)*	Medications Administer Medications Supply
	S100 Supply	If enabled, use to record supply of S100 medications.		
	Medication Summary	Go to the **Medication Summary** tab.	Medication View *(on page 811)*	Medication View
Pathology		Use to add a pathology request	Investigations *(on page 299)*	Investigations
Imaging		Use to add a diagnostic imaging request	Investigations *(on page 299)*	Investigations

Table 23. Main Toolbar (continued)

Button	Secondary Link	Description	Module	User Group System Rights required
Recall		Add a manual recall		
Letter		Add a new letter		
Scan		Scan a new document	Document Scanning	Document Scanning
Attachment		Add a new Attachment		
Message		Add an intramail message		
Send SMS		Send an SMS message		
Change		Update item details		

Table 23. Main Toolbar (continued)

Button	Secondary Link	Description	Module	User Group System Rights required
 **Remove**		For security, Communicare requires a reason to remove many items from a patient's Clinical Record and keeps a database record that can be retrieved if required (right-click and select Show Deleted Items). This is called logical deletion. Selected items are deleted in one of a number of ways: • Normally the item will be permanently deleted after a warning is shown. This applies to Procedures, Conditions, Immunisations, Adverse Reactions, Referrals, Admissions, History. These items will not be revealed when you select Show Deleted Items. • For items in the Clinical Items summary, this action removes only the summary, not the item. • For prescriptions, the deletion is logical • For a regular medication on the summary page, the action removes that medication from the regular list. To return the item, right-click the medication and select Make Regular. • For investigation results, a matched and reviewed result cannot be deleted. If the result is not matched to a request, it can be logically deleted: this action unmatches the result from the patient. To undelete this result, go to the Review Results window on the main toolbar and match this result to the patient again. • For the patient's documents and care plans, the deletion is logical. • For Administer and Supply, the deletion is logical. **Tip:** To display deleted medications and other items, in the clinical record, on the **Detail** tab, right-click and select **Show Deleted Items**.		

Table 23. Main Toolbar (continued)

Button	Secondary Link	Description	Module	User Group System Rights required
Biographics		View or amend patient details	Biographics	
Reports		Print patient's current service details, summary information or labels	Clinical Reporting	
Charts		View a list of available charts		

Go To		Jump to external services with which Communicare is integrated:
		• **AIR** - if you are using the client adapter to access Services Australia, check the patient's immunisation history in the Australian Immunisation Register.
		• **Australian Immunisation Register portal** - if you are using the web service to access Services Australia, check the patient's immunisation history in the Australian Immunisation Register.
		• **NCSR Hub** - display the patient's NCSR record
		• **HealthLink SmartForms** - open the HealthLink SmartForms directory. Relevant data from the patient's Communicare record is added to the form you select.
			`Electronic Claims`
			`NCSR Integration`
				`AIR Patient Integration`
				`NCSR Integration`
				`HealthLink SmartForms integration`

Services		Display a list of patient's services	Service Recording	
Claims		View all Medicare items previously selected for claiming for the patient, including all items marked for claiming, whether or not they have been submitted, processed or paid		

Table 23. Main Toolbar (continued)

Button	Secondary Link	Description	Module	User Group System Rights required
 **Open My Health Record**		Access a patient's My Health Record profile. The button background is red if the patient does not have an existing My Health Record, or green if the patient does have an existing My Health Record. If MeHR to My Health Record Transition is enabled, you can also use this option to access a patient's MeHR profile.	My Health Record Access My Health Record Assisted Registration MeHR to My Health Record Transition	My Health Record Access My Health Record Assisted Registration
 **Transport**		Use to manage patient transport requirements	Transport Management Transport Services	
 Pause		Quickly pause the service without displaying customary service exit prompts		
 Help		Open the help		
		Access a patient's MeHR profile. The button background is red if the patient does not have an existing MeHR, or green if the patient does have an existing MeHR. If MeHR to My Health Record Transition is enabled, this option is available only if the following conditions are true: • Patient has a MeHR • Patient does not have a My Health Record • Provider has MeHR access • Provider does not have My Health Record access	MeHR MeHR Administration MeHR e-Registration Auto-Prompt MeHR to My Health Record Transition	

Table 23. Main Toolbar (continued)

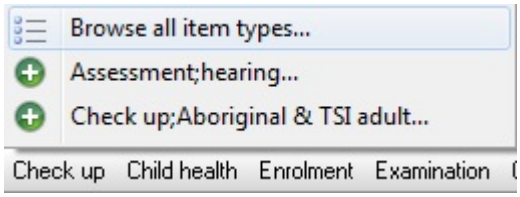
Button	Secondary Link	Description	Module	User Group System Rights required
		Send a health profile to MeHR. If MeHR to My Health Record Transition is enabled, this option is available only if the patient does not have a My Health Record and the provider does not have access to the My Health Record.	MeHR MeHR Administration MeHR e-Registration Auto-Prompt MeHR to My Health Record Transition	
		The patient's current Information Sharing Consent status. Click to change the patient's consent status. •  - the patient has not been asked for their consent •  - the patient has given their consent •  - the patient has refused to share their data across multiple organisations. This button is available only if more than one organisation exists in Organisation Maintenance.	Information Sharing Consent Maintenance Information Sharing Consent Recording	
Health Care Home (HCH)		The patient HCH Tier details are displayed next to the patient banner only if the patient is registered for HCH and the HCH Tier is recorded.		

Finding out more detail about an item

For any item in the clinical record, right-click and select **Find Associated Service Details**. Communicare will take you to the service details for that item, by highlighting the progress notes that belong with that item on the **Progress Notes** tab. To display further details about a progress note, double-click it.

Commonly used clinical items

At the bottom of the clinical record are buttons which, when clicked, display a menu of commonly used items.

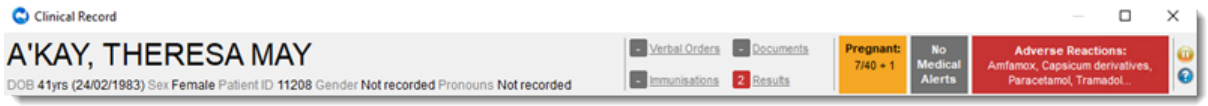


These menu buttons can be configured at your site to reflect your own needs. Your Communicare Administrator can define buttons by creating a keyword of `$Button Name` and attaching this keyword to the appropriate items (see Clinical Item Keyword *(on page 889)*). The items are listed alphabetically.

Clinical Record Header

A patient's personal details, any actions required and important clinical information are included in the banner of the patient's clinical record.

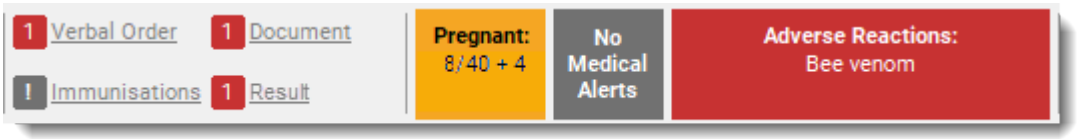
The patient banner is displayed at the top of all windows in a patient's clinical record.



It includes:

- Patient details summary, derived from the patient's biographics:
  - Patient's full name
  - Age
  - Date of birth
  - Sex
  - Communicare patient ID
  - Gender
  - Pronouns
  - Medical Record Number (where provided and configured)
  - Health Care Homes Status (where enabled)

  Where no value is recorded for date of birth, sex, gender or pronouns, `Not recorded` is displayed.
- Action required banner - important clinical information and actions required.
  Click any link to go to the appropriate section in the clinical window.



Actions list

The left side of the banner contains links to the following information:

- **Verbal Orders** - a count of active, unreviewed verbal orders. This link is visible only if the `Medications Management` module is enabled.
- **Documents** - a count of unreviewed documents. This link is visible only if you belong to a user group with the `Electronic Documents` system right.
- **Immunisations** - an exclamation mark (**!**) indicates that there are immunisations recorded for this patient.
- **Results** - a count of unreviewed pathology and radiology results. Grey indicates that there are no unreviewed results. Click the link to go to the **Detail > Ix Result** tab which lists the unreviewed results. Double-click a result to review it. This link is visible only if you belong to a user group with the `Investigations` system right.
- **NCSR** - a count indicates that alerts exist for this patient in the NCSR hub. Grey indicates no alerts exist, patient not found or Medicare provider number doesn't exist. For more information, see Patient banner *(on page 793)*.

The background of the link icons are colour-coded:

- 

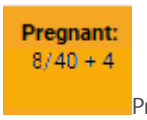
Red - indicates that attention is required. For example, if there are unreviewed investigations for this patient.
- 

Grey - indicates that no action is required. For example, the documents link is grey when there are no unreviewed documents in the system for this patient.
- 

Grey with icon - indicates that no action is required but information is available. Hover over the icon to display further information. For example, this patient has immunisations listed in Communicare.

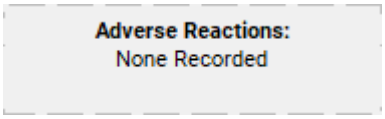
Clinical information

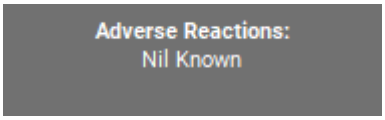
The right section of the banner displays important clinical information:

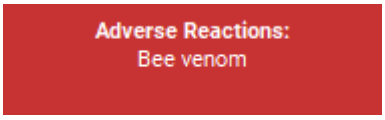
- 

Pregnancy - if a patient is pregnant and the pregnancy has been recorded on the **Obstetrics** tab, the pregnancy panel is displayed with a yellow background. The panel shows the gestation of the pregnancy. Click to go to the **Current Pregnancy** tab and view the obstetrics summary. For more information about the gestation displayed, see Gestation calculation *(on page 137)*.
- 

Medical alerts - a panel indicating any medical alerts that apply to the patient. If present, click to go to the **Alerts and Other Information** pane on the **Main Summary**. Otherwise, `No Medical Alerts` is displayed.
- Adverse reactions - a panel listing as many allergies and adverse reactions as possible. Click to go to the **Adverse Reaction Summary** pane on the **Main Summary**. The adverse reactions panel is displayed in one of the following ways:

- 

- no allergies or adverse reactions have been recorded for this patient. You will be prompted to record adverse reactions when prescribing.
- 

- a clinician has determined that this patient does not have any allergies or had any adverse reactions and has set **Nil Known** in the **Adverse Reaction Summary**.
- 

- allergies or adverse reactions are included in this patient's clinical record.

Summary tab

The **Summary** tab contains a summary of the patient's clinical record.

From the **Summary** tab, you can access summaries of a patient's clinical information:

- Main Summary *(on page 122)*

  By default, the **Main Summary** tab is displayed when you open a patient's clinical record.
- Medication Summary *(on page 127)*
- Social & family History *(on page 131)*
- Care Plan *(on page 131)*
- Obstetrics *(on page 132)*

Main Summary

Use the **Main Summary** to get an overview of your patient's health. The **Main Summary** is displayed when you open a patient's clinical record.

The panes visible in the **Main Summary** depend on which System Parameters *(on page 810)* are set.

For any item included on the **Main Summary** tab, to go to the service in which the item was added, right-click the item and select **Find Associated Service Details**.

Active Problem/Significant History

The clinical items for which you set **Display on Main Summary** are listed in the **Active Problem/Significant History** pane together with additional information. Only one item is listed for each clinical item type, no matter how many times it is selected for display on the main summary.

The additional information displayed depends on the **Clinical Summary Style** set for your health service:

- **Consolidated**:
  - **Times** - a count of the number of times this clinical item type occurs in the patient's record, regardless of whether the other occurrences have been marked for **Display on Main Summary**.
  - **First** - the date of the first occurrence of this type of clinical item.
  - **Last** - the date of the most recent occurrence of this type of clinical item.
- **Simple**:
  - **Date**
  - **Class**
  - **Status**
  - **Comment**

For more information about **Clinical Summary Style**, see System Parameters - Clinical *(on page 816)*.

To display a clinical item on the **Main Summary** tab, set **Display on Main Summary** when you add the clinical item to the clinical record. To display a clinical item that already exists on the **Main Summary** tab, on the **Progress Notes** or **Detail** tabs, double-click the item and set **Display on Main Summary**.

To remove a clinical item type from the **Main Summary** tab, right-click the clinical item type and select **Remove Item from Summary**. The original entries are not affected.

Alert information

The **Alerts and Other Information** or **Alerts** pane shows important information that you need to be aware of when dealing with this patient.

> **Note:**
> The visibility of alerts in the clinical record may be restricted. See System Rights *(on page 923)* for more information.

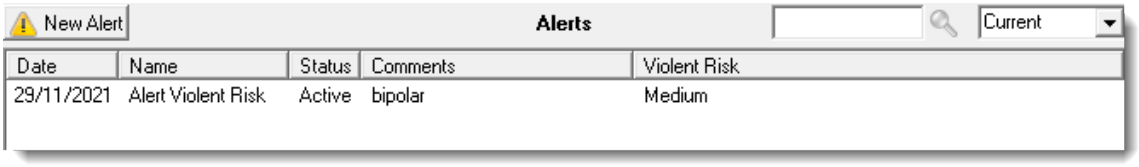
Your health service may use either free text alerts which are displayed in the **Alerts and Other Information**, or structured alerts, which are displayed in the **Alerts** pane.

- Free text alerts - add or update alerts by typing in the pane or deleting the relevant parts of the information. To format, edit or print the text, right-click in the pane and select the required option.

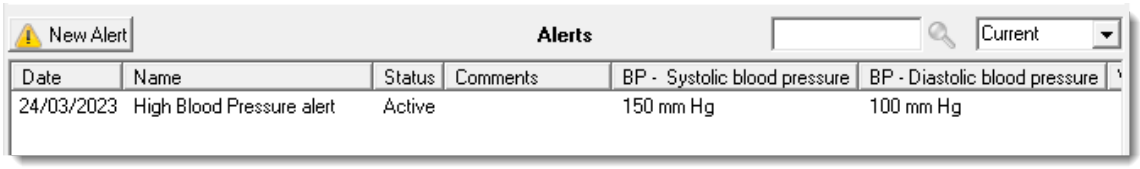
  If any text is added to the **Alerts and Other Information** pane, the banner shows **Has Medical Alerts**.

  Set **At risk if appointments are missed** to filter patients with an upcoming or missed appointment in some appointments reports. If an appointment is missed, the header of this section is highlighted in red.

- Structured Alerts - if enabled, any clinical items of class Alert *(on page 894)* added to the clinical record are displayed in the **Alerts** pane.



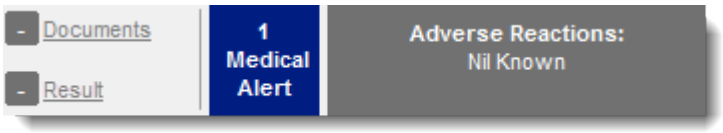
Individual qualifiers can also be added as extra columns to structured alerts. For details on how to set qualifiers to be displayed in structured **Alerts**, see Qualifier - show on alert summary *(on page 897)*.



To enable structured alerts, in **System Parameters > System**, enable **Structured Alerts**.

To add new structured alerts, click **New Alert** or add a clinical item of class `Alert`. To edit an item, double-click it and edit as you would for any clinical item.

If a patient record has a structured alert, a count of alerts is added to banner.



To change the status of a structured alert, right-click and select one of the following options:

- **Make Active** - structure alerts are automatically active when you first add them. You can make an inactive alert active again.
- **Make Inactive** - if an alert is not currently relevant, set it to inactive. Inactive alerts can be activated again.
- **Make Resolved** - if an alert is has been resolved, set it to resolved. The alert is removed from the alert list.

To search for an alert, enter a search term in the search field. Restrict the results by selecting a status on which to filter.

Adverse Reaction Summary

The **Adverse Reaction Summary** shows information for the current patient.

To add an adverse reaction, click **New Adverse Reaction**. For more information, see Adverse Reaction Maintenance *(on page 255)* form.

When adding a reaction, any current prescriptions that conflict with the adverse reaction are presented. When adding any prescriptions in the future, any conflicts require acknowledgement before prescribing can continue.

To display the most recent date that the patient was assessed for adverse reactions in the **Assessment Date** field, select an adverse reaction.

To view the details of reaction, double-click it.

To edit a reaction, right-click the required reaction and select **Edit Reaction**.

To delete a reaction, right-click the required reaction and select **Delete Reaction**.

Qualifier Summary

The **Qualifier Summary** pane displays the most recent measurements taken for qualifiers *(on page 897)* marked for summary in **File > Reference Tables > Qualifier Types**.

The order in which the qualifiers are displayed is determined by the **Summary Order** value defined in **File > Reference Tables > Qualifier Types**. If no values are set, qualifiers are ordered alphabetically.

If the date is highlighted in red, the measurement has exceeded the **Currency** period defined in **File > Reference Tables > Qualifier Types**.

For details on how to set what qualifiers are displayed on the **Qualifier Summary**, the currency period and display order of a qualifier, see Create and Edit Qualifiers *(on page 897)*.

The date and value shown here may refer to data that is otherwise not visible to the user because it is attached to a clinical item type that the user is not allowed to view or may have been collected in a service associated with a program that the user is not allowed to see. However, if the user is not allowed to see any of the clinical item types that have this qualifier attached, that user will not see the qualifier listed in the qualifier summary at all.

To view a qualifier's history in the **Previous Measurements** window, double-click it. Only data that you're allowed to see is displayed.

To Do

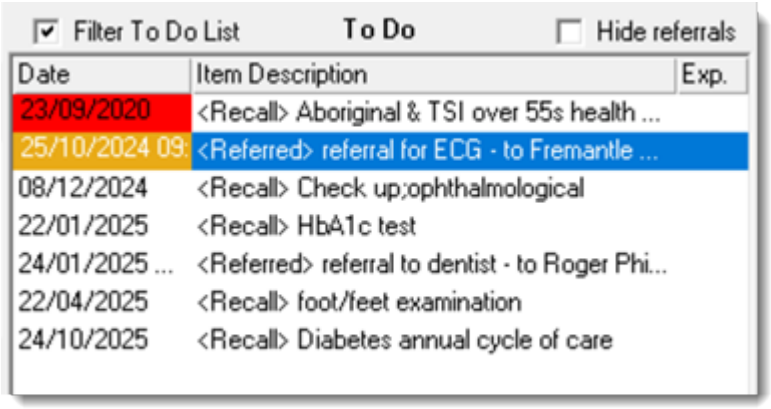
The bottom right-hand pane displays a summary of all recalls and referrals overdue, due and scheduled. For more information, see To Do list *(on page 125)*.

To Do list

The **To Do** list displays outstanding recalls and incomplete referrals that may require follow up. Recalls and incomplete referrals are added to the **To Do** list automatically when a recallable clinical item is added to a service or when a recall is added by Communicare.

The **To Do** list is displayed on the **Main Summary** and **Progress Notes** tabs.

Items listed in the **To Do** list are colour-coded by due status:



- Scheduled - white
- Due in the next 30 days - amber
- Overdue - red

> **Tip:**
> To limit the items displayed in the **To Do** list, use either or both of the following filters:
>
> - To limit the items listed to those due within the next year, set **Filter To Do List**, or right-click and select **Limit display to one year**.
> - To display only recalls, set **Hide referrals** or right-click and select **Hide referrals**. Referrals are always displayed when you open a new service.

If a recall or referral was added manually, to display the service during which the recall or referral was added on the **Progress Notes** tab, right-click and select **Find Associated Service Details**.

Recalls

To complete, modify or cancel a recall, double-click an item in the list and select the option you require.

If an expiry date has been specified for a recall, the time remaining until its expiry is displayed in the **Exp.** column.

For more information about recalls, see Recalls *(on page 348)*.

Referrals

The **To Do** list also shows incomplete referrals that were added to the clinical record as recallable, referral clinical items, for example, `Referral (for);ECG`. Incomplete referrals may be referrals that have been made, but there is no confirmation or appointment date yet known, or referrals that have an appointment date, but the outcome has not been recorded yet. Referral letters without an associated clinical item are not included in the **To Do** list.

> **Tip:**
> If you expect to see a referral but it is not displayed, ensure **Hide referrals** is not set.

Overdue referrals can be managed in the following ways:

- If the referral is no longer required it can be cancelled in the same manner as a recall. Cancelled referrals are removed from the **To Do** list.
- If an appointment date or other response from the referree has been received, double-click on the referral and enter the details. Until there is an appointment date, the referral is ordered by the date of referral. Once there is an appointment date this becomes the date of the referral.
- Once a referral is complete, double-click on the referral and enter a date completed (**Referral Complete** date). The referral is removed from the **To Do** list and added to the **Detail** tab of the clinical record.

For WACHS, the **Referral Management** system module is enabled, and incoming referrals are managed from the **Manage Incoming Referrals** window. For more information, see Referral Management *(on page 342)*.

Referral Status

A referral might have one of these statuses.

Communicare defines the following statuses for a referral.

- Recall (awaiting referral). The patient has not actually been referred yet. This status is used to indicate those patients that you wish to refer when the service becomes available. In a remote community, for example, children that need to see the ear specialist may have a recall for a referral added until the specialist's next visit.
- Referred (referred and waiting for a response). The patient has been referred, that is the referral letter (or similar) has been sent. An appointment may or may not have been made, but the treatment has not been performed.
- Complete. The patient has been treated by the specialist.

Medication Summary

The **Medication Summary** displays all active medications, including once-off or regular medications prescribed to the patient, supplied, administered, or added to their medication history.

> **Warning:**
> The **Medication Summary** is an overview of the patient's medication profile. Medications associated with restricted viewing or program rights may not be visible to users who do not have the appropriate viewing rights or program access.
>
> Clinicians should always confirm that the medications listed on a patient's **Medication Summary** are an accurate representation of the medications that the patient is currently prescribed.

If prescribing is enabled for your organisation, and you have **Medication View** and **Prescribing** rights, you can repeat, edit or stop medications from the **Medication Summary**.

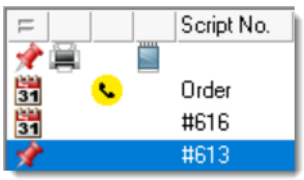
The **Medication Summary** icon changes according to its content, but is not affected by Medication History items.

- - white background, there are no medications on this tab
- - red background, some regular medications have expired
- - green background, there are medications listed and no regular medications have expired

> **Tip:**
> To jump to the **Medication Summary** from the main toolbar, select **Medication > Medication Summary** or press `SHIFT+CTRL+F9`.

Current and regular medications codes

Icons and codes are displayed to the left of the medications listed, indicating the status of that medication.



> **Tip:**
> The icons and codes are also described in the legend at the bottom of the **Medication Summary** tab.

- Medication type:
  - Regular Medication - any medication that the patient would be expected to take continually and set as **Regular Medication** when prescribing, generally for a chronic disease. Regular medications are always listed on the **Medication Summary** until they are explicitly stopped because they are no longer clinically required.
  - Once Off Medication - any medication for acute clinical presentations that the patient will take until the prescribed course is complete and set as **Once off/Short Course** when prescribing. Once off medications are no longer displayed on the **Medication Summary** after they have passed their until date because they are no longer current.
  - Stopped or Represcribed Medication - stopped or represcribed regular medication, either manually because it is no longer clinically required, or automatically because a new regular medication is prescribed that matches the initial medication.

    Represcribed medications are prefixed with `<Represcribed date>`.

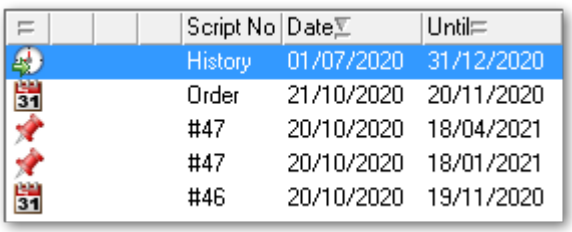
    Stopped medications are prefixed with `<Stopped date>` and are displayed in grey text.

    Manually stopped medications are displayed on the **Medication Summary** until they reach their until date. Automatically stopped medications remain listed in the **Medication Summary** for the rest of the day and are then removed.
  - Expired Regular Medication - expired regular medication that has passed its until date. Expired regular medication should be represcribed or stopped. It remains listed in the **Medication Summary** until it is stopped.
  - Medication History - all medication records added to the patient's clinical record using Medication History. These records are prefixed with `<History>`. You cannot prescribe, print or issue repeats for historical scripts.
- Medication Status: Finalise - if the medication is not yet finalised, the Finalise icon is displayed and no script number or medication type is listed.
- Verbal order:
  - Verbal order, unreviewed - unreviewed verbal orders.
  - Verbal order, reviewed - reviewed verbal orders.
- Notes: Notes - comments are included in the **Internal Comments** field of the prescription.

Other information

The following information is also displayed for medications where relevant:

- **Script No.** - displays the type of medication, one of:



    - For prescriptions, after the prescription is finalised, the `#script_number` is displayed
    - For medication orders, `Order` is displayed
    - For medication history items, `History` is displayed
- **Date** - the date on which the medication was prescribed, ordered or added as a history item
- **Until** - the date calculated from the duration, after which the medication expires in Communicare. The duration is calculated from the total number of packs together with repeats, assuming that each pack lasts 1 month, to a maximum of 12 months.
    - For regular medications, if the until date specified when the medication was prescribed has passed, the background of the **Until** date field is coloured red.
    - For regular medications with fewer than 28 days left on the prescription, the background of the **Until** date field is coloured gold to remind you to represcribe the medication to ensure that the patient has enough supply of the medication.
    - For once-off and short course medications with fewer than 28 days left, the background of the **Until** date field is coloured gold.
    - Once off or short course medications are removed from the **Medication Summary** when the until date has passed.
- **Repeat**, **Edit**, **View**, **Stop** - links to actions you can perform on the medications
- **Medication** - the medication prescribed, ordered or recorded as a history item. For more information about the layout, see Active Ingredient Prescribing *(on page 230)*.
- **Route** - the route of administration for the medication
- **Dosage** - the dosage or DAA specified for a prescription.
- **Order Instructions** - the order instructions specified for a medication order.
- **Last Supplied** and **Qty Supplied** - the date on which the medication was last supplied from imprest and the number and type of units that were supplied
- **Last Administered** and **Qty Administered** - the date on which the medication was last administered to the patient and the number and type of units that were administered.
- **ePrescription Status** - the most recent prescription format and send status for an ePrescription:
    - `Sent SMS | Sent Email | Sent Printed Token` - the ePresciption was successfully sent
    - `Resend SMS | Resend Email | Resend Printed Token` - the ePresciption was successfully sent again
    - If the ePrescription was stopped or deleted in Communicare:
        - `Cancel Created` - the medication was stopped or cancelled in Communicare by the user
        - `Cancel Initiated` - a cancellation or cease message has been sent to eRx, but no response has yet been received
        - `Cancel Successful` - the cancellation or cessation was successful
    - `Cancel Failed | Cancel Failed - PDS unavailable` - the cancellation or cessation failed

Tip:

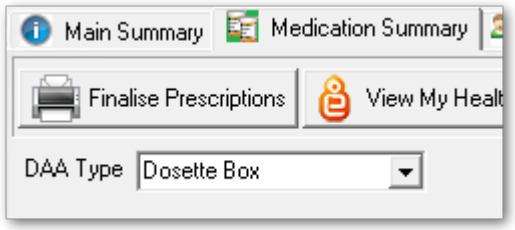
You can sort the data based on a particular column: in the column header, click Sort. The column being used to sort the data displays the Sort icon. To revert to the default sorting, right-click and select **Reset Normal Ordering**.

You can also reorder the columns as required. Click a column header and drag and drop it in the required location. The new column order is unique to your login and is applied to all patient records that you open in the future. To reset the column order, in the **Medication Summary**, right-click and select **Reset Column Ordering to Default**.

Settings

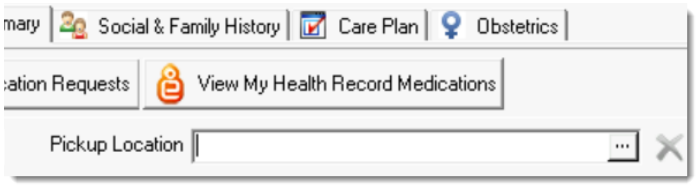
DAA type

You can set a default Dosage Administration Aid (DAA) type for a patient so that when you prescribe a medication, the patient's preferred DAA type is selected automatically. Set the patient's preferred DAA type in **Medication Summary > DAA Type** field.



Pickup location

If you use medication requests or consolidated orders, you can set the location from which the medication will be supplied to a patient after it has been fulfilled. Select the patient's preferred location from the **Medication Summary > Pickup Location** field.



To clear the pickup location, click  Clear.

Displaying all medications

The full list of a patient's medication for all time is displayed on the **Detail** tab. This list includes expired once off and short course medications and stopped regular medications.

> **Remember:**
> Medications associated with restricted viewing or program rights to which the user does not have access are not displayed.

To display all medications, in the **Detail** tab, set **View Clinical Items** by **Class** and select the **Rx - Prescription** tab.

Medications Link

To view a list of a patient's current and previous medications in the **Medications** tab, click **Medication Detail**.

The link is always blue, but if there is no medication detail, the link displays **No Medication Detail**.

If you cannot see the **Medication Detail** link at the bottom of the **Medication Summary** page of the clinical record, you do not have permission to view medication detail.

Social & Family History

Use the  **Social & Family History** tab on the **Summary** in the clinical record to manage the patient's social and family history.

Any information added to the `Social & Family History` clinical item type is summarised on the **Social & Family History** tab.

You can provide updates in the `Social & Family History` clinical item to the `Social history` or `Relevant family history` qualifiers or directly in the **Social & Family History** tab. All updates are displayed in both the tab and the `Social & Family History` clinical item. If a `Social & Family History` clinical item doesn't already exist for the patient, it is added.

> **Tip:**
> To refresh the information displayed on the tab, change to another tab and back again.

> **Note:**
> When the clinical item is created, it uses the current date instead of the date of the service. This means that even if the date of the service is changed to a past date when updating the history, Communicare creates a clinical item with today's date.

Care Plans

Use the  **Care Plan** tab on the **Summary** in the clinical record to manage a patient's care plans.

Before you can add a care plan for a patient, the care plan template must be added to Communicare and assigned the Document type of `Care plan template` and a viewing right. Care plans are displayed on both the **Care Plan** tab and on the **Detail** tab under the class of **Documents**. For more information, see Communicare Templates *(on page 957)*.

To view care plans, you must belong to a user group with the same viewing right as that assigned to the care plan template, typically `Care Plan`.

The icon for the **Care Plan** tab changes according to the content.

-  - displayed when there are no active care plans
-  - displayed if there are one or more active care plans and you have the correct viewing rights to see the care plan

To add a new care plan for a patient:

1. In the patient's clinical record, on the **Summary > Care Plan**tab, click  **New Care Plan**.
2. In the **Select Document Template** window, select the required care plan and click  **Select**.

   > **Tip:**
   > Each patient can have only one care plan for each topic.

   A blank care plan opens in the **Letter Writer**.

3. Complete the care plan as required.
4. Click Close and in the **Save** window, click **Yes**.
5. Click **Save**.

The care plan is saved in the user's clinical record and displayed on the **Care Plan** tab.

If you need to print the care plan, on the **Care Plan** tab, click **Print/Preview Current Care Plan**.

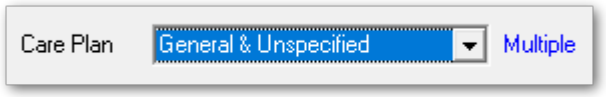
If you need to update a care plan, click **Revise Care Plan** and repeat steps 3-5 above.

If the selected care plan is no longer required or valid, to archive the care plan, click **Archive Care Plan**. The archived care plan document is available on the **Detail** tab.

Multiple care plans

If you have multiple care plan templates that belong to separate default topics, you can add more than one care plan, as long as each care plan uses a template with a different default topic. For example, a patient can have two care plans, one that belongs to the `General & Unspecified` default topic and the other that belongs to the `Psychological` default topic.

If a patient has multiple care plans, on the **Care Plan** tab, `Multiple` is displayed beside the topic.



To display the required care plan, select the topic to which it belongs from the **Care Plan** list.

Obstetrics & Pregnancy

Use the **Obstetrics** tab to view all pregnancies past and present, start and end a pregnancy, and record antenatal checkups.

Only users who have the `Maternal & Sexual Health` viewing right will see the details on the **Obstetrics** tabs.

The antenatal record records the pregnancy number for all ICPC-2 PLUS clinical items that record either a pregnancy start, pregnancy check or pregnancy end.

> **Tip:**
> Your Administrator can customise Communicare pregnancy items:
>
> - Use your own antenatal check by attaching the **System Code** of `PRE` and the **Rule Code** of `PR-CHECK` to an item
> - Disable any of the pregnancy end items provided by ICPC-2 PLUS that are not required

All Obstetrics tabs display the following information:

- **Description of Pregnancy** - lists information from each antenatal check. To view information from previous pregnancies where relevant, click Next Pregnancy or Previous Pregnancy arrows on either side of the heading.
- **Relevant Medical History** - displays any important clinical items that relate to obstetrics for which **Display on Obstetric Summary** has been set. To remove an item from the list, deselect **Display on Obstetric Summary** in the clinical item or right-click the item in the list and select **Remove Item from Obstetric Summary**.

  Set the default value of **Display on Obstetric Summary** in the clinical item type in the Clinical Item Type Reference Table *(on page 886)*.

Deleting Pregnancy Start and Pregnancy End items recorded by mistake

If you accidentally record an incorrect new pregnancy, end pregnancy or past pregnancy item, delete the item from the **Detail** tab or the **Progress Notes** tab.

In the **Obstetrics** tab, you can double-click an item to edit it, but you cannot delete it.

Recording a new pregnancy

When a woman presents with a confirmed pregnancy, start a new pregnancy.

The **Obstetrics** tab is available only for patients with a sex of Female.

> **Tip:**
> Your site may have defined a custom clinical item for start of a pregnancy.

You can record a new pregnancy either on the **Obstetrics** tab, or by selecting one of the other pregnancy clinical items as normal. Use the **Obstetrics** tab to record the pregnancy details described here.

To start a new, confirmed pregancy:

1. In the patient's clinical record, go to the **Summary > Obstetrics > Obstetric History** tab.
2. Click **New Pregnancy > Pregnancy;confirmed**.
3. In the **Add Clinical Item** window for **Pregnancy;confirmed**, complete the details.

   The only required field is **Pregnancy Number** which increments automatically for all ICPC-2 PLUS clinical items that record a pregnancy start in Communicare.

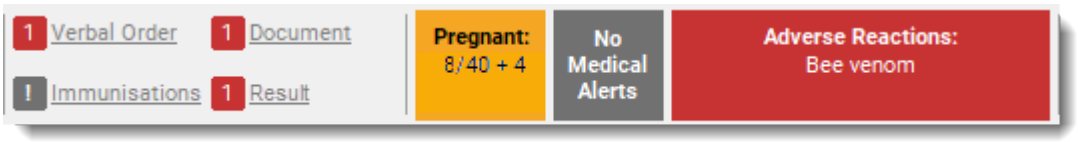
   > **Note:**
   > Ensure that you record the correct pregnancy number even if previous pregnancies are not yet recorded. Communicare uses the pregnancy number to link pregnancy checks and pregnancy end.

4. Record the estimated delivery date (EDD) using one of the following methods:
   - LNMP:
     a. If known, from the **Date of LNMP** calendar, select the date that the patient's last normal menstrual period (LNMP) commenced.
     b. Click in the **Estimated delivery (by date)** field and in the **Confirm** window, click **Yes**.
   - Ultrasound: if an ultrasound has already been performed and an estimated delivery date acquired, enter the this date in the **Estimated delivery (by ultrasound)** field.

> **Tip:**
>
> If you click in the **Estimated delivery (by date)** field after you enter an Estimated delivery (by ultrasound) and confirm it, the Estimated delivery (by ultrasound) date is used.
>
> If required, you can override the calculated date: click in the **Estimated delivery (by date)** and enter the required date.

5. To calculate the gestation, click in the **Gestation** field.
   Gestation is calculated by counting back from the EDD to the date of the clinical item.
6. If you want to record previous pregnancies in Communicare without having to record the entire history as individual past pregnancies, in the **Gravida** field, enter the total number of pregnancies including the current pregnancy.
   - If you want to distinguish between pregnancies, click in the **Parity**, **Number of miscarriages** or **Number of terminations** and enter the number of pregnancies with each outcome.
   - To view details of previous pregnancies, click Chart.
7. Enter any foetal observations and other information.
8. Click **Save**.
9. If there are existing medications that interact with a pregnancy, the **Pregnancy Interactions** window is displayed. Read the interactions and click **Noted**.
10. In the **Confirm Automatic Recall** window, set a recall interval and responsibility and click **Save**.

The patient's current pregnancy information is displayed on the **Summary > Obstetrics > Current Pregnancy** tab and a pregnancy alert is displayed in the banner.



> **Remember:**
> If there were any pregnancy interaction warnings, go to the **Medication Summary** and review the patient's current medications.

Record any updates to the estimated delivery, antenatal checkups and other obstetric immunisations and procedures in new clinical items.

To edit the original **Pregnancy;confirmed** item, on the **Current Pregnancy** tab, click **Current Pregnancy No.**.

> **Note:**
> Do not edit the original **Pregnancy;confirmed** item to edit the EDD. Instead add a new antenatal checkup.

Recording past pregnancies

You can add past pregnancies that were not recorded in Communicare at the time of pregnancy.

The **Obstetrics** tab is available only for patients with a sex of Female.

You can record a past pregnancy in either on the following ways:

- Past pregnancy clinical item with details
- As a number of pregnancies using gravidity either when adding a new pregnancy or at any time

To record details of a past pregnancy:

1. In the patient's clinical record, go to the **Summary > Obstetrics > Obstetric History** tab.
2. Click **Past Pregnancy** and select the appropriate clinical item. For example, `Delivery;normal vag;liveborn`.
3. In the **Pregnancy Number** field, enter the correct pregnancy number. Communicare uses the pregnancy number to link pregnancy checks and pregnancy end.
4. In the **Date of delivery** field, enter the baby's birth date.
5. Enter any other information known.
6. Click **Save**.

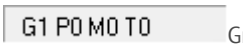
All pregnancy outcomes are listed on the **Summary > Obstetrics > Obstetric History** tab, in the **Previous Obstetric History** table.

If you want to edit a pregnancy outcome later, for example, to add the baby's name and sex, double-click it in the **Previous Obstetric History** table.

Gravidity

You can record past pregnancies simply as a number of gravida, parity, number of miscarriages or number of terminations, in the format **Gn Pn Mn Tn** without having to record the entire history as individual past pregnancies.

To record past pregnancies as a number:

1. In the patient's clinical record, go to the **Summary > Obstetrics > Current Pregnancy** tab.
2. Click 

Gravida and select **Gravidity**.
3. In the **Gravidity** window, click in the **Parity**, **Number of miscarriages** or **Number of terminations** and enter the number of pregnancies with each outcome.

   To view details of previously recorded pregnancies where available, click  Chart.
4. Click **Save**.

The number of pregnancies recorded are displayed on the **Gravida** button.

Recording antenatal checks

Record antenatal checks by completing a recall or adding an antenatal item to the obstetric record.

If you are creating your own antenatal check, build it using Communicare's qualifiers so that useful summary data can be displayed in the **Description of Pregnancy** table.

You can complete an antenatal check either from the **Progress Notes** or **Obstetrics** tab.

To record an antenatal check:

1. In the patient's clinical record, either:
    - Use the **Obstetric** tab:
        a. Select **Summary > Obstetrics > Current Pregnancy** tab.
        b. Select **Antenatal Check > Check up;antenatal**.
    - Use the **Progress Notes** tab, in the **To Do** list, double-click `<Recall> antenatal checkup` and click **Complete it**.
2. Enter information for the completed observations.
3. Click **Save**.

Each antenatal checkup is displayed in the **Description of Pregnancy** table on the **Current Pregnancy** tab. If you want to edit an antenatal check, double-click it in the **Description of Pregnancy** table.

Change the pregnancy displayed by clicking the Next Pregnancy or Previous Pregnancy arrows on either side of the heading.

If any serious issues arise during antenatal checkups add a Pregnancy Alert. Alerts are not specific to an individual pregnancy: they are saved and will show in subsequent pregnancies. To add an alert, type in the **Pregnancy Alert** field, or double-click in the field to open a text editor. The **Pregnancy Alert** label is highlighted red if there is alert information entered.

Add any pregnancy management information to the **Pregnancy Management Plan** field. Management information is not specific to an individual pregnancy: it is saved and will show in subsequent pregnancies. Double-click in the field to open a text editor where you can provide more information and attach images and so on.

If you need a hardcopy of the antenatal summary, click  **Letter** and select **Antenatal Care Record**.

To generate a report of all currently pregnant women for a selected locality group, select **Report > Pregnancy > Current Antenatal List**. This report is ordered by EDD and indicates gestation and the date of the last antenatal check. You may find women at the top of the list who are more than 50 weeks pregnant, with the label `Pregnancy outcome not recorded`.

Ending a pregnancy

Record the outcome of a pregnancy in Communicare.

Your administrator can add to and remove items from the list of ICPC-2 PLUS coded possible outcomes.

To end a pregnancy:

1. In the patient's clinical record, select **Summary > Obstetrics > Current Pregnancy** tab.
2. Click **End Pregnancy** and select the outcome from the list. For example, `Delivery;normal vag;liveborn`.
3. Check that you have the correct pregnancy in the **Pregnancy Number** field.
4. Complete the other fields as required.
5. Click **Save**.

All pregnancy outcomes are listed on the **Summary > Obstetrics > Obstetric History** tab, in the **Previous Obstetric History** table.

If you want to edit a pregnancy outcome later, for example, to add the baby's name and sex, double-click it in the **Previous Obstetric History** table.

Recording Multiple Births

To record that a patient has given birth to more than one baby, add an end of pregnancy item for each baby born, appropriate to their outcome with each baby's details on a separate item. Each outcome should have the same pregnancy number.

Important:
If your patient has a multiple pregnancy and miscarries one or more of the babies but the pregnancy has at least one viable foetus and continues, do not record an end of pregnancy item until the woman has delivered. Entering the miscarriage at the time it occurs will end the pregnancy on Communicare, which cancels future antenatal recalls, and so on. Instead, make a note in progress notes or add a comment to the last antenatal check, then when she has delivered, add in the appropriate items.

For example, a woman has a confirmed pregnancy and is carrying twins. One miscarries at 11/40, the other pregnancy is carried to term and is a normal vaginal delivery. Make a note of the miscarriage, then when she delivers, add in two separate end of pregnancy items: `Miscarriage` and `Delivery;normal vag;liveborn`.

Gestation calculation

Current pregnancies recorded in Communicare are displayed in the banner.

Pregnancy in the banner

The pregnancy label in the banner may show any of the following:

- If the gestation can be calculated and is less than 50 weeks, the label reads `Pregnant (n/40) + days`, where *n* is the current gestation in weeks.
- If the gestation can be calculated and is 50 weeks or more, the label reads `Pregnancy outcome not recorded`
- If the gestation cannot be calculated, the label reads `Pregnant (gestation unknown)`.

The gestation shown in the banner is calculated in the following way:

- If an Estimated delivery (by date) is recorded for the current pregnancy, this is used to calculate the gestation based on today's date
- If there is no Estimated delivery (by date) recorded for the current pregnancy, the Estimated delivery (by ultrasound) is used to calculate gestation based on today's date
- If no estimated delivery date is recorded for the current pregnancy, the latest Gestation is used based on the date the latest gestation was recorded and today's date
- If no estimated date and no gestation is recorded for the current pregnancy, the Date of LNMP is used based on today's date

This means that the latest recorded Estimated date of delivery (by date) is in fact the current 'best guess'. For this reason, if a recent ultrasound is deemed to be more accurate that the latest Estimated date of delivery (by date), the latter should be updated with the recent ultrasound estimate.

Progress Notes

The  **Progress Notes** tab displays historical services on the left, and enables you to edit your current note and view the to-do list on the right-hand side.

Progress Notes are available for all providers for each service.

An Australian English spell checker is included with the current progress note, which automatically checks for spelling errors while you type and underlines incorrectly spelled words with a red wavy line. To run the spell checker on the note manually, right-click the note and select **Spell Check**.

To access various printing and editing options, right-click an historical service or current service. To configure the printing options, contact Communicare Support.

Historical Notes

Historical notes are displayed with the newest services first in reverse chronological order (by date). Contacts by providers within each encounter are displayed in chronological order from top to bottom.

Each encounter is separated by a header which groups together the contacts for that encounter. The header displays the day, date and place of the encounter.

Each contact is separated by a header which displays the provider name, speciality, time of the contact, reason for encounter (if available), `<Amended>` if a progress note was changed, and `<Deleted>` for older versions. Below the header the progress notes for that contact are displayed.

The note currently being edited on the right-hand side is not displayed below its contact header in the historical notes list, but is identified with the **Current Contact** icon.

The historical notes list is automatically refreshed every 60 seconds to display any changes to a patient's notes made by other providers.

Adjusting the detail shown in the historical note list

You can adjust the level of detail displayed in the historical note list. Changes to the detail level are saved between sessions on the same computer.

To adjust the detail level for all historical notes, using the  **Detail** controls, either click a particular detail level, or click Plus or Minus.

To adjust the detail level for each individual contact's notes, on the left of the contact header, click Plus or Minus.

In a single note in the historical notes list:

- To increment the detail level for all contacts' notes belonging to that encounter, click the service header. Continue to click the service header to increase the detail level.
- To increment the detail level for one contact's notes, click their contact header. Continue to click the contact header to increase the detail level of their notes.
- For a clinical item, to expand the detail level shown for that item when at detail level 3, double-click on that clinical item.

Table 24. Progress Notes - levels of detail

Detail Level	Description
1	Displays only the encounter and contact headers.

Table 24. Progress Notes - levels of detail (continued)

Detail Level	Description
2	Displays three lines of text of the contact note. The text displayed can be a combination of any of the following: • Free text entered by a user • The first line of a clinical item's description (not including qualifiers).
3	Displays all free text and clinical items in the note at full size. However, each clinical item displays only the first line of its description.
4	Displays all free text and clinical items in the note at full size including the full details of each clinical item.
5	Displays the full note including all clinical items and their qualifiers. Amended and deleted items are also displayed at this level. Deleted notes are displayed in grey text with `<Deleted>` appended to the contact header. Where a progress note has been amended, any earlier versions are also listed under the current version with a grey box for audit purposes. A footer for each note displays audit fields for the last user that modified the note, the time and date of the modification, and the viewing rights assigned to the note.

Clinical Information

Clinical information recorded during an encounter is added to the **Progress Notes** tab.

Clinical information added during the encounter is displayed in the progress notes surrounded by a border. Each entry contains the following information:

- Icon showing the type of information, such as clinical item, or medication
- Date of service
- Type of information, such as:
  - Clinical item
  - Medication details
  - Type of investigation
  - Type of imaging
  - Letter
  - Recall

Clinical items also include the following information:

- Comments added to the clinical item
- If the clinical item has been added to the **Main Summary** tab, the word `Summary`
- If the clinical item has been added to the **Obstetric Summary** tab, the word `Obstetric Summary`

As you add items to the patient's record, they are added to the bottom of the current note. You can't edit clinical items in the note, but you can type text before and after the item if required.

If you have the appropriate system access rights, such as `Prescribing` or `Investigations`, you can modify an item. To edit an item, double-click it in the current progress note to open it, and edit as required.

You can edit a clinical item from another service only if it has not been deleted, you have sufficient rights to edit it, and another user does not currently have it open. To edit a clinical item from another service, click and drag it to the current note. Modified items are marked as `<Modified>`. The original clinical item text will remain unchanged.

Deleted clinical items cannot be edited. Deleted items are marked as `<Deleted>` and the text is greyed out.

Viewing Progress Notes

You can tag a progress note for a particular discipline, such as Psychological, and limit the visibility of the progress note to other users.

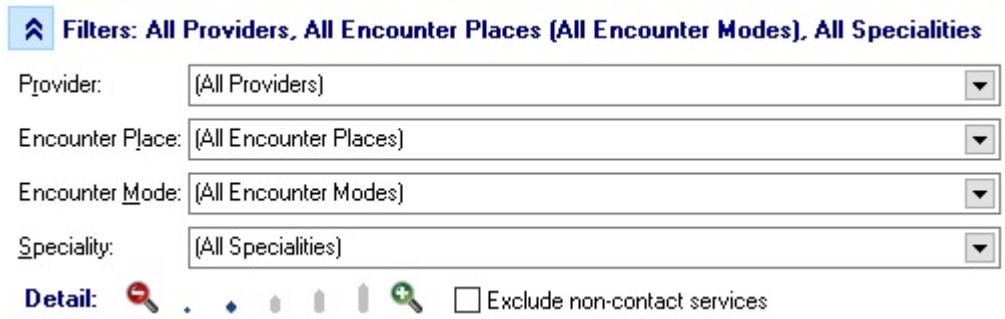
What other users will see depends on their level of access. For example:

- Users who do not have any viewing rights cannot see progress notes.
- Users who do not have the viewing right attached to a progress note cannot see that progress note, but can see items within the note they have the right to see.
- Users who do not have the viewing right for an item that is displayed in a progress note, cannot see that particular item, but can see the note and other items they do have the rights to see.
- Users who do have the viewing right for an item that is displayed in a progress note, can always see that item, regardless of other rights.

To tag a progress note, from the **Viewing right (excluding Clinical Items)** list, select the required tag.

Filtering

By default, historical progress notes from all providers, encounter places and modes, and specialities are displayed. You can limit the notes displayed by using one or more filters. You can filter by Provider, Encounter Place, Encounter Mode or Speciality. The filters are reset to the default when the next clinical record is opened.



To apply filters:

1. Click **Filters**.
2. Choose one or more filters from the following lists:
    - **Provider** - select a provider from the list
    - **Encounter Place** - select an encounter place within your organisation from the list
    - **Encounter Mode** - select an encounter mode from the list
    - **Specialty** - select a specialty from the list
3. To set the Encounter Mode to `(All Client Contact Modes)`, set **Exclude non-contact services**.

To clear the filters, select `All Providers`, `All Encounter Places`, `All Encounter Modes`, and `All Specialities` from each list.

Editing Service Details

To edit the current service details, click on the service or contact header buttons above the current progress note. See Service Record Maintenance *(on page 98)* for more information.

Editing a previous contact

You can change the active contact to edit a previous contact note if you were part of that past service.

To change to another service, drag and drop any of the contact or service headers onto the current note. Communicare checks if you were part of that service and if you have the appropriate permissions before changing to that contact note. If you were not part of the past service, you won't be able to switch or edit the previous progress note. You will be prompted with what to do with the service you are changing from. For more information, see Service Exit *(on page 95)* and Deleting Incorrect Progress Notes *(on page 145)*.

Once a service has been amended, the contact header is displayed in the Historical Notes prefixed with `<Amended>`. Earlier versions of the progress note may also be viewed in the history when the detail level is set to 5 *(on page 139)*.

To Do

The bottom third of the right-hand pane displays a summary of all recalls and referrals overdue, due and scheduled. For more information, see To Do list *(on page 125)*.

Reasons For Visit

Your health service may require you to record one or more reasons for a patient's visit in their clinical record. The reason for the patient's visit may be added manually or automatically.

To enable reasons for a patient's visit to be added manually in progress notes, **Reason For Visit** must be set in System Parameters - Clinical *(on page 816)*.

To enable reasons for a patient's visit to be added to the **Reason For Visit** list automatically from clinical items, **Reason For Encounter** must also be set in System Parameters - Clinical *(on page 816)*.

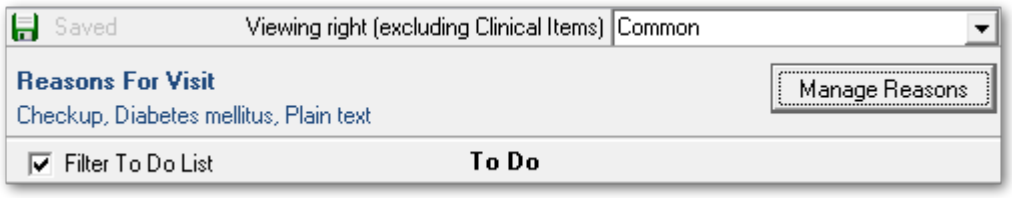
If required, for each encounter, you can specify up to four reasons for a patient's visit to your health service.

You can add reasons for a patient's visit either automatically from the clinical item, or manually in the progress notes.

To add a reason for a patient's visit automatically from a clinical item:

1. In the patient's clinical record, click **Clinical Item**.
2. In the **Clinical Terms Browser**, select the required item.
3. In the **Add Clinical Item** window, set **Reason For Encounter**.
4. Click **Save**.

The selected reasons are displayed on the **Progress Notes** tab.



In the **Progress Notes**, if you delete a clinical item for which you set **Reason for Encounter**, it is also removed from the **Reasons For Visit** list.

At the end of a consultation, to specify a reason for the patient's visit manually in their clinical record:

1. On the **Progress Notes** tab, in the **Reasons for Visit** section, click **Manage Reasons**.
2. In the **Reasons for Visit** window, click ▾ Select and from the **Reason 1** list, select the primary reason for the patient's visit. Both the clinical items that have been previously applied to this patient, and all items in the Reasons for Visit lookup table are included in the list.
3. Alternatively, in the **Reason 1** field enter a reason.
4. If required, repeat steps 2 or 3 in the other **Reason** fields, adding up to 4 reasons.
5. Click **OK**.

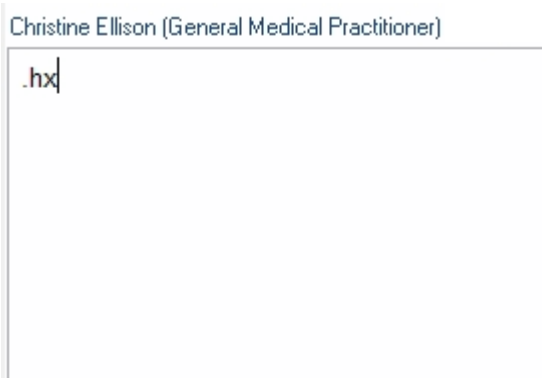
Using Text Shortcuts

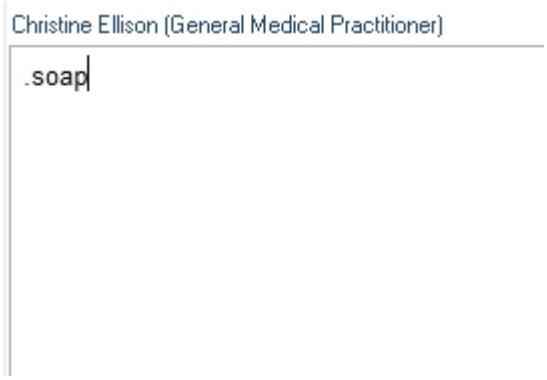
Use text shortcuts to improve efficiency when writing progress notes or letters for commonly used blocks of text.

Shortcuts are specific to your health service and are maintained in the **File > Reference Tables > Text Shortcuts**. For more information, see Text Shortcuts *(on page 876)*.

To use a text shortcut:

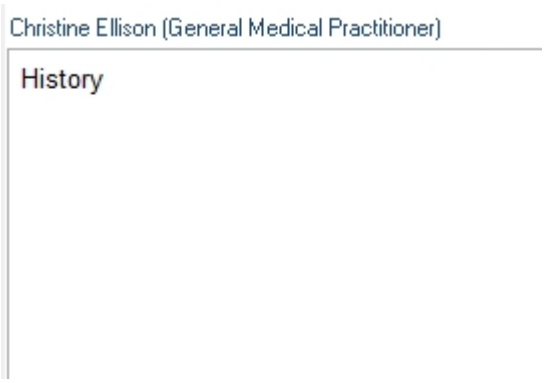
1. In a free text progress note or letter, type the shortcut text, making sure the shortcut word is separate from the text around it, using either a space in front of the shortcut or entering it on its own line. For example, `.hx` for `History` or `.soap` for `S O A P`.

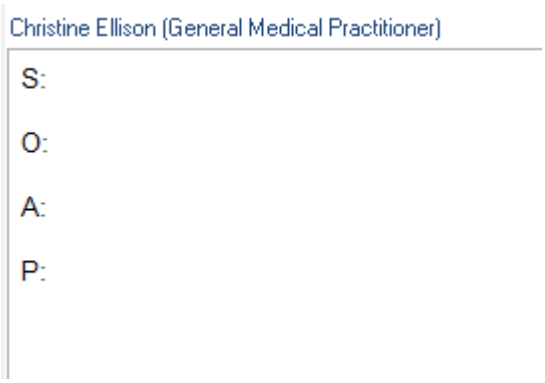




2. Once you have typed the shortcut, press Space or Enter after the shortcut to expand the shortcut to the configured text.

For example:





View Progress Notes for Service

The **Progress Notes for Service** window allows you to see a quick read-only view (at detail level 5) of all Progress Notes associated with a given service, without having to open the Clinical Record.

To view the **Progress Notes for Service** window, in the **Bulk Bills Status** window, click **Progress Note** in the toolbar.

Note:
User access rights determine what elements of notes are visible. See Progress Notes *(on page 137)* for more information.

Editing Progress Notes

If you were part of a service you can edit progress notes added to that service.

When you amend a progress note from a previous service or day, the original progress note is retained for audit purposes.

> **Tip:**
> You can continue to edit progress notes added to today's services without triggering the progress note audit: when you open a patient's **Clinical Record**, in the **Select Service** window, select **Yes - Open selected service**.

A day is a calendar day. If you write and close a progress note at 23:55 for example, you have a grace period of 5 minutes to make changes without audits appearing.

Progress note restrictions are based on the Communicare log on username:

- Users who do not have any viewing rights cannot view, write or change any progress notes.
- Users who do not have the viewing right attached to a progress note cannot see that progress note.
- Progress notes can only be written if you log on to Communicare with a username that identifies the provider. Anyone can write or change a progress note on behalf of a provider who does not have a logon username.

  > **Tip:**
  > Specify a provider's username and any delegated providers in **File > Reference Tables > Provider**. If electronic claiming is enabled, only the Administrator or the provider can change these details.

- If a provider has a delegated user, the delegated user can also write or change the progress notes for that provider.

To edit a progress note:

1. Set the history filter to detail level 5 *(on page 139)* so you can view the changes.
2. To change to the service with the progress note that you want to edit, drag and drop the contact or service headers onto the current contact note.
   Communicare checks if you were part of that service and if you have the appropriate permissions before changing to that contact note. If you were not part of the past service, you won't be able to switch or edit the previous progress note.
3. You will be prompted with what to do with the service you are changing from.
   Typically close the current service:
   a. In the **Select a different service** window, click **Yes - Open Selected service instead of current service**.
   b. In the **Service exit** window, click **Ignore - No service has been provided**.
4. Edit the progress note.
5. Close the clinical record.

Once a service has been amended, the contact header displayed in the historical notes is prefixed with <Amended>.

To view earlier versions of the progress note, set the detail level to 5 *(on page 139)*. The original progress note is displayed with a grey background for audit purposes.

You can also print audited progress notes to the Patient Summary. For example, in the clinical record:

1. Select **Reports > Patient Summary**.
2. In the **Patient Summary** window, click **Customise**.
3. On the **Consultations** tab, set both **Progress Notes** and **Progress Notes Audit** to include this information.
4. Click **Print**.

Deleting Incorrect Progress Notes

You can delete progress notes incorrectly added during the current service and also delete historical progress notes that you added in previous services.

Only the progress notes for the current consultation can be changed. In order to change other progress notes you will have to first select the correct consultation.

When viewing or changing Progress Notes in Communicare, there are some restrictions for security reasons.

Progress note restrictions are based on the Communicare log on username:

- Users who do not have any viewing rights cannot view, write or change any progress notes.
- Users who do not have the viewing right attached to a progress note cannot see that progress note.
- Progress notes can only be written if you log on to Communicare with a username that identifies the provider. Anyone can write or change a progress note on behalf of a provider who does not have a logon username.

> **Tip:**
> Specify a provider's username and any delegated providers in **File > Reference Tables > Provider**. If electronic claiming is enabled, only the Administrator or the provider can change these details.

- If a provider has a delegated user, the delegated user can also write or change the progress notes for that provider.

To edit notes entered into the clinical record for an incorrect patient and then entered into the correct clinical record:

1. Open the clinical record that contains the incorrect progress note.
2. On the **Progress Note** tab, ensure that the progress note information is on the right hand side.
3. Click the progress note once to select it and either right-click and select **Delete Item** or click **Delete** in the toolbar.
4. When all incorrect progress notes are deleted, click Close to close the clinical record.
5. Open the correct patient clinical record and document the progress notes that were deleted from the incorrect clinical record.
6. Close the clinical record.

All progress notes display the username of the user who created or modified that progress note. Where a progress note was amended after the original service, it will display a prefix of `<Amended>` in the contact header in the progress note history. With detail level 5, any previous versions are displayed in the progress note history, and are shown in grey with a prefix of `<Deleted>` in the contact header.

Deleting historical progress notes

If you don't realise your mistake until later, you can delete progress notes from previous days in the incorrect patient file, if you were part of that past service. Previous contacts are displayed in the progress notes on the left hand side as an historical contact.

To delete a progress note incorrectly added to one patient's file and add it to another:

1. Open the clinical record that contains the incorrect progress note.
2. On the **Progress Note** tab, ensure that the progress note you need to delete is displayed on the left hand side.
3. Select and drag the service detail containing that progress note to the right into the current contact window.
    a. In the **Select a different service** window, click **Yes - Open Selected service instead of current service**.
    b. In the **Service exit** window, click **Ignore - No service has been provided**.
4. You can now edit the service. Click the progress note once to select it and either right-click and select **Delete Item** or click **Delete** in the toolbar.
5. Enter a free text note for audit purposes.
6. Close the clinical record.

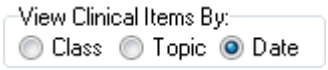
Deleted progress notes and an amended progress note are displayed in the historical note list. To display the deleted progress notes, adjust the level of detail displayed to detail level 5. The deleted progress note is displayed in grey text with `Deleted` appended to the contact header.

You can now open the clinical record for the correct patient and add a note and the missing clinical items.

Detail tab

The **Detail** tab displays the clinical items and clinical data that make up a patient's clinical record. The content displayed depends on the type of clinical item or data. Investigations and medications are also listed.

You can select the way in which clinical items about the current patient are listed. Select from the following options:



- **Class** - groups clinical items by the **Class** attribute (data values), or clinical data of the same type on separate tabs. If a tab is not displayed for a patient, there are no clinical items of that class or clinical data included in that patient's record. The following tabs may be included:
  - **Admission** - lists all clinical items recorded in Communicare with a **Class** attribute of **Admission**.
  - **Adverse Reaction** - lists any recorded adverse reactions.
  - **Alert** - in V20.1 and later, lists any recorded structured alerts.
  - **Condition** - lists all clinical items recorded in Communicare with a **Class** attribute of **Condition**.
  - **Document** - lists all incoming and outgoing documents and letters including referral letters.
    - Incoming documents - unreviewed, incoming documents are highlighted in red; reviewed documents are not highlighted.
    - Outgoing documents - for documents sent using secure messaging, the status of the secure message & the recipient's name are displayed when you select the document. Document information is also displayed in the **Documents and Results > Outgoing Documents** tab. For information about secure message statuses, see Outgoing document status *(on page 304)*.
  - **History** - lists all clinical items recorded in Communicare with a **Class** attribute of **History**.
  - **Immunisation** - lists a patient's full immunisation record, that is all clinical items recorded in Communicare with a **Class** attribute of **Immunisation**. If this tab is not displayed, no immunisations have been recorded in Communicare.
  - **Ix Request** - lists all investigation requests.
  - **Ix Result** - lists all investigation results.
    - Unreviewed results are highlighted in red.
    - Reviewed results are not highlighted.
  - **Procedure** - lists all clinical items recorded in Communicare with a **Class** attribute of **Procedure**.
  - **Referral** - lists all clinical items recorded in Communicare with a **Class** attribute of **Referral**.
    - The date displayed is the date the referral was created; if an appointment is added the date displayed is the date of the appointment
    - Active referrals are highlighted in gold.
    - Expired referrals are highlighted in red.
    - Completed referrals are not highlighted.
  - **Rx - Administer** - lists medications that were administered to the patient.

    - **Rx - Prescription** - lists a patient's full prescribing record for all time, including regular and once-off prescriptions and medication orders. It also lists all expired and stopped medications that are no longer displayed on the **Medication Summary**.
        - Active medications are highlighted in green.
        - Expired medications are highlighted in red.
    - **Rx - Supply** - lists medications that were supplied to the patient.
    - **SMS** - lists all SMS messages sent to the patient.

> **Tip:**
> If your site does not use Prescribing, and some medications are still recorded, you may see **Acute Medication** and **Chronic Medication** instead of **Rx - Prescription**.

- **Topic** - groups medical or health related data. Use this view to show information about general health or a medical area of interest. Each topic for which the patient has information recorded is displayed on a separate tab. If the patient has no information recorded under a topic, no tab is displayed. For example, if a patient has no information recorded about Child health, the tab for the topic **Child** does not display. Topics are unique to each organisation. Two special tabs are:
    - **Medication** - shows prescriptions, administer and supply records
    - **Unclassified Documents** - shows documents not yet sorted into an appropriate topic
- **Date** - the default option that lists all the clinical items chronologically starting with the most recent at the top of the list. Its primary purpose is to see what has happened recently, or for a period in the past.

> **Tip:**
> The same information can be viewed in different ways. Every clinical item appears under one clinical item class and one topic. For example, if a referral to an ENT specialist is recorded for a patient, it appears both under the class **Referral** and under the **Ear** topic.

Communicare retains the last tab viewed for both **View by class** and **View by topic**. For example, if the **Referral** tab is viewed for a patient and a new patient is selected, the **Referral** tab is initially shown for the new current patient.

Clinical items can be added, changed and deleted, or recalls completed from all clinical record views. Double-click a clinical item to display details for viewing and editing, depending on what type of clinical item is selected. If the item is a recall you will be prompted to complete the recall.

> **Tip:**
> To display items that have been logically deleted (flagged as deleted but not removed from the database), right-click in the item list and select **Show Deleted Items**.

Detail tab actions

For any item listed on the **Detail** tab you can right-click and take further specific or general actions:

- **Find Associated Service Details** - display the service on the Progress Notes tab during which the clinical item was added
- **Show Deleted Items** - toggle between displaying deleted clinical items and medications or not. Deleted items are prefixed with `<Deleted>`.

- **Reset Normal Ordering** - if you have ordered the data based on a particular column, use to revert to the default ordering
- **Service List** - display a list of all services for the patient
- For prescribed medications:
    - **Stop Medication** - stop a medication you want to discontinue
    - **Adjust Medication** - change the duration, until date and add comments
    - **Make Regular** - convert a once-off or short course medication to a regular medication
    - **Create Once Off Medication Order** - create a medication order from a prescription medication for administer or supply
    - **Edit Medication** - edit a medication created by you in the current service that has not been finalised
    - **Repeat Medication (represcribe)** - represcribe the selected medication
    - **Delete Medication (prescribed in error)** - delete a medication that was prescribed in error
    - **Finalise Prescriptions** - if you have a prescriber number, finalise a prescription to assign a script number
    - **Reprint Prescriptions** - if you have a prescriber number and you've made changes, reprint a prescription. Ensure you destroy any scripts that you have already printed.
- **Request a Pathology Investigation** - open the **Add Investigation Request (Pathology)** window
- **Request a Diagnostic Imaging Investigation** - open the **Add Investigation Request (Imaging)** window
- **Hide normal results from monitoring system** - hide normal results from virtual health monitoring applications in the **Detail** tab in all clinical records. For more information, see Hiding normal monitoring results *(on page 804)*.

Tip:

For conditions, including pregnancy, procedures and history items, to check for any medication interactions, select **Check Interactions**.

For investigations, you can also print and edit investigation requests, and edit investigation results.

Details search

To filter clinical items:

1. In the **Search text** field, enter a word or phrase.
2. Click Search Now.

Only those items with that word or phrase in the name or comment are displayed.

To clear the search and display all items, click Clear Search.

To filter items automatically as you type, set **Search Automatically**.

Qualifiers pane

Qualifiers for the record in the main window pane are displayed in a pane of their own at the bottom right. Double-click on a qualifier to display previous measurements.

Changing the order of items

Items in the clinical record can be ordered by other columns such as Description, Comment, and so on by clicking on the title at the top of the column. To restore the default order, right-click a column and select the required option.

> **Tip:**
> Several of the clinical record views are ordered by a combination of both planned and actual date. These views show the ordering icons in both the planned and actual date columns.

Clinical items

A *clinical item* is the basic element of a clinical record *(on page 112)*.

Clinical items are an essential building block for providing a care pathway with the clinical record workflow.

Clinical items are developed using standards and guidelines that inform the care pathway and the data that must be recorded.

Using clinical items, clinicians record a clinical event in a patient's record using qualifiers to ask relevant clinical questions and record responses in a structured way. The structured data that results informs automated recalls, charts, reports, letters, care plans, investigations, medications and Medicare submissions.

Clinical items are included in Communicare by default. Items can be added for your health service or customised. For more information about customisations, see Clinical Item Maintenance *(on page 884)*.

All clinical items

Every clinical item *(on page 885)*:

- Belongs to a particular Clinical Item Class *(on page 893)*
- Has a Clinical Item Topic *(on page 891)*
- Has a Viewing Right *(on page 903)* (displayed at the bottom left hand corner)
- Has either an actual date or a planned date (or both)

All clinical items include the following fields:

- **Comment** - optional free text (or, for Chronic and Acute Medications, the name of the medication). Long comments may be truncated in some reports and grids. Double-click the item to display the full comment.
- **Date/Time** - the date and time at which the clinical item actually occurred, which may be Performed Date, From Date, Date referred, Date admitted, and so on. Each clinical item can be configured to be recorded with either a date only or both a date and time by your Communicare Administrator in Clinical Item Type Properties *(on page 886)*. The default is date only.
- **Display on Summary** - this item type should be added to the Clinical Summary. Deselect to remove an item from the clinical summary. This is not visible for the Alert class type.
- **Display on Obstetric Summary** - for female patients set 'Display on Obstetric Summary' to add or remove an item from a patient's obstetric summary. This is not visible for the Alert class type.
- **Reason for Encounter** - if enabled, set to indicate that this clinical item provides the reason for the encounter and if Reason For Visit is also enabled, one of up to four reasons for the patient's visit. This is not visible for the Alert class type.

Items that were recalls

Clinical items that were recalls include the following fields:

- **Planned Date** - the date the Recall clinical item is due
- **Expiry Date** - the date the Recall clinical item is due to expire. This is enabled only if your Communicare Administrator has allowed this behaviour for this recall type.
- **Responsibility** - the users responsible for completing the recall
- **Cancellation reason** - visible if the item is a cancelled recall

Some clinical items

Any clinical item may have supplementary qualifiers *(on page 897)*. These collect a variety of data in the form of dates, drop-down lists, free text, images, numbers, memos, Yes/No tickboxes and references to another patient.

Numeric qualifiers may have a range of allowed values defined. These values appear in brackets after the units and cannot be exceeded.

Calculated qualifiers are qualifiers that can be calculated from a patient's existing information. A Calculated qualifier will have a **Calculate** or a **Recalculate** button underneath the value. Click the button for Communicare to automatically calculate the qualifier's value.

To the right of the qualifiers will be the date and value of the most recent same qualifier type recorded for that patient. There may also be a button to see all previous values of that qualifier type.

Clinical items of a particular class

Other attributes will appear depending on the class of the clinical item. See Clinical Item Attributes *(on page 154)*.

Clinical items linked to clinical programs

Some clinical items can be used to enrol or exit patients from a clinical program. For example:

- For drug and alcohol treatment service programs, **Alcohol/Other Drug respite enrolment** and **Alcohol/Other Drug respite exit**, **Alcohol/Other Drug treatment enrolment** and **Alcohol/Other Drug treatment exit**
- For Headspace programs, **Headspace;Enrolment** and **Headspace;Closure**
- For home support programs **HACC/CHSP Enrolment** and **HACC/CHSP Exit**
- For integrated team care programs, **ITC Enrolment** and **ITC Exit**
- For primary mental health contacts, **PMHC Episode Start** and **PMHC Episode End**

Enrol patients into a clinical program using the enrolment clinical item, then add activity items as required. When the clinical program is complete, to remove the patient from the program, either complete the exit recall or add the matching exit clinical item to the patient's clinical record.

Tip:
You cannot add activity items until after a patient has been enrolled in a program. However, you can still add activity items after a patient has been exited from a program. This allows for genuine backdating of clinical items. For example:

- If you are using an offline client and your clinical program enrolments and exits have got out of step, you can backdate an exit.
- If items are out of sequence, correct the items.
- For a patient who exited last week, record an action from two weeks ago.

Read-only clinical items

Some clinical items may be created and maintained in other systems and integrated into Communicare. These items can be marked as read-only by Customers or Integrators to prevent them from being edited. Read-Only items cannot be edited, deleted, cancelled or completed in Communicare.

Add a clinical item to a patient's record

Record a patient's history, conditions, check ups, procedures, immunisations, referrals, admissions and alerts using clinical items.

Commonly used clinical items are displayed in the shortcut bar at the bottom of all clinical records, by default grouped by:

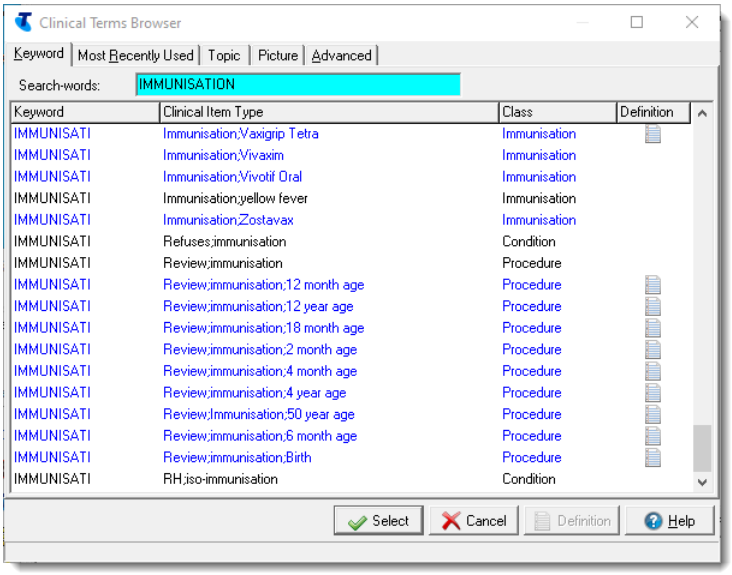
- **Calculator** - assessment and audit clinical items, for example, for Kessler 10 for mental health assessment or alcohol consumption audit
- **Check up** - general items, for example, for Aboriginal and Torres Strait Islander or Women's Health check-ups
- **Child health** - items for children's check-ups including birth and age-based development checks
- **Enrolment** - items for enrolment in alcohol-related programmes
- **Examination** - items for examinations grouped by clinical item topics, for example, cardiovascular or respiratory
- **Group** - items for group work, for example, counselling or educational groups
- **HACC/CHSP** - items related to HACC or CHSP
- **Immunisation** - items for immunisations
- **Referral** - clinical items for referrals grouped by specialty, for example, dentist or paediatrician. Specialists should be included in the Address Book and marked for Referrals.
- **STI** - clinical items for STI screening or treatment.

You can use either of the following methods to add a clinical item to a patient's clinical record:

- Shortcut to a clinical item for commonly used clinical items
- Clinical items search

To search for and complete a clinical item:

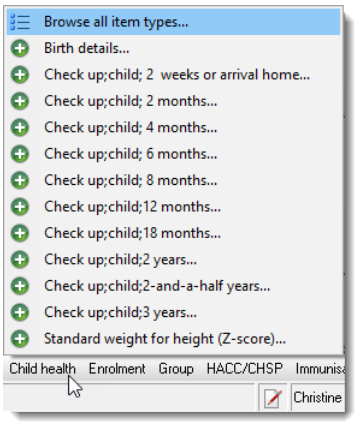
1. In the patient's clinical record, click **Clinical Item** or press `F11`.



2. In the **Search-words** field, enter a term you would expect to find in the clinical item.
3. Alternatively, go to the tab that is most likely to show the clinical item you need.
4. Double-click the clinical item you require.
5. In the Clinical Item, complete as much information as you want to, including:
    a. In the **Comment** field, enter any observations.
    b. From the **From Date** calendar, select when the symptoms are reported to have started.
    c. Set **Display on Main Summary** if this is a significant, active health event that should be given prominence on the main summary.
    d. If required, set **Reason for Encounter** to indicate that this is either the main reason for encounter, or if Reason For Visit is also enabled, one of up to four reasons for the patient's visit.
6. Click **Save**.

Alternatively, to select and complete a commonly used clinical item:

1. In the shortcut bar, click the required group and select the required clinical item from the list.



2. Complete the required fields.
3. Click **Save**.

Information you provided in the clinical item is displayed on the **Progress Notes** tab and is summarised on the **Detail** tab.

To print a clinical item, click **Print & Save**. After printing the clinical item, your changes are saved and the item is closed.

If the clinical item currently being added is a Referral, you can generate a CDA e-Referral document for the patient. An e-Referral can be uploaded to the My Health Record or sent via Secure Messaging within the first 8 hours of saving the document. To generate an e-Referral, click **Save & Create eReferral**. The clinical item is saved and closed, and an e-Referral is opened. To learn more about the e-Referral document type, see e-Referrals *(on page 322)*.

Clinical Item Attributes

Clinical items have other attributes determined by their Clinical Item Class *(on page 893)*.

Admissions

- **Admitted to** - the institution the patient was admitted or referred to (see Address Book *(on page 335)* for information about maintaining this list)
- **Transport mode** - the mode of transport used when admitting the patient (see Transport Mode *(on page 903)* for information about maintaining this list)
- **Alcohol related** - the clinical item was caused by or related to alcohol consumption
- **Emergency** - An Admission may be marked as an Emergency. Emergency admissions may be considered to be evacuations.

Conditions

- **Episode** - defines the episode of care as First, New or Ongoing.
- **Alcohol related** - the clinical item was caused or related to alcohol consumption

History

(No additional fields)

Immunisations

- **Actual duration (minutes)** - the time spent in minutes performing the clinical item
- **Route and Site** - records the route and site of the immunisation
- **Dose (this course)** - specify if the immunisation is the first, second, or so on in a course
- **Dose Number** - specify the immunisation dose number until now
- **Performed at** *current encounter place*- set if the immunisation was performed at the clinic. If you are recording historical immunisations performed elsewhere in Australia, deselect this option. This field is used for the **ACIR (Done Here)** report.
- **Administered overseas** - if you are recording historical immunisations performed overseas, set instead of **Performed at** *current encounter place*.
- **Vaccine batch** - record the batch number of the vaccine
- **Serial Number** - record the serial number of the vaccine if required. If **Serial Number Mandatory** is set in the clinical item type properties, you must record the serial number.
- **Vaccine expiry date** - record the expiry date of the vaccine

Procedures

- **Actual duration (minutes)** - the time spent performing the clinical item in minutes

Referrals

- **The patient is referred** - record referrals to another organisation or referrals to this organisation. If the Referral Management *(on page 342)* module is enabled:
    - This field is disabled and you can create only outgoing referrals
    - Create incoming referrals from the Referrals menu.
- **Organisation** - the professional or institution the patient was referred to or from (see Address Book *(on page 335)* for information about maintaining this list)
- **Provider referred to** - free text to record a particular name
- **Appointment Date** - record the date and time of an appointment
- **Escort** - free text to record the name of an escort for the patient
- **Transport mode** - the mode of transport used when the patient is to attend an appointment (see Transport_Mode for where to maintain this list)
- **Referral Complete** - the date the referral is deemed to have been completed
- **The referral is Critical** - set if the referral is critical for reporting purposes
- **The referral is an Emergency** - set to mark the admission as an emergency admission or evacuation
- **The referral is Alcohol related** - set to mark the clinical item as caused by or related to alcohol consumption
- **Current Referral status is** - a label showing the current status of the referral

Acute Medications and Chronic Medications (Prescribing not enabled)

- If Prescribing is not used, the **Comment** field for Acute Medications is labelled **Acute medication** and the **Date** is labelled **Date prescribed**
- If Prescribing is not used, the **Comment** field for Chronic Medications is labelled **Chronic medication**, the **Date** is labelled **From Date**, and an **End Date** field is added

Alert

- **Status** - set the alert status to Active, Inactive, Resolved, Entered In Error

Clinical Terms Browser

The Clinical Terms Browser is displayed each time you need to select a Clinical Item Type.

Clinical terms are the words used to describe each Clinical Item Type. The terms browser is the tool that you use to select the words that will describe the condition, procedure, referral, recall, etc. that you wish to record.

The browser window features five tabs to allow terms to be selected using entirely different methods. The five tabs are titled Keyword, Most Recently Used, Topic, Picture and Advanced.

Keyword Searching

Any number of keywords may be defined for a clinical term. Keywords can be any word of two or more characters that you may wish to use to locate a clinical term. The keywords do not necessarily have to be in the terms. For example, 'Heart Attack' could be located using keywords 'Heart', 'Attack', 'Infarction', 'MI' or any other word or abbreviation you care to define.

Enter the starting characters of a keyword to search for all terms that have keywords starting with those characters. For Example DIAB will list all diabetes terms. The search can be further refined by entering the starting characters of a second

word. Terms that do not contain a word starting with those characters will be eliminated. For Example, DIAB ME will shorten the list to 'Diabetes melitus' only.

Episode

When a condition is diagnosed it may be classified as one of the following:

- The FIRST episode of the condition for the patient
- A NEW episode of a condition that a patient has had before
- An ONGOING episode of a previously diagnosed condition

Use of the episode code is enabled or disabled in System Parameters.

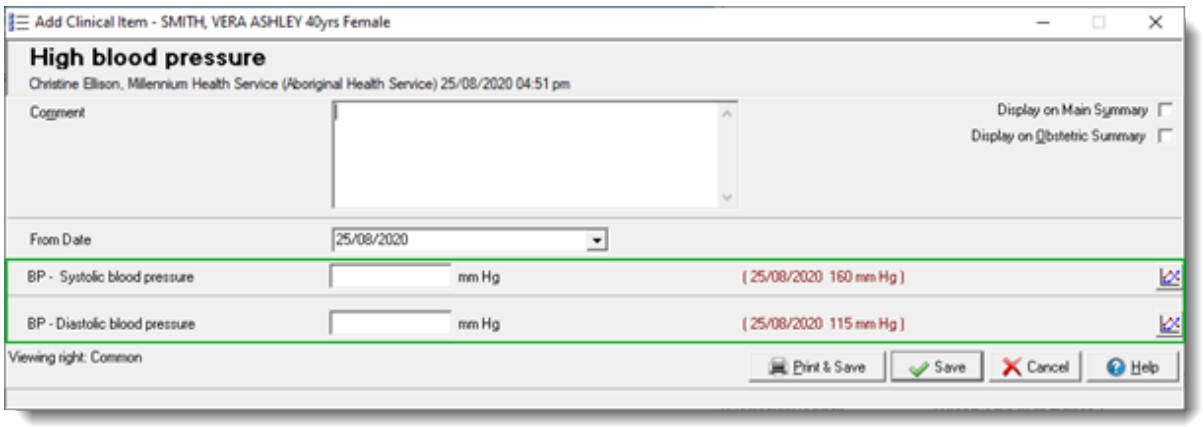
If the episode code is in use, every encounter with a patient should have the Reason For Encounter (RFE) recorded with an episode code.

If the episode code is not in use, only a new diagnosis should be recorded.

Qualifier edit panes

In the clinical item, set or change the values of qualifiers associated with that clinical item in the qualifier edit panes.

Qualifier edit panes are displayed in the clinical item if the clinical item has associated qualifiers. For example, clinical item `High blood pressure` has BP qualifiers.



If a qualifier has previously recorded values for that patient, the date and value of the most recent observation is displayed in brackets.

To display a complete list of previous values for a qualifier for comparison, click Previous Measurements.

If the qualifier contains an image, to display the image at full size, double-click the image. Double-click to close the window.

Resizing images

Communicare puts a restriction of 500Kb on any image that can be stored as a qualifier. If the image you have is very high resolution then you can reduce the size of the file by doing the following:

1. Open the image file in Microsoft Paint (**Start > All Programs > Accessories > Paint**).
2. Select **Image > Stretch/Skew** and adjust the horizontal and vertical stretch values to the required size, say 50%.

> **Tip:**
> You can also use **Image > Flip/Rotate** if required.

3. Select **File > Save As** and from **Save as type**, select **JPEG (*;*.JPEG;*.JPE;*.JFIF)**.
4. Enter a different file name if required and click **Save**.

This will reduce the size of the file size considerably with no noticeable loss of detail when viewed on the computer screen.

Uploading images from external USB devices

You can upload images to various locations in Communicare, including qualifiers, letters and patient biographics.

You can also upload icons with a `.ico` format to qualifiers.

> **Note:**
> Large icons and icons with compression are not supported by Communicare. Limit icons to 64x64px.

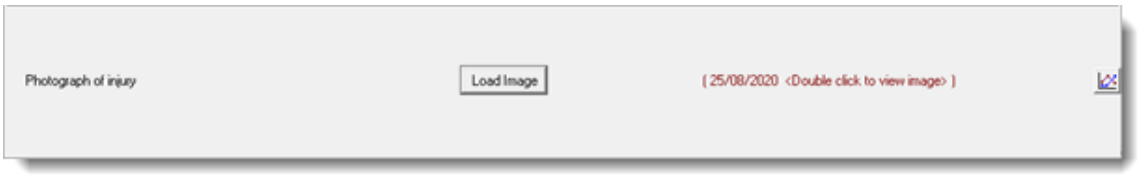
An image can be uploaded directly into Communicare from an external device if it is recognised as a `USB Mass Storage Device`, that is, it is mounted as a drive, with a letter, in Windows when it is connected. For example, external HDDs, USB sticks, most cameras.

Phones and tablets cannot be used to directly import an image to Communicare. These devices are not recognised as a `USB Mass Storage Device`. Instead they appear as a device in Microsoft Windows, and are not mounted as a drive. To import an image stored on a phone or tablet, first copy the image from the device to a local folder, then browse to this folder from within Communicare.

> **Tip:**
> This restriction also applies to PDF files uploaded as attachments.

To upload an image to a qualifier after you have copied it to the Communicare server:

1. In the clinical record, add a clinical item that has associated image qualifier. For example, clinical item `Domestic violence` which has an image qualifier of `Photograph of injury`.



2. In the clinical item, the qualifier lists any images that have previously been uploaded to the same clinical item:
   - The date of the most recent image uploaded for this qualifier is listed. To view the most recent image, double-click the link.
   - To display a complete list of previous images for comparison, click Previous Measurements. Double-click an item in the list to open it.
3. To load a new image, click **Load Image**. The image is displayed in the qualifier in the clinical item window.
4. Click **Save**.

Memo View/Edit Form

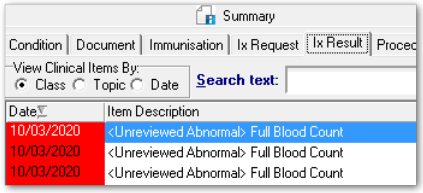
This form is most commonly opened by double-clicking on a supported memo field. This form allows the user to easily view the value of a memo field in Communicare. If the field is editable, this form will also allow the user to enter text to update the memo.

Right-clicking on this form brings up the cut-copy-paste-delete functions. There is also a print button which can be used to print a report with the text inside the memo field.

Previous measurements

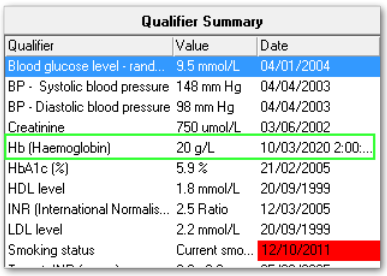
The **Previous measurements** window lists all previous measurements for a qualifier.

When you record the value for a qualifier, such as Haemoglobin or BP, in a clinical item, the date and time that the value was recorded is also saved. You can take the same observations and record values for the same test multiple times per day. Separate entries are displayed for each observation in the clinical record, **Detail > Ix Result** tab.



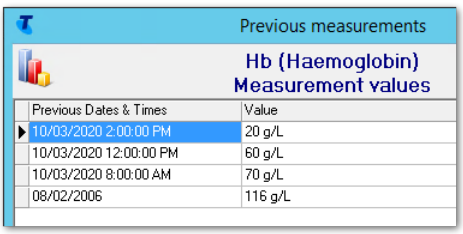
The most recent value for a qualifier is displayed in various places throughout Communicare, including:

- In the clinical record, **Main Summary > Qualifier Summary** pane



- In a clinical item, for the relevant field
- In the letter writer, when you add a **Clinical Record > Latest Qualifier >** *test*, for example, `Hb (Haemoglobin)`.

To display all previous measurements for a test in the **Previous measurements** window:

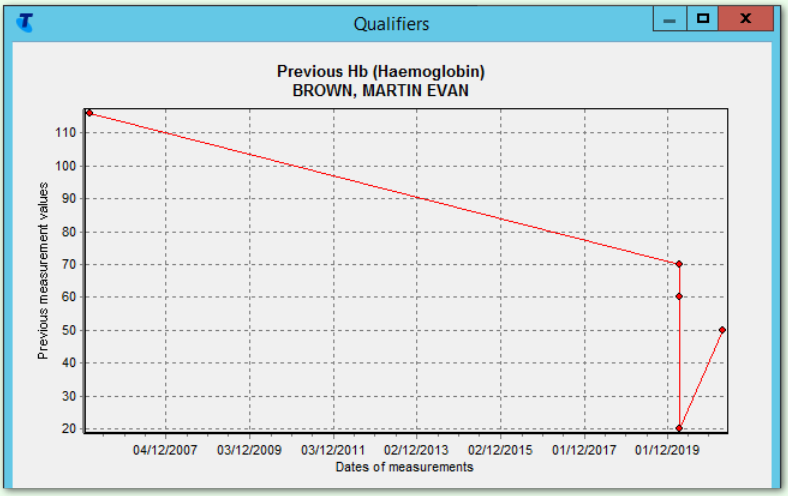


- In the clinical record, **Main Summary > Qualifier Summary**, double-click the test
- In the clinical record, **Detail > Ix Result** tab, select a test and in the **Qualifier** pane, double-click a value
- In a clinical item, for a value, click Previous Measurements

If the measurement values are numerics, to graph all measurements, in the **Previous measurements** window, click **Chart**.

Tip:

If there are multiple measurements in a day, all values are plotted on the graph in a vertical line.



To print a `Measurement History Report` for the current patient, click **Print**.

Tip:

To generate a list of all measurements for a patient for a particular qualifier or qualifiers that can be printed, run one of the following reports:

- **Qualifiers > Patient Measurement History**
- **Qualifiers > Patient Multiple Qualifier History**

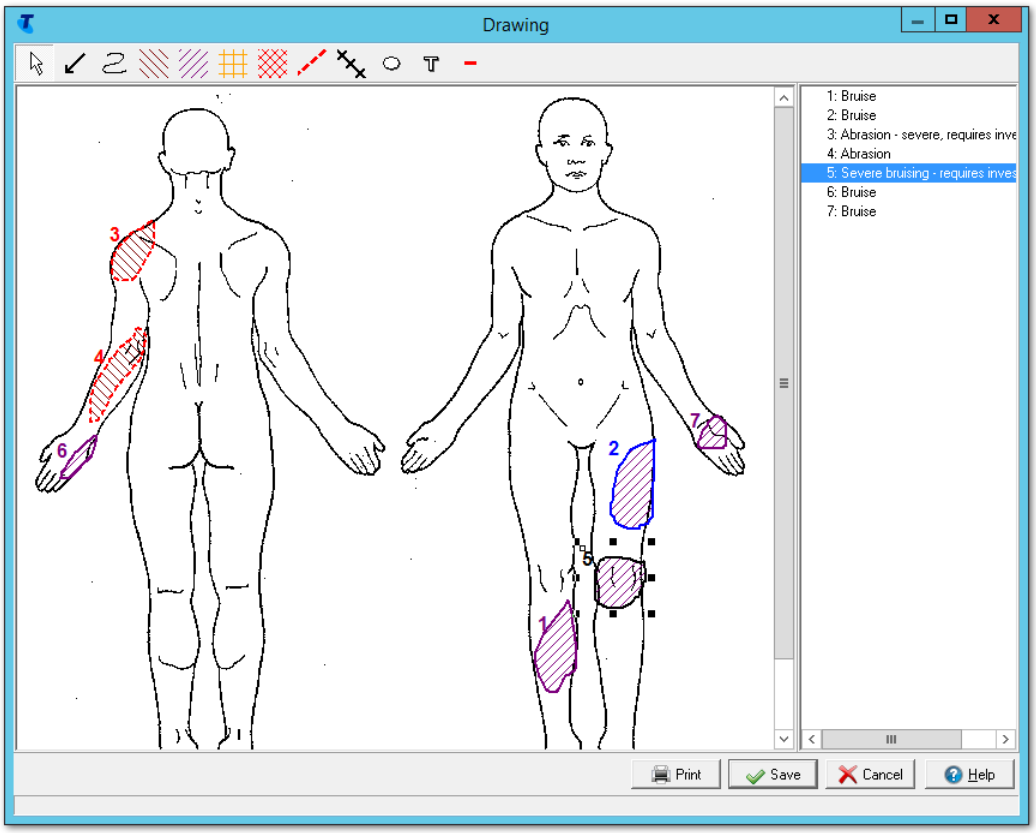
Add drawings to clinical items

Use drawing qualifiers in clinical items to more accurately display conditions or procedures on preset clinical images.

Clinical items such as `Exam;skin` and `Exam;breast` can include clinical images.

To add information to a clinical image:

1. In a relevant clinical item, such as `Exam;skin`, in the **Drawing** qualifier, double-click the clinical image.



2. In the **Drawing** window, click a drawing tool and draw on the image.
   Use any of the following drawing tools to add clinical items of interest to the image:
   - Pointer - use to identify a specific area
   - Pen - use for freehand drawing
   - Abrasion - use to draw an enclosed region and fill with a pattern to identify an abrasion
   - Bruise -use to draw an enclosed region and fill with a pattern to identify a bruise
   - Burn - use to draw an enclosed region and fill with a pattern to identify a burn
   - Pain - use to draw an enclosed region and fill with a pattern to identify pain
   - Laceration - use to draw a region identifying a laceration
   - Suture - use to draw a region identifying sutures
   - Ellipse - use to draw an ellipse tool for any purpose
   - Text - use to add text to the drawing. Typically, use with the pen and pointer which will need further explanation. Edit the font style, colour and size if required.

   Each addition to the drawing is numbered and listed in the key on the right.

3. A default annotation is added for each drawing object, identified by number. If required, edit the annotation to provide more information regarding the object. For example, you could explain the cause of a burn in the annotation:
    a. Either right-click a drawing element and select **Edit Annotation**, or in the key, double-click the required entry.
    b. In the **Annotations** window, edit the default annotation or add extra information.
4. If required, edit the outline colours and styles and interior pattern and colour of the drawing object:
    a. Right-click a drawing element and select **Edit Style**.
    b. In the **Brush properties** window, edit the required attributes.
5. If required, to print the drawing click **Print**. If you print a drawing, all annotations are printed.
6. Click **Save**.

The drawing is added to the progress note for the clinical item.

If you printed the drawing, a report is displayed that includes patient information and information about the drawing qualifier and clinical item. The drawing is scaled to the page, and the annotations are printed in a key on a separate page.

If required, you can add the drawing to a letter. The drawing includes a key with callouts and any annotations you have added. For more information, see Writing letters and referrals *(on page 319)*.

Special Qualifiers

Special qualifiers include calculating qualifiers, HL7 qualifiers, required qualifiers, qualifiers with a range and qualifiers linked to system codes.

Calculated Qualifiers

Some qualifiers are calculated automatically, such as BMI *(on page 162)* and GFR *(on page 162)*. Other special qualifiers are used in their calculation, such as:

- Weight - must be in kg
- Height - must be in cm
- Creatinine - can be in umol/L or mmol/L

_Special_Qualifiers__HL7_Qualifiers

Some qualifiers are used to automatically extract values from HL7 format electronic investigation results. Running the report at **Report > Reference Tables > Numeric Qualifiers - Central** will show you these qualifiers.

Required Qualifiers

When completing a clinical item you may notice some qualifiers have a red or blue dot next to them. A red dot indicates that a value must be entered before the clinical item can be completed. If a required qualifier is not recorded then the item becomes an 'incomplete' item and a recall is created for the item. A blue dot marks a required qualifier that has already been addressed within a specified time interval.

Qualifiers with a range

Some numeric qualifiers have a restriction on the range of values that can be entered. These are particularly useful in cases where different units may be used, such as trying to enter grams instead of kilograms.

System Codes

Some qualifiers are recognised in Communicare reports by a special system code. Running the report at **Report > Reference Tables > System Codes and Rule Codes** will show you these qualifiers.

Body Mass Index

The Body Mass Index special qualifier calculates BMI to 1 decimal place.

The Body Mass Index special qualifier uses the formula:

```
WEIGHT / (HEIGHT X HEIGHT)
```

Where:

- WEIGHT is in kg
- HEIGHT is in m

Communicare requires the qualifiers to use the following units:

- Weight in kg
- Height in cm

Add the BMI qualifier to a clinical item along with Weight and Height. If Weight or Height are not provided at the same time, the most recent measure of weight or height is used.

Glomerular Filtration Rate

The special qualifiers GFR (actual body weight) and GFR (ideal body weight) calculate the Glomerular Filtration Rate to 1 decimal place based on the Cockcroft and Gault formula.

For female patients:

```
((140 - AGE) X WEIGHT) / SE CREATININE
```

For male patients:

```
(((140 - AGE) X WEIGHT) / SE CREATININE) x 1.23
```

Where:

- AGE is in completed years
- WEIGHT is in kg
- SE CREATININE is in umol/l

For `GFR (actual body weight)`, the actual body weight is used. For `GFR (ideal body weight)` the maximum adult lean weight is used if this is lower than the actual body weight. This is calculated as:

```
(HEIGHT x HEIGHT) x 25
```

Where Height is in m

Communicare requires the qualifiers to use the following units:

- Weight in kg
- Height in cm
- Se Creatinine in either umol/L or mmol/L

Add the GFR (actual body weight) qualifier and the GFR (ideal body weight) qualifier to separate clinical items:

- Add the GFR (actual body weight) qualifier with Weight and Creatinine.
- Add the GFR (ideal body weight) qualifier with Weight, Height and Creatinine.

> **Tip:**
> If Weight, Height or Creatinine are not provided at the same time, the most recent measure of weight, height or creatinine are used.

Required qualifiers

Some clinical items have required qualifiers that allow multiple providers to contribute to a health assessment over a period of time.

When all qualifiers are complete and the required evidence is recorded, a Medicare claim can be made.

Required qualifiers in a clinical item are displayed in the following way:

-  A red dot to the left of the qualifier indicates that this qualifier must be addressed within the period defined as the required interval, for example, 6 months
-  If the qualifier is addressed within the time interval *on any clinical item type* for that patient, the dot changes to blue.

If a clinical item is saved and all the required qualifiers with red dots that appeared at the beginning have been addressed, the item has a status of `Complete`. However, if a required qualifier is not addressed:

- The item has a status of `Incomplete`
- A recall is created so that the provider can address the incomplete information. The recall is listed in the **Main Summary > To Do** list, prefixed with <`Recall`>.

  You cannot edit or add a required qualifier for a previously saved incomplete item, for example through the progress notes. Instead you must use the recall to add the information.

Required qualifier information is typically recorded in the **Main Summary > Qualifier Summary**.

For example, a health service completes a check with required qualifiers in the following way:

1. The patient first sees a healthworker:
   a. The healthworker opens the patient's clinical record and adds the `Check up;Aboriginal & TSI adult` to the patient's clinical record.
   b. The healthworker completes the required qualifiers on the **Pre-check** tab then clicks **Save** to save the clinical item. A recall is created and added to **Main Summary > To Do** list, prefixed with <`Recall`>.
2. The patient then sees a nurse to have their immunisations:

   a. The nurse opens the patient's clinical record and in the **Main Summary > To Do** list, double-clicks `<Recall>Aboriginal & TSI adult health check`.
   b. In the **Manage Recall** window, the nurse clicks **Complete it**.
   c. The nurse completes the required qualifiers on the **Pre-check** tab for the immunisation information then saves the clinical item. The clinical item is still incomplete, so is still listed on the **Main Summary > To Do** list, prefixed with `<Recall>`.
3. The patient now sees a doctor:
   a. The doctor opens the patient's clinical record and in the **Main Summary > To Do** list, double-clicks `<Recall>Aboriginal & TSI adult health check`
   b. In the **Manage Recall** window, the doctor clicks **Complete it**.
   c. In the clinical item, the doctor reviews the information already recorded then goes to the **Examination of the patient** tab and records values for the required qualifiers.
   d. On the **Assessment of patient** tab, the doctor completes the health check and clicks **Save**.

All required qualifiers were completed, so the clinical item now has a status of `Complete` and the recall is removed from the **To Do** list.

For information about setting up clinical items with required qualifiers, see Clinical Item Type Properties *(on page 886)*.

Editing using the progress note

If you edit the required qualifiers from the progress note, you may encounter the following behaviour:

- You can edit required qualifier fields entered in the original progress note and any other qualifiers in the same clinical item.
- If you edit an already complete clinical item using the progress note and by removing a required qualifier render the item incomplete, you must complete the recall to make the clinical item complete again.
- If you remove required qualifiers that were completed in a different service (even if by a different provider), the original progress note is not affected, but the status of the clinical item may change from complete to incomplete. Complete the recall to remedy this situation.

Finding Hidden Windows

The **Bring to Front** navigation bar stays on top of other windows and indicates which windows are open.

This navigation bar is displayed whenever you open one of the following windows:

- Adverse Reaction *(on page 255)*
- Investigation Request *(on page 305)*
- Progress Note (Clinical Record) *(on page 137)*
- Scanned Document *(on page 316)*
- Letter Writer *(on page 323)*
- Clinical Item Maintenance *(on page 150)*
- Care Plan *(on page 131)*
- My Health Record Documents *(on page 786)*
- MEHR Profile *(on page 773)*

Open windows are highlighted in red. Click an icon to bring that window to the top. Windows that are not currently open are greyed out.

Position the navigation bar anywhere on your screen, where it will remain until Communicare is restarted. By default the navigation bar is located at the top left of the screen.

Data Entry Wizard

The Communicare Data Entry Wizard allows users to enter a clinical item into multiple patient records with ease. This is extremely useful when entering, say, a particular immunisation given to a group of patients.

The user is prompted at first to confirm the details *(on page 111)* of the services performed (provider name, encounter place and mode and date) and then select a clinical item from the Clinical_Terms_Browser.

The Patient_Search form is then presented to select the first patient. Details of that item are presented for adding a comment or any qualifiers that may be attached to the item. If there is an automated recall then the usual form *(on page 353)* is presented to edit, cancel or accept the recall for that patient.

Once you have finished entering the details for the first patient, the patient search screen is presented again to select the next patient, and so on until all patients have had the item recorded. At this point the patient search is cancelled.

The user can now change the service details to enter items for another provider, mode, place or date. There is an option to specify whether to mark created encounters as Not Claimable. The user can also select a different clinical item and enter that for a group of patients.

The rights to use the data entry wizard can be given to users without granting them the right to open patients' clinical records. This is particularly useful when the provider is not a health professional but is recording a non-medical service, such as providing transport, or when the provider is a visiting specialist, such as a dentist, and is required to record some specific procedures but not to consult the full clinical record.

Rules obeyed by the Data Entry Wizard

Data Entry Wizard is not the Clinical Record.

Data Entry Wizard is a stripped down version of the Clinical Record and it only allows adding clinical items to a patient's clinical record without opening the full clinical record.

As such some restrictions apply:

- When selecting the provider, place and mode of the service a date is also required.
- The service is created or started only if the clinical item has been added to the clinical record.

These are the rules used for creating/starting a service:

1. If no encounter exists with the selected place/mode for the selected patient then a date only encounter is created.
2. If an encounter exists but it is not started then the encounter is started and finished.
3. If an encounter exists but it is not finished then the encounter is finished.
4. If an encounter exists but it is finished then the encounter is not changed.

This means that if a doctor saw the patient in the morning and finished the service it does not matter when we use Data Entry Wizard because we will preserve the existing timestamps. It also means that if there is a booking or waiting encounter for the patient we will start and finish it automatically.

There will be a progress note generated for the service, with the clinical item added. This item will have the viewing right normally associated with it, and the note will have your default viewing right (the same as a service you normally create receives).

Intramail

Use the intramail system to send secure internal electronic messages within Communicare.

> **Note:**
> A standard activation fee applies. For more information, contact Communicare Support *(on page)*.

Using intramail, you can:

- Send a formatted, internal message to any user or group
- View sent and received messages
- Manage intramails
- Create mail groups from the list of registered Communicare users

Enabling intramail

To enable intramail, in **File > System Parameters > System** tab, set `Intramail`.

When intramail is enabled, an  Intramail icon is displayed in the main Communicare toolbar footer.

Sending Intramail

You can send an intramail message to other Communicare users within your health centre from the main toolbar. You can also send messages to another health practitioner from within a patient's record.

If you send an intramail message from within a patient's record, the patient is automatically associated with the message and the message is added to the patient's clinical record.

To compose a new intramail message:

1. Either:
   - In the main Communicare toolbar, click  Intramail icon.
   - From the **Clinical Record** window, in the toolbar, click  **Message**. Intramail messages sent from this window are bound to the selected patient.
   - If the **Intramail** window is open, click  **New**.
2. In the **Intramail - New Message** window, click **To** and select one or more recipients. For more information, see Intramail address book *(on page 168)*.
3. In the **Subject** field, enter a subject for the intramail.

   > **Remember:**
   > Searches may be performed on the subject only, so make the subject descriptive.

4. The patient is already selected if you are sending an intramail from the patient's clinical record. For other methods, if required, add a patient to whom this intramail message relates:
   a. Click **Patient**, and in the **Patient Search** window, select the patient.
   b. If required, customise the patient-related information:

- **Place Mode** - select a site from the list mode sites. If you are sending an intramail from the patient's clinical record, you cannot edit the mode.
- **Viewing Right** - select the access right associated with viewing the intramail message from the patient's progress notes.
- **Topic** - select from the topics that relate to the intramail message.

c. To save the intramail message to a patient's progress notes, set **Save message to progress notes**.

5. In the message body, enter your message. Use the text options to apply formatting.
6. Click **Send**.

If an intramail recipient is listed in the **Provider Planned Absence** list in Communicare and is absent, an alert message is displayed with the details of the absent providers.

If a patient is selected, for the given patient, any sent Intramail messages are listed on the **Detail** tab and displayed on the **Progress Notes** tab, prefixed with `Intramail Message`.

To view a message, on the **Detail** tab, double-click it.

You cannot edit intramail messages that have already been sent.

To delete an intramail:

1. In the **Intramail** window, select the message.
2. Click **Delete**.

If the intramail is associated with a patient, it is still listed on the **Detail** tab and displayed on the **Progress Notes** tab from where it can be opened.

Opening Intramail

If you have any unread intramail messages, a count is shown in the footer in the main Communicare toolbar.

To read any unread messages and display the **Intramail** window, double-click the

Intramail count in the toolbar footer.

The **Intramail** window functions like an email application. On the tabs:

- **Received** - lists all intramail messages that have been sent to you.

  Unread messages are shown in bold. The **Intramail** window opens with the first row selected and marked as read. To toggle a message as read or unread, select the message and in the toolbar, click **Mark as Unread** or **Mark as Read**.

  Messages sent to you that are not associated with a patient are visible to you only, no other users can have access to view or manage these intramail messages. Messages sent to you that are associated with a patient will be visible to you only within the **Intramail** window, however they will be accessible to view or manage in the patient's clinical

record by any user who has the viewing right associated with the intramail message and has access to clinical records. You can reply to and forward emails as normal.

> **Tip:**
> To open a patient's record from an intramail, in the message, click the patient's name in the **Patient** field.

The count of unread messages in the Communicare footer is updated as messages are read.

- **Sent Items** - lists all of the intramail messages that you have sent to other users within the system.
- **Deleted Items** - are kept for audit purposes

To delete an intramail:

1. In the **Intramail** window, select the message.
2. Click **Delete**.

If the intramail is associated with a patient, it is still listed on the **Detail** tab and displayed on the **Progress Notes** tab from where it can be opened.

Refine the intramail messages displayed using the filters:

- Date range - filter the intramails displayed based on the number of days selected. The default is `7 days`, which shows intramails from the last seven days.
- **Show unread only** - for received intramails, if this option is set, list only those intramails that you haven't read
- `Search` - search the subject line of the intramails in the current folder only. To also search the message content, set **Include message content**.

Intramail address book

An intramail message can be sent to any user or group that is displayed in the address book, which displays all registered Communicare users at a Communicare site.

To display the **Select Recipients** address book window, in the **Intramail - New Message** window, click **To**.

If a user's first and last name have not been defined, the user's login name is displayed.

Groups are differentiated from individual users by a group icon.

To select recipients:

1. In the **Intramail - New Message** window, click **To**.
2. Select one or more recipients from the list of registered Communicare users or groups of users as a recipient. To select more than one user or group, press CTRL+click or SHIFT + up or down arrow keys.

> **Tip:**
> To view or edit the current list of addressee groups, click **Groups Editor**.

3. Click right arrow to move the recipients to the right pane.
4. Repeat for all recipients then click **OK**.

You are returned to the **Intramail Message** window where you can compose your message.

Intramail Groups Editor

Use the **Intramail Groups Editor** to manage user groups for intramail messaging at your site.

Create groups with users who exist in Communicare. All groups created in the **Intramail Groups Editor** are available to all users and can therefore be edited or deleted by any user.

If a user's first and last name have not been defined, the user's login name is displayed.

To add a group:

1. In the **Intramail** window or address book, click **Groups Editor**.
2. In the **Intramail Groups Editor**, click **Add Group**.
3. In the **Group Name** window, add a name for the group and click **OK**.
4. In the **Intramail Groups Editor**, select the new group and click **Add Members**.
5. In the **Intramail Users and Groups** window, select one or more users from the list of registered Communicare users and click **OK**. Only those users who are not already included in the group are listed. To select more than one user, press CTRL+click or SHIFT + up or down arrow keys.
6. In the **Intramail Groups Editor**, click **Save & Close**.

Groups are listed in the **Groups Editor Main** pane.

To view the users in a group, highlight it in the list and click **View Members**.

To add new members to the group, highlight the group in the list and repeat steps 4-6 above.

To remove members from a group:

1. Highlight the group in the list and click **Remove Members**.
2. In the **Intramail Users** window, select one or more users to remove. Only intramail users currently in the group are displayed.
3. Click **OK**.

To display the details and permissions for users in a group, for the required group, click ⊞Expand.

To delete a group, highlight the group in the list and click **Delete Group**. Users are removed from the group automatically.

Medications

This topic covers all Medications Management functionality within Communicare.

Medication Overview

Displays all Prescription, Administer and Supply medication information for the selected patient.

The overview also includes any medication history taken verbally from a patient, prefixed with `<History>`.

Medication Management Configuration

Medications management changed significantly in V21.2 and later. Before you upgrade from V19.2 and earlier, consider the configuration options available for medications management in Communicare.

Your health service requires medications management if at your health service, healthcare providers require access to one or more of the following medication management functions: prescribe and chart medication orders or both; administer and supply medications or both; view medications; manage imprest cupboard; manage patient medication inventory and supply that's been packed by an external pharmacist.

To configure Communicare for medication management, select the medication management scenario that applies to your health service.

Key Concepts: Medication Management

The primary elements for configuring medication management are described here. If you have more complex medication management requirements at your health service, for example extemporaneous preparations, recording medication history, custom prescription templates, speak to Communicare Support. The scenarios list all elements to be considered and configured.

Table 25. Primary medication management functionality

Record a Medication	Medication Authorisation	Record Administer and Supply	Medication Stock
Prescriptions • PBS/Private Prescription **Medication Requests** • Rural and Remote prescribing (such as, S100 Scheme, HCP, Rural Script) • External pharmacy fill the script and send to health service for supply • Patient inventory **Medication Order** • Chart a medication order for administer or supply	**Verbal Orders** • Seek authorisation to administer or supply medication **Scope of Practice** • Authorisation to chart a medication order without a verbal order.	**Administer and Supply** • To record the administration or supply of medication	**Imprest** • Medication cupboard, stock-on-shelf inventory **Consolidated Orders** • Patient inventory of medications that are pack and labelled by an external pharmacist

Table 26. Primary configuration elements for medication management

System Parameters	Providers	Reference Tables	User Groups	Clinical Record
• System Modules • Clinical - Prescribing Options • Prescription Forms • Web Services (if using Clinical Decision Support)	• Prescriber Number • Verbal Order • Scope of Practice	• Formularies • Formularies - Scope of practice • Address Book (if using consolidated orders) • Encounter Places (if using consolidated orders)	• System Rights • Formulary Rights • Scope of Practice	• Pickup location • DAA type

Table 27. Medication management configuration prompts

Question	Functionality
Do you have doctors or nurse practitioners or both, who write prescriptions?	This can be managed by using `prescribing`
Do you have an agreement with an external pharmacist who packs DAAs and medications for your patients to collect from the clinic?	This can be managed by using `medication requests`
Do you have doctors or nurse practitioners or both, who chart medication orders for other clinicians to administer or supply medications to patients?	This can be managed by using `medication orders`
Do nurses ring doctors who are off site for a medication chart order (to be signed later), for example verbal telephone orders?	This can be managed by using `verbal orders`
Do nurses have a specific scope of practice to chart a medication order, for example nurse initiated medications or CARPA or a state based SASA orders that they administer or supply to patients?	This can be managed by using `scope of practice`
Do you have nurses or health practitioners who administer or supply medications or both to patients?	This can be managed by using `administer` and `supply`
Do you have a cupboard or stock-on-shelf imprest that you maintain and administer or supply medications to patients from?	This can be managed by using `imprest management`
Do you order patient medications regularly from your external pharmacist and keep a patient inventory of DAAs and medications for patients to collect from your clinic?	This can be managed by using `medication requests` and `consolidated orders`

Note:
For sites that have **Use Rural Prescription Form** enabled in V19.2 that would like to continue to use the rural health centre prescription functionality in V21.3. See Scenario 13 *(on page 222)*

For sites upgrading to V21.2 or later

Consider the following information before you upgrade:

- **Verbal Orders** and **Standing Orders** - the `Medications Management` module must be enabled for verbal orders and scope of practice to be active. Without this module, the section on the provider table will not be visible. If `Medications Management` was already enabled before you upgraded, it will still be enabled.
- **Provider Table** - the verbal order setting from the previous version will be maintained. The setting for standing orders will be copied to Scope of Practice. If previously set, this will remain set. Encounter places will remain as before.
- **Formularies** - formulary names and the selected drugs are copied to the new version of Communicare. The setting for Standing Orders will be copied to Scope of Practice. If previously set this will remain set.
- **User Rights** - formularies selected in the **Formulary Rights** tab for each user group are maintained. Set scope of practice rights in the new **Scope of Practice** list.

Scenario 1

Only doctors prescribe PBS scripts, no verbal orders, no scope of practice.

Clinicians employed at our health service are authorised, within their defined national registration category, to write a prescription (for example, PBS) which is printed on individual PBS script paper.

We offer no other type of medication services.

System Parameter - Configuration

Configure the following settings in **File > System Parameters**.

Table 28. System Parameters - Configuration

System Parameters		
System - Modules *(on page 812)*	**Medication View**	On
	Medications Management	Off
	Prescribing	On
System Parameters - Clinical *(on page 816)*	**Brand**	Off
	Generic Prescribing	On
	Generic Prescribing Mandatory	Off
	Enforce choice of once off/short course or regular medication	Optional
	Print prescription by default	Optional
	Use Health Centre Prescription defaults	Off
	Show generics in Drug Browser	Optional
	Use default prescription repeats	Optional
	Show Prescriber's Comments	Off
	Use RTPM Service	VIC only optional
	Require password on adverse reaction prescribing	Optional
	Enable label printing	Off
	Print Labels by default	Off
	Default label count	Off

Table 28. System Parameters - Configuration (continued)

System Parameters		
System Parameters - Prescription Forms *(on page 832)*	**Custom prescriptions**	Optional
	Interactions - Include non-specific category interactions	Optional
	Interactions - Exclude minor non-specific pregnancy	Optional
	Consolidated orders	Off
	Consolidated order templates	Off
	Medication Requests • Name • Plural Name • Information Text • Selection Information Text	Off
	Medication Request template	Off
	Create medication request by default	Off
	Show out of stock inventory	Off
	Print S8 prescriptions on a separate page	Off
System Parameters - Web Services *(on page 825)*	**Clinical Decision Support (CDS)**	Optional - but encouraged as a clinical safety initiative

Reference Tables - Configuration

Configure the following settings in **File > Reference Tables**.

Table 29. Reference Tables - Configuration

Reference Tables		
Adding and Editing Encounter Places and Modes *(on page 872)*	**Medication Pick up Location**	Off
Formularies *(on page 861)*	**Formulary**	Optional - Create as required
Scope of Practice *(on page 278)*	**Scope of Practice**	Off

User Group - Configuration

Configure the following settings in **File > User Groups**.

Table 30. User Group - Configuration

User Groups						
Provider Type	**System Right**		**Viewing Right**	**Program Right**	**Formulary Right**	**Scope of Practice**
PBS Prescriber *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	Optional - Create as required	Off
	Medication View	On				
	Medication Administer	Off				

Table 30. User Group - Configuration (continued)

User Groups						
	Medication Dispense	Off				
	Medication Supply	Off				
	Medication History	On				
	Prescribing Full	On				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				

Tip:
On the **Formulary Rights** tab, set **All Products** formulary. Optionally create other locally defined formularies.

Providers - Configuration

Configure the following settings in **File > Providers**.

Table 31. Providers - Configuration

Providers					
Provider Type	**Prescriber Number**	**Verbal Order**	**Schedule Drug Selection**	**Encounter Place**	**Use Scope of Practice**
PBS Prescriber *(on page 917)*	To be recorded	Not viewable	Not viewable	Not viewable	Not viewable

Printer Assignment - Configuration

Configure the following settings in **File > Printer Assignments**.

Table 32. Printer Assignments - Configuration

Printer Assignments		
Printer Assignments *(on page 618)*	**Prescriptions**	Set tray default
	Medication Labels - Label Template	Off

Scenario 2

Prescribe PBS scripts, include verbal orders, no scope of practice.

Clinicians employed at our health service are authorised, within their defined national registration category, to write a prescription (for example, PBS, rural and remote prescriptions (S100 Scheme, HCP)) which are printed on individual PBS script paper.

Health practitioners who are not prescribers are required to seek verbal orders for specific scheduled medication (for example, S8).

System Parameter - Configuration

Configure the following settings in **File > System Parameters**.

Table 33. System Parameters - Configuration

System Parameters		
System - Modules *(on page 812)*	**Medication View**	On
	Medications Management	On
	Prescribing	On
System Parameters - Clinical *(on page 816)*	**Brand**	Off
	Generic Prescribing	On
	Generic Prescribing Mandatory	Off
	Enforce choice of once off/short course or regular medication	Optional
	Print prescription by default	Optional
	Use Health Centre Prescription defaults	Off
	Show generics in Drug Browser	Optional
	Use default prescription repeats	Optional
	Show Prescriber's Comments	Off
	Use RTPM Service	VIC only optional
	Require password on adverse reaction prescribing	Optional
	Enable label printing	Off
	Print Labels by default	Off
	Default label count	Set as required
System Parameters - Prescription Forms *(on page 832)*	**Custom prescriptions**	Optional
	Interactions - Include non-specific category interactions	Optional
	Interactions - Exclude minor non-specific pregnancy	Optional
	Consolidated orders	Off
	Consolidated order templates	Off
	Medication Requests • Name • Plural Name • Information Text • Selection Information Text	Off
	Medication Request template	Off
	Create medication request by default	Off
	Show out of stock inventory	Off
	Print S8 prescriptions on a separate page	Off
System Parameters - Web Services *(on page 825)*	**Clinical Decision Support (CDS)**	Optional - but encouraged as a clinical safety initiative

> **Tip:**
> If the `Medications Management` module is enabled, **Print labels by default** doesn't work.

Reference Tables - Configuration

Configure the following settings in **File > Reference Tables**.

Table 34. Reference Tables - Configuration

Reference Tables		
Adding and Editing Encounter Places and Modes *(on page 872)*	**Medication Pick up Location**	Off
Formularies *(on page 861)*	**Formulary**	Optional - Create as required
Scope of Practice *(on page 278)*	**Scope of Practice**	Off

> **Tip:**
> Set up **formularies** to restrict what medications a nurse can view in MIMS or create **medication orders** for.

User Group - Configuration

Configure the following settings in **File > User Groups**.

Table 35. User Group - Configuration

User Groups						
Provider Type	**System Right**		**Viewing Right**	**Program Right**	**Formulary Right**	**Scope of Practice**
PBS Prescriber *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	Off
	Medication View	On				
	Medication Administer	Off				
	Medication Dispense	Off				
	Medication Supply	Off				
	Medication History	On				
	Prescribing Full	On				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				
Health Practitioner (who is not a prescriber) *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	Off
	Medication View	On				
	Medication Administer	Off				
	Medication Dispense	Off				
	Medication Supply	Off				
	Medication History	On				

Table 35. User Group - Configuration (continued)

User Groups						
	Prescribing Full	Off				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				
Health Practitioner, prescriber with restrictions, such as Nurse Practitioner *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	Off
	Medication View	On				
	Medication Administer	Off				
	Medication Dispense	Off				
	Medication Supply	Off				
	Medication History	On				
	Prescribing Full	On				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				

Tip:
On the **Formulary Rights** tab, set **All Products** formulary. Optionally create other locally defined formularies.

Providers - Configuration

Configure the following settings in **File > Providers**.

Table 36. Providers - Configuration

Providers					
Provider Type	**Prescriber Number**	**Verbal Order**	**Schedule Drug Selection**	**Encounter Place**	**Use Scope of Practice**
PBS Prescriber *(on page 917)*	To be recorded	N/A	N/A	N/A	Off
Health Practitioner (who is not a prescriber) *(on page 917)*	N/A	On	Set one or more options	Set as required	Off
Health Practitioner, prescriber with restrictions, such as Nurse Practitioner *(on page 917)*	To be recorded	On	Set one or more options	Set as required	Off

Tip:
Verbal Order:S1, **S2**, **S3**, **S4**, **S5**, **S6**, **S7**, **S8**, **S9**, **Un-Scheduled**- set one or more options to require that any medication order charted for medications included in the selected Schedule requires a verbal order. For example,

if a nurse needs to be able to prescribe S1, S2 and S3 medications without a verbal order, deselect **S1**, **S2** and **S3** and set **S4**-**S9**.

Tip:
To require a verbal order only for particular encounter places, select the required Encounter Place.

If you deselect an encounter place, the provider does not require a verbal order at that encounter place.

If you want a provider to always require a verbal order at all encounter places, for **Encounter Places**, set **Select All**.

Printer Assignment - Configuration

Configure the following settings in **File > Printer Assignments**.

Table 37. Printer Assignments - Configuration

Printer Assignments		
Printer Assignments *(on page 618)*	**Prescriptions**	Set tray default
	Medication Labels - Label Template	Off

Scenario 3

Prescribe PBS scripts, verbal orders, scope of practice.

Clinicians employed at our health service are authorised, within their defined national registration category, to write prescriptions (for example, PBS, rural and remote prescriptions (S100 Scheme, HCP)) which are printed on individual PBS script paper.

Health practitioners who are not prescribers are required to seek verbal orders for specific scheduled medication (for example, S8).

Health practitioners who are not prescribers are authorised to chart medication orders within a defined scope of practice (for example, CARPA, SASA, nurse initiated medications). These medications may be defined by drug or by schedule. Medications outside the scope of practice require a verbal order.

System Parameter - Configuration

Configure the following settings in **File > System Parameters**.

Table 38. System Parameters - Configuration

System Parameters		
System - Modules *(on page 812)*	**Medication View**	On
	Medications Management	On
	Prescribing	On
System Parameters - Clinical *(on page 816)*	**Brand**	Off
	Generic Prescribing	On
	Generic Prescribing Mandatory	Off
	Enforce choice of once off/short course or regular medication	Optional

Table 38. System Parameters - Configuration (continued)

System Parameters		
	Print prescription by default	Optional
	Use Health Centre Prescription defaults	Off
	Show generics in Drug Browser	Optional
	Use default prescription repeats	Optional
	Show Prescriber's Comments	Off
	Use RTPM Service	VIC only optional
	Require password on adverse reaction prescribing	Optional
	Enable label printing	Off
	Print Labels by default	Off
	Default label count	Set as required
System Parameters - Prescription Forms *(on page 832)*	**Custom prescriptions**	Optional
	Interactions - Include non-specific category interactions	Optional
	Interactions - Exclude minor non-specific pregnancy	Optional
	Consolidated orders	Off
	Consolidated order templates	Off
	Medication Requests • Name • Plural Name • Information Text • Selection Information Text	Off
	Medication Request template	Off
	Create medication request by default	Off
	Show out of stock inventory	Off
	Print S8 prescriptions on a separate page	Off
System Parameters - Web Services *(on page 825)*	**Clinical Decision Support (CDS)**	Optional - but encouraged as a clinical safety initiative

Tip:
If the `Medications Management` module is enabled, **Print labels by default** doesn't work.

Reference Tables - Configuration

Configure the following settings in **File > Reference Tables**.

Table 39. Reference Tables - Configuration

Reference Tables		
Adding and Editing Encounter Places and Modes *(on page 872)*	**Medication Pick up Location**	Off

Table 39. Reference Tables - Configuration (continued)

Reference Tables		
Formularies *(on page 861)*	**Formulary**	On - Create as required
Scope of Practice *(on page 278)*	**Scope of Practice**	On - Create as required

Tip:

Set up **formularies** to restrict the medications a nurse can view in MIMS, or create **medication orders** for.

Medications listed in a **Scope of Practice** will not require a verbal order for user groups assigned with the scope of practice.

User Group - Configuration

Configure the following settings in **File > User Groups**.

Table 40. User Group - Configuration

User Groups						
Provider Type	**System Right**		**Viewing Right**	**Program Right**	**Formulary Right**	**Scope of Practice**
PBS Prescriber *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	Off				
	Medication Dispense	Off				
	Medication Supply	Off				
	Medication History	On				
	Prescribing Full	On				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				
Health Practitioner (who is not a pre-scriber) *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	Off				
	Medication Dispense	Off				
	Medication Supply	Off				
	Medication History	On				
	Prescribing Full	Off				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				

Table 40. User Group - Configuration (continued)

User Groups						
Health Practitioner, prescriber with restrictions, such as Nurse Practitioner *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	Off				
	Medication Dispense	Off				
	Medication Supply	Off				
	Medication History	On				
	Prescribing Full	On				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				

Tip:
On the **Formulary Rights** tab, set **All Products** formulary. Optionally create other locally defined formularies. Assign the same formulary as scope of practice.

Providers - Configuration

Configure the following settings in **File > Providers**.

Table 41. Providers - Configuration

Providers					
Provider Type	**Prescriber Number**	**Verbal Order**	**Schedule Drug Selection**	**Encounter Place**	**Use Scope of Practice**
PBS Prescriber *(on page 917)*	To be recorded	N/A	N/A	N/A	Off
Health Practitioner (who is not a prescriber) *(on page 917)*	N/A	On	Set one or more options	Set as required	On
Health Practitioner, prescriber with restrictions, such as Nurse Practitioner *(on page 917)*	To be recorded	On	Set one or more options	Set as required	On

Tip:
Verbal Order:S1, **S2**, **S3**, **S4**, **S5**, **S6**, **S7**, **S8**, **S9**, **Un-Scheduled**- set one or more options to require that any medication order created for medications included in the selected Schedule requires a verbal order. For example, if a nurse needs to be able to prescribe S1, S2 and S3 medications without a verbal order, deselect **S1**, **S2** and **S3** and set **S4**-**S9**.

Tip:
To require a verbal order only for particular encounter places, select the required Encounter Place.

If you deselect an encounter place, the provider does not require a verbal order at that encounter place.

If you want a provider to always require a verbal order at all encounter places, for **Encounter Places**, set **Select All**.

Tip:
Medication listed in a **Scope of Practice** that is assigned to a user group that the provider belongs to, overrides the **Verbal Order > Schedule Drug Selection** selected for the provider.

Printer Assignment - Configuration

Configure the following settings in **File > Printer Assignments**.

Table 42. Printer Assignments - Configuration

Printer Assignments		
Printer Assignments *(on page 618)*	**Prescriptions**	Set tray default
	Medication Labels - Label Template	Off

Scenario 4

Prescribe PBS scripts, chart medication orders, administer and supply using clinical items, or external to Communicare, no verbal orders, no scope of practice.

Clinicians employed at our health service are authorised, within their defined national registration category, to write prescriptions (for example, PBS, rural and remote prescriptions (S100 Scheme, HCP)) which are printed on individual PBS script paper.

Health Practitioners employed at our health service are authorised, within their defined national registration category to chart a medication order.

Health practitioners who are not prescribers are authorised to chart medication orders within a defined scope of practice (for example, CARPA, SASA, nurse initiated medications).

The administration or supply of medications is recorded using clinical items or is recorded externally to Communicare. For example, using paper-based medication charts.

System Parameter - Configuration

Configure the following settings in **File > System Parameters**.

Table 43. System Parameters - Configuration

System Parameters		
System - Modules *(on page 812)*	**Medication View**	On
	Medications Management	Off
	Prescribing	On

Table 43. System Parameters - Configuration (continued)

System Parameters		
System Parameters - Clinical *(on page 816)*	**Brand**	Off
	Generic Prescribing	On
	Generic Prescribing Mandatory	Off
	Enforce choice of once off/short course or regular medication	Optional
	Print prescription by default	Optional
	Use Health Centre Prescription defaults	Off
	Show generics in Drug Browser	Optional
	Use default prescription repeats	Optional
	Show Prescriber's Comments	Off
	Use RTPM Service	VIC only optional
	Require password on adverse reaction prescribing	Optional
	Enable label printing	On
	Print Labels by default	On
	Default label count	Set as required
System Parameters - Prescription Forms *(on page 832)*	**Custom prescriptions**	Optional
	Interactions - Include non-specific category interactions	Optional
	Interactions - Exclude minor non-specific pregnancy	Optional
	Consolidated orders	Off
	Consolidated order templates	Off
	Medication Requests • Name • Plural Name • Information Text • Selection Information Text	Off
	Medication Request template	Off
	Create medication request by default	Off
	Show out of stock inventory	Off
	Print S8 prescriptions on a separate page	Off
System Parameters - Web Services *(on page 825)*	**Clinical Decision Support (CDS)**	Optional - but encouraged as a clinical safety initiative

Reference Tables - Configuration

Configure the following settings in **File > Reference Tables**.

Table 44. Reference Tables - Configuration

Reference Tables		
Adding and Editing Encounter Places and Modes *(on page 872)*	**Medication Pick up Location**	Off
Formularies *(on page 861)*	**Formulary**	On - Create as required
Scope of Practice *(on page 278)*	**Scope of Practice**	Off

Tip:
Set up **formularies** to restrict what medications a nurse can view in MIMS or create **medication orders** for.

User Group - Configuration

Configure the following settings in **File > User Groups**.

Table 45. User Group - Configuration

User Groups						
Provider Type	**System Right**		**Viewing Right**	**Program Right**	**Formulary Right**	**Scope of Practice**
PBS Prescriber *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	Off
	Medication View	On				
	Medication Administer	Off				
	Medication Dispense	Off				
	Medication Supply	Off				
	Medication History	On				
	Prescribing Full	On				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				
Health Practitioners (who is not a prescriber) *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	Off
	Medication View	On				
	Medication Administer	Off				
	Medication Dispense	Off				
	Medication Supply	Off				
	Medication History	On				
	Prescribing Full	Off				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				

Table 45. User Group - Configuration (continued)

User Groups						
Health practitioners, prescriber with restrictions, such as Nurse Practitioner *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	Off
	Medication View	On				
	Medication Administer	Off				
	Medication Dispense	Off				
	Medication Supply	Off				
	Medication History	On				
	Prescribing Full	On				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				

Tip:

On the **Formulary Rights** tab, set **All Products** formulary. Optionally create other locally defined formularies.

Formulary - create a formulary to restrict the MIMS medication view and available list of medications for charting medication orders. Assign the formulary to the user group.

Providers - Configuration

Configure the following settings in **File > Providers**.

Table 46. Providers - Configuration

Providers					
Provider Type	**Prescriber Number**	**Verbal Order**	**Schedule Drug Selection**	**Encounter Place**	**Use Scope of Practice**
PBS Prescriber *(on page 917)*	To be recorded	Not viewable	Not viewable	Not viewable	Not viewable
Health Practitioner (who is not a prescriber) *(on page 917)*	N/A	Not viewable	Not viewable	Not viewable	Not viewable
Health Practitioner, prescriber with restrictions, such as Nurse Practitioner *(on page 917)*	To be recorded	Not viewable	Not viewable	Not viewable	Not viewable

Printer Assignment - Configuration

Configure the following settings in **File > Printer Assignments**.

Table 47. Printer Assignments - Configuration

Printer Assignments		
Printer Assignments *(on page 618)*	**Prescriptions**	Set tray default
	Medication Labels - Label Template	Select dispense label template

Scenario 5

Prescribe PBS scripts, chart medication orders, administer and supply using clinical items or external to Communicare, verbal orders, no scope of practice

Clinicians employed at our health service are authorised, within their defined national registration category, to write prescriptions (for example, PBS, rural and remote prescriptions (S100 Scheme, HCP)) which are printed on individual PBS script paper.

Health Practitioners employed at our health service are authorised, within their defined national registration category to chart a medication order.

Health practitioners who are not prescribers are authorised to chart medication orders within a defined scope of practice (for example, CARPA, SASA, nurse initiated medications). These medications are defined by drug schedule. Medications outside the defined scheduled drug parameter require a verbal order.

Health practitioners who are not prescribers are required to seek verbal orders for specific scheduled medication (for example, S8).

The administration or supply of medications is recorded and displayed in the patient's clinical record as a clinical item or they are recorded externally to Communicare, such as on a paper-based medication chart.

System Parameter - Configuration

Configure the following settings in **File > System Parameters**.

Table 48. System Parameters - Configuration

System Parameters		
System - Modules *(on page 812)*	**Medication View**	On
	Medications Management	On
	Prescribing	On
System Parameters - Clinical *(on page 816)*	**Brand**	Off
	Generic Prescribing	On
	Generic Prescribing Mandatory	Off
	Enforce choice of once off/short course or regular medication	Optional
	Print prescription by default	Optional
	Use Health Centre Prescription defaults	Off
	Show generics in Drug Browser	Optional
	Use default prescription repeats	Optional
	Show Prescriber's Comments	Off

Table 48. System Parameters - Configuration (continued)

System Parameters		
	Use RTPM Service	VIC only optional
	Require password on adverse reaction prescribing	Optional
	Enable label printing	On
	Print Labels by default	Off
	Default label count	Set as required
System Parameters - Prescription Forms *(on page 832)*	**Custom prescriptions**	Optional
	Interactions - Include non-specific category interactions	Optional
	Interactions - Exclude minor non-specific pregnancy	Optional
	Consolidated orders	Off
	Consolidated order templates	Off
	Medication Requests • Name • Plural Name • Information Text • Selection Information Text	Off
	Medication Request template	Off
	Create medication request by default	Off
	Show out of stock inventory	Off
	Print S8 prescriptions on a separate page	Off
System Parameters - Web Services *(on page 825)*	**Clinical Decision Support (CDS)**	Optional - but encouraged as a clinical safety initiative

Tip:
If the `Medications Management` module is enabled, **Print labels by default** doesn't work.

Reference Tables - Configuration

Configure the following settings in **File > Reference Tables**.

Table 49. Reference Tables - Configuration

Reference Tables		
Adding and Editing Encounter Places and Modes *(on page 872)*	**Medication Pick up Location**	Off
Formularies *(on page 861)*	**Formulary**	On - Create as required
Scope of Practice *(on page 278)*	**Scope of Practice**	Off

Tip:
Set up **formularies** to restrict what medications a nurse can view in MIMS or create **medication orders** for.

User Group - Configuration

Configure the following settings in **File > User Groups**.

Table 50. User Group - Configuration

User Groups						
Provider Type	**System Right**		**Viewing Right**	**Program Right**	**Formulary Right**	**Scope of Practice**
PBS Prescriber *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	Off
	Medication View	On				
	Medication Administer	Off				
	Medication Dispense	Off				
	Medication Supply	Off				
	Medication History	On				
	Prescribing Full	On				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				
Health Practitioners (who is not a prescriber) *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	Off
	Medication View	On				
	Medication Administer	Off				
	Medication Dispense	Off				
	Medication Supply	Off				
	Medication History	On				
	Prescribing Full	Off				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				
Health Practitioners, prescriber with restrictions, such as Nurse Practitioner *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	Off
	Medication View	On				
	Medication Administer	Off				
	Medication Dispense	Off				
	Medication Supply	Off				
	Medication History	On				
	Prescribing Full	On				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				

Tip:
On the **Formulary Rights** tab, set **All Products** formulary. Optionally create other locally defined formularies.

Providers - Configuration

Configure the following settings in **File > Providers**.

Table 51. Providers - Configuration

Providers					
Provider Type	**Prescriber Number**	**Verbal Order**	**Schedule Drug Selection**	**Encounter Place**	**Use Scope of Practice**
PBS Prescriber *(on page 917)*	To be recorded	N/A	N/A	N/A	Off
Health Practitioner (who is not a prescriber) *(on page 917)*	N/A	On	Set one or more options	Set as required	Off
Health Practitioners, prescriber with restrictions, such as Nurse Practitioner *(on page 917)*	To be recorded	On	Set one or more options	Set as required	Off

Tip:
Verbal Order:S1, **S2**, **S3**, **S4**, **S5**, **S6**, **S7**, **S8**, **S9**, **Un-Scheduled**- set one or more options to require that any medication order created for medications included in the selected Schedule requires a verbal order. For example, if a nurse needs to be able to prescribe S1, S2 and S3 medications without a verbal order, deselect **S1**, **S2** and **S3** and set **S4**-**S9**.

Tip:
To require a verbal order only for particular encounter places, select the required Encounter Place.

If you deselect an encounter place, the provider does not require a verbal order at that encounter place.

If you want a provider to always require a verbal order at all encounter places, for **Encounter Places**, set **Select All**.

Printer Assignment - Configuration

Configure the following settings in **File > Printer Assignments**.

Table 52. Printer Assignments - Configuration

Printer Assignments		
Printer Assignments *(on page 618)*	**Prescriptions**	Set tray default
	Medication Labels - Label Template	Select dispense label template

Scenario 6

Prescribe PBS scripts, chart medication orders, record administer and supply using clinical items or externally to Communicare, verbal orders, scope of practice.

Clinicians employed at our health service are authorised, within their defined national registration category, to write prescriptions (for example, PBS, rural and remote prescriptions (S100 Scheme, HCP)) which are printed on individual PBS script paper.

Health Practitioners employed at our health service are authorised, within their defined national registration category to chart a medication order.

Health practitioners who are not prescribers are authorised to chart medication orders within a defined scope of practice (for example, CARPA, SASA, nurse initiated medications). These medications may be defined by drug or by schedule. Medications outside the scope of practice require a verbal order.

Health practitioners who are not prescribers are required to seek verbal orders for specific scheduled medication (for example, S8).

Administration or supply of medications is recorded in the patient's progress notes as a clinical item or they are recorded externally to Communicare, such as on a paper-based medication chart.

System Parameter - Configuration

Configure the following settings in **File > System Parameters**.

Table 53. System Parameters - Configuration

System Parameters		
System - Modules *(on page 812)*	**Medication View**	On
	Medications Management	On
	Prescribing	On
System Parameters - Clinical *(on page 816)*	**Brand**	Off
	Generic Prescribing	On
	Generic Prescribing Mandatory	Off
	Enforce choice of once off/short course or regular medication	Optional
	Print prescription by default	Optional
	Use Health Centre Prescription defaults	Off
	Show generics in Drug Browser	Optional
	Use default prescription repeats	Optional
	Show Prescriber's Comments	Off
	Use RTPM Service	VIC only optional
	Require password on adverse reaction prescribing	Optional
	Enable label printing	On
	Print Labels by default	Off
	Default label count	Set as required

Table 53. System Parameters - Configuration (continued)

System Parameters		
System Parameters - Prescription Forms *(on page 832)*	**Custom prescriptions**	Optional
	Interactions - Include non-specific category interactions	Optional
	Interactions - Exclude minor non-specific pregnancy	Optional
	Consolidated orders	Off
	Consolidated order templates	Off
	Medication Requests • Name • Plural Name • Information Text • Selection Information Text	Off
	Medication Request template	Off
	Create medication request by default	Off
	Show out of stock inventory	Off
	Print S8 prescriptions on a separate page	Off
System Parameters - Web Services *(on page 825)*	**Clinical Decision Support (CDS)**	Optional - but encouraged as a clinical safety initiative

Tip:
If the `Medications Management` module is enabled, **Print labels by default** doesn't work.

Reference Tables - Configuration

Configure the following settings in **File > Reference Tables**.

Table 54. Reference Tables - Configuration

Reference Tables		
Adding and Editing Encounter Places and Modes *(on page 872)*	**Medication Pick up Location**	Off
Formularies *(on page 861)*	**Formulary**	On - Create as required
Scope of Practice *(on page 278)*	**Scope of Practice**	On - Create as required

Tip:

Set up **formularies** to restrict what medications a nurse can view in MIMS or create **medication orders** for.

Medications listed in a **Scope of Practice** will not require a verbal order for user groups assigned with the scope of practice.

User Group - Configuration

Configure the following settings in **File > User Groups**.

Table 55. User Group - Configuration

User Groups						
Provider Type	**System Right**		**Viewing Right**	**Program Right**	**Formulary Right**	**Scope of Practice**
PBS Prescriber *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	Off				
	Medication Dispense	Off				
	Medication Supply	Off				
	Medication History	On				
	Prescribing Full	On				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				
Health practitioners (who is not a prescriber) *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	Off				
	Medication Dispense	Off				
	Medication Supply	Off				
	Medication History	On				
	Prescribing Full	Off				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				
Health practitioners, prescriber with restrictions, such as Nurse Practitioner *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	Off				
	Medication Dispense	Off				
	Medication Supply	Off				
	Medication History	On				
	Prescribing Full	On				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				

Tip:

On the **Formulary Rights** tab, set **All Products** formulary. Optionally create other locally defined formularies.

Formulary - create a formulary to restrict the MIMS medication view and available list of medications for charting medication orders. Assign the formulary to the user group.

Scope of Practice - assign the same formulary as scope of practice.

Providers - Configuration

Configure the following settings in **File > Providers**.

Table 56. Providers - Configuration

Providers					
Provider Type	**Prescriber Number**	**Verbal Order**	**Schedule Drug Selection**	**Encounter Place**	**Use Scope of Practice**
PBS Prescriber *(on page 917)*	To be recorded	N/A	N/A	N/A	Off
Health Practitioner (who is not a prescriber) *(on page 917)*	N/A	On	Set one or more options	Set as required	On
Health Practitioner, prescriber with restrictions, such as Nurse Practitioner *(on page 917)*	To be recorded	On	Set one or more options	Set as required	On

Tip:
Verbal Order:S1, **S2**, **S3**, **S4**, **S5**, **S6**, **S7**, **S8**, **S9**, **Un-Scheduled**- set one or more options to require that any medication order created for medications included in the selected Schedule requires a verbal order. For example, if a nurse needs to be able to prescribe S1, S2 and S3 medications without a verbal order, deselect **S1**, **S2** and **S3** and set **S4**-**S9**.

Tip:
To require a verbal order only for particular encounter places, select the required Encounter Place.

If you deselect an encounter place, the provider does not require a verbal order at that encounter place.

If you want a provider to always require a verbal order at all encounter places, for **Encounter Places**, set **Select All**.

Tip:
Medication listed in a **Scope of Practice** that is assigned to a user group that the provider belongs to, overrides **Verbal Order > Schedule Drug Selection** selected for the provider.

Printer Assignment - Configuration

Configure the following settings in **File > Printer Assignments**.

Table 57. Printer Assignments - Configuration

Printer Assignments		
Printer Assignments *(on page 618)*	**Prescriptions**	Set tray default
	Medication Labels - Label Template	Select dispense label template

Scenario 7

Prescribe PBS scripts, chart medication orders, administer and supply using medications management, verbal orders, scope of practice.

Clinicians employed at our health service are authorised, within their defined national registration category, to write prescriptions (for example, PBS, rural and remote prescriptions (S100 Scheme, HCP)) which are printed on individual PBS script paper.

Health Practitioners employed at our health service are authorised, within their defined national registration category to chart a medication order.

Health practitioners who are not prescribers are authorised to chart medication orders within a defined scope of practice (for example, CARPA, SASA, nurse initiated medications). These medications may be defined by drug or by schedule. Medications outside the scope of practice require a verbal order.

Health practitioners who are not prescribers are required to seek verbal orders for specific scheduled medication (for example, S8).

The quantity and the date last administered and last supplied or both, of a medication are displayed in the patient's medication summary.

System Parameter - Configuration

Configure the following settings in **File > System Parameters**.

Table 58. System Parameters - Configuration

System Parameters		
System - Modules *(on page 812)*	**Medication View**	On
	Medications Management	On
	Prescribing	On
System Parameters - Clinical *(on page 816)*	**Brand**	Off
	Generic Prescribing	On
	Generic Prescribing Mandatory	Off
	Enforce choice of once off/short course or regular medication	Optional
	Print prescription by default	Optional
	Use Health Centre Prescription defaults	Off
	Show generics in Drug Browser	Optional
	Use default prescription repeats	Optional
	Show Prescriber's Comments	Off

Table 58. System Parameters - Configuration (continued)

System Parameters		
	Use RTPM Service	VIC only optional
	Require password on adverse reaction prescribing	Optional
	Enable label printing	On
	Print Labels by default	Off
	Default label count	Set as required
System Parameters - Prescription Forms *(on page 832)*	**Custom prescriptions**	Optional
	Interactions - Include non-specific category interactions	Optional
	Interactions - Exclude minor non-specific pregnancy	Optional
	Consolidated orders	Off
	Consolidated order templates	Off
	Medication Requests • Name • Plural Name • Information Text • Selection Information Text	Off
	Medication Request template	Off
	Create medication request by default	Off
	Show out of stock inventory	Off
	Print S8 prescriptions on a separate page	Off
System Parameters - Web Services *(on page 825)*	**Clinical Decision Support (CDS)**	Optional - but encouraged as a clinical safety initiative

Tip:
If the `Medications Management` module is enabled, **Print labels by default** doesn't work.

Reference Tables - Configuration

Configure the following settings in **File > Reference Tables**.

Table 59. Reference Tables - Configuration

Reference Tables		
Adding and Editing Encounter Places and Modes *(on page 872)*	**Medication Pick up Location**	Off
Formularies *(on page 861)*	**Formulary**	On - Create as required
Scope of Practice *(on page 278)*	**Scope of Practice**	On - Create as required

Tip:

Set up **formularies** to restrict what medications a nurse can view in MIMS or create **medication orders** for.

Medications listed in a **Scope of Practice** will not require a verbal order for user groups assigned with the scope of practice.

User Group - Configuration

Configure the following settings in **File > User Groups**.

Table 60. User Group - Configuration

User Groups						
Provider Type	**System Right**		**Viewing Right**	**Program Right**	**Formulary Right**	**Scope of Practice**
PBS Prescriber *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	On				
	Medication Dispense	Off				
	Medication Supply	On				
	Medication History	On				
	Prescribing Full	On				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				
Health Practitioners (who is not a prescriber) *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	On				
	Medication Dispense	Off				
	Medication Supply	On				
	Medication History	On				
	Prescribing Full	Off				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				
Health Practitioners, prescriber with restrictions, such as Nurse Practitioner *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	On				
	Medication Dispense	Off				
	Medication Supply	On				
	Medication History	On				
	Prescribing Full	On				

Table 60. User Group - Configuration (continued)

User Groups						
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				

Tip:

On the **Formulary Rights** tab, set **All Products** formulary. Optionally create other locally defined formularies.

Formulary - create a formulary to restrict the MIMS medication view and available list of medications for charting medication orders. Assign the formulary to the user group.

Scope of Practice - assign the same formulary as scope of practice.

Providers - Configuration

Configure the following settings in **File > Providers**.

Table 61. Providers - Configuration

Providers					
Provider Type	**Prescriber Number**	**Verbal Order**	**Schedule Drug Selection**	**Encounter Place**	**Use Scope of Practice**
PBS Prescriber *(on page 917)*	To be recorded	N/A	N/A	N/A	Off
Health Practitioner (who is not a prescriber) *(on page 917)*	N/A	On	Set one or more options	Set as required	On
Health Practitioner, prescriber with restrictions, such as Nurse Practitioner *(on page 917)*	To be recorded	On	Set one or more options	Set as required	On

Tip:

Verbal Order:S1, **S2**, **S3**, **S4**, **S5**, **S6**, **S7**, **S8**, **S9**, **Un-Scheduled**- set one or more options to require that any medication order created for medications included in the selected Schedule requires a verbal order. For example, if a nurse needs to be able to prescribe S1, S2 and S3 medications without a verbal order, deselect **S1**, **S2** and **S3** and set **S4**-**S9**.

Tip:

To require a Verbal Order only for particular encounter places, select the required Encounter Place.

If you deselect an encounter place, the provider does not require a verbal order at that encounter place.

If you want a provider to always require a verbal order at all encounter places,for **Encounter Places**, set **Select All**.

Tip:
Medication listed in a **Scope of Practice** that is assigned to a user group that the provider belongs to, overrides **Verbal Order > Schedule Drug Selection** selected for the provider.

Printer Assignment - Configuration

Configure the following settings in **File > Printer Assignments**.

Table 62. Printer Assignments - Configuration

Printer Assignments		
Printer Assignments *(on page 618)*	**Prescriptions**	Set tray default
	Medication Labels - Label Template	Select dispense label template

Scenario 8

Prescribe PBS scripts, chart medication orders, administer and supply medications using medications management, verbal orders, scope of practice, imprest.

Clinicians employed at our health service are authorised, within their defined national registration category, to write prescriptions (for example, PBS, rural and remote prescriptions (S100 Scheme, HCP)) which are printed on individual PBS script paper.

Health Practitioners employed at our health service are authorised, within their defined national registration category to chart a medication order.

Health practitioners who are not prescribers are authorised to chart medication orders within a defined scope of practice (for example, CARPA, SASA, nurse initiated medications). These medications may be defined by drug or by schedule. Medications outside the scope of practice require a verbal order.

Health practitioners who are not prescribers are required to seek verbal orders for specific scheduled medication (for example, S8).

The quantity and the date last administered and last supplied or both, of a medication are displayed in the patient's medication summary.

Medication imprest cupboard stock ordering is managed through the imprest drug list and imprest orders.

System Parameter - Configuration

Configure the following settings in **File > System Parameters**.

Table 63. System Parameters - Configuration

System Parameters		
System - Modules *(on page 812)*	**Medication View**	On
	Medications Management	On
	Prescribing	On
System Parameters - Clinical *(on page 816)*	**Brand**	Off
	Generic Prescribing	On

Table 63. System Parameters - Configuration (continued)

System Parameters		
	Generic Prescribing Mandatory	Off
	Enforce choice of once off/short course or regular medication	Optional
	Print prescription by default	Optional
	Use Health Centre Prescription defaults	Off
	Show generics in Drug Browser	Optional
	Use default prescription repeats	Optional
	Show Prescriber's Comments	Off
	Use RTPM Service	VIC only optional
	Require password on adverse reaction prescribing	Optional
	Enable label printing	On
	Print Labels by default	Off
	Default label count	Set as required
System Parameters - Prescription Forms *(on page 832)*	**Custom prescriptions**	Optional
	Interactions - Include non-specific category interactions	Optional
	Interactions - Exclude minor non-specific pregnancy	Optional
	Consolidated orders	Off
	Consolidated order templates	Off
	Medication Requests • Name • Plural Name • Information Text • Selection Information Text	Off
	Medication Request template	Off
	Create medication request by default	Off
	Show out of stock inventory	Off
	Print S8 prescriptions on a separate page	Off
System Parameters - Web Services *(on page 825)*	**Clinical Decision Support (CDS)**	Optional - but encouraged as a clinical safety initiative

Tip:
If the `Medications Management` module is enabled, **Print labels by default** doesn't work.

Reference Tables - Configuration

Configure the following settings in **File > Reference Tables**.

Table 64. Reference Tables - Configuration

Reference Tables		
Adding and Editing Encounter Places and Modes *(on page 872)*	**Medication Pick up Location**	Off
Formularies *(on page 861)*	**Formulary**	On - Create as required
Scope of Practice *(on page 278)*	**Scope of Practice**	On - Create as required

Tip:

Set up **formularies** to restrict what medications a nurse can view in MIMS or create **medication orders** for.

Medications listed in a **Scope of Practice** will not require a verbal order for user groups assigned with the scope of practice.

User Group - Configuration

Configure the following settings in **File > User Groups**.

Table 65. User Group - Configuration

User Groups						
Provider Type	**System Right**		**Viewing Right**	**Program Right**	**Formulary Right**	**Scope of Practice**
PBS Prescriber *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	On				
	Medication Dispense	Off				
	Medication Supply	On				
	Medication History	On				
	Prescribing Full	On				
	Prescribing Once Off/ Short course	On				
	Imprest Management	On - Assign to imprest managers				
Health Practitioners (who is not a prescriber) *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	On				
	Medication Dispense	Off				
	Medication Supply	On				
	Medication History	On				
	Prescribing Full	Off				

Table 65. User Group - Configuration (continued)

User Groups						
	Prescribing Once Off/ Short course	On				
	Imprest Management	On - Assign to imprest managers				
Health Practitioners, with restrictions, such as a Nurse Practitioner *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	On				
	Medication Dispense	Off				
	Medication Supply	On				
	Medication History	On				
	Prescribing Full	On				
	Prescribing Once Off/ Short course	On				
	Imprest Management	On - Assign to imprest managers				

Tip:

On the **Formulary Rights** tab, set **All Products** formulary. Optionally create other locally defined formularies.

Formulary - create a formulary to restrict the MIMS medication view and available list of medications for charting medication orders. Assign the formulary to the user group.

Scope of Practice - assign the same formulary as scope of practice.

Providers - Configuration

Configure the following settings in **File > Providers**.

Table 66. Providers - Configuration

Providers					
Provider Type	**Prescriber Number**	**Verbal Order**	**Schedule Drug Selection**	**Encounter Place**	**Use Scope of Practice**
PBS Prescriber *(on page 917)*	To be recorded	N/A	N/A	N/A	Off
Health Practitioner (who is not a prescriber) *(on page 917)*	N/A	On	Set one or more options	Set as required	On

Table 66. Providers - Configuration (continued)

Providers					
Health Practitioner, prescriber with restrictions, such as a Nurse Practitioner *(on page 917)*	To be recorded	On	Set one or more options	Set as required	On

Tip:
Verbal Order:S1, **S2**, **S3**, **S4**, **S5**, **S6**, **S7**, **S8**, **S9**, **Un-Scheduled**- set one or more options to require that any medication order created for medications included in the selected Schedule requires a Verbal Order. For example, if a nurse needs to be able to prescribe S1, S2 and S3 medications without a verbal order, deselect **S1**, **S2** and **S3** and set **S4**-**S9**.

Tip:
To require a verbal order only for particular encounter places, select the required Encounter Place.

If you deselect an encounter place, the provider does not require a verbal order at that encounter place.

If you want a provider to always require a verbal order at all encounter places,for **Encounter Places**, set **Select All**.

Tip:
Medication listed in a **Scope of Practice** that is assigned to a user group that the provider belongs to overrides **Verbal Order > Schedule Drug Selection** selected for the provider.

Printer Assignment - Configuration

Configure the following settings in **File > Printer Assignments**.

Table 67. Printer Assignments - Configuration

Printer Assignments		
Printer Assignments *(on page 618)*	**Prescriptions**	Set tray default
	Medication Labels - Label Template	Select dispense label template

Scenario 9

Prescribe PBS Scripts, chart medication orders, administer and supply using medication management, medication requests, verbal orders, scope of practice.

Clinicians employed at our health service are authorised, within their defined national registration category, to write prescriptions (for example, PBS, rural and remote prescriptions (S100 Scheme, HCP)) which are printed on individual PBS script paper or printed on a single batch prescription which is sent by the health service to the pharmacy for dispensing.

Our health service stocks and supplies patient prescription medications, that are packed by an external pharmacist.

Health Practitioners employed at our health service are authorised, within their defined national registration category to chart a medication order.

Health practitioners who are not prescribers are authorised to chart medication orders within a defined scope of practice (for example, CARPA, SASA, nurse initiated medications). These medications may be defined by drug or by schedule. Medications outside the scope of practice require a verbal order.

Health practitioners who are not prescribers are required to seek verbal orders for specific scheduled medication (for example, S8).

The quantity and the date last administered and last supplied or both, of medicines are displayed in the patient's medication summary.

System Parameter - Configuration

Configure the following settings in **File > System Parameters**.

Table 68. System Parameters - Configuration

System Parameters		
System - Modules *(on page 812)*	**Medication View**	On
	Medications Management	On
	Prescribing	On
System Parameters - Clinical *(on page 816)*	**Brand**	Off
	Generic Prescribing	On
	Generic Prescribing Mandatory	Off
	Enforce choice of once off/short course or regular medication	Optional
	Print prescription by default	Optional
	Use Health Centre Prescription defaults	Optional
	Show generics in Drug Browser	Optional
	Use default prescription repeats	Optional
	Show Prescriber's Comments	On
	Use RTPM Service	VIC only optional
	Require password on adverse reaction prescribing	Optional
	Enable label printing	On
	Print Labels by default	Off
	Default label count	Set as required
System Parameters - Prescription Forms *(on page 832)*	**Custom prescriptions**	Optional
	Interactions - Include non-specific category interactions	Optional
	Interactions - Exclude minor non-specific pregnancy	Optional
	Consolidated orders	Off
	Consolidated order templates	Off

Table 68. System Parameters - Configuration (continued)

System Parameters		
	Medication Requests • Name • Plural Name • Information Text • Selection Information Text	On
	Medication Request template	On
	Create medication request by default	On
	Show out of stock inventory	On
	Print S8 prescriptions on a separate page	On
System Parameters - Web Services *(on page 825)*	**Clinical Decision Support (CDS)**	Optional - but encouraged as a clinical safety initiative

Tip:

If the `Medications Management` module is enabled, **Print labels by default** doesn't work.

Use Health Centre Prescription defaults - if used with **Enforce choice of once off/short course or regular medication**, regular medication duration does not default to the Health Centre prescription default duration.

Show Prescriber's Comments - if enabled prints the prescriber's comments on the medication request.

Medication Request - if enabled optional to set **Name**, **Plural Name**, **Information Text**, **Selection Information Text**.

Medication Request template - can be reprinted only by users with a recorded prescriber number.

Reference Tables - Configuration

Configure the following settings in **File > Reference Tables**.

Table 69. Reference Tables - Configuration

Reference Tables		
Adding and Editing Encounter Places and Modes *(on page 872)*	**Medication Pick up Location**	On
Formularies *(on page 861)*	**Formulary**	On - Create as required
Scope of Practice *(on page 278)*	**Scope of Practice**	On - Create as required

Tip:

Set up **formularies** to restrict what medications a nurse can view in MIMS or create **medication orders** for.

Medications listed in a **Scope of Practice** will not require a verbal order for user groups assigned with the scope of practice.

User Group - Configuration

Configure the following settings in **File > User Groups**.

Table 70. User Group - Configuration

User Groups						
Provider Type	**System Right**		**Viewing Right**	**Program Right**	**Formulary Right**	**Scope of Practice**
PBS Prescriber *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	On				
	Medication Dispense	Off				
	Medication Supply	On				
	Medication History	On				
	Prescribing Full	On				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				
Health Practitioners (who is not a prescriber *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	On				
	Medication Dispense	Off				
	Medication Supply	On				
	Medication History	On				
	Prescribing Full	Off				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				
Health Practitioners, prescriber with restrictions, such as Nurse Practitioner *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	On				
	Medication Dispense	Off				
	Medication Supply	On				
	Medication History	On				
	Prescribing Full	On				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				

Tip:

On the **Formulary Rights** tab, set **All Products** formulary. Optionally create other locally defined formularies.

Formulary - create a formulary to restrict the MIMS medication view and available list of medications for charting medication orders. Assign the formulary to the user group.

Scope of Practice - assign the same formulary as scope of practice.

Providers - Configuration

Configure the following settings in **File > Providers**.

Table 71. Providers - Configuration

Providers					
Provider Type	**Prescriber Number**	**Verbal Order**	**Schedule Drug Selection**	**Encounter Place**	**Use Scope of Practice**
PBS Prescriber *(on page 917)*	To be recorded	N/A	N/A	N/A	Off
Health Practitioner (who is not a prescriber) *(on page 917)*	N/A	On	Set one or more options	Set as required	On
Health Practitioner, prescriber with restrictions, such as a Nurse Practitioner *(on page 917)*	To be recorded	On	Set one or more options	Set as required	On

Tip:
Verbal Order:S1, **S2**, **S3**, **S4**, **S5**, **S6**, **S7**, **S8**, **S9**, **Un-Scheduled**- set one or more options to require that any medication order created for medications included in the selected Schedule requires a Verbal Order. For example, if a nurse needs to be able to prescribe S1, S2 and S3 medications without a verbal order, deselect **S1**, **S2** and **S3** and set **S4**-**S9**.

Tip:
To require a verbal order only for particular encounter places, select the required Encounter Place.

If you deselect an encounter place, the provider does not require a verbal order at that encounter place.

If you want a provider to always require a verbal order at all encounter places,for **Encounter Places**, set **Select All**.

Tip:
Medication listed in a **Scope of Practice** that is assigned to a user group that the provider belongs to overrides **Verbal Order > Schedule Drug Selection** selected for the provider.

Printer Assignment - Configuration

Configure the following settings in **File > Printer Assignments**.

Table 72. Printer Assignments - Configuration

Printer Assignments		
Printer Assignments *(on page 618)*	**Prescriptions**	Set tray default
	Medication Labels - Label Template	Select dispense label template

Clinical Record - Configuration

When prescribing medications, use the following settings.

Table 73. Clinical Record - Configuration

Clinical Record - Medication Summary		
Medication Requests *(on page 244)*	**Pickup Location**	Set as per patient's instruction
	DAA Type	Set as per patient's instruction

Scenario 10

Prescribe PBS scripts, chart medication orders, administer and supply using medications management, medication requests, imprest, verbal orders, scope of practice.

Clinicians employed at our health service are authorised, within their defined national registration category, to write prescriptions (for example, PBS, rural and remote prescriptions (S100 Scheme, HCP)) which are printed on individual PBS script paper or printed on a single batch prescription which is sent by the health service to the pharmacy for dispensing.

Our health service stocks and supplies patient prescription medications, that are packed by an external pharmacist.

Health Practitioners employed at our health service are authorised, within their defined national registration category to chart a medication order.

Health practitioners who are not prescribers are authorised to chart medication orders within a defined scope of practice (for example, CARPA, SASA, nurse initiated medications). These medications may be defined by drug or by schedule. Medications outside the scope of practice require a verbal order.

Health practitioners who are not prescribers are required to seek verbal orders for specific scheduled medication (for example, S8).

The quantity and the date last administered and last supplied or both, of medicines are displayed in the patient's medication summary.

Medication imprest cupboard stock ordering is managed through the imprest drug list and imprest orders.

System Parameter - Configuration

Configure the following settings in **File > System Parameters**.

Table 74. System Parameters - Configuration

System Parameters		
System - Modules *(on page 812)*	**Medication View**	On
	Medications Management	On
	Prescribing	On
System Parameters - Clinical *(on page 816)*	**Brand**	Off
	Generic Prescribing	On
	Generic Prescribing Mandatory	Off
	Enforce choice of once off/short course or regular medication	Optional
	Print prescription by default	Optional
	Use Health Centre Prescription defaults	Optional
	Show generics in Drug Browser	Optional
	Use default prescription repeats	Optional
	Show Prescriber's Comments	On
	Use RTPM Service	VIC only optional
	Require password on adverse reaction prescribing	Optional
	Enable label printing	On
	Print Labels by default	Off
	Default label count	Set as required
System Parameters - Prescription Forms *(on page 832)*	**Custom prescriptions**	Optional
	Interactions - Include non-specific category interactions	Optional
	Interactions - Exclude minor non-specific pregnancy	Optional
	Consolidated orders	Off
	Consolidated order templates	Off
	Medication Requests • Name • Plural Name • Information Text • Selection Information Text	On
	Medication Request template	On
	Create medication request by default	On
	Show out of stock inventory	On
	Print S8 prescriptions on a separate page	On
System Parameters - Web Services *(on page 825)*	**Clinical Decision Support (CDS)**	Optional - but encouraged as a clinical safety initiative

Tip:

If the `Medications Management` module is enabled, **Print labels by default** doesn't work.

Use Health Centre Prescription defaults - if used with **Enforce choice of once off/short course or regular medication**, regular medication duration does not default to the health centre prescription default duration.

Show Prescriber's Comments - if enabled prints the prescriber's comments on the medication request.

Medication Request - if enabled optional to set **Name**, **Plural Name**, **Information Text**, **Selection Information Text**.

Medication Request template - can be reprinted only by users with a recorded prescriber number.

Reference Tables - Configuration

Configure the following settings in **File > Reference Tables**.

Table 75. Reference Tables - Configuration

Reference Tables		
Adding and Editing Encounter Places and Modes *(on page 872)*	**Medication Pick up Location**	On
Formularies *(on page 861)*	**Formulary**	On - Create as required
Scope of Practice *(on page 278)*	**Scope of Practice**	On - Create as required

Tip:

Set up **formularies** to restrict what medications a nurse can view in MIMS or create **medication orders** for.

Medications listed in a **Scope of Practice** will not require a verbal order for user groups assigned with the scope of practice.

User Group - Configuration

Configure the following settings in **File > User Groups**.

Table 76. User Group - Configuration

User Groups						
Provider Type	**System Right**		**Viewing Right**	**Program Right**	**Formulary Right**	**Scope of Practice**
PBS Prescriber *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	On				
	Medication Dispense	Off				
	Medication Supply	On				
	Medication History	On				
	Prescribing Full	On				

Table 76. User Group - Configuration (continued)

User Groups						
	Prescribing Once Off/ Short course	On				
	Imprest Management	On - Assign to imprest managers				
Health Practitioner (who is not a prescriber *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	On				
	Medication Dispense	Off				
	Medication Supply	On				
	Medication History	On				
	Prescribing Full	Off				
	Prescribing Once Off/ Short course	On				
	Imprest Management	On - Assign to imprest managers				
Health Practitioner, prescriber with restrictions, such as a Nurse Practitioner *(on page 842)*	**Consolidated Orders - Manage**	Off	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	On				
	Medication Dispense	Off				
	Medication Supply	On				
	Medication History	On				
	Prescribing Full	On				
	Prescribing Once Off/ Short course	On				
	Imprest Management	On - Assign to imprest managers				

Tip:

On the **Formulary Rights** tab, set **All Products** formulary. Optionally create other locally defined formularies.

Formulary - create a formulary to restrict the MIMS medication view and available list of medications for charting medication orders. Assign the formulary to the user group.

Scope of Practice - assign the same formulary as scope of practice.

Providers - Configuration

Configure the following settings in **File > Providers**.

Table 77. Providers - Configuration

Providers					
Provider Type	**Prescriber Number**	**Verbal Order**	**Schedule Drug Selection**	**Encounter Place**	**Use Scope of Practice**
PBS Prescriber *(on page 917)*	To be recorded	N/A	N/A	N/A	Off
Health Practitioner (who is not a prescriber) *(on page 917)*	N/A	On	Set one or more options	Set as required	On - select appropriate
Health Practitioner, prescriber with restrictions, such as a Nurse Practitioner *(on page 917)*	To be recorded	On	Set one or more options	Set as required	On - select appropriate

Tip:
Verbal Order:S1, **S2**, **S3**, **S4**, **S5**, **S6**, **S7**, **S8**, **S9**, **Un-Scheduled**- set one or more options to require that any medication order created for medications included in the selected Schedule requires a verbal order. For example, if a nurse needs to be able to prescribe S1, S2 and S3 medications without a verbal order, deselect **S1**, **S2** and **S3** and set **S4**-**S9**.

Tip:
To require a verbal order only for particular encounter places, select the required Encounter Place.

If you deselect an encounter place, the provider does not require a verbal order at that encounter place.

If you want a provider to always require a verbal order at all encounter places,for **Encounter Places**, set **Select All**.

Tip:
Medication listed in a **Scope of Practice** that is assigned to a user group that the provider belongs to overrides **Verbal Order Schedule Drug Selection** selected for the provider.

Printer Assignment - Configuration

Configure the following settings in **File > Printer Assignments**.

Table 78. Printer Assignments - Configuration

Printer Assignments		
Printer Assignments *(on page 618)*	**Prescriptions**	Set tray default
	Medication Labels - Label Template	Select dispense label template

Clinical Record - Configuration

When prescribing medications, use the following settings.

Table 79. Clinical Record - Configuration

Clinical Record - Medication Summary		
Medication Requests *(on page 244)*	**Pickup Location**	Set as per patient's instruction
	DAA Type	Set as per patient's instruction

Scenario 11

Prescribe PBS scripts, chart medication orders, administer and supply using medications management, medication requests, consolidated orders, verbal orders, scope of practice.

Clinicians employed at our health service are authorised, within their defined national registration category, to write prescriptions (for example, PBS, rural and remote prescriptions (S100 Scheme, HCP)) which are printed on individual PBS script paper or printed on a single batch prescription which is sent by the health service to the pharmacy for dispensing.

Our health service stocks and supplies patients' prescription medications, that are packed by an external pharmacist.

Health Practitioners employed at our health service are authorised, within their defined national registration category to chart a medication order.

Health practitioners who are not prescribers are authorised to chart medication orders within a defined scope of practice (for example, CARPA, SASA, nurse initiated medications). These medications may be defined by drug or by schedule. Medications outside the scope of practice require a verbal order.

Health practitioners who are not prescribers are required to seek verbal orders for specific scheduled medication (for example, S8).

The quantity and the date last administered and last supplied or both, of medicines are displayed in the patient's medication summary.

After review, bulk orders for patient inventory of prescription medications are sent to the supplier. When the patient's order is received, the inventory for the patient's medication is receipted against the order.

System Parameter - Configuration

Configure the following settings in **File > System Parameters**.

Table 80. System Parameters - Configuration

System Parameters		
System - Modules *(on page 812)*	**Medication View**	On
	Medications Management	On
	Prescribing	On
System Parameters - Clinical *(on page 816)*	**Brand**	Off
	Generic Prescribing	On
	Generic Prescribing Mandatory	Off

Table 80. System Parameters - Configuration (continued)

System Parameters		
	Enforce choice of once off/short course or regular medication	Optional
	Print prescription by default	Optional
	Use Health Centre Prescription defaults	Optional
	Show generics in Drug Browser	Optional
	Use default prescription repeats	Optional
	Show Prescriber's Comments	On
	Use RTPM Service	VIC only optional
	Require password on adverse reaction prescribing	Optional
	Enable label printing	On
	Print Labels by default	Off
	Default label count	Set as required
System Parameters - Prescription Forms *(on page 832)*	**Custom prescriptions**	Optional
	Interactions - Include non-specific category interactions	Optional
	Interactions - Exclude minor non-specific pregnancy	Optional
	Consolidated orders	On
	Consolidated order templates	Set as required
	Medication Requests • Name • Plural Name • Information Text • Selection Information Text	On
	Medication Request template	On
	Create medication request by default	On
	Show out of stock inventory	Optional
	Print S8 prescriptions on a separate page	On
System Parameters - Web Services *(on page 825)*	**Clinical Decision Support (CDS)**	Optional - but encouraged as a clinical safety initiative

Tip:

If the `Medications Management` module is enabled, **Print labels by default** doesn't work.

Use Health Centre Prescription defaults - if used with **Enforce choice of once off/short course or regular medication**, regular medication duration does not default to the health centre prescription default duration.

Show Prescriber's Comments - if enabled prints the prescriber's comments on the medication request.

Medication Request - if enabled optional to set **Name**, **Plural Name**, **Information Text**, **Selection Information Text**.

Medication Request template - can be reprinted only by users with a recorded prescriber number.

Show out of stock inventory - if off, the default view is inventory stock only.

Reference Tables - Configuration

Configure the following settings in **File > Reference Tables**.

Table 81. Reference Tables - Configuration

Reference Tables		
Adding and Editing Encounter Places and Modes *(on page 872)*	**Medication Pick up Location**	On
Formularies *(on page 861)*	**Formulary**	On - Create as required
Scope of Practice *(on page 278)*	**Scope of Practice**	On - Create as required

Tip:

Set up **formularies** to restrict what medications a nurse can view in MIMS or create **medication orders** for.

Medications listed in a **Scope of Practice** will not require a verbal order for user groups assigned with the scope of practice.

User Group - Configuration

Configure the following settings in **File > User Groups**.

Table 82. User Group - Configuration

User Groups						
Provider Type	**System Right**		**Viewing Right**	**Program Right**	**Formulary Right**	**Scope of Practice**
PBS Prescriber *(on page 842)*	**Consolidated Orders - Manage**	On	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	On				
	Medication Dispense	Off				
	Medication Supply	On				
	Medication History	On				
	Prescribing Full	On				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				
Health Practitioner (who is not a pre-scriber) *(on page 842)*	**Consolidated Orders - Manage**	On	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	On				
	Medication Dispense	Off				

Table 82. User Group - Configuration (continued)

User Groups						
	Medication Supply	On				
	Medication History	On				
	Prescribing Full	Off				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				
Health Practitioner, prescriber with restrictions, such as a Nurse Practitioner *(on page 842)*	**Consolidated Orders - Manage**	On	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	On				
	Medication Dispense	Off				
	Medication Supply	On				
	Medication History	On				
	Prescribing Full	On				
	Prescribing Once Off/ Short course	On				
	Imprest Management	Off				

Tip:

On the **Formulary Rights** tab, set **All Products** formulary. Optionally create other locally defined formularies.

Formulary - create a formulary to restrict the MIMS medication view and available list of medications for charting medication orders. Assign the formulary to the user group.

Scope of Practice - assign the same formulary as scope of practice.

Providers - Configuration

Configure the following settings in **File > Providers**.

Table 83. Providers - Configuration

Providers					
Provider Type	**Prescriber Number**	**Verbal Order**	**Schedule Drug Selection**	**Encounter Place**	**Use Scope of Practice**
PBS Prescriber *(on page 917)*	To be recorded	N/A	N/A	N/A	Off
Health practitioner (who are not a prescriber *(on page 917)*	N/A	On	Set one or more options	Set as required	On

Table 83. Providers - Configuration (continued)

Providers					
Health Practitioner, prescriber with restrictions, such as a Nurse Practitioner *(on page 917)*	To be recorded	On	Set one or more options	Set as required	On

Tip:
Verbal Order:S1, **S2**, **S3**, **S4**, **S5**, **S6**, **S7**, **S8**, **S9**, **Un-Scheduled**- set one or more options to require that any medication order created for medications included in the selected Schedule requires a Verbal Order. For example, if a nurse needs to be able to prescribe S1, S2 and S3 medications without a verbal order, deselect **S1**, **S2** and **S3** and set **S4**-**S9**.

Tip:
To require a verbal order only for particular encounter places, select the required Encounter Place.

If you deselect an encounter place, the provider does not require a verbal order at that encounter place.

If you want a provider to always require a verbal order at all encounter places,for **Encounter Places**, set **Select All**.

Tip:
Medication listed in a **Scope of Practice** that is assigned to a user group that the provider belongs to overrides **Verbal Order > Schedule Drug Selection** selected for the provider.

Printer Assignment - Configuration

Configure the following settings in **File > Printer Assignments**.

Table 84. Printer Assignments - Configuration

Printer Assignments		
Printer Assignments *(on page 618)*	**Prescriptions**	Set tray default
	Medication Labels - Label Template	Select dispense label template

Clinical Record - Configuration

When prescribing medications, use the following settings.

Table 85. Clinical Record - Configuration

Clinical Record - Medication Summary		
Medication Requests *(on page 244)*	**Pickup Location**	Set as per patient's instruction
	DAA Type	Set as per patient's instruction

Scenario 12

Prescribe PBS scripts, chart medication orders, administer and supply using medications management, medication requests, consolidated orders, imprest, verbal orders, scope of practice.

Clinicians employed at our health service are authorised, within their defined national registration category, to write prescriptions (for example, PBS, rural and remote prescriptions (S100 Scheme, HCP)) which are printed on individual PBS script paper or printed on a single batch prescription which is sent by the health service to the pharmacy for dispensing.

Our health service stocks and supplies patients' prescription medications, that are packed by an external pharmacist.

Health Practitioners employed at our health service are authorised, within their defined national registration category to chart a medication order.

Health practitioners who are not prescribers are authorised to chart medication orders within a defined scope of practice (for example, CARPA, SASA, nurse initiated medications). These medications may be defined by drug or by schedule. Medications outside the scope of practice require a verbal order.

Health practitioners who are not prescribers are required to seek verbal orders for specific scheduled medication (for example, S8).

The quantity and the date last administered and last supplied or both, of a medication are displayed in the patient's medications summary.

Medication imprest cupboard stock ordering is managed through the imprest drug list and imprest orders.

After review, bulk orders for patient inventory of prescription medications are sent to the supplier. When the patient's order is received, the inventory for patient's medication is receipted against the order.

System Parameter - Configuration

Configure the following settings in **File > System Parameters**.

Table 86. System Parameters - Configuration

System Parameters		
System - Modules *(on page 812)*	**Medication View**	On
	Medications Management	On
	Prescribing	On
System Parameters - Clinical *(on page 816)*	**Brand**	Off
	Generic Prescribing	On
	Generic Prescribing Mandatory	Off
	Enforce choice of once off/short course or regular medication	Optional
	Print prescription by default	Optional
	Use Health Centre Prescription defaults	Optional
	Show generics in Drug Browser	Optional
	Use default prescription repeats	Optional
	Show Prescriber's Comments	On
	Use RTPM Service	VIC only optional

Table 86. System Parameters - Configuration (continued)

System Parameters		
	Require password on adverse reaction prescribing	Optional
	Enable label printing	On
	Print Labels by default	Off
	Default label count	Set as required
System Parameters - Prescription Forms *(on page 832)*	**Custom prescriptions**	Optional
	Interactions - Include non-specific category interactions	Optional
	Interactions - Exclude minor non-specific pregnancy	Optional
	Consolidated orders	On
	Consolidated order templates	Set as required
	Medication Requests • Name • Plural Name • Information Text • Selection Information Text	On
	Medication Request template	On
	Create medication request by default	On
	Show out of stock inventory	Optional
	Print S8 prescriptions on a separate page	On
System Parameters - Web Services *(on page 825)*	**Clinical Decision Support (CDS)**	Optional - but encouraged as a clinical safety initiative

Tip:

If the `Medications Management` module is enabled, **Print labels by default** doesn't work.

Use Health Centre Prescription defaults - if used with **Enforce choice of once off/short course or regular medication**, regular medication duration does not default to the health centre prescription default duration.

Show Prescriber's Comments - if enabled prints the prescriber's comments on the medication request.

Medication Request - if enabled optional to set **Name**, **Plural Name**, **Information Text**, **Selection Information Text**.

Medication Request template - can be reprinted only by users with a recorded prescriber number.

Show out of stock inventory - if off, the default view is inventory stock only.

Reference Tables - Configuration

Configure the following settings in **File > Reference Tables**.

Table 87. Reference Tables - Configuration

Reference Tables		
Adding and Editing Encounter Places and Modes *(on page 872)*	**Medication Pick up Location**	On
Formularies *(on page 861)*	**Formulary**	On - Create as required
Scope of Practice *(on page 278)*	**Scope of Practice**	On - Create as required

Tip:
Set up **formularies** to restrict what medications a nurse can view in MIMS or create **medication orders** for.

Medications listed in a **Scope of Practice** will not require a verbal order for user groups assigned with the scope of practice.

User Group - Configuration

Configure the following settings in **File > User Groups**.

Table 88. User Group - Configuration

User Groups						
Provider Type	**System Right**		**Viewing Right**	**Program Right**	**Formulary Right**	**Scope of Practice**
PBS Prescriber *(on page 842)*	**Consolidated Orders - Manage**	On	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	On				
	Medication Dispense	Off				
	Medication Supply	On				
	Medication History	On				
	Prescribing Full	On				
	Prescribing Once Off/ Short course	On				
	Imprest Management	On - Assign to imprest managers				
Health Practitioner (who is not a prescriber *(on page 842)*	**Consolidated Orders - Manage**	On	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	On				
	Medication Dispense	Off				
	Medication Supply	On				
	Medication History	On				
	Prescribing Full	Off				

Table 88. User Group - Configuration (continued)

User Groups						
	Prescribing Once Off/ Short course	On				
	Imprest Management	On - Assign to imprest managers				
Health Practitioner, prescriber with restrictions, such as a Nurse Practitioner *(on page 842)*	**Consolidated Orders - Manage**	On	Common	N/A	On - select appropriate	On - select appropriate
	Medication View	On				
	Medication Administer	On				
	Medication Dispense	Off				
	Medication Supply	On				
	Medication History	On				
	Prescribing Full	On				
	Prescribing Once Off/ Short course	On				
	Imprest Management	On - Assign to imprest managers				

Tip:

On the **Formulary Rights** tab, set **All Products** formulary. Optionally create other locally defined formularies.

Formulary - create a formulary to restrict the MIMS medication view and available list of medications for charting medication orders. Assign the formulary to the user group.

Scope of Practice - assign the same formulary as scope of practice.

Providers - Configuration

Configure the following settings in **File > Providers**.

Table 89. Providers - Configuration

Providers					
Provider Type	**Prescriber Number**	**Verbal Order**	**Schedule Drug Selection**	**Encounter Place**	**Use Scope of Practice**
PBS Prescriber *(on page 917)*	To be recorded	N/A	N/A	N/A	Off
Health Practitioner (who is not a prescriber *(on page 917)*)	N/A	On	Set as required	Set as required	On

Table 89. Providers - Configuration (continued)

Providers					
Health Practitioner, prescriber with restrictions, such as a Nurse Practitioner *(on page 917)*	To be recorded	On	Set as required	Set as required	On

Tip:
Verbal Order:S1, **S2**, **S3**, **S4**, **S5**, **S6**, **S7**, **S8**, **S9**, **Un-Scheduled**- set one or more options to require that any medication order created for medications included in the selected Schedule requires a verbal order. For example, if a nurse needs to be able to prescribe S1, S2 and S3 medications without a verbal order, deselect **S1**, **S2** and **S3** and set **S4**-**S9**.

Tip:
To require a verbal order only for particular encounter places, select the required Encounter Place.

If you deselect an encounter place, the provider does not require a verbal order at that encounter place.

If you want a provider to always require a verbal order at all encounter places,for **Encounter Places**, set **Select All**.

Tip:
Medication listed in a **Scope of Practice** that is assigned to a user group that the provider belongs to overrides **Verbal Order > Schedule Drug Selection** selected for the provider.

Printer Assignment - Configuration

Configure the following settings in **File > Printer Assignments**.

Table 90. Printer Assignments - Configuration

Printer Assignments		
Printer Assignments *(on page 618)*	**Prescriptions**	Set tray default
	Medication Labels - Label Template	Select dispense label template

Clinical Record - Configuration

When prescribing medications, use the following settings.

Table 91. Clinical Record - Configuration

Clinical Record - Medication Summary		
Medication Requests *(on page 244)*	**Pickup Location**	Set as per patient's instruction
	DAA Type	Set as per patient's instruction

Scenario 13

For sites that have **Use Rural Prescription Form** enabled in V19.2 that would like to continue to use the rural health centre prescription functionality in V21.3.

V19.2 to V21.3 comparison - Rural Health Centre Prescription Form

Rural Prescription Forms in V19.2 have been superseded in Communicare V21.3 by medication requests.

If you were using rural prescriptions in V19.2 and would like to continue to use the rural prescription functionality in V21.3, you will need to enable medication requests and set medication prescription defaults.

Table 92. System Parameter Configuration settings V19.2 compared to V21.3

V19.2	V21.3
Rural Prescription Form • When prescribing medications, default medications to regular and for a duration of 365 days and • Ability to create a Health Centre Prescription/ Rural Prescription.	**Health Centre Prescription defaults** • When prescribing medications, default medications to regular and for a duration of 365 days. **Medication Request** • Ability to create a Health Centre Prescription/ Rural Prescription.

- If **Use Rural Prescription Form** is enabled in V19.2, when upgraded to V21.3 the **Use Health Centre Prescriptions defaults** will be enabled.
- In V21.3 the **Use Health Centre Prescriptions defaults** option does not enable printing of rural prescription/health centre prescriptions.
- To be able to print a health centre prescription, you must enable **Medication Request**

V21.3 Configuration of Medication Requests

System Parameter - Configuration

To enable medication requests:

1. Select **File > System Parameters > Prescription Forms** tab.
2. In the **Medication Request Options** section, set **Enable Medication Request** and associated Medication Request configuration parameters *(on page 832)*.
3. Select **System Parameters > Clinical** tab.
4. Set medication prescription defaults for one or both of the following options:
    - **Enforce choice of once off/short course or regular medication**
    - **Health Centre Prescription defaults**

> **Tip:**
> These selections result in the following behaviour:
> - If **Enforce choice of once off/short course or regular medication** is set, at the time of prescribing the provider will be forced to select if the medication is a once off/short course or a regular medication. Use this option if you'd like to force providers to select if the medication is a once off /short course or regular medication and have the medication default to a MIMS-defined duration.

- If **Health Centre Prescription default** is set, at the time of prescribing the medication will default to a regular medication and for a duration of 365 days. Use this option if you'd like the medication to default to regular and for a duration of 365 days at the time of prescribing.
- If both **Enforce choice of once off/short course or regular medication** and **Health Centre Prescription default** are enabled, at the time of prescribing the provider will be forced to select if the medication is a once off/short course or a regular medication and the medication will default for a duration of 365 days. Use this option if you'd like to force providers to select if the medication is a once off or regular medication and have the medication default to a duration of 365 days.

See System Parameters - Clinical *(on page 816)* for further information.

5. Click **Save**.

Reference Tables - Configuration

1. Select **File > Reference Tables > Encounter Place**.
2. Select the **Encounter Place** where medications are picked up from.
3. Set **Medication Pickup Location**.
4. Click **Close**.

Clinical Record - Configuration

To print a medication request, use the following settings:

1. Open the patients clinical record.
2. Set the patients preferred **Pickup Location**.

Tip:
If the patient's preferred **Pickup Location** is not set, a medication request cannot be printed.

Prescribing

Use Communicare to prescribe medications.

Prescribing is divided into three actions:

- Write a Prescription *(on page 224)* - use when you want to write a prescription, print it and give it to a patient to fill outside your health service
- Create a Medication Order *(on page 235)* - use when you want to administer or supply medication from within your health service
- Record Medication History *(on page 283)* - use when you want to record any medication that the patient may have taken, but which was not provided by your health service

Tip:
Communicare Administrators can edit Provider information in **File > Reference Tables > Provider**.

Write Prescriptions

Use the **Add Medication** window, **Write a Prescription** tab when you want to write a prescription, print it and give it to a patient to fill outside your health service.

To prescribe medications for a patient in Communicare, you must have a Prescriber number and the user group to which you belong must have Prescription access rights. Restricted providers can prescribe medication that is included in their user group's Scope of Practice.

If **Medication > Add Medication** is not available, ask your Communicare Administrator to enable `Prescribing - Full` or `Prescribing - Once Off/Short Course` for your user group.

If there are no details in the **Drug Browser**, ask your Communicare Administrator to arrange the import of MIMS Pharmaceutical Database *(on page 271)*.

You cannot record a medication with a date after a patient's date of death.

When you add a prescription, it always defaults to the date of the service; you cannot change the date of an individual medication. If you need to add an historical medication or backdate a medication, add it using Medication History *(on page 283)*.

In V22.1 and later, Communicare supports ePrescribing for providers who have opted in and have adequate information recorded in Communicare. ePrescribing replaces paper scripts, so information that was written manually on prescriptions to communicate with the dispenser of the medication must instead all be recorded when prescribing. Use the fields described in Table 93: ePrescribing fields *(on page 224)* to record additional ePrescribing information, which is included on the prescription.

Table 93. ePrescribing fields

ePrescribing field	Description
Regulation 49 (Regulation 24)	For medical practitioners, midwives and nurse practitioners, if hardship conditions apply, set **Regulation 49 (Regulation 24)** to authorise the original and repeat supplies of PBS medications to be supplied to the patient at one time. Regulation 49 was previously Regulation 24. If set: • On the **Medication Summary**, `[Regulation 49]` is appended to the medication in the **Current/Regular Medication** list • On the **Detail** tab for the medication, `Regulation 49 (Regulation 24) Yes` is included • For paper scripts, the following words are printed: ◦ For non-RPBS patients, `one supply` ◦ For RPBS patients, `hardship conditions apply` For more information, see pbs.gov.au.

Table 93. ePrescribing fields (continued)

ePrescribing field	Description
Script Retained by Pharmacy	Set if the pharmacist should retain the script for a controlled medication instead of returning it to the patient. For example, for controlled medicines such as Methadone, Dexamphetamine. **Note:** The patient is not sent an ePrescription token or any repeat tokens. Options to send or resend an ePrescription token by SMS or email are disabled. This medication is excluded from the ASL. The usual workflow would be: 1. The prescriber prints the ePrescribing token and hands it to the patient. The prescriber also relays paper evidence of the prescription to the necessary pharmacy. 2. The patient takes the token to a pharmacy, which becomes the supplying pharmacy. 3. The pharmacy retains the prescription and supplies all repeats of the medication.
Unusual Dosage	Set if the dosage prescribed is outside the recommended therapeutic levels. If set, `Unusual Dosage Yes` is included on the **Detail** tab for the medication.
Note to Pharmacist (ePrescriptions only)	Use to include prescription notes for the pharmacist, such as details of unusual dosages, staged supply and so on. Any notes you add are included only with electronic prescriptions.
Authority Number for Controlled Substances	For controlled substances, enter the number provided by your state or territory that gives you authority to prescribe controlled substances. The name of this field depends on which state or territory the encounter place from which the prescriber is prescribing is based: • NSW and NT - **Authorisation Number for Controlled Substances** • QLD and ACT - **Approval Number for Controlled Substances** • SA - **Permit Number for Controlled Substances** • TAS - **Authority Number** • VIC - **Warrant Number for Controlled Substances** • WA - **Authority Number**
Dispensing Pharmacy	NSW only - enter the name of the pharmacy from which the prescription is to be dispensed

Table 93. ePrescribing fields (continued)

ePrescribing field	Description
Urgent Supply (Script Owing)	For urgent cases where you have telephoned a pharmacist and asked them to supply a medication without a prescription, set **Urgent Supply (Script Owing)** for the subsequent prescription. The prescriber should also relay paper evidence of the prescription to the necessary pharmacy. The prescriber must then forward the written prescription and duplicate to the pharmacist within seven days of the date of supply. **Note:** The patient is not sent an ePrescription token or any repeat tokens. Options to send or resend an ePrescription token by SMS or email are disabled. This medication is excluded from the ASL. If set, `Urgent Supply (Script Owing) Yes` is included on the **Detail** tab for the medication.
Exclude from Active Script List	Set if a patient wants you to exclude this prescription from their Active Script List.

To add a prescription for a patient:

1. In a patient's Clinical Record, click  **Medication > Add Medication** or press `F9`.
   - If a warning is displayed that there is no adverse reaction information recorded, click **Yes** and review with the patient.
   - To record any problems, on the **Main Summary**, click **New Adverse Reaction**. See Adverse Reaction Maintenance *(on page 255)* for more information.
2. From the **Drug Browser**, select the medication you want to prescribe.

   Tip:
   When using generic prescribing, formulation and pack are displayed in a single field. If you are searching for a specific formulation and pack for a specific brand, to display all options for equivalent active ingredient medications that have slightly different packaging or formulation, deselect **Show generics not brands**.

3. If there are any pregnancy interactions, condition or procedure interactions, or drug interactions or warnings, they are listed in the **Medications Warnings** window. If you want to proceed, click **Noted**, otherwise click **Cancel** and repeat steps 1-2.

   In the **Medications Warnings** window:
   - If a medication contains a generic component for which a patient has a recorded allergic adverse reaction, a reaction is displayed. If you choose to proceed with the prescription, enter your password. The action is logged.
   - If the patient is pregnant, the pregnancy banner is displayed.
   - If the patient is pregnant or possibly pregnant and there is a pregnancy interaction with the selected drug, ADEC Pregnancy Category warnings are displayed.
   - If condition interaction support is available at your health service, and the patient has a condition with which the medication interacts, a condition interaction is displayed.

- If there is an interaction between this medication and the patient's other active medications, a drug interaction is displayed.
- For more information, see Medication Warnings *(on page 259)*.

4. Details from MIMS for the selected medication are added to the **Add Medication** window, including:
   - Interactions and warnings - for example, if the patient is pregnant or possibly pregnant, ADEC Pregnancy Category warnings
   - PBS information - Strength, Max PBS packs and Max PBS repeats
   - Payment Scheme, for example, PBS, RPBS or Private
   - LEMI and LMBC information

   a. In the **Add Medication** window, go to the **Write a Prescription** tab.

   - To add adverse reactions, click Add. For more information, see Adverse Reaction Maintenance *(on page 255)*.
   - To check any existing medications, click Medication Overview.
   - To prescribe a medication for a patient, the patient must have a data of birth recorded. If a date of birth is not recorded, the **Medication** field is highlighted in red. Click **Cancel**, go to the patient's biographics and add a date of birth before proceeding.
5. For **Medication Type**, select either **Once Off / Short Course** or **Regular Medication** depending on whether this medication is to treat an acute or chronic condition.
6. Where available, for **Prescribed Using**, select either **Generic name** or **Brand name**.
   - For brand name medications, the formulation, strength, pack size and number of packs are displayed, except for items on the LEMI, which display only the brand name.
   - These details are not displayed for generic drugs, except:
     - If there are multiple items in the pack, full details are included
     - If the words `modified` or `release` appear in the formulation, the generic formulation is shown. For example, `Metformin hydrochloride modified release tablet, 500 mg`.

> **Tip:**
> Ensure you read any information banners relating to brand prescribing.

7. If required, to allow pharmacists to substitute brands, where applicable set **Allow brand substitution**.
8. If you want to change medication, in the **Medication** field, click **Choose**.

> **Tip:**
> To add this medication to your list of preferred medications and list it automatically every time you enter the drug browser, click Favourite.

9. If you want to edit the pack size, in the **Pack Size** field, enter the required value.
10. In the **Number of Packs** field, enter the number of packs you want to prescribe.
11. In the **Repeats** field, enter the number of repeats required.
12. The default value displayed in the **Duration** field is the total number of packs together with repeats, assuming that each pack lasts 1 month and determines how long once off prescriptions are displayed in the **Medication Summary**, to a maximum of 12 months. The dosage that you specify does not affect the default calculation. The date in the **Until** field is calculated from the duration. The duration is used by the drug interactions function to determine if a warning should be displayed. Adjust either the duration or date until if required.
13. If there are repeats, depending on the medication and your jurisdiction, for Schedule 8 and Schedule 4D drugs, in the **Interval Between Repeats** field, specify the minimum number of days required before a repeat can be filled:

- Schedule 4D and Schedule 8 - NSW and Tas
- Schedule 8 - ACT, NT, Qld, WA

14. For **DAA Required**, if the patient uses a Dosage Administration Aid, click **Yes**.

    a. From the **DAA type** list, select the type of DAA used.

    > **Tip:**
    > If there is a default DAA type set for the patient in the **Medication Summary > DAA Type** field, this is automatically set for the medication.

    b. In the **DAA** fields, either:
    - In the DAA **Breakfast**, **Lunch**, **Dinner** and **Bedtime** fields, enter the dosage required at each.
    - If you'd prefer to provide dosage instructions instead of a dosage for each time period, set **As per Dosage** and specify instructions as described in the next step.

15. In the **Dosage Instructions** field, enter dosage instructions for the medication using full text or short codes.

    > **Tip:**
    > For ePrescribing, either DAA or dosage information is required. Remember to include both dose and frequency.

    To use short codes, for example, `BD` for twice a day, or `CF` for with food, start typing the short code:
    - Matching short codes are listed as you type. Press `Enter` or `Tab` to select a phrase. Use the up and down arrows to move up and down the list.
    - If you have completed the short code, press the space bar to select the text that that code represents.
    - Click Add shortcode or press `F2` to see a list of all short codes available for your health organisation. Use the up and down arrows to move up and down the list.

16. The **Route of Administration** field displays the value provided by MIMS. If required, select a new value or delete the default value.

    Prescriptions written before Communicare is upgraded to V22.1 will not have a value and the default value from MIMS will only be added when the medication is repeated or represcribed.

    > **Note:**
    > For ePrescribing, a route of administration is required. If MIMS does not include a route of administration for a medication, `As Directed` is added.

17. From the **Payment scheme** list, select the payment scheme if it is different to that listed.
    If you select `RPBS` for a medication that is not PBS-listed, but which has been given ad-hoc approval by the DVA for supply to patients with funding from the DVA, also set **Unlisted RPBS Authority**. In the **PBS/RPBS Approval Number** field, be sure to also include the RPBS approval number. For more information, see Unlisted repatriation authority *(on page 235)*.
18. If this prescription will be sent to the dispenser electronically instead of being printed, use the fields described in Table 93: ePrescribing fields *(on page 224)* to record additional ePrescribing information, which is included on the prescription.
19. If the medication requires authority:

- For Streamlined Authority:
    a. In the **PBS/RPBS Approval Number** field, click **Choose** and select the appropriate approval number. This number is printed on the script and checked by pharmacists when they dispense the medication.
    b. From the **Approved Indication** list, select the indication text.
- For Authority medication:
    a. If you have a previous authority number for this medication, set **Previous Authority**.
    b. Otherwise, ring the PBS or DVA number provided and provide the patient's details, the **PBS/RPBS Authority Number** listed and the clinical indication.
    c. In the **PBS/RPBS Approval Number** field, enter the number provided to you. This number is printed on the script and checked by the pharmacist when they dispense the medication.

> **Tip:**
> For emergency provisions *(on page 234)*, use `P9999Rx`.

    d. Click Authority Indication Information to check the approved clinical indication that must be met when prescribing this medication.
- If the prescription has repeats and you want the pharmacist to return it to the patient when it is filled, set **Return to Patient** to print the words `Return to Patient` on the prescription.

20. In the **Internal Comments** field, enter any additional information for other prescribers at your health service, for example, for up-titration notes.

> **Tip:**
> This information is displayed as a Note on the **Medication Summary** and if the medication is added to a medication request this information is included.

21. From the **Reason (Clinical Item)** list, select from the existing clinical items associated with the patient. If you haven't yet added a clinical item for the condition that the medication treats, click **Add Reason** and select a new clinical item.
    Alternatively, if there is no codified clinical item available, in the **Reason (Free Text)** field, type a reason for prescribing.
22. If the patient is registered for CTG PBS co-payment relief and this option is set in their biographics *(on page 37)*, to print the PBS or RPBS script with a CTG code, set **CTG PBS co-payment relief**.
23. If the patient gives their consent to share this information with My Health Record, set **Consent to send to My Health Record**. If the patient has a My Health Record, this option is automatically set.
    Setting this option sets a flag for eRx which tells them whether or not to send the medication information for the patient to My Health Record. Communicare does not send this information to My Health Record separately. For more information, see Electronic Transfer of Prescriptions (ETP) *(on page 249)*.
24. If required, click Ellipsis and set one or both of the following options:
    - **Save medication as favourite** - add the medication to your list of favourites displayed when you first open the **Drug Browser**.
    - **Save medication as default** - to save the quantity, repeats, dosage instructions and duration for this medication. This information is automatically included whenever you prescribe this medication for any

patient. Set this option for medications that typically require the same dosage instructions for any patient, for example, *Yasmin*.

> **Note:**
> If you have **Generic Prescribing** set in System Parameters and you save a medication that you have prescribed by brand as default, the medication is still prescribed by generic when you next prescribe it.

25. If you want to add another medication for the patient, click **Add another item** to save the first medication and clear all fields. Repeat steps 2-19 to add another medication.
26. If you are a prescribing a schedule 8 medication, enter your password again to confirm the medication.
27. Click **Save**.

If your health service is set up for Real-Time Prescription Monitoring (RTPM), and the medication is a controlled medicine, Communicare sends information to the RTPM service for your state on the internet. RTPM results are then displayed for each drug prescribed. For more information, see RTPM *(on page 280)*.

You can edit prescriptions only if the service is still open and the prescription hasn't been finalised.

> **Note:**
> For enterprise customers, if ETP is enabled for your encounter place and no locality is set for your encounter place or organisation, you can't save new prescriptions. For more information, see Electronic Transfer of Prescriptions *(on page 249)*.

To generate a script number and send the prescription to your ETP service or print the prescription, finalise the prescription. Finalise the medication from the **Medication Summary**, or when you close the clinical record. For more information, see Finalise Prescriptions *(on page 240)*.

If you have written a prescription that is part of a medication request, and you need to supply some of the medication to the patient now to cover the period until the medication request is fulfilled by the pharmacy and arrives for the patient, you can create a medication order from the prescription.

To view the medicines that have been uploaded to My Health Record, in the **Medication Summary**, click **View My Health Record Medications**.

Active Ingredient Prescribing

Prescriptions created in Communicare V20.2 and later meet the requirements of the Active Ingredient Prescribing legislation (2019), which is mandatory from 1 February 2021.

This legislation ensures that doctors make a clinical decision about the inclusion of the brand by prohibiting prescribing software from including brand names on prescriptions by default.

To meet the requirements of the legislation, set your **Prescribing Options** to **Generic Prescribing**. For more information, see Prescribing options in System Parameters - Clinical *(on page 819)*.

Prescriptions created before the introduction of active ingredient prescribing are displayed according to the new rules if doing so does not change the original intent of the prescriber.

For those medications on the LEMI, prescriptions created before the upgrade are displayed as intended by the original prescriber. However, if a prescription is reprinted, the format abides by the new rules for prescriptions.

Generic medications

Active ingredients are included on all Pharmaceutical Benefits Scheme (PBS) and Repatriation PBS (RPBS) prescriptions, except for medications with four or more active ingredients and a number of other specified items (see LEMI and LMBC below).

For generic medications, Communicare lists each of the items in the pack where each item is made up of one or more active ingredients with varying strengths.

```
active_ingredient1 strength, active_ingredient2 strength,
active_ingredient3 strength, active_ingredient4 strength
form unit_volume [pack_size] Rpts:number_of_repeats
```

The following rules are used to determine the generic composition of a brand drug/pack:

- PBS prescriptions - if the generic composition contains only one item with one active ingredient, the form is not included.
- However, if the formulation of the product contains the terms `modified` or `release`, each active ingredient in the product indicates the form.
- Also, if the formulation of the product does not contain the terms "modified" or "release", but an active ingredient within it does contain these terms, this active ingredient indicates the form of the ingredient.
- The volume information is added only when it is available. If the volume is 1 per unit, that is 1 / g, the 1 is ignored. For example, `50 mg / g` compared to `50 mg / 2 g`.
- If subpackage information is present, this is used, otherwise the number of items per pack is used. For example, `[8]x2` means that there are 2 subpackages of 8 items in each pack.

Examples

- One item, with one active ingredient:

  ```
  Metformin hydrochloride 500 mg coated tablet
  ```

- One item, with three active ingredients of varying strengths:

  ```
  Aluminium hydroxide 250 mg/5 mL, Magnesium hydroxide 120 mg/5 mL,
  Magnesium trisilicate 120 mg/5 mL oral suspension 500 mL [1]x2
  ```

- Two items, each with one active ingredient:

  ```
  Peginterferon alfa-2b 80 mcg powder for injection [4] & Ribavirin 200 mg capsule [140]
  ```

- Two items, with three active ingredients each:

  ```
  Paracetamol 300 mg, Dextromethorphan hydrobromide monohydrate 10 mg capsule & Paracetamol 300 mg,
  Dextromethorphan hydrobromide monohydrate 10 mg, Doxylamine succinate 6.25 mg capsule [12]
  ```

Brand medications

Prescribers may continue to include a brand name on prescriptions wherever clinically necessary for their patient.

When you prescribe by brand, the format of the medication displayed in and printed from Communicare is as follows:

```
active_ingredient strength form (BRAND_NAME)
```

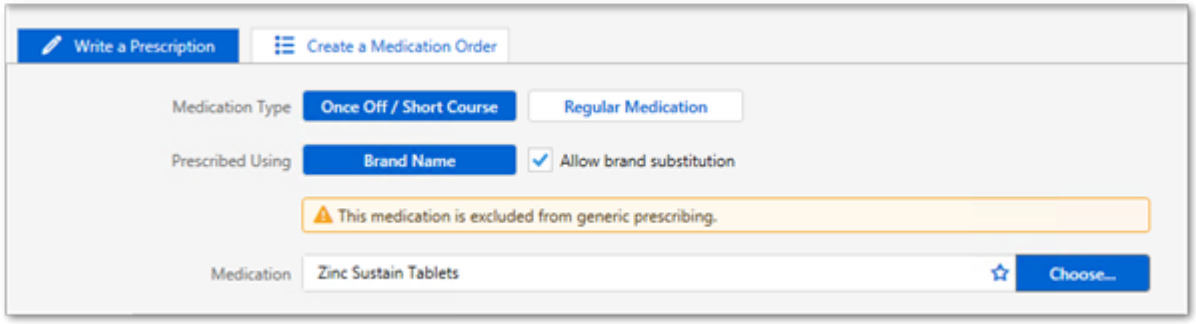
For example:

```
Warfarin sodium 1 mg tablet (COUMADIN)
```

where COUMADIN is the brand name.

LEMI

Items included in the LEMI *(on page)* are displayed and printed by brand in Communicare. In Communicare, when you add, edit or represcribe an item included in the LEMI, you can select the medication only by brand and an information banner is displayed, `This medication is excluded from generic prescribing`.

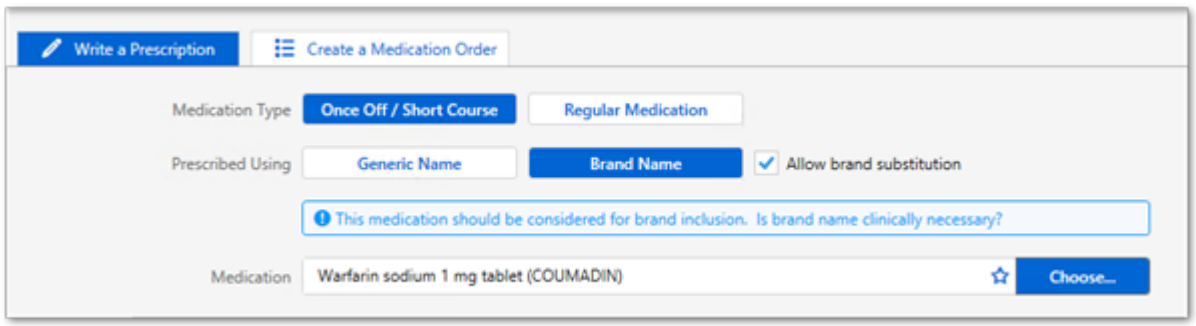


For those medications on the LEMI, prescriptions created before the upgrade are displayed as intended by the original prescriber. However, if a prescription is represcribed or reprinted, the format abides by the new rules for prescriptions, except for medications that are represcribed in bulk. For these medications, if they were prescribed by active ingredient before the upgrade and are on the LEMI, they are represcribed by active ingredient.

LMBC medications

Medications included in the LMBC *(on page)* are flagged in Communicare. Providers should consider prescribing these medications by brand. For example, Marevan and Coumadin are not bioequivalent despite both having the same active ingredient of warfarin sodium, so should be prescribed by brand.

In Communicare, when you add, edit or represcribe a medication on the LMBC, the following warning banner is displayed, `This medication should be considered for brand inclusion. Is brand name clinically necessary?`.



Extemporaneous preparations

If you prescribe an extemporaneous medication, an extemporaneous preparation medication warning is first displayed then the following format for the medication is displayed in Communicare:

```
generic
recipe
```

The format of extemporaneous preparations printed from Communicare is as follows:

```
active_ingredient strength form, volume (FREE TEXT)
recipe
```

`FREE TEXT` indicates that this is a custom medication.

For example:

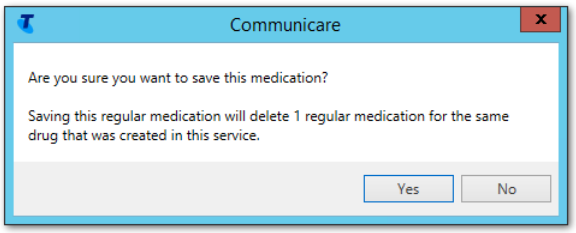
```
Boric acid 1g Solution, 60 mL (FREE TEXT)
Formulation: Mix 20mL of 5% Boric Acid solution with 40mL of deionised or distilled water.
```

Prescribing regular and STAT/PRN medication

Occasionally you may need to supply or prescribe the same medication with the same strength as a regular medication, but with different dosage instructions.

Using Communicare, you can prescribe STAT/PRN medication alongside a regular medication, either by creating a medication order for supply to the patient, or by prescribing an additional once-off medication.

There can be only one regular medication with the same active ingredients. If you try and add another regular medication with the same active ingredients, the following warning is displayed:



If you proceed, the previous regular medication is deleted.

Use a medication order

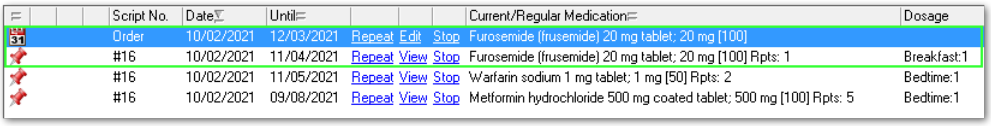
Scenario: A patient is on Furosemide 20mg daily via DAA, and the patient often calls into the clinic and requires a STAT/PRN 20mg dose of Furosemide.

Requirement: A prescription for a DAA for 20mg Furosemide and a STAT/PRN medication order for Furosemide 20mg.

To achieve this outcome:

1. Write a regular prescription for Furosemide 20mg daily via DAA.
2. Create a once off/short course medication order for Furosemide 20mg that you can supply to the patient from your imprest.

> **Tip:**
> Depending on your clinical requirements, adjust the end date of the order as required.



Script No.	Date	Until				Current/Regular Medication	Dosage
Order	10/02/2021	12/03/2021	Repeat	Edit	Stop	Furosemide (frusemide) 20 mg tablet; 20 mg [100]	
#16	10/02/2021	11/04/2021	Repeat	View	Stop	Furosemide (frusemide) 20 mg tablet; 20 mg [100] Rpts: 1	Breakfast:1
#16	10/02/2021	11/05/2021	Repeat	View	Stop	Warfarin sodium 1 mg tablet; 1 mg [50] Rpts: 2	Bedtime:1
#16	10/02/2021	09/08/2021	Repeat	View	Stop	Metformin hydrochloride 500 mg coated tablet; 500 mg [100] Rpts: 5	Bedtime:1

Use a once-off prescription

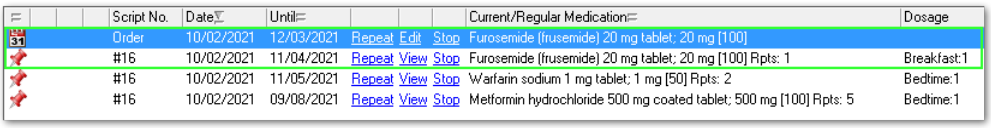
Scenario: A patient is on Furosemide 20mg daily via DAA and you want the patient to have a second packet with a PRN dose of Furosemide 20mg.

Requirement: A prescription for a DAA for Furosemide 20mg, and a PRN prescription for 20mg Furosemide.

To achieve this outcome:

1. Write a regular prescription for Furosemide 20mg daily via DAA.
2. Write a once-off/short course prescription for Furosemide 20mg.

> **Tip:**
> Depending on your clinical requirements, adjust the end date of the once-off prescription as required.

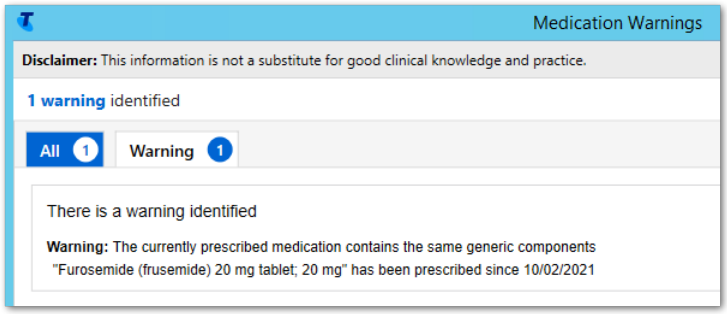


Script No.	Date	Until				Current/Regular Medication	Dosage
Order	10/02/2021	12/03/2021	Repeat	Edit	Stop	Furosemide (frusemide) 20 mg tablet; 20 mg [100]	
#16	10/02/2021	11/04/2021	Repeat	View	Stop	Furosemide (frusemide) 20 mg tablet; 20 mg [100] Rpts: 1	Breakfast:1
#16	10/02/2021	11/05/2021	Repeat	View	Stop	Warfarin sodium 1 mg tablet; 1 mg [50] Rpts: 2	Bedtime:1
#16	10/02/2021	09/08/2021	Repeat	View	Stop	Metformin hydrochloride 500 mg coated tablet; 500 mg [100] Rpts: 5	Bedtime:1

Notes

> **CAUTION:**
> **Be careful not to overdose the patient when writing multiple prescriptions for the same drug.**

In both scenarios, when you add another medication with the same generic components as a regular prescription, you get the following warning:



Note the warning and proceed.

Emergency Provisions for PBS Authority Approval

In the event of natural disasters or other emergencies, prescribe medications so that they meet emergency provisions and patients can continue to access their essential medicines at the usual PBS or RPBS cost.

To meet emergency provisions:

- Do not prescribe with increased quantity
- Do not increase repeats beyond the scheduled amount
- Use the authority approval number of `P9999Rx`

Communicare will generate the authority script number as normal.

For more information, see https://www.pbs.gov.au/info/publication/factsheets/pbs-arrangements-natural-disasters-and-emergencies.

Unlisted repatriation authority

Using unlisted repatriation authority, you can prescribe an authority script for a medication that is not listed on the PBS or RPBS for patients with a DVA (Department of Veterans' Affairs) number.

The prescriber needs to provide an RPBS approval number.

In Communicare V22.1 and later, this replaces using extemporaneous preparations to trigger authority for certain drugs.

Typically RPBS benefits for dispensed medications match the benefits under PBS. However in some cases the DVA will provide ad-hoc *unlisted repatriation authority* for non-PBS-listed drugs to be supplied to patients with funding from the DVA.

Where unlisted repatriation authority is granted, prescribers call the DVA and seek approval from them to fund the medication under RPBS, even though the drug isn't listed. The approval works in an equivalent way to a PBS/RPBS telephone authority: the prescriber provides the indication, drug, and PBS Authority Number to the operator and in response, the PBS Approval Number is supplied to the prescriber, who includes it on either the paper or ePrescription to allow the benefit to be claimed by the dispenser.

Unlisted repatriation authority may also be relevant where the requirements for streamlined authority approval, or restricted benefits are not met. For example, if the prescriber wants to treat the patient with a drug for a condition that is not listed on the clinical indications for the given authority, they could seek the ad-hoc approval.

Unlisted repatriation authority is available only for patient's who have a DVA card.

Create Medication Orders

If you are a doctor, create a Medication Order for medication to be administered or supplied at your health service. If you are a nurse or health worker, create a medication order for the associated verbal or written order from an authorised provider.

If **Medication > Add Medication** is not available, ask your Communicare Administrator to enable `Prescribing - Full` or `Prescribing - Once Off/Short Course` for your user group.

If there are no details in the **Drug Browser**, ask your Communicare Administrator to arrange the import of MIMS Pharmaceutical Database *(on page 271)*.

You cannot record a medication with a date after a patient's date of death.

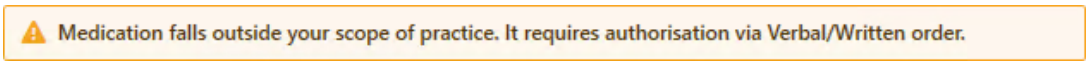
When you add a medication order, it always defaults to the date of the service; you cannot change the date of an individual medication.

To add a medication order for a patient:

1. In a patient's Clinical Record, click  **Medication > Add Medication** or press F9.
    - If a warning is displayed that there is no adverse reaction information recorded, click **Yes** and review with the patient.
    - To record any problems, on the **Main Summary**, click **New Adverse Reaction**. See Adverse Reaction Maintenance *(on page 255)* for more information.
2. From the **Drug Browser**, select the medication you want to order. If your user group has a restricted formulary, only medications included in that formulary are displayed.

> **Tip:**
> When using generic prescribing, formulation and pack are displayed in a single field. If you are searching for a specific formulation and pack for a specific brand, to display all options for equivalent active ingredient medications that have slightly different packaging or formulation, deselect **Show generics not brands**.

3. If there are any drug interactions or warnings, they are listed in the **Medications Warnings** window. In the **Medications Warnings** window:
    - If the patient is pregnant, the gestation is displayed.
    - If the patient is pregnant or possibly pregnant and there is a pregnancy interaction with the selected drug, ADEC Pregnancy Category warnings are displayed.
    - If you want to proceed, click **Noted**, otherwise click **Cancel** and repeat steps 1-2.
4. Details from MIMS for the selected medication are added to the **Add Medication** window, including:
    - Interactions and warnings - for example, if the patient is pregnant or possibly pregnant, ADEC Pregnancy Category warnings
    - PBS information - Strength, Pack Size
    - LEMI and LMBC information
5. In the **Add Medication** window, go to the **Create a Medication Order** tab.
    - To add adverse reactions, click Add. See Adverse Reaction Maintenance *(on page 255)* for more information.
    - To check any existing medications, click Medication Overview
    - If the medication is outside your scope of practice, the following message is displayed:



6. For **Medication Type**, select either **Once Off / Short Course** or **Regular Medication** depending on whether this medication is to treat an acute or chronic condition.
7. Where available, for **Order Using**, select either **Generic name** or **Brand name**.
    - For brand name medications, the formulation, strength, pack size and number of packs are displayed, except for items on the LEMI, which display only the brand name.
    - These details are not displayed for generic drugs, except:
        - If there are multiple items in the pack, full details are included
        - If the words `modified` or `release` appear in the formulation, the generic formulation is shown. For example, `Metformin hydrochloride modified release tablet, 500 mg`.

> **Tip:**
> Ensure you read any information banners relating to brand prescribing.

8. If you want to change medication, in the **Medication** field, click **Choose**. To add this medication to your list of preferred medications and list it automatically every time you enter the drug browser, click Favourite.
9. If the selected medication falls outside your Scope of Practice, enter details of the verbal or written order from an authorised provider. You cannot select yourself as the authorising clinician.

    a. From the **Authorising Clinician > Doctor Review** list, select the provider who provided the verbal or written order. The list includes providers who:
        - Have a prescriber number
        - Have a username associated with their provider name
        - Have a Communicare log in name and whose access has not been disabled
        - Have Clinical Records and Medication View system rights for their user group *(on page 842)*

    b. If required by your health service, from the **Authorising Clinician > Staff Member** list, select a second provider who verified the verbal or written order. The list includes all providers whose access has not been disabled.

10. If you want to edit the pack size, in the **Pack Size** field, enter the required value.
11. In the **Number of Packs** field, enter the number of packs included in the Medication Order.
12. The default value in the **Duration** field is the total number of packs together with repeats, assuming that each pack lasts 1 month, and determines how long the prescription is listed on the Medication Summary. The dosage that you specify does not affect the default calculation. The date in the **Until** field is calculated from the duration. The duration is used by the drug interactions function to determine if a warning should be displayed. Adjust either the duration or date until if required.
13. The **Route of Administration** field displays the value provided by MIMS. If required, select a new value.
    Not all medications will have a default route of administration. Prescriptions written before Communicare is upgraded to V22.1 will not have a value. If the prescription is repeated or represcribed, the default value from MIMS is added.
14. In the **Order Instructions** field, enter administer or supply instructions for the medication using short codes or full text. For example, enter `BD` for *twice a day*, or `CF` for *with food*.
    - To see a list of short codes available for your health organisation, click **Add shortcode** or press `F2`.
    - If the medication is for supply and you want to copy the order instructions to the **Label Instructions** field, click **Copy to Label Instructions**.
15. If the medication is for supply, in the **Label Instructions** field, edit the instructions copied from the order instructions or enter dosage instructions to be printed to a label using short codes or full text.
16. In the **Internal Comments** field, enter any additional information to include in the order.
17. From the **Reason (Clinical Item)** list, select from the existing clinical items associated with the patient. If you haven't yet added a clinical item for the condition that the medication treats, click **Add Reason** and select a new clinical item.
    Alternatively, if there is no codified clinical item available, in the **Reason (Free Text)** field, type a reason for prescribing.
18. If your health service supplies medication from the medication order and you want to print a label to adhere to the medication, set **Print medication label**.

> **Tip:**
> If your health service uses this approach for supplying medications, the `Medications Management` module is not enabled in **File > System Parameters > System** tab and **Enable label printing** is set in **File > System Parameters > Clinical** tab.

19. If required, click  Ellipsis and set one or both of the following options:
    - **Save medication as favourite** - add the medication to your list of favourites displayed when you first open the Drug Browser.
    - **Save medication as default** - to save the quantity, repeats, dosage instructions and duration for this medication. This information is automatically included whenever you prescribe this medication for any patient. Set this option for medications that typically require the same dosage instructions for any patient, for example, *Yasmin*.

    > **Note:**
    > If you have **Generic Prescribing** set in System Parameters and you save a medication that you have prescribed by brand as default, the medication is still prescribed by generic when you next prescribe it.

20. If you want to add another medication for the patient, click **Add another item** to save the first medication and clear all fields. Repeat steps 2-16 to add another medication.
21. If your user group has the appropriate system rights and you want to now administer or supply the medication, click **Save & Supply**.
22. If the patient gives their consent to share this information with My Health Record, set **Consent to send to My Health Record**. If the patient has a My Health Record, this option is automatically set.
    Setting this option sets a flag for eRx which tells them whether or not to send the medication information for the patient to My Health Record. Communicare does not send this information to My Health Record separately. For more information, see Electronic Transfer of Prescriptions (ETP) *(on page 249)*.
23. Click **Save**.

If you clicked **Save & Supply**, the **Administer and Supply Medication** window is displayed. Enter administer or supply information about the medication. For more information, see Administer and Supply Medication *(on page 284)*.

If you set **Print medication label**, medication labels are printed.

If the medication order was raised from a verbal order, the authorising Doctor is notified of the verbal order awaiting approval.

The medication and associated condition are recorded in the patient's clinical record. Medications are listed on the **Summary > Medication Summary**, the **Progress Notes** tab, and the **Detail > Rx - Prescription** tabs.

On the **Medication Summary**:

- Medication is visible and current on the **Medication Summary** tab of the clinical record until the duration elapses.
- Regular medications are listed on the **Medication Summary** until they are removed. If the duration has elapsed, regular medication shows a red until date.
- Once-off or Short Course medications are listed on the **Medication Summary** only until the specified duration expires.
- The  Unreviewed Verbal Order icon is displayed for medication orders raised through verbal orders that are not yet reviewed

The medication can now be administered or supplied to the patient, either by you or a health worker.

To view the medicines that have been uploaded to My Health Record, in the **Medication Summary**, click **View My Health Record Medications**.

Create Medication Orders from Prescriptions

If you have written a prescription that is part of a Medication Request, and you need to supply some of the medication to the patient now to cover the period until the the pharmacy order is fulfilled and arrives for the patient, you can create a medication order from the prescription.

To view the prescription and copy its details to a medication order, you must belong to a user group that has `Prescribing - Full` or `Prescribing - Once Off/Short Course` rights.

You can create medication orders only for active prescriptions that are not stopped, deleted or expired.

To copy a prescription to a medication order for a patient:

1. After you have added the prescription, in the patient's Clinical Record, go to the **Summary > Medication Summary** tab or the **Detail > Rx - Prescription** tab.
2. Right-click the required medication, and select **Create Once Off Medication Order**.
3. You will have already reviewed the interactions. Additionally you are warned that `The currently prescribed medication contains the same generic components`. In the **Medications Warnings** window, click **Noted**.
4. Details from the prescription are copied to the **Create Once Off Medication Order** window.
5. If required, to suit your Imprest edit **Order Using** and select either **Generic name** or **Brand name** depending what you have in stock.
6. In the **Number of Packs** field, enter the number of packs included in the Medication Order. The default is `1`.
7. The **Duration** is set to 1 day. Adjust either the duration or date until if required.
8. In the **Order Instructions** field, enter administer or supply instructions for the medication using short codes or full text. For example, enter `BD` for *twice a day*, or `CF` for *with food*.
    - To see a list of short codes available for your health organisation, click **Add shortcode** or press `F2`.
    - If the medication is for supply and you want to copy the order instructions to the **Label Instructions** field and overwrite existing label instructions, click **Copy to Label Instructions**.
9. Dosage Instructions and DAA Dosage Instructions are copied where available from the prescription to the **Label Instructions** field. If the medication is for supply, in the **Label Instructions** field, edit the copied instructions or enter dosage instructions to be printed to a label using short codes or full text.
10. In the **Comments** field, enter any additional information to include in the order.
11. The clinical item associated with the original prescription is copied to the **Reason** field in the medication order. If required, you can remove or replace the clinical item:
    - To replace the copied clinical item with a new one, click **Add Reason** and select a new clinical item. Alternatively, if there is no codified clinical item available, in the **Reason (Free Text)** field, type a clinical reason for this medication order.
    - To remove an item and leave the reason blank, click Remove.
12. Click **Save**.

The medication and associated condition are recorded in the patient's clinical record. Both the regular medication and the once-off / short course copy are listed on the **Summary > Medication Summary** and the **Detail > Rx - Prescription** tabs.

On the **Medication Summary**:

- Medication is visible and current on the **Medication Summary** tab of the clinical record until the duration elapses.
- Regular medications are listed on the **Medication Summary** until they are removed. If the duration has elapsed, regular medication shows a red until date.
- Once-off or Short Course medications are listed on the **Medication Summary** only until the specified duration expires.

The medication can now be administered or supplied to the patient, either by you or a health worker.

Finalise Prescriptions

You can finalise prescriptions to send for ePrescribing, print or update without printing out prescriptions.

If you are using ePrescribing, tokens for finalised ePrescriptions are sent to the patient or their carer using SMS or email, via a central repository, such as eRx. Prescriptions are also added to the Active Script List unless consent is withdrawn.

To use the ePrescribing options in V22.1 and later, your health service, prescribers and local pharmacies must be prepared. For more information, see ePrescribing *(on page 250)*.

> **Tip:**
> To finalise prescriptions, you must be a prescriber and have a prescriber number.

Table 94. Patient prescription formats

Type	Format	Description
Printed	**Printed Prescription**	A traditional paper script is printed for you to hand to the patient.
ePrescribing options - visible only if ePrescribing is enabled and the patient has a verified and active IHI	**SMS ePrescription**	A token is texted to the patient's mobile phone. They present this token at the pharmacist.
	Email ePrescription	A token is emailed to the patient's email address. They present this token at the pharmacist.
	Printed ePrescription Token	The token is printed for you to hand to the patient. This is not a prescription and does not require a signature. Use this option if the patient does not have a smart phone or email address, or if the token is not transmitted successfully by other methods.
Record updates only	**Don't Print or Send**	For updates to medications only. No token is generated and the prescription is not printed.

To finalise prescriptions, generate script numbers and send to eRx:

1. In the clinical record, on the **Summary > Medication Summary** tab, click **Finalise Prescriptions**.

   > **Tip:**
   > Alternatively, on the **Medication Summary** tab or **Detail** tab, right-click on a medication and select **Finalise prescriptions**.

2. In the **Finalise Prescriptions** window, all current medications that have not been finalised or printed are listed and selected. If medication requests are enabled and **Create Medication Request by Default** *(on page 832)* is set, regular

medications are added to the medication request instead (for more information, see). In the **Create Prescriptions** step, deselect any medications in the table for which you don't want to create a printed or electronic prescription.

3. From the **Patient Prescription Format** options, select the way in which you want the prescription to be delivered to the patient, their carer or the pharmacy, if at all (see Table 94: Patient prescription formats *(on page 240)*).

> **Tip:**
> Patients must have a IHI number to receive ePrescription tokens. If the patient's preference for how they want to receive their scripts is selected in **Biographics > Personal** tab, **Prescription Format**, this option is selected. If there is no option selected, **Printed Prescription** is set by default.

For SMS or email options, the information included in the patient's biographics, if any, is displayed. Customise this information for only this prescription if required: phone numbers must be 10 or 11 characters; email addresses must be valid. Any new information you add here is not saved back to the patient's biographics.

4. If medication requests are enabled for your health service, and you want to create a medication request *(on page 244)*, you can either do so now or after you finalise the medications from the **Medication Summary** tab.

> **Tip:**
> You cannot create medication requests for back-dated services.

If you want to create a medication request now:

a. In the **Create Medication Request** step, set **Yes**.
   - The patient's current medications that were included in a previous medication request are listed with a status of *Existing*.
   - If **Create Medication Request by Default** *(on page 832)* is set, any new regular medications are selected with a status of *New*.
   - All active regular medications, DAA medications and medications that are included in the current, active request are selected by default.
   - Medications included in a DAA are grouped by DAA type and assigned a number. Items included in the same DAA type cannot be separated.
   - For medications that are already finalised, the number of the prescription to which the medication belongs is displayed.

b. Deselect any medications that you don't want to include in the new medication request.

c. If you are arranging supply of the patient-specific medication, from the **Pickup Location** list, select the location from which the patient will collect their medication. If the pickup location is already set in the clinical record **Medication Summary**, that location is included in the medication request automatically. If the current encounter place is a nominated medication pickup location, it is selected as the pickup location by default. For more information, see Encounter Place *(on page 865)*.

d. From the **Medication Request Format** options, if you want to print the medication request, set **Printed Medication Request**. Alternatively, if you don't need a printed medication request or are using consolidated orders, set **Don't print**.

5. Click **Finalise**.
6. If you selected an ePrescribing option (see Table 94: Patient prescription formats *(on page 240)*), patient, prescriber and medication details are displayed in the **Preview Prescription** window.

> **Tip:**
> This process simulates the paper prescribing process, where you check the printed prescription before signing it.

Details for the prescriber who is finalising the prescription are listed, regardless of whoever initially prescribed the medication.

a. To step through and review each prescription, click **Next**.
b. To complete the prescription, click **Send All**.

If you find something you want to update, click **Cancel Review** to return to the **Finalise Prescriptions** window.

The medication and associated condition are recorded in the patient's clinical record.

Medications are listed on the **Summary > Medication Summary** tab, with complete information on the **Detail > Rx - Prescription** tab.

On the **Medication Summary**:

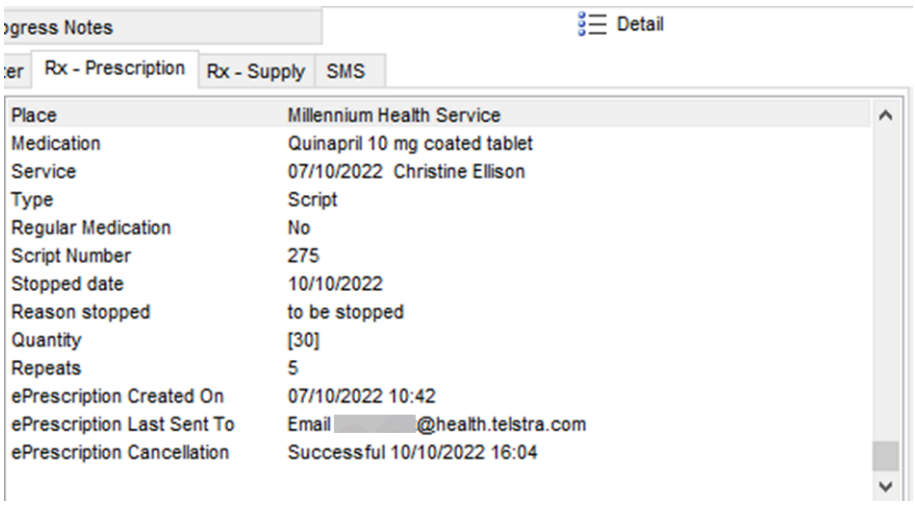
- Once-off medications are listed on the **Medication Summary** only until the specified duration elapses.
- Regular medications are listed on the **Medication Summary** until they are stopped or represcribed.
- If the new prescription for a regular medication has the same product, form and pack codes as an existing regular medication, the original medication is stopped, even if it is already expired.
- If you save a second prescription for a regular medication with the same product, form and pack codes as a medication that you have already prescribed during the same service, the first medication is deleted. If you have already printed the prescription for the first medication, ensure that you destroy it.

If you selected an ePrescribing option at step 3 *(on page 241)* above, Communicare sends the prescriptions to eRx, then:

- Sends a token for each medication to the patient or their carer using separate SMS messages or emails
- Prints a separate token for each medication
- If the patient has consented, adds the medication to their Active Script List

The ePrescription Summary *(on page 252)* shows whether ePrescriptions have been successfully sent and allows you to resend the ePrescription. If the ePrescription cannot be created, you can print the prescriptions as paper prescriptions. Where a paper prescription is created because the ePrescription failed, the medication is still sent to eRx as a paper prescription and an eRx barcode is printed on the paper prescription. The paper prescription is not an ePrescription so the prescriber must sign the script. If you cancel the transmission of the ePrescriptions, all ePrescription tokens are printed with a new SCID.

Details of the ePrescription are displayed on the **Detail** tab of the patient's clinical record:



- `ePrescription Created On` - the date and time at which this ePrescription was first successfully transmitted to eRx
- `ePrescription Last Sent To` - the ePrescription format and the most recent phone number or email address to which the ePrescribing token was successfully transmitted via eRx
- `ePrescription Cancellation` - if this ePrescription was stopped or deleted in Communicare, one of:
  - `Created` - the time the medication was stopped or cancelled in Communicare by the user
  - `Initiated` - a cancellation or cease message has been sent to eRx, but no response has yet been received
  - `Successful` - the date and time at which the cancellation or cessation was successful in eRx
  - `Failed: reason provided by eRx` or `Failed - PDS unavailable` - the reason that the cancellation or cessation failed

> **Tip:**
> To show deleted medications, in the medication list, right-click and select **Show Deleted Items**.

If you chose to print, the tokens or PBS Scripts and medication request are printed:

- If your printer assignment is set to PDF, and you chose to print tokens and the medication request, ePrescribing tokens are printed first, followed by the medication request when this process is complete. PDFs are saved to your `Downloads` folder.
- If your printer assignment is set to PDF, and you chose to print PBS Scripts and the medication request, two **Save PDF File As** windows are displayed, one after the other. Enter a name for each PDF file. A single PBS Script listing all PBS items is saved first, followed by the medication request.

Any medications that were not finalised, but were included in the new medication request are finalised when the medication request is created.

If you chose to create a medication request, it supersedes any previous medication requests and is listed in the **Medication Requests** window with a status of `Active`.

For medications that were finalised only, if custom prescription forms are enabled, and you chose to print the prescriptions, they are printed using your own template, otherwise they are printed on preprinted PBS forms.

If you created a medication request and your health service uses consolidated orders, you can now create a consolidated order *(on page 292)*.

To resend ePrescriptions *(on page 254)* or print prescriptions later that have already been finalised, in the clinical record on either the **Summary > Medication Summary** tab or the **Detail** tab, right-click a medication and select **Reprint or Resend Prescriptions**.

If you chose not to print the medication request when you finalised the medications, you can print it later from the **Medication Requests** window. For more information, see Add and print medication requests *(on page 245)*.

Medication Requests

In Communicare V20.2 and later, you can create medication requests. Medication requests combine multiple medications on one prescription.

Note:
Medication requests replace

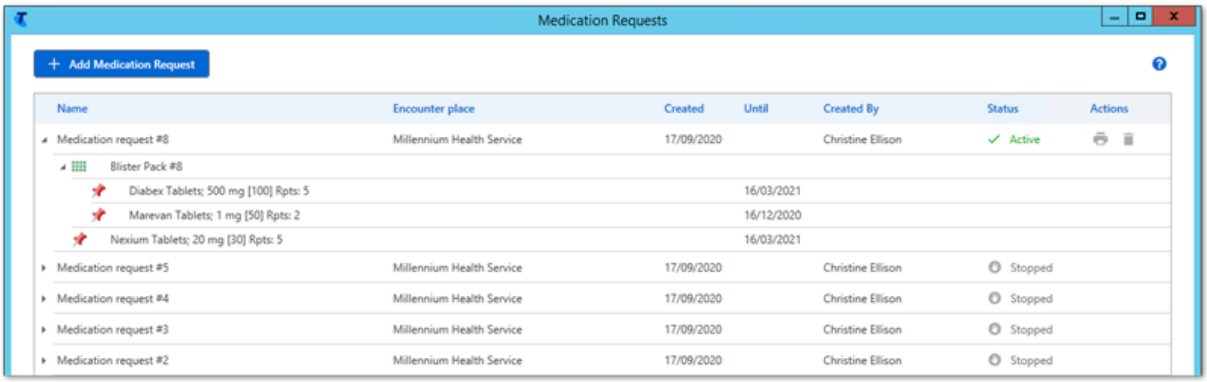
Medication requests can be sent to a pharmacy for dispensing. Instead of printing individual PBS scripts, you can print a medication request which is the equivalent of a single batch prescription. If you stock your patient's prescription medications at your health service, or are the health provider for a remote site that stocks prescription medications for your patients, you can use medication requests to help manage the patient's medications.

Tip:
Medication requests replace the Health Centre Prescriptions, Rural Prescribing and S100 Prescribing.

Note:
Medication requests are not enabled by default. Communicare Administrators can enable medication requests in System Parameters. For more information, see System Parameters - Prescription Forms *(on page 832)*.

To display the current medication request, in the patient's clinical record, on the **Summary > Medication Summary** tab, click **Medication Requests**.

The **Medication Requests** window shows the current medication request, including any DAA medication groups, and also lists all superseded medication requests.



The following details are displayed for the medication request:

- **Encounter Place** - the encounter place for the current service or the selected pickup location for patient-specific inventory
- **Created** - the date on which the medication request was created
- **Until** - the until date of each medication
- **Created by** - name of the provider who created the medication request
- **Status** - one of the following:
    - `Active` - the current medication request
    - `Stopped` - any superseded medication requests
    - `Cancelled` - any medication request that has been cancelled

If you need to check the medications included in a previous medication request, or check the contents of a previous DAA medication group, expand the required medication request.

Medications in the medication request display the usual medication icons.

Table 95. Medication request - medication icons

Icon	Description
	Identifies once off or short course medications
	Identifies regular medications
	Identifies a medication group included in a DAA. A separate medication group is created for each DAA type: • Blister Pack • Sachet • Dosette Box • Bag (OP) • Packet The medication group number is incremented each time you adjust the medications included in that DAA type, that is, each time you add, delete, update, repeat, represcribe or stop a medication included in that DAA. To see previous medication groups, open the superseded medication requests.

Add and print medication requests

Medication requests combine multiple medications on one prescription. If you need to adjust the medications included in a medication request, add a new medication request to supersede the old one.

To view medication requests, you must belong to a user group with the `Prescribing - Full` or `Prescribing Once Off/Short Course` system rights. To create or delete medication requests, you must also be a prescriber or have a prescriber number.

If you belong to a user group with the `Prescribing Once Off/Short Course` system right, but you do not have a prescriber number, you can view and reprint medication requests.

To add subsequent medication requests:

1. On the **Medication Summary**, click  **Medication Requests**.
2. In the **Medication Requests** window, click **Add Medication Request**.

In the **Add Medication Request** window, all active, finalised prescriptions including medications grouped by DAA type are displayed.

All active regular medications, DAA medications and medications that are included in the current, active request are selected by default.

3. In the **Create a medication request** step:
    a. If the location from which the medication will be supplied to the patient after it has been fulfilled is separate to the current encounter place, from the **Pickup Location** list, select this location. If the pickup location is already set in the clinical record **Medication Summary**, that location is included in the medication request automatically. If the current encounter place is a nominated medication pickup location, it is selected as the pickup location by default. For more information, see Encounter Place *(on page 865)*.
    b. Select the medications and medication groups that you want to include in the medication request. For each medication, add notes if required.
4. In the **Do you need to print today?** step, if you want to print the medication request, set **Yes**.

> **Tip:**
> If consolidated orders are enabled for your health service, you can't print medications included in a medication request to a PBS script.

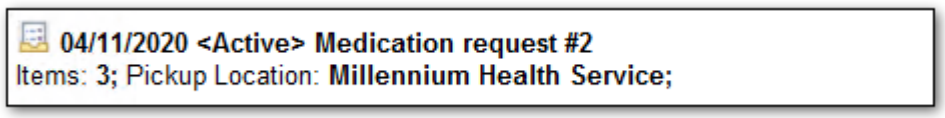
5. Click **Save**.

The new medication request is listed in the **Medication Requests** window with a status of `Active` and the number of the medication request is incremented.

The new medication request is also listed on the **Progress Notes** tab using the following format:

```
Date <Active> Medication request #x
Items: y; Pickup Location: z;
```

For example:



When a medication request is superseded, on the **Progress Notes** tab, its prefix is updated to `<Stopped>`. Cancelled medication requests are also listed and prefixed with `<Cancelled>`.

If you chose to print, the medication request is printed.

If your health service uses consolidated orders, you can now create a consolidated order.

If you chose not to print in step 4 *(on page 246)*, and you now want to print the current medication request, click Reprint.

If you decide the medication request is incorrect and you want to cancel it, click Cancel. Alternatively, create a new medication request to supersede the current one.

Supply Medication Requests

After a medication request has been fulfilled by an external pharmacy, you can record when a patient picks up their medication.

> **Tip:**
> To use this feature, medication requests must be enabled for your health service and there must be existing patient inventory recorded using consolidated orders.

If you want to toggle between showing all medications and hiding medications included in a request for which there is no inventory, in **System Parameters**, enable **Show Out of Stock Inventory**.

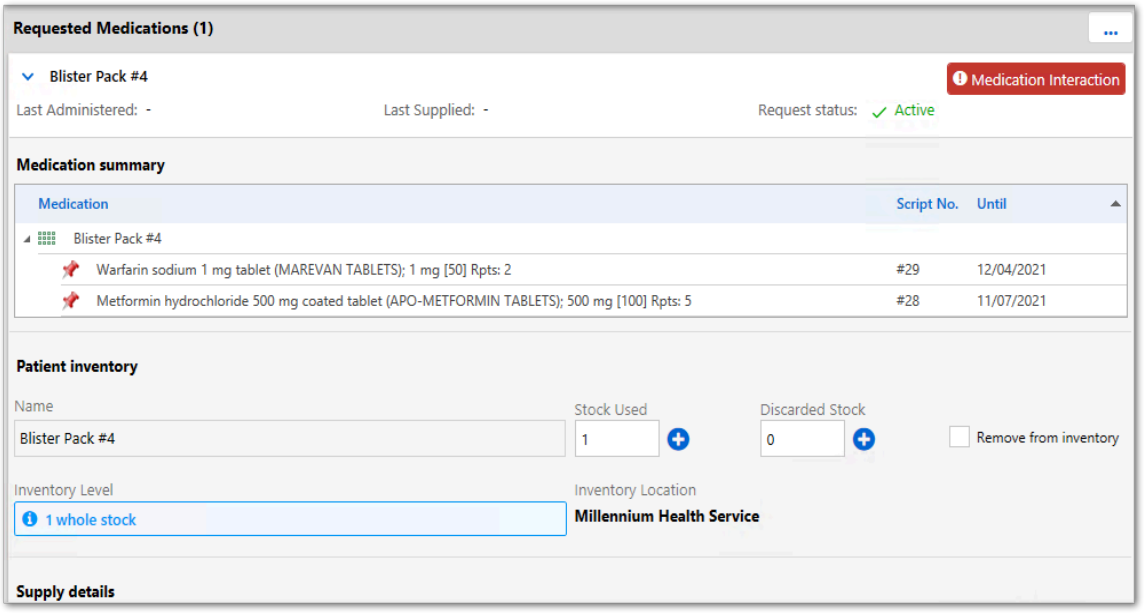
For more information, see System Parameters - Prescription Forms *(on page 832)*.

After you have received patient-specific inventory from the pharmacy, you can supply it to the patient.

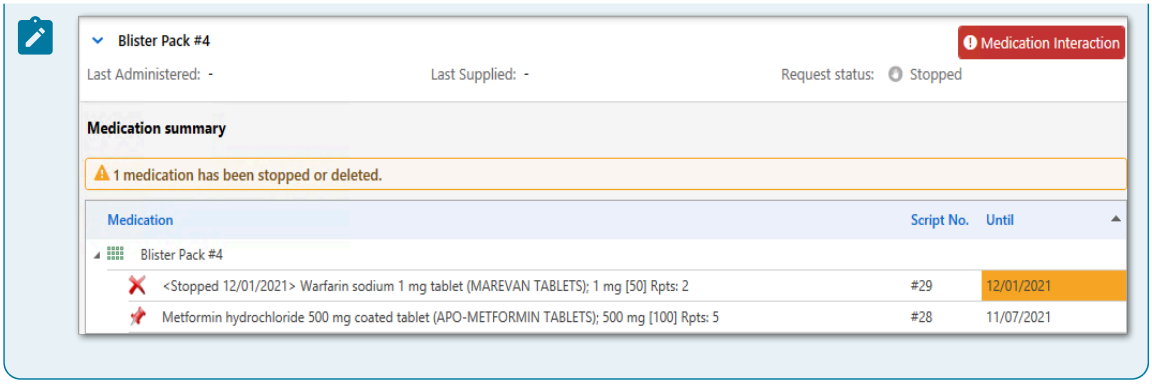
To record the supply of patient-specific inventory to the patient:

1. In the clinical record, add and finalise medications and create a medication request.
   For more information, see Finalise Prescriptions *(on page 240)*.
2. Select **Medication >** **Administer & Supply**.
3. In the **Requested medications** section of the **Administer and Supply Medication** window, expand the medication or DAA pack that you want to supply to the patient from their fulfilled inventory.

   > **Tip:**
   > Ensure that the **Request status** is `Active`.



> **Note:**
> If any medications included in the patient inventory have been stopped or deleted, the **Request status** is changed to `Stopped` or `Cancelled`, and in the medication list, a warning banner is displayed and the affected medication is prefixed with `<Stopped date>` or `<Deleted date>`.



4. In the **Patient inventory** section, in the **Stock Used** field, enter the number of individual stock items supplied, or click Increment.

> **Tip:**
> The amount of medication listed in the **Inventory Level** is controlled by the inventory levels recorded in the **Qty in stock** field in the draft consolidated order. For more information, see Create a draft consolidated order *(on page 294)*.

   If the ability to hide inventory with no stock is enabled for your site, to show all medication requests, click Options and select **Show out of stock inventory**. If this option is not selected, only those medications that have stock or that have been updated in the current service are displayed.

   The **Inventory Level** is decremented by the number of stock items supplied.

5. Ensure that the pickup location recorded under **Inventory Location** is correct.
6. In the **Supply details** section, in the **Supply Quantity and Units** fields:
   - Enter the amount of medication supplied
   - Select the medication units

> **Tip:**
> For DAA packs, ensure that the units match the DAA type.

7. From the **Supply Mode** list, select whether the medication was supplied to the patient or their carer or service provider.
8. In the **Notes** field, enter any pertinent notes.
9. Click **Save**.

The date and quantity of supply are added to the **Medication Summary** tab.

Last Supplied	Qty
06/10/2020	1.00 Pack
06/10/2020	1.00 Blister Pack
06/10/2020	1.00 Blister Pack

The date and time of supply is added to the supply record and is visible when you next open the **Administer and Supply Medication** window.

A supply record is added to the **Progress Notes**. The record shows the Supply Medication icon, the date, and is prefixed with the word <Supply>. For example:

Entries are also added to the **Detail** tab:

- By date, prefixed with <Supply>
- On the **Medication** topic tab, prefixed with <Supply>
- On the **Rx - Supply** class tab, prefixed with <Inventory>

Note:
If a regular medication has been created, a medication request created and the medication supplied, all in the same service, you cannot then represcribe the medication in that service.

Removing patient-specific inventory

When a patient's medications are changed, you can mark the superseded stock as discarded and remove the medication request from the inventory.

To update a patient-specific inventory:

1. Select **Medication** > **Administer & Supply**.
2. In the **Requested medications** section of the **Administer and Supply Medication** window, expand the medication or DAA type record that you want to adjust.
3. In the **Patient inventory** section, in the **Discarded Stock** field, enter the number of individual stock items that you are discarding, or click Increment.
   The **Inventory Level** is decremented by the number of stock items you enter.
4. If you also want to remove the medication or DAA type from the inventory record in the database, set **Remove from inventory** and in the confirmation window, click **Yes**.
5. Click **Save**.

If you removed the medication or DAA type from the inventory record, you can no longer record administration or supply for that medication.

Discarded stock is not recorded in the **Progress Notes** or **Detail** tab.

Electronic Transfer of Prescriptions

Communicare can be configured for electronic transfer of prescriptions (ETP) to a central repository.

In Communicare V22.1 and later, Communicare supports ETP for both printed PBS prescriptions and ePrescribing.

If ETP is configured, whenever a prescription is created, the information is sent off to a central repository.

> **Note:**
> Offline (Data Sync) Clients *(on page 667)* do not support ETP.

To enable ETP with Communicare, complete the following steps:

1. Register at least one clinician in your organisation as a Prescriber at the eRx (www.erx.com.au) website. eRx is the ETP service that Communicare integrates with to enable ETP. With the registration, although individual prescriber details are entered, it allows ETP to be used by anyone in the same organisation.
2. Contact Communicare Support to confirm that registration has been initiated and arrange for ETP to be enabled. Communicare Support will add the ETP service details to **File > System Parameters > Web Services** tab. For more information, see Script Exchange system parameters *(on page 829)*.
3. Check that a locality is set for your encounter place. For Communicare to be able to transfer prescriptions to the ETP service, your encounter place must include a locality in **File > Reference Tables > Encounter Place**.

   > **Note:**
   > If ETP is enabled for your encounter place and no locality is set for your encounter place, or for your organisation in **File > Organisation Maintenance**, you can't save new prescriptions.

After you have set up ETP:

- Whenever a PBS prescription is created, the information is sent off to the ETP service, such as eRx.
- When you delete a PBS prescription, Communicare sends an update to the ETP service to cancel that medication. Similarly, if you stop a medication from a previous service that has been sent to the central repository, but do not represcribe it, a cancellation is sent.

For setting up ePrescribing, see ePrescribing *(on page 250)* for additional steps.

Data privacy and security

In Communicare V22.1 and later, for printed PBS prescriptions, your patients' relevant personal information is encrypted and sent from your Communicare server to an ETP service, such as eRx, via Communicare Next Generation. The data is retained by Communicare Next Generation. Communicare Next Generation is hosted on Microsoft Azure cloud services, in highly secure data centres based in Australia (Sydney, Canberra, Melbourne) which meet the Australian Standards for Information Security. Microsoft has been awarded Certification for Protected data in Australia. For more information about how Telstra Health manages personal information, see our privacy policy.

ePrescribing

In Communicare V22.1 and later, Communicare supports ePrescribing for registered providers who have opted in to ePrescribing.

In V22.1 and later, if ePrescribing using tokens is configured, whenever an eScript is created, Communicare sends a token to the patient or their carer using SMS or email via a central repository, such as eRx.

When the patient goes to collect the prescription, any pharmacist participating in ePrescribing can then scan the token to download the information about the prescription electronically from the central repository. This can greatly reduce errors with reading and interpreting printed prescriptions.

If a patient is registered for Active Script List (ASL), eScripts can also be sent directly to a patient's ASL instead of the patient or their carer. The ASL lists all active prescriptions and repeats that are available for the pharmacist to dispense. The patient or their carer then needs only to provide identification when they collect their prescription.

The token is suitable for a single repeat of the medication, the pharmacy is responsible for sending a new token for any repeats.

Set up ePrescribing

To set up ePrescribing:

- For your health service:
    1. Ensure your local pharmacies are ready to dispense electronic prescriptions.
    2. Ensure your practice has a Healthcare Provider Identifier-Organisation (HPI-O) number and is connected to the Health Identifiers Service.
    3. Follow the steps to enable ETP:
        a. Register at least one clinician in your organisation as a Prescriber at the eRx (www.erx.com.au) website. eRx is the ETP service that Communicare integrates with to enable ETP. With the registration, although individual prescriber details are entered, it allows ETP to be used by anyone in the same organisation.
        b. Contact Communicare Support to confirm that registration has been initiated and arrange for ETP to be enabled. Communicare Support will add the ETP service details to **File > System Parameters > Web Services** tab. For more information, see Script Exchange system parameters *(on page 829)*.
        c. Check that a locality is set for your encounter place. For Communicare to be able to transfer prescriptions to the ETP service, your encounter place must include a locality in **File > Reference Tables > Encounter Place**.

            Note:
            If ETP is enabled for your encounter place and no locality is set for your encounter place, or for your organisation in **File > Organisation Maintenance**, you can't save new prescriptions.

- For any provider who has opted in to ePrescribing, the following information must be recorded in Communicare:
    - The provider must belong to a user group which has the **Prescribing** system right set.
    - In **File > Providers**, providers must have:
        - **Logon User Name**
        - Full name
        - PBS **Prescriber Number**
        - A validated **HPI-I Number**
        - **Qualifications** recorded
        - **Enable ePrescribing** set

Because ePrescribing relies on the prescriber's identity within the prescribing system to replace a signature on paper, ADHA has imposed additional requirements on system security and user authentication.

- Passwords for providers using ePrescribing must meet the following requirements:
    - Be at least 8 characters and contain no more than 255 characters
    - Include at least one letter
    - Include at least one number
    - May include special characters

These requirements will be enforced for new users or for existing users who change their password in V22.1 and later.

- Communicare is locked and users must log in again after 15 minutes of inactivity and when prescribing schedule 8 medications. This requirement helps prevent a prescriber having drugs prescribed under their identity if they leave their computer unattended.

Using ePrescribing

To use ePrescribing:

1. Ensure your practice team are up-to-date with electronic prescribing.
2. With your patients, discuss the option of receiving a prescription electronically. If they opt in:
    - Ensure patient phone and email addresses are current so that they can receive ePrescribing tokens.
    - Set the patient's preferred prescription format in  **Biographics > Personal** tab, **Prescription Format**.
3. Prescribe using ePrescribing prescription formats. For more information, see Table 94: Patient prescription formats *(on page 240)*.

For training about ePrescribing in Communicare, see ePrescription eLearning.

Sending ePrescriptions

When you send an ePrescription, you know immediately whether the prescription has been successfully sent to eRx.

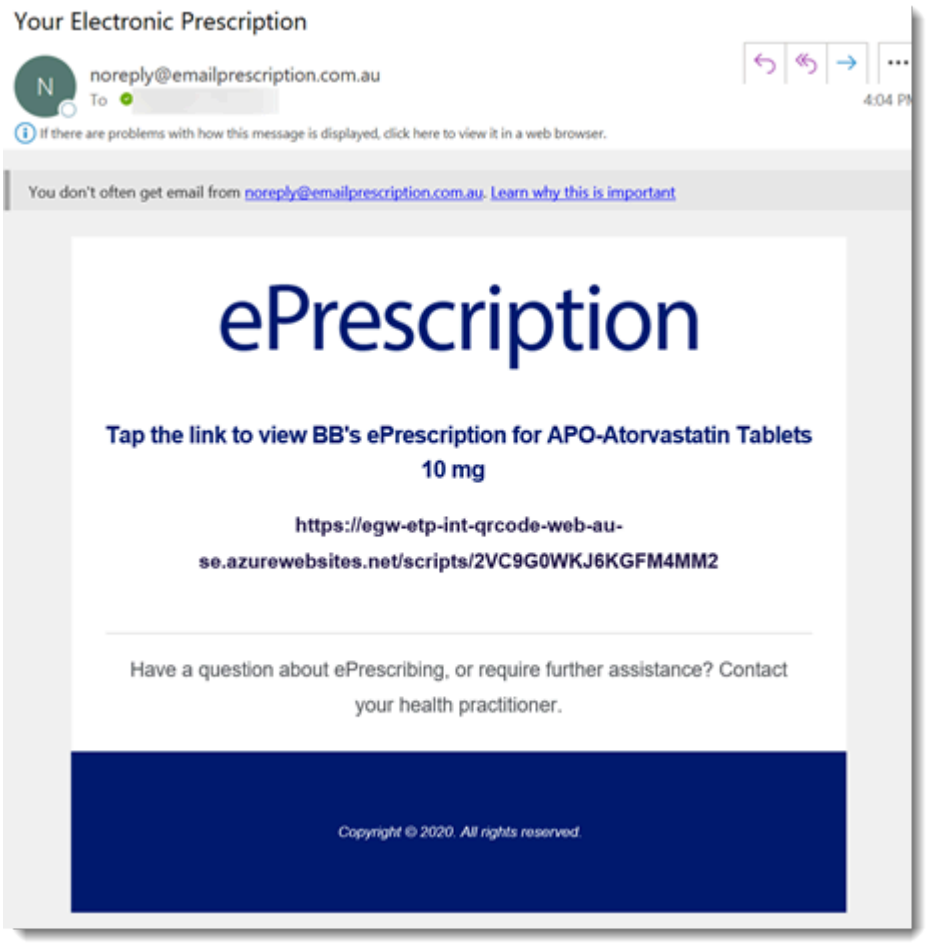
 In the **ePrescription Summary**, any medications that failed to send are listed and display an error. Depending on the error, you can either:

- Send the failed medications again, click **Resend**.
- Print a token for each medication on paper to hand to the patient, click **Print Prescriptions**.
- Print a paper prescription. Where a paper prescription is created because the ePrescription failed, the medication is still sent to eRx as a paper prescription and an eRx barcode is printed on the paper prescription. The paper prescription is not an ePrescription so the prescriber must sign the script.

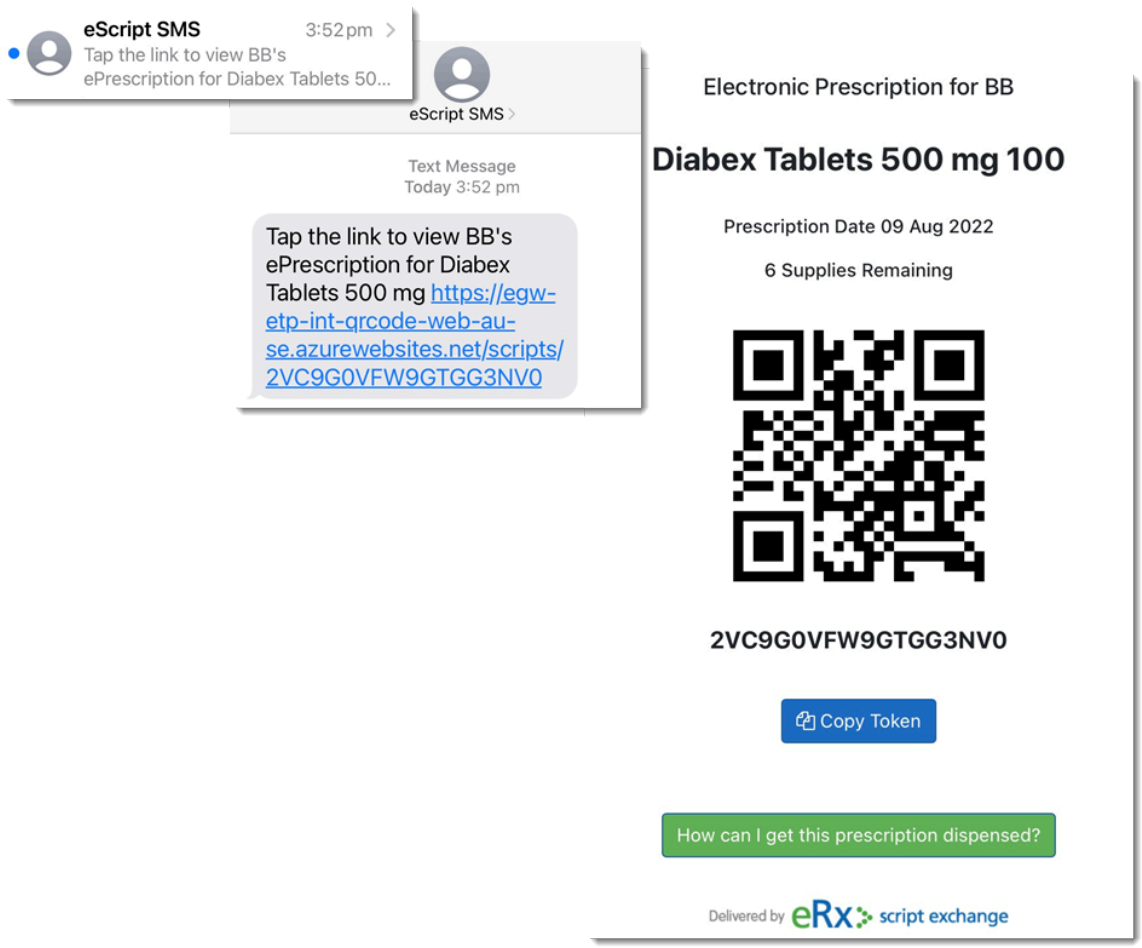
 All medications that have been successfully sent to the ETP service are grouped and display a message of `medications sent successfully`.

For successful ePrescriptions, patients receive the following communication from eRx:

- If emailed, an email from `noreply@emailprescription.com.au` with the subject of `Your Electronic Prescription` for each medication. For example:



- If sent by SMS, a text message from `eScript SMS` for each medication, with a link to the ePrescription. For example:



Resending ePrescriptions

If a patient has lost an ePrescription token, any prescriber can resend an ePrescription to the ETP service so that the token is sent to the patient again or can be printed.

The medication must be finalised and current.

To request that the ETP service resends an ePrescription token:

1. In the patient's clinical record, select the **Summary > Medication Summary** or the **Detail** tab.
2. Right-click the medication and select **Reprint or Resend Prescription**.
3. In the **Resend ePrescription** window, select the way in which you want the ePrescription to be delivered to the patient, or if you want to print the token.
4. For **SMS** or **Email** options, the information included in the patient's biographics, if any, is displayed. Customise this information for this ePrescription if required.
5. Click **Resend**.

If the request to resend the prescription is successfully sent to the ETP service, you'll receive a confirmation message and the ePrescription token is sent to the patient again, or the token is printed. The SCID and token will be the same as the original ePrescription.

The phone number or address to which the token is sent is stored.

Print Prescriptions

When you close the clinical record, you are prompted to finalise any prescriptions that haven't been finalised or printed that day.

If you want to print prescriptions before you close the record, you can print when you finalise prescriptions. Finalising a prescription assigns a script number to the prescription, so it is not necessary to print if a physical prescription is not required.

> **Note:**
> To finalise and reprint prescriptions, you must be a prescriber and have a prescriber number.

Printing uses the Printer Assignments. You can print either to PDF or a printer. If you need only to assign a script number, you can instead just finalise *(on page 240)* the prescription.

On the **Medication Summary**, for any prescription that has not been printed or finalised, the  print icon is displayed.

To print all new prescriptions:

1. In the clinical record, on the **Medication Summary** tab, click  **Finalise Prescriptions**.
2. In the **Finalise Prescriptions** window, in the **Finalise Prescriptions** step, select the medications you want to print.
3. In the **Do you need to print today?** step, set **Yes**.
4. In **What do you need to print?**, select PBS Scripts.
5. Click **Finalise**.

Any unprinted prescriptions are sent to your default printer.

If you print the prescription at a later date to the service, the date of the prescription is adjusted to the date of printing.

Add Adverse Reactions

Record an adverse reaction for a reaction a patient has to a substance of any sort.

> **Tip:**
> When prescribing, until an adverse reaction or nil known reaction is recorded, clinicians will be prompted to provide this information.

All users will be able to view a patient's reactions, and will receive a warning if prescribing medication for which a patient has a recorded allergic adverse reaction. However, only users who belong to a user group with the `Common` viewing right will be able to add adverse reaction information to a user's clinical record.

Only users who belong to a user group with the `Adverse Reaction Administration` system right can delete or update adverse reactions.

Definitions of clinical terms provided by NEHTA Adverse Reactions Data Specfications v1.1 29/02/2008.

To add a new adverse reaction to a patient's clinical record:

1. In the clinical record, on the **Main Summary**, click  **New Adverse Reaction**.

> **Tip:**
> If the patient does not have any allergies or hasn't experienced any adverse reactions, instead set **Nil Known**.

2. In the **New Adverse Reaction** window, from the **Information Provided By** list, select a category for the source of the adverse reaction health information.
3. Select the agent or substance that causes the adverse reaction:
    a. Select the tab for the type of allergy.
    b. Scroll and select the allergen from the list or in the **Search** field enter a search term.

   The agent type is identified as a Generic, a Drug brand, or a Non-Drug allergy. Drug allergies provide extra checking beyond the chosen drug. **Include other drugs of the same substance class for warnings?** is set by default. When set, any drug that is in the same substance class as that chosen also generates an alert. Alerts are also based on any drugs that have cross sensitivities.

   The **Non-Drug** tab lists all active, non-medicinal concepts from the SNOMED CT-AU terminology. If you view or edit a non-drug adverse reaction added before SNOMED CT-AU terminology was implemented, the substance or agent is listed using old terminology, which includes Animal, Chemical, Environment and Food agents.
4. From the **Certainty** list, select the degree of confidence that you have that the selected agent or substance caused the adverse reaction.
   Select from:
    - **Certain** - a clinical event, including laboratory test abnormality, occurring in a plausible time relationship to agent exposure or administration, and which cannot be explained by concurrent disease or other agents or chemicals. The response to withdrawal of the agent (dechallenge) should be clinically plausible. The event must be definitive pharmacologically or phenomenologically, using a satisfactory rechallenge procedure if necessary.
    - **Probably/Likely** - a clinical event, including laboratory test abnormality, with a reasonable time relationship to agent exposure or administration, unlikely to be attributed to concurrent disease or other agents or chemicals, and which follows a clinically reasonable response on withdrawal (dechallenge). Rechallenge information is not required to fulfil this definition.
    - **Possible** - a clinical event, including laboratory test abnormality, with a reasonable time time relationship to agent exposure or administration, but which could also be explained by concurrent disease or other agents or chemicals. Information on agent withdrawal may be lacking or unclear.
    - **Unlikely** - a clinical event, including laboratory test abnormality, with a temporal relationship to agent exposure or administration which makes a causal relationship improbable, and in which other agents, chemicals or underlying disease provide plausible explanations.
5. From the **Date of Exposure** calendar, select the date or date and time that the exposure to the agent or substance occurred.
6. From the **Date of Onset** fields, select the date when the adverse reaction first occurred or started showing symptoms or signs. Set the year, month and day if known. Otherwise, set the year and month, or only the year. If the patient doesn't know when the adverse reaction started, set **Not Known**.
7. In the **Reaction Type** pane, select the reaction type.
   Reaction types are taken from SNOMED CT-AU terminology and are arranged in a hierarchy, from least to most specific reaction type. Select the most appropriate reaction type:

- **Adverse reaction** - the default option and least specific reaction type. The WHO in 1972 defined an adverse reaction as *"a response to a drug which is noxious and unintended, and which occurs at doses normally used in man for the prophylaxis, diagnosis, or therapy of disease, or for the modifications of physiological function"*.
- **Allergic reaction** - Allergies are an overreaction of the immune system to substances that generally do not affect other individuals (from US Centre for Disease Control). Allergic reactions range from merely bothersome to life-threatening.
  - **Hypersensitivity reaction type I** - immediate hypersensitivity reaction or anaphylaxis, the most severe reaction
  - **Hypersensitivity reaction type II** - cytotoxic or cytolytic antibody reactions, e.g. transfusion reaction
  - **Hypersensitivity reaction type III** - immune-complex reactions, e.g. serum sickness
  - **Hypersensitivity reaction type IV** - delayed T cell mediated reactions, e.g. poison ivy
- **Non-allergic reaction** - the immune system is not involved with non-allergic reactions
  - **Drug interaction** - a substance (usually another drug) affects the activity of a drug when both are administered together.
    - **Drug interaction with drug** - one drug alters the pharmacological effect of another drug. The pharmacological effect of one or both drugs may be increased or decreased, or a new and unanticipated adverse effect may be produced.
    - **Drug interaction with food** - the food a person eats affects the ingredients in a drug so it doesn't work the way it should. Drug-food interactions can happen with both prescription and over-the-counter medicines, including antacids, vitamins and iron pills.
  - **Food intolerance** - adverse reaction to a food or food component. Food intolerances are sometimes confused with food allergies, but involve only the digestive system, whilst food allergies involve the immune system.
  - **Medication side-effect** - adverse drug reactions which do not depend on an immunological reaction against the drug, but on its pharmacological effects.
  - **Toxicity** - the degree to which a substance (a toxin or poison) can harm humans or animals. Acute toxicity involves harmful effects in an organism through a single or short-term exposure.

8. In the **Clinical Manifestation(s)** pane, select one or more signs and symptoms of the adverse reaction manifested by the patient. Where required, from the **Severity** list, select the severity of the symptoms.
9. In the **Reaction Status** pane, set the whether the adverse reaction is considered an active or inactive health challenge.
   Select from:
   - **Active - no rechallenge performed** - the adverse reaction is considered an ongoing health issue, e.g. active allergy to penicillin or bee sting
   - **Inactive - no rechallenge performed** - the adverse reaction is not considered an ongoing health issue, e.g. intolerance to lactose was suspected, but this now does not appear to be the case
   - **Rechallenge outcome - active** - a rechallenge of the adverse reaction has occurred and it is still considered an ongoing health issue, e.g. an adverse reaction to penicillin was reported. A clinically controlled rechallenge was performed, resulting in symptoms and signs of continuing allergy.
   - **Rechallenge outcome - inactive** - a rechallenge of the adverse reaction has occurred and it is no longer considered an ongoing health issue, e.g. the subject of care had a reported adverse event to bee sting. After a course of desensitisation, a rechallenge produced no reaction - the problem determined now as inactive.
10. Click **Save**.

The new adverse reaction is listed in the patient's clinical record:

- On the **Main Summary**, in the **Adverse Reaction Summary** panes. Reactions to drugs are listed in the left pane; reactions to other substances such as bee venom are listed in the right pane.
- In the action required banner *(on page 120)*.

Tip:
Newly added reactions can be deleted or updated within 24 hours if required.

To edit or delete an adverse reaction, on the **Main Summary**, in the **Adverse Reaction Summary** pane, right-click a reaction and select **Edit Reaction** or **Delete Reaction**.

When prescribing, clinicians will receive a warning if prescribing a medication which contains a drug for which a patient has a recorded allergic adverse reaction.

If enabled, clinicians will be required to enter their password to proceed with a prescription for which the patient has a recorded allergic adverse reaction. The **Require password on adverse reaction prescribing** option is set by default. To turn off this feature, deselect it in **File > System Parameters > Clinical** tab.

Decision Support

Communicare provides prescribing decision support based on clinical items with a valid ICPC-2 PLUS code and uses pharmaceutical content sourced from the MIMS drug database.

Communicare includes the following interaction checks based on the MIMS drug database:

- Drug interactions
- Pregnancy interactions
- Condition interactions
- Warnings where duplicate active medications are prescribed with the same generic components (excludes duplicate drug therapy warnings); or where a patient has an adverse reaction recorded to a drug brand, drug class or generic drug that has since become out-of-date.

Note:
Interaction warnings are displayed regardless of the user's program rights, viewing rights or system rights.

Important:
This is a decision support tool only and is not a substitute for good clinical decisions or practise. You should always verify and confirm the accuracy of any life-threatening information and critically important results.

If you open an historical prescription:

- Drug to drug interactions current at the time of prescribing are displayed
- Condition and pregnancy interactions from the current version of MIMS are displayed

Table 96. Decision support

Support type	Description	MIMS database used	Communicare version
Drug	Checks for interactions between the active ingredients in medications and adverse reactions to drugs.	DrugAlert	V19.1 and later

Table 96. Decision support (continued)

Support type	Description	MIMS database used	Communicare version
Pregnancy	• Drug to pregnancy interactions - checks an individual new medication for any pregnancy interactions. • Pregnancy to drug interactions - when you add a new pregnancy, checks the patient's active medications for interactions with a pregnancy.	HealthAlert	• V20.1 and later • V20.2 and later
Condition	• Drug to condition interactions - checks for any interactions against a patient's conditions when you add a new medication. • Condition to drug interactions - checks for any interactions between that condition and the patient's active medication list when you add a condition.	HealthAlert	V20.2 and later

Medication Warnings

The **Medication Warnings** window displays drug and adverse reaction warnings, and pregnancy, condition and drug interaction warnings. Use this information to support your prescribing decisions.

> **Note:**
> The information provided by this package is not a substitute for good clinical knowledge and practise.

This module uses the MIMS databases installed locally.

When you write or repeat a prescription, create a medication order or administer and supply a medication, the newly selected drug is checked against the patient's existing clinical items, clinical data and all currently prescribed medications. Medications are treated as current if they have not expired.

Warnings are displayed in the following priority order:

- Extemporaneous *(on page 260)* - extemporaneous preparations are listed
- Reaction *(on page 260)* - warnings are displayed for medications for which the patient has a recorded adverse reaction
- Pregnancy *(on page 260)* interactions - any interactions between the active ingredients in the medication and pregnancy are listed
- Condition *(on page 260)* interactions - if condition interaction support is available at your health service, any interactions between the active ingredients in the medication and the patient's recorded conditions or procedures are listed
- Drug *(on page 261)* interactions - any interactions between two nominated generic substances are listed
- Warning *(on page 262)*:
    - Out-of-date drug brands, drug classes or generic drugs for which an adverse reaction is recorded.
    - Any duplication of active ingredients between medications is displayed in the following order:
        - Currently prescribed medications
        - Previously stopped medications

To proceed, read the warnings and interactions either on the **All** tab, where all warnings and interactions are listed, or by warning type on each separate tab, and click **Noted**.

Extemporaneous

Extemporaneous preparations are listed, but interaction and adverse reaction checks and drug warnings are not provided. Use your clinical knowledge to determine the safety of the preparation.

Reactions

When prescribing, clinicians will receive a reaction warning if prescribing medication which contains a generic component for which a patient has a recorded allergic adverse reaction. If enabled, clinicians will be required to enter their password to proceed with a prescription for which the patient has a recorded allergic adverse reaction, and the action is logged. If the Substance Warning has been applied to the reaction, all generic components of the same substance class will have a warning. Those generic components with cross sensitivities are also included.

Pregnancy interactions

When you add a medication, if a female patient is pregnant, a pregnancy status banner is displayed in the **Medication Warnings** window and any interactions between the active ingredients in the medication and pregnancy are listed.

Tip:
Non-current medications, including expired, regular medications are not checked for interactions. Interactions are displayed regardless of your program rights, viewing rights, or system rights. You can customise the pregnancy interactions displayed. For more information, see System Parameters - Prescription Forms *(on page 832)*.

You can also check pregnancy interactions later, after you have already prescribed medications.

Interactions are listed in severity order.

Note:
Interaction support is available only for clinical items with a valid ICPC-2 PLUS code.

Condition interactions

If condition interaction support is available at your health service, when you add a medication any clinical item that is a condition or a procedure and has a valid ICPC-2 PLUS code is checked for possible interactions. Any interactions between the active ingredients in the medication and the patient's conditions or procedures are listed. Only condition interactions for the relevant medication route are displayed.

All conditions for a patient are checked, including those that are no longer active.

Tip:
Non-current medications, including expired regular medications are not checked for interactions. Interactions are displayed regardless of your program rights, viewing rights, or system rights.

You can also check condition interactions later, after you have already prescribed medications.

Interactions are listed in severity order.

Note:
Interaction support is available only for clinical items with a valid ICPC-2 PLUS code.

Drug interactions

The MIMS database is used to check the documented interactions between two nominated generic substances. When a brand is selected, each generic component (or its allocated class) is compared against every other generic component (both those on the prescription being generated and those on the patient's current medication list) on an individual (paired) basis. When more than two generic substances are prescribed, the database checks the interaction between all possible paired combinations of generics, but cannot provide information about the overall combination.

The compound effect of the interactions arising from the combination of more than two generics cannot be evaluated using this database, because the number of possible permutations and combinations make it impossible to generate full interaction data using current technology. Therefore, the prescribing clinician must assess the combined consequences of all the displayed interactions for each patient.

Note:
Even if no interaction message is displayed it doesn't necessarily mean that none applies for the generic selected. It is the responsibility of the prescriber to evaluate all information in the clinical setting before making any final prescribing decision.

Tip:
Non-current medications, including expired regular medications are not checked for interactions. Interactions are displayed regardless of your program rights, viewing rights, or system rights.

Severity ratings

Drug interactions are listed from the most severe with the best documentation to the least severe.

Table 97. Severity ratings

MIMS Severities	Example
Severe (1): The interaction between these medications may be life-threatening or may cause permanent damage. These medications are not usually used concurrently; medical intervention may be required.	
Moderate (2): These medications may interact, resulting in the potential deterioration of the patient's condition. The patient should be monitored for possible manifestations of the interaction. Medical intervention or a change in therapy may be required.	
Minor (3): Clinical effects of the interaction are limited and may be bothersome but would not usually require a major change to therapy. The patient should be monitored for possible manifestations of the interaction.	
Caution (4): The interaction may occur based on the mechanism of action of the co-administered medicines. Be alert for increased or decreased effect, depending on the combination of medicines.	

Table 97. Severity ratings (continued)

MIMS Severities	Example
Not Clinically Significant (5): The interaction may occur, but the outcome is not clinically significant.	1 2 3 4 **5** 6
Not Established (6): The interaction may theoretically occur due to its pharmacokinetics and pharmacodynamics. There have not been any established reports of the interaction.	1 2 3 4 5 **6**

Documentation levels

Documentation levels are defined as:

- Well established - there have been several published reports of this interaction. The pharmacological explanation of why the interaction occurs is well documented and understood. There are usually controlled studies that have established that the interaction exists.
- Good - although controlled studies may not have been performed, several case reports have been documented and other data strongly suggests this interaction exists.
- Limited - few reports of this interaction exist. These few reports usually consist of limited case reports where clinically sound justification of the interaction is found.
- Not established - the interaction may have occurred with other medicines within the same class, or there is a theoretical possibility that the interaction exists.

Warnings

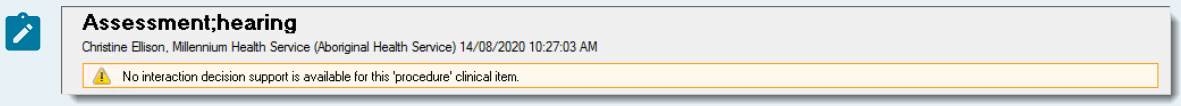
Out-of-date drug brands, drug classes or generic drugs for which an adverse reaction is recorded are listed. Clinical decision support is no longer available for these drugs. Update the adverse reaction recorded in the patient record with a current drug brand, drug class or generic drug. For more information, see Add Adverse Reactions *(on page 255)*

Conflicts where common generic substances exist in multiple drugs currently being prescribed are listed (to advise against overdose). Warnings are also displayed where the same generic substance has been prescribed to the patient in the past, then stopped for a reason.

Condition Interactions

If condition interaction support is available at your health service, when you add a new condition or procedure to a patient's clinical record, it is checked against the patient's active medications for any interactions.

Note:
Interaction support is available only for clinical items with a valid ICPC-2 PLUS code. In the **Clinical Terms Browser**, clinical items with a valid ICPC-2 PLUS code are displayed in black text. If you select a different type of clinical item distributed by Communicare (displayed in blue text) or a local clinical item (displayed in purple text), a message similar to the following message is displayed in the clinical item when you add a condition, history or procedure item or complete a recall:




```
No interaction decision support is available for this condition clinical item.
```

Any active medications with a matching medication route for which there are interactions identified in the MIMS database for the new condition are listed in the **Condition Interactions** window. Active medications are those that are not stopped, expired or deleted.

To proceed, read the interactions and click **Noted**.

Remember:
After you have added the clinical item, review the patient's current medications in light of the condition interaction warnings. If you don't have the required viewing rights to review the medications, refer the review to a provider who does.

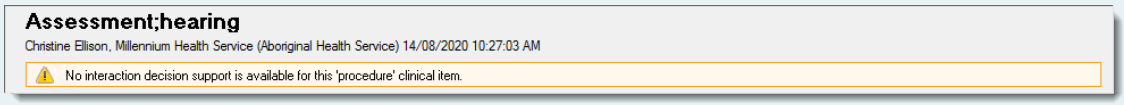
To check condition interactions later, after you have already prescribed medications:

1. On the **Detail** tab, set **View Clinical Items By** to **Class**.
2. On the **Condition** tab, right-click a condition clinical item, such as `asthma`, and select **Check Interactions**.

Pregnancy Interactions

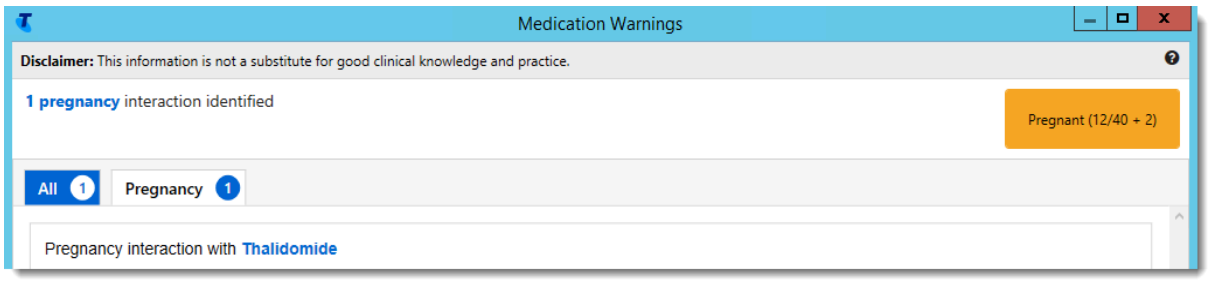
When you add a new pregnancy to a female patient's clinical record, the patient's active medications are checked for any interactions.

Note:
Interaction support is available only for clinical items with a valid ICPC-2 PLUS code. In the **Clinical Terms Browser**, clinical items with a valid ICPC-2 PLUS code are displayed in black text. If you select a different type of clinical item distributed by Communicare (displayed in blue text) or a local clinical item (displayed in purple text), a message similar to the following message is displayed in the clinical item when you add a condition, history or procedure item or complete a recall:




```
No interaction decision support is available for this condition clinical item.
```

A pregnancy banner is displayed in the **Medication Warnings** window and any active medications for which there are interactions identified in the MIMS database for pregnancy are listed in the **Pregnancy** interactions tab. For example:



Active medications are those that are not stopped, expired or deleted.

Tip:
You can customise the pregnancy interactions displayed. For more information, see System Parameters - Prescription Forms *(on page 832)*.

To proceed, read the interactions and click **Noted**.

Remember:
After you have added the clinical item, review the patient's current medications in light of the pregnancy interaction warnings. If you don't have the required viewing rights to review the medications, refer the review to a provider who does.

To check pregnancy interactions later, after you have already prescribed medications:

1. On the **Detail** tab, set **View Clinical Items By** to **Class**.
2. On the **Condition** tab, right-click a pregnancy clinical item, such as `confirmed pregnancy`, and select **Check Interactions**.

Stop a Medication

You can discontinue a regular or once-off medication because the patient no longer takes this medication for whatever reason.

Discontinuing a regular medication also stops the prescription. You can stop the prescription from either the **Medication Summary** or **Detail** tab.

Note:
You should only delete medications if the medication was prescribed in error, not as an alternative to stopping a medication.

To discontinue regular or once-off medication from the **Medication Summary**:

1. In the Clinical Record, go to the **Medication Summary** tab.
2. For the medication you want to discontinue, click **Stop**.
3. In the **Stop Medication** window, enter why the medication is being discontinued. Enter at least 5 characters for most medications except those added to the clinical record as medication history, for which a reason is not mandatory.
4. From the **Date** calendar, select the date at which the medication is to be stopped. The stop date cannot be before the date the medication was prescribed.
5. Click **OK**.

If the medication is once-off or short course, that medication is stopped. If the medication is regular, it is stopped and all previous prescriptions with an until date in the future are also stopped. On the **Medication Summary** tab, in the medication list the medication remains listed for the rest of the day, with the following updates:

- Stopped medications are labelled <Stopped> and displayed in grey text, then removed from the **Medication Summary** after 24 hours.
- Medication has been stopped is displayed
- Date displayed in the **Until** column is changed to the stopped date
- Prefix <Stopped> is added to the medication in the **Medication** column
- If you stop an expired, regular medication, it is removed from the **Medication Summary** immediately.
- If the stopped medication is included in the current medication request, the medication request is also stopped.

If the medication was prescribed using an ePrescription format, stopped medications are also stopped on the ETP service, such as eRx, as are any repeats.

Stopped medications are removed from the My Health Record.

Stopping a prescription

To stop the current prescription:

1. In the Clinical Record, go to the **Detail** tab.
2. For the current prescription that you want to stop, right-click the medication and select **Stop Medication**.
3. In the **Stop Medication** window, enter why the prescription is being stopped. Enter at least 5 characters for most medications except those added to the clinical record as medication history, for which a reason is not mandatory.
4. From the **Date** calendar, select the date at which the prescription is to be stopped. The stop date cannot be after the expiry date of the prescription, nor can it be before the date the medication was prescribed.
5. Click **OK**.

On the **Detail** tab, the medication remains listed, with the following updates:

- Prefix <Stopped date> is added to the medication in the **Item Description** column with the stopped date

On the **Medication Summary** tab,

- The entry is greyed out
- Medication has been stopped is displayed
- Date displayed in the **Until** column is changed to the stopped date
- Prefix <Stopped date> is added to the medication in the **Medication** column

Stop Multiple Medications

You can stop multiple current or expired regular and once-off medications simultaneously.

To stop medications, you must have full prescribing rights or once-off prescribing rights.

You cannot stop the following medications:

- Medications that have already been stopped
- Deleted medications
- Medications added to Communicare using Medication History

To stop multiple medications:

1. In a patient's Clinical Record, on the **Medication Summary**, click **Stop Medications**. All medications that can be stopped are listed with the oldest first.
   In the **Stop Medications** window, to view a subset of the current medications, set the required filter. For example, to view only regular medications, set **Regular**.
2. In the medications list, select all the medications you want to stop.
3. In the **Reason for stopping medications** pane, in the **Reason** field, enter why you want to stop these medications. Enter at least 5 characters.
4. In the **Date** field, today's date is included by default. You can select an alternative date which must be no earlier than the start date of the most recent selected prescription.
5. Click **Stop**.
6. In the **Stop Medications** window, click **Yes**.

The selected medications are stopped and shown as stopped on the **Medication Summary**.

Repeat medications

Create a repeat for medication orders or represcribe regular and once off prescriptions.

If you have a Prescriber number and belong to a user group with `Prescribing - Full` access rights, you can quickly create a repeat for medication orders or represcribe regular and once off prescriptions.

If you belong to a user group with `Prescribing - Once Off/Short Course` access rights or do not have a Prescriber number but have the required medication included in your Scope of Practice, you can create repeats only for once off medication orders.

You cannot repeat or represcribe the following medications:

- Stopped medications
- Deleted medications
- Regular medications that have been created, a medication request raised and the medication supplied in the current service
- Medications that have an unreviewed verbal order
- Prescriptions for deceased patients

Tip:
In the **Medication Summary**, medications nearing the end of their prescription duration are colour-coded:

- If the prescription is within 28 days of expiry, the **Until** date displays a gold background
- If the prescription has expired, the **Until** date of regular medications displays a red background

To represcribe a single medication:

1. In the patient's clinical record, on the **Medication Summary**, for the medication you want to represcribe, click **Repeat**, or right-click and select **Repeat Medication (represcribe)**.
2. In the **Medication Warnings** window, review the warnings and if you want to proceed, click **Noted**.
3. If required, edit the prescription or medication order.

- The default DAA type of the original medication is maintained, even if the patient has a different default DAA type set.

  Change the DAA Type if required.
- If the original prescription had a PBS Authority Number, **Previous Authority** is set and a new PBS Authority Number number is generated. In the **PBS Approval Number** field, enter a new approval number.
- For controlled substances, in the **Authority Number** *(on page 225)* field, enter the number provided by your state or territory that gives you authority to prescribe controlled substances again.
- If a custom route of administration was selected in the original prescription, the custom route is preserved, otherwise the default route from MIMS is used.

4. If you are a prescribing a schedule 8 medication, enter your password again to confirm the medication.
5. Click **Save**.

If your health service is set up for Real-Time Prescription Monitoring (RTPM), and the medication is a controlled medicine, Communicare sends information to the RTPM service for your state on the internet. RTPM results are then displayed for each drug prescribed. For more information, see RTPM *(on page 280)*.

If the medication falls outside your scope of practice, a verbal order is raised.

Finalise or print the medication from the **Medication Summary**, or finalise the prescription when you close the clinical record and print if required. For more information, see Finalise Prescriptions *(on page 240)*.

After it has been finalised, the repeated prescription is displayed on the **Medication Summary** and **Detail** tab with a prefix of `<Represcribed date>`.

Represcribe multiple medications

You can represcribe multiple current, regular and once off medications simultaneously and change the duration for all medications if required. You can also represcribe expired regular medications.

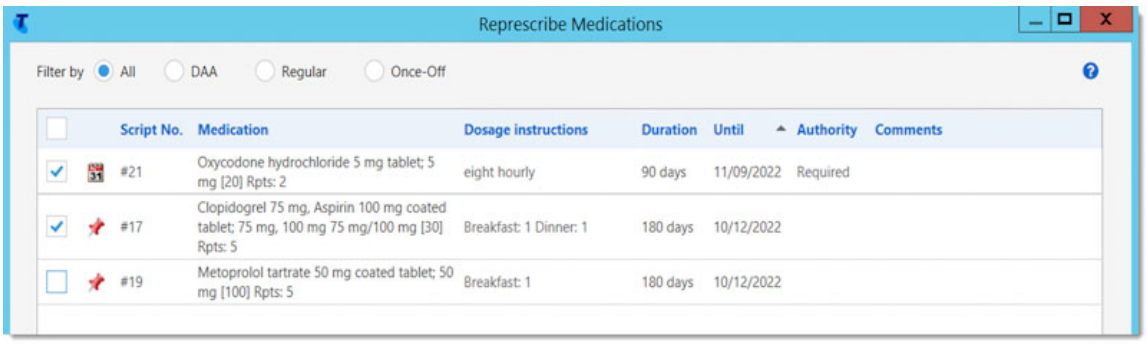
To represcribe medications, you must have a prescriber number.

You cannot represcribe the following medications:

- Stopped medications
- Deleted medications
- Regular medications that have been created, a medication request raised and the medication supplied in the current service
- Medications that have an unreviewed verbal order
- Medications added to Communicare using Medication History

To represcribe multiple medications:

1. In a patient's Clinical Record, on the **Medication Summary**, click **Represcribe Medications**. All medications that can be represcribed are listed with the prescriptions expiring soonest listed first.
2. In the **Represcribe Medications** window, to view a subset of the current medications, set the required filter. For example, to view only regular medications, set **Regular**.



3. In the medications list, select all the medications you want to represcribe.

> **Tip:**
> If you are required to provide a new Authority Number *(on page 225)*, `Required` is displayed in the **Authority** column.

4. To use the duration specified in the original prescription to calculate the until date from today's date, select **Use duration from original medication**.
5. Alternatively, to align all prescriptions for medication reviews to a new until date, calculated from today's date:

    a. Select **Update medication duration**.

    b. Enter the duration, either:
        - In the **Duration** field, enter the required duration in days, weeks, months or years.
        - In the **Until** calendar, select when you want the new prescriptions to be valid until in Communicare.

6. Click **Represcribe**.
7. In the **Repeat Medications** window, click **Yes** and confirm that you want to represcribe the selected medications.
8. If there are any warnings in the **Medication Warnings** window, either:
    - Click **Cancel**, and repeat steps 3-7, adjusting the medications that you are represcribing.
    - Review the medications, either:
        - Review a medication warning and click **Noted & Next** until you've reviewed all warnings.
        - Set **Noted** for each medication and click **Noted & Close**.
9. For any medication that requires a new Authority Number *(on page 225)*, the **Bulk Represcribe Medication** window is displayed. This is similar to the **Add Medication** window but allows limited editing, including providing a new number.
10. If required, edit the prescription or medication order.

    - The default DAA type of the original medication is maintained, even if the patient has a different default DAA type set.

      Change the DAA Type if required.

    - If the original prescription had a PBS Authority Number, **Previous Authority** is set and a new PBS Authority Number number is generated. In the **PBS Approval Number** field, enter a new approval number.
    - For controlled substances, in the **Authority Number** *(on page 225)* field, enter the number provided by your state or territory that gives you authority to prescribe controlled substances again.
    - If a custom route of administration was selected in the original prescription, the custom route is preserved, otherwise the default route from MIMS is used.

11. If you are a prescribing a schedule 8 medication, enter your password again to confirm the medication.
12. Click **Save**.

If your health service is set up for Real-Time Prescription Monitoring (RTPM), and the medication is a controlled medicine, Communicare sends information to the RTPM service for your state on the internet. RTPM results are then displayed for each drug prescribed. For more information, see RTPM *(on page 280)*.

The medications are listed on the **Medication Summary**.

If the represcribed medications are included in the current medication request, the medication request is also stopped.

The default DAA type of the original medication is maintained, even if the patient has a different default DAA type set.

Finalise or print the medications from the **Medication Summary**, or finalise the prescriptions when you close the clinical record and print if required. For more information, see Finalise Prescriptions *(on page 240)*.

After they have been finalised, the repeated prescriptions are displayed on the **Medication Summary** and **Detail** tab with a prefix of `<Represcribed date>`.

Make Medications Regular or Once-off

If you decide that a patient should continue taking a once-off medication that you have previously prescribed, you can change it to a regular medication. Similarly, if you want to stop a regular medication after the current prescription, you can change it to a once-off medication.

To make a once-off prescription regular:

1. Open the patient's clinical record.
2. On the **Medication Summary** tab, right-click the medication and select **Make Regular**. You can also make the medication regular from the **Detail** tab, details list.
3. In the **Confirm** window, click **Make Regular**.

In the **Medication Summary**, the medication is now listed as a regular medication. Any current regular medications for the same drug are stopped.

Making regular prescriptions once-off

To make a regular prescription once-off:

1. Open the patient's clinical record.
2. On the **Medication Summary** tab, right-click the medication and select **Make Once Off**. You can also make the medication once-off from the **Detail** tab, details list.
3. In the **Confirm** window, click **Make Once-Off**.

In the **Medication Summary**, the medication is now listed as a once-off medication.

Adjust Medications

In V20.2 and later, you can adjust the duration of a medication. Use this feature to change the expiry date of the medication shown in Communicare when you want a patient to take more or less of a medication that has already been prescribed.

To adjust a medication, you must meet the following requirements:

- Full prescribing rights
- Prescriber number

The medication must also be active and not be stopped, expired or deleted.

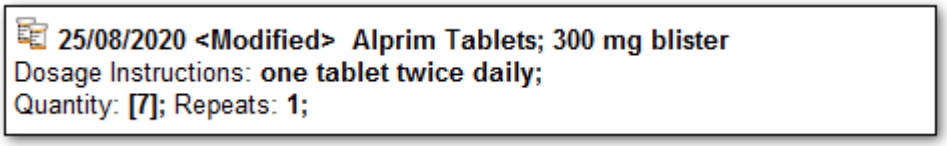
To adjust a medication:

1. Open the patient's clinical record.
2. On the **Medication Summary** tab, right-click the medication and select **Adjust Medication**. You can also adjust the medication from the **Detail** tab, details list.
3. In the **Adjust Medication** window, in the **Duration** or **Until** field, enter when you want the medication to expire in Communicare.
4. In the **Comment** field, provide information about why you have adjusted the expiry of the medication.
5. Click **Save**.

In the **Medication Summary**, the medication's new expiry date is listed in the **Until** column.

To view the comment, select the medication and click **View**.

The adjusted medication is also shown on the **Progress Notes** tab, with a prefix of *date* `<Modified>`. For example:



Delete Medications

Delete a medication only if it was prescribed in error. If you no longer want a patient to take a prescribed medication, stop *(on page 264)* that medication instead.

> **Tip:**
> You cannot delete a medication that is included in the current medication request.

To delete a medication:

1. On the **Medication Summary** or **Detail** tab of a patient's clinical record, right-click the medication you want to delete and select **Delete Medication (prescribed in error)**.
2. Record the reason the medication is being deleted, for example, `Prescribed in error`. Enter at least five characters. The delete reason is not required for medication history recorded in error.
3. Click **OK**.

If the medication was prescribed using a token-based ePrescription format, the deleted medications is cancelled on the ETP service, such as eRx.

The record for the deleted medication is not erased from the database, but is marked as being deleted together with the reason.

Tip:
To see deleted medications, on the **Detail** tab of a patient's clinical record, in the item list, right-click and select **Show Deleted Items**. Deleted medications are prefixed with <Deleted>.

Choose Streamlined Authority

When a PBS medication is listed under the streamlined authority rules, a streamlined authority approval number is automatically added to a prescription.

Alternatively:

- If there is no approval number for that medication, you will still need to phone the hotline to get a number
- If there are multiple approval numbers, choose the appropriate indication:
    1. In the **Add Medication > Write a Prescription** tab, click **Choose**.
    2. In the **Streamlined Authority** window, select the appropriate approved indication.
    3. Click **OK**.

Drug Browser

In the **Drug Browser**, you can browse product information from the MIMS Pharmaceutical database.

Note:
An annual licence fee applies for the use of the MIMS Australia Pharmaceutical Database. The MIMS database is updated monthly and can be downloaded from the Communicare website. For more information, see MIMS Database Import *(on page 860)*.

Drugs listed in the **Drug Browser** are colour-coded:

- User Defined - extemporaneous preparations (drug recipes). See Extemporaneous Preparations (Drug Recipes) *(on page 273)* for more details.
- Authority - a Pharmaceutical Benefits Scheme (PBS) prescription for these drugs requires prior approval from the Department of Human Services. A Repatriation Pharmaceutical Benefits Scheme prescription (RPBS) for these drugs requires prior approval from the Department of Veterans' Affairs (DVA). The approval number must be included in the prescription.
- Streamlined Authority - a PBS or RPBS prescription for these drugs requires the prescriber to select a streamlined authority code from the approved indications listed for the drug. This code must be included in the prescription.
- Section 100 - items available under special arrangement. See http://www.pbs.gov.au/browse/section100 for more details.
- PBS/RPBS - PBS or RPBS prescriptions can be made for these drugs: they are listed on both the PBS and RPBS schedules.
- RPBS Only - RPBS prescriptions can be made for these drugs as they are listed on the RPBS schedule.

    Tip:
    Any drug which is not included in the RPBS schedule can still be prescribed under RPBS, but requires prior approval from the DVA. The approval number must be included in the prescription and **Unlisted RPBS Authority** must be set.

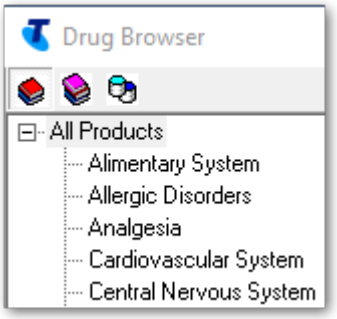
- Others - drugs that do not belong to any of the above categories. They can only be prescribed privately.

> **Tip:**
> Some drugs belong to more than one category. For example, a Section 100 drug may also be Streamlined Authority drug. The drug is assigned the colour of the highest ranking category, as dictated by the order above, that is, **User Defined** is the highest category and **Others** is the lowest.

Selecting a drug

To browse all product information from the MIMS database in the **Drug Browser**, in the main toolbar click  . Alternatively, the **Drug Browser** is displayed when you add medications to a patient's clinical record, allowing you to select a product to prescribe.

You can either search for a specific drug or select a grouping and browse the drug database by that grouping. Choose from:



- Product section
- Therapeutic class
- Manufacturer

> **Tip:**
> When you add a medication, the list of drugs displayed in the **Drug Browser** may be limited by your formulary rights.

To search for a specific drug:

1. If the drug is in your favourites, set **List favorites**.
2. To search for a drug based on brand name and generic name, in the **Product** field, enter at least three characters. For example, type `ASP` displays a list of all products with a brand name starting with *ASP* and all products with a generic name starting with *ASP*.
3. To see active ingredient, generic names instead of the brand names, set **Show generics not brands**.

   > **Note:**
   > If you show generics and view the product information, only one of the brands is displayed if there are multiple brands with the same generic components, strength and pack size.

4. Click the drug you are interested in. To display further information about the drug:

- To display the **Product Information** window with full MIMS details for the selected drug, click  .
- To display the **Consumer Medicines Information** window with full MIMS details for the selected drug, click  .

5. To select the required drug, double-click it.

If you are adding a medication, the selected drug is displayed in the **Add Medication** window.

If you are browsing drugs, the **Product Information** window is displayed.

Extemporaneous Preparations (User Defined Drug Recipes)

To display any previously defined extemporaneous preparations (drug recipes), either:

- In the section group, select **Extemporaneous Preparations**
- In the manufacturer group, select **Extemporaneous Preparations (User Defined)**

See Extemporaneous Preparations (Drug Recipes) *(on page 273)* for more details.

Extemporaneous Preparations (Drug Recipes)

Use **Extemporaneous Preparations** to define drug recipes for display in the drug browser and for use when prescribing medications.

To work with extemporaneous preparations, select **File > Reference Tables > Extemporaneous Preparations**.

> **Note:**
> Extemporaneous preparations must be used with care. They are not checked against adverse reactions, indications, or condition, pregnancy or drug interactions.

To add a new extemporaneous preparation, click Add.

To edit an extemporaneous preparation, select the required preparation and click Edit.

To delete an extemporaneous preparation, select the required preparation and click Delete.

Adding and Editing Extemporaneous Preparations

From the **Extemporaneous Preparations** window, you can add, edit or delete extemporaneous preparations.

To define an extemporaneous preparation, you must have privileges to prescribe and modify Reference Tables.

> **Note:**
> The name of the extemporaneous preparation combined with the form must be less than 100 characters long.

To create a new extemporaneous preparation:

1. Select **File > Reference Tables > Extemporaneous Preparations**.
2. In the **Extemporaneous Preparations** window, click Add.

3. In the **Extemporaneous Preparation** window, in the **Name** field, add a descriptive name for the preparation. For example, `Boric acid 1g`.
4. From the **Form** list, select the form of the drug. For example, `Solution`.
5. In the **Formulation** field, enter the drug recipe. For example, `Mix 20mL of 5% Boric Acid solution with 40mL of deionised or distilled water.`
6. If required, complete the other fields:
    - In the **Strength** field, enter the total volume of the preparation and the units. For example, `60mL`.
    - In the **Quantity** field, enter the number of items in the pack.
    - In the **Default Repeats** field, enter the default number of repeats displayed when prescribing the item.
    - From the **Type** options, set the availability of the item. For example, **Rx**.
    - If the formulation contains any Schedule 8 ingredients, set **Schedule 8**.
7. Click **Save**.

The new extemporaneous preparation is displayed in the drug browser and can be prescribed.

When a script using an extemporaneous preparation is printed, the formulation (or drug recipe) is printed on the script below the name of the item.

To edit an extemporaneous preparation:

1. In the **Extemporaneous Preparations** window, select the required preparation and click Edit.
2. Repeat steps 4-7 above, editing only the required fields.

Create an extemporaneous preparation for DVA DAA

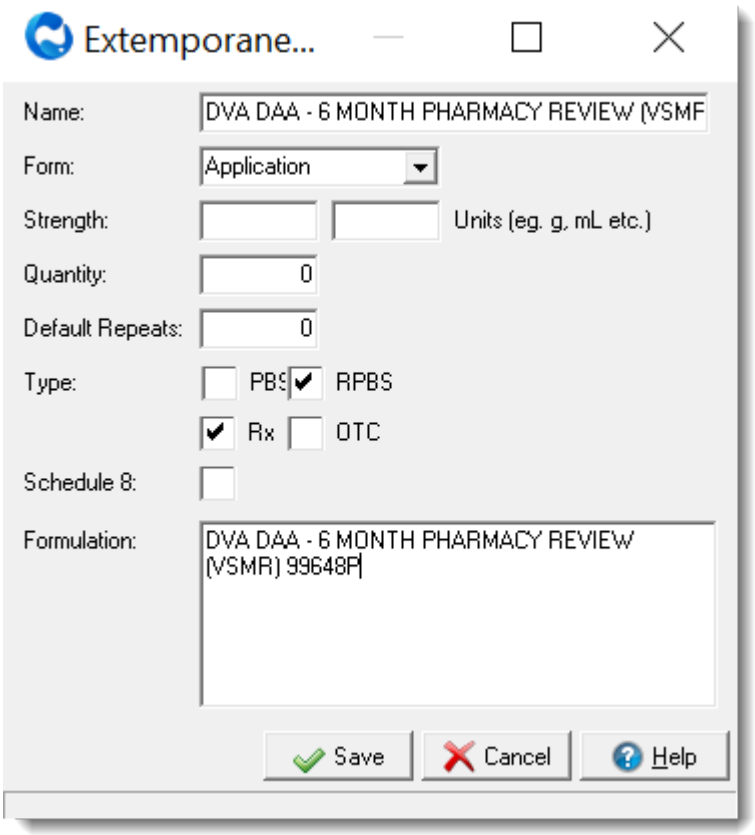
You can set up extemporaneous preparations so that clinicians can select a DVA prescription for a DAA review or DAA supply item in the Drug Browser.

To define an extemporaneous preparation, you must have privileges to prescribe and modify Reference Tables.

> **Note:**
> The name of the extemporaneous preparation combined with the form must be less than 100 characters long.

To create a new extemporaneous preparation:

1. Select **File > Reference Tables > Extemporaneous Preparations**.
2. In the **Extemporaneous Preparations** window, click Add.

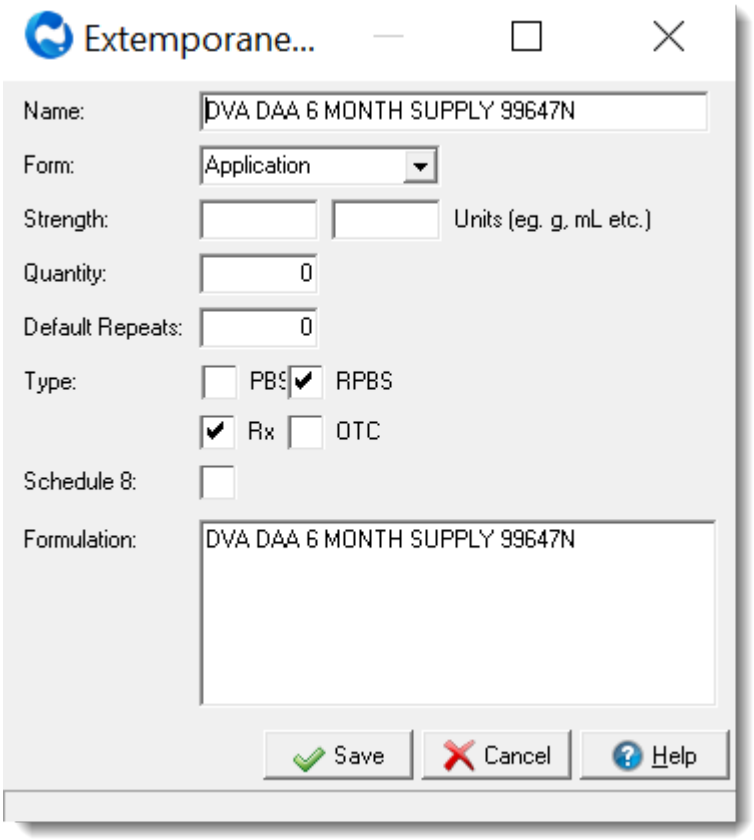


3. In the **Extemporaneous Preparations** window, in the **Name** field, add a descriptive name for the preparation. For example, `DVA DAA 6 MONTH PHARMACY REVIEW (VSMR) 99648P`.
4. From the **Form** list, select the form of the drug. For example `Application`.
5. In the **Formulation** field, enter the recipe. Repeat the description name. For example, `DVA DAA 6 MONTH PHARMACY REVIEW (VSMR) 99648P`.
6. Leave the **Strength** fields blank: strength is not required.
7. In the **Quantity** and **Default Repeats** fields, enter the number `0` for the number of items in the pack and repeats displayed when prescribing the item.

> **Note:**
> `0` in the **Quantity** and **Default Repeats** fields triggers a request for an authority number when prescribing.

8. In the **Type** options, set the availability of `RPBS` and `Rx`.
9. Click **Save**.
10. Repeat steps 2-9 for `DVA DAA 6 MONTH SUPPLY 99647N`.

Example of completed **Extemporaneous Preparations** non-drug medication:



The new extemporaneous preparation is displayed in the drug browser and clinicians can now write a DVA DAA prescription review or supply item.

To edit an extemporaneous preparation:

1. In the **Extemporaneous Preparations** window, select the required preparation and click Edit.
2. Repeat steps 4-9 above, editing only the required fields.

Write a DVA DAA Prescription or Review

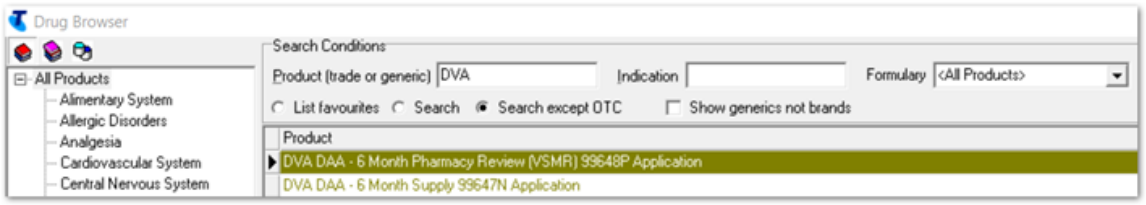
If you are a clinician, you can create a DVA prescription with an authority number for a DAA review or DAA supply.

To write a DVA DAA review or supply, an extemporaneous preparation of a non-drug prescription has to have already been created. If there are no details in the **Drug Browser**, ask your Communicare Administrator to create an Extemporaneous Preparation *(on page 274)*.

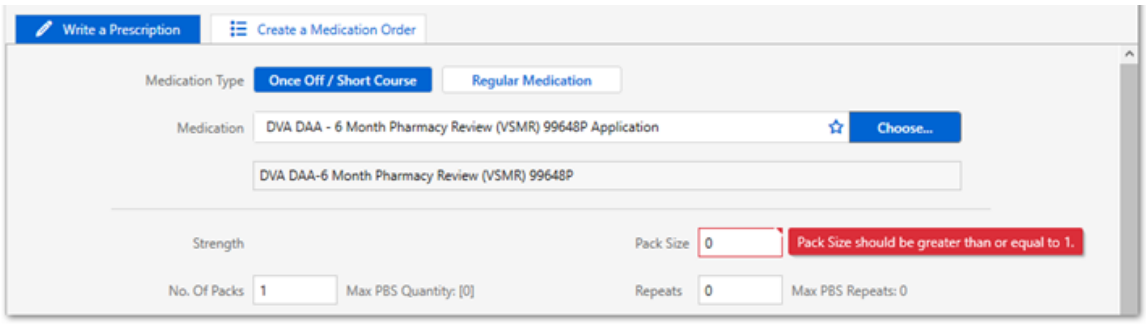
Follow the prescribing procedure in Write Prescriptions *(on page 224)* with the following changes.

To add an extemporaneous preparation non-drug prescription for a patient:

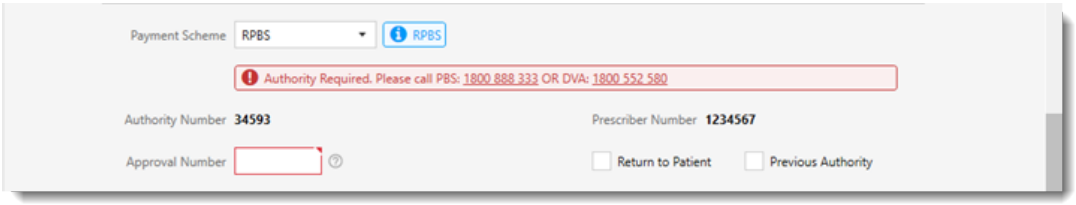
1. In a patient's Clinical Record, click **Medication** or press F9.
2. In the **Drug Browser**window, select the **Search except OTC** field.
3. In the **Product** field, type in **DVA**.
4. Select the **Extemporaneous Preparation** non-drug script.



5. In the **Pack Size** field, enter `1`.



6. If the medication requires authority:
    a. For Streamlined Authority, in the **Approved Number** field, click **Choose** and select the appropriate approval number.
    b. From the **Approved Indication** list, select the indication text.
    c. For Authority medication, if you have a previous authority number for this medication, set **Previous Authority**.
    d. Otherwise, ring the DVA number provided and provide the patient's details, the Authority Number and the clinical indication.
    e. In the **Approval Number** field, enter the number provided to you.



7. Click **Save**.

Verbal Orders

Verbal Orders are available when the Medication Management module is enabled.

Communicare Administrators configure individual providers to require verbal orders when creating medication orders for particular medications according to whether the medication is outside an individual's scope of practice, or for particular Schedule classifications and encounter places. A Verbal Order is required if:

- A provider attempts to create a medication order for a medication that is not included in their Scope of Practice. For more information, see Scope of Practice *(on page 278)*.
- A provider attempts to create a medication order for a medication that is part of a restricted Schedule classification (S1, S2, S3, S4, S5, S6, S7, S8, S9, Unscheduled) and encounter place. For more information, see Providers *(on page 917)*.
- A provider attempts to create a medication order at a selected encounter place. For more information, see Providers *(on page 917)*.

You can use either Scope of Practice, Schedules or both. For example, configure a Registered Nurse to be able to order the following medications without requiring a verbal order:

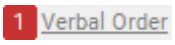
- S2 and S3 medications using Schedules, for example, paracetamol.
- Extra medications within their clinical pathway using the Scope of Practice, for example, antibiotics.

Communicare checks configured schedules first, then the Scope of Practice list if the medication isn't included in the allowed schedule.

Doctors

Doctors provide the authority for verbal orders and review verbal orders when a medication order is created. See Medication Summary *(on page 127)* and Create a Medication Order *(on page 235)* for more information.

Unreviewed verbal orders are displayed:

- In the Clinical Record:
  - In the Action Required Banner *(on page 120)*, for example, 
  - In the Medication Summary *(on page 127)*, for example, 
- In the main toolbar, for example, 

Scope of Practice

Use Scope of Practice to allow a provider to create a medication order for a defined list of medications.

If a medication is not included in a provider's scope of practice, a verbal order is required when creating a medication order.

If non-prescribing providers want to represcribe a medication prescribed by a provider, the medication must be included in their scope of practice.

To configure a provider's scope of practice:

1. Configure one or more formularies as a scope of practice:
   a. Select **File > Reference Tables > Formularies**.
   b. For the required formulary, set **Use as Scope Of Practice**. See Formularies *(on page 861)* for more information.
2. Set individual providers to use scope of practice:
   a. Select **File > Providers**.
   b. For the selected provider, in the **Verbal Order** section, set **Use Scope of Practice**. See Provider *(on page 917)* for more information.
3. Set one or more scopes of practice for each user group:
   a. Select **File > User Groups**.
   b. In the **User Group Maintenance** window, select a user group.
   c. On the **Scope of Practice** tab, select one or more scopes of practice.
   d. On the **Formulary Rights** tab, at a minimum, set the formularies included in the user group's scope of practice. Include any other formularies that you want the user group to be able to see in the drug browser in order to create a medication order. Medications outside of the scope of practice would require a Verbal Order.
   e. Click **Save**.

When a provider creates a medication order for a medication within their scope of practice, no verbal order is required.

When a provider creates a medication order for a medication outside their scope of practice, a verbal order is required and the authorising clinician must be selected.

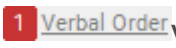
Reviewing verbal orders

An unreviewed verbal order is a verbal order for a medication order that is awaiting approval from the authorising doctor.

To view unreviewed verbal orders, the `Medications Management` module must be enabled.

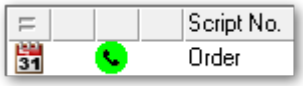
When you log in, a count of the unreviewed verbal orders, where you are the nominated provider, is displayed in the footer of the main toolbar.

As the authorising doctor, to review verbal orders:

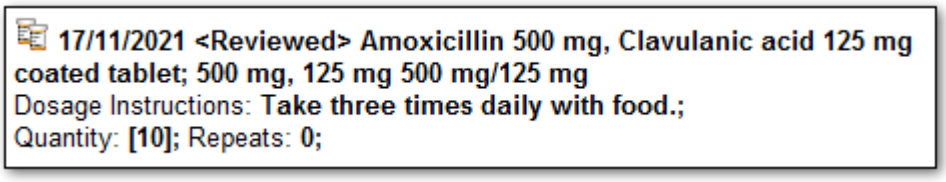
1. To display a list of unreviewed verbal orders, in the footer of the main toolbar, click  Unreviewed Verbal Orders.
2. To open a patient's clinical record, in the **Unreviewed Verbal Orders** list, for a particular patient, click **Open clinical record**.
3. An unreviewed verbal order count is displayed in the Action Required banner at the top of the clinical record. Either:
    - To open the **Detail > Rx - Prescription** tab, click  **Verbal Order** in the banner. The medication is listed with the prefix `<Unreviewed Verbal Order>`.
    - Go to the **Summary > Medication Summary**, where the medication is flagged as needing review.

4. Right-click the medication and select **Review Verbal Order**.
5. In the **Verbal Order** window, the verbal order details are summarised in the top pane. Verbal order details cannot be edited.
6. If the verbal order has been incorrectly assigned to you:
    a. Click **Reassign Order**.
    b. In the **Reassign verbal order** window, from the **Authorising Clinician** list, select an alternative clinician from the list of providers at this encounter place.
    c. If required, in the **Comments** field, add any supporting information.
    d. Click **Save**.
7. In the **Verbal Order** window, in the **Review** confirmation pane, set **I have read and reviewed the patient's order**.
8. Today's date is selected by default. If the review needs to be back-dated, from the **Reviewed On** calendar, select the review date.
9. If required, in the **Reviewer Comments** field, enter any comments.
10. Click **Save**.

On the **Medication Summary**, the verbal order is displayed as reviewed.

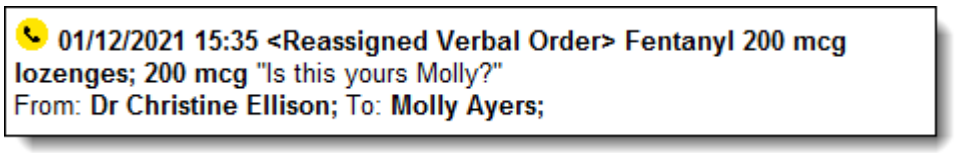


In the clinical record, the prefix <Unreviewed Verbal Order> is removed from the medication entry on the **Detail** tab and the **Progress Notes** show <Reviewed>.



If the verbal order has been reassigned to an alternative clinician:

- A progress note is added to the clinical record prefixed with <Reassigned verbal order>. Both the clinician from whom it was reassigned and the new clinician to whom it is assigned are listed.



- The verbal order is displayed in the selected clinician's list of verbal orders to authorise. The new clinician can review and authorise the verbal order following the steps above.

If there are no further verbal orders to review, the Verbal Order icon shows 0, for example  .

Deleted medication won't appear in the unreviewed verbal order list and you cannot edit or review a verbal order for deleted medication.

If you want to edit the comments you added to a verbal order, right-click the medication on the **Medication Summary** or **Detail** tab and select **Edit Verbal Order**. Any updates to verbal orders are logged.

Real time prescription monitoring

If your site is integrated with eRx, Communicare can be configured so that whenever a monitored medicine is prescribed and the prescription is about to be saved, the information is validated by the state's real time prescription monitoring service against the National Data Exchange (NDE) using eRx.

For health services in all states and territories, Communicare supports the NDE and real time prescription monitoring. The NDE monitors all Schedule 8 (S8) controlled medications and jurisdiction-specific Schedule 4 (S4) medications. Each state has its own real time prescription monitoring service:

- ACT - Canberra Script
- NSW - SafeScript NSW
- NT - NTScript
- QLD - QScript
- SA - ScriptCheckSA
- TAS - TasScript
- VIC - SafeScript, health.vic website
- WA - ScriptCheck WA (SCWA)

To use real-time prescription monitoring, ensure that the following criteria are met:

- An HPI-O is selected for each Encounter Place where prescribing occurs.
- All prescribing providers have a Provider Number entered for each Encounter Place at which they prescribe.

Note:
Real time prescription monitoring functionality is not available in the Offline Client.

Real time prescription monitoring in NSW

SafeScript NSW is available for prescribers and pharmacists statewide.

To get started, prescribers and pharmacists will need to:

1. Register for SafeScript NSW.
2. Request Communicare Support to enable SafeScript NSW in Communicare.
3. Install the SafeScript NSW/RTPM Notification Client app.
4. Complete the accredited eLearning modules.
5. Learn about the support available from SafeScript NSW, including a dedicated 24/7 clinical advice line, technical support, and enhancements to local HealthPathways

If you're already registered, log in and start using SafeScript NSW. To learn more, visit the SafeScript NSW website.

Enable and use RTPM

After you have enabled RTPM, when you prescribe a medication, the RTPM service is contacted when you attempt to save the prescription.

To enable RTPM integration in Communicare:

1. Select **File > System Parameters** tab.
2. On the **Clinical** tab, set **Use RTPM Service**.
3. On the **Web Services** tab, **in the Real-Time Prescription Monitoring (RTPM) Service** pane:
    - In the **URL** field, enter the URL of the RTPM API.
    - In the **API Key** field, enter the RTPM key.
4. Click **Save** and enter the authority code provided by Communicare Support *(on page)*.

After the RTPM service has been enabled, when you prescribe a medication and save it, Communicare contacts the RTPM service via eRx and sends the following information:

- The patient's Medicare number and individual reference number, if one is recorded, so that the patient can be identified.
- AMT codes, to identify the medication being prescribed.

The RTPM service performs real-time prescription monitoring and returns a response.

Depending on the results, one of the following alerts is displayed in Communicare.

Table 98. RTPM alerts

RTPM alert icon	Description
	There is no cause for concern in the information on the patient's RTPM profile.
	There is information on the patient's RTPM profile you should evaluate before continuing with this script.
	The patient has recent alerts.
	There is a problem communicating with the RTPM service. To continue prescribing the current medication, the prescriber must include the method used for checking this prescription and click **I have checked by another method**. Include any additional details concerning the verification process.

Review the alerts:

- To view extra information from the Health Professional Portal and the patient's profile, click **Extra Details**.

> **Note:**
> ScriptCheck is no longer supported in Internet Explorer. To display extra details, change your default browser to Microsoft Edge.

- If you want to prescribe the monitored drug, click **OK - Proceed**.
- If you no longer want to prescribe the monitored drug, click **Go Back** to return to the Add **Medications** window.

RTPM errors

If system is not correctly configured, you may see one of the following RTPM error messages.

Table 99. RTPM error messages

Error	Description
`Real-time prescription monitoring is not currently required in this state or territory`	RTPM has been enabled and the Encounter Place locality is not within a state where RTPM is mandated. If the organisation spans more than one state, where at least one state requires RTPM, users in the non-RTPM locations will still see this message when prescribing monitored drugs.
`No valid HPI-O has been configured for the Encounter Place. Please contact your Administrator.`	An Encounter Place does not have an HPI-O selected.

Table 99. RTPM error messages (continued)

Error	Description
`No valid Provider Number has been configured for the Encounter Place. Please contact your Administrator.`	The current user does not have a provider number entered against the current encounter place.

Medication History

Use Medication History to record current medications for a patient of your health service that your patient is taking but which may have been prescribed in hospital or at another service.

> **Tip:**
> If your health service would prefer to use another term for *Medication History*, contact Communicare Support. The term you select will be used throughout the clinical record.

Any user who belongs to a user group with `Medication History` system rights can add a medication to a patient's Medication History, regardless of formulary or prescribing rights. If `Medication History` is not enabled for your group, ask your administrator to it. For more information, see User Groups *(on page 842)*.

If there are no details in the **Drug Browser**, ask your administrator to arrange the import of MIMS Pharmaceutical Database *(on page 271)*.

The medication history of a patient is not shared with My Health Record or MeHR.

> **Note:**
> You cannot prescribe, print or issue repeats for medications recorded in the Medication History window.

You cannot record a medication with a date before a patient's birth or after a patient's date of death.

Complete as much information in the record as possible.

To add medication history for a patient:

1. In a patient's Clinical Record, select  **Medication >**  **Add Medication History** or press Shift+F9.
2. In the **Drug Browser** window, select the appropriate medication and read and acknowledge any interactions or other prescriptions.
3. In the **Add Medication History** window, check that the patient's biographics, your provider details and the service details displayed in the banner are all correct.
4. In the **Medication frequency** field, select either **Once Off/Short Course** or **Regular Medication**.
5. From the **Start Date** calendar, select when the medication was first administered or type the date in the format `dd/mm/yyyy`.
6. From the **End Date** calendar, select when the medication was last administered if applicable.
7. In the **Dosage Instructions** field, enter dosage information using short codes or full text.
8. From the **Source** list, select where information about the medication came from: **Advised by Patient**, **Advised by Care Giver**, **Discharge Summary** or **Other**.
9. In the **Additional Comments** field, add any further relevant information.

10. If you want to add another medication for the patient, click Add another item to save the first medication and clear all fields. Repeat steps 2 *(on page 283)*-9 *(on page 283)* to add another medication.
11. Click **Save**.

An entry is added to the patient's historical clinical record. The entry is dated with the start date selected in the record and added to the medication window, including:

- **Detail > Rx - Prescription** tab, prefixed with`<History>`
- Medication Summary *(on page 127)*, prefixed with `<History>` and with a script number of `History`. For example:

- Progress Notes, prefixed with `<Medication History>`

In the **Medication Summary** or **Medication Detail** window, you can edit, stop and delete any medication added to a patient's record in the **Add Medication History** window. However, you can't prescribe, complete verbal orders, issue a repeat, print a prescription or supply and administer medication for any medication added to a patient's record in the **Add Medication History** window.

If you add medications to a letter using **Clinical Record > Current/Regular Medication**, medication history items are also included if they are still current. For these items, a prefix of `Source: source selected in step`8 *(on page 283)*`;` is added to any comments that may have been included when the medication was added to the patient's record. For example, `Source: Advised by Patient; tonsillitis`.

Administer and Supply Medication

In Communicare V20.1 and later, the separate Supply and Administer functions are merged into a single Administer and Supply function. Use **Administer and Supply** to record the administration or supply of a medication, or both administration and supply of a medication during the current service.

You can also use **Administer and Supply** to record the supply of patient-specific inventory. For more information, see Supply Medication Requests *(on page 247)*.

To access this functionality, the `Medications Management` module must be enabled for your organisation in the System Parameters *(on page 810)* window.

To administer and supply medication, you must belong to a user group with the following system rights:

- `Medications Administer`
- `Medications Supply`
- `Medication View`

You can administer and supply regular and once-off medications for which a Medication Order has been charted, either by you or by other service providers. You can then edit any administer record that you have created within the last 24 hours.

> **Tip:**
> If your health service uses medication requests, you can also supply patient-specific inventory supplied by an external pharmacy to a patient. For more information, see Supply Medication Requests *(on page 247)*.

Note:
You cannot administer or supply medication added to a patient's clinical record using Medication History *(on page 283)*. Instead, chart new Medication Orders for these medications. Administer and Supply also cannot be used from the Communicare Offline Client, or if the patient is deceased.

Recording medication administration

Create an administration entry each time you administer medication directly to a patient. You can record multiple administration entries during an extended service.

To record the administration of a medication:

1. In the Clinical Record, select  **Medication >**  **Administer & Supply**. The **Administer and Supply Medication** window lists all active medications associated with the current patient, with the medication administered most recently listed first.
2. In either the **Regular Medications** or **Once off/Short Course** medications pane, click **>** to expand the required medication.
   Details of the medication including formulation, dosage instructions and order instructions are displayed. If the medication has been administered in the current encounter or the last 24 hours, administration details are listed.

   Tip:
   To display the history for medication administered to the patient more than 24 hours ago, click **Medication Overview**.

3. If there is an allergy, drug interaction or warning associated with this medication, **Medication Interaction** is displayed. Click **Medication Interaction** to display the medication warnings.
4. From the **Brand Name** list, select the medication available in Imprest at your organisation, either a brand name or any generic of the same formulation. If the medication brand isn't available in Imprest for your encounter place and a generic alternative is in stock, it is displayed. If neither a brand nor generic are available in Imprest, the **Imprest Level** displays `Stock level not found in imprest`.

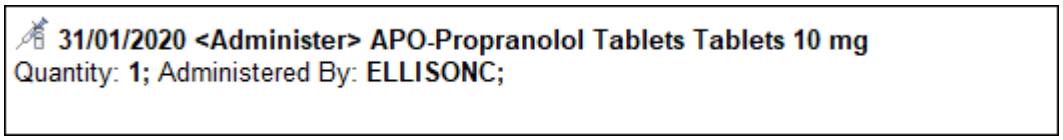
   Tip:
   If you select an alternative brand or generic medication in Imprest, that medication is updated for all administer and supply records for the service.

5. Record the stock details of the medication to update your Imprest system:
   - If the administration uses a whole bottle or pack of medication, for the **Whole Stock Used** field, click  Increment to add the amount of stock used.
   - If the administration completes a bottle or pack of medication, for the **Open Stock Finished** field, click  Increment to add the amount of stock completed.
   - If the administration is from a new bottle or pack of medication, for the **New Open Stock** field, click  Increment to add the amount of stock opened.
6. Click **Add administration**.
7. In the **Administration Details** fields, record each administration attempt:

- In the **Quantity** field, use the arrows to select the amount of medication administered, or enter a fractional amount.
- From the **Unit** list, select the measure used for the medication.
- From the **Route** list, select the manner in which the medication was administered.
- From the **Site** list, select where the medication was administered.
- From the **Status** list:
  - If you successfully administered the medication, select `Success`.
  - If you failed to administer the medication, select `Failure`.
  - If the status changes in the 24 hours after administration, change the status. For example from `Success` to `Failure`.
- If you failed to administer the medication, from the **Failure Reason** list, select why the administration failed. For example, `Vomited`.
- If required, in the **Comments** field, add any pertinent information about the event.

8. Click **Save**.

An administer record is added to the **Progress Notes**. The record shows the Administer Medication icon, the date, and is prefixed with the word <Administer>. For example:



An entry is also added to the **Detail** tab, the **Rx - Supply** class tab and the **Medication** topic tab.

Editing administration records

You can edit the status, failure reason and any comments for any medication administration entries that were recorded by you over the last 24 hours.

For example, you can edit a medication administration to record that the administration failed because the patient vomited.

To edit the administration details of a medication from the last 24 hours:

1. If the record is already open, go to step 4.
2. In the Clinical Record, select **Medication >** **Administer & Supply**.
3. Expand the medication whose details you want to edit.
4. In the **Administration details** section, edit the administration details:
   - From the **Status** list, select whether the medication was successfully administered.
   - If the medication could not be administered, in the **Failure Reason** field, enter why administration failed.
   - If required, in the **Comments** field, add any pertinent information about the event.
   - If required, delete a record entered by mistake, click Bin.
5. Click **Save**.

Deleting administration records

If it was recorded in error, you can delete any medication recorded and saved by you in the current service.

To delete administration of a medication recorded in the current service:

1. If the record is already open, go to step 4.
2. In the Clinical Record, select **Medication** > **Administer & Supply**.
3. Expand the medication whose administration you want to delete.
4. In the **Administration details** section, for the administration you want to delete, click Bin.
5. In the **Delete Administration** window, in the **Reason** field, enter information about why you're deleting the administration. Enter at least 5 characters.
6. Click **OK**.
7. Click **Save**.

Recording medication supply

If you provide medication to a patient or their carer from your stock, record a supply record for the medication.

> **Tip:**
> If your health service uses medication requests, you can also supply patient-specific inventory supplied by an external pharmacy to a patient. For more information, see Supply Medication Requests *(on page 247)*.

If you want to print labels for the supplied medication, you must first configure the system and the provider profile:

- Select **File > System Parameters > Clinical** tab, and in **Medication Labels**:
  - Set **Enable label printing**
  - Set **Print labels by default**
  - Add a value to the **Default label count** field
- Select **File > Printer Assignments**, select **Medication Labels** and from the **Medication Label Template** list, select a template.

> **Tip:**
> Medication labels can only be printed for medication orders *(on page 235)*. They cannot be printed for prescriptions or medication requests.

Supply does not affect the Imprest.

To record the supply of a medication:

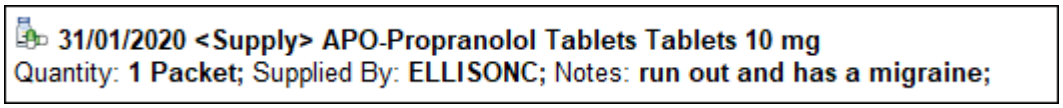
1. In the Clinical Record, select **Medication** > **Administer & Supply**.

   > **Tip:**
   > To review the history of medication supplied to the patient, click **Medication Overview**.

2. Expand the medication that you want to add a supply record to.
3. In the **Supply Quantity and Units** fields:
   - Enter the amount of medication supplied, including fractional amounts where required
   - Select the medication units
4. From the **Supply Mode** list, select how the medication was supplied.
5. In the **Supply Notes** field, enter any pertinent notes.

6. If you want to print labels to attach to the medication, in the **Print Labels** field, enter the number of labels required and click **Print Labels**.
7. Click **Save**.

A supply record is added to the Progress Notes. The record shows the Supply Medication icon, the date, and the word <Supply>. For example:



An entry is also added to the **Detail** tab, the **Rx - Supply** class tab and the **Medication** topic tab.

Editing supply of a medication

If required, you can edit supply details for a medication recorded by you in the same service.

Changes to supply do not affect the Imprest.

To edit the supply details of a medication in the current service:

1. If the record is already open, go to step 4.
2. In the Clinical Record, select **Medication** > **Administer & Supply**.
3. Expand the medication whose details you want to edit.
4. In the **Supply details** section, edit the supply details where required:
    a. In the **Supply Quantity and Units** fields:
        - Edit the amount of medication supplied, including fractional amounts where required
        - Edit the medication units
    b. From the **Supply Mode** list, select an alternative method for how the medication was supplied.
    c. In the **Supply Notes** field, edit the pertinent notes.
    d. If you want to reprint labels to attach to the medication, in the **Print Labels** field, enter the number of labels required and click **Print Labels**.
5. Click **Save**.

Deleting supply of a medication

If you recorded and saved the supply of a medication in error, during the same service you can delete the supply record.

Changes to supply do not affect the Imprest.

To delete the supply of a medication in the current service:

1. If the record is already open, go to step 4.
2. In the Clinical Record, select **Medication** > **Administer & Supply**.
3. Expand the medication whose supply you want to delete.
4. In the **Supply details** section, for the supply you want to delete, click Bin.
5. In the **Delete Supply** window, in the **Reason** field enter information about why you're deleting the supply record. Enter at least 5 characters.
6. Click **OK**.
7. Click **Save**.

Reprinting medication labels

If a label fails to print because of printer problems, you didn't print labels during the initial supply, or you don't use the  **Administer & Supply** option in Communicare, you can print or reprint a medication label for a medication order from the patient's clinical record.

To access this functionality, the `Medications Management` module must be enabled and you must belong to a user group with the `Medication View` system right.

The prerequisites for printing a label *(on page 237)* during supply apply.

To reprint a medication label:

1. In the Clinical Record, go to **Summary > Medication Summary** or the **Detail** tab.
2. Right-click the medication order and select **Print Label**.

Imprest Management

Imprest Management allows management of the Imprest drug list and the Imprest orders.

To enable the Imprest Management functionality, in **File > System Parameters > System** tab, enable the **Medications Management** module.

To access the Imprest system, users must belong to a user group that includes the `Imprest Management` system right.

To manage imprest:

- To manage the list of all the Imprest available, including search, add, edit, delete, print and clone the imprest, select **File > Imprest Management > Manage Imprest**.
- To manage the Imprest orders, including search, add, finalise, print, receive or cancel existing orders, select **File > Imprest Management > Manage Imprest Orders**

Managing Imprest

Use the **Imprest Management** window to manage the medications available in Imprest at your encounter place.

To manage Imprest, you must belong to a user group that includes the `Imprest Management` system right.

> **Note:**
> Each encounter place can have only one Imprest.

The Imprest record for a medication is automatically updated when you add Imprest details to an Administer record, or add or remove a Supply record in the **Administer & Supply** window, or a medication order is filled and completed.

To create an Imprest:

1. Select **File > Imprest Management > Manage Imprest**.
2. In the **Imprest Management** window, click ✚Add.
3. In the **Imprest Details** window, in the **Imprest Name** field, enter a name for the Imprest for reference.
4. To start using the Imprest immediately, set **Enabled**.
5. In the **Contact Person** field, enter the name of the person who manages the Imprest.
6. In the **Email** and **Phone** fields, enter an email address and phone number for the Imprest contact.

7. In the **Default Supplier** field, click Ellipsis and select the main supplier from the address book.
8. From the **Encounter Place** list, select the encounter place with which to associate this Imprest. Only those encounter places which do not yet have an associated Imprest are listed.
9. In the **Notes** field add any further information for this Imprest.
10. Click Save.

The Imprest is created and the **Updated By** and **Updated Date** fields are automatically populated:

- **Updated By** - shows the username of the person logged in, or if the username is associated with a provider, their provider name.
- **Updated Date** - shows the date when the Imprest was last saved.

You can now add medications in stock to the Imprest and use Imprest management.

Adding medications to an Imprest

To add medications to an Imprest:

1. Select **File > Imprest Management > Manage Imprest**.
2. In the **Imprest Management** window, double-click the required imprest at your encounter place.
3. In the **Imprest Details** window, click Add.
4. In the **Drug Browser**, select the medication that you want to add and click **Select**. Both the generic and brand name for the selected medication are added to the imprest list. The Pack size and PBS Quantity from MIMS are added to that entry.
5. For the medication that you just added, click in the **Min Quantity** column and add a minimum quantity of the medication that you want to maintain in your Imprest. This value is used to calculate order quantities automatically if required when you are doing an Imprest order.
6. Click in the **Usual Quantity** column and add the usual quantity of the medication that you want to maintain in your Imprest. Together with the Minimum Quantity this value is used to calculate order quantities automatically if required when you are doing an Imprest order.
7. In the **Whole Stock Level** column, enter the whole, unbroken stock quantity.
8. In the **Open Stock Level** column, enter the open, broken stock quantity.
9. Click Save.

The medication is now available for Administer and Supply *(on page 284)*. Imprest stock levels are adjusted when Administer Imprest quantities are adjusted or Supply records are created.

If an administer or supply record is deleted, the deleted quantity is automatically added back to the Imprest stock.

Imprest Orders

Use the Imprest Orders window to create and manage an order for your supplier.

To create and manage orders, you must belong to a user group that includes the `Imprest Management` system right.

Imprest orders go through the following stages:

- Draft
- Finalised
- Filled & Complete

To create an Imprest order:

1. Select **File > Imprest Management > Manage Imprest Orders**
2. In the **Imprest Orders** window, click Add.
3. In the **Imprest Order Details** window, from the **Imprest Name** field, select your Imprest. All items included in your imprest are listed in the table. A status is displayed for medication with low or no stock:
    - Medications for which the whole stock + open stock level is less than or equal to the minimum quantity are displayed with a status of Low.
    - Medications for which the whole stock + open stock level is zero are displayed with a status of No Stock.
4. In the **Order Title** field, enter a name for the order for tracking purposes.
5. If required, in the **Supplier** field, click Ellipsis and from the **Address Book**, select your supplier.
6. In the **Notes** field, enter any notes about this order.
7. If you want to calculate quantities for the order automatically based on the minimum and usual quantities:
    a. Click **Insert Suggested Order Quantity**. Values are calculated only for medications with less stock than that specified as the usual quantity.
    b. In the confirmation window, if you want to calculate order quantities only for medications with low or no stock, set **Insert quantity only for low or no stock**.
    c. Click **Yes**. Order quantities to bring the Imprest level back to the usual quantity excluding any open stock are added to the **Order Quantity** column.
8. Review the order quantities.
9. Click **Save and Close**.

A draft of the Imprest order is saved and listed in the Imprest Orders window.

Draft orders are new orders that are under review and not yet finalised. Draft orders can be:

- Saved and edited later
- Cancelled if previously saved
- Printed if previously save

Next, finalise the order.

Finalising Imprest orders

When your Imprest order has been reviewed and you are ready to send it to the supplier, finalise the order.

To finalise the order:

1. In the Imprest Order Details window, click **Finalise & Print**.
2. In the **Finalise Order** confirmation window, click **Yes**.
3. In the **Print Preview** window, review the order and either:

    - To print a PDF or a hard copy of the order, click **Print**.
    - To send the order securely, select a recipient who is linked to an SMD vendor and enabled for secure messaging, click **Send Secure**. See Secure Messaging *(on page 341)* for more information.
4. Send the order to your supplier.

Communicare generates an Order ID and adds it to the order.

The date when the status is changed to `Finalised & Sent` is added to the **Sent On** field.

The status of the Imprest order is updated to `Finalised` in the **Imprest Orders** window. For Finalised orders:

- Order details cannot be changed
- The order can be cancelled if required

Next, fill and complete the order.

Filling and completing Imprest orders

When you receive the order from your supplier, fill and complete the Imprest order so that your stock levels are accurate.

To fill and complete the Imprest order:

1. In the **Imprest Order Details** window, if you received what you ordered, to automatically fill the **Received Quantity** column for all medications in the Imprest with the Order Quantity for each medication, click **Insert Suggested Received Quantity**.
2. In the confirmation window, click **Yes**.
3. Click **Fill & Complete**.
4. In the **Complete Order** window, click **Yes**.

The value in the **Received Quantity** field is added to the existing stock levels and the **Whole Stock Level** quantity for each medication is updated.

The status of the Imprest Order is updated to `Filled & Complete`. Filled and completed orders:

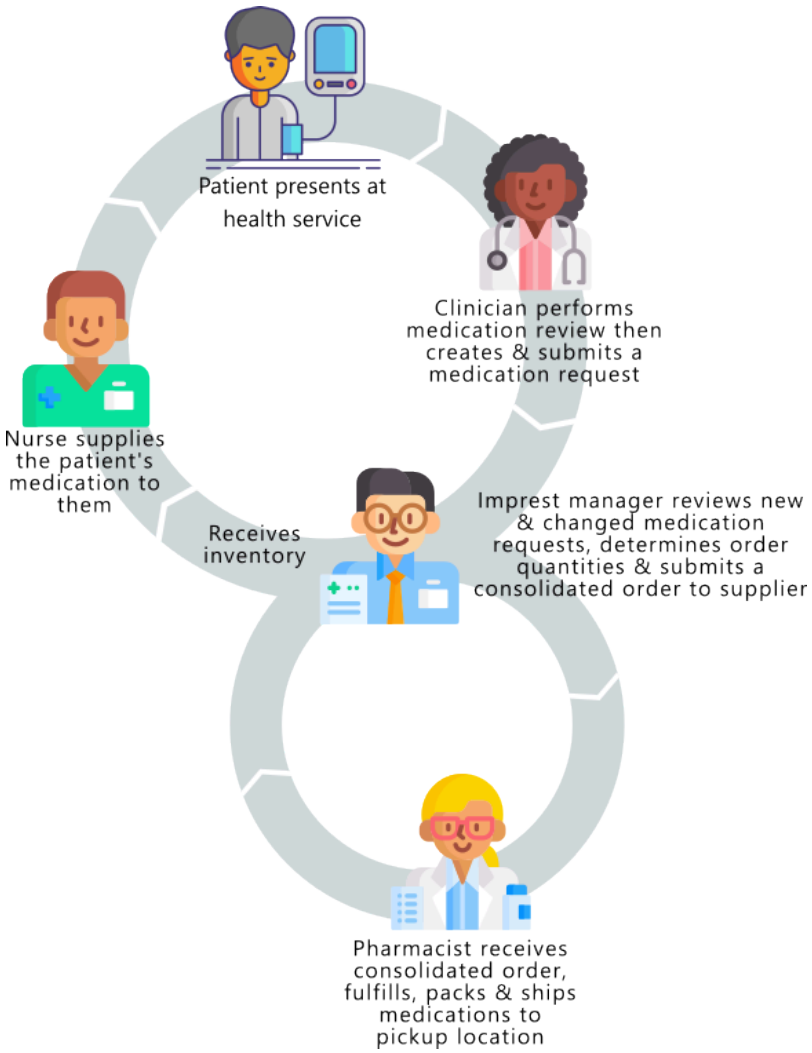
- Cannot be cancelled
- Can be printed

The quantity fields are updated in the Imprest order and the details of the supply are listed in the **Imprest Orders** window.

Consolidated Orders

Consolidated orders are groups of medication requests that have been requested from an external pharmacy.

If you stock your patient's prescription medications at your health service, or are the health provider for a remote site that stocks prescription medications for your patients, you can use medication requests to help manage the patient's medications and consolidated orders to manage the inventory.



Tip:
Consolidated orders are part of the `Medications Management` module. Both medication requests and consolidated orders must be enabled and you must belong to a user group which has the `Consolidated Order - Manage` system right set. For more information, see System Parameters - Prescription Forms *(on page 832)*.

To display the **Consolidated orders** summary window, select **File > Imprest Management > Manage Patient Consolidated Orders**.

The **Consolidated orders** summary lists the consolidated orders and the status and other summary details for the consolidated orders for your location.

Table 100. Consolidated orders summary information

Column	Description
Order ID	Internal order number
External ID	External consolidated order ID number

Table 100. Consolidated orders summary information (continued)

Column	Description
Status	• **Draft** - a new consolidated order that is not yet ready to be sent to the external pharmacy for fulfilment • **Ordered** - a consolidated order that has been sent to the external pharmacy for fulfilment • **Completed** - a consolidated order that has been filled by the external pharmacy and the medications received at the pickup location • **Cancelled** - the consolidated order is no longer required and has been cancelled
Order created	The date on which the draft consolidated order was created
Order sent	The date on which the consolidated order was sent to the external pharmacy for fulfilment
Order received	The date on which the filled consolidated order was received at the pickup location
Supplier	The name of the external pharmacy fulfilling the consolidated order
Filled	The filled status reflects the progress of the order: • **Filled** - the entire consolidated order was received from the external pharmacy • **Partial** - only part of the consolidated order was received from the external pharmacy • **Unfilled** - the external pharmacy could not fulfil the consolidated order
Actions	Reprint - for consolidated orders with a status of `Ordered` or `Completed`, if you have a template set for consolidated orders, you can print a copy of the consolidated order. The copy of the order is displayed in your PDF viewer, with a print type of `Reprint`.

To limit the number of consolidated orders displayed, select a value for one or more filters:

- **Pickup Location**
- **Status**
- **Filled**

If you want to check a particular consolidated order and you know the ID, enter the ID in the **Search by ID** field.

Create a draft consolidated order

Your Imprest Manager can use consolidated orders to manage your inventory of prescribed, patient-specific medications.

Your location must be enabled as a medication pickup location. You should also have a supplier set in the address book.

If you want to print your consolidated orders, ensure that a template is set in system parameters. For more information, see System Parameters - Prescription Forms *(on page 832)*.

Your Imprest manager can review changed medication requests and determine the quantity of medications that need to be ordered from a supplier for each patient after completing a stocktake of existing medications. The quantities required can then be added to a draft consolidated order.

All active medication requests are listed in the draft consolidated order, sorted alphabetically by patient.

Medication requests are assigned a status in relation to the last consolidated order date, which was when a consolidated order was last ordered. Use the status to help manage your consolidated orders and inventory. The status of medication requests may be one of the following. Statuses are listed in order of precedence, if a status meets more than one status category, the higher status is used.

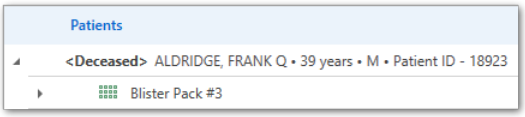
Table 101. Consolidated order - medication request status

Icon	Status	Description
	`Error`	The medication request has a quantity to order, but it contains a medication that has been stopped or cancelled. If a patient with an existing medication request is marked as deceased, the medication request in the consolidated order also shows an error.
	`Stopped`	The medication request was stopped or cancelled after the last consolidated order date and there is now no active medication request for the patient. Only the latest stopped or cancelled medication request is shown. Expired once-off medications included in the request show an  expired icon.
	`Warning`	The current, active medication request was included in a previous consolidated order that was ordered, but the medication request contains a medication that has expired.
	`Supplied`	Inventory has been supplied to the patient since the medication request was added to the draft consolidated order.
	`New`	A new, active medication request was added for a patient after the consolidated order was last ordered and there are no previous medication requests for the patient. Medication requests remain in `New` until a quantity is ordered. For the first draft consolidated order created for an encounter place, all medication requests will have a status of `New`.

Table 101. Consolidated order - medication request status (continued)

Icon	Status	Description
	Changed	A new, active medication request was added for a patient after the consolidated order was last ordered who has an existing medication request or a quantity has been added to the consolidated order for the medication request.

Each patient entry shows the patient name, age, sex, and Patient ID. The MRN is displayed instead of the Patient ID if **Display MRN in Clinical Record** is set in **File > System Parameters > Patient** tab. If the patient is deceased, the entry is prefixed with <Deceased>. For example:

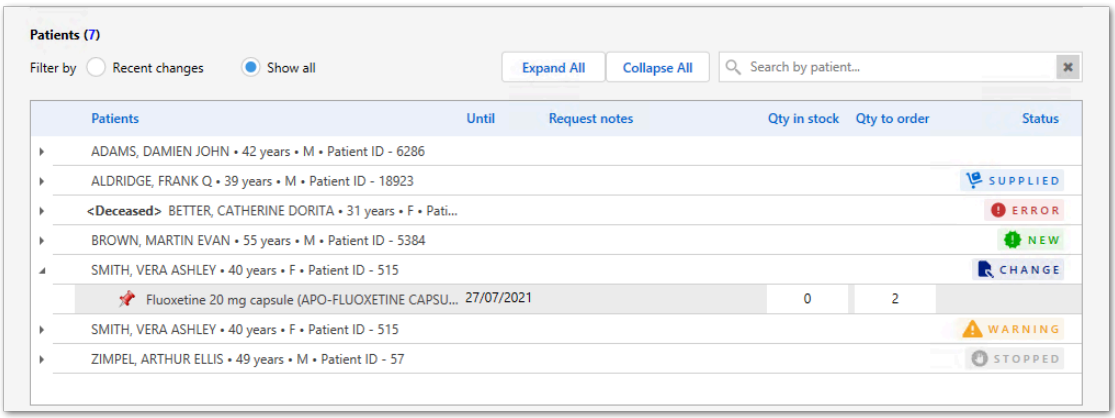


Tip:
To view the medication requests for all patients, click **Expand all**. Otherwise, to expand the record for an individual patient, click the caret. To view only medication requests that have one of the above statuses, set **Filter by** to **Recent changes**.

Note:
Each encounter place can have only one consolidated order in a draft state at a time.

To create a draft consolidated order:

1. In the **Consolidated Orders** summary window, click **Create new order**.
   A new, draft, consolidated order is created. The order is automatically assigned an order number, which is incremented with each new order. The draft consolidated order lists all active medication requests by patient, which have not already been included in a consolidated order.
2. Select the pharmacy that will fulfill your order. In the **Supplier** field, click Ellipsis and select a supplier from the address book.
3. If the supplier requires a separate ID, in the **External ID** field, enter the required value.
4. If you want to add a general note for the supplier, add it to the **Notes** field.
5. In the list of patients' medication requests, for each medication and DAA type, click in the **Qty in stock** field and enter the amount of that medication you already have in stock, and in the **Qty to order** field and enter the amount of that medication or DAA you need supplied.



> **Tip:**
>
> To find a particular patient, in the **Search by patient** field, enter any text that matches the patient's name, or their Patient ID or UMRN. To clear the search and show all medication requests, click Clear.
>
> Any notes added to a medication request when prescribing are listed for each medication request.

6. When you have completed the values for existing inventory and the required stock for each patient, click **Save and order**.

> **Tip:**
> To save an incomplete consolidated order that is still in progress, click **Save as draft**.

If the consolidated order is still in progress, it is listed in the **Consolidated Orders** summary window with a status of `Draft`.

If you saved and ordered the consolidated order, it is listed in the **Consolidated Orders** summary window with a status of `Ordered`. If you have a template set for consolidated orders, the consolidated order is printed to a PDF and displayed in your PDF viewer. Send this order to your supplier.

> **Tip:**
> You can check when an order was last updated and by whom. When an order is updated, the time, date and username of the user who made the changes are recorded in the order. For example, `Last edited at` *`time`* `on` *`date`* `by` *`username`*`.`

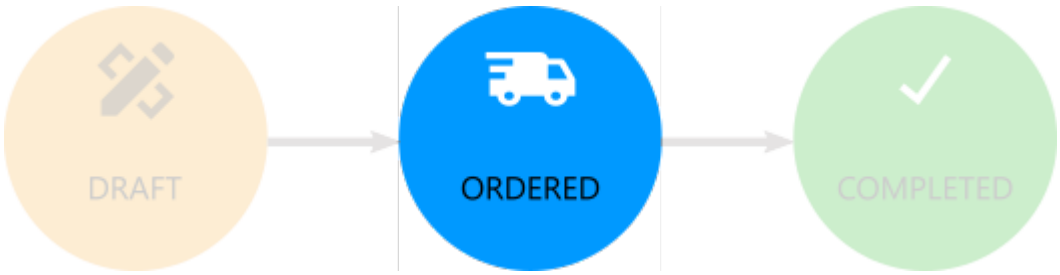
After you have saved a draft consolidated order, you can view or edit the order before placing it.

> **Tip:**
> If you later want to order a draft consolidated order, and the status of any medication requests included in the order has changed to `Error` or `Stopped`, you should instead cancel the order and correct the requests for the affected patients.

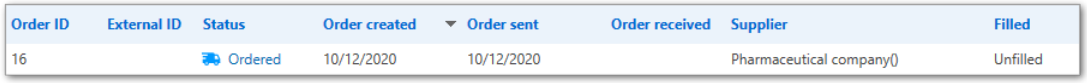
You can also cancel an order if it is no longer required. In the **Consolidated order** window, click **Cancel order**.

Record inventory in an ordered consolidated order

After you have saved and ordered a consolidated order, you can record the quantity of each medication request received from your supplier and track any stock yet to be received.



Ordered consolidated orders are listed in the **Consolidated Orders** summary window, with a status of `Ordered` and an initial filled status of `Unfilled`.



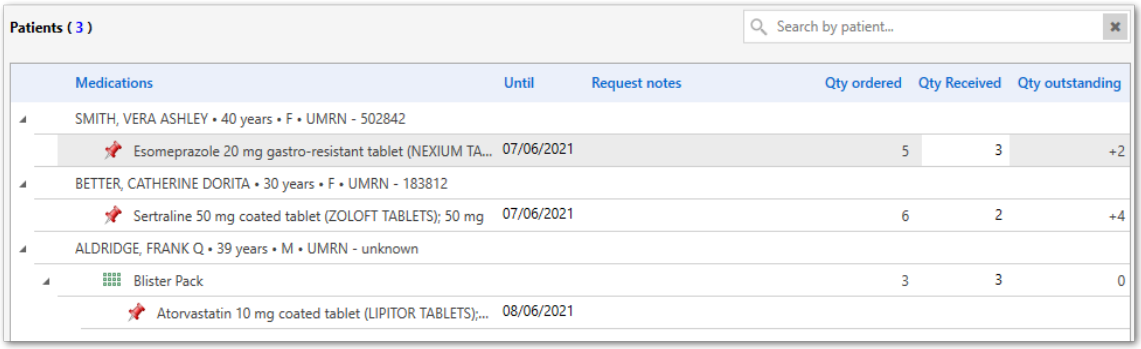
Order ID	External ID	Status	Order created	Order sent	Order received	Supplier	Filled
16		Ordered	10/12/2020	10/12/2020		Pharmaceutical company()	Unfilled

Use the ordered consolidated order to record medications received by you from the supplier.

> **Tip:**
> Only those medications for which you provided an order quantity in the draft consolidated order are included in the ordered consolidated order.

To record medications received from your supplier:

1. Select **File > Imprest Management > Manage Consolidated Orders**.
2. In the **Consolidated Orders** summary window, double-click the consolidated order with a status of `Ordered`.



Patients (3) — Search by patient...

Medications	Until	Request notes	Qty ordered	Qty Received	Qty outstanding
SMITH, VERA ASHLEY • 40 years • F • UMRN - 502842					
Esomeprazole 20 mg gastro-resistant tablet (NEXIUM TA...	07/06/2021		5	3	+2
BETTER, CATHERINE DORITA • 30 years • F • UMRN - 183812					
Sertraline 50 mg coated tablet (ZOLOFT TABLETS); 50 mg	07/06/2021		6	2	+4
ALDRIDGE, FRANK Q • 39 years • M • UMRN - unknown					
Blister Pack			3	3	0
Atorvastatin 10 mg coated tablet (LIPITOR TABLETS);...	08/06/2021				

3. In the ordered **Consolidated order** window, for each medication or DAA pack, in the **Qty Received** column, enter the number of packs received from your supplier.

   The value in the **Qty outstanding** column is updated automatically. If you receive the same number of packs as you ordered, this value will be 0. If you received fewer packs than you ordered, this value shows the number of packs that have not been supplied compared to what you ordered. If you receive additional stock, this value will be negative.

   > **Tip:**
   >
   > To find a particular patient, in the **Search by patient** field, enter any text that matches the patient's name, or their Patient ID or UMRN. To clear the search and show all medication requests, click Clear.
   >
   > Any notes added to a medication request when prescribing are listed for each medication request.

4. If the order is only partially filled, click **Update**.
5. If all medications in the order have been supplied and the order is complete, click **Complete Order**.

If any part of the consolidated order is not received from the supplier and there is an outstanding quantity recorded, the **Patients** section is marked as `Partially Filled` 

. In the summary, the consolidated order shows a filled status of `Partial`.

In the summary, if all medication in the order has been received, the consolidated order shows a filled status of `Filled`. If you have also marked the order as complete, the status is `Completed`. The date that the order was marked as completed is recorded in the order.

> **Tip:**
> You can check when an order was last updated and by whom. When an order is updated, the time, date and username of the user who made the changes are recorded in the order. For example, `Last edited at` *`time`* `on` *`date`* `by` *`username`*`.`

You can cancel an order for whatever reason if it is no longer required. In the **Consolidated order** window, click **Cancel order**.

View a completed or cancelled consolidated order

If required, you can review a completed consolidated order. You can also view cancelled orders.

Complete consolidated orders are listed in the **Consolidated Orders** summary window with a status of `Completed` and a filled status of `Filled`.

Order ID	External ID	Status	Order created	Order sent	Order received	Supplier	Filled
16		✓ Completed	10/12/2020	10/12/2020	10/12/2020	Pharmaceutical company()	Filled

> **Tip:**
> You cannot edit completed or cancelled consolidated orders.

To view a completed or cancelled consolidated order:

1. Select **File > Imprest Management > Manage Consolidated Orders**.
2. In the **Consolidated orders** summary window, double-click the consolidated order with a status of `Completed` or `Cancelled`.

Clinical Support

Investigations and documents

Communicare receives pathology and imaging results, letters and other documents electronically and sends documents and letters electronically using HL7 messages.

Incoming documents and results

Previously, Communicare used `CCareQueue_Results` to process incoming messages for most health services. In V22.2 and later, the Secure Message Exchange (`CCareQueue_SMD`) is used to send and receive ADHA compliant, interoperable, secure messages.

Communicare supports the following incoming documents with embedded data.

Table 102. Supported incoming document formats

Format	Description	Further information
HL7 (ORU): • HL7 (ORU) + PDF • HL7 (ORU) + formatted text (FT) • HL7 (ORU) + plain text • HL7 (ORU) + PIT • HL7 (ORU) + HTML	For incoming pathology and imaging results. Coded qualifiers such as HBa1C, HDL, LDL are added to the corresponding qualifier fields in Communicare automatically if the OBX lines are coded.	For customers using **CCareQueue_SMD** for ADHA compliant, interoperable secure messaging, Communicare supports: • HL7 V2.3 ORU • HL7 V2.3.1 ORU Communicare supports storing the same report in multiple formats and uses the first report with a valid size in the following priority order: • PDF • HTML • RTF • TXT
• HL7 (MDM) + CDA • HL7 (REF) + PDF • HL7 (REF) + HTML	For incoming referrals, letters and documents.	Communicare supports: • HL7 V2.3.1 MDM message with CDA document • HL7 V2.3.1 REF • HL7 V2.4 REF **Tip:** If incoming letters or documents are listed on the **Ix Results** tab, ask the sender to send documents in one of these formats instead of as HL7 ORU files.
• PIT (PIT)	Communicare still accepts PIT, however, coded qualifiers such as HBa1C, HDL, LDL, are not automatically added to the qualifier fields in Communicare and are not included in the qualifier summary, reports and graphs unless added manually to the patient's clinical record.	Ask your lab to return HL7 (ORU) with embedded PIT instead. If you are using Medical-Objects for receiving documents and results, you will only be able to receive PIT (PIT) files and will not be able to receive HL7 (ORU) files. Communicare is collaborating with Medical-Objects to resolve HL7 (ORU) compatibility problems. Communicate requires that PIT files are encoded with UTF-8.

Once processed, incoming documents and results are displayed in  **Documents and Results**. If the document or result is matched to a patient, it is also displayed in their clinical record.

Table 103. Location of incoming documents and results

Description	 **Documents and Results tab**	Clinical record tab
Incoming results	**Investigation Results**	**Detail > Ix Results**
Incoming referrals, letters and documents	**Received Documents**	**Detail > Document**

In incoming documents, the provider is identified by a valid Medicare provider number. If the provider number matches that of a provider added to Communicare, the provider name included in Communicare is listed in the  **Documents and Results > Provider** column. If the provider cannot be matched, the provider is displayed as `UNKNOWN`.

Tip:
If the incoming message contains long names, they may be truncated. Names are limited to the following:

- 40 characters - receiving doctor's name; patient's name
- 100 characters - address
- 55 characters - laboratory name

Outgoing documents

Communicare sends outgoing letters and documents, and referrals and discharge summaries using the letter format, to recipients via HealthLink, Argus or SMD in both PDF and RTF formats. CDA documents, such as eReferrals and discharge summaries are sent securely using HL7 MDM. Recipients receive PDF, RTF, or CDA, depending on which format their system supports.

Table 104. Supported outgoing document formats

Format	Description	Further information
• HL7 (REF) + PDF • HL7 (REF) + RTF	For outgoing letters and documents, and referrals and discharge summaries using the letter format	Communicare sends HL7 V2.4 REF_I12 if the recipient supports it, otherwise the following version is sent: • Argus - HL7 V2.3.1 REF • HealthLink - HL7 V2.3.1 REF • SMD - HL7 V2.4 REF

Table 104. Supported outgoing document formats (continued)

Format	Description	Further information
• HL7 (MDM) + CDA	For outgoing eReferrals and discharge summaries sent securely	Communicare supports: • HL7 V2.3.1 MDM messages with CDA documents To generate CDA documents: • Login account must have a linked provider • Provider must have a valid HPI-I • Encounter place must have a valid HPI-O • Patient must have a valid IHI

Outgoing HealthLink messages contain an EDI code for your organisation so that message recipients can reply to your address if required. Include the EDI code provided to you by HealthLink in System Parameters - Secure Messaging *(on page 824)*.

Documents and results summary

Use the **Documents and Results** window to display internal, incoming and outgoing documents and incoming results for any patient at your service.

To display documents and results, in the toolbar, click  **Documents and Results**.

The Communicare **Documents and Results** window is separated into four main tabs:

- **Investigation Results** - a list of investigation results received directly from pathology or imaging laboratories. To view the result and match it to a patient and an outstanding investigation request, double-click a result. To view investigation results, you must belong to a user group with the `Investigations` system right. For more information, see Investigation results *(on page 309)*.
- **Scanned and Attached Documents** - a list of documents that were internally scanned or attached. To add documents:
  - To scan a document, click  Scan. For more information, see Scanning documents *(on page 316)*.
  - To attach a PDF document, click  Attach.

  For more information, see Scanning documents *(on page 316)*.
- **Received Documents** - a list of documents received via Secure Messaging.
- **Outgoing Documents** - a list of documents generated within Communicare, including documents that have been sent via Secure Messaging or uploaded to My Health Record. For more information, see Outgoing document status *(on page 304)* below.

To step through the documents or results, click  Next or  Previous. To jump to the last entry, click  Last. To jump to the first entry, click  First.

To view a document or result and match it to a patient, set the provider, mark it as reviewed, and so on, either select it and click  or double-click it. Inside a document or result, click **OK Prior** or **OK Next** to step through the attached documents.

Filtering documents and results

In all tabs, set a filter to restrict the number of documents displayed. Apply one or more of the following filters:

- **Status** - filter by relevant status, the default is `Unreviewed`, except for outgoing documents which have a default of `Pending` or `Error`.
- **Provider** - filter by provider name. Click  and select from:
  - `All providers` - the default which displays all documents and results for the selected date range with an assigned provider and where a provider is not assigned and the provider is unknown. To reset the list to `All providers`, in the **Provider** field, press `Delete` or `Backspace`.
  - `My results` | `My documents` - displays documents and results assigned only to the current provider for the selected date range.
  - `Unknown providers` - displays documents and results for the selected date range that are not assigned to a provider, or where the assigned provider is not linked to any encounter place.
  - *provider name* - displays documents and results assigned only to the selected provider. Providers are listed in the **Select Provider** window if there are any documents or results assigned to them in the selected date range. A provider may be referenced by different variants of their name. If you select a provider name, only results using that variant of the provider's name are displayed.
- **Include Unknown Providers** - include or exclude documents or results not assigned to a provider or where the assigned provider is not linked to any encounter place. Unknown providers are included by default: `Unknown` is displayed in the **Doctor** column.
- **Encounter Place** - filter the results on any tab by the encounter place they are expected to be relevant to. The provider numbers on the incoming results are checked against the provider numbers for the selected encounter place or its children. Select an Administrative Encounter Place to aggregate results from all Service Encounter Places that belong to it. To list results for all encounter places, select `All Places`.
- **Include Unknown Encounter Places** - set to include encounter places where either the provider number information is missing or the provider number attached to the document or results does not exist in Communicare. The provider number is specific to an encounter place. Unknown encounter places are not included by default.
- Date selectors - filter documents by date range. Click **Refresh** to apply the filter.

Communicare will apply the filters that were previously selected the next time you open  **Documents and Results**, that is, any status, provider or encounter place selected and whether to include unknown providers or encounter places. Any custom date range is not maintained. Instead the date range selected from the **Default Date Range** list is used, which is `Last 6 Months` by default.

Customising how the documents and results are displayed

To sort on a column, click the arrow or right-click and select **Sort Ascending** or **Sort Descending**.

To rearrange columns, click in the header and drag the column to the required position.

To automatically size a column to fit the longest text contained in that column, right-click and select **Best Fit**.

To automatically size all columns to best fit the text they contain, right-click and select **Best Fit (all columns)**.

To show hidden columns which contain additional information, click  Ellipsis and select **Show hidden columns**.

Outgoing document status

Outgoing Documents can have one of the following statuses:

- `Sent` - an acknowledgement of successful delivery has been received from the recipient's secure messaging system
- `Pending or Error` - a document queued or sent via secure messaging has this status until Communicare receives confirmation that it has reached its destination, which may take up to 24 hours.
- `Pending` - a document queued or sent via secure messaging has this status until Communicare receives confirmation that it has reached its destination, which may take up to 24 hours.
- `Error` - an error was encountered with queuing or sending the document. To determine the source of the error, contact Communicare Support and provide the message tracking ID displayed at the bottom of the window in bold, blue text. Based on the error cause, Communicare Support may recommend one of the following actions:
  - `Resend Document` - to queue and send the document using Secure Messaging, click  Resend, or right-click and select **Resend Document**. The status returns to `Pending`.

    > **Tip:**
    > Available only for documents with status of `Error` or My Health Record status of `Error` and requires Argus version 6.0.15 or higher.

  - **Error - Dealt With** - if a document cannot (or does not need to) be sent again, print, post or fax it and click  Error - Dealt with.
- `Saved` - the document was generated in Communicare and was not sent.
- `Deleted` - the document was deleted from the user interface, but still exists on the database.

> **Tip:**
> For documents sent using secure messaging, you can also see the secure message status & the recipient's name in the patient's clinical record, **Detail > Document** tab. For more information, see Detail tab *(on page 147)*.

Incoming document status

Typically, any incoming documents with errors are listed on the  **Documents and Results > Received Documents** tab with an error displayed in the **Error** column. If you are expecting a document that has not arrived and is not listed in the **Documents and Results** window, check the incoming folders for both the file and an acknowledgement generated.

Communicare processes incoming documents from multiple SMD vendors, each of which prefers a different structure for their incoming documents. The location for different incoming documents and their acknowledgements is configured in `CCareQueue_Smd.config.json` for your site by the Implementation team when Communicare is installed. For example:

Table 105. Example incoming message & acknowledgement location

Vendor	REF	ORU
HealthLink messages	`C:\HLINK\HL7_in\RDSAU\*.hl7`	`C:\HLINK\HL7_in\LAB2\*.hl7`
HealthLink acknowledgements	`C:\HLINK\HL7_in\RDSAU\*.ack`	`C:\HLINK\HL7_in\LAB2\*.ack`

Table 105. Example incoming message & acknowledgement location (continued)

Vendor	REF	ORU
Argus messages	`C:\SMD\Argus\Incoming\*.hl7`	
Argus acknowledgements	`C:\SMD\Argus\Outgoing\*.ack`	

Typical reasons for failure might include:

- Name or sex missing - both are required
- Document is too big - the document cannot be received if it exceeds the size set in **File > System Parameters > Devices** tab, **Maximum Document Size** field

My Health Record status

The **My Health Record** column displays the status of the document, relative to the My Health Record. This column pertains to CDA documents only, all other document types will display `N/A`:

- `Pending` - the document has been queued for upload/superseding to the My Health Record
- `Upload` - the document was successfully uploaded to the My Health Record
- `Error` - the document failed to upload to the My Health Record.
- `Superseded` - the document was superseded on the My Health Record
- `Removed` - the document has been removed from the My Health Record
- `Unknown` - no attempt has been made to upload the document to the My Health Record

CDA Clinical Documents

Documents such as Discharge Summaries and Specialist Letters that are received in the HL7 v3 CDA file format are imported as XML files and are displayed after being transformed into a readable HTML document. The Style sheet used for this transformation is distributed by Communicare on behalf of NeHTA. If the display of the document is incorrect or unreadable, your CDA Stylesheet may need updating. Contact Communicare Support for further assistance.

Deleting received documents

If a document arrives that is clearly not for a patient in the database, select it and click Delete. Deleted documents are deleted from the user interface, but still exist on the database.

If a result is deleted in error, set the filter to show Deleted results and delete the result in the same way: it will become an unmatched, unreviewed result once again.

Investigations

Investigation requests

Create an imaging or pathology request from within a patient's clinical record.

To request a pathology or imaging investigation, you must belong to a user group that has the `Investigations` system right enabled.

A default claiming provider may be selected for your organisation in Organisation Maintenance *(on page 840)*. The default provider is an organisation-wide option and is available only for the encounter places where the provider has a provider number.

Note:
Providers other than those identified as investigation claimants for an encounter place can order investigations if **Allow Investigation Request on Behalf of another claiming provider** is enabled in Organisation Maintenance *(on page 840)* and they have a Medicare Provider number. Providers who have a Medicare Provider Number and have **Ix Claimant** set for an encounter place in **File > Providers >** *provider*, are not given the option to order investigations on behalf of another provider. If a provider with a Medicare Provider Number needs to order tests on behalf of another provider, **Ix Claimant** should not be set for the required encounter place. For more information, see Providers *(on page 920)*.

The process for requesting a pathology or imaging investigation is similar.

To request a new investigation:

1. In a patient's Clinical Record, click:
   -  **Pathology** to add a pathology investigation for a patient
   -  **Imaging** to add an imaging investigation for a patient
2. In the **Add Investigation Request** window, from the **Investigation Provider** list, if there is more than one provider defined for your encounter place, select an investigation provider.
3. If you are not an investigation claimant for your encounter place, from the **Claiming Provider** list, select the provider who you would like to make the request on behalf of. The **Claiming Provider** list contains only providers who are investigation claimants for the current encounter place.

   Tip:
   If you are an investigation claimant provider at the encounter place from which you are ordering the test, you will not get the option to select a different claiming provider.

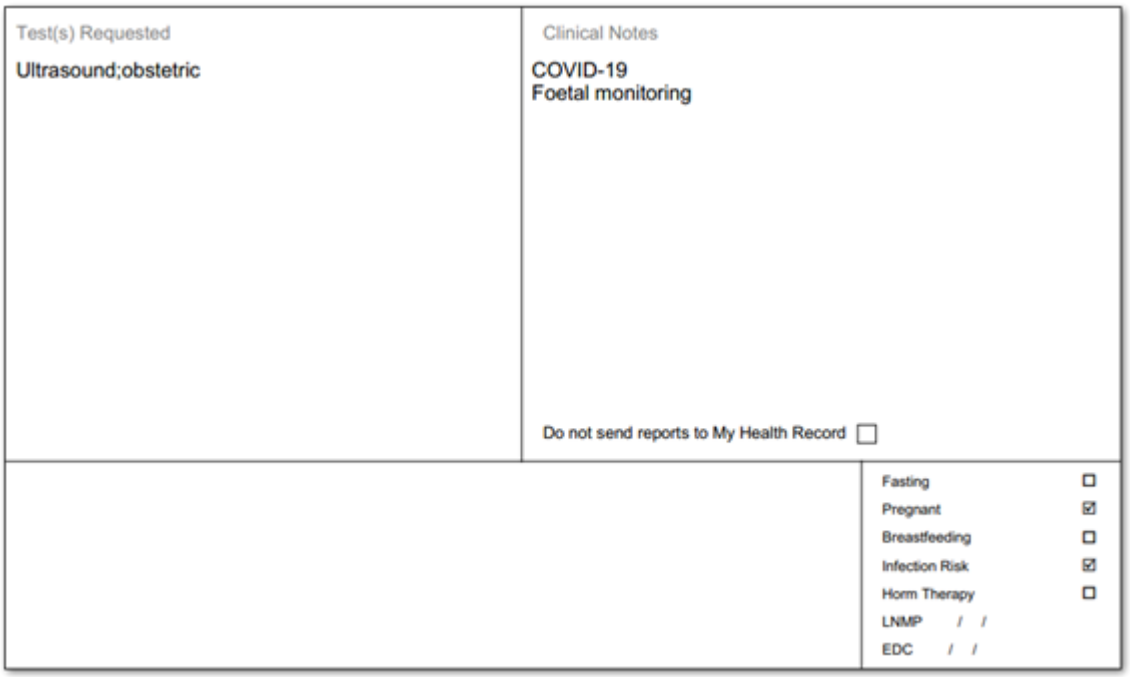
4. In the short list of available investigations, select the required investigation and click **>**Add, or double-click the investigation. To add all items in a filtered list, click **>>**Add All. The investigations you have selected are listed in the **Investigations Requested** pane. These tests will be printed on the request form. To remove a requested item, click **<**Remove.
5. If the investigation you want to request is not in the short list, in the **Search Investigations** field, enter a keyword, or two keywords separated by a space to find the investigation you require. For information about adding an investigation to the short list for future requests, see Creating new request types *(on page 308)*.
6. Set clinical options. For any options that you set, an **X** is placed in the relevant box on the request form. If an option doesn't exist on the printed template, the label is added to the clinical notes format, for example, `Fasting`.
   a. If your patient is fasting, set **Fasting**.
   b. If your patient is pregnant, set **Pregnant**.
   c. For imaging requests, if your patient is breastfeeding, set **Breastfeeding**.
   d. For imaging requests, if your patient is unwell and poses a risk to imaging staff, set **Infection Risk**. Add details about the infection to the text field.
7. In the **Copy To** field, enter the names and details of any other providers the results of the investigation should also be sent to, other than yourself.
8. From the **Investigation Reason** list, select an existing clinical item for the patient to which this investigation relates, or click  Clinical Item and select a new clinical item.

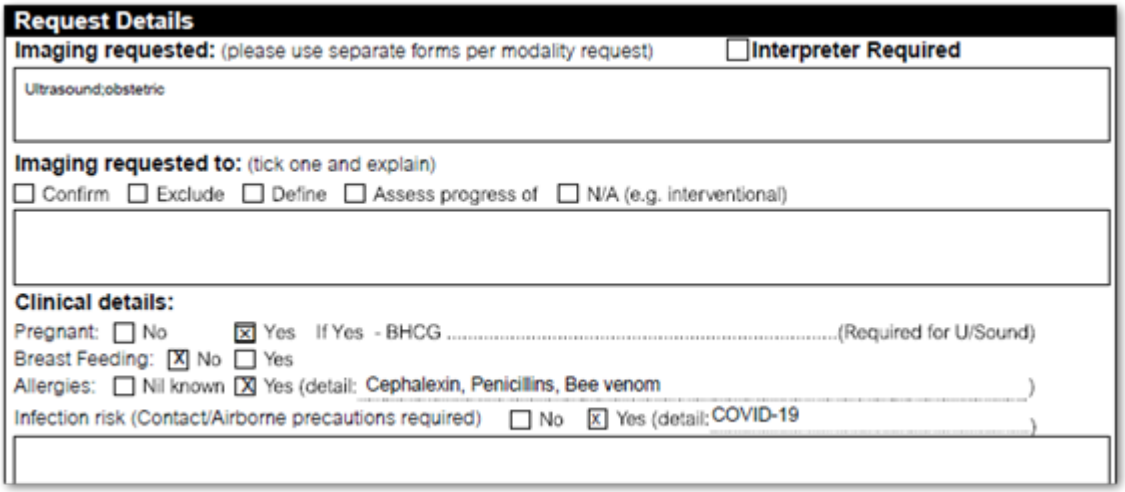
9. If an investigation must be performed urgently, set **Urgent** and in the **Reply To** field, enter your monitored phone or email details.
10. If a patient's welfare is at risk, set **Critical if result outstanding**. The investigation will be given a higher priority in the **Report > Investigations > Outstanding requests by provider** report.
11. From the **Printing Format** list, select a predefined print format. The format defaults to that specified for the Investigation Provider in the Address Book.
12. In the **Clinical Notes** field, add any extra information that the lab or imaging practice needs to know. Carriage returns are replaced with spaces.

> **Note:**
> For most clients, clinical notes longer than 145 characters are truncated in the investigations template. If you are using a custom template, you may be able to include extra information.

13. **Do not send reports to My Health Record** shows the patient's preference recorded in **Patient Consents to Upload to My Health Record**. This preference will be printed on the investigation request form. Communicare does not upload the request or result to My Health Record, irrespective of whether this option is set or not. This option is displayed irrespective of whether the My Health Record module is enabled or disabled.
14. Click **Print & Save**.

The imaging request is displayed in a PDF viewer. The patient's details, tests requested and the clinical details set are displayed in the template. Depending on the template, the clinical detail information you provided is displayed either in the clinical notes or the relevant checkboxes are selected. Clinical information is displayed before any other clinical notes. For example, in the following request forms, the standard Communicare template displays the infection risk in the clinical notes, the second template displays the infection risk details separately.




Request Details
Imaging requested: (please use separate forms per modality request) Interpreter Required
Ultrasound;obstetric
Imaging requested to: (tick one and explain)
Confirm Exclude Define Assess progress of N/A (e.g. interventional)
Clinical details:
Pregnant: No Yes If Yes - BHCG .....(Required for U/Sound)
Breast Feeding: No Yes
Allergies: Nil known Yes (detail: Cephalexin, Penicillins, Bee venom)
Infection risk (Contact/Airborne precautions required) No Yes (detail: COVID-19)

For some health services, for imaging requests using templates that show allergies, any adverse reactions recorded in the clinical record are also transcribed into the **Allergies** field. If no adverse reactions are recorded, **Allergies** is left blank. If you have recorded **Nil Known** adverse reactions in the clinical record, **Nil known** is checked on the imaging request form.

> **Tip:**
> Check that your clinical notes are complete in the investigations template and have not been truncated.

To print the request, click **Print**.

Requests are displayed as clinical items on the **Detail** tab: **Class** of **Ix Request**; or **Topic** of **Investigations**. Select a request to display its details in the right pane.

To view requested tests that have not had a result matched to them, run the reports in **Report > Investigations > Outstanding Requests by Provider**.

Next, match and review results *(on page 309)*.

Printing and Reprinting Requests

To update and reprint a request in the current service:

1. On the **Progress Notes** or **Details** tab, double-click the request to open it.
2. Make the required changes.
3. Click **Print & Save**.

To reprint a request, right-click on the request and select **Print Investigation Request**.

Creating new request types

If you belong to a user group with the Reference Tables system right right enabled, you can update the short list of investigations displayed in the investigation request form.

If one of your commonly requested tests is not on the short list:

1. Select **File > Reference Tables > Investigations > Investigations**.
2. Set **Short Listed** for any test you want added to the list.
3. Click **Save**.

If a keyword does not find the correct test, go to **File > Reference Tables > Investigations > Investigations Keywords** and add an appropriate keyword.

Bulk Assignment

When this option has been selected as a system parameter (see System Parameters - Clinical *(on page 816)*), for plain paper pathology request forms only a label is appended to the top right of the form indicating that this is a bulk assignment request and where the requester's signature is normally added is a label indicating that a signature is not required. This option should only be used with the express permission of all pathology labs used at the health service and should not be enabled if the feature to use another claiming provider is enabled.

Investigation results

You can review investigation results received directly from pathology or imaging laboratories and matched to patients.

To display a list of investigation results received for all patients, in the toolbar, click  **Documents and Results > Investigation Results** tab. Review and match a patient's investigation results from this tab. For more information, see Reviewing and matching results *(on page 309)*.

> **Tip:**
> Results matched to a patient are displayed in their clinical record:
>
> - To display investigation results, on the **Detail** tab, set **View Clinical Items By** to `Class` and select the **Ix Result** tab.
> - To display both requests and investigation results, on the **Detail** tab, set **View Clinical Items By** to `Topic` and select the **Investigations** tab.
>
> If a result is unreviewed, the date is highlighted in red. To review a result, double-click it.

Results received electronically are saved to the Communicare server at `\\Communicare_installation\Results` by default.

A service checks every 5 minutes for files in this folder and processes the results, which then appear on the **Investigation Results** tab. Your Communicare Administrator should check `\\Communicare_installation\Results` for any files older than 24 hours. If there are old files, report the problem to Communicare Support.

Reviewing and matching results

Use the  **Documents and Results > Investigation Results** tab to review automatically matched incoming patient results, match requests to results, and match results manually to a patient that couldn't be matched automatically.

The pathology lab software sends results for download every hour or so. Results are imported by Communicare within a minute of being downloaded.

Communicare can display results in the following formats:

- PDF
- HTML
- Text

Results may be received in more than one format and you can choose to display the results in your preferred format. By default, the PDF is displayed if received. If only HTML and Text are received, the HTML is displayed by default.

Tip:
If only the name of the request or the following error is displayed, Communicare does not support the format in which the result was sent:

```
No supported result format (plain text or PDF) sent by investigation provider
```

Contact the laboratory and ask them to send the results again in a text or PDF format.

Communicare automatically attempts to match results to patients when the results are received. The patient is determined by looking for a unique match based on the following criteria, in the stated order:

1. Medicare number (prefix), date of birth and sex
2. Preferred surname (exact), preferred given names (prefix), date of birth and sex
3. Any surname soundex, any given names soundex, date of birth and sex

Note:
Changes to biographics after the result is received, but before it is reviewed are not considered.

The matched patient is approved by a clinician when reviewing the result. Results can be reviewed in the **Match and Review Results** window or from the patient's clinical record.

If Communicare is unable to match a result to a patient, the results must be reviewed and matched manually. Similarly, any requests with the same reference number as the result are listed in the **Match and Review Results** window for manual matching.

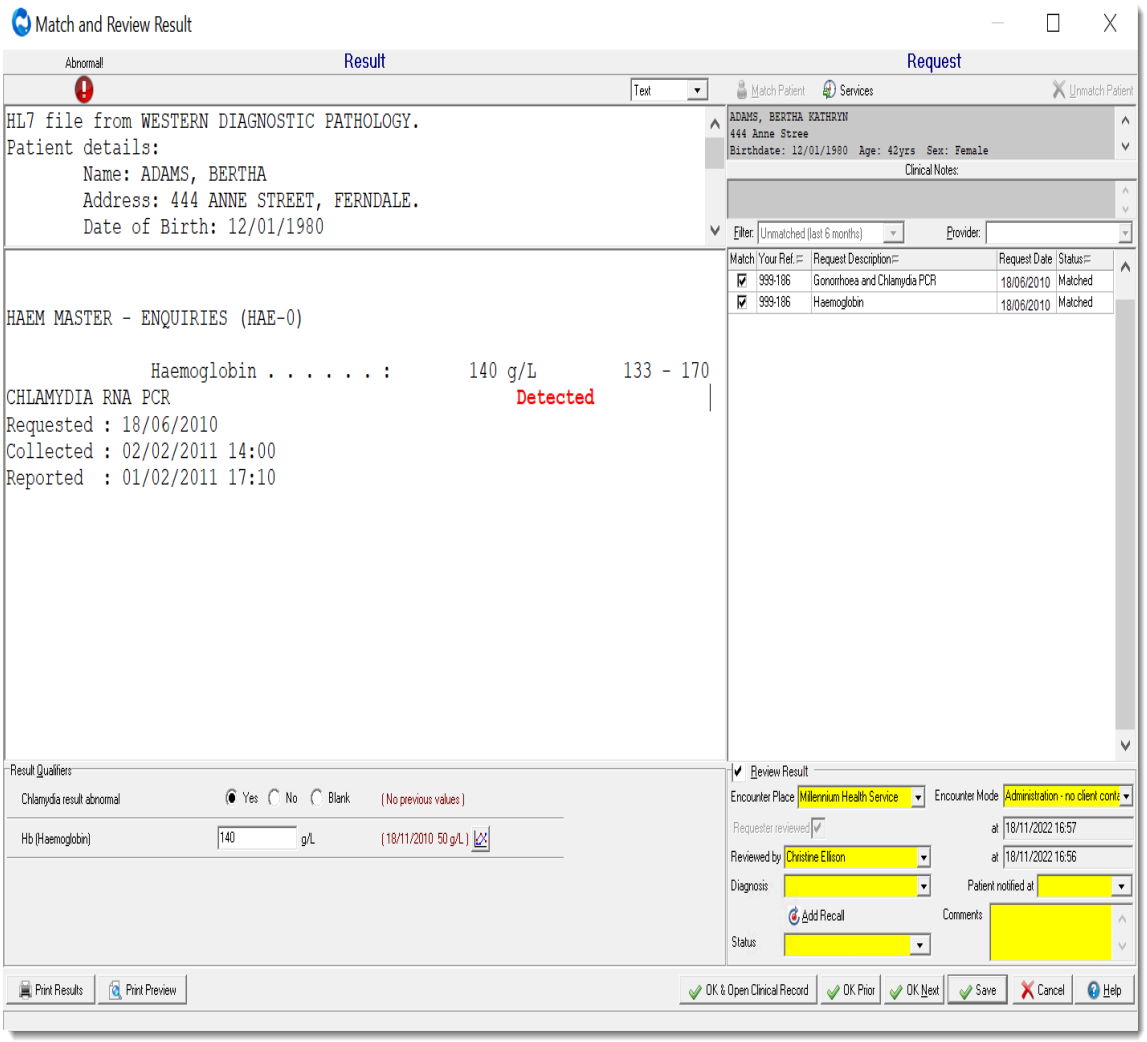
To match a result to a patient:

1. In the  **Documents and Results** window, on the **Investigation Results** tab, double-click a result.

   Tip:
   To filter the results, set filter information above the table. For example, to review requests made by you, from the **Provider** list, select your name. For more information, see Filtering documents and results *(on page 303)*.

   If the result is available in more than one format, select your preferred display format from the list.

   Results are displayed in the left pane and the patient and request information in the right pane. Any qualifiers associated with the results are displayed in the lower left pane.



If a time zone is provided in the result sent by the lab, the time is converted to local time. If no time zone is provided, the time included in the result is used verbatim.

2. If the result has been matched to the correct patient, go to step 4. Otherwise, match the result to a patient:
    a. In the **Match and Review Result** window, click  **Match Patient**.
    b. In the **Select Patient** window, search for the patient to whom the result might apply by name, date of birth or Medicare number. If you cannot find the patient, add the patient to the database as a Transient Patient so that you can review the result. Click **New Patient** and add the patient as normal. The patient details are inserted automatically into the pathology results
3. In the request list, match the result to a request:
    - Select all requests that apply to this result. You may select more than one request if the result contains data for more than one request. You may also select a request that has previously been matched to another result if this result is subsequent to that initial result.
    - If the investigation was not requested using Communicare, select `There is no request for this result`.
    - If the lab has not returned the reference number sent with the request, unmatched requests from the past six months are listed. Change the filter to **All** to display all past requests with a status of either `Matched` (the request has been matched to at least one result) or `Pending` (the request has not yet been matched to a result).

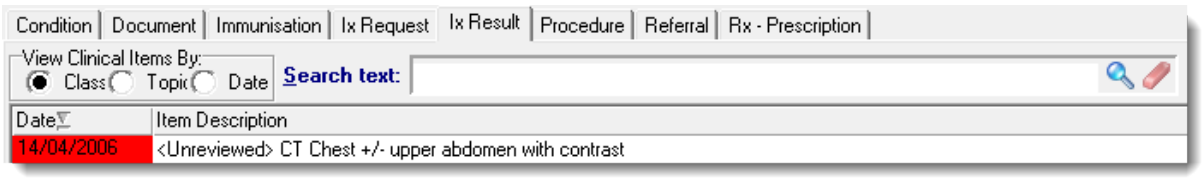
4. Review the results, either:
    - Continue to review the results here:
        a. Set **Match**.
        b. Set **Review Result**.
        c. Check that your encounter place and mode are correct.
        d. If you requested the investigation, set **Requester reviewed**, otherwise, from the **Reviewed by** list, select your name. A date is added to the appropriate field and the result changes status to `Reviewed`.
        e. If the investigation results in a diagnosis, from the **Diagnosis** list, select a diagnosis.
        f. If the patient has been notified of the results, in the **Patient notified at** field, add the date when they were notified.
        g. To add a recall for the patient, click **Add Recall** and complete the recall information. See Recalls *(on page 348)* for more information.
        h. The status of the investigation result is imported from the pathology file, but you can also update the status manually. To update the status, from the **Status** list, select the required status.
        i. In the **Comments** field, enter any further information.
    - Review the results in the patient's clinical record instead:
        a. Set **Match**.
        b. Click **OK & Open Clinical Record**.
        c. Complete steps b-i above.
5. If you want to check when the patient's last or next appointment is, click **Services**.

> **Tip:**
>
> You can also book another appointment for the patient: in the **Service List** window displayed, click **Book Appointment**.

6. Click **Save**. Alternatively, click **OK Prior** or **OK Next** to review the previous or next result.

After a result is matched to a patient, you can review it in the patient's clinical record.

On the **Detail > Ix Result** tab, unreviewed results are highlighted:



After you have reviewed the result, it is listed on the **Detail > Ix Result** tab prefixed with `<Reviewed>`:

- To display a summary of the investigation in the right pane, select it in the result list in the left pane
- To open a result, double-click **Investigation Result** or right-click the result and select **Edit Investigation Result**

If you didn't select all requests associated with the result, requests that are not marked as having had the result received will stay on the report for outstanding requests, **Report > Investigations > Outstanding Requests by Provider**.

You can short list a number of clinical items recallable from the **Match and Review Result** window. Ask your administrator to assign the keyword **$IxRecall** to the required items.

Reviewing and inserting result qualifiers

If an investigation request matched to a result is known to have certain qualifiers associated with it, these qualifiers will be linked through to the investigation result.

This allows qualifiers that were automatically imported (via LOINC codes) to be reviewed while reviewing the result itself.

The most recent value recorded previously in Communicare for a qualifier is displayed. After you have reviewed the results, click Previous Measurements to display all previous values.

Numeric and true/false qualifiers are supported. Numeric qualifiers receive the numeric value coded by the laboratory in the result. True/false qualifiers receive the **Abnormal** flag coded by the laboratory in the result. This means that the qualifier will record whether the lab declared the result to be abnormal, not the actual text returned by the lab.

Qualifiers that were automatically imported will be pre-filled. This means that they can be modified if absolutely necessary. Qualifiers that could not be pre-filled but are still returned in the result can be inserted.

Any OnQualifier recall rules will fire when the reviewed result is saved.

Adding a manual result

Manual results, for example, results returned in paper format or verbally can also be recorded in Communicare for an existing request.

> **Tip:**
> Add a new request for the manual result if one doesn't exist, see Investigation Requests *(on page 305)*. If you can't find a test name, choose `Pathology test not otherwise specified` with the keyword **PATH**. Ensure that **Print** is deselected and save.

To record a result manually:

1. On the **Detail > Ix Request** tab, right-click the request to which you want to add a result and select **Add Manual Investigation Result**.
2. In the confirmation window, click **Yes**.
3. In the **Match and Review result** window, in the left pane, enter the results.
4. Set **Review Result** and provide any other information required, such as from the **Status** list, select **Interim**.
5. A comment of `Manual investigation result` is included in the **Comments** field. Add more information if required.
6. Click **Save** and **Yes**.

The result is listed on the **Detail > Ix Result** tab prefixed with <Reviewed> and a comment of `Manual investigation result`.

Reassigning investigation results

You can assign an investigation result to another provider for review.

To reassign an investigation result to another provider for review:

1. In the  **Documents and Results** window, on the **Investigation Results** tab, select the result you want to reassign and click  Reassign.

   > **Tip:**
   > To display the **Provider Reassignment** window from anywhere in the **Investigation Results** tab, press `r`.

2. In the **Provider Reassignment** window, from the **with** list of providers, select the provider who you'd like to review the results instead.

   > **Tip:**
   > All enabled providers are included so the list can be long. Start typing a provider's name to jump to it in the list, then select it.

3. Click **OK**.

Deleting investigation results

If a result is not matched and it has been sent to your health service by mistake or is not relevant to any of your patients, you can delete it.

To delete a result:

1. In the  **Documents and Results** window, on the **Investigation Results** tab, select the result in the list that you want to remove.
2. Click  Delete.

The deleted results are no longer listed in the **Investigation Results** tab by default, however they are not deleted from Communicare.

If a result is deleted in error, set the filter to show Deleted results and delete the result in the same way: it will become an unmatched, unreviewed result once again.

Documents

Documents can be received from external sources, sent from Communicare or added to Communicare.

Documents and access rights

All documents are subject to Viewing Rights *(on page 903)*. This means that if a document is marked as highly sensitive and you do not have the right to see highly sensitive data you will not be able to see the document. However, all documents with no viewing right assigned (except incoming electronic documents) will be visible to all users.

Documents will always be visible to users inside the clinical record if the users have the appropriate level of access to see them.

Note:
Documents such as letters created with no viewing right are visible only to users who belong to a user group that has the `Electronic Documents` system right enabled. Incoming documents do not have a viewing right until one is assigned and are not visible to users unless they belong to a user group with the `Electronic Documents` system right. This approach prevents potentially sensitive information being visible to everyone.

Documents and system rights

System rights assign the security access level for using Communicare modules. There are two system rights in Communicare that deal with Documents:

- `Document Scanning` - users can scan documents into Communicare from the **Documents and Results** window and from within the clinical record.
- `Electronic Documents` - users can create any outgoing document from the **Documents and Results** window. All users can create outgoing documents from within the clinical record. This system right also allows users to see incoming documents that do not have an access right assigned. This means only users with the `Electronic Documents` system right can see the incoming documents as they arrive. After incoming documents have been reviewed, they are visible according to their newly assigned viewing right.

Table 106. Summary of document access

Document type	With Viewing Right	Without Viewing Right
Scanned document	Visible only to those with that viewing right	Visible only to those with `Electronic Documents` system right
Incoming document	Visible only to those with that viewing right	Visible only to those with `Electronic Documents` system right
Other documents (letters created in Communicare)	Visible only to those with that viewing right	Visible only to those with `Electronic Documents` system right

Read-only documents

Read-only documents in Communicare cannot be modified under any circumstances.

Any of the following conditions will make a document read-only:

- The document is not outgoing, that is, it is incoming, or hasn't been created by your organisation
- The document is a Care Plan, Care Plan Template or Attachment
- The document has been sent or is being sent
- The document has been saved for more than eight hours
- All Clinical Document Architecture (CDA) documents become read-only as soon as they have been saved.

Editing read-only documents

You cannot modify a document once it has become read-only, although the details section may be changed or updated. However, if the document was not an incoming document, attachment or CDA document, you can create a copy of the document and edit that. To create a copy:

1. Open the Clinical Record for the patient.
2. On the **Detail** tab, locate the document you want to edit and double-click the document.
3. Click **Create New** to open a new document that is identical to the original document, and can now be edited.

The new document will be linked to the current service, and the old document will remain unchanged.

Add documents

Documents are the electronic reflection of printed material that is important enough to be recorded in the patient's file. Only add documents to Communicare that cannot be encoded using normal clinical items.

If a document can be encoded or recorded as a normal clinical item it does not need to be recorded as a document. Clinical items are structured so that relevant health information can be extracted by using reports, whereas documents cannot be analysed with any reliability by any method.

Limit the use of documents to those cases where the information does not need to be encoded into clinical items and clinical details are not required. Documents are useful for logging actions that have been performed. It can be useful, for example, to store a scanned document from a faxed or emailed discharge summary.

Scanned documents are those documents that are directly scanned into Communicare. All other documents are electronic documents.

Scanning documents

You can scan new documents directly from the main toolbar or from within a Clinical Record.

Scanner settings can be found on the **File > System Parameters**, **Devices** tab.

You can also view existing scanned documents by double-clicking on a document record either in the Browse Documents window or the Clinical Record. In this case the  Scan New Document button is not enabled.

Remember:
Important considerations when scanning documents:

- Scanned paper records are more difficult to read than original paper records.
- Scans are rarely needed if proper summaries are maintained. Proper summaries including past health problems are a requirement for RACGP accreditation.
- Scanning of old paper records is not an RACGP standards requirement.
- The size of your Communicare database will be inflated by many times, making backups and maintenance more difficult and time consuming.
- The effect of inflating the database by scanning a large unspecified volume of documents over a relatively short period of time is unknown. It has not been tested.
- The maximum size for a single scanned document in Communicare is defined in System Parameters. If you must scan a document that is larger than this, consider scanning it as two documents.

To scan a document relevant to a patient:

1. In the patient's clinical record, click  **Scan**.
   The Place Mode, Patient and Provider details are filled in automatically.
2. To select a scanner to use, click  .
   For more information on scanner choice for use with Communicare see Important Non-Communicare Maintenance *(on page 967)*.

3. From the **Topic** list, select a topic.
4. In the **Comment** field, enter a comment.
5. Click  Scan New Document at the top left.
    - If the document that you're scanning is several pages long, set **Multipage** to store several pages in a single document.
    - The total pages field shows the total number of pages scanned in this session
    - Each page can be viewed using the left and right arrow buttons
    - Navigate to a particular page by entering the page in the current page field
6. Refine the scan as required.
   Changes to size, colour or orientation are temporary and are there to assist with viewing documents within Communicare. Changes are not saved and aren't applied when the document is printed.
    - From the Scale list, view the documents at a variety of sizes. The default is PageWidth.
    - Click  Rotate Image 90deg to change the orientation of the document from landscape to portrait and back.
    - Click  Invert Colours to improve the readability of documents in some circumstances.
    - Click  Print Document to print to the Communicare Default printer set in Printer Assignments *(on page 618)*.
7. Click **Save**.

The document is saved to Communicare.

You can also scan documents into Communicare from the following locations:

- Select **File > Documents > Scan New Document**
- Select **File > Documents > Browse Documents**
- Click  **Documents and Results** and on the **Scanned and Attached Documents** tab, click  Scan New Document.

Attachments

You can attach clinical and related documents sourced from email or elsewhere to a patient's clinical record as PDF documents.

You can then view these documents in Communicare alongside the patient's data.

Note:
Do not attach documents that should have been added to the patient's record using clinical items and so on.

A valid attachment is a document that meets the following criteria:

- It is a PDF document with the extension `.pdf`. If the document is not a PDF, it must be converted to PDF first before it can be attached. Talk to your administrator about the best way to do this.
- It is less than or equal to the size limit for documents, the default is 512KB. Documents larger than this cannot be stored in the database.

> **Tip:**
> Take care not to save the same attachment to a patient's record multiple times.

To add a document:

1. Either:
   - On the clinical record, drag and drop the document or click **Attachment** on the clinical record toolbar.

     You cannot drag and drop folders or multiple files. Drag and drop also doesn't work in the following circumstances:
     - When dragging from a local desktop to a remote desktop session.
     - When dragging from a local desktop to Communicare published as an application via Citrix.
     - When dragging an attachment within an email application (such as Microsoft Outlook) to Communicare.
   - In **Documents and Results > Scanned Documents and Attachments** tab, click Attachment and select the document you want to attach.
2. In the **PDF Viewer**, you can review the document, select the document date, add an appropriate comment, and also choose the viewing right and topic. The comment will default to the file name (without the path or extension), but can be edited.
   The date will default to the time the attachment was last modified and cannot be set to a future date or no date.
3. Click **Save**.

Once attached, the document cannot be changed.

Attached documents are listed on the **Detail** tab of the clinical record, prefixed with `Attachment` and are also displayed on the progress notes. For example:

If the document is unreviewed, it is also added to the count of unreviewed documents in the banner.

To open the document, click **Documents** in the banner or double-click the item in the progress notes or on the **Detail** tab.

You can edit the comment, viewing right and topic if required.

Send documents

Using Communicare you can send documents electronically.

If there is a need to send a letter it is useful to have it recorded just as a history log. Documents written in Communicare can then be sent using secure email.

Referral letters should be created from a referral clinical item so that follow-up can be monitored. The referral letter itself is a record of what was written but the clinical item is a record that a referral has been initiated.

Writing letters and referrals

You can write letters and referrals from a patient's clinical record. You can also write letters from  **Documents and Results** or from **File > Documents**.

Letter templates are created by users with `Reference Tables` rights in **Tools > Communicare Templates**.

A document can be sent to only one recipient. After it has been sent, the document, recipient, sender and patient details cannot be changed, however, the document can be sent again.

If you want to provide patient-specific information in a letter or referral, create it from the clinical record: click  **Letter**. Encounter place and mode, patient details, and provider details are filled in automatically.

Alternatively, create a blank letter using one of the following methods:

- Select **File > Documents > Write New Letter**
- Select **File > Documents > Browse Documents**, and on the **Outgoing Documents** tab, click  Write a new letter
- Click  **Documents and Results** and on the **Outgoing Documents** tab, click  Write a new letter

> **Note:**
>
> From  **Documents and Results**, ensure you specify the place mode, patient and provider if they are not already specified, before using a blank template or any of the data objects.

To write a referral or letter about a patient:

1. In the patient's clinical record, click  **Letter**.
2. In the **Select Document Template** window, select a letter template in the list and click **Select**. For example, select `Antenatal Care Record` for a referral, select `Referral Letter (Standard)`.
   Encounter place and mode, patient details, and provider details are filled in automatically, except if you use the blank letter template.
3. If you selected a referral template, in the **Address Book**, select an addressee.
4. Compose or edit the letter or referral:
   - To insert links to web pages, documents, images and local network folder shares to tie patient documents to other resources, click  or select **Insert > Hyperlink**.

     > **Note:**
     > Communicare will try to open the hyperlink target using the default viewing application. If a default application does not exist, choose the best program with which to open the link target from the **Open With** window.

- To insert images, click Picture or select **Insert > Picture**. Communicare supports the following image file types in letters: JPEG (*.jpeg), Windows Bitmap (*.bmp), Icon files (*.ico), Windows Metafiles (*.emf;*.wmf), and GIF (*.gif).
- To spell check the letter, click .

5. Add patient-specific information from the right-hand pane:
   - Either double-click or drag an item onto the letter.
   - To insert clinical information, expand **Clinical Record** and select the required item. For example, to insert the latest BP into the Antenatal Care Record:
     a. With the cursor in the **BP** field, select **Clinical Record > Latest Qualifier (Value only)**.
     b. In the **Qualifier Type** window, in the **Locate** field, enter `BP`.
     c. Select **BP - Diastolic Blood Pressure** and click **Select**. The most recent value is inserted into the letter.
     d. Repeat steps a-c for **BP - Systolic Blood Pressure**.
   - Some items will prompt you for information, such as:
     - **Clinical Record > Investigation Results** - select CTRL+click to select multiple results
     - **Clinical Record > Progress Notes** - select and preview one note at a time
   - To insert drawings attached to a clinical item:
     a. Select **Clinical Record** and double-click **Latest Qualifier**.
     b. In the **Qualifier Type** window, in the **Locate** field, enter a drawing qualifier, for example `Drawing:body (front and back)`.

        The drawing and a key including annotations are added to the letter. For more information about drawings, see Add drawings to clinical items *(on page 159)*.
6. From the **Topic** field, select an appropriate topic. Documents are filed with a Class type of `Document` and can be found under the **Topic** tab that you select.
7. In the **Comment** field, enter a useful comment. You can later use the comment to search for a specific letter without having to open each letter in turn.
8. Either print the letter or send it electronically, or both:
   - To print the letter only, click **Print and Save**.
   - To send the letter electronically only:
     a. Select an addressee if you have not already: in the **Outgoing** pane, double-click in the **To** field and select an addressee.
     b. Click **Send Secure**.
   - To print the letter and leave the window open to also send electronically:
     a. Check the layout, click Print Preview.
     b. Click Print.
9. Click **Save**.

Letters and referrals are sent securely as PDFs when `CCareQueue_SMD` next runs. Outgoing documents are saved to `C:\CCare\Communicare\out_doc` and are displayed on **Documents and Results > Outgoing Documents** tab.

Tip:
If an error occurs while sending a document securely, either on the Communicare side or SMD vendor end, click  Resend to try to send the document again.

Saved letters are printed to PDF.

If you entered a useful topic and comment, the letter can be easily retrieved from the **Detail** tab of the clinical record. Documents have a Class type of `Document` and can be found under the **Topic** tab that you specified.

Tip:
If you are sending the letter or referral using PDS and the recipient cannot receive the document you attempted to send, you will see one of the following errors:

Table 107. Errors displayed if recipient cannot receive the letter or referral

Action	Error if recipient cannot receive the message
Create a referral and send as a letter	`The selected recipient cannot receive this document type`
Create a referral and send as eReferral	`Communicare cannot send CDA eReferrals via secure messaging`

If you later open a document from the **Details** tab in the clinical record, you are prompted with several choices:

- Incoming documents will always open in read-only with no prompt.
- For other read only documents, either:
  - View the document as it is without being able to change the data in it.
  - Create a copy of the document with the same data that you can edit. The old document will not be overwritten or lost.
- For editable documents:
  - View the existing document - this will open the document but not allow any changes to be made.
  - Modify the existing document as it is.
  - Create a copy of the document with the same information in it that you can edit. The old document will not be overwritten or lost.

Selecting a template

Use the **Select Document Template** window to select a template when creating a document or writing a letter.

If you open the letter writer from the clinical record, you can choose from existing templates.

To find a particular template, in the **Search Text** field, enter part of the template name you are looking for. Communicare will filter the templates as you type.

If you want to provide patient-specific information in a letter or referral, create it from the clinical record: click  **Letter**. Encounter place and mode, patient details, and provider details are filled in automatically.

Alternatively, create a blank letter using one of the following methods:

- Select **File > Documents > Write New Letter**
- Select **File > Documents > Browse Documents**, and on the **Outgoing Documents** tab, click Write a new letter
- Click **Documents and Results** and on the **Outgoing Documents** tab, click Write a new letter

Send eReferrals

Communicare can create and send eReferrals in the CDA format compliant with eHealth standards in Australia.

An eReferral is a referral of a subject of care such as a patient or client from one health care provider to another.

- The `eReferral` Clinical Item must be enabled. See Clinical Item Types *(on page 885)*.
- Encounter places *(on page 872)* must have an HPI-O *(on page 632)* configured.
- The current Provider must have an HPI-I *(on page 632)*.
- The patient must have an IHI *(on page 632)*.
- Secure Messaging must be configured if you plan to send via secure messaging. See Secure Messaging *(on page 341)*.
- My Health Record must be configured if you plan to upload to the My Health Record. See My Health Record *(on page 780)*.

eReferral CDA document data sections:

- Referee - the specialist to whom the patient is being referred, populated from the Provider referred to field in the Referral class clinical item.
- Medical History - the past and current medical history of the patient, including problem and diagnosis, and any medical or surgical procedures recorded in their clinical record, populated from any procedure and condition clinical class items recorded on the main summary *(on page 122)* screen.
- Medications - current medications recorded in Communicare. See Medication Summary *(on page 127)*.
- Adverse Reactions - lists any adverse reactions recorded for the patient in Communicare. See Clinical Record - Summary Tab *(on page 122)*.
- Diagnostic Investigations - contains any investigation results for investigations that were received and matched to the patient's record in the 30 days prior to the referral date.

To create and send an eReferral:

1. Open the clinical record for the patient for whom you want to create an eReferral.
2. Create a `Referral` class clinical item. Search for the keyword `referrals`.
3. Add the required details.
4. Click **Save & Create eReferral**.
5. The **View eReferral** window displays the required information based on the data entered in the `eReferral` clinical item.
    a. Use the tree to exclude any clinical information listed that is not relevant, or needs to be excluded from the document.
    b. In the **Details** panel at the bottom of the window, from the **To** field select a document recipient.
    c. When ready, save, print, or upload to My Health Record *(on page 780)*.
    d. Send the eReferral securely using Secure Messaging *(on page 341)*. Click **Send Secure**.
    e. Click **Save and Upload to My Health Record**. If you have previously uploaded an eReferral, set **Supersede** to replace the previous My Health Record document with a new document from Communicare.

Letter viewer

Use the **Letter Viewer** to view the contents of a document without printing it.

You cannot edit the letter from this window.

Discharge Summaries

Communicare can create and send Discharge Summaries either in the CDA format (compliant with eHealth standards in Australia) or in a less constrained RTF format. RTF format Discharge Summaries cannot be sent to MeHR, whereas CDA format documents can be sent to either My Health Record or MeHR.

- The `Discharge;hospital;summary` Clinical Item must be enabled. See Clinical Item Types *(on page 885)*.
- Encounter places *(on page 872)* must have a valid HPI-O *(on page 632)* configured.
- The current Provider must have a valid HPI-I *(on page 632)*.
- The patient must have a valid IHI *(on page 632)*.
- If you plan upload to the My Health Record, My Health Record must be configured. See My Health Record *(on page 780)*.
- If you plan to send via secure messaging, Secure Messaging must be configured. See Secure Messaging *(on page 341)*.

A discharge summary is a collection of information about events during care by a provider or organisation, which is released when the subject of care is discharged from the care of the provider organisation.

To create and send a discharge summary:

1. Open the clinical record for the patient for whom you want to create a discharge summary and add a new clinical item of type `Discharge;hospital;summary`.
2. Complete the discharge information. All fields must be completed if a CDA format document is required and HPI-O, HPI-I and IHI are also required. HPI-O, HPI-I and IHI health identifiers are not required for RTF format.
    - **Clinical Synopsis** - summary information or comments about the clinical management of the patient, and the prognosis of diagnoses and problems identified during the healthcare encounter. It may also include health related information pertinent to the patient, and a clinical interpretation of relevant investigations and observations performed on the patient (including pathology and diagnostic imaging).
    - **Hospital Discharge Date** - the date that the patient was discharged from hospital, on or after the admission date.
    - **Hospital Admission Date** - the date that the patient was admitted to hospital.
    - **Separation Mode** - status at separation of the patient and place to which the person is released, based on the Australian Institute of Health and Welfare's Mode of Separation (seeMeteor). Must be one of the following values:
        - Discharge/transfer to (an)other acute hospital
        - Discharge/transfer to a residential aged care service, unless this is the usual place of residence
        - Discharge/transfer to (an)other psychiatric hospital
        - Discharge/transfer to other health care accommodation (includes mothercraft hospitals)
        - Statistical discharge - type change
        - Left against medical advice/discharge at own risk
        - Statistical discharge from leave
        - Died
        - Other (includes discharge to usual residence, own accommodation/welfare institution (includes prisons, hostels and group homes providing primarily welfare services))

- **Primary Healthcare Provider** - the health care provider nominated by the patient as being primarily responsible for their ongoing health care, taken from the address book *(on page 335)*. The provider must have an HPI-I *(on page 632)* and HPI-O *(on page 632)*.
- **Discharge Arranged Services** - services that have been provided for or arranged for the patient.
- **Discharge Recommendation Recipient** - a person or organisation at whom the discharge recommendation is directed, taken from the address book *(on page 335)*. If the recipient is a person, that person must have an HPI-I *(on page 632)* and an HPI-O *(on page 632)*. If the recipient is an organisation, that organisation must have an HPI-O *(on page 632)*.
- **Discharge Recommendation** - recommendations to a recipient healthcare provider or subject of care that are relevant to the continuity of care and management of the subject of care after discharge. This may include information such as: information and education that has been provided to and discussed with the patient, their family , carer or other relevant parties, including awareness or lack of awareness of diagnosed conditions, and relevant health management; an indication of whether the patient or carer has understood the information or instructions provided; information or recommendations given by a health care provider during the health event to another health care provider responsible for the ongoing care of the patient.

3. Once you have filled in all the discharge details, either:
   - For a CDA Discharge Summary, click **Save & Create eDischarge Summary**. The **View Discharge Summary** window displays a tree view of the document on the right and a preview on the left. Communicare will have gathered the required information based on the data entered in the Discharge Summary clinical item, and any clinical information that has been entered against the patient within the date range of the hospital visit required for the summary document, as entered on the Discharge Summary clinical item.
     a. Use the tree to exclude any clinical information listed that is not relevant, or needs to be excluded from the document.
     b. In the **Details** panel at the bottom of the window, from the **To** field, select a document recipient.
     c. When ready, save, print, or upload to the My Health Record *(on page 780)* and send it in the same way as other documents. For more information, see Writing letters and referrals *(on page 319)*.
     d. Click **Save and Upload to My Health Record**.
     e. If you have previously uploaded a discharge summary, set **Supersede** to replace the previous My Health Record document with a new document from Communicare.
   - To write a discharge letter in RTF format, click **Save & Write Discharge Summary**.
     a. In the **Write a new Discharge Summary Letter** window, write a letter.
     b. When the required edits are complete, save or print the document in the usual way. Send the Discharge Summary securely using Secure Messaging: click **Send Secure**. For more information, see Writing letters and referrals *(on page 319)*.

If you chose the eDischarge option, the document is queued and will upload to My Health Record at the next upload.

Tip:
If you are sending the discharge summary using PDS and the recipient cannot receive the document you attempted to send, you will see one of the following errors:

Table 108. Errors displayed if recipient cannot receive the discharge summary

Action	Error if recipient cannot receive the discharge summary
Create a discharge summary and send as a letter	`The selected recipient cannot receive this document type`

Table 108. Errors displayed if recipient cannot receive the discharge summary (continued)

Action	Error if recipient cannot receive the discharge summary
Create a discharge summary and send as CDA	`Communicare cannot send CDA discharge summaries via secure messaging`

eDischarge CDA Document Summary Data sections

- **Problems/Diagnoses This Visit** - contains any `Condition` class clinical items that were recorded between the admission and discharge dates.
- **Clinical Interventions Performed This Visit** - contains any `Procedure` class clinical items that were conducted between the admission and discharge dates.
- **Clinical Synopsis** - populated from the free text field on the `Discharge;hospital;summary clinical` item.
- **Diagnostic Investigations** - contains any investigation results for investigations that were conducted between the admission and discharge dates.
- **Current Medications On Discharge** - contains medications recorded in Communicare that the patient will continue or commence on discharge.
- **Ceased Medications** - contains any medications recorded in Communicare that were stopped, cancelled or ran their course between the admission and discharge dates.
- **Adverse Reactions** - lists any adverse reactions recorded for the patient on their clinical record.
- **Alerts** - lists any alerts recorded for the patient on their clinical record.
- **Arranged Services** - populated from the `Discharge;hospital;summary` clinical item.
- **Record of Recommendations and Information Provided** - populated from the `Discharge;hospital;summary` clinical item.
- **Participants** - contains all providers who recorded a service for this patient in Communicare between the admission and discharge dates.
- **Primary Recipients** - contains the details of the discharge summary recipient selected in the **To** field of the **Document View** window.

Receive documents

Using Communicare you can receive documents electronically.

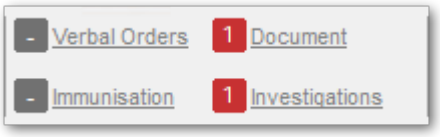
CDA documents sent to Communicare through Secure Messaging or File Drop are listed with all other documents on the  **Documents and Results > Received Documents** tab. Received CDA documents are read-only. You can open received CDA documents and assign them to patients as you would for any other received document.

After a document has a patient, provider and topic selected the document is deemed to be processed. The document will be attached to a patient's clinical record once a name is attached. If a topic has not been selected, in the patient's clinical record, the document is displayed on the **Unclassified Documents** tab when in **Topic** view. In **Class** view, documents appear under **Document**.

Reviewing documents

You can review incoming or scanned documents from a patient's clinical record or more generally from  **Documents and Results**.

If a patient has an unreviewed incoming or scanned document, in their clinical record, the **Document** link in the banner shows a count. For example:



To review a document:

1. Either:
   - In a patient's clinical record:
     a. In the banner, click **Document**.
     b. On the **Document** tab, in the list double-click the document you want to review with a prefix of `<Unreviewed>`.
   - In the main toolbar:
     a. Click **Documents and Results**.
     b. Go to the **Scanned and Attached Documents** tab.
     c. Double-click the document you want to review.
2. In the **Edit PDF Attachment** window, set **Reviewed**.

   From the clinical record, the current service provider, at the encounter place and mode of the current service, and under the program attached to the current service are added. These details cannot be edited.

   On the **Documents and Results > Scanned and Attached Documents** tab, the reviewer, place and program default to those selected in the Provider Mode Place selection *(on page 111)*. The Encounter Mode defaults to `Administration - No client contact`. If it does not, the mode defaults to that selected on the Provider Mode Place selection *(on page 111)*. Update these details as required.
3. If you want to add a recall:
   a. Click **Add Recall** and select a recall, investigation or treatment item.
   b. In the **Add Recall** window, enter the required information.
   c. Click **Save**.

   For information about shortlisting clinical items recallable from the document window, see Matching and Reviewing Results *(on page 309)*.
4. Click **Save**.

After a document has been reviewed, its status changes to `<Reviewed>`, the reviewing details (that is, reviewer, place, mode and program) become read-only. The **Documents** count in the banner is decreased by 1.

The review date is set to the current date and attached to the first started service for the current date which matches the selected patient, reviewing provider, place, mode and program. If there aren't any, a new service is created with these details, and a status of `Finished` and the reviewed document attached to it.

The document is added to a patient's clinical record once a name is attached and in the patient's clinical record, is listed in **Detail > Class > Document**. If a topic has not been selected, the document is displayed on **Detail > Topic > General & Unspecified** tab.

If you later need to change any of the review details, the document must be edited and reviewed again. To edit document properties:

1. Either:
    - In the clinical record, on the **Detail > Document** tab, right-click the document with a status of `<Reviewed>` and select **Edit Document Properties**.
    - In **Documents and Results**:
        a. On the **Scanned and Attached Documents** tab, from the **Status** list, select **Reviewed**.
        b. Double-click the required document.
2. Click **Show Details**.
3. Deselect **Reviewed**.
4. Click **Save**.

Repeat the procedure above to review the document.

Delete documents

Use the **Browse Documents** window to delete documents.

Documents are removed from display but are not deleted from the database.

To delete a document:

1. Select **File > Documents > Browse Documents**.
2. In the **Browse Documents** window, go the tab which contains the document you want to delete.
   For example, go to the **Scanned and Attached Documents** tab.
3. Display the document you want to delete.
    - If the document has not been processed, to display all unreviewed documents, from the **Status** field, select `Unreviewed`.
    - To display a reviewed document for a particular date, from the **Status** field, select `Reviewed` and select a date range.
4. Select the document you want to delete and click Delete.
5. Enter a reason for the removal of the document of at least 5 characters and click **OK**.

The document is logically deleted.

To display documents that have been deleted, in the **Browse Documents** window, from the **Status** field, select `Deleted`.

In a patient's clinical record, to display deleted documents and other items, on the **Detail** tab, in the item list, right-click and select **Show Deleted Items**. Deleted items are prefixed with `<Deleted>`.

Clinical Document Architecture (CDA)

Communicare can send and receive CDA documents.

CDA Clinical Document Architecture (CDA) is the standard format for eHealth Messages in Australia.

Communicare is compliant with NEHTA for unpacking and rendering CDA documents, packaging CDA documents, and producing the following documents. Communicare can create and send the following CDA Document types:

- Discharge Summaries *(on page 323)*
- eReferrals *(on page 322)*

- Event Summaries *(on page 329)*
- Shared Health Summaries *(on page 331)*

Common Data

All CDA documents contain the following sections:

- Custodian:
  - The organisation in charge of maintaining the document, that is, the steward that is entrusted with the care of the document.
  - Every CDA document can only have one custodian.
  - The Custodian field is populated with data from the organisation and requires that the organisation has a valid HPI-O. See Organisational Parameters - General *(on page 835)*.
- Author:
  - The healthcare provider who composed the CDA Document.
  - Every CDA document can have only one author.
  - The Author field is populated with the details of the current provider and requires that the provider has a valid HPI-I (see Edit Provider *(on page 921)*) and the encounter place has a valid HPI-O (see Edit Encounter Place *(on page 872)*).
- Subject of care:
  - Identifies the person for whom the healthcare event, encounter or clinical interaction has been captured or interchanged, that led to the creation of the document. In other words, the subject of the information.
  - Every CDA document can have only one subject of care.
  - The subject of care is populated with the details from the patient's biographic record and requires that the patient has a valid IHI. See Patient Biographics *(on page 30)*.

Upload to My Health Record

You can upload the following CDA document to a patient's My Health Record *(on page 780)*:

- eReferrals
- Discharge Summaries
- Event Summaries
- Shared Health Summaries

Upload to a Private Repository

Some large health organisations may choose to upload the following CDA documents to a private repository instead of a patient's My Health Record *(on page 780)*:

- Event Summaries
- Shared Health Summaries

Sending Documents Securely

You can send eReferrals and Discharge Summary CDA documents securely via Secure Messaging *(on page 341)*.

Saving a CDA Document

Whenever you upload a CDA document to My Health Record, or send via Secure Messaging, the document is automatically saved. However, you can also manually save eReferrals and Discharge Summaries.

In the Document view window, click **Save**.

Saved documents are listed in a patient's Clinical Record, on the **Detail** tab.

Receiving a CDA Document

CDA documents may be received into Communicare using Secure Messaging *(on page 341)* or File Drop.

CDA documents in the My Health Record *(on page 780)* can be opened for viewing, however these documents cannot be saved into Communicare's database. See Viewing My Health Record Documents *(on page 786)*.

Security

- The My Health Record security model does not support Communicare's Viewing Rights. Granting access to the My Health Record to users with limited Viewing Rights may result in those users viewing restricted information in the My Health Record.
- Care should be taken when submitting documents to the My Health Record to ensure that sensitive data is not uploaded by mistake.
- Communicare recommends that users who access the My Health Record should have full Viewing Rights.

Event Summaries

Communicare creates Event Summaries in the CDA format compliant with eHealth standards in Australia. Event summaries can then be uploaded to My Health Record or an internal CDA repository.

An Event Summary is a record, reported by a clinician, of significant health care events involving the subject of care.

The following configuration is required before Event Summaries can be generated:

- Encounter places *(on page 872)* must have a valid HPI-O *(on page 632)* configured.
- The current Provider must have a valid HPI-I *(on page 632)*.
- The patient must have a valid IHI *(on page 632)*.
- Either My Health Record or an internal CDA repository must be configured. See My Health Record *(on page 780)*.

When you exit a service, you can send an Event Summary for the patient to My Health Record, if they have a valid IHI *(on page 632)*.

To upload an Event Summary to My Health Record:

1. After you have completed a service, close the Clinical Record.
2. In the **Service exit** window, set **Send Event Summary to My Health Record**.

- This option is automatically selected if the patient consents to My Health Record uploads, or if the patient has not been asked whether they consent to My Health Record uploads. See My Health Record Upload Consent *(on page 787)*.
- If there are no MHR options available in the **Service exit** window, the patient may not have a valid IHI. Click **My Health Record** to display information about why an Event Summary cannot be generated.
- If you are exiting a service that is not for today's date, this window is not displayed and you cannot generate an Event Summary.

3. Click **Yes - This service is now complete**.
4. In the **Service Record** window, complete the Medicare details and click **Claim now** or the Private billing details and click **Save**. The Event Summary is generated and displayed in the **New Event Summary** window. Only information from the current service is included.
5. In the Event Summary tree view in the right panel, select the information to include in the Event Summary and exclude any information that is not relevant. The information included by default depends on whether or not the **Select all Event Summary clinical data items by default** system parameter is set. Include any or all of the following information:
   - **Event Details**:
     - **Clinical Synopsis** - a clinical synopsis of the event and its reasons, including any qualifiers that have been recorded in this encounter, where the qualifier type has the category of `Clinical Synopsis` (see **File > Reference Tables > Qualifier Types**).
     - **Progress Notes** - the progress notes from this service encounter from all providers, including free text and the summary line of each clinical item added to the progress note.
   - **Adverse Reactions** - lists any adverse reactions for the patient that were recorded in the current service. See Clinical Record - Summary Tab *(on page 122)*.
   - **Immunisations** - lists any immunisation class clinical items that were recorded during the current service. See Clinical Records *(on page 112)*.
   - **Diagnoses / Intervention**:
     - **Problem / Diagnosis** - lists any condition class clinical items that were recorded during the current service. See Clinical Records *(on page 112)*.
     - **Procedures** - lists any procedure class clinical items that were recorded during the current service. See Clinical Records *(on page 112)*.
   - **Medications** - lists any new medications, and any existing medications that are still current. See Medication Summary *(on page 127)*.
   - **Diagnostic Investigations** - lists any investigation requests or results from the current service. See Investigations *(on page 299)*.
6. If you want to edit progress notes in the Event Summary:
   a. Select one of the Clinical Synopsis options.
   b. Click **Edit Clinical Synopsis**.
   c. In the **Edit Clinical Synopsis** window, add notes anywhere.
   d. Click **Save**. These changes do not alter the data recorded in the database, only the event summary.
7. To display the history for any data section for which additional data is recorded in the current service, except for the progress notes and clinical synopsis, click **Show History**.
8. When you are happy with the document, click **Save and Upload to My Health Record**.

The document is queued and is uploaded to My Health Record at the next upload.

If you generate another Event Summary for the same service, **Supersede** is set. This option replaces the previous Event Summary uploaded to My Health Record with a new document from Communicare. You can supersede a document if the following conditions are met:

- You were the author of the document.
- The HPI-O recorded in Communicare matches the HPI-O of the document.
- The document types match, that is, you can only replace an Event Summary with another Event Summary.
- You have not clicked **Save**.

Shared Health Summaries

Communicare creates Shared Health Summaries in the CDA format compliant with eHealth standards in Australia. Shared Health Summaries can then be uploaded to My Health Record or an internal CDA repository.

A Shared Health Summary is a clinical document written by the nominated provider, that contains key pieces of information about an individual's health status and is useful to a wide range of providers in assessing individuals and delivering care. Shared Health Summaries contain medical history and adverse reactions, immunisations and medications from the current service.

The Personally Controlled Electronic Health Records Act states that the author of a Shared Health Summary should be one of the following:

- Medical Practitioners
- Registered Nurses
- Aboriginal or Torres Strait Islander health practitioners, with a Certificate IV in Aboriginal or Torres Strait Islander Primary Health Care (Practice)

The following configuration is required before Shared Health Summaries can be generated:

- Encounter places *(on page 872)* must have a valid HPI-O *(on page 632)* configured.
- The current Provider must have a valid HPI-I *(on page 632)*.
- The patient must have a valid IHI *(on page 632)*.
- Either My Health Record or an internal CDA repository must be configured. See My Health Record *(on page 780)*.

When you exit a service, you can send a Shared Health Summary for the patient to My Health Record if they have a valid IHI *(on page 632)*, or to an internal CDA repository.

To upload an Event Summary to My Health Record:

1. After you have completed a service, close the Clinical Record.
2. In the **Service exit** window, set **Send Shared Health Summary to My Health Record**.
    - This option is automatically selected if the patient consents to My Health Record uploads, or if the patient has not been asked whether they consent to My Health Record uploads. See My Health Record Upload Consent *(on page 787)*.
    - If there are no MHR options available in the **Service exit** window, the patient may not have a valid IHI. Click **My Health Record** to display information about why an Event Summary cannot be generated.
    - If you are exiting a service that is not for today's date, this window is not displayed and you cannot generate an Event Summary.
3. Click **Yes - This service is now complete**.

4. In the **Service Record** window, complete the Medicare details and click **Claim now** or the Private billing details and click **Save**.
   The Shared Health Summary is generated and displayed in the **New Shared Health Summary** window. Only information from the current service is included.
5. In the **Shared Health Summary** tree view in the right panel, select the information to include in the Shared Health Summary and exclude any information that is not relevant. The information included by default depends on what you included in the Event Summary for the same service. If an Event Summary was not created for the service, no items are selected. Include any or all of the following information:
   - **Adverse Reactions** - lists any adverse reactions for the patient that were recorded in the current service. See Clinical Record - Summary Tab *(on page 122)*.
   - **Immunisations** - lists any immunisation class clinical items that were recorded during the current service. See Clinical Records *(on page 112)*.
   - **Medical History** - lists any procedures and conditions from previous service encounters. These are not included by default.
   - **Medications** - lists any new medications, and any existing medications that are still current. See Medication Summary *(on page 127)*.
6. If you want to edit progress notes in the Event Summary:
   a. Select one of the Clinical Synopsis options.
   b. Click **Edit Clinical Synopsis**.
   c. In the **Edit Clinical Synopsis** window, add notes anywhere.
   d. Click **Save**. These changes do not alter the data recorded in the database, only the event summary.
7. To display the history for any data section for which additional data is recorded in the current service, except for the progress notes and clinical synopsis, click **Show History**.
8. When you are happy with the document, click **Save and Upload to My Health Record**.

The document is queued and is uploaded to My Health Record at the next upload.

Shared Health Summary Exclusion Statements

Set exclusion statements for any section in the Shared Health Summary that does not include data.

When a user is generating a Shared Health Summary and there is no data in a data section (Medication, Problem/Diagnosis, Procedures and Immunisations) the user must set the exclusion statement for that section. Select from the following options:

- **None known** - use when you want to make a positive statement that there are no known items. This is equivalent to *no clinically significant items known*. The absence of items in a list is not evidence that there are none known, even if the expectation is that the user will record any existing items in the system. Communicare does not set this exclusion statement if there are no list items, instead it is a positive statement made by a healthcare provider before or during the document authoring process.
- **None supplied**- use when there are no items to list, and the user has not made an explicit statement of **None known**. **None supplied** does not imply anything at all about whether there are items, or whether they are known, or why there are no items supplied. Except for shared health summaries, Communicare sets this exclusion statement automatically, in the absence of any list items, and where the user has had the opportunity to specify a different exclusion statement but has not done so.

If the user excludes all clinical information using the tree in the document, it will default to an exclusion statement of **None Supplied**.

CDA Third Party Storage

Instead of sending CDA documents like the Event Summary and Shared Health Summary to My Health Record directly, some large health services may use a private repository.

Event Summary and Shared Health Summary documents are created by a clinician when finishing a service. The documents are digitally signed to prevent tampering.

Configuring use of a private CDA repository

Follow these steps to configure Communicare to save CDA documents to a private repository.

The following configuration is required before summaries can be generated:

- Encounter places *(on page 872)* must have a valid HPI-O *(on page 632)* configured.
- The current Provider must have a valid HPI-I *(on page 632)* that is linked to their Communicare login username
- NASH Org Certificate *(on page 857)* matching the encounter place's HPI-O. The NASH certificate is used to sign the CDA document.

To configure Communicare to save CDA documents to a private repository, complete the following steps:

1. Disable My Health Record access:
    a. Log into Communicare as an administrator.
    b. Select **File > System Parameters**, **System** tab.
    c. In the modules list, deselect **My Health Record Access**.
2. Enable use of the private repository:
    a. On the **System** tab, in the modules list, set **Third Party CDA**.
    b. On the **Web Services** tab, ensure that **Enable HI Service** is set.
    c. On the **Integration** tab, in the **Private repository name** field, enter the name of your private repository.
    d. On the **Integration** tab, if you don't want to include patient addresses and phone numbers in the generated XML documents, deselect **Include patient contact details**. Patient contact details are not displayed in the rendered summaries, but are included in the XML source if this option is set.
    e. Click **Save**.
    f. Enter your authority code provided by Communicare Support.
    g. Restart Communicare.
3. Set certificates:
    a. Select **File > Organisation Maintenance**.
    b. Open your health service and on the **Certificates** tab, in the **HI Certificate** field, select your HI certificate.
    c. Click **Save**.
4. Grant access to the module to user groups:
    a. Select **File > User Groups**.
    b. Select the user group that you want to grant access to.
    c. On the **System Rights** tab, set **Third Party CDA**.
    d. Click **Save**.

You can now generate and save CDA Event Summaries and Shared Health Summaries to your private CDA repository.

Saving documents to a private repository

Follow these steps to save CDA documents to a private repository.

To save Event Summary and Shared Health Summary documents to a private CDA repository:

1. After you have completed a service, close the Clinical Record.
2. In the Service exit window, set both **Send event summary to repository** and **Send Shared Health Summary to repository**, where repository is the name of your private repository set in step 3.c *(on page 333)* of the CDA configuration.
3. Click **Yes - This service is now complete**.
4. In the **Service Record** window, complete the Medicare details and click **Claim now** or the Private billing details and click **Save**. The Event Summary is generated and displayed. Only information from the current service is included.
5. In the **New Event Summary** window, in the tree view in the right panel, select the information to include in the Event Summary and exclude any information that is not relevant. Include any or all of the following information:
    - **Event Details**:
        - **Clinical Synopsis** - a clinical synopsis of the event and its reasons, including any qualifiers that have been recorded in this encounter where the qualifier type has the category of Clinical Synopsis (see **File > Reference Tables > Qualifier Types**).
        - **Progress Notes** - the progress notes from this service encounter from all providers, including free text and the summary line of each clinical item added to the progress note.
    - **Adverse Reactions** - lists any adverse reactions for the patient that were recorded in the current service. See Clinical Record - Summary Tab *(on page 122)*.
    - **Immunisations** - lists any immunisation class clinical items that were recorded during the current service. See Clinical Records *(on page 112)*.
    - **Diagnoses / Intervention**:
        - **Problem / Diagnosis** - lists any condition class clinical items that were recorded during the current service. See Clinical Records *(on page 112)*.
        - **Procedures** - lists any procedure class clinical items that were recorded during the current service. See Clinical Records *(on page 112)*.
    - **Medications** - lists any new medications, and any existing medications that are still current. See Medication Summary *(on page 127)*.
    - **Diagnostic Investigations** - lists any investigation requests or results from the current service. See Investigations *(on page 299)*.
6. If you want to edit progress notes in the Event Summary:
    a. Select one of the Clinical Synopsis options.
    b. Click **Edit Clinical Synopsis**.
    c. In the **Edit Clinical Synopsis** window, add notes anywhere.
    d. Click **Save**. These changes do not alter the data recorded in the database, only the event summary.
7. To display the history for any data section for which additional data is recorded in the current service, except for the progress notes and clinical synopsis, click **Show History**.
8. Click **Save and Upload to repository**.
9. In the **Shared Health Summary Exclusion Statements** window, from the **Problems / Diagnoses** list, select `None Supplied` and click **Generate Shared Health Summary**. Conditions and procedures for the current service are not included in the Shared Health Summary.
10. In the **New Shared Health Summary** window, in the tree view in the right panel, select the information to include in the Shared Health Summary and exclude any information that is not relevant. The information included by default depends on what you included in the Event Summary for the same service. If an Event Summary was not created for the service, no items are selected. Include any or all of the following information:

- **Adverse Reactions** - lists any adverse reactions for the patient that were recorded in the current service. See Clinical Record - Summary Tab *(on page 122)*.
- **Immunisations** - lists any immunisation class clinical items that were recorded during the current service. See Clinical Records *(on page 112)*.
- **Medical History** - lists any procedures and conditions from previous service encounters. These are not included by default.
- **Medications** - lists any new medications, and any existing medications that are still current. See Medication Summary *(on page 127)*.

11. When you are happy with the document, click **Save and Upload to repository**.

The document is queued for upload to your private repository.

To display the CDA documents:

1. In Communicare, select  **Documents and Results** and go to the **Outgoing Documents** tab.
2. From the **Status** list, select `All`.

Double-click a document to open it and confirm that it contains the expected content.

Combined Address Book

The combined address book stores local address book entries and allows you to search multiple, online provider directories.

To display the address book, select **File > Address Book** (`CTRL+ALT+B`). Use the address book:

- To search the local address book
- To search online provider directories
- To add addresses to the local address book, either manually or from the online provider directories
- To add an addressee to a letter, referral or clinical item
- For Secure Messaging *(on page 341)* if the addressee is linked to HealthLink

In V22.2 and later, Communicare can use the Secure Message Exchange and `CCareQueue_SMD` to search online provider directories (SMD vendors), including HealthLink, and to send and receive secure messages using HL7 V2.4 or HL7 V2.3.1.

If you have the `Address Book Maintenance` system right, you can insert, update or delete records from the address book, including if you are redirected from a letter, referral, clinical item and so on.

Before users can search the online provider directories, the combined address book must be configured. For more information, see Address Book configuration *(on page 341)*.

Search for an address

The Combined Address Book is displayed whenever you need to add an addressee.

For example, from a patient's clinical record, you might add a referral to an oral surgeon at a hospital and use the **Address Book** to find the hospital and surgeon. The addressee's details are included in the letter or eReferral automatically, or you may change those details before sending or printing.

Note:
To search the online provider directories, and import to and edit the local address book, you must belong to a user group that has the `Address Book Maintenance` system right. You can still send to providers already included in your local address book if you don't have this system right.

Use the **Address Book** to search online provider directories for an individual or organisation and create a record in your local address book. You can only send referrals and so on to addressees included in your local address book. Entries in the local address book are displayed when you first open the **Address Book** window.

In V22.2 and later, Communicare can use the Secure Message Exchange and `CCareQueue_SMD` to search online provider directories (SMD vendors), including HealthLink, and to send and receive secure messages using HL7 V2.4 or HL7 V2.3.1.

An individual provider may have multiple entries in separate online provider directories, depending on which services they are subscribed to and their:

- Speciality
- Organisation
- Location
- SMD vendor

An organisation may have multiple entries in online provider directories, depending on which services they are subscribed to and the following criteria:

- Practice name
- Location
  - Organisations can have one or more healthcare services at a location
  - Multiple specialties at a single location can be one healthcare service, or multiple specialities with the same organisation and location
- SMD vendor

Table 109. Address book search options

Search criteria	Online	Local	Notes
Individual	✓	✓	Enter all or part of an individual's name.
Organisation	✓	✓	To return an organisation, specify the complete organisation name. When searching by organisation name, individuals of that organisation are returned only if they have been added to the local address book.
Department	✗	✓	Specify departments for organisations only.

Table 109. Address book search options (continued)

Search criteria	Online	Local	Notes
Specialty	✓	✓	Use to search for individuals by specialty. For online searches, select from the list of specialties. For local searches, you can also search using free text. **Tip:** Communicare lists the entire set of SNOMED CT practitioner roles in the **Specialty** field, but HealthLink and Argus support different subsets of these roles. If no results are returned for the specialty for which you are searching, try a similar specialty.
Service type	✗	✓	Service types are maintained by Communicare Administrators: • **Admissions** - used when adding an admission clinical item type to a patient clinical record and for Admission reports • **Referrals** - used when adding a referral clinical item type to a patient clinical record and for Referral reports • **Transport** - used when adding a stop to a transport service • **Pathology** - used when adding investigation requests. Also set whether request forms for this place are printed to plain paper or to a preprinted request form. The requester can override this default when making a request. • **Radiology** - used when adding radiology requests. Also set whether request forms for this place are printed to plain paper or to a preprinted request form. The requester can override this default when making a request. • **Billing** - used when recording a Payer of type Other for private billing • **Supplier** - used when recording an Imprest stock supplier For example, administrators can set your preferred pathology and imaging providers which are then listed in the **Investigation Provider** list in the **Investigation Request**.

To search for an individual or organisation in your local address book or the online provider directories:

1. If you've been redirected from a letter, referral, clinical item and so on, go to the next step, otherwise select **File > Address Book**.
2. In the **Address Book** window, enter the name of an individual or organisation in the **Search** field. If this search returns too many results, enter additional search criteria in the appropriate fields.

   Tip:
   Only those results that match all the search criteria you specify are returned.

- For most searches, in the **Search** field, enter the name of the provider for whom you want to search, or the healthcare service organisation for which you want to search.

  > **Tip:**
  > If you are unsure of a provider's other information, such as their suburb, include only their name.

- In the **Location** field, enter a suburb, state or postcode.
- For individual's, from the **Specialty** list, select a provider's speciality.
- In the **Provider number** field, enter the Medicare Online Claiming provider number associated with a provider for an encounter place.
- For local address book searches, to search by department or service type, click **More Options**:
  - In the **Department** field, enter a department name.
  - For administrators wanting to maintain preferred suppliers and so on, from the **Service Type** list, select the service type you want to review. For more information, see Table 109: Address book search options *(on page 336)*.

3. To search both your local address book and the online provider directories, set **Search Online**.

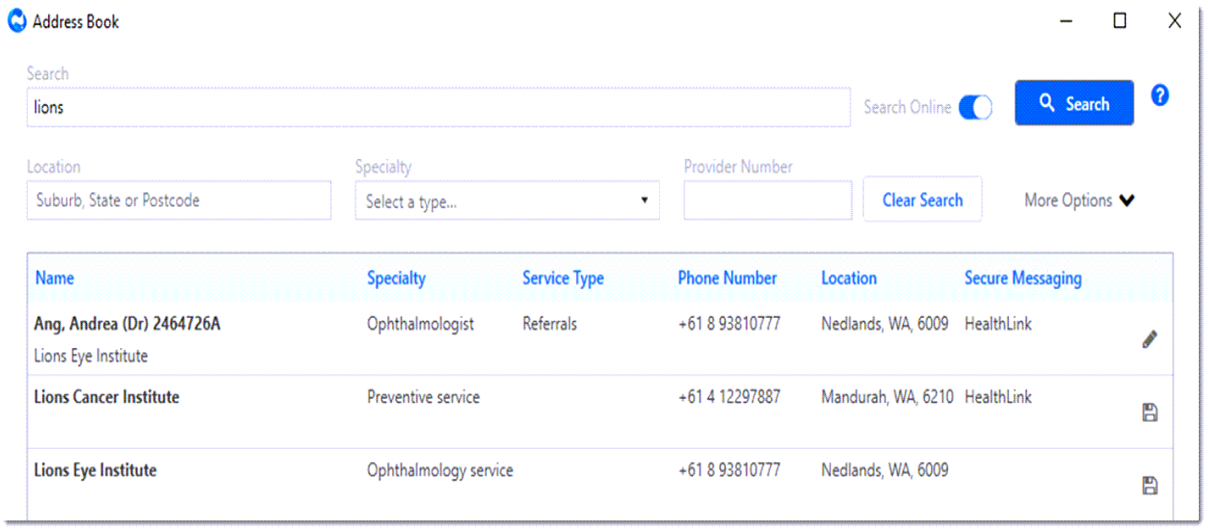
   > **Tip:**
   > To display all entries in your local address book, deselect **Search online**, and don't set any search criteria.

4. Click **Search**.

The results from your search are listed in the **Address Book** window. Each entry displays one of two icons:

- Edit - this entry is already included in your local address book. Addresses included in your local address book are listed first. To edit the entry, click Edit
- Save - this online entry is yet to be saved to your local address book. To save a provider or organisation from an online provider directory to your local address book, click Save.

> **Tip:**
> Add a contact to your local Communicare address book for a provider at each organisation that you want to contact. For example, if you want to refer patients to Dr Kidman at both State Health and Cardicare, add both results. If you add a result that is already included in the local address book, it is not added again, but the details are refreshed.



Individuals and organisations are listed with addresses included in your local address book first, then alphabetically by name.

- If an individual provider is registered at more than one organisation, or with more than one SMD vendor, they will be listed more than once.
- If an organisation is registered at more than one location, with a separate speciality, or with more than one SMD vendor, they will be listed more than once.
- If the addressee is linked to HealthLink, the vendor is listed in the **Secure Messaging** column and the addressee can be used for Secure Messaging *(on page 341)*.

Note:
Communicare makes every effort to display the data returned from the directory services in the appropriate fields. However, we rely on the directory services to provide the data in a consistent way, so results may not always be what you expect.

To select a provider or organisation and copy the details to your letter, referral or clinical item:

- For an entry included in your local address book, double-click an entry to select it.
- For an online entry, first save it to your local address book and then select it:
  1. For the required entry, click Save.
  2. In the **Address Book Entry** window, click **Save**.
  3. In the **Address Book** window, double-click the entry to select it.

Add and edit an address

Use the **Address Book Entry** window to maintain the details of people, organisations and places.

For those entries that have been saved from an online provider directory and for which secure messaging is enabled, **Secure Messaging Enabled** is displayed in the top, right corner.

Note:
If you add an HPI-I, HPI-O, or HI number for an individual or organisation, Communicare checks that the number is in the correct format but does not check the number with Services Australia.

To add an entry manually:

1. Select **File > Address Book**.
2. In the **Address Book** window, click **Add New**.
3. In the **Address Book Entry** window, in the **Forenames** and **Surname** fields, enter an individual's given and family names; or for an organisation, in the **Name** field, enter the organisation name. Where appropriate, Communicare displays an individual's name if there is one, otherwise the organisation name.
4. For an individual:
    - In the **Specialty** field, enter the speciality for this contact.
    - In the **Provider Number** field, enter the provider number for the contact at the required organisation.
    - In the **HPI-I Number** field, enter the current Healthcare Provider Identifier - Individual number assigned to the provider. This number is used only if sending eReferrals, it is not used for most secure messages.
5. For an organisation:
    - In the **Department** field, enter the department available at this organisation in which you are interested. If you write referrals for different departments at this organisation, leave this blank.
    - In the **ABN** field, enter the organisation's ABN.
    - In the **HPI-O Number** field, enter the current Healthcare Provider Identifier, which is the organisation number assigned to the encounter place. This number is used only if sending eReferrals, it is not used for most secure messages.
    - In the **Practice Name** field, enter the organisation name associated with the organisation's HPI-O in the Healthcare Provider Directory (HPD). Address book entries that have a different name recorded in Communicare to that registered in the HPD can make use of this. For example, a service under the auspice of another. Make sure you also include an HPI-O. If the organisation name in Communicare is different to the name recorded in the HPD, you will be prompted to allow this field to be set to the value in the HPD.
6. In the **Contact Details** fields, enter the required information.
7. For administrators, set the **Service Type**. For more information, see Table 109: Address book search options *(on page 336)*
8. Click **Save**.

A new contact is added to your local address book.

You can now use address book entries in the following areas:

- Any entry can be used in letter writing and if address details are specified these can be used for the addressee.
- An entry can only be used for Secure Messaging *(on page 341)* if it is linked to an SMD vendor.

To edit a contact, in the **Address Book** window, for a previously saved address, click Edit and update the required details.

If you saved the entry from an online provider directory service, the local record is permanently linked to the matched record in the provider directory and subsequent changes to the record in the provider directory are synchronised overnight with the local address book entry. For records from a provider directory, those fields that are linked to the record in the

provider directory are read-only, as any changes would be overwritten by the synchronisation process. You can add extra information in the blank fields if required, but these may be overwritten when the record is synchronised.

To remove an entry from your address book, click **Delete Entry**. If the contact was saved from an online provider directory, it is removed from your local address book, but the listing in the online provider directory is unaffected. Any extra information you have added is also deleted.

Address Book configuration

Use the combined address book to search multiple online provider directories, and add addresses to your local address book.

The combined address book supports secure messaging using HealthLink.

Communicare Support will configure the following settings.

Table 110. Address book settings

Setting	Combined address book	Notes
File > System Parameters > System tab, **Address Book Integration - ADHA PDS**	✗	Deprecated.
File > System Parameters > System tab, **Address Book Integration - EPD**	✗	Deprecated with Argus now end-of-life. For more information, see System Parameters - Web Services *(on page 825)*.
File > System Parameters > Web Services tab, **Secure Message Exchange**	✓	Communicare Support enter the URL & certificate and set **Enable Secure Message Exchange**. The certificate determines which online provider directories the health service can access. For more information, see System Parameters - Web Services *(on page 825)*.

Secure Messaging

Secure Message Delivery (SMD) is the government standard for sending medical documents and messages securely and safely.

Only certain sites can send and receive documents using secure messaging. Communicare imports and saves addresses from SMD vendor HealthLink to the local, combined address book. Secure messages and documents are then sent directly to HealthLink.

Tip:
If a recipient is linked to HealthLink and enabled for secure messaging, the vendor is listed in the **Secure Messaging** column in the combined address book *(on page 335)*, and the Secure Message Enabled icon is displayed for an individual entry.

To enable Secure Messaging you will need:

- Registration with SMD vendor HealthLink

> **Tip:**
> Contact HealthLink to set up an appropriate subscription for sending and receiving. If you are only using receiving capabilities for a secure message network, and want to start using secure messaging for sending, update your subscription with HealthLink.

- Configuration for HealthLink and Secure Message Exchange, see Address Book configuration *(on page 341)*
- A valid security certificate for your site or HPI-O
- An address entry for your site in the National Health Services Directory

If you want to enable secure messaging in Communicare, contact Communicare Support for further information.

Send a document securely to a registered provider from a patient's clinical record or from  **Documents and Results**. For more information, see Writing letters and referrals *(on page 319)*

Referral Management

Manage incoming internal and external referrals from a single list.

> **Note:**
> This functionality is available only to the Western Australian Country Health Service. In Communicare offline mode, incoming referrals are listed in the Clinical Record, but you cannot modify them.

Only users who belong to a user group *(on page 842)* with the Referral Management system right can use Referrals.

To enable users in a user group to access Referral Management:

1. Select **File > User Groups**.
2. In the **User Group Name** list, select the user group to which you want to grant access. For example, `Clerical`.
3. On the **System Rights** tab, set **Referral Management**.
4. Click **Save**.

Users in the updated group must restart Communicare for the changes to take effect.

The **Referrals** menu option is added to the main Communicare toolbar.

Adding incoming referrals

For WACHS, use the **Incoming Referral Details** window to add incoming referrals from the referral hub to the relevant patient record for patients who have a Communicare record.

> **Note:**
> This functionality is available only to the Western Australian Country Health Service. In Communicare offline mode, incoming referrals are listed in the Clinical Record, but you cannot modify them.

You can also modify incoming referrals.

To add an incoming referral to Communicare, either:

- In the main menu, select **Referrals > Add Incoming Referral**.
- From the **Manage Incoming Referrals** window, click Add.

To add an incoming referral:

1. Select **Referrals > Add Incoming Referral**.
   If you can't see this menu, ask your Communicare Administrator to add the Referral Management system right to your user group.
2. In the **Search** window, enter some search conditions, such as a name, and select the patient to whom the referral refers.
3. In the **Incoming Referral** window, check the patients details and history if required:
   - If your user group has the Biographics system right, to check the patient's biographics, click **Biographics**.
   - To view a list of all incoming referrals recorded for the selected patient, click **Referral History**. By default, the list shows incoming referrals recorded in the last year. Use the date filter to view incoming referrals for a specific date range.
4. From the **Appointment Payment** list, select a payment category for appointments associated with the payment.
5. In the **Attachments** pane, if applicable, attach a document. Attached documents are listed in the Attachments table and in the Clinical Record, Documents. Attached documents cannot be changed, but can be removed from the list.

   Note:
   Removing a document from the referral list does not remove it from the Clinical Record.

   a. If you have an electronic copy of a document in PDF format, click Attach File and select the document.
   b. If you have a a hardcopy of a document, click Scan and Attach File and scan the file. Your user group must have the Document Scanning system right to use this function.
   c. When the document is displayed in the document window:
      i. From the **Date** calendar, select the date of the referral.
      ii. From the **To** list, select a clinician if applicable.
      iii. If you are a clinician and are simultaneously reviewing the document, set **Reviewed** and check the **Reviewed by** and **at** date, and add a comment to the **Comment** field.
      iv. If you want to restrict who can view the document, from the **Viewing Right** list, select a viewing group.
      v. If you want to categorise the referral by topic, from the **Topic** list, select a topic.
      vi. If you want to categorise the referral by program, from the **Program** list, select a program.
      vii. Click **Save**.
   d. To view a detailed list of all attachments, click Attached Documents.
6. In the **Referral Details** pane, add details of the referral:
   a. In the **Date Referred** field, add the date that the referral was written.
   b. If the patient is being referred again, set **Re-referral**.
   c. In the **Validity Period** field, enter how long the referral is valid for in months, weeks or days. For example, 90 days. The date that the referral is valid until is calculated and displayed in the **Until** field.
   d. In the **Received Date** field, enter the date that the referral was acknowledged as received by your health service.
   e. If applicable, add escort information and any comments, and from the **Transport Mode** list, select a transport mode.
7. In the **Referrer** pane, add referrer information:

a. From the **Source** list, select the source of the referral.
b. In the **Name** field, enter the name of the referrer.
c. In the **Address** field, enter the address of the referrer, or click the ellipsis and select the address from your address book.

8. In the **Referred To** pane, enter information about your organisation:
   a. From the **Encounter Place** list, click the ellipsis and select your organisation from the list all encounter places, including service encounter and administrative encounter places.
   b. From the **Clinic Category** list, select a clinic category.
9. In the **Status** pane, check the status. By default, for all new incoming referrals, the status is set to `Waiting` and the field is disabled until it is saved for the first time.
   - For any change made to the status, record a reason for the change. Reasons are logged in the **Status History** window.
   - The following business rules apply when changing the status:
     - Waiting referrals can be Cancelled, Rejected or Closed
     - Active referrals can be Closed
     - Cancelled, Rejected or Closed referrals can be reinstated. When a referral is reinstated, Communicare automatically changes the status to either `Waiting` or `Active`, depending on what the previous status was, and the **Status History** is updated.
10. In the **Additional Factors** pane, set any additional factors pertinent to the referral.
11. In the **Appointment Factors** pane, set any additional factors that might affect appointment schedule.
12. If the referral cannot be prioritised, or an appointment cannot be booked for a prioritised referral, in the **Pending Reason** pane, set **Referral Pending**. If a referral is set as pending, also enter the following information:
    a. From the **Pending Reason** list, select a reason why the referral can't be actioned.
    b. In the **Pending Due By** field, enter a date by which the pending referral should be resolved.
    c. In the **Pending Comment** field, add any other relevant information.
13. In the **Prioritisation** pane, enter priority information:
    a. If required, from the **Presenting Issue** list, select an item that applies to this referral from the ICPC-2 PLUS list.
    b. From the **Reason for Referral** list, select a reason.
    c. From the **Priority** list, select a priority. By default, for all new incoming referrals the priority is set to `Awaiting Triage`.
    d. If required in the **Appointment Due By** and **Length of Appointment** lists, select a value. This is for information only, and has no relation to the Appointments Book.
14. In the **Additional Issues** pane, click ✚Add and record any other issues that relate to the same speciality as the referral. Each issue added is assigned a number and can be marked as completed when resolved. Add, mark as complete and delete issues as required.
15. If the referral has been prioritised and has a status of `Waiting` or `Active`, in the **Appointments** pane, book an appointment. Click Appointment Book to open the appointment book and add an appointment for your organisation. See Appointment Book *(on page 55)* for more information.

> **Tip:**
> To view all appointments for the patient, including those not related to the referral, click Service List.

16. Click **Save and Close**.

Communicare assigns a unique referral number which is displayed after a referral is saved for the first time.

After a referral is saved, it is listed in the patient's Clinical Record, in the:

- **Progress Notes > To Do** list with a prefix of `<Incoming Referral>`
- **Detail** tab list with a prefix of `<Incoming Referral>`
- **Manage Incoming Referrals** window

Manage Incoming Referrals

For WACHS, use the **Manage Incoming Referrals** window to manage all incoming referrals that have been entered into Communicare.

> **Note:**
> This functionality is available only to the Western Australian Country Health Service. In Communicare offline mode, incoming referrals are listed in the Clinical Record, but you cannot modify them.

Incoming referrals are displayed in either:

- **Incoming Referrals** - list of all incoming referrals, irrespective of status
- **Waitlist** - list of all incoming referrals that have been prioritised, that is the priority is not `Awaiting Triage`

To open an incoming referral, double-click a referral record.

To print the referral list, click Print.

To search for specific referrals, select a value from one or more of the following lists and click **Search**:

- **Clinic Category** - by default, incoming referrals from all clinics are listed
- **Encounter Place** - by default, incoming referrals from all encounter places are listed
- **Status** - by default, both tabs list all incoming referrals with a status of `Waiting`
- **Priority** - by default:
  - Referrals with a priority of `Awaiting Triage` are listed on the **Incoming Referrals** tab
  - Iincoming referrals with a priority of `All` are listed on the **Waitlist** tab

To find a referral:

1. Click **Search** to apply the search criteria that you've selected.
2. In the **Find** field, enter a search term.

> **Tip:**
> Only those rows that are already displayed are searched.

In addition to the information specified in the **Incoming Referrals** window, list days are displayed on the **Manage Incoming Referrals** tab. List days are the number of days since the referral was received. That is, the difference between the Received Date and today. List days are not displayed for closed, rejected or cancelled referrals. If a Waiting referral is closed, rejected or cancelled and then reinstated, the List Days are recalculated from the referral Received Date.

Incoming Referrals

On the **Incoming Referrals** tab, you can also add new referrals.

To add a new incoming referral, click ✚Add. See Incoming Referral Details *(on page 342)* for further information.

To copy an incoming referral, click Copy Referral. The following information is copied:

- Patient details, including:
  - Patient Id
  - Interpreter Required
  - Appointment Payment
- Referral details, including:
  - Date Referred
  - Received Date
  - Referral Validity
  - Referral Priority
  - Encounter Place Referred To
  - Referral Source
  - Referrer's Name
  - Referrer's Address
  - Referral Comment
  - Referral attachments
- All attachments.

> **Note:**
> Copying a referral with documents attached won't duplicate the documents in the patient Clinical Record.

If a referral is pending, the pending reason and due by date are displayed on the **Incoming Referrals** tab.

Birth Notifications

For customers who belong to the Western Australian Country Health Service, use the `Birth Notifications` module to manage notifications related to births from a single list.

Prerequisites

- Available only to the Western Australian Country Health Service in Communicare V18.4 and later. This module must be set up by a Telstra Health Implementation Consultant. Contact Communicare Support for further information.
- The `Birth Notifications` module must be enabled. In **File > System Parameters > System** tab, set **Birth Notifications**.
- You must belong to a user group with the `Birth Notifications` system right enabled. In **File > User Groups > System** tab, for the required user group, set **Birth Notifications**.

> **Note:**
> In Communicare offline mode, the `Birth Notifications` module is disabled.

Actioning Birth Notification

When Communicare receives a birth notification, it attempts to automatically match the mother and child patient records. If the automatic matching wasn't successful or was incorrect, you can manually match the mother or child.

Note:
This module is available only to the Western Australian Country Health Service in Communicare V18.4 and later.

To action a birth notification

1. To match a mother or child manually or correct a mismatched patient records:
    a. Select **Births**.
    b. In the **Manage Birth Notifications** window, to match a birth notification, click **Match Patient**.
    c. If a mother or child is matched incorrectly, click the ellipsis button (...).
        - To clear the matched patient, click **Unmatch Patient**
        - To match to a different patient, click **Match Patient**
2. Select from the following birth notification statuses:
    - `New` - state for a new birth notification
    - `Pending Contact` - waiting for communication with the carer of the baby
    - `Contact Complete` - contact has been completed
    - `Service Complete` - service completed as a result of the notification
    - `Duplicate` - a duplicate birth notification that does not need to be actioned
3. If required, assign the birth notification to a specific encounter place to indicate where it should be actioned.

Once a patient is matched to a birth notification, the birth notification will appear in the patient's clinical record.

After both mother and child are matched, the birth notification can be marked as reviewed. After the birth notification has been marked as reviewed, the matched mother and child cannot be changed. Reviewing a birth notification works in the same manner as other documents. For more information, see Reviewing Documents *(on page 325)*.

When the child status is live born, both the mother and the child records must be matched before you can mark it as reviewed. In the event of a stillborn child, the Reviewed check box is enabled once the mother has been matched.

Birth Notification Details

Access and manage all birth notifications recorded in Communicare.

Note:
This module is available only to the Western Australian Country Health Service in Communicare V18.4 and later.

By default, birth notifications are listed in the order in which they are received, that is, the most recently received birth notification appears at the top of the list.

To open a birth notification, double-click on a birth notification record.

To search for anything on birth notifications, in the **Search** field, enter a search term.

To filter birth notifications, select from the following fields:

- **Status** - by default, birth notifications of any status are displayed.
- **Encounter Place** - by default birth notifications for all encounter places are displayed.

- **Locality Group** - by default birth notifications with any locality, suburb or address are displayed.
- **From/To Date** - by default birth notifications for last 30 days are displayed.

The following columns are displayed for the Birth Notifications list:

- **Received Date** - the date when the Birth Notification is received by Communicare.
- **Mother Name** - the mother's name included in the birth notification. This value does not change even if the mother's record is matched to a different patient in the **Birth Notification** window.
- **Mother MRN** - the mother's MRN included in the birth notification. This value does not change even if the mother's record is matched to a different patient in the **Birth Notification** window.
- **Mother Matched** - indicates whether the mother is matched in Communicare or not.
- **Child MRN** - the child's MRN included in the birth notification. This value does not change even if the child's record is matched to a different patient in the **Birth Notification** window.
- **Child Matched** - indicates whether the child is matched in Communicare or not.
- **Child DOB** - the child's date of birth included in the birth notification. This value does not change even if the child's record is matched to a different patient in the **Birth Notification** window.
- **Child Sex** - the Child's sex included in the birth notification file. This value does not change if the child's record is matched to a different patient in the **Birth Notification** window.
- **Status At Birth**
- **Address** - the mother's address included in the birth notification file.
- **Encounter Place** - the encounter place assigned to the Birth Notification.
- **Status** - the current status of the birth notification.
- **List Days** - the number of days between the child's date of birth and today. This value is calculated and updated only if the birth notification status is `New` or `Pending Contact`.

Recalls

Recalls are the elements that make up a care plan. Recalls can be either generated automatically by Communicare or manually created by the user.

A recall is an event that is planned (it has a planned date) but has not yet occurred (it has no actual or performed date). Recalls are commonly generated for procedures and immunisations, but may also be generated for other clinical item types, provided that the clinical item type is recallable. For more information about how a clinical item type is made recallable, see Clinical Item Type Properties - General tab *(on page)*.

All patient recalls have a date on which the recall is due (the planned date) and a recall purpose or reason (a clinical item type).

Automated recall types are defined in the Communicare database. Your Communicare Administrator can add new automated recall types or remove existing ones. Only automated recall types that are enabled are used by Communicare to generate recalls.

> **Tip:**
> For a full list of automated recall types, run **Report > Reference Tables > Automated Recall Types**.

The Communicare automated recall mechanism automatically generates recalls and displays them for review. You can change or delete one or more of the recalls generated, or accept the recalls without change.

Once a recall is generated it is treated the same as other clinical items and can, for example, be deleted.

All recalls that apply to a patient are listed in the patient's clinical record, in the To Do list *(on page 125)*.

Automated recalls

Communicare can automatically create one or more recalls when particular events occur.

- `On Registration` - when a patient is added to or exists in Communicare, a recall is added to all patients' files according to the parameters you set. You should define the item you are recalling and the age at which the recall should be dated. Other parameters are optional. These recalls are typically used as reminders rather than for critical recalls.
- `On Completion` - these recalls are created only when a specific procedure is added to or exists in a patient's file. Define both the recall and the item or item group that triggers the recall. The actual date for a clinical item is set.
- `On Presentation` - these recalls are created only when a specific condition is added to or exists in a patient's file. Define both the recall and the item or item group that triggers the recall.
- `On Qualifier` - these recalls are created when a user enters a specific response to a qualifier.

  If a required qualifier is not addressed, a recall is added automatically. This recall behaves like a manual recall.

The age of the patient at the date of registration, presentation, completion or qualifier definition may affect whether a recall is automatically created. For example, childhood immunisation review recalls are not created for patients first registered in Communicare as adults.

As the patient ages, automatically generated recalls that fall outside the age filters are automatically deleted daily.

Automated Recall Types

Automated recall types control the automatic generation of recalls. They can be edited by the Communicare Administrator.

Note:

Changing the details of Automated Recall Types affects the future generation of recalls and attempts to force existing recalls to conform to the new rules.

Recalls created by a service provider are not deleted, except in the following circumstances:

- If you regenerate recalls
- If the recall is no longer valid. For example:
  - If the patient's sex has changed or the recall rule sex has changed
  - If the patient's aboriginal status has changed or the recall rule aboriginal status has changed
  - If the minimum or maximum age has changed or the patient's age is no longer within the recall rule range

To create an automated recall:

1. Select **File > Reference Tables > Automated Recall Types**.
2. In the **Automated Recall Types** window, click Add.
3. In the **Recall type properties** window, from the **When** list, select the type of rule. Choose from:

- `On Registration` - a recall is added to all patients' files according to the parameters you set. You should define the item you are recalling and the age at which the recall should be dated. Other parameters are optional.
- `On Completion` or `On Presentation` - these recalls are created only when a specific procedure (on completion) or condition (on presentation) is added to or exists in a patient's file. Define both the recall and the item or item group that triggers the recall.
- `On Qualifier` - this rule behaves like the `On Completion` and `On Presentation` recalls but is triggered by a response to a qualifier. Specify the qualifier. If the qualifier is numeric, a range of values can be specified. If the qualifier is **Yes/No** or a checkbox, define the response (any, true or false). If the qualifier is a dropdown list, define the outcome.

4. In the **Recall for** field, click ⋯ Ellipsis and in the **Clinical Terms Browser**, select the clinical item for which you are creating a recall.
   Ensure that the clinical item class is appropriate for the rule type selected in step 3.
5. Specify other information appropriate to the rule type selected in step 3.
   - **Sex** - all recall types can consider the sex of the patient. If you specify a sex, the automated recall is not added to a patient of the other sex, or no sex.
   - **Aboriginal only** - all recall types can consider the aboriginality of the patient. Set to include only those patients who are Aboriginal or Torres Strait Islander, or both.
   - **Min Age**, **Max Age** - all recall types can consider the minimum age and the maximum age. If a patient has a recall still outstanding and reaches the maximum age, the recall is deleted by the system. Minimum age for On Registration recalls is very rarely required. Discuss with Communicare before enabling this rule.
   - **Age** - for `On Registration`, specify the age of the patient when the recall will be due.
     - If you want the recall to trigger for all patients, including those younger than the age you specify and those not yet added to the system, set an age and ensure the **Min Age** is null. For example, set age to `12y` to trigger a recall for all patients under 12 years and those not yet added to the system, which will be due on their 12th birthday.

       Tip:
       You can filter the **To Do** list to only display recalls that are due soon.

     - Ensure you include a measure: `d` for days, `w` for weeks, `m` for months, `y` for years. Communicare assumes a value with no other information is in days.

       Note:
       A month is always 30 days and a year is always 365 days, so 12 months is slightly less than 1 year.

   - **Offset** - for `On Completion` and `On Presentation` instead of specifying the age of the patient as a date for the recall, define the time after the trigger item is added for the recall.
   - **Responsibility** - assign the responsibility to complete a recall to a user group as a default for the recall type. All new recalls then have the responsibility set to that default user group.
   - **Expiry** - for `On Completion`, `On Presentation` and `On Qualifier` recalls, specify an interval of time following the planned date of the automated recall. If a user has not completed or cancelled a recall before

its expiry has elapsed, the system cancels the recall with the reason `Expired`. This option is only available for clinical item types with **Allow Recall Expiry** selected.

- **Needs confirmation by user** - set to force providers to confirm that they want a recall before they can save it. Set this option if you want providers to think about a recall before automatically generating it.

6. Set **Enabled**.
7. Click **Save**.

The recall type is added to the list in the **Automated Recall Types** window. Recall types are colour-coded:

- Red - `On Registration` recall types
- Blue - `On Completion` recall types
- Purple - `On Presentation` recall types
- Green - `On Qualifier` recall types
- Grey - all disabled recall types

Enabling automated recalls automatically generates recalls for the item in all eligible patient files. However, if a patient has had the same automated recall type previously cancelled in their clinical record, Communicare respects that past decision and a new automated recall is not generated.

If required you can disable an automated recall type. All automatically generated recalls will be deleted, including those that have any comments or that have been customised. `On qualifier` recalls are not deleted because they behave like manual recalls. For more information, see Removing outstanding recalls *(on page 357)*.

To hide all disabled recall types, in the **Automated Recall Types** window, set **Hide Disabled**.

Automated Recall Events

Recalls are automatically generated when these events occur.

- OnRegistration
- OnPresentation
- OnCompletion
- OnQualifier

Age and sex filters are available for any recall event. However, sex filters are rarely required for OnPresentation and OnCompletion events and are best avoided because they can compromise recall regeneration if a patient's sex is recorded incorrectly.

On Registration

The On Registration event occurs when a patient's date of birth is first added to the Biographics record.

Normally, this is when a patient's record is first added to the system. However, if Biographics are added without a date of birth, Communicare delays generation of the On Registration recalls until the date of birth is entered.

On Presentation

The On Presentation event occurs when a condition is entered into a patient's clinical record.

On Completion

The On Completion event occurs when a recall is completed, or when a recallable clinical item is entered into a patient's clinical record.

On Qualifier

When an automated recall is triggered by a qualifier you must define the qualifier and the response.

Thus, if the qualifier is a reference type qualifier, the options must be specified. For a numeric qualifier you can enter a range of values that will trigger the recall. For Yes/No and checkbox qualifiers, define the specific response.

Note:
Unlike the other automated recall types, enabling and disabling this type of automated recall has no immediate effect on patient data. An enabled rule is effective only for future responses and a disabled rule does not remove previously confirmed recalls. Thus, introducing a recall triggered by a particular response to a qualifier does not automatically create recalls for historic data. Likewise, disabling an automated recall of this type does not revert recalls that have already been created.

Recalling on both On Registration and On Presentation Events

Typically you should not generate recalls on both `On Registration` and `On Presentation` events. However, it can be done successfully if due care and diligence are exercised.

If both `On Registration` and `On Presentation` events generate recalls, run a `Recall Duplication` report periodically to identify and correct duplicate recalls and provide training to the operators who generated the duplicates. Contact Communicare Support if you need assistance with a Recall Duplication report.

Note:
Duplicate recalls are generated only by active intervention by the operator.

Example

This issue is most easily understood by considering the following scenario.

An `On Registration` event has generated a Pneumovax recall for a patient's 50th birthday. Later, a diagnosis of *Diabetes Mellitus* is made some time before the 'age 50' Pneumovax has been given. An `On Presentation` event will warn the operator that a recall for Pneumovax already exists for age 50 and will not generate an additional recall unless **Confirm** is set. This requires diligence from the operator to not set **Confirm** but instead either:

- Adjust the **Planned Date** for the existing recall. Setting **Confirm** would result in 2 Pneumovax recalls which might not be properly spaced.
- Actually give the immunisation at the time of diagnosis. The outstanding recall is automatically completed and a new recall generated by the `On Completion` event.

Not reading the warning message and setting **Confirm** regardless could result in a recall on the 50th birthday, which is sooner than desired.

Note:
This situation only arises after active intervention by an operator to change the default action and indicates the need for operator training.

Automated Recall Confirmation

Before an On Completion or On Presentation recall is generated, the **Confirm Automated Recall** window is displayed.

This window displays:

- **Recall Interval** - the time to elapse before the next recall is due as a result of this recall. Intervals can be Days, Months, or Years.
- **Planned Date** - the actual date on which the recall will take place. Altering this field will automatically change the **Recall Interval** shown.
- **Expiry Date** - (optional) the date after which this recall will be automatically cancelled if not already completed or cancelled. The Expiry Date is initially calculated from the Planned Date using the expiry settings on the Automated Recall Type *(on page 349)*. This option is available only for clinical item types that have the **Allow Recall Expiry** option selected.
- **Responsibility for this recall** - the group of users responsible for completing this recall.
- **Confirmation** - may be set by default depending on the settings in Automated Recall Type *(on page 349)*. Only confirmed recalls with a tick are generated.

Click **Reset** to undo any the changes you may have just made.

Click **Cancel** to close the window without generating any recalls.

Recalls Generated by Multiple Events

Some automated recalls are generated by multiple events.

For example, recalls for a condition check can result from several conditions.

Communicare prevents automatically generated, multiple outstanding recalls of different types. However, multiple outstanding recalls of the same type can be created manually.

If an event occurs that would normally create a recall and an uncompleted recall of the same type exists, a warning is displayed and a new recall is not created unless you set **Confirm**.

Effect of Patient Date Of Birth on Recall Generation

Automated recall creation can be controlled by the age of the patient. An automated recall type can be designated as specific to a patient older than or younger than defined ages or within an age range.

Note:
The patient's age is displayed at the top of the clinical record and should be checked as a part of confirming the patient's identity before using the clinical record. This simple precaution will avoid the risk of inconsistent recalls due to significant changes in patient's dates of birth.

OnRegistration *(on page 351)* recalls are always generated to fall due at a particular patient age.

If a patient is recorded without a date of birth:

- OnRegistration *(on page 351)* recalls are not created until a date of birth is entered.
- OnCompletion *(on page 352)* and OnPresentation *(on page 351)* recalls which would normally have been filtered out due to the patient's age are generated regardless.
- When a patient age exceeds the upper age limit of an automated recall, the recall is not deleted.

If the patient's Date of Birth is altered, existing OnRegistration *(on page 351)* recalls are deleted and recreated. However, other recalls that have been suppressed or deleted on the basis of patient age are not recreated. This is unlikely to be significant provided the changes are either small or are made before there has been significant activity in the patient's clinical record. Significant changes to a patient's date of birth, such that an adult becomes a child, when adult recalls have already been completed or cancelled will result in inconsistent recalls.

Effect of Patient Sex on Recall Generation

Automated recall creation can be controlled by the sex of the patient, that is an automated recall type can be designated as specific to a patient of a certain birth sex.

> **Note:**
> The patient's name and sex is displayed at the top of the clinical record. Check the patient's identity and sex before using the clinical record. This simple precaution will avoid the risk of inconsistent recalls due to incorrect biographics.

If a patient is recorded without specifying a sex:

- Recalls are generated without regard for patient sex.
- OnCompletion *(on page 352)* and OnPresentation *(on page 351)* recalls which would normally have been filtered out due to the patient's sex will be generated regardless.

If the patient's sex is altered, existing OnRegistration *(on page 351)* recalls are deleted and recreated. However, other recalls that have been suppressed on the basis of patient sex will not be recreated. This is unlikely to be significant since sex filters are rarely needed on OnCompletion or OnPresentation recalls.

Effect of Aboriginality on Recall Generation

Automated recalls can be restricted to those who identify as Aboriginal or Torres Strait Islander.

If **Aboriginal Only** is set on Automated Recall Types, recalls are generated only when a patient's **Aboriginality** is set to:

- `Aboriginal but not Torres Strait Islander`
- `Torres Strait Islander but not Aboriginal`
- `Both Aboriginal and Torres Strait Islander`

Other Automated Recall Types are generated without regard to a patient's Aboriginality.

If the patient's aboriginality is altered, existing On Registration *(on page 351)* recalls are deleted and recreated. However, other recalls that have been suppressed on the basis of patient aboriginality will not be recreated. This is unlikely to be significant since aboriginality filters are rarely needed on OnCompletion or OnPresentation recalls.

Manual Recall Creation

You can create recalls manually for clinical item types that have automated recalls and for certain other Clinical Item Types that do not have automated recalls.

Whether a Clinical Item Type can be defined as a recall is predefined in the Communicare database. Only clinical item types with **Recallable** set in Clinical Item Type properties can be selected when adding a recall.

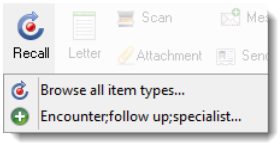
Adding recalls manually

Recalls are typically generated automatically, but you can add a recall to a patient's clinical record directly or from an incoming result.

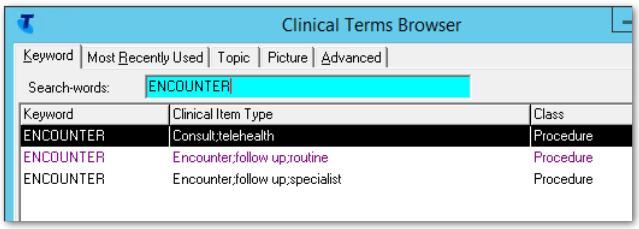
> **Tip:**
> If the recall you require is not listed, ask your Administrator to add a recallable Clinical Item Type *(on page 886)* with the correct #unique_474 *(on page)*.

To add a manual recall to the patient's clinical record:

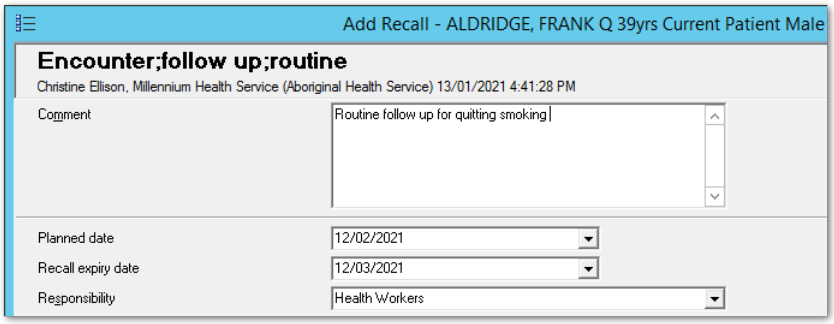
1. In the clinical record, click **Recall**.
2. In the manual recall list, select the required recall, or select `Browse all item types`.



   All clinical item types with a class of `Procedure`, `Immunisation` or `Referral` that have been set to **Recallable** and have a keyword of `$Recall` are displayed.
3. If you chose to browse for the item, in the **Clinical Terms Browser**, in the **Search-terms** field, enter a phrase. For example, `Encounter`.



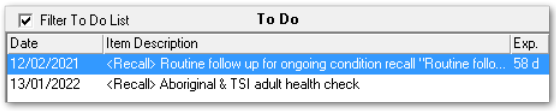
   Only those clinical item types with a class of `Procedure`, `Immunisation` or `Referral` that have been set to **Recallable** are displayed.
4. Select the required clinical item in the list, and click **Select**.
5. In the **Add Recall** window, from the **Planned date** calendar, select when you would like to see the patient.



6. If **Allow Recall Expiry** has been enabled for the Clinical Item Type, if required, from the **Recall expiry date** calendar, select when the recall will automatically be removed from the patient's file if it has not been completed by that date.

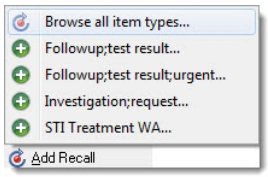
7. From the **Responsibility** list, select who is responsible for managing the recall.
8. Click **Save**.

The recall is added to the patient's **To Do** list in their clinical record. The recall shows the due date for the recall in the **Date** column and the number of days remaining until the recall expires in the **Exp** column.



You can also add a manual recall to a patient's **To Do** list from investigation results.

In the investigation result, click **Add Recall** and follow steps 2-8 above.



Regenerating recalls

Every time a recall type is edited, the system attempts to rebuild all the automated recalls of that particular type.

You can regenerate recalls in one of the following ways:

- To regenerate automated recalls and leave recalls that have comments attached or have non-standard intervals untouched, in the **Automated Recall Types** window, right-click the automated recall type and select **Regenerate recalls**. This option is not available for On Qualifier automated recalls.
- Alternatively, you can force a more rigorous and slower regeneration of automated recalls using the procedure described below.

Note:
The order in which recalls are enabled and disabled or disabled and enabled affects which recalls are regenerated and how.

Note:
Manually entered recalls are never deleted.

This feature allows the system to regenerate recalls after changes to details of the automated recall type. Be aware however, that when you enable the recall type again, the recalls may not be generated in exactly the same way as they originally were. The differences are subtle and should not be a problem, but you should be aware of them.

For example, manually deleted recalls may be regenerated when they may not be wanted. For this reason it is usually better to cancel an unwanted recall type rather than delete it.

Note:
Any recall associated with the recall rule you chose to regenerate recalls for are deleted, even if they were added by a provider. Any recalls that are not associated with a recall rule and were manually added by a provider are not deleted.

To force the regeneration of automated recalls including generated recalls that have comments attached or have non-standard intervals, except `On Qualifier` automated recalls:

1. Select **File > Reference Tables > Automated Recall Types**.
2. In the **Automated Recall Types** window, double-click the recall type that you want to regenerate recalls for.
3. In the **Recall type properties** window, deselect **Enabled** and click **Save**.
4. In the **Automated Recall Types** window, right-click the now disabled recall type and select **Delete outstanding recalls** and in the **Confirm** window, click **Yes**.
5. Double-click the recall type, set **Enabled** again and click **Save**.
6. Right-click the automated recall type and select **Regenerate recalls**.

Be patient, there may be thousands of recalls to create, so it may take a while to regenerate.

Completing recalls

Complete a recall either directly or indirectly.

To complete a recall directly:

1. Open the patient's clinical record.
2. From the **Summary > Main Summary > To Do** list (or the **Detail** tab), double-click a recall and select **Complete it**.
3. In the clinical item, add values to all the fields that are missing information. Incomplete qualifiers are highlighted with an Incomplete qualifier icon. Tabs with missing information display a warning icon.
4. Click **Save**.

Completing a recall changes the recall into a clinical item.

To complete a clinical item indirectly you can add the same clinical item as the one in the recall. This adds the item and completes the recall automatically.

When a clinical item is added that is also found as a recall the system decides automatically what to do. The rules are:

- If there is another clinical item of the same type at a later date than the new one, do not do anything extra.
- If not, find the oldest recall for this clinical item type and if found, complete the recall. This way adding a clinical item instead of completing the recall is effectively the same thing as completing the recall.

Remember:
Adding a clinical item will complete the recall no matter how far in the future it was planned.

Removing outstanding recalls

Occasionally, you may want to remove recalls that are no longer relevant from patient records. Before you attempt to remove recalls, or request that Communicare does this for you, check the following information.

Types of recall

There are three types of recall. The type of recall determines future Communicare behaviour:

- Manual recalls - these recalls are added to Communicare by a user. Manual recalls can be cancelled or deleted with no future problems, unless another user wanted that recall to remain until dealt with. Remove these recalls as a patient presents or run the `Recall Due` report and referring to that, remove the recalls from patients' files. Contact Communicare Support for help to remove large numbers of manual recalls.
- Automated recalls - these recalls are added to a patient's record as a result of an automated recall rule. Disabling the rule removes these recalls from all patient files, unless the recall has been edited by a user. If the rule is enabled again, the rule adds the recalls back into patient records.
- Recalls generated from incomplete procedures - these recalls are put into a patient's file because a procedure, such as an Aboriginal adult health check, did not have all the required qualifiers addressed. Recalls from incomplete procedures appear in the database as manual recalls and behave in the same way. If recalls from incomplete procedures are cancelled, this is a declaration that there is no need to record that the health check is under way but not yet complete. If recalls from incomplete procedures are deleted, they can reappear whenever the incomplete item is edited, either by a Communicare user or by a database upgrade.

Recall reasons

Some recall types are clearly important and should never be cancelled or deleted without a review of the patient's clinical record. These recalls should not be adjusted automatically. However, some recall types are reminders and are less important. From time to time, a health service may review those reminders that were entered by recall rules, usually On Registration rules, but occasionally On Completion or On Presentation rules. Where a particular recall is no longer required, turning off the rule removes most recalls.

Ways to remove recalls

Do not complete recalls just to remove them. Completing recalls declares that the activity to which it relates has been completed. For example, a patient due for a pap smear has had the pap smear on the date that the recall was completed. Instead use one of the following options:

- Cancelling recalls - records that the recall for an activity was cancelled by your health service on this day, with a comment if required. Any new automated rules relating to that activity are ignored for that patient. If you require recalls for the patient in future, add them manually.
- Deleting recalls - removes all evidence that the recall ever existed. Turning on an automated rule again, or failing to turn off a rule, replaces the recalls for all eligible patients.

Recommendations

Communicare advises the following approach:

1. Disable all unwanted automated recall rules. This action cleans up most overdue recalls. This step must be completed before Communicare can consider any request to cancel recalls of this type in bulk. To disable all unwanted recall rules:
    a. Log on as Administrator and select **File > Reference Tables > Automated Recall Types**.
    b. Double-click the rule you want to disable.
    c. In the **Recall Type Properties** window, deselect **Enabled**.
    d. Click **Save**.
    e. To delete any remaining recalls created by that rule, whether or not it was accepted or modified by a user, right-click the rule and select **Delete Outstanding recalls**. In the **Confirm** window, click **Yes**.
2. Cancel other outstanding manual, automated or incomplete recalls.

- Cancelling recalls ensures that there is a record in the database that the recall did exist but was cancelled by the health service. If required, provide a comment that can be attached to all cancelled recalls.
- Cancelling old recalls solely because of their due date is not recommended. Some recalls are essential but appear outdated because the default due date is relative to their date of birth. For example, if there is a rule that all patients should have an influenza immunisation from the age of six months, any patient who has never had one has a recall dated from when they were six months old; so a 50 year old with no immunisations recorded has a recall due in 1970 but it is still current and should remain there until the patient has been given the immunisation.
- Deleting recalls is not recommended.

Further help

If you still need assistance with removing outstanding recalls, raise a request with Communicare Support. Depending on the complexity of your request, this task may incur costs.

Cancelling Recalls

Cancellation is the preferred means of indicating that a recall is no longer required.

When a recall is cancelled, a record of the reason for the cancellation is recorded. Cancelled recalls are excluded from patient recall and recall performance reports.

Cancelling a recall is preferable to deleting it because:

- A record is retained indicating the reason the recall is not to be performed.
- Automatically generated recalls will be recreated by the system under certain circumstances. Cancelled recalls are not recreated in these circumstances. See Automated Recall Types *(on page 349)* for details.

When a recall is cancelled, there are a variety of different reasons that you may provide for cancelling the recall, including the following:

- Cancelled by service - the item is cancelled by the health service, that is, the health service no longer provides this procedure or immunisation. This reason is also used by Communicare when asked to 'clean up' manual recalls or unwanted automatic recalls such as retrospective antenatal or postnatal recalls inserted by a new recall rule.
- Declined by patient - the patient refuses the recall.
- Declined by patient for all time - the patient refuses the recall and does not want to be asked in the future.
- Declined by user - the automated recall was not accepted by the provider when prompted by an On Completion or On Presentation rule.
- Did not attend - the provider cancelled the recall because the patient didn't attend until too late and it is no longer relevant. Use if you have been able to contact the patient, but they have not attended the health service.
- Not required - the provider cancelled the recall because it is no longer required. For example, a wound management recall for a wound that has now completely healed.
- Patient deceased - for providers who want to tidy up the record of a deceased patient.

> **Tip:**
> Recall reports always exclude deceased patients, so it is not necessary to cancel recalls for deceased patients.

- Patient moved away - for providers who consider this recall not to be relevant should the patient return from wherever they moved to.

> **Tip:**
> Recall reports can be filtered by patient status. If the recall will be relevant if the patient returns to the health service, update the patient's address and make the patient transient, and run reports for current patients only.

- Patient could not be found - use when a recall is for a specific event and the patient could not be found in time and the recall is no longer relevant. Use if you have tried to follow up but have not been able to contact the patient.

Immunisation Reviews

Immunisation Reviews are reminders at set ages to review which immunisations each patient has had, and what immunisations they are due.

At certain ages children and adults are due for sets of immunisations. For example at 2 months, 4 months, 6 months, 12 months, 18 months, 4 years, 12 years and 50 years.

At each Immunisation Review the health provider should review which immunisations each patient has had, give the patient the immunisations they are due, and record all immunisations given in Communicare.

For information about the current immunisation schedule, see National Immunisation Schedule.

Example of Immunisation Review Schedule

Use the following example protocol to ensure that, regardless of the age at which a patient is first added to Communicare, there will only ever be one overdue recall (the previous age review).

> **Note:**
> Ensure that you complete and record the specific immunisations in a patient's clinical record before you complete the immunisation review recall item.

- `Review;immunisation;Birth` - On Registration recall due at birth with a maximum age of 2 months.
- `Review;immunisation;2 month age` - On Registration recall due at age 2 months with a maximum age of 4 months.
- `Review;immunisation;4 month age` - On Registration recall due at age 4 months with a maximum age of 6 months.
- `Review;immunisation;6 month age` - On Registration recall due at age 6 months with a maximum age of 12 months.
- `Review;immunisation;12 month age` - On Registration recall due at age 12 months with a maximum age of 18 months.
- `Review;immunisation;18 month age` - On Registration recall due at age 18 months with a maximum age of 4 years.
- `Review;immunisation;4 year age` - On Registration recall due at age 4 years with a maximum age of 12 years.
- `Review;immunisation;12 year age` - On Registration recall due at age 12 years with a maximum age of 15 years.
- `Review;immunisation;50 year age` - On Registration recall due at age 50 years.

Tip:
You can add immunisation reviews and recall rules for other milestones locally to suit your environment.

As a patient ages and is not seen the recalls are cleaned up automatically to make sure that unnecessary recalls are not left behind.

An immunisation review at a specific age should necessarily include a full review of the patient's immunisation history and catch-up immunisations arranged if required.

Special Considerations For Fluvax Recalls

Fluvax requires special consideration.

Fluvax has two unique features that warrant special consideration when considering automation using Communicare recalls.

- Firstly, Fluvax is a seasonal vaccination. Recalls generated by OnRegistration or OnPresentation events will rarely align appropriately with the Fluvax season.
- Secondly, Fluvax is indicated both for age (50 years) and a range of chronic diseases. The latter presents a challenge in keeping automated recall types up-to-date as additional disease clinical item types are defined in Communicare.

Recommendation

Seasonally, when the Fluvax becomes available, run a Fluvax report that lists all patients over 50 plus those with diagnoses that indicate Fluvax, excluding those that have been given Fluvax since February of the current year. If you need assistance to create the Fluvax Report, contact Communicare Support with a written list of the chronic conditions to be included.

Communicare Support can also provide a SQL Script that can be run annually to create appropriate recalls on a seasonal basis. Creating recalls will enhance opportunistic immunisation.

Generally don't generate recalls on both OnRegistration and OnPresentation events, though it can be done successfully if due care and diligence are exercised. For more information, see Recalling on both On Registration and On Presentation Events *(on page 352)*.

Special Considerations For Pneumovax Recalls

Pneumovax requires special consideration.

Recalling patients for Pneumovax immunisation presents a challenge because Pneumovax is indicated for both age (18 months and 50 years) and a range of chronic diseases. The latter presents a challenge in keeping Automated Recall Types up-to-date as additional disease Clinical Item Types are defined in Communicare.

Recommendation

Ensure all users are properly trained in the use of Communicare and understand the importance of reading displayed warnings. Administer Pneumovax at the time of diagnosis of an indicating chronic condition, or at least adjust the existing recall.

Generally don't generate recalls on both OnRegistration and OnPresentation events, though it can be done successfully if due care and diligence are exercised. For more information, see Recalling on both On Registration and On Presentation Events *(on page 352)*.

Recall migration

If the recall policies for your site or for clinical items change, your site can migrate your recalls using one of the following approaches.

> **Note:**
> Ensure that you speak to Communicare Support before migrating recalls.

Table 111. Example recall migration strategies

What	Who	Clean up
Disable the original recall rule and enable the new recall rule	Migration managed by your Communicare Administrator at your site	Manage recalls that are not automatically removed manually as patients present or run Recalls Due report and manually convert disabled recalls to new recall
Original recalls are progressively updated	Migration managed by your Communicare Administrator at your site	If the correct sequence is followed, Communicare will create a new On Registration recall with the same due date as the original recall
New recalls preserving the due date of the original recall are added, duplicating the original recall	Migration facilitated by Communicare Support using a custom SQL script to replace the original recall with the new recall	On registration recalls will be created for all patients, including those who have already declined the recall. The original recalls will remain in the clinical record and will need to be completed or cancelled.
New recalls preserving the due date of the original recall replace the original recalls	Migration completed by Communicare Support using a stored procedure in addition to an SQL script to reconcile recalls	None

Cancer recalls

Additional clinical items were added in V21 following advice and consultation with the GP Review of Clinical Software for compliance with the National Cancer Screening Guidelines.

If you use your own clinical items for the management of cancer screening, check the content of the new and updated clinical items. You may also need to review your current cancer screening recall protocols. There are no central recall protocols.

> **Note:**
> Follow the guidance provided by various organisations that explain the clinical aspects to cancer screening. The information provided here is for reference only.

Central terms related to cancer screening and management

Use the following new and updated clinical items, care plans and investigations in Communicare, in addition to the existing items, to assist with cancer screening and management.

Table 112. New and updated central terms used for cancer screening and management in V21

Clinical items	Care plan templates	Investigations
Test;cervical screening or **Results;cervical screening**	**Cancer Screening Care Plan Female**	**CST routine**
Test;cervical;co-test	**Cancer Screening Care Plan Male**	**HPV + LBC - co test DES exposure**
Screening;breast cancer		**HPV + LBC - co test Follow up of AIS**
Screening;bowel cancer		**HPV + LBC - co test Symptomatic**
Screening;prostate cancer		**HPV + LBC - co test Test of cure – HSIL**
Screening;cervical cancer Not recommended. Use **Test;cervical screening** instead which has updated qualifiers		**HPV test - Follow up of intermediate risk**
Test;result;cervical screening		**HPV test - Immune deficient**
Followup;cervical screening;abnormal		**HPV test - Previous unsatisfactory HPV test**
Results;bowel cancer screening		**HPV test - Self collection**
Results;prostate cancer screening		**LBC only - Follow up of self-collection**
Results;breast cancer screening		**LBC only - Unsatisfactory LBC result**
Opt Out of Cancer Screening		
National Cancer Screening Register RRN		
National Indigenous Bowel Cancer Screen		
Gender Information > Cancer Screening Requirements		
National Lung Cancer Screening Program		
Results;lung cancer screening LDCT		

Tip:

You may choose to add the relevant clinical items to a **Women's health** button.

To display all cervical items and investigations, search for *cervical*.

To display all bowel items, search for *bowel*. Search for specific investigations by name.

To display all Lung Cancer Screening Program items, search for *lung cancer screening*.

Cancer recall examples

The following scenarios are examples of how some health services may choose to manage their cancer screening recalls.

General information

For providers using the **Results...** clinical items, when entering results, backdate this item to the date of the actual test (collection date).

Based on an assessment of the results of the screening, where a recall rule presents a date for the next recall for a screening, the provider must check the interval or due date and update it manually if required.

Tip:
If a default interval is changed, Communicare remembers the new interval for that patient and for that specific recall rule.

Bowel cancer screening recall scenarios

Add recalls for bowel cancer screening. Choose the scenario that best suits your health service.

Note:
Clinicians should refer to the Clinical Guidelines for Bowel Cancer Screening and any documentation, letters or alerts from the National Cancer Screening Register for information about recall intervals and add the planned recalls for treatment such as referrals or tests.

Tip:
Links to the relevant guidelines are listed at the top of the **Results;bowel cancer screening** clinical item.

Scenario A - No recall protocol

Some health services may elect not to have a recall protocol for Bowel Cancer Screening. Patients over 50 or in high-risk groups are assessed on presentation and tests requested as required. GP Review of Clinical Software does not recommend this approach.

Scenario B - Initial recall only

Use an on registration recall that triggers the first recall at age 50 years and before 74 years. As patients present, the next recall must be manually added after results are received and interpreted.

Add a recall to **File > Reference Tables > Automated Recall Types** using the following values.

Table 113. Bowel cancer screening recall - initial on registration recall only

Property	Values for On Registration
Example	
Recall for	`Screening;bowel cancer` (or site equivalent)

Table 113. Bowel cancer screening recall - initial on registration recall only (continued)

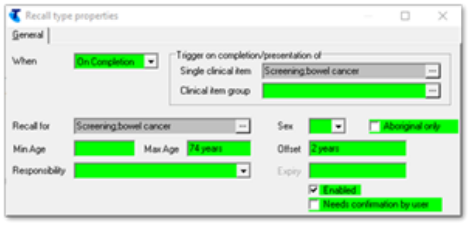
Property	Values for On Registration
Sex	blank
Min Age	blank
Max Age	`74 years`
Age	`50 years`

Scenario C - Simple cycle

This is an initial recall at age 50 years but before 74 years followed by two-yearly recalls. The recall is normally completed once the result is known, and the interval can be adjusted or accepted.

Add two recalls to **File > Reference Tables > Automated Recall Types** using the following values.

Table 114. Bowel cancer screening recall - simple cycle

Property	Values for On Registration	Values for On Completion Trigger
Example		
Recall for	`Screening;bowel cancer` (or site equivalent)	`Screening;bowel cancer`
Sex	blank	blank
Min Age	blank	blank
Max Age	`74 years`	`74 years`
Age	`50 years`	-
Trigger on completion/presentation of for **Single clinical item**	-	`Screening;bowel cancer`
Offset	-	`2 years`

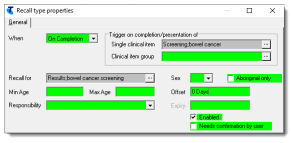
Scenario D - Cycle including results

This is an initial recall at age 50 years but before 74 years which triggers a recall to record the results. At this stage completion of the results triggers the next recall for bowel screening and the interval can be adjusted as required.

Add three recalls to **File > Reference Tables > Automated Recall Types** using the following values.

> **Note:**
> The qualifier results of the bowel cancer screening, high risk patient clinical guidelines or letters and notifications from the NCSR are not factored into this recall option. Clinicians should manually adjust the recall date as required.

Table 115. Bowel cancer screening recall - cycle including results

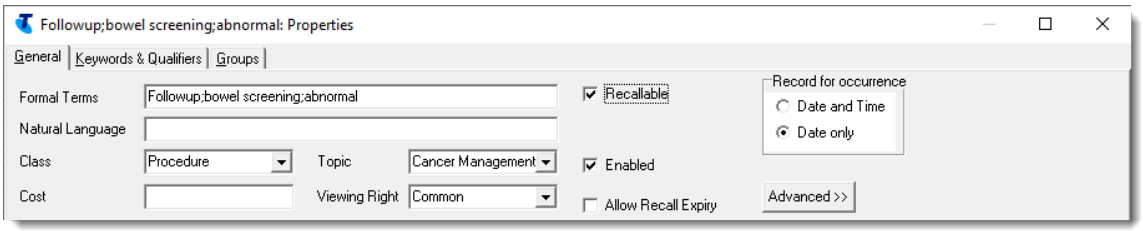
Property	Values for On Registration	Values for On Completion Trigger 1	Values for On Completion Trigger 2
Example			
Recall for	`Screening;bowel cancer` (or site equivalent)	`Results;bowel cancer screening`	`Screening;bowel cancer`
Sex	blank	blank	blank
Min Age	blank	blank	blank
Max Age	`74 years`	`74 years`	`74 years`
Age	`50 years`	-	-
Trigger on completion/presentation of for **Single clinical item**	-	`Screening;bowel cancer`	`Screening;bowel cancer`
Offset	-	`0 days`	`2 years`

Scenario E - Qualifier-driven cycle

This is an initial recall at age 50 years but before 74 years which triggers a recall to record the results. When the results are recorded it is a qualifier that triggers the next recall.

To implement this recall scenario:

1. In **File > Reference Tables > Automated Recall Types**, add the On Registration recall from Scenario B *(on page 364)*.
2. Also add the On Completion Trigger 1 recalls listed in Table 116: Bowel cancer screening recall - qualifier-driven cycle - on completion recalls *(on page 367)*.
3. In **File > Reference Tables > Clinical Item Types**, add a follow up clinical item locally for bowel screen abnormal results, **Followup;bowel screening;abnormal**.



4. Add the On Qualifier recalls for different results described in Table 117: Bowel cancer screening recall - qualifier-driven cycle - on qualifier recalls *(on page 367)*
5. Add the On Completion Trigger 2 recall in Table 116: Bowel cancer screening recall - qualifier-driven cycle - on completion recalls *(on page 367)*.

Table 116. Bowel cancer screening recall - qualifier-driven cycle - on completion recalls

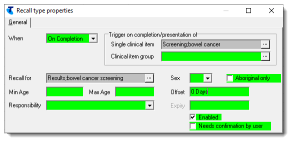
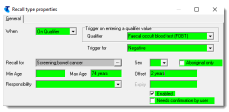
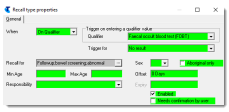
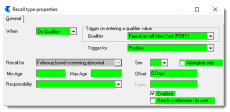
Property	Values for On Registration	Values for On Completion Trigger 1	Values for On Completion Trigger 2
Example			
Recall for	`Screening;bowel cancer` (or site equivalent)	`Results;bowel cancer screening`	`Screening;bowel cancer`
Sex	blank	blank	blank
Min Age	blank	blank	blank
Max Age	`74 years`	`74 years`	`74 years`
Age	`50 years`	-	-
Trigger on completion/presentation of for **Single clinical item**	-	`Screening;bowel cancer`	`Followup;bowel cancer;abnormal`
Offset	-	`2 years`	`2 years`

Table 117. Bowel cancer screening recall - qualifier-driven cycle - on qualifier recalls

Property	Values for On Qualifier 1	Values for On Qualifier 2	Values for On Qualifier 3	Values for On Qualifier 4
Example				
Recall for	`Screening;bowel cancer` (or site equivalent)	`Followup;bowel screening; abnormal`	`Followup;bowel screening; abnormal`	`Followup;bowel screening; abnormal`
Qualifier	`Faecal occult blood test (FOBT)`	`Faecal occult blood test (FOBT)`	`Faecal occult blood test (FOBT)`	`Faecal occult blood test (FOBT)`
Trigger for	`Negative`	-	`No result`	`Positive`
Sex	blank	blank	blank	blank
Min Age	blank	blank	blank	blank
Max Age	`74 years`	blank	blank	blank
Age	-	-	-	-
Offset	2 years	`0 Days`	`0 Days`	`0 Days`

Breast cancer screening recall scenarios

Add recalls for breast cancer screening. Choose the scenario that best suits your health service.

Note:
Clinicians should refer to the Clinical Guidelines for Breast Cancer Screening and any documentation, letters or alerts from the Breast Screening Register for information about recall intervals and add the planned recalls for treatment such as referrals or tests.

Tip:
Links to the relevant guidelines are listed at the top of the **Results;breast cancer screening** clinical item.

Scenario A - No recall protocol

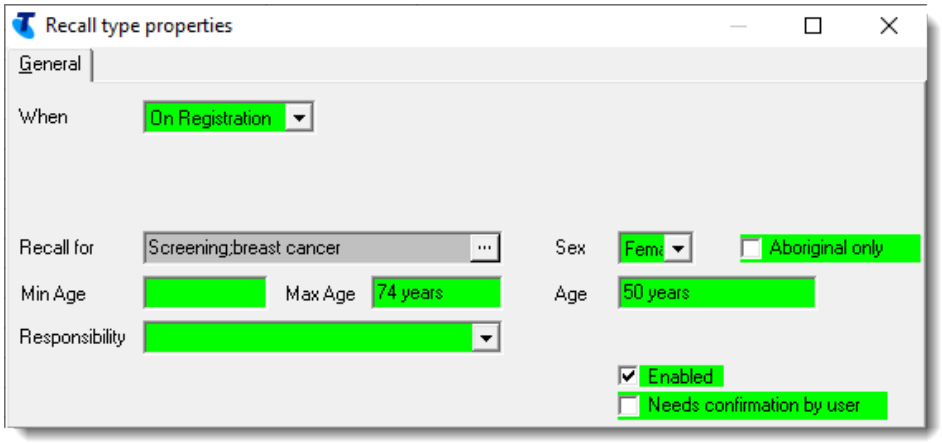
Some health services may elect not to have a recall protocol for Breast Cancer Screening. Patients over 50 or in high-risk groups are assessed on presentation and tests requested as required. GP Review of Clinical Software does not recommend this approach.

Scenario B - Initial recall only

Use an on registration recall that triggers the first recall at age 50 years and before 74 years. As patients present, the next recall must be manually added after results are received and interpreted.

Add a recall to **File > Reference Tables > Automated Recall Types** using the following values.

Table 118. Breast cancer screening recall - initial on registration recall only

Property	Values for On Registration
Example	
Recall for	`Screening;breast cancer` (or site equivalent)
Sex	`Female`
Min Age	blank
Max Age	`74 years`
Age	`50 years`

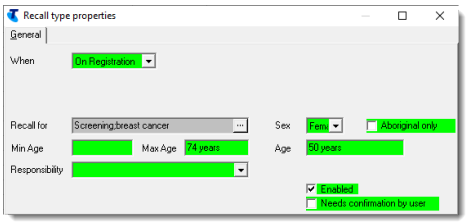
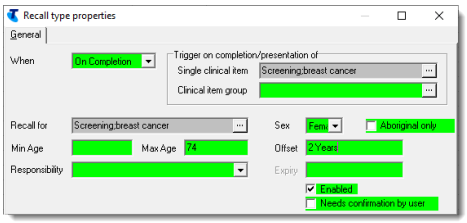
Scenario C - Simple cycle

This is an initial recall at age 50 years but before 74 years followed by two-yearly recalls. The recall is normally completed once the result is known, and the interval can be adjusted or accepted.

Add two recalls to **File > Reference Tables > Automated Recall Types** using the following values.

Note:
The completion of the **Results;breast cancer screening**, high risk patient clinical guidelines or letters and notifications from state Breast Screen agencies are not factored into this recall option. Clinicians should manually adjust the recall date as required.

Table 119. Breast cancer screening recall - simple cycle

Property	Values for On Registration	Values for On Completion Trigger
Example		
Recall for	`Screening;breast cancer` (or site equivalent)	`Screening;breast cancer`
Sex	`Female`	`Female`
Min Age	blank	blank
Max Age	`74 years`	`74 years`
Age	`50 years`	-
Trigger on completion/presentation of for **Single clinical item**	-	`Screening;breast cancer`
Offset	-	`2 years`

Scenario D - Cycle including results

This is an initial recall at age 50 years but before 74 years which triggers a recall to record the results. At this stage completion of the results triggers the next recall for breast screening and the interval can be adjusted as required.

Add three recalls to **File > Reference Tables > Automated Recall Types** using the following values.

> **Note:**
> High risk patient clinical guidelines or letters and notifications from state Breast Screen agencies are not factored into this recall option. Clinicians should manually adjust the recall date as required.

Table 120. Breast cancer screening recall - cycle including results

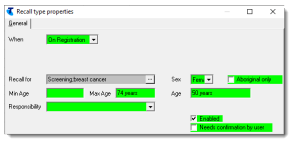
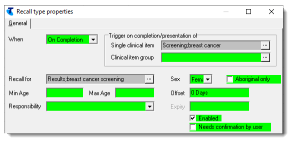
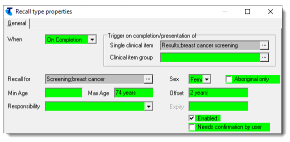
Property	Values for On Registration	Values for On Completion Trigger 1	Values for On Completion Trigger 2
Example			
Recall for	`Screening;breast cancer` (or site equivalent)	`Results;breast cancer screening`	`Screening;breast cancer`
Sex	`Female`	`Female`	`Female`
Min Age	blank	blank	blank
Max Age	`74 years`	blank	`74 years`
Age	`50 years`	-	-
Trigger on completion/presentation of for **Single clinical item**	-	`Results;breast cancer screening`	`Screening;breast cancer`

Table 120. Breast cancer screening recall - cycle including results (continued)

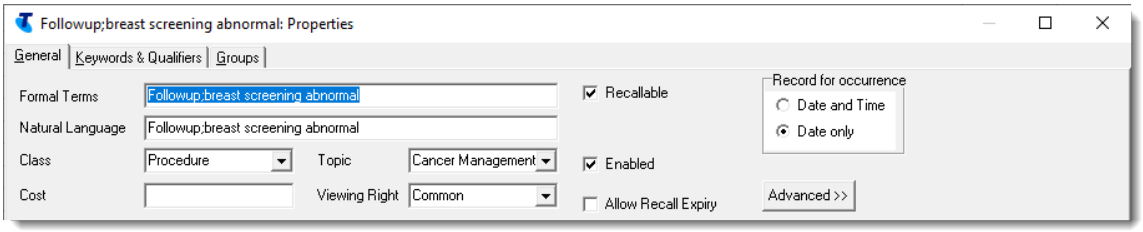
Property	Values for On Registration	Values for On Completion Trigger 1	Values for On Completion Trigger 2
Offset	-	`0 days`	`2 years`

Scenario E - Qualifier-driven cycle

This is an initial recall at age 50 years but before 74 years which triggers a recall to record the results. When the results are recorded it is a qualifier that triggers the next recall.

To implement this recall scenario:

1. In **File > Reference Tables > Automated Recall Types**, add the On Registration recall from Table 118: Breast cancer screening recall - initial on registration recall only *(on page 368)*.
2. Also add the On Completion Trigger 1 recalls listed in Table 121: Breast cancer screening recall - qualifier-driven cycle - on completion recalls *(on page 370)*.
3. In **File > Reference Tables > Clinical Item Types**, add a follow up clinical item locally for breast screen abnormal results, **Followup;breast screening;abnormal**.



4. Add the On Qualifier recalls for different results described in Table 122: Breast cancer screening recall - qualifier-driven cycle - on qualifier recalls *(on page 371)*.
5. Add the On Completion Trigger 2 recall in Table 121: Breast cancer screening recall - qualifier-driven cycle - on completion recalls *(on page 370)*.

> **Note:**
> High risk patient clinical guidelines or letters and notifications from state Breast Screen agencies are not factored into this recall option. Clinicians should manually adjust the recall date as required.

Table 121. Breast cancer screening recall - qualifier-driven cycle - on completion recalls

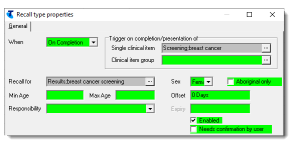
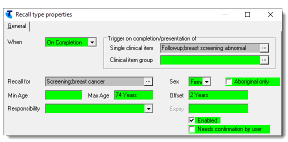
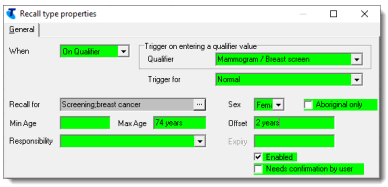
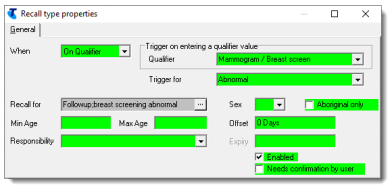
Property	Values for On Registration	Values for On Completion Trigger 1	Values for On Completion Trigger 2
Example			
Recall for	`Screening;breast cancer` (or site equivalent)	`Results;breast cancer screening`	`Screening;breast cancer`
Sex	`Female`	`Female`	`Female`
Min Age	blank	blank	blank
Max Age	`74 years`	`74 years`	`74 years`

Table 121. Breast cancer screening recall - qualifier-driven cycle - on completion recalls (continued)

Property	Values for On Registration	Values for On Completion Trigger 1	Values for On Completion Trigger 2
Age	`50 years`	-	-
Trigger on completion/presentation of for **Single clinical item**	-	`Screening;breast cancer`	`Followup;breast screening;abnormal`
Offset	-	`2 years`	`2 years`

Table 122. Breast cancer screening recall - qualifier-driven cycle - on qualifier recalls

Property	Values for On Qualifier 1	Values for On Qualifier 2
Example		
Recall for	`Screening;breast cancer` (or site equivalent)	`Followup;breast screening; abnormal`
Qualifier	`Mammogram/Breast Screen`	`Mammogram/Breast Screen`
Trigger for	`Normal`	`Abnormal`
Sex	`Female`	`Female`
Min Age	blank	blank
Max Age	`74 years`	blank
Age	-	-
Offset	2 years	`0 Days`

Cervical cancer screening recall scenarios

Add recalls for cervical cancer screening. Choose the scenario that best suits your health service.

Note:
Clinicians should refer to the Clinical Guidelines for Cervical Cancer Screening and any documentation, letters or alerts from the National Screening Register for information about recall intervals and add the planned recalls for treatment such as referrals or tests.

Tip:
Links to the relevant guidelines are listed at the top of the **Test;result;cervical screening** clinical item.

Scenario A - No recall protocol

Some health services may elect not to have a recall protocol for Cervical Cancer Screening.

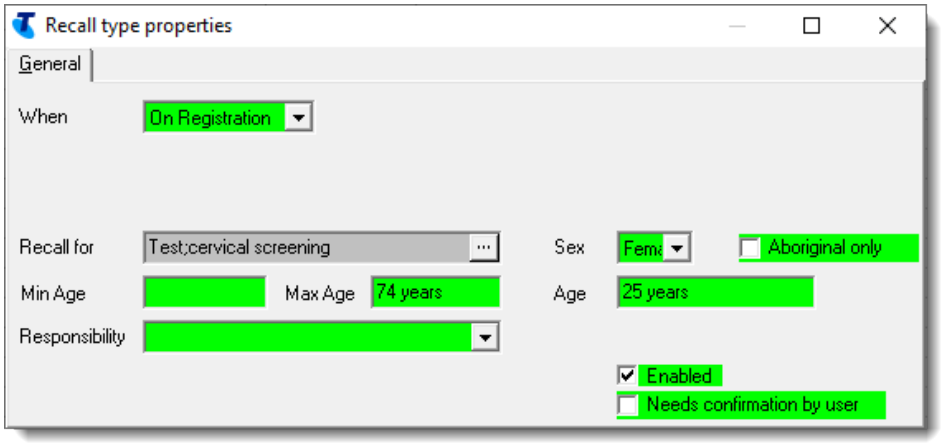
Patients over 25 or in high-risk groups are assessed on presentation and tests requested as required. GP Review of Clinical Software does not recommend this approach.

Scenario B - Initial recall only

Use an on registration recall that triggers the first recall at age 25 years but before 74 years. As patients present, the next recall is manually added after results are received and interpreted.

Add a recall to **File > Reference Tables > Automated Recall Types** using the following values.

Table 123. Cervical cancer screening recall - initial on registration recall only

Property	Values for On Registration
Example	
Recall for	`Test;cervical screening`
Sex	`Female`
Min Age	blank
Max Age	`74 years`
Age	`25 years`

Scenario C - Simple cycle

This is an initial recall at age 25 years but before 74 years followed by five-yearly recalls. In this case the completion of the recall is normally done after the result is known, so that the interval can be accepted or adjusted.

Add two recalls to **File > Reference Tables > Automated Recall Types** using the following values.

> **Note:**
> The completion of the **Test;result;cervical screening** or **Results;cervical screening**, high risk patient clinical guidelines or letters and notifications from the NCSR are not factored into this recall option. Clinicians should manually adjust the recall date as required.

Table 124. Cervical cancer screening recall - simple cycle

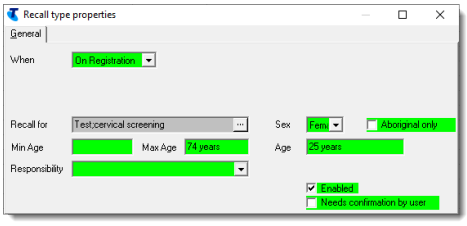
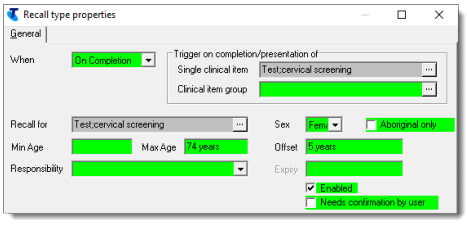
Property	Values for On Registration	Values for On Completion Trigger
Example		

Table 124. Cervical cancer screening recall - simple cycle (continued)

Property	Values for On Registration	Values for On Completion Trigger
Recall for	`Test;cervical screening`	`Test;cervical screening`
Sex	`Female`	`Female`
Min Age	blank	blank
Max Age	`74 years`	`74 years`
Age	`25 years`	-
Trigger on completion/presentation of for **Single clinical item**	-	`Test;cervical screening`
Offset	-	`5 years`

Scenario D - Cycle including results

This is an initial recall at age 25 years but before 74 years which triggers a recall to record the results. At this stage completion of the results triggers the next recall for cervical screening and the interval can be adjusted as required.

Add three recalls to **File > Reference Tables > Automated Recall Types** using the following values.

Note:
Consider abnormal results when determining the On Completion recall for the next test.

The qualifier results of the cervical cancer screening, high risk patient clinical guidelines or letters and notifications from the NCSR are not factored into this recall option. Clinicians should manually adjust the recall date as required.

Table 125. Cervical cancer screening recall - cycle including results

Property	Values for On Registration	Values for On Completion Trigger 1	Values for On Completion Trigger 2
Example			
Recall for	`Test;cervical screening`	`Test;result; cervical screening` or `Results;cervical screening`	`Test;cervical screening`
Sex	`Female`	`Female`	`Female`
Min Age	blank	blank	blank
Max Age	`74 years`	blank	`74 years`
Age	`25 years`	-	-
Trigger on completion/presentation of for **Single clinical item**	-	`Test;cervical screening`	`Test;result; cervical screening` or `Results;cervical screening`
Offset	-	`0 days`	`5 years`

Scenario E - Qualifier-driven cycle

This is an initial recall at age 25 years but before 74 years which triggers a recall to record the results. When the results are recorded, it is a qualifier that triggers the next recall.

To implement this recall scenario:

1. In **File > Reference Tables > Automated Recall Types**, add the On Registration recall from Table 126: Cervical cancer screening recall - qualifier-driven cycle - on completion recalls *(on page 374)*.
2. Also add the On Completion Trigger recall listed in Table 126: Cervical cancer screening recall - qualifier-driven cycle - on completion recalls *(on page 374)*.
3. Add the On Qualifier recalls for different results described in Table 127: Cervical cancer screening recall - qualifier-driven cycle - on qualifier recalls *(on page 374)*.

Note:
Where a patient has an abnormal result and is recalled for a follow up, no automatic recalls are suggested for next steps because of the complexity of cervical recall process flows. Clinicians should manually add a recall for the appropriate treatment, such as Colposcopy, referral, retest. Letters and notifications from the NCSR including suggested actions need to be manually actioned by clinicians.

Where the manual action includes adding a recall for **Test;cervical screening**, any automated recalls continue to function as expected.

Table 126. Cervical cancer screening recall - qualifier-driven cycle - on completion recalls

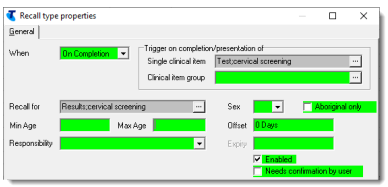
Property	Values for On Registration	Values for On Completion Trigger
Example		
Recall for	`Test;cervical screening`	`Test;result; cervical screening` or `Results;cervical screening`
Sex	`Female`	`Female`
Min Age	blank	blank
Max Age	`74 years`	blank
Age	`25 years`	-
Trigger on completion/presentation of for **Single clinical item**	-	`Test;cervical screening`
Offset	-	`0 days`

Table 127. Cervical cancer screening recall - qualifier-driven cycle - on qualifier recalls

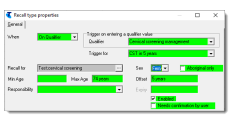
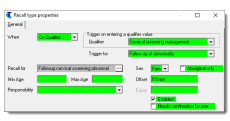
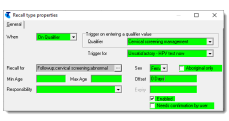
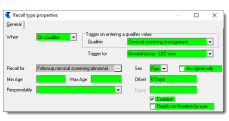
Property	Values for On Qualifier 1	Values for On Qualifier 2	Values for On Qualifier 3	Values for On Qualifier 4
Example				

Table 127. Cervical cancer screening recall - qualifier-driven cycle - on qualifier recalls (continued)

Property	Values for On Qualifier 1	Values for On Qualifier 2	Values for On Qualifier 3	Values for On Qualifier 4
Recall for	`Test;cervical screening` (or site equivalent)	`Followup;cervical screening; abnormal`	`Followup;cervical screening; abnormal`	`Followup;cervical screening; abnormal`
Qualifier	`Cervical screening management`	`Cervical screening management`	`Cervical screening management`	`Cervical screening management`
Trigger for	`CST in 5 years`	`Follow up of abnormality`	`Unsatisfactory - HPV test now`	`Unsatisfactory - LBC now`
Sex	`Female`	`Female`	`Female`	`Female`
Min Age	blank	blank	blank	blank
Max Age	`74 years`	blank	blank	blank
Age	`-`	-	-	-
Offset	`5 years`	`0 Days`	`0 Days`	`0 Days`

Prostate cancer screening recall scenarios

Add recalls for prostate cancer screening. Choose the scenario that best suits your health service.

Note:
Clinicians should refer to the Clinical Guidelines for Prostate Cancer Management:

- https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/prostate-cancer-screening
- https://www.prostate.org.au/awareness/for-healthcare-professionals/clinical-practice-guidelines-on-psa-testing/

The Royal Australian College of General Practitioners (RACGP) states that *"Screening of asymptomatic (low-risk) men for prostate cancer by prostate specific antigen (PSA) testing is not recommended"*" therefore `on registration` recalls are not shown.

Tip:
Because results for prostate cancer screening involve a high level of clinical analysis and decision, no `on result` or `on qualifier` recalls are shown.

Scenario A - No recall protocol

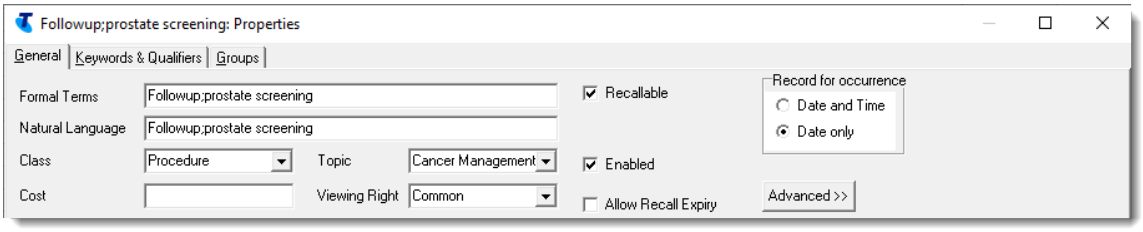
Example recall protocols are listed below in cases where prostate cancer screening has been done by the GP.

Where GPs decide to perform prostate cancer screening, they may manually add the clinical item of **Screening;prostate cancer** to record that it has been done.

Scenario B - Results recall

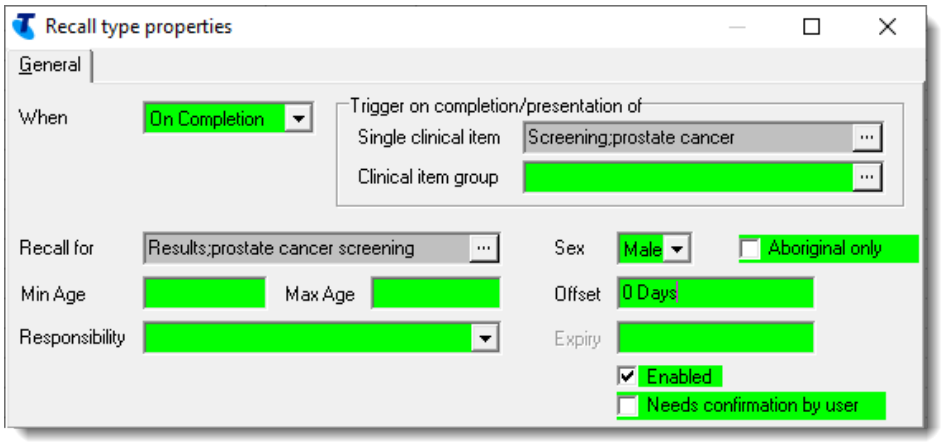
To implement this recall scenario:

1. In the clinical record, manually add the clinical item **Screening;prostate cancer**.
2. In **File > Reference Tables > Automated Recall Types**, add the On Completion recall described in Table 128: Prostate cancer screening recall - on completion recall *(on page 376)*.
3. In **File > Reference Tables > Clinical Item Types**, add a **Followup;prostate screening**, **Followup;test result** or **Followup;test result;urgent** follow up recall clinical item locally.



4. In the clinical record, manually add the recall clinical item you created in the previous step.

Table 128. Prostate cancer screening recall - on completion recall

Property	Values for On Registration
Example	
Recall for	`Results;prostate cancer screening`
Sex	`Male`
Min Age	blank
Max Age	blank
Age	-
Trigger on completion/presentation of for **Single clinical item**	`Screening;prostate cancer`
Offset	`0 days`

Lung cancer screening recalls

Add recalls for the National Lung Cancer Screening Program (NLCSP).

Set up lung cancer screening recalls

Your Communicare Administrator can set up lung cancer screening recalls:

1. Update Central Data to add the NLCSP clinial items, including **Results;lung cancer screening LDCT** for your health service.
2. In **File > Reference Tables > Automated Recall Types**, add the. Set automatic recall rules for recalls based on results: On Qualifier **NLCSP Results Low Dose CT Scan** Recall for **National Lung Cancer Screening Program**, set a trigger for 24 months, 12 months, 6 months, 3 months.

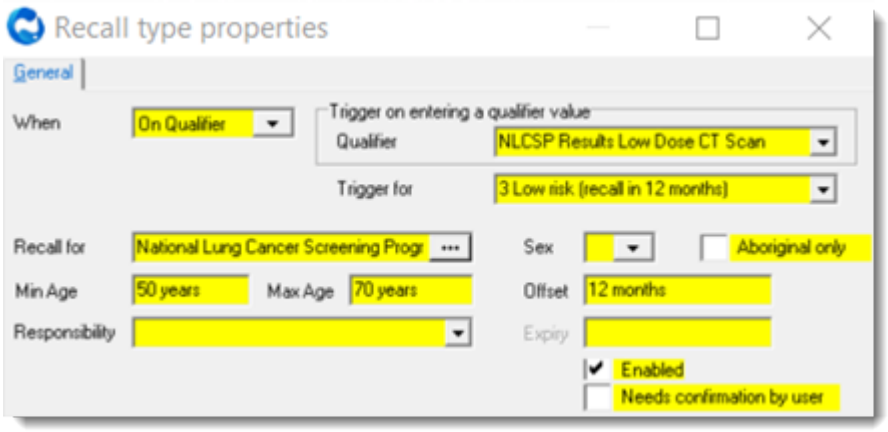


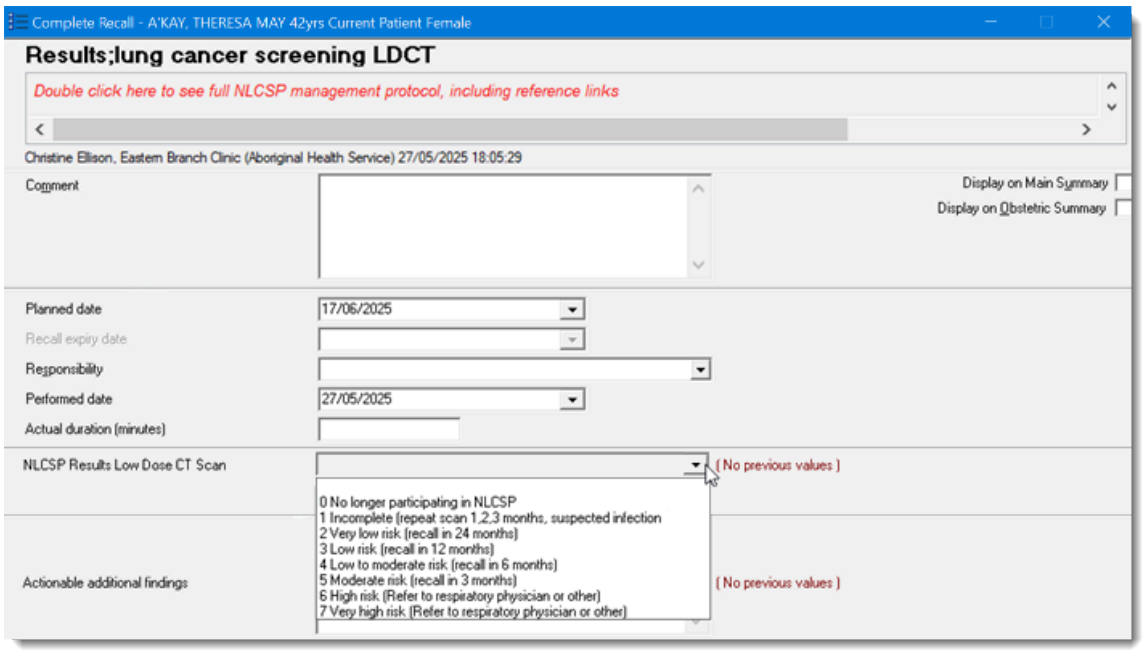
Table 129. Lung screening result automated recall categories

Result category	Automated recall period
0 No longer participating in NLCSP	No recall
1 Incomplete (repeat scan 1,2,3 months, suspected infection)	No ongoing automated recalls; the clinician should add an appropriate recall date manually at the time of completion. ◦ Add **Offset** of `0 days` ◦ Set **Needs confirmation by user**
2 Very low risk (recall in 24 months)	◦ Add **Offset** of `24 months`
3 Low risk (recall in 12 months)	◦ Add **Offset** of `12 months`
4 Low to moderate risk (recall in 6 months)	◦ Add **Offset** of `6 months`
5 Moderate risk (recall in 3 months)	◦ Add **Offset** of `3 months`
6 High risk (Refer to respiratory physician)	No ongoing automated recalls; the clinician should add an appropriate recall date manually at the time of completion. ◦ Add **Offset** of `0 days` ◦ Set **Needs confirmation by user**
7 Very high risk (Refer to respiratory physician)	No ongoing automated recalls; the clinician should add an appropriate recall date manually at the time of completion. ◦ Add **Offset** of `0 days` ◦ Set **Needs confirmation by user**

Add NLCSP recalls to a patient's record

For a clinician, after a patient has been referred for the NLCSP and you receive the results of their Low Dose CT Scan, to add a recall:

1. In a patient's clinical record, add the clinical item **Results;lung cancer screening LDCT**.
2. Complete the clinical item as normal, ensuring you select a result category from the **NLCSP Results Low Dose CT Scan** list.



3. Click **Save**.

Recalls are listed in the **To Do** list in the patient's clinical record. To complete a recall, double-click it in the list.

When the **Results;lung cancer screening LDCT** clinical item is completed, a new recall for the NLCSP clinical item is triggered for the required follow up.

Datasets

Datasets are a user-friendly coding system, giving health professionals a standardised way to record data and report on data entered in a patient's clinical record.

Several different agencies supply standardised datasets. Certain datasets may require that your organisation meet specific registration requirements with the supplier of the dataset before it can be enabled for your health service.

Note:
To enable a dataset, a central update will need to be applied to your production database. Contact Communicare Support to request a dataset.

Australian Nurse-Family Partnership Program

The Australian Nurse-Family Partnership Program (ANFPP) dataset is available to health services registered as ANFPP providers.

The Nurse Family Partnership program comprises a series of data collection forms that are completed by a home visiting nurse to collect information that is designed to suit a number of purposes. They include:

- Identify and describe risk characteristics of the client
- Keep a record of services provided and planned for future visits
- Evaluate the effectiveness of the nursing process
- Monitor program fidelity
- Evaluate the effectiveness of the program and outcomes achieved

In Australia the Nurse Family Partnership program is delivered as part of a continuum of care delivered by Aboriginal Medical Services and their partner organisations and is an enhancement to existing maternal and child health services. Aboriginal Medical Services use a combination of electronic patient information systems and manual data collection to support service delivery and have developed communication arrangements with hospitals and other service providers to enable information exchange to support share care of antenatal clients.

This dataset was created in 2009 by JTA International and was last updated in 2022 by the College of Nursing & Midwifery at Charles Darwin University.

ANFPP provide training and documentation to health services before this dataset is made available in Communicare. For more information, see http://www.anfpp.com.au/contact-us

After the ANFPP training is complete, contact Communicare Support and arrange for the ANFPP dataset to be imported to your Communicare instance.

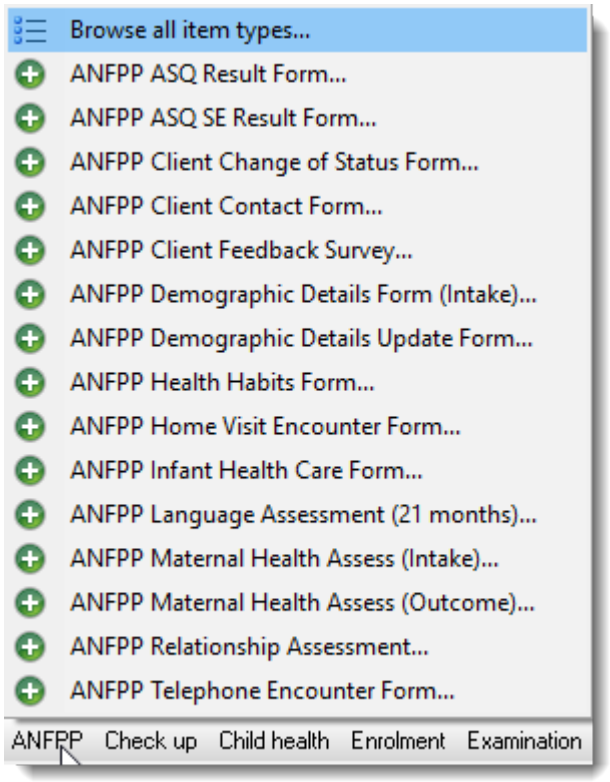
The import creates a set of clinical items and reports that reflect the paper data collection forms.

The Australian Nurse-Family Partnership dataset comprises the following items:

- Clinical items:
    - **ANFPP ASQ Result Form**
    - **ANFPP ASQ SE Result Form**
    - **ANFPP Client Change of Status Form**
    - **ANFPP Client Contact Form**
    - **ANFPP Contact with Service Agency**
    - **ANFPP DANCE**
    - **ANFPP Demographic Details Form (Intake)**
    - **ANFPP Demographic Details Update Form**
    - **ANFPP Domestic and Family Violence**
    - **ANFPP Edinburgh Postnatal Screening Tool**
    - **ANFPP FPW Home Visit Form**
    - **ANFPP Growth and Empowerment Measure**
    - **ANFPP Health Habits Form**
    - **ANFPP Home Visit Encounter Form**
    - **ANFPP Infant Health Care Form**
    - **ANFPP Kimberley Mum's Mood Scale**
    - **ANFPP Maternal Health Assess (Intake)**
    - **ANFPP PLUM and HATS Result Form**
    - **ANFPP Pregnancy Outcome Form**
    - **ANFPP Program End**
    - **Referral;ANFPP**
- Reports, **ANFPP >** :
    - **Client Attrition Summary V3**
    - **Client Summary V3**
    - **Data Dictionary**
    - **Data Export V3**
    - **Formal Reflection Activity V3**
    - **Home Visit Summary (CC) V3**

- **Home Visit Summary V3**
- **Referral and Outcome Log V3**

ANFPP clinical items are prefixed with ANFPP and are added to a **ANFPP** button in clinical records.



> **Tip:**
> After the ANFPP dataset is enabled, your Communicare Administrator must manually enable the clinical items in **File > Reference Tables > Clinical Item Types** before clinicians can use them.

If you need help completing the ANFPP clinical items, email helpdesk@anfpp.com.au.

For more information about ANFPP reports, see ANFPP reporting *(on page 467)*.

Communicare Infrastructure

This dataset must not be disabled. It is used by Communicare internally and many parts of Communicare depend on it.

Communicare Value Added

The `Communicare Value Added` dataset includes clinical item types not yet included in ICPC-2 PLUS, such as custom check-ups and the Aboriginal and Torres Strait Islander Health Checks. This data set is required for antenatal care reporting.

Drug and Alcohol Treatment Service

The `Drug and Alcohol Treatment Service` (DATS) dataset is required for residential drug and alcohol services that need to submit data using the National Minimum Dataset. There are variations for NSW.

The DATS dataset comprises the following items:

- Clinical items:
    - **Alcohol/Other Drug respite enrolment**
    - **Alcohol/Other Drug respite exit**
    - **Alcohol/Other Drug treatment enrolment**
    - **Alcohol/Other Drug treatment exit**
    - **DATS Counselling group**
    - **DATS Cultural group**
    - **DATS Educational group**
    - **DATS Living skills group**
    - **DATS Other group**
    - **DATS Sport/Recreation group**
    - **DATS Support group**
    - **Sobering-up overnight stay**
- Recalls:
    - **Alcohol/Other Drug respite exit**
    - **Alcohol/Other Drug treatment exit**
- Reports for DATS NSW:
    - **Monthly Episodes Export**
    - **Monthly Other Drugs Export**
    - **Monthly Other Services Export**
    - **Monthly Pharmacotherapy Type Export**
    - **Monthly Previous Services Export**
    - **Monthly Service Contacts Export**

Tip:
After the `Drug and Alcohol Treatment Service` dataset is enabled, your Communicare Administrator must manually enable the clinical items in **File > Reference Tables > Clinical Item Types** before clinicians can use them.

The DATS clinical items are assigned the DATS keyword which clinicians can use to find the Drug and Alcohol Treatment Service clinical items in the **Clinical Terms Browser**.

Enrol patients into a DATS program using either of the enrolment clinical items, then add activity items as required. When the DATS program is complete, to remove the patient from the program, complete the recall, which opens the matching exit clinical item and save it.

Tip:
You cannot add activity items until after a patient has been enrolled in a program. However, you can still add activity items after a patient has been exited from a program. This allows for genuine backdating of clinical items. For example:

- If you are using an offline client and your clinical program enrolments and exits have got out of step, you can backdate an exit.
- If items are out of sequence, correct the items.
- For a patient who exited last week, record an action from two weeks ago.

Flinders Care Plan

The `Flinders Care Plan` dataset is made available to health services that are part of the *Flinders Program* and have undergone required training with Flinders University, S.A.

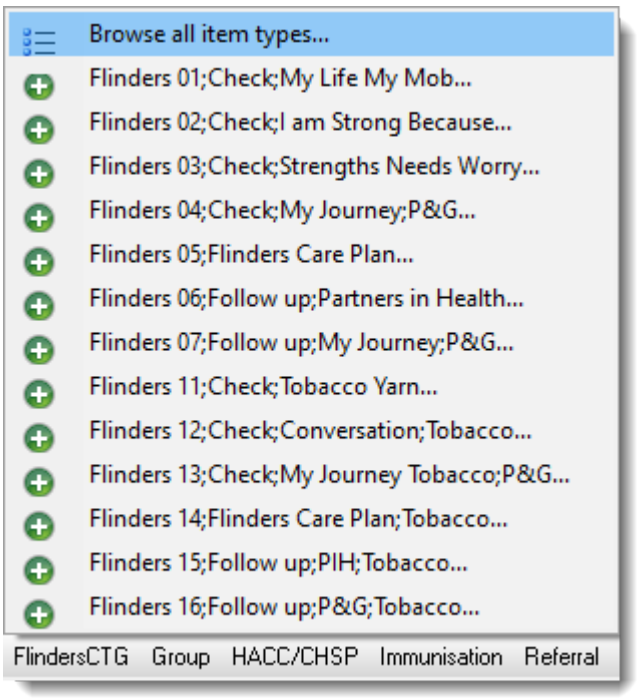
The Flinders Care Plan uses the Flinders Model of Chronic Disease Care Management as adapted for Closing the Gap.

Flinders University requires that health services complete training before the Flinders Care Plan dataset is made available to sites. For more information on how to apply, see http://www.flinders.edu.au/medicine/sites/fhbhru/programs-services/ or https://www.flindersprogram.com.au/.

The `Flinders Care Plan` dataset comprises the following items:

- Clinical items:
    - **Flinders 01;Check;My Life My Mob**
    - **Flinders02;Check;I am Strong Because**
    - **Flinders03;Check;Strengths Needs Worry**
    - **Flinders04;Check;My Journey;P&G**
    - **Flinders05;Flinders Care Plan**
    - **Flinders06;Follow up;Partners in Health**
    - **Flinders07;Follow up;My Journey;P&G**
    - **Flinders11;Check;Tobacco Yarn**
    - **Flinders12;Check;Conversation;Tobacco**
    - **Flinders13;Check;My Journey Tobacco;P&G**
    - **Flinders14;Flinders Care Plan;Tobacco**
    - **Flinders15;Follow up;PIH;Tobacco**
    - **Flinders16;Follow up;P&G;Tobacco**
- Reports:
    - **Analysis Report**
    - **Recalls Due**
    - **Target Population**
- Automatic recall rules:
    - **Flinders03;Check;Strengths Needs Worry** On Completion **Flinders06;Follow up;Partners in Health**
    - **Flinders04;Check;My Journey;P&G** On Completion **Flinders05;Flinders Care Plan**
    - **Flinders04;Check;My Journey;P&G** On Completion **Flinders07;Follow up;My Journey;P&G**
    - **Flinders06;Follow up;Partners in Health** On Completion **Flinders06;Follow up;Partners in Health**
    - **Flinders07;Follow up;My Journey;P&G** On Completion **Flinders07;Follow up;My Journey;P&G**
    - **Flinders12;Check;Conversation;Tobacco** On Completion **Flinders07;Follow up;My Journey;P&G**
    - **Flinders13;Check;My Journey Tobacco;P&G** On Completion **Flinders14;Flinders Care Plan;Tobacco**
    - **Flinders13;Check;My Journey Tobacco;P&G** On Completion **Flinders16;Follow up;P&G;Tobacco**
    - **Flinders15;Follow up;PIH;Tobacco** On Completion **Flinders15;Follow up;PIH;Tobacco**
    - **Flinders16;Follow up;P&G;Tobacco** On Completion **Flinders16;Follow up;P&G;Tobacco**
- Letter templates:
    - **Flinders Care Plan - Chronic Condition - Self Management**
    - **Flinders Care Plan - Tobacco Intervention - Self Management**

The Flinders Care Plan clinical items are prefixed with `Flinders` and are added to a **FlindersCTG** button in clinical records.



Tip:
After the `Flinders Care Plan` dataset is enabled, your Communicare Administrator must manually enable the clinical items in **File > Reference Tables > Clinical Item Types** before clinicians can use them.

If you need help completing Flinders Care Plan clinical items or other support, contact the Flinders Model team at http://flindersprogram.com/ or telephone (08) 8404 2607.

For Communicare technical support, speak to your Communicare Administrator or contact Communicare Support as normal.

Home Support Programs

Communicare supports three home support programs.

- CHSP - Commonwealth Home Support Program for all states
- HACC WA - Home and Community Care program for WA
- HACC Victoria - Home and Community Care program for Victoria

HACC and CHSP are separate but similar programs. In most states, state-funded HACC was replaced by the Commonwealth-funded CHSP. However, both WA and Victoria still have a HACC program for younger patients ineligible for CHSP. WA and Victoria have separate reporting for HACC.

Tip:
To use the CHSP dataset in Communicare:

- In most states, arrange for Communicare Support to enable the HACC and CHSP dataset. You can then use any of the **HACC/CHSP** clinical items to record CHSP information or HACC information in WA, to capture data required by the reporting body.
- If you are in Victoria, arrange for Communicare Support to enable the HACC and CHSP (Victoria) dataset.
- For CHSP, if you want to do bulk uploads to the Department of Social Services, Data Exchange Portal, request the **DSS Exchange XML CHSP (HACC)** report from Communicare Support, who will customise the report for your health service and add it to Communicare.

CHSP

To record CHSP-related encounters so that the data can be used in the CHSP, use CHSP-specific clinical items.

In all states except Victoria, enable the HACC and CHSP dataset. For Victoria, enable the HACC and CHSP (Victoria) dataset.

Use the **HACC/CHSP** * clinical items to record encounters associated with CHSP.

Table 130. HACC/CHSP clinical items

Clinical item	Description
HACC/CHSP Allied Health Care	Record allied health services separately. At reporting time, a total for all allied health assistance provided to a client is calculated.
HACC/CHSP Assessment	Assessment activities directly attributable to individual care recipients.
HACC/CHSP Carer Counselling/Support	Counselling, support, information and advocacy support services that help clients and carers deal with their situation. Includes dementia support and counselling and carer support and counselling.
HACC/CHSP Carer Information	Record carer information for people who provide regular, sustained care and assistance without payment other than a pension or benefit.
HACC/CHSP Carer Respite Care	Record assistance provided to carers reported on the MDS record, for relief from their caring role. If the care recipient has no carer, the service types is instead **Social Support**.
HACC/CHSP Case Management	Record case management - coordination of planning and delivery of services to the client by an identified case manager or care coordinator.
HACC/CHSP Centre-based day care	Record assistance provided to the client to attend or participate in group activities at a centre or excursions conducted by centre staff.
HACC/CHSP Client Care Coordination	Record client care coordination.
HACC/CHSP Counselling/Support, etc.	Record counselling, support, information and advocacy for clients or their carers.
HACC/CHSP Domestic Assistance	Record domestic assistance.

Table 130. HACC/CHSP clinical items (continued)

Clinical item	Description
HACC/CHSP Enrolment	Use this clinical item to record the beginning of a CHSP service in Communicare and include the patient in CHSP reporting. **Note:** Add this clinical item before you add any other CHSP-related items.
HACC/CHSP Exit	Add this clinical item to report that the patient has stopped receiving services during the current reporting period and has exited from the CHSP.
HACC/CHSP Functional Assessment	Record the extent to which the patient is able to perform daily living activities and whether they have behavioural or memory problems. This identifies areas in which a person requires assistance and quantifies the extent of the assistance required.
HACC/CHSP Goods and Equipment	Record equipment or goods provided to the patient.
HACC/CHSP Home Maintenance	Record assistance with the maintenance or repair of the patient's home, garden or yard.
HACC/CHSP Home Modification	Record structural changes to the patient's home so they can continue to live in and move safely around the house.
HACC/CHSP Meals Provided	Record meals prepared outside the patient's home and delivered to the patient and meals provided at a centre. Count the meals separately for each location.
HACC/CHSP Nursing Care	Record health care provided to the patient by a registered or enrolled nurse in their home or at any other location.
HACC/CHSP Other Food Services	Record assistance provided with preparing a meal at the patient's home, or advice on nutrition, food storage or preparation.
HACC/CHSP Personal Care	Record assistance provided to the patient for daily self care tasks such as eating and bathing, and medication monitoring.
HACC/CHSP Social Support	Record social support provided by a paid or volunteer companion at home or using community services so that the patient can participate in community life.
HACC/CHSP Transport	Record transport assistance provided to the patient either directly, by driving them somewhere or indirectly with taxi vouchers or subsidies. Count the number of one-way trips.

To record CHSP services:

1. Enrol the patient in CHSP. Add the **HACC/CHSP Enrolment** clinical item to the patient's clinical record.
2. For each contact, record the type of assistance provided, using a specific clinical item as described in Table 130: HACC/CHSP clinical items *(on page 384)* .
3. If the patient no longer receives CSHP-related services, add the **HACC/CHSP Exit** clinical item.

Tip:
You cannot add activity items until after a patient has been enrolled in a program. However, you can still add activity items after a patient has been exited from a program. This allows for genuine backdating of clinical items. For example:

- If you are using an offline client and your clinical program enrolments and exits have got out of step, you can backdate an exit.
- If items are out of sequence, correct the items.
- For a patient who exited last week, record an action from two weeks ago.

HACC WA

To record HACC WA-related encounters so that the data can be used to report for HACC in WA, use HACC-specific clinical items.

For WA, enable the HACC and CHSP dataset.

Use the **HACC/CHSP *** clinical items to record encounters associated with HACC in WA.

Table 131. HACC/CHSP clinical items

Clinical item	Description
HACC/CHSP Allied Health Care	Record allied health services separately. At reporting time, a total for all allied health assistance provided to a client is calculated.
HACC/CHSP Assessment	Assessment activities directly attributable to individual care recipients.
HACC/CHSP Carer Counselling/Support	Counselling, support, information and advocacy support services that help clients and carers deal with their situation. Includes dementia support and counselling and carer support and counselling.
HACC/CHSP Carer Information	Record carer information for people who provide regular, sustained care and assistance without payment other than a pension or benefit.
HACC/CHSP Carer Respite Care	Record assistance provided to carers reported on the MDS record, for relief from their caring role. If the care recipient has no carer, the service types is instead **Social Support**.
HACC/CHSP Case Management	Record case management - coordination of planning and delivery of services to the client by an identified case manager or care coordinator.
HACC/CHSP Centre-based day care	Record assistance provided to the client to attend or participate in group activities at a centre or excursions conducted by centre staff.
HACC/CHSP Client Care Coordination	Record client care coordination.
HACC/CHSP Counselling/Support, etc.	Record counselling, support, information and advocacy for clients or their carers.
HACC/CHSP Domestic Assistance	Record domestic assistance.

Table 131. HACC/CHSP clinical items (continued)

Clinical item	Description
HACC/CHSP Enrolment	Use this clinical item to record the beginning of a HACC service in Communicare and include the patient in reporting. **Note:** Add this clinical item before you add any other HACC-related items.
HACC/CHSP Exit	Add this clinical item to report that the patient has stopped receiving services during the current reporting period and has exited from the HACC.
HACC/CHSP Functional Assessment	Record the extent to which the patient is able to perform daily living activities and whether they have behavioural or memory problems. This identifies areas in which a person requires assistance and quantifies the extent of the assistance required.
HACC/CHSP Goods and Equipment	Record equipment or goods provided to the patient.
HACC/CHSP Home Maintenance	Record assistance with the maintenance or repair of the patient's home, garden or yard.
HACC/CHSP Home Modification	Record structural changes to the patient's home so they can continue to live in and move safely around the house.
HACC/CHSP Meals Provided	Record meals prepared outside the patient's home and delivered to the patient and meals provided at a centre. Count the meals separately for each location.
HACC/CHSP Nursing Care	Record health care provided to the patient by a registered or enrolled nurse in their home or at any other location.
HACC/CHSP Other Food Services	Record assistance provided with preparing a meal at the patient's home, or advice on nutrition, food storage or preparation.
HACC/CHSP Personal Care	Record assistance provided to the patient for daily self care tasks such as eating and bathing, and medication monitoring.
HACC/CHSP Social Support	Record social support provided by a paid or volunteer companion at home or using community services so that the patient can participate in community life.
HACC/CHSP Transport	Record transport assistance provided to the patient either directly, by driving them somewhere or indirectly with taxi vouchers or subsidies. Count the number of one-way trips.

To record HACC services in WA:

1. Enrol the patient in HACC. Add the **HACC/CHSP Enrolment** clinical item to the patient's clinical record.
2. For each contact, record the type of assistance provided, using a specific clinical item as described in Table 131: HACC/CHSP clinical items *(on page 386)*.
3. If the patient no longer receives HACC-related services, add the **HACC/CHSP Exit** clinical item.

Tip:
You cannot add activity items until after a patient has been enrolled in a program. However, you can still add activity items after a patient has been exited from a program. This allows for genuine backdating of clinical items. For example:

- If you are using an offline client and your clinical program enrolments and exits have got out of step, you can backdate an exit.
- If items are out of sequence, correct the items.
- For a patient who exited last week, record an action from two weeks ago.

HACC Vic

To record HACC-related encounters so that the data can be used to report for HACC in Victoria, use HACC-specific clinical items.

For Victoria, enable the `HACC and CHSP (Victoria)` dataset.

Use the **HACC/CHSP** * clinical items to record encounters associated with HACC in Victoria.

Table 132. HACC/CHSP clinical items

Clinical item	Description
HACC/CHSP Allied Health Care at Centre	Record allied health services provided at centres separately. At reporting time, a total for all allied health assistance provided to a client is calculated.
HACC/CHSP Allied Health Care at Home	Record allied health services provided at home separately. At reporting time, a total for all allied health assistance provided to a client is calculated.
HACC/CHSP Assessment	Assessment activities directly attributable to individual care recipients.
HACC/CHSP Carer Counselling/Support	Counselling, support, information and advocacy support services that help clients and carers deal with their situation. Includes dementia support and counselling and carer support and counselling.
HACC/CHSP Carer Information	Record carer information for people who provide regular, sustained care and assistance without payment other than a pension or benefit.
HACC/CHSP Carer Respite Care	Record assistance provided to carers reported on the MDS record, for relief from their caring role. If the care recipient has no carer, the service types is instead **Social Support**.
HACC/CHSP Case Management	Record case management - coordination of planning and delivery of services to the client by an identified case manager or care coordinator.
HACC/CHSP Client Care Coordination	Record client care coordination.
HACC/CHSP Counselling/Support, etc.	Record counselling, support, information and advocacy for clients or their carers.
HACC/CHSP Domestic Assistance	Record domestic assistance.

Table 132. HACC/CHSP clinical items (continued)

Clinical item	Description
HACC/CHSP Enrolment (Vic)	Use this clinical item to record the beginning of a HACC service in Communicare and include the patient in reporting. **Note:** Add this clinical item before you add any other HACC-related items.
HACC/CHSP Exit	Add this clinical item to report that the patient has stopped receiving services during the current reporting period and has exited from the HACC.
HACC/CHSP Functional Assessment (Vic)	Record the extent to which the patient is able to perform daily living activities and whether they have behavioural or memory problems. This identifies areas in which a person requires assistance and quantifies the extent of the assistance required.
HACC/CHSP Goods and Equipment	Record equipment or goods provided to the patient.
HACC/CHSP Home Maintenance	Record assistance with the maintenance or repair of the patient's home, garden or yard.
HACC/CHSP Meals Provided	Record meals prepared outside the patient's home and delivered to the patient and meals provided at a centre. Count the meals separately for each location.
HACC/CHSP Nursing Care	Record health care provided to the patient by a registered or enrolled nurse in their home or at any other location.
HACC/CHSP Other Food Services	Record assistance provided with preparing a meal at the patient's home, or advice on nutrition, food storage or preparation.
HACC/CHSP Personal Care	Record assistance provided to the patient for daily self care tasks such as eating and bathing, and medication monitoring.
HACC/CHSP Planned Activity Group	Record assistance provided in groups.
HACC/CHSP Social Support	Record social support provided by a paid or volunteer companion at home or using community services so that the patient can participate in community life.
HACC/CHSP Transport	Record transport assistance provided to the patient either directly, by driving them somewhere or indirectly with taxi vouchers or subsidies. Count the number of one-way trips.

To record HACC services in Vic:

1. Enrol the patient in HACC. Add the **HACC/CHSP Enrolment** clinical item to the patient's clinical record.
2. For each contact, record the type of assistance provided, using a specific clinical item as described in Table 132: HACC/CHSP clinical items *(on page 388)*.
3. If the patient no longer receives HACC-related services, add the **HACC/CHSP Exit** clinical item.

Tip:
You cannot add activity items until after a patient has been enrolled in a program. However, you can still add activity items after a patient has been exited from a program. This allows for genuine backdating of clinical items. For example:

- If you are using an offline client and your clinical program enrolments and exits have got out of step, you can backdate an exit.
- If items are out of sequence, correct the items.
- For a patient who exited last week, record an action from two weeks ago.

Home support reporting

Uploading CHSP data to DSS

CHSP customers can create and export XML files for bulk upload to the Department of Social Services, Data Exchange Portal.

As a CHSP customer, you will have the **Report > DSS > DSS Exchange XML CHSP (HACC)** (or similar) report installed.

Only Administrators can run this report.

To extract the performance data from Communicare for upload to the Department of Social Services, Data Exchange Portal:

1. Select **Report > Search Reports**.
2. In the **Search** field, enter `DSS`.
3. Click on **DSS Exchange XML CHSP (HACC)** and read the instructions.
4. Right-click on **DSS Exchange XML CHSP (HACC)** and select **Edit Report**.
    a. In the **Parameters** section, edit the report dates.

    Tip:
    Your outlet activity ID should be recorded and the age limits should be appropriate to your state.

    - First date to report, for example, `01-JUL-2021`
    - Last date to report, for example, `31-DEC-2021`

    b. Click **Save**.
5. In the **Reports Search** window, click **Open Report**.
6. In the report, click **Advanced**.
7. After a few minutes when you have data on the screen, click **Export data**.
8. In the **Step #1: Field Selection** window, click double arrow to move all entries from **Source table fields** to **Destination Table fields** and click **Next**.
9. In the **Step #2: Destination type** window, select **ASCII** and click **Next**.
10. In the **Step #3: Destination Parameters** window:
    a. In the **Field delimiter** field, clear the entry so that it is blank.
    b. In the **File name** field enter a location on your PC and a filename with a `.xml` extension. For example, `C:\DSS\Reporting\CHSP_20210701.xml`.
    c. Click **Next**.
11. In the **Last Step: Export Data** window, click **Export**.

The window closes and you can also close the data window.

Find the file you saved when exporting and upload this to the DSS Data Exchange portal. For further information, see CHSP Reporting.

> **Tip:**
> If you encounter any errors, send the details to Communicare Support.

HACC reporting

Run the HACC reports to generate files containing information relating to HACC.

To display the HACC reports, select **Report > HACC**.

Table 133. CHSP reports

Report	Description
Client list	Lists all clients enrolled in the HACC program at the selected reference date. Use internally to find clients who are in the HACC or should be exited from the program.
Full query	Administrators only This report is based on the **Quarterly extract** and can be used as the basis for any other HACC reporting based on the same data. **Note:** This query does not increment the transmission number. **Tip:** The report layout does not fit on the screen. Use **Advanced** or **Export** if you want to see all the data.
Quarterly extract	Administrators only Produces the quarterly HACC extract for WA. It may take a long time to run and is not designed for on-screen display. **Note:** Only run this report to produce the quarterly extract for WA. **Tip:** If you have the Report Scheduler configured, use it to generate the extract at the end of each quarter and send it as a CSV file. (A schedule should have been created when this report was installed. If so, modify the recipients and enable it.)

Table 133. CHSP reports (continued)

Report	Description
Quarterly extract (Victoria)	Administrators only Produces the quarterly HACC extract for Victoria. It may take a long time to run and is not designed for on-screen display. It complies with Transmission Protocol HACC MDS v2.0.1 Modified for Victoria. **Note:** Only run this report to produce the quarterly extract for Vic. **Tip:** If you have the Report Scheduler configured, use it to generate the extract at the end of each quarter and send it as a CSV file. (A schedule should have been created when this report was installed. If so, modify the recipients and enable it.)
Summary	Administrators only Produces a list of patients whose data would be submitted to HACC for the specified period. The extract sent to HACC does not contain names, so this report can also be used to match the SLK (Statistical Linkage Key) to real names. Run this report just before the **Quarterly extract** to ensure that the expected patients are included.
Time Analysis	Use to track time spent servicing HACC clients. Time is totalled for each category in which HACC time has been recorded.

To manually extract the performance data from Communicare:

1. In WA, select **Report > HACC > Quarterly extract**.
2. In Victoria, select **Report > HACC > Quarterly extract (Victoria)**.
3. Click **Yes**.
4. Fill in the parameters.

   Tip:
   For all reports, use the **Age Filter** when you want to include only HACC clients who are under 50 or under 65 and not Aboriginal. Patients with no date of birth are not included unless the filter is set to `All clients`.

5. Once the report is displayed on the screen, click **Save Report**.
6. Select a suitable folder on your computer and enter a meaningful name.

> **Tip:**
> For Victoria, the name should be `HACC__ + 5 digit agency_identifier + 4 digit year + quarter number + transmission number (zero padded)+ 01.csv`. There must be exactly 20 characters before `.csv`. For example, `HACC__01234200630101.csv`.

7. Change the **Save as type** to `Comma Separated(*.CSV)` and click **Save**.

In Victoria, send the CSV file to `haccmds.data@dhs.vic.gov.au`.

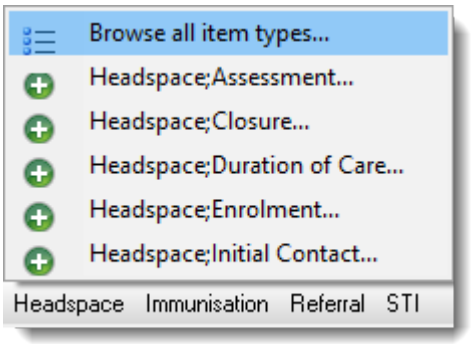
Headspace

Headspace provides mental health support services to young people aged 12 to 25 years, who are experiencing, or at risk, of mental ill-health.

The Headspace dataset comprises the following items:

- Clinical items:
  - **Headspace;Initial Contact**
  - **Headspace;Assessment**
  - **Headspace;Enrolment**
  - **Headspace;Duration of Care**
  - **Headspace;Closure**
- Report: **Report > Headspace > Data Export**
- Automatic recall rule: **Outcome of Headspace assessment**, - On Qualifier - **Headspace;Enrolment**
- Letter templates:
  - **Headspace Instrument - K-10**
  - **Headspace Instrument - SOFAS**
  - **Headspace Instrument - WHO Assist Q1&2 Scale**

Headspace clinical items are prefixed with `Headspace` and are added to a **Headspace** button in clinical records.



> **Tip:**
> After the `Headspace` dataset is enabled, before clinicians can use them, your Communicare Administrator must manually enable the following:

- Headspace clinical items in **File > Reference Tables > Clinical Item Types**
- Headspace automated recall in **File > Reference Tables > Automated Recall Types**
- Headspace letter templates in **Tools > Communicare Templates**

Recording Headspace encounters

If you provide Headspace services, you can assess and enrol the patient into Headspace and record Headspace encounters using specific clinical items.

To display and use the Headspace dataset, you must belong to a user group with the `Common` viewing right.

For each client, full biographics must be recorded in patient details, including language, language spoken at home, country of birth, marital status, client's name, sex, date of birth and address.

Tip:
If the sex is neither Male nor Female, or the marital status is `Married (registered or de facto)`, specify further detail in the **Headspace;Initial Contact** clinical item.

To record Headspace activities:

1. At initial contact, record referral and additional personal information in the **Headspace;Initial Contact** clinical item.
2. For clients who want MH or AOD assistance, complete the **Headspace;Assessment** clinical item.
3. For an assessment that accepts a client for treatment, complete the **Headspace;Enrolment** item.
4. For each service after enrolment, complete the **Headspace;Duration of Care** clinical item and record complexity, location and nature.
5. When the duration of care ends, complete the **Headspace;Closure** clinical item.

The **Headspace;Duration of Care** item cannot be added unless there is an enrolment prior to the duration of service and no closure after the duration of service. Enrol a client again by adding an enrolment after a closure.

Tip:
Duration of service is recorded automatically by Communicare by timing how long the clinical record is open. For a service that takes longer, or is shorter than the time the clinical record is open, record the actual time on the **Details** tab when you end the service or edit the service from the  **Service Recording** window.

Tip:
You cannot add activity items until after a patient has been enrolled in a program. However, you can still add activity items after a patient has been exited from a program. This allows for genuine backdating of clinical items. For example:

- If you are using an offline client and your clinical program enrolments and exits have got out of step, you can backdate an exit.
- If items are out of sequence, correct the items.
- For a patient who exited last week, record an action from two weeks ago.

Run the Headspace data export *(on page 395)* when required.

Headspace Data Export

This program creates the seven data export files required for Headspace reporting. It must be used only in conjunction with the Headspace dataset.

Before you can record Headspace encounters or report on them, the Headspace dataset must be imported into the Communicare database and enabled. For more information, see Headspace *(on page 393)*.

To export the report:

1. Select **Report > Headspace > Data Export**.
2. In the Data Export tool, log on.
3. Enter a date range for the data to include in the export and a destination folder. You are warned if export files already exist in the destination folder.

Healthy Under 5 Kids

The `Healthy Under 5 Kids` dataset supports the Healthy Under 5 Kids Partnering with Families Program (2019), Northern Territory Government, Department of Health (DoH) initiative.

This program incorporates a series of age-specific child health checks which include growth assessment and the childhood vaccination schedule. AMSANT and DoH have jointly worked to make this program available through the Communicare system. For information relating to data and electronic health record system functionality, contact AMSANT. For queries relating to the Healthy Under 5 Kids program, contact NT DoH, Child & Youth Health Strategy Unit.

The `Healthy Under 5 Kids` dataset comprises the following items:

- Clinical items:
  - **Check up;Healthy Kids Check**
  - **Check up;HU5K child health check 4 wks**
  - **Check up;HU5K child health check 8 wks**
  - **Check up;HU5K child health check 4 mths**
  - **Check up;HU5K child health check 6 mths**
  - **Check up;HU5K child health check 9 mths**
  - **Check up;HU5K child health check 12 mths**
  - **Check up;HU5K child health check 18 mths**
  - **Check up;HU5K child health check 2 yrs**
  - **Check up;HU5K child health check 2.5 yrs**
  - **Check up;HU5K child health check 3 yrs**
  - **Check up;HU5K child health check 3.5 yrs**
  - **Check up;HU5K child health check 4 yrs**
  - **Check up;HU5K child health check 4.5 yrs**
  - **Check up;HU5K;Child Hx & Risk Assessment**
  - **Check up;HU5K;First Assessment**
- Reports:
  - **Recalls > Healthy Under 5s Checks** for patients with a recall due or overdue

Tip:
After the `Healthy Under 5 Kids` dataset is enabled, your Communicare Administrator must manually enable the clinical items in **File > Reference Tables > Clinical Item Types** before clinicians can use them.

The HU5K clinical items are assigned the `Healthy Ki` keyword which clinicians can use to find the HU5K clinical items in the **Clinical Terms Browser**.

ICPC-2 PLUS

ICPC-2 PLUS is a core dataset used by Communicare. The dataset allows health professionals to record symptoms, diagnoses, past health problems and processes (such as procedures, counselling and referrals) in a standardised way.

The International Classification of Primary Care [Version 2] (ICPC-2) is a classification designed for primary care, developed by the World Organisation of Family Doctors (Wonca). It classifies information relating to why the patient has come for the consultation (the reasons for encounter), the problems managed during the encounter, procedures, referrals, imaging and pathology tests. ICPC-2 has been endorsed as the Australian standard for classification in general practice and patient self-reported data... ICPC-2 PLUS is an extended terminology based on ICPC-2. It has been designed specifically for use in electronic health records. It was developed using over one million encounter records and therefore uses terms that are common in Australian general practice. ("ICPC-2 PLUS, INFORMATION FOR USERS", WHO Collaborating Centre for Strengthening Rehabilitation Capacity in Health Systems University of Sydney, Sydney School of Health Sciences, 2023)

) ICPC-2 PLUS is also known as the BEACH coding system.

ICPC-2 PLUS is the preferred dataset for Communicare. All reports available for use within Communicare are structured using this dataset

The ICPC-2 PLUS dataset is supplied by University of Sydney. Charges apply for end users of ICPC-2 PLUS. All end users must sign an ICPC-2 PLUS end user contract before access to ICPC-2 PLUS is provided. For more information, contact Communicare Support.

Immunisation Age Based Reviews

The Immunisation Age Based Reviews dataset defines regular immunisation reviews based on age.

When this dataset is enabled, the automated recall system will populate eligible patients' clinical records with recalls for:

- `Review;immunisation;Birth` - On Registration recall due at birth with a maximum age of 2 months.
- `Review;immunisation;2 month age` - On Registration recall due at age 2 months with a maximum age of 4 months.
- `Review;immunisation;4 month age` - On Registration recall due at age 4 months with a maximum age of 6 months.
- `Review;immunisation;6 month age` - On Registration recall due at age 6 months with a maximum age of 12 months.
- `Review;immunisation;12 month age` - On Registration recall due at age 12 months with a maximum age of 18 months.
- `Review;immunisation;18 month age` - On Registration recall due at age 18 months with a maximum age of 4 years.
- `Review;immunisation;4 year age` - On Registration recall due at age 4 years with a maximum age of 12 years.

- `Review;immunisation;12 year age` - On Registration recall due at age 12 years with a maximum age of 15 years.
- `Review;immunisation;50 year age` - On Registration recall due at age 50 years.

If your organisation is reporting on the nKPI, NT AHKPI or NSW KPI for 'proportion of children who are fully immunised', the business rules of the reports are that the report will not look for evidence of each and every immunisation required at specific ages, but rather will look for:

- Overdue recalls for age-based reviews
- Evidence of completed age-based reviews
- Absence of overdue recalls for any immunisation other than those known to be influenza vaccines.

Tip:
If your organisation is reporting on the nKPI, NT AHKPI or NSW KPI, this dataset must be enabled. If your organisation would like to create locally maintained versions of these clinical items to be able to add additional qualifiers, ensure that the export code associated with each review;immunisation<insert age> is included in the clinical item, as it is the export code that enables the reporting outcome of fully immunised children.

For more information see Key Performance Indicators *(on page 677)*

Immunisation Vaccines

The Immunisation Vaccines dataset is a list of vaccines by brand name and includes the AIR Export Codes.

When this dataset is enabled, the vaccines can be recorded as structured data (clinical items and qualifiers) within Communicare.

The vaccine clinical items are populated with the AIR vaccine code in the clinical items export code field. The export code is one of the components that will transmit the immunisation notification to the AIR. Without the AIR export code, the immunisation will not be transmitted to the AIR.

The AIR export codes are sourced from Services Australia: Services Australia AIR export codes.

Immunisations

Influenza immunisations are recognised using the Export Codes on clinical items of type `Immunisation;brand code` for the GNFLU vaccine and its equivalents, described in Equivalent and partial equivalent vaccines table - GNFLU entry. For example, GNFLU, PANVAX, FLUVAX, and so on. These vaccines may change annually.

Note:
Listed in the Non-standard vaccines and Equivalent and partial equivalent vaccines tables are:

- COVID-19 vaccines. For example, AstraZeneca COVISHIELD (ASTCOV), Bharat Biotech Covaxin (BHACOV), Pfizer Comirnaty (COMIRN), Immunisation;Pfizer Bivalent (COMBIV), AstraZeneca Vaxzevria (COVAST), Gamaleya Sputnik V (GAMSPU), Moderna Spikevax (MODERN), Moderna Bivalent Spikevax (MODBIV), Novavax NUVAXOVID (NOVNUV), Sinovac Coronavac (SINCOR).
- Monkey Pox vaccines. For example, ACAM2000 (ACAM), Generic Smallpox (GNPOX), JYNNEOS (JYNNEO).

- Japanese Encephalitis vaccines. For example, Imojev (IMOINT), IXIARO (IXIARO).
- Meningococcal vaccines. For example, MenQuadfi (MENQDF).

For customers using the Immunisation Vaccines dataset, example codes include:

- **Immunisation;flu, GNFLU**
- **Immunisation;influenza, GNFLU**
- **Immunisation;Afluria Quad, AFLR**
- **Immunisation;Afluria Quad (NIP), AFLQUA**
- **Immunisation;Afluria Quad (Non-NIP), QUADAF**
- **Immunisation;Agrippal, AGRPAL**
- **Immunisation;Flucelvax Quad, FCELQD**
- **Immunisation;Fluzone High-Dose Quad, FLHDQD**
- **Immunisation;Fluarix, FLRIX**
- **Immunisation;Fluarix Tetra, FLUTET**
- **Immunisation;Fluarix Tetra (NIP), FLXTET**
- **Immunisation;Fluarix Tetra (Non-NIP, ARXFLU**
- **Immunisation;Fluad, FLUAD**
- **Immunisation;Fluzone High-Dose, FLUHID**
- **Immunisation;Fluad Quad, FLUQAD**
- **Immunisation;Fluarix Tetra, FLUTET**
- **Immunisation;bioCSL Fluvax, FLUVAX**
- **Immunisation;Fluvirin, FLVRN**
- **Immunisation;FluQuadri Junior, FQDJN**
- **Immunisation;FluQuadri, FQUAD**
- **Immunisation;Fluvax Junior, FVXJNR**
- **Immunisation;Influvac Tetra, INFLTA**
- **Immunisation;Influvac, INFLUV**
- **Immunisation;Panvax (H1N1 Influenza), PANVAX**
- **Immunisation;Panvax (H1N1) 0.25ml, PANVAX**
- **Immunisation;Panvax (H1N1) 0.5ml, PANVAX**
- **Immunisation;Vaxelis, VAXLIS**
- **Immunisation;Vaxigrip, VAXGRP**
- **Immunisation;Vaxigrip Tetra, VAXTET**
- **Immunisation;Vaxigrip Junior, VGRJNR**

Integrated Team Care

You can use Communicare to record Integrated Team Care (ITC) activity.

Tip:
To use the ITC dataset in Communicare, arrange for Communicare Support to enable the `Integrated Team Care` dataset. You can then use any of the **ITC** clinical items to record ITC information and capture the data required for reporting.

The dataset can be customised to suit the needs of your health service. If your dataset does contain local modifications, you may see differences from the information described here or additional items.

This dataset is based on the initial requirements of Murrumbidgee PHN as interpreted by Riverina Aboriginal Medical and Dental Corporation who funded the initial development in 2016.

Recording ITC activities

If you receive a referral for a patient who requires integrated team care activities, you can assess and enrol the patient into ITC and record ITC activities using specific clinical items.

To display and use the ITC dataset, you must belong to a user group with the `Common` viewing right.

To record ITC activities:

1. When you receive an internal or external ITC referral for a patient, assess the patient. Add the **ITC Assessment** clinical item to the patient's clinical record. Ensure that the performed date is that of the actual assessment.

   > **Tip:**
   > The referral may come from an external source such as an incoming referral letter, or one of the two internal referral items for ITC: **Referral;INTERNAL;Coordinator ITC** or **Referral;INTERNAL;Outreach Worker; ITC**.

   Complete an assessment even if the client is not eligible or if the client declines.

   This clinical item captures the date of the referral (to report on waiting times), the source of the referral (if self or carer referred, a document or a formal referral does not need to exist), smoking status, primary diagnosis (that is, the reason for referral) and the outcome. The outcome is required: if the response is `Eligible`, you are prompted to add a recall for enrolment; if the response is `Ineligible` or `Client decline`, no further action is required.
2. In the patient's clinical record, enrol the patient in ITC. Add the **ITC Enrolment** clinical item to the patient's clinical record, recording if care coordination or supplementary services or both are approved. Ensure that the performed date is that of the actual acceptance into the program.
3. For each support event, record the type of service provided, using a specific clinical item. If a single service comprises more than one service, the items can be added multiple times. Each supplementary service item captures the type of item and whether the service was brokered or purchased. These items must have a performed date of the actual date of support.
   - For care coordination, use **ITC Care Coordination**.
   - For supplementary services, use one of the following clinical items:
     - **ITC Supplementary Services;Medical Aids**
     - **ITC Supplementary Services;Allied Health**
     - **ITC Supplementary Services;Specialists**
     - **ITC Supplementary Services;Transport**
   - For outreach worker activity, use **ITC Outreach Worker**
4. Periodically record a client evaluation using the **ITC Client Evaluation 2** clinical item.
5. If the patient no longer receives ITC support services, add the **ITC Exit** clinical item and include a reason for leaving. Ensure that the performed date is that of the actual exit from the program.

Record activity during the formal enrolment period.

Tip:
You cannot add activity items until after a patient has been enrolled in a program. However, you can still add activity items after a patient has been exited from a program. This allows for genuine backdating of clinical items. For example:

- If you are using an offline client and your clinical program enrolments and exits have got out of step, you can backdate an exit.
- If items are out of sequence, correct the items.
- For a patient who exited last week, record an action from two weeks ago.

Run the internal management reports weekly to assess progress and reporting accuracy.

If a client needs further integrated team care in future, repeat these steps to enrol the client in ITC again.

Integrated Team Care reports

Communicare provides Integrated Team Care (ITC) reports that you can run to monitor progress and separate reports suitable for reporting to your local primary health network.

To run an ITC report, select **Report > Integrated Team Care**.

Run the following internal reports regularly to monitor progress:

- **Client Evaluations**
- **Client List**
- **Demographics and Outcomes**

Run the reports titled **Report -** to send to your Primary Health Network. These reports break the reporting requirements into sections as described in the following table.

Table 134. ITC reports

Report	Covers
Report – Miscellaneous A	• New clients assessed/enrolled in the reporting period by referral source • New clients assessed/enrolled in the reporting period by locality • New clients assessed/enrolled in the reporting period by indigenous status • New clients assessed/enrolled in the reporting period by sex • New clients assessed/enrolled in the reporting period by primary diagnosis
Report – Miscellaneous B	• New clients assessed/enrolled in the reporting period by smoking status • Clients discharged in the reporting period by smoking status

Table 134. ITC reports (continued)

Report	Covers
Report – Miscellaneous C	• Clients assessed with current COPD plan • Clients assessed with other current plan • Clients assessed with current GPMP/TCA
Report – Miscellaneous D	• Clients discharged with current COPD plan • Clients discharged with other current action plan • Clients discharged with current GPMP/TCA
Report – Miscellaneous E	• New clients assessed/enrolled in the reporting period by client survey response • Clients discharged in the reporting period by client survey response • Clients assessed/enrolled following a previous exit
Report – Care Coordination A	• Patients enrolled to receive care coordination • Eligible patients not yet enrolled • New patients assessed/enrolled in the reporting period • Patients discharged in the reporting period
Report – Care Coordination B	• Unique services in the reporting period/Care coordination services • Unique services in the reporting period/Supplementary services • Unique services in the reporting period/Outreach worker services • Unique services in the reporting period/Other services • Breakdown of Outreach Worker Services
Report – Supplementary Services	• Allied Health Services • Specialist Services • Transport Services • Medical Aids
Report – Outreach Worker	• Outreach Worker Services

iSISTAQUIT

The `iSISTAQUIT` dataset is made available to health services that are part of the *iSISTAQUIT* research program and have undergone the required training with the University of Newcastle.

iSISTAQUIT (implement Supporting Indigenous Smokers To Assist Quitting) is a multi-component intervention aimed at improving health providers' provision of smoking cessation care to pregnant Aboriginal and Torres Strait Islander women, funded by the Commonwealth Government.

Training in how to deliver the iSISTAQUIT program must be completed with the iSISTAQUIT research team before the iSISTAQUIT dataset is enabled for your site. For further information, contact SISTAQUIT@newcastle.edu.au .

The `iSISTAQUIT` dataset comprises the following items:

- Clinical items:
  - **iSISTAQUIT;Assessment**
  - **iSISTAQUIT;Eligibility**
- Automatic recall rules:
  - **iSISTAQUIT;Eligibility** On Presentation **Pregnancy;confirmed**
  - **iSISTAQUIT;Assessment** On Qualifier **iSISTAQUIT001**
  - **iSISTAQUIT;Assessment** On Qualifier **iSISTAQUIT35**, trigger for 3 days, 1 week, 2 weeks, 3 weeks, 4 weeks with an offset of 3 days
- Letter templates:
  - **iSISTAQUIT quit plan**

Tip:

After the `iSISTAQUIT` dataset is enabled, your Communicare Administrator must manually enable the clinical items in **File > Reference Tables > Clinical Item Types** before clinicians can use them.

Before enabling the automated recalls, ask Communicare Support to enable the **iSISTAQUIT;Eligibility** automated recall rule which adds a recall for all pregnant women. Communicare Support will also run a script that removes the recall for women who are no longer pregnant but leaves it for women who are currently pregnant.

Your Administrator should also add a weekly scheduled report, which uses the `Recalls Due Multiselect` and includes the **iSISTAQUIT:Eligibility** and **iSISTAQUIT;Assessment** parameters.

If you need help completing iSISTAQUIT clinical items or other support, contact the iSISTAQUIT research team at SISTAQUIT@newcastle.edu.au.

For Communicare technical support, speak to your Communicare Administrator or contact Communicare Support as normal.

National Lung Cancer Screening Program

Clinical items, qualifiers and reports for the National Lung Cancer Screening Program (NLCSP) are available for all health services through Central.

The NLCSP is a joint Australian, State and Territory Government targeted screening program scans to look for lung cancer in high-risk people without any signs or symptoms suggestive of lung cancer. The program is managed by the National Cancer Screening Register (NCSR) and:

- Targets eligible people aged 50-70 years of age with a history of tobacco cigarette smoking.
- Provides free low-dose CT scans to participants every two years unless a screen-detected abnormality is found.

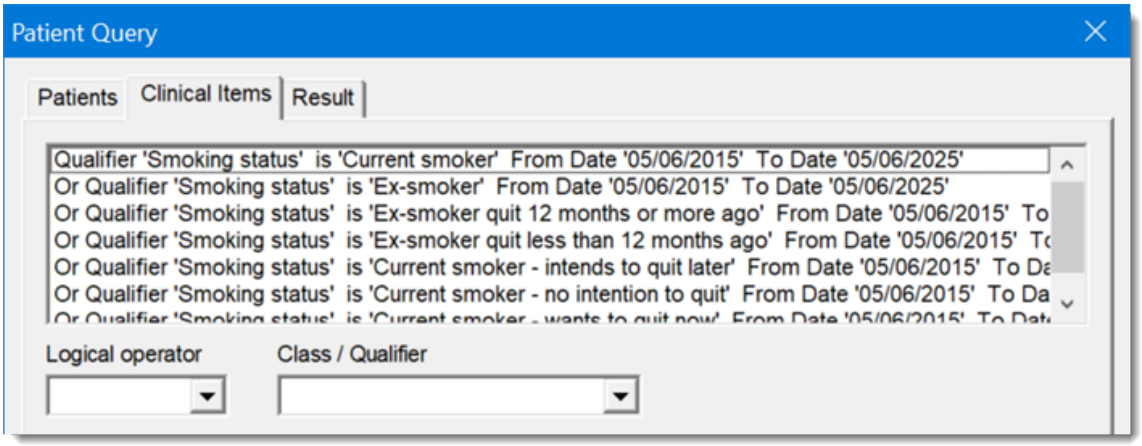
Healthcare providers with an MBS provider number and authority to request CT imaging provide eligible participants with a low-dose CT scan request form and enrol participants in the program.

If your health service is already registered with the NCSR for the National Bowel Cancer Screening Program or the National Cervical Cancer Screening Program, you do not need to register again. If your health service is not registered, see https://www.ncsr.gov.au/information-for-healthcare-providers/healthcare-provider-forms-and-guides/healthcare-provider-portal-user-guide.html for more information.

Use the following clinical data to manage NLCSP screening, follow-up and interaction with the NCSR.

- To identify patients who may be eligible to participate in the NLCSP, use a report that includes the **smoking status** qualifier. This qualifier is used in many reports, particularly check ups. For example:
    - **Addiction;smoking;tobacco**
    - **Advice/education;smoking**
    - **CV Risk Calculator...**
    - **Check up;Aboriginal**
    - **Check up;RHD and acute rheumatic fever**
    - **Check up;antenatal**
    - **Check up;over 75s**
    - **Cough;smokers...**
    - **Counselling;smoking**
    - **Cycle of care;annual;diabetes**
    - **Exam;pre-consult**
    - **ITC...**
    - **Inhalation;smoke**
    - **National Lung Cancer Screening Program**
    - **Passive smoking**
    - **Problems;smoking;tobacco**
    - **Smokerlyzer...**
    - **Smokers lung**
    - **Smoking;tobacco**
    - **Unable (to);stop smoking**
    - **iSISTAQUIT;Assessment**

  Alternatively, your Communicare Administrator could run **Report > Patients > Patient Query** to identify eligible patients, using age and qualifier operations. For example,



- Clinical items:
  - **National Lung Cancer Screening Program**

    > **Note:**
    > Your Communicare Administrator should add **Low Dose CT scan** to your health service's investigations list and keywords.

  - **Results;lung cancer screening LDCT**
- Qualifiers:
  - **Start Smoking Age**
  - **Quit Smoking Age**
  - **Duration Smoking**
  - **Average Daily Cigarette Consumption**
  - **Smoking Pack-Years**
- Letter template for referrals:
  - **NLCSP Low Dose CT Referral (linked clinical information)**
- Automatic recall rules for recalls based on results: On Qualifier **Results;lung cancer screening LDCT** Recall for **National Lung Cancer Screening Program**, trigger for 24 months, 12 months, 6 months, 3 months.

  For more information, see Lung cancer screening recalls *(on page 376)*.

> **Tip:**
> Communicare Support may need to run Central Update out of hours before this clinical data is available.
>
> Your Communicare Administrator may need to manually enable the clinical items in **File > Reference Tables > Clinical Item Types** and enable the automated recalls before clinicians can use them.

For Communicare technical support, speak to your Communicare Administrator or contact Communicare Support as normal.

NLCSP for Clinicians

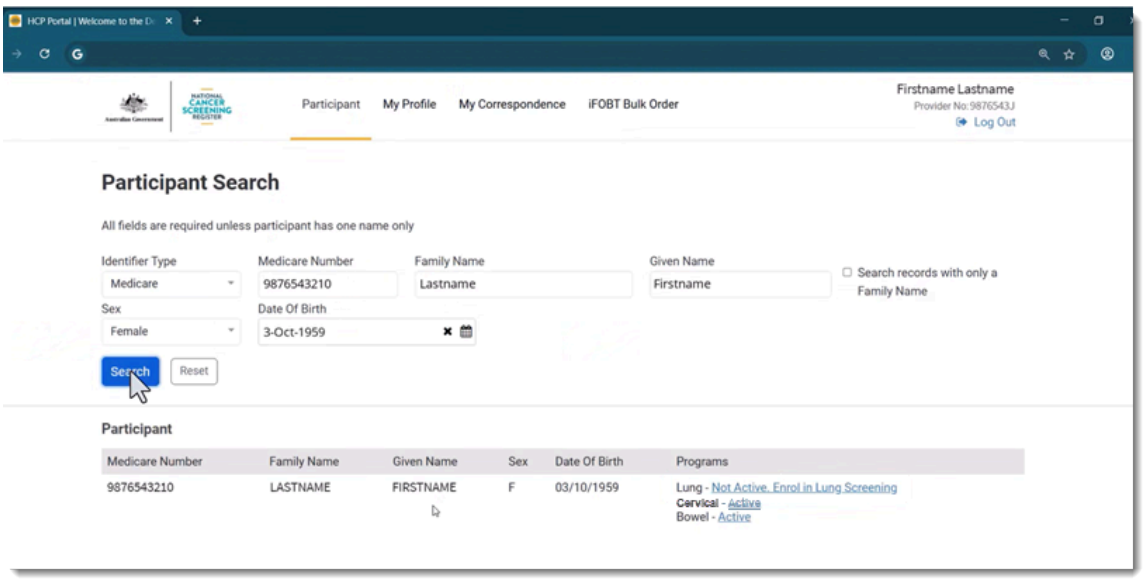
Enrol your patients in the National Lung Cancer Screening Program (NLCSP), refer them for screening and record results.

Enrol your patients

Ask you Communicare Administrator to generate a list of patients who may be eligible for the NLCSP. For more information, see Reports to find eligible patients *(on page 403)*.

Register eligible patients with the NCSR:

1. In Communicare, from a patient's record, select **Go To > NCSR Hub**.
2. Alternatively, is NCSR is not integrated with Communicare, log into the NCSR HCP Portal directly and search for the patient.
3. In the NCSR HCP Portal for the patient, select **Lung - Not Active. Enrol in Lung Screening**.

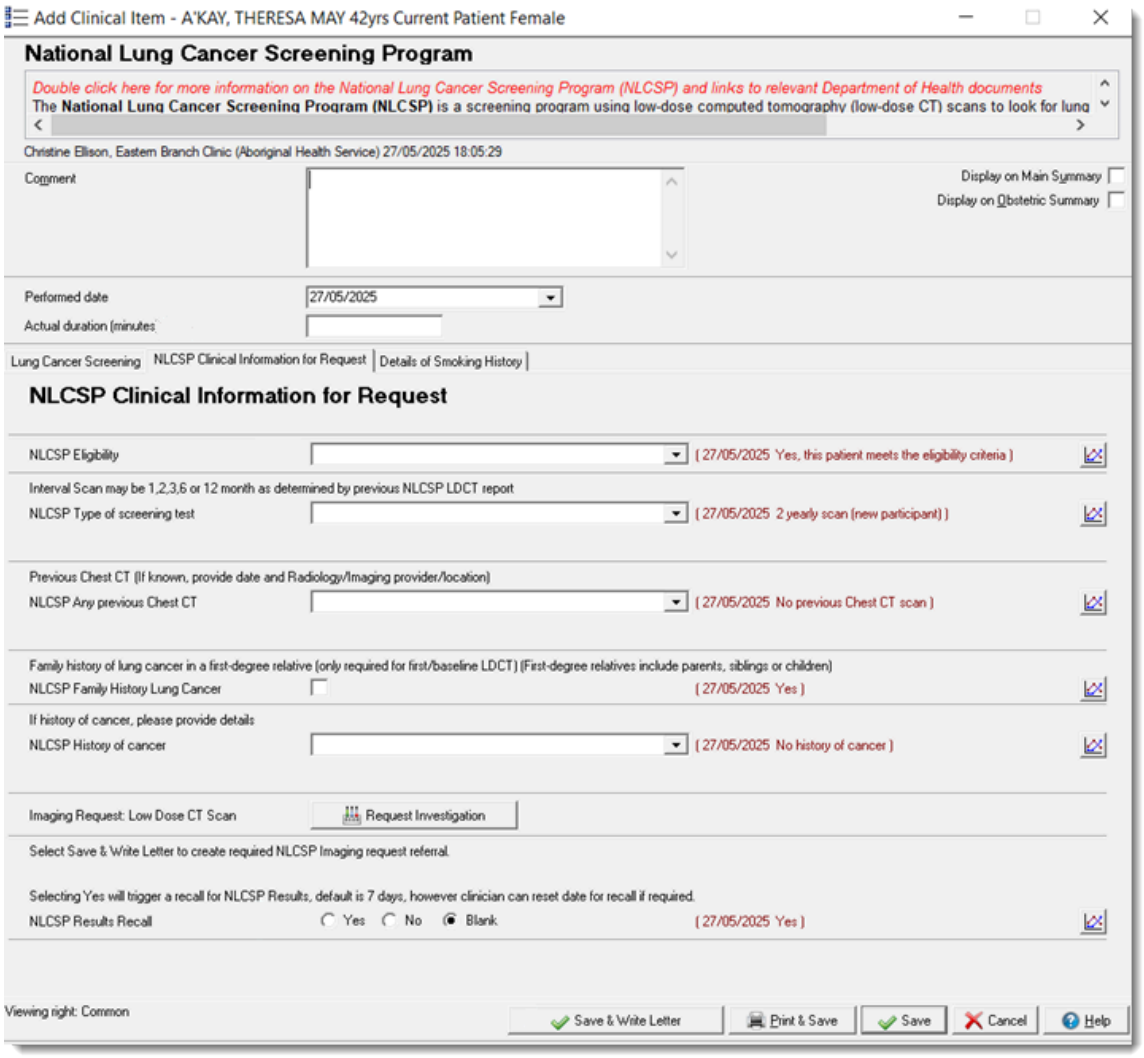


4. Complete the eligibility and enrolment form for your patient.

Refer your patients for screening

At an eligible patient's next encounter, refer them for Lung cancer screening:

1. Open the patient's clinical record as usual.
2. Add the **National Lung Cancer Screening Program** clinical item to the patient's clinical record.
3. Complete the information on all tabs.



4. Click **Save & Write Letter**.
5. Select and complete the **NLCSP Low Dose CT Referral (linked clinical information)** template.

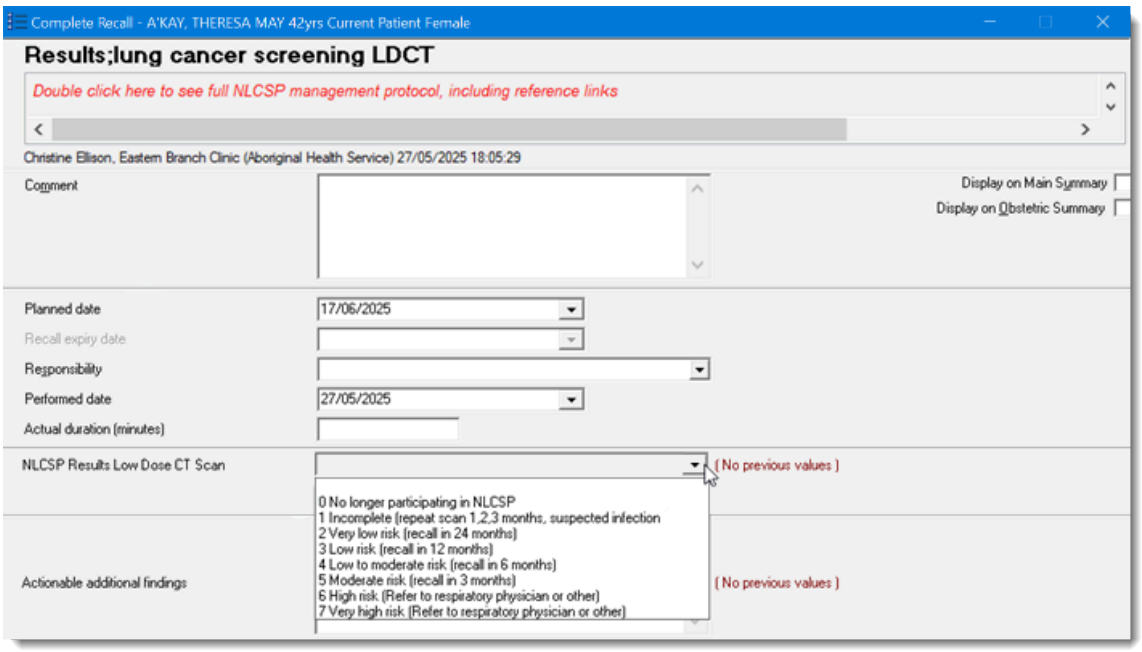
Information from the clinical item is included in both the **Low Dose CT Scan** imaging request and the **NLCSP Low Dose CT Referral (linked clinical information)** document template.

Print the request and referral and hand them to your patient.

Add NLCSP results and recalls to a patient's record

After a patient has been referred for the NLCSP and you receive the results of their Low Dose CT Scan, add their results and a recall to their clinical record:

1. In a patient's clinical record, add the clinical item **Results;lung cancer screening LDCT**.
2. Complete the clinical item as normal, ensuring you select a result category from the **NLCSP Results Low Dose CT Scan** list.



3. Click **Save**.

Recalls are listed in the **To Do** list in the patient's clinical record. To complete a recall, double-click it in the list.

When the **Results;lung cancer screening LDCT** clinical item is completed, a new recall for the NLCSP clinical item is triggered for the required follow up.

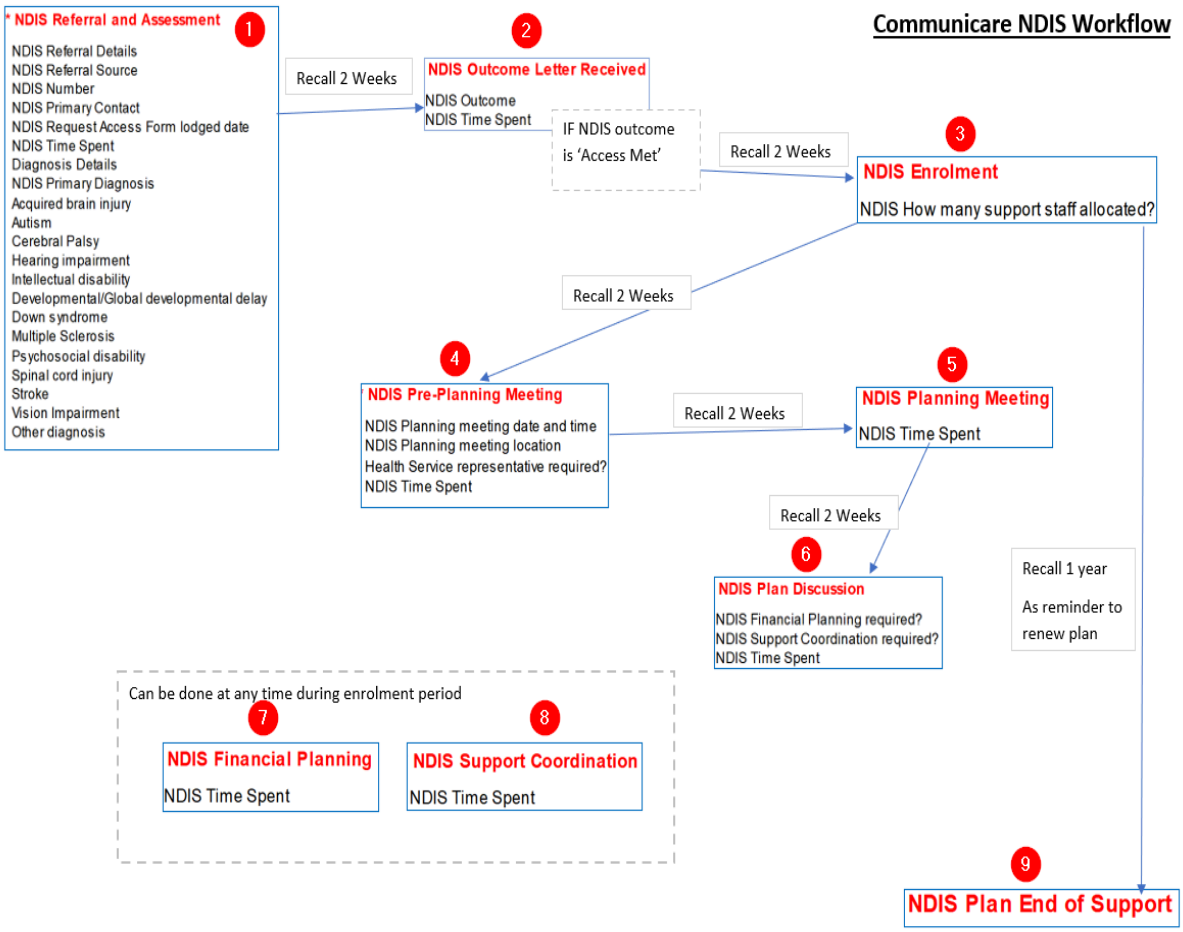
NDIS

Communicare has developed a simple workflow and dataset for services that provide NDIS brokerage or support coordination.

> **Tip:**
> Record the status of a patient's NDIS application in their biographics. After a patient is registered with the NDIS, record their number. Use these recorded values in letters: in the letter writer, select **Patient > NDIS...**. For more information, see NDIS fields *(on page 36)* and Writing letters and referrals *(on page 319)*.

If this dataset suits your needs, lodge a request with Communicare Support to import the dataset to your Communicare instance.

> **Note:**
> After the NDIS dataset is imported, it becomes a local dataset, unique to your Communicare instance. Because it is not a central dataset, it will not be updated and maintained by Communicare.



1. NDIS Referral and Assessment
    - First step
    - Includes the qualifiers listed
    - Upon completion, recall in 2 weeks for NDIS Outcome Letter Received
2. NDIS Outcome Letter Received
    - If NDIS Outcome is 'Access Met', recall in 2 weeks for NDIS Enrolment
3. NDIS Enrolment
    - On NDIS Enrolment, how many support staff are allocated
    - Upon completion, recall in 2 weeks for NDIS Pre-planning Meeting
    - Upon completion, recall in 1 year for NDIS Plan End of Support
4. NDIS Pre-Planning Meeting
    - Fill in the item
    - Upon completion, recall in 2 weeks for NDIS Planning Meeting
5. NDIS Planning Meeting
    - Upon completion, recall in 2 weeks for NDIS Plan Discussion
6. NDIS Plan Discussion
    - If NDIS Financial Planning required, add recall for NDIS Financial Planning (not shown in this example)
    - If NDIS Support Coordination required, add recall for NDIS Support Coordination (not shown in this example)
7. NDIS Financial Planning
    - Can now undertake NDIS Financial Planning
    - Can only be done after an NDIS Enrolment has been completed (must be during an enrolment period)

8. NDIS Support Coordination
    - Can now undertake NDIS Support Coordination
    - Can only be done after an NDIS Enrolment has been completed (must be during an enrolment period)
9. NDIS Plan End of Support
    - When patient no longer requiring support

> **Tip:**
> If this NDIS workflow and dataset does not suit your needs, contact Communicare Support to discuss your requirements.

Primary Mental Health Care

Many Communicare health services are required to submit data relating to primary mental health contacts to the Government via their local Primary Health Network. Communicare has an optional dataset and reports suite to address both data collection and data upload.

> **Tip:**
> To use the Primary Mental Health Care, Version 4.1, Minimum Dataset (PMHC MDS) in Communicare:
>
> - Request the PMHC MDS and reports from Communicare Support, who will add the required data collection items and reports.
> - Request training. Primary mental health staff will need to be introduced to the concept of PMHC and be shown the relevant clinical items.

To collect the data required for reporting, mental health care providers need to identify the start of an *episode*, record all contacts relating to the episode and then record the end of the episode. For PMHC, an episode is *a more or less continuous period of contact between a client and a PHN-commissioned provider organisation/clinician that starts at the point of first contact, and concludes at discharge.*

In version 4.0, the concept of an *intake* was introduced. Intake is captured by the episode start clinical item: the user records if the episode includes the intake assessment, if the intake assessment was done elsewhere, the intake organisation must be recorded.

For more information, see PMHC-MDS Data Specification (https://docs.pmhc-mds.com/projects/data-specification/en/latest/index.html).

Recording PMHC

To record PMHC encounters so that the data can be used in the PMHC MDS, use PMHC-specific clinical items.

Use the following clinical items for primary mental health contacts. These are included in the PMHC MDS and can usually be found on a button in the clinical record labelled **PMHC**.

- **PMHC Episode Start** - this must be completed at the start of any new episode (a series of contacts over a period of time related to the same mental health issues). Ensure that you include intake context:
    - `Intake and treatment Episode`
    - `Intake Only Episode` - also record the referred to organisation path
    - `Treatment Only Episode` - also record the intake organisation path

- **PMHS Service Contact** - this must be completed every time the client attends during the ongoing episode. This cannot be added until there is an episode start and not after an episode end.
- **PMHC Episode End** - this must be completed at the same time as the final service contact for the ongoing episode when the episode is deemed to be over.
- **PMHC Client** (optional) – captures information relating to the client that is not currently recorded in the patient biographics.

To record primary mental health contacts:

1. Ensure that the client's biographic details, including languages spoken, are up-to-date. Use **PMHC Client** to capture any additional client information that is not included in the patient biographics.
2. At the start of an episode, add both **PMHC Episode Start** and **PMHS Service Contact** to the patient's clinical record and address every qualifier if possible. You cannot record a service contact if there is no open episode, that is, an episode that has been started but not yet ended.
3. At every subsequent contact, add **PMHS Service Contact** to the patient's clinical record and address every qualifier if possible.
4. When you deem that the episode is over, complete both **PMHS Service Contact** and **PMHC Episode End**.

Tip:
You cannot add activity items until after a patient has been enrolled in a program. However, you can still add activity items after a patient has been exited from a program. This allows for genuine backdating of clinical items. For example:

- If you are using an offline client and your clinical program enrolments and exits have got out of step, you can backdate an exit.
- If items are out of sequence, correct the items.
- For a patient who exited last week, record an action from two weeks ago.

Running and uploading PMHC reports

Run the PMHC reports to generate a file containing data from the PMHC clinical items, which you can then upload to the PMHC portal.

Use the following reports to generate Microsoft Excel spreadsheets for submission to the PHN. Run these reports from **Report > PMHC**.

- **CLIENTS**
- **COLLECTION OCCASIONS**
- **EPISODES**
- **IAR DST**
- **INTAKE EPISODES**
- **INTAKES**
- **K10P**
- **K5**
- **METADATA**
- **Portal Error Details**
- **PRACTITIONERS**

- **SDQ**
- **SERVICE CONTACT PRACTITIONERS**
- **SERVICE CONTACTS**

For details about the program or the content of the items, and for information relating to the upload, contact your local PHN.

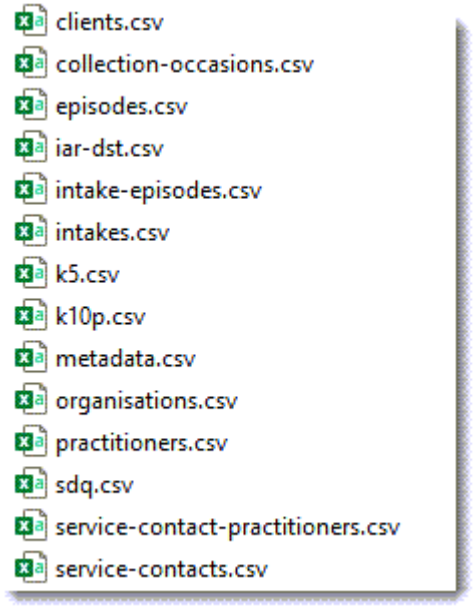
> **Note:**
> Some optional information is not captured, such as the year of birth of the provider. Communicare V22.1 and later includes K10 and K5 assessment items but not the SDQ. If you already have an SDQ in Communicare, contact Communicare Support for advice on export codes required to ensure the reports find these items.

To extract the PMHC data from Communicare:

1. Select **Report > PMHC >** *report_name* and in the report, click **Yes**.

   > **Tip:**
   > The reports you need to run depend on whether or not you are an intake only, treatment only, or combined service.

2. Repeat for each of the PMHC reports you need to run.



3. When you have all the files, add them to an archive and name the file `PMHC_Month_YYYY.zip`. Remember this name, you will need it later.

To upload the files to the PMHC portal, follow the instructions provided by PMHC (https://docs.pmhc-mds.com/projects/user-documentation/en/latest/upload.html).

For details of the program or the content of the items, and for information relating to the upload, contact your local Primary Health Network.

For questions about where the reports find the data they require, contact Communicare Support.

RACGP Aboriginal & TSI Health Check

The `RACGP Aboriginal & TSI Health Check` dataset enables the combined annual Aboriginal and Torres Strait Islander health check which was developed in conjunction with the RACGP and NACCHO.

The `RACGP Aboriginal & TSI Health Check` dataset comprises the following items:

- Clinical items:
  - **Check up;Aboriginal & TSI Annual Health**

    This item covers all age groups; age filters determine which data is displayed.
  - **Check up;Aboriginal & TSI Annual NO MBS**
- Document templates:
  - **Health Check Report (Full) Age 0 to 5**
  - **Health Check Report (Full) Age 6 to 12**
  - **Health Check Report (Full) Age 13 to 24**
  - **Health Check Report (Full) Age 25 to 49**
  - **Health Check Report (Full) Age 50 and over**

Other items referenced in the Health Check are included as clinical items in the `Communicare Value Added` dataset in Communicare V21.3 and later after a central update is run:

- **Red Flags Early Identification**
- **Checklist;Advanced Care Plan** (Assessment Advanced Care Planning)
- **NDIS reference number**

You can use these independently of the **Check up;Aboriginal & TSI Annual Health** clinical item if required.

> **Tip:**
> Before Communicare Support enables the `RACGP Aboriginal & TSI Health Check` dataset for your health service, you need to plan for the change: discuss recall migration and the processes for migrating to the new Health Check clinical item with Communicare. If your set up is complex, you may need Communicare to create a script to migrate the recalls for a quoted fee. For a demonstration of the Health Check, see Health Check Clinical Item.

RHD and acute rheumatic fever

You can use Communicare to manage RHD check-ups and reviews.

This technical information is not clinical advice although it does reflect clinical guidelines.

Ensure you review existing protocols before implementing any of these rules.

If locally defined clinical items are to be used, the rules need to be set up manually. If you want to implement any of the recall protocols described here (for example, you want to use the specialist referral recalls) contact Communicare Support as we may be able to insert these rules automatically for you.

Any questions regarding clinical procedures should be directed to an appropriate clinical body. Any questions regarding the implementation or behaviour of these rules can be directed to Communicare Support.

For further clinical information, refer to:

- 2020 Australian guideline for prevention, diagnosis and management of acute rheumatic fever and rheumatic heart disease (3rd ed)
- RHD Australia website for information and resources, including educational resources for families and communities.
- NT Rheumatic Heart Disease Register:
    - Central Australia:
        - Ph: 08 895 16909
        - Email: RHDAliceSprings@nt.gov.au
    - Top End:
        - Ph: 08 892 28454
        - Email:RHDDarwin@nt.gov.au

RHD initial recall

Use this information to set-up recall protocols for the management of RHD and acute rheumatic fever.

Tip:
To use the RHD dataset in Communicare, arrange for Communicare Support to enable the `RHD and acute rheumatic fever` dataset. You can then set up the required recalls and use the **RHD** clinical items.

The `RHD and acute rheumatic fever` dataset creates the following rules:

- **Check up;RHD and acute rheumatic fever**
- **Review;GP;RHD and ARF**

It also contains some automated *on qualifier* recall rules.

Your health service must use ICPC2-Plus as your principle clinical coding system or have created local clinical items of type `Condition` to code RHD diagnoses.

If your health service has its own RHD check-up and review items, substitute your local items where this information refers to the central items.

You can configure the check-up to be triggered by either a set of specific diagnoses or by any diagnosis in the **Rheumatic Fever/Heart Disease** clinical item group. For example, any of the following clinical items.

Table 135. Clinical items in the Rheumatic Fever/Heart Disease clinical item group

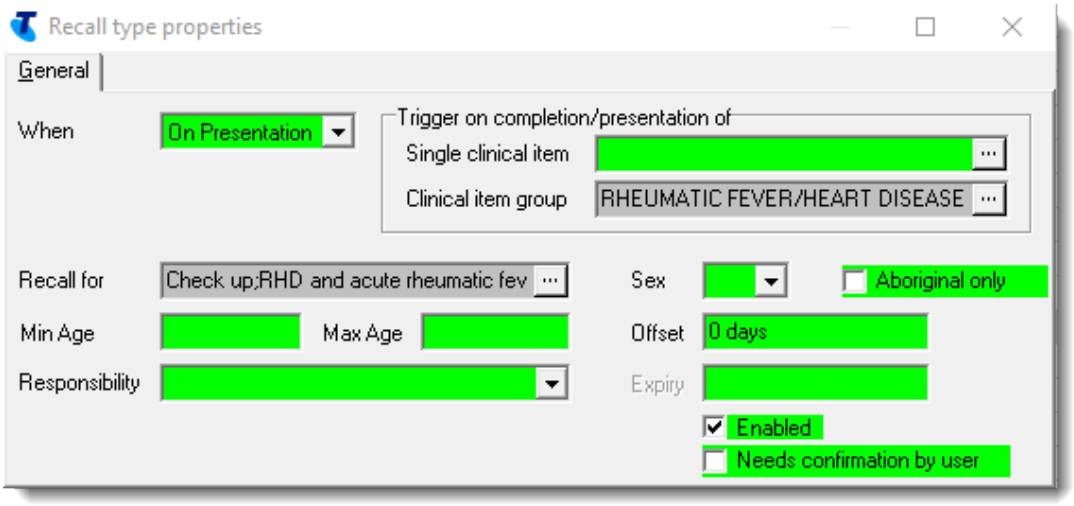
Disease;rheumatic heart **Disease;rheumatic heart;mild** **Disease;rheumatic heart;modera** **Disease;rheumatic heart;severe**	**Carditis;rheumatic;acute** **Carditis;rheumatic;chronic**
Rheumatic fever **Rheumatic fever;acute**	**Endocarditis;rheumatic**
Chorea **Chorea;rheumatic** **Chorea;Sydenhams**	**Myocarditis;rheumatic;acute** **Myocarditis;rheumatic;chronic**

Table 135. Clinical items in the Rheumatic Fever/Heart Disease clinical item group (continued)

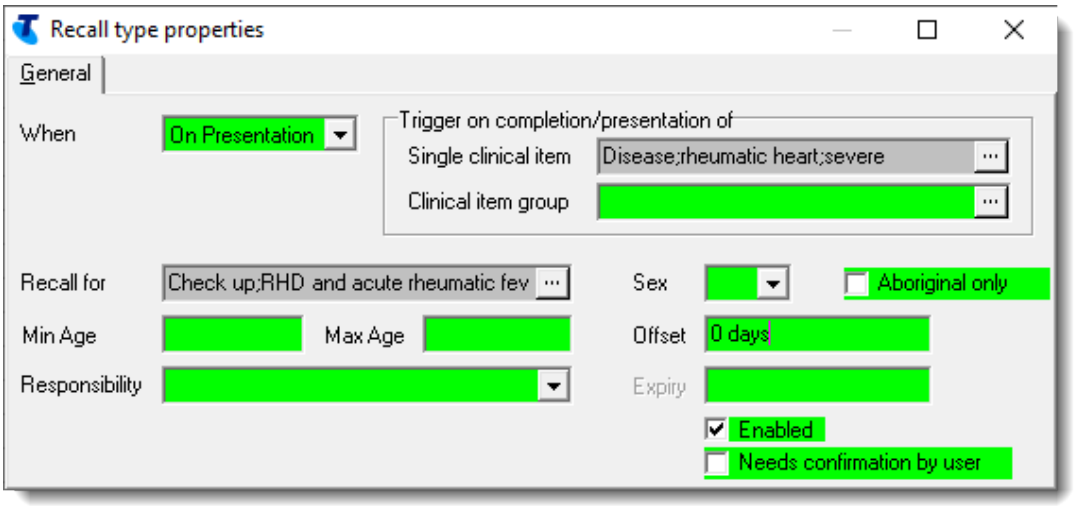
Stenosis;aortic;rheumatic **Stenosis;arterial;rheumatic** **Stenosis;mitral;rheumatic**	**Pericarditis;rheumatic;acute** **Pericarditis;rheumatic;chronic**

To trigger the first check-up:

1. Select **File > Reference Tables > Automated Recall Types**
2. Set up either of the following recalls:
   - An *on presentation* recall rule to offer a check-up immediately following any diagnosis in the RHEUMATIC FEVER/HEART DISEASE clinical item group. For example:



   - If it is not appropriate for all the diagnoses above to trigger a check-up, create an *on presentation* recall rule for each diagnosis that you want to include. For example:



Tip:
Any rules concerning the maximum or minimum age of the patient will apply to the age of the patient at the time of the diagnosis.

When new diagnoses are added, the clinician will be prompted to accept offering a recall for a check-up due immediately.

For patients with a pre-existing condition that is a trigger for the rule, a recall is added for a check-up, due the same day as the initial diagnosis, if that patient does not yet have either a recall, cancelled recall or completed item for the check-up. If a check-up is found in any state, a recall is not added.

For a patient who has multiple diagnoses for the same item (or items in the same group) only one recall is created and the due date is the date of the latest diagnosis.

Recalls for ongoing RHD management

Add *on qualifier* and *on completion* rules to continue the recall protocols for the patient after the initial recall.

> **Tip:**
> To record secondary prophylaxis, a local clinical item with the export code `BICILLIN` must be configured. Commonly, this is **Injection;Bicillin LA**.

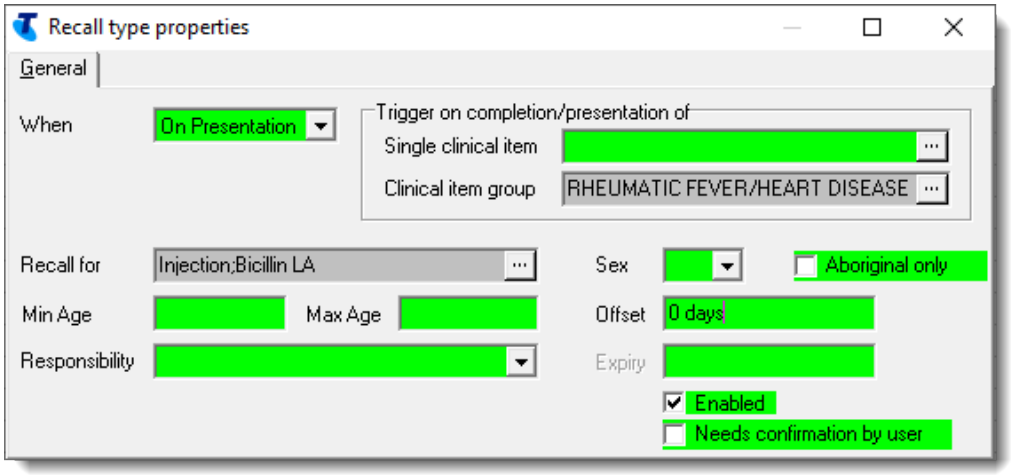
The `RHD and acute rheumatic fever` dataset creates the following rules:

- On recording an outcome for the qualifier `Next RHD/ARF check up due` a recall is offered for the next **Check up;RHD and acute rheumatic fever** due according to the interval specified.

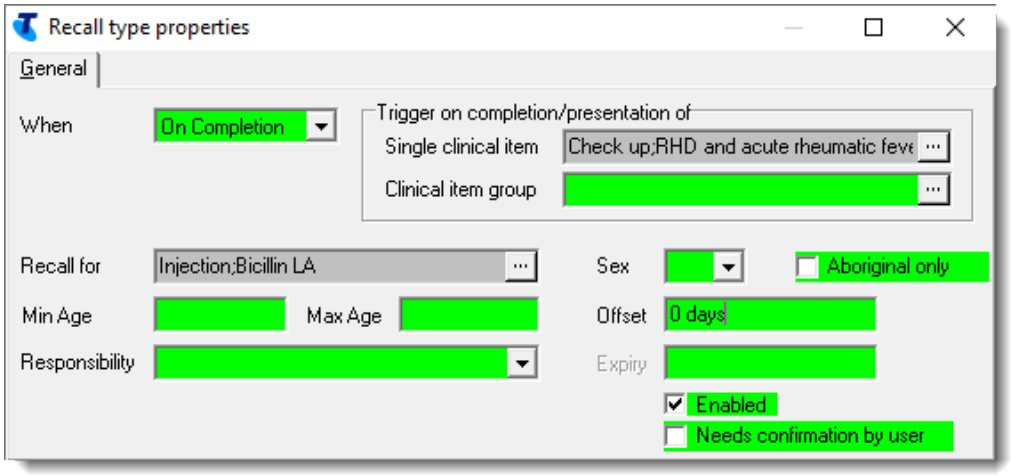
  On completing a positive outcome for the qualifier `GP review required?` a recall is offered for a **Review;GP;RHD and ARF** due immediately.

1. Set up recalls for secondary prophylaxis injections:

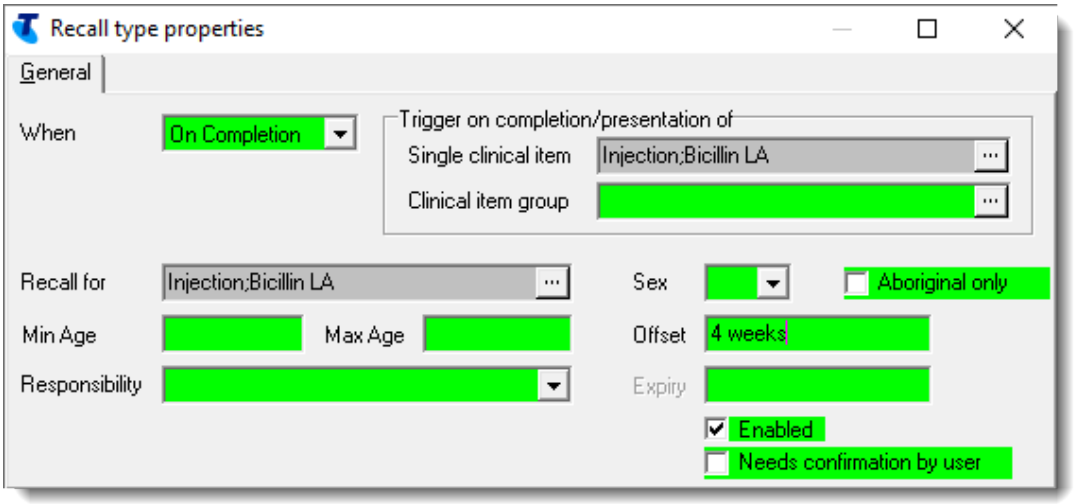
   a. A trigger for the first recall, either:
      - Triggering from the diagnosis - commonly, a health service will already have a recall rule to trigger the Bicillin injections. It may be triggered by a group of conditions (see below) or by a selection of specific conditions in different rules. Use this rule to check all previous diagnoses of RHD and add a recall if there has never been a Bicillin recorded.



- Triggering from the completion of the first check up



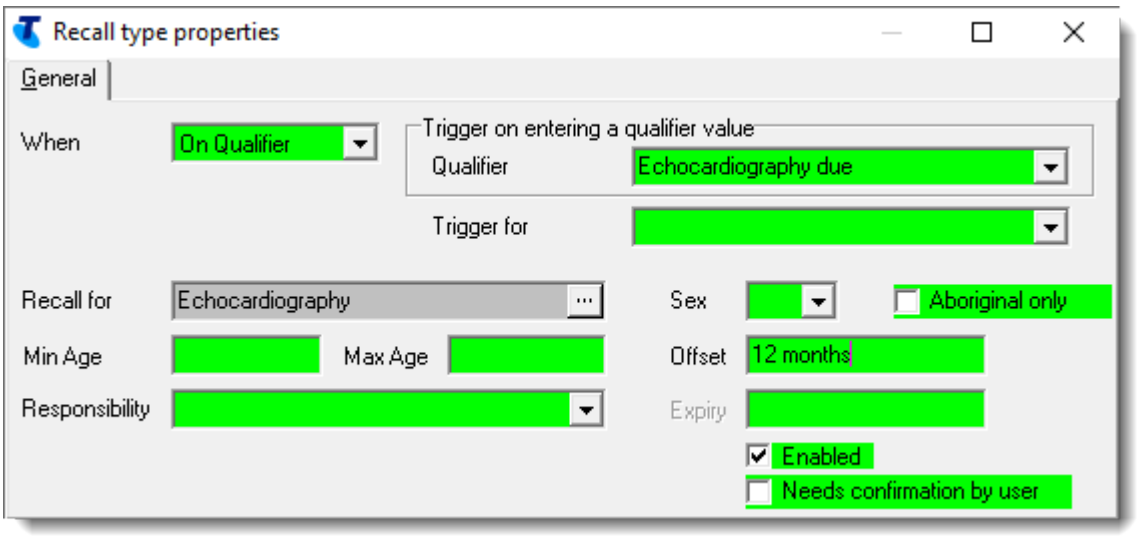
b. Once the first injection has been given, an ongoing *on completion* recall to manage the four-weekly or three-weekly injections until cancelled.



Note:
The default is for 4 weeks, but when the prompt is given, the clinician can adjust this to 3 weeks if required. This value will be remembered for that patient until it is altered again in the future.

2. Set up recalls for echocardiography.

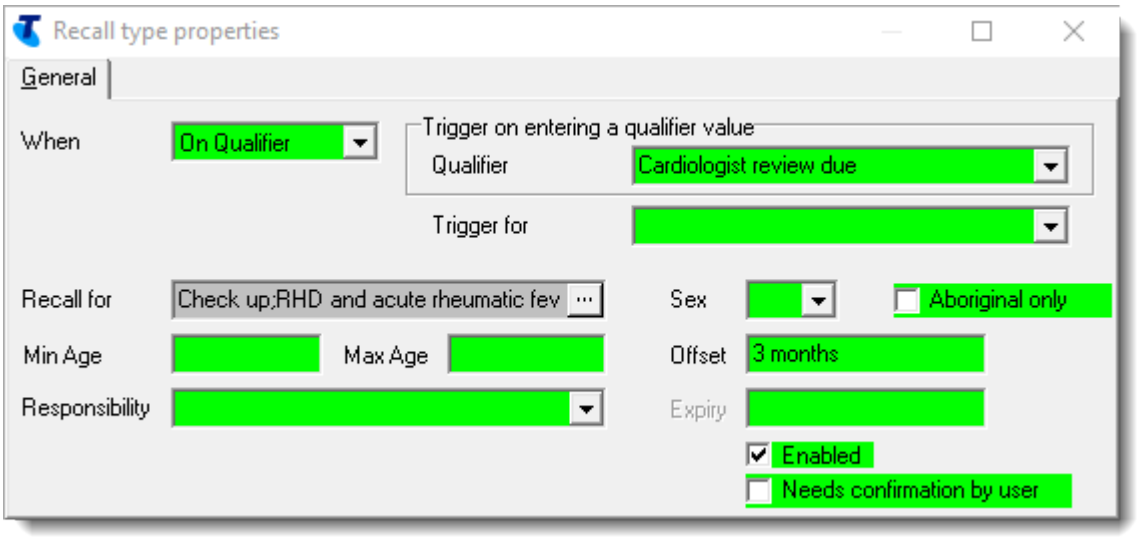
Recalls for the clinical item **Echocardiography** can be triggered *on qualifier* based on the `Echocardiography` due qualifier.



Set the following recalls:

- Offset of `12 months` to trigger a recall for Echocardiography due in 12 months
- Offset of `2 years` to trigger a recall for Echocardiography due in 2 years
- Offset of `3 months` to trigger a recall for Echocardiography due in 3 months
- Offset of `3 years` to trigger a recall for Echocardiography due in 3 years
- Offset of `6 months` to trigger a recall for Echocardiography due in 6 months
- Offset of `Now` to trigger a recall for Echocardiography due in 0 days

3. Set up recalls for specialist follow-ups.



The check-up has required qualifiers to declare when the next review is due by:

- Cardiologist – `Cardiologist review due`
- Physician – `Physician review due`
- Paediatrician - `Paediatric review due`
- Dentist – `Dental review due`

> **Tip:**
> Recalls for the GP review and next check-up are centrally distributed.

Depending on the health service, different approaches will be taken to recording recalls for these reviews. A large health service may require recalls for appropriate reviews or consults and the specialists may be 'in-house'. Health services may have visiting specialists and prefer to trigger recalls for the same or for referrals. More remote health services may trigger referrals to external specialist away from the community.

If you already have clinical items for specialist reviews, these can be used in the recall rules. Otherwise, consider the following ICPC terms:

- Recalls for in-house management for the next consultation or review by each specialist:
  - **Consult;cardiologist**
  - **Consult;physician** (create this item locally)
  - **Consult;paediatrician**
  - **Consult;dentist**
- Recalls for external management or for formal referral details to be recorded:
  - **Referral;cardiologist**
  - **Referral;physician**
  - **Referral;paediatrician**
  - **Referral;dentist**

For patients who already have a response to the qualifier, the recall rule will do nothing, it is effective only from the date of enabling.

When new responses are added, the clinician is prompted to accept the recall for the appropriate item due after the specified interval.

RHD recall rules summary

To manage RHD patients, consider implementing the following recall rules.

Table 136. Rules to trigger first RHD check-up using clinical item group

Clinical item group	Period	Recall type	Trigger	Offset
Rheumatic Fever/ Heart Disease	-	On Presentation	**Check up;RHD and acute rheumatic fever**	0 days
Alternatively, trigger first check-up using individual conditions:				
Clinical item	**Period**	**Recall type**	**Recall for**	**Offset**
Disease;rheumatic heart	-	On Presentation	**Check up;RHD and acute rheumatic fever**	0 days
Disease;rheumatic heart; mild	-	On Presentation	**Check up;RHD and acute rheumatic fever**	0 days
and so on...				

Table 137. Rules to manage RHD secondary prophylaxis

Clinical item group or recall for	Period	Recall type	Trigger	Offset
Rheumatic Fever/ Heart Disease	-	On Presentation	**Injection;Bicillin LA**	0 days
Clinical item	**Period**	**Recall type**	**Recall for**	**Offset**
Injection;Bicillin LA	-	On Completion	**Injection;Bicillin LA**	4 weeks

Table 137. Rules to manage RHD secondary prophylaxis (continued)

Clinical item group or recall for	Period	Recall type	Trigger	Offset
Alternatively, trigger the first injection on completion of a **Check up;RHD and acute rheumatic fever**				

Table 138. Rules to manage RHD echocardiography

Trigger	Period	Recall type	Recall for	Offset
Echocardiography due	12 months	On Qualifier	**Echocardiography**	12 months
Echocardiography due	2 years	On Qualifier	**Echocardiography**	2 years
Echocardiography due	3 months	On Qualifier	**Echocardiography**	3 months
Echocardiography due	3 years	On Qualifier	**Echocardiography**	3 years
Echocardiography due	6 months	On Qualifier	**Echocardiography**	6 months
Echocardiography due	now	On Qualifier	**Echocardiography**	0 days

Table 139. Rules to manage RHD specialist reviews

Trigger	Period	Recall type	Recall for	Offset
Cardiologist review due	12 months	On Qualifier	**Consult;cardiologist** or **Referral;cardiologist**	12 months
Cardiologist review due	3 months	On Qualifier	**Consult;cardiologist** or **Referral;cardiologist**	3 months
Cardiologist review due	6 months	On Qualifier	**Consult;cardiologist** or **Referral;cardiologist**	6 months
Cardiologist review due	now	On Qualifier	**Consult;cardiologist** or **Referral;cardiologist**	0 days
Physician review due	12 months	On Qualifier	**Consult;physician** or **Referral;physician**	12 months
Physician review due	3 months	On Qualifier	**Consult;physician** or **Referral;physician**	3 months
Physician review due	6 months	On Qualifier	**Consult;physician** or **Referral;physician**	6 months
Physician review due	now	On Qualifier	**Consult;physician** or **Referral;physician**	0 days
Paediatric review due	12 months	On Qualifier	**Consult;paediatrician** or **Referral;paediatrician**	12 months
Paediatric review due	3 months	On Qualifier	**Consult;paediatrician** or **Referral;paediatrician**	3 months
Paediatric review due	6 months	On Qualifier	**Consult;paediatrician** or **Referral;paediatrician**	6 months
Paediatric review due	now	On Qualifier	**Consult;paediatrician** or **Referral;paediatrician**	0 days

Table 139. Rules to manage RHD specialist reviews (continued)

Trigger	Period	Recall type	Recall for	Offset
Dental review due	12 months	On Qualifier	**Consult;dentist** or **Referral;dentist**	12 months
Dental review due	3 months	On Qualifier	**Consult;dentist** or **Referral;dentist**	3 months
Dental review due	6 months	On Qualifier	**Consult;dentist** or **Referral;dentist**	6 months
Dental review due	now	On Qualifier	**Consult;dentist** or **Referral;dentist**	0 days

STRIVE

The STRIVE dataset enables you to paticipate in the randomised community trial to control sexually transmitted infections in remote Aboriginal communities in northern and central Australia.

The `STRIVE` dataset comprises the following items:

- Clinical items:
  - `STI Screening` *STATE*, for example, **STI Screening WA**
  - `STI Treatment` *STATE*, for example, **STI Treatment WA**
- Recall rules
- Reports, request the following reports which will be listed under **Report > STI** in Communicare:
  - **Individual patients seen with STI test requested**
  - **Individual patients with positive STI test**
  - **Individual tests with positive STI test**
  - **Residents seen with STI test requested**
  - **Time to treatment**
  - **Treated and retested**
  - **Treated within one week**
  - **STRIVE External Report**
  - **STRIVE Quality Report**

Participating health services should import this dataset and request the accompanying reports from Communicare Support. Health services should also request the import of the codes used by their specific STI pathology lab so that Communicare recognises local laboratory codes used for some STI results.

Tackling Smoking

The `Tackling Smoking` dataset captures data required for the South Australian Tackling Smoking Program.

Any local clinical item that is an indication of patient involvement in tobacco use services or QUIT workshops should belong to a clinical item group name `Tobacco use services` or `QUIT Workshops` respectively.

The `Tackling Smoking` dataset comprises the following items:

- Clinical items:

> **Tip:**
>
> The review is used whenever reviewing Tackling Smoking with a client and the follow up is used when following this up. (Your administrator may automate a rule to trigger a recall for the follow up whenever a review is completed).
>
> Use the keyword `tackling` to find these clinical items.

    - **Review;Tackling Smoking**
    - **Followup;Tackling Smoking**
- Reports:
    - **Clients and Smoking** - looks at all client contacts between two dates and indicates if a smoking matter was recorded. The data is disaggregated by provider type. Smoking matters include:
        - The recording of a smoking status qualifier, identified by the system codes of SMO or SMP
        - The recording of a clinical item that belongs to the `Tobacco use service` group or the `Quit workshops` group.
    - **Export Report** - shows all Tacking Smoking review items with their referral data.
    - **Patients with ongoing support** - identifies all clients who have had at least one Tackling Smoking review or follow up item recorded between two dates and also indicates those with a further item recorded within three months of another. The report includes subsequent items recorded after the last date of the report but not those recorded before the first date of the report.

The George Institute

The George Institute dataset enables integration with The George Institute HealthTracker™.

After your site has completed training in how to use the George Institute HealthTracker™ tool, configure HealthTracker integration in Communicare. For more information, see HealthTracker *(on page 762)*.

Finance

Make electronic claims with Medicare Australia, including Bulk Bill claims or if your health service operates fully or partially as a private business, bill a patient privately.

Online Claiming

If your clinic is set up to make claims from Medicare, providers or reception can submit a Medicare claim electronically, either from the **Service Record** after closing a clinical record, or by opening the **Service Record** from the  **Service Recording** window.

To make claims from Medicare:

- Your site and providers must be registered with Services Australia.
- The Encounter Place must have a Minor ID which is used when claims are sent to Medicare. This number is generated and provided by Communicare. For more information, see Adding and Editing Encounter Places and Modes *(on page 872)*.
- Any provider for whom claims will be submitted must have a provider number for the encounter place or a Specialty type of `General Medical Practitioner`. For more information, see Providers *(on page 917)*.
- The `Electronic Claims` module must be enabled.

  > **Note:**
  > A standard activation fee applies. For more information, contact Communicare Support *(on page)*.

  This module enables bulk bill claims, private claims and the verification of a patient's Medicare details and eligibility using OPV or EPV.
- Users making claims must belong to a user group that has the `Billing` system right.
- Optionally, clinical items can be linked to specific MBS items to simplify claiming. For more information, see Clinical Item Type Properties *(on page 886)*.

Getting Started with Online Claiming

Before you can use Electronic Claims you must be registered with Medicare Australia.

What to do first

Download registration forms from http://www.medicareaustralia.gov.au/provider/business/online/register/apply.jsp.

You will need the following information to register:

- Name of Practice - the name of your clinic
- Contact person at practice - a technical person nominated as the contact person for your clinic
- Location ID - request your location ID from Communicare Support
- Location Certificate
- Payee Provider *(on page 921)* - a designated provider who will be associated with the clinic's bank account

Medicare contact information

Medicare Australia's contact information:

- Online claiming Helpdesk - 1800 700 199
- Online claiming Registration webpage - http://www.medicareaustralia.gov.au/provider/business/online/register/apply.jsp
- Department of Human Services, Medicare program -1300 660 035

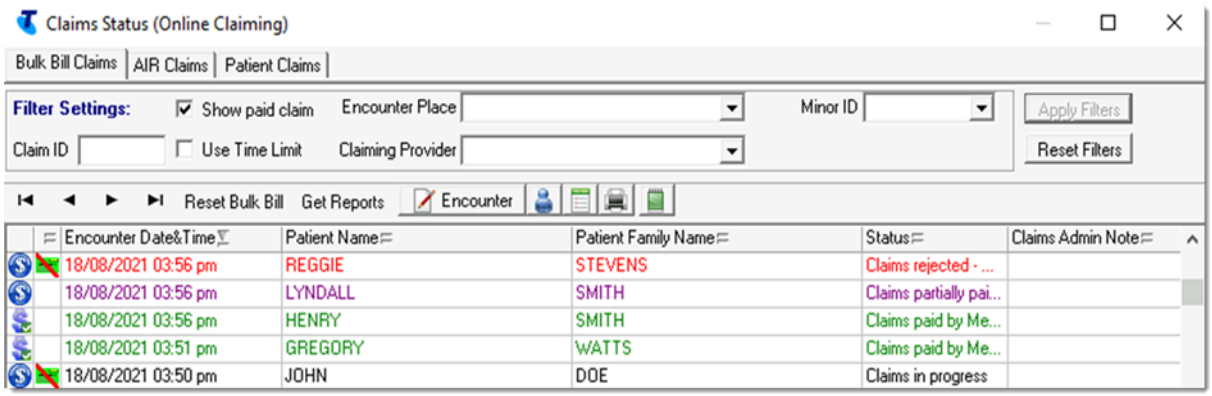
Bulk Bill Claims (Online Claiming)

Use the **File > Online Claiming > Bulk Bill Claims** tab to manage claims bulk billed to Medicare using Medicare Australia's online claiming, where the cost of the encounter is covered by Medicare.

Encounters list

The encounters list shows all encounters that have been generated since online claiming was enabled, and:

- Have a provider with a valid provider number or have a claim item set
- Are not marked as **Not claimable** (see Service Record *(on page 98)* for details)
- The patient is not fictitious
- The encounter status is waiting, started, paused or finished (but not withdrawn)
- Have not been paid
- Are within the legal time limit for electronically claimable services imposed by Medicare Australia



The fields in the encounter list are:

- Claim status icon and **Status** - the current status of the encounter claims. Multiple claim items for one encounter may be included in one claim. Select a claim to list the claim items separately.

Table 140. Online claiming - claims status

Icon	Status	Description
	`Claims in progress`	The claim has been sent or is in progress and there is not yet an outcome. The claim may have failed validation: check the **Result Text Message** field and the **Claim Status** for more information. For more information, see Troubleshooting online claims to Medicare *(on page 430)*. If a claim remains in this status for more than 7 days, **Reset Bulk Bill** becomes available. Do not click **Reset Bulk Bill** except in consultation with Communicare Support or Medicare Australia.

Icon	Status	Description
	`Claims partially paid by Medicare Australia`	If all claim items are partially paid, the text is purple. If some claim items have different statuses, the text is black. Review the Medicare report and the Service Record, where the status of individual items is displayed. **Tip:** Click  **Encounter** to open the Service Record and amend the MBS items: for example, deselect a failed item and select a more appropriate item before claiming again. The whole claim is resubmitted and Medicare identifies which items are yet to be paid. For more information, see Troubleshooting online claims to Medicare *(on page 430)*.
	Claim status unknown	Claim is potentially claimable: the service has at least one provider with a provider number, but the claim has not been sent or marked as not claimable. For more information, see Troubleshooting online claims to Medicare *(on page 430)*.
	`Claims rejected - View Report`	Text is red. Claim is not paid. As for partially paid claims, review the Medicare report and the Service Record and resubmit the claim if appropriate. For more information, see Troubleshooting online claims to Medicare *(on page 430)*.
	`Claims paid by Medicare Australia`	Text is green. Claim has been successfully paid. No further action is required.

- Information - for example,  `Medicare Card details incomplete`, displayed for an encounter if the patient's Medicare Card details are incomplete
- **Encounter Date and Time** - the start date and time of an encounter. If only the date is used, the date of the encounter.
- **Patient Name** - the patient's given names. If the patient is registered for HCH and the tier is recorded, the patient's HCH tier detail is highlighted.
- **Patient Family Name** - the patient's family name.
- **Claims Admin Note** - click  Admin Note to add or edit any notes associated with the claim.

Filtering the encounters list

Set filters to limit the number of claims displayed.

To filter the encounter list:

1. Apply one of more of the following filters:
    - **Claim ID** - enter a value to list claims that contain only the specified claim ID. Enter as much of the claim ID as required. For example, `P003` returns `P0031@`, `P0031@`... `P0039@`.

      To search for inpatient claim IDs, enter a search term starting with `#`. For example, `#P003` returns `#P0031@`, `#P0032@`...`#P0039@`.
    - **Claiming Provider** - select a provider from the list to display claims only for that specific provider
    - **Encounter Place** - select an encounter place from the list to display claims only for a specific Encounter Place
    - **Show Paid Claim** - set to display only paid claims. By default, Communicare displays only those claims that have not been paid.
    - **Use Time Limit** - by default, only claims that are within the 2 year legal time limit imposed by Medicare Australia for electronically claimable services are displayed. Deselect to display all claims up to 50 years old.
    - **Minor ID** - select a minor location ID from the list to display claims only for that location ID.
2. Click **Apply Filters**.

Only those encounters that meet the filter criteria are displayed.

To display all encounters again, click **Reset Filters**.

Viewing and editing encounters

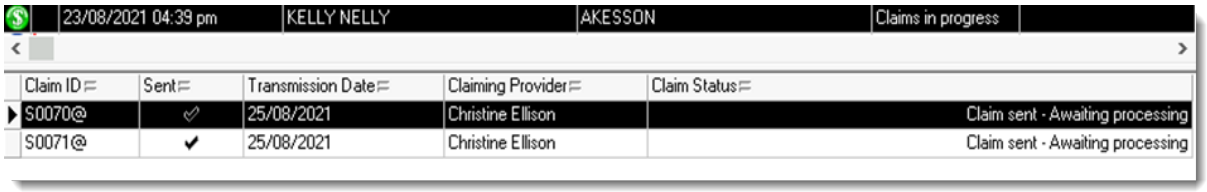
From the **File > Online Claiming > Bulk Bill Claims** tab, you can edit encounters that haven't yet been sent or view them if they have. Typically, you would edit encounters that fail validation.

Select the encounter you want to view or edit and select one of the following options:

- **Encounter** - click to open the service record where you can edit MBS items associated with the service
- - click to edit patient details, including specifying or updating a Medicare number
- - click to view the progress note associated with the immunisation
- - click to print out a Medicare online claiming bulk bill assignment of benefit form for the selected patient
- - click to add an administrative note about the encounter

Bulk bill claims are automatically sent to Medicare by Communicare using Medicare Australia's online claiming when a service is complete.

Select an encounter from the encounters list to display information about the claims associated with that encounter in the claims list.



Information about a claim includes:

- **Claim ID** - unique identifier for a given month, which together with the date, identifies a claim within the online claiming system
- **Sent** - flag showing that the claim has been sent to Medicare Australia. If a claim is sent it cannot be modified.

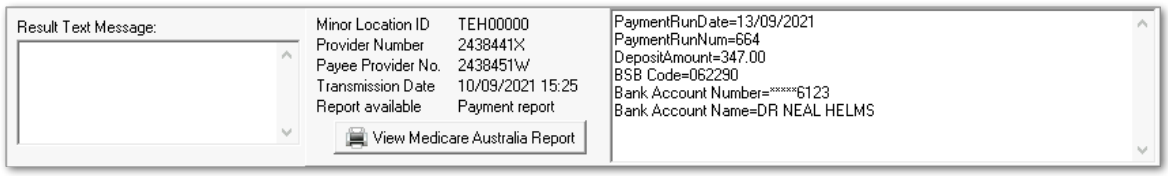
- **Transmission Date** - the transmission date if the claim has been sent
- **Claiming Provider** - claiming provider for the claim
- **Claim Status** - current state of the specific claim. A claim can have one of the following states:
    - `Error: Claim not sent - please retry`
    - `Claim waiting in queue`
    - `Claim sent - Awaiting processing`
    - `Claim processed - Awaiting Payment`
    - `Claim paid by Medicare Australia`
    - `Claim rejected - View Medicare Australia Report`
    - `Claim discarded` - when a rejected claim is retransmitted, the original claim is discarded

Claims are sent at the interval and times configured in `CCareQueue_ServicesAustralia`. By default, claims are sent hourly, 9:00-11:00am.

If a claim shows an error or is rejected, investigate the reason. If there is a problem with the patient or service record, correct it so that the claim can be resubmitted. For more information, see Working with submitted Medicare Claims *(on page 427)*.

Claim details

For a claim selected in the claims list, if there was an attempt to transmit the claim to Medicare Australia, details about the claim are displayed at the bottom of the window:



- **Result Text Message** - details of an attempt to process a claim returned by Services Australia or reasons for a failure to send. You can look up a Medicare reason code at PBS reason and rejection codes.
- **Minor Location ID**
- **Provider Number**
- **Payee Provider No.**
- **Transmission Date** - the date and time when this claim was transmitted to Medicare Australia if it was successfully transmitted
- **Report available**
- **View Medicare Australia Report** - where there is a report available, click to display information from Medicare, including a `Medicare - Online Claiming Bulk Bill Report` or DB4 form received from Services Australia after a claim is processed. Depending on whether the claim has been fully processed and paid or not, the available report will change. You may see either of the following reports:
    - Processing report - available where Medicare has accepted the claim and started to process it. Medicare may return a patient status code which indicates problems with the Medicare card details in the original claim. One of the following codes may be displayed in the **Medicare card flag** field:
        - `8023` - patient identification amended
        - `8024` - patient Medicare Issue number changed
        - `8025` - patient Medicare Number changed
        - `8026` - patient card will expire shortly
        - `8027` - patient card expired. Future services may be rejected.
        - `8028` - old Medicare Issue number for patient. Future services may be rejected.

- Payment report - available after Medicare has processed the claim and sent payment to the service provider. This report provides information about a service and its claim items. It includes details of payments deposited, a list of claims and transactions covered by the payment, explanations of all accepted and paid bulk bill claims, referral information, processing information and so on.

> **Note:**
> If a claim does not progress from having a processing report to having a payment report, your local administrator should ensure that the Provider Number was correctly linked to the Minor ID at the time the claim was processed. Call Medicare eBusiness to check the status of the claim if you aren't sure.

- **Payment Details** - details of payments made for a processed claim

Administrator jobs

Administrators should check Regular Administrator Tasks *(on page 964)* for details of online claiming maintenance.

Working with submitted Medicare Claims

Use **File > Online Claiming > Bulk Bill Claims** tab to manage the life cycle of a Medicare claim from the moment the claim is sent to Medicare until the moment of payment.

Once a bulk bill claim is submitted to Medicare and accepted by Medicare it is assessed for its validity. The assessment process determines how much of the claimed amount will be paid. The assessment can result in either the claim being rejected, fully paid or partially paid.

Reporting on Medicare

Whilst individual claims can be reviewed from the **Online Claiming** window, if you are reviewing bulk claims, refer to Communicare reports. Use the reports in **Report > Electronic Claims** to report on Medicare revenue and to reconcile practice accounts with Medicare Bulk Bill claims submitted with Communicare.

- To reconcile bank account statements for paid claims, use **Report > Electronic Claims > EFT Payments**. This report:
  - Displays a list of payments made by Medicare Australia by date range
  - Can be filtered by payee provider number, and Minor Location ID
  - Shows date, run number, payee provider number and amount paid

> **Note:**
> The **EFT Payments** report reports only paid claims, so may vary from between other reports.

- To check for claims that have been rejected, use **Report > Electronic Claims > Rejected by Period**. This report displays a list of claims that have been rejected by Medicare, for a selected date range. Partially rejected claims are also reported.
- To check for claims that have been only partially paid, use **Report > Electronic Claims > Partially paid with error message**. This report displays a list of claims that have been partially paid by Medicare, for a selected date range. You can also include claims that have been rejected fully or show discarded claims only.
- To investigate decreases in Medicare revenue, use **Report > Electronic Claims > Check Items and Claims**. Use this report to:

- Cross check completed procedures or immunisations performed with Medicare Claims. The output includes only those services with the selected procedures or immunisations. Claims by any providers on the service are included.
- Specify all items or a specific procedure or immunisation that normally attracts a Medicare claim to check that the correct item has been marked for claiming. All claims for each service are shown, regardless of whether they have been sent successfully or not.
- Investigate claims that are associated with a single service.

Checking that all claims have been properly submitted to Medicare Australia

To find all claims that have not been transmitted:

1. On the **File > Online Claiming > Bulk Bill Claims** tab, in the encounters list, click the **Status** column heading twice to order the encounters by descending claim status. All encounters with a claim that failed to be transmitted are listed at the top of the list.
2. For an encounter, select a claim and look at the information in the **Result Text Message** field. This is the message returned by Services Australia, and shows why the transmission failed.
3. If the error was an internet connection error, when your internet is working, submit the claim again:
    a. Click  **Encounter** or click the yellow triangle (View Claim details) to display the Service Record *(on page 98)* window.
    b. Click **Claim now** again.

The claim is prioritised and is submitted electronically to Medicare Online immediately.

If the error describes a problem with your provider number or other problems, resubmit the claim. See below for more information.

Checking if a claim has been accepted or rejected by Medicare Australia

All claims transmitted using online claiming have up to three stages: Sent, Processed, Paid. After a claim is sent it generally takes 1-3 days to be processed, but in some cases, if there are problems it can take a week or longer to be processed.

Resubmitting claims with a status of Claim sent - Awaiting processing

To resubmit claims with a claim status of `Claim sent - Awaiting processing`:

1. Wait until at least 7 days have passed since you submitted the claim.
2. For a claim that has a claim status of Claim sent - Awaiting processing, call Medicare on 1800 700 199 to confirm that they did not receive the claim. If they did receive claim, do not complete these steps.
3. If Medicare definitely did not receive the claim, click **Reset Bulk Bill**. The Reset action deletes all information about the online claim for this encounter in Communicare. If the claim was received by Medicare Australia, but has not yet processed and you reset it, the claim might eventually be paid by Medicare, but Communicare will not record this information.
4. Click **Encounter**.
5. In the **Service Record** window, fix any problems.
6. Click **Claim now**.

The claim is prioritised and is submitted electronically to Medicare Online immediately.

Resubmitting claims with a status of Claim rejected - View Report

To resubmit claims with a status of `Claim rejected - View Report`:

1. For a claim that has a claim status of `Claim rejected - View Report`, click **View Medicare Australia Report**.
2. Review the report.
3. For the rejected claim, click **Encounter**.
4. In the **Service Record** window, fix any problems.
5. Click **Claim now**.

The claim is prioritised and is submitted electronically to Medicare Online immediately.

Resubmitting partially paid claims with a status of Claim partially paid by Medicare Australia

To resubmit claims with a status of `Claim partially paid by Medicare Australia`:

1. In the encounter list, select the encounter.
2. Click **Encounter**.
3. On the **Service Record > Medicare** tab, some items will display a red cross icon and some a green dollar icon. The green dollar indicates a paid item, which cannot be edited. The red cross icon indicates a rejected item, which can be edited.
4. Correct the items with a red cross. Do not deselect the rejected items until you have claimed the additional items. This approach ensures that the claim remains in the **Bulk Bills Claims** tab until it is fully paid.
5. Click **Claim now**.

A new claim is generated for all items in the original claim that were not paid.

The claim is prioritised and is submitted electronically to Medicare Online immediately.

If the original claim now contains only paid items and unsent or reset items, it is considered to be fully paid.

Frequently Asked Questions

- Q: Why doesn't the **Show paid claims** filter work?

  A: Click **Apply Filters** after selecting a filter to apply it to the encounter list.

- Q: Why can't I reset a rejected claim using the **Reset Bulk Bill** button?

  A: This button is used only to reset a claim that is being ignored by Medicare. Resubmit a rejected claim for it to be resent.

- Q: Why can't I see the provider names in the encounter grid?

  A: There can be multiple claiming providers on a single encounter so providers are displayed in the claims grid. Use the **Filter Provider** option to hide all encounters except those for a specified provider.

- Q: How do I check the status of a claim from the Service Record?

  A: Edit the service details and change to the **Medicare** tab. If there is no icon next to an item it has not been sent or is still in the queue. The icons that may appear are:

- Claim pending
- Claim rejected
- Claim paid

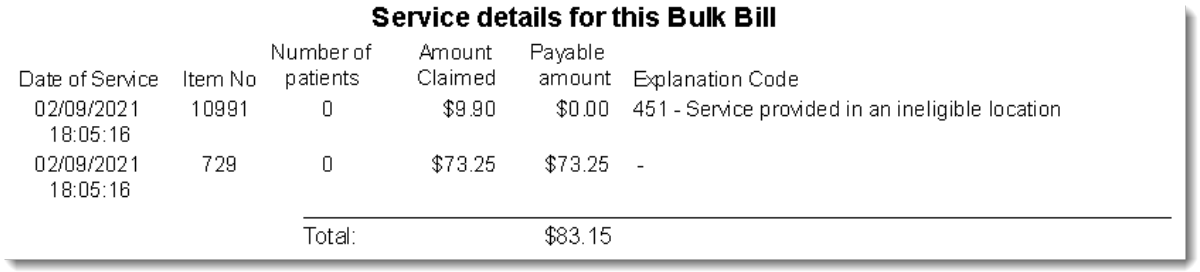
Troubleshooting online claims to Medicare

For Medicare bulk bill claims that have a status of `Claims in progress`, `Claims partially paid` and `Claims rejected`, review why this might happen so that you can correct and resubmit the claims.

Overview

In **File > Online Claiming > Bulk Bill Claims** tab, any explanation for the status of a claim returned by Medicare Online is displayed in the **Result Text Message** field. The information in the **Claim Status** column provides further information.

If a claim is processed, further information is also provided in the `Explanation Code` column in the bulk bill report. On the **Bulk Bill Claims** tab, click **View Medicare Australia Report**. The code and its message tell you what the problem is.



Service details for this Bulk Bill

Date of Service	Item No	Number of patients	Amount Claimed	Payable amount	Explanation Code
02/09/2021 18:05:16	10991	0	$9.90	$0.00	451 - Service provided in an ineligible location
02/09/2021 18:05:16	729	0	$73.25	$73.25	-
		Total:		$83.15	

> **Tip:**
> Services Australia provides a complete list of Medicare claiming return codes https://www.servicesaustralia.gov.au/organisations/health-professionals/topics/medicare-digital-claiming-return-codes/33171.

Generally:

- Three digit codes indicate how the claim was assessed, and relate to rules for Medicare benefits.
- Four digit codes indicate an error with the claim submitted or a data or service issue. Four digit codes starting with the following indicate:
  - `90` - data issue. These errors are common and relate to information that Medicare has assessed and deemed to be incorrect.
  - `30` - transmission problems, for example, connection problems with:

- Firewall
- Internet
- Medicare Server unavailable

> **Fastpath:**
> Check the Medicare Online Claiming service status and your own internet connection. Communicare will advise users of any issues we are made aware of.

- 1 - functional issues, for example:
  - Data validation issues
  - Assessment condition
  - General errors

Table 141. Common Medicare online claiming explanation codes and their resolution

Code	Message	Possible resolution
141	No benefit payable for services performed by this provider	Wrong item number used for the selected provider. Choose a different item.
160	Maximum number of services for this item already paid	The maximum number of claims has already been made for the item number. Choose only codes without a maximum limit
162	Benefit has been previously paid for this service	Equivalent service details have already been submitted and paid. Check payments.
179	Benefit not payable - associated service already paid	Ensure you select all claimable items for a service. If you need to claim two of the same item, mark as **Not duplicate service** and provide information in the **Service Text** field.
255	Benefit assigned has been increased	Check on the Communicare User Portal that you are using the latest MBS. Where a claim has been submitted with a lower payable amount, Medicare will pay the current rate.
374	Old card issue used - benefit not payable	Update the patient's Medicare card information in their biographics.
451	Service provided in an ineligible location	Item number used in the wrong context
500	Rejected in association with another item in this claim	Rejected along with other items in the same claim that have issues. Check for other items with errors and correct all items.
529	Bulk bill additional item claimed incorrectly	An Medicare service and its related bulk bill item must be claimed together. Ensure they weren't claimed separately, and check for valid concessions where appropriate.
619	Servicing provider number not open at date of service	Check the provider number registration at the time of the service. The provider must have an active provider number when a service is delivered.

Table 141. Common Medicare online claiming explanation codes and their resolution (continued)

Code	Message	Possible resolution
9202	Invalid value for data item. The data element does not comply with the values permitted or has failed a check digit check.	In patient biographics, a PO Box might be set as a home address instead of a physical location, or the Medicare card needs to be validated. If you correct any problems and the issue isn't resolved, contact Medicare eBusiness on `1800 700 199` and check the details.
9204	Date in future. The date supplied must not be in the future	You cannot claim for services where the service is delivered in the future. Correct the service date.
9210	Date of service must be no more than two years in the past	You cannot claim for historical services where the service is more than 2 years in the past. Check Medicare bulk bill claims regularly, preferably daily.
9309	Referral issue date must be supplied, and must be prior to, or the same as, the date of the medical service, cannot be before the date of birth, nor after the referral start date	Ensure that when **Specialist Services** is selected for the Service Record, a valid date is entered in the **Referral Issue Date** field, unless there is a relevant override.
9326	Hospital details must be supplied in the text field/Insufficient information provided	For a specialist service with an override type of `Hospital` selected, ensure that **Inpatient** is also selected so that the Hospital Facility ID *(on page 872)* for the encounter place is included in the claim.
3000-3999	General claim error	Refer these claim errors to Medicare eBusiness on `1800 700 199`for review. Communicare Support can assist with investigation when Medicare have identified the cause of the failure.

Bulk Bill - Electronic Claims (Medicare Australia's online claiming) Wizard

Use the **Bulk Bill - Electronic Claims (Medicare Australia's online claiming) Wizard** to confirm the details of the items and the amounts claimed before actually transmitting them.

Bulk Bill details

The **Bulk Bill - Electronic Claims (Medicare Australia's online claiming) Wizard** window is displayed from the **Service Record** when you click **Claim Now**.

After you click **Accept**, the claim is placed in a queue to access Medicare Australia's online claiming.

If the service is a batch claim, the items from all the services are batched together and displayed. For batch claims, the claim can include up to 80 services with a maximum of 14 MBS items in each service.

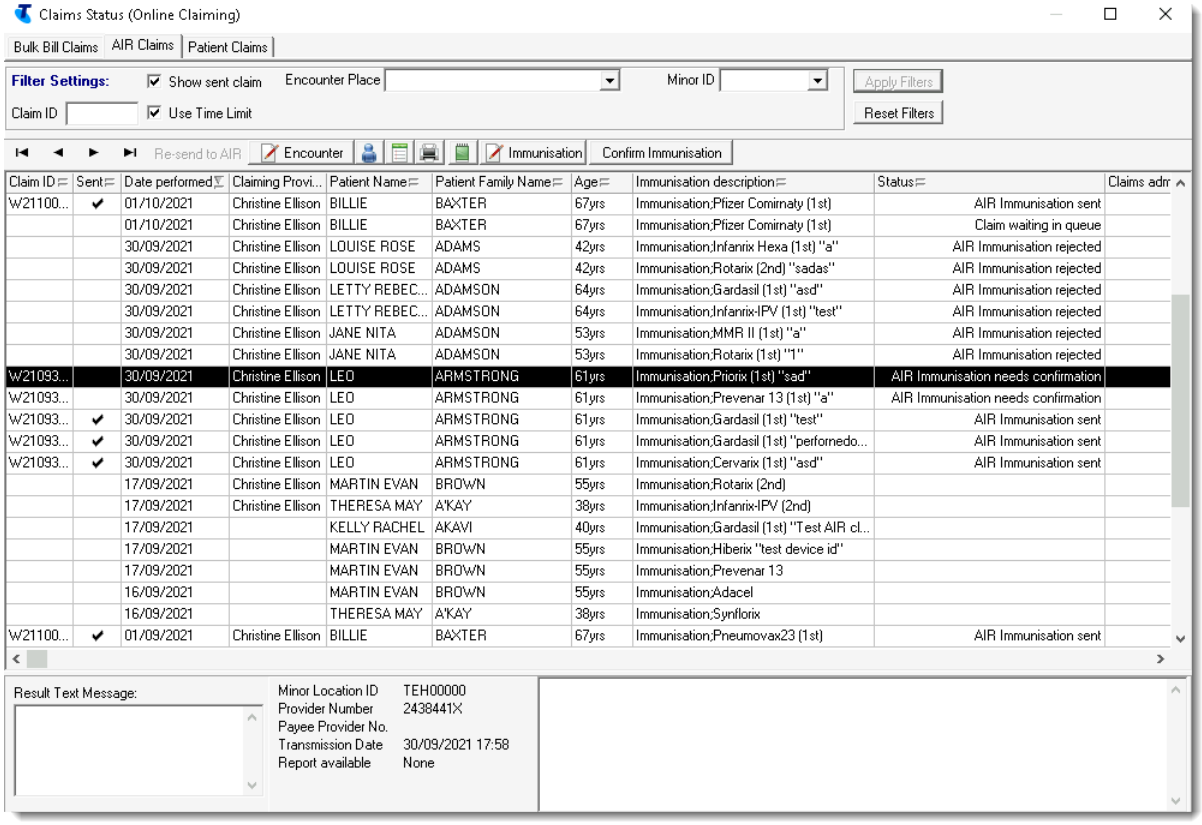
If you are using a Data Synchronisation (Communicare Offline) client, this will be placed on the queue on the Server when you next synchronise. You can only claim for a service from a Data Synchronisation (Communicare Offline) client if the service was created entirely offline, and has not yet been uploaded to the online database.

Practitioner Declaration

If the provider has chosen to use a signing token s/he must provide the password for the token before submitting the claim. No one can submit claims in this provider's name unless they have the token and the password. This option is not available on a Data Synchronisation Client.

Australian Immunisation Register uploads

Use the **File > Online Claiming > AIR Claims** tab to view a list of all immunisations recorded in Communicare where the immunisation type has a valid AIR code, and to check that the immunisation record has been successfully uploaded to Australian Immunisation Register (AIR).



Claim ID	Sent	Date performed	Claiming Provi...	Patient Name	Patient Family Name	Age	Immunisation description	Status	Claims adm
W21100...	✔	01/10/2021	Christine Ellison	BILLIE	BAXTER	67yrs	Immunisation;Pfizer Comirnaty (1st)	AIR Immunisation sent	
		01/10/2021	Christine Ellison	BILLIE	BAXTER	67yrs	Immunisation;Pfizer Comirnaty (1st)	Claim waiting in queue	
		30/09/2021	Christine Ellison	LOUISE ROSE	ADAMS	42yrs	Immunisation;Infanrix Hexa (1st) "a"	AIR Immunisation rejected	
		30/09/2021	Christine Ellison	LOUISE ROSE	ADAMS	42yrs	Immunisation;Rotarix (2nd) "sadas"	AIR Immunisation rejected	
		30/09/2021	Christine Ellison	LETTY REBEC...	ADAMSON	64yrs	Immunisation;Gardasil (1st) "asd"	AIR Immunisation rejected	
		30/09/2021	Christine Ellison	LETTY REBEC...	ADAMSON	64yrs	Immunisation;Infanrix-IPV (1st) "test"	AIR Immunisation rejected	
		30/09/2021	Christine Ellison	JANE NITA	ADAMSON	53yrs	Immunisation;MMR II (1st) "a"	AIR Immunisation rejected	
		30/09/2021	Christine Ellison	JANE NITA	ADAMSON	53yrs	Immunisation;Rotarix (1st) "1"	AIR Immunisation rejected	
W21093...		30/09/2021	Christine Ellison	LEO	ARMSTRONG	61yrs	Immunisation;Priorix (1st) "sad"	AIR Immunisation needs confirmation	
W21093...		30/09/2021	Christine Ellison	LEO	ARMSTRONG	61yrs	Immunisation;Prevenar 13 (1st) "a"	AIR Immunisation needs confirmation	
W21093...	✔	30/09/2021	Christine Ellison	LEO	ARMSTRONG	61yrs	Immunisation;Gardasil (1st) "test"	AIR Immunisation sent	
W21093...	✔	30/09/2021	Christine Ellison	LEO	ARMSTRONG	61yrs	Immunisation;Gardasil (1st) "performedo...	AIR Immunisation sent	
W21093...	✔	30/09/2021	Christine Ellison	LEO	ARMSTRONG	61yrs	Immunisation;Cervarix (1st) "asd"	AIR Immunisation sent	
		17/09/2021	Christine Ellison	MARTIN EVAN	BROWN	55yrs	Immunisation;Rotarix (2nd)		
		17/09/2021	Christine Ellison	THERESA MAY	A'KAY	38yrs	Immunisation;Infanrix-IPV (2nd)		
		17/09/2021		KELLY RACHEL	AKAVI	40yrs	Immunisation;Gardasil (1st) "Test AIR cl...		
		17/09/2021		MARTIN EVAN	BROWN	55yrs	Immunisation;Hiberix "test device id"		
		17/09/2021		MARTIN EVAN	BROWN	55yrs	Immunisation;Prevenar 13		
		16/09/2021		MARTIN EVAN	BROWN	55yrs	Immunisation;Adacel		
		16/09/2021		THERESA MAY	A'KAY	38yrs	Immunisation;Synflorix		
W21100...	✔	01/09/2021	Christine Ellison	BILLIE	BAXTER	67yrs	Immunisation;Pneumovax23 (1st)	AIR Immunisation sent	

All immunisations recorded in Communicare where the immunisation type has a valid AIR code that meet the following criteria are listed:

- The immunisation must have a valid Claiming Provider, which is sent with the AIR record.
- A value is required for **Dose number** or **Dose (this course)**

> **Note:**
> If a value is recorded for both fields, **Dose number** has precedence.

- The immunisation was added, or a recall completed, after 1995
- The immunisation has a valid export code in **File > Reference Tables > Clinical Item Types**. Ask your Communicare Administrator about this. If you are using the immunisation list supplied by Communicare, this is up-to-date.

If a patient can't be identified by the AIR, error `AIR-E-1026 - Individual information provided is insufficient` is returned. For more information, see Patient details are incomplete or invalid *(on page 648)*.

Each entry includes the following information:

- **Claim ID** - a unique identifier for a given month which together with the date, uniquely identifies an AIR record. If your health service is using batch claims, each item in a batch is assigned the same claim ID.
- **Sent** - a flag showing whether the AIR record has been sent to the AIR or not. After the AIR record has been sent, the immunisation cannot be modified.
- **Date performed** - the date when the immunisation was performed.
- **Claiming Provider** - the provider sent with the record. The provider is selected using the following criteria, in the order listed. If no provider exists for any of the criteria, the record is not submitted.
    - AIR Provider number against the encounter place of the service. If this number does not belong to an actual provider, the encounter place name is shown instead.
    - If no AIR Provider number has been entered against the encounter place, the provider number of the default AIR claimant recorded against the encounter place.
    - If there is no default AIR claimant recorded against that encounter place, the provider number of the provider who recorded the immunisation.
    - If this provider doesn't have a valid provider number for this encounter place, the provider number of any other claiming provider that was on the same service is used.
- **Patient Name** & **Patient Family Name** - the patient's HCH Tier detail is highlighted if the patient is registered for HCH and the tier is recorded.
- **Age**
- **Immunisation description** - the immunisation's clinical item, **Dose** or **Dose (this course)** and any comments.
- **Status** - current status of the AIR record upload. If this is blank, an AIR record has not yet been submitted for this immunisation.

The following patient and provider identifier information is also uploaded to the AIR:

- The patient's IHI
- Information about who administered the immunisation and who entered the data, for both the individual, using the HPI-I, and organisation, using the HPI-O

For more information about identifiers, see HI Service *(on page 632)*.

Filtering the immunisations list

Set filters to limit the number of immunisations displayed.

To filter the immunisation list:

1. Apply one of more of the following filters:
    - **Claim ID** - enter a value to list records that contain only the specified claim ID. Enter as much of the claim ID as required. For example, `P003` returns `P0031@`, `P0031@`... `P0039@`.

      To search for inpatient claim IDs, enter a search term starting with `#`. For example, `#P003` returns `#P0031@`, `#P0032@`...`#P0039@`.
    - **Show sent claim** - set to also display those immunisations that have already been sent to AIR
    - **Encounter Place** - select an encounter place from the list to display immunisations only for a specific Encounter Place
    - **Minor ID** - select a minor location ID from the list to display claims records for that location ID.

    - **Use Time Limit** - by default, only records from the last 6 months are displayed. Deselect to display all records up to 50 years old.
    - **Hide Given Elsewhere** - set to display only those immunisations administered at your health service. Immunisations for which **Administered overseas** was set or for which **Performed at** *your health service* was not set are not displayed. The setting you choose persists when you next open the **AIR Claims** tab.
2. Click **Apply Filters**.

Only those immunisations that meet the filter criteria are displayed.

To display all immunisations again, click **Reset Filters**.

AIR record uploads

After a service is completed, any immunisations with a valid AIR code are submitted to AIR automatically by Communicare without requiring further intervention, independently of any Medicare claims.

If an immunisation is successfully submitted to the AIR, it shows a status of `AIR immunisation sent`.

AIR uploads are sent at the interval and time configured in `CCareQueue_ServicesAustralia.exe`. By default, `CCareQueue_ServicesAustralia.exe` uploads to the AIR at 12pm-2pm daily.

Immunisation uploads that were not completed and are not waiting on confirmation and for which the immunisation details or patient biographics have been updated during the interval configured in `CCareQueue_ServicesAustralia` are also resent to the AIR.

AIR record uploads cannot be initiated manually.

Groups

For AIR uploads, immunisations are grouped in the following way:

- All general immunisations administered at the current encounter place are grouped together by encounter and provider
- Historical immunisations administered within Australia are grouped together by encounter and provider
- Historical immunisations administered overseas are grouped together by encounter and provider
- Immunisations for the same patient are grouped into a single batch if batch claiming is enabled

Each submission contains at most 20 encounters with up to 5 encounters for each service.

AIR upload statuses

The possible claim statuses are:

- `AIR immunisation sent`
- `Claim waiting in queue`
- `AIR Immunisation rejected` - for information about troubleshooting failed or rejected immunisation uploads, see Troubleshooting AIR uploads *(on page 645)*
- `AIR Immunisation needs confirmation` - for information about confirming an immunisation upload, see Confirming immunisation claims *(on page 644)*

Viewing and editing immunisations

From the **Claims Status (Online Claiming) > AIR Claims** tab, you can edit immunisations that haven't yet been sent or view them if they have. Typically, you would edit immunisations that fail to upload.

Select the immunisation you want to view or edit and select one of the following options:

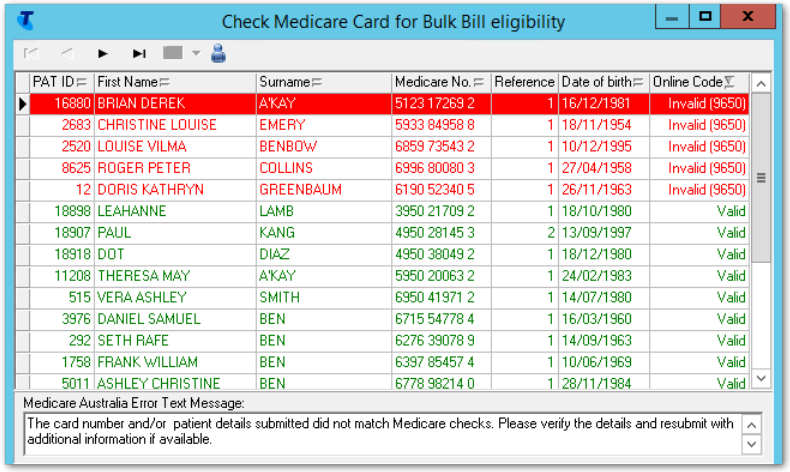
- **Encounter** - click to open the service record so that you can edit the service associated with the immunisation
- - click to edit patient details
- - click to view the progress note associated with the immunisation
- - click to print out a Medicare online claiming bulk bill assignment of benefit form for the selected patient
- - click to add an administrative note about the immunisation
- **Immunisation** - click to open the immunisation clinical item where you can edit any details or add missing information
- **Confirm Immunisation** - for immunisation records rejected for clinical reasons or because a patient was not found, click to confirm that the immunisation is correct and upload to the AIR. For more information, see Confirming immunisation claims *(on page 644)*.

Check Medicare Card Eligibility

Use the **Check Medicare Card for Bulk Bill Eligibility** window to help manage your patients' Medicare details.

To view a list of patients and their Medicare details recorded in Communicare, select **Tools > Check Medicare Card Eligibility**.

The **Check Medicare Card for Bulk Bill Eligibility** window displays the patients' details, their Medicare card details and the validation code for the Medicare card of each patient.



The Medicare card details can be in one of the following states:

- `Unknown` - the card has never been validated with Medicare Australia
- `Invalid (code)` - the Medicare card is invalid for the reason provided. The reason code is listed in the **Online Code** field and details are provided in the **Medicare Australia Error Text Message** field.

- `Valid (code)` - the Medicare card is valid but a minor detail such as the reference number is incorrect. The reason code is listed in the **Online Code** field and details are provided in the **Medicare Australia Error Text Message** field.
- `Valid` - Medicare Australia validated this Medicare card for bulk billing purposes

Information displayed in the **Check Medicare Card for Bulk Bill Eligibility** window is colour-coded:

- Patients with valid Medicare card details are displayed in green text
- Patients with invalid Medicare card details are displayed in red text
- Patients with Medicare card details that have never been validated are displayed in black text

To check the Medicare card status of an individual patient, select a patient in the list and click Check this patient's Medicare Card.

> **Tip:**
> Patients are sorted by ID by default. To sort by Medicare status, in the table, click **Online Code**.
>
> Record the Medicare details for patients with a status of `Unknown`. Update the Medicare details for patients with a status of `Invalid`.

Alternatively, update the Medicare details of a single patient in their patient record. In the **Check Medicare Card for Bulk Bill Eligibility** window, click Biographics. For more information, see Medicare details *(on page 40)*.

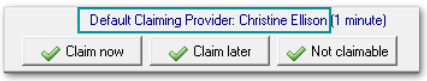
> **Tip:**
> Check the Medicare details for a patient any time in their biographics.

Claiming Medicare from Service Recording (Reception)

If your health service is integrated with Medicare, reception can submit an electronic claim from the **Service Recording** window after the clinician has closed the service.

To submit a Medicare claim:

1. Click Service Recording.
2. In the **Service Recording** window, double-click the patient for whom you want to submit a claim and click **Edit Service Details**.
3. If you need to check a patient's Medicare details, call Medicare Indigenous Helpline 1800 556 955 or Medicare Card enquiries 132 150.
4. In the **Service Record** window, on the **Medicare** tab, check that the provider listed as the Default Claiming Provider is correct. If the provider is incorrect, on the **Detail** tab, select the correct provider.



5. To display previous items that have been marked for claiming for this patient, whether they have been paid or not, click **MBS Items History**.
6. In the list of items, select those that you want to claim. Most common MBS items are listed. If the item you want to claim is not listed, either:

- If you know the number of an item which is not listed, in the **Claim another MBS item** field, enter the number and click  Add.
- Search for an item:
    a. Click  Search.
    b. In the **Search MBS Items** field, enter a search term. For example, `pregnancy`.
    c. In the list, select an item and click **Select**. The item is added to the list in the **Service Record** window and is selected.

7. If you want to claim an item more than once, right-click the item and select **Add this MBS item again**.
8. If you want to claim an item that does not have a simple fee (such as a home visit), right-click on the item and select **Display the derived fee description for this MBS item**. Using the description, fill in the details required. For example, amount claimed, number of patients seen, and so on.
9. If the item being claimed requires details of a referring provider, select the item and select **Specialist Services** and complete the specialist's details.
    - To add details of the last referring provider for the patient, click **Use last referrer**.
    - The **Referred** field on the far right of the grid indicates whether an item has **Specialist Services** selected. If it has been selected and details are complete, a green dot will be displayed. If it has been selected, but some details are missing, a yellow dot is displayed. No image is displayed if **Specialist Services** is not selected.

> **Note:**
> Referral details are only included once per claiming provider, so select only one item per specialist claiming provider.

10. To view or edit administration notes related to the claim, click  Admin notes.
11. If enabled, to claim the items as an Inpatient Service, select **Inpatient**.
12. When you are confidant that the items to claim are correct, click **Claim now**.

The claim is queued to submit electronically to Medicare Online when `CCareQueue_ServicesAustralia` next runs.

If Communicare is configured to print, an Assignment Form is printed for the patient to sign.

In the **Service Record** window, on the **Medicare** tab, next to each item claimed there is an icon showing its status:

-  Claim pending
-  Claim rejected
-  Claim paid

If this is a batch claim, all Medicare items from all services are batched together for the patient for that particular provider for the same encounter place. Click **Accept** to send the claim to the server to be sent to Medicare Australia for processing.

If you clicked **Claim Later**, the claim is stored so it can be claimed later. If it's a batch claim, if an active batch exists for the same patient for that provider and encounter place, the claim is added to that batch. Otherwise a new batch is created.

If you submitted a claim incorrectly, correct it as quickly as possible. See Correcting Medicare Claims *(on page 106)* for more information.

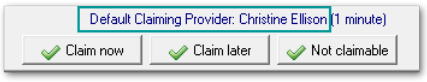
Check details of Medicare claims on **File > Online Claiming > Bulk Bill Claims** tab. See Working with submitted Medicare Claims *(on page 427)* for more information.

Claiming Medicare (Doctor)

If your health service is integrated with Medicare, you can submit an electronic claim when you close a service if you are the provider.

To submit a Medicare claim when you close a service:

1. In the Clinical Record, click Close.
2. Click **Yes - This service is now complete** or **No - Patient will see another provider**. You can claim for your portion of the service in either case.
3. If you need to check a patient's Medicare details, call Medicare Indigenous Helpline 1800 556 955 or Medicare Card enquiries 132 150.
4. In the **Service Record** window, on the **Medicare** tab, check that you are listed as the Default Claiming Provider. If not, on the **Detail** tab, select your name.



5. To display previous items that have been marked for claiming for this patient, whether they have been paid or not, click **MBS Items History**.
6. In the list of items, select those that you want to claim. Most common MBS items are listed. If the item you want to claim is not listed, either:
   - If you know the number of an item which is not listed, in the **Claim another MBS item** field, enter the number and click Add.
   - Search for an item:
     a. Click Search.
     b. In the **Search MBS Items** field, enter a search term. For example, `pregnancy`.
     c. In the list, select an item and click **Select**. The item is added to the list in the **Service Record** window and is selected.
7. If you want to claim an item more than once, right-click the item and select **Add this MBS item again**.
8. If you want to claim an item that does not have a simple fee (such as a home visit), right-click on the item and select **Display the derived fee description for this MBS item**. Using the description, fill in the details required. For example, amount claimed, number of patients seen, and so on.
9. If the item being claimed requires details of a referring provider, select the item and select **Specialist Services** and complete the specialist's details.
   - To add details of the last referring provider for the patient, click **Use last referrer**.
   - The **Referred** field on the far right of the grid indicates whether an item has **Specialist Services** selected. If it has been selected and details are complete, a green dot will be displayed. If it has been selected, but some details are missing, a yellow dot is displayed. No image is displayed if **Specialist Services** is not selected.

> **Note:**
> Referral details are only included once per claiming provider, so select only one item per specialist claiming provider.

10. To view or edit administration notes related to the claim, click Admin notes.

11. If enabled, to claim the items as an Inpatient Service, select **Inpatient**.
12. When you are confidant that the items to claim are correct, click **Claim now**.

The claim is queued to submit electronically to Medicare Online when `CCareQueue_ServicesAustralia` next runs.

If Communicare is configured to print, an Assignment Form is printed for the patient to sign.

In the **Service Record** window, on the **Medicare** tab, next to each item claimed there is an icon showing its status:

-  Claim pending
-  Claim rejected
-  Claim paid

If this is a batch claim, all Medicare items from all services are batched together for the patient for that particular provider for the same encounter place. Click **Accept** to send the claim to the server to be sent to Medicare Australia for processing.

If you clicked **Claim Later**, the claim is stored so it can be claimed later. If it's a batch claim, if an active batch exists for the same patient for that provider and encounter place, the claim is added to that batch. Otherwise a new batch is created.

If you submitted a claim incorrectly, correct it as quickly as possible. See Correcting Medicare Claims *(on page 106)* for more information.

Check details of Medicare claims on **File > Online Claiming > Bulk Bill Claims** tab. See Working with submitted Medicare Claims *(on page 427)* for more information.

History of MBS Items for a Patient

Review the history of MBS items claimed for a patient.

To display the MBS item history, either:

- In a patient's record, click  **Claims**.
- In the **Service Record** window, click  **MBS Items History**.

The **History of MBS Items** window lists the date of service and the MBS items claimed. When using Online Claiming the payment status, whether the item has been paid or not, is also displayed.

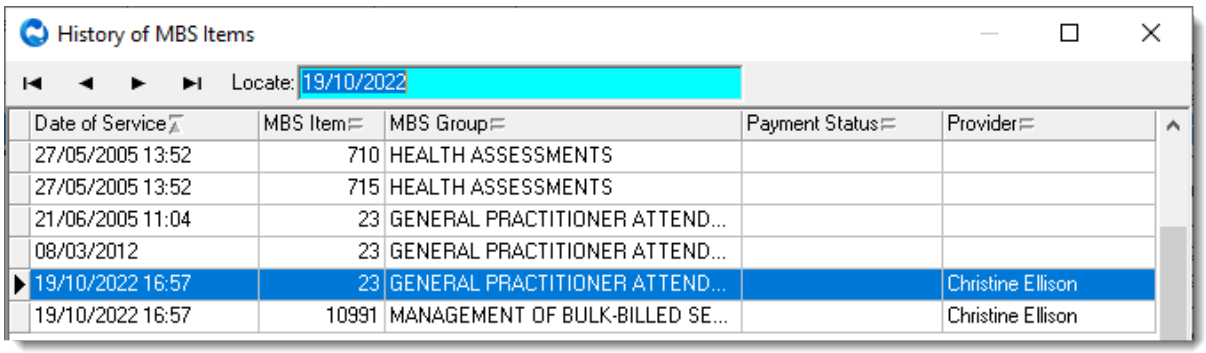
If an item has been marked for claiming but not yet claimed the provider name will be empty.

Items marked with an asterisk (*) indicate Inpatient Service.

To search for particular items:

1. Click the column header for the column you want to search. For example, **MBS Item**. The selected column header displays either of the following icons depending on the display order you have chosen (youngest first, highest item number first and so on):  .
2. In the **Locate** field, enter an exact search term and press Enter. For example, `10991` or for a date, `19/10/2022`.

The first occurrence of the matching term is selected.



Allied Health Claims in Communicare

1. The allied health workers must have their provider number(s) recorded in the Provider Table in Communicare for each encounter place. This can be done by your Communicare Administrator or by the provider themselves, by going to File| Reference Tables|Provider. Check the 'Always show the Medicare items...' checkbox only if the allied health worker is going to make claims themself. Ticking this box will mean that each time the Health Worker closes the Clinical Record, the Medicare items list will be displayed for the Health Worker to tick the item to be claimed. If this box is not ticked, then the Health Worker must click on the yellow triangle at the bottom of the clinical record to display the Medicare Items or do the same thing in the Service Recording window. The Health Worker must also be registered with Medicare Online to make electronic Medicare claims.

2. The allied health workers must be entered in the Address Book. Check the 'Referrals Place' checkbox. (File|Reference Tables|Address Book)

3. The referring doctor must make a referral using the appropriate Allied Health template to the appropriate allied health worker. This authorises qualified allied health workers to make a specific number of claims for a specific item.

4. If the healthworker is part of a service with another provider who has a provider number recorded in Communicare, then the claiming provider must either:

a. have the claimant box (to the right of their name on the Detail tab), ticked to show they are the default claiming provider on this service, or;

b. In the Medicare tab make sure that the Provider selected is themself for each item being claimed by them.

IF THE ALLIED HEALTH WORKER IS MAKING CLAIMS then they should find the Medicare claims form by either clicking the yellow triangle at the bottom of the clinical record or by closing the clinical record (if they are in the clinical record for that service).

IF A DESIGNATED USER IS MAKING THE CLAIMS then they find the Medicare claims form by clicking yellow triangle in Service Recording or Bulk Bill Status.

5. Marking a service as 'Not claimable':

a. If there is only one potential claimant on a service and there is no claim to be made then the service should be marked as not claimable;

b. If there is more than one potential claimant on a service then the service should only be made not claimable of no-one is going to make a claim. This means that if a healthworker sees a patient and is not going to make a claim they should NOT mark the service non claimable if the patient is then going to see a doctor otherwise the doctor will not be prompted

to make a claim. Similarly a doctor should not mark a service as not claimable if the healthworker has initiated a claim and this has not yet been sent to Medicare.

Useful report

The report at Report|Electronic Claims|CDM Summary for Selected Patient is useful for checking which EPC items have already been claimed for a patient.

Aftercare

T8.7 Aftercare (Post-operative Treatment)

T8.7.1 Section 3(5) of the Health Insurance Act states that services included in the Schedule (other than attendances) include all professional attendances necessary for the purposes of post-operative treatment of the patient (for the purposes of this book, post-operative treatment is generally referred to as "after-care"). However, it should be noted that in some instances the after-care component has been specifically excluded from the item and this is indicated in the description of the item. In such cases benefits would be payable on an attendance basis where post-operative treatment is necessary. In other cases, where there may be doubt as to whether an item actually does include the after-care, this fact has been reinforced by the inclusion of the words "including after-care" in the description of the item.

T8.7.2 After-care is deemed to include all post-operative treatment rendered by medical practitioners and need not necessarily be limited to treatment given by the surgeon or to treatment given by any one medical practitioner.

T8.7.3 The amount and duration of after-care consequent on an operation may vary between patients for the same operation, as well as between different operations which range from minor procedures performed in the medical practitioner's surgery, to major surgery carried out in hospital. As a guide to interpretation, after-care includes all attendances until recovery from the operation (fracture, dislocation etc.) plus the final check or examination, regardless of whether the attendances are at the hospital, rooms, or the patient's home.

T8.7.4 Attendances which form part of after-care, whether at hospitals, rooms, or at the patient's home, should not be shown on the doctor's account. When additional services are itemised, the doctor should show against those services on the account the words "not normal after-care", with a brief explanation of the reason for the additional services.

T8.7.5 Some minor operations are merely stages in the treatment of a particular condition. Attendances subsequent to such operations should not be regarded as after-care but rather as a continuation of the treatment of the original condition and attract benefits. Items to which this policy applies are Items 30219, 30223, 32500, 34521, 34524, 38406, 38409, 39015, 41626, 41656, 42614, 42644, 42650 and 47912. Likewise, there are a number of services which may be performed during the aftercare period of procedures for pain relief which would also attract benefits. Such services would include all items in Groups T6 and T7 and Items 39013, 39100, 39115, 39118, 39121, 39127, 39130, 39133, 39136, 39324 and 39327.

T8.7.6 Where a patient has been operated on in a recognised hospital as a public patient (as defined in Section 3(1) of the Health Insurance Act), and where aftercare is directly related to the episode of admitted care for which the patient was treated free of charge as a public patient, the aftercare should be provided free of charge as part of the public hospital service.

Note For more details please contact the Australian Department of Health and Ageing about Medicare Benefits Schedule

Not duplicate service

T8.3 Not Being a Service Associated with a Service to which another Item in this Group Applies

T8.3.1 "Not being a service associated with a service to which another item in this Group applies" means that benefit is not payable for any other item in that Group when it is performed on the same occasion as this item. eg. item 30106.

T8.3.2 "Not being a service associated with a service to which Item ..... applies" means that when this item is performed on the same occasion as the reference item no benefit is payable. eg. item 39330.

T8.4 Not Being a Service to which another Item in this Group Applies

T8.4.1 "Not being a service to which another item in this Group applies" means that this item may be itemised if there is no specific item relating to the service performed, eg. Item 30387 (Laparotomy involving operation on abdominal viscera (including pelvic viscera), not being a service to which another item in this Group applies). Benefits may be attracted for an item with this qualification as well as benefits for another service during the course of the same operation.

Note For more details please contact the Australian Department of Health and Ageing about Medicare Benefits Schedule

Not part of a multiple procedure

T8.2 As an Independent Procedure

T8.2.1 The inclusion of this phrase in the description of an item precludes payment of benefits when:

- (i) a procedure so qualified is associated with another procedure that is performed through the same incision, eg. nephrostomy (Item 36552) in the course of an open operation on the kidney for another purpose;
- (ii) such procedure is combined with another in the same body area, eg. direct examination of larynx (Item 41846) with another operation on the larnyx or trachea;
- (iii) the procedure is an integral part of the performance of another procedure, eg. removal of foreign body (Item 30067/30068) in conjunction with debridement of deep or extensive contaminated wound of soft tissue, including suturing of that wound when performed under general anaesthetic (Item 30023).

T8.5 Multiple Operation Formula

T8.5.1 The fees for two or more operations, listed in Group T8 (other than Subgroup 12 of that Group), performed on a patient on the one occasion (except as provided in paragraph T8.5.3) are calculated by the following rule:-

- 100% for the item with the greatest Schedule fee
- plus 50% for the item with the next greatest Schedule fee
- plus 25% for each other item.

Note:

- (a) Fees so calculated which result in a sum which is not a multiple of 5 cents are to be taken to the next higher multiple of 5 cents.
- (b) Where two or more operations performed on the one occasion have Schedule fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.

- (c) The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.
- (d) For these purposes the term "operation" only refers to all items in Group T8 (other than Subgroup 12 of that Group).

T8.5.2 This rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient if the medical practitioner who performed the operation did not also perform or assist at the other operation or any of the other operations, or administer the anaesthetic. In such cases the fees specified in the Schedule apply.

T8.5.3 Where two medical practitioners operate independently and either performs more than one operation, the method of assessment outlined in paragraph T8.5.1 would apply in respect of the services performed by each medical practitioner.

T8.5.4 If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.

T8.5.5 There are a number of items in the Schedule where the description indicates that the item applies only when rendered in association with another procedure. The Schedule fees for such items have therefore been determined on the basis that they would always be subject to the "multiple operation rule".

T8.5.6 Where the need arises for the patient to be returned to the operating theatre on the same day as the original procedure for further surgery due to post-operative complications, which would not be considered as normal aftercare - see paragraph T8.7. Such procedures would generally not be subject to the "multiple operation rule". Accounts should be endorsed to the effect that they are separate procedures so that a separate benefit may be paid.

Note For more details please contact the Australian Department of Health and Ageing about Medicare Benefits Schedule

Patient Claim Management

Patient Claims are Medicare Claims lodged by patients who have received professional medical services, but have not assigned their rights to Medicare benefits to the Servicing Practitioner.

Communicare supports Interactive Patient Claims, which allows real-time processing of a single claim where the patient pays and is reimbursed by Medicare. This service is available during Medicare operating hours.

Real-time processing follows a cycle of:

1. Transmit
2. Assessment
3. Return of an outcome to the sending location

To submit a Patient Claim on behalf of the patient, follow these steps:

1. At the end of the service, on the **Private** tab:
    a. In the list of Medicare items, select all items that apply.
    b. From the **Payment Method** list, select the payment method used.
    c. In the **Amount Paid** field, enter the amount paid. Click **Pay In Full** if the patient paid the full account.
    d. Generate the invoice for the service, click **Invoice / Receipt**.
2. In the **Invoice** window, select  **Patient Claim > Claim now**.

> **Note:**
> If the button is not available, the claim has already been submitted. **Patient Claim > Claim now** is also disabled if:
>
> - There is no MBS item to claim
> - The provider doesn't have a provider number
> - The Communicare client is offline.

3. On the **Patient Claim Summary** window, review the claim details:
    - To submit the claimant's address to Medicare, set **Include Claimants's Address**.

      > **Note:**
      > The claimant's address must only be transmitted at the request of the claimant. For Medicare, these address details are temporary and must be used for that claim only. If no address is supplied, the address held by Medicare will be used for correspondence relating to the claim.

    - The following business rules apply:
        - Where a patient has only one name, that name should appear in the **Patient Family Name**' field and the word *Onlyname* be entered in the **Patient First Name** field.
        - A claim can include up to maximum of 14 items, any further items are discarded from the claim.
4. To submit the claim to the Medicare, click **Submit Claim**.

If the claim is successful, a **Statement of Claim and Benefit Payment** is generated and displayed. From Services Australia: *A Statement of Claim and Benefit is provided to the claimant when a patient claim has been lodged in real time, processed by the agency and a benefit amount returned to the claimant.*

If required, print this statement and give it to the patient. For successful claims, **Patient Claim** is replaced with **View Claim**.

If the claim is unsuccessful:

- With a non-fatal error - the claim is referred to a Medicare operator for assessment and a **Lodgement Advice statement** is generated and displayed. From Services Australia: *A Lodgement Advice is provided to the claimant when a patient claim has been lodged in real time and referred to an agency operator for action.*. Print this statement and give it to the patient. The patient must contact Medicare for further claim updates. **Patient Claim** is replaced with **View Claim**.
- With a fatal error - the claim has been rejected by the Medicare. An error code with a message is displayed and no statement is generated. The claim can be resubmitted once the error is fixed.

Deleting a Patient Claim

A request to delete a patient claim can be submitted to Medicare only if it is submitted on the same day as the claim has been successfully accepted by Medicare.

To submit the delete request:

Click **Delete Claim**.

> **Tip:**
> If the date of submitting the claim is different from the date on which the claim needs to be deleted then the Delete Claim button is not visible.

If required, you can resubmit a patient claim. A patient claim can be resubmitted only if:

- Patient Claim has been rejected by Medicare
- Patient Claim has been deleted (Same Day Delete)

To resubmit a Patient Claim, on the **Invoice** window click **Patient Claim**. If the claim cannot be resubmitted, the button is not visible.

Patient Claims - Interactive

Use the **Claims Status (Online Claiming) > Patient Claims** tab to manage interactive patient claims to Medicare.

Patient Claims are Medicare Claims lodged by patients who have received professional medical services, but have not assigned their rights to Medicare benefits to the Servicing Practitioner. Communicare supports Interactive Patient Claims which allows real-time processing of a single claim and is available during Medicare operating hours.

Patient claim encounter list

The patient claim encounter list shows all encounters for which an invoice has been generated and the patient claim has been transmitted to Medicare.

For each encounter, the following information is displayed:

- **Invoice no.** - the invoice number.
- **Encounter Date and Time** - the Start Date and Time on an encounter. If date only is used then this is the date of the encounter.
- **Claim ID** - unique identifier for a given month, which together with the date, identifies a claim within the online claiming system
- **Patient Name** - name of the patient for whom the claim is submitted. The patient's HCH Tier detail is highlighted if the patient is registered for HCH and the Tier is recorded.
- **Claimant Name** - claimant for the claim.
- **Claim Status** - current state of the specific claim.

  A patient claim can have one of the following states:
  - `Accepted`
  - `Batch Claim`
  - `Accepted - Pending Assessment`
  - `Rejected`
  - `Deleted`
  - `Discarded` - when a rejected claim is retransmitted, the original claim is discarded
- **Provider Name** - service provider name

Filtering the encounters list

Set filters to limit the number of claims displayed.

To filter the encounter list:

1. Apply one of more of the following filters:
    - **Claim ID** - enter a value to list claims that contain only the specified claim ID. Enter as much of the claim ID as required. For example, `P003` returns `P0031@`, `P0031@`... `P0039@`.
    - **Encounter Place** - select an encounter place from the list to display claims only for a specific Encounter Place
    - **Use Time Limit** - by default, only claims that are within the 2 year legal time limit imposed by Medicare Australia for electronically claimable services are displayed. Deselect to display all claims up to 50 years old.
    - **Minor ID** - select a minor location ID from the list to display claims only for that location ID.
    - **Claim Status** - select to display only those claims with a particular status
    - **Invoice No** - enter a value to display a claim associated with a particular invoice number
2. Click **Apply Filters**.

Only those encounters that meet the filter criteria are displayed.

To display all encounters again, click **Reset Filters**.

Claim details

Select a claim in the claim list to display details about that claim:

- **Result Text Message** - details of an attempt to send a claim, including reasons for failure to send.
- **Minor Location ID**, **Provider Number**, **Payee Provider Number**
- **Transmission Date** - the Date and Time when this claim was transmitted to Medicare Australia

Medicare reason codes

You can look up a Medicare reason code at http://www.medicareaustralia.gov.au/provider/vendors/reason-codes/medicare.shtml.

Private Billing

If your health service operates fully or partially as a private business, enable the **Private Billing** module so that your health service can bill a patient privately.

> **Note:**
> A standard activation fee applies. For more information, contact Communicare Support *(on page)*.

If your health service operates as a private clinic, you decide what fees to charge for the services you provide, and bill the patient directly for payment in full.

Some patients may be supported in paying their medical costs by third party insurers such as Medicare, WorkCover or their Private Health fund. Once they have paid for their clinic visit, they can claim and receive the relevant patient rebates for the services received, subsidising or covering all fees charged.

Charging private billing

When a clinician closes a clinical record, or service details are opened from the Service Recording, the **Medicare** tab is displayed

To change to private billing, on the **Detail** tab, set **Claim Type** to `Private`. This action changes the **Medicare** tab to the **Private** tab. See Service Record - Private *(on page 107)* for more information.

Managing private billing

To manage private billing invoices, select **File > Private Billing Administration**. See Private Billing Administration *(on page 449)* for more information.

A private billing invoice lists all items provided for a patient encounter that relate to a payer and the balance due. The 'Payer' field identifies who is going to pay for the service, that is, the individual or organisation who is responsible for the account, who may be different to the patient or recipient of the service. For all patients over 15 years of age, the patient is the default private payer. Update this default in Patient Biographics.

Payers for organisations must be included in the Communicare Address Book.

After a payment is made for the invoice, the payment received details are also displayed.

Private Billing Reports

To run reports on Private Billing Claims and Payments for any given date range, select **Report > Private Billing**.

Enable Private Billing

If your health service bills patients privately, enable the **Private Billing** module.

To enable your health service to privately bill patients for services, complete the following steps:

1. Activate the Private Billing module:
    a. Select **File > System Parameters > System** tab.
    b. Set **Private Billing**.
    c. In the confirmation window, to import your MBS Favourites into the private billing fee schedule, click **Yes**. You can adjust the fee schedule later.
    d. Click **Save**.
    e. Enter your authority code and click **Save**.
2. Assign user system rights:
    a. Select **File > User Groups**.
    b. Select the user group to which you want to assign billing user rights.
    c. Set one or both of the following options.

    > **Tip:**
    > The following rights apply to both private billing and Medicare bulk billing.

        - **Billing** - to allow in the user group to make claims
        - **Billing Administration** - to allow users in the user group to administer claims

    d. Click **Save**.
3. Set up at least one private billing type. See **File > Reference Tables > Private Billing > Billing Type**. See Billing Types *(on page 881)* for more information.
4. For each billing type that is an organisation, there must be a record in the address book. To add organisations for private billing to the address book, select **File > Address Book**. For more information, see Search for an address *(on page 335)*.
5. Set up the private billing fee schedule:

- If you added your MBS Favourites when you activated the module, edit these records. Otherwise, add each billing item individually.
- For each fee item, you can set a different fee for each billing type. For example, a private practice might charge $50 for a Standard Consultation to an individual and $75 for Workers Compensation because of the administrative tasks involved.
- Link a fee item to a Medicare Benefits Schedule (MBS) item so a patient can claim a Medicare refund for the linked MBS item. For example, a Private practice short consult can be linked to MBS Item 3 - Brief Consult Level A.
- To add and edit fee schedules, select **File > Reference Tables > Private Billing > Fee Schedule**. See Fee Schedule *(on page 879)* for more information.

Private Billing Administration

Use the **Private Billing Administration** window to manage invoices and associated transactions for privately billed services.

The **Private Billing Administration** window lists all invoices from the last 30 days and all charges without an invoice date. Charges raised without an invoice do not have an invoice date assigned.

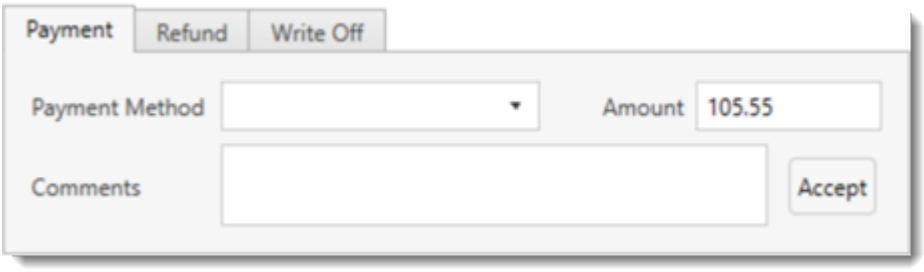
The **Private Billing Administration** window is refreshed automatically every 30 secs. Click **Refresh** to update the data immediately.

For each invoice, the following details are displayed:

- **Bill To** - the billing type to which the invoice is billed, for example, `Private`.
- **Invoice No** - the invoice number.
- **Invoice Date** - the date on which the invoice date was generated.
- **Patient Name** - the patient's full name. To display the patient's full details or update any patient information, click  View or Amend Patient Details.
- **Provider Name** - the provider for whom the invoice was billed.
- **Payer** - the full name of the person responsible for paying the invoice. To select a different payer, click  Add Payer. This option is disabled if the invoice is billed to a billing type of `Organization`.
- **Payer Address** - the address of the person or organisation responsible for paying the invoice.
- **Invoice Amount**
- **Amount Paid**
- **Balance Due** - Invoice Amount minus Amount Paid plus any Write Off
- **Invoice Status** - the status of the invoice depends on whether the invoice has been generated for the service, or the balance due, or if the invoice has been voided. An invoice might have one of the following statuses:
  - `No Invoice` - no invoice has been generated yet, but a charge may have been raised. All invoice-related fields will be blank if no billing information was recorded when the service was completed and the options are not available.
  - `Paid` - the invoice is fully paid.
  - `Outstanding` - the balance due for the invoice.
  - `Void` - the invoice has been voided or cancelled.
- **Invoice Transactions** - a list of all the transactions for the selected invoice. The invoice transactions are also displayed on the printed invoice.

Processing invoices

In the **Private Billing Administration** window, use the following options to process an invoice:



- **Payment** - accept payment for an unpaid or partially paid invoice. The Payment amount cannot be greater than the Balance Due amount.

  When you complete the payment, the invoice status is updated and a transaction of type `Payment` is added to the Invoice Transactions history.

  Payment cannot be accepted for a Paid or Void invoice.

- **Refund** - refund any amount paid against the invoice. The refund amount cannot be greater than the amount paid.

  When you complete the refund, the invoice status is updated and a transaction of type `Refund` is added to the Invoice Transactions history.

- **Write Off** - write off any balance due amount. The write off amount cannot be greater than the balance due amount. No Payer/Receiver or Payment/Refund method is recorded.

  When you complete the write off, the invoice status is updated and a transaction of type `Write Off` is added to the Invoice Transactions history.

Other invoice actions

In the **Private Billing Administration** window, you can also complete the following actions:

- To view and reprint the selected invoice using the invoice template selected in Printer Assignments, click **View/Print Invoice**. In the **Invoice** window:
  - To send an invoice securely to a recipient linked to an SMD vendor and enabled for secure messaging, click **Send Secure**. For more information, see Secure Messaging *(on page 341)*.
  - To submit a claim to Medicare for reimbursement or as partial payment, click **Patient Claim**.
- To view the service encounter details for the selected invoice, click **Encounter**. If there is no invoice attached, you can also edit the charge.
- To edit an invoice, by making it void and creating a new service record, click **Edit Invoice** and record a reason for the edit. Details of the original Service Record are displayed. After the details are edited and saved or a new invoice is generated, a new record is added to **Private Billing Administration**. The existing invoice is marked as void and the balance due is changed to 0.

  Invoices cannot be edited if any amount has been paid (part or full) against the selected invoice. Refund any paid amount before editing the invoice.

- To cancel an invoice, click **Void Invoice** and record the reason for the cancellation.

The Balance Due for voided invoices is set to 0. Invoices cannot be voided if there is any amount paid, either in part or full, against the selected invoice. First refund any amount paid.

Voided invoices are printed with a `VOID` watermark.

Add Patient Payer

In order to charge the patient for the service provided, Communicare maintains account holder details for the patient. You can add payers who are responsible for the account as required.

If your user group has Billing rights for the **Private Billing** module, you can use the **Patient Payer Management** window to add a new payer from a list of existing patients, or add a new payer who is not in the database.

To display the Patient Payer Management window, use one of the following approaches:

- From Patient Biographics:
    1. In the **Add or change patient biographic details** window, select a patient.
    2. In the **Change Person Details** window, on the **Administration** tab, click **Manage Payer(s)**.
- In the Service Record at completion of a service encounter:
    1. On the **Detail** tab, set **Private**.
    2. On the **Private** tab, click **Add Payer**.
- From Service Recording:
    1. In the **Service Recording** window, double-click a service.
    2. Click **Edit Service Details**'.
    3. On the **Detail** tab, set **Private**.
    4. On the **Private** tab, click **Add Payer**.
- If your user group has Billing Administration system rights, for an existing invoice, select **File > Private Billing Administration** and in the **Payer/Receiver** field, click Add Payer.

All patients over 15 years old are assumed to be the default payer, however you can specify a different payer. There can be only one default payer for a patient.

To add a payer:

1. In the **Patient Payer Management** window, click Add.
2. In the **Patient Search** window, enter details and search for the payer.
3. If the new payer does not exist in the database, click **New Patient**. The payer can be added as a non-patient. See Adding a New Patient *(on page 45)* for more information.
4. Otherwise, select a patient from the list of existing patients and click **Select Patient**. The selected patient is added to the list of payers.
5. If you want to make the person you just entered responsible for all accounts for the patient, in the **Patient Payer Management** window, set **Default Payer**.
6. If required, from the **Payment Method** list, select the payer's preferred payment method.
7. Click Save.

If selected as the default payer, the new payer is listed in the **Payer** field for that patient whenever a payment window is displayed.

Reports

Communicare has extensive reporting features.

To access reports, select **Report >** *required report*.

Communicare's reports are an invaluable management tool with varying levels of user configurability. These include:

- Standard reports - designed and defined by Communicare with minimum user input
- Patient Query reports - enable you to define specific criteria and values
- Query Builder *(on page 576)* - a sophisticated query by example (QBE) module included with Communicare
- SQL Reports - distributed with Communicare or developed by power users

An icon is displayed next to each report name to identify the type of report:

Table 142. Types of report

Icon	Report type	Colour	Description
	Hard-coded report	White	Hard-coded queries are built into the Communicare code and cannot be imported, exported or modified. They have set permission rights.
	Central SQL query	Blue	Central SQL reports are maintained and distributed by Communicare. These reports are overwritten with the latest version every time Communicare is upgraded. They can be modified by updating the parameters, outputs and additional access rights. If you update a Central report, you must change the report name to ensure that it is not overwritten at the next Communicare upgrade. System Administrators may update a central report without changing its name, however it will be overwritten by the new central version of the report the next time Communicare is upgraded.
	Local SQL query	Yellow	If a new SQL query is created, or a central SQL query is modified at the SQL level, the report becomes 'local' and the icon changes to yellow. **Note:** If a central SQL query's SQL is modified and it was not cloned first, the report name should be altered or it will be overwritten during an upgrade.
	Query Builder report	White	

All Communicare reports are consistent in their layout and appearance. The name of the report is displayed at the top of each page with any report options specified for the report. At the bottom of each page the date and time the report was produced shows at the centre; and the page number is on the right.

User access to SQL reports

Access to SQL reports is restricted in the following ways:

- To access central SQL and local SQL reports, your user group requires both `Management Reporting` and `Clinical Reporting` system rights at a minimum.
- Some SQL reports have an additional system right specified by default. For example, the central SQL reports under **Report > Appointments** also require the `Appointments` system right.
- Some SQL reports have defined viewing rights or system rights. For example, the Conditions SQL reports may be configured to have an additional requirement for the `Clinical Records` system right. This means your user group requires the following system rights to run any Conditions report:
  - `Management Reporting`
  - `Clinical Reporting`
  - `Clinical Records`
- A small number of SQL reports, such as some in **Report > Reference Tables > Clinical Item** can only be run by users in the `System Administrators` user group. Administrator-only reports have the text `ONLY ADMINISTRATOR CAN RUN THIS REPORT` at the bottom of the report description.
- Viewing Rights and Program Rights

  When a report is run, the current user's Viewing Rights and Program Rights are respected in the output. For example, you run a condition report which shows a list of presentations of selected conditions. If your user group doesn't have the `Psychological` viewing right set, the output won't display any conditions attached to the `Psychological` viewing right, such as `Depression`.

  Note:
  For scheduled reports, Viewing Rights and Program Rights are ignored and the full report is generated. The report scheduler has no understanding of the Viewing Rights or Program Rights associated with the email recipient list.

User access to hard-coded reports

Access to hard-coded reports is restricted in the following ways:

- All users have access to the hard-coded reports in **Report > Reference Tables**
- Users who belong to the `System Administrators` user group have access only to **Report > Headspace > Data export**.
- For other hard-coded reports, the system rights set for the user group *(on page 842)* to which you belong determine which reports you can access.

Table 143. System rights required for access to hard-coded reports reports

Report > Group System	System Right Required
Report > Appointments	Appointments
Report > Clinical Attendance	Management Reporting
Report > Encounter Analysis	
Report > Population Analysis	
Report > Procedures	

Table 143. System rights required for access to hard-coded reports reports (continued)

Report > Group System	System Right Required
Report > Referrals	
Report > Patients > Births	
Report > Patients > Deaths	
Report > Patients > Patient Card Numbers	
Report > Patients > Patient Query	
Report > Conditions	Clinical Reporting
Report > Immunisations	
Report > Medications	
Report > Recalls	
Report > Patients > Patient Summary	
Report > Patients > Patient Labels	Biographics

Modifying reports

To create a new query, modify a query, export or import a query, the user group to which you belong requires the `Report Administration` system right.

If an SQL report is disabled or was created by a user who has made it `not public`, it cannot be seen by other users.

Running Communicare reports

To run a report:

1. Select **Report >** *report required*.
2. Alternatively, if you don't know which report you need, select **Report > Search Reports**. See Report Search *(on page 455)* for more information.
3. Read the detailed description and click one of the buttons:
    - **Yes** - run the report to produce a printable report suitably laid out with title and details
    - **No** - cancel the operation and don't run the report
    - **Export** - open and display the results in Microsoft Excel if this program is installed on your computer
    - **Advanced** - open the results in a grid with options at the bottom to edit the printable layout (and preview the results) or export the results with user-defined selections.
4. Enter the required parameters and click **OK**.

Requesting a new Communicare report

To request that Communicare creates a new SQL report for your system, submit a Report Request.

Reports Search

If you can't remember the name or categorisation of the report you need, you can search for it using keywords. You can also use the Reports Search window to run the same report multiple times without having to search for it again.

To search for a report:

1. Select **Report > Search Reports**.
2. If you have previously added the report you need to your favourites, select **Show favourites**.
3. In the **Reports Search** window, in the **Search** field, enter a search term, for example, `pregnancy`. The report pane lists all reports that contain the search term, either in the report title or the comments. The search term is not case sensitive.
4. Select the report you need. The report description is displayed in the right pane.
5. If you're likely to need this report often, click **Add to Favourites**. Your favourites are unique to you and aren't reflected in other user's **Report Search** window.
6. Double-click the report, or click **Open Report** to open the selected report.
7. Click **Yes** to run the report, or **Export** to export the report to Microsoft Excel.

Administrators can right-click a report and select **Edit Report** to edit the report in the SQL Report Editor. See Edit SQL Reports *(on page 583)* for more information.

Report Options

Selection Options, or selection criteria, determine the content of the report.

Not all options are available or apply to all reports. For example, a patient age option makes no sense on a birth weight report. The following options are those which are commonly available for Communicare reports.

Selection Options

Common selection options are:

- From Date - Restrict to items occurring on or after a certain date.
- To Date - Restrict to items occurring on or before a certain date.
- From Age - Include patients greater than or equal to this age in years.
- To Age - Include patients less than or equal to this age in years.
- Specific Locality - restricts a report to patients whose residence is in a particular Locality.
- Locality_Group - restricts a report to patients whose residence in any one of a group of localities.
- All Localities - includes all patients irrespective of where they currently live.
- Special. If the Check Box or Lookup options have been named in the System_Parameters (Patient tab) then they are available as report selections.

Print Options

Print options control the detail included in a report.

Common print options are:

- Totals only - Suppress all detail and print only the total values.
- Include addresses.

Grouping Options

Grouping options allow information to be grouped by a particular value such as locality, i.e. all information applicable to the grouping is shown together. In general, sub-totals for each grouping are also shown.

Ordering Options

Ordering options control the value or values used to sequence information shown in a report.

Word Processor Merge File

The **Write Word Processor Merge File** option creates a comma delimited text file suitable for merging into a Word processor document to create a mail out.

When the report is run, the **Save Word Processor Merge File** dialog displays. Select the desired folder/directory and enter a file name and click on Save. The merge file is created and the report is also produced.

When the merge file has been created, start the word processor (Microsoft Word or WordPerfect) and create the merge document. The fields in the merge file are not named because different word processors use different field naming mechanisms.

The fields in the merge file are as follows:

- Patient's preferred name forenames
- Patient's preferred name family name
- Current home address line 1
- Current home address line 2
- Current home address locality name (suburb)
- Current home address state
- Current home address post code
- Current home telephone no.

Note:
Any commas present, for example in the address lines, are replaced by spaces.

Exporting Queries

If required, you can export a report to Microsoft Excel or other alternative formats.

Usually a QueryBuilder or SQL report is run and a printable display is presented to the user. The layout of the report is designed to be printed. However, sometimes the data is required in a different format, for example for electronic distribution to non-Communicare users or for further manipulation in a program other than Communicare.

Query results may be exported in several ways:

- Export straight to Microsoft Excel:

  Run a report and select **Export**. If you have Excel installed on your computer, it opens with the exported data displayed in the table. You can manipulate and save this data using Excel. This is the easiest way to export data from a Communicare report.

- Advanced export, where you can select the data exported and the format:
  1. Run a report and select **Advanced**. The results are displayed in a grid.
  2. In the **Results** window, click **Export data**.
  3. Transfer the required data from the Source fields to the Destination window and click **Next**.
  4. Select the required program format type and click **Next**. For example, select **Excel (DDE)** to produce an Excel spreadsheet; **ASCII** to create a text file with various options presented in the next window.

> **Tip:**
> Take care to change the default date format from `MM/DD/YYYY` to `DD/MM/YYYY` and to declare a file name.

5. Verify the number of records and click **Export**.

- Alternatively, click **Export** in the Advanced results

The exporting process will begin and on completion a success message will be displayed.

- Save the printout of the report
  1. Run a report.
  2. In results window, click  Save Report.
  3. In the **Save report** window, save as an HTML document (*.HTM), Excel spreadsheet (*.XLS), RTF File (*.RTF), Comma Separated (*.CSV), Text file (*.TXT) or Simple XML Document (*.XML).

> **Note:**
> This approach saves the printed layout and may not include all the raw data, especially if the layout includes headings and subheadings and the CSV option is chosen. For a comprehensive export of all raw data use Export instead.

Charts

Communicare Charts display numeric data in an easy to read graphical format.

Most charts support the following features:

- **Legend** - the key that names each line on the chart. Set or clear **Legend** to display or hide the legend.
- **Labels** - display the actual measurement value for each point on the chart. Set or clear **Labels** to display or hide the labels.
- **Print** - prints a paper copy of the chart.
- **Zoom** - zoom in on any area of a chart by dragging from left to right across the area to be viewed. Drag from right to left across any part of the chart to zoom out again.

Aboriginality Chart

This report produces a pie chart of the patient population make-up analysed by Aboriginality.

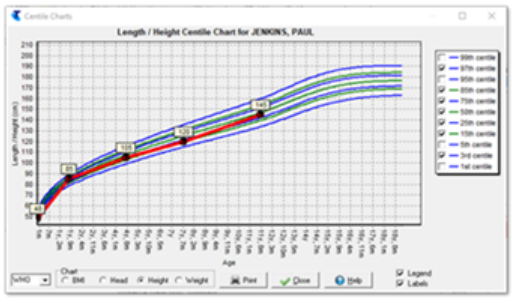
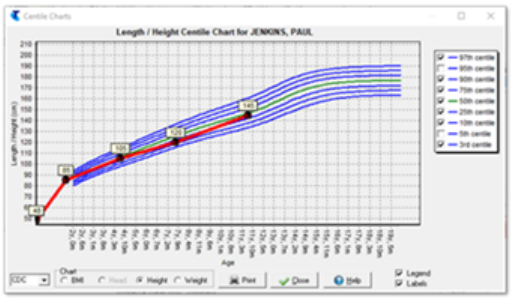
Find this report at **Report > Population Analysis > Aboriginality Chart**.

Centile Chart

From a child's clinical record, you can display a graphical representation of the child development growth charts with the child's measurements recorded in clinical items plotted.

Communicare's child growth charts are based on either WHO or CDC datasets.

Table 144. Comparison of CDC and WHO centile charts

	WHO	CDC
Dataset	2007 child growth data published by the World Health Organisation. For more information, see http://www.who.int/childgrowth/en/ and http://www.who.int/growthref/en/	2000 child growth charts published by the Centre for disease control and prevention (CDC)
Data starts from	Birth	2 years* **Note:**
Data includes	BMI, Height, Weight, Head Circumference	BMI, Height, Weight
Centiles	1, 3, 5, 15, 25, 50, 75, 85, 95, 97, 99	3, 5, 10, 25, 50, 75, 90, 95, 97
Example		

Notice:
No warranty is given or implied as to the accuracy or validity of the child development data or chart presentation. The responsibility for the use and interpretation of these charts lies with the user. In no event shall Telstra Health be liable for damages arising from their use.

Centile charts show the position of a measured parameter within a statistical distribution and are useful for plotting changing parameters, such as assessing a child's height or weight over time. They do not show if a parameter is normal or abnormal, rather how it compares with that measurement in other individuals. For example, if a child's height is on the 25th centile, for every 100 children of that age, 25 would be expected to be shorter and 75 taller.

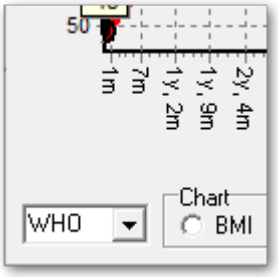
Tip:

- The patient's measurements are plotted if they are recorded in a clinical item such as `Check up;height/weight` that includes measurement qualifiers for height, weight and head circumference (WHO only).
- The Weight chart includes a birth weight if one has been entered in biographics or the `Birth details` clinical item.
- The centile charts are appropriate for the sex of the patient. If sex is not recorded, no centile charts are displayed.
- BMI is plotted only if it has been calculated in a clinical item.
- The length/height-for-age charts are discontinuous between 730 and 731 days, where the measurement changes from recumbent length to standing height at the age of two years.
- *Communicare does not publish CDC data for children younger than 2 years. The CDC itself states: *"The WHO growth standards are recommended for use with children younger than aged 2 years"*. (Using the WHO Growth Charts: Recommendations) The CDC further states:

> “
>
> Using the WHO growth standard for infants and children birth to aged 2 years has several advantages over the CDC growth reference for children of the same age including:
> - The WHO growth standard charts utilize growth of the breastfed infant as the norm for growth.
> - The WHO standards are based on high quality data collected for children younger than aged 2 years.
>
> ”
>
> (Using the WHO Growth Charts: Summary)

To view the centile charts, in the patient's clinical record, on the toolbar, click **Charts > Centile**.

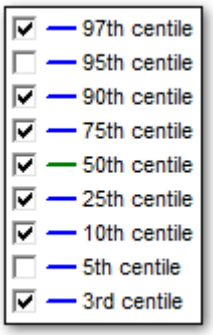
To change the data set, from the list, select either **WHO** or **CDC**. For example, `WHO`:



In the **Chart** section, set the chart that you want to display. For example, `Height`:

> **Tip:**
> To zoom in on the chart, click and drag from top-left to bottom-right on the area of interest. Zoom out by dragging in the opposite direction.

Use the centile key to select the centile lines you want displayed on the chart. For example, for CDC:



To hide the centile key, deselect **Legend**.

To remove labels for the child's measurements, deselect **Labels**.

Preterm Centile Chart

Charts for head circumference, height (length) and weight can be viewed for children who were born preterm.

Preterm Centile charts are based on the *Fenton 2013 Preterm charts*.

In order to graph patient data, the following information must exist for the patient:

- Patient Biographics:
  - Date of Birth
  - Sex
- Birth details recorded in the **Birth Details** clinical item:
  - Height
  - Weight
  - Head circumference
  - Gestational age at birth - if weeks and days are known, enter the weeks as a whole number and days as a decimal, rounded to 1 decimal place. For example, for 31/40 + 4 enter 31.6.
    - 0.1 for one day
    - 0.3 for two days
    - 0.4 for three days
    - 0.6 for four days
    - 0.7 for five days
    - 0.9 for six days
- Any clinical items containing child growth information:
  - Height
  - Weight
  - Head circumference

To display a child's preterm centile chart, in their clinical record, on the toolbar select  **Charts > Preterm Centile**.

Qualifiers Chart

Qualifier charts can be used to plot numeric qualifier data for a patient.

Chart types define the sort of patient data that can be plotted together on a chart. Any number of chart types can be defined.

To display a qualifier chart:

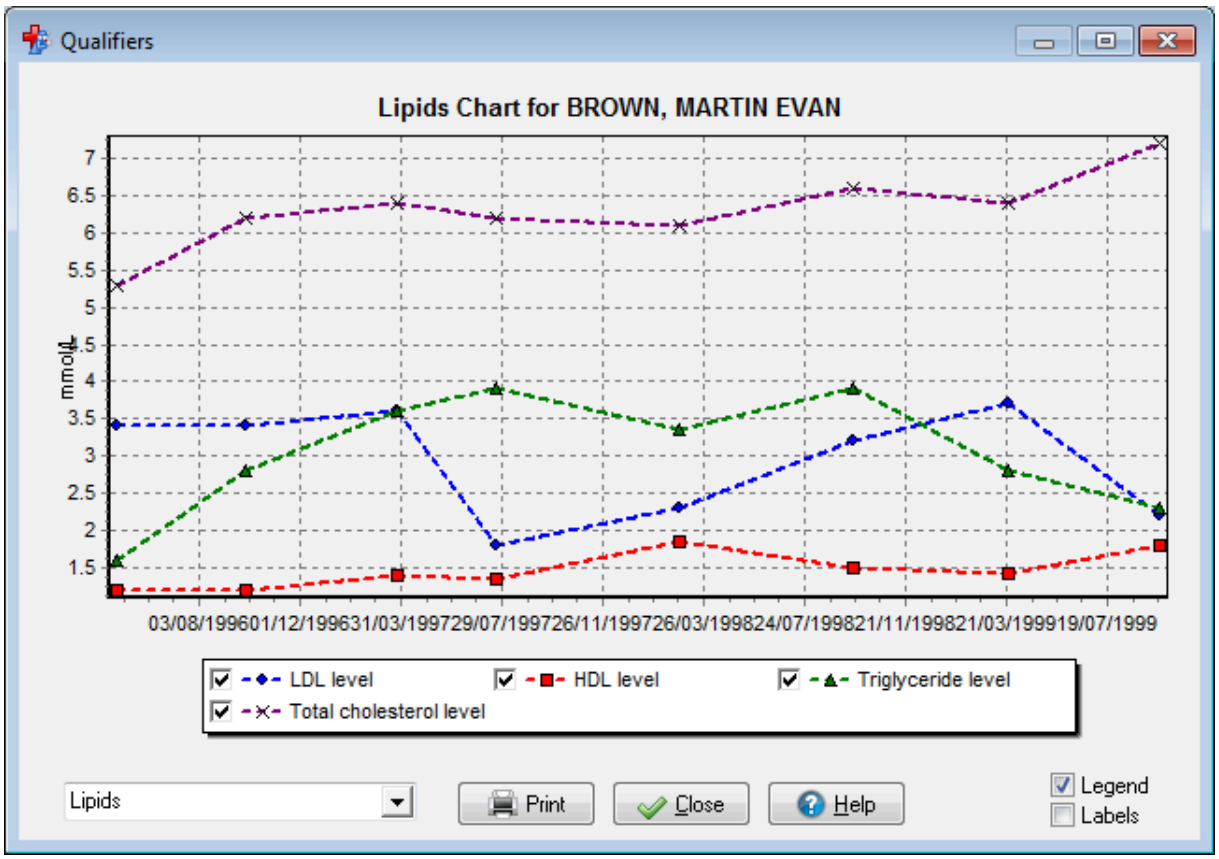
1. In a patient's clinical record, on the toolbar select  **Charts > Qualifiers**.
2. In the **Qualifiers** chart, from list at the bottom-right, select the chart type you want to display.

   The list includes only the chart types for which there is data for this patient. For example, the Blood Pressure chart will not appear on the list if the patient has no Blood Pressure on record. If the patient has no data which corresponds to any chart then a message is displayed and the chart window does not open.
3. In the legend, set which measures you want to hide or show.

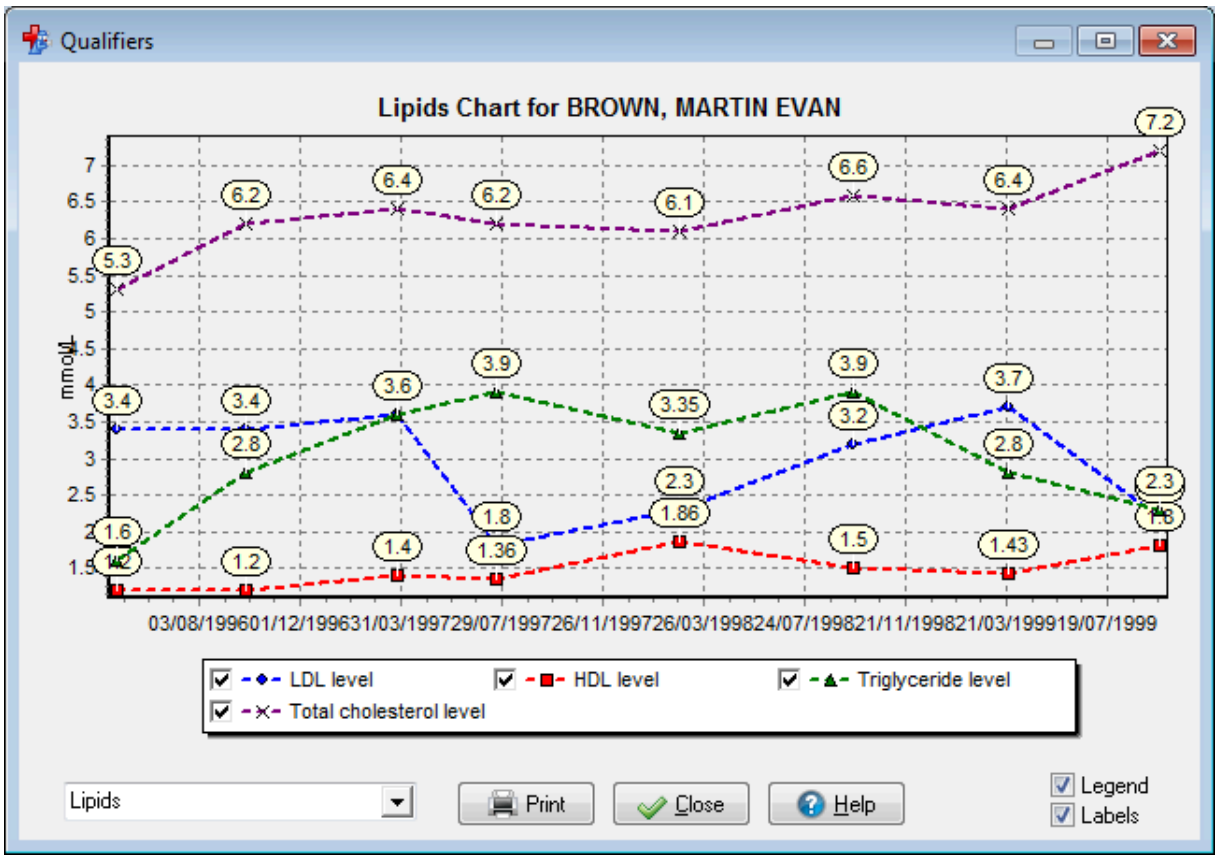
Tip:

Values which appear as *greater than* (>) or *less than* (<) are displayed with a different point marker. Use the legend to help you identify *greater than* values, which have an upward pointing yellow triangle, and *less than* values with a downward pointing yellow triangle, for example, eGFR values >90. If the values are *greater than or equal to* (>=) or *less than or equal to* (<=) the colour of the triangle is green.

For example, a Lipids chart with a selectable legend:



eGFR example displaying >90 values:



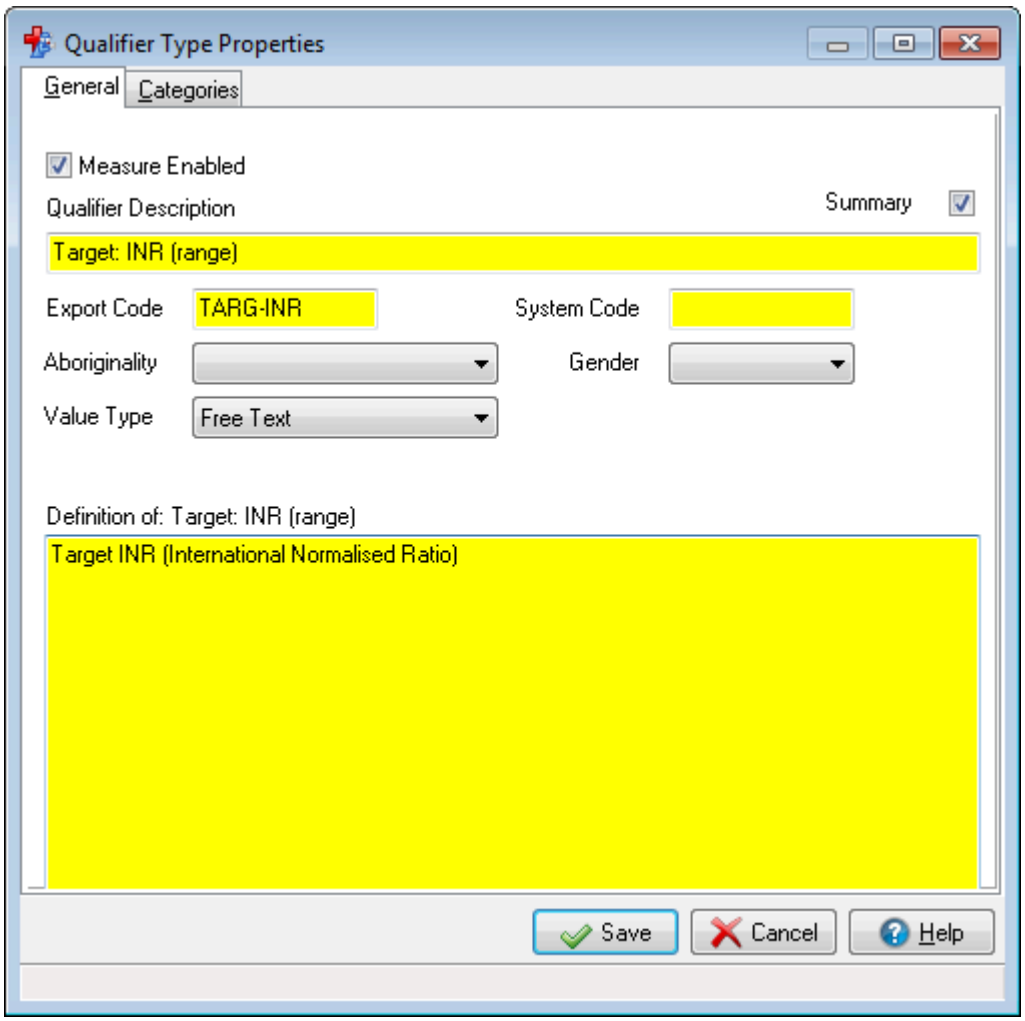
INR Chart

This report prints the current (latest) Target INR (International Normalised Ratio) value and date and displays a table containing historical dates with INR values and warfarin dosages with the associated clinical item comment.

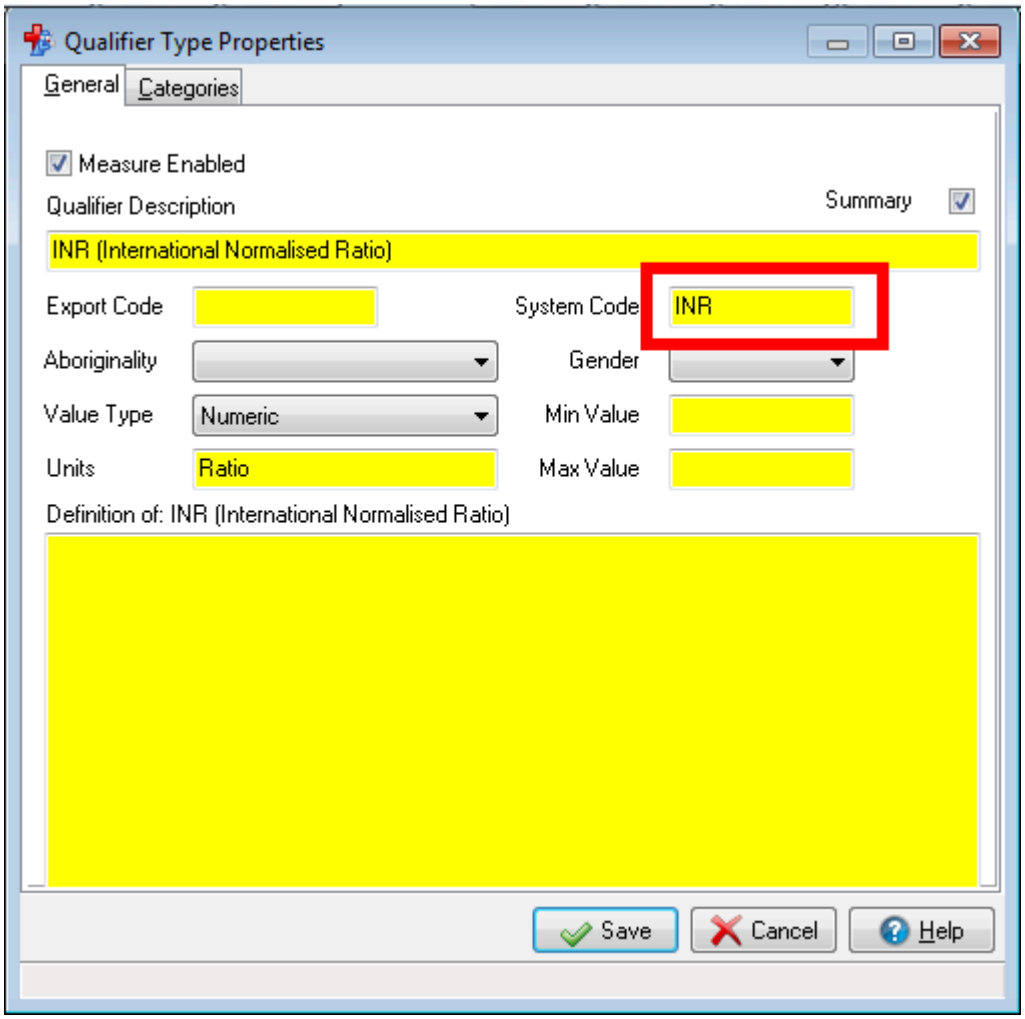
For a date and comment to be included, a clinical item must have one of the following qualifiers with a recorded value: INR, Target INR, Warfarin dose.

The report will print for the current patient if printed from the Clinical Record or will prompt for patient selection of launched from the report menu or report search screen.

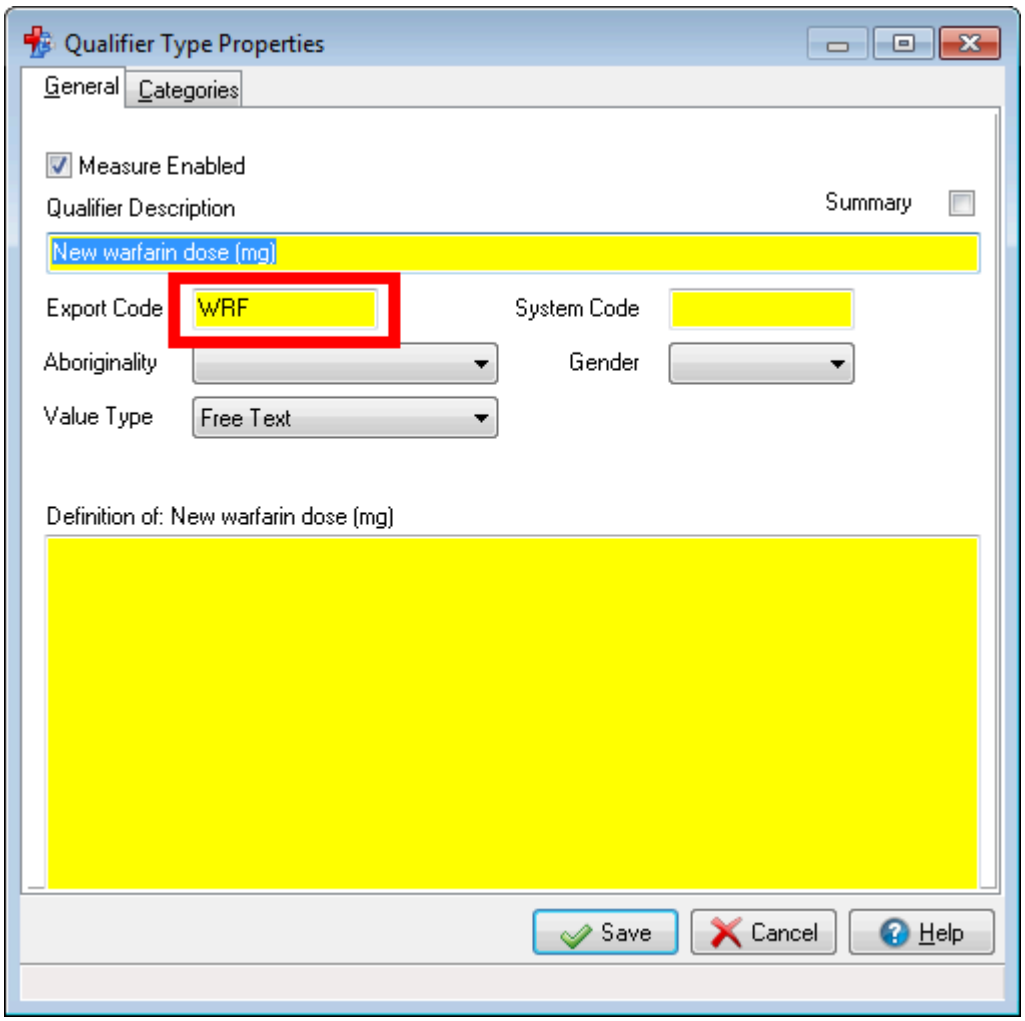
The Target INR value is calculated as the latest measure value for a qualifier with an export code of `TARG-INR`.



The INR values shown in the table are values for qualifiers for the central INR qualifier or any qualifier with the system code of `INR`.



The Warfarin dosages shown are any qualifier values associated with the export code of WRF. Warfarin dosages will look at the text value and then the numeric value of the measure if no text value is present.



To display a patient's INR chart, in their clinical record, on the toolbar select **Charts > INR Chart**.

Special Project Reports

Special Project reports are those written to address specific reporting requirements from various programs, projects and agencies.

Most reports are distributed as part of each Communicare release. They can be made `not public` by your Administrator if the reports are not required.

Where indicated, some reports are not distributed but are available on request.

ABCD / One21seventy Reporting

This report addresses the clinical audit to be performed at clinics participating in ABCD and One21seventy reporting (Menzies School of Health Research).

To run this report, select **Report > ABCD One21seventy > Clinical Audit Protocol**.

ABCD and One21seventy clinical audit eligibility criteria:

- Diabetes Type 11 Audit (Vascular and Metabolic)

  Be a Regular Client of the service, =>15 years and have a condition with ICPC code T90.

- Coronary Heart Disease (Vascular and Metabolic)

  Be a Regular Client of the service, =>15 years and have a condition with ICPC codes K74 - 77.

- Chronic Heart Failure (Vascular and Metabolic)

  Be a Regular Client of the service, =>15 years and have 4 or more symptoms with ICPC codes A04, A11, K01-K03, K05, K07, K22, K29, K85, K87, K90, K99, N05, R02, R05.

- Renal Disease (Vascular and Metabolic)

  Be a Regular Client of the service, =>15 years and have a condition with ICPC codes U14, U28 and U88.

- Hypertension (Vascular and Metabolic)

  Be a Regular Client of the service, =>15 years and have a condition with ICPC codes K85 - 87.

- Acute Rheumatic Fever and Rheumatic Heart Disease

  Be a Regular Client of the service and have a condition with ICPC codes K71.

- Preventive Audit

  Be a Regular Client of the service, =>15 and <65 years old and not have diagnoses of Diabetes Type II, Hypertension, Coronary Heart Disease, Chronic Heart Failure, Acute Rheumatic Fever/Rheumatic Heart Disease (ARF/RHD) or Renal Disease. Not be pregnant or less than 6 weeks post partum at time of audit.

- Maternal Health Clinical Audit

  Be a Regular Client of the service and have an infant aged =>2 months and <14 months.

- Child Health Clinical Audit

  Be a Regular Client of the service and between 3 months and <15 years.

- Mental Health Clinical Audit

  Be a Regular Client of the service,=>16 years and have a condition with ICPC codes P71-P82, P86, P98 or P99.

ANFPP reporting

ANFPP reports are made available with the ANFPP dataset.

The Australian Nurse Family Partnership Program (ANFPP) dataset is available to health services registered as ANFPP providers. Any required reports are distributed directly by the ANFPP or can also be requested from Communicare Support. Once enabled, ANFPP reports can be found at **Report > ANFPP**. For more information, see Australian Nurse-Family Partnership Program *(on page 378)*.

APCC Reporting

Communicare supports the Australian Primary Care Collaboratives reporting on Program Topic Measures. The current reports support the April 2009 specifications.

Requirements

The ICPC-2 PLUS dataset must be used to code conditions. Any imported data or local terms need to be coded with a suitable ICPC-2 PLUS code.

The MIMS database must be used to prescribe medications.

All patients to be included in the APCC reports must have a status of current patient and have a date of birth and sex.

The following qualifiers must be 'summary' qualifiers: ACR (alb/creat/ratio), BP Systolic blood pressure, BP Diastolic blood pressure, HbA1c, Smoking status, Total cholesterol level. If you use an alternative to Smoking status then it must have a system code of SMO and the reference measures must have the following system codes: S for smokers, N for non-smoker (i.e. never smoked) and E for ex-smokers.

The Communicare value added clinical item Cycle of care;diabetes;annual (or a local item made of the same central qualifiers) needs to be used to record how much of the cycle of care has been recorded.

The Communicare Smoking status qualifier should be used to record smoking status. However, a local qualifier can be used so long as it is a reference type qualifier and has the system code of SMO and the references have current smoking statuses with a system code of S, ex-smoker statuses with a system code of E and non-smoking (never smoked) statuses with a system code of N.

Definitions

- CHD: Any diagnosis with the ICPC code of K74, K75, K76, K53 or K54.
- Diabetes: Any diagnosis with the ICPC code of T89 or T90.
- COAD: Any diagnosis with the ICPC code of R95.
- Anti-platelets: Any current or regular prescription for a drug in the MIMS class 39.
- Statins: Any current or regular prescription for a drug in the MIMS class 92.
- ACE/ARB: Any current or regular prescription for a drug in the MIMS class 405, 838 or 189.
- Influenza: Any completed item with the export code 'FLUVAX'.
- Pneumovax: Any completed item with the export code 'PNEUMO'.
- Pap smear: Any investigation request called 'Pap smear'.
- Breast Screen: Any completed item with the export code 'BREAST'.
- Spirometry: Any completed item with the export code 'SPIRO'.

Reports

There are nine reports to be found at **Report > APCC**:

- All the Measures: This report can be run for a specified locality group, or all locality groups. Options are to include the summary data, for manual submission, or the full data. This report is comprehensive and may take some time to run.
- These reports are sections of the above report and may be more suitable to run separately for large databases:
    - CHD Measures: This is the CHD section only, details as above.
    - Diabetes Measures: This is the Diabetes section only, details as above.
    - COPD Measures: This is the COPD section only, details as above.
    - General Measures: This is the General section only, details as above.
    -
- These reports provide the patient names for the data supplied above and can be used to verify the data:

- CHD Patients: This report offers the user a selected locality group and a selected item from the CHD Measures report and will present a list of patients that satisfy the criteria for that item. For example, 001 CHD Register gives the full list of current CHD patients.
- Diabetes Patients: These are the Diabetes patients only, details as above.
- COPD Patients: These are the COPD patients only, details as above.
- General Patients: These are the General patients only, details as above.

BTH and Link Up Reporting

Audit Bringing them Home and Link Up questions.

Table 145. BTH and Link Up reports

Report > Admissions	Description
Admissions Report	Lists clients who are included on the Bringing them Home (BTH) and Link Up questions on the OATSIH Services Reporting questionnaire. A client is listed only once even if they have multiple services. A client's generational status is recorded on a qualifier which is usually associated with BTH Counselling, but many be associated with any appropriate type of clinical item. The qualifier is called 'Stolen generation'. A client is considered to be a BTH or Link Up client if they have been serviced at a "BTH" or "Link Up" encounter place or as part of a "Bringing Them Home", "BTH" or "Link Up" encounter program, during the selected reporting period. Use this report to audit your OSR BTH and Link Up questions.

Child Health Check Initiative Reporting

Communicare provides a special dataset with a clinical item designed to capture data recorded on form 2224 (0709) from the Department of Health and Ageing.

Using the Dataset

Sites participating in the Northern Territory Child Health Check Initiative will need to arrange with Communicare to have the CHC Initiative dataset imported so that data can be recorded in the clinical item NT Aboriginal and Torres Strait Islander Child Health Check. In addition there are some reports and a letter template that need to be imported or enabled.

Recording the data

To initiate a child health check, the NT Aboriginal and Torres Strait Islander Child Health Check item should be selected from the Check up button in the child's clinical record. Until the NT Child Health Check Status qualifier is set to Ready to send to AIHW the item will be deemed incomplete and a recall will be created. Subsequent additions to this check should be done by double-clicking on the recall.

When the NT Child Health Check Status qualifier is set to Ready to send to AIHW the data will be submitted securely to AIHW the following evening. This action can be delayed by locating the compete item on the detail tab and deleting the Ready to send to AIHW qualifier. The complete item will become incomplete.

If a parent requires a written copy of the major health problems and issues and intervention/action recommendations, select the Save & Write Letter button and choose the template CHCI Parental Report.

To re-send after further amendments, locate the complete item on the detail tab, make your amendments and then change the status from Sent to AIHW to Ready to send to AIHW.

Reporting on the data

The Communicare database will send the data securely using Argus. To do this the report **CHC Initiative > Daily Extract** must exist and be scheduled to send the results in xml format securely to AIHW. Once a check has been sent the NT Child Health Check Status qualifier is set to Sent to AIHW automatically.

Reports to run on a regular basis for internal reporting can be found at **Report > CHC Initiative**.

DATS NSW Reports

NSW Drug and Alcohol Coordinators should run the DATS NSW reports to create the files for monthly submission to the Centre for Drug and Alcohol, NSW Department of Health no later than the 21st day of the month following the month of data collection.

To run a report:

1. As an Adminsitrator, select **Report > DATS NSW >** *required report*.
2. Click **Advanced**.
3. Complete the fields and click **OK**.
4. In the Query Results window, click Export data.
5. Click select all to select all fields and move them to the **Destination table fields** list, and click **Next**.
6. For the **Destination type**, set **ASCII** and click **Next**.
7. In the **Destination Parameters** window:
    a. Set **Delimit numeric fields**.
    b. In the **File name** field, enter the filepath and file name for this report (refer to Table 146: DATS NSW reports *(on page 470)*. For example, `C:\DATS\202208\episode.txt`.
    c. Click **Next**.
8. Enter the number of records to export. Ensure that the number of records to export matches the source number of records
9. Click **Export**.

Table 146. DATS NSW reports

Report > DATS NSW	Description
Monthly Episodes Export	Creates the `episode.txt` file for monthly submission. All fields and records are exported in ASCII format using the filename `episode.txt` (in lower case).
Monthly Other Drugs Export	Creates the `otherdrg.txt` file for monthly submission. All fields and records should be exported in ASCII format using the filename `otherdrg.txt` (in lower case).

Table 146. DATS NSW reports (continued)

Report > DATS NSW	Description
Monthly Other Services Export	Creates the `othersrv.txt` file for monthly submission. All fields and records should be exported in ASCII format using the filename `othersrv.txt` (in lower case).
Monthly Pharmacotherapy Type Export	Creates the `pharmaco.txt` file for monthly submission. All fields and records should be exported in ASCII format using the filename `pharmaco.txt` (in lower case).
Monthly Previous Services Export	Creates the `prevtrmt.txt` file for monthly submission. All fields and records should be exported in ASCII format using the filename `prevtrmt.txt` (in lower case).
Monthly Service Contacts Export	Creates the `srvccnct.txt` file for monthly submission. All fields and records should be exported in ASCII format using the filename `srvccnct.txt` (in lower case).

Flinders Care Plan reports

Flinders program reports are made available with the `Flinders Care Plan` dataset.

For health services that are part of the *Flinders Program* and that have undertaken training with the Flinders University, S.A., the `Flinders Care Plan` dataset is made available.

This dataset includes the **Flinders CTG** reports:

- **Analysis Report** - identifies all patients with a Flinders Care Plan and the status of that plan
- **Recalls Due** - patient details for patients with a recall for any Flinders My Health Story or Tobacco care plan items overdue or due in the next specified time period
- **Target Population** - identifies all current patients aged 8 - 95 years for a selected locality group

Reports can be found at **Report > Flinders CTG**.

HACC Reporting

Communicare supplies datasets for recording Home and Community Care data and reports for data export.

The Home and Community Care (HACC) Program is a central element of the Australian Government's aged care policy, providing community care services to frail aged and younger people with disabilities, and their carers.

For more information, see Home Support Programs *(on page 383)*.

Technical Support for HACC

Ring 1800-638-427 or email mdssupport@haccmds.gov.au.

Headspace Data Export

This program creates the seven data export files required for Headspace reporting. It must be used only in conjunction with the Headspace dataset.

Before you can record Headspace encounters or report on them, the Headspace dataset must be imported into the Communicare database and enabled. For more information, see Headspace *(on page 393)*.

To export the report:

1. Select **Report > Headspace > Data Export**.
2. In the Data Export tool, log on.
3. Enter a date range for the data to include in the export and a destination folder. You are warned if export files already exist in the destination folder.

Healthy for Life Reporting

Communicare provides reports to cover the essential indicators required for Healthy for Life. The current reports satisfy the Version 3.1 (January, 2008) Healthy for Life software requirements.

The reports depend on all regular Aboriginal clients having a status of Current Patient and having their Aboriginality recorded as Aboriginal, Torres Strait Islander or Aboriginal & T.I.

Maternal/Antenatal

The five reports in this section require that users use the pregnancy clinical items and qualifiers provided by ICPC-2 PLUS as part of the ICPC2 dataset and the pregnancy items provided by Communicare as part of the Communicare Value Added dataset. Your administrator can check the system parameters to see if these datasets have been imported into your system.

These reports need to find data relating to the start and end of pregnancies, pregnancy number, gestation, Aboriginality of the father, baby's birth weight, and the smoking, alcohol and illicit drug use of the mother at various stages of the pregnancy. It is extremely unlikely that these reports will yield any meaningful retrospective data without a careful survey of how this information has been collected in the past. Communicare can advise you on this process.

Childhood Health

These reports depend on the site claiming item 715 electronically for completed child health checks and the completion of immunisation and immunisation review recalls for children. Sites that do not use immunisation recalls or immunisation review recalls will find that 100% of their children are fully immunised.

Sites that use alternative child health checks and do not claim Medicare items must code their child health check with the system code CHC.

Adult Health

This report depends on the site claiming the Medicare Aboriginal health check items electronically for completed adult health checks. The report reports on item 715 and breaks into adult (the old item 710) and aged (the old 704 and 706) based on age (15-54 and over 55s).

Sites that use alternative adult health checks and do not claim Medicare items must code their adult health check with the system code AHC (for 15-54 year olds) or OHC (for 55 year olds and older).

Chronic Disease

These reports depend on the site claiming items 721 and 723 electronically for completed care plans and on all current patients with diabetes or coronary heart disease having the condition recorded in Communicare using a clinical item with an appropriate ICPC-2 PLUS code. APCC sites should already have these conditions recorded appropriately.

Sites that use alternative care plans and do not claim Medicare items must select the clinical item that they use to record a completed care plan.

Diabetes

These reports depend on all current patients with diabetes having the condition recorded in Communicare using a clinical item with an appropriate ICPC-2 PLUS code. APCC sites should already have these conditions recorded appropriately. HbA1c results must be recorded in a qualifier (this is done automatically for sites receiving pathology results electronically in HL7 format) and blood pressure must also be recorded in the appropriate qualifiers.

The report shows HbA1c results received electronically from a pathology lab and also those recorded regardless of the source. This allows clinics that measure their own HbA1c to report appropriate figures.

Diabetes definitions: at the time of writing the report looks for any condition with the ICPC code T90:

Diabetes;Type 2 Diabetes mellitus	Diabetes;adult onset Diabetes;non insulin depend	Diabetes;Type 2;insulin treate

Coronary Heart Disease

These reports depend on all current patients with coronary heart disease having the condition recorded in Communicare using a clinical item with an appropriate ICPC-2 PLUS code. APCC sites should already have these conditions recorded appropriately. Blood pressures must also be recorded in the appropriate qualifiers.

CHD definitions: at the time of writing the reports look for any condition or procedure defined by APCC as a coronary heart disease or relating to a coronary heart disease:

Aneurysm;artery;coronary Angina pectoris Angina;unstable Angioplasty;artery;coronary Cardiac vasospasm Coronary artery disease Coronary heart disease Disease;atherosclerotic;heart Disease;ischaem heart;chronic	Disease;ischaem heart;subacut Disease;ischaemic heart Graft;coronary artery bypass IHD with angina IHD without angina Infarction;myocardial Infarction;myocardial;acute Infarction;myocardial;healed Infarction;myocardial;old	Insufficiency;coronary Ischaemia;myocardial;chronic Occlusion;coronary Pain;angina Postmyocardial infarct syndrom Rupture;artery;coronary Spasm;artery;coronary Stent(s);coronary

National KPI reports

Communicare provides reports to cover National Key Performance Indicators for Indigenous Primary Health Care (2012).

For more information, see Key Performance Indicators *(on page 677)*.

NT AHKPIs

Additional information for NT AHKPI.

Before you start

> **Note:**
> For best results when reporting, use the datasets provided by Communicare rather than creating your own.

Before you can effectively use the NT AHKPIs you need to configure parts of your database.

Encounter place

Configure your encounter places:

1. Select **File > Reference Tables > Encounter Place**.
2. If you have only one clinic:
    a. From the **Locality Group** list, select `Health Service Area`.
    b. In the **DHF Health Service Code** field, enter the five digit code allocated by the Department of Health and Families.
3. If you have multiple clinics, each encounter place must be allocated a unique locality group that defines the localities covered by that encounter place. Ideally all localities in the Health Service Area will be allocated to a single smaller locality group that will be allocated to a single encounter place. Each encounter place must also be given the appropriate DHF Health Service Code.

> **Tip:**
> To help you edit or create these groups, run the report **Report > Reference Tables > Locality Group Analysis**. Enter a range of post codes that covers your Health Service Area and the report will show you which localities belong to which locality group.

Data requirements

Review the data collection requirements. Check the Healthy for Life *(on page 472)* reports - many of the indicators are comparable to those defined for Healthy for Life.

Further data collection requirements include:

- Anaemic children are identified by their latest qualifier Hb (Haemoglobin) recorded during the reporting period being less than 110 g/L (less than 105 g/L if under 12 months old).
- Patients with albuminuria are defined as having a latest qualifier ACR (Alb/Creat Ratio) recorded during the reporting period as being greater than 3.4.
- Patients are recognised as being on an ACE inhibitor, or ARB drug by checking their regular and current medications as selected from the appropriate ATC (Anatomical Therapeutic Chemical) codes.
- PAP smears are counted by looking for investigation requests for tests whose description starts with **PAP smear** (case insensitive) or for clinical items with the export code **PAPSMEAR**.
- If you do not make Medicare claims then you will need to make sure that clinical items used to record care plans and health checks have the following system codes:
    - GP management plan items must use **CPA**
    - Team care arrangements must use **TCA**
    - Adult health checks must use **AHC**
    - Child health checks must use **CHC**
    - Elderly health checks must use **OHC**

- Clients are assumed to be fully immunised if they have no overdue recalls for immunisations (excluding Panvax and Fluvax) or immunisation reviews that were due before the reference date or have an appropriate completed review. Immunisation review items should start `Review;immunisation;` followed by the age, for example, `Review;immunisation;2 months age`

Running the NT Aboriginal Health Key Performance Indicators (NT AHKPI) reports

Run the NT AHKPI reports from **Report > NT KPI**. Run each individual report to show data for each KPI.

The data export file is created at **Report > NT KPI > AHKPI Data Export**.

A summary view of the data export file is available at **Report > NT KPI > AHKPI Data Export Summary**.

Note:
Reports adhere to *NT Aboriginal Health Key Performance Indicators*, Definitions, October 2013, Version 2.0.4.

Because data is disaggregated by age, patients with no date of birth will not be included.

OATSIH Service Activity Reporting

Communicare provides specialised reports for each of the statistical questions in the Service Activity Report.

Questions 3a, 3b, 3c, and 3d relate to episodes of health care. The information for these questions is drawn from the Service Recording *(on page 86)* module, with reference to patient data and provider details. Episodes of care that involve only providers with specialty of Transport worker are excluded from all of question 3 answers.

Question 3b relates to clients who normally live outside your health service area. To do this, the report utilises a special locality group called 'Health Service Area'. It is important that this locality group contains every locality covered by your health service and no localities that are not covered. To help you with this Communicare provides a report on the Reports| Reference Tables menu called Localities Not in Health Service Area. Check that no localities on that report fall within your health service area.

Question 4a relates to client contacts. This question requires the contacts to be divided by the clinical specialty of the provider, for example, Doctor, Nurse. Communicare accomplishes this by counting contacts according to each provider's specialty. However, for transport services the question wants the contacts divided according to whether the client was being taken to see 'health professionals who work at this service' or 'health professionals who do not work for this service'. Transport activity that does not directly relate to health care, such as delivery of meals or taking a client shopping, should be excluded. Transport services recorded in Service Recording *(on page 86)* by Transport workers do not usually have information about health professional the client is going to see, particularly when the provider does not work for your health service. However, the Transport Module *(on page 81)* does record information about where each client is taken. For this reason, it is preferable to record transport services in the Transport Module *(on page 81)* rather than the Service Recording *(on page 86)* module. In either case, Communicare will report all the relevant information on the report, so you can interpret it as necessary.

Question 4b and 4c relate to influenza and pneumococcal vaccinations. Health services record immunisations in a variety of ways, so this report counts all immunisations that contain the letters 'PNE' or 'FLU'. The report also includes qualifiers (except BATCH) because some health service record immunisations provided by other agencies and identify them with a qualifier. In this case also, the report should be read and interpreted as necessary.

Group episodes

Currently these reports look for clinical items with the word 'GROUP' in the description. Patients with such an item on the same day are assumed to have attended the same group meeting.

Communicare Support provides a confidential, free-of-charge service whereby all of these reports can be run for you and the results returned to you on a SAR report form.

Perinatal Depression Project Reporting

There are two associated reports for the National Perinatal Depression Initiative at:

- **Report > Pregnancy > Perinatal Depression Project**
- **Report > Pregnancy > EPDS Scores**

The data required for these reports is found in a single clinical item Perinatal Depression Assessment. This item captures scores from the Edinburgh Postnatal Depression Scale.

STRIVE Reporting

STRIVE is a randomised community trial to control sexually transmitted infections in remote Aboriginal communities in northern and central Australia.

Objectives of STRIVE:

- Primary:
  - To determine whether targeted clinical review and support provided to health services can achieve substantive and sustained improvements in the provision of sexual health clinical services in remote Aboriginal communities.
  - To determine whether the attainment of best practice levels in clinical activity can reduce the prevalence of STIs in these communities.
- Secondary:
  - To measure the impact of the STRIVE trial on health service staff.
  - To measure other non-STRIVE activities which may influence sexual health service delivery.

Reports are distributed to participating health services as required.

To be included in the STRIVE reporting:

- STI screening must be recorded using the clinical item `STI Screening` *STATE* with an export code of `STI-SCR`.
- Screenings for asymptomatic patients should have the first **STI signs and symptoms** qualifier set to `Asymptomatic`.
- Pathology requests must be for tests found using the keyword of `STI`.
- Abnormal results must be recorded using the Yes/No qualifiers for the specific infection, for example, `Chlamydia result abnormal`. These are offered in the pathology review if either the lab returns a known code or the result is matched to one of the known tests.
- Treatment must be recorded using the clinical item `STI Screening` *STATE* with an export code of `STI-TRT`.
- In all cases as much information as is required on the screening or treatment items should be provided.
- The reports at **Report > STI** make reasonable attempts to find the data relating to a screening, pathology request, result, result review, treatment and subsequent screening. The time sequence is not always linear and not always complete.

Tackling Smoking Reporting

Tackling Smoking reports include information captured in the clinical items enabled with the `Tackling Smoking` dataset.

> **Tip:**
> To be included in the reports, any local clinical item that is an indication of patient involvement in tobacco use services or QUIT workshops should belong to a clinical item group named `Tobacco use services` or `QUIT Workshops` respectively.

`Tackling Smoking` reports are found in the **Report** menu:

- Clients and Smoking: This report looks at all client contacts between two dates and indicates if a smoking matter was recorded. The data is disaggregated by provider type. Smoking matters include:
  - The recording of a smoking status qualifier (identified by the system codes of SMO or SMP); or
  - The recording of a clinical item that belongs to the 'Tobacco use service' group or the 'Quit workshops' group.
- Export Report: This report is designed for export to Excel and shows all Tacking Smoking review items with their referral data.
- Patients with ongoing support: This report identifies all clients who have had at least one Tackling Smoking review or follow up item recorded between two dates and further indicates those with a further item recorded within three months of another. The report includes subsequent items recorded after the last date of the report but not those recorded before the first date of the report.

Miscellaneous Special Reporting

Communicare distributes some reports useful for sending to external organisations in addition to those outlined in their own topic.

Northern Territory CDC Immunisation Report

This is found at: **Report > Immunisations > Report for CDC-NT**

This can be used for periodic immunisation reporting to CDC.

Northern Territory Growth and Assessment Report

This is found at: **Report > Procedures > GAA Record Sheet NT**

This report shows under 5s weight, height and haemoglobin recorded on the latest item that has the option to record the haemoglobin or on the same day as this item was recorded.

Admissions Reports

Report on admissions made to your health service.

Table 147. Admissions Reports

Report > Admissions	Description
Admissions	Lists admissions made. These can be specified by admission reason, date range, locality, and age group.

Table 147. Admissions Reports (continued)

Report > Admissions	Description
Emergency Admissions (evacuations)	Counts the number of emergency admissions (evacuations) made during a selected period for each encounter place, sorted by admission reason. The report counts all admissions added to patients' clinical records where **Emergency** was set and any admission item called `Evacuation`.

Appointments Reports

These reports relate specifically to the Appointments module and are only available to sites that have Appointments features enabled.

Tip:
To print the appointment book, select **Report > Appointments > Appointment Book** and set the date and other filters you require.

Table 148. Appointments reports

Report > Appointments	Description
Appointment Book	Print the appointment book in a format that can be used in an emergency as a paper appointments book. It is also useful when reviewing the set up of the appointment book. One Provider is printed per page. Cancelled sessions are automatically excluded from the list.
Appointment Details	Shows each future session with the time of appointment and patient name, home address and phone numbers. Print and take on home visit appointments or to make telephone calls to remind patients of upcoming appointments.
Attendance Analysis by Place Mode	Session attendance by Session Name, Place Mode and Provider name with any changes made during the actual session. Use this report to count the number of episodes of care by type of session or clinic held over a selected period. For example: find the number of clients who attended an Antenatal Clinic held at location X last year.
Attendance Count	A count of all appointments kept, cancelled and `Did not attend` between two dates, including walk-in patient services.
Attendance Count by Provider	A count of all appointments kept, cancelled and `Did not attend` between two dates, including walk-in patient services, broken down by provider.
Cancelled Bookings	All appointments cancelled between two dates, including the username of the user who cancelled each appointment and the username of the user who created the initial appointment.
Cancelled Sessions	All sessions cancelled between two dates for sessions planned between two dates, including the username of the user who cancelled each session and the username of the user who created the initial session.

Table 148. Appointments reports (continued)

Report > Appointments	Description
Duty Roster	All sessions scheduled between two dates. The provider, place, facility, start and end times are shown. Use this report to generate a duty roster.
Missed Appointment Analysis	Counts the number of missed appointments by session type and includes past bookings that are either still booked or have been cancelled with the reason `Did not attend`. Filter by date range, sex and Aboriginality. Use this report to evaluate the effectiveness of client reminder systems.
Missed appointment letter	Lists details for letters to clients who have missed appointments during a selected date range and includes past bookings that are either still booked or have been cancelled with the reason `Did not attend`. Use to print a standard letter for each patient who has missed an appointment or to print reminder letters.
Missed appointment list	Lists details of missed appointments for a selected date range and includes past bookings that are either still booked or have been cancelled with the reason `Did not attend`. Use this report as a worklist to follow-up clients who have missed an appointment.
Reminder letters list	Lists details of upcoming appointments for aselected date range. Use to print a standard letter for each patient who has an upcoming appointment or to print reminder letters.
Requirement Details	Shows each future session with the time of appointment and patient name, home address, phone numbers and email addresses. Print and take on home visit appointments or use to remind patients of upcoming appointments.
Requirements	Use to manage Appointment Requirements *(on page 859)*. For example, it can be used: • By the transport officer to print a list of all appointments where transport is required • By an interpreter to see when interpreter services are required • By staff to print a list of appointments requiring test results, to ensure that the results are available in time for the appointment.
Reschedule Queue Details	Shows appointments cancelled with the intention to reschedule that may not have been rescheduled. By default, the reschedule list presented when you select that option is only for those whose original booking is still in the future. This report allows you to look back.
Reserved Comment Analysis	Analyses 'Reserved' comments for all appointment slots that have been reserved. Results are broken down by encounter place and provider.
Session analysis by Place Mode	Analyses appointment session by Session Name and Place Mode. Use this report to count the number and type of sessions (i.e. clinics) held over a selected period. The report counts individual sessions, total timeslots available and how many males and females attended an appointment.

Table 148. Appointments reports (continued)

Report > Appointments	Description
Session analysis by Provider	Counts the number of days on which there was at least one session for each provider or speciality type between two dates analysed by day of the week. Cancelled sessions are excluded.
Timeslot Analysis	Analyses all timeslots and shows those that were booked, those not booked and those reserved. Results are broken down by encounter place, session type and provider.
Timeslot Details	Shows all timeslots for a specified provider between two dates and all patient bookings and status. Use this report as a brief summary of future appointments or as an analysis of past appointments.
Transport Requirements	Lists address details for clients with appointments in need of transport. Appointments listed are those appointments booked with a "transport requirement" and incomplete referrals that have an appointment time. Cancelled, withdrawn, waiting, started, paused or finished services are not included. Only incomplete referrals with an appointment date are included. The report lists place of appointment, time of appointment, client name, client address and comment or transport mode. Use this report as a work list for transport drivers.
Walk-in patient analysis	Counts the number of episodes of health care for clients who did not have an appointment during a selected period, by place mode, Aboriginality and sex. Non-client contact and fictitious patient episodes are excluded. Services involving transport workers only are also excluded. Both Started and Finished services are counted. Booked and Waiting services are excluded.

Appointment Booking Slip

The Appointment Booking Slip report prints a list of all future appointments for a single patient.

The slip is printed on the printer assigned to Appointment Reminder Slips.

To print the Appointment Booking Slip, open the **Service List** window from the **Appointment Book** or clinical record. For more information, see Patient Appointment and Service History *(on page 62)*.

Bulk Cancellation Report

If multiple appointments are cancelled in a single operation, this report is run automatically. It shows appointment details, patient name and age, telephone number (if present) and address.

This report is not available from the **Report** menu.

Audit Logs Reports

Report on access to personal records.

Table 149. Audit logs reports

Report > Audit Logs	Description
Biographics Checks Analysis	Analysis of biographics checks relative to services recorded. The report counts any access to a patient's biographics (at any time within the report range) as a check and any service within the report range as a service. Only patients who have a service record are included. If the service status of <All Services> is selected then all services are counted, including bookings (even if the patient did not attend), a contact service or a non-contact service. The option 'Only actual contact services' includes only contact services that actually started. **Tip:** To confirm that biographics have been checked, in a patient's biographics, users should click **Change Details** and then either **Review & Save** or **Cancel** (if all details are still correct). A value of 100% means that clinic staff check biographic details for all patient services.
Biographics Reviewed on Service Date	shows all patients that presented for at least one contact service at a selected encounter place between two dates and shows if the biographics were reviewed, simply opened or neither. Use this report to check the frequency with which staff are checking and reviewing patient biographics on presentation at that place. Only patients who have a contact service and who are not fictitious are included. Patients who have subsequently died are included. Patients with multiple services on a single day are reported only once. The review is done by opening a patient's biographics and closing by clicking **Review & Save**. The review can be any time on theday of the service. If biographics were not reviewed but were opened, these services are also itemised (any user who opens biographics regardless of whether they closed the window using **Review & Save**, **Save** or **Cancel** is logged).
HI Service Access by patient	Exports the access log for the HI Service into a CSV file. The user can choose to output only the access log lines where errors were encountered.
HI Service Access	Exports the access log for the HI Service into a CSV file. The user can choose to output only the access log lines where errors were encountered.
Merged and Deceased Patients	Shows details of the merging, deleting and deceasing of patients. It shows the date of the action and the user that performed the action as well as details of the patient.

Table 149. Audit logs reports (continued)

Report > Audit Logs	Description
Patient record access by date	Lists the users who accessed the clinical record by opening it or print/preview it in a period of time for patients living in a specific locality group. The report lists date and time of action, username, type of action, patient name, patient DOB. There is a count of services for each patient on the day of access. For users who accessed the record that left behind a progress note there is a note stating 'Note recorded'. If no note was left but the username is associated with a provider who performed a service on that day then the note states 'Included in service'. Backdated services will appear as if there were no services for that patient on that day but there was a note left by the user.
Patient record access by patient	Lists the users who accessed the clinical record by opening it or print/preview it in a period of time. The report lists date and time of action, username, type of action, patient name, patient DOB. There is a count of services for each patient on the day of access. For users who accessed the record that left behind a progress note there is a note stating 'Note recorded'. If no note was left but the username is associated with a provider who performed a service on that day then the note states 'Included in service'. Backdated services will appear as if there were no services for that patient on that day but there was a note left by the user.
Patient record access by user	Lists the users who accessed the clinical record by opening it or print/preview it in a period of time. The report lists date and time of action, username, type of action, patient name, patient DOB. There is a count of services for each patient on the day of access. For users who accessed the record that left behind a progress note there is a note stating 'Note recorded'. If no note was left but the username is associated with a provider who performed a service on that day then the note states 'Included in service'. Backdated services will appear as if there were no services for that patient on that day but there was a note left by the user.
Patient status change	Shows all changes (manual or automatic) to a patient's status recorded between two dates for patients living in a specific locality group. Use this report to see who might be manually adjusting a patient's status or which changes have been made automatically according to the status change rules.

Table 149. Audit logs reports (continued)

Report > Audit Logs	Description
Username activity	Audits a user logging off, logging on, or credentials changed, in addition to when reauthentication is required to complete an action. Log off and credential change activities are only captured in V22 and later. If reporting on time periods earlier than V22, only log on events may be audited. Where Communicare is improperly closed, log off activities may not be captured. Login and log off are reported if the username is currently linked to the provider record; credential changes will not report a provider.
Username activity detailed	Audits access to the database, clinical records, biographics, progress notes, documents and results by a specific user between two dates.

Clinical Record Reports

These reports use common selection and print options to report and analyse groups of patient clinical records.

Table 150. Clinical record reports

Report > Clinical Record	Description
Adverse Reactions Audit	Shows all patients who have some form of Adverse Reaction recorded. Display all patients with alert data or only those with alerts containing the keywords 'adverse', 'reaction', 'allergy', 'allergic', 'sensitivity', 'intolerance', 'intolerant', 'nkda' or 'nka' and details of the alert. You can also show all patients or only those without a formally recorded adverse reaction. Use this data to assist in transcribing reactions into the new Adverse Reaction feature. Alerts and ICPC Adverse Effect codes should be discontinued, and all adverse reactions in the future should be recorded using the new feature. This will allow users to be warned of reactions when prescribing medication. Administrators should run this report. Users without the system right of **Clinical Record** will not be able to see any of the alert data.
Adverse Reactions New and Modified	Identify records where an adverse reaction has been added or modified within a date range. Use the report to monitor record accuracy as well as to the identify cases requiring notification to the Australian Adverse Drug Reaction Reporting System.
Alcohol Related Items	Shows all clinical items recorded as alcohol-related between two dates. Fictitious patients are excluded. Before providers can capture this information, **Alcohol** must be set on the **File > System Parameters > Clinical** tab.

Table 150. Clinical record reports (continued)

Report > Clinical Record	Description
Alert Analysis	Analyses patients by status and counts those with something recorded in the alert of the clinical record or any adverse reactions and those with nothing. Details are broken down into those with free text alerts, those with no known allergies, those with drug allergies and those with non-drug allergies. Use this report to analyse compliance with recording of patient drug allergies and other important information.
Conditions and Qualifiers Analysis	Lists all patients who satisfy the biographic criteria with the latest value and date for up to four numeric qualifiers and one non-numeric qualifier. It also lists the latest diagnosis for each patient that belongs to a specified clinical item group. An additional filter allows you to show either all patients (with any item in the clinical item group selected) or only those patients who have an item in the clinical item group selected. For example, you may choose to select the weight, BMI, HbA1c and cholesterol for women aged over 40 and show the latest diagnosis of diabetes. This will allow you to monitor progress of known diabetic patients and also examine qualifiers for patients without such a diagnosis to identify patients that should be recalled for a consultation. For those qualifiers not required, select `(N/A)`. Similarly, if you do not need to examine a clinical item group, select `(N/A)`.
Infections Between Two Dates	Shows all recorded infections between two dates grouped by topic and infection.
INR Chart	Prints the current (latest) Target INR (International Normalised Ratio) value and date and displays a table containing historical dates with INR values and warfarin dosage with the associated clinical item comment. For more information, see INR Chart *(on page 463)*.
Kidney Disease Outcomes	Shows the most recent GFR for any current patient whose most recent ACR was > 3.4 mg/mmol. GFR is recorded in mL/min. Also included are any patients with a diagnosis from the URINARY DISEASE, OTHER group. The results are grouped into appropriate categories to indicate the level of Chronic Kidney Disease. Definitions are from the Kidney Disease Outcomes Quality Initiative. Also included is a record of patients who are currently or regularly being prescribed an ACE inhibitor or ARB. Also shown is the most recent diagnosis from the URINARY DISEASE, OTHER group. This can be used to see if a patient's most recent diagnosis is consistent with the latest pathology results. The report uses the Communicare Central qualifiers of 'ACR (Alb/Creat Ratio)' and 'GFR (ideal body weight)' or 'GFR (actual body weight)' or 'eGFR (Estimated GFR)'. **Note:** These results are intended as a guide to patient management only. Care should be taken when interpreting these results.

Table 150. Clinical record reports (continued)

Report > Clinical Record	Description
No Formal Allergy Status Recorded	Lists the patients whio do not have any formal Adverse Reaction Status recorded. The report does not check the "Alerts and Other Information" section. Export this report to include patient address and phone numbers.
NT Renal Care Summary Report HRN	Report for the NT DHF Renal Care Coordinator showing all patients with a latest GFR less than 60 broken down into each stage of renal failure. The latest GFR and creatinine values are shown. When exporting to Excel there are additional data for the most recent ACR, BP, potassium, LDL, smoking status, Hb and HbA1c. It is similar to the Kidney Disease Outcomes report, except it is based only on GFR values and does not consider ACRs or diagnoses.
Patients with Dx but no Item	Lists all patients who have a clinical item within a selected clinical item group who do not have a specific completed clinical item type or vice versa. This is a patient-based report. It will list patients once only, regardless of the number of times group clinical items have been recorded for the patient. Use this report to locate all patients belonging to a particular disease or other group who do not have a specific completed clinical item or for patients with the completed clinical item but no specific diagnosis or other clinical item (e.g. look for patients with diabetes, non-insulin dependent who do not have a completed **Cycle of care;annual;diabetes**).
Patients with Dx but no Qualifier	Lists all patients who have a clinical item within a selected clinical item group who do not have a specific numeric qualifier within a specified range or vice versa (only the latest qualifier for a patient is considered). This is a patient-based report. It will list patients once only, regardless of the number of times group clinical items have been recorded for the patient. Use this report to locate all patients belonging to a particular disease or other group who do not have a specific qualifier of a specific value or for patients with the qualifier but no specific diagnosis or other clinical item (e.g. look for patients with diabetes, non-insulin dependent who have a BMI greater than 30).
Patients with Dx but no Recall	Lists all patients who have a clinical item within a selected clinical item group who do not have a recall for a selected procedure or vice versa. This is a patient-based report. It will list patients once only, regardless of the number of times group clinical items have been recorded for the patient. Use this report to locate all patients belonging to a particular disease or other group who do not have a recall for a recommended periodic procedure or for patients with a recall for a procedure but no specific diagnosis or other clinical item (e.g. look for patients with diabetes, non-insulin dependent who do not have a recall for **Cycle of care;annual;diabetes**).

Table 150. Clinical record reports (continued)

Report > Clinical Record	Description
Procedures and Referrals by Provider	For the selected date range, for each provider, lists: • Provider name • Place mode where the procedures/referrals were done • Name of the procedure/referral • Number of times the procedure/referral was done Providers who have performed no procedures during the selected period are not listed on the report. Fictitious patient procedures are excluded. Use this report to gain an appreciation of the data recording and clinical service activity of each provider.
Qualifier Analysis for Selected Provider	Shows counts of the qualifier usage of all clinical items recorded by a specified provider for a specific clinical item or class, including averages, maxima and minima for numeric qualifiers and individual counts of each reference type qualifier response. Numeric qualifiers are also summed for a grand total - this is not a sensible value for, say, HbA1c and should be ignored, but is valuable for numeric qualifiers such as 'Amount spent in dollars', and so on. Use this report to analyse responses to the qualifiers of particular items that belong together. It can also be used to summarise and monitor details that are recorded by a specific provider.
Selected Clinical Item Group Analysis	Counts all clinical items recorded between two dates where the clinical item belongs to a selected clinical item group. The report excludes fictitious patients but includes deceased patients. Filter by patient's locality or locality group where they were living at the time of the diagnosis. Partially complete procedures, that is, those with required qualifiers that have not been completed, are included in this report. For each item in the selected clinical item group, the report lists: • Clinical Item Type • Locality of the client's home • Count of the clinical item for clients living at that locality • Total count of the clinical item for all localities • Recording provider Use this report to report on outbreaks of particular groups of disease, or to count particular types of procedures performed.
Selected Clinical Item Group	Lists all clinical items recorded between two dates where the clinical item belongs to a selected clinical item group. The report excludes fictitious patients but includes deceased patients. Partially complete procedures, that is, those with required qualifiers that have not been completed, are included in this report. Use this report to report on outbreaks of particular groups of disease for all localities.

Table 150. Clinical record reports (continued)

Report > Clinical Record	Description
Social and Family History Analysis	Analyses patients by status and counts those with something recorded in the social or family history of the clinical record and those with nothing. Use this report to analyse compliance with recording of social and family history.
Social and Family History Patients	Analyses patients by status and indicates those with something recorded in the social or family history of the clinical record and those with nothing. Use this report in conjunction with the Social and Family History Analysis report.
Unconfirmed Diagnoses	Lists all patients who have a condition within a selected clinical item group where the comment contains a question mark (?). Use this report to locate all patients belonging to a particular disease or other group whose condition may still need confirmation. Where the condition is confirmed, the clinical item should be edited to remove the question mark. Where the condition is not confirmed, the item should be deleted (note that the original progress note will contain evidence of the initial suspicions). Unconfirmed diagnoses in Communicare are considered for reporting purposes and for calculations such as cardiovascular risk.

Conditions Reports

Report on conditions recorded at your health service.

Table 151. Conditions reports

Report > Conditions	Description
Conditions Report	Lists patients who have a condition recorded. The standard report options determine which conditions are included in the report and other report characteristics. If a patient has two (or more) conditions recorded, they will appear twice (or more) in the report.
Diabetes and Hypertension Measures	Lists the latest 'contact' service date, GFR, ACR, HBA1C and Cholesterol Ratio for all current patients who have a Diabetes or Hyertension diagnosis. HbA1c results recorded as percent are converted to mmol/mol. The Diabetes diagnosis is determined by the clinical item group **Diabetes (non-gestational)**. The hypertension diagnosis is determined by the clinical item group **Hypertension (non-gestational)**. Results that are more than 6 months old are asterisked. Non-contact services are ignored. Use this report to help monitor the progress of diabetic and hypertensive patients.

Table 151. Conditions reports (continued)

Report > Conditions	Description
First time diagnosis	This report lists and counts the clients who have a diagnosis within a selected grouper for the first time during a selected period. Diagnoses considered are all those where there has been no previous one or any where the episode has been recorded as 'First'. Diagnoses recorded as 'Ongoing' are excluded. Only current patients are included. Use this report to measure disease incidence or to audit medical records.
Prevalence/Incidence Analysis	Lists the prevalence and incidence of specified (or all) conditions. List conditions by condition, date range, locality, and age group. Before providers can capture this information, **Alcohol** must be set on the **File > System Parameters > Clinical** tab.
Selected Topic	Shows conditions recorded between two dates for a specified topic, including patient names or just a count. For example, selecting 'Eye' will give you a count of conditions for eye diagnoses and complaints.
Services Waiting With Asthma	Reports all patients who are currently 'waiting' (that is, they have arrived and have not yet been seen) who have ASTHMA. This query can easily be adapted (if necessary), using SQL Report Editor to search for a different condition description.
Waiting With Selected Clinical Item Group	This query reports all patients who are currently 'waiting' (that is, they have arrived and have not yet been seen) who have a condition belonging to a specified clinical item group. Use it to identify waiting patients for specific targeting.

Conditions Report

The Conditions report lists patients who have a condition recorded.

The standard report options determine which conditions are included in the report and other report characteristics. If a patient has two (or more) conditions recorded, they will appear twice (or more) in the report.

Prevalence/Incidence Analysis

This report lists the prevalence and incidence of specified (or all) conditions.

List conditions by condition, date range, locality, and age group.

Before providers can capture this information, **Episode** must be set on the **File > System Parameters > Clinical** tab.

COVID-19 Reports

Table 152. COVID-19 reports

Report > COVID-19	Description
Rollout Plan	Use this report to monitor coverage of COVID-19 vaccinations. This report shows patients grouped in the following way: • More than two doses given already. • Two doses given already. • One dose given already. • Elderly adults aged 80 years and over. • Elderly adults aged 70-79 years. • Aboriginal and Torres Strait Islander people > 55. • Adults with an underlying medical condition. • Adults aged 60-69 years. • Adults aged 50-59 years. • Aboriginal and Torres Strait Islander people 18-54. • Adults aged 18-49 years. • Children aged 12-17 years. • Children aged 5-11 years. • Children aged 0-4 years. • [Other patients]. Each record shows the patient ID, name, sex, if Indigenous, whether they have a chronic condition in their clinical summary and if they are pregnant. It also shows a count of COVID-19 immunisations given, how many Pfizer doses, how many AstraZeneca doses and the number of cancellations. The last immunisation given is displayed and the earliest due recall is also displayed. The report can be filtered by locality group, patient status, Indigenous status and age. To show the following details, export to Microsoft Excel: • Patient's mobile phone if recorded and if not then the home phone and if this is unknown then the work phone • Date of birth • Age • Locality • Place where last COVID-19 immunisation was administered • Last non-COVID-19 immunisation given • Next recall for **Consent;COVID-19 vaccination**

Table 152. COVID-19 reports (continued)

Report > COVID-19	Description
Under-5s At Risk	Shows clinical items recorded in a child's record that may indicate that the child is a priority for getting COVID-19 vaccinations. The report addresses the Australian Government Department of Health COVID-19 vaccination recommendation for some children aged 6 months to 4 years (dated 12 August 2022). Australia's immunisation experts, the Australian Technical Advisory Group on Immunisation, recommend COVID-19 vaccination for children aged 6 months to 4 years with severe immunocompromise, disability, and those who have complex or multiple health conditions that increase their risk of severe COVID-19. The clinical items used to compile this report are based on apparent alignment with the ICPC2+ codes and the ATAGI recommendations for inclusive conditions. It is not a definitive list, rather a tool to identify priority patients for review. The report identifies children who have a formal diagnosis identified with an ICPC2+ code. The items included are: • Items that are part of NEOPLASMS MALIGNANT ICPC2-groupers. • Items that are part of the CONGENITAL ANOMALY groupers for BLOOD, CARDIOVASCULAR, DIGESTIVE, NEUROLOGICAL, RESPIRATORY and NEUROLOGICAL and some from the MUSCULOSKELETAL grouper. • Items that are part of the DISABILITY groupers for BLOOD, CARDIOVASCULAR, DIGESTIVE, NEUROLOGICAL, RESPIRATORY and NEUROLOGICAL. • Items that are part of the GROWTH DELAY ICPC2-grouper. • Diabetes Type 1 and Type 2 items. • Coronary Heart Disease items. • Renal items. • Lung disorder items. • Behavioural items – ADHD, Autism, FASD, etc.

Database Consistency Reports

These reports provide information about the state of your database.

These reports either complement the Database Consistency report or are useful for database monitoring.

Table 153. Database Consistency reports

Report > Database Consistency	Description
Central Reports	Shows reports at this site that are distributed by Communicare. Administrators can use this report to find reports that have been added in the latest release by entering the date of the latest upgrade for the **Created since** parameter. The report is ordered by the date the report was added to the database.
Current Version Numbers	Shows the current version of your reference data for MBS, MIMS, SNOMED and the Health Data Portal (nKPI) reports. Compare the dates of your datasets regularly and at least monthly, with those posted on the Communicare User Portal.

Table 153. Database Consistency reports (continued)

Report > Database Consistency	Description
Database Consistency Check	Checks the Communicare database and produces a report showing any data problems found. Administrators can also run this report from **Tools > Database Consistency Check**. For more information, see Database Consistency Check *(on page 954)*.
Documents to consider rescanning	Lists oversized documents that should be scanned again if it is possible to do so, to reduce the size of the document. Excessively large documents can cause your database to become bloated and can cause systems errors. To replace oversized documents: 1. Print the document. 2. Delete the original, scanned document. Enter a reason for deletion as `SIZE`. 3. Scan the document again. The original scanned document remains in your database. Contact Communicare Support to arrange the physical deletion of all logically deleted documents with a reason for deletion of `SIZE`.
Fictitious Patients	Generates a list of patients that are marked as fictitious or patients to consider marking fictitious. Run this report to identify any patients who may have been incorrectly marked as fictitious or to find patients suitable for training purposes. **Patients to consider making Fictitious** are identified as having a current status other than fictitious and meet either of the following conditions: • Contain any of the following in their first or last name: `TEST`, `TRAINING`, `DUMMY`, `FICTITIOUS`, `XX`, `12` • Have ever had a patient status of `fictitious` **Note:** Patients who are currently deceased but who have ever been ficitious may need to be undeceased if they are fictitious. Deceased patients who are actually fictitious may appear under some report filters that include deceased patients.
Local Reports	Shows reports enabled at this site that do not appear to be distributed as part of a Communicare upgrade and reports that have been modified in some way. Administrators can use this report to find possible local and altered reports that may need fixing or updating. The report shows reports created or modified since a specified date, red dates indicate if the report was newly added or newly modified (or both).

Table 153. Database Consistency reports (continued)

Report > Database Consistency	Description
Localities with Invalid Postcodes	Find localities with invalid postcodes. Use this report to assist with adding valid postcodes for locally added localities as reported in the database consistency check. Where a duplicate is recorded, contact Communicare Support for advice.
Localities with Invalid States	Find localities with invalid states. Use this report to assist with adding valid states for locally added localities as reported in the database consistency check. Where a duplicate is recorded, contact Communicare Support for advice.
NASH Certificate Expiry	In V21.2 and later, lists installed certificates with unknown expiry dates, or that will expire in the next 60 days. For certificates installed after you have updated to V21.2 or later, if the certificate will expire in the next 60 days, the following output is displayed for that certificate: `expires in XXX days - renew certificate`. **Tip:** For certificates installed before you updated to V21.2 or later, the following output is displayed for that certificate: `unknown expiry - reinstall certificate`. To display the certificate's expiry, reinstall the certificate and run the report again.
Pending Argus 4 Documents	Administrators can generate a list of all pending, secure Argus documents.
Pre-upgrade check	This report is run by Communicare Support or Administrators before an upgrade. Current considerations are: • MIMS issue date if using Prescribing • MBS issue date if using Electronic Claims • Datasets not currently selected for import • Current use of Consolidated clinic summary style • Clinical items that may need converting
Report Usage	Administrators can analyse the use of reports at your site.
Scheduled Reports	Shows all active scheduled reports and the frequency at which they are run. Use this report to identify reports that no longer need to be scheduled and to identify peak days where a large number of reports may be scheduled.

Table 153. Database Consistency reports (continued)

Report > Database Consistency	Description
Scheduled Reports Count	Shows the number of scheduled reports due to be run in the next 90 days for each day where there is at least one. Use this report to identify peak activity days.
Scheduled Reports Monitor	Indicates if a scheduled report due to be run, was in fact run. Use this report to see if a report failed to run at night for some reason. For example, the time allocated for this had expired. Run the report for yesterday: today's date will produce an empty report and a date prior to yesterday may produce inconclusive results if a report was successfully run on a date later than the date entered. This report shows one of the following statuses for each scheduled report: • `OK` - the report ran successfully when it was scheduled • `Possible problem` - the report failed to run for some reason, possibly because there is nothing to report • No comment - the report has run successfully since the date entered, and there is no way of knowing if it ran successfully on the entered date or not.
Unused Address Book Entries	This is a legacy report run by Administrators that shows the Address Book entries deleted on upgrade from V11.4 and earlier. These are the entries that came from the Argus AUD, have not been referenced anywhere in Communicare, and do not have an export code of KEEP (case insensitive).
Withdrawn Services	Shows incorrectly withdrawn services. For services identified in this report, update the service details and do the following: 1. Deselect **Withdrawn**. 2. Provide a start and end time. 3. Click **Save**.

Documents Reports

Report on documents created in, sent from, or added to Communicare.

Table 154. Documents reports

Report > Documents	Description
Added Between Two Dates	Lists electronic documents recorded by providers between two dates. Use this report to report on Care Plans prepared, incoming scanned documents, outgoing letters, and so on. The report is sorted by provider and date of document and shows the patient, document date, comment and provider where these are recorded. The date range parameters check the date and time that the document was added to the database but the output reports the declared date. This means that a document added within the date range but backdated to an earlier date will still be shown with the backdated date as the document date.
Analysis by Topic	Counts all documents recorded by providers between two dates grouped by topic.
Analysis	Counts documents recorded during a selected date range, with a wide variety of selection criteria. Selections can be made by: • Provider (individually, all separately or all together) • Incoming or Outgoing documents • Document type • Document status • Date range The analysis shows the number of documents and the number of individual patients involved. Use this to report on care plans prepared, incoming scanned documents, outgoing letters, and so on. To show the number of individual patients who have care plans: • To count the number of care plans created, select a document type of `Care Plan Template`. • To count care plans including care plan revisions, select a document type of `Care Plan Document`
CDA Document Analysis	Analysis of CDA Documents between two dates. Lists patient names and counts or just a count if the option to not show patient names has been selected under subheadings for the type of document (such as, Discharge Summary, Shared Health Summary, eReferral, Event Summary, Specialist Letter). Use this report to identify patients where a CDA document has been sent, including to identify patients where an event summary has been sent to the My Health Record.

Table 154. Documents reports (continued)

Report > Documents	Description
Referral Documents	Lists electronic documents recorded by providers between two dates where the letter was generated from a template of type **Referral Letter**. This report will include letters generated from a referral and letters manually added using a referral template, where there may not be a corresponding referral item. If the letter was generated from a referral item, the document description starts `Referral Letter` otherwise it starts `Letter`. The report is sorted by provider and date of document and shows the patient, document date, comment and provider where these are recorded.
Secure Electronic Documents Analysis	Use to monitor the impact of Secure Electronic Messages on this Health Service. The report shows: • A count of all electronic documents created in Communicare that are marked as secure emails. • A count of all above documents that are flagged as already sent. • A count of all electronic documents received in Communicare. • A count of all above documents that are marked as reviewed by doctors. • The date of the last document sent by Communicare. • The date of the last document received by Communicare.

Drug and Alcohol Treatment Reports

Report on client enrolments and exits to Drug and Alcohol Treatment programs and analyse the effectiveness of the service.

Table 155. Drug and Alcohol Treatment reports

Report > Drug and Alcohol Treatment	Description
Client Exits	Shows all exits recorded between two dates, including exit date, name of client, file ID, home town and length of stay to the nearest week. Use it to help analyse service effectiveness. Only Administrators can run this report.
Clients in Residence	Lists the names of all clients in residence on a selected date. Use this report to confirm that all residential clients have been properly admitted, or to check if a particular client is currently in residence.
Enrolments and Exits	Lists all client enrolments and exits during the selected period, analysed by Aboriginality and age group. Use this report to evaluate utilisation of the drug and alcohol centre. Fictitious clients are ignored.
Episodes by Language	Lists the number of episodes between selected dates, analysed by principal drug of concern. Fictitious clients are ignored.

Table 155. Drug and Alcohol Treatment reports (continued)

Report > Drug and Alcohol Treatment	Description
Episodes by Locality	Lists the number of episodes between selected dates, analysed by locality and principal drug of concern. Fictitious clients are ignored.
Exit analysis	Lists all client exits during the selected period, analysed by Aboriginality and age group. Use this report to evaluate utilisation of the drug and alcohol centre. Fictitious clients are ignored.
Exit referral analysis	Lists all client exits during the selected period, analysed by exit referral type. Use this report to measure referrals made on client exit from the treatment program. Fictitious clients are ignored.
Groups and Episodes	This report is similar to the DASAR report on "Groups and Episodes". A "Group" is counted when one or more clients have a "DATS Group activity". An "Episode" is counted for each client who attends. This is in accordance with the definitions used for the DASAR. For example, if 5 clients attend a "DATS Cultural group" and 7 clients attend a "DATS Education group" on the same day, this report will list: • 1 "DATS Cultural group" with 5 episodes. • 1 "DATS Education group" with 7 episodes. Fictitious clients are excluded.
NT Monthly Episodes	Prints information equivalent to the Northern Territory Client Database Episode form. If applicable, run once for each month and sent to: Planning & Information Officer Alcohol and Other Drugs Program PO Box 40596 Casuarina NT 0811
NT Monthly Registrations	Prints information equivalent to the Northern Territory Client Database Registration form. If applicable, run once for each month and sent to: Planning & Information Officer Alcohol and Other Drugs Program PO Box 40596 Casuarina NT 0811
Re-Admissions	Lists clients who were readmitted during a selected period. Use this report to list clients with multiple admissions. Fictitious clients are excluded.

Table 155. Drug and Alcohol Treatment reports (continued)

Report > Drug and Alcohol Treatment	Description
Residential Occupancy by Age	Lists the number of nights of occupancy between selected dates, divided between clients aged under16 years and over. Use this report to complete occupancy analysis. Fictitious clients are ignored.
Residential Occupancy by Source	Lists the number of nights of occupancy between selected dates, analysed by source of referral. Fictitious clients are ignored.

Electronic Claims Reports

Use the electronic claims reports to manage Medicare claims and payments.

Table 156. Electronic claims reports

Report > Electronic Claims	Description
Batched By Period	Displays a list of online claims for a selected date range that are associated with multiple services, and includes reference, date, patient name and status. Fictitious patients and withdrawn services are excluded.
Bulk Bills Status	Shows all the records visible in the **File > Online Claiming > Bulk Bill Claims** tab for claims that are associated with a single service, and includes details of patient Medicare card status and any error messages that are reported when attempting to send. Paid claims and discarded claims are excluded. Export the report to Excel for analysis. Use the report to assist in the maintenance and monitoring of the Bulk Bill Status for claiming purposes.
By period	Displays a list of online claims for a selected date range that are associated with a single service, and includes reference, date, patient name and status. Fictitious patients and withdrawn services are excluded.

Table 156. Electronic claims reports (continued)

Report > Electronic Claims	Description
CDM Summary for Selected Patient	Enables you to keep track of Chronic Disease Mangement (CDM) claims for a selected patient. The report shows all claims within the last 18 months that are associated with a single service, for GP management plans (721), team care arrangements (723), reviews (732), Aboriginal health assessments (704 to 710 and 715), Aboriginal health check referrals (10987) and follow ups (10997) and any items from groups Allied Health Services (M3), Allied Health Group Services (M9) and Allied Health Services for Indigenous Australians who have has a health check (M11). The following COVID-19 MBS items are included as equivalents of the health assessment and chronic disease management items: • 721 also includes items 92024, 92068, 229, 92055, 92099 • 723 also includes items 92025, 92069, 230, 92056, 92100 • 732 also includes items 92028, 92072, 233, 92059, 92103 • 715 also includes items 92004, 92016, 228, 92011, 92023 • 10997 also includes 93201, 93203 • 10987 also includes 93200, 93202 • Group M3: 93000, 93013 • Group M11: 93048, 93061 Where there have been no claims in the last 2 years `nothing to report` is shown.
CDM Summary Patients with current 723	Enables you to keep track of Chronic Disease Mangement (CDM) claims for patients with a current paid claim for a 723. The report shows all claims within the last 18 months that are associated with a single service, for GP management plans (721), team care arrangements (723), reviews (732), Aboriginal health assessments (704 to 710 and 715), Aboriginal health check referrals (10987) and follow ups (10997) and any items from groups Allied Health Services (M3), Allied Health Group Services (M9) and Allied Health Services for Indigenous Australians who have has a health check (M11). The following COVID-19 MBS items are included as equivalents of the health assessment and chronic disease management items: • 721 also includes items 92024, 92068, 229, 92055, 92099 • 723 also includes items 92025, 92069, 230, 92056, 92100 • 732 also includes items 92028, 92072, 233, 92059, 92103 • 715 also includes items 92004, 92016, 228, 92011, 92023 • 10997 also incudes 93201, 93203 • 10987 also includes 93200, 93202 • Group M3: 93000, 93013 • Group M11: 93048, 93061

Table 156. Electronic claims reports (continued)

Report > Electronic Claims	Description
Check Items and Claims	Use this report to cross check completed procedures and immunisations performed with Medicare claims associated with a single service. Only services with the selected procedures or immunisations are included. Claims by all providers on the service are shown. Use this report to specify a specific procedure or immunisation (or all) that normally attracts a Medicare claim to see if the correct item has been marked for claiming. All claims for each service are shown, regardless of whether they have been sent successfully or not.
Claims and Payments by Provider	Shows selected providers who have claimed MBS items during a selected period and shows the number of claims made, the amount claimed and the amount already paid by Medicare Australia. This report includes only claims that are associated with a single service. The figures are broken down by whether the service for which the items were claimed was in or out of normal clinic hours for weekdays, Saturdays and Sundays. Results can be filtered by Encounter Place and Encounter Program.
Claims on Behalf of a Doctor	For claims that are associated with a single service, displays names of providers associated with a service in which an item was claimed on behalf of a medical practitioner, including all items in the Miscellaneous category groups of items claimed by a nurse or by an aboriginal health worker on behalf of a medical practitioner. Use the report to see which nurses and healthworkers are claiming on behalf of a doctor. Medicare Plus items are not included in the report. The report looks for items selected for claiming - claims may or may not have been sent, paid or rejected.
Claims on Behalf of a Doctor by Client	For claims that are associated with a single service, displays names of clients and dates of service for services in which a Medicare claim was made on behalf of another medical practitioner, including all items in the Miscellaneous category groups of items claimed by a nurse or by an aboriginal health worker on behalf of a medical practitioner. The report looks for items selected for claiming - claims may or may not have been sent, paid or rejected.
Claims on Behalf of a Doctor Missed	For claims that are associated with a single service, lists all services where a Medicare claim item has been selected but there is no claiming doctor on the service. Use this report to find services where a potential claim may be lost because a claiming doctor has not been added to the service. For example, a nurse may have ticked item 10993 after performing an immunisation but forgotten to add the doctor's name to the service.

Table 156. Electronic claims reports (continued)

Report > Electronic Claims	Description
Daily Claim Activity	For claims that are associated with a single service, lists the number of encounters, the number of encounters actually claimed and the value of the claims by provider and day for the selected period, assuming that all claims will be processed and paid. Services that are not claimable are not counted by this report. Use this report to check that services are being claimed and to analyse claim activity.
EFT payments	For claims that are associated with a single service, displays a list of payments made by Medicare Australia, for a selected range of dates, including date, run number, payee provider number and amount paid. Use this report to reconcile bank account statements. Claim Status: This report may differ from other electronic claims reports because it only reports on claims that have been paid by Medicare.
For Selected Item Number	For claims that are associated with a single service, displays a list of names of patients for whom a selected MBS item has been claimed for a selected date range, including patient, MBS Item Number, Amount Claimed and Amount Paid.
Items Claimed by Providers by Date	For claims that are associated with a single service, displays a list of MBS Item Numbers (online claims) that have been claimed, processed or paid by HIC, for a selected date range, including Provider, MBS Item Number, Amount Claimed, Count. The report groups by Provider showing the number of times each item was claimed and the total amount claimed for that item. Claims that are still in the queue or have encountered a transmission error will not be included until they have been successfully sent. Rejected claims are also excluded. For these reasons, don't run this report with a very recent **Last date to report** such as `TODAY`.
Items Claimed Count by Date	For claims that are associated with a single service, counts the number of times each MBS item has been claimed during a selected date range, including MBS Item Number, MBS Item description and the number of times claimed and total amount claimed. Use this report for an overview of claim activity, such as the number of health checks claimed. Filter by encounter place, mode and program. Claims that are still in the queue or have encountered a transmission error will not be included until they have been successfully sent. Rejected claims are also excluded. For these reasons, don't run this report with a very recent **Last date to report** such as `TODAY`.
Medicare number validation status	Analyses the HIC online validation status of all patients in the Communicare database. Use this report to detect when additional Medicare validation is required.

Table 156. Electronic claims reports (continued)

Report > Electronic Claims	Description
Outstanding claims	For claims that are associated with a single service, shows all patients with an outstanding Medicare claim where the claim is within the last two years. The services reported are those where items have been selected and **Claim Now** has been clicked but the claim has still not yet been sent.
Partially paid by period	For claims that are associated with a single service, displays a list of Electronic Claims that have been partially paid by Medicare Australia, for a selected date range, including Claim ID, Service Date and Time, Patient Name, Provider Name, Amount Claimed, Amount Paid, Payment Date and Run Number.
Partially paid with erroe message	For claims that are associated with a single service, displays a list of Electronic Claims that have been partially paid by Medicare Australia, for a selected date range, including Claim ID, Service Date and Time, Patient Name, Provider Name, Amount Claimed, Amount Paid, Payment Date and Run Number. If required include fully rejected claims or show only discarded claims.
Payment Run Number Details	For claims that are associated with a single service, displays a list of Electronic Claims that have been paid by Medicare Australia, for a selected payment run number, including reference, date, patient name, provider, amount claimed and amount paid, grouped by Payee Provider Number and Servicing Provider showing total amount claimed for each provider. Use this report to see the details of a payment run number.
Payment Transaction List	For claims that are associated with a single service, displays a list of payments made by Medicare Australia for a selected date range, including Payment Date (the date when Medicare Australia made the payment), Payment Run Number, Payee Provider Number, Transaction Reference and Amount Paid. Use this report to reconcile Communicare's payment records to your bank statement.

Table 156. Electronic claims reports (continued)

Report > Electronic Claims	Description
Payment Transaction List Reconcile	For claims that are associated with a single service, displays a list of payments made by Medicare Australia for a selected date range showing only those payments that have services done outside the reporting interval, including Payment Date, Payment Run Number, Payee Provider Number, Transaction Reference and Amount Paid. The Payment Date is the date when Medicare Australia made the payment, which is typically one working day before the payment appears on your bank statement. Use this report to find out how many claims were paid in the reporting period that were performed outside the reporting period or were paid outside the reporting period but were performed inside the reporting period. This is useful when reconciling the services performed with the amounts paid. • Use Payment Transaction List to get full list of the payment within a period • Use Services Claimed by Provider to get full list of the services performed within a period • Use this report to establish the amount overlapping between the 2 reports. All positive amounts paid are claims paid within the reporting period and performed outside the reporting period. All negative amounts paid are claims paid outside the reporting period and performed inside the reporting period.
Provider Activity	For claims that are associated with a single service, shows a provider's claim summary for all services between two dates. It is similar to the Service Recording window but individual MBS items and their statuses are shown.
Rejected by Period	For claims that are associated with a single service, displays a list of Electronic Claims (Online Claims) that have been rejected by Medicare, for a selected date range. Partially rejected claims are also reported. The report shows reference, date, patient name, provider and amount claimed.
Service Activity Report	For claims that are associated with a single service, displays a comprehensive summary of all items claimed using Medicare's online claiming. Individual claims are shown with date, place, doctor, item number and amounts claimed and paid. If required, select claims only for services flagged as after hours. Export the report to Microsoft Excel and manipulate it to extract detailed information concerning claims and payments.

Table 156. Electronic claims reports (continued)

Report > Electronic Claims	Description
Service Provider Duration and Claims	Shows the duration of services recorded for a selected provider between two dates with details of Medicare items claimed. Use this report to audit length of consultations with Medicare items claimed. The duration will be the time the clinical record was open for that provider unless it has been manually adjusted. Only services with Medicare claims are included (whether paid or not paid). No client contact services are excluded. Services with no length are excluded (for example, the claimant was added to the service but did not open the clinical record).
Services Claimed by Encounter Plc (Totals)	For claims that are associated with a single service, displays total Medicare revenue for each encounter place for a date range, including Provider Name, Total Amount Claimed, Total Amount Paid. Use this report to obtain total Medicare revenue figures for each provider.
Services Claimed by Provider (Details)	For claims that are associated with a single service, displays a list of services between a date range, that have been claimed, including Claim ID, Service Date, Patient Name, Amount Claimed, Amount Paid, Payment Date and Payment Run Number, grouped by Provider. Use this report to obtain Medicare revenue figures for each provider.
Services Claimed by Provider (Totals)	For claims that are associated with a single service, displays total Medicare revenue for each provider for a date range, including Provider Name, Total Amount Claimed, Total Amount Paid. Use this report to obtain total Medicare revenue figures for each provider.
Services Claimed for Patient	For claims that are associated with a single service, displays a list of services between a date range, that have been claimed for a patient and includes Claim ID, Service Date, Amount Claimed, Amount Paid, Payment Date, Payment Run Number and Provider. Use this report to obtain Medicare billing figures for a selected patient.
Services Not Claimed by Period	For claims that are associated with a single service, displays a list of Services that have not been claimed from Medicare, for a selected date range and includes reference, date, patient name and amount if any. Use this report to get a list similar to the one visible in **File > Online Claiming > Bulk Bill Claims**tab. The report identifies services that should be claimed or marked as not claimable.
Services Not Claimed by Provider	For claims that are associated with a single service, displays a list of Services that have not been claimed from Medicare, for a selected date range and includes reference, date, patient name and amount if any, grouped by place, mode and provider. Use this report to identify services that should be claimed or marked as not claimable.
Services Not Processed by Period	For claims that are associated with a single service, displays a list of electronic claims sent but not processed for a selected date range and includes reference, date, patient name and status.

Table 156. Electronic claims reports (continued)

Report > Electronic Claims	Description
Services Paid by Period	For claims that are associated with a single service, displays a list of services between a date range that have been paid by Medicare Australia, including those partially paid. It shows Claim ID, Service Date, Patient Name, Provider Name, Amount Claimed, Amount Paid, Payment Date and Payment Run Number. Use this report if you want to export the list of all claims to Microsoft Excel.

Encounter Analysis

These reports analyse patient encounters that have been recorded using the Service Recording *(on page 86)* module.

In addition to the usual Report Options *(on page 456)* these report allow selection by time of day and day of week.

Table 157. Encounter analysis reports

Report > Encounter Analysis	Description
Accreditation Audit	Shows all patients seen by a provider between two dates where any of the following has still not been recorded: • Allergy status (either an allergy or 'nil known' not recorded) • Social and family history (one or both missing) • Emergency contact name and phone missing. If either a number or a name is included, the encounter is not included in the report. Fictitious and deceased patients are excluded. When the data was recorded and by whom are not considered. If the report is run for all providers, there is a page break between each one.
Average Waiting Time in Minutes	Reports average service waiting times between two selected dates for encounter places and modes that record arrival times. Also reported is the percentage of services where the patient waited over one hour. The first percentage includes services where there was no waiting time because the patient did not arrive via a reception area that recorded the arrival time - use this for backwards compatability. The second percentage excludes such services and only counts patients that had a waiting time recorded.
Child Contact Analysis	Summary of children who were current and under 5 years old at the end of the report period who were seen between two dates that have had a haemoglobin, height and weight recorded or not recorded in that period. Also reported are children who had overdue immunisation reviews or immunisations that were not performed.

Table 157. Encounter analysis reports (continued)

Report > Encounter Analysis	Description
Clinic Days by Place and Type	Counts the number of days that clients were serviced with specific "Clinic" type procedures, for each "encounter place". This count may be considered as the number of clinics (of particular types) that have been provided. The report also includes the number of episodes that occurred at each place. Episodes (services) that do not include a specific "Clinic" type procedure are not be counted. Non-contact services are not included in this report. Use this report to see the number of days Clinic type services were provided at each place and the number of episodes. This is a good indication of Clinic service level activity for a health service which operates from multiple places.
Clinic Days by Place with Episode Count	Counts the number of days that clients were serviced from each "encounter place". This count may be considered as the number of clinics that have been provided. The report also includes the number of episodes that occurred at each place.Non-contact services are not included in this report. Use this report to see the number of days that services were provided at each place and the number of episodes. This is a good indication of service level activity for a health service which operates from multiple places.
Condition Analysis	Provides an analysis of Conditions recorded during services. It can be used to indicate the number of consultations occurring due to particular conditions if your Practice Policy is to record the Reason For Encounter for every service. Since a number of conditions can be recorded in a single encounter, there are two totals recorded at the end - the number of conditions and the number of distinct encounters. (+) next to a date indicates that the encounter has already been recorded for a different condition.
Contacts by Client Type and Provider	Analyses patient contacts by patient status, patient Aboriginality, provider speciality and provider name for a selected period, including 'no client contact' services. Fictitious clients are excluded. Use this report to evaluate service activity.
Contacts by Place	Counts the number of contacts between two dates, excluding non-client services. The report is split into the following age groups: • 0-4 • 5-9 • 10-14 • 15-54 • 55-64 • 65+ The report is disaggregated by Aboriginality, sex and age group. Age is calculated as at the end of the reporting period. The report displays a count of the number of contacts per age group for each sex and Aboriginality, and displays totals for sex and Aboriginality, and grand totals for each age group. The report can be filtered by Encounter Place and Program.

Table 157. Encounter analysis reports (continued)

Report > Encounter Analysis	Description
Contacts by Place and Mode and Program	Audits each provider's use of mode, place and program. The report also shows viewing rights assigned to the progress note (if any). Use this report to see if providers are recording services with appropriate details. If you run this report and you do not have appropriate program or viewing rights, you will not see data associated with programs and rights you are not allowed to see.
Contacts by Provider and Aboriginality	Analyses patient contacts by provider, place, mode, Aboriginality, sex and age for a selected period. Use this report to evaluate service activity.
Contacts by Provider Type and Name	Similar to the "Contacts" question OATSIH "SAR" Report menu, but instead of listing by "worker type" it also includes worker's names, and can be run for a selected range of dates. • Non-client contact and fictitious patient episodes are excluded. • Both Started and Finished services are counted. • Booked and Waiting services are excluded.
Contacts by Speciality	Counts all client contacts for services between two dates filtered and grouped by speciality type, encounter place, encounter mode and encounter program, including days of service, contacts by sex and individuals by sex. If required, disregard the place, mode or program groupings so that the resultant data shows speciality type contacts.
Contacts Locality Analysis	Displays client locality, the number of contacts and the number of individuals seen during the reporting period for each locality, excluding ficticious patients, non-patients and non-contact and administration encounter modes. This report relates to the "Rural & Remote Areas Mental Health" project. It counts the number of "clinically significant" services delivered directly to a client. A "clinically significant" service is any service that is relevant to the health needs of the client and is not restricted to face to face contact, but excludes services of an administrative nature. Filter by program and locality grouping.
Contacts Mode Analysis	Displays the method of delivery and the count of patients disaggregated by sex and totals for each, excluding ficticious patients, non-patients and non-contact and administration encounter modes. This report relates to "Rural & Remote Areas Mental Health" projects and counts the number of individual services provided by each method of delivery. Filter for a particular program and locality group into which the patient's home address falls at the time of the encounter.
Count by Clinic, Aboriginality, Sex, Age	Counts the number of encounters during a selected period, analysed by encounter place, Aboriginality, sex and age group.

Table 157. Encounter analysis reports (continued)

Report > Encounter Analysis	Description
Episodes after hours	Similar to the "Episodes" question on the OATSIH "SAR" Report menu, except that it reports only "after hours" services and numbers are broken down into Place Mode. The report can be run for any desired period. • Non-client contact and fictitious patient episodes are excluded. • Services involving transport workers only are excluded. • Both Started and Finished services are counted. • Booked and Waiting services are excluded.
Episodes by Indigenous Status and Program	Lists by program, patient names and the number of times program has been used by each patient according to indigenous status. Use this report to evaluate program service activity. • Deceased clients are included in this report. • Fictitious clients are excluded.
Episodes by Place and Mode and Program	Similar to the "Episodes" question on the OATSIH "SAR" Report menu, except that numbers are broken down into Place, Mode and Program and the report can be run for any desired period. The report is disaggregated by Program, Encounter Place, Encounter Mode. Totals are provided per Encounter Mode, Encounter Place. The report may be filtered by Encounter Place, Encounter Mode, Program. • Non-client contact and fictitious patient episodes are excluded. • Services involving transport workers only are excluded. • Both Started and Finished services are counted. • Booked and Waiting services are excluded.
Episodes of health care	Similar to the "Episodes" question on the OATSIH "SAR" Report menu, except that numbers are broken down into Place Mode and the report can be run for any desired period. • Non-client contact and fictitious patient episodes are excluded. • Services involving transport workers only are excluded. • Both Started and Finished services are counted. • Booked and Waiting services are excluded.
Episodes of health care (Full)	Analyses services between two dates by encounter place, patient status and patient's home locality group at the end of the reporting period. • Non-client contact and fictitious patient episodes are excluded. • Services involving transport workers only are excluded. • Both Started and Finished services are counted. • Booked and Waiting services are excluded.

Table 157. Encounter analysis reports (continued)

Report > Encounter Analysis	Description
Episodes of health care by Place	Episodes of care for a specific encounter place by Aboriginality, sex and age group, excluding 'No client contact' services. Age is at time of encounter, grouped by: • 0-4 • 5-9 • 10-14 • 15-54 • 55-64 • 65+
Frequent Patient Analysis	Analyses the frequency of visits and claims for MBS items 721 or 723 for all patients aged 15 years or over where at least five services were performed by doctors between two dates. • 721 also includes MBS items 92024, 92068, 229, 92055, 92099. • 723 also includes MBS items 92025, 92069, 230, 92056, 92100. • Items 721 and 723 are considered if they have been ticked for claiming, regardless of whether the claim has been paid or not. If two doctors see the patient on the same visit this is counted as two doctor visits. No client contacts are excluded. Only services that are started, paused or finished are included.
Individual Patients Serviced	Counts the number of individual clients serviced, divided by Aboriginality and sex for a selected range of dates. Use this report to report on the QUMAX population served between two dates. Services that have not started or finished, non contact services and fictitious patients are excluded.
Individual Patients Serviced (Full)	Analyses individuals seen between two dates by encounter place, patient status and patient's home locality group at the end of the reporting period. A client is counted only once. • Non-client contact and fictitious patient episodes are excluded. • Both Started and Finished services are counted. • Booked and Waiting services are excluded.

Table 157. Encounter analysis reports (continued)

Report > Encounter Analysis	Description
Individuals by Age Group	This report relates to the "Mental Health Services in Rural and Remote Areas" Project and refers to the individuals who are receiving some level of service within the reporting period. The report breaks down the number of patients seen during a reporting period, grouped into the following age groups: • 0 to 17 years • 18 to 65 years • 65 and older The report counts patients only once and disaggregates by sex and totals for each. The report excludes ficticious patients and excludes non-contact and administration encounter modes. Patients who have been marked as deceased during the reporting period are reported in a separate grouping. Patients can be filtered by current locality group.
Individuals by Encounter Place	Lists all patients who attended a specified encounter place with their mailing address and telephone details. Use this report to contact patients who attended a particular clinic between two dates. The age filter is based on the patient's current age.
Individuals Seen by Provider	Reports on individual patients seen by a selected provider (or any provider with a selected speciality type) and can be run for a selected range of dates. Patients can be grouped by Aboriginality. • Non-client contact and fictitious patient episodes are excluded. • Both Started and Finished services are counted. • Booked and Waiting services are excluded.
Individuals Seen Only Once	Shows individual clients serviced only once between two dates and not seen at all since the last date to report at a specific encounter place, including the date of the last service and the speciality types of the providers seen on that visit. Use this report to identify patients who may be set as current or transient but who should more properly be manually set to past or transient. Patient status is the patient's current status, not the status at the time of the service. Similarly the patient age is the age today not the age at the time of the service. • Patients with no date of birth are excluded. • Non-client contact services are excluded. • Services that have not started or finished and non contact services are excluded.

Table 157. Encounter analysis reports (continued)

Report > Encounter Analysis	Description
Individuals Serviced by Age Group	Counts the number of individual clients serviced during a selected period, analysed by 5-year age group and Aboriginality. The age that the client was at the end of the reporting period determines their age group. The locality group is the locality of the patient's home address at the end of the reporting period.
Individuals Serviced with HCC	Reports the number of patients seen at least once between two dates with or without a Health Care Card, Pension Card or Seniors Card, grouped by Aboriginality and sex. Filter by encounter place and the locality group the patient was living in at the time. 'No client contacts' are excluded.
Locality Service Count	Counts the number of services provided to patients whose home address is in the selected locality or locality group at the time of the service, during a selected period. Where a service took place before a patient's earliest known address this service is not included, because the home address of the patient cannot be determined. The report divides services between those provided during 'normal hours' and those provided 'after hours'. Fictitious patients are excluded.
Locality Service Patients	Lists the names of patients who have been serviced, where the patient's current address was in the selected locality at the time of the service, during a selected period. Fictitious patients and 'no client contact' services are excluded.
Multiple Services for Today	Counts all the services for each patient who has had more than one service today. Use this query at the end of the day to find patients with multiple services. Some may not be genuine multiple services.
Patients in the Clinic	Shows patients present in the clinic between two date/times. Use this report to find who was in a specific clinic between two times, either for all or part of the time. This report can be useful when following up potential contact with infectious patients who also attended at that time. The following services are not included: • Any 'no client contact' mode. • Any 'Telehealth' mode. • Telephone. • Client's home. Enter times in 24 hour clock format as 'hh:mm' or 'hhmm'.

Table 157. Encounter analysis reports (continued)

Report > Encounter Analysis	Description
Provider Data Audit	For each provider shows who provided service during a selected period, the number of "Contacts", the number of clinical items and the number of progress notes recorded. Use this report to audit providers' data recording. • Fictitious patient episodes are excluded. • Both Started and Finished services are counted. • Booked and Waiting services are excluded.
Provider Data Audit Details	For a selected provider who provided services during a selected period, shows the number of "Contacts" and the number and type of clinical items recorded. Use this report to audit a provider's data recording. • Fictitious patient episodes are excluded. • Both Started and Finished services are counted. • Booked and Waiting services are excluded. • Recalls are excluded.
Provider, Mode and Place Analysis	Provides an analysis of patient encounters performed by selected Providers by mode and place. It can be used to help assess Provider workload and activity.
Reason for Encounter	Shows all contact services with the RFE (reason for encounter) if the health service has enabled this functionality. Also shown are all other clinical item types added to the service by any provider who saw the patient at that time. 'No client contact' services are excluded.
Service Activity by Class	Counts the number of times each type of clinical item has been recorded divided by class, for a selected range of dates and patient's home address locality group. Use this report to determine the level of activity performed during the selected period. Incomplete recalls and fictitious patients are excluded.
Service Provider Analysis	Provides an analysis of patient encounters performed by selected Providers. It can be used to help assess Provider workload and activity.
Service Provider Duration	Shows the duration of services recorded for a selected provider between two dates.
Service Provider Duration Analysis	Shows the total duration of services recorded for a selected provider or all providers between two dates. Use this report to find details for providers who need to submit time spent on services as part of their reporting requirements. This report will detail only the total amount of time that a clinical record was open unless the provider has been manually editing the duration for each service to reflect the time spent on that service.

Table 157. Encounter analysis reports (continued)

Report > Encounter Analysis	Description
Services Count	Reports the number of services provided to male and female patients. This report groups results by encounter place and encounter mode.
Services Count (Periodical)	Counts services performed between two dates grouped daily, weekly, monthly or annually. Export to Microsoft Excel to produce a chart for display in presentations.
Services Count by Age and Sex	Counts individual patients of a selected sex and age range who have received services during a selected period. It also counts the number of services performed. The age is the age of the patient on the day of the service. This report includes patients who have since deceased. An individual who has had services at more than one place or by more than one mode will be counted separately for each place or mode.
Services List by Age and Sex	Lists individual patients of a selected sex who have received services during a selected period. This report includes 'no client contact' services and patients who have since deceased.
Services List by Speciality	Lists all patient services provided during a selected period by a specified speciality type. Use this report to print out services provided by, say, all paediatricians or dietitians between two dates. The age of the patient is calculated at the end of the report period. This report includes 'no client contact' services and patients who have since deceased.
Weekly Activity	Daily analysis of provider services. Use this report as a weekly summary of provider activity. Enter a date range and specify all services, just contact services or just no contact services. Fictitious patient encounters are excluded.

Condition Analysis

This report provides an analysis of Conditions recorded during services.

If your Practice Policy is to record the Reason For Encounter for every service, use this report to indicate the number of consultations occurring due to particular conditions. Since a number of conditions can be recorded in a single encounter, there are two totals recorded at the end - the number of conditions and the number of distinct encounters. (+) next to a date indicates that the encounter has already been recorded for a different condition.

Provider, Mode and Place Analysis

This report provides an analysis of patient encounters performed by selected Providers by mode and place.

It can be used to help assess Provider workload and activity.

Service Provider Analysis

This report provides an analysis of patient encounters performed by selected Providers. It can be used to help assess Provider workload and activity.

Health Care Providers Reports

Report on health care providers at your service.

Table 158. Provider reports

Report > Health Care Providers	Description
Provider List	Shows health care provider details required for transmission to the Improvement Foundation Web Portal. The report includes all providers that have a DoH Provider Number who were enabled for all or part of the reporting period.

Immunisations Reports

Report on immunisations.

Table 159. Immunisations reports

Report > Immunisations	Description
ACIR	Lists all immunisations performed on children aged under 7 years between selected dates. It includes all information required for submission to the ACIR. This report includes patients deceased since the immunisation.
ACIR (Done Here)	Lists all immunisations performed on children aged under 7 years between selected dates. It includes all information required for submission to the ACIR. This report includes patients deceased since the immunisation. **Note:** Unlike the **Immunisations ACIR** report, this report only looks for immunisations that were done at your health service. If you only record immunisations done at your health service, use **Immunisations ACIR** instead. This report is distributed on the condition that you set **Performed at** *Name of Encounter Place* for all immunisations done at your health service, or that a special qualifier called **Immunisation given here** has been attached and set.
ACIR Electronic Claims	Shows all the records visible in the **File > Online Claiming > AIR Claims** tab including the recorder of the immunisation. Run for a selected date range and include sent claims and items that are linked to services that have been marked as 'not claimable' if required . 'Not claimable' items are hidden on the **AIR Claims** tab. Use this report to print or export details of AIR claims.

Table 159. Immunisations reports (continued)

Report > Immunisations	Description
Annual Fluvax List	Lists current patients who should be part of the annual influenza vaccinations. Current patients qualify if they meet any of the following conditions: • 65 years old or over and are not Aboriginal • 6 months old or over and are Aboriginal • Over 6 months old, less than 5 years, and any Aboriginality • Have a diagnosed respiratory disease • Have a BSL over 8 mmol/L in the last 24 months • Have a HbA1c over 64 mmol/mol (8%) in the last 24 months • Have a BP over 120/75 in the last 24 months • Have an ACR over 20 mg/mmol in the last 24 months • Are prescribed any regular medication Patients are excluded if they have had an influenza vaccination in the current calendar year. For more information, see National Immunisation Program Schedule.
Annual Fluvax List NT	Provides a list of current patients who should be part of the annual influenza vaccinations in the Northern Territory. Current patients qualify if they meet any of the following conditions: • 65 years old or over • 6 months old or over and are Aboriginal • Over 6 months old, less than 5 years • Over 6 months old and have a chronic disease Specify from the parameter if it is different from `Chronic Conditions (All)`. Patients are excluded if they have had an influenza vaccination in the current calendar year. For more information, see https://nt.gov.au/wellbeing/healthy-living/immunisation/adult-vaccinations.
Details for selected immunisation	Lists all details for a selected immunisation given at a specified encounter place. Use this report to create a register for immunisations of a specific type, for example Gardasil (HPV vaccination). You are prompted for a date range, sex and an age range.
Details for selected immunisation with Address	Lists all details for a selected immunisation given at a specified encounter place, including the patient's address details Use this report to create a register for immunisations of a specific type, for example Gardasil (HPV vaccination). You are prompted for a date range, sex and an age range.

Table 159. Immunisations reports (continued)

Report > Immunisations	Description
Flu and Pneumo Imms by Encounter Place	Influenza and pneumococcal vaccinations performed by encounter place and mode. You can specify an age range based on the age of the patient when the vaccination was given. This report is similar to the "Vaccinations" question on the OATSIH "SAR" report, except that numbers are broken down into Place Mode and the report can be run for any desired period and patient age range.
Fluvax performed this year	Lists all 'Flu' immunisations performed in the current calendar year for a specified locality group. Use this report to determine whether a patient should be immunised for the current flu season.
HPV Registry Notification	Lists all details for any HPV immunisation given. You are prompted for a date range. Use this report to create a register for HPV immunisations. This report looks for any immunisation type containing the terms 'HPV', 'Gardasil' or 'Ceravix'. Immunisations must be recorded as being **Performed at** *Name of Encounter Place* . If the service is associated with a Medicare claim, the claiming doctor's details are provided. Immunisations performed with no Medicare claim attached are reported as 'No Claiming Doctor'. To display all information, export this report. When printed, not all information is shown and there are page breaks between any different encounter places and claiming doctors.
Immunisation Summary for Selected Patient	Lists all immunisations recorded for a selected patient.
Immunisations Performed	A complete list of patients who have immunisations that have been completed. Specific immunisation types or all immunisations due, can be selected. Localities, age groups and time periods can also be specified.
Individuals immunised	Counts the number of individual clients who have received a specific immunisation, analysed by age, locality group and Aboriginality. Use this report to determine the number of clients immunised over a selected period. Each client is counted once only.
Report for CDC-NT	Lists all details for immunisations given at a specified encounter place or all encounter places formatted for use by CDC NT to enter into the Immunisation database. You are prompted for a date range and encounter place. Patient age grouping is determined by the age of the patient at the start of the report period.

Table 159. Immunisations reports (continued)

Report > Immunisations	Description
Summary	Lists the number of each immunisation performed during a selected period. Use this report as an immunisations performance indicator, to count any immunisations done by this health service, or count all immunisations recorded, analysed by provider if required. Analysing immunisations "not done here" by provider reports the provider who recorded the immunisation.

Immunisations Performed Report

This report produces a complete listing of patients who have immunisations that have been completed. Specific immunisation types or all immunisations due, can be selected. Localities, age groups and time periods can also be specified.

Investigations Reports

Report on investigations.

Table 160. Investigations reports

Report > Investigations	Description
LOINC Codes Received	Counts investigation result data received where a code has been included by the lab (for example, a LOINC). Use this report to assess which results you receive from your lab that you can report on at an atomic level. • Observation name - the name given to the element by your lab. • LOINC num - the code used by the lab for this element. • Test code - the name of the whole result returned by the lab. • Total - the number of such results received between two dates.
Outstanding Requests by Provider	Lists all investigation requests for which no result has yet been matched, looking back a specified number of days, by pathology provider with the oldest requests first for living patients only. Select the provider's name or a specific test. The provider role parameter allows you to select either the provider who made the request, regardless of a specified 'on behalf of' provider or to use the 'on behalf of' provider instead.
Patients with Unmatched Results	Lists all patients with unmatched pathology results that have not been deleted. These results are not in a patient's clinical record nor have they been reviewed. To match the results manually, select  **Documents and Results > Investigation Results** tab and order the unreviewed results by patient name. Double-click a result to open it and then match and review it. For more information, see Reviewing and matching results *(on page 309)*.
Requested	Lists all investigation requests made between two dates, organised by encounter place.

Table 160. Investigations reports (continued)

Report > Investigations	Description
Requests and Results Count	Counts all investigations requested, by name, or all results received, by name, between two dates. The date range includes requests by date requested and results by date received. A single result received from a pathology lab may include multiple requested tests.
Results Received	Displays all results for a specified investigation received between two dates for patients between two ages at the time of the test. Only results matched to a patient are considered. A result of 'Not stated' may indicate a normal result - check with your pathology lab to confirm this.
Investigations Unreviewed Abnormal Content	Use this report to highlight abnormal parts of results that may require immediate action. Shows all atomised results received as HL7 investigation results where: • The specific element is flagged as abnormal, in the relevant OBX segments. • The result is not yet reviewed. Filter the report by specific test result and/or the sending laboratory. Fictitious patients are excluded but deceased patients are included. Export to Excel to see additional fields such as receiving doctor.
Unreviewed Results	Lists all unreviewed pathology results. This report can be used by providers who do not have full investigations rights but need to see which patients have received results that need reviewing. To view the results, open the clinical record for a patient and click on the **Results** link in the banner. Results for patients with a patient ID of 'Unmatched' cannot be seen in the clinical record. A user with `Investigations` rights must first match the result to the correct patient in the **Match and Review Result** window.

Medications Reports

Report on medications.

Table 161. Medications reports

Report > Health Care Providers	Description
Chronic Medications and Reviews	For health services using clinical items of the class 'Chronic Medication' instead of the **Prescribing** module, lists patient's Chronic Medication and the date of the last medication review. Only current patients are included in the list.

Table 161. Medications reports (continued)

Report > Health Care Providers	Description
CTG Prescriptions Count	Provides a count of medications prescribed during a selected period at a selected encounter place or all encounter places that were marked as Closing the Gap prescriptions.
Dosette Label for Selected Patient	A snapshot of the **Medication Summary** for a selected patient. It is not a prescription but may be used as a dosette box label. Wherever possible the patient's clinical record should be checked for changes made since the printing of this label.
Locality medication list	Lists all current medications for all current patients grouped by locality, where current medications are regular medications and once-off medications for which the days supply has not expired. Use this report as a working medication list when making locality visits. Order by surname or first name within the locality. This report lists current patients only. Transient, past and fictitious patients are excluded.
Medication Summary for Selected Patient	A snapshot of the **Medication Summary** for a selected patient. It is not a prescription but may be used as a record of the patient's current medications. Wherever possible, the patient's clinical record should be checked for changes made since the printing of this report.
My Prescription Defaults	
Outstanding Verbal Orders	Similar to the window that shows a user's unreviewed verbal orders but additionally shows the date and name of the prescription and its status. It also allows all outstanding verbal orders for other providers to be seen. If a prescription has expired or has been stopped, review the verbal order from the **Detail** tab of the clinical record: right-click and select **Review Verbal Order**. If a prescription has been deleted, before you can review the verbal order, on the **Detail** tab, right-click and select **Show Deleted Items**.
Patients on selected Brand	Lists all patients who are either currently on a once-off medication for which the days supply has not expired or on a regular medication, who have ever been prescribed a particular brand medication. This report includes only medications prescribed by brand, medications prescribed generically are excluded.
Patients on selected Generic	Lists all patients who are either currently on a once-off medication for which the days supply has not expired or on a regular medication, who have ever been prescribed medication containing a selected generic drug. Use this report to identify patients who use a particular medication.

Table 161. Medications reports (continued)

Report > Health Care Providers	Description
Patients on selected Therapeutic Class	Lists all patients who are either currently on a once-off medication for which the days supply has not expired or on a regular medication, who have ever been prescribed a medication belonging to a selected therapeutic class. Use this report to identify patients who use a particular medication. Filter to select only patients that have first been prescribed the selected therapeutic class after a specified date or have last been prescribed the selected therapeutic class after a specified date.
Patients Prescribed selected Generic	Lists all patients who have been prescribed a medication containing a selected generic drug within a selected period of time. Use this report to identify patients who have been given a particular medication within a particular period. You may find this useful when reconciling drug stock quantities. This report will not include any prescriptions prescribed by brand where the brand has subsequently been deleted by MIMS.
Patients with expired Regular Medications	Lists all current patients who have regular medications which will have expired by a specified, valid date. Use this report to produce a list of patients whose regular medications are due for review by a doctor. Transient, past and fictitious patients are excluded.
Patients with Multiple Regular Medications	Lists all current patients who have multiple, regular medications. Specify the minimum number of regular medications to limit patient's included in the report. Transient, past and fictitious patients are excluded.
Patients with Multiple Same Medications	Shows patients in a selected locality group with multiple, current prescriptions for the same medication. Consider making these medications regular so that they appear only once in the medication summary with details of the latest script.
Prescriptions Count	Provides a list and count of medications prescribed during a selected period at a selected encounter place or all encounter places. Use this report to analyse the medications prescribed.
Reason for Prescribing	Shows all patients and prescriptions where a prescription was made between two dates with a reason for prescribing belonging to a specified clinical item group. (Note that the **Reason for Prescribing** is an optional field.) For example, to find all prescriptions recorded as having type 2 diabetes as the reason for prescribing, select the clinical item group or DIABETES, NON-INSULIN DEPENDENT.

Table 161. Medications reports (continued)

Report > Health Care Providers	Description
Unprescribed Regular Medications	Lists patients who have any regular medication records where the medication has yet to be prescribed. This situation can arise in the following cases: • The rural prescription is used and a medication was added as a regular medication but the rural prescription was not generated. • Some regular medication data was imported from another database but has not been converted or represcribed as a MIMS medication.

Chronic Medications and Reviews

For health services using clinical items of the class 'Chronic Medication' instead of the **Prescribing** module, lists patient's Chronic Medication and the date of the last medication review.

The standard report options determine which chronic medications are included in the report and other report characteristics. If a patient has two (or more) chronic medications recorded, then they will appear twice (or more) in the report.

MeHR Reports

Check MeHR upload information.

Table 162. MeHR reports

Report > MeHR	Description
Consumer Reconciliation	This is an extract, not designed for printing. Run this report when MeHR wants an extract to reconcile the MeHR repository with the local database.
Current MeHR Status	Counts patient MeHR status by current status and shows percentages of patients active, temporary, inactive and not registered. Filters are provided for record storage location and locality.
Processing Queue	Show the current processing queue for MeHR. The report displays all orders still sitting in the queue because they were not processed regardless of reason. Use this report to determine if there is something not working with Argus and with MeHR in general. Shows the identifier for each MeHR order type. • MeHR Order type | Record in queue • Current Health Profile | Patient Identifier Event Summary | Service identifier • Investigation Result | Investigation Result identifier Revoke Investigation Result | Investigation Result identifier Deactivate Event Message | Service identifier Antenatal Report | Patient Identifier

Patients Reports

Patients reports provide information about individual patients.

Table 163. Patients reports

Report > Patients	Description
Address Details	Shows address details for patients of a selected age and locality or locality group, including all phone numbers. Use this report to check patient addresses. An additional filter allows you to report only those details with potential issues that may cause problems when communicating with third parties such as Medicare and AIR.
Administration Notes	Shows administration notes for selected patients.
Biographics Added	Lists biographic details for new patients added to the Communicare database since a selected date. The username of the provider who added the patient is also displayed. Filter to show patients added who do not have sex recorded, date of birth or Medicare number, and so on. Column CRN refers to the Centrelink information: • H=Health Care Card • P=Pension • S=Seniors • N=No Card • ?=Unknown but number recorded Column SEX refers to the patient sex: • F=Female • M=Male • D=Indeterminate • I=Intersex • N=Not Stated • U=Unknown / Inadequately Described • Blank: Not recorded Sex is deemed as 'not recorded' when it is blank , 'Not Stated' or 'Unknown/Inadequately Described'. Fictitious patients are excluded.

Table 163. Patients reports (continued)

Report > Patients	Description
Biographics Added - Risk Audit	Lists biographic and clinical details for new patients added to the Communicare database between two dates. Filter to show patients added who have no sex recorded, date of birth or Medicare number, and so on. This report needs to be run by a user with access to the **Common** viewing right in order to see these risk factors. The report shows if adverse reactions have been assessed and also shows if there is a current family history, social history, smoking and alcohol status recorded. There is also a count of the number of consultations with a GP (where the GP recorded a progress note) since the patient was added (for more than 9 visits this is shown as 9+. For smoking, the following codes are used: • S (smoker) • N (non-smoker) • E (ex-smoker) For alcohol, the following codes are used: • D (drinker) • N (non-drinker) • E (ex-drinker) Both the standard qualifiers and the pregnancy qualifiers are used. (For alcohol, smoking, family history and social history, system codes are used so health services that use their own qualifiers will have these included if they have the appropriate system codes attached.) Fictitious patients are excluded.
Biographics Filter	Prints the patient's full name and you can choose from a variety of additional output fields such as date of birth, locality, patient ID and various other identification numbers such as Medicare and IHI number. This is the most versatile biographics report. Use this report to create patient lists. There is a variety of filters with which to limit the set of patients reported including patient status, sex, aboriginality, age, locality, and so on.
Biographics for Selected Patient	Shows all information recorded in a selected patient's biographics.
Birth Details Audit	Checks all 'Birth Details' items and indicates where the date has not been set to the date of birth of the patient in whose record the item is recorded. Key details are displayed for auditing.

Table 163. Patients reports (continued)

Report > Patients	Description
Births	Lists patients born with their birth weights. The standard report options determine which patient births are included in the report and other report characteristics. The report totals show number of births with average birth weight by locality. This report uses the earliest residence locality recorded. If births are recorded at the time of birth, this will accurately reflect the residence locality at birth (actual place of birth may be a hospital). If the report is run for patients who were recorded a considerable time after birth and the first residence recorded is not the residence locality at birth, then the report will be inaccurate.
Births by Aboriginality	Shows patients born between two dates showing their name, mother (if recorded), locality, date of birth and birth weight (if recorded). Birth weight is selected from the patient biographics or, if this is not recorded, from the most recent weight recorded with a date equal to the date of birth of the patient. The locality is the locality of the patient at the end of the report period. If a birth was recorded later than the end date of the report the locality is displayed as '[Registered > DD/MM/YYYY]'. There is a filter to just show patients with no birthweight recorded or those born under 2500g or those born under 2000g.
Card Numbers by Locality Group	Produces an alphabetical listing of all patients, including their date of birth, Health Care Card number and Medicare card number. Filter by current status and locality group

Table 163. Patients reports (continued)

Report > Patients	Description
Child Growth Faltering	For children under 5, looks at all patients aged between two ages and shows their latest weight with the date taken, how many standard deviations above or below the mean at the age this was recorded and whether this has changed since the previous weight taken at least two weeks before (that is has the latest weight changed to a different standard deviation). If a child's weight has declined, this is reported as down even if it is within the same standard deviation. Also shown is the latest Hb with the date taken and if that value was anaemic for a child of the age and sex at the time of recording. The column SEX refers to the patient sex: F=Female, M=Male, D=Indeterminate, I=Intersex, N=Not Stated, U=Unknown / Inadequately Described, Blank: Not recorded. Column SEX refers to the patient sex: • F=Female • M=Male • D=Indeterminate • I=Intersex • N=Not Stated • U=Unknown / Inadequately Described • Blank: Not recorded Where a child has a 'Gestational age at birth' recorded on the 'Birth details' item in their record of 36 weeks or less, a label 'Prem' is shown.
Child Weight Analysis	For children under 10, looks at all patients aged between two ages and shows their latest weight with the date taken, how many standard deviations above or below the mean at the age this was recorded. The results are grouped and ordered from overweight to underweight.

Table 163. Patients reports (continued)

Report > Patients	Description
Chronic Disease Clients (Default)	A generic report that finds chronic disease patients based on conditions recorded in their clinical record. Patients can be filtered by status, Aboriginality, sex, age, locality group, patient group and date of last contact. The resulting list shows all patients with at least one chronic disease (as defined below) and shows the date of the last MBS item 721, 723, 732 and 715 claim. The date of the last update to the care plan document is also shown (only care plan documents visible on the care plan tab are included). These COVID-19 MBS items are included as equivalents of the health assessment and chronic disease management items: • 721 also includes items 92024, 92068, 229, 92055, 92099 • 723 also includes items 92025, 92069, 230, 92056, 92100 • 732 also includes items 92028, 92072, 233, 92059, 92103 • 715 also includes items 92004, 92016, 228, 92011, 92023 Only conditions classified by ICPC2 in the grouper 'CHRONIC CONDITIONS (ALL)' are included. Only conditions in the following topics are considered: 'Cardiovascular', 'Respiratory', 'Endocrine, Metabolic and Nutritional' and 'Urological'. Because this report is generic in nature, to suit local needs, copy & modify the report and mark as 'not public'. Advise your staff to use your variation which should be named without '(default)' in the report name. Your local variant of this report will not be maintained by Communicare.
Clinical Item Group by Item	Lists all current patients who have a clinical item within a selected clinical item group, filtered by patient status, Aboriginality and Record Storage Site. This is a patient-based report. It lists patients once only, regardless of the number of times particular clinical items have been recorded for the patient. The patient will be reported multiple times where different clinical item types have been recorded within the selected group. Use this report: • To locate all patients belonging to a particular disease or other group when the item detail is required. • As a chronic disease register by selecting a specific clinical item group or CHRONIC CONDITIONS (ALL). • As a performance report to find the number of clients who have had procedures. For example, selecting group CHECKUPS (ALL) to list all clients who have had checkups.
Clinical Item Group by Locality	Lists all patients who have a clinical item within a selected clinical item group, organised by current home locality. Use this report to locate all patients belonging to a particular disease or other group. This is a patient-based report. It lists patients once only, regardless of the number of times group clinical items have been recorded for the patient.

Table 163. Patients reports (continued)

Report > Patients	Description
Clinical Item Group by Locality and Item	Lists all current patients who have a clinical item within a selected clinical item group, organised by current home locality. Use this report to locate all patients belonging to a particular disease or other group when the item detail is required. This is a patient-based report. It lists patients once only, regardless of the number of times particular clinical items have been recorded for the patient. The patient will be reported multiple times where different clinical item types have been recorded within the selected group.
Clinical Item Group by Patient Group Membership	Lists patients who have clinical items recorded in a selected Clinical Item Group, e.g. Chronic Conditions (All), and are or are not part of a selected patient group on a specified date, filtered by patient status, Aboriginality and locality group. This can be used, for example, to find Aboriginal patients with a chronic disease who have not been registered with PIP if you use a patient group to record PIP registration.
Clinical Item Group Patient Labels	Prints a mailing address label for all current patients who have a clinical item within a selected clinical item group and have or have not been seen since a specified date, filtered by locality group, patient status and Aboriginality. There is an option to include the mother's name on the address label if this is recorded in biographics and if the patient is under 18 years old. Use this report to print address labels for all patients belonging to a particular disease or other group who may need a standard letter concerning their attendance or non-attendance at the health service. This is a patient-based report. It lists patients once only, regardless of the number of times particular clinical items have been recorded for the patient.
Clinical Records Added	Lists all recalls completed and other clinical items added since the selected date. Fictitious patients are excluded.
Date of Last Service	Produces a sorted list of current patient names, addresses and telephone numbers and the date of their latest service. A filter can be applied to select only those patients whose last visit was after a specified date or to select only those patients whose last visit was before a specified date (this portion includes patients who have never visited). 'No client contact' services are excluded.
Deaths	Lists patients who have died. The standard report options determine which patient deaths are included in the report and other report characteristics. The report totals show number of deaths with average age by locality.

Table 163. Patients reports (continued)

Report > Patients	Description
Duplicate Babies	Looks for babies added with the given name 'BABY OF [MOTHER]' or 'BO [MOTHER]' or 'B/O [MOTHER]' or 'NEWBORN' where there exists another record for a patient with the same date of birth and surname. Also searched for are 'TWIN 1 OF', 'TWIN 2 OF', 'TRIP 1 OF', and so on. For more information, see Adding a New Patient *(on page 45)*. Use this report to find duplicate records for babies added before the given names were known. Once duplicate records are confirmed the patients should be merged.
Eligible for CTG Co-payment Relief	Shows all patients marked in biographics as being registered for CTG PBS co-payment relief or who have had a 'PIP - Patient Consent' letter, 'PIP - Registration' letter or 'PIP - Registration and Consent' letter recorded. Also shown are the latest date of recording of a 'PIP - Patient Consent' letter and/or 'PIP - Registration' letter and/or 'PIP - Registration and Consent' letter. The report can be filtered by Aboriginality to find any patients registered who are not Aboriginal or do not have this status recorded. A further filter allows you to find patients not recorded as registered. The 'CD' column indicates if the patient has a condition shown on their clinical summary that belongs to the CHRONIC CONDITIONS (ALL) group.
Emergency Contacts	Shows details of emergency contact information stored on the **Patient Biographics > Social** tab. Use this report to find patients with no emergency contact information or to review the completeness of this data. Set filters to include patients without any information or those with information, complete or partial and by locality group.
Group Members	Produces a list of members of a specific patient group during a specified time period. Deceased and fictitious patients are excluded.
IHI Missing Attempts	Lists attempts to find individual Health Identifiers for patients who do not currently have one visible in the patient biographics.
Individual Health Identifiers	Shows the IHI for selected patients if it is known, with the status of the IHI displayed (such as, Disabled, Missing) if the IHI is not recorded.
Invalid Health Care Card Details	Lists all patients who are missing Centrelink numbers or have expired cards. The report includes spaces for HIC to write in the correct details. There are options to specify patient status and Aboriginality. Patients with 'No Card' selected are excluded.

Table 163. Patients reports (continued)

Report > Patients	Description
Invalid Medicare Details	Lists all patients who are missing Medicare card number details, have expired cards or have failed online validation, bu locality if required. The report includes spaces for Medicare Australia to write in the correct details. Use this report to create a list that may be sent to Medicare Australia to solicit corrected numbers. Users of online claiming should validate Medicare cards *(on page 436)* for all patients before running this report. The report can be run for all patients (except fictitious patients) or for patients of a selected status, such as current patients. You can also use this report to check for those patients with duplicate Medicare card numbers. This feature relies on online validation having been performed for all patients beforehand. Deceased patients are excluded.
Invalid Mobile Phone Numbers	Shows patients with mobile phone numbers that are unsuitable for use in automated SMS messaging, for appointment reminders, and so on. Acceptable mobile phone numbers can have spaces, hyphens and/or brackets and must start with '04' and must have at least ten digits. Additional digits will be ignored. Additional text is allowed so long as the phone number adheres to the above rules. Excluded from this report are mobile phone numbers of '00' as this is an accepted convention indicating that the patient has no mobile phone number.
List by Special Lookup	Lists patients by their special lookup options.
List for Selected Age and Status	Lists living patients in a selected age range and a selected status for a specific locality.
List for Selected Locality	Lists patients of a selected current status whose home address is in the selected locality.
List for Selected Locality Group	Lists all current patients living in a selected locality group.
Medicare Card Validation Errors	Displays patients who are unable to have their Medicare details validated due to errors. The patients are grouped by the particular error message.
Medicare Cards about to Expire	Shows all patients with Medicare cards where the expiry date is within the next specified number of days or unknown. The Medicare expiry date is not automatically updated by the electronic patient card validation program so this information must be kept up to date manually.

Table 163. Patients reports (continued)

Report > Patients	Description
My Health Record Registered Patients	Shows basic biographic details required for registration of patients who appear to have registered for a My Health Record or not. There is a filter to allow you to select either registered patients or unregistered patients. This is the logic that is used: • If the patient was registered for a My Health Record using this Communicare database then they are classified as 'Registered'. • If an attempt was made to open a My Health Record and a My Health Record was found then they are classified as 'Registered'. • If an attempt was made to open a My Health Record and the My Health Record was identified as private then they are classified as 'Registered'. This means that some patients in this report may have a My Health Record if they registered themselves or registered outside this Communicare database and have not yet attended the clinic to be seen by a provider with the rights to access that patient's My Health Record. These patients are classified as 'Unregistered'.
Names By Age	Lists patients by age in years.
Names with Illegal Characters	Lists patients with illegal characters in any of their names. Use this report to fix these patients with an alias as well as a preferred name.
NDIS Status	Lists all patients with an NDIS status, grouped by the status.
Patient Card Numbers	Produces an alphabetical listing of all patients their Date of Birth, Health Care Card Number and Medicare Card Number.
Patient Labels	Print labels for the selected patient. Different types of label can be printed. The type of label printed from any particular workstation is controlled by Patient Label Options. For more information, see Patient Labels *(on page 532)*.
Patient Mailing Label	Prints a single mailing address label for a selected patient. This has been tested using a ZebraLink TLP 2844-Z printer with Avery L7042D labels (70mm x 42 mm). To adapt it for other label printers copy and edit this report and change the label layout to suit.
Patient Query	The Patient Query is a powerful tool that allows you to produce a list or count of patients according to a wide variety of selection criteria. Use this report when none of the other reports can produce the results you require. If for example you want a list of patients who have had a particular immunisation, it would be better to use the Immunisations Performed report than the Patient Query.

Table 163. Patients reports (continued)

Report > Patients	Description
Patient Specimen Label	Prints a single specimen label for a selected patient. This has been tested using a ZebraLink TLP 2844-Z printer with Avery L7042D labels (70mm x 42 mm). To adapt it for other label printers copy and edit this report and change the label layout to suit.
Patient Summary	Prints information about the current patient. For more information, see Patient Summary *(on page 533)*.
Patients Not Seen Recently	Shows all patients within a specified age range that have not had a contact service recorded within a specified time period (previous number of months). Use this report to find children between two ages who have not been seen recently enough for a health check.
Program Current Enrolments	Lists the names of clients currently enrolled in programs. Programs in this report are defined as those for which enrolment is defined by the addition of a clinical item with a rule code of 'xx-ENROL' where 'xx' is a two character code identifying the program. Use this report to manage program enrolments. Fictitious clients are ignored.
Search By Age	Lists living patients in a selected Locality Group and age range with options to filter by patient status and patient sex and includes patient ID, name, Medicare number and date of birth. The age range must be specified in years, months, weeks and days presented as, for example: • '5Y 7M 2W 0D' means 5 years and 7 months and 2 weeks • '5Y 6M 0W 0D' means 5 and a half years • '0Y 0M 2W 3D' means 2 weeks and 3 days
Search By Street Name	Reports all patients living in a particular street. A case insensitive text search of the whole of the patient address, for any word or part of a word entered into either line 1 or line 2 of a patient's current address., is performed for the street name entered when the report is run. Use this report to find patients where the correct locality may not have been recorded as such.
Special Check (Unconfirmed Patients)	Lists all the patients who have not had the special check "Confirmed". The report excludes fictitious patients and is grouped into 'Never asked' and 'denied consent'.

Table 163. Patients reports (continued)

Report > Patients	Description
With Names Reversed	Shows all patient names where the reversed names are recorded for another patient. For example, where a patient MARTIN SMITH exists and there is a patient with the name SMITH MARTIN, this report lists both patients. Use this report to check that a patient has not been incorrectly recorded. There are options to only consider those patients with the same sex or those with an exact or similar date of birth. Patients with no date of birth are not included. Duplicates should be merged and the reversed alias deleted.
With Same DoB, Medicare No	Lists details of patients with identical dates of birth and Medicare card living in a particular locality group. The issue number and the reference number are ignored unless the option to include them is selected. Use this report to find possible duplicate patients with different names. Note that twins sharing the same Medicare card and parents sharing the same Medicare card and date of birth will be reported also.
With Selected Clinical Item	Lists all current patients with a selected clinical item. This report is patient-based, not clinical item-based. It will list a patient only once, regardless of the number of times the clinical item is recorded in the patient's record. Patient contact information, specifically their Phone, Work and Mobile numbers are included in the Excel version of this report Complete and incomplete items are included in this report (i.e. recalls and cancelled recalls are excluded). Patient status and age is assessed at the time of running the report.
Without DoB or Sex	Lists all patients who do not have a date of birth or sex recorded. Column SEX refers to the patient sex: • F=Female • M=Male • D=Indeterminate • I=Intersex • N=Not Stated • U=Unknown / Inadequately Described • Blank: Not recorded
Without Selected Clinical Item	Lists all current patients between two ages who have not had a specified clinical item added between two dates. This report can be used, for example, to find all patients over 50 who have not had a Fluvax in the previous 12 months.

Table 163. Patients reports (continued)

Report > Patients	Description
Without Selected Recall	Lists all patients between two ages who do not have a specified recall. This report can be used, for example, to find all women over 15 who do not have an existing pap smear recall.

Births Report

The Births report lists patients born with their birth weights.

The standard report options determine which patient births are included in the report and other report characteristics.

The report totals show number of births with average birth weight by locality.

This report uses the earliest residence locality recorded. If births are recorded at the time of birth then this will accurately reflect the residence locality at birth (actual place of birth may be a hospital).

If the report is run for patients who were recorded a considerable time after birth and the first residence recorded is not the residence locality at birth, then the report will be inaccurate.

Deaths Report

The Deaths report lists patients who have died.

The standard report options determine which patient deaths are included in the report and other report characteristics.

The report totals show number of deaths with average age by locality.

Patient Labels

Use **Tools > Patient Label Options** to control the type of label printed from any particular workstation.

Different types of label can be printed.

To print patient labels for the current patient, click  **Patient Labels** on the main toolbar or select **Report > Patient Reports > Patient Labels**.

Unistat 38941 / Avery Laser L7160 Type Labels

L7160 labels are formatted to be suitable for letters, notes and sample bottles.

Patient name and address details are printed on the top half of the label and Date of Birth (DoB), Health Care Card (HCC) and Medicare numbers are printed on the bottom half. This allows the label to be cut in half and used as an address label.

These Communicare labels are designed for printing on Avery Laser L7160 label stationery or equivalent (21 labels per sheet, each 63.5 mm x 38.1 mm).

Unistat 38935 / Avery Laser DL30 Type Labels

DL30 labels are formatted for sample bottles.

Along with basic patient identity information, this label features:

- A heading, which is usually set to indicate the place where the sample was taken, for example, `Millennium Health`
- Spaces for date, time and specimen to be written by hand

These Communicare labels are designed for printing on Avery Laser DL30 label stationery or equivalent (30 labels per sheet, each 64.0 mm x 25.4 mm).

Unistat 38937 / Avery Laser L7163 Type Labels

L7163 labels are also suitable for sample bottles but are larger and contain more detail than the DL30 labels. The additional details include patient address, patient Aboriginality and the name of the health service.

These Communicare labels are designed for printing on Avery Laser L7163 label stationery or equivalent (14 labels per sheet, each 99.1 mm x 38.1 mm).

Custom Report Type Labels

If available, you can select a specific report that has been written to suit your needs. This report can be adapted for a specific label size and to contain specific data. It can also be written to print to a specialised label printer so it can print one label rather than an A4 page of labels.

Alternatively, you can use the generic label report found at **Reports > Patients > Patient Mailing Label** that uses Avery L7042D labels.

Patient Query

The Patient Query is a powerful tool that allows you to produce a list or count of patients according to a wide variety of selection criteria.

Use this report when none of the other reports can produce the results you require. If for example you want a list of patients who have had a particular immunisation, it would be better to use the Immunisations Performed report than the Patient Query.

Patient Summary

The **Patient Summary** report prints information about the current patient and can also export all the clinical documents related to the patient.

Use the patient summary when you need to hand the patient over to another clinician, for example, during medical evacuation, or to print documents for medicolegal matters.

To print a patient summary:

1. Open the **Patient Summary**, either:
    - In the main toolbar, click  **Patient Summary** and in the patient search window, search for and select the patient for whom you want to print a summary.
    - In a patient's clinical record, select **Reports > Patient Summary**.
2. In the **Patient Summary** window, from the **Use** list, select the patient summary you require. STANDARD includes and displays the maximum amount of information about a patient.

> **Tip:**
> If you want to include additional information or export letters as PDF instead of RTF, you can customise the export. For more information, see Customise the Patient Summary Export *(on page 534)*.

3. Default information is included automatically. To select additional information, click **Customise**. For example
   - On the **Biographic** tab, add reference numbers, death or gender information.
   - On the **Clinical Record** tab, add Investigation Results and set Export Documents to include documents such as letters and submitted HealthLink SmartForms.
   - On the **Consultations** tab, add progress notes.
4. To review the information included, click **Preview**.
5. If you are happy with the information included, to print the summary, in the preview or **Patient Summary** window, click **Print**.
6. Select a location to which you want to save the Patient Summary and its attached documents and specify a name if required.
7. Click **Close**.

The Patient Summary and attached documents are saved to the location you selected with the name you specified. The Patient Summary is opened in your default PDF reader. Letters and so on created in Communicare are exported to RTF by default.

Submitted HealthLink SmartForms are exported with the Patient Summary in the saved format of the form, either HTML or PDF. Parked HealthLink SmartForms are not exported

Customise the Patient Summary Export

Customise the **Patient Summary** report to your precise requirements for a single export or by creating a new report option set.

Users with `Report Administration` system rights can save new customised reports for future use, or save modifications to existing customised reports.

You would typically modify the patient summary only for clinical reasons. You must start from an existing definition and change it to your requirements.

You can also export clinical documents related to the patient.

> **Tip:**
> Everyone at your health service shares the same patient summaries, so you can use those created by other users.

To create a custom patient summary:

1. Open the **Patient Summary**, either:
   - In the main toolbar, click **Patient Summary** and in the patient search window, search for and select the patient for whom you want to print a summary.
   - In a patient's clinical record, select **Reports > Patient Summary**.
2. In the **Patient Summary** window, from the **Use** list, select STANDARD which includes the maximum amount of information about a patient.

3. Click **Customise**.
4. On the **Clinical Record** tab:
    a. To export clinical items for a selected period only, in the **Items from** and **To** fields, enter a date range in the format `dd/mm/yyyy`.
    b. To export all documents from the **Documents** tab in the clinical record, regardless of the date range set for clinical items, set **Export Documents**.

    > **Tip:**
    > If you want all clinical documents to be exported as PDFs, also set **Export RTF as PDF**.

    c. Deselect any information that you don't want to export.
5. On the **Consultations** tab, to export consultations for a selected period only, in the **From** and **To** fields, enter a date range in the format `dd/mm/yyyy`. Deselect any information you don't want to export.
6. Step through the **Biographic** and **Practice** tabs and select information to include in the summary.
7. To check the custom patient summary, click **Preview**.
8. To make further updates, click **Close** and repeat steps 3-6.
9. To print the patient summary and export the documents, click **Print**.

    First select the location to which you want to save the Patient Summary, and then a folder for the patient's clinical documents.
10. When you are happy with the new summary, click **Close**:
    a. In the **Changed Patient Summary Parameters** window, in the **New parameter set name** field, enter a name that identifies the summary's use. For example, `Audiometrist` for summaries appropriate for Audiometrists.
    b. Click **Save**.
11. Click **Close**.

The Patient Summary is saved as a PDF to the location you selected with the name you specified and is opened in your default PDF reader.

Exported documents are saved using the following naming convention:

```
DOC-PATNNNN-YYYYMMDD-DISPLAY_DESC/REQUESTED_TESTS-N
```

where:

- *NNNN* - Patient ID
- *YYYYMMDD* - date the document was added to Communicare
- *DISPLAY_DESC/REQUESTED_TESTS* - information to describe the document such as the document type or test and letter type and organisation or comment

> **Note:**
> Windows special characters added to comments that cannot be used in filenames are replaced with an underscore in the filename of the exported file. These characters are

```
\ / : * ? " < > |
```

- *N* - a document count

Investigation results are exported using the following naming convention:

```
IX-PATNNNN-YYYYMMDD-TEST-N
```

Historical data that was imported into Communicare and attached to a clinical record is exported as an external file, which is saved using the following naming convention:

```
External-PATNNNN-YYYYMMDD-DISPLAY_DESC-N
```

For example, for Martin Brown:

```
DOC-PAT5384-20031204-Scanned document _Discharge summary_-1
DOC-PAT5384-20120308-Referral letter _Royal Perth Hospital Cardiology_-3
IX-PAT5384-20140622-COMPLETE BLOOD EXAM-1
External-PAT5384-20031101-old_record_-1
```

Note:
The complete name of the document, including the directory path, is limited by Microsoft Windows to 260 characters. Because the name of the document exported by Communicare may be up to 150 characters, limit where the documents are saved to a directory with a path of no more than 100 characters. For more information, see https://docs.microsoft.com/en-us/windows/win32/fileio/naming-a-file.

PIP Reports

Use the PIP report to generate Practice Incentives Program Quality Improvement Measures.

The report extracts the following information:

- Proportion of patients with diabetes with a current HbA1c result.
- Proportion of patients with a smoking status.
- Proportion of patients with a weight classification.
- Proportion of patients aged 65 and over who were immunised against influenza.
- Proportion of patients with diabetes who were immunised against influenza.
- Proportion of patients with COPD who were immunised against influenza.
- Proportion of patients with an alcohol consumption status.
- Proportion of patients with the necessary risk factors assessed to enable CVD assessment.
- Proportion of female patients with an up-to-date cervical screening.
- Proportion of patients with diabetes with a blood pressure result.

For more information see https://www1.health.gov.au/internet/main/publishing.nsf/Content/PIP-QI_Incentive_guidance.

Table 164. PIP reports

Report > PIP	Description
Quality Improvement Measures	Generates a JSON file for PIP QI upload. To run the report: 1. Click **Yes**. 2. Click **OK**. 3. When the file has been generated: ◦ From the **Save as type** field, select `Text file (*.TXT)` ◦ Enter a **File name** ending in `.json`, for example, `PIPQI_Report.json`. Alternatively, use the advanced settings: 1. Click **Advanced**. 2. Click **OK**. 3. When the file has been generated: a. Click Export data. b. Click **>>** to select all data and click **Next**. c. Set **ASCII** and click **Next**. d. Remove the **Field delimiter** and enter a file name ending in `.json`. Click **Next**. e. Click **Export**.

Population Analysis

Report on the demographics of your patients.

Table 165. Population Analysis reports

Report > Population Analysis	Description
Aboriginality Chart	Produces a pie chart of the patient population make-up analysed by Aboriginality.
Added to Communicare by Month	Lists the number of new patients added to the Communicare database by year and month. To count the number of patients belonging to a specific patient group, select that group (the option '<N/A>' will report zero). Fictitious patients are excluded from this report, but no other account of patient status is made.
Age Groups 5 Yearly	Gives an age sex breakdown of patients by 5 yearly age groups. Use this report to gain an appreciation of your client population's age profile. Select a client status to report, or report all statuses. Client age and status is evaluated as of the day the report is run. Export the report to Microsoft Excel to easily create a graph of your population profile.

Table 165. Population Analysis reports (continued)

Report > Population Analysis	Description
Age Groups Needs Analysis	Gives an age sex breakdown of patients by 'Needs Analysis' age groups.
Age Groups SHE	Gives an age sex breakdown of patients by SHE age groups.
Care Plan Count	Counts the number of clients with and without a care plan. Use this report to determine the proportion of clients who have care plans.
Clinical Item Group Count	Count clients who have a clinical item within a selected clinical item group. Use this report to determine the prevalence of a disease group. This is a patient-based report. It will count patients once only, regardless of the number of times group clinical items have been recorded for the patient. The report lists current patients only.
Count by Aboriginality	Counts all patients by patient status and by Aboriginality. There is an option to group by Communicare Patient Status, AIHW Client Status and Combine Status. Deceased and fictitious patients are excluded.
Count by Locality	Shows the number of current patients living in each locality for a selected client status or for all statuses. Use this report to again an appreciation of the geographic distribution of where your clients live.
Count by Locality Group	Shows the number of current patients whose address locality is in each locality group, by locality to give a dynamic look at which patient localities have been included in which locality group. Run this query to detect localities that have not been included in the desired groups.
Count by Status	Counts the number of patients in the database by current status and by sex. You are required to enter a reference date: use `today` for an up to date count. If you use a reference date, the report will look at a patient's status and address on that day to compile the report.
Population Breakdown	Analyses current patients only. The results are organised by Aboriginality, locality, specified age group and sex.
With Clinical Item	Analyses current patients with a specified clinical item added between two dates compared to the total population. The results are organised by Aboriginality, locality, specified age group and sex.

Table 165. Population Analysis reports (continued)

Report > Population Analysis	Description
With Clinical Item Group	Analyses current patients with an item from a specified clinical item group added between two dates compared to the total population. The results are organised by Aboriginality, locality, specified age group and sex.
With Qualifier	Analyses current patients with a specified qualifier added between two dates compared to the total population. The results are organised by aboriginality, locality, specified age group and sex.

Pregnancy Reports

Report on pregnancy numbers, outcomes, diabetes and mental health.

Table 166. Pregnancy reports

Report > Pregnancy	Description
Current Antenatal List	Shows summary details for all currently pregnant women. The list is ordered by EDD with the earliest first. Use this report to find women who are due to give birth or have not yet had the outcome of their pregnancy recorded. Also shown is the date of the last item and a count of items that appear in the details of the current pregnancy. These items are those that appear on the Antenatal Check button (for example, **Check up;antenatal** and other pregnancy procedures). Contributing pregnancy factors (clinical items added after the pregnancy start to indicate, say, twins) can be included or excluded as required. Export this report to Microsoft Excel to include mailing address details that can be used for a mail merge.
EPDS	EPDS scores by collection occasion for National Perinatal Depression Initiative.
NT Diabetes in Pregnancy Clinical Register	Provides information for the DIP Register referral. The information relates to a single patient. This report should be printed and attached to referrals to the Diabetes in Pregnancy Register. The report contains biographic information about the patient; details of the referring provider and clinic; gestation, LMP and EDD for the current pregnancy; latest height, BP and risk factors; current and regular medications; past diagnoses of diabetes and hypertension (gestational and non-gestational); dates and values of the following measures recorded in the previous nine months: weight, glucose level, Hb, HbA1c, eGFR, ACR, creatinine, lipids, smoking and alcohol status changes.

Table 166. Pregnancy reports (continued)

Report > Pregnancy	Description
Outcomes	Analyses all pregnancy outcomes between two dates. Use this report to find all women who have ended a pregnancy in a given period. It is also useful when requiring supplementary information relating to the Healthy for Life maternal and antenatal reports. Also shown is the date of the first postnatal check after the end of the pregnancy and the number of whole weeks between these two events.
Perinatal Depression Project	Report of EPDS for National Perinatal Depression Initiative.
Weight Gain Analysis	Shows all pregnancy outcomes between two dates and shows all mothers' weight measurements from 90 days before conception to the end of the pregnancy. This report can be used to see all mothers with diabetes living in a selected locality group

Private Billing Reports

Table 167. Private Billing reports

Report > Private Billing	Description
Claims Between Two Dates	Claims for services provided between two dates. This report shows all services between two dates where a private claim has been made. It shows the amount claimed, amount paid and balance for each service.
Outstanding Balances	Private Billing outstanding balances. TBC.
Payments Between Two Dates	Private Billing payments made between two dates. This report shows all payments between two dates for private claims. It shows the payment method.

Procedures Reports

Report on procedures, clinical items and qualifiers.

Table 168. Procedures reports

Report > Procedures	Description
Adult Health Check Uptake Analysis	Analyses the uptake of the Adult Health Checks. Use this report to determine your client population's uptake of the adult health check. You are required to enter a reference date that the report will use to determine client age (for population) and the number who have had a check. The period considered is the previous 2 years for 15 to 54 year olds or 1 year for older patients. Both complete and incomplete checks are counted. Age and status are calculated as at the reference date. This report looks for the standard clinical items: **Check up;aboriginal & TI adult**, **Check up;aboriginal & TI over 55's** and **Over 75's Health Check** as distributed by Communicare. Clinical items flagged as Adult Health Checks with system code AHC (for 15-54 year olds) or OHC (for over 55s) and EHC (for over 75s) are also recognised. This report does not consider either indigenious status or the prior claiming of a 715 check in its calculation of the number of clients eligible for the "over 75's" check.
Antenatal checks completed before 20 weeks	Lists the number of women who had an antenatal check before week 13 and those with a check before week 20 during the selected period. The results are broken down by Aboriginality. Use this report as a measure of antenatal care program effectiveness. The totals for checks before 20 weeks include those women with a first check before 13 weeks. Only antenatal checks with a system code of PRE and a rule code of PRCHECK where the `Gestation` qualifier has been recorded are included.
Cervical Screening Analysis	Shows the number of female clients who have had any type of cervical screening procedure performed within a specified number of years of the reference date of the report. Health services that record cervical screening as clinical items can use this report to measure how effective their cervical screening program is. The total number of women in the target age range is also shown. Excludes women with a recorded hysterectomy. This report also looks at any condition or history clinical item if it has the export code of CST. This is to include woman who have had a cervical screening but not necessarily performed at this health service. Also included are patients with cervical screening requests, cervical screening results and those with a True/False qualifier recorded as 'Yes'.

Table 168. Procedures reports (continued)

Report > Procedures	Description
Check Up analysis by age group and gender	Counts all checkup clinical items recorded between two dates. The check-ups must belong to the grouper Check Ups (All). Use this to report count the number of check ups completed for children, adults and elderly people. For males and females in age groups 0-14, 15-55 and 55+, the report lists: • Check up type, such as, Child development check • Number of checks performed • Total number of checks for sex and age group Partially complete procedures, that is, those with required qualifiers that have not been completed, are excluded. The report excludes fictitious patients but includes deceased patients.
Child Health Check Uptake Analysis	Analyses the uptake of the Child Health Check (MBS Item 708). Use this report to determine your client population's uptake of the child health check. You are required to enter a reference date and the report will count Aboriginal children between two ages on that date and show how many had a Child Health Check within the previous 12 months, complete or otherwise. Age and status are calculated as at the reference date. This report looks for the item **Check up;aboriginal & TI child {708}** as distributed by Communicare or other clinical item flagged as a Child Health Check with system code CHC.
Child Immunisation Review Analysis	Shows the number of clients under 15 years who do not have any overdue immunisation review recalls. Use this report to evaluate the effectiveness of your health service's child immunisation surveillance program. Immunisation review recalls should only be completed when a child's immunisations are up-to-date. This report will then indicate how many children are up-to-date and how many are not. Cancelled reviews are ignored by this report. Consider sourcing reports from AIR to verify and confirm the results of this report.
Count by Special Lookup	Counts the number of procedures (Class = Procedure) completed during a selected period, grouped by special lookup. If Special Lookup is used to indicate a patient's Health Worker for instance, this query shows the number of procedures performed on each Health Worker's patient (not necessarily by that Health Worker).

Table 168. Procedures reports (continued)

Report > Procedures	Description
GAA Record Sheet	Shows all patients under 5 years old who live in the Health Service Area with the last Growth Assessment Action details. Administrators can run this report so they can submit details of Growth Assessment Action to the relevant reporting body. You are prompted for two dates to define the reporting period. Patients included are all patients who were under 5 at the start of the reporting period. This report looks for a clinical item called **Check up;child development** with the qualifiers 'Weight', 'Height', 'Head Circumference' and 'Hb (Haemoglobin)'. This report must be edited if any of these descriptions change.
GAA Record Sheet NT	Shows all patients under 5 years old who live in the Health Service Area with the last Growth Assessment Action details. Use this report to submit details of Growth Assessment Action to the relevant reporting body. You are prompted for two dates to define the reporting period. Patients included are all patients who were under 5 at the start of the reporting period. This report looks for the latest clinical item that has a 'Hb (Haemoglobin)' attached and shows the qualifers 'Weight', 'Height' and 'Hb (Haemoglobin)' if they were recorded on the same day. There is an option to use the latest Hb as the date or only a day where all three qualifiers were recorded. Note also that patients who were under 6 months at the time of the GAA are not required to have a haemoglobin recorded. Status is calculated as follows: • D - If patient is now deceased • O - If patient was older that 5 years at the end of the reporting period • V - If the patient status is not current • X - If the patient's address is outside the Health Service Area • M - If the patient status is Current and has been measured • P - If the patient status is Current and has not been measured.
Group Activities	Tis report is similar to the OATSIH SAR question: 'What type of groups were run by your service and how many people attended'. However, this report provides options for a range of dates and an option for analysis by provider and shows number of individuals as well as number of attendees. This report looks for all items with 'group' in the description. Clients who have this item added for the same day are assumed to have attended the same group activity. This report is for identified clients. To report on unidentified clients, **Group Activities - Unidentified Clients** report. Fictitious clients are excluded.

Table 168. Procedures reports (continued)

Report > Procedures	Description
Group Activities - Unidentified Clients	This report is similar to the OSR question: 'What type of groups were run by your service and how many people attended', except for 'un-identified patients' and group activities. It provides options for a range of dates and an option for analysis by provider and shows number of individuals as well as number of attendees. This report includes only clinical items where at least one of the GRP qualifiers has a value. If a provider records a clinical item for a group event and fails to record at least one of the attendance qualifiers, that item is not counted in the total events. Filter by: • Encounter Place • Encounter Mode • Program • Group • Group Type • Provider (single provider, group by each provider or view all together) Non-patients are included. Fictitious clients are excluded.
NT RHD Monthly Bicillin Report	Use this report for the NT Government Department of Health Rheumatic Heart Disease Register. All patients of a selected status and locality group are shown with completed LA Bicillin clinical items for each four-week period from a specified date for thirteen periods. The date of the next recall is also displayed. Patients are selected based on a condition recorded that belongs to the ICPC grouper of RHEUMATIC FEVER/HEART DISEASE. LA Bicillin items must have the export code of `BICILLIN` to be included.
Outcome and Topic Analysis	This report is available in the following styles: • Patient Conditions by Topic and Frequency Lists Condition Topics (Clinical Item Type Topic for Class = Condition) for conditions in descending order by frequency. For each topic, lists patient details (site/patient/birthdate) for patients in the population. Note that "frequency" is the number of occurrences of the Topic in the population defined by the selection in effect (the selected site, or all sites, and so on). • Procedure Outcome Analysis Lists for each procedure qualifiers measured as part of that procedure, and summarises (counts, averages) the outcomes. Average outcomes display only for numerical qualifiers. Displayed precision of averages is 2 fractional decimal digits more than the number of fractional decimal digits actually encountered in the data for that qualifier. • Procedure Outcomes for Patient Shows qualifiers and their outcomes in order by date for each patient.

Table 168. Procedures reports (continued)

Report > Procedures	Description
Pap Smear Analysis	This report shows the number of female clients who have had any type of "Pap smear" procedure performed within a specified number of years of the reference date of the report. The total number of women in the target age range is also shown. Excludes women with a recorded hysterectomy. Health services that record Pap smear "procedures" as clinical items can use this report to measure how effective their Pap smear program is. This report includes any condition or history clinical item if it has the export code of PAPSMEAR so that women who have had a pap smear but not necessarily performed at this health service are counted. Also included are patients with pap smear requests, pap smear results and those with the qualifier 'pap smear done' recorded as 'Yes'.
Performed	Produces a complete list of patients who have had procedures performed. Specific procedure types or all procedures can be selected. Localities, age groups and time periods can also be specified.
Performed by Client	Lists the clients who have had a selected procedure performed during a selected period. Use this report to list the clients who have had a particular procedure. The report lists Client name and Date procedure performed.
Performed by date with qualifiers	Lists a selected procedure or all procedures performed during a selected period. Use this report as a simple alternative to the procedures performed report when qualifiers values are required in a date ordered list. The report groups the procedures by place, all places or a single place for all or a specified provider. Partially complete procedures and recalls are not included. The report lists for all patients (except fictitious patients): • Date of procedure • Name of client • The name of the procedure performed (with comment) • Qualifiers (if any) recorded on the procedure
Performed by date with qualifiers (export)	Shows all procedures, complete or incomplete, performed between two dates with qualifier values presented as columns rather than rows. The report has no print layout so must be exported to Microsoft Excel to be of value. Up to 87 qualifiers are shown with a warning in the last column if there are more than 87 qualifiers on the procedure. Row 2 defines the qualifier name. The qualifiers are presented in the same order as they are on the clinical item when the user adds the data. Export data to sort and filter in Microsoft Excel to find procedures where qualifier responses of a particular value are of interest. Remove the first row and use the second row as the header row.

Table 168. Procedures reports (continued)

Report > Procedures	Description
Performed by Provider Place and Mode	Use this report to gain an appreciation of the data recording and clinical service activity of each provider. For each provider, this report lists: • Provider name • Place mode where the procedures were done • Name of the procedure • Number of times the procedure was done • A count of females, males and unknown sex depending on the filter • Total duration in minutes as recorded. Providers who have not performed any procedures during the selected period are not listed on the report. The report can be run for a selected range of dates and for a selected place or all places. Fictitious patient procedures are excluded.
Performed for Selected Item Button	Show counts of the usage of all clinical items that appear on a single clinical item button in the clinical record. Use this report to analyse the frequency of use of clinical items presented on a single clinical item button. The count includes all saved, complete and incomplete items.

Table 168. Procedures reports (continued)

Report > Procedures	Description
Performed List	Lists a selected procedure or all procedures performed during a selected period, grouped by place, all places or a single place. Use this report as an SQL alternative to the **Procedures Performed** report. The report should be run by a user with access to all clinical items, such as Administrator. The report lists: • The name of the procedure performed • The date the procedure was performed • The patient's name and ID Reports can be selected by • Encounter place • Procedure - selected procedure or all procedures • Date range of procedure performed • Status of patient • Sex • Aboriginality • Age of patient (at end of reporting period) • Current locality group • Current locality • Record storage site Reports can be selected by: • Encounter place • Procedure - selected procedure or all procedures • Date range of procedure performed • Status of patient • Sex • Aboriginality • Age of patient (at end of reporting period) • Current locality group • Current locality • Record storage site Recalls are not counted.

Table 168. Procedures reports (continued)

Report > Procedures	Description
Performed List by Keyword	Lists procedures performed during a selected period where the procedures share a selected keyword, grouped by place, all places or a single place. The report should be run by a user with access to all clinical items, such as Administrator. The report lists: • The name of the procedure performed • The date the procedure was performed • The patient's name and ID Reports can be selected by: • Encounter place • Keyword • Date range of procedure performed • Status of patient • Sex • Aboriginality • Age of patient (at end of reporting period) • Current locality group • Current locality Recalls are not counted.
Performed List with Selected Qualifier	Lists a selected procedure or all procedures performed during a selected period with the option of displaying a selected qualifier (if this qualifier is attached to the selected procedure), grouped by place, all places or a single place. The report should be run by a user with access to all clinical items, such as Administrator. The report lists: • The name of the procedure performed • The date the procedure was performed • The patient's name and ID • The selected qualifier result. Reports can be selected by: • Encounter place • Procedure - selected procedure or all procedures • Date range of procedure performed • Status of patient • Sex • Aboriginality • Age of patient (at end of reporting period) • Current locality group • Current locality • Record storage site. Recalls are not counted.

Table 168. Procedures reports (continued)

Report > Procedures	Description
Performed Summary	This report totals a selected procedure or all procedures performed during a selected period, grouped by place, all places or a single place. Use this report as a simple alternative to the **Procedures Performed** report when only basic activity information is required. The report should be run by a user with access to all clinical items, such as Administrator. The report lists: • The name of the procedure performed • The number of times the procedure was performed • The total number of procedures for each encounter place. Reports can be selected by: • Encounter place • Program • Procedure - selected procedure or all procedures • Date range of procedure performed • Status of patient • Sex • Aboriginality • Age of patient (at end of reporting period) • Current locality group • Current locality • Record storage site. Partially complete procedures and recalls are not counted.
Performed with Required Qualifiers	Lists clinical items with required qualifiers (such as the Aboriginal & TSI adult check), incomplete or complete, performed between two dates for a selected provider. Use this report to distinguish between partially completed procedures and wholly completed procedures. Duplicate records are not shown. That is, if a provider has made more than one iteration of the same incomplete item it is listed only once. Only currently enabled clinical items are offered for selection.
Procedures History for Selected Patient	Shows all details of a selected procedure recorded for a specified patient between two dates.
Qualifier Analysis for Selected Item	Shows counts of the qualifier usage of a single clinical item including averages, maxima and minima for numeric qualifiers and individual counts of each reference type qualifier response. Use the report to analyse responses to the qualifiers of a particular procedure. Items with no qualifiers recorded are not included.

Table 168. Procedures reports (continued)

Report > Procedures	Description
Qualifier Analysis for Selected Item Button	Shows counts of the qualifier usage of all clinical items that appear on a single clinical item button in the clinical record, including averages, maxima and minima for numeric qualifiers and individual counts of each reference type qualifier response. Use this report to analyse responses to the qualifiers of particular items that belong together. Numeric qualifiers are also summed to give a total: this is not a sensible value for, say, HbA1c and should be ignored, but is valuable for numeric qualifiers such as 'Amount spent in dollars', and so on. Items with no qualifiers recorded are not included.
SA RHD Bicillin Injection Masterchart	Use this report for the SA Government Rheumatic Heart Disease Register. All patients of a selected status and locality group are shown with completed LA Bicillin clinical items for each four-week period from a specified date for thirteen periods. The date of the next recall is also displayed. Patients are selected based on a condition recorded that belongs to the ICPC grouper of RHEUMATIC FEVER/HEART DISEASE and LA Bicillin items must have the export code of BICILLIN to be included.
WA RHD Monthly Bicillin Report	Use this report for the WA Rheumatic Heart Disease Register & Control Program All patients of a selected status and locality group are shown with completed LA Bicillin clinical items for each four-week period from a specified date for thirteen periods. The date of the next recall is also displayed. Patients are selected based on a condition recorded that belongs to the ICPC grouper of RHEUMATIC FEVER/HEART DISEASE and LA Bicillin items must have the export code of BICILLIN to be included.

Procedure Outcome/Topic Analysis

This report is available in several styles.

- Patient Conditions by Topic and Frequency

  Lists Condition Topics (Clinical Item Type Topic for Class = Condition) for conditions in descending order by frequency. For each topic, lists patient details (site/patient/birthdate) for patients in the population. Note that "frequency" is the number of occurrences of the Topic in the population defined by the selection in effect (the selected site, or all sites, and so on).

- Procedure Outcome Analysis

  Lists for each procedure qualifiers measured as part of that procedure, and summarises (counts, averages) the outcomes.

  Average outcomes display only for numerical qualifiers. Displayed precision of averages is 2 fractional decimal digits more than the number of fractional decimal digits actually encountered in the data for that qualifier.

- Procedure Outcomes for Patient

  Shows qualifiers and their outcomes in order by date for each patient.

Procedure Performed Report

This report produces a complete list of patients who have had procedures performed.

Specific procedure types or all procedures can be selected. Localities, age groups and time periods can also be specified.

Qualifiers Reports

Report on patients, or patient numbers with clinical items in their clinical records with particular qualifiers.

Table 169. Qualifiers reports

Report > Qualifiers	Description
Anaemic Children 5-15 Years	Analyses the most recent haemoglobin result for all patients aged between 5 and 15 years. The results are ordered by outcome using the following criteria: • Child aged 5 to 7 years at the end of the reporting period whose latest Hb recorded between two specified dates was less than 115. • Child aged 8 to 11 years at the end of the reporting period whose latest Hb recorded between two specified dates was less than 119. • Male child aged 12 to 15 years at the end of the reporting period whose latest Hb recorded between two specified dates was less than 125. • Female child aged 12 to 15 years at the end of the reporting period whose latest Hb recorded between two specified dates was less than 118.
BMI Analysis	Reports on BMIs for children from 0 to 228 months. Patients are only included if they have a BMI recorded. They are categorised according to their latest BMI and which percentile this was at the time of recording. Categories are: • Less than 5th percentile • Less than 15th percentile but more than 5th percentile • More than 85th percentile but less than 95th percentile • More than 95th percentile • Within 15th to 85th percentile' Column SEX refers to the patient sex: • F=Female • M=Male • D=Indeterminate • I=Intersex • N=Not Stated • U=Unknown / Inadequately Described • Blank: Not recorded If the sex is listed as anything other than `Female`, the male percentiles are used by default.

Table 169. Qualifiers reports (continued)

Report > Qualifiers	Description
Clinical Item Group Analysis	Lists all patients who have a clinical item within a selected clinical item group. Use this report to check on the frequency of testing for patients with a specific chronic disease. For example, to monitor HbA1c checking for diabetes patients, select a DIABETES group and HbA1c . This is a patient-based report. It lists patients once only, regardless of the number of times group clinical items have been recorded for the patient. The report then further shows if each patient has had a specific qualifier recorded in the previous 6 months, 12 months or two years. There is an option to include another qualifier (for example, select 'HbA1c (%)' as the qualifier and 'HbA1c' as the alternative qualifier to include both measurements recorded in % and those recorded as mmol/mol) - either qualifier will be considered.
Latest Value	Selects only the most recent result for all patients with a selected qualifier. The report shows: • Patient name • Date of outcome (qualifier) • Outcome (qualifier value) The results are ordered by outcome which makes it particularly useful for Dropdown list, Yes, No and Tick Box qualifiers as well as Date qualifiers. Reports can be selected by • Qualifier type (except numeric - see note above) • Date range (reporting period) • Encounter place • Procedure - selected procedure or all procedures • Date range of procedure performed • Current status of patient • Sex • Aboriginality • Age of patient (at end of reporting period) • Current locality group • Current locality • Record storage site For numeric qualifiers, use the **Selected Qualifier (numeric)** report instead.
Latest Value (memo)	Selects only the most recent result for all patients (of a selected status) with a selected memo qualifier. Use this report for clinical audit. The report shows patient names with date and clinical item type used to record the selected qualifier. The results are ordered by outcome.

Table 169. Qualifiers reports (continued)

Report > Qualifiers	Description
Latest Value (numeric)	Selects only the most recent result for all patients (of a selected status) with a selected numeric qualifier. Use this report for clinical audit. The report shows patient names with date and clinical item type used to record the selected qualifier. The results are ordered by outcome.
Latest Value Count	Selects only the most recent result for all patients with a selected patient status and qualifier type. Use this report to count the number of clients with particular qualifier values, for example smoking status. The report does not show patient names, only outcomes and numbers of clients. The results are ordered by outcome which makes it particularly useful for Dropdown list, Yes, No and Tick Box qualifiers. For numeric qualifiers, use the **Selected Qualifier (numeric)** report instead.
Patient Measurement History	Lists all of the previous measurements for a specific numeric measurement for a particular patient from most recent to the earliest.
Patient Multiple Qualifier History (Numeric)	Lists the values of up to ten numeric qualifiers over a period of time for a specific patient. Measures recorded at the same time are shown 'in line' with the date they were recorded. The most recent measures are shown at the top.
Selected Qualifier	Selects all patients with a selected qualifier recorded between two dates and displays the results recorded. The report shows patient names with date and clinical item type used to record the selected qualifier. The results are ordered by outcome which makes it particularly useful for Dropdown list, Yes, No and Tick Box qualifiers as well as Date qualifiers. For numeric qualifiers, use the **Selected Qualifier (numeric)** report instead.
Selected Qualifier (memo)	Selects all patients with a selected memo qualifier recorded between two dates and displays the results recorded. The report shows patient names with date and clinical item type used to record the selected qualifier.
Selected Qualifier (numeric)	Selects all patients (of selected status) with a selected numeric qualifier recorded between two dates and displays the results recorded. Use this report for clinical audit. The report shows patient names with date and clinical item type used to record the selected qualifier. The results are ordered by outcome.

Table 169. Qualifiers reports (continued)

Report > Qualifiers	Description
Value Count	Counts values for a selected qualifier type within a selected date range and patient status. Use this report to count the number of clients with particular qualifier values, for example the positive results and the number of negative results that have been recorded for a particular test. The report does not show patient names, only outcomes and numbers of clients. The results are ordered by outcome which makes it particularly useful for Dropdown list, Yes, No and Tick Box qualifiers. Sites that record transport using a qualifier for 'Transport Place' may also use this report to count the number of times clients have been transported to each place.
With Selected Numeric values	Lists all living patients who have a selected numeric qualifier value in a selected range. Use It could be used to report everyone who has a particular qualifier, for example, 'Body Mass Index' between 20 and 30.

Patient Measurement History Report

This report lists all of the previous measurements for a specific numeric measurement for a particular patient from most recent to the earliest.

Recalls Reports

Report on recalls.

Table 170. Recalls reports

Report > Recalls	Description
Cancelled Recalls	Displays details of recalls cancelled between two dates. Specify a cancellation reason type or a recall type if required.

Table 170. Recalls reports (continued)

Report > Recalls	Description
Child Health Check Chart	Lists children between two ages (and under 5 years old) and shows child development checks that have been performed, have a recall or are due without a recall being present. This report uses the standard **Check up;child** clinical items and the **Check up;Healthy Kids Check** item. Also included are HU5K checks. The 9 month HU5K check is considered an 8 month check for compatibility with the standard child health checks. Specify the ordering of the report (patient name or date of birth), patient status, locality group and age range. Show all eligible patients or only those with a check due or due by a specified date (for example, you may specify a date in 7 days' time so that reminder letters can be sent). Each check is shown with the following notation: • --: Check not performed. • Done: Check done and recorded. • X: Check cancelled. • Recall: An incomplete recall is in place. • DUE: The child has no completed check or a recall and is now over the age that this check is due by the specified date. A blank entry means the check has not been performed, there is no recall and the check is not due until after the specified date. To include local clinical items, use the following export codes: • First check after birth: CHC-FA or HU5K-FA. • 2 months, 6-8 weeks: CHC-8W or HU5K-8W. • 4 months: CHC-4M or HU5K-4M. • 6 months: CHC-6M or HU5K-6M. • 8 months, 9 months: CHC-8M or HU5K-9M. • 12 months: CHC-12M or HU5K-12M. • 18 months: CHC-18M or HU5K-18M. • 2 years: CHC-2Y or HU5K-2Y. • 2.5 years: CHC-30M or HU5K-30M. • 3 years: CHC-3Y or HU5K-3Y.
Completion Rate	For all recallable clinical item types, shows the number actually completed and the number due or overdue. If you select a specific encounter place, ensure that the associated locality group is also selected as automated recalls are not associated with an encounter place unless they have been manually accepted by a provider. Referrals are excluded. Deceased and fictitious patients are excluded from the calculation.

Table 170. Recalls reports (continued)

Report > Recalls	Description
Completion Rate Automated Recalls	For all enabled automatically generated recallable clinical item types, shows the number of recalls overdue and the percentage of recalls completed. The report can be run for any selected status, but it is most meaningful when run for current patients. It will then indicate automated recalls that you may wish to either disable or focus on. Manually generated recalls are excluded from the calculation. The formula used is: (Recalls complete * 100) / (Recalls complete and incomplete (due before today)) Deceased and fictitious patients are excluded from the calculation.
Contraception Recalls Due	Lists details of all current patients who have contraceptive recalls due now, or up to 7 days in the future. Use this report as a work list for contraceptive recalls. This report lists recalls in any clinical item group with the word CONTRACEPTION in its title. Make sure locally defined terms are included in groups.
Count by Type	Counts all recalls by type whether due or not. Filter by patient locality group.
Due - By Keyword	Reports all recalls due within a specified number of days where the recall type has a selected keyword. Use to create work lists for all localities, or a specific locality. This report is grouped by locality then ordered by due date.
Due - By Locality	Lists recalls due within the next 14 days, grouped by home address locality or for a selected locality only. Use this report to see recalls due in particular localities. Also use this report to export recalls to Microsoft Excel. When exported, this report also includes a special format "due date".
Due - By Record Storage Location	Report all recalls due up to a specified number of days ahead for a specified record storage location. Use this report to create work lists. This report is the SQL version of the Recalls Due Form and can be used to schedule reports for automated generation and e-mail delivery. There is an option to exclude on registration recalls.

Table 170. Recalls reports (continued)

Report > Recalls	Description
Due - Selected Clinical Item Group	Report all recalls due up to a specified number of days ahead for patients with a condition belonging to a selected clinical item group or clinical item and living in a selected locality or locality group. Use this report to create work lists. This report includes filters for provider and encounter place. When these filters are used any 'on registration' recalls are excluded as are 'on completion' and 'on presentation' recalls that were enabled after the trigger item was added to the database. There is an option to exclude on registration recalls.
Due - Selected Locality Group	Lists recalls due within the next specified days, by Locality Group, and indicates if the patient already has an appointment booked in the future and how many times the patient has been seen since the recall was due. Clinics can use this report to see which of the recalls they have generated (either manually or by accepting On Completion or On Presentation recalls) are (over)due or nearly due. On Registration recalls are not listed by this report.
Due - Selected Provider and Item	Lists recalls due within the next specified number of days, for a specific item, which were generated by the selected provider. A provider may use this report to see which of the recalls they have generated (either manually or by accepting On Completion or On Presentation recalls) are (over)due or nearly due. The Provider selection box only shows currently enabled providers. The option to show <All Providers> includes recalls made by currently disabled providers and automated on registration recalls. On Registration recalls are only shown if <All Providers> is selected. On Completion and On Presentation recalls that were generated retrospectively are only shown if <All Providers> is selected.
Due - Selected Provider Name	Lists recalls due within the next specified number of days, which were generated by the selected provider. A provider may use this report to see which of the recalls they have generated (either manually or by accepting On Completion or On Presentation recalls) are (over)due or nearly due. The Provider selection box only shows currently enabled providers. The option to show <All Providers> includes recalls made by currently disabled providers and automated on registration recalls. On Registration recalls are only shown if <All Providers> is selected. On Completion and On Presentation recalls that were generated retrospectively are only shown if <All Providers> is selected.

Table 170. Recalls reports (continued)

Report > Recalls	Description
Due - Selected Topic	Report all recalls due up to a specified number of days ahead that belong to a selected clinical item topic for patients living in a specific locality or locality group. Use the report, for example, to find all 'ear' recalls by selecting the topic 'Ear'.
Due Despite Later Investigation Result	Shows patients where there is a result for a selected investigation and a recall due for a selected clinical item that is older than the date of the test. Use this report to find patients where there may be a recall for, say, a pap smear, but the result has already arrived and may even have been reviewed but the recall remains. To select a result enter all or part of the test name as returned by the pathology or radiology lab - all results matching the search will be checked.
Due Except Selected Recall Types	Report all recalls due up to a specified number of days ahead with options to exclude pap smears (including Women's Health checks), mammograms, aboriginal health checks,immunisation reviews or immunisations. Filter by patient's current locality or locality group.
Due Transient Clients by Record Site	Lists all recalls due, up to 14 days in advance, for transient clients, by "record storage" place. Use this report to list recalls for clients who may be regular visitors to a clinic's area of responsibility.
Health Check Management	Lists all patients with a health check which has been started but has not yet been completed. Included is any health check with the system code of CHC, AHC, EHC or OHC. For example, **Aboriginal & TSI adult check**. Use this report to find check ups that are in progress including those that are just waiting for a doctor to complete. A claim is due if the latest claim is more than the claim interval ago and the item is 100% complete. Complete the item and make the claim. The item should be completed if the latest claim is less than the claim interval ago and the item date is older or equal to the claim date. These COVID-19 MBS items are included as equivalents of the 715 health assessment item: 92004, 92016, 228, 92011, 92023. Each record indicates the percentage of required qualifiers that have been completed in a timely manner. This is useful to indicate where a check up is 'nearly' complete rather than 'just started'. For records with a comment that only a doctor can complete that is some time in the past, but may now be out of date, the percentage complete will give an indication of whether the checks that have been done are not too long ago. Fictitious patients are excluded but patients who have become deceased within the last six months are included. Patients with a cancelled recall are also excluded.

Table 170. Recalls reports (continued)

Report > Recalls	Description
Healthy Under 5s Checks	Wallchart for recalls due in the next one, three or six calendar months. This report requires the HU5K dataset and appropriate recall protocols to be enabled. The report prompts for patient status, locality group and maximum age of patient in years. Only patients with a recall overdue or due in the next specified interval are included.
Immunisation Review Chart	Shows all child immunisation reviews for children under a specified age. Reviews that have been completed are recorded as 'Done', reviews planned show the planned date and reviews not recorded are shown empty. Use this report to monitor completion of reviews of immunisations for children. The report can be ordered by name or date of birth (youngest first).
Immunisation Reviews Due	Lists all **Review;immunisation** recalls due within the next specified days for patients between two selected ages. The age range must be specified in years, months, weeks and days. For example: • '5Y 7M 2W 0D' means 5 years and 7 months and 2 weeks. • '5Y 6M 0W 0D' means 5 and a half years. • '0Y 0M 2W 3D' means 2 weeks and 3 days. Immunisation recalls should be recorded using specific recalls which have descriptions beginning **Review;immunisation;** followed by the age due.
Immunisation Reviews Reminder Letters	Lists details of upcoming immunisation reviews. Use it to automatically generate recall letters for patients with due or overdue immunisation reviews. Children under 18 years old will have the letter addressed c/o any recorded mother, father or carer (selected in that order). Click **Yes** to print a standard letter for each patient who has an upcoming review. Click **Advanced** to export this list as a word processor merge file to send reminder letters.
Immunisations Due Form	This report is used as a data entry form. It produces a complete list of patients who have immunisations that are currently due or outstanding. This report can be printed and used for such areas as school or remote clinic visits. Specific immunisation types or all immunisations due, can be selected. Localities and age groups can also be specified.

Table 170. Recalls reports (continued)

Report > Recalls	Description
Incomplete for a Selected Clinical Item	Lists all patients with a selected clinical item which has been started but has not yet been completed. Use this report to find check ups that are in progress including those that are just waiting for a doctor to complete. Each record indicates the percentage of required qualifiers that have been completed in a timely manner. This is useful to indicate where a check up is 'nearly' complete rather than 'just started'. For records with a comment that only a doctor can complete that is some time in the past, but may now be out of date, the percentage complete will give an indication of whether the checks that have been done are not too long ago. Fictitious patients are excluded but patients who have become deceased within the last six months are included. Patients with a cancelled recall are also excluded.
Patient To Do List	Shows the filtered To Do list for selected patients. Filter by patient status, locality or locality group and specified clinical items (including just recalls or just incomplete referrals). Select Yes to exclude On Registration recalls and filter out any recall that has been put in a patient's To Do list by an automated on registration rule.
Patient To Do List for Selected Patient	Shows the filtered To Do list for a selected patient. You can filter just recalls or just incomplete referrals. Select Yes to exclude On Registration recalls and filter out any recall that has been put in a patient's To Do list by an automated on registration rule.
Recalls and Imms Due Form	This report is used as a data entry form. It shows all outstanding recalls for the patients selected by the standard report options used. It has spaces to enter a recall completed date and next due date. The next due date (for the next recall) is optional and should only be used when the patient needs to be recalled at other than the standard recall interval or not at all. Recalls for deceased patients are excluded.
Recalls Due	Report all recalls due up to a specified number of days ahead. Use this report to create work lists. Run this report in Advanced mode or export to Microsoft Excel to display Medicare numbers. This report is the SQL version of the **Recalls Due Form** and can be used to schedule reports for automated generation and email delivery. This report includes filters for provider and encounter place. When these filters are used, any 'on-registration' recalls are excluded as are 'on-completion' and 'on-presentation' recalls that were enabled after the trigger item was added to the database. Additionally, filter by locality or locality group, recall, patient status, patient group, recall responsibility, age range, sex, provider, encounter place and patient risk status (using the 'At risk if appointments are missed' tickbox on the clinical record). There is an option to exclude on-registration recalls.

Table 170. Recalls reports (continued)

Report > Recalls	Description
Recalls Due Form	Produces a complete list of patients who have recalls that are currently due or outstanding. This report can be printed and used for such areas as home or remote clinic visits. Specific recall types or all recalls due, can be selected. Localities and age groups can also be specified.
Recalls Due Multiselect	Reports all recalls due up to a specified number of days ahead. Either all recall types or up to five specified recall types can be selected. Use this report to create work lists. This report is an SQL version of the **Recalls Due Form** and can be used to schedule reports for automated generation and email delivery. This report includes filters for provider and encounter place. When these filters are used any 'on registration' recalls are excluded as are 'on completion' and 'on presentation' recalls that were enabled after the trigger item was added to the database. The clinical item group filter is based on the patient having at least one clinical item belonging to that group in their clinical record of any date. It identifies patients with a specific chronic disease and is not related to the type of recall. There is an option to exclude on registration recalls.
Reminder Letters	Lists details of upcoming recalls for a specific reason. Use this report to automatically generate recall letters for patients with due or overdue recalls. The Provider selection box only shows currently enabled providers. The option to show All Providers includes recalls made by currently disabled providers and automated on registration recalls. Click **Yes** to print a standard letter for each patient who has an upcoming review. Click **Advanced** to export this list as a word processor merge file to send reminder letters.
Reminder Letters for Selected Provider	Lists details of all upcoming recalls created by a specific provider. Use it to automatically generate recall letters for patients with due or overdue recalls. Click **Yes** to print a standard letter for each patient who has an upcoming review. Click **Advanced** to export this list as a word processor merge file to send reminder letters.

Table 170. Recalls reports (continued)

Report > Recalls	Description
Test Result Followup	Lists details of all patients who have any incomplete recalls for any test results follow-up due in the next specified number of days. Use this report as a work list to contact patients who require follow-up after pathology results have been returned. The report will include any recall that starts with the words **Followup;Test result** and any other recall that appears on the **Add Recall** button on the **Match and Review Result** window. For more information, see Reviewing and matching results *(on page 309)*.
With Expiry Dates	Displays details of recalls that have expiry dates. Specify a recall type if required.

Immunisations Due Form

This report is used as a data entry form. It produces a complete list of patients who have immunisations that are currently due or outstanding.

Specific immunisation types or all immunisations due, can be selected. Localities and age groups can also be specified. This report can be printed and used for such areas as school or remote clinic visits.

Recalls and Immunisations Due

This report is used as a data entry form. It shows all outstanding recalls for the patients selected by the standard report options used.

It has spaces to enter a recall completed date and next due date. The next due date (for the next recall) is optional and should only be used when the patient needs to be recalled at other than the standard recall interval or not at all. Recalls for deceased patients are excluded.

Recalls Due Form

This report produces a complete list of patients who have recalls that are currently due or outstanding.

Specific recall types or all recalls due, can be selected. Localities and age groups can also be specified. This report can be printed and used for such areas as home or remote clinic visits.

Reference Tables Reports

These reports enable you to print information from the Reference Tables.

Tip:
If you can't find the precise report you need, consider using Query Builder instead.

Table 171. Reference Tables reports

Report > Reference Tables	Description
Address Book	Print the address book. Print to Microsoft Excel to show audit fields.
Appointments Session Templates	Lists the templates defined in the Appointments Session Templates table.

Table 171. Reference Tables reports (continued)

Report > Reference Tables	Description
Automated Recall Loops	Shows automated recall types diagrammatically so that recall protocols can be seen and assessed.
Automated Recall Types	Lists details of the Automated Recall Types. Use Selection and Ordering options to configure the report to give the list that best suits your needs.
Cause of Death Factor Types	Lists all of the Death Factors that are defined in Communicare. Use this report in conjunction with the Cause of Death Types report.
Cause of Death Types	Lists all of the Death Causes that are defined in Communicare. Use this report in conjunction with the Death Factor Type report.
Clinical Item Group Membership	Displays the Clinical Item Groups that a Clinical Item belongs to (if any).
Clinical Item Groups	Lists all clinical items within a selected clinical item group or all clinical item groups that a clinical item belongs to, which is useful in gaining an understanding of the scope of clinical item groups. Disabled terms are excluded. There are options to filter by viewing right and by ICPC component. Because the report can be very long, especially if you use ICPC-2 PLUS and select `All Clinical Item Types and Groups`, consider viewing the report on your computer or exporting it rather than printing it.
Clinical Item Type Details	Displays details of a single clinical item including all the qualifiers, and options available in lists. Use to present to users for discussion at a design stage or as the basis for a paper data collection form that providers can take to remote areas, transferring the data into Communicare when they return.
Clinical Item Type Usage	Analyses usage of clinical item types and qualifiers, showing which items have been used and how often. Usage is counted by distinct patient. Patients with current status of `Fictitious Patient` are excluded from this report.

Clinical Item Types	Lists Clinical Item Types.
	
	Select the items to be included in the report from:
	
	• All Items
	• A specific Class
	• A specific Topic
	• All Recallable items
	• Further options enable you to:
	  ◦ List the Qualifiers that are associated with each item
	  ◦ Suppress items that are not enabled
	  ◦ Include ID numbers

Clinical Item Types - Immunisations	Lists all immunisation clinical item types along with their ICPC and AIR codes and whether the immunisation is included on the clinical record **Immunisations** button. Use this report to confirm that your system contains a complete and up-to-date list of immunisations.

Table 171. Reference Tables reports (continued)

Report > Reference Tables	Description
Clinical Item Types Added	Details new items and qualifiers added in the previous specified days. Administrators can use this report to report on items and qualifiers created whilst on site or to find new Central items.
Clinical Item Types and Qualifier usage	Lists enabled Clinical Item Types with associated qualifiers that have been used in the past 30 days, along with a count of the number of times the term has been used in that period Administrators can use this report to evaluate clinical item and qualifier usage. Records created by SYSDBA and disabled qualifier types are excluded.
Clinical Item Types Disabled with Recalls	Administrators can use this report to itemise clinical item types that have been disabled but for which there are outstanding recalls for patients (excluding fictitious and deceased patients). Run the Recalls Due report for each item to find out patient details and consider cancelling such recalls as no longer required.
Clinical Item Types non-ICPC	Lists enabled local Clinical Item Types (with associated qualifiers) that are not official ICPC terms, along with a count of the number of times the term has been used in the past 30 days. Administrators can use this report to identify non-ICPC terms that are not being used and should be disabled, or mapped to ICPC.
Clinical Item Types non-ICPC Disabled	Lists disabled local Clinical Item Types (with associated qualifiers) that are not official ICPC terms, along with a count of the number of times the term has been used. Administrators can use this report to identify non-ICPC terms that are have been used and should be converted, re-enabled or mapped to ICPC.
Clinical Item Types With Selected Qualifier	Lists all clinical items with a selected qualifier attached. Use this report to see where a particular qualifier can be entered by providers. Your viewing rights may preclude you from seeing all clinical items.
Clinical Item Types Without Keywords	Lists any enabled clinical items which have no keywords attached. These terms cannot be found using the keyword search until they have at least one keyword attached.
Dosage instruction shortcuts	Lists text shortcuts that can be used when prescribing medications.
Duplicate Qualifier Types	Reports items that have a square bracket in the description that surround a number. Qualifier descriptions must be unique. Following Central imports to Communicare, any duplicate descriptions which already existed on the local database are made unique by appending a number in square brackets. For example, the description `Iron` would be changed to `Iron[1]`. Use this query to help you resolve duplicate descriptions.

Table 171. Reference Tables reports (continued)

Report > Reference Tables	Description
Encounter Places	Lists all encounter places and enabled modes.
Formularies	Lists formulary details. If a product was deleted from MIMS, the date it was deleted is displayed. If only a pack size was deleted, `Pack only` is displayed. To show items accidentally selected, select `<Errors>`. If any records are reported here, contact Communicare Support.
ICPC SNOMED Mappings	Lists all Clinical Item Types with or without an ICPC Code and with or without a SNOMED code. This report identifies any Clinical Item Types that are missing mappings between ICPC and SNOMED and vice versa or to review matching that has already been done.
Investigation Keywords	Lists keywords for requesting investigations. Select `Central`, `Local` or `All` keywords.
Investigations	Lists all investigations that can be requested and indicates if they have been shortlisted.
Investigations Local STI Codes	Lists local lab codes for STI results. These codes are imported as part of the STRIVE project. If the codes are sent by the lab in electronic HL7 results, Communicare will interpret the abnormality flag as a result for the specified qualifier.
Investigations With Linked Qualifiers	Lists investigations that trigger qualifier collection. This information is relevant for the STRIVE project.
Investigations Without Keywords	Lists any enabled investigations that have no keywords attached. These terms cannot be found using the keyword search until they have at least one keyword attached. Use **File > Reference Tables > Investigations > Investigation Keywords** to add a keyword to these investigations.
Localities Not in Health Service Area	Lists the locality names of any localities in which current patients live that are not included in the Locality Group called `Health Service Area`. The report is ordered by the number of current patients living in each locality. Use this query to verify that the `Health Service Area` locality group includes all localities covered by your Health Service. Localities with an asterisk are preferred localities.

Table 171. Reference Tables reports (continued)

Report > Reference Tables	Description
Locality Group Analysis	Lists all localities with a postcode between two values showing which are in which locality group. Up to eighteen locality groups are considered. Use this report to check that your Health Service Area and other locality groups are comprehensively defined. Localities with an asterisk are preferred localities. Refer to http://www.aus-emaps.com/postcode_finder.php for maps with postcode boundaries.
Locality Groups	Lists all Locality Groups along with the Localities that are included in each group.
MBS Items	Lists all short-listed MBS Items along with their long and short descriptions. Use this report to check that appropriate short descriptions have been given to each MBS Item.
MBS Items Added	Lists all MBS Items added in the last import along with their long and short descriptions. Use this report to check that appropriate short descriptions and short-listing has been given to each MBS Item you may wish to short-list.
Non-ICPC Central Items	Details of non-ICPC2 Central items.
Numeric Qualifiers	Lists numeric qualifiers ordered by units and name. Use it to check for qualifiers that may need converting to central qualifiers.
Numeric Qualifiers - Central	Lists Central numeric qualifiers, with details. This report shows all qualifiers that can be automatically extracted from HL7 pathology results as well as other centrally maintained numeric qualifiers. LOINC codes are recorded on incoming HL7 pathology results and are recorded in Communicare as qualifiers. This report lists the LOINC codes included in qualifiers & the units used.
Preferred Localities	Lists all localities that have been marked as `Preferred`. It is useful to help keep the list of preferred localities as short as possible, because it simplifies Patient address entry.
Private Billing Items	Lists all Private Billing Items along with their private billing type, code, description, taxable status, and if applicable, their MBS number and fee. Use this report to check which fee schedule items exist under which billing types. This report can also be exported to Excel.
Providers List by Specialty	Lists providers includes in the Providers reference table, including their speciality. Providers who have recorded no activity in the last 60 days are marked. Use this information to disable inactive providers.

Table 171. Reference Tables reports (continued)

Report > Reference Tables	Description
Providers with Numbers	Lists all providers with a HPI-I, a DOH provider number or a DOH prescriber number.
Qualifier Type Usage	Analyses the usage of qualifier types. Use to detect which qualifiers have been used and how often. A date of 01-JAN-1990 means that the qualifier was created before auditing of the creation details. The default user for such qualifiers is ADMINISTRATOR.
Quick Access Button Items	Lists all the items that are set to appear on quick access buttons in the clinical record. The Communicare Administrator can add items and buttons by adding a keyword starting with $ to the clinical item. For example, an item with a keyword of `$Check up` appears on a button labelled `Check up`. The keyword `$IxRecall` adds the item as a recall onto the button for adding recalls when reviewing investigation results. The keyword `$Recall` adds items as a recall to the **Add Manual Recall** button in the clinical record.
Recalls Disabled by Central Data Update	Lists Automated Recall Types that have been disabled by the central data update. To do so it makes several assumptions and may list some extraneous records. Examine the SQL in the report editor to see the full selection criteria. Use this report to find recalls that may need to be enabled again following a central data update.
Reports and Comments	Lists all reports and their comments.
Reports SQL Code	Lists all the SQL code for SQL reports.
System Codes and Rule Codes	Administrators can run this report to list all system codes and rule codes attached to clinical items and system codes attached to qualifiers. Export codes are also included.
System Parameters	Lists the main system parameters for this database. Use it whenever you need to find out which modules are enabled.
Text Shortcuts	Lists all current text shortcuts that may be used in progress notes and letter writing. Use this report to give to Communicare users as a guide to shortcuts.

Referrals Reports

The referrals reports list and analyse referrals.

Referrals are clinical items with a class of `Referral`.

Table 172. Referrals reports

Report > Referrals	Description
Analysis by Organisation and Reason	Analyses referrals by organisation and referral reason. Use this report to count the types of referrals made to each organisation referred to, including internal referrals.
Analysis by Type and Organisation or Person	Counts referrals (incoming and outgoing) by the type of referral (reason) and the organisation or person referred to or from, where: • Referrals To are outgoing referrals to the external organisation or person • Referrals From are incoming referrals from the external organisation or person. Use this report to measure referral activity within the organisation. Filter by: • Critical Status • Emergency Status • Locality • Referrals To or From the Organisation • Any Referral Reason Fictitious clients are ignored.
Analysis of Escorted referrals	Analyses escorted referrals by referral reason. Use this report to count the types of referrals which were escorted. Cancelled referrals are not counted.
Complete or with Appointment between two dates	List all referrals that may have been completed. The report looks for referrals that have either: • An appointment date between two specified dates and no referral complete date • A referral complete date between the same two dates regardless of appointment date. Use this report to get details of referrals that were actually completed between two dates and also to highlight referrals that should have been completed so that action can be taken. Only referrals 'to' are considered, not referrals 'from'.
Incomplete and Awaiting	List all referrals that have not been completed. This report prompts for a date range, the default being from two years ago to today. Recalls are shown with the due date instead of the referred date and are referrals that have not yet been made (that is, there is a recall for a referral but it has not yet been initiated).

Table 172. Referrals reports (continued)

Report > Referrals	Description
Patient Referrals by Organisation and Provider	Lists all incomplete and complete referrals in a selected period for a selected organisation or all organisations. Use this report to track referrals allocated to workers within your section. The report is grouped by organisation, provider referred to, status and sex, and shows patient name, referral reason and who made the referral.
Referral Appointments	Lists incomplete referrals by appointment time. Use this report as an aid to arranging client transport. Recalls for referral and referrals without an appointment are not listed.
Referral Appointments Needed	Lists incomplete referrals without an appointment time. Use this report as a work list to book appointments for referrals that have no appointment. Recalls for referrals more that 2 years old are not listed. **Tip:** Click **Advanced** in patient search to open client files and record appointment times.

Table 172. Referrals reports (continued)

Report > Referrals	Description
Referrals	Lists and analyse referrals. Use the following styles: • Patient Referral Outcome - lists qualifier outcomes associated with referrals associated with each patient. Referrals with no associated qualifiers are not included and you can only select 'Show Critical Referrals Only'. • Referral Analysis - summarises (count, estimated cost) referrals by reason. You can only select 'Show Critical Referrals Only'. • Referrals by Patient - lists details (where / reason / comment / status / date) for all referrals by date for each patient. Referrals can be to or from. You can only select 'Show Critical Referrals Only'. • Referrals From by Organisation - lists details (from where / comment / status / date / patient) for patient referrals from an organisation in order by organisation. The summary for each organisation shows the number of males, females and the total. You can print just this summary. • Referrals From by Reason - lists details (from where / comment / status / date / patient) for patient referrals from an organisation in order, by reason. The summary for each reason shows the number of males, females and the total. You can print just this summary. • Referrals To by Organisation - lists details (from where / comment / status / date / patient) for patient referrals to an organisation in order, by organisation. The summary for each organisation shows the number of males, females and the total. You can print just this summary. • Referrals To by Reason - lists details (from / where / comment / status / date / patient) for patient referrals to an organisation in order, by reason. The summary for each reason shows the number of males, females and the total. You can print just this summary. • Referrals To/From by Reason - lists details (patient / status / date / comment / locality / phone / address) for patient referrals to/from an organisation in order, by reason. The summary for each reason shows the number of males, females and the total. You can print just this summary. Other options control printing of comments/ locality/ address detail. This report excludes fictitious patients.
Reminder Letters	Lists details of upcoming referral appointments for a selected date range. Click **Yes** to print a standard letter for each patient who has an upcoming appointment. Click **Advanced** to export this list as a word processor merge file to send reminder letters.

Table 172. Referrals reports (continued)

Report > Referrals	Description
Summary	Counts the number of "referrals to" and "referrals from" the organisation for a referral reason. Use this report to summarise the reasons for "referrals to" and "referrals from" the organisation. The report is grouped into "Referrals To" and "Referrals From": • Referrals To are outgoing referrals to the external organisation or person • Referrals From are incoming referrals from the external organisation or person. The report displays the number of referrals for each referral reason, and totals the number of referrals to and from the organisation. The report can be filtered by: • Encounter Place • Encounter Mode • Program • Referral Reason

Advanced Referral Report Options

In addition to the usual Report Options *(on page 456)*, the Referral reports allow selection where appropriate by:

- Referral Reason
- Referral Status
- Referral Type
- Referred To/From
- Patient - Selected patient or all patients

SMS Reports

Report on SMS appointment cancellations and batches.

Table 173. SMS reports

Report > SMS	Description
Appointments Cancelled by SMS	Use this report to show appointments that have been automatically cancelled by the patient declining via SMS. Filter by the scheduled date of the appointment and encounter place.
Batch Report Details	For a particular batch, list all patients the message was sent to, their number, the message itself, and success or failure (with error) for each. Also included are messages sent individually, which appear with the template of '[Manual]'.

Table 173. SMS reports (continued)

Report > SMS	Description
Batch Report Summary	List all batches that have been sent within a date range with the SMS query name, the number of texts, and whether if it was successful (including an error if it failed). Also included are messages sent individually, which appear with the template of '[Manual]'.

Transport Reports

Print a form for transport services.

Table 174. Transport reports

Report > Transport	Description
Daily Work Tally Sheet	Print a form for a transport worker to use when performing transport services. Use one form for each journey. On return to the clinic, transcribe the data into Communicare.

Transport Management Reports

Report on information entered using the **Transport Management** module.

Table 175. Transport Management reports

Report > Transport Management	Description
Daily Transport Itemised	Create a summary list of the daily transport requirements. The list will show active bookings for the selected day only. Export to Microsoft Excel for full data, otherwise click **Yes** to see a printable summary.
Daily Transport Requirements	A detailed list of the daily transport requirements. The list will also show requirements from previous days which have not been fulfilled.
Missed Bookings	A detailed list of patients who missed a transport booking between two dates for one of the following reasons: • Patient did not attend. • Refused by patient. • Cancelled by patient. Transport bookings that are still outstanding are not included. A filter for patient home address is provided.

Table 175. Transport Management reports (continued)

Report > Transport Management	Description
Pick-ups and Drop-offs	Displays the number of passengers picked up and dropped off for each place between two dates. The report includes the dates entered. • Pickups and Dropoffs count only those transport management services where the outcome is 'Transport provided'. • DNA counts services where the outcome is 'Patient did not attend. • DNF counts services where the outcome is 'Patient could not be found'. • REFUSALS counts services where the outcome is 'Refused by patient'. • CANCEL counts services where the outcome is 'Cancelled by patient', 'Cancelled by service', 'Patient transported by other means' or 'Appointment rescheduled'. Where Transport Services data is included the Aboriginality is not recorded therefore these data only appear when the Aboriginality option is 'Unknown' or 'All'). Active bookings are not included.
Services by Driver	Displays the number of journeys, total distance travelled, total time spent travelling and number of passengers picked up and dropped off by each driver between two dates. The report includes the dates entered.
Services Provided	Count of transport services provided by patient. This report shows patient names with a count of how many transport services were completed, are still active or were cancelled/DNA between two dates. 'DNA' includes all cancelled bookings as well as no shows, refusals, rescheduled bookings and bookings where the patient was transported by other means.

User Groups reports

Report on user groups.

Note:
Only administrators can run these reports.

Table 176. User Groups reports

Report > User Groups	Description
Default Settings	Shows default place, mode, program and provider for all users who still have a logon and have logged on at least once. Administrators can use this report to make sure that default settings are appropriate.
Formulary Rights Grid	Shows the formulary rights for each user group in the form of a grid for easy interpretation and management.
Program Rights Grid	Shows the program rights for each user group in the form of a grid for easy interpretation and management.

Table 176. User Groups reports (continued)

Report > User Groups	Description
System Rights Grid	Shows the system rights for each user group in the form of a grid for easy interpretation and management.
Usernames	Lists all usernames with access to Communicare sorted by user group and active status. The report shows the number of days each user has logged on to Communicare in the last 60 days and the total number of users.
Viewing Rights Grid	Shows the viewing rights for each user group in the form of a grid for easy interpretation and management.

Workstations Reports

Report on workstations.

Table 177. Workstations reports

Report > Workstations	Description
Client List	Count the number of Communicare licences (workstations) used in the last 60 days. This report lists workstation computer names and Communicare usernames.
Client List - Five Fortnights User Median	Count the number of Communicare licences (Users) that have been used in the last 5 fortnights, excluding the users MEDISYS, CCUSER, SYSDBA & CENTRAL. The five fortnights are calculated backwards from day before the reference date. For current usage enter today's date or 'TODAY'. If you want to include today's partial usage, enter tomorrow's date or 'TOMORROW'.
Client List selected date range	Count the number of Communicare licences (workstations) used in a selected range of dates. This report lists workstation computer names and Communicare usernames.
Client Users	Locate all workstations that are running Communicare. This report lists workstation computer names and the user names that were logged on at the time Communicare was started. It is limited to the last 60 days.
Client Versions	Find workstations that have not been upgraded to the current version of Communicare. This report lists computer name and Communicare version number used in the last 7 days.
Rolling Fortnightly Averages	Licence review report. This report shows the previous eight 12-month periods, starting with each quarter, and calculates the rolling average users per fortnight over the 12-month period.

Table 177. Workstations reports (continued)

Report > Workstations	Description
Workstation Client List selected date range	Lists each computer accessing a Communicare database during a selected period, with the Communicare and Windows user names. This report shows: • Workstation computer names • Communicare user names • Windows user names Communicare system accounts (CCUSER and MEDISYS) are excluded. Use this query to count the number of Communicare licences (workstations) used in a selected range of dates. Also use this report to identify terminal servers.

Quick Print Services

This function in Service Recording produces quick and convenient reports that list services.

- **Patients in the clinic now (waiting, started and paused services)** - prints a list of all patients in the clinic at the time of generating the report, that is, they have arrived or are being seen. It will always be current regardless of the date in view. It ignores filter settings.
- **Full list for the day in view** - prints the full service list for the day currently selected. It ignores all filter settings except for the date.
- **Current filtered selection** - prints the list of services currently in view. It honours all Service Record Filter Selections *(on page 109)*.

The reports default to the printer specified for Service Recording in Printer Assignments *(on page 618)*.

Reporting group activity

Your service can set up clinical items to record group attendance broken down into demographics of your own choosing. You can then report on these demographics using a standard Communicare supplied report.

To record attendance at group activities anonymously, use an `unidentified clients` patient. To set up your system to record anonymous attendance and be able to report on it:

- Set up a patient using the following settings:
  - **Surname** - `UNIDENTIFIED CLIENTS` (recommended by Communicare, although it need not be this description exactly)
  - **Locality** - `Other / Elsewhere`
  - **Status** `Non Patient`
  - Leave all other Biographic information blank
- Create a clinical item with GROUP in the description. For example, `Creche;Group attendance`
- Create numeric qualifiers with a System Code of GRP and a description of the group. For example, `Males 0-9`, `Females 0-9`, `Males 10-19`, `Females 10-19`...
- Attach the qualifiers to the Clinical Item and any appropriate key words.

Running the report

To report on the recorded activities, run **Report > Procedures > Group Activities - Unidentified Clients**.

This report is similar to the OSR question: *What type of groups were run by your service and how many people attended?*. However, this report is for unidentified patients and group activities.

It provides options for a range of dates and an option for analysis by provider and shows both the number of individuals and number of attendees.

This report looks for all qualifiers with the GRP System Code.

You can filter by Encounter Place, Encounter Mode, Program, Group, Group Type, Provider (single provider, group by each provider or view all together).

Fictitious clients are excluded. Non-patients are included.

Query Builder

The Communicare Query Builder module is a sophisticated query by example (QBE) application that you can use to produce a large variety of specific user-defined reports.

Any user who has basic knowledge and experience with general Query tools will find Query Builder straightforward and relatively simple to use.

Once a Query Builder query (report) has been saved, it can be run from the Communicare **Report** menu. Query builder reports can be distinguished from other reports by the  Query Builder icon displayed next to the report name on the menu.

> **Tip:**
> This Query Builder topic contains only the basic information needed to "drive" Query Builder and is not intended to be a detailed query tool guide.

Communicare uses a relational database which simply means groups of related data kept together. This data is stored in tables, for example, patient details are stored in one table and provider details in another. These tables are related to each other (or linked) when there is a patient encounter or clinical visit. Each table consists of fields, such as Patient ID, Patient Forename, Patient DOB. Together the fields which make up a single patient's details or profile is known as a record.

> **Tip:**
> These terms are often used interchangeably, but mean the same thing:
>
> - Table = File
> - Column = Field
> - Row = Record

Queries are the means of extracting specific records (which meet certain criteria) from one or more related tables. For example, a list of all male patients who visited the clinic in the last week who saw a particular provider. Queries can become very complex and sophisticated. Often the best method is to "build" them gradually to ensure the results are accurate and relevant.

Note:
Never assume the results of your query are correct. Always verify them to ensure accuracy. For example, a query's result may return no records. This can mean that no-one meets the criteria set or there is an error in one or more of your criteria. Be cautious!

To open the Query Builder in Communicare, select **Tools > Query Builder > Query Builder**.

Useful information

When the report selects patient names or when the report selects services, use the following:

FULL_NAME_AGE_TITLE_TODAY	CURRENT_STATUS	SEQUENCE_DATE	PAT_ENC_STAT
PATIENT	**PATIENT**	**PATIENT SERVICE**	**PATIENT SERVICE**
CCare	CCare	CCare	CCare
	<> 'SF'	BETWEEN $FromDate AND $ToDate || ' 23:59:59'	in ('S','F','P')
FULL_NAME_AGE_TITLE_TODAY	**CURRENT_STATUS**	**SEQUENCE**	**PAT_ENC_STAT**
Show	Not Show	Show	Not Show
T13	T13	T7	T7

If you need to include deceased patients, the 'Or' condition for CURRENT_STATUS should read null.

See Also Access Control for Query Builder Reports *(on page 930)*, Report Naming *(on page 614)*.

Parameters for Query Builder report

When a Query Builder report requires input parameters, the **Report Parameters** window is displayed.

To display the **Report Parameters** window, select **Report >** *query builder type report*. If the report requires input parameters, the window is displayed.

Query Builder type reports are identified with a  Query Builder report icon.

A parameter can be entered and edited. The OK button will accept the parameter. The Cancel button will end preparation of the report. When the parameters are accepted a report will be displayed.

Query Builder *(on page 576)* type reports that require multiple parameters will have a separate parameter window appear for each parameter.

Communicare will 'remember' the values entered by you when you last used a parameter of the same name. For example, if you entered the value '01/01/2006' for the parameter 'First Date to Report', any other query requiring that parameter will have that value entered by default.

Where Definition

When you double-click on one of the cells on the Condition row of the Query_Grid, the Enter the where definition dialog box is displayed. The current Table and Field names are displayed in the top left corner.

A Logical Operator is then selected from the drop down box, for example `=, <, >, <=; >=, <>`, and so on, and a value is then entered in the text box. For example, to set the condition of all patients over the age of 15 the operator is `>` and the value is 15.

If you need to create a more complex formula, simply add a logical operator after this condition such as OR or AND, then type a second condition. Alternatively, to enter a range of values use `>` 15 in the Condition line, then `< 65` in the OR line. The result will be all patients aged between 16 and 64.

Note:
You cannot add an OR condition if the first condition line is empty.

Note:
When using Dates in Query Builder, the format must be `DD-MMM-YYYY`, for example, `09-JAN-2000`

Conditions can be very complex. If you are unfamiliar with the concept of operators and conditions practice with some simple examples and gradually expand the criteria.

Use the **Expert Mode** tab to enter calculated field definitions more quickly once you are used to their syntax and how the program operates. The right side of the window lists the data fields and the calculated fields already defined, while the left side lists the operators. No special assistants are provided, and variables are created manually.

Note:
When using Dates in Expert Mode the format must be `'DD-MMM-YYYY'` with the date surrounded by single quotes `'` `'`. For example, `'09-JAN-2000'`.

Data Models

Models are a set of related tables which form a group.

For example, the `Services` data model contains the tables: Service, Provider, Assistant, Encounter Place and Encounter Mode. All of these tables are needed to run a Service related query.

Communicare provides the following predefined data models. You cannot create or save your own models in Query Builder.

- `Appointment`
- `AppointmentTemplate`
- `ClinicalRecord`
- `Demographics`
- `Services`
- `Users`

To open a model:

1. In the Query Builder, select **File > Open Model**.
2. Select the required model.

After you open a data model, in the **Query Builder** window one or more relevant tables are displayed in the top section and the selection Query Grid is displayed in the bottom section.

You can add additional tables or remove existing tables if required, however they will change only for this session and the model will revert to its original configuration when closed.

Note:
You can add tables only if they are related. If two tables are related a line appears between the two windows in the **Query Builder** window. If this link does not appear, your query will probably require an additional table.

Tip:
There is no Query set, this is for you to determine.

Tables View

Use the top section of the **Query Builder** window to view the tables when you open a model or run a sample or saved query.

Each table contains the table's name (Title) and lists all its field names.

To print the complete Tables view (model) or copy it to the clipboard for use in other applications, select **File >** *required option*.

To scroll the Table Model, click Touch Scroller.

To move a table, click and drag the Title (Table Name).

To add a table, select **Tables > Add a Table**.

To remove a table, right-click on the required table.

Saving Queries

After creating and running your query you can save this query for future use if required. Queries can be saved in either the database or as a file.

To save a query, select **SQL > Save Query**. See Loading and Saving Queries *(on page 614)* for more information.

Saving a Query Builder report as an SQL report

Sometimes you may want to convert a Query Builder report to SQL. This may be to access the increased functionality of SQL or to schedule the report for automated running. The following steps allow this conversion without having to re-design the layout:

1. Export the QB report somewhere (for example, `My Documents`). This will create two files: `[QB report].QRY` and `[QB report].MKR`
2. Open the QB report in Query Builder and select **SQL > View SQL** or click the spectacles icon.
3. Click **Save SQL** and navigate to where you saved the QB query and give it a different report name: `[SQL report].SQL`
4. In Query Builder select **SQL > Query Info** or click on the iQ icon and copy and save this text. Close Query Builder.
5. Open the folder where the files are and open `[SQL report].SQL` in Notepad. At the beginning, insert a new line and type `/**/`.
6. Paste the query info between the asterisks: `/*This is the query info.*/` and save your changes
7. Copy `[QB report].MKR`. Rename the copy the same as the `.SQL` file but with the extension `.MKR: [SQL report].MKR`.
8. Use Communicare to import the SQL report.

> **Note:**
> If the Query Builder report has parameters, open the report in the SQL editor and change **$Parameter_name** to **:Parameter_name**.

Query Grid

Use the bottom section of the Query Builder window to design the query.

> **Note:**
> If no selection criteria is entered (i.e. the grid is left blank) the resulting query will be ALL data contained in ALL tables in the **Tables View** window.

To enter field details in the grid, the easiest method is to double-click on the required field in the **Tables View** window one at a time. This will automatically fill (populate) the criteria columns from left to right. Alternatively, you can drag the required field name from the top section onto the required criteria column.

- **Field** - automatically displays the selected field name, eg: Surname
- **Table** - automatically displays the selected table name, eg: Patient
- **Database** - automatically displays the selected database name, eg: CCare
- **Sort** - (Optional) double-click to determine if you want the results sorted in ascending or descending order for this field, eg: A - Z or Z - A
- **Condition** & **OR** - the grid includes two lines for entering conditions. The first line is labelled Condition; and the second line is labelled OR, allowing you to enter an alternative without needing to enter complex formulas. When you double-click on one of the cells in this line, the **Where Definition** window is displayed.
- **Aggregate Function** - double-click on the cell to display the list of applicable functions. Aggregate functions are only accepted in certain cases.
- **Field Name** - automatically displays the selected field name, eg: Surname
- **Visible** - (Optional) double-click to determine if you want this field's data to be displayed in the final results, eg: DOB is the criteria but for confidentiality reasons this is not to be shown in resulting report.
- **Group** & **Group Condition** - to enter a group, double-click in the desired cell. The word GROUP is displayed, followed by an order number. This number defines the field grouping order. This is the same principle used for sorts. You can add a HAVING clause by entering it in the Group's Condition line (or by adding it to the global HAVING clause). A detailed explanation of SQL is beyond the scope of this document. We will simply discuss the effects, limits and constraints of the GROUP BY command.
- **Local Alias** - automatically displays the database alias name for the selected table and field (System-defined)
- **Global Where** - the query definition allows you to enter a filter condition for each field. This is normally sufficient, but in some cases you may need to add global filtering conditions at will. This option allows you to enter a WHERE clause that is added automatically to the query conditions. It also allows you to create a basic filter that is independent of the conditions defined for each field. For example, you can limit a query by default to all patients in a specific community whatever the search conditions used for the fields.
- **Global Having** - the HAVING clause is used with the GROUP BY clause. It acts a bit like a WHERE clause (see your server's SQL manual to understand the exact effect of HAVING). This clause is very similar to the Global Where clause described above.

- **Distinct Mode**- eliminates duplicate names in the query result. To activate Distinct Mode, select **SQL > Distinct Mode**.
- **Initialise Query** - This option clears the query space. Any calculated fields that may have been defined are not deleted (this must be performed manually, unless you load another model). This makes it easy to recognize a new query without needing to redefine the calculated fields. To activate Init Query, select **SQL > Init Query**.

SQL Reports

With prior SQL knowledge, reports can be prepared in SQL and imported for ongoing use in Communicare.

SQL Reports are identified in the main **Report** menu, prefixed with either a yellow  SQL icon, or blue  Central Report icon.

To import SQL reports:

1. Click **Import** from one of the following locations:
    - **File > Queries > Import Query from file**
    - **Report > Search Report**
    - **Tools > SQL Report Editor**
2. In the **Load query from a disk file** window:
    a. Set the file to the type being imported (`*.QRY`, `*.SQL` or `*.XML`).
    b. Navigate to the location of the SQL Report that is required, and click **OK**.
3. If you want other users to be able to use this report then make it Public when prompted.
4. If you import a report with the same name as a current report you will be prompted to confirm you wish to overwrite the report with the imported version. Only users belonging to the System Administrator group may overwrite a central report this way.

Imported reports are listed in the **Report** menu, prefixed with the yellow  SQL icon.

See Edit SQL Reports *(on page 583)* for more detail.

If required, you can export SQL reports.

To export SQL exports:

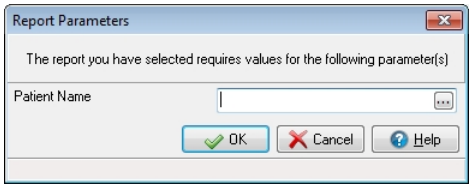
1. Select **File > Queries > Export Query to file**.
2. Click **Export**.
3. In the **Save a query to disk file** window, click **Export**.
4. Navigate to the folder where you want to save the report. Two files are created, `*.sql` is the code and `*.mkr` is the layout. Both files are required.
5. Click **OK**.

See Also Parameters for SQL Reports *(on page 581)*

Parameters for SQL Reports

When an SQL report requires input parameters the **Report Parameters** window is displayed.

For example:



Enter values for the parameters and click **OK**. The report is then generated.

Communicare remembers the values entered by you when you last used a parameter of the same name. For example, if you entered the value `01/01/2006` for the parameter **First Date to Report**, any other query requiring that parameter has that value entered by default.

Special Date Parameters

> **Note:**
> Always check that the date has been interpreted correctly by checking the label to the right before running the report.

Communicare SQL reports recognise the following entries for dates:

- A date in various formats such as DD/MM/YYYY, and so on, but we recommend the following formats which are unambiguous:

```
DD-MMM-YYYY (e.g. 10-FEB-2007)
YYYY-MM-DD (e.g. 2007-02-10)
```

  Other formats, complete or otherwise, will be interpreted (for example, 10/2/07). Always check the date is what you intend.
- Offsets from yesterday, today, tomorrow, for example:

```
today - 2
tomorrow + 1
```

- A specific day of the current week, `Sunday/Monday/Tuesday/Wednesday/Thursday/Friday/Saturday`, for example:

```
Friday
```

- A day in a different week, `(Sunday/Monday/Tuesday/Wednesday/Thursday/Friday/Saturday) of (last/this/next) week`, for example

```
Monday of last week
```

- A date made up of a day, month and year. The tailing portions may be omitted. The portions are separated by `/` or `of`.
  - Day portion:
    - a day number, for example

```
15
```

    - a relative day, `(first/second/third/fourth/fifth/last)` `(Sunday/Monday/Tuesday/Wednesday/Thursday/Friday/Saturday/day)` `[(+|-) n]`, for example:
      second last day of the month, `last day - 1`
      fifth Sunday (if there is no fifth, it goes to the next month) `fifth Sunday`
  - Month portion:

- a month relative to a set month, `Month [(+|-) n]`, for example:

```
February + 1
```

- a relative month, `(last/this/next) month [(+|-) n]`, for example:

```
last month + 2
```

- Year portion:
  - a year relative to a particular year, `[(+|-) n]`, for example:

```
2007 - 1
```

  - a relative year, `(last/this/next) [financial] year [(+|-) n]`, for example:

```
this year - 5
last financial year
```

Tip:

- Weeks start on Sunday and end on Saturday
- Days of the week can be written in full or using the three letter equivalent, for example, `Friday` or `Fri`
- Months of the year can be written in full or using the three letter equivalent, for example, `January` or `Jan`
- Financial year can be abbreviated to `fin year`

Examples

```
1 of Jan of last year
1 of April of 2006
first Monday of last month
last day -2 of last month
last day of this month
first day of January
second Monday of next month
last day of June of this financial year
```

Edit SQL Reports

Use the **Edit SQL Reports** window to edit SQL reports from within Communicare.

Tip:
See SQL Snippets *(on page 589)* for handy SQL code.

SQL Report options:

- Enabled - enables or disables the report.
- Viewing Rights - if a viewing right is selected, the report is available only to users who have the selected viewing right.
- System Rights - if a System Right is selected, the report is available only to users who have the selected system right.

Preparing an SQL report

SQL Reports can be prepared in the SQL Editor or your favourite text editor (e.g. Notepad).

The first comment included in the sql file should display the purpose of the report. For example `/* This report displays the home address of all patients */`. The filename will be used by Communicare to display the report within the **Report** menu. For example, when a new report is imported with a filename of `Clinical_Record_Reports Test.sql`,  **Test** is added to **Report > Clinical Record Reports**.

Refer to Report Naming *(on page 614)* for more details.

Creating Parameters for SQL Reports

To create a parameter in an SQL report simply prefix a colon (:) to a parameter name. Be mindful that it is the parameter name (minus the colon and underscores) which will be displayed in the **Report Parameters** window as a user prompt.

In the example above the SQL where clause might have looked like this:

```
where locality_name = :Count_patients_in_locality
   and pat_sex = :Enter_M_or_F_for_gender
   and date_of_birth > :Born_after
```

You can manually define the order in which the parameters are displayed in the **Report Parameters** window in the PARAMETERS section. The easiest way to do this is:

1. Write the report.
2. Make sure that the report runs, click **Preview Query**.
3. Right-click on the SQL Editor form and click **Insert parameters**.

This will automatically create the PARAMETERS section and insert the parameters with a blank ORDER attribute. If the PARAMETERS section already exists, parameters that aren't already in there will be added to the top. Simply add a number to the ORDER attribute to influence the position of that parameter.

```
<PARAMETERS UseXMLDisplayCase=off >
  <First_date order=1 />
  <Last_date order=2 />
```

The Attribute **UseXMLDisplayCase** above will use the name as it is displayed in the PARAMETERS section instead of how it is displayed in the SQL for the **Report Parameters** window prompt. This can be turned on and off by changing the value from 'off' to 'on' and back. In the XML, you can change the CASE of the name but you cannot change the actual words without having to update the SQL. This means `FIRST_DATE` can be updated to `First_date` without having to update the SQL, but if it is changed to `Start_date`, any occurance of `:FIRST_DATE` in the report will need updated to `:START_DATE`.

Define default values, list or form parameters for SQL Reports

You can provide a default value for a parameter in the PARAMETERS section. This is particularly important if you add a parameter to a report which may be used by a Scheduled Report, otherwise the Scheduled Report may stop working.

```
/* This report has a default date. */
   /*
   <PARAMETERS>
   <REPORT_DATE
```

```
    DEFAULT="01-JAN-1900"
  >
  </REPORT_DATE>
  </PARAMETERS>
  */

  select full_name

  from patient

  where date_of_birth >= :Report_date
```

If you want a parameter to have a Drop Down List so users can search for the items they want,you can use a special syntax to enable the feature in your report.

Every report has a comment block at the beginning of the report. You can have a second comment block with the Drop Down List Parameters.

Example:

```
/* This report will print Medicare Card details about one or all patients. */
  /* This is the second comment block and is an example of how to use the
  special Drop Down List
```

PARAMETERS is the section that has everything regarding the parameters of the sql report.

```
<PARAMETERS>
```

The way parameter names are displayed on the Parameters form can be changed by using the attribute named DISPLAYCASE or USEXMLDISPLAYCASE (see above for more detail on UseXMLDisplayCase) in the PARAMETERS section or DISPLAYNAME against the specific parameter in the PARAMETERS section. The Parameter USEXMLDISPLAYCASE overrides DISPLAYCASE, and DISPLAYNAME overrides everything.

To use DISPLAYNAME, right-click the report editor and click **Insert parameters**. This will insert the parameters into a PARAMETERS section automatically. Locate the parameter you are after and add `DISPLAYNAME="insert new name here"` including the double quotes.

```
<PARAMETERS UseXMLDisplayCase=off >
  <First_date order=1 DisplayName="First date to report" />
  <Last_date order=2 />
```

Using DISPLAYCASE, the Parameter Name can be changed to be displayed in Upper Case, Lower Case or Proper Case as long as DISPLAYNAME isn't being used and USEXMLDISPLAYCASE is either off or the paramter doesn't exist in the PARAMETERS SECTION.

Table 178. DISPLAYCASE parameter in SQL reports

DISPLAYCASE Attribute Value	Parameter Before	Displayed Parameter Name
PROPER	REPORT DATE	Report Date
LOWER	REPORT DATE	report date
UPPER	REPORT DATE	REPORT DATE

Table 178. DISPLAYCASE parameter in SQL reports (continued)

DISPLAYCASE Attribute Value	Parameter Before	Displayed Parameter Name
NONE	*REPORT DATE*	*REPORT DATE* (Unchanged)

Example:

```
<PARAMETERS DISPLAYCASE="PROPER">
```

Alternatively, PARAMETERS can accept an attribute named **Output** which can have the values of:

- **CSV** for forcing the report to be output to a Comma Separated Value file and not seen visually

  ```
  <PARAMETERS OUTPUT="CSV">
  ```

- **RWS_** for forcing the report to be output to a Comma Separated Value file and uploaded to the web. The report will not be seen visually.

  ```
  <PARAMETERS OUTPUT="RWS_ANFPP">
  ```

PATIENT_NAME is the name of the parameter you want to define. This has to be a parameter in your sql report query

```
<PATIENT_NAME
```

The displayed position in the Report Parameters List can be defined by using ORDER. If you want the parameter to be first then the value is 1, second then the value is 2 and so on.

```
ORDER="1"
```

The statement is a normal sql select statement. Anything goes. If a statement is found, a regular drop down parameter is created.

```
STATEMENT="select FULL_NAME
                         , pat_id from patient
                    union
                    select cast('<All Patients>' as VarChar(40)) FULL_NAME
                         , cast(-1 as integer) pat_id
                    from rdb$database"
```

A default value can be defined.

```
 DEFAULT="<All Patients>"
```

All Properties of a parameter must have an equal sign and the values must be within double quotes.

If a drop down is not wanted but instead one of the built-in functions is required, assign the FUNCTION property.

```
 FUNCTION="SELECT_PATIENT"
```

All Properties of a parameter must have an equal sign and the values must be within double quotes.

All section tags are surrounded by the less than and greater than symbols (`<>`). All Sections must end with a `</section>`.

```
>
</PATIENT_NAME>
```

```
</PARAMETERS>
*/
```

This example provides a full description of all properties accepted and recognised by a DROP DOWN LIST PARAMETER in Communicare.

First we have the required header section.

```
/* This is a sample report */

/*
<PARAMETERS>
```

PATIENT_NAME is the name of the parameter passed to the following SQL code.

```
<PATIENT_NAME
```

STATEMENT is the SQL Query that is used for the Drop Down

```
STATEMENT="select distinct FULL_NAME
                           , PAT_ID
             from patient"
```

SEARCH is the field that you want to be ordered on the Drop Down

```
SEARCH="FULL_NAME"
```

SEARCHCASE is the case sensitivity for the field. If you want no distinction between upper case and lower case you can say upper or you can say none to make it case sensitive. The default is upper. Possible values are UPPER and NONE.

```
SEARCHCASE="UPPER"
```

RETURN_RESULT is the field that you want returned by the Drop Down to the parameter on the report.

```
RETURN_RESULT="PAT_ID"
```

ORDER is the desired position that you want this parameter to appear in the SQL Parameters form for entering in data. eg. 1 - First, 2 - Second etc.

```
 ORDER="1"
```

Next we finish off the PATIENT_NAME parameter information, the PARAMETERS section and the comment block containing it.

```
>
</PATIENT_NAME>

</PARAMETERS>
*/
```

The rest of the file contains the actual query that uses these parameters.

```
select pat_id
        , FULL_NAME
        , medicare_no
        , medicare_ref_no
        , medicare_expiry

   from patient

   where (pat_id = :Patient_Name
     or Cast(-1 as integer) = :Patient_Name)
```

The next example is a fully workable sql report. If you want to see how this works you can just copy this report and save it into an sql file then import it into Communicare.

```
/* This report will print Medicare Card details about one or all patients. */
   /* This is the second comment block and is an example of how to use the
   special Drop Down List
   <PARAMETERS>
   <FIRST_PATIENT
          STATEMENT="select FULL_NAME
                         , pat_id from patient
                       union
                     select cast('<All Patients>' as VarChar(40)) FULL_NAME
                         , cast(-1 as integer) pat_id
                     from rdb$database"
          DEFAULT="<All Patients>"
   >
   </FIRST_PATIENT>

   <SECOND_PATIENT
          FUNCTION="SELECT_PATIENT"
   >
   </SECOND_PATIENT>

   </PARAMETERS>
   */

   select pat_id
        , FULL_NAME
        , medicare_no
        , medicare_ref_no
        , medicare_expiry

   from patient

   where (pat_id = :FIRST_PATIENT
```

```
    or Cast(-1 as integer) = :FIRST_PATIENT
    or pat_id = :SECOND_PATIENT)
```

SMS Report Guidelines

SMS Reports may be created on the SMS Batch Query window, see Sending Batch SMS Messages *(on page 79)*

These reports must satisfy the following criteria:

- They must have an output attribute on the parameters set to 'XML', i.e.:
- They must output only the following field names (use field aliases) in exactly the following order:
    - PatId (an integer field)
    - PatientName (a string field)
    - MobileNumber (a string field)
    - Text (a string field)
- Note that if the Text field is longer than 160 characters this will be truncated down to 160 before the SMS is sent

Reports added in the SMS Batch Query window that satisfy the above criteria will be able to be used to send SMS batches.

SQL Snippets

SQL Snippets

These sections contain code you can copy and paste when creating SQL reports in Communicare.

Useful information

- When the report selects patient names, use:

```
SELECT P.FULL_NAME_AGE_TITLE_TODAY
FROM PATIENT P
WHERE (P.CURRENT_STATUS not in ('SF', 'SNP'))
```

- If you need to include deceased patients then the WHERE clause should be:

```
WHERE ((P.CURRENT_STATUS not in ('SF', 'SNP'))
  OR (P.CURRENT_STATUS IS NULL))
```

- When the report selects services, use:

```
SELECT PE.SEQUENCE_DATE


FROM PAT_ENCOUNTER PE


WHERE (PE.SEQUENCE_DATE >= :First_date_to_report)
AND (PE.SEQUENCE_DATE - 1 < :Last_date_to_report)
AND (PE.PAT_ENC_STAT in ('S','F','P'))
```

Finding current patients living in the HSA between two ages today

```
select count(*)
```

```
from patient p

join (locality l
join locality_combine_locals lcl on l.locality_no = lcl.locality_no
join locality_combine lc on lcl.locality_combine_no = lc.locality_combine_no
  and lc.locality_combine_desc_uc = 'HEALTH SERVICE AREA') on p.locality_no = l.locality_no

where p.current_status = 'SC'
and p.age_birthyears_today between :Lower_age and :Upper_age
```

Finding current patients living in the HSA between two ages at a specified time

```
select count(*)

from patient p
join (pat_group_member pgm
join pat_group pg on pg.pat_grp_no = pgm.pat_grp_no
  and pg.sys_code = 'SC'
  and pgm.join_date <= :Reference_date
  and (pgm.exit_date > :Reference_date
    or pgm.exit_date is null)) on pgm.pat_id = p.pat_id
join (pat_address pa
join locality l on pa.locality_no = l.locality_no
   and pa.home_indic = 'Y'
   and pa.from_date <= :Reference_date
   and (pa.to_date >= :Reference_date
     or pa.to_date is null)
join locality_combine_locals lcl on l.locality_no = lcl.locality_no
join locality_combine lc on lcl.locality_combine_no = lc.locality_combine_no
  and lc.locality_combine_desc_uc = 'HEALTH SERVICE AREA') on p.pat_id = pa.pat_id

where cu_agebirthyears(p.date_of_birth,:Reference_date) between :Lower_age and :Upper_age
```

Adding known aliases as a single field

Copy this into the select statement, replacing the alias p (as in p.pat_id) if the patient table has a different alias in your query:

```
(select list(x.family_name || ', ' || f_lrtrim(x.pat_forenames), '; ')
 from patient_alias x
 where x.pat_id = p.pat_id
 and x.current_alias_indicator = 'N')
```

For QueryBuilder users:

1. Open your query and go to **Tables > Calculated fields**.
2. Add a new field called aliases and copy the following into the definition field:

```
(select list(x.family_name || ', ' || f_lrtrim(x.pat_forenames), '; ')
from patient_alias x where x.pat_id = T8.pat_id and x.current_alias_indicator = 'N')
```

3. Click **OK**
4. Select the PATIENT table as the attachment table.
5. Click **OK**.
6. Select **Show > Adjust virtual space**. You will see a new field at the bottom of the patient table called **aliases**. Use it as a regular database field and it will show all aliases separated by semicolons.

Patient Status Snippets

```
/*This provides a dropdown list for CURRENT patient status selection.*/

/*
<PARAMETERS>

<PATIENT_STATUS
  STATEMENT="select grp_desc
                , pg.sys_code
            from pat_group pg
            join pat_group_type pgt on pg.pat_grp_type_no = pgt.pat_grp_type_no
            where pgt.sys_code = 'STA'
            and pg.grp_enabled = 'T'
            union
            select cast((select grp_desc
                     from pat_group
                     where sys_code = 'SC'
                     and grp_enabled = 'T') ||
                     ' or ' ||
                     (select grp_desc
                     from pat_group
                     where sys_code = 'ST'
                     and grp_enabled = 'T') as varChar(40)) grp_desc
                , 'SCT' sys_code
            from rdb$database
            union
            select cast('<Any except fictitious or deceased>' as varChar(40)) grp_desc
                , '---' sys_code
            from rdb$database
            union
            select cast('<Any except fictitious>' as varChar(40)) grp_desc
                , '===' sys_code
            from rdb$database
            union
            select cast('Deceased' as varChar(40)) grp_desc
                , 'XXX' sys_code
            from rdb$database"
```

```
  DEFAULT="<Any except fictitious>"
>
</PATIENT_STATUS>

</PARAMETERS>
*/

...
where ((p.current_status = :Patient_status)
  or ('---' = :Patient_status
    and (p.current_status not in ('SF', 'SNP')))
  or ('===' = :Patient_status
    and (p.current_status not in ('SF', 'SNP')
      or p.current_status is null))
  or ('XXX' = :Patient_status
    and p.current_status is null)
  or ('SCT' = :Patient_status
    and (p.current_status = 'SC'
      or p.current_status = 'ST')))
...
```

```
/*Get the display description for patient current status.*/

select pg.grp_desc current_status_desc
...

from patient p
join pat_group pg on p.current_status = pg.sys_code
...
```

Clinical Item Type Snippets

```
/*This provides a form for selecting a clinical item group.*/

/*
<PARAMETERS>

<CLINICAL_ITEM_GROUP
  FUNCTION="SELECT_MORB_GROUP"
>
</CLINICAL_ITEM_GROUP>

</PARAMETERS>
*/

...
```

```
where (group_no = :Clinical_Item_Group)
...
```

```
/*This provides a form for selecting a clinical item type.
  Only enabled clinical items may be selected using this method.*/

/*
<PARAMETERS>

<CLINICAL_ITEM_TYPE
  FUNCTION="SELECT_TERMS_ANY_CLASS"
>
</CLINICAL_ITEM_TYPE>

</PARAMETERS>
*/

...
where (morb_type_no = :Clinical_Item_Type)
...
```

```
/*This provides a form for selecting a procedure type clinical item type.
  Only enabled clinical items may be selected using this method.*/

/*
<PARAMETERS>

<CLINICAL_ITEM_TYPE
  FUNCTION="SELECT_PROCEDURE_TERMS"
>
</CLINICAL_ITEM_TYPE>

</PARAMETERS>
*/

...
where (morb_type_no = :Clinical_Item_Type)
...
```

Patient Search Snippets

```
/*This snippet allows you to find the parent/guardian of a child.
It looks for a MOTHER, FATHER or CARER recorded as either kin or emergency
contact and prioritises them in that order then displays the first found.*/

select p.full_name
     , cu_substr(max(guard.name),
         cu_strpos('#', max(guard.name)) + 1,
```

```
         strlen(max(guard.name)) - cu_strpos('.',max(guard.name))) PARENT_GUARDIAN_NAME
     , cu_substr(max(guard.name),
         1,
         cu_strpos('#' ,max(guard.name)) - 1) PARENT_GUARDIAN_RELATION
...

from patient p
left outer join (--guard
select pk.pat_id
     , trim(pk.kin_type_desc_uc) ||
         '#' ||
         upper(pk.kin_name) name
from pat_kin_view pk
where pk.kin_type_desc_uc in ('MOTHER', 'FATHER', 'CARER')
union
select x.pat_id
     , trim(kte.kin_type_desc_uc) ||
         '#' ||
         upper(x.emergency_contact_name) name
from patient x
join kin_type kte on kte.kin_type_no = x.emergency_contact_type
  and kte.kin_type_desc_uc in ('MOTHER', 'FATHER', 'CARER')
) guard on guard.pat_id = p.pat_id
  and p.age_birthyears_today < 18
where p.age_birthyears_today < 18

group by 1
...
```

```
/*This snippet will show a patient's chronic diseases.
These are conditions marked as summary and belonging to the CHRONIC
CONDITIONS (ALL) group.*/

select p.full_name
     , list(distinct cd.nat_lan_term, ', ') CHRONIC_CONDITIONS
...

from patient p
left outer join (pat_morb_view cd
join morb_group_link mgl on mgl.morb_type_no = cd.morb_type_no
  and cd.morb_subtype = 'C'
  and cd.summary_item = 'T'
join morb_group mg on mg.group_no = mgl.group_no
  and mg.group_desc_uc = 'CHRONIC CONDITIONS (ALL)') on cd.pat_id = p.pat_id

group by 1
...
```

```
/*This snippet will show a patient's current mailing address.*/

select p.full_name
     , pa.address_line1
     , pa.address_line2
     , coalesce(la.locality_name || ' ' ||
         la.locality_state || ' ' ||
         la.locality_post_code, la.locality_name) locality
...

from patient p
left outer join (--addr
select px.pat_id
     , max(cu_formatdatetime(px.from_date, 'YYYYMMDD') || '.' || lpad(px.pat_address_no, 8, '0')) mail
from pat_address px
where px.mail_indic = 'Y'
group by 1
) addr on addr.pat_id = p.pat_id
left outer join (pat_address pa
join locality la on la.locality_no = pa.locality_no) on pa.pat_address_no =
 cu_stripfirstword(coalesce(addr.mail, '00000000.00000000'), '.')

...
```

```
/*This snippet will show a patient's current temporary address.*/

select p.full_name
     , pa.address_line1
     , pa.address_line2
     , coalesce(la.locality_name || ' ' ||
         la.locality_state || ' ' ||
         la.locality_post_code, la.locality_name) locality
...

from patient p
left outer join (--addr
select px.pat_id
     , max(case
         when px.temp_indic = 'Y' then
           cu_formatdatetime(px.from_date, 'YYYYMMDD') || '.' || lpad(px.pat_address_no, 8, '0')
           else null
       end) temp
     , max(case
         when px.current_address = 'T' then
           cu_formatdatetime(px.from_date, 'YYYYMMDD') || '.' || lpad(px.pat_address_no, 8, '0')
           else null
       end) home
```

```
from pat_address px
group by 1
) addr on addr.pat_id = p.pat_id
left outer join (pat_address pa
join locality la on la.locality_no = pa.locality_no) on pa.pat_address_no =
 cu_stripfirstword(coalesce(addr.temp, '00000000.00000000'), '.')
  and cu_striplastword(addr.temp, '.') >= cu_striplastword(addr.home, '.')

...
```

Locality Snippets

```
/*This provides a dropdown box of preferred localities.*/

/*
<PARAMETERS>

<LOCALITY
  STATEMENT="select locality_name
                  , locality_no
             from locality
             where locality_preferred = 'Y'
             union
             select cast('<All Localities>' as Varchar(40)) locality_name
                  , cast(-1 as integer) locality_no
             from rdb$database"
  DEFAULT="<All Localities>"
>
</LOCALITY>

</PARAMETERS>
*/

...
where (locality_no = :Locality
  or Cast(-1 as integer) = :Locality)
...
```

```
/*This provides a dropdown box of locality groups.*/

/*
<PARAMETERS>

<LOCALITY_GROUP
  STATEMENT="select locality_combine_desc
                  , locality_combine_no
             from locality_combine"
```

```
>
</LOCALITY_GROUP>

</PARAMETERS>
*/

...
join locality_combine_locals lcl on lcl.locality_no = p.locality_no
  and lcl.locality_combine_no = :Locality_Group
...
where (locality_combine_no = :Locality_Group)
...
```

```
/*This provides a dropdown box of locality groups including all locality groups.*/

/*
<PARAMETERS>

<LOCALITY_GROUP
  STATEMENT="select locality_combine_desc
                 , locality_combine_no
             from locality_combine
             union
             select cast('<All Locality Groups>' as Char(30)) locality_combine_desc
                 , cast(-1 as integer) locality_combine_no
             from rdb$database
             union
             select cast('<Not in Health Service Area>' as Char(30)) locality_combine_desc
                 , cast(-2 as integer) locality_combine_no
             from rdb$database"
  DEFAULT="<All Locality Groups>"
>
</LOCALITY_GROUP>

</PARAMETERS>
*/

...
left outer join locality_combine_locals lcl on lcl.locality_no = p.locality_no
  and lcl.locality_combine_no = :Locality_Group
left outer join (locality_combine_locals hsal
join locality_combine hsa on hsa.locality_combine_no = hsal.locality_combine_no
  and hsa.locality_combine_desc_uc = 'HEALTH SERVICE AREA') on hsal.locality_no = p.locality_no
...
where (lcl.locality_combine_no = :Locality_Group
  or cast(-1 as integer) = :Locality_Group
  or (cast(-2 as integer) = :Locality_Group
```

```
    and hsal.locality_no is null))
...
```

Provider Snippets

```
/*This provides a dropdown box of provider names.*/

/*
<PARAMETERS>

<PROVIDER
  STATEMENT="select provider_desc
                  , provider_no
             from provider
             union
             select cast('<All Providers>' as VarChar(40)) provider_desc
                  , cast(-1 as integer) provider_no
             from rdb$database"
  DEFAULT="<All Providers>"
>
</PROVIDER>

</PARAMETERS>
*/

...
where (provider_no = :Provider
  or Cast(-1 as integer) = :Provider)
...
```

```
/*This provides a dropdown box of currently enabled provider names.*/

/*
<PARAMETERS>

<PROVIDER
  STATEMENT="select provider_desc
                  , provider_no
             from SERVICE_PROVIDER_SELECT(null, 'TODAY', null, null)
             union
             select cast('<All Providers>' as Char(60)) provider_desc
                  , cast(-1 as integer) provider_no
             from rdb$database"
  DEFAULT="<All Providers>"
>
</PROVIDER>
```

```
</PARAMETERS>
*/

...
where (provider_no = :Provider
  or Cast(-1 as integer) = :Provider)
...
```

Encounter Place, Mode and Program Snippets

```
/*This provides a search box of encounter places where multilevel hierarchical encounter places are used.
Both 'administrative' and 'service' places can be selected.*/

/*
<PARAMETERS>

<ENCOUNTER_PLACE
  FUNCTION="SELECT_ENCOUNTER_PLACE"
>
</ENCOUNTER_PLACE>

</PARAMETERS>
*/

...
where (enc_place_no in (select enc_place_no from GET_ENC_PLACE_AND_DESCENDANTS(:Encounter_Place))
or cast(-1 as integer) = :Encounter_Place)
...
```

```
/*This provides a search box of encounter places where multilevel hierarchical encounter places are used.
Only 'service' places can be selected, but the hierarchy is still displayed.*/

/*
<PARAMETERS>

<ENCOUNTER_PLACE
  FUNCTION="SELECT_SERVICE_ENCOUNTER_PLACE"
>
</ENCOUNTER_PLACE>

</PARAMETERS>
*/

...
where (enc_place_no = :Encounter_Place
  or Cast(-1 as integer) = :Encounter_Place)
...
```

```
/*This provides a dropdown box of encounter places.*/

/*
<PARAMETERS>

<ENCOUNTER_PLACE
  STATEMENT="select distinct trim(ep.enc_place_desc) || case
                      when mode.enabled = 'T' then ''
                      else ' (not used)'
                    end
                  , ep.enc_place_no
             from encounter_place ep
             left outer join (
             select emp.enc_place_no
                  , max(emp.mode_place_enabled) enabled
             from encounter_mode_place emp
             group by 1
             ) mode on mode.enc_place_no = ep.enc_place_no
             union
             select cast('<All Encounter Places>' as Char(40)) enc_place_desc
                  , cast(-1 as integer) enc_place_no
             from rdb$database"
  DEFAULT="<All Encounter Places>"
>
</ENCOUNTER_PLACE>

</PARAMETERS>
*/

...
where (enc_place_no = :Encounter_Place
  or Cast(-1 as integer) = :Encounter_Place)
...
```

```
/*This provides a dropdown box of encounter places with an option to show all encounter places together.*/

/*
<PARAMETERS>

<ENCOUNTER_PLACE
  STATEMENT="select enc_place_desc
                  , enc_place_no
             from encounter_place
             union
             select cast('<All Encounter Places Together>' as Char(40)) enc_place_desc
                  , cast(-1 as integer) enc_place_no
             from rdb$database
```

```
             union
             select cast('<All Separate Encounter Places>' as Char(40)) enc_place_desc
                  , cast(-2 as integer) enc_place_no
             from rdb$database"
  DEFAULT="<All Encounter Places Together>"
>
</ENCOUNTER_PLACE>

</PARAMETERS>
*/

...
case
  when Cast(-1 as integer) = :Encounter_Place then '<All Encounter Places Together>'
  else enc_place_desc
end Place
...
where (enc_place_no = :Encounter_Place
  or Cast(0 as integer) > :Encounter_Place)
...
```

```
/*This provides a dropdown box of encounter modes.*/

/*
<PARAMETERS>

<ENCOUNTER_MODE
  STATEMENT="select em.enc_mode_desc
                  , em.enc_mode_no
             from encounter_mode_place emp
             join encounter_mode em on emp.enc_mode_no = em.enc_mode_no
             union
             select cast('<All Encounter Modes>' as Char(50)) enc_mode_desc
                  , cast(-1 as integer) enc_mode_no
             from rdb$database"
  DEFAULT="<All Encounter Modes>"
>
</ENCOUNTER_MODE>

</PARAMETERS>
*/

...
where (enc_mode_no = :Encounter_Mode
  or Cast(-1 as integer) = :Encounter_Mode)
...
```

```
/*This provides a dropdown box of record storage sites.*/

/*
<PARAMETERS>

<RECORD_STORAGE_SITE
  STATEMENT="select enc_place_desc
                  , enc_place_no
             from encounter_place
             where record_storage = 'T'
             union
             select cast('<Any Record Storage Site>' as Char(40)) enc_place_desc
                  , cast(-1 as integer) enc_place_no
             from rdb$database
             union
             select cast('<All Patients>' as Char(40)) enc_place_desc
                  , cast(-2 as integer) enc_place_no
             from rdb$database
             union
             select cast('<No Record Storage Site>' as Char(40)) enc_place_desc
                  , cast(-3 as integer) enc_place_no
             from rdb$database"
  DEFAULT="<All Patients>"
>
</RECORD_STORAGE_SITE>

</PARAMETERS>
*/

...
where ( (p.record_storage_site_no = :Record_Storage_Site)
  or (cast(-1 as integer) = :Record_Storage_Site
    and p.record_storage_site_no is not null)
  or (cast(-2 as integer) = :Record_Storage_Site)
  or (cast(-3 as integer) = :Record_Storage_Site
    and p.record_storage_site_no is null) )
...
```

```
/*This provides a dropdown box of encounter programs.*/

/*
<PARAMETERS>

<ENCOUNTER_PROGRAM
  STATEMENT="select enc_program_desc
                  , enc_program_no
             from encounter_program
```

```
            union
            select cast('<All Encounter Programs>' as varChar(40)) enc_program_desc
                 , cast(-1 as integer) enc_program_no
            from rdb$database"
  DEFAULT="<All Encounter Programs>"
>
</ENCOUNTER_PROGRAM>

</PARAMETERS>
*/

...
where (enc_program_no = :Encounter_Program
  or Cast(-1 as integer) = :Encounter_Program)
...
```

Patient Group Snippets

```
/*This provides a dropdown box for patient groups.*/

/*
<PARAMETERS>

<PATIENT_GROUP
  STATEMENT="select pg.grp_desc
                 , pg.pat_grp_no
            from pat_group pg
            join pat_group_type pgt on pg.pat_grp_type_no = pgt.pat_grp_type_no
              and pgt.sys_code <> 'STA'
            where pg.grp_enabled = 'T'
            union
            select cast('<No Patient Group>' as VarChar(40)) grp_desc
                 , cast(-2 as integer) pat_grp_no
            from rdb$database
            union
            select cast('<All>' as VarChar(40)) grp_desc
                 , cast(-1 as integer) pat_grp_no
            from rdb$database"
  DEFAULT="<All>"
>
</PATIENT_GROUP>

</PARAMETERS>
*/

...
```

```
left outer join (pat_group_member pgm
join pat_group pg on pg.pat_grp_no = pgm.pat_grp_no
join pat_group_type pgt on pgt.pat_grp_type_no = pg.pat_grp_type_no
  and pgt.sys_code <> 'STA'
  and pg.grp_enabled = 'T'
  and pg.pat_grp_no = :Patient_Group) on pgm.pat_id = p.pat_id
...
where ((((pgm.pat_grp_no = :Patient_Group)
    and (pgm.join_date <= :Reference_date)
    and ((pgm.exit_date > :Reference_date)
      or (pgm.exit_date is null)))
  or (Cast(-1 as integer) = :Patient_Group))
  or (pgm.pat_grp_no is null
    and :Patient_Group = -2))
...
```

Special Checkbox and Lookup Snippets

```
/*This provides a dropdown box for special lookup.*/

/*
<PARAMETERS>

<SPECIAL_LOOKUP
  STATEMENT="select lookup_1_desc
                  , lookup_1_no
             from special_lookup_1
             where trim(lookup_1_desc) <> ''
             union
             select cast('<Patients without ' ||
                      trim(pat_special_lookup_1_label)  ||
                      '>' as varchar(30)) lookup_1_desc
                  , cast(-2 as integer) lookup_1_no
             from system_parameter
             where system_parameter_no = 1
             and trim(pat_special_lookup_1_label) <> ''
             union
             select cast('<Patients with ' ||
                      trim(pat_special_lookup_1_label)  ||
                      '>' as varchar(30)) lookup_1_desc
                  , cast(-1 as integer) lookup_1_no
             from system_parameter
             where system_parameter_no = 1
             and trim(pat_special_lookup_1_label) <> ''
             union
             select cast('<All patients>' as varchar(30)) lookup_1_desc
                  , cast(0 as integer) lookup_1_no
```

```
            from rdb$database"
  DEFAULT="<All patients>"
>
</SPECIAL_LOOKUP>

</PARAMETERS>
*/

...
where ((special_lookup_1 = :Special_Lookup)
  or (Cast(-1 as integer) = :Special_Lookup
    and special_lookup_1 is not null)
  or (Cast(-2 as integer) = :Special_Lookup
    and special_lookup_1 is null)
  or (Cast(0 as integer) = :Special_Lookup))
...
```

```
/*This provides a dropdown box for special checkbox.*/

/*
<PARAMETERS>

<SPECIAL_CHECKBOX
  STATEMENT="select cast(trim(pat_special_cb_1_label) as varchar(30)) CBox
                 , cast(1 as integer) CBoxNo
             from system_parameter
             where pat_special_cb_1_label <> ''
             union
             select cast('Not ' ||
                      trim(pat_special_cb_1_label) as varchar(30)) CBox
                 ,  cast(0 as integer) CBoxNo
             from system_parameter
             where pat_special_cb_1_label <> ''
             union
             select cast('Unknown' as varchar(30)) CBox
                  , cast(-2 as integer) CBoxNo
             from system_parameter
             union
             select cast('<Any>' as varchar(30)) CBox
                  , cast(-1 as integer) CBoxNo
             from system_parameter"
  DEFAULT="<Any>"
>
</SPECIAL_CHECKBOX>

</PARAMETERS>
*/
```

```
...
where ((p.special_cb_1 = case :Special_Checkbox
      when 1 then 'T'
      when 0 then 'F'
    end
  or cast(-1 as integer) = :Special_Checkbox)
  or (p.special_cb_1 is null
    and :Special_Checkbox = -2))
...
```

Sex Snippets

```
/*This provides a dropdown box for patient sex.*/

/*
<PARAMETERS>

<PATIENT_SEX
  STATEMENT="select sex_caption, sex_code
             from sex
             union
             select cast('Sex Not Recorded' as char(40)) sex
                  , cast('X' as char(1)) sex_code
             from rdb$database
             union
             select cast('Male or Female only' as char(40)) sex
                  , cast('1' as char(1)) sex_code
             from rdb$database
             union
             select cast('Neither Male nor Female' as char(40)) sex
                  , cast('0' as char(1)) sex_code
             from rdb$database
             union
             select cast('<All Patients>' as char(40)) sex
                  , cast('*' as char(1)) sex_code
             from rdb$database"
  DEFAULT="<All Patients>"
>
</PATIENT_SEX>

</PARAMETERS>
*/

...
where ((p.pat_sex = :Patient_Sex)
  or (p.pat_sex is null
```

```
    and cast('X' as char(1)) = :Patient_Sex)
  or (p.pat_sex in ('M', 'F')
    and cast('1' as char(1)) = :Patient_Sex)
  or (p.pat_sex is distinct from 'M'
    and p.pat_sex is distinct from 'F'
    and cast('0' as char(1)) = :Patient_Sex)
  or (cast('*' as char(1)) = :Patient_Sex))
...
```

Gender Snippets

```
/*This snippet will find a patients's gender if it is recorded.
The logic behind this code is to present any formal recording of gender with an option
to assume the patient sex is the gender if gender is not formally recorded. The decision
to include the sex as gender will need to be made by understanding the context of the
reporting, including any formal specifications provided by the reporting body. */

select p.pat_id
     /*This case statement uses the gender recorded in biographics and if this is not known
       then uses the latest gender recorded as a qualifier and if this is not known
       then uses the patient's sex (remove is not desired) and if this is not known
       then returns 'Not recorded'*/
     , cast(replace(case
         when trim(gl.display_name) <> '' then gl.display_name
         when trim(cu_stripfirstword(g.gender, '#')) <> '' then cu_stripfirstword(g.gender, '#')
         --remove this next line if you don't want it to assume that the patient's sex is there gender if
 it is not specified:
         when trim(x.sex_description) <> '' then x.sex_description
         else 'Not recorded'
       end, 'Cisgender', 'Cisgender - ' || x.sex_description) as varchar(100)) as gender

from patient p
/*This join looks up the sex at birth*/
left outer join sex x on x.sex_code = p.pat_sex
/*This join looks up the gender if recorded on the biographics form*/
left outer join general_lookup gl on gl.lookup_type = 'Genders'
  and gl.lookup_id = p.gender_id
/*This join looks up the latest gender recorded as a qualifier*/
left outer join (--g
select pm.pat_id
     , max(cu_formatdatetime(pm.pat_morb_act_date, 'YYYYMMDD') || lpad(pm.morb_no,8,'0') || '#' ||
         mrt.measure_ref_type_desc) gender
from measurement_type mt
join pat_measure me on me.measure_type_no = mt.measure_type_no
  and mt.measure_type_desc_uc = 'GENDER'
join measurement_ref_type mrt on mrt.measure_ref_type_no = me.measure_ref_type_no
join pat_morb_view pm on pm.morb_no = me.morb_no
```

```
group by 1
) g on g.pat_id = p.pat_id
```

Aboriginality Snippets

```
/*This provides a dropdown box of aboriginal types.*/

/*
<PARAMETERS>

<ABORIGINAL_TYPE
  STATEMENT="select ab_type_desc
                  , ab_type_no
             from aboriginal_type
             union
             select cast('<Unknown>' as Char(40)) ab_type_desc
                  , cast(0 as integer) ab_type_no
             from rdb$database
             union
             select cast('<All Aboriginality Types>' as Char(40)) ab_type_desc
                  , cast(-1 as integer) ab_type_no
             from rdb$database"
  DEFAULT="<All Aboriginality Types>"
>
</ABORIGINAL_TYPE>

</PARAMETERS>
*/

...
where (ab_type_no = :Aboriginal_type
  or (cast(0 as integer) = :Aboriginal_type
    and ab_type_no is null)
  or cast(-1 as integer) = :Aboriginal_type)
...
```

```
/*This provides a dropdown box for aboriginality.*/

/*
<PARAMETERS>

<ABORIGINALITY
  STATEMENT="select cast('Aboriginal' as VarChar(14)) aboriginality
                  , cast(1 as integer) ab_no
             from rdb$database
             union
             select cast('Non-aboriginal' as VarChar(14)) aboriginality
```

```
                , cast(2 as integer) ab_no
            from rdb$database
            union
            select cast('Unknown' as VarChar(14)) aboriginality
                , cast(-2 as integer) ab_no
            from rdb$database
            union
            select cast('<All>' as VarChar(14)) aboriginality
                , cast(-1 as integer) ab_no
            from rdb$database"
  DEFAULT="<All>"
>
</ABORIGINALITY>

</PARAMETERS>
*/

...
where ((aboriginal = case :Aboriginality
      when 1 then 'T'
      when 2 then 'F'
    end
  or cast(-1 as integer) = :Aboriginality)
  or (aboriginal is null
    and :Aboriginality = -2))
...
```

Patient Snippets

```
/*This provides the patient search form for selecting a patient
  This is the preferred method of selecting a patient.*/

/*
<PARAMETERS>

<PATIENT
  FUNCTION="SELECT_PATIENT"
>
</PATIENT>

</PARAMETERS>
*/

...
where (pat_id = :Patient)
...
```

```
/*This provides a dropdown box of patient names.
  This method is useful when a restricted list of patients is required.
  Method also allows the report to run for either a single patient
  or all patients.*/

/*
<PARAMETERS>

<PATIENT
  STATEMENT="select full_name
                  , pat_id
             from patient
             union
             select cast('<All Patients>' as VarChar(40)) full_name
                  , cast(-1 as integer) pat_id
             from rdb$database"
  DEFAULT="<All Patients>"
>
</PATIENT>

</PARAMETERS>
*/

...
where (pat_id = :Patient
  or Cast(-1 as integer) = :Patient)
...
```

Dialect 3 Troubleshooting

Possible Errors in Reports when switching to Firebird Dialect 3 in Communicare V18.3 and later.

In Communicare V18.3, the database dialect changed from dialect 1 to dialect 3. This change introduced a stricter standard of SQL and new reserved words, meaning some custom reports in Communicare may require modification.

Below is a list of possible errors caused by the dialect change, and how to fix them. Should the error persist, please contact Communicare Support for further assistance.

Table 179. Dialect 3 errors

Error	Possible Cause	Solution
Access violation	Double quotes `" "` are not valid string delimiters in Dialect 3. In some cases, a double quote will cause an Access Violation, in other cases, a more obvious SQL error.	Replace double quotes (“) with single quotes (‘).

Table 179. Dialect 3 errors (continued)

Error	Possible Cause	Solution
Dynamic SQL Error: SQL error code = -206. Column unknown.	Column does not belong to referenced table. Example 1: `select p.pat_id from pat_measure me join pat_morb_view xpm on me.morb_no = xpm.morb_no join patient p on p.pat_id = xpm.pat_id join (morbidity_measurement mm join morb_type_view mt on mt.morb_type_no = mm.morb_type_no and p.date_of_birth = 'today' ) on me.measure_type_no = mm.measure_type_no`	`select p.pat_id from pat_measure me join pat_morb_view xpm on me.morb_no = xpm.morb_no join patient p on p.pat_id = xpm.pat_id join (morbidity_measurement mm join morb_type_view mt on mt.morb_type_no = mm.morb_type_no) on me.measure_type_no = mm.measure_type_no and p.date_of_birth = 'today' --moved to here`
	Example 2 `Select … from pat_morb_view pm left outer join (pat_encounter_view pe join encounter_mode_place emp on emp.enc_place_no = pm.enc_place_no and emp.enc_mode_no = pe.enc_mode_no join encounter_mode em on em.enc_mode_no = emp.enc_mode_no) on pe.enc_no = pm.enc_no join patient p on p.pat_id = pm.pat_id`	`Select … from pat_morb_view pm left outer join (pat_encounter_view pe join encounter_mode_place emp on emp.enc_place_no = pe.enc_place_no and emp.enc_mode_no = pe.enc_mode_no join encounter_mode em on em.enc_mode_no = emp.enc_mode_no) on pe.enc_no = pm.enc_no join patient p on p.pat_id = pm.pat_id`

Dynamic SQL Error: Expression evaluation not supported.	Strings cannot be added or subtracted in dialect 3. For example:
	`'TODAY' – 366`
	Also (frequently used in reports):
	`(START_DATE<(:Last_date_to_report + 1))`
		Cast the dates first:
		`(CAST('TODAY' AS DATE) – 366`
		`(START_DATE<(cast(:Last_date_to_report as DATE) + 1))`

Datatypes are not comparable in expression UNION.	A union has different datatypes in the select statement	Need to make sure that the columns in the union are the same datatype. We now use TIMESTAMPs instead of DATE fields.
Dynamic SQL Error: Expression evaluation not supported.	Invalid data type in DATE/TIME/TIMESTAMP addition or subtraction in add_datetime(). Example 1: `current_date - pmv.pat_morb_act_date project_date`	`datediff(day from pmv.pat_morb_act_date to current_date) project_date`

Table 179. Dialect 3 errors (continued)

Error	Possible Cause	Solution

	Example 2:
	`modified_date > :param + 1`
	`where :param can have values like 'today'`
		`modified_date - 1 > :param`

Dynamic SQL Error: Expression evaluation not supported	Strings cannot be multiplied in dialect 3. For example:
	`evr.sys_code * we.pat_measure_value priority`
	`where sys_code is a CHAR(3) and pat_measure_value is numeric`
		Cast the string as a Numeric
		`CAST(evr.sys_code AS NUMERIC) * we.pat_measure_value priority`

Arithmetic overflow or division by zero has occurred.	Arithmetic exception, numeric overflow, or string truncation. For example: `cast(cast( pm.pat_morb_act_date as char(11))as date)`	`cast( pm.pat_morb_act_date as date)`
A number of new reserved keywords are introduced.	Ensure your DSQL statements and procedure/trigger sources don't contain those keywords as identifiers. Otherwise, you'll need to either use them quoted (in Dialect 3 only) or rename them, or add an underscore, which the reports will ignore, thus avoiding changes to the report layouts. For example: `count(case when pat_sex is null then pat_id else null end) unknown`	`count(case when pat_sex is null then pat_id else null end) _unknown`
Mixed explicit and implicit joins	Improperly mixed explicit and implicit joins are not supported anymore, as per the SQL specification. It also means that in the explicit A JOIN B ON <condition>, the condition is not allowed to reference any stream except A and B.	See examples above.

FieldName: _____ not found	This could be a missing alias for a cast in the parameters section
	`<SHOW_SENT_CLAIMS`
	`STATEMENT="select cast('Yes' as VarChar(3))`
	`from rdb$database`
	`union`
	`select cast('No' as VarChar(3))`
	`from rdb$database"`
	`DEFAULT="No"`
	`>`
		`<SHOW_SENT_CLAIMS`
		`STATEMENT="select cast('Yes' as VarChar(3)) display_field`
		`from rdb$database`
		`union`
		`select cast('No' as VarChar(3)) display_field`
		`from rdb$database"`
		`DEFAULT="No"`
		`>`

Table 179. Dialect 3 errors (continued)

Error	Possible Cause	Solution
No error but incorrect data whenever dividing two integers where the result is an integer.	In dialect 1 the result of dividing two integers is rounded up or down (14/10 = 1 and 15/10 = 2) but in dialect 3 it is always rounded down (14/10 and 15/10 are both 1)	When dividing integers always cast integers as floats before doing the division.
String Overflow	Casting a timestamp that has a time as varchar(11) now results in a string overflow issue. This technique was used in the distant past before we had the cu_formatdatetime function. The offending code looks like this: `cast(pe.start_date as varchar(11))`	Use the UDF: `cu_formatdatetime(pe.start_date, 'DD-MMM-YYYY')`

Other tips:

- All DATE fields that need to contain a time need to be changed to a TIMESTAMP
- All DATE fields that need to contain a time ONLY need to be changed to a TIME

Firebird HQBird 4 Troubleshooting

With the update from Firebird 2.5.x to Firebird HQBird 4.x there are changes to the way SQL queries are handled.

If you write SQL or reports that query the Communicare database, the following SQL features that work in Firebird 2.5 either don't work in Firebird 4 or should not be used:

- Use `LOCALTIMESTAMP` instead of `CURRENT_TIMESTAMP`.
- The return type of `'COUNT'` columns is now `'long'`, not `'int'`. If you have anything assuming `'int'` you may see an error due to `'long'` being larger.
- Good practice:
  - All tables should be assigned aliases.
  - Field aliases should use the 'as' keyword, for example, `'select p.pat_id as patient_id'` rather than `'select p.pat_id patient_id'`.
- Be consistent with the coding of table joins:
  - As a general rule you should use inner joins before left outer joins.
  - Rather than using `'inner join'` it is better to use `'join'`.
  - Rather than using `'left outer join'` it is preferable to use `'left join'`.

Table 180. Replacement SQL for Firebird HQBird 4

Old SQL	Replacement SQL
`'today'`	`Cast('today' as timestamp)`
`'now'`	`Cast('now' as timestamp)`
`'1996-01-01'`	`Timestamp '1996-01-01'`
`Cast('1900-01-01' as timestamp`	`Timestamp '1900-01-01'`
`Union`	`Union All` (when distinct list is not required)

Table 180. Replacement SQL for Firebird HQBird 4 (continued)

Old SQL	Replacement SQL
`1=1`	`True`
`SELECT *`	Use defined column list
`Strlen()`	`Char_Length()`
`rtrim(ltrim('xxx'))`	`coalesce(trim('xxx'), '')`
`'starts'`	`'starting with'`

Report Naming

Query Builder and SQL reports are added to the **Report** menu or submenus according to the name they are given.

A report with a single word name is placed directly on the **Report** menu. Examples of single word report names are, MyReport, My_Report and Evacuations. Report names like these are generally best avoided because if too many are created they will cause the reports menu to become excessively long. An excessively long menu may need to be scrolled to be seen in its entirety, which makes it difficult to use.

Giving a report a multiple word name will cause it to be placed on a submenu. This is generally a much better option. Examples of the recommended format are: Health_Analysis Diabetes, Health_Analysis Asthma. These reports will be placed on a submenu called **Health Analysis**.

Only queries set as Public will be visible to other users. For all queries that are not required by other users, don't set **Public**. Organise public queries into logical submenus to maintain ease of use.

See also Report Access *(on page 930)*, Access Control for Query Builder Reports *(on page 930)*.

Loading and Saving Queries

The following load/save functions are available from the SQL Report Editor window, Report Search window, and Query Builder submenu options:

- Load a query or data model from the database.
- Save a query into the database. Queries saved in the database can be run directly from the reports menu and optionally shared by other users.
- Import a query from a disk file and save it into the database.
- Export a query from the database to a disk file. Queries exported to disk files can be emailed to other Communicare sites.
- Rename queries that belong to you. A query's name decides which report sub-menu the query is listed on, if any. See Report Naming *(on page 614)* for more information.
- Change the Public property of queries that belong to you. Public queries are displayed on all users' report menus.
- Delete queries belonging to you from the database.

Note:
Users in the **Administrators** group can change and delete queries belonging to any user.

See also Access Control for Query Builder Reports *(on page 930)*, Report Naming *(on page 614)*, SQL Reports *(on page 581)*

Report Wizard

Query Builder has an extensive viewing and reporting feature allowing you to set the format and layout of reports.

After your query has run and the results are displayed in the data table you can view the results in a Form by clicking on the Form mode button at the bottom right of the results window. This displays one record at a time rather than a list of records.

To print the results data click on the Print data button at the bottom right of the results window and the Report Wizard window will be displayed.

The Report Wizard

Preview or print from this form using the appropriately labelled buttons.

Use the Printer button to set paper size and orientation. Remember to save these settings if they are always to apply to this report.

Use the Labels button to allow you to design layouts suitable for various sizes of label.

The Edit Rep. button allows you to perform a number of modifications to the layout and design of your printed report. These include but are not restricted to the following:

- Fields - Column width, Alignment, Borders & Frames, Colour & Shading, Field position, Text Style & Size
- Groups - group the data according to fields or expressions
- Options - Titles, Headers and Footers can be designed here. The Edit band button next to each band opens a Drag 'n' drop report designer.

Editing report layout bands

There is a variety of objects you can drop onto a band. Drag the appropriate object onto the band and, making sure it is selected, edit using the various options available.

- Label - set the size, style of text, alignment and caption
- DB Text - specify the field, apply a mask
- Sys Data - specify a system parameter such as date or time
- Expression - click on the ellipsis next to the Expr: box to construct an expression
- Parameter - in addition to PracticeName (the name of your practice) and UserName (the name with which you logged on to Communicare) you can also use any of the parameters you were prompted to provide as you ran the query. Parameter_0 is the first parameter you were prompted for, Parameter_1 the second, etc. Select them from the ellipsis button. Text can be added to the [$parameter_n$] to further qualify the label (for example, From [$parameter_0$] to [$parameter_1$] might show as From 1-January-2003 to 1-January-2004 on the printed report.
- Shape - choose a shape and set its properties

Report Scheduler

Use the Report Scheduler to run a report nightly and email the report to interested users.

Before you can schedule any reports to be run, configure your mail server and an email address allocated for the exclusive use of the Communicare server. For more information, see Email Server *(on page 839)*.

The Report Scheduler runs a report every 3 minutes between 8:30pm and midnight each night. A maximum of 70 reports can be run. If any reports take more than 3 minutes to run, fewer reports will be completed. If required, you can extend the time period in which the reports are generated.

Note:
Any report that runs for more than 30 minutes is terminated.

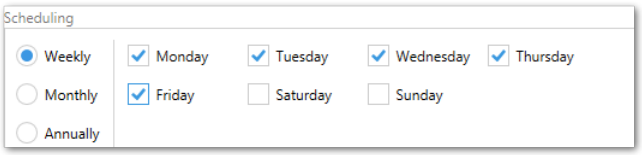
To schedule a report:

1. Select **Tools > Scheduled Reports**.
2. Click ✚Add.
3. From the **Report** list, select the required report.
   The report is enabled by default.
4. If you want to send the report to a secure email address, set **Send Securely**.
   Standard email is not secure, so if the report includes confidential information, be sure to send it securely.
5. From the **Format** list, select a format for the report.
   Select from:
   - **HTML** - the format used by web pages
   - **RTF** - a format which virtually all word processors can read
   - **TXT** - plain, unformatted text
   - **XLS** - Microsoft Excel spreadsheet format, also readable using OpenOffice
   - **CSV** - comma delimited list, a common format for sending data extracts. To add column headings to the data extracted for context, set **Include Header**.
   - **XML** - used to send data extracts between computer systems. The version implemented here has a root (**XML_ROOT**) with lines (**XML_LINE**) containing a node for each column returned by the query. The root and line node names can be specified by returning columns named **XML_ROOT** and **XML_LINE** containing the names of these nodes.

   If the report you have chosen has an output parameter set to `RWS_`, this format is ignored.
6. In the **Recipient(s)** field, enter the email addresses to which you want to send the report.

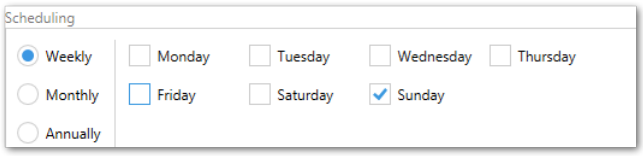
   If you set **Send Securely**, click **Address Book** and select a single, secure recipient from the address book.

   You must specify at least one address.
7. If required, in the **Reply To** field, enter an address to which the recipient of the report email can reply.
8. If required, in the **Subject** field, edit the subject of the email, which contains the name of the report.
9. In the **Description** field, provide some information about the report and why it is being sent.
10. In the **Parameters** list, click in the **Value** column and enter values specific to the selected report.
    For more information, see Parameters for SQL Reports *(on page 581)*.
11. In the **Scheduling** pane, set when you want to generate and send the report.
    - To generate daily reports, set **Weekly** and the days when you want to the report to run.



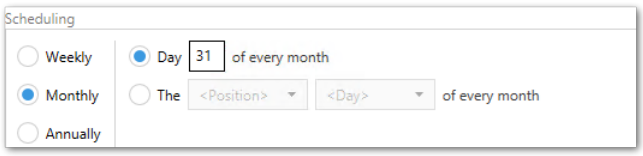
    - To generate weekly reports, set **Weekly** and set a single day.

> **Tip:**
> If you would like the report to be available first thing in the morning, ensure the day before is selected as the report runs at night. For example, set **Sunday** for Monday morning delivery.

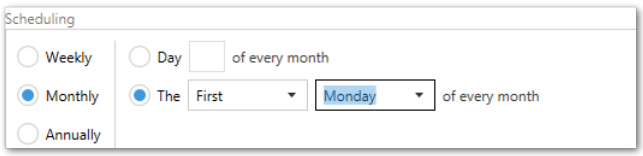


- To generate monthly reports by day, select a numerical day.

> **Tip:**
> If you would like this report to run on the final day of the month, enter `31` to ensure that all months are included.

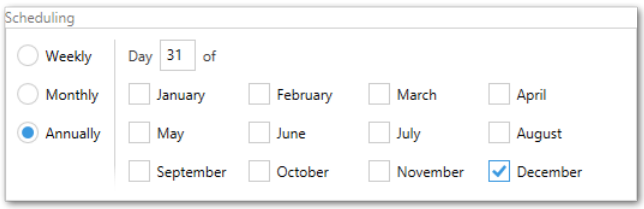


- To generate monthly reports by position, select the position and day. For example, the `First Monday` of every month.



- To generate reports annually, set **Annually**, enter a day and select a month.

> **Tip:**
> If you would like this report to run on the final day of the month, enter `31` to ensure that all months are included.



> **Note:**
> Take care when entering literal values for the date range.
>
> If you enter an exact date range, fully specifying the dates, Communicare will continue to use these dates for each subsequent generation of the report. For example, if you want a report to run each month, and the report is set up to capture data from between 01/01/2012 and 31/01/2012, it will continue to report data

from this date range, no matter what month the report is generated in. Instead, use relative parameters, such as `First day of last month` and `Last day of last month`.

Similarly, if you enter a literal value for a day of the month in a date parameter, the report will only be generated for months that contain this day. For example, if you want a report to be run each month and capture data from the previous month, date parameters of `1st day of last month` to `31st of last month` will only be valid when the previous month had 31 days. Instead use `First day of last month` and `Last day of last month`.

12. Click Save.

After you set up the required report parameters, Communicare delivers the report to the email addresses included on the schedule.

The Report Scheduler runs continuously until manually altered.

Note:
By default, Microsoft Outlook removes additional line spaces from the email sent. If this is confusing to the recipient, they should go to **Tools > Options > Preferences > email options** and deselect **Remove extra line breaks in plain text messages**. For more information, see the documentation for your email program.

Clinical Terms Group Browser

The clinical terms group browser is the window that pops up each time you need to select a Clinical_Item_Groups. It has been designed to be easy to use, no matter how long your list of clinical item types is.

Clinical terms are the words used to describe each Clinical_Item_Type. The group browser is the tool that you use to select a group of related terms.

Keyword Searching

Any number of keywords may be defined for a group. Keywords can be any word of two or more characters that you may wish to use to locate a group. The keywords do not necessarily have to be in the terms of the group.

Enter the starting characters of a keyword to search for all terms that have keywords starting with those characters. For Example DIAB will list all diabetes groups. The search can be further refined by entering the starting characters of a second word. Groups that do not contain a word starting with those characters will be eliminated. For Example DIAB A will shorten the list to 'Diabetes (all)' only.

Printer Assignments

Set printer assignments for different report categories so that a specific printer is used.

By default, all reports are printed on the Windows default printer. This can be inconvenient when, for instance, you want Patient Labels *(on page 532)* to be printed on a printer that is always loaded with label stationary, while all other reports are printed on another printer.

The **Printer Assignments** window allows you to:

- Associate specific printers with different categories of reports and forms
- Set the Microsoft Windows window to be displayed for different categories
- Select a Paper Source on that printer for the category

To display the Printer Assignments window, select **File > Printer Assignments**.

Set **Show Dialog** to force the printer window to appear when printing a particular category, so that you can select the particular printer you need on each occasion. This is of immense value to users who move from room to room or clinic to clinic and need fine control over the printer used.

Set **Paper Source** to allocate a tray for a particular category, so different categories can be printed from different paper sources on a shared printer. Set **Paper Source** to blank (first item in the drop down list) to use Microsoft Windows printing preferences.

Printer Search Order

When printing in Communicare, the correct printer is selected using the following search order:

1. If a printer is specifically assigned to the current print request (e.g. prescriptions, clinical drawings), the assigned printer is used.
2. Otherwise, if a specific assignment cannot be found and a Communicare Default printer assignment is found, this printer is used.
3. If neither 1 or 2 are found, the Windows Default printer is used.

Unavailable Printers

If a printer is unavailable, its name will appear in red next to its assignment. Attempting to print to this printer will cause the default to be used instead.

Assignments List

Not all features use printer assignments. The following features print directly to the Microsoft Windows default printer instead:

- Consolidated orders
- Custom prescription forms, standard and S8 templates
- HealthLink SmartForms
- Medication requests
- MIMS Drug Information

The following features use printer assignments.

Table 181. Assignments list

Assignment Name	Description
Communicare Default	All reports except patient summaries and label reports; Scanned documents; Investigation results
Patient Labels	All patient label reports
Supply Labels	All supply labels

Table 181. Assignments list (continued)

Assignment Name	Description
Patient Summaries	Patient Summary reports, Qualifier Charts (including Previous Measurements), Child Development Centile Charts, Patient Service reports, Patient MeHR consultation reports
Medicare Assignment Forms	Bulk Bill Assignment Advice Forms
Appointment Reminder Slips	Appointment booking and reminder slips
Prescriptions	PBS prescription forms
Investigations - Pathology	Investigation Request Forms for Pathology
Investigations - Imaging	Investigation Request Forms for Imaging
Prescription Labels	Prescription labels (including single labels)
Letter Writing	Used for Letters. You cannot specify a paper source for this printer assignment. Instead, change the default paper source for the associated printer in Microsoft Windows printing preferences.
Clinical Drawings	Drawing Qualifiers (Clinical Drawings)
Service Recording	Service lists
Charts	All charts accessible via the clinical record.
Billing Invoice	Private Billing Invoice. Please choose the Invoice template name.

Integrations

Communicare integrates with National and State services, external reporting solutions and utilities that expand Communicare's reporting and other capabilities.

Services Australia

Communicare interacts with Services Australia web services.

The following functions interact with Services Australia:

- Online Patient Verification (OPV) - used for Medicare validation
- Enterprise Patient Verification (EPV) - used for Medicare validation
- Bulk-bill claiming - used for Medicare claims
- Australia Immunisation Register (AIR) - used to access the Australian Immunisation Register
- Interactive Patient Claiming (IPC) - used for Medicare claims

Data privacy and security

In Communicare V21.3 and later, to support Services Australia interactions, your patients' relevant personal information is encrypted and sent from your Communicare server to Services Australia web services via Communicare Next Generation. The data is retained by Communicare Next Generation. Communicare Next Generation is hosted on Microsoft Azure cloud services, in highly secure data centres based in Australia (Sydney, Canberra, Melbourne) which meet the Australian Standards for Information Security. Microsoft has been awarded Certification for Protected data in Australia. For more information about how Telstra Health manages personal information, see our privacy policy.

PRODA

In Communicare V21.3 and later Communicare authenticates to Services Australia using PRODA.

Previously, Communicare used Medicare PKI certificates and a client adapter service to authenticate to Services Australia. Medicare PKI certificates were linked to organisations. The PRODA device effectively replaces the Medicare PKI certificate. Minor IDs are still required.

To use the Services Australia web services, your organisation must be registered with Services Australia using the Provider Digital Access (PRODA) system. PRODA is used to verify and manage providers' details and access a range of government online services.

A PRODA device belongs to one organisation. For Communicare to communicate with Services Australia and access Medicare Online or Australian Immunisation Register (AIR), you must register a Business to Business (B2B) Device for your organisation in PRODA. A B2B device allows your organisation to have authorised access to a *service provider* using a software product.

Information:
A service provider is a service such as Medicare Online, Australian Immunisation Register (AIR), or others such as Health Professional Online Services (HPOS). The former two are relevant to Communicare. Not all service providers are relevant to Communicare.

Within your organisation, only PRODA members who have the Device-Management attribute may register and manage B2B devices.

You can register a B2B device to either the parent or the subsidiary organisation within PRODA. For information about registering subsidiary organisations, see Medicare Guide.

For more information about PRODA, see PRODA (Provider Digital Access) - Services Australia.

Tip:
If you need assistance setting up your B2B device, contact the Communicare Support.

Activating your B2B device

Activating a B2B device is a two step process:

1. Register the device with PRODA.
2. Provide the Device Activation Code that you receive from Services Australia to Communicare Support who will activate your device.

Registering your B2B device

To register a B2B device with PRODA:

1. Log into PRODA and select **Organisations** at the top right of the window.
2. From **Organisations**, select the name of the organisation you want to register the new B2B device to. Ensure that the selected organisation has a valid status, and that the ABN is correct.
3. On the **Manage my organisation > B2B Devices** tab, click **Register New B2B Device**.
4. Enter a Device Name. The device name should be descriptive enough that you or another user can identify what the device is used for and what service transactions it's performing. The device name must be unique to your organisation. The name may contain any of the following characters:
    - Alphabetic
    - Numeric
    - Underscores
    - Hyphens
    - Full stops

   The name may not contain any spaces.
5. In the **Description** field, add any other information that will help you identify the device.
6. Click **Register Device**.

Registration is completed. You will receive a *Device Activation Code*, which is valid for up to 7 days.

Tip:
As soon as you are presented with the code, record it in a safe location, as it is not stored.

Activating your device

Note:
So that Communicare Support can activate your device, raise a ticket as promptly as possible and make sure you include the Device Activation Code.

Communicare Support records the device ID for your organisation in Medicare Services Australia system parameters *(on page 827)*. You can also have a separate PRODA device ID for your encounter place *(on page 872)*.

> **Note:**
> Once your device is activated, it will remain valid for 6 months. You will need to renew it from PRODA at least every 6 months to avoid interruption to Communicare's access to connected services.

Communicare will send your administrator an email when expiry of your device is approaching, within 28 days by default. The email includes the following information:

- The email is sent to the email recipient configured in `CCareQueue_ServicesAustralia` . For more information, see Services Australia interaction defaults *(on page 630)*.
- The subject line is similar to: `Communicare PRODA device expiry warning`.
- The email is sent from the **Sender** configured for your health service in Organisation Parameters - Email Server *(on page 839)*, for example, `system@communicare.com.au`.

> **Important:**
> Renew the registration when you receive the email. If the device registration expires, your site won't be able to make claims from, or be paid by Medicare.

To renew your device registration, follow the link in the email or go to the PRODA portal and click **Renew**.

Extending your PRODA B2B device

Your site must extend the expiry date of your B2B device every 6 months.

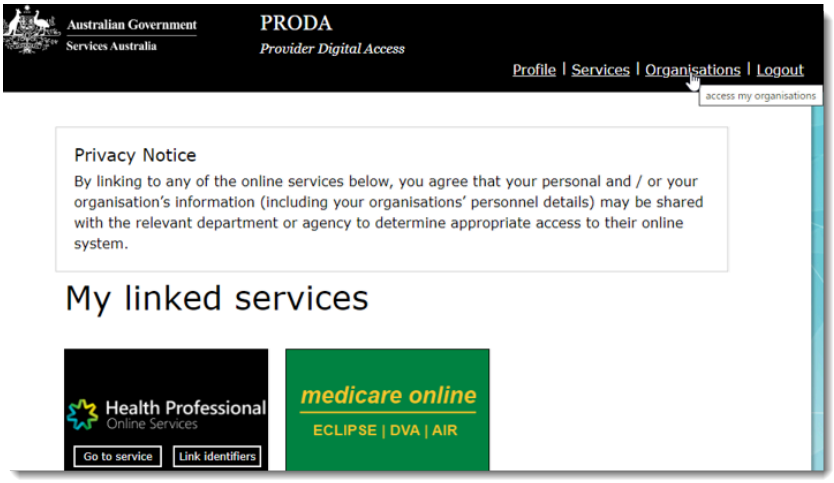
> **Note:**
> If you don't extend your device, your Medicare claiming and AIR uploads could be interrupted and you will need to create a new device.

Communicare and PRODA remind you before the device expiry date. As soon as you receive a reminder, a user who has access to the relevant PRODA Organisation and has the `Device-Management` role should update your device.

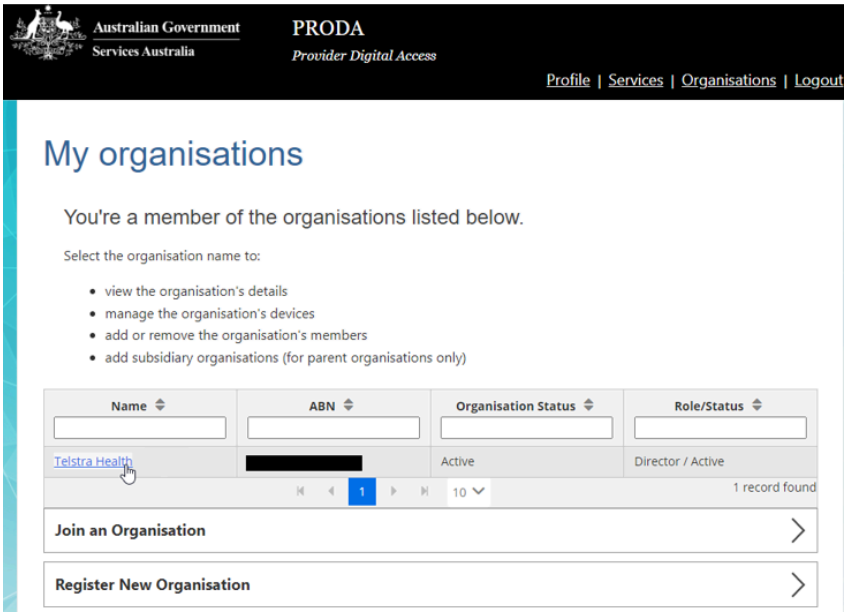
> **Tip:**
> If you are having trouble extending the expiry of your B2B device, contact the PRODA Helpdesk on 1800 700 199, Option 1.

To renew the B2B device in PRODA:

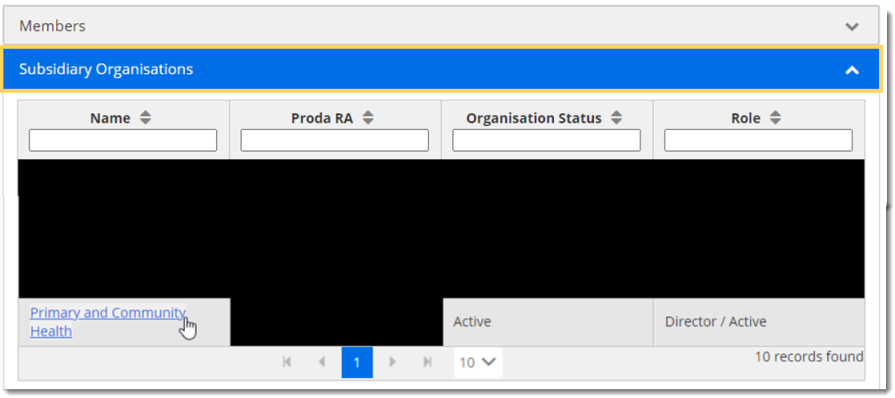
1. Log into PRODA and select **Organisations** at the top right of the window.



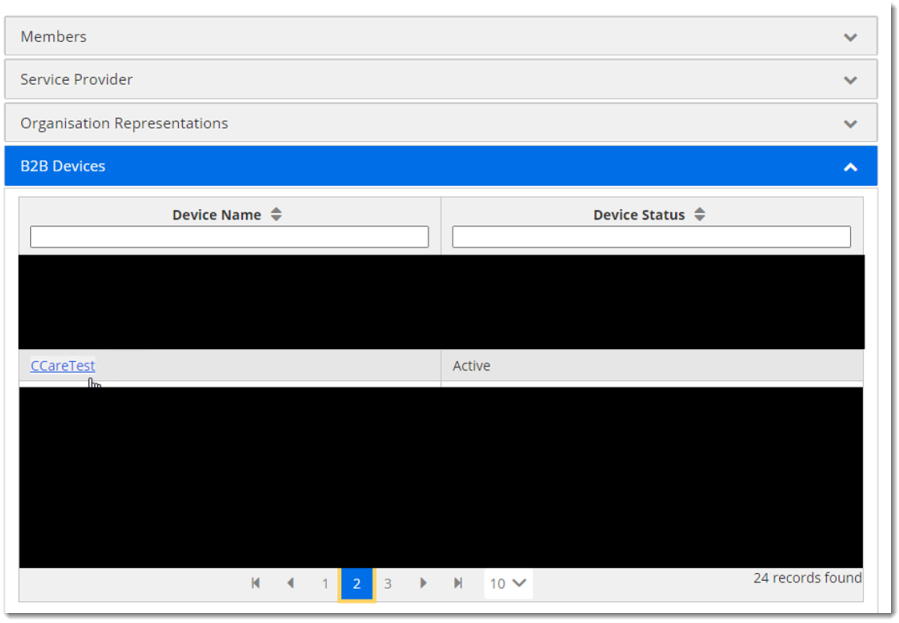
2. On the **My organisations** page, in the **Name** field, select the name of the organisation you want to update.



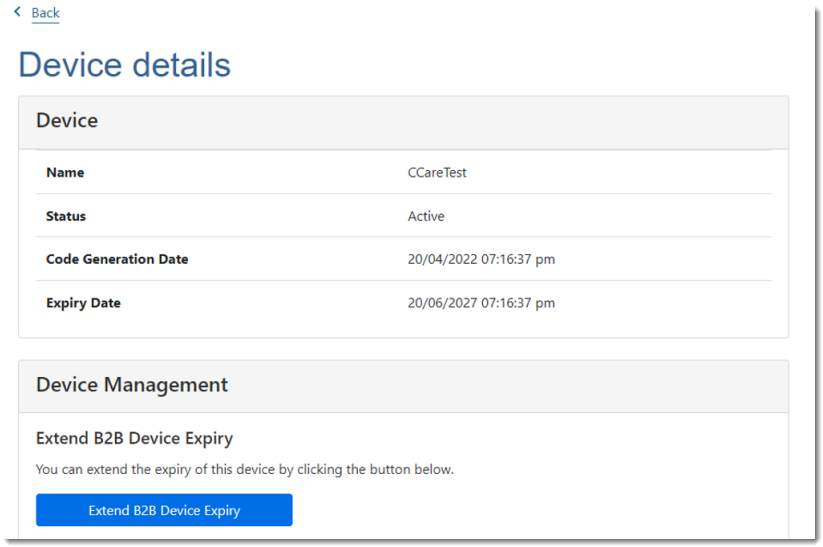
3. Some organisations will have a subsidiary organisation in which the device was created. If you do, from the **Subsidiary Organisations** list, select the relevant subsidiary organisation, otherwise, go to the next step.



4. From the **B2B Devices** list, select the device that you want to update.

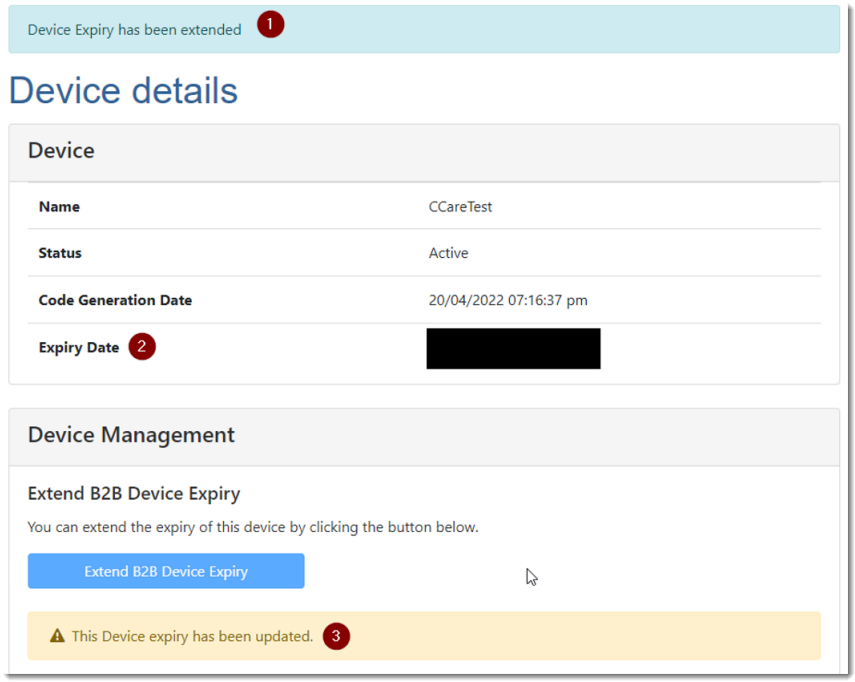


5. On the **Device details** window, click **Extend B2B Device Expiry**.



6. Click **Yes** to confirm that you want to extend the expiry date of the B2B device.

7. Observe that the expiry date of the device has been extended.



Once you have extended your B2B device in PRODA, you do not need to do anything else. You do not need to advise Communicare when you have done this, the system will automatically detect this has occurred.

Remember:
Repeat these steps before the device's next expiry date.

Managing your Minor ID

It is important that Medicare is advised of the relevant Minor ID for each organisation. In Communicare, Minor IDs can be specified at the organisation level or encounter place level.

Where a Minor ID is specified at the organisation level, and no Minor ID is specified at the encounter place level, the organisation level Minor ID is used. Where a Minor ID is specified at the organisation level, and a different Minor ID is specified at the encounter place level, the encounter place Minor ID is used.

The same logic applies to B2B devices.

The AIR system requires a unique Minor ID per AIR provider number (information provider) for authentication and authorisation purposes for every AIR-WS request. An AIR provider number can only be linked to one PRODA organisation account. If your organisation has more than one AIR provider number, create a sub-organisation for each provider number you want to link. For more information, see PRODA (Provider Digital Access) - Services Australia.

You can advise Medicare Online of your Minor ID when you create a Service Provider in PRODA:

1. Log into PRODA and select **Organisations** at the top right of the window.
2. From **Organisations**, select the organisation for which you want to manage the Minor ID. You can select a subsidiary organisation to manage at this step instead of a top-level organisation.
3. Select **Service Provider > Add Service Provider**.

4. Select **Medicare Online/ECLIPSE/DVA/AIR > Add Service Provider**. You have now left PRODA and are working in the Organisation Linking system.
5. Read the Linking Terms and Conditions. If you agree, set all three boxes and select **Accept**.
6. Identify your organisation:
    a. Answer the question: **Has your organisation been issued with a PKI site certificate by us?**
    b. If you select `Yes`, for the question **What is your PKI RA number?**, enter your organisation's PKI RA number.
    c. In the **Identifier** field, enter your organisation's Minor ID number, and click **Next**.
7. Your organisation is identified and a relationship with Medicare Online established. Click **Next**.

> **Tip:**
> You may register more than one Minor ID for an organisation.

Configuring Communicare for Online Claiming

After you have advised Communicare Support of the PRODA device activation code, we will process the activation on our end, and configure Communicare's System Parameters to connect to Services Australia.

We will notify you when your configuration is complete.

System Administrators can check the progress on the **File > System Parameters > Web Services** tab. If **Enable Medicare Services Australia** is set and the fields are populated, the set up is nearly complete.

After you receive confirmation that the set up is complete, do the following:

1. Add your Minor ID to the **Location ID** field in **File > Organisation Maintenance >** *organisation* **> Electronic Claims** tab. Use your highest, organisation-level Minor ID here. You can override the Minor ID at the encounter place level.
2. If required, update the Minor ID for each encounter place that you want to claim under a different Minor ID in the **HIC Minor Location ID** field in **File > Reference Tables > Encounter Place >** *encounter place*. You needn't update encounter places you want to claim under the Minor ID from step 1 *(on page 627)*.
3. For each encounter place that will be used for claiming, enter the encounter place device ID in the **PRODA Device ID** field in **File > Reference Tables > Encounter Place >** *encounter place*.
4. Ensure that each claiming provider has a Medicare provider number included for each encounter place they will be claiming from in **File > Providers >** *provider*, **Provider Number** column.

You will now be able to submit bulk bill claims to Medicare.

Configuring Communicare for AIR integration

After you have been advised that Communicare V21.3 or later is connected to Services Australia you can complete integration with the AIR.

Communicare must be configured to use Services Australia's Web Services, and you must have registered for a B2B Device and PRODA logon for your organisation.

Advise Services Australia if your site has an allocated minor ID. For linking purposes, immunisation providers should also advise the agency of their minor ID by filling out the Online Claiming Provider Agreement (HW027) form.

The Communicare V21.3 or later installation includes the **CCareQueue_ServicesAustralia** service, which must be running.

AIR requires an information provider and immunisation provider. In Communicare, the AIR information provider and immunisation provider is the same person and is set to the same value if an immunisation is set to **Performed here**. The AIR provider is set to the first available value from the following provider numbers:

1. **AIR Provider No**
2. **Default AIR Provider**
3. Medicare provider number for the service provider
4. Medicare provider number for the service claiming provider

To integrate with the AIR:

1. Specify a provider number for your encounter place in **File > Reference Tables > Encounter Place >** *encounter place*. Include a provider number in either of the following fields:
    - **AIR Provider No** - if your organisation is intending on transmitting immunisation notifications to the AIR, apply for a location-specific provider number from Services Australia.
    - **Default AIR Provider** - add an individual as the default provider for your encounter place who has a discipline of medical practitioner, midwife or nurse practitioner, and holds a valid Medicare provider number for the location.

    > **Note:**
    > If this individual provider leaves your organisation, ensure that you update this field to a current employee of your organisation who holds a valid provider number.

    > **Note:**
    > The encounter place or organisation must have a valid B2B device enrolled to allow uploads to the AIR.

2. In **File > System Parameters > System** tab, enable the following datasets so that immunisations can be recorded as structured data (clinical items and qualifiers) in Communicare. These datasets include the AIR export codes.
    - **Immunisation Age Based Reviews** - you must enable this dataset if your organisation is reporting for nKPI, NT AHKPI or NSW KPI and clinicians must record immunisations in the `Review;immunisation;age` clinical items. Automated recalls are included with this dataset.
    - **Immunisation Vaccines**
3. In **File > User Groups**, ensure that any user who wants to access the AIR integration belongs to a user group with the following system rights:
    - `Clinical Records`
    - `AIR Patient Integration`

Immunisations recorded as Immunisation clinical items will be uploaded to the AIR and providers can view a patient's immunisation history recorded in the AIR.

If you have trouble uploading immunisations to the AIR, check Ensuring an immunisation can be uploaded to AIR *(on page 644)*.

Online Patient Verification

Online Patient Verification (OPV) is the process where a single patient's Medicare card number is sent to Services Australia and is validated against the details that Medicare holds.

Note:
OPV is used for online claiming.

An OPV check happens in the following circumstances:

- In  **Patient Biographics > Personal** tab, **Medicare** pane, when you click **Check Card Online**.
- When you save a patient's biographics
- For patient interactive claims
- In **Tools > Medicare Card Eligibility** when you check a patient's Medicare details

The following patient details are sent to Services Australia as part of the OPV:

- Given and family names set for Medicare
- Date of birth
- Medicare number
- Medicare reference number

If the OPV finds any discrepancies in the patient's details, Services Australia may return suggested alternatives for the following:

- Given name
- Medicare number
- Medicare reference number

Note:
The Minor ID and PRODA device ID are used in the OPV check. If no encounter place is set, the organisation's Minor ID and PRODA device ID are used. If the encounter place is set, its Minor ID and PRODA device ID are used if they exist.

Enterprise Patient Verification

Enterprise Patient Verification (EPV) validates the Medicare card details automatically for all patients in the database that haven't been checked recently in one submission to Services Australia.

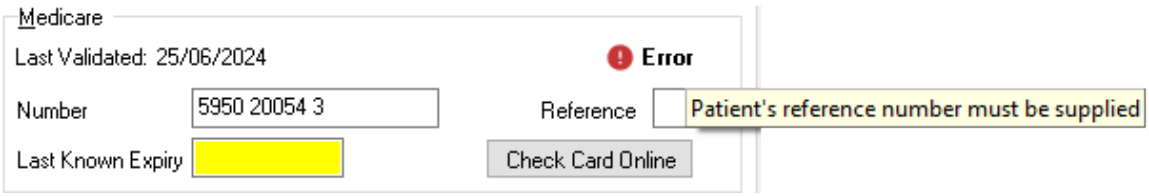
Any Medicare card that has not been validated with Services Australia in the last 30 days that first passes Medicare card number validation is checked with Services Australia.

EPV is run by the `CCareQueue_ServicesAustralia` service. You can configure when and how often EPV is run.

When EPV validates the Medicare card details, it may automatically update any of the following details in Communicare:

- Medicare number
- Medicare reference number

  Before updating a patient's Medicare and reference number after an EPV validation, Communicare checks whether there are any patients recorded with the same details. For any conflicts, Communicare clears the Medicare reference number and displays the following message in Patient Biographics: `Patient's reference number must be supplied`.



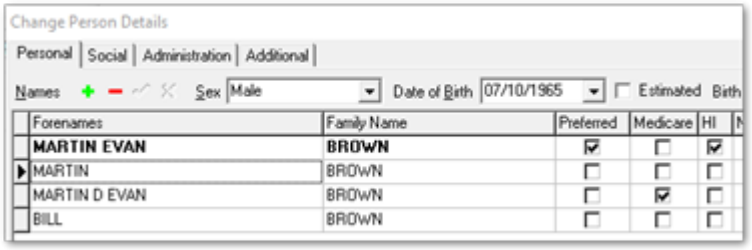
Update the patient's Medicare information when they present at your site.

- Patient name

A patient can have multiple names or aliases. Only the name set for Medicare use in Patient Biographics is validated. If a different name is returned, the following rules are applied to determine which name is automatically set for Medicare use:

  - If the name returned from Medicare is different to that sent, and the name exists in the patient record, this name is set for Medicare use.
  - If the name returned from Medicare has no existing, exact match, and there is more than one name that contains the returned name, the name that is listed first alphabetically is set for Medicare use.
  - If there is no existing match, a new patient alias is created and set for Medicare use.

For example, if `Martin Brown` is sent for validation and Medicare returns `Evan Brown` for this patient, Medicare is set to `Martin D Evan Brown`, an existing alias that contains `Evan` and is the first alias alphabetically.



> **Tip:**
> The **Preferred** name, **HI** name and **Nyaparu** or equivalent name set are not affected.

Services Australia interaction defaults

In Communicare V21.3 and later, the `CCareQueue_ServicesAustralia` service manages integration between Communicare and the Services Australia web service.

For the Communicare server, `CCareQueue_ServicesAustralia` is installed and configured as part of the upgrade process. `CCareQueue_ServicesAustralia` is not required for the Communicare client, Offline Client or Demo.

Configuration

If required, you can request that Communicare Support customise when your Communicare installation communicates with Services Australia and adjust other timings and intervals.

Table 182. `CCareQueue_ServicesAustralia` Scheduler configuration defaults

Section	Setting	Default
Bulk Bill Claims	The period during which Medicare claims are submitted to Services Australia.	`09:00:00` - `11:00:00`

Table 182. `CCareQueue_ServicesAustralia` Scheduler configuration defaults (continued)

Section	Setting	Default
	The interval at which `CCareQueue_ServicesAustralia` submits claims to Services Australia.	`60` minutes
	The number of days after an encounter during which you can submit a claim for that encounter.	`180` days
	The number of days after which you can resubmit a failed claim to Medicare.	`7` days
EPV Claims	Include bulk checking of patients' Medicare details using EPV. The details of up to 250 patients can be checked in one submission.	
	Check the Medicare details for patients whose details haven't been checked in this period or in the last 72 hours.	`30` days
	The number of hours after which a patient's details which have failed validation are resubmitted to Medicare.	`24` hours
	The period during which bulk checking of patients' Medicare details using EPV occurs.	`09:00:00` - `21:00:00`
	The interval at which `CCareQueue_ServicesAustralia` looks for patients to validate with Services Australia.	`60` minutes
PRODA Notifications	The number of days before the PRODA device for Communicare expires that a warning email is sent to the administrator using `blat.exe`.	`28` days
	The email address of the administrator to whom the PRODA device expiry warning is sent.	blank
AIR Claims	The period during which submissions are sent to the AIR.	`12:00:00` - `14:00:00`
	The interval at which `CCareQueue_ServicesAustralia` looks for immunisations to submit to AIR.	`60` minutes
	The number of days after an encounter during which you can upload immunisations to AIR from that encounter.	`180` days
	Immunisations that were not completed and not waiting on confirmation and for which the immunisation details or patient biographics have been updated during this period are resubmitted to the AIR.	`24` hours
AIR Confirmations	The period during which submissions of claim confirmations are sent to AIR start.	`08:00:00` - `18:00:00`
	The interval at which `CCareQueue_ServicesAustralia` looks for claim confirmations to submit to AIR.	`20` minutes
	The number of days after an encounter during which you can submit claim confirmations to AIR from that encounter.	`180` days
Bulk Bill Legacy Claims	The time at which legacy claims are submitted to Medicare Online. This occurs once daily.	`23:00:00`

Table 182. `CCareQueue_ServicesAustralia` Scheduler configuration defaults (continued)

Section	Setting	Default
	The number of days after the lodgement date that a legacy claim can automatically be submitted to Medicare Online. Claims older than this are not submitted.	`180` days

HI Service

The Healthcare Identifier Service (HI Service) is a module that communicates with Medicare.

The HI Service searches for or validates:

- Individual Healthcare Identifiers (IHI) - patient identifier
- Healthcare Provider Identifier - Individual (HPI-I) provider identifier
- Healthcare Provider Identifier - Organisation (HPI-O) identifier

Individual Healthcare Identifiers (IHI)

All patients have been allocated an Individual Healthcare Identifier (IHI) by Medicare. The IHI is used for integration with My Health Record and ePrescribing. The IHI may also be used by the AIR to identify patients if there is insufficient other information.

Enter the patient's IHI number in their  Patient Biographics. A manually entered IHI is validated with Medicare automatically when you move your cursor out of the **IHI Number** field. Alternatively, click  Validate. An error is displayed for retired and expired IHIs. If the IHI cannot be validated, it will not be available for use within Communicare.

When you save a patient's biographics, Communicare attempts to search for the patient's IHI if one has not been entered. For a search to be attempted, the following patient information must be recorded:

- Given name (forename)
- Family name
- Sex
- Date of birth
- Medicare number or DVA number or both

If Communicare finds the IHI number to be invalid, the IHI number is removed and a search is performed using their other details.

If any of the following details change, Communicare attempts to validate the IHI using the new details:

- IHI number
- Medicare number
- Medicare individual reference number (IRN)
- DVA number

If IHI validation has not occurred in the last 24 hours, Communicare validates the IHI when sending an ePrescription. If a patient's IHI cannot be verified or its status is not active, ePrescribing is not available.

To view a patient's IHI history, click  IHI History.

- All manually entered IHIs are stored in IHI History even if they have not been validated.
- All automatically entered IHIs are stored in IHI History
- IHI History lists the status of each IHI number.
- Retired and expired IHIs are stored in IHI History.

Healthcare Provider Identifier - Individual (HPI-I)

All providers have been allocated an HPI-I by Medicare. A provider can obtain their HPI-I by logging into the Australian Health Practitioner Regulation Agency (AHPRA) website (http://www.ahpra.gov.au/).

Enter HPI-I numbers against a Provider *(on page 921)* or an address book entry *(on page 339)*. A manually entered HPI-I will be validated with Medicare automatically when you move out of the **HPI-I Number** field. Alternatively, click  Validate. If the HPI-I cannot be validated, it will not be available for use within Communicare.

To view a provider's HPI-I history, click  History.

When you save a Provider or Address Book entry details, Communicare attempts to search for the HPI-I if one has not been entered. For a search to be attempted for the HPI-I, the following information must be included in either the provider's record or the provider's entry in the address book:

- In **File > Providers**, **Provider** window, the provider's registration number and family name need to have been recorded in the **Registration Number** and **Surname** fields.
- In **File > Address Book Maintenance**, **Address Book Entry** window, the provider's given name and family name need to have been recorded in the **Forenames** and **Surname** fields.

Healthcare Provider Identifier - Organisation (HPI-O)

Your organisation needs to apply to Medicare to obtain an HPI-O.

Enter HPI-O numbers against an Encounter Place *(on page 872)*, Organisation *(on page 835)* or an address book entry *(on page 339)*. A manually entered HPI-O will be validated with Medicare automatically when you move off the HPO-I field. Alternatively, click  Validate. If the HPI-O cannot be validated, it will not be available for use within Communicare.

For ePrescribing, your encounter place must have a HPI-O number and be connected to the HI Service.

To view an Encounter Place, Organisation or Address Book Entry's HPI-O history, click  History.

When you save an Encounter Place, Organisation or an Address Book Entry's details, Communicare will attempt to search for the HPI-O if one has not been entered. For a search to be attempted the organisation name for the organisation or Address Book Entry or the encounter place's name need to have been completed.

Healthcare Identifier Statuses

Table 183. Healthcare Identifier status

Colour Code	Number Enabled Status
White	There is no healthcare identifier or it has been validated with Medicare (statuses should be visible below the box) and it is usable within Communicare.

Table 183. Healthcare Identifier status (continued)

Colour Code	Number Enabled Status
Purple	The healthcare identifier has not been validated with Medicare due to user cancellation of the check, insufficient details to perform the check, or connection problems. Statuses will show as `Unknown`. The healthcare identifier will not be usable elsewhere in Communicare until it has been validated.
Red	The healthcare identifier has been validated with Medicare (correct statuses will show below the box) however it has been disabled for use. A user prompt should explain the reason, most likely it is due to being a duplicate of another healthcare identifier record. To resolve the problem, correct the details.

Healthcare Identifier Checks

When the module performs a search or validation you will see one of two working windows pop-up to indicate that a Medicare check is taking place. If time is critical, you may click **Cancel**, however it is better to let the Healthcare Identifier check complete successfully. The wait time is normally under four seconds. In either case the Healthcare Identifier check may be followed by a message that describes the outcome.

- `Searching patient IHI with Medicare` - displayed when saving a patient, provider, encounter place, organisation or address book entry without a Healthcare Identifier, if sufficient details are available.
- `Validating patient IHI with Medicare` - displayed in the following circumstances:
  - When a new healthcare identifier has been manually entered,
  - A core patient, provider, encounter place, organisation or address book entry details with an existing Healthcare Identifier have been modified
  - Two patient records have been merged (with at least one IHI available for use)
  - When you click  Validate
  - This window may also appear when:
    - A patient's My Health Record is accessed and the patient's IHI has not been validated in the IHI Revalidation Period *(on page 819)*.
    - You attempt to create a CDA document that contains healthcare identifiers that have not been validated in the past 24 hours.
    - You attempt to send a CDA document that contains healthcare identifiers that have not been validated in the past 24 hours.
    - You attempt to upload a CDA document to the My Health Record that contains healthcare identifiers that have not been validated in the past 24 hours.

Module Availability

For the HI service to be available you will need the following:

- Internet access to access the Medicare's HI Service.
- The HI Service URL. See System Parameters - Web Services *(on page 825)*.
- A Medicare encryption certificate. See Organisation Parameters - Certificates *(on page 841)*.
- A password for the certificate. See Organisation Parameters - Certificates *(on page 841)*.
- The HI Service needs to be enabled in Communicare. See System Parameters - Web Services *(on page 825)*.
- Your Organisation will need to have a HPI-O. See Organisational Parameters - General *(on page 835)*.

This module is not available in Offline (Data Sync) Clients *(on page 667)*.

Tip:
The Demo version of Communicare connects to the test HI Service. Searches and validation cannot be done on real patients, providers or organisations.

When Communicare starts, an automated process checks that the module is available. If for some reason Communicare cannot communicate with the HI Service, the module is disabled.

Module Configuration

The HI Service module configuration options can be found in System Parameters - Web Services *(on page 825)*, and may be set by a Communicare administrator or Communicare Support once a certificate has been issued for use with the service. See the aforementioned topic for details on how to obtain the certificate.

More Information

For more information about the Healthcare Identifiers Service, see the Medicare website (http://www.medicareaustralia.gov.au/provider/health-identifier/index.jsp).

Viewing Healthcare Identifier History

Healthcare Identifier History displays all Healthcare Identifier records in reverse chronological order, with their last known statuses.

Statuses

The following table explains Healthcare Identifier statuses:

Table 184. Healthcare Identifier statuses

Number Status	Record Status	Meaning
Active	Verified	The record has been confirmed as active and verified by the HI Service, and should be available for use in Communicare.
Unknown	Unknown	The record has not been confirmed as active, has not been verified or is invalid, and is not available for use in Communicare.

Australian Immunisation Register

The Australian Immunisation Register (AIR) is a national register that records all vaccines given to all people in Australia.

Only a recognised vaccination provider can update the AIR. This includes Doctors, such as a General Practitioner, Community Health Centres or Pharmacists.

As long as all the qualifying data requirements have been met, an immunisation recorded as a clinical item in Communicare is automatically transmitted from Communicare to the AIR and recorded in an individual patient's national AIR record.

If your organisation is participating in any of the following programs, you will be required to report on patients who are immunised:

- National Key Performance Indicators for Aboriginal and Torres Strait Islander Primary Health Care (nKPI)
- Northern Territory Aboriginal Health Key Performance Indicators (AHKPI)
- New South Wales Key Performance Indicators (NSW KPI)

Configuring Communicare for AIR integration

After you have been advised that Communicare V21.3 or later is connected to Services Australia you can complete integration with the AIR.

Communicare must be configured to use Services Australia's Web Services, and you must have registered for a B2B Device and PRODA logon for your organisation.

Advise Services Australia if your site has an allocated minor ID. For linking purposes, immunisation providers should also advise the agency of their minor ID by filling out the Online Claiming Provider Agreement (HW027) form.

The Communicare V21.3 or later installation includes the **CCareQueue_ServicesAustralia** service, which must be running.

AIR requires an information provider and immunisation provider. In Communicare, the AIR information provider and immunisation provider is the same person and is set to the same value if an immunisation is set to **Performed here**. The AIR provider is set to the first available value from the following provider numbers:

1. **AIR Provider No**
2. **Default AIR Provider**
3. Medicare provider number for the service provider
4. Medicare provider number for the service claiming provider

To integrate with the AIR:

1. Specify a provider number for your encounter place in **File > Reference Tables > Encounter Place >** *encounter place*. Include a provider number in either of the following fields:
    - **AIR Provider No** - if your organisation is intending on transmitting immunisation notifications to the AIR, apply for a location-specific provider number from Services Australia.
    - **Default AIR Provider** - add an individual as the default provider for your encounter place who has a discipline of medical practitioner, midwife or nurse practitioner, and holds a valid Medicare provider number for the location.

    > **Note:**
    > If this individual provider leaves your organisation, ensure that you update this field to a current employee of your organisation who holds a valid provider number.

    > **Note:**
    > The encounter place or organisation must have a valid B2B device enrolled to allow uploads to the AIR.

2. In **File > System Parameters > System** tab, enable the following datasets so that immunisations can be recorded as structured data (clinical items and qualifiers) in Communicare. These datasets include the AIR export codes.
    - **Immunisation Age Based Reviews** - you must enable this dataset if your organisation is reporting for nKPI, NT AHKPI or NSW KPI and clinicians must record immunisations in the `Review;immunisation;age` clinical items. Automated recalls are included with this dataset.
    - **Immunisation Vaccines**
3. In **File > User Groups**, ensure that any user who wants to access the AIR integration belongs to a user group with the following system rights:
    - `Clinical Records`
    - `AIR Patient Integration`

Immunisations recorded as Immunisation clinical items will be uploaded to the AIR and providers can view a patient's immunisation history recorded in the AIR.

If you have trouble uploading immunisations to the AIR, check Ensuring an immunisation can be uploaded to AIR *(on page 644)*.

Creating custom immunisation clinical items

The Immunisation Vaccine dataset is regularly updated as new immunisations are released onto the market. If your site regularly upgrades to the latest version of Communicare you will have the most up-to-date Immunisation Vaccine dataset.

When new immunisations are released, details about the immunisation are posted on the User Portal. Raise a request with Communicare Support to have your Immunisation Vaccine dataset updated.

If your site chooses to add an immunisation to the Communicare database between upgrades, you must follow the format described below. When your site upgrades to the latest Immunisation Vaccine dataset, and the central import disables any local terms you have created and adds the central term. If you did not follow the format when you created an immunisation clinical item in the local database there may be potential impacts on reporting, such as a duplicate clinical items.

To create a new immunisation clinical item:

1. As an Administrator, select **File > Reference Tables > Clinical Item types**.
2. In the **Clinical Item Type Maintenance** window, click ✚Add.
3. In the **New Item: Properties** window, on the **General** tab:
    a. In the **Formal Terms** field, enter `Immunisation;new_immunisation_name`
    For example, `Immunisation;Adacel`
        - Use a capital letter "I" for immunisation
        - Do not insert a space either side of the semi colon
        - Use a capital letter for the immunisation name
    b. Copy the term from the **Formal Terms** field to the **Natural Language** field.
    c. From the **Class** list, select `Immunisation`.
    d. From the **Topic** list, select the topic that aligns most closely with the immunisation.
    e. From the **Viewing Rights** list, select `Common`, unless there is a compelling reason to use a different viewing right.
    f. Set **Recallable** to make the immunisation recallable.
    g. Set **Enabled**.
    h. Do not set **Allow Recall Expiry** unless there is a significant reason to have a recall expiry for the immunisation.
    i. Set **Record of occurrence** to **Date only**.
4. Click **Advanced** and provide the following information.

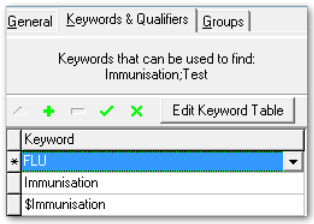
a. In the **Export Code** field, enter the AIR export code.
   The export code enables the transmission of the immunisation notification to the AIR. A list of the AIR vaccine codes can be found on the Services Australia - AIR vaccine code formats website.

b. In the **ICPC 2 Plus** pane, in the **Code** field, enter the ICPC-2 PLUS code.
   The ICPC-2 PLUS code can be inferred from other immunisations with the same topic in Communicare or by researching the ICPC-2 PLUS website.

c. If the immunisation requires a definition or instruction, in the **Definition of** field, enter instructions.

d. All other fields can be left as they are, no further configuration is required.

5. On the **Keywords & Qualifiers** tab, click Add to add a row, then the caret in the row and start typing the keyword you want to add for the immunisation.



> **Tip:**
> To list this new immunisation in the **Immunisation** shortcut list in each patient's clinical record, choose `$Immunisation` as one of the keywords. To display this new immunisation in the **Clinical Terms Browser** when clinicians enter Immunisation as a search term, choose `Immunisation` as one of the keywords.

6. Repeat step 5, adding all keywords that you think clinicians might use when trying to find the clinical item. If the keyword you want to use is not available, click **Edit Keyword Table** and add a new keyword.
7. On the **Groups** tab, set any groups that apply.
8. Click **Save**.

The immunisation is added to the **Clinical Terms Browser**. If you added `$Immunisation` as one of the keywords, it is also added to the **Immunisation** shortcut list in each patient's clinical record

Recording Immunisations

Record immunisations in an immunisation clinical item.

Before you administer an immunisation, you can check the vaccines recorded on the AIR that have been administered to the patient and the vaccines due. For more information, see Australian Immunisation Register portal *(on page 655)*.

To record an immunisation:

1. In a patient's clinical record, in the footer, select **Immunisation >** *required immunisation*.
   Not all immunisations are included in the **Immunisation** shortcut list.
2. Alternatively, click **Clinical Item**.
3. In the **Clinical Terms Browser**, in the **Search-words** field enter a search term. For example, `Immunisation`.

> **Tip:**
> To list all supported COVID-19 vaccines, use the keyword `COVID19`.

4. Select the required item in the list and click **Select**.
5. In the `Immunisation` clinical item, if you want the immunisation listed on the **Summary > Main Summary** tab, set **Display on Main Summary**.
6. If required, in the **Comment** field, enter a comment.
7. In the **Performed date** field, today's date is selected by default. If you are recording an historical immunisation, set the date for when the immunisation occurred.
8. If required, in the **Actual duration (minutes)** field, enter the duration in minutes.
9. If required, from the **Route and Site** list, select how and where on the body the vaccine was administered.
   The route of administration is required for some vaccines, for example, Imojev and Jespect; and restricted for others, for example for JYNNEOS.
10. From the **Vaccine Type** list, select the vaccine funding program under which this vaccine is being administered.
11. If the patient is pregnant, ensure **Antenatal** is set.
    This field is displayed only for female patients aged 10-65 years and is selected automatically if an active pregnancy is recorded in the patient's clinical record.
12. In the **Dose (this course)** field, enter the dose number for this course.
    For a vaccine given at birth, select `Birth` or enter `B`.
13. Alternatively, in the **Dose number** field, enter the dose number for this course.

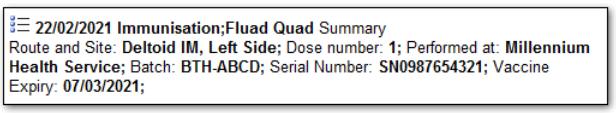
> **Note:**
> You must include a dose in either the **Dose number** or **Dose (this course)** field or the upload of the immunisation record to the AIR will fail. If a value is recorded for both fields, **Dose number** has precedence.

> **Tip:**
>
> A dose number of `0` is interpreted as a birth dose.
>
> The AIR records vaccine doses at the antigen level, not by brand. Record the dose number based on the number of previous doses of the particular antigen that has been administered. For example, if the DTP vaccine Infanrix Hexa dose 1,2 and 3 are recorded on the AIR for an individual, and DTP vaccine Tripacel is given at 18 months, Tripacel should be recorded as dose 4, because it is the fourth of a DTP containing vaccine; in this instance Tripacel should not be recorded as dose 1.

14. If you are administering the immunisation today, set **Performed at** *current encounter place*. This field is used for the `AIR (Done Here)` report.
    If you are recording historical immunisations performed elsewhere in Australia, deselect this option.
15. If you are recording historical immunisations performed overseas, instead set **Administered overseas**.
    a. From the **Country** list, select the country or region in which the immunisation was administered to the patient.
16. If required, in the **Vaccine batch** field, enter the alphanumeric batch details.
    The vaccine batch number is required for all COVID-19 vaccinations and some other vaccines, for example, Adacel, Pneumovax 23, Shingrix. Letters in the batch number must be uppercase.

17. The AIR no longer requires you to record a serial number. However, if **Serial Number Mandatory** is set for an immunisation clinical item, in the **Serial Number** field, enter the serial number. Alternatively, to use a barcode scanner, ensure the cursor is positioned in this field and scan the barcode.
    For more information, see Clinical Item Type Properties *(on page 886)*.
18. From the **Vaccine expiry date** calendar, select when the vaccine expires.
19. If if don't want this immunisation uploaded to the AIR, set **Do not send to AIR**.
20. Click **Save**.

The immunisation record and selected details are displayed on the **Progress Notes** and **Detail** tab. Not all details are displayed.



If you elected not to upload the immunisation to the AIR, this is noted on the **Detail** tab together with other details about the immunisation including the patient's antenatal status.

The location recorded for the immunisation will be one of the following, depending on the option selected:

- `Performed at: current encounter place`
- `Performed elsewhere`
- `Administered Overseas: Yes`

Check that immunisations have uploaded to the AIR in **File > Online Claiming > AIR Claims** tab. For more information, see Australian Immunisation Register uploads *(on page 433)*.

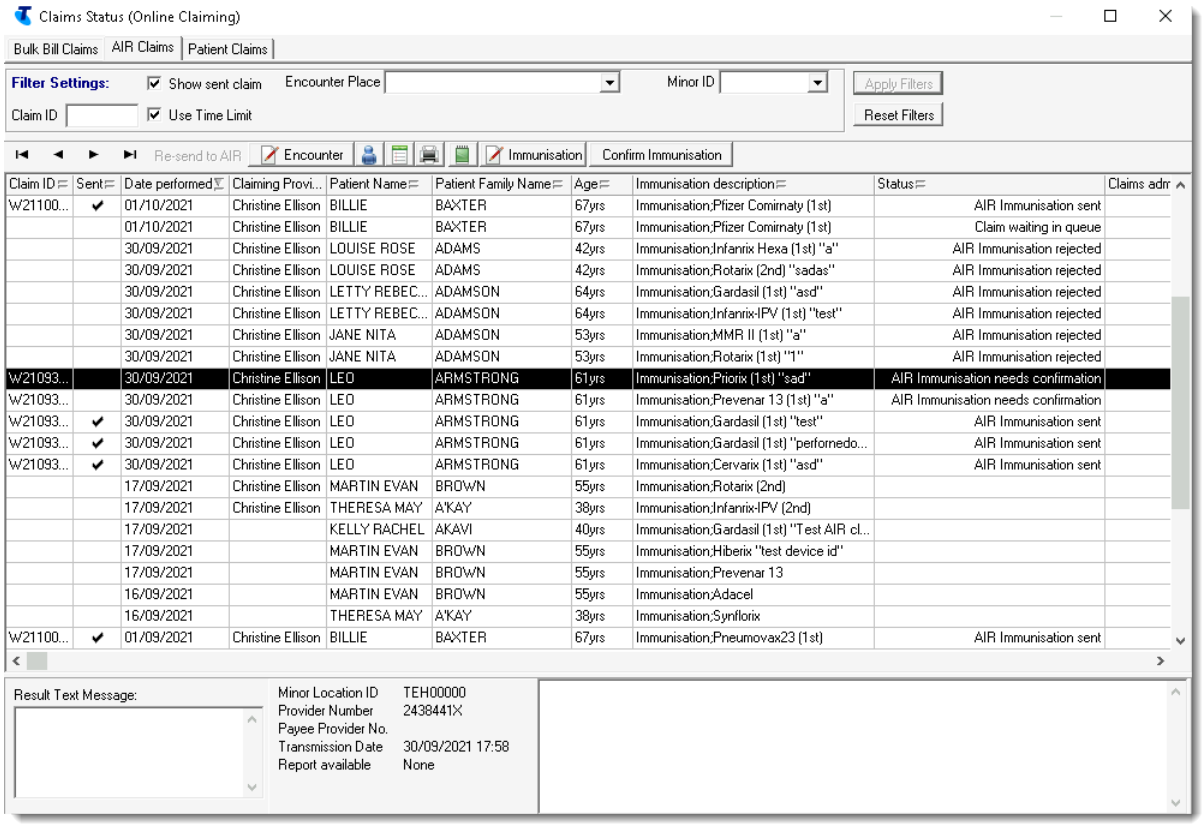
> **Tip:**
> Immunisations that you elected not to upload to the AIR are not displayed on the **AIR Claims** tab.

Follow your own protocols for managing immunisation recalls, immunisation rejections and so on.

> **Tip:**
> If the `Immunisation Age Based Reviews` dataset is enabled, the automated recalls for each age-based immunisation are automatically enabled. If this was an age-based immunisation, from the **To Do** list on the **Summary > Main Summary**, double-click the recall to open it and then complete the recall.

Australian Immunisation Register uploads

Use the **File > Online Claiming > AIR Claims** tab to view a list of all immunisations recorded in Communicare where the immunisation type has a valid AIR code, and to check that the immunisation record has been successfully uploaded to Australian Immunisation Register (AIR).



All immunisations recorded in Communicare where the immunisation type has a valid AIR code that meet the following criteria are listed:

- The immunisation must have a valid Claiming Provider, which is sent with the AIR record.
- A value is required for **Dose number** or **Dose (this course)**

> **Note:**
> If a value is recorded for both fields, **Dose number** has precedence.

- The immunisation was added, or a recall completed, after 1995
- The immunisation has a valid export code in **File > Reference Tables > Clinical Item Types**. Ask your Communicare Administrator about this. If you are using the immunisation list supplied by Communicare, this is up-to-date.

If a patient can't be identified by the AIR, error `AIR-E-1026 - Individual information provided is insufficient` is returned. For more information, see Patient details are incomplete or invalid *(on page 648)*.

Each entry includes the following information:

- **Claim ID** - a unique identifier for a given month which together with the date, uniquely identifies an AIR record. If your health service is using batch claims, each item in a batch is assigned the same claim ID.
- **Sent** - a flag showing whether the AIR record has been sent to the AIR or not. After the AIR record has been sent, the immunisation cannot be modified.
- **Date performed** - the date when the immunisation was performed.
- **Claiming Provider** - the provider sent with the record. The provider is selected using the following criteria, in the order listed. If no provider exists for any of the criteria, the record is not submitted.

    - AIR Provider number against the encounter place of the service. If this number does not belong to an actual provider, the encounter place name is shown instead.
    - If no AIR Provider number has been entered against the encounter place, the provider number of the default AIR claimant recorded against the encounter place.
    - If there is no default AIR claimant recorded against that encounter place, the provider number of the provider who recorded the immunisation.
    - If this provider doesn't have a valid provider number for this encounter place, the provider number of any other claiming provider that was on the same service is used.
- **Patient Name** & **Patient Family Name** - the patient's HCH Tier detail is highlighted if the patient is registered for HCH and the tier is recorded.
- **Age**
- **Immunisation description** - the immunisation's clinical item, **Dose** or **Dose (this course)** and any comments.
- **Status** - current status of the AIR record upload. If this is blank, an AIR record has not yet been submitted for this immunisation.

The following patient and provider identifier information is also uploaded to the AIR:

- The patient's IHI
- Information about who administered the immunisation and who entered the data, for both the individual, using the HPI-I, and organisation, using the HPI-O

For more information about identifiers, see HI Service *(on page 632)*.

Filtering the immunisations list

Set filters to limit the number of immunisations displayed.

To filter the immunisation list:

1. Apply one of more of the following filters:
    - **Claim ID** - enter a value to list records that contain only the specified claim ID. Enter as much of the claim ID as required. For example, `P003` returns `P0031@`, `P0031@`... `P0039@`.

      To search for inpatient claim IDs, enter a search term starting with `#`. For example, `#P003` returns `#P0031@`, `#P0032@`...`#P0039@`.
    - **Show sent claim** - set to also display those immunisations that have already been sent to AIR
    - **Encounter Place** - select an encounter place from the list to display immunisations only for a specific Encounter Place
    - **Minor ID** - select a minor location ID from the list to display claims records for that location ID.
    - **Use Time Limit** - by default, only records from the last 6 months are displayed. Deselect to display all records up to 50 years old.
    - **Hide Given Elsewhere** - set to display only those immunisations administered at your health service. Immunisations for which **Administered overseas** was set or for which **Performed at** *your health service* was not set are not displayed. The setting you choose persists when you next open the **AIR Claims** tab.
2. Click **Apply Filters**.

Only those immunisations that meet the filter criteria are displayed.

To display all immunisations again, click **Reset Filters**.

AIR record uploads

After a service is completed, any immunisations with a valid AIR code are submitted to AIR automatically by Communicare without requiring further intervention, independently of any Medicare claims.

If an immunisation is successfully submitted to the AIR, it shows a status of `AIR immunisation sent`.

AIR uploads are sent at the interval and time configured in `CCareQueue_ServicesAustralia.exe`. By default, `CCareQueue_ServicesAustralia.exe` uploads to the AIR at 12pm-2pm daily.

Immunisation uploads that were not completed and are not waiting on confirmation and for which the immunisation details or patient biographics have been updated during the interval configured in `CCareQueue_ServicesAustralia` are also resent to the AIR.

AIR record uploads cannot be initiated manually.

Groups

For AIR uploads, immunisations are grouped in the following way:

- All general immunisations administered at the current encounter place are grouped together by encounter and provider
- Historical immunisations administered within Australia are grouped together by encounter and provider
- Historical immunisations administered overseas are grouped together by encounter and provider
- Immunisations for the same patient are grouped into a single batch if batch claiming is enabled

Each submission contains at most 20 encounters with up to 5 encounters for each service.

AIR upload statuses

The possible claim statuses are:

- `AIR immunisation sent`
- `Claim waiting in queue`
- `AIR Immunisation rejected` - for information about troubleshooting failed or rejected immunisation uploads, see Troubleshooting AIR uploads *(on page 645)*
- `AIR Immunisation needs confirmation` - for information about confirming an immunisation upload, see Confirming immunisation claims *(on page 644)*

Viewing and editing immunisations

From the **Claims Status (Online Claiming) > AIR Claims** tab, you can edit immunisations that haven't yet been sent or view them if they have. Typically, you would edit immunisations that fail to upload.

Select the immunisation you want to view or edit and select one of the following options:

-  **Encounter** - click to open the service record so that you can edit the service associated with the immunisation
-  - click to edit patient details
-  - click to view the progress note associated with the immunisation
-  - click to print out a Medicare online claiming bulk bill assignment of benefit form for the selected patient

-  - click to add an administrative note about the immunisation
-  **Immunisation** - click to open the immunisation clinical item where you can edit any details or add missing information
- **Confirm Immunisation** - for immunisation records rejected for clinical reasons or because a patient was not found, click to confirm that the immunisation is correct and upload to the AIR. For more information, see Confirming immunisation claims *(on page 644)*.

Ensuring an immunisation can be uploaded to AIR

After you have configured your encounter place and Communicare to integrate with the AIR, you must ensure that information is correctly recorded.

Check that immunisations have uploaded to the AIR in **File > Online Claiming > AIR Claims** tab. For more information, see Australian Immunisation Register uploads *(on page 433)*.

If an immunisation record fails to upload to the AIR, check that the following information is recorded correctly.

1. In the patient's biographics, check the following:
    - The patient can be identified by the AIR. For more information, see Patient details are incomplete or invalid *(on page 648)*.
    - The patient name includes only A-Z characters, hyphens (without surrounding spaces), apostrophes, numerics and spaces
    - In the address fields, check the following:
        - The **Line 1** and **Line 2** fields contain only numeric and alphabetic characters and hyphens with no spaces around the hyphen
        - The **Line 1** and **Line 2** fields do not contain `PO Box` or `c/-`
        - The **Line 1** field contains content
        - The **Locality** field has a valid postcode and is not set to **Other / elsewhere**
2. In the immunisation clinical item added to a patient's record, check the following:
    - A value is recorded in either the **Dose (this course)** or **Dose number** field
    - For vaccines that require a serial number, for example, `Comirnaty`, a valid number is recorded in the **Serial Number** field
3. To allow upload to the AIR, each immunisation clinical item must be set up correctly and include a valid export code. For example, `Comirnaty` would have the export code of `COMIRN`.

For more information, see Troubleshooting AIR uploads *(on page 645)*.

Confirming immunisation claims

The AIR will sometimes reject immunisations added in an immunisation clinical item and sent to the AIR.

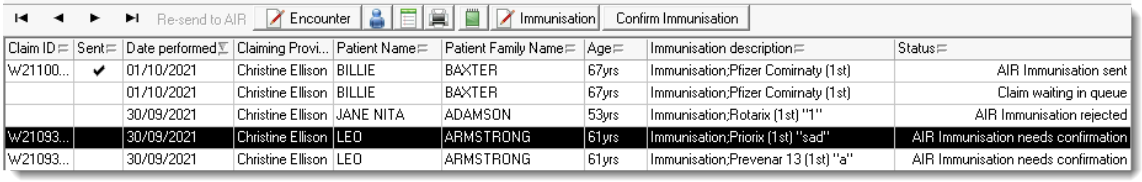
An AIR immunisation record may be rejected for one of the following reasons:

- Patient not found - the details for a patient in Communicare and the AIR don't match or the patient is a newborn baby and does not yet exist in the AIR. If the details are correct, you need to confirm the immunisation details for error `AIR-W-1004 - Individual not found`.
- Clinical - you have recorded a vaccine which is outside the AIR parameters.

Under some circumstances, the AIR will allow you to upload the rejected immunisation record.

To confirm an immunisation record and upload it to the AIR:

1. Go to the **File > Online Claiming > AIR Claims** tab.



2. In the **Status** column, select an attempted upload with a status of `AIR immunisation needs confirmation`.
3. To check that the immunisation record is correct and edit it if required, click **Immunisation**.
4. If the record is correct, in the **AIR Claims** tab, click **Confirm Immunisation**.

The status of the immunisation upload changes to `AIR confirmation waiting in queue`. After it has been uploaded to the AIR the status changes to `AIR immunisation sent`.

If multiple immunisations were included in a service and uploaded to the AIR and more than one needs confirmation, all immunisations with an error are confirmed when one is confirmed. For example, there are multiple immunisations for a 2 month old baby given a first dose of Infanrix Hexa, Rotarix, Prevenar 13 and Nimenrix, that have failed with error `AIR-W-1004 - Individual not found`. They are all confirmed when the first immunisation, Infanrix Hexa, is confirmed.

If you don't confirm an immunisation, it will remain in the `AIR immunisation needs confirmation` status on the **AIR Claims** tab.

After the immunisation has been uploaded to the AIR, you can view it in the **Australian Immunisation Register portal** window *(on page 655)*.

Troubleshooting AIR uploads

Sometimes an upload to the AIR fails and the upload status is set to `AIR Immunisation rejected`. Here you can review the most common reasons why this might happen.

> **Tip:**
> Any errors or warnings returned from the AIR will display a code in the format `AIR-E-XXXX` or `AIR-W-XXXX` on the **File > Online Claiming > AIR Claims** tab, in the **HIC Status Code** column. In the **HIC Status Message** column, a detailed, easy to understand error message is displayed from the AIR. For a list of error and warning codes, see AIR error messages *(on page 650)*.

For immunisations that were not completed and are not waiting on confirmation and have failed to upload to the AIR, check the error returned from the AIR and correct the problem in Communicare. Communicare resends any claims to the AIR for which the immunisation details or patient biographics have been updated during the interval configured in `CCareQueue_ServicesAustralia`, which is the last 24 hours by default.

Immunisation details are incomplete or incorrect

If an immunisation's details are incorrect or invalid, correct them in the immunisation clinical item.

Table 185. Immunisation details incomplete or incorrect

Data	Rule	Code
Vaccine Code	Must be set	AIR-E-1023
	Must be a valid format	AIR-E-1016
Vaccine Dose	Either **Dose (this course)** or **Dose number** must be set	AIR-E-1024
	Must be a valid format	AIR-E-1016
Vaccine Batch Number	If set, must be a valid format	AIR-E-1016
	Required for all COVID-19 vaccinations and some other vaccines, for example, Adacel, Pneumovax 23, Shingrix. Letters in the batch number must be uppercase	AIR-E-1016
Vaccine Serial Number	If set, must be a valid format. Only alphanumeric characters and the following special characters are valid: `! " % & ' ( ) * + , - . / : ; < = > ? _ #`	AIR-E-1016
Date of Immunisation	Must be after the individual's date of birth	AIR-E-1015
	Cannot be a future date	AIR-E-1018
	Cannot be prior to 1 Jan 1996	AIR-E-1022
Dose	The dose given exceeds the maximum allowed by AIR for a course of immunisations for that vaccine **Tip:** The AIR records vaccine doses at the antigen level, not the vaccine brand. Notify the AIR of a dose number based on the number of previous doses of a particular antigen. For example, if the DTP vaccine Infanrix Hexa dose 1,2 and 3 are recorded on the AIR for an individual, and DTP vaccine Tripacel is given at 18 months, Tripacel should be recorded as dose 4, because it is the fourth of a DTP-containing vaccine.	AIR-W-0105
Administered Overseas	Cannot be set if the immunisation was performed here and a value was provided for the immunisation provider including provider number, HPI-I and HPI-O	AIR-E-1070
Duplicate	Duplicate vaccination already exists in AIR	AIR-E-0102

Provider and encounter errors

If a provider or encounter place details are incorrect or invalid, correct them in the reference tables.

Table 186. Provider and encounter errors

Data	Rule	Code
Information Provider Number	Must be a valid format	AIR-E-1016
	Must be comprised of: • Provider Stem – a 6-digit number • 1 Practice Location Character • 1 Check Digit	

Table 186. Provider and encounter errors (continued)

Data	Rule	Code
	If less than 8 characters, the numeric component will be filled with leading zeros prior to validation.	
	If using an AIR Provider Number instead, it must comprise: • State code – alpha in UPPERCASE • 5 digit number • Alpha in UPPERCASE check digit • blank	
	If the checks fail, an error is returned	AIR-E-1017
	Provider number must exist and be current at the receipt date (current date) in the AIR System	AIR-E-1029
Immunisation Provider Number	If set, must be a valid format	AIR-E-1016
	Must be comprised of: • Provider Stem – a 6-digit number • 1 Practice Location Character • 1 Check Digit	
	If less than 8 characters, the numeric component will be filled with leading zeros prior to validation.	
	If using an AIR Provider Number instead, it must comprise: • State code – alpha in UPPERCASE • 5 digit number • Alpha in UPPERCASE check digit • blank	
	Must be provided unless the encounter was given by another provider in Australia or an unknown provider. In this case, the AIR uses a generic history provider number to reflect an unknown provider was involved. This is not the information provider number in the add encounter request.	
	If the checks fail, an error is returned	AIR-E-1017
	Provider number must exist and be current at the date of service in the AIR System	AIR-E-1028
HPI-O Number	If set, must be 16 numeric characters	AIR-E-1016
HPI-I Number	If set, must be 16 numeric characters	AIR-E-1016
School ID	If set, must be a valid format	AIR-E-1016
	Must be a valid school ID	AIR-E-1027
Encounter	Must be a valid value	AIR-E-1017
	Must not be more than maxEncounter value of the claim	AIR-E-1013
	Must be a valid sequential ID commencing with 1.	AIR-E-1041
Claim Sequence Number	Must be set if Claim ID is set. This is a generated sequence, 0 - 9999	AIR-E-1034

Table 186. Provider and encounter errors (continued)

Data	Rule	Code
	If set, must be a valid format	AIR-E-1016
Episode	Must be a valid value 1-5 episodes per encounter	AIR-E-1017
	Must be a valid sequential ID commencing with 1	AIR-E-1014

Patient details are incomplete or invalid

If a patient's details are incorrect or invalid, correct them in the patient's biographics.

Table 187. Patient identification rules

Data	Rule	Error code
Combination of identifiers	If individual information provided is insufficient and the minimum details required were not met, in Patient Biographics, ensure that at least one combination of the following identifiers exists and is validated: • Medicare Card Number, Date of Birth, Last Name • Date of Birth, Post Code, Last Name, First Name • Date of Birth, Last Name, First Name, IHI Number • Medicare Card Number and Medicare Card Individual Reference Number (IRN) • Date of Birth, Post Code, Last Name, only name indicator The AIR prioritises field matching in the order listed. If all fields are submitted, only the minimum fields are used for matching. This applies to adding a planned catch up and when adding an immunisation to the AIR.	AIR-E-1026 `Individual information provided is insufficient`
Combination of identifiers	If an individual does not exist in the AIR, or a combination of the minimum requirements failed validation, an error is returned.	AIR-W-1004
Combination of identifiers for new individuals	Confirmation request for a new individual; minimum details not supplied. For confirmation of a new individual, the following information is required: first name, last name, date of birth, sex, address line one, locality and postcode. For more information, see Confirming immunisation claims *(on page 644)*.	AIR-E-1042
Date of birth	Must be in a valid format	AIR-E-1016
	Must be a valid date	AIR-E-1017
	Must not be in the future	AIR-E-1018
	Must not be more than 130 years in the past	AIR-E-1019
Sex	If set, must be either `Male` or `Female`	AIR-E-1017
Sex mismatch	The sex of the patient recorded in the AIR and Communicare are different. If you receive this error, record antenatal immunisations directly in the AIR.	AIR-E-1089
First name Last name	If included, must only contain alpha, numeric, apostrophe, space and hyphen characters. Spaces must not appear immediately before or after apostrophes and hyphens	AIR-E-1016

Table 187. Patient identification rules (continued)

Data	Rule	Error code
Aboriginal or Torres Strait Islander Status	If set, must be a valid value: • Y - Of Aboriginal or Torres Strait Islander descent (or both) • N - Not of Aboriginal or Torres Strait Islander descent • Only stored if it is supplied, and this is a new individual	AIR-E-1017
Address Line One	If set, must be a valid format. Must only contain alpha, numeric, apostrophe, space, and hyphen characters. Spaces must not appear immediately before or after hyphens. The patient address cannot contain `PO Box` or `c/-`.	AIR-E-1016
Address Line Two	If set, must be a valid format. Must only contain alpha, numeric, apostrophe, space, and hyphen characters. Spaces must not appear immediately before or after hyphens.	AIR-E-1016
	May only be set if line one of the address details is supplied; if Address Line Two is set, Address Line One must first be set.	AIR-E-1037
Postcode	Must be a valid postcode An Administrator can review attempted AIR claims for patients without a valid postcode in the `CCareQueue_ServicesAustralia` log file. Entries will be similar to: `[INF] Skipping air claim... as patient... is missing a post code!`	AIR-E-1043
Locality	Must be a valid format. The patient locality cannot be set to `Other / elsewhere`.	AIR-E-1016
restrictions	If the individual has certain restrictions on their record, an error is returned. Contact AIR for more information.	AIR-E-1058

Table 188. Medicare and identification rules

Date	Rule	Code
Medicare Card Number	If set, must be 9 numbers, and 1 card issue number	AIR-E-1016
	Must be set if Individual Reference Number (IRN) is set	AIR-E-1020
Individual Reference Number	Cannot be set to 0	AIR-E-1017
	If set, must be a valid format	AIR-E-1016
IHI Number	If set, must be 16 numeric characters	AIR-E-1016

Note:
If a patient has a sibling's Medicare number recorded in Communicare, the AIR may upload an immunisation to the wrong sibling's record, despite the Medicare number failing validation. If this occurs, in the AIR portal in Communicare, the immunisation will also be displayed for the wrong sibling. To fix this problem, remove the incorrect Medicare number, which breaks the AIR link to the wrong record.

Planned catch up

If you apply for a planned catch up date, you may see the following errors

- Where a patient is older than 20 years, a catch-up date will not be generated, and the system will return an error of AIR-E-1047
- A catch up date can only be set once per individual
- If the existing catch up date or a generated catch up date is in the past, a warning is returned; AIR-W-1011
- The catch up date is calculated as today + 6 months, or patient's 20th birthday; whichever is earlier
- If the individual has certain restrictions on their record, an error of AIR-E-1067 will be returned; contact AIR for more information

AIR error messages

You may receive any of the following error or warning messages from the AIR that require you to make changes in Communicare.

Note:
These codes are correct at the time of printing but may change. The information displayed in the **File > Online Claiming > AIR Claims** tab, in the **HIC Status Code** and **HIC Status Message** columns, comes from Services Australia and is the definitive reference.

Table 189. AIR error messages

AIR reason code	Message text
AIR-W-0100	Antigen has been administered under the minimum required age
AIR-W-0101	Minimum interval between doses of the same antigen is not met
AIR-E-0102	Check for duplicate vaccination services already in AIR system.
AIR-W-0102	Duplicate antigen dose
AIR-W-0103	Duplicate antigen dose
AIR-W-0104	Minimum interval between doses of the same antigen is not met
AIR-W-0105	Dose is greater than the maximum allowable dose
AIR-W-0106	Higher dose is already administered by the same provider
AIR-W-0107	Dose administered at greater than recommended schedule age
AIR-W-0108	Dose administered under the recommended schedule age
AIR-W-0109	Higher dose is already administered by a different provider
AIR-W-0110	Period between doses of the same antigen is less than 6 months
AIR-W-0111	Period between doses of the same antigen is less than 6 months
AIR-W-0112	Dose is greater than the maximum allowable dose
AIR-W-0113	Dose given at < schedule age 42 months
AIR-W-0114	Dose given at < schedule age 42 months
AIR-W-0115	Antigen has been administered under the minimum required age
AIR-W-0116	DTP dose 4 already given at < 42 months
AIR-W-0300	Duplicate – this service was previously reported by the same provider
AIR-W-0301	Duplicate – this service was previously reported by the same provider
AIR-W-0303	Duplicate history form episode
AIR-W-0305	Greater than 5 episodes given on the same date of service

Table 189. AIR error messages (continued)

AIR reason code	Message text
AIR-W-0334	HepB dose 3 should not be given at less than 15 weeks of age.
AIR-W-0400	Accept and submit to AIR
AIR-W-1001	Encounter was NOT successfully recorded. Correct the details or submit confirmation accepting episode(s) status.
AIR-W-1004	Individual was not found. Correct the individual's details or confirm and accept individual's details are correct.
AIR-E-1005	The request contains validation errors.
AIR-E-1006	An unexpected error has occurred. Please try again shortly. If the problem persists, take a screenshot of the error and email it to AIR.INTERNET.HELPDESK@servicesaustralia.gov.au along with a description of what you were doing at the time the error occurred.
AIR-W-1008	There are encounter(s) that were not successfully recorded. Correct the details or submit confirmation accepting episode(s) status.
AIR-E-1046	There are encounter(s) that were not successfully recorded. Correct the details and submit for processing again or remove the invalid encounter(s).
AIR-E-1058	This individual’s record cannot be viewed or updated at this time.
AIR-W-1059	The immunisation details for this individual cannot be viewed at this time. You can record encounter(s) for this individual.
AIR-E-1062	Some fields in this record may not be available for updating. You can record encounter(s) for this individual.
AIR-W-1010	Catch-up date already exists for the individual.
AIR-W-1011	Catch-up date period has expired.
AIR-E-1012	An error occurred during the assessment of the individual.
AIR-E-1013	The maximum number of encounters has been exceeded.
AIR-E-1014	An error was detected with the episode sequencing. The sequence numbers must begin with 1 and increment by one as each episode is added.
AIR-E-1015	Date of Service must be after individual’s Date of Birth.
AIR-E-1016	Invalid format for field {0}, for data item with value {1}. Check that the immunisation information provided is valid.
AIR-E-1017	Invalid value {0} for field {1}. The data element does not comply with the values permitted or has failed a check digit check. Check that the immunisation information provided is valid.
AIR-E-1018	Date field {0} with value {1} is in future. The date supplied must not be in the future. The service date must be in the past.
AIR-E-1019	Date field {0} with value {1} is more than 130 years in the past. The service date must be within the last 130 years.
AIR-E-1020	Individual’s Medicare card number must be supplied if IRN is set.
AIR-E-1021	Immunising Provider Number must be supplied.
AIR-E-1022	Date of Service is invalid.

Table 189. AIR error messages (continued)

AIR reason code	Message text
AIR-E-1023	Vaccine code is invalid.
AIR-E-1024	Vaccine dose is invalid.
AIR-E-1025	Encounter has more than one episode with an equivalent vaccine.
AIR-E-1026	Individual information provided is insufficient
AIR-E-1027	School ID is invalid.
AIR-E-1028	Immunisation Provider number must exist and be current at the date of submission in the AIR System.
AIR-E-1029	Information Provider number must exist and be current at the date of submission in the AIR System.
AIR-E-1030	Invalid Confirmation flag is set but individual has been matched.
AIR-E-1031	Invalid Confirmation flag is set but individual's Medicare Card details have been provided.
AIR-E-1033	Claim ID must be set if this is a confirmation request.
AIR-E-1034	Claim sequence must be set if Claim ID is set.
AIR-E-1035	Individual not found.
AIR-E-1036	Postcode and Locality combination must be valid.
AIR-E-1037	Address line two can only be set if address line one is provided.
AIR-E-1038	Customer ID {dhs-auditId} must be valid format
AIR-E-1039	Minor ID: {dhs-auditId} is not authorised to perform this action for Information Provider {informationProviderNumber}. Check that the provider is registered with AIR.
AIR-E-1040	Claim ID must NOT be set unless this is a confirmation request.
AIR-E-1041	An error was detected with the Encounter sequencing. The sequence numbers must begin with 1 and increment by one as each Encounter is added.
AIR-E-1042	For confirmation of a new individual, the following information is required, first name, last name, date of birth, gender, address line one, locality and postcode are required.
AIR-E-1043	Postcode {0} is not a valid postcode. Provide a valid postcode for the patient.
AIR-E-1044	Individual's AIR registration is not current at the date of service {dateOfService} or cannot be viewed or updated at this time. Check that the provider is registered with AIR.
AIR-E-1045	Error occurred during assessment of individual.
AIR-E-1047	Catch-up date cannot be generated for individuals over 20 years.
AIR-E-1049	A natural immunity for this disease has been previously recorded.
AIR-E-1050	End date is before start date. For the supplied field {0} with value {1}, is in the past or incorrect. Check the start and end dates.

Table 189. AIR error messages (continued)

AIR reason code	Message text
AIR-E-1051	End date is required for temporary type. For the supplied field {0} with value {1}, the field{0} is earlier than the start date.
AIR-E-1052	Encounter cannot be found.
AIR-E-1053	Immunisation cannot be changed.
AIR-E-1054	Date of Service cannot be updated.
AIR-E-1055	Submission date is invalid (or not matched?).
AIR-E-1056	Date of Service cannot be greater than receipt date.
AIR-E-1057	Individual Identifier is invalid.
AIR-E-1061	Individual Identifier is invalid or has expired.
AIR-E-1063	Information provider {informationProviderNumber} is not authorised to use this service. Check that the provider is registered with AIR.
AIR-E-1064	Details are invalid or you are not authorised to update this encounter.
AIR-E-1065	The Acknowledgement field must be selected to change the Additional Vaccines Required Indicator.
AIR-E-1066	For the supplied field {0} with value {1}, is in the past or incorrect. Check that the immunisation information provided is valid.
AIR-E-1067	This action cannot be performed against the individual's record.
AIR-E-1068	Antigen code is invalid.
AIR-E-1069	{0} or {1} is required. Check that all required immunisation information is provided.
AIR-E-1070	Immunisation provider details should not be supplied for encounters administered overseas.
AIR-E-1079	Country/Region code is required when administeredOverseas is 'true'.
AIR-E-1080	Country/Region code should not be supplied unless administered overseas.
AIR-E-1081	Batch number is mandatory for {0} vaccines.
AIR-E-1082	{0} should not be supplied if {1} is 'true'.
AIR-E-1083	A Medical Contraindication for this disease has been previously recorded.
AIR-E-1084	Invalid code for Vaccine type.
AIR-E-1085	Invalid code for Route of administration.
AIR-E-1086	The values supplied for Vaccine type and Vaccine code are not compatible.
AIR-E-1087	The values supplied for Route of administration and Vaccine code are not compatible.
AIR-E-1088	{0} is mandatory for {1} vaccines. {0} = field name {1} = supplied vaccine code>
AIR-E-1089	The sex of the patient is recorded in AIR as female and as not female in Communicare. If you receive this error, record antenatal immunisations directly in the AIR via HPOS.

Deleting immunisations uploaded to the AIR

Immunisations are recorded in Communicare as clinical items. You can delete immunisations that have been uploaded to the AIR but you must complete additional steps.

Note:
Any immunisation that you delete from Communicare must also be deleted from the AIR if it has already been uploaded.

To delete an immunisation uploaded to the AIR:

1. Check the upload status of the immunisation in **File > Online Claiming > AIR Claims** tab.

   Tip:
   Set **Show sent claims** to also list immunisations that have already been uploaded.

2. In a patient's record, on the **Detail > Immunisation** tab, select the immunisation that was incorrectly recorded.
3. Click **Delete**.
4. On the **Progress Note** tab, for the date on which the immunisation was recorded and its clinical item, add a progress note stating why the immunisation was deleted.
5. Update the patient's immunisation on the AIR site, which may involve contacting Services Australia directly. For more information, see https://www.servicesaustralia.gov.au/how-to-update-encounter-using-air-site-through-hpos.

After the immunisation has been deleted from the AIR site, the AIR Portal in Communicare should be updated.

AIR and Government reporting requirements

For Communicare to be able to transmit immunisation information to the AIR, and to meet national and state reporting requirements the following elements must be complete.

Table 190. Requirements for uploading to AIR and for reporting

Element	Required for transmission to AIR	Required for nKPI, NT AHKPI, NSW KPI reporting
Encounter place configured with AIR Provider number	✓	
Clinical item configured with AIR Export code	✓	✓
`CCareQueue_ServicesAustralia` configured	✓	
Biographics - names Names must include only alphabetic characters and hyphens without surrounding spaces.	✓	
Biographics - addresses Addresses must not include PO Box numbers in line 1 or 2 of the address field. Address names must include only alphabetic characters and hyphens without surrounding spaces.	✓	
Biographics - locality A locality with a postcode number recorded in the patient's biographic	✓	
Biographics - a valid Medicare number		

Table 190. Requirements for uploading to AIR and for reporting (continued)

Element	Required for transmission to AIR	Required for nKPI, NT AHKPI, NSW KPI reporting
Clinical Item - `Immunisation;`*`immunisation brand type`*	✓	
Immunisation qualifier - **Dose this Course** or **Dose Number**	✓	
Immunisation qualifier - **Route and Site**		
Immunisation qualifier - **Performed at this encounter place**		
Immunisation qualifier - **Serial Number** Required for some immunisations such as `Comirnaty`	✓	
Immunisation qualifier - **Vaccine batch (QLD)**	✓	
Immunisation qualifier - **Vaccine batch (all other states and territories)**		
Immunisation qualifier - **Vaccine expiry date**		
Clinical Item - age-based immunisation review completed `Review;immunisation;Birth|2 month age|4 month age|6 month age|12 month age|18 month age|4 year age|50 year age`		✓
Clinical Item - `Immunisation;`*`influenza brand type`*		✓

Australian Immunisation Register portal

View a patient's immunisation information recorded in the AIR from Communicare.

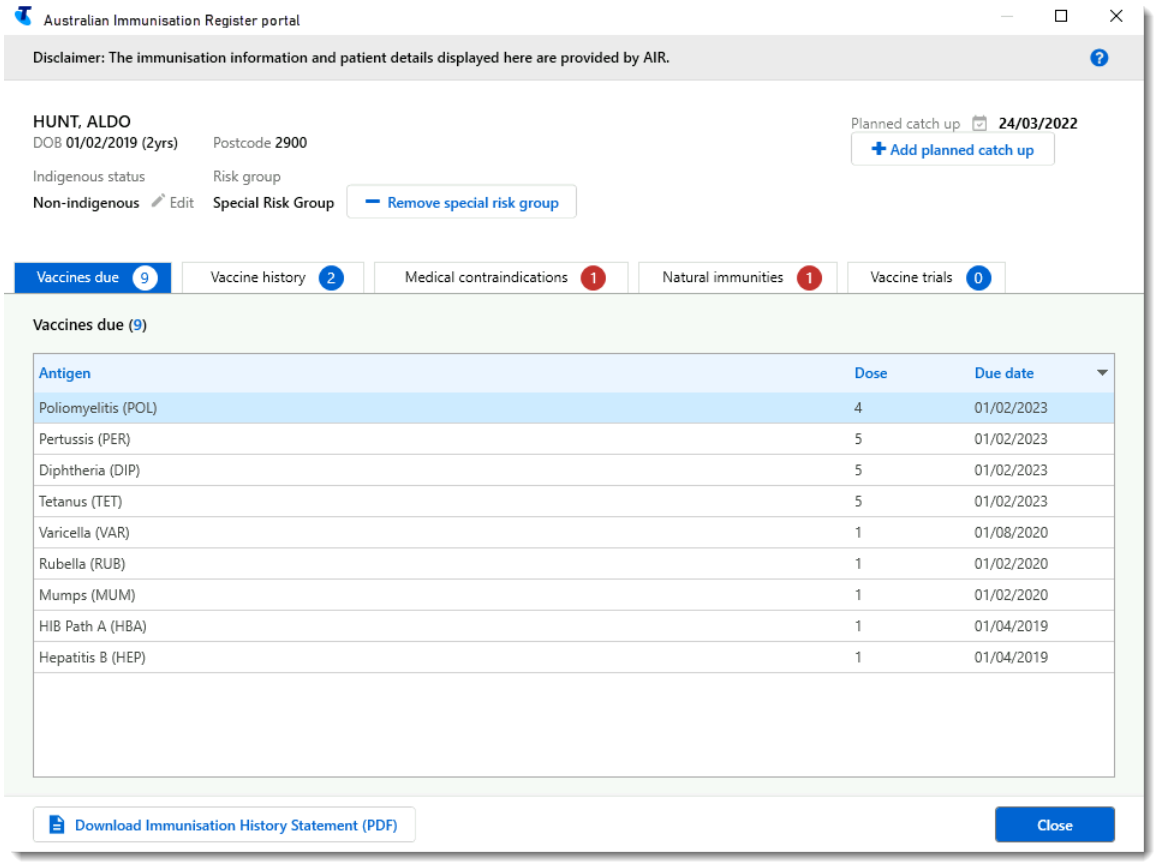
To view a patient's immunisation history recorded in the AIR, you must belong to a user group with the `AIR Patient Integration` system right.

If a patient has any immunisation history recorded in the AIR, you can view their records, even if they do not have a Medicare card, except in the offline client.

> **Note:**
> Communicare displays but does not store information retrieved from the AIR.

To display a patient's immunisation history recorded in the AIR, in a patient's clinical record, select **Go To > Australian Immunisation Register portal**. If your Communicare instance does not have any other integrations, **Australian Immunisation Register portal** is displayed in the main menu of a patient's clinical record.

In addition to personal details, Communicare displays the following information from the AIR in the **Australian Immunisation Register portal** window:



Tip:
You may not be able to see all tabs and edit options. Services Australia determines the immunisation information available to you as an individual provider and whether you can add or update immunisation details.

- **Vaccines due** - an individual's vaccine Due Details as returned by AIR.
- **Vaccine history** - an individual's immunisation history as recorded on the AIR.
- **Medical contraindications** - any medical contraindications that an individual has for particular vaccines and their components recorded on the AIR. The individual is not required to be vaccinated with the contraindicated vaccine, or equivalents, during the recorded contraindication period.
- **Natural immunities** - any natural immunities that an individual has that are recorded on the AIR. A natural immunity may be recorded for a patient if they are *"... assessed by a general practitioner, a paediatrician, a public health physician, an infectious diseases physician or a clinical immunologist as not requiring a vaccination because the individual has contracted a disease or diseases, and as a result has developed a natural immunity"* (Services Australia - *Web Services, Australian Immunisation Register (AIR), AIR Developers Guide, 25 August 2021*).
- **Vaccine trials** - any vaccine trial that the patient is participating in that has been approved by the Department of Health and is recorded on the AIR. The trial only appears on the patient's history for the duration of the trial period. The patient may have participated in historical vaccine trials that do not appear on the AIR.

A count of the number of vaccines recorded for each category is displayed in the tab heading. For example, 2.

If there are any medical contraindications, a count is displayed in red. For example, 2.

Note:
If `Error retrieving information from Services Australia` is displayed, Communicare cannot connect to the AIR and no information is displayed in the **Australian Immunisation Register portal** window. Try again later.

If the AIR indicates that an immunisation action is required for this patient, the **Action Required** banner is displayed. For example, ACTION REQUIRED. For more information, see Updating vaccine history *(on page 659)*.

Tip:
To update information to the AIR, you must belong to a user group with the `AIR Patient Integration Update` system right.

Indigenous status

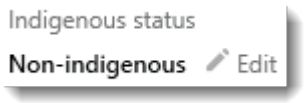
The personal details for the patient recorded in the AIR are displayed in the **Australian Immunisation Register portal** window, including their Indigenous status.

Recording an Indigenous status on the AIR helps vaccination providers to identify and give the clinically correct vaccination schedule. If an individual's Indigenous status is incorrect, you can update it and upload the change to the AIR.

Note:
The Indigenous status recorded in the AIR database is distinct from other Government databases, and can be updated independently of other organisations such as Medicare. In the AIR, an individual's Indigenous status is either *Indigenous* or *Non-indigenous*, there is no further specificity.

To update a patient's Indigenous status:

1. In the **Australian Immunisation Register portal** window, in the **Indigenous status** click **Edit**.



2. In the **Change indigenous status** window, click **Change indigenous status**.

The Indigenous status change is saved and uploaded to the AIR.

Special risk groups

You can flag patients at risk as belonging to a special risk group. For example, preterm babies, and those with chronic health conditions. If a patient is a member of a special risk group, they may require additional vaccines and extra follow up.

Tip:
The current special risk groups are identified in the Australian Immunisation Handbook.

To identify a patient as belonging to a special risk group:

1. In the **Australian Immunisation Register portal** window, click **Add special risk group**.

2. Read the disclaimer from the AIR and click **Add special risk group** to acknowledge it.

The patient is flagged with the *Additional Vaccines Required Indicator* in the AIR.

If a patient is no longer at risk, you can remove the special risk flag: click **Remove special risk group**.

Immunisation history statement

To download a PDF of all vaccines an individual has received that are recorded in the AIR:

1. Click **Download Immunisation History Statement (PDF)**.
2. In the **Save File** window, select where you'd like to save the PDF and specify a filename.

The Immunisation statement is downloaded to the location you selected. View it with a PDF reader.

Australian Immunisation Register portal logging

Updates made in the **Australian Immunisation Register portal** are not recorded in the clinical record in Communicare automatically. However, whenever a change is made, the operation and the user who made the change are logged for audit purposes. The following operations are logged:

- Open **Australian Immunisation Register portal**
- Add planned catchup
- Add special risk group
- Edit vaccine history
- Add medical contraindication
- Add natural immunity
- Edit indigenous status
- Download immunisation statement

To review the logs, run any of the **Report > Audit Logs > Patient record access by...** reports.

Adding a planned catch up vaccination schedule

If a child or other patient is behind in their vaccinations, you can request a catch up schedule from the AIR.

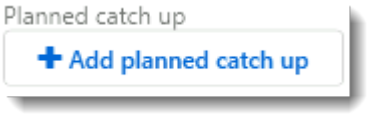
> **Tip:**
> To update information to the AIR, you must belong to a user group with the `AIR Patient Integration Update` system right.

For some Centrelink payments and services such as Family Tax Benefit (FTB) Part A or child care fee assistance, children must be fully immunised. Similarly, adults may require catch up vaccinations because of their health, age, lifestyle or occupation.

"Catch-up vaccination aims to provide optimal protection against disease as quickly as possible by completing a person's recommended vaccination schedule in the shortest but most effective time frame."Australian Immunisation Handbook, https://immunisationhandbook.health.gov.au/catch-up-vaccination

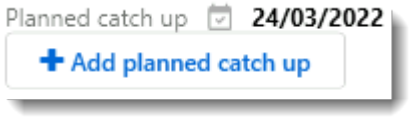
To commence a planned catch up:

1. In the **Australian Immunisation Register portal** window, click **Add planned catch up**.

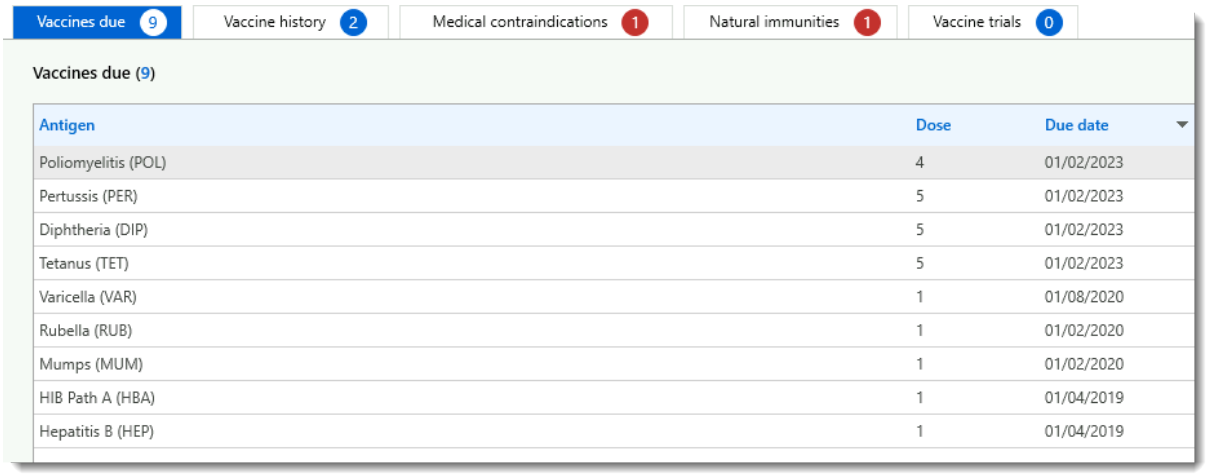


2. In the **Add planned catch up** window, read the disclaimer from the AIR and click **Add catch up date**.

After you have requested a planned catch up schedule, Communicare displays the date from the AIR by which the outstanding vaccinations should be completed.



The individual vaccines due with assigned due dates are listed on the **Vaccines due** tab.



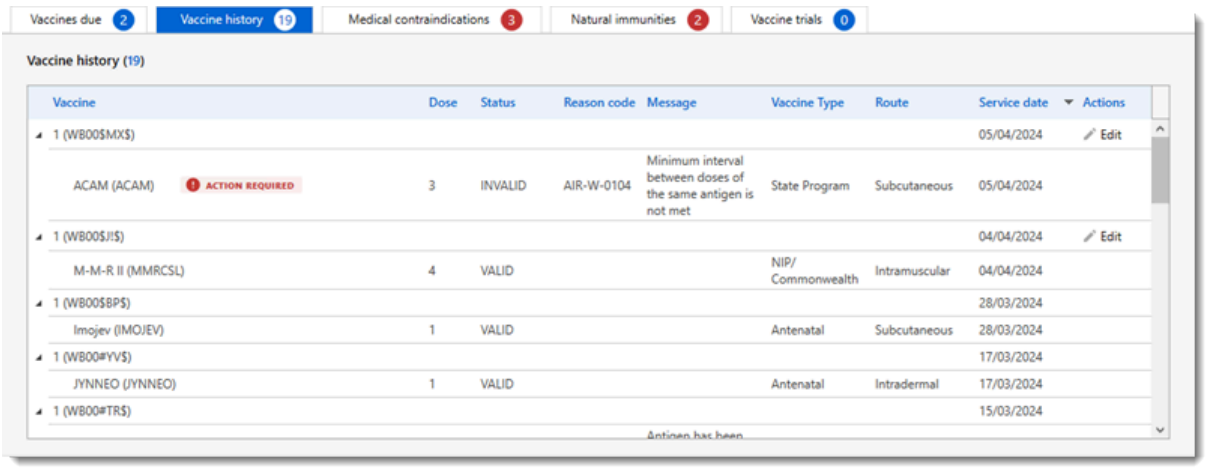
For more information about scheduling catch up vaccinations, see https://immunisationhandbook.health.gov.au/catch-up-vaccination.

Updating vaccine history

If you are a vaccination provider, you can update vaccines recorded by you that have previously been submitted to the AIR, if the AIR flags them as requiring action or as editable.

> **Tip:**
> To update information to the AIR, you must belong to a user group with the `AIR Patient Integration Update` system right.

On the **Australian Immunisation Register portal > Vaccine history** tab, if a vaccine has a status of `Invalid`, it either is only partially processed or it requires clarification from the provider.



Depending on what the AIR requires, you may be able to edit any of the following vaccine information:

- Date of service
- Vaccine
- Vaccine code
- Vaccine dose number

  If a dose is displayed as V for individuals older than 20, the dose number has been adjusted by the AIR.
- Vaccine batch number
- Vaccine serial number
- Route of administration
- Vaccine type
- Antenatal status of the patient

Tip:
The **Actions** column is visible only when the AIR determines that the vaccines from one or more encounters are editable so that a provider can update the vaccines for an individual. If the AIR determines that a provider can edit a vaccine, **Edit** is displayed for that vaccine. If the vaccine has an ACTION REQUIRED `Action Required` banner, the AIR has flagged the vaccine and you must correct its details before it can be resubmitted and processed. Vaccines with a status of `Valid` can be edited at the provider's discretion.

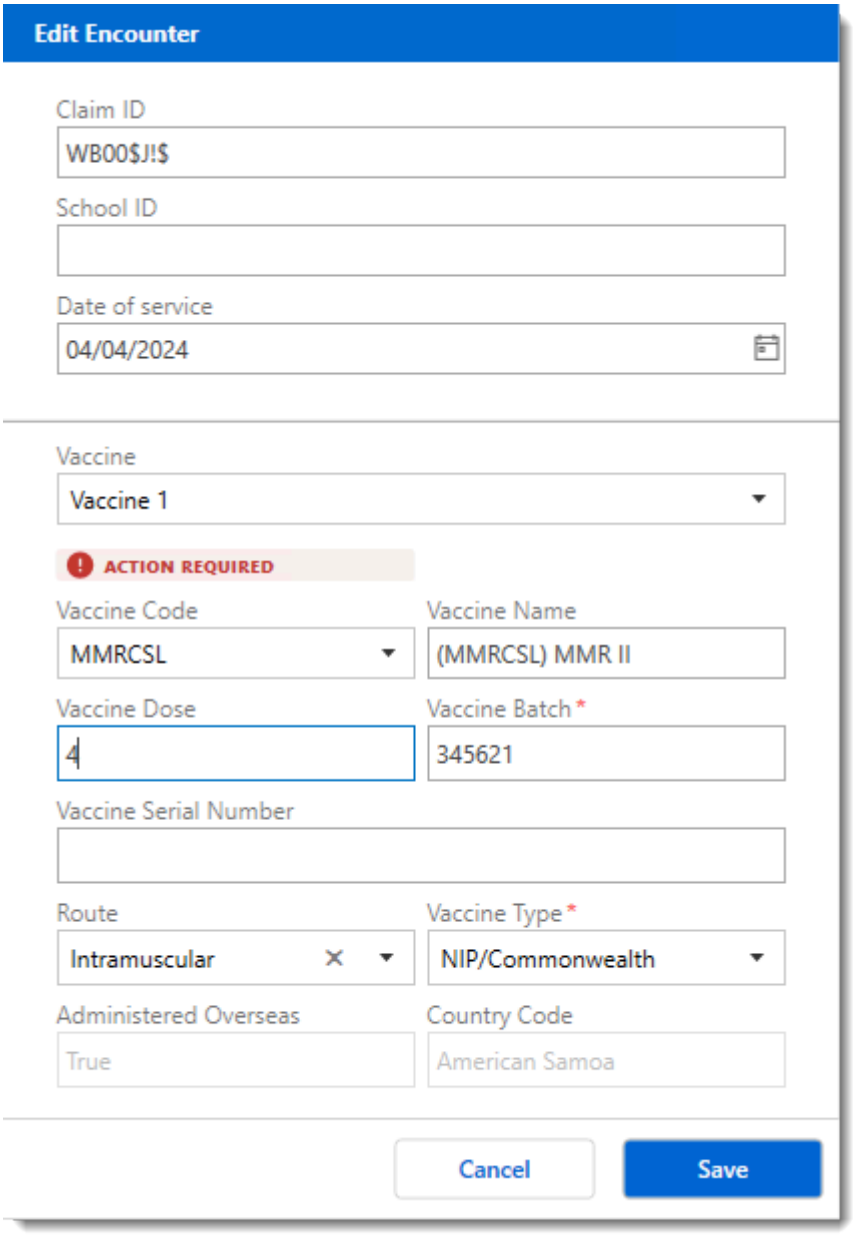
You cannot update vaccines that meet the following criteria:

- Vaccines submitted by other vaccination providers
- Vaccines for which an AIR information payment for completing a schedule has been paid

To update a vaccine:

1. In the **Australian Immunisation Register portal** window, on the **Vaccine history** tab, for an encounter that contains a vaccine with an ACTION REQUIRED `Action Required` tag, or a valid vaccine that can be updated, click **Edit**.

> **Tip:**
> If there are multiple vaccines, take note of their order. Vaccines are listed in reverse order, so the last vaccine listed for an encounter is `Vaccine 1`.



2. In the **Edit Encounter** window, from the **Vaccine** list, select the vaccine you need to update.
   All vaccines that were originally uploaded to the AIR for the encounter that includes the vaccine you need to update are listed.
3. Edit the incorrect vaccine details.
4. Click **Save**.

All vaccines that were originally uploaded to the AIR for the encounter that includes the vaccine you updated are included in the subsequent update to the AIR.

Note:
Neither the patient's clinical record nor the claims status are updated automatically in Communicare.

To ensure that the information recorded in Communicare reflects the information uploaded to the AIR, from the clinical record, edit the immunisation clinical item in the original encounter.

Adding medical contraindications to the AIR

You can add permanent or temporary medical contraindications for a patient to indicate that a patient should not be given a particular antigen.

Tip:
To update information to the AIR, you must belong to a user group with the `AIR Patient Integration Update` system right.

If an individual has a medical contraindication recorded, they are not required to be vaccinated with that vaccine, or equivalents, during the recorded contraindication period, and the Department of Health may consider the individual up to date for certain purposes, such as childcare enrolments or family assistance payments.

Contraindications are considered valid by the AIR in specific scenarios. For example:

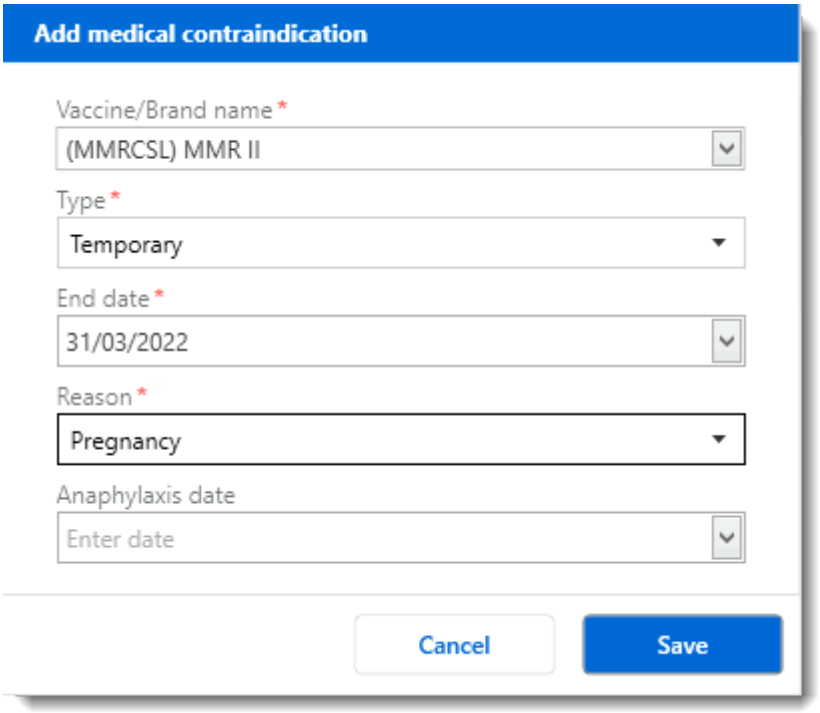
Table 191. Valid contraindication reasons and types

Reason for contraindication	Type
Previous anaphylaxis (to vaccine/vaccine component)	Permanent
Significant immunocompromise (relevant to live attenuated vaccines only)	Permanent
Acute major medical illness	Temporary
Significant immunocompromise of short duration (relevant to live attenuated vaccines only)	Temporary
Individual is pregnant (relevant to live attenuated vaccines only)	Temporary

Note:
The medical basis for vaccine exemption is explained in the The Australian Immunisation Handbook.

To add a medical contraindication:

1. In the **Australian Immunisation Register portal** window, on the **Medical Contraindications** tab, click **+Add medical contraindication**.



2. In the **Add medical contraindication** window, from the **Vaccine/Brand name** list, select the vaccine for which you want to add a medical contraindication.
3. From the **Type** list, select the type of contraindication, either `Temporary` or `Permanent`.
4. For temporary contraindications, in the **End date** field enter an end date for the contraindication period.
5. From the **Reason** list, select why this medical contraindication applies to this patient.
6. If the contraindication is required because of previous anaphylaxis, in the **Anaphylaxis date** field, enter the date of occurrence.
7. Click **Save**.

The medical contraindication is added to the list on the **Medical contraindication** tab and uploaded to the AIR. The individual is not required to be vaccinated with the vaccine, or equivalents, during the recorded contraindication period.

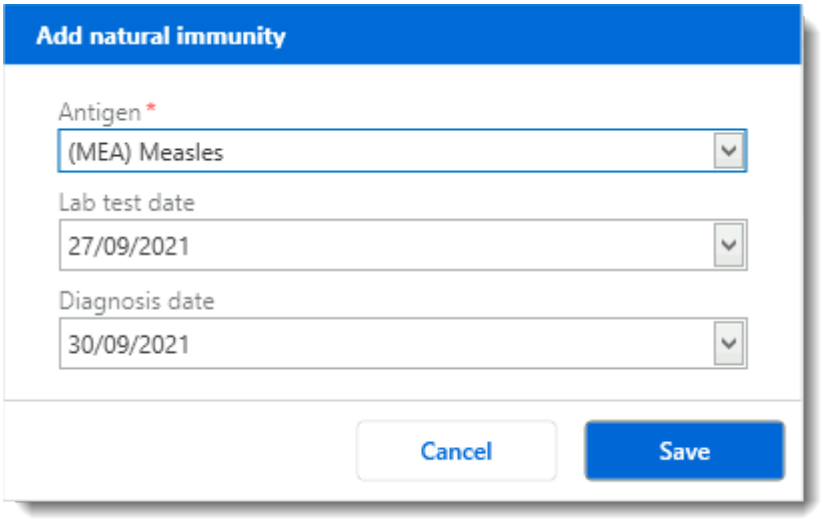
Adding natural immunities to the AIR

Patients may be exempt from an immunisation because they have a natural immunity.

> **Tip:**
> To update information to the AIR, you must belong to a user group with the `AIR Patient Integration Update` system right.

To record a natural immunity:

1. In the **Australian Immunisation Register portal** window, on the **Natural immunities** tab, click **+Add natural immunity**.



2. In the **Add natural immunity** window, from the **Antigen** list, select the antigen to which the patient is immune.
3. If required, you can also add the date at which this immunity was tested or a diagnosis date or both.
4. Click **Save**.

The antigen is added to the list on the **Natural immunities** tab and uploaded to the AIR.

Data Synchronisation

Data Synchronisation (DataSync) enables medical professionals to run clinics and deliver services in some of the most remote and isolated regions of Australia.

Data Synchronisation enables clinics to deliver services offline with up-to-date patient records and information in remote sites or locations where there are challenges with limited internet connectivity.

Remote clinics and sites can operate with as close to real time data as is possible within the limitations of network connectivity, reducing the time taken and internet data used to keep the Communicare database updated across all workstations.

Clinicians take a copy of the data when they go away from the clinic and upload their changes when they come back.

Communicare DataSync synchronises patient data and records with the core Communicare database as required.

Data Synchronisation can also be used as a Disaster Recovery solution if required.

Warning:
Synchronise your offline client back to your core Communicare database daily so that the most up-to-date data is available for the user taking the laptop off-site and offline the next day. The data on your offline laptop is the previous night's backup data and only gets more out of date each day that you don't synchronise your laptop. If you fail to update your offline client, the live data on the database is not a full record for the patients whose information was updated on the offline client. Your Communicare Administator should ensure that the synchronisation completes successfully, and report any problems to Communicare Support.

About DataSync

Communicare's DataSync enables you to deliver clinic services offline and then synchronise your patient information and records with your main Communicare server whenever a network connection is present.

To do this, you will have a local DataSync server that you can access at your practice, which automatically downloads the most current version of your database from your Communicare Server, allowing you to update your workstations locally at your clinic. Each workstation, such as a laptop, with DataSync can then be taken offsite and used in an Offline mode, using the Offline Client to run remote clinics and provide patient services.

When you next return to your clinic or have access to a suitable internet connection and connect to your network, any changes that have been made to patient records in the interim can be uploaded to the central database on the Communicare Server by running the **Synchronise Data** application.

Your clinic's DataSync server:

- Allows you to download and update your Communicare Database on your local network without the need for additional internet connectivity and traffic
- Use the high-speed transfer of a local network to reduce the time taken to update the database on each client workstation.

For example:

1. Millennium Health Service has their main server located in Site A. They have a remote outpost, Site B, that uses laptops offline when conducting remote visits where there is no network connectivity.
2. Each day, provided the Offline Clients upload any new records or information from their laptops, a backup that takes place in the afternoon or evenings with the Communicare Server will add all of the changes that have been recorded to the main clinic's online client information from the day. This new updated database is then downloaded by the Data Sync client in the evening or overnight.
3. Each user can then locally download the most up-to-date version of their entire clinic's patient information easily to their workstation in the evening or the next morning, before they leave again to work offline in another location.

Important:
Any changes uploaded from other Offline Clients and any files changed since the last backup was taken do not appear on the Offline Client until the next backup cycle is complete.

Each Offline Client's changes remain in their workstation database and are available on that workstation until they are included in the next Communicare backup cycle.

Updating the offline database

There are two models for updating the offline database:

- Offline client - each laptop does a full download from the server
- Incremental sideloader - used where the internet connection is slow and unreliable.

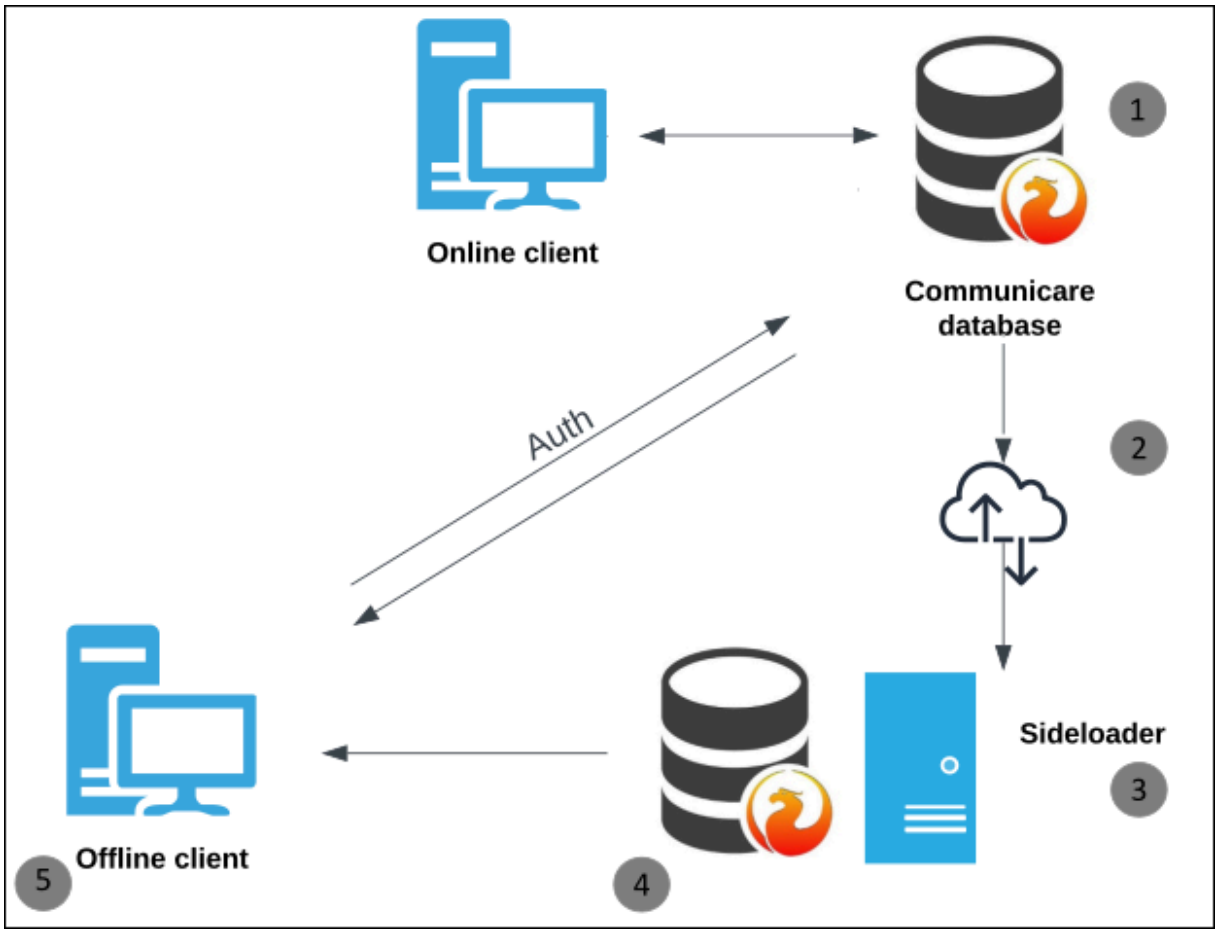
In both cases, the offline client synchronises the data back to the clinic server.

Incremental sideloader

To use the incremental sideloader:

1. The clinic does a differential download from the server (WAN)
2. Each laptop then does a full download from the clinic (LAN)

Data flow:



1. The database server creates a differential backup nightly.
2. The sideloader downloads the differential backup of the database over an internet connection.
3. nbk0 (level 0 backup stays here), nightly nbk1 (level 1 backup download)
4. Sideloader restores the nbk0 + nbk1 files into a usable database (.fdb) which is a logical copy of the database at the time the nbk1 was created (where an nbk1 file exists). Where only an nbk0 exists, the data is current at the time of the nbk0 creation.
5. The offline client streams `Replica.side` from the sideloader and renames it as `Replica.fdb`.

> **Note:**
> The morning after syncing, this database should be roughly the same currency as a database synced directly from the Communicare database as these are created only when the nightly backup runs. Therefore at best the data is approximately 12 hours old at time of syncing.

Using the Offline Client

When healthworkers leave the clinic to work remotely, they should first ensure that the Communicare instance on their laptop is up-to-date.

When you leave the clinic to work remotely, you should use the following workflow:

1. Synchronise data *(on page 667)* from the Communicare Production Server to the laptop.
2. Leave the clinic with the laptop and work offline *(on page 667)*.
3. Return to the clinic and upload changes *(on page 668)* from the laptop to the Communicare Production Server.

Synchronising your data - download

To take Communicare offline and have it function effectively away from the office, the data must first be synchronised to ensure that the offline database is up-to-date and accessible.

> **Warning:**
> Synchronise your offline client back to your core Communicare database daily so that the most up-to-date data is available for the user taking the laptop off-site and offline the next day. The data on your offline laptop is the previous night's backup data and only gets more out of date each day that you don't synchronise your laptop.
> If you fail to update your offline client, the live data on the database is not a full record for the patients whose information was updated on the offline client.

To synchronise your data:

1. On your laptop, click **Synchronise Communicare** or if you are already logged into Communicare, select **Tools > Synchronise with Server**.
2. If you are logging in, in the **Communicare Login** window, enter your username and password in the relevant fields and select your organisation from the list. You may also be asked for a workstation location.
3. In the **Synchronise Communicare** window, if a backup has been recently completed, you will get the following message: `There is no new backup available to synchronise with.` You don't need to synchronise with the server. Otherwise the backup will start.
4. After the backup has been completed, click **Start download**.
5. After the download has completed, click **Start Offline Communicare** to open Communicare in offline mode.

> **Note:**
> Ensure that you log into Communicare using the offline client before you leave your health service so that you know everything is working correctly.

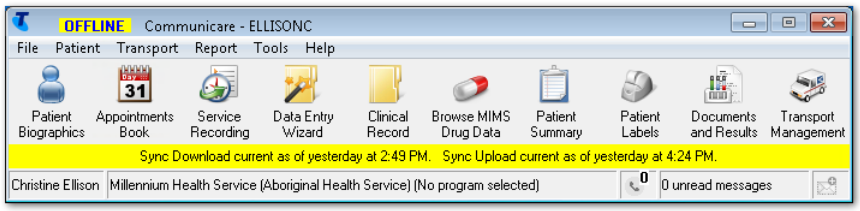
Working offline

> **Note:**
> Following the installation of DataSync, new users wanting to start using Communicare offline will need to first log in to their online version of Communicare, complete a backup (this can be requested through Support if it's not possible to wait for the usual overnight backup process), and then synchronise their data once the backup cycle has been completed, otherwise their user ID and password will not be recognised in the offline database.

To work offline:

1. On your laptop, double-click **Communicare Offline**.
2. The Communicare Login window shows `Working Offline` and the date and time of the replica you are using. Login using your usual credentials.

After login is completed, your Communicare toolbar is displayed, showing the current replica in use.



Tip:
When working in the Offline Client, the date of the last synchronisation with the server is displayed in the main toolbar.

- `Sync Download current as of xxxxx` shows the most recent date that the database finished downloading and restoring from the server.
- `Sync Upload current as of xxxxx` shows the date when local changes were last uploaded to the server.

Synchronising your data - upload

Data is synchronised between a laptop running the offline Communicare client and the core Communicare server if a patient's record has been changed since the last time the laptop was synchronised with the server.

When you return to an office or internet connection, the offline client needs to upload its changed data (patient records and visit information) to the Communicare core production server and synchronise offline to online. The program will check if there is data to upload, whether there is a new version of Communicare available and if there is a new data to download.

The Data Synchronisation Client can only be used in conjunction with the server it originated from. For example, if your site has multiple servers it will not be able to install a Data Sychronisation Client from Server 1 and then upload changes to Server 2. You will always have to come back to Server 1 to synchronise changes.

Note:
Depending on the speed of the connection and the volume of data, the new data loaded into the system after synchronisation may not appear immediately after uploading. If the new data is still not available online a few hours after synchronising, contact Communicare Support who will be able to provide an update or resolve this for you.

To upload your data:

1. On your laptop, click **Synchronise Communicare** or if you are already logged into Communicare, select **Tools > Synchronise with Server**.
2. If you are logging in, in the Communicare Login window, enter your username and password and select your organisation. You may also be asked for a workstation location.

3. The Synchronisation program opens and detects any changes that occurred while you were offline. To synchronise the data from the offline client to the server, click **Upload data to server**.

   > **CAUTION:**
   > **Do not click Discard data. Information entered offline will be irretrievably lost.**

4. When the synchronisation is complete you will see the message `Your data was uploaded successfully`. Click **Close**.

Synchronising Communicare performs a data export on the laptop and sends this data to the server. The server places the changes in a queue which means that your changes will not appear in Communicare on the server immediately after you have finished uploading your changes. The import runs at a lower priority on the server. The busier your server is, the longer it will take for your changes to appear.

> **Note:**
> If the synchronisation does not successfully complete, report the problem to Communicare Support.
>
> Your Communicare Administrator should check `\\Communicare_installation\Results` for any files older than 24 hours. If there are old files, report the problem to Communicare Support.
>
> The server will prepare a database every evening and this will be available for DataSync Clients to download the next day. Changes uploaded from other DataSynch Clients and indeed any changes made since the database was created, will not appear on the Data Synchronisation Client.

If there is a new database available for download, you will be presented with an option to download it manually. You would typically do this in the morning before you go offline.

> **Tip:**
> If you want to leave your laptop in the clinic overnight and have it download the updated database automatically when it is ready, click **Wait for new backup and download when available**. Your laptop will then be ready to take offline in the morning.

Offline client functionality

Most features in Communicare work in offline mode just as they do in the standard operating environment. However, without an active connection to the internet, there are certain third-party related services and features, and some standard features that cannot function.

Features with limited or no support are listed in the following table. If a feature is not listed, it is expected to be fully functional.

Table 192. Features that are limited or not supported in the offline client

Feature	No Access	View Only	Impact
Address Book Management	X		You cannot edit the address book
Adverse Reactions		X	You cannot delete adverse reactions
Appointment Book	X		You cannot book an appointment

Table 192. Features that are limited or not supported in the offline client (continued)

Feature	No Access	View Only	Impact
Biographics			You cannot amend patient current status, manage payer, or change information sharing status
Bulk Bill wizard	X		You cannot bulk bill patients in real time
Change Password	X		You cannot change a password
Clinical Items		X	You cannot delete clinical items
Communicare Data Updater	X		Do not run the Data Updater in the offline client. An internet connection is required.
Documents			You cannot browse documents. However, you can write a new letter and scan a new document. In V21.2 and later, you can generate the following My Health Record documents if the OfflineClient.EnableMyHealthRecord system setting is enabled: • eDischarge Summary • eReferral • Shared Health Summary • Event Summary Contact Communicare Support for more information.
ePrescribing	X		You cannot create ePrescriptions in the offline client. All ePrescription options are disabled and the prescription type defaults to `Printed Prescription` when you finalise prescriptions. However, you can reprint tokens for ePrescriptions prescribed previously when the user was online.
Find Duplicate Patients	X		You cannot find duplicate patients
HealthLink SmartForms		X	You can view SmartForms that have already been submitted, but cannot create or submit new SmartForms, edit parked SmartForms or delete SmartForms
HI Service		X	Health Identifier entry is disabled
Immunisation Claims			You cannot make AIR claims
Import Medicare Number file	X		You cannot import the Medicare number file
Imprest Management	X		You cannot manage your Imprest or Imprest orders
Medications - Administer & Supply	X		You cannot record administration or supply of a medication order
Medications - Consolidated Orders	X		You cannot create or manage consolidated orders
Merge Patients	X		You cannot merge patient records
My Health Record		X	You cannot register patients or access any My Health Record functionality except to generate My Health Record related documents, as described in the Documents *(on page 670)* row.

Table 192. Features that are limited or not supported in the offline client (continued)

Feature	No Access	View Only	Impact
NCSR	X		You cannot see NCSR alerts or access the NCSR Hub from Communicare in the offline client.
Online Claiming			You cannot claim a service that has not been entirely created offline
Pathology & investigation results		X	You cannot match and review patient results
Private Billing Administration	X		You cannot manage invoices and associated transactions for privately billed services
System Parameters	X		You cannot update system parameters
Transport	X		You cannot book transport
User Groups	X		You cannot add or edit user groups

Data Synchronisation rules

Patient data changed in the offline Communicare client is synchronised with the core Communicare database.

The Data Synchronisation Client will consider a health record changed if:

- The clinical record has been opened for that patient since the last time the laptop was synchronised.
- A clinical item has been recorded using the Data Entry Wizard *(on page 165)* since the last time the laptop was synchronised.
- A patient's biographic details have been opened in the Patient Biographics *(on page 30)* since the last time the laptop was synchronised.

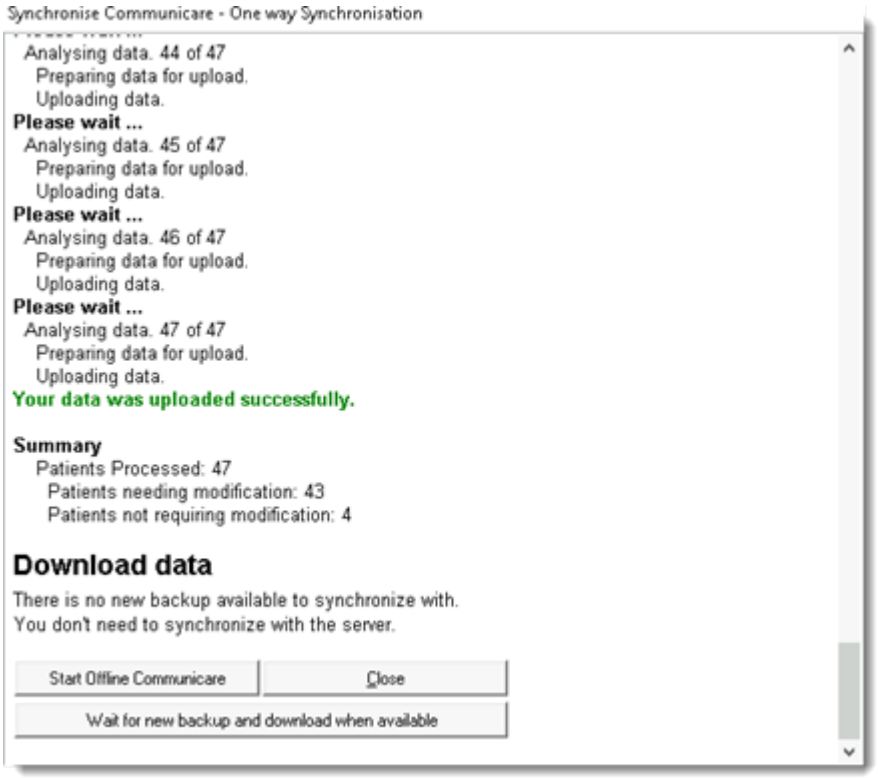
Note:
You cannot delete clinical items from a patient's record in the offline client. The deletion of clinical items is not supported in the Data Synchronisation Client.

You can however, delete prescriptions, regular medications, letters, scanned documents, and investigation requests and results in the offline client.

Data Export Rules

The export mechanism will generate one XML file with the entire electronic record of a patient for each patient record that is deemed to have changed since the last time it was synchronised.

A summary is displayed when synchronisation is complete, showing how many records have been updated.



The patient data that is exported to XML includes:

- Patient Biographics (excluding patient status changes)
- Clinical Items
- Care Plans
- Prescriptions
- Documents
- Progress notes
- HIC claims
- Investigation requests

The generated XML includes all reference table definitions for the exported clinical items, so that the electronic health record can be imported to another clinic. The reference data exported includes:

- Encounter places used
- Clinical Item Types used with the attached measurements and keywords
- Providers used

Note:
You cannot export investigation results, including data related to reviewing or other editing of results. You can read results but not receive or review results in the offline version of Communicare.

Data Import Rules

Electronic Health Records can arrive into Communicare in three ways:

- Data Synchronisation Client uploading changed health records
- Manual import of a patient from a different system
- Updated Health Records coming from another server via Server to Server synchronisation

Regardless of how the electronic health record arrives into Communicare, a strict set of rules is always obeyed when importing the health record. In order to describe these rules we use the following conventions:

- The XML file containing the record we are about to import is called "Source".
- The Communicare database to which the record will be imported is called "Target".
- The modified timestamp of a record in Source XML is called "SMT" and it is stored as a UTC value.
- The modified timestamp of a record in Target database is called "TMT" and is stored as a UTC value.

These are the rules followed by the data import:

- If a Source patient is not found in Target, then it will be inserted with the entire Health Record.
- If a Source patient is found in Target and the SMT is greater than the TMT, then it will update Target patient.
- If a Source patient is found in Target and the SMT is less than or equal to the TMT, then it will not update Target patient.
- If a Source reference record is not found in Target, then it will be imported. If the record is from another Server, it will, in most cases be imported with a modified description that will contain the 'site id' of the originating site - 'A description' becomes 'A Description[XXX]' where XXX is the 'site id' of the Source Server.
- Central data items distributed by Communicare are not updated and they will be matched based on primary key.

Additionally, there are rules which are applied to fields within a record:

- If a Source field is null it will not be imported into Target (except for the case where the rule for patient encounter import below takes precedence above this rule).

Special rules apply when importing patient encounter data. This rule takes precedence above all other rules for patient encounter import.

- The more advanced patient encounter record is retained, while the less advanced patient encounter record is thrown away. For example, if Source encounter has status `Booked` while the Target encounter has status `Finished`, no change is made to the target encounter. However, if Source encounter has status `Finished` while the Target encounter has status `Booked`, Target is overwritten with Source.
- The rank of an encounter status from least advanced to most advanced is:
    1. `Booked`
    2. `Cancelled`
    3. `Waiting`
    4. `Withdrawn`
    5. `Started`, `Paused`, `Finished` are equally ranked
- Only when the status of the encounter is the same for both Source and Target is the next rule applied.

Important Data Import Issues

Table 193. Data import issues and resolutions

Issue	Resolution
Use of datasets with enrolment and exit items (e.g. HACC, Drug and Alcohol)	Where items depend on a single enrolment and a single exit, make sure that the enrolment and exit items are recorded only once, preferably on the Server database.
Pregnancy starts	Make sure that pregnancy starts for a specified pregnancy number are recorded only once.
Reference Tables	Changes to reference tables are not imported during Data Synchronisation, hence editing reference tables is disabled.
Patient matching	If a patient is added to the Source and the Target, the two records will be matched based on Name, Date of Birth and Sex. If these fail to match, a duplicate patient record is created. To avoid this situation, make sure this information is as complete and accurate as possible. **Note:** Medicare number is not used in this matching process.

Installing Offline Clients

DataSync tools keep the Offline Clients and Communicare production server synchronised. Administrators should install an Offline Client to any laptop that is taken off site.

These instructions assume that the Communicare Production Server is on-site and that the clinic and any Offline Clients are updated using the same LAN.

Note:
The version of the Communicare Production Server and of the Offline Client must match.

To install a Communicare Offline Client to a laptop:

1. On the laptop, uninstall any previous versions of the client.
2. On the Communicare Production Server, navigate to `C:\Installation_files\CCare`.
3. Copy the following files from the Communicare Production Server to the client machine:
    - `CCareSetup.exe`
    - `CCSetup.ini`
    - `Communicare`
    - `Setup.exe`
4. On the laptop, right-click `Setup.exe` and select `Run as Administrator`.

The entire Communicare database is copied to the laptop.

The **Communicare Offline** shortcut is added to the desktop.

To ensure everything is working correctly, users should synchronise their data and log into **Communicare Offline** at the clinic before they go offline. For more information, see Using the Offline Client *(on page 667)*.

When internet access is available, each Offline Client connects to the internet to upload its latest XML file of database changes to the Communicare Production server. This process happens automatically when the Client runs **Synchronise Communicare** on each workstation that has been used offline. DataSync uses a naming convention for the XML file similar to the following, `CCRepl YYYY-MM-DD 14-05-36-127 _ 00005228-0B63.xml`.

Using DataSync for disaster recovery

DataSync can be used to provide a disaster recovery solution.

As with most disaster recovery solutions, there are some limitations about the data and services that can be retained in some situations.

When using Communicare's DataSync feature as a disaster recovery solution, recovery of any data is limited to the data which was current from the most recent backup file sent to your local DataSync server. Typically this would contain all patient record updates from the previous day.

Important:
Any data not backed up to your Communicare Server will not be available for use when operating a disaster recovery solution until online client functionality or a Production Server environment is restored, and both the server's and clients' DataSync settings are configured as required, enabling synchronisation to take place.

Currently, the following approaches are supported for your Communicare implementation business continuity.

Table 194. Approaches for using DataSync as a disaster recovery solution

Approach	Application	Information
Spare local laptop or desktop with Offline Client installed	Simple, small-scale client implementations	This requires a spare local laptop that is synchronised daily with the most recent Communicare production server backup. Any new data from other local machines created since the last upload will not be available with this solution. When operations are ready to resume, the offline client can then synchronise any offline date to the production server and all other local machines can then continue operating as usual.
A local disaster recovery server with DataSync installed becomes the Communicare production server	More complex organisations or those with mobile users who are already using DataSync to support their business operations	Provides a close to fully functional Communicare production server solution. Requires a DataSync server that meets the minimum requirements. Any new data from online local machines created since the last backup cycle will not be available. However, with a Support request, all workstations in the Local Network can be configured to switch to using the DataSync server as the temporary disaster recovery server. Any data held in offline clients can be uploaded after online functionality is restored.

Table 194. Approaches for using DataSync as a disaster recovery solution (continued)

Approach	Application	Information
A secondary production server to fail over to if the primary production server goes down	Complex organisations with Communicare installations at multiple sites	This can be implemented in a number of ways. For example, having a live, mirrored Communicare production server; or depending on infrastructure and connectivity, scheduling intra-day backups to a secondary server, resulting in minimal data loss in the event of a disaster.

DataSync support

Check this list of commonly asked questions and answers relating to the use of Communicare DataSync before contacting Communicare Support.

Table 195. DataSync FAQ

Problem	Answer
Why won't my user name and password work when I try to log into the Offline Client?	If you've only just been given a login to Communicare, your username and password may not have been updated in the Offline Client yet. This is because the Offline Client uses the data from the most recent backup that has been downloaded. To correct this, contact Support or your local administrator and request a manual backup.
I didn't receive a notification that my offline client files were uploaded.	1. Log into Communicare Online and search for a record or information that would relate to your latest upload. 2. If you cannot connect, check your internet connection is active. 3. If the results are still missing, run **Synchronise Communicare** again. 4. If your updates are still missing, contact Communicare Support for further assistance to resolve this for you.
My database update didn't work.	1. Check your internet connection. 2. Check your user login details. 3. Check the disk space. 4. Confirm there is a new download available.
I need to leave for a clinic & can't wait to download the morning backup.	The information from the last remote, offline clinic will still be available on the laptop that was last used for that clinic, so taking the same laptop for that clinic is the easiest option if there isn't time to download the consolidated backup of the database. However, ensure you synchronise the laptop as soon as possible.
There is new information from this morning that I need offline this afternoon.	Contact Communicare Support to manually request a backup throughout the day. **Note:** This could impact the performance of the Communicare system while the backup completes.

Table 195. DataSync FAQ (continued)

Problem	Answer
Can patient information be compromised by other laptops using DataSync?	Generally, there shouldn't be any patient information related issues. However there may be gaps in patient data until each Offline client has run the **Synchronise Data** application. If you have any specific concerns because of information you are expecting to be available, ask your Communicare Administrator to check the **Synchronisation Results** folder for any records that may have failed to update and to see if they can be resolved with the clinician or user who updated the information.

Key Performance Indicators

Health service management personnel can collate, analyse and report on National Key Performance Indicators and state-based Key Performance Indicators using Communicare.

Note:
You can make National Key Performance Indicator (nKPI), Online Services Reports (OSR) and Health Care Provider (HCP) submissions from Communicare, using the Government Reporting Tool *(on page 754)*.

Data can also be reviewed at any time using the following Communicare report suites:

- **Report > nKPI**
- **Report > OSR**
- **Report > Health Care Providers**

For state-based reports:

- In New South Wales, run the reports in **Report > NSW KPI**.
- In the Northern Territory, run the reports in **Report > NT KPI**. For more information, see NT AHKPIs *(on page 473)*.

Data requirements

To use Communicare for reporting on Key Performance Indicators, the following data requirements must be met:

- Conditions are coded using the central ICPC2-Plus dataset
- Prescriptions are recorded using the prescribing module which relies on the MIMS Pharmaceutical database
- Medicare claims are bulk-billed and use the Communicare electronic claims module
- Pathology results are delivered electronically using HL7 results with appropriate coding returned by the lab
- Common qualifiers that may be recorded as point of care testing or transcribed results, for example, from a hospital discharge document, use the central qualifiers. If your health service departs from the central dataset (for example, to record an ACR or GFR) it is your responsibility to transcribe the associated system code or export code if the concept remains the same. For reference qualifiers, such as smoking status, attention must be made to each reference's system and export code.
- For state-based reporting, the health service is already configured for National KPI reporting and needs only to consider state indicators that have no nKPI equivalent. Wherever possible, given the definitions, data collection requirements are common across the KPI reports.

National Key Performance Indicators

Use this information to assist with the Indigenous primary health care key performance indicators (nKPI) and Online Services Report (OSR) reporting within Communicare.

This document outlines the way in which information recorded in Communicare is identified for each indicator to enable health services to advise users on how best to ensure the most accurate recording of data for the National Key Performance indicators (nKPI) and Online Services Report (OSR) reports.

Demographics overview

Only those patients who meet the required Indigenous status, record status, patient status, age, or address are included in the reporting for supported encounter modes and contact types.

Indigenous status

National Key Performance Indicator reporting almost exclusively reports on patients who are recorded as being Indigenous. In Communicare this means that they have an Indigenous Status recorded in their biographics of one of the following:

- `Aboriginal but not Torres Strait Islander`
- `Torres Strait Islander but not Aboriginal`
- `Both Aboriginal and Torres Strait Islander`

Any exceptions are stated in the definition for that specific indicator.

OSR reporting is disaggregated by Indigenous Status. In these reports the following mapping is done:

- `Aboriginal & Torres Strait Islander` - includes all patients with one of the above statuses recorded in their biographics.
- `Non-Aboriginal` - any patient with an Indigenous Status of `Neither Aboriginal nor Torres Strait`
- `Not Recorded` - any patient where the Indigenous Status is `Not stated/inadequately described` or `Not applicable`.

Note:
For OSR reporting, fictitious patients are excluded. Patients who died before the end of the reporting period are counted if they had any activity during the report period. Non-patient records are included to record group activity and contacts made with patients who do not normally attend this health service. For the purposes of disaggregation by Indigenous Status, all non-patients are recorded as `Not Recorded`.

Record status

For the AIHW definition of a *Regular Client* this status is determined by looking at the contacts made with a patient in the two years preceding the end of the report period. In Communicare, a patient's status must be one of the following:

- `Current`
- `Transient`
- `Past`
- `Banned 30 days`
- `Banned 60 days`

Patients who have a Communicare patient status of `Fictitious` (either at the time the report is run or at the end of the report period) are excluded. Patients who had a Communicare patient status of `Non-Patient` at the end of the report period are also excluded.

Only services that have started are included: services with a status of `Started`, `Paused` or `Finished` are included. Services with the following statuses are excluded:

- `Booked`
- `Cancelled`
- `Waiting`
- `Withdrawn`

Additionally, services with the following modes are excluded:

- All `no client contact` modes
- `Administration – client contact`

If a patient has at least three such services in the two years preceding the end of the report period and they were still alive at the end of the report period, then they are deemed to be a regular client. However, see the comments in the Residence section below relating to the patient's home address at the end of the report period and how this relates to use of the Locality Group parameter in Communicare reports.

OSR reporting does not use the *Regular Client* status. All patient records are included except Fictitious patient records. Non-patient records are included but reported with an Indigenous Status of `Not Recorded`.

Patient status

For nKPI reporting, all patients with a status of `Non-Patient` are excluded even if they have three visits in the previous two years.

For OSR reporting, the `Non-Patient` status is treated in the following way:

- If the patient record has an MRN of #GROUP, group activity will be counted but not in the contacts, episodes or individuals reports.
- If the patient record has an MRN of #ANON, any activity is disregarded. This means that the patient record is for anonymous activity and any age, sex or Indigenous status will be unknown so the data cannot be disaggregated.
- If the patient record does not have an MRN of either #ANON or #GROUP, activity will also be disregarded.

To assist in the identification of any existing Non-Patient records where the addition of either #ANON or #GROUP is needed, refer to the report at **Report > OSR > Non-Patient Analysis**.This report should eventually report three main sections (if anonymous or group activity is recorded at the health service):

- Group activity record: an example is UNIDENTIFIED CLIENTS. If the patient ID has an asterisk, this is currently being used for group activity.
- Anonymous patient record: examples might be NEEDLE EXCHANGE, MALE or WALKIN, UNKNOWN.
- Other non-patient records: these should all be real people but who only attend the health service for specific purposes other than their main health care, such as, dental only patients or ITC patients referred from a private GP for supplementary services. If they should be included in the nKPI reports and the OSR reports, their status must be changed from non-patient.

Tip:

Only use the `Non-Patient` status for the following reasons:

- To record biographic details of a carer who is responsible for a patient of the health service but who does not attend for their own health care
- To record a real patient who may attend the health service for a single purpose, such as a dental clinic, but who belongs to another health service and does not require any other health service delivery, such as health check reminders, blood tests, chronic disease management, and so on.
- To record anonymous services such as group information sessions, anonymous needle exchange, health promotion events, and so on.

Residence

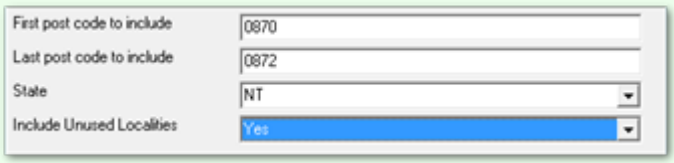
A patient must have had a home address at the end of the report period. What this means is that a patient added after the end of the report period will not be included even if they have backdated service activity.

When the Locality Group filter is used for any of the Communicare reports the patient list is filtered to those patients whose home address locality at the end of the report period was within the defined list of localities that make up that locality group. It is important that the locality groups defined at the health service are accurate and inclusive. To help you review your locality groups run the following reports:

- To print a list of all localities within all locality groups, run **Report > Reference Tables > Locality Groups**. Maintenance to these lists is done at **File > Reference Tables > Locality Groups**.
- To look for omissions and mistakes, run **Report > Reference Tables > Locality Group Analysis**.

Tip:

Run this report with a range of post codes that covers your health service area completely.



The resulting report will show all locality groups and indicate which localities belong to multiple or no such groups. Maintenance to these lists is done at **File > Reference Tables > Locality Groups**.

Age groups

The default nKPI age groups are:

- 0-4 years
- 5-14 years
- 15-24 years
- 25-34 years
- 35-44 years
- 45-54 years

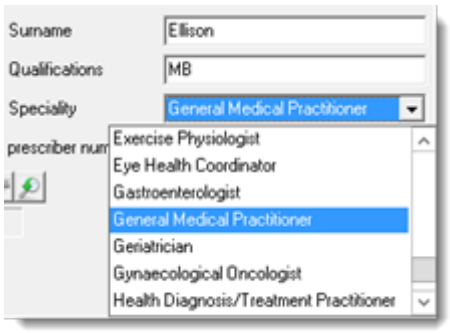
- 55-64 years
- 65+ years

Where stated in a specific indicator these may vary. For example, child immunisation age groups differ as do antenatal care age groups.

Age is calculated at the end of the report period (unless a specific indicator states otherwise). Patients who died during the preceding two years but who have had three valid services recorded will be excluded.

Contact types

OSR reporting requires disaggregation of provider types when reporting on contacts. In Communicare, a provider type is in recorded in Communicare in the Provider reference table: in **File > Providers**, select the provider type from the **Speciality** list.



For information about how the Communicare speciality is mapped to the OSR contacts report, see Client Contact Types reference *(on page 698)*

Note:
Services provided exclusively by a Transport Worker (as recorded in Communicare in the Provider reference table) are excluded from the OSR Episodes of Health Care report.

Encounter modes

Services recorded for most encounter modes where there is patient contact are included in nKPI and OSR reports.

Table 196. Encounter modes

Encounter Mode	Consultation Delivery	Description	Included in reports	Automated patient status updates?
Aboriginal Health Service	In person	Use to record a clinical consultation where the patient attended the clinic.	nKPI and OSR	Yes
Administration - client contact	Administrative - in person	Use to record that although the health service has seen the patient it was not for a clinical reason.	None	Yes
Administration - no client contact	None	Use to record administrative work for a patient.	None	No

Table 196. Encounter modes (continued)

Encounter Mode	Consultation Delivery	Description	Included in reports	Automated patient status updates?
Clinical administration – client contact	Administrative - in person	Client contact that is more clinically focused than `Administration - client contact`.	nKPI and OSR **Note:** Inclusion in reports may be affected by provider type.	Yes
Clinical administration – no client contact	None	Clinical administration, for example: • Updating clinical history - allergies, past medical, surgical. Gynae history, family and social history • Referrals – child health, dietitian, allied health, social work, GP, OT, exercise physiologist, pharmacist • Applications – My Aged Care, MASS, Centrelink, Lions Club equipment • Immunisations – history, data entry, documentation verification • Pathology – follow up and organising treatment • Notifications – schools, GP, hospital, discharge planners • Discharge planning	None	No
Client's Home	In person	Use to record where workers from the health service deliver services at the client's home. Use instead of creating a separate encounter place for each client.	nKPI and OSR	Yes
Clinic - Consult	In person	Use to record a clinical consultation where the patient attended the clinic.	nKPI and OSR	Yes
Commercial setting (eg pharmacy)	In person	Use to record where workers from the health service deliver services at a business such as a pharmacy. Use instead of creating a separate encounter place for each business.	nKPI and OSR	Yes

Table 196. Encounter modes (continued)

Encounter Mode	Consultation Delivery	Description	Included in reports	Automated patient status updates?
Community Health Centre	In person	Use at community health centres to record a clinical consultation where the patient attended the health service.	nKPI and OSR	Yes
Community Services Centre	In person	Use to record where workers from the health service deliver services at a Community Services Centre. Use instead of creating a separate encounter place for each centre.	nKPI and OSR	Yes
Contact Attempt Unsuccessful - no client contact	None	Use to record attempted contact.	None	No
Court	In person	Use to record where workers from the health service deliver services at court. Use instead of creating a separate encounter place for each court.	nKPI and OSR	Yes
Day Aged Care Centre	In person	Use to record where workers from the health service deliver services at a day aged care centre. Use instead of creating a separate encounter place for each centre.	nKPI and OSR	Yes
Day Procedure Centre (Free-standing)	In person	Use at day procedure centres to record a clinical consultation where the patient attended the centre.	nKPI and OSR	Yes
Dental Room	In person	Use to record a clinical consultation where the patient attended a consulation in the dental room.	nKPI and OSR	Yes
Dispensary - no client contact	None	Use to record dispensary work for a patient.	None	No
Drug and Alcohol Agency	In person	Use at drug and alcohol agencies to record a clinical consultation where the patient attended the health service.	nKPI and OSR	Yes
Health Care Practitioner Office (any discipline)	In person	Use to record a clinical consultation for a health care practitioner that does not fit any other category.	nKPI and OSR	Yes
Health Service	In person	Use for non-indigenous health services to record a clinical consultation where the patient attended the health service.	nKPI and OSR	Yes
Hospital - All types	In person	Use in hospitals to record a clinical consultation where the patient attended the hospital.	nKPI and OSR	Yes

Table 196. Encounter modes (continued)

Encounter Mode	Consultation Delivery	Description	Included in reports	Automated patient status updates?
Hospital - Emergency Department	In person	Use in hospital EDs to record a clinical consultation where the patient attended the ED.	nKPI and OSR	Yes
Hospital - General Practice	In person	Use in hospital-based general practices to record a clinical consultation where the patient attended the practice.	nKPI and OSR	Yes
Hostel	In person	Use to record where workers from the health service deliver services at a hostel. Use instead of creating a separate encounter place for each hostel.	nKPI and OSR	Yes
Inreach	In person	Use to record inreach consultations.	nKPI and OSR	Yes
Mobile Clinic	In person	Use to record where workers from the health service go out in a mobile clinic to deliver services. Use instead of creating a separate encounter place.	nKPI and OSR	Yes
Nursing Home	In person	Use to record where workers from the health service deliver services at a nursing home. Use instead of creating a separate encounter place for each centre.	nKPI and OSR	Yes
Other	In person	Use to record where workers from the health service deliver services at a service encounter or physical place that is not otherwise described, read "Other means" or "Other service delivery mode".	nKPI and OSR	Yes
Outreach	In person	Use to record where workers from the health service go out into the community to deliver services. Use instead of creating a separate encounter place.	nKPI and OSR	Yes
Prison	In person	Use to record where workers from the health service deliver services at a prison. Use instead of creating a separate encounter place for each prison.	nKPI and OSR	Yes
Renal Dialysis Centre (Free-standing)	In person	Use to record where workers from the health service deliver services at a freestanding renal dialysis centre. Use instead of creating a separate encounter place for each centre.	nKPI and OSR	Yes

Table 196. Encounter modes (continued)

Encounter Mode	Consultation Delivery	Description	Included in reports	Automated patient status updates?
Respite Care Facility (non-Hostel or Nursing Home)	In person	Use to record where workers from the health service deliver services at a respite care facility. Use instead of creating a separate encounter place for each facility.	nKPI and OSR	Yes
School	In person	Use to record where workers from the health service go to a school to deliver services. Use instead of creating a separate encounter place for each school or youth club.	nKPI and OSR	Yes
Supported residential accommodation	In person	Use to record where workers from the health service deliver services at supported residential accommodation. Use instead of creating a separate encounter place for each centre.	nKPI and OSR	Yes
Telehealth Video	Video conferencing	Use to record services where the contact between the Communicare provider and the patient was using video conferencing.	nKPI and OSR	Yes
Telehealth - Provider	Telephone or by another device such as a computer, with or without video	Use to record remote telehealth consultations during the COVID-19 pandemic.	nKPI and OSR	Yes
Telehealth - Recipient	Facilitator only	Use where a consultation happened between a provider elsewhere and a patient, such as between a specialist and patient at a hospital, and the Communicare provider only facilitated the contact by providing a room and remote conferencing equipment.	nKPI and OSR	Yes
Telephone	Telephone	Use to record a clinical consultation performed over the telephone between the Communicare provider and the patient.	nKPI and OSR	Yes

The following services are generally excluded:

- Any `no client contact` service.
- The contact service of `Administration - client contact`.
- `Waiting`, `Booked` or `Cancelled` services.
- Services provided by providers with a speciality of `transport worker`.
- Services recorded using the `Transport` module.
- Services recorded for fictitious clients.

Identifying data required for nKPI reporting

The nKPI reports extract data from clinical items in patient records and Medicare claims.

Conditions

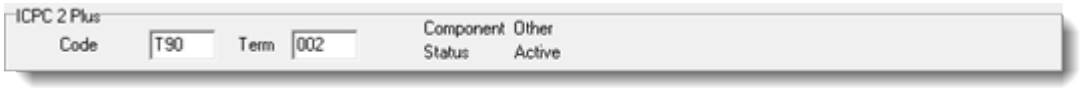
Many of the performance indicators depend on recognising patients because of a documented condition. This is done by referencing ICPC codes attached to the Communicare condition clinical items.

System administrators can review ICPC codes.

To review codes for a single condition:

1. Select **File > Reference Tables > Clinical Item Types**.
2. In the **Clinical Item Type Maintenance** window, double-click an item and click **Advanced**.

The ICPC code and term are listed in the **ICPC 2 Plus** section.



To review all items with the same or similar codes:

1. In the **Clinical Item Type Maintenance** window, right-click and select **Show Hidden Columns**.
2. Scroll to the right to find the **ICPC Code** column and click the header to order by ICPC code.

Type No	Description	Class	Topic	ICPC Code	ICPC Term
2000003640	Diabetes;non insulin depend	Condition	Endocrine, ...	T90	005
2000003717	Diabetes;adult onset	Condition	Endocrine, ...	T90	007
2000003719	Diabetes;Type 2	Condition	Endocrine, ...	T90	009
2000008342	Diabetes;Type 2;insulin tre...	Condition	Endocrine, ...	T90	016
2000009839	Hyperglycaemia (diabetic)	Condition	Endocrine, ...	T90	019
2000002696	Beri Beri	Condition	Endocrine, ...	T91	001
2000004044	Deficiency;nutritional	Condition	Endocrine, ...	T91	002
2000004051	Deficiency;vitamin	Condition	Endocrine, ...	T91	003

Tip:
To move a column, click and drag the header.

Conditions are recorded in Communicare by adding a clinical item of type `Condition` to the patient. For chronic conditions the date of diagnosis is disregarded. For some conditions, if specified, the date of diagnosis will be required to be within the report period.

Note:
Conditions added to a patient record have no status other than `Complete`, so all such items are considered to be confirmed. Any informal comment that may indicate that the condition is not yet confirmed are disregarded.

For details of which ICPC codes are referenced for specific indicators, check the indicator.

Procedures and immunisations

Because health services may have configured local ways of documenting specific procedures and immunisations, the reports will often look for a system code or, more often, an export code. Review codes in the same way as ICPC codes *(on page 686)*.

Because both procedures and immunisations can have a status of `Recall`, `Cancelled`, `Incomplete` or `Complete` the indicator will consider the status. In most cases the status must be `Complete` in order to be counted, but for some indicators, such as **PI04 (immunised children)**, recalls are considered as well. See each indicator for details.

System codes

Three-character system codes are often used within Communicare to identify clinical items to the Communicare program but are also used for identifying items for reporting. For example, AHC is used to identify annual adult Aboriginal health checks.

> **Note:**
> No local items should have system codes unless they have been verified as suitable and correctly identify the item.

To review system codes:

1. Select **Report > Reference Tables > System Codes and Rule Codes**.
2. To review local items, use the following settings:
    - From the **Item or qualifier** list, select `Clinical Items`.
    - From the **Item or qualifier** list, select `Local Only`.
3. To review central items, use the following settings:
    - From the **Item or qualifier** list, select `Clinical Items`.
    - From the **Item or qualifier** list, select `Central Only`. To review both local and central items, select `<All>`.

For details of which system codes are referenced for specific indicators, check the indicator.

Export codes

Export codes are used exclusively for reporting. They can be up to eight characters in length. For example, CST is used to identify procedures that are evidence of a cervical screening or equivalent having been performed.

For immunisations, the codes used as export codes are the AIR immunisation codes. For example, VAXGRP identifies an adult Vaxigrip immunisation when reporting on influenza immunisations.

Review codes in the same way as ICPC codes *(on page 686)* or run **Report > Reference Tables > System Codes and Rule Codes**

For details of which system codes are referenced for specific indicators, check the indicator.

Qualifier codes

Qualifiers are attached to clinical items, and are used in Communicare to capture detailed data relating to such things as blood pressures, HbA1cs, ACRs, eGFRs, and so on. Because qualifiers can also be locally defined, we use system codes and export codes to formally identify them for reporting purposes. For example, an HbA1c recorded as percent has a system code of HBA; for HbA1cs recorded in mmol/mol, a system code of HBM is used.

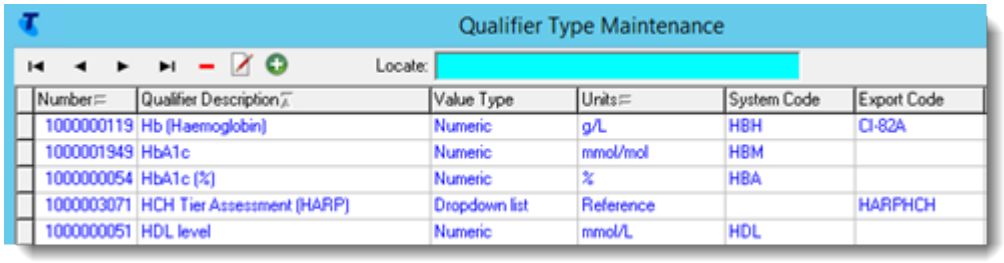
Note:
Local qualifiers must be are reviewed for both system and export codes.

To review codes for a single qualifier:

1. Select **File > Reference Tables > Qualifier Types**.
2. In the **Qualifier Type Maintenance** window, double-click an item.

The system code is listed in the **System Code** field.

To review all system and export codes, in the **Qualifier Type Maintenance** window, right-click and select **Show Hidden Columns**.



To generate a report of qualifier system codes:

1. Select **Report > Reference Tables > > System Codes and Rule Codes**.
2. To review local qualifier codes, use the following settings:
    - From the **Item or qualifier** list, select `Qualifiers Items`.
    - From the **Item or qualifier** list, select `Local Only`.

Medicare claims

Where an indicator refers to evidence of a Medicare claim for a specific item or items, the data is collected on the patient encounter, often referred to in Communicare as a *service*.

For inclusion in both nKPI and OSR reporting, the claim has only to be selected to be included. The following statuses are included:

- `Selected`
- `Sent`
- `Accepted` (which is interpreted as paid)
- `Rejected`

Claims that have been discarded by the local claims administrator are excluded from reporting. Claims can be discarded only following rejection by Medicare.

To assess if a patient has a specific item claimed within a specific time period:

- In the clinical record, click **Claims**.
- In the **Service Record** window, on the **Medicare** tab, click **MBS Items History**.

Condition codes reference

Find the active ICPC-2 PLUS condition codes for NKPI reporting here.

Diabetes

A patient is recognised as having Type II diabetes if they have a condition recorded with the ICPC code of T90. The date of diagnosis is disregarded.

As of December 2021, the active ICPC2-Plus terms for Type II diabetes used for nKPI reporting are:

Table 197. Diabetes included terms

Condition subgroup	Code	Clinical term
TYPE 2 DIABETES	T90005	Diabetes non insulin depend
	T90007	Diabetes adult onset
	T90009	Diabetes Type 2
	T90016	Diabetes Type 2 insulin treated
UNSPECIFIED DIABETES	T90002	Diabetes mellitus

To find all terms, use **Report > Reference Tables > Clinical Item Groups**. Use the following parameters:

- **Clinical Item or Group** - `<All Clinical Items and Groups>`
- **ICPC Code** - `T90`

COPD

COPD diagnoses are recognised from the ICPC code of R95 or R79. As of December 2021, the active ICPC2-Plus terms used for nKPI reporting are:

Table 198. COPD included terms

Condition subgroup	Code	Clinical term
CHRONIC BRONCHITIS	R79002	Bronchiolitis chronic
	R79003	Bronchitis chronic
COPD	R95001	Chronic obstr airways disease
	R95002	Chronic obstr pulmon disease
	R95004	Chronic obstr lung disease
	R95008	Chronic airways limitation
	R95009	Chronic airways disease
EMPHYSEMA	R95006	Emphysema

To find all terms, use **Report > Reference Tables > Clinical Item Groups**. Use the following parameters:

- **Clinical Item or Group** - `<All Clinical Items and Groups>`
- **ICPC Code** - `R95` or `R79`

CKD

Chronic Kidney Disease diagnoses are recognised from the following ICPC and ICPC2-Plus codes: U99, U88, U85001.

As of December 2021, the active ICPC2-Plus terms used for nKPI reporting are listed below.

Table 199. CKD included terms

Condition subgroup	Code	Clinical term
CKD 3	U99037	Chronic kidney disease stage 3
	U99037	Disease kidney chronic stage 3
	U99043	Disease kidney chronic stage 3A
	U99044	Disease kidney chronic stage 3B
CKD 4	U99038	Chronic kidney disease stage 4
	U99038	Disease kidney chronic stage 4
CKD 5	U99039	Chronic kidney disease stage 5
	U99039	Disease kidney chronic stage 5
DIALYSIS	U59001	Dialysis;kidney (renal)
	U59008	Haemodialysis
Kidney transplant	U28001	Renal transplant

CVD

Cardiovascular disease diagnoses are recognised from the following ICPC and ICPC2-Plus codes: K89, K90, K91, K92, K74, K75, K76, K52008, K53003, K53007, K53009, K53010, K54007, K91011, K91014, U99028.

As of December 2021, the active ICPC2-Plus terms used for nKPI reporting are listed below.

Table 200. CVD included terms

Condition subgroup	Code	Clinical term
ACUTE CORONARY SYNDROME (ACS)/ ANGINA	K74001	Angina pectoris
	K74002	Pain angina
	K74004	Unstable angina
	K74006	Insufficiency coronary
	K74007	IHD with angina
	K74008	Acute coronary syndrome
	K74008	Acute coronary syndrome
CAROTID ARTERY STENOSIS	K91014	Stenosis artery carotid
	K91014	Stenosis, artery, carotid
	K91016	Disease carotid
CEREBROVASCULAR DISEASE	Code unavailable	Lacunar stroke
	Code unavailable	Migrainous stroke
	K22	Personal history of cardiovascular disease (Risk factor for CVD incl)
	K89008	Insufficiency vertebrobasilar
	K89011	Insufficiency cerebrovascular
	K90002	Cerebrovascular accident

Table 200. CVD included terms (continued)

Condition subgroup	Code	Clinical term
	K90004	Haemorrhage;subarachnoid
	K90006	Haemorrhage cerebral
	K90010	Infarction cerebral
	K90011	Occlusion cerebral
	K90012	Paralysis poststroke/CVA
	K90017	Stroke
	K90018	Thrombosis artery cerebral
	K90018	Thrombosis;artery;cerebral
	K90020	Embolism;cerebral
	K90025	Paresis poststroke/CVA
	K90026	Hemiparesis post stroke/CVA
	K91006	Disease cerebrovascular
	K91007	Cerebral artery aneurysm
	K91008	Occlusion precerebral
	K91009	Ischaemia cerebral
	K91010	Stroke/cva old
	K91011	Stenosis arterial precerebral
	K91012	Thrombosis artery precerebral
	K91013	Embolism;precerebral
	K91014	Stenosis;artery;carotid
	K91015	Atherosclerosis cerebral
	K92018	Embolism, arterial
CEREBROVASCULAR DISEASE - TIA	K89001	Transient ischaemic attack
	K89004	Vertebral artery syndrome
	K89005	Basilar artery syndrome
	K89008	Insufficiency basilar
	K89015	RIND syndrome
CORONARY HEART DISEASE	K74006	Insufficiency coronary
	K74007	IHD with angina
	K75004	Occlusion coronary
	K75008	Thrombosis artery coronary
	K76005	Disease atherosclerotic heart
	K76008	Ischaemia myocardial chronic
	K76011	Disease ischaem heart subacute
	K76013	Coronary artery disease
	K76013	Coronary heart disease

Table 200. CVD included terms (continued)

Condition subgroup	Code	Clinical term
	K76014	Disease ischaemic heart
	K76015	Disease ischaem heart chronic
	K76018	IHD without angina
	K76019	Atherosclerosis coronary
	K92007	Occlusion arterial
	K92022	Stenosis artery
	K92024	Atherosclerosis
	K92025	Arteriosclerosis
	K92028	Insufficiency vascular
	K92030	Atherosclerosis aorta
	K92031	Disease small vessel
	K75009	Embolism artery coronary
MYOCARDIAL INFARCTION	K75001	Infarction heart
	K75002	Infarction myocardial acute
	K75010	Infarction impending
	K75011	Postmyocardial infarct syndrome
	K75013	Infarction myocardial
	K75014	Heart attack
	K75015	Myocardial infarction STEMI
	K75016	Myocardial infarction non STEMI
	K76006	Infarction myocardial healed
	K76006	Infarction myocardial old
PERIPHERAL VASCULAR DISEASE (PVD)	Code unavailable	Arteriosclerosis obliterans
	K92003	Disease peripheral vascular
RENAL ARTERY STENOSIS	Code unavailable	Stenosis artery renal
SURGERY - CARDIOVASCULAR - CAROTID	K52008	Endarterectomy internal carotid
	K53007	Stent(s) carotid
	K91016	Disease carotid
SURGERY - CARDIOVASCULAR - CORONARY	K53003	Angioplasty;artery;coronary
	K53009	Stent(s)coronary
	K54007	Graft coronary artery bypass
SURGERY - CARDIOVASCULAR - RENAL ARTERY	U99028	Renal artery stenosis - Stent

Procedure, Immunisation, Pathology & Medicare codes reference

Find the active ICPC-2 PLUS Procedure, Immunisation, Pathology and Medicare codes for NKPI reporting here.

Annual Health Assessments

Currently (February 2018) annual health assessments are only referenced in nKPIs by the associated Medicare claim (715, 228, 92004, 92016, 92011, 92023).

For OSR reporting the following System Codes are referenced on clinical items only whenever a patient has no claim for Medicare item 715 (or 228, 92004, 92016, 92011, 92023):

- AHC for adult annual health checks
- CHC for child annual health checks
- OHC for over-55s annual health checks

Care Plans

Currently (February 2018) care plans are only referenced in nKPIs by the associated Medicare claim (721 721, 229, 92024, 92068, 92055, 92099).

- The System Code used to identify care plan assessments is CPA.
- The System Code used to identify Team Care Arrangements is TCA.

Pregnancy and Cervical Screening Items

These Rule Codes are referenced:

- PR-CHECK – any procedure identified by this rule code will be deemed to be an antenatal check. By checking the pregnancy number and then looking for an explicit gestation or by comparing with the pregnancy outcome, the trimester in which the first antenatal check was performed can be calculated.

These Export Codes are referenced:

- CST, HPV, LBC - any procedure that is evidence that a cervical screening test, human papillomavirus or liquid based cytology has been performed.

Substance Use (Drug and Alcohol) Items

These Export Codes are referenced:

- DA-ENROL – identifies a formal enrolment to a course of drug and alcohol treatment. If this clinical item has a reference qualifier with an export code of 'DA-TDS' where a reference with an export code of 2 has been recorded then the treatment is deemed to be residential.
- DA-EXIT – formally marks the end of a period of drug and alcohol treatment.
- DR-ENROL – identifies the start of a period of respite for patients receiving drug and alcohol treatment.
- DR-EXIT - formally marks the end of a period of respite.
- DA-SUOS – identifies an occasion of sobering up during an overnight stay

Immunisations

Influenza immunisations are recognised using the Export Codes on clinical items of type `Immunisation;`*`brand code`* for the GNFLU vaccine and its equivalents, described in Equivalent and partial equivalent vaccines table - GNFLU entry. For example, GNFLU, PANVAX, FLUVAX, and so on. These vaccines may change annually.

Note:
Listed in the Non-standard vaccines and Equivalent and partial equivalent vaccines tables are:

- COVID-19 vaccines. For example, AstraZeneca COVISHIELD (ASTCOV), Bharat Biotech Covaxin (BHACOV), Pfizer Comirnaty (COMIRN), Immunisation;Pfizer Bivalent (COMBIV), AstraZeneca Vaxzevria (COVAST), Gamaleya Sputnik V (GAMSPU), Moderna Spikevax (MODERN), Moderna Bivalent Spikevax (MODBIV), Novavax NUVAXOVID (NOVNUV), Sinovac Coronavac (SINCOR).
- Monkey Pox vaccines. For example, ACAM2000 (ACAM), Generic Smallpox (GNPOX), JYNNEOS (JYNNEO).
- Japanese Encephalitis vaccines. For example, Imojev (IMOINT), IXIARO (IXIARO).
- Meningococcal vaccines. For example, MenQuadfi (MENQDF).

For customers using the Immunisation Vaccines dataset, example codes include:

- **Immunisation;flu, GNFLU**
- **Immunisation;influenza, GNFLU**
- **Immunisation;Afluria Quad, AFLR**
- **Immunisation;Afluria Quad (NIP), AFLQUA**
- **Immunisation;Afluria Quad (Non-NIP), QUADAF**
- **Immunisation;Agrippal, AGRPAL**
- **Immunisation;Flucelvax Quad, FCELQD**
- **Immunisation;Fluzone High-Dose Quad, FLHDQD**
- **Immunisation;Fluarix, FLRIX**
- **Immunisation;Fluarix Tetra, FLUTET**
- **Immunisation;Fluarix Tetra (NIP), FLXTET**
- **Immunisation;Fluarix Tetra (Non-NIP, ARXFLU**
- **Immunisation;Fluad, FLUAD**
- **Immunisation;Fluzone High-Dose, FLUHID**
- **Immunisation;Fluad Quad, FLUQAD**
- **Immunisation;Fluarix Tetra, FLUTET**
- **Immunisation;bioCSL Fluvax, FLUVAX**
- **Immunisation;Fluvirin, FLVRN**
- **Immunisation;FluQuadri Junior, FQDJN**
- **Immunisation;FluQuadri, FQUAD**
- **Immunisation;Fluvax Junior, FVXJNR**
- **Immunisation;Influvac Tetra, INFLTA**
- **Immunisation;Influvac, INFLUV**
- **Immunisation;Panvax (H1N1 Influenza), PANVAX**
- **Immunisation;Panvax (H1N1) 0.25ml, PANVAX**
- **Immunisation;Panvax (H1N1) 0.5ml, PANVAX**
- **Immunisation;Vaxelis, VAXLIS**
- **Immunisation;Vaxigrip, VAXGRP**
- **Immunisation;Vaxigrip Tetra, VAXTET**
- **Immunisation;Vaxigrip Junior, VGRJNR**

Immunisation Reviews

Immunisation reviews must be named as indicated here (case insensitive):

- Starts with REVIEW;IMMUNISATION;6 MONTH
- Starts with REVIEW;IMMUNISATION;12 MONTH
- Starts with REVIEW;IMMUNISATION;18 MONTH
- Starts with REVIEW;IMMUNISATION;4 YEAR

Export codes were introduced for June 2018 reporting and are included here for health services who wish to name their immunisation review items differently:

- **IMRV-BIR** REVIEW;IMMUNISATION;BIRTH
- **IMRV-02M** REVIEW;IMMUNISATION;2 MONTH
- **IMRV-04M** REVIEW;IMMUNISATION;4 MONTH
- **IMRV-06M** REVIEW;IMMUNISATION;6 MONTH
- **IMRV-12M** REVIEW;IMMUNISATION;12 MONTH
- **IMRV-18M** REVIEW;IMMUNISATION;18 MONTH
- **IMRV-04Y** REVIEW;IMMUNISATION;4 YEAR
- **IMRV-12Y** REVIEW;IMMUNISATION;12 YEAR
- **IMRV-50Y** REVIEW;IMMUNISATION;50 YEAR

Group Activity

For OSR group activity recording the following export codes are recognised as group activity:

- **HP-GRPT** will be resolved as 'Tobacco use treatment/prevention groups'.
- **HP-GRPA** will be resolved as 'Alcohol misuse treatment/prevention grps'.
- **HP-GRPP** will be resolved as 'Physical activity/healthy wt activities'.
- **HP-GRPC** will be resolved as 'Chronic disease client support groups'.
- **HP-GRPL** will be resolved as 'Living skills groups'.
- **HP-GRPU** will be resolved as 'Cultural groups'.
- **HP-GRPM** will be resolved as 'Men's groups'.
- **HP-GRPW** will be resolved as 'Women's groups'.
- **HP-GRPY** will be resolved as 'Youth groups'.
- **HP-GRP** will be resolved as the name of the clinical item.

These additional codes are used for the maternal and child health group activities:

- **MCH-GRPA** will be resolved as 'Antenatal groups'.
- **MCH-GRPM** will be resolved as 'Maternal and baby/child health groups'.
- **MCH-GRPP** will be resolved as 'Parenting and parenting skills groups'.
- **MCH-GRP** will be resolved as the name of the clinical item.

Pathology

For some indicators, reference is made to pathology requests or results recorded in a patient record. For example, cervical screenings can be identified by the recording of a clinical item or a qualifier but also by the recording of a test request or the receiving of a test result.

Test Requests

Cervical screening: Request terms with the keywords of CST, HPV, or LBC will be recognised as requests for cervical screening test, human papillomavirus or liquid based cytology.

Review your request term keywords at **File > Reference Tables > Investigations > Investigation Keywords**.

To print out a list, run the report at **Report > Reference Tables > Investigation Keywords**.

Test Results

For cervical screening, results are recognised if the name of the test returned by the lab includes any of the following strings of text (all case insensitive):

- CST
- HPV
- LBC
- CERVICAL SCREEN
- GYNAECOLOGICAL CYTOLOGY
- NCSP

Medicare Claims

The following Medicare claim numbers are referred to in the nKPI indicators:

- **715** (228, 92004, 92016, 92011, 92023): [nKPI, OSR] Annual health assessments for Indigenous patients.
- **721** (229, 92024, 92068, 92055, 92099): [nKPI, OSR] GP management plans
- **10986**: [OSR only] Healthy Kids Check performed by nurse or Aboriginal Health Practitioner.

> **Note:**
> This Medicare item was made inactive on 1st November 2015 but the indicator still references this item.

Health Care Home Trial

Enrolment in the Health Care Home Trial is managed using clinical items with these codes:

- **HC-ENROL** – this should be the rule code and export code for the enrolment item
- **HC-EXIT** – this should be the rule code and export code for the exit item

Qualifiers reference

Find the active ICPC-2 PLUS qualifier codes for NKPI reporting here.

Numeric qualifiers

These **System Codes** are referenced in each specific indicator but are reproduced here for general reference:

- BPS - Systolic blood pressure measured in mmHg
- BPD - Diastolic blood pressure measured in mmHg
- WKG – Patient weight in kg
- HCM – Patient height in cm
- BMI – Patient BMI

- HBH – HbA1c in %
- HBM – HbA1c in mmol/mol
- ACR - Albumin creatinine ratio
- GFE – eGFR (estimated glomerular filtration rate) in mL/min/1.73m2
- CHO – Total cholesterol level in mmol/L
- HDL – HDL level in mmol/L
- CHR – Total cholesterol level/HDL ratio
- GSA – Gestational age at birth in weeks recorded in the baby's record)
- GST – Gestation in weeks (recorded in the mother's record)

These **Export Codes** are referenced:

- AUDITC – Alcohol audit C score
- AAQ99 – Full alcohol audit score
- CVR-N05F - Framingham cardiovascular risk recorded in %
- CVR-N05C – CARPA cardiovascular risk recorded in %

Reference qualifiers

These **System Codes** are referenced in each specific indicator but are reproduced here for general reference:

- `SMO` – Smoking Status where the dropdown references have a system code of S, N, or E (smoker, non-smoker and ex-smoker). Note that for local qualifiers a system code of U may be used if there is an option that does not define any of the three categories – it will be reported as 'Undefined'.
- `SMP` – Smoking during pregnancy where the dropdown references have a system code of S, N, or E (smoker, non-smoker and ex-smoker). Note that for local qualifiers a system code of U may be used if there is an option that does not define any of the three categories – it will be reported as 'Undefined'.
- `ALC` – Alcohol consumption where the dropdown references have a system code of D, N, or E (drinker, non- drinker and ex- drinker).
- `ALP` – Alcohol during pregnancy where the dropdown references have a system code of D, N, or E (drinker, non-drinker and ex-drinker).

These **Export Codes** are referenced:

- `DA-TDS` – Treatment delivery setting (for residential drug and alcohol treatment)
- `AAQ01` – Alcohol audit question 1 - "How often do you have a drink containing alcohol?". The export code of the dropdown reference is the allocated score.
- `AAQ02` - Alcohol audit question 2 - "How many drinks containing alcohol do you have on a typical day when you are drinking?". The export code of the dropdown reference is the allocated score.
- `CVR-R05F` - cardiovascular risk recorded as a reference qualifier where the dropdown references have a system code of H, M, L or U (high, moderate, low and unknown).
- `CVR-R05C` - cardiovascular risk recorded as a reference qualifier where the dropdown references have a system code of H, M, L or U (high, moderate, low and unknown).
- `CT-RSLT` or `TTANGO Chlamydia` - use with any existing local qualifiers currently used to record POC STI testing to show that a chlamydia result has been received for PI25.
- `NG-RSLT` or `TTANGO Gonnorrhoea` - use with any existing local qualifiers currently used to record POC STI testing to show that a gonorrhoea result has been received for PI25.

Miscellaneous qualifiers

These **Export Codes** are referenced in each specific indicator:

- `CST`, `HPV`, `LBC` - Any Yes/No or checkbox qualifier with this export code is deemed to be evidence of a cervical screening test, human papillomavirus or liquid based cytology if the value is True (i.e. the response is `Yes` or the qualifier is selected).

Client Contact Types reference

Each Communicare speciality type is mapped to a reporting category provided by AIHW.

OSR Provider Type mapping

Communicare specialty workers are shown in uppercase below.

Table 201. Communicare to AIHW provider type mapping

Communicare Speciality	AIHW provider type
• ABORIGINAL AND TORRES STRAIT ISLANDER FAMILY HEALTH WORKER • ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH WORKER	Aboriginal and Torres Strait Islander Health Worker (ATSIHW)
ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER	Aboriginal and Torres Strait Islander Health Worker Practitioner

Table 201. Communicare to AIHW provider type mapping (continued)

Communicare Speciality	AIHW provider type
• ABORIGINAL AND TORRES STRAIT ISLANDER LIAISON OFFICER • ABORIGINAL COMMUNITY SUPPORT WORKER • AMBULANCE OFFICER • ASSISTANT IN NURSING • CHILD CARE WORKER • CHRONIC CARE COORDINATOR • CLINICAL ALLERGIST • COMMUNITY / FAMILY REPRESENTATIVE • COMMUNITY SERVICES WORKER • EPIDEMIOLOGIST • HEALTH INFORMATION MANAGER • HEALTH PRACTICE MANAGER • HEALTH PROMOTION OFFICER • HOME HELP WORKER • HOSPITAL SCIENTIST • INTERPRETER/TRANSLATOR • MEALS/FOOD SERVICES WORKER • MEDICAL INTERN • MEDICAL PRACTITIONER IN TRAINING • MEDICAL RECEPTIONIST • OTHER PROFESSION/DISCIPLINE • PHARMACY TECHNICIAN • PHLEBOTOMIST • PHYSICIAN'S ASSISTANT • RECREATION WORKER • REGISTERED PARAMEDIC • RESIDENT MEDICAL OFFICER • RESIDENT MEDICAL OFFICER • SONOGRAPHER • TECHNICIAN • THERAPIST'S ASSISTANT • THERAPY AIDE • VOLUNTARY WORKER	Other health / clinical staff
• ABORIGINAL AND TORRES STRAIT ISLANDER MENTAL HEALTH WORKER • EMOTIONAL AND SOCIAL WELLBEING STAFF • PSYCHOTHERAPIST • TEAM. PSYCHOGERIATRIC ASSESS TEAM (PGAT) • YOUTH WORKER	Social and Emotional Well Being staff | SEWB staff other or not specified

Table 201. Communicare to AIHW provider type mapping (continued)

Communicare Speciality	AIHW provider type
• ACUPUNCTURIST • ALLIED HEALTH AIDE • ALTERNATIVE THERAPIST • ASTHMA EDUCATOR • ATTENDANT CARER • CARDIAC EDUCATOR • CHIROPRACTOR • CHRONIC CARE COORDINATOR • COMMUNITY PARAMEDICAL • DERMAL CLINICIAN • DISABILITY SERVICES WORKER • ENVIRONMENTAL HEALTH OFFICER • EXERCISE PHYSIOLOGIST • EYE HEALTH COORDINATOR • HEALTH DIAGNOSIS/TREATMENT PRACTITIONER • HOME CARE WORKER • HOMOEOPATH • MASSAGE THERAPIST • MUSIC THERAPIST • NATURAL THERAPY PROFESSIONAL • NATUROPATH • OCCUPATIONAL THERAPIST • ORTHOTIC PROSTHETIST • ORTHOTIST • OSTEOPATH • PERSONAL CARE ASSISTANT • PHYSIOLOGIST • REHABILITATION AIDE • SPEECH PATHOLOGIST • SPEECH THERAPIST • TEAM. AGED CARE ASSESSMENT TEAM (ACAT) • TEAM. MULTI-DISCIPLINARY TEAM	Allied Health Professional | Allied health other or not specified

Table 201. Communicare to AIHW provider type mapping (continued)

Communicare Speciality	AIHW provider type
• ANAESTHETIST • CLINICAL CYTOPATHOLOGIST • CLINICAL HAEMATOLOGIST • CLINICAL PHARMACOLOGIST • EMERGENCY MEDICINE SPECIALIST • GASTROENTEROLOGIST • GERIATRICIAN • GYNAECOLOGICAL ONCOLOGIST • IMMUNOLOGIST • INFECTIOUS DISEASES PHYSICIAN • INFECTIOUS DISEASES SPECIALIST • INTENSIVE CARE ANAESTHETIST • INTENSIVE CARE MEDICINE SPECIALIST • MEDICAL DIAGNOSTIC RADIOGRAPHER • MEDICAL ONCOLOGIST • NEPHROLOGIST • NEUROLOGIST • NEUROSURGEON • NUCLEAR MEDICINE TECHNOLOGIST • ORAL AND MAXILLOFACIAL SURGEON • ORTHOPAEDIC SURGEON • ORTHOPTIST • PALLIATIVE MEDICINE PHYSICIAN • PATHOLOGIST • PLASTIC AND RECONSTRUCTIVE SURGEON • PUBLIC HEALTH PHYSICIAN • RADIATION ONCOLOGIST • RADIOLOGIST • RADIOTHERAPIST • RESPIRATORY PHYSICIAN • RHEUMATOLOGIST • SEXUAL HEALTH PHYSICIAN • SPECIALIST MEDICAL PRACTITIONER • SPECIALIST PHYSICIAN • UROLOGIST • VETERINARIAN	Medical Specialist | Specialist other or not specified
AUDIOLOGIST	Allied Health Professional | Audiologist / audiometrist
• BTH COUNSELLOR • COUNSELLOR • FAMILY VIOLENCE CASE MANAGER • FAMILY VIOLENCE COORDINATOR • FAMILY VIOLENCE COUNSELLOR	Social and Emotional Well Being staff | Counsellor
CARDIOLOGIST	Medical Specialist | Cardiologist
• CARDIOTHORACIC PHYSIOTHERAPIST • PHYSIOTHERAPIST • RESPIRATORY PHYSIOTHERAPIST	Allied Health Professional | Physiotherapist

Table 201. Communicare to AIHW provider type mapping (continued)

Communicare Speciality	AIHW provider type
• CARDIOTHORACIC SURGEON • SURGEON • VASCULAR SURGEON	Medical Specialist | Surgeon
• CHILD HEALTH NURSE • ENROLLED NURSE • ENROLLED NURSE (MENTAL HEALTH) • MOTHERCRAFT NURSE • NURSE EDUCATOR • NURSE MANAGER • NURSE PRACTITIONER • NURSE RESEARCHER • REGISTERED NURSE • REGISTERED NURSE (DEVT'L DISABILITY) • REGISTERED NURSE (MENTAL HEALTH)	Nurses
• CLINICAL PSYCHOLOGIST • NEUROPSYCHOLOGIST • PSYCHOLOGIST	Social and Emotional Well Being staff | Psychologist
• DENTAL - TECHNICIAN OR PROSTHETIST • DENTAL ASSISTANT • DENTAL PROSTHETIST • DENTAL TECHNICIAN	Dental support (e.g. dental assistant / dental technician)
• DENTAL HYGIENIST • DENTAL SPECIALIST • DENTAL THERAPIST • DENTIST	Dentists / dental therapists
DERMATOLOGIST	Medical Specialist | Dermatologist
DIABETES EDUCATOR	Allied Health Professional | Diabetes educator
DIETITIAN	Allied Health Professional | Dietician
• DRUG AND ALCOHOL COUNSELLOR • SUBSTANCE MISUSE WORKER	Substance misuse / drug and alcohol worker
EAR, NOSE AND THROAT SPECIALIST	Medical Specialist | Ear Nose and Throat Specialist
ENDOCRINOLOGIST	Medical Specialist | Endocrinologist
• GENERAL MEDICAL PRACTITIONER • PRINCIPAL HOUSE OFFICER • REGISTRAR	Doctor - General Practitioner

Table 201. Communicare to AIHW provider type mapping (continued)

Communicare Speciality	AIHW provider type
MIDWIFE	Midwives
OBSTETRICIAN AND GYNAECOLOGIST	Medical Specialist | Obstetrician / Gynaecologist
OPHTHALMOLOGIST	Medical Specialist | Ophthalmologist
OPTOMETRIST	Allied Health Professional | Optometrist
PAEDIATRICIAN	Medical Specialist | Paediatrician
PHARMACIST	Allied Health Professional | Pharmacist
PODIATRIST	Allied Health Professional | Podiatrist
PSYCHIATRIST	Medical Specialist | Psychiatrist/Psychiatric Register
RENAL MEDICINE SPECIALIST	Medical Specialist | Renal Medicine Specialist
SEXUAL HEALTH WORKER	Sexual health worker
• SMOKING CESSATION COORDINATOR • SMOKING CESSATION OFFICER	Tobacco worker / coordinator
SOCIAL WORKER	Social and Emotional Well Being staff | Social Worker
TRADITIONAL HEALER	Traditional healer
TRANSPORT WORKER	Transport worker
WELFARE WORKER	Social and Emotional Well Being staff | Welfare Worker

Note:
Any other speciality types that may be added from time to time will be mapped to 'Other health / clinical staff' unless there is a clear mapping available. In some cases, this may be a temporary mapping pending a decision from the AIHW as to the preferred grouping.

OSR to Communicare reverse mappings

Table 202. Main contact types

OSR contact type	Communicare Speciality
Aboriginal and Torres Strait Islander Health Worker (ATSIHW)	ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH WORKER, ABORIGINAL FAMILY HEALTH WORKER
Aboriginal and Torres Strait Islander Health Worker Practitioner	ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER
Dental support (e.g. dental assistant / dental technician)	DENTAL - TECHNICIAN OR PROSTHETIST, DENTAL ASSISTANT, DENTAL PROSTHETIST, DENTAL TECHNICIAN
Dentists / dental therapists	DENTAL HYGIENIST, DENTAL SPECIALIST, DENTAL THERAPIST, DENTIST
Doctor - General Practitioner	• GENERAL MEDICAL PRACTITIONER • PRINCIPAL HOUSE OFFICER • REGISTRAR
Midwives	MIDWIFE

Table 202. Main contact types (continued)

OSR contact type	Communicare Speciality
Nurses	CHILD HEALTH NURSE, ENROLLED NURSE, ENROLLED NURSE (MENTAL HEALTH), MOTHERCRAFT NURSE, NURSE EDUCATOR, NURSE MANAGER, NURSE PRACTITIONER, NURSE RESEARCHER, REGISTERED NURSE, REGISTERED NURSE (DEVTL DISABILITY),REGISTERED NURSE (MENTAL HEALTH)
Other health / clinical staff	ABORIGINAL AND TORRES STRAIT ISLANDER LIAISON OFFICER, ABORIGINAL COMMUNITY SUPPORT WORKER, AMBULANCE OFFICER, ASSISTANT IN NURSING, CHILDCARE WORKER, CLERICAL / ADMINISTRATIVE WORKER, CLINICAL ALLERGIST, COMMUNITY / FAMILY REPRESENTATIVE, COMMUNITY SERVICES WORKER, DAY CARE WORKER, EPIDEMIOLOGIST, HEALTH INFORMATION MANAGER, HEALTH PRACTICE MANAGER, HEALTH PROMOTION OFFICER, HOME HELP WORKER, HOSPITAL SCIENTIST, INTERPRETER/TRANSLATOR, MEALS/FOOD SERVICES WORKER, MEDICAL INTERN, MEDICAL PRACTITIONER IN TRAINING, MEDICAL RECEPTIONIST, OTHER PROFESSION/DISCIPLINE, PHARMACY TECHNICIAN, PHLEBOTOMIST, PHYSICIAN'S ASSISTANT, RECREATION WORKER, REGISTERED PARAMEDIC, RESIDENT MEDICAL OFFICER, SONOGRAPHER, TECHNICIAN, THERAPIST'S ASSISTANT, THERAPY AIDE, VOLUNTARY WORKER
Sexual health worker	SEXUAL HEALTH WORKER
Substance misuse / drug and alcohol worker	DRUG AND ALCOHOL COUNSELLOR, SUBSTANCE MISUSE WORKER
Tobacco worker / coordinator	SMOKING CESSATION COORDINATOR, SMOKING CESSATION OFFICER
Traditional healer	TRADITIONAL HEALER
Transport worker	TRANSPORT WORKER

Table 203. Medical specialists

OSR specialist type	Communicare Speciality
Cardiologist	CARDIOLOGIST
Dermatologist	DERMATOLOGIST
Ear Nose and Throat Specialist	EAR, NOSE AND THROAT SPECIALIST
Endocrinologist	ENDOCRINOLOGIST
Obstetrician / Gynaecologist	OBSTETRICIAN AND GYNAECOLOGIST
Ophthalmologist	OPHTHALMOLOGIST
Paediatrician	PAEDIATRICIAN
Psychiatrist/Psychiatric Register	PSYCHIATRIST
Renal Medicine Specialist	RENAL MEDICINE SPECIALIST

Table 203. Medical specialists (continued)

OSR specialist type	Communicare Speciality
Specialist other or not specified	ANAESTHETIST, CLINICAL CYTOPATHOLOGIST, CLINICAL HAEMATOLOGIST, CLINICAL PHARMACOLOGIST, EMERGENCY MEDICINE SPECIALIST, GASTROENTEROLOGIST, GERIATRICIAN, GYNAECOLOGICAL ONCOLOGIST, IMMUNOLOGIST, INFECTIOUS DISEASES PHYSICIAN, INFECTIOUS DISEASES SPECIALIST, INTENSIVE CARE ANAESTHETIST, INTENSIVE CARE MEDICINE SPECIALIST, MEDICAL DIAGNOSTIC RADIOGRAPHER, MEDICAL ONCOLOGIST, NEPHROLOGIST, NEUROLOGIST, NEUROSURGEON, NUCLEAR MEDICINE TECHNOLOGIST, ORAL AND MAXILLOFACIAL SURGEON, ORTHOPAEDIC SURGEON, ORTHOPTIST, PALLIATIVE MEDICINE PHYSICIAN, PATHOLOGIST, PLASTIC AND RECONSTRUCTIVE SURGEON, PUBLIC HEALTH PHYSICIAN, RADIATION ONCOLOGIST, RADIOLOGIST, RADIOTHERAPIST, RESPIRATORY PHYSICIAN, RHEUMATOLOGIST, SEXUAL HEALTH PHYSICIAN, SPECIALIST MEDICAL PRACTITIONER, SPECIALIST PHYSICIAN, UROLOGIST, VETERINARIAN
Surgeon	CARDIOTHORACIC SURGEON, SURGEON, VASCULAR SURGEON

Table 204. Social and emotional wellbeing / Counsellors

OSR specialist type	Communicare Speciality
Counsellor	• BTH COUNSELLOR • COUNSELLOR • FAMILY VIOLENCE CASE MANAGER • FAMILY VIOLENCE COORDINATOR • FAMILY VIOLENCE COUNSELLOR
Psychologist	CLINICAL PSYCHOLOGIST, PSYCHOLOGIST, NEUROPSYCHOLOGIST
SEWB staff other or not specified	ABORIGINAL MENTAL HEALTH WORKER, EMOTIONAL AND SOCIAL WELLBEING STAFF, PSYCHOTHERAPIST, TEAM. PSYCHOGERIATRIC ASSESS TEAM (PGAT), YOUTH WORKER
Social Worker	SOCIAL WORKER
Welfare Worker	WELFARE WORKER

Table 205. Allied health professionals

OSR specialist type	Communicare Speciality
Allied health other or not specified	ACUPUNCTURIST, ALLIED HEALTH AIDE, ALTERNATIVE THERAPIST, ASTHMA EDUCATOR, ATTENDANT CARER, CARDIAC EDUCATOR, CHIROPRACTOR, CHRONIC CARE COORDINATOR, COMMUNITY PARAMEDICAL, DERMAL CLINICIAN, DISABILITY SERVICES WORKER, ENVIRONMENTAL HEALTH OFFICER, EXERCISE PHYSIOLOGIST, EYE HEALTH COORDINATOR, HEALTH DIAGNOSIS/TREATMENT PRACTITIONER, HOME CARE WORKER, HOMOEOPATH, MASSAGE THERAPIST, MUSIC THERAPIST, NATURAL THERAPY PROFESSIONAL, NATUROPATH, OCCUPATIONAL THERAPIST, ORTHOTIC PROSTHETIST, ORTHOTIST, OSTEOPATH, PERSONAL CARE ASSISTANT, PHYSIOLOGIST, REHABILITATION AIDE, TEAM. AGED CARE ASSESSMENT TEAM (ACAT), TEAM. MULTI-DISCIPLINARY TEAM
Diabetes educator	DIABETES EDUCATOR
Dietician	DIETITIAN

Table 205. Allied health professionals (continued)

OSR specialist type	Communicare Speciality
Optometrist	OPTOMETRIST
Pharmacist	PHARMACIST
Physiotherapist	PHYSIOTHERAPIST, CARDIOTHORACIC PHYSIOTHERAPIST, RESPIRATORY PHYSIOTHERAPIST
Podiatrist	PODIATRIST
Speech Pathologist	SPEECH PATHOLOGIST, SPEECH THERAPIST

Reporting parameters

Reporting periods

National KPI reports are due at the end of the calendar year and the end of the financial year (31 December and 30 June). The nominal report period is one year but some of the reports are 'point in time' assessments as of the end of the report period. In these cases, there will be a currency period defined. For example, patients who, at the end of the report period, have had an HbA1c in the previous six months. See each indicator for details.

The OSR reports are due at the end of the financial year (30 June). Again, the nominal report period is one year.

Report parameters

nKPI report parameters

nKPI reports have the following parameters:

- **Locality Group** - displays a list of all the locality groups configured on the database. Typically select one of the following:
  - `<All Locality Groups>` - effectively bypasses any reference to a patient's home address at the end of the report period. Choose this option unless a decision has been made to exclude some patients based on where they lived at the end of the report period. For example, health services with large numbers of frequent visitors whose main health service is elsewhere.
  - `Health Service Area` - limits the report to patients whose home address at the end of the report period was a locality defined in this locality group. It is the health service's responsibility to make sure that this locality group covers the full geographical area covered by the health service. This option will effectively exclude frequent visitors from outside the health service area.

  All other options are defined by the health service. The only times another locality group should be chosen is for internal reporting where a health service has multiple clinics covering different areas and for the few databases that cover more than one organisation where each is required to report separately to the Health Data Portal.
- **Patient Indicator** - must be set to `AIHW Regular Client`, unless the report is being used for internal reporting only and `Communicare Current Patient` status is more relevant to the health service.
- **Last Report Date** - either `31st December` or `30th June` of the relevant year. However, for internal reporting only, interim dates can be set. Typically choose the last date of any month rather than other dates of the month, because some indicators that look back a year or six months to determine a currency of some data values will round to the nearest month.

There are some exceptions to the parameters presented for specific nKPI reports:

- **PI01** and **PI02** - you cannot select a patient indicator because all children born in the report period who have been added to the database prior to the end of the report period are included, unless they are Fictitious or were a Non-Patient at the end of the report period.
- **PI18** and **PI19** (eGFR) - include an additional parameter of `Chronic Disease` to allow the report to be generated for either Diabetes Type II patients or Cardiovascular disease patients. Some patients with co-morbidities will appear in both options so totalling numbers from both must be done with care.

Note:
There are two reports for each nKPI: one contains the totals in a grid and the other lists patient names for internal data verification and clinical action only.

OSR report parameters

OSR reports all have the following parameters:

- **End of Year to Report** - set to `30th June` of the relevant year. For internal reporting purposes, any date can be selected. Typically, choose the last date of any month rather than other dates of the month because some indicators that look back a year or six months to determine a currency of some data values will round to the nearest month.
- **Locality Group** - see description above *(on page 706)*.

Encounter place subset parameter (optional)

An optional **Encounter place subset** parameter is available on the nKPI reports and the OSR reports CS-1, CS-2 and CS-3. The Encounter place subset is supported by the nKPI reports and GRT in *Specifications for National Key Performance Indicators and Online Services Reporting* V16.1 and later (July 2024).

This option is relevant for health services where only some of the encounter places need to report nKPI or OSR data.

The Encounter place subset requires a token. Contact Communicare Support to configure subsets of encounter place for reporting.

NKPI summary

Summary of NKPI reports.

Note:
This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

Table 206. NKPI reports

NKPI report	Description	Further information
PI 01	Indigenous babies born within the previous 12 months whose birth weight has been recorded	PI 01 *(on page 709)* Revised since the initial build
PI 02	Indigenous babies born within the previous 12 months whose birth weight results were low, normal, or high	PI 02 *(on page 710)* Revised since the initial build

Table 206. NKPI reports (continued)

NKPI report	Description	Further information
PI 03	Regular clients for whom an MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715 or equivalent) was claimed	PI 03 *(on page 711)* Revised October 2023
PI 04	Indigenous children who are fully immunised	Retired October 2023
PI 05	Regular clients with Type II diabetes who have had an HbA1c measurement result recorded	PI 05 *(on page 712)*
PI 06	Regular clients with Type II diabetes whose HbA1c measurement result was within a specified level	PI 06 *(on page 713)*
PI 07	Regular clients with a chronic disease for whom a GP Management Plan (MBS Item 721) was claimed	PI 07 *(on page 714)* Revised October 2023
PI 08	Regular clients with a chronic disease for whom a Team Care Arrangement (MBS Item 723) was claimed	Retired June 2021
PI 09	Regular clients whose smoking status has been recorded Communicare	PI 09 *(on page 716)* Revised since the initial build
PI 10	Regular clients with a smoking status result Communicare	PI 10 *(on page 716)* Revised since the initial build
PI 11	Smoking in Pregnancy	PI 11 *(on page 717)* Revised since the initial build
PI 12	Body mass index of clients	PI 12 *(on page 717)* Revised since the initial build
PI 13	Regular clients who had their first antenatal care visit	PI 13 *(on page 719)* Revised since the initial build
PI 14	Regular clients aged 6 months and over who are immunised against influenza	PI 14 *(on page 718)* Revised since the initial build
PI 15	Regular clients with Type II diabetes or COPD who are immunised against influenza	Retired December 2021
PI 16	Regular clients whose alcohol consumption status has been recorded	PI 16 *(on page 720)*
PI 17	Regular clients who had an AUDIT-C with result within specified levels	Retired June 2023
PI 18	Proportion of Indigenous regular clients with a selected chronic disease who have a kidney function test result recorded.	PI 18 *(on page 720)* Revised since the initial build

Table 206. NKPI reports (continued)

NKPI report	Description	Further information
PI 19	Proportion of Indigenous regular clients with a selected chronic disease who have had a kidney function result (eGFR and ACR) within a specified level.	PI 19 *(on page 722)*
PI 20	Regular clients who have had the necessary risk factors assessed to enable CVD assessment	PI 20 *(on page 725)*
PI 21	Regular clients aged 35 to 74 years who have had an absolute cardiovascular disease risk assessment with results within specified levels	PI 21 *(on page 726)*
PI 22	Regular clients who have had a cervical screening disaggregated by age groups	PI 22 *(on page 727)* Revised since the initial build
PI 23	Regular clients with Type II diabetes who have had a blood pressure measurement result recorded	PI 23 *(on page 728)*
PI 24	Regular clients with Type II diabetes whose blood pressure measurement result was less than or equal to 140/90 mmHg	PI 24 *(on page 729)* Revised since the initial build
PI 25	Proportion of Indigenous regular clients who have a test result for one or more sexually transmissible infections (STI).	PI 25 *(on page 730)* Revised October 2023
PI 26	Proportion of Indigenous regular clients ages 0-14 years who have a completed ear health check	PI 26 *(on page 731)* New October 2023
	Total Number of Clients	Not distributed with Communicare at this time

PI 01 - Birthweight recorded

Proportion of Indigenous babies born within the previous 12 months whose birth weight has been recorded.

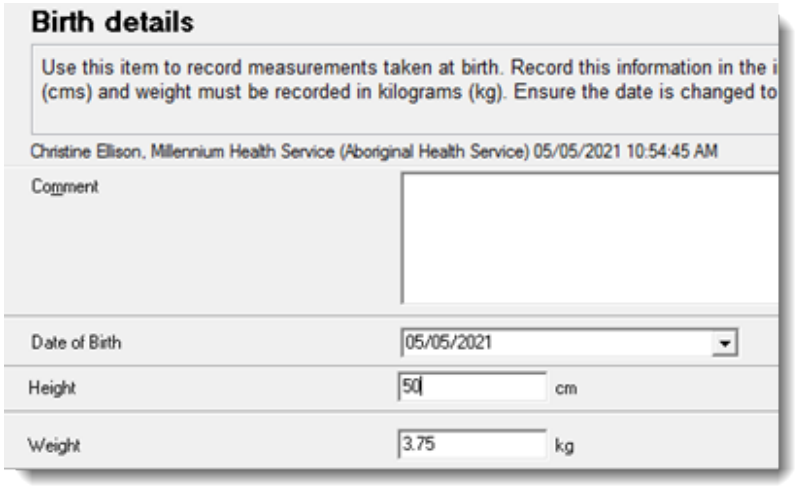
Notes

- Birth weights are obtained from the infant's record.
- Birth weight may be recorded either in the infant's biographics or as a weight qualifier recorded on day of birth.
- All births in last 12 months are considered whether infant was a regular client or not.
- The infant must have at least one recorded visit to the health service.

Table 207. NKPI PI 01

Element	Description
Communicare reports	• **Report > National KPI > PI01 Birth Weight Recorded** • **Report > National KPI > PI01 Birth Weight Recorded Patients**

Table 207. NKPI PI 01 (continued)

Element	Description
Numerator	A patient must have a birth weight recorded in either: • **Biographics > Birth weight**  • **Weight** qualifier on any clinical item that has the same performed date as the patient's date of birth, such as `Birth details`. 
Denominator	• All patient records where the date of birth is within the report period and who are Indigenous are included unless they were added after the end of the report period, are fictitious or were a non-patient at the end of the report period. • Patients are excluded if their birth weight is known to be less than 400g or their gestation at birth is known to be less than 20 weeks. • If the birth weight and gestation at birth are both unknown they are included.
Additional data recording considerations	If birth weight is not recorded on the biographics form but is recorded on the `Birth details` clinical item, this item must have the same date as the date of birth of the patient. To audit incorrect dates on this item, use the report at **Report > Patients > Birth Details Audit**.

This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

PI 02 - Birthweight result

Proportion of Indigenous babies born within the previous 12 months whose birth weight has been recorded

Notes

- Birth weight is categorised as one of the following:
  - Low - less than 2,500 grams
  - Normal - 2,500 grams to less than 4,500 grams
  - High - 4,500 grams and over
- Birth weights are obtained from the infant's record.
- Birth weight may be recorded either in the infant's biographics or as a weight qualifier recorded on the day of birth.
- All births in the last 12 months are considered, whether the infant was a regular client or not.
- The infant must have at least one recorded visit to the health service.

Table 208. NKPI PI 02

Element	Description
Communicare reports	• **Report > National KPI > PI02 Birth Weight Categories** • **Report > National KPI > PI02 Birth Weight Categories Patients**
Numerator	As for the numerator rules for PI01 *(on page 709)* but disaggregated into the three categories of Low, Normal and High.
Denominator	As for the denominator rules for PI01 *(on page 709)*.
Additional data recording considerations	As for PI01 *(on page 709)*.

This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

PI 03 - Indigenous Health Assessment completed

Proportion of regular clients who received an MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715 or any equivalent such as 228, 92004, 92016, 92011 or 92023).

Description

Proportion of Indigenous regular clients who are either:

- Aged 0-14 years and who have received an MBS Health Assessment for Aboriginal and Torres Strait Islander People within the previous 12 months
- Aged 15 years and over and who have received an MBS Health Assessment for Aboriginal and Torres Strait Islander People within the previous 24 months

Notes

- User may select between AIHW's definition of Regular Client (attended the OATSIH-funded primary health care service at least 3 times in 2 years), or Communicare's Current Patient status.
- Patients must be recorded as Aboriginal or Torres Strait Islander or both.
- A patient is deemed to have received an MBS Health Assessment if a service has the MBS item selected for claiming, regardless of whether it has been submitted or paid.

Table 209. NKPI PI 03

Element	Description
Communicare reports	• **Report > National KPI > PI03 Health Checks** • **Report > National KPI > PI03 Health Checks Patients**
Numerator	A documented 715 (or any equivalent such as 228, 92004, 92016, 92011 or 92023) claim for a service within one year (0-14 year olds) or two years (15+ year olds) of the end of the report period is required. For more information, see Medicare claims *(on page 688)*. • Calculation A: Number of *[Disaggregation: Sex]* Indigenous regular clients aged *[Disaggregation: Age]* who have a current completed in-person MBS-rebated Indigenous health assessment (MBS items: 715 or 228) • Calculation B: Number of *[Disaggregation: Sex]* Indigenous regular clients aged *[Disaggregation: Age]* who have a current completed Telehealth MBS-rebated Indigenous health assessment (MBS items: 92004, 92016)
Denominator	Regular, Indigenous patients as of the end of the report period. • Calculation A and B: total number of *[Disaggregation: Sex]* Indigenous regular clients aged *[Disaggregation: Age]*
Disaggregation	• Age: ◦ 0–4 years ◦ 5–14 years ◦ 15–24 years ◦ 25–34 years ◦ 35–44 years ◦ 45–54 years ◦ 55–64 years ◦ 65 years and older • Sex: ◦ Male ◦ Female • Type of health assessment: ◦ In-person MBS-rebated Indigenous health assessment ◦ Telehealth MBS-rebated Indigenous health assessment
Additional data recording considerations	none

This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

PI 05 - HbA1c recorded

Proportion of regular clients with Type II diabetes who have had an HbA1c measurement result recorded.

Description

Proportion of Indigenous regular clients who have either:

- Type II diabetes and who have had an HbA1c measurement result recorded within the previous 6 months
- Type II diabetes and who have had an HbA1c measurement result recorded within the previous 12 months

Notes

- User may select between AIHW's definition of Regular Client (attended the OATSIH-funded primary health care service at least 3 times in 2 years), or Communicare's Current Patient status.
- Patients must be recorded as Aboriginal or Torres Strait Islander or both.
- Only Type II diabetes is considered (any ICPC code of T90). Type I diabetes, secondary diabetes, gestational diabetes mellitus (GDM), previous GDM, impaired fasting glucose, impaired glucose tolerance are not included. For more information, see System codes *(on page 687)*.
- Any qualifier with a system code of `HBA` and units of `%` or a system code of `HBM` and units of `mmol/mol` is considered an HbA1c measurement. These results can be received from an incoming pathology report or manually entered into an existing Clinical Item with a qualifier of HbA1c. For more information, see Qualifier codes *(on page 687)*.

Table 210. NKPI PI 05

Element	Description
Communicare reports	• **Report > National KPI > PI05 Diabetes HbA1c Tests** • **Report > National KPI > PI05 Diabetes HbA1c Tests Patients**
Numerator	Any of the patients included who have a recorded HbA1c within 6 months or 12 months of the end of the report period. For more information about codes, see Procedure, Immunisation, Pathology & Medicare codes reference *(on page 692)*.
Denominator	Regular, Indigenous patients with a diagnosis of Type II diabetes from any time. For more information about codes, see Condition codes reference *(on page 689)*.
Additional data recording considerations	Clinicians must record HbA1c results correctly. They should not enter a % result in the HbA1c qualifier or a mmol/mol result in the HbA1c (%) qualifier. Use **Report > Qualifiers > With Selected Numeric values** to look for outliers such as abnormally high % values or abnormally low mmol/mol values. For more information, see Qualifier codes *(on page 687)*. Mistakes should be corrected.

This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

PI 06 - HbA1c result

Proportion of regular clients with Type II diabetes whose HbA1c measurement result was within a specified level

Description

Number of Indigenous regular clients who have Type II diabetes and who have had an HbA1c measurement result recorded within the previous 6 or 12 months.

Notes

- User may select between AIHW's definition of Regular Client (attended the OATSIH-funded primary health care service at least 3 times in 2 years), or Communicare's Current Patient status.
- Patients must be recorded as Aboriginal or Torres Strait Islander or both.
- Only Type II diabetes is considered (any ICPC code of T90). Type I diabetes, secondary diabetes, gestational diabetes mellitus (GDM), previous GDM, impaired fasting glucose, impaired glucose tolerance are not included. For more information, see System codes *(on page 687)*.
- Any qualifier with a system code of `HBA` and units of `%` or a system code of `HBM` and units of `mmol/mol` is considered an HbA1c measurement. These results can be received from an incoming pathology report or manually entered into an existing Clinical Item with a qualifier of HbA1c. For more information, see Qualifier codes *(on page 687)*.
- Only the most recent HbA1c measurement result for each time period is considered.

Table 211. NKPI PI 06

Element	Description
Communicare reports	• **Report > National KPI > PI06 Diabetes HbA1c Results 06 Months** • **Report > National KPI > PI06 Diabetes HbA1c Results 12 Months** • **Report > National KPI > PI06 Diabetes HbA1c Results Patients**
Numerator	The latest HbA1c within the specified time period is used. If it was recorded as % it is first converted to mmol/mol and rounded to a whole number after multiplying by 10.93 and adding 23.5. The groupings are less than or equal to 53 mmol/mol, greater than 53 and less than or equal to 64 mmol/mol and less than 86 mmol/mol.
Denominator	Regular, Indigenous patients with a diagnosis of Type II diabetes from any time.
Additional data recording considerations	Clinicians must record HbA1c results correctly. They should not enter a % result in the HbA1c qualifier or a mmol/mol result in the HbA1c (%) qualifier. Use **Report > Qualifiers > With Selected Numeric values** to look for outliers such as abnormally high % values or abnormally low mmol/mol values. Mistakes should be corrected.

This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

PI 07 - Chronic Disease Management Plan prepared

Proportion of regular clients with a chronic disease who have received a GP Management Plan (MBS Item 721 or any equivalent such as 229, 92024, 92068, 92055, 92099).

Description

Proportion of Indigenous regular clients who have Type II diabetes and who have received a GP Management Plan (MBS Item 721 or any equivalent such as 229, 92024, 92068, 92055, 92099) within the previous 24 months.

Notes

- User may select between AIHW's definition of Regular Client (attended the OATSIH-funded primary health care service at least 3 times in 2 years), or Communicare's Current Patient status.
- Patients must be recorded as Aboriginal or Torres Strait Islander or both.
- A patient is deemed to have received a GP Management Plan if a service has the MBS item checked for claiming, regardless of whether it has been submitted or paid.

Table 212. NKPI PI 07

Element	Description
Communicare reports	• **Report > National KPI > PI07 Diabetes GP Management Plan** • **Report > National KPI > PI07 Diabetes GP Management Plan Patients**
Numerator	Currently this report looks for evidence of a 721 (or any equivalent such as 229,92024, 92068) Medicare claim. For more information, see Medicare claims *(on page 688)*.
Denominator	Currently this indicator looks only for patients with Type II diabetes.
Additional data recording considerations	Health Services who are part of the Health Care Homes trial will not be documenting care plans with a claim for item 721 or any equivalent such as 229, 92024, 92068, 92055, 92099 so will need to document these care plans with a clinical item. From June 2018 this indicator will also recognise a completed procedure with an export code of CPA as being evidence of a care plan being completed.

This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

PI 09 - Smoking status recorded

Proportion of regular clients whose smoking status has been recorded.

Description

Proportion of Indigenous regular clients who have had their smoking status recorded.

Notes

- User may select between AIHW's definition of Regular Client (attended the OATSIH-funded primary health care service at least 3 times in 2 years), or Communicare's Current Patient status.
- Patients must be recorded as Aboriginal or Torres Strait Islander or both.
- Patients must have had a qualifier recorded with a system code of SMO or SMP to be included. Central qualifiers are `Smoking status` and `Smoking during pregnancy`. For more information, see Qualifier codes *(on page 687)*.

Table 213. NKPI PI 09

Element	Description
Communicare reports	• **Report > National KPI > PI09 Smoking Status** • **Report > National KPI > PI09 Smoking Status Patients**
Numerator	The latest smoking status recorded before the end of the report period is used: there is no currency period. For details of system codes used to identify smoking statuses, see Procedure, Immunisation, Pathology & Medicare codes reference *(on page 692)*.
Denominator	Regular, Indigenous patients aged 11 years and over.
Additional data recording considerations	none

This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

PI 10 - Smoking status

Proportion of regular clients whose smoking status has been recorded.

Description

Proportion of Indigenous regular clients who have had their smoking status recorded.

Notes

- User may select between AIHW's definition of Regular Client (attended the OATSIH-funded primary health care service at least 3 times in 2 years), or Communicare's Current Patient status.
- Patients must be recorded as Aboriginal or Torres Strait Islander or both.
- Patients must have had a qualifier recorded with a system code of `SMO` or `SMP` to be included. Central qualifiers are `Smoking status` and `Smoking during pregnancy`. For more information, see Qualifier codes *(on page 687)*.

Table 214. NKPI PI 10

Element	Description
Communicare reports	• **Report > National KPI > PI10 Smoking Status Result** • **Report > National KPI > PI10 Smoking Status Result Patients**
Numerator	The latest smoking status recorded before the end of the report period is used: there is no currency period. For details of system codes used to identify smoking statuses, see Procedure, Immunisation, Pathology & Medicare codes reference *(on page 692)*.
Denominator	Regular, Indigenous patients aged 11 years and over who have had their smoking status recorded.
Additional data recording considerations	none

This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

PI 11 - Smoking status of females who gave birth

Proportion of regular clients who have given birth in the previous 12 months whose smoking status has been recorded.

Description

Proportion of Indigenous regular clients who have had their smoking status recorded.

Notes

- User may select between AIHW's definition of Regular Client (attended the OATSIH-funded primary health care service at least 3 times in 2 years), or Communicare's Current Patient status.
- Patients must be recorded as Aboriginal or Torres Strait Islander or both.
- Patients must have had a qualifier recorded with a system code of SMO or SMP to be included. Central qualifiers are `Smoking status` and `Smoking during pregnancy`. For more information, see Qualifier codes *(on page 687)*.

Table 215. NKPI PI 11

Element	Description
Communicare reports	• **Report > National KPI > PI11 Smoking in Pregnancy** • **Report > National KPI > PI11 Smoking in Pregnancy Patients**
Numerator	The latest smoking status recorded before the end of the report period is used: there is no currency period.
Denominator	Regular, Indigenous patients aged 11 years and over who have had their smoking status recorded.
Additional data recording considerations	none

This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

PI 12 - Body mass index of clients

Proportion of Indigenous regular clients who have a Body Mass Index (BMI) result within specified categories.

Description

Proportion of regular clients who are Indigenous, aged 18 and over who have had their body mass index (BMI) classified as one of the following in the previous 24 months:

- Underweight (<18.50)
- Normal weight (>=18.50 but <25)
- Overweight (>=25 but <30)
- Obese (>=30)

If there is no BMI recorded or it was recorded more than 24 months ago, the BMI is classified as `Not calculated`.

Notes

- The user may choose either AIHW's definition of Regular Client (attended the OATSIH-funded primary health care service at least 3 times in 2 years), or Communicare's Current Patient status.
- Patients must be recorded as Aboriginal or Torres Strait Islander or both.
- Only the most recent measurement result with a system code of BMI in the previous 24 months is considered.

Table 216. NKPI PI 12

Element	Description
Communicare reports	• **Report > National KPI > PI12 Overweight** • **Report > National KPI > PI12 Overweight Patients**
Numerator	This report looks only for recorded BMIs, it does not calculate BMIs based on weight, height and age.
Denominator	Regular, Indigenous patients with a BMI recorded.
Additional data recording considerations	Health services should encourage the recording of BMIs for all patients.

This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

PI 13 - First Antenatal Visit

Proportion of regular female clients who received antenatal care within specified periods.

Notes

- User may select between AIHW's definition of Regular Client (attended the OATSIH-funded primary health care service at least 3 times in 2 years), or Communicare's Current Patient status.
- Patients must be recorded as Aboriginal or Torres Strait Islander or both.
- Any clinical item with a system code of PRE and a rule code of PR-CHECK can be used. For more information, see System codes *(on page 687)*.
- Although the category of `No result` is included as part of the specifications, the additional category of `(No known antenatal care)` is specifically to report on patients where, in Communicare, the clinical item `No known antenatal care` has been recorded, and there is no prior or subsequent antenatal activity recorded.
- Percentages may not add up to 100%.

Table 217. NKPI PI 13

Element	Description
Communicare reports	• **Report > National KPI > PI13 Antenatal Care** • **Report > National KPI > PI13 Antenatal Care Patients**

Table 217. NKPI PI 13 (continued)

Element	Description
Numerator	For details of how to recognise an antenatal check, see Procedure, Immunisation, Pathology & Medicare codes reference *(on page 692)*. • Always record the gestation at the time of recording an antenatal check. • Antenatal checks recorded must have the same number as the pregnancy outcome to be included. • Performed date and pregnancy number must be completed.
Denominator	Women who have given birth in the report period.
Additional data recording considerations	**Note:** Ensure that both the gestation of the pregnancy outcome and the date of delivery are recorded. Without these two data, the earliest antenatal check may not be recognised unless it has the gestation explicitly recorded at that time.

This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

PI 14 - Clients who are immunised against influenza

Proportion of Indigenous patients aged 6 months and over who are immunised against influenza.

Notes

- User may select between AIHW's definition of Regular Client (attended the OATSIH-funded primary health care service at least 3 times in 2 years), or Communicare's Current Patient status.
- Patients must be recorded as Aboriginal or Torres Strait Islander or both.

Table 218. NKPI PI 14

Element	Description
Communicare reports	• **Report > National KPI > PI14 Influenza Immunisations** • **Report > National KPI > PI14 Influenza Immunisations Patients**
Numerator	For more information, see Export codes *(on page 687)*. For details of influenza clinical item export codes, see Procedure, Immunisation, Pathology & Medicare codes reference *(on page 692)*.
Denominator	Regular, Indigenous patients aged 6 months and over at the end of the report period.
Additional data recording considerations	This report relies on valid AIR codes for influenza vaccines being recorded as the export code for such immunisation types. New codes may be introduced with each season.

This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

PI 16 - Alcohol consumption recorded

Proportion of regular clients whose alcohol consumption status has been recorded.

Description

Proportion of Indigenous regular clients aged 15 years and over where their health provider has recorded:

- Whether the client consumes alcohol
- The amount and frequency of the client's alcohol consumption

Notes

- User may select between AIHW's definition of Regular Client (attended the OATSIH-funded primary health care service at least 3 times in 2 years), or Communicare's Current Patient status.
- Patients must be recorded as Aboriginal or Torres Strait Islander or both.
- Patients must have had a qualifier with a system code of ALC or ALPrecorded to be included
  - Central qualifiers are `Alcohol Consumption Level` and `Alcohol Consumption During Pregnancy`.
  - Example clinical items include `Check up;Aboriginal & TSI adult`, `Check up;antenatal`
  - Alternatively, in the `AUDIT-C` assessment (`Check up;alcohol;AUDIT-C`), they may have at least the first two qualifiers recorded, or an AUDIT-C score or a full AUDIT score.

Table 219. NKPI PI 16

Element	Description
Communicare reports	• **Report > National KPI > PI16 Alcohol Status** • **Report > National KPI > PI16 Alcohol Status Patients**
Numerator	This report looks for any evidence in the previous two years of either alcohol consumption level, or an AUDIT-C score or a full AUDIT score or both question 1 and question 2 of the AUDIT C/AUDIT being recorded at the same time.
Denominator	Regular, Indigenous patients.
Additional data recording considerations	none

This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

PI 18 - Kidney Function Testing

Proportion of Indigenous regular clients with a selected chronic disease who have a selected kidney function test result recorded.

Description

Proportion of regular clients who are Indigenous aged 18 years and over, who are recorded as having one of the following:

- Type 2 diabetes
- Cardiovascular disease (CVD)
- Type 2 diabetes and/or CVD

and who have also had one of the following:

- An estimated glomerular filtration rate (eGFR) and an albumin/creatinine ratio (ACR) test result recorded
- Only an eGFR test result recorded
- Only an ACR test result recorded
- Neither an eGFR nor an ACR test result recorded

within the previous 12 months.

Notes

- User may select between AIHW's definition of Regular Client (attended the OATSIH-funded primary health care service at least 3 times in 2 years), or Communicare's Current Patient status.
- Patients must be recorded as Aboriginal or Torres Strait Islander or both.
- ACR results are identified as belonging to a qualifier with the system code of ACR and eGFR results are identified as belonging to a qualifier with the system code of GFE. Both laboratory and manually entered results are included. For more information, see System codes *(on page 687)*.

Table 220. NKPI PI 18

Element	Description
Communicare reports	• **Report > National KPI > PI18 Kidney Function** • **Report > National KPI > PI18 Kidney Function Patients**
Numerator	ACR and eGFR results must be within 12 months of the end of the report period. Both CVD and diabetes patients are disaggregated by whether or not they have both an e-GFR,and ACR, or neither.
Denominator	Regular, Indigenous patients aged 18 years and over at the end of the report period with Type 2 diabetes or CVD. For more information about condition codes, see Condition codes reference *(on page 689)*.

Table 220. NKPI PI 18 (continued)

Element	Description
Disaggregation	• Age ◦ 18–24 years ◦ 25–34 years ◦ 35–44 years ◦ 45–54 years ◦ 55–64 years ◦ 65 years and older • Sex ◦ Male ◦ Female • Chronic disease ◦ Type 2 diabetes ◦ Cardiovascular disease ◦ Either or both of the above • Test ◦ an eGFR only ◦ an ACR only ◦ both an eGFR and an ACR ◦ neither an eGFR nor an ACR
Additional data recording considerations	• Type 2 diabetes – specifically excludes Type I diabetes, secondary diabetes, gestational diabetes mellitus (GDM), previous GDM, Impaired fasting glucose, and impaired glucose tolerance • ACR – refers to an albumin/creatinine ratio • an eGFR only – a recorded eGFR result, where an ACR result HAS NOT been recorded • an ACR only – a recorded ACR result, where an eGFR result HAS NOT been recorded • both an eGFR and an ACR – a recorded eGFR result AND a recorded ACR result • neither an eGFR NOR an ACR – an eGFR result AND an ACR result HAS NOT been recorded • Negative ACR and eGFR values are reported as not recorded

This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

PI 19 - Kidney function test result

Proportion of Indigenous regular clients with a selected chronic disease who have had a kidney function result (eGFR and ACR) within a specified level.

Description

Proportion of regular clients who are Indigenous aged 18 years and over, who are recorded as having one of the following:

- Type 2 diabetes
- Cardiovascular disease (CVD)
- Type 2 diabetes and/or CVD

whose estimated glomerular filtration rate (eGFR) AND albumin/creatinine ratio (ACR) recorded within the previous 12 months were categorised as:

- Normal risk
- Low risk
- Moderate risk
- High risk

Table 221. eGFR & ACR risk categories

Risk level	Description
Normal risk	eGFR greater than or equal to 60 mL/min/1.73m² and: • ACR less than 3.5 mg/mmol for females • ACR less than 2.5 mg/mmol for males.
Low risk	• eGFR greater than or equal to 45 mL/min/1.73m² and less than 60 mL/min/1.73m² and either: ◦ ACR less than 3.5 mg/mmol for females ◦ ACR less than 2.5 mg/mmol for males. OR • eGFR greater than or equal to 60 mL/min/1.73m² and either: ◦ ACR greater than or equal to 3.5 mg/mmol and less than or equal to 35 mg/mmol for females ◦ ACR greater than or equal to 2.5 mg/mmol and less than or equal to 25 mg/mmol for males.
Moderate risk	• eGFR greater than or equal to 45 mL/min/1.73m² and less than 60 mL/min/1.73m² and either: ◦ ACR greater than or equal to 3.5 mg/mmol and less than or equal to 35 mg/mmol for females ◦ ACR greater than or equal to 2.5 mg/mmol and less than or equal to 25 mg/mmol for males. OR • eGFR greater than or equal to 30 mL/min/1.73m² and less than 45 mL/min/1.73m2 and either: ◦ ACR less than 35 mg/mmol for females ◦ ACR less than 25 mg/mmol for males
High risk	• eGFR greater than or equal to 30 mL/min/1.73m² and either: ◦ ACR greater than 35ml/mmol for females ◦ ACR greater than 25mg/mmol for males mg/mmol OR • eGFR less than 30 mL/min/1.73m² and : ◦ Any ACR result for both females and males

Notes

- User may select between AIHW's definition of Regular Client (attended the OATSIH-funded primary health care service at least 3 times in 2 years), or Communicare's Current Patient status.
- Patients must be recorded as Aboriginal or Torres Strait Islander or both.

Table 222. NKPI PI 19

Element	Description
Communicare reports	• **Report > National KPI > PI19 Kidney Function Results Patients** • **Report > National KPI > PI19 Kidney Function Results**
Numerator	• ACR results are identified as belonging to a qualifier with the system code of ACR. Both laboratory and manually entered results are included. For more information, see System codes *(on page 687)*. • eGFR results are identified as belonging to a qualifier with the system code of GFE. Both laboratory and manually entered results are included. GFR results of `>60` are included in the group `Greater than or equal to 60 but less than 90`.
Denominator	Regular, Indigenous patients aged 18 years and over at the end of the report period with Type II diabetes or CVD.

Disaggregation	• Age
	  ◦ 18–24 years
	  ◦ 25–34 years
	  ◦ 35–44 years
	  ◦ 45–54 years
	  ◦ 55–64 years
	  ◦ 65 years and older
	• Sex
	  ◦ Male - calculation A
	  ◦ Female - calculation B
	• Chronic disease
	  ◦ Type 2 diabetes
	  ◦ Cardiovascular disease
	  ◦ Either or both of the above

Additional data recording considerations	• Where an eGFR result of `>60` has been returned by a lab these are reported as `Greater than or equal to 60 but less than 90`. • Renal function risk result classifications differ between males and females. • Type 2 diabetes – specifically excludes Type I diabetes, secondary diabetes, gestational diabetes mellitus (GDM), previous GDM, Impaired fasting glucose, and impaired glucose tolerance • ACR – refers to an albumin/creatinine ratio • Negative ACR and eGFR values are reported as not recorded

This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

PI 20 - CVD risk assessment factors

Proportion of regular clients who have had the necessary risk factors assessed to enable cardiovascular disease (CVD) assessment

Description

Proportion of Indigenous regular clients with no known cardiovascular disease (CVD), assessed aged 35 to 74, with information available to calculate their absolute CVD risk.

Notes

- User may select between AIHW's definition of Regular Client (attended the OATSIH-funded primary health care service at least 3 times in 2 years), or Communicare's Current Patient status.
- Patients must be recorded as Aboriginal or Torres Strait Islander or both.
- Patients must have a sex and date of birth.
- Patients must have the following recorded in the previous 24 months:
    - Smoking status (reference qualifier with system code of SMO or SMP).
    - Systolic blood pressure (numeric qualifier with system code of BPS).
    - Either total cholesterol and HDL (numeric qualifiers with system codes of CHO and HDL) or cholesterol/HDL level (numeric qualifier with system code of CHR).
    - For more information about qualifier system codes, see Qualifier codes *(on page 687)*.

Table 223. NKPI PI 20

Element	Description
Communicare reports	• **Report > National KPI > PI20 CVD Risk Factors** • **Report > National KPI > PI20 CVD Risk Factors Patients**
Numerator	All defined measures must have been recorded in the previous two years.
Denominator	Regular, Indigenous patients aged 35 years and under 75 years old at the end of the report period without a CVD diagnosis. For more information about condition codes, see Condition codes reference *(on page 689)*.
Additional data recording considerations	**Note:** some patients will not have all the measures recorded, but will still have an absolute CV risk recorded for indicator PI 21 *(on page 726)*. This may be a data entry issue or may relate to some patients who can have a high risk inferred due to age and other conditions. For example, over 60 years with diabetes and microalbuminuria.

This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

PI 21 - CVD risk assessment result

Proportion of regular clients aged 35 to 74 years who have had an absolute cardiovascular disease (CVD) risk assessment with results within specified levels.

Description

Proportion of Indigenous regular clients, aged 35 to 74 and with no known history of cardiovascular disease (CVD), who have had an absolute CVD risk assessment recorded within the previous 24 months and whose CVD risk was categorised as one of the following:

- High (greater than 15% chance of a cardiovascular event in the next 5 years)
- Moderate (10–15% chance of a cardiovascular event in the next 5 years)
- Low (less than 10% chance of a cardiovascular event in the next 5 years)

Notes

- User may select between AIHW's definition of Regular Client (attended the OATSIH-funded primary health care service at least 3 times in 2 years), or Communicare's Current Patient status.
- Patients must be recorded as Aboriginal or Torres Strait Islander or both.
- Patients must have a sex and date of birth.
- Patients must have a record of their cardiovascular risk (high, moderate or low) recorded within the previous 24 months. For the purpose of this report the cardiovascular risk needs to be recorded as a reference type qualifier or a numeric type qualifier with appropriate export or system codes:
    - For CARPA STM guidelines used by the NT for NKPI reporting, either of the following:
        - Reference type qualifier with an export code of `CVR-R05C` and dropdown references with system codes of `H`, `M` or `L` (for high, moderate or low)
        - Numeric type qualifier with units of % and an export code of `CVR-N05C`

> **Note:**
> CARPA STM results will be adjusted for Aboriginal patients to remove the 5% loading and Aboriginal patients aged between 20 and 34 years are not included in this report.

    - For Framingham calculations, used by all states other than the NT, either of the following:
        - Reference type qualifier with an export code of `CVR-R05F` and dropdown references with system codes of `H`, `M` or `L` (for high, moderate or low)
        - Numeric type qualifier with units of % and an export code of `CVR-N05F`
    - The `CVD Risk Calculator (AusCVDRisk)` clinical item, used to capture the output of the online AUSCVDRisk calculator for the patient's record, is not currently used for NKPI reporting.

Table 224. NKPI PI 21

Element	Description
Communicare reports	• **Report > National KPI > PI21 CVD Risk** • **Report > National KPI > PI21 CVD Risk Patients**
Numerator	For export codes used, see Qualifiers reference *(on page 696)*.

Table 224. NKPI PI 21 (continued)

Element	Description
Denominator	Regular, Indigenous patients aged 35 years and under 75 years old at the end of the report period with a CV risk assessment but without a CVD diagnosis. For more information about condition codes, see CVD condition codes *(on page 690)*.
Additional data recording considerations	Health services should determine if they are going to use the Framingham or CARPA calculator distributed with Communicare and consider disabling the one they do not use. This report will use Framingham scores as they are recorded but will remove the 5% loading that the CARPA calculation does for Indigenous patients before reporting. Also, see comments for PI 20 *(on page 725)*.

This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

PI 22 - Female clients who have had a cervical screening (HPV) test

Proportion of female Indigenous regular clients who have had a cervical screening (HPV) test

Description

Proportion of female Indigenous regular clients aged 25–74, who have not had a hysterectomy and who have had a cervical screening (human papillomavirus (HPV)) test within the previous 5 years where the test occurred on or after 1 December 2017.

Notes

- User may select between AIHW's definition of Regular Client (attended the OATSIH-funded primary health care service at least 3 times in 2 years), or Communicare's Current Patient status.
- Patients must be recorded as Aboriginal or Torres Strait Islander or both.
- A cervical screening result is any incoming electronic pathology result identified as being a cervical screening where its laboratory description contains **CST**, **HPV**, **LBC**, **CERVICAL SCREEN**, **GYNAECOLOGICAL CYTOLOGY** or **NCSP**.
- A cervical screening request is a pathology request which has a keyword of **CST**, **HPV**, or **LBC**.
- A cervical screening clinical item is a completed item of any class with the export code of CST, HPV or LBC.
- A cervical screening qualifier is any qualifier which is a Yes/No qualifier with the export code of CST, HPV or LBC where the response recorded was `Yes`.

Table 225. NKPI PI 22

Element	Description
Communicare reports	• **Report > National KPI > PI22 Cervical Screening** • **Report > National KPI > PI22 Cervical Screening Patients**
Numerator	For details of how evidence of a cervical screening is determined, see Procedure, Immunisation, Pathology & Medicare codes reference *(on page 692)*.
Denominator	Regular, Indigenous women aged 25 years and above to less than 75 years.
Additional data recording considerations	none

This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

PI 23 - Blood Pressure recorded

Proportion of regular clients with Type 2 diabetes who have had a blood pressure measurement result recorded.

Description

Proportion of regular clients who are Indigenous, have Type 2 diabetes and who have had a blood pressure measurement result recorded at the primary health care service within the previous 6 months.

Notes

- User may select between AIHW's definition of Regular Client (attended the OATSIH-funded primary health care service at least 3 times in 2 years), or Communicare's Current Patient status.
- Patients must be recorded as Aboriginal or Torres Strait Islander or both.
- Only Type II diabetes is considered (any ICPC code of T90). Type I diabetes, secondary diabetes, gestational diabetes mellitus (GDM), previous GDM, impaired fasting glucose, impaired glucose tolerance are not included. For more information, see System codes *(on page 687)*.
- Any qualifier with a system code of BPS or BPD is considered a systolic or diastolic blood pressure measurement. For more information, see Qualifier codes *(on page 687)*.

Table 226. NKPI PI 23

Element	Description
Communicare reports	• **Report > National KPI > PI23 Diabetes BP Tests** • **Report > National KPI > PI23 Diabetes BP Tests Patients**
Numerator	Both diastolic and systolic blood pressure must be recorded at the same time.
Denominator	Regular, Indigenous patients with a diagnosis of Type II diabetes from any time. For more information about condition codes, see Condition codes reference *(on page 689)*.
Additional data recording considerations	**Note:** Local clinical items should not contain more than one qualifier with the system code of BPS and one with the system code of BPD as this is not currently supported and may lead to anomalies in both PI 23 and PI24. For more information, see Qualifier codes *(on page 687)*.

This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

PI 24 - Blood Pressure result

Proportion of Indigenous regular clients with Type 2 diabetes whose blood pressure measurement result was within specified categories

Description

Proportion of regular clients who are Indigenous, have Type 2 diabetes and whose blood pressure measurement result, recorded within the previous 6 months, was less than or equal to 140/90 mmHg.

Notes

- User may select between AIHW's definition of Regular Client (attended the OATSIH-funded primary health care service at least 3 times in 2 years), or Communicare's Current Patient status.
- Patients must be recorded as Aboriginal or Torres Strait Islander or both.
- Only Type II diabetes is considered (any ICPC code of T90). Type I diabetes, secondary diabetes, gestational diabetes mellitus (GDM), previous GDM, impaired fasting glucose, impaired glucose tolerance are not included. For more information, see System codes *(on page 687)*.
- The patient does not have a blood pressure measurement of less than or equal to 140/90 mmHg if either the systolic or diastolic reading is above the threshold (140 and 90 respectively).
- Only the most recent blood pressure measurement result in previous 6 months is considered.

Table 227. NKPI PI 24

Element	Description
Communicare reports	• **Report > National KPI > PI24 Diabetes BP Results** • **Report > National KPI > PI24 Diabetes BP Results Patients**
Numerator	Both diastolic and systolic blood pressure must be recorded at the same time. A blood pressure is deemed to be low if the systolic value is 140 or less and the diastolic value is 90 or less.
Denominator	Regular, Indigenous patients with a diagnosis of Type II diabetes from any time who have a blood pressure recorded. For more information about condition codes, see Condition codes reference *(on page 689)*.
Additional data recording considerations	**Note:** Local clinical items should not contain more than one qualifier with the system code of BPS and one with the system code of BPD as this is not currently supported and may lead to anomalies in both PI 23 and PI24. For more information, see Qualifier codes *(on page 687)*.

This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

PI 25 - STI result recorded

Proportion of Indigenous regular clients who have a test result for one or more sexually transmissible infections (STI).

Description

Proportion of Indigenous patients aged 15 to 34 years who had an STI result recorded within the previous 12 months for:

- Chlamydia
- Gonorrhoea
- Chlamydia and gonorrhoea

Notes

- User may select between AIHW's definition of Regular Client (attended the OATSIH-funded primary health care service at least 3 times in 2 years), or Communicare's Current Patient status.
- Patients must be recorded as Aboriginal or Torres Strait Islander or both.
- Patients deceased at the end of the reporting period are not included.
- An STI result is:
    - Any incoming electronic pathology result identified as being a chlamydia or gonorrhoea test by known LOINCs. Where no LOINC is returned by the lab, the test name is parsed for a small set of keywords but also excludes some chlamydia results based on exclusion terms. *See the specifications referenced below and refer to Appendix F - STI Coding framework for details.*
    - Any reference type qualifier defined with an export code of `CT-RSLT` (indicating a chlamydia result has been received) or `NG-RSLT` (indicating a gonorrhoea result has been received). In addition, the TTANGO qualifiers of `TTANGO Chlamydia` and `TTANGO Gonnorrhoea` are accepted. The export codes should be attached to any existing local qualifiers currently used to record POC STI testing.

Table 228. NKPI PI 25

Element	Description
Communicare reports	• **Report > National KPI > PI25 STI Results Patients** • **Report > National KPI > PI25 STI Results**
Numerator	The number of regular clients aged 15-34 years who have had a chlamydia and/or gonorrhoea test result recorded within the previous 12 months.
Denominator	The number of regular, Indigenous patients aged 15-34 years at the end of the report period

Disaggregation	• Age
	  ◦ 15–19 years
	  ◦ 20-24 years
	  ◦ 25-29 years
	  ◦ 30-34 years
	• Sex
	  ◦ Male
	  ◦ Female

Additional data recording considerations	-

This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

PI 26 - Ear Health Check

Proportion of Indigenous regular clients ages 0-14 years who have a completed ear health check recorded.

Description

Proportion of Indigenous regular clients who, in the previous 12 months, have had a completed check that was recorded, of the:

- Appearance of both ear canals and eardrums
- Movement of both eardrums
- Appearance of both ear canals and ear drums and movement of both ear drums

Both ears should be checked; however, if a person has only one ear, only one ear can be checked. If there is detail in the patient record specific to only the left or right ear the patient will still be included in the relevant measure code.

Notes

Note:
New system and export codes have been added to relevant central qualifiers in Communicare to support recording data for this PI. Communicare Administrators should assess whether their local qualifiers need to similarly be updated. For more information, see Codes to support nKPI PI 26 Ear Health Checks *(on page 735)*.

- User may select between AIHW's definition of Regular Client (attended the OATSIH-funded primary health care service at least 3 times in 2 years), or Communicare's Current Patient status.
- Patients must be recorded as Aboriginal or Torres Strait Islander or both.
- Patients deceased at the end of the reporting period are not included.

Table 229. NKPI PI 26

Element	Description
Communicare reports	• **Report > National KPI > PI26 Ear Health Checks Patients** • **Report > National KPI > PI26 Ear Health Checks**
Numerator	• Calculation A: number of Indigenous regular clients aged *[Disaggregation: Age]* who have had a completed check of the appearance of both ear canals and ear drums within the previous 12 months. • Calculation B: number of *[Disaggregation: Gender]* Indigenous regular clients aged *[Disaggregation: Age]*who have had a completed check of the movement of both eardrums within the previous 12 months. • Calculation C: number of *[Disaggregation: Gender]* Indigenous regular clients aged *[Disaggregation: Age]*who have had a completed check of the appearance of both ear canals and eardrums and the movement of both eardrums within the previous 12 months.

Table 229. NKPI PI 26 (continued)

Element	Description
Denominator	Calculation A, B and C: total number of *[Disaggregation: Gender]* Indigenous regular clients aged *[Disaggregation: Age]*.
Disaggregation	• Age ◦ 0-11 months ◦ 12-23 months ◦ 24-35 months ◦ 36-59 months ◦ 5-9 years ◦ 10-14 years • Gender ◦ Male ◦ Female
Additional data recording considerations	-

This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

Ear Health Check Included Clinical Items and Qualifiers

Use these Central clinical items for ear health conditions or procedures to capture evidence of an appearance or movement check to include in nKPI and NT KPI reporting for PI 26 Ear Health Checks.

Table 230. Ear Health Check Clinical Items

Group	Clinical Item	Code[1]	Appearance, Movement or Both
Otitis externa	Otitis externa	H70002	Both
	Swimmers ear	H70003	
Otitis media	Effusion;middle ear	H72001	Both
	Glue ear	H72002	
	Otitis media	H71003	
	Otitis media (with);effusion	H72005	
	Otitis media;acute	H71002	
	Otitis media;acute;no perforat	H71020	
	Otitis media;acute;perforation	H71021	
	Otitis media;chronic	H74004	
	Otitis media;nonsuppurative	H72003	
	Otitis media;perforated	H71004	
	Otitis media;serous	H72004	
	Otitis media;suppurative;acute	H71009	

1. The code is a combination of the ICPC-2 PLUS Code and Term values.

Table 230. Ear Health Check Clinical Items (continued)

Group	Clinical Item	Code[1]	Appearance, Movement or Both
	Otitis media;suppurative;chron	H74006	
Myringitis	Myringitis	H71001	Appearance
	Myringitis;chronic	H74002	
	Inflammation;tympanic membra	H71006	
	Tympanitis	H71005	
Perforation of tympanic membrane	Perforation;ear drum	H77002	Appearance
	Perforation;tympanic membran	H77001	
	Rupture(trauma/pres); eardrum	H79003	
Cholesteatoma	Cholesteatoma	H74005	Appearance
Otorrhoea	Discharge;ear	H04001	Appearance
	Pus (from);ear	H04002	
Bleeding from Ear	Bleeding;ear	H05001	Appearance
Procedure	Endoscopy;diagnostic;ear	H40001	Appearance
	Test;tympanometry	H39007	Movement
	Check up;complete;ear	H30001	Both
	Exam;complete;ear B	H30002	
	Assessment;complete;hearing	H30003	
	Myringotomy	H51010	
	Grommet(s)	H53003	
	Drainage tube(s);middle ear	H53004	
	Myringoplasty	H54006	
	Tympanoplasty	H54007	
	Otorrhoea;tympanostomy tube	H72007	
Hearing loss	Deafness	H86003	Both
	Deafness;sensorineural	H86002	
	Deafness;mixed	H86005	
	Deafness;conductive	H86004	
	Problem;hearing	H02006	
	Unable (to);hear	H02001	
	Deaf mutism	H86001	
	Disturbed;hearing	H02002	
	Diminished;hearing	H02003	
	Loss (of);hearing	H02004	
	Deafness;partial;bilateral	H86007	
	Deafness;total;bilateral	H86008	

1. The code is a combination of the ICPC-2 PLUS Code and Term values.

Table 230. Ear Health Check Clinical Items (continued)

Group	Clinical Item	Code[1]	Appearance, Movement or Both
	Deafness;congenital	H86009	

Table 231. Central Qualifiers used in PI26

Sys Code	Name	Number	M Type	Export Code
L	Drawing:eardrum (L tympanic membrane)	1000003176	(W)	OTO-NKPI
L	Ear exam: left	1000000945	(R)	OTO-NKPI
L	Ear exam: left comments/action	1000000944	(T)	OTO-NKPI
L	Otoscope image left ear	1000003404	(I)	OTO-NKPI
L	Otoscopy - Left	1000000277	(T)	OTOSCOPY
L	Otoscopy left ear	1000000217	(R)	OTOSCOPY
L	Tympanometry - L Canal Vol	1000000295	(N)	TYM-NKPI
L	Tympanometry - L Category	1000000301	(R)	TYM-NKPI
L	Tympanometry - L Compliance	1000000297	(N)	TYM-NKPI
L	Tympanometry - L Pressure	1000000299	(N)	TYM-NKPI
L	Tympanometry - L ear - interpretation	1000003247	(R)	TYM-NKPI
L	Tympanometry - left	1000002059	(R)	TYM-NKPI
LR	Drawing:eardrum (L, R tympanic membrane)	1000001649	(W)	OTO-NKPI
LR	Tympanometry notes	1000003403	(M)	TYM-NKPI
R	Drawing:eardrum (R tympanic membrane)	1000003175	(W)	OTO-NKPI
R	Ear exam: right	1000000947	(R)	OTO-NKPI
R	Ear exam: right comments/action	1000000946	(T)	OTO-NKPI
R	Otoscope image right ear	1000003405	(I)	OTO-NKPI
R	Otoscopy - Right	1000000278	(T)	OTOSCOPY
R	Otoscopy right ear	1000000218	(R)	OTOSCOPY
R	Tympanometry - R Canal Vol	1000000296	(N)	TYM-NKPI
R	Tympanometry - R Category	1000000302	(R)	TYM-NKPI

1. The code is a combination of the ICPC-2 PLUS Code and Term values.

Table 231. Central Qualifiers used in PI26 (continued)

Sys Code	Name	Number	M Type	Export Code
R	Tympanometry - R Compliance	1000000298	(N)	TYM-NKPI
R	Tympanometry - R Pressure	1000000300	(N)	TYM-NKPI
R	Tympanometry - R ear - interpretation	1000003246	(R)	TYM-NKPI
R	Tympanometry - right	1000002058	(R)	TYM-NKPI

Tip:

To help understand which qualifiers used at your health service use the relevant export and system codes for nKPI and NT KPI reporting for PI 26 Ear Health Checks, generate a list of all qualifiers; run **Report > Reference Tables > System Codes and Rule Codes**.

Codes to support nKPI PI 26 Ear Health Checks

Add export and system codes to any qualifiers used in local clinical items that you want to use to capture evidence of an appearance or movement check to include in nKPI and NT AHKPI reporting for PI 26 Ear Health Checks.

For a list of Central qualifiers included in PI26 reports, see Ear Health Check Included Clinical Items and Qualifiers *(on page 732)*.

To include local qualifiers in nKPI or NT KPI reporting, in **File > Reference Tables > Qualifier Types**:

1. For nKPIs, identify a qualifier as an appearance check by adding either the export code of `OTO-NKPI` or `OTOSCOPY`. The nKPI PI26 includes both `OTO-NKPI` and `OTOSCOPY`.

   Tip:
   If the qualifier should be included in the *NT AHKPI indicator 1-20 Ear Disease in Children*, use the export code of `OTOSCOPY` only. For more information, see NT AHKPIs *(on page 473)*.

2. Identify a qualifier as a movement check by adding the export code of `TYM-NKPI`
3. Identify each of the appearance or movement checks with a system code of `L`, `R` or `LR` to identify that the qualifier check covers either the left or right or both ears.
4. Add options for each qualifier that record that a check was not done with a system code of 0. All other options that record that a check was performed satisfactorily should have a system code of 1. If there is no system code recorded it is assumed that the check was done.

OSR summary

Summary of Online Services Report (OSR) data collection.

Note:
This information relates to V18.0 of the *Specifications for National Key Performance Indicators and Online Services Reporting* (Solving Health, Specifications for National Key Performance Indicators and Online Services Reporting

V18.0. Sydney: Solving Health, February 2025). For more information, see https://www.solvinghealth.au/specifications.

The OSR collects national data about organisations which receive funding from the Indigenous Australians' Health Programme (IAHP) to deliver health services to Aboriginal and Torres Strait Islander people. These services include primary health care, maternal and child health care.

The OSR dataset focuses on the characteristics of these services, along with the activities and services they provide. It provides a basic measure of activity, volume and coverage of services. It does not collect information on Indigenous health outcomes, which is collected in the National Key Performance Indicators (nKPIs). For more information, see https://www.health.gov.au/topics/aboriginal-and-torres-strait-islander-health/reporting/osr.

Table 232. Summary of OSR reports

OSR report	Description	Further information
OSR CS-1	How many episodes of health care were provided by your health service during year?	CS-1 *(on page 737)*
OSR CS-2	How many client contacts were made by each type of worker from the service during the year?	CS-2 *(on page 738)*
OSR CS-3	How many individual clients were seen by your health service during the period?	CS-3 *(on page 738)*
OSR CS-4	How many Adult Health Checks and Chronic Disease Management Plans were done during the year?	CS-4 *(on page 739)*
OSR HP-1	How many health promotion group activities were run during the year?	HP-1 *(on page 739)*
OSR L-6	How many clients were seen by the Link Up Service during the year?	L-6 *(on page 740)*
OSR L-7	How many client contacts were provided by the Link Up service during the year?	L-7 *(on page 740)*
OSR MCH-1	How many Child Health Checks were done during the year?	MCH-1 *(on page 741)*
OSR MCH-2	How many individual mothers have attended routine antenatal care during the year?	MCH-2 *(on page 741)*
OSR MCH-3	How many antenatal and maternal group activities were run during the year?	MCH-3 *(on page 742)*
OSR S-6	How many distinct individual clients were seen by your organisation during the year?	S-6 *(on page 742)*
OSR S-7a	How many distinct individual clients received residential treatment/rehabilitation at your organisation during the year?	S-7a *(on page 743)*
OSR S-7b	What was the total length of stay for each of your clients in residential treatment / rehabilitation during the year?	S-7b *(on page 743)*

Table 232. Summary of OSR reports (continued)

OSR report	Description	Further information
OSR S-7c	How many residential treatment/rehabilitation episodes of care were provided by your service during the year?	S-7c *(on page 744)*
OSR S-10	How many distinct clients attended your sobering-up and/or residential respite/short term care programs during the year?	S-10 *(on page 744)*
OSR S-11	How many 'sobering up/residential respite/short-term' episodes of care were provided by your service during the year?	S-11 *(on page 745)*
OSR S-13	How many individual clients received 'non-residential/follow up / after care' from your organisation during the year?	S-13 *(on page 745)*
OSR S-14	How many 'non-residential/follow up / after care' episodes of care were provided by your service during the year?	S-14 *(on page 746)*
OSR SE-6	How many individual clients were seen by SEWB Counsellors during the year?	SE-6 *(on page 747)*
OSR SE-7	How many client contacts were made by SEWB Counsellors during the year?	SE-7 *(on page 747)*
OSR HCP	Health Care Provider (HCP) report	Included in Communicare V18.1 and later HCP *(on page 748)*

OSR CS-1a - Episodes of care

Number of episodes of care provided within the previous 12 months.

Description

The report counts all services except:

- Any `no client contact` service.
- The contact service of `Administration - client contact`.
- `Waiting`, `Booked` or `Cancelled` services.
- Services provided by providers with a speciality of `transport worker`.
- Services recorded using the `Transport` module.
- Services recorded for fictitious clients.

If there are multiple services recorded on the same day, only one is counted for this report.

Table 233. OSR CS-01

Element	Description
Communicare reports	• **Report > OSR > CS-01 Episodes of Health Care**
Business rules	Described above.

Table 233. OSR CS-01 (continued)

Element	Description
Additional data recording considerations	**Note:** Currently there is no distinction between the encounter place or contact types for multiple services recorded on the same day.

OSR CS-2 - Client contacts

How many client contacts were made by each type of worker from the service during the year?

Description

The report counts all services except:

- Any `no client contact` service.
- `Waiting`, `Booked` or `Cancelled` services.
- Services recorded for fictitious clients.

Services recorded in either the `Transport Management` or `Transport Services` module are also included.

Table 234. OSR CS-02

Element	Description
Communicare reports	• **Report > OSR > CS-02 Contacts by Worker Type**
Business rules	For information about how Communicare speciality types are mapped, see Client Contact Types reference *(on page 698)*. For specific reverse mappings, see Client Contact Types reference *(on page 698)*.
Additional data recording considerations	A provider who is part of a service does not need to have recorded any clinical information to be included. This means that a claiming doctor who is added to a contact service for the purposes of making a Medicare claim only is included in this report.

OSR CS-3a - Individual clients seen

How many Adult Health Checks and Chronic Disease Management Plans were done during the year?

Description

The report counts all clients who had services except the following and services recorded for fictitious clients.:

- Any `no client contact` service.
- `Waiting`, `Booked` or `Cancelled` services.

Table 235. OSR CS-03

Element	Description
Communicare reports	• **Report > OSR > CS-04 Clinical Activities**

Table 235. OSR CS-03 (continued)

Element	Description
Business rules	This report counts individuals who are included at least once in CS-2 *(on page 738)*.
Additional data recording considerations	none

OSR CS-4 - Clinical Services CS-4 Record the count for the following clinical activities carried out during the Financial Year

How many Adult Health Checks and Chronic Disease Management Plans were done during the year?

Description

Health checks are identified either by Medicare claims for item 715 or alternatively by clinical items with the system code of CHC (Child Health Check), AHC (Adult Health Check) and OHC (Older person Health Check). If both a MBS 715 and an alternative health check are recorded for the same patient, only the 715 check is counted.

Chronic disease management plans are identified either by Medicare claims for item 721 or alternatively by clinical items with the system code of CPA. If both a MBS 721 and any clinical items with system code CPA are recorded for the same patient, only the 721 plan is counted.

Note:
Because the claim and the evidence of the claim can be recorded on separate occasions, and because items 715 and 721 are usually annual claims, individual patients rather than individual claims or completed clinical items are reported .

Table 236. OSR CS-04

Element	Description
Communicare reports	• **Report > OSR > CS-04 Clinical Activities**
Business rules	Evidence of claims for items 715 and 721 is searched for and if none is found, the clinical items are searched using the system codes of CHC, AHC, OHC and CPA.
Additional data recording considerations	none

OSR HP1 - Health Promotion HP-1 How many group activities and population health promotional activities has your organisation run during the Financial Year?

How many health promotion group activities were run during the year?

Description

The report counts procedures with an export code starting HP-GRP, analysed by day and encounter place in order to deduce the number of group sessions conducted, assuming that the same type of session is not run repeatedly on the same day at the same place.

For detailed information about export codes, see Procedure, Immunisation, Pathology & Medicare codes reference *(on page 692)*.

Table 237. OSR HP-1

Element	Description
Communicare reports	• **Report > OSR > HP-01 HP Group Activities**
Business rules	All clinical items with appropriate codes recorded in any patient record are deemed to be evidence of attendance at a group health promotion event. Actual attendance is not counted so where a non-patient record is used to record anonymous attendance, the event is still recorded.
Additional data recording considerations	No clinical items with these codes are distributed by Communicare so all data collection for this indicator is done using locally defined procedures.

OSR L-6 - Link Up L-6 How many individual clients were seen by SEWB funded counsellors during the Financial Year?

How many clients were seen by the Link Up Service during the year?

Description

Link-up service contacts are identified by encounter place names which contain the words `BTH` or `Link Up` or encounter program names which contain the words `BTH`, `Link Up` or `Bringing Them Home`.

Table 238. OSR L-6

Element	Description
Communicare reports	• **Report > OSR > L-06 Individual Link Up Clients**
Business rules	Any patient with at least one contact service recorded during the report period at a BTH or Link Up encounter place or recorded with the associated BTH or Link Up encounter program.
Additional data recording considerations	none

OSR L-7 - Link Up L-7 How many client contacts were provided by the Link Up organisation during the Financial Year?

How many client contacts were provided by the Link Up service during the year?

Description

Link-up service contacts are identified by encounter place names which contain the words `BTH` or `Link Up` or encounter program names which contain the words `BTH`, `Link Up` or `Bringing Them Home`.

Table 239. OSR L-7

Element	Description
Communicare reports	• **Report > OSR > L-07 Link Up Contacts**
Business rules	All contact services recorded during the report period at a BTH or Link Up encounter place or recorded with the associated BTH or Link Up encounter program.

Table 239. OSR L-7 (continued)

Element	Description
Additional data recording considerations	none

OSR MCH-1 - Maternal and Child Health MCH-1 Record the number of child health checks conducted in the Financial Year

How many Child Health Checks were done during the year?

Description

Health checks are identified by the client being 0 to 4 years of age and either a Medicare claimed for item 715 or alternatively by clinical item with the system code of CHC. If both a MBS 715 and an alternative health check (CHC) are recorded for the same patient, only the 715 check is counted.

Note:
Because the claim and the evidence of the claim can be recorded on separate occasions, and because item 715 is usually an annual claim, individual patients are reported rather than individual claims or completed clinical items. MBS item 10986 Healthy Kids Check are identified by Medicare claims for item 10986.

Table 240. OSR MCH-1

Element	Description
Communicare reports	• **Report > OSR > MCH-01 Child Health Checks**
Business rules	This report counts individuals with evidence of an annual child health check during the report period. A patient with two such checks is reported once only.
Additional data recording considerations	Medicare Item 10986 is no longer available.

OSR MCH-2 - Maternal and Child Health MCH-2 Record the number of individual mothers who have attended a routine antenatal care conducted by your organisation during the Financial Year

How many individual mothers have attended routine antenatal care during the year?

Description

Antenatal checks are identified by procedures with a PR-CHECK rule code; that is, all those items listed on the **Obstetrics** tab, **Antenatal Check**.

Table 241. OSR MCH-2

Element	Description
Communicare reports	• **Report > OSR > MCH-02 Individual Antenatal Care Clients**

Table 241. OSR MCH-2 (continued)

Element	Description
Business rules	Any woman with an antenatal check performed during the report period is included. For details of how to record an antenatal check, see Procedure, Immunisation, Pathology & Medicare codes reference *(on page 692)*. **Note:** If the response to the qualifier `Antenatal check performed` is anything starting with `Elsewhere…` the check is ignored. That is, if the response is `At this encounter place` or there is no response, the check is counted.
Additional data recording considerations	none

OSR MCH-3 - Maternal and Child Health MCH-3 Record whether your organisation ran the following antenatal and maternal group activities during the Financial Year

How many antenatal and maternal group activities were run during the year?

Description

Where possible, record the number of sessions run.

The report counts procedures with an export code starting `MCH-GRP`, analysed by day and encounter place in order to deduce the number of group sessions conducted, assuming that the same type of session is not run repeatedly on the same day at the same place.

For details about export codes, see Procedure, Immunisation, Pathology & Medicare codes reference *(on page 692)*.

Table 242. OSR MCH-3

Element	Description
Communicare reports	• **Report > OSR > MCH-03 MCH Group Activities**
Business rules	All clinical items with appropriate codes recorded in any patient record is deemed to be evidence of attendance at a maternal and child health group health promotion event. Actual attendance is not counted so where a non-patient record is used to record anonymous attendance, the event is still recorded.
Additional data recording considerations	No clinical items with these codes are distributed by Communicare so all data collection for this indicator is done using locally defined procedures.

OSR S-6 - Standalone Substance Use S-6 How many distinct individual clients were seen by your organisation during the Financial Year?

How many distinct individual clients were seen by your organisation during the year?

Description

The report counts all clients who had services (except: 'no client contact' services; 'waiting', 'booked' or 'cancelled' services) and services recorded for fictitious clients, who satisfy at least one of the following criteria:

- Were receiving residential drug and alcohol care during part or all of the reporting period.
- Had received some 'sobering up/residential respite/short-term' episodes of care during part of the reporting period.
- Received a service associated with an encounter program containing the words 'DRUG' and/or 'ALCOHOL' and/or 'AOD'.
- Received a service associated with an encounter place containing the words 'DRUG' and/or 'ALCOHOL' and/or 'AOD'.
- Received a service provided by a 'Drug and alcohol counsellor' or a 'Substance misuse worker'.
- Received a service having at least one procedure or referral that is not a recall or a cancelled recall having a keyword containing the words 'DRUG' and/or 'ALCOHOL' and/or 'AOD'.

Table 243. OSR S-6

Element	Description
Communicare reports	• **Report > OSR > S-06 Individual Clients**
Business rules	The description above details which services are counted as substance use services.
Additional data recording considerations	This indicator was initially specified for standalone substance use services only but has since been extended to mainstream health services who receive funding for substance use support. As such it is not yet clearly defined but the above conditions are fairly comprehensive although they may over-report activity of this type.

OSR S-7a - Standalone Substance Use S-7a How many distinct individual clients received residential treatment / rehabilitation at your organisation during the Financial Year?

How many distinct individual clients received residential treatment/rehabilitation at your organisation during the year?

Description

Residential treatment is identified by enrolments. Enrolments are identified by export code `DA-ENROL` with a `Treatment delivery setting` qualifier (`DA-TDS` export code) set to `Residential Treatment Facility`.

Enrolments recorded for fictitious clients are not included.

Table 244. OSR S-7a

Element	Description
Communicare reports	• **Report > OSR > S-07 Individual Rehabilitation Clients**
Business rules	The alcohol and other drug dataset distributed by Communicare includes items with the appropriate codes to record the start and end of periods of treatment. For details about codes, see Procedure, Immunisation, Pathology & Medicare codes reference *(on page 692)*.
Additional data recording considerations	The Communicare report numbering dates from an earlier numbering system for OSR reporting – report 7 now reports for indicator 7a.

OSR S-7b - Standalone Substance Use S-7b What was the total length of stay for each of your clients in residential treatment / rehabilitation during the Financial Year?

What was the total length of stay for each of your clients in residential treatment / rehabilitation during the year?

Description

Residential treatment is identified by enrolments. Enrolments are identified by export code `DA-ENROL` with a `Treatment delivery setting` qualifier (`DA-TDS` export code) set to `Residential Treatment Facility`.

Enrolments recorded for fictitious clients are not included.

Table 245. OSR S-7b

Element	Description
Communicare reports	• **Report > OSR > S-07a Length of Stay**
Business rules	The alcohol and other drug dataset distributed by Communicare includes items with the appropriate codes to record the start and end of periods of treatment. For details about codes, see Procedure, Immunisation, Pathology & Medicare codes reference *(on page 692)*.
Additional data recording considerations	The Communicare report numbering dates from an earlier numbering system for OSR reporting – report 7a now reports for indicator 7b.

OSR S-7c - Standalone Substance Use S-7c How many residential treatment / rehabilitation episodes of care were provided by your organisation during the Financial Year?

How many residential treatment/rehabilitation episodes of care were provided by your service during the year?

Description

Residential treatment is identified by enrolments. Enrolments are identified by export code `DA-ENROL` with a `Treatment delivery setting` qualifier (`DA-TDS` export code) set to `Residential Treatment Facility`.

Enrolments recorded for fictitious clients are not included.

Table 246. OSR S-7c

Element	Description
Communicare reports	• **Report > OSR > S-07b Residential Episodes**
Business rules	The alcohol and other drug dataset distributed by Communicare includes items with the appropriate codes to record the start and end of periods of treatment. For details about codes, see Procedure, Immunisation, Pathology & Medicare codes reference *(on page 692)*.
Additional data recording considerations	The Communicare report numbering dates from an earlier numbering system for OSR reporting – report 7b now reports for indicator 7c.

OSR S-10 - Standalone Substance Use S-10 How many distinct clients attended your sobering-up and/or residential respite/short term care programs during the Financial Year?

How many distinct clients attended your sobering-up and/or residential respite/short term care programs during the year?

Description

Sobering-up and/or Residential Respite/Short-term care episodes are identified by clinical items with export codes of DR-ENROL and DA-SUOS.

Table 247. OSR S-10

Element	Description
Communicare reports	• **Report > OSR > S-10 Individual Non-Rehab Clients**
Business rules	The alcohol and other drug dataset distributed by Communicare includes items with the appropriate codes to record the start and end of periods of treatment. For details about codes, see Procedure, Immunisation, Pathology & Medicare codes reference *(on page 692)*.
Additional data recording considerations	none

OSR S-11 - Standalone Substance Use S-11 How many 'sobering up / residential respite / short-term' episodes of care were provided by your organisation during the Financial Year?

How many 'sobering up/residential respite/short-term' episodes of care were provided by your service during the year?

Description

Sobering-up and/or Residential Respite/Short-term care episodes are identified by clinical items with export codes of DR-ENROL and DA-SUOS.

Table 248. OSR S-11

Element	Description
Communicare reports	• **Report > OSR > S-11 Episodes Non-Rehab Clients**
Business rules	The alcohol and other drug dataset distributed by Communicare includes items with the appropriate codes to record the start and end of periods of treatment. For details about codes, see Procedure, Immunisation, Pathology & Medicare codes reference *(on page 692)*.
Additional data recording considerations	none

OSR S-13 - Standalone Substance Use S-13 How many individual clients received 'non-residential / follow up / after care' from your organisation during the Financial Year?

How many individual clients received 'non-residential/follow up / after care' from your organisation during the year?

Description

The report counts all clients who had services (except: 'no client contact' services; 'waiting', 'booked' or 'cancelled' services) and services recorded for fictitious clients, who satisfy at least one of the following criteria:

- Received a service associated with an encounter program containing the words 'DRUG' and/or 'ALCOHOL' and/or 'AOD'.
- Received a service associated with an encounter place containing the words 'DRUG' and/or 'ALCOHOL' and/or 'AOD'.
- Received a service provided by a 'Drug and alcohol counsellor' or a 'Substance misuse worker'.
- Received a service having at least one procedure or referral that is not a recall or a cancelled recall having a keyword containing the words 'DRUG' and/or 'ALCOHOL' and/or 'AOD'.

Excluded are services where the client was receiving residential drug and alcohol care at that time or attended a group session or was receiving 'sobering up/residential respite/short-term' care as a part of that service.

Table 249. OSR S-13

Element	Description
Communicare reports	• **Report > OSR > S-13 Individual Non-Residential Clients**
Business rules	The description above details which services are counted as substance use services.
Additional data recording considerations	This indicator was initially specified for standalone substance use services only but has since been extended to mainstream health services who receive funding for substance use support. As such it is not yet clearly defined but the above conditions are fairly comprehensive although they may over-report activity of this type.

OSR S-14 - Standalone Substance Use S-14 How many 'non-residential / follow up / after care' episodes of care were provided by your organisation during the Financial Year?

How many 'non-residential/follow up / after care' episodes of care were provided by your service during the year?

Description

The report counts all clients who had services (except: 'no client contact' services; 'waiting', 'booked' or 'cancelled' services) and services recorded for fictitious clients, who satisfy at least one of the following criteria:

- Received a service associated with an encounter program containing the words 'DRUG' and/or 'ALCOHOL' and/or 'AOD'.
- Received a service associated with an encounter place containing the words 'DRUG' and/or 'ALCOHOL' and/or 'AOD'.
- Received a service provided by a 'Drug and alcohol counsellor' or a 'Substance misuse worker'.
- Received a service having at least one procedure or referral that is not a recall or a cancelled recall having a keyword containing the words 'DRUG' and/or 'ALCOHOL' and/or 'AOD'.

Excluded are services where the client was receiving residential drug and alcohol care at that time or attended a group session or was receiving 'sobering up/residential respite/short-term' care as a part of that service.

Table 250. OSR S-14

Element	Description
Communicare reports	• **Report > OSR > S-14 Episodes of Non-Residential Care**
Business rules	The description above details which services are counted as substance use services.

Table 250. OSR S-14 (continued)

Element	Description
Additional data recording considerations	This indicator was initially specified for standalone substance use services only but has since been extended to mainstream health services who receive funding for substance use support. As such it is not yet clearly defined but the above conditions are fairly comprehensive although they may over-report activity of this type.

OSR SE-6 - Social and Emotional Wellbeing SE-6 How many individual clients were seen by SEWB funded counsellors during the Financial Year?

How many individual clients were seen by SEWB Counsellors during the year?

Description

Table 251. OSR SE-6

Element	Description
Communicare reports	• **Report > OSR > SE-06 Individual SEWB Clients**
Business rules	For information about how Communicare speciality types are mapped, see Client Contact Types reference *(on page 698)*. Patients with at least one service recorded in the report period with any Communicare Speciality type that maps to an AIHW provider type of `Social and Emotional Well Being staff | Counsellor` are counted once only.
Additional data recording considerations	none

OSR SE-7 - Social and Emotional Wellbeing SE-7 How many client contacts were provided by the SEWB funded counsellors during the Financial Year?

How many client contacts were made by SEWB Counsellors during the year?

Description

Table 252. OSR SE-7

Element	Description
Communicare reports	• **Report > OSR > SE-07 SEWB Contacts**
Business rules	For information about how Communicare speciality types are mapped, see Client Contact Types reference *(on page 698)*. All services recorded in the report period with any Communicare Speciality type that maps to an AIHW provider type of `Social and Emotional Well Being staff | Counsellor` are counted.
Additional data recording considerations	none

OSR HCP Health Care Provider (HCP) report

Health Care Provider (HCP) report

Description

The Health Care Provider (HCP) report refers to the report submitted annually to the Department of Health by all Australian Government funded Indigenous health services who are eligible to claim Medicare benefits for primary health care services.

This report shows all providers that have a DOH Provider Number who were enabled for all or part of the reporting period.

Table 253. OSR HCP

Element	Description
Communicare reports	• **Report > Health Care Providers > Provider List**
Business rules	All providers recorded in **File > Provider** who have at least one DOH Provider number and who were not disabled before the start of the report period nor only enabled after the end of the report period.
Additional data recording considerations	none

NSW KPIs

Additional information for NSW KPIs.

Before you start

Note:
Configuration notes are valid for the Version 5.0 of the NSW KPI reports.

If your health service is using Communicare 'out of the box' and has taken advantage of datasets provided by Communicare, only the codes highlighted here need to be considered.

Note:
For best results when reporting, use the datasets provided by Communicare rather than creating your own.

Clinical items

This section identifies any local clinical items that may be evidence of procedures and other activity required for specific indicators.

Configuration is done at **File > Reference Tables > Clinical Item Types**.

Table 254. Required clinical items

Performance indicator	For	Description
Smoking Cessation		• Any procedure or referral which is evidence of smoking cessation must use the system code SCS • Any procedure or referral performed which is in the **Tobacco use services**
Immunisation Types	Influenza	Communicare supports the Generic Influenza AIR vaccine, with vaccine code **GNFLU**, and its equivalents described in Equivalent and partial equivalent vaccines table - GNFLU entry. For example, GNFLU, PANVAX, FLUVAX, and so on.
	Pertussis	The following export codes identify pertussis vaccines: ADCL, ADPO, BOOST or BOIPV.

If you do not make Medicare claims, make sure that clinical items used to record care plans and health checks use the following system codes.

Qualifiers

This section identifies any local qualifiers that may be evidence of details required for specific indicators.

Configuration is done at **File > Reference Tables > Qualifier Types**.

Table 255. Required qualifiers

Performance indicator	Code	Description
Smoking Cessation	`BIP`	Any clinical item that is evidence of 'brief intervention' should have a qualifier that is either: • A Yes/No qualifier with a system code of `BIP` • A reference qualifier where relevant responses have system codes of `BIP`.

Table 255. Required qualifiers (continued)

Performance indicator	Code	Description
Smoking Status	SMO or SMP	The central qualifiers are appropriately coded, but if a local variation is used the qualifier itself must be a reference qualifier with the system code SMO or SMP (if recorded during a pregnancy). Each reference must be coded in the following way: • System Codes: ◦ S - current smoker ◦ E - ex-smoker ◦ N - never smoked • For export code SMO: ◦ 1 - wants to quit now ◦ 2 - wants to quit later ◦ 3 - no intention of quitting ◦ 4 - quit less than 12 months ago ◦ 5 - quit 12 months or more ago ◦ 7 = non-smoker • For export code SMP: ◦ 1 - daily smoker ◦ 2 - weekly smoker ◦ 3 - irregular smoker ◦ 4 - quit during pregnancy ◦ 5 - quit before pregnancy ◦ 6 - non-smoker

Table 255. Required qualifiers (continued)

Performance indicator	Code	Description
Central pathology qualifiers	BPS, CHO, CHR, HDL, CVR-R05C, CVR-R05F, ACR, GFE, HBA, HBM, AUDITC, XHB, XHC, XCL, XGN, XSY, XHI	Only of interest if the health service has local equivalents: • Systolic blood pressure is determined as the latest qualifier with system code BPS • Total cholesterol is determined as the latest qualifier with system code CHO or CHR • High density lipoprotein is determined as the latest qualifier with system code HDL or CHR • CVD risk assessment is determined as the latest qualifier with export code CVR-R05C • (CARPA) or CVR-R05F (Framingham). • Urinary Albumin Creatinine Ratio is determined as the latest qualifier with system code ACR. • Estimated Glomerular Filtration Rate is determined as the latest qualifier with system code GFE. • HbA1c is derived from numeric qualifiers with a system code of HBA and units % or HBM and units mmol/mol converted to percentage. • AUDIT-C Score is determined by numeric qualifiers with an export code of AUDITC. • `Hepatitis B result abnormal` yes/no qualifier (system code XHB). The qualifier must be set to **Yes** to be counted. • `Hepatitis C result abnormal` yes/no qualifier (system code XHC). The qualifier must be set to **Yes** to be counted. • `Chlamydia result abnormal` yes/no qualifier (system code XCL). The qualifier must be set to **Yes** to be counted. • `Gonorrhoea result abnormal` yes/no qualifier (system code XGN). The qualifier must be set to **Yes** to be counted. • `Syphilis result abnormal` yes/no qualifier (system code XSY). The qualifier must be set to **Yes** to be counted. • `HIV result abnormal` yes/no qualifier (system code XHI). The qualifier must be set to **Yes** to be counted.

Investigation Requests

This section identifies keywords that need to be attached to any of your investigation request terms to identify them as STI test requests.

Configuration is done at **File > Reference Tables > Investigations > Investigation Keywords**.

STI request terms

Table 256. STI request terms

Infection	keyword
Hepatitis B	**HepB**
HBV DNA Viral load test	**HBV**
HCV RNA test	**HVCRNA**

Table 256. STI request terms (continued)

Infection	keyword
Chlamydia	**CHLAMYDIA**
Gonorrhoea	**GONORRHOEA**
Syphilis	**SYPHILIS**
HIV	**HIV**

Liver Function Tests

Liver Function Tests are determined from Pathology test requests that have a keyword of **LFT**.

Central and imported codes

This section refers to codes that are attached to ICPC2-Plus items, MIMS medications, incoming pathology results (LOINCs), and so on. Some labs use their own local codes to identify pathology results and use of LOINCs for text-based results is not consistent.

Table 257. Central & imported codes

Database	Report	Description
MIMS	Smoking Cessation	Medications with an indication containing the text **smok** or **nicotine** are identified as smoking cessation treatments. For example, the drug Champix is included because it has an indication of **Nicotine dependence**.
	CVD Risk Treatment	Medications with an indication of **hyperlipidaemia**, **hypercholesterolaemia** or **hypertension** are identified as smoking cessation treatments. For example, the drug Cleviprex is included because it has an indication of **Hypertension**.
	DAA Treatment	Recent prescriptions are identified by the following generic components: pegylated interferon, daclatasvir, sofosbuvir + ledipasvir, ribavirin, sofosbuvir, paritaprevir + ritonavir + ombitasvir + dasabuvir, paritaprevir + ritonavir + ombitasvir + dasabuvir + ribavirin.
LOINC		Incoming pathology results are identified by LOINCs (if supplied by the lab) for the specified STI. For more information, see https://loinc.org/. Additionally, if only positive results are reported, the lab must return an abnormal code.
ICPC Diagnoses		Specific conditions for specific indicators are identified in the NSW specifications document *Aboriginal Health Program Key Performance Indicators: Data Specifications 2019/20-2021/22 Version 5.0 February 2021*

NT AHKPIs

Additional information for NT AHKPI.

Before you start

> **Note:**
> For best results when reporting, use the datasets provided by Communicare rather than creating your own.

Before you can effectively use the NT AHKPIs you need to configure parts of your database.

Encounter place

Configure your encounter places:

1. Select **File > Reference Tables > Encounter Place**.
2. If you have only one clinic:
    a. From the **Locality Group** list, select `Health Service Area`.
    b. In the **DHF Health Service Code** field, enter the five digit code allocated by the Department of Health and Families.
3. If you have multiple clinics, each encounter place must be allocated a unique locality group that defines the localities covered by that encounter place. Ideally all localities in the Health Service Area will be allocated to a single smaller locality group that will be allocated to a single encounter place. Each encounter place must also be given the appropriate DHF Health Service Code.

> **Tip:**
> To help you edit or create these groups, run the report **Report > Reference Tables > Locality Group Analysis**. Enter a range of post codes that covers your Health Service Area and the report will show you which localities belong to which locality group.

Data requirements

Review the data collection requirements. Check the Healthy for Life *(on page 472)* reports - many of the indicators are comparable to those defined for Healthy for Life.

Further data collection requirements include:

- Anaemic children are identified by their latest qualifier Hb (Haemoglobin) recorded during the reporting period being less than 110 g/L (less than 105 g/L if under 12 months old).
- Patients with albuminuria are defined as having a latest qualifier ACR (Alb/Creat Ratio) recorded during the reporting period as being greater than 3.4.
- Patients are recognised as being on an ACE inhibitor, or ARB drug by checking their regular and current medications as selected from the appropriate ATC (Anatomical Therapeutic Chemical) codes.
- PAP smears are counted by looking for investigation requests for tests whose description starts with **PAP smear** (case insensitive) or for clinical items with the export code **PAPSMEAR**.
- If you do not make Medicare claims then you will need to make sure that clinical items used to record care plans and health checks have the following system codes:
    - GP management plan items must use **CPA**
    - Team care arrangements must use **TCA**
    - Adult health checks must use **AHC**
    - Child health checks must use **CHC**
    - Elderly health checks must use **OHC**

- Clients are assumed to be fully immunised if they have no overdue recalls for immunisations (excluding Panvax and Fluvax) or immunisation reviews that were due before the reference date or have an appropriate completed review. Immunisation review items should start `Review;immunisation;` followed by the age, for example, `Review;immunisation;2 months age`

Running the NT Aboriginal Health Key Performance Indicators (NT AHKPI) reports

Run the NT AHKPI reports from **Report > NT KPI**. Run each individual report to show data for each KPI.

The data export file is created at **Report > NT KPI > AHKPI Data Export**.

A summary view of the data export file is available at **Report > NT KPI > AHKPI Data Export Summary**.

Note:
Reports adhere to *NT Aboriginal Health Key Performance Indicators*, Definitions, October 2013, Version 2.0.4.

Because data is disaggregated by age, patients with no date of birth will not be included.

Government Reporting Tool

Use the Government Reporting Tool (GRT) to extract primary health care key performance indicators (nKPIs) for indigenous people from Communicare, analyse the data and directly upload the data to the Health Data Portal.

Since January 2019, the Government Reporting Tool (GRT) has been used to extract data for the nKPI, OSR and Health Care Provider (HCP) submissions from Communicare. This tool should be used by health service management personnel who are responsible for periodically collating, analysing and reporting on nKPI data. The GRT uploads the extracted data to the Commonwealth Department of Health (DoH) Health Data Portal.

Tip:
For more information about Indigenous Health Data Reporting, see IHDR User Help.

Before each submission period, Communicare Support will contact local Communicare Administrators to ensure that the GRT is accessible and any updates to the GRT and reports are communicated.

Data can also be reviewed at any time using the following Communicare report suites:

- **Report > nKPI**
- **Report > OSR**
- **Report > Health Care Providers**

Communicare Administrators should run these reports regularly to check that their health service's data is on track before the January and July submission deadlines.

Note:
For state-based reporting, NT KPI *(on page 473)* and NSW KPI *(on page 748)* reporting suites are available in Communicare as both individual reports and aggregated summaries. Refer to your state health departments for the correct process to submit your data.

Government Reporting Tool prerequisites

Before you run the Government Reporting Tool and upload Indigenous Health Data from Communicare to the Health Data Portal, ensure that each of the following steps are completed:

1. Obtain the AIHW security data token from the Department of Health.
2. Communicare Support has enabled the data token for your site.
3. Communicare Support has set up and configured SQL Server Express for your organisation.
4. Communicare Support has installed the Government Reporting Tool on your organisation's Communicare server and ensured that it is working correctly.

Government Reporting Tool overview

To ensure that your site is ready for the reporting submission period, complete the following steps:

1. Ensure Communicare is configured in accordance with the NPKI information *(on page 678)* and that staff are using the correct items.
2. Use the Communicare reports to audit biographics for missing data and ensure staff are using the correct place and mode to record consults.
3. Run the nKPI reports *(on page 707)*, OSR and Health Care provider reports *(on page 735)* reports in Communicare to verify the state of the data and repeat steps 1-2 if required. For a list of the available government report suites in Communicare, see Statutory Reporting and Communicare *(on page 755)*.
4. Ensure the Government Reporting Tool is installed and accessible by the Communicare Administrator or person responsible for uploading to the Health Data Portal.

When these steps are complete, you can run the Government Reporting Tool to submit your data to the DoH Health Data Portal.

Statutory Reporting and Communicare

There are currently four major reporting suites in Communicare for government reporting. Other program reporting suites may exist on your database, such as PMHC, CHSP, ITC, HACC, ANFPP, APCC.

Reporting suites

Reports usually have the following parameters:

- A date range or report date where the end date is usually 30th June or 31st December. For internal reporting this can be any date required. Where a 'from date' is collected it may be ignored for some indicators where the currency period is defined in the indicator.
- A locality group parameter with the option **<All Locality Groups>**. In most cases this last option should be selected but where more than one organisation shares a database, or internal reporting for separate regions is required, a specific locality group may be selected.
- A patient indicator that can be `AIHW Regular Client` or `Communicare Current Patient`. OSR, nKPI and NSW reports must be uploaded with the `AIHW Regular Client` option selected.

The four reporting suites below essentially perform similar tasks for different agencies but differ in various ways. This table is to help you understand the differences.

Table 258. Comparison of KPI reporting suites

Reporting	OSR	National KPI	NT AHKI	NSW KPI
Included in Communicare	Yes CS-01 to CS-04 HP-01 L-06 to L-07 MCH-01 to MCH-03 S-06 to S-07, S-10 to S11 & S-13 to S-14 SE-06 to SE-07 HCP Additional: `Episodes and Contacts by Clinic` – may be required for separate reporting for remote clinics	Yes PI01 to PI25 Additional: `Patient List` – identified patients defined as regular `Version` – specifies the version of the reports	Yes AHKPI 1-01 to AHKPI 1-20 Additional: `Setup` – report to assist configuring encounter places and locality groups	Yes KPI 01 to KPI 09
Can be run by a non-Administrator	Yes	Yes	Yes	Yes
Can report on patient names	No	Yes Each report has a companion report that displays patient names	Yes Each report shows patient names	Yes Each report has the option to include patient names or not

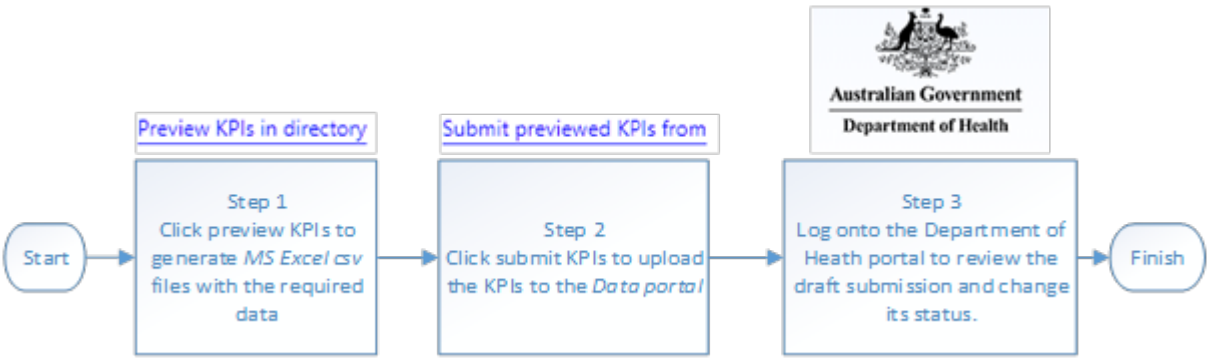
Single report available	No	Yes
		`Summary` - reports on any indicator where there is some data
			Yes
			`AHKPI Data Export`
			`AHKPI Data Export for Selected Clinic`
			`AHKPI Data Export Summary`
				Yes
				`Data Summary`

Table 258. Comparison of KPI reporting suites (continued)

Reporting	OSR	National KPI	NT AHKI	NSW KPI
Upload functionality	Communicare's Government Reporting Tool - Includes only CS-01 to CS-03 (renamed as AP1 to AP3) and HP-01 (renamed as CSP2)	Communicare's Government Reporting Tool - all indicators	Data Export manually uploaded to NT portal - run `AHKPI Data Export` and save output as a CSV file	Manual data entry - `Data Summary` to be printed and transcribed into NSW portal

Run the Government Reporting Tool

At reporting time, use the Government Reporting Tool to extract the nKPI data you need from Communicare and submit it to the Department of Health Data Portal.

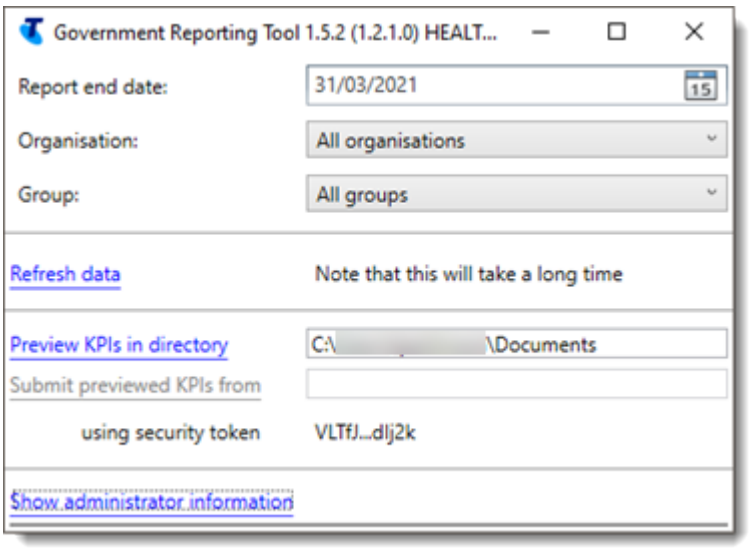


The overall process for extracting Indigenous Health Data from Communicare and uploading the data into the Health Data Portal can be distilled into the following steps:

1. Using the Government Reporting Tool, extract data from Communicare to spreadsheets which you can review.
2. Using the Government Reporting Tool, upload the KPI data to the Health Data Portal.
3. In the Health Data Portal, review and confirm the submission.

To run the Government Reporting Tool on or after 1 July of each year:

1. In the Microsoft Windows Explorer, go to `\\Communicare servername\Install\GRT`, where `servername` is the hostname assigned to your Communicare server by your Administrator or IT.
2. Double-click **GovernmentReportingTool** to run it.



The title bar of the **Government Reporting Tool** displays the version of the tool, the username of the person who is logged on and the name of the computer. Check with Communicare Support that you are running the latest version.

3. In the **Government Reporting Tool** window:
   a. From the **Report end date** calendar, set the reporting date to the end of the reporting period. No data recorded after this date is included in the nKPIs.
   b. From the **Organisation** list, select the organisation for which the KPI extract will be generated or set to `All Organisations`.

      Note:
      Often the Health Data Portal only accepts submissions for which `All Organisations` has been selected.

   c. From the **Group** list, select a locality group. This determines which patients are included in the KPI extract.
4. If you have updated the Communicare nKPI configuration as described in NPKI information *(on page 678)*, click **Refresh data**. The tool retrieves data that is new or has been updated in Communicare since it was last run. The refresh process takes 5 - 60 minutes.

   Tip:
   Data is automatically refreshed nightly. Click **Show administrator information** to see when the data was last refreshed.

   You can also click this link in the following circumstances:
   - You are directed to by the tool because it has detected an issue
   - You have retrospectively updated historical encounters and want these historical updates included in the nKPI reports
5. When the data is refreshed, click **Preview KPIs in directory**. This process takes 1-5 minutes.
   The directory to which the files have been saved is opened when the process is complete.
6. If required, manually review the CSV output files using Microsoft Excel.

   Tip:
   To display the files in a format where you can filter and sort the data:

a. In Microsoft Excel, press CTRL+A to select all data.
b. Select **Insert > Table.**

7. After you have reviewed the KPIs, to submit the KPIs to the Health Data Portal in draft form click **Submit previewed KPIs from**. This process takes 1-5 minutes.

Note:
This link is enabled only if the KPIs have been generated using an Organisation and Locality Group that has an AIHW security token for your site.

The Indigenous Health Data extracted from Communicare is uploaded to the Health Data Portal.

Log onto the Commonwealth Department of Health (DoH) Health Data Portal and review the draft submission and complete the data asset upload process. When you are satisfied with the submission, change its status.

If you encounter problems using the Government Reporting Tool:

1. Click **Show administrator information**.
2. Copy or take a screen capture of all the content in the **Show administrator information** pane and attach it to a ticket for Communicare Support for resolution.

Tip:
Scroll down to view all data.

GRT output files

The Government Reporting Tool produces the following files.

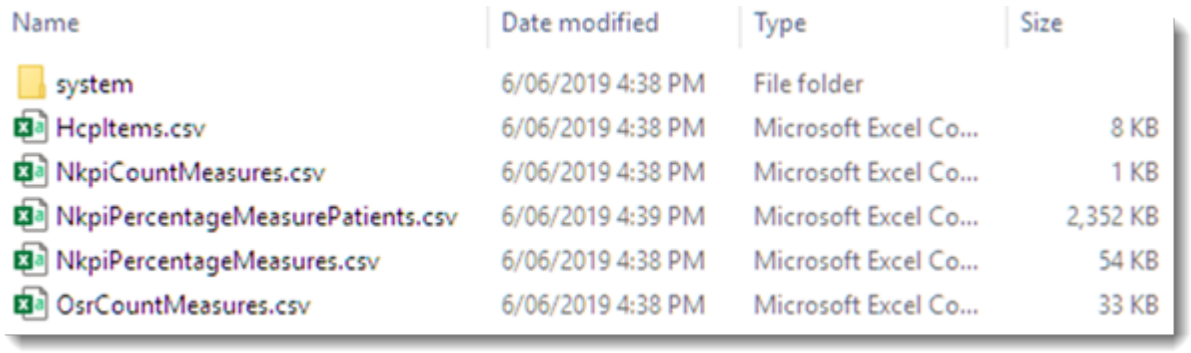


Table 259. Files produced by the GRT

File	Purpose
`HcpItems.csv`	A list of providers
`NkpiCountMeasures.csv`	A count of the total number of clients included for each KPI
`NkpiPercentageMeasurePatients.csv`	The numerator, denominator and percentage for each KPI, that is the underlying data. This is equivalent to the nKPI Patients Report in Communicare.
`OsrCountMeasures.csv`	Counts for operational services
`system\Manual - HCP - Org.xml`	This file is used if it's necessary to manually upload the HCPs to the Health Data Portal using the Department of Health website.

Table 259. Files produced by the GRT (continued)

File	Purpose
`system\Manual - NKPI - Org.xml`	This file is used if it's necessary to manually upload the nKPIs to the Health Data Portal using the Department of Health website.
`system\Manual - OSR - Org.xml`	This file is used if it's necessary to manually upload the OSRs to the Health Data Portal using the Department of Health website.

Troubleshoot the GRT

If you have a problem running the Government Reporting Tool, check here before contacting Communicare Support

Check the following:

1. Your domain user account or group has been given access to the GRT.
2. The GRT is being passed through the correct hostname to the SQL Server that it uses.
3. There are no security policies blocking access to TCP and UDP ports 1434 and 1433 on the SQL Server.
4. There are no group policies preventing the GRT being run. Check with your Network System Administrator.
5. You have access to the shared folder where the GRT is installed.
6. The SQL Server is running.

If you are still experiencing difficulties contact Communicare Support.

Manually upload nKPI files to the Health Data Portal

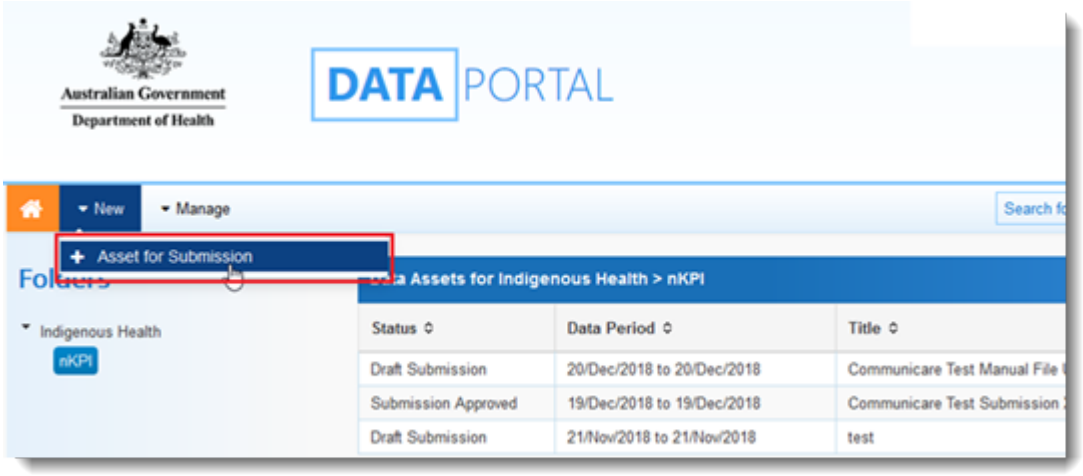
Running the Government Reporting Tool automatically uploads all of the necessary data to the Health Data Portal.

However, if you encounter connection errors, you can upload the xml files created by the tool to the Health Data Portal manually.

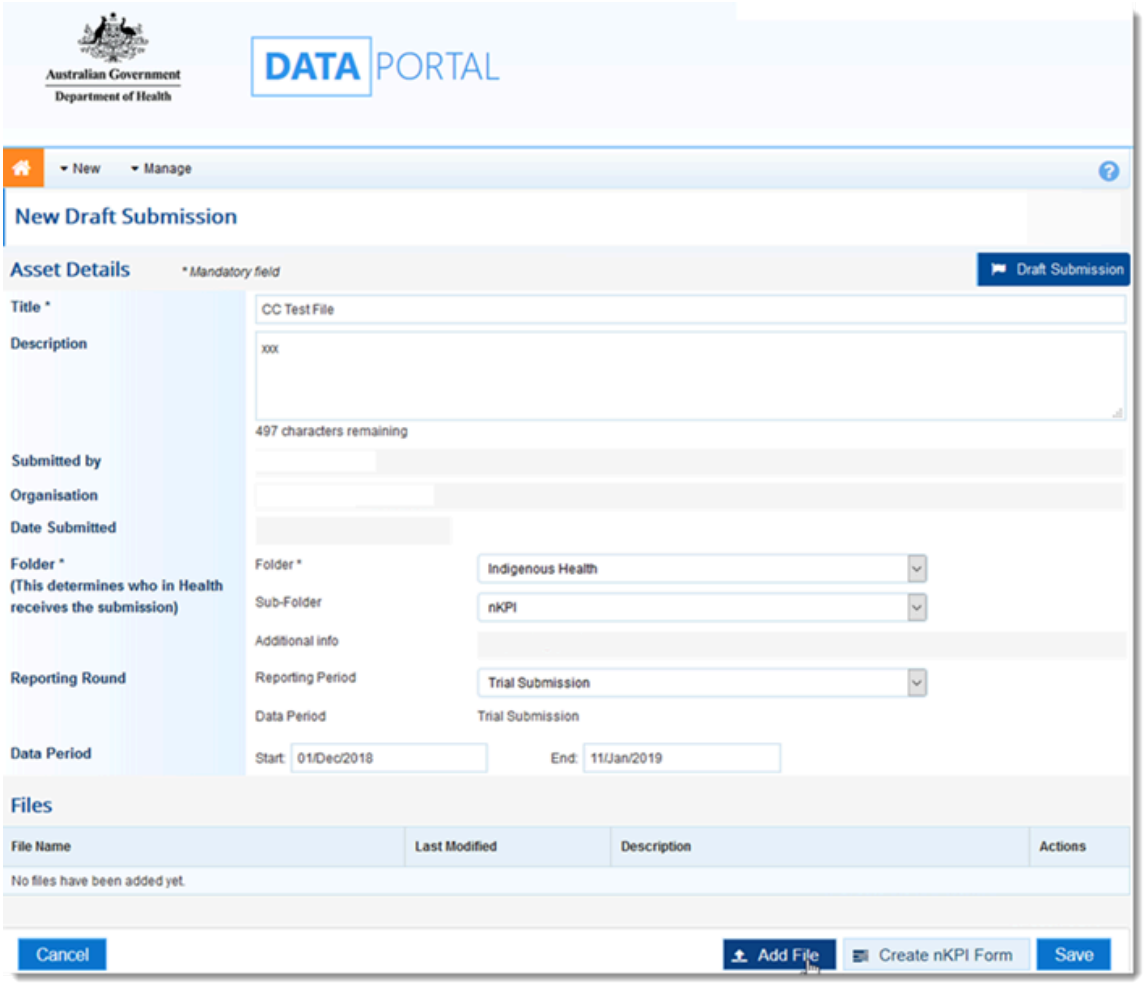
Note:
This information is a general guide only. For further support and help, see Indigenous Health Data Reporting (IDHR) or call 1800 316 387 (8.30am to 5pm AEST Monday to Friday, excluding ACT and national public holidays).

If the automatic upload to the Health Data Portal fails, to upload the files generated by the Government Reporting Tool manually:

1. Copy the XML files created by the Government Reporting Tool to your computer. For more information, see GRT output files *(on page 759)*.
2. Log into the Health Data Portal.
3. Select **New > Asset for Submission**.



4. In the **New Draft Submission** window, add information to all required fields:



a. In the **Title** field, add a title.
b. From the **Folder** list, select the required folder. For example, `Indigenous Health`.
c. In the **Data Period** fields, enter the reporting period.
d. If required, click **Create nKPI Form**.
e. Click **Add File** and upload the xml file from your computer.
f. Click **Save**.

HealthTracker

Communicare can be integrated with The George Institute HealthTracker™, a decision support system developed by the researchers at The George Institute for Global Health to assist primary care health staff in best practice management and prevention of cardiovascular disease, diabetes and chronic kidney disease.

Clinicians can use the Communicare HealthTracker to generate an interactive health risk assessment which shows recommendations based on guidelines. They can demonstrate to patients how reducing a risk factor such as smoking can affect that patient's risk and provide tailored advice to patients to assist with the management and prevention of cardiovascular disease, diabetes and chronic kidney disease.

The interactive report uses the qualifiers and measurements recorded in the **George Institute HealthTracker** clinical item.

There is no cost to Communicare sites for the implementation, training and use of the HealthTracker™ tool.

Healthtracker details

Cardiovascular Risk is calculated using the Framingham Risk Equation and Diabetes Risk is calculated using the AUSDRISK™ tool.

Recommendations from current Australian guidelines are incorporated into a single algorithm to provide tailored management support. The following guidelines have been used in the development of the HealthTracker™ algorithm:

- National Vascular Disease Prevention Alliance Guidelines for the management of absolute cardiovascular risk (2012)
- National Heart Foundation Guide to the management of hypertension in Adults (2016)
- National Heart Foundation Reducing risk in heart disease: an expert guide to clinical practice for secondary prevention of coronary heart disease (2012)
- National Heart Foundation/Cardiac Society of Australia and New Zealand Guidelines for Atrial Fibrillation (2018)
- Royal Australian College of General Practitioners Management of type 2 diabetes: A handbook for general practice (2020)
- Royal Australian College of General Practitioners Guidelines for preventive activities in general practice 9th edition (2018)
- Kidney Health Australia Chronic Kidney Disease Management in Primary Care 4th edition (2020)
- Australian Stroke Foundation Clinical Guidelines for Stroke Management (2020)
- 2018 NACCHO/ RACGP National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people

HealthTracker™ has been extensively evaluated in a large cluster randomised controlled trial involving 40 General Practices and 20 Aboriginal Community Controlled Health Services in NSW and Queensland. It was associated with improvements in guideline-recommended screening for CVD risk and improved prescribing, particularly for people at high CVD risk who were not receiving guideline-recommended medications, see https://www.ahajournals.org/doi/10.1161/CIRCOUTCOMES.114.001235. The intervention was also found to be highly cost effective, see https://www.mja.com.au/journal/2020/213/2/computer-guided-quality-improvement-tool-primary-health-care-cost-effectiveness.

HealthTracker data privacy and security

The George Institute has strict privacy requirements for handling data and fully complies with the Australian Privacy Principles and laws. Deidentified data is securely sent to The George Institute's servers, which are located within an ISO 27001 certified data centre in Sydney. The servers process the data through the HealthTracker™ rules engine to generate the results. No data is retained by The George Institute at the completion of this process.

HealthTracker training

Training in how to use the George Institute HealthTracker™ will be conducted by The George Institute remotely, ideally in small group sessions. Training must be completed before the **George Institute HealthTracker** clinical item is enabled for your site.

Information describing the HealthTracker™ included by Communicare is an overview only. More in-depth information about the functionality and use of the HealthTracker™ will be covered in the training provided by The George Institute.

For an overview of the George Institute HealthTracker™ in Communicare, see https://youtu.be/FSumkO2lF4c.

Enable HealthTracker

After your site has completed training in how to use the George Institute HealthTracker™ tool, configure HealthTracker integration in Communicare.

Configuration must be completed by a Communicare Administrator.

To enable the HealthTracker dataset in Communicare:

1. Enable the George Institute HealthTracker dataset:
    a. Select **File > System Parameters > System** tab.
    b. In the **Datasets** section, set **The George Institute**.
    c. Click **Save** and enter the daily authority code provided to you by Communicare Support.
2. Enable the George Institute HealthTracker Dataset in Communicare:
    a. Ensure that no-one is using the Communicare server or clients.
    b. From the Communicare installation folder, run `CCCentralDataUpdate.exe`.

    > **Tip:**
    > The central database can be found at `C:\Data\CENTRAL.fdb`.

3. The HealthTracker report references a number of family history clinical items. Add the following clinical items to **File > Reference Tables > Clinical Item Types** if they do not already exist, using the following values:

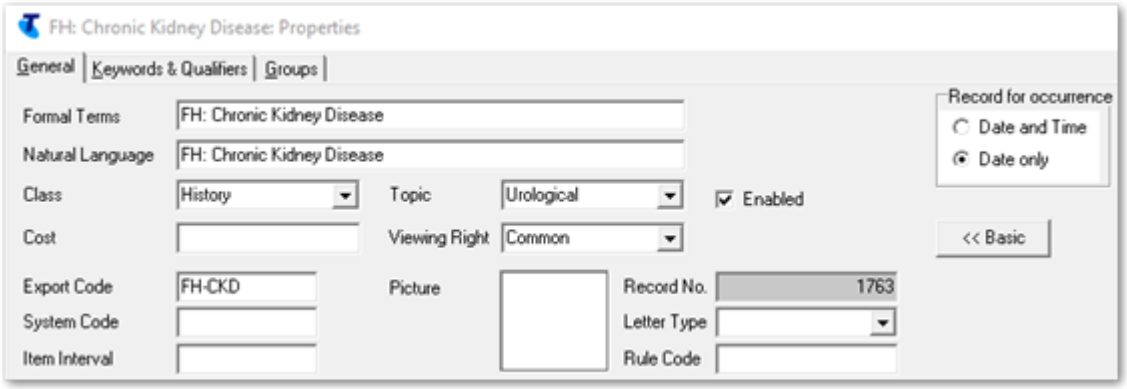


Table 260. Family history clinical items referenced by HealthTracker

Formal Terms	Topic	Export Code
FH: Chronic Kidney Disease	`Urological`	`FH-CKD`

Formal Terms	Topic	Export Code
FH: Diabetes Mellitus	`Endocrine, Metabolic and Nutritional`	`FH-DIAB`
FH: Cardiovascular Disease <60	`Cardiovascular`	`FH-CVD`
FH: Myocardial Infarction 45-60	`Cardiovascular`	`FH-MI45+`
FH: Myocardial Infarction <45	`Cardiovascular`	`FH-MI45-`
FH: Myocardial Infarction >60	`Cardiovascular`	`FH-MI60+`

For all clinical items, ensure the following fields are also set:

- **Natural Language** - use the value used in **Formal Terms**
- **Class** - set to `History`
- **Viewing Right** - set to `Common`
- Set **Summary**, **Date only**, **Enabled**

The HealthTracker dataset is enabled.

Communicare Support configure the integration settings. To view the settings, select **File > System Parameters > HealthTracker** tab. Do not change these settings unless instructed to by Communicare Support or our technical teams.

> **Note:**
> Add the `Risk Dial Web Service URL` as a Trusted Site to each user's internet browser settings.

George Institute has assigned rulesets to Communicare on the HealthTracker Service Platform which is available for integration and consumption. It has input and output requirements, all accessible using the same Service API. The health assessment result is available to Communicare for users to interpret and can also be saved as part of a patient clinical record.

Use HealthTracker

When HealthTracker™ configuration is complete, clinicians can add the **George Institute HealthTracker** clinical item to a patient clinical record and generate a HealthTracker™ report.

> **Note:**
> By using George Institute HealthTracker clinical item, the user is bound by the George Institute terms and conditions of use. To read the full terms and conditions, in the **George Institute HealthTracker** clinical item, double-click the red disclaimer text at the top of the window.

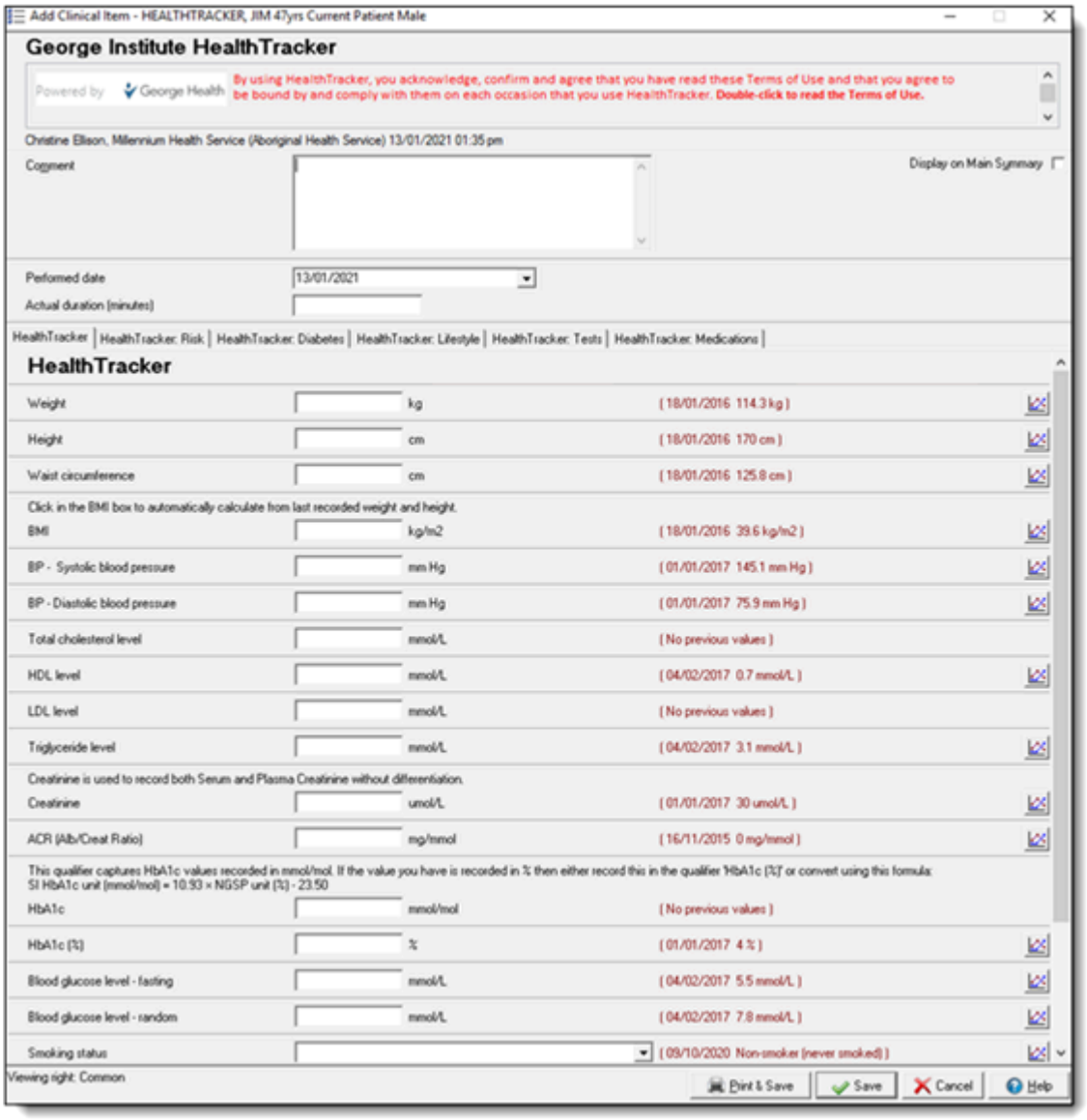
In Communicare, the **George Institute HealthTracker** clinical item can be used in the same way as any other clinical item.

To add the **George Institute HealthTracker** clinical item:

1. In Communicare, in a patient's clinical record, click **Clinical Item**.
2. In the **Clinical Terms Browser**, in the **Search-words** field, enter `George` and select **George Institute HealthTracker**.
3. In the George Institute HealthTracker clinical item, double-click the red disclaimer text at the top of the window and read the terms and conditions of use.
4. Complete the information on the **HealthTracker** tab or section.

Tip:

Information on the other tabs is provided by The George Institute after a patient's information is sent to them.



To provide the most accurate report the following qualifiers and data elements are required:

- Items required for the CVD risk calculation:
  - Age
  - Sex
  - Total cholesterol
  - HDL
  - Blood pressure
  - Smoking status
- For other HealthTracker™recommendations, also include:
  - Aboriginal or Torres Strait Islander status/ethnicity
  - Weight, height

        - Diabetes-related risk factors, such as, Albuminuria (ACR), Fasting blood glucose, HbA1c
        - CKD-related risk factors, such as, Creatinine
        - CVD-related risk factors, such as, LDL, Triglycerides
    - Other relevant history:
        - Past medical history
        - Medications
        - Family history recorded in the following Family History clinical items:
            - **FH: Chronic Kidney Disease**
            - **FH: Diabetes Mellitus**
            - **FH: Cardiovascular Disease <60**
            - **FH: Myocardial Infarction 45-60**
            - **FH: Myocardial Infarction <45**
            - **FH: Myocardial Infarction >60**

When adding information:

- The latest recorded qualifier measurements are displayed in red text next to the data entry field. Enter new measurements in the input fields during a service.
- If a new qualifier measurement is not added, Communicare sends the latest existing qualifier measurement to the HealthTracker system for inclusion in the report.

5. When you have provided sufficient information, at the bottom of the clinical item, click **Send to George Institute**.

The data you provided is sent in an encrypted form for analysis by the HealthTracker™ algorithm.

Based on the patient's qualifier measurements, history, biographics, medications and conditions, the HealthTracker™ produces an interactive report and displays it in the default browser. The report may take several seconds to generate, and the **Communicating with George Institute** window is displayed until the results are returned.

Note:
To interact with the HealthTracker tool, the patient sex must be set to either male of female. If sex is set to anything else in the patient biographics, a warning is displayed when you attempt to generate the report from the clinical item.

Error and warning messages may be encountered when submitting the clinical item to George Institute HealthTracker service. Below are the types of messages a user can receive as part of the submission:

- Error 101 - shown when the service encounters an error while accessing the database
- Error 102 - shown when the service encounters an error while accessing the George Institute HealthTracker Service
- Error 103 - shown when the service encounters an error related to data validity and when the service response status code is non-200
- Error 104 - shown when the required settings for George Institute HealthTracker Service are not set
- Warning - shown when the value of an input qualifier falls outside the valid range

Review the report. The report can be used interactively: demonstrate to patients how reducing a risk factor such as smoking can affect the patient's risk and provide tailored advice to assist with the management and prevention of cardiovascular disease, diabetes and chronic kidney disease.

If required, based on your review, edit the output qualifier fields and add notes or additional information before saving the clinical item. The returned results become part of the clinical item record for the patient. Details are also saved as a progress note.

Note:
The progress note is the only record of what was displayed in the HealthTracker™ reports. No data is kept by The George Institute after the report is closed.

Review HealthTracker report

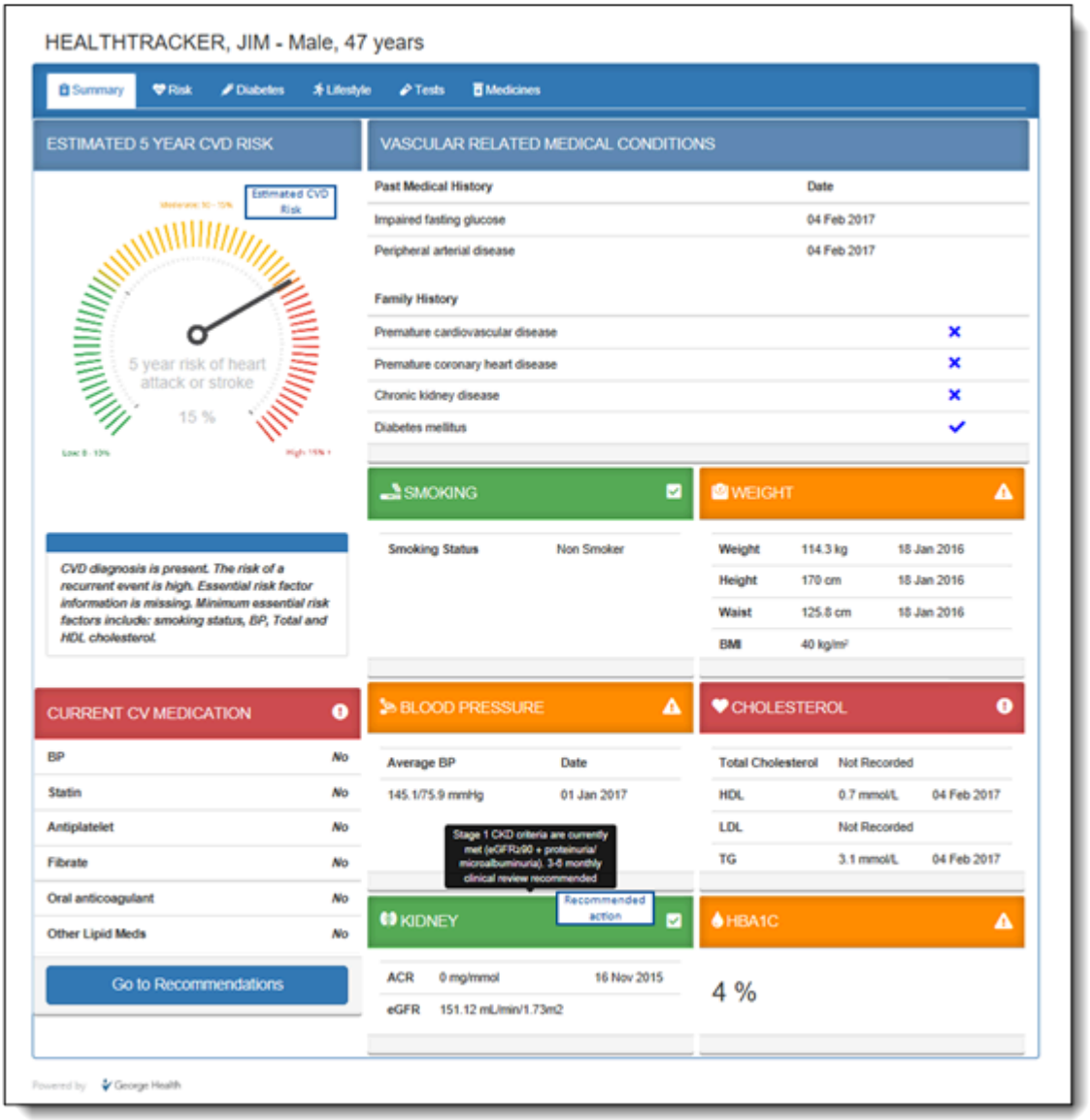
The George Institute HealthTracker™ displays results for a patient in the default browser.

Use the interactive graphical display to explain to patients their cardiovascular, diabetes and kidney disease risks. This allows the patient and health professional to assess current and projected risk and to perform "what if" scenarios. For example, the effects on future risk if the patient can stop smoking, and so on.

On all tabs, the recommendation status is displayed using traffic light colours:

- Green - the measurement or findings are in the normal acceptable range
- Orange - the measurement or findings are above the normal acceptable range. This serves as a warning and should prompt recommendations.
- Red - the measurement or findings are on high and should be acted on
- Blue - the measurement or findings are unknown or an assessment or recommendation can't be provided

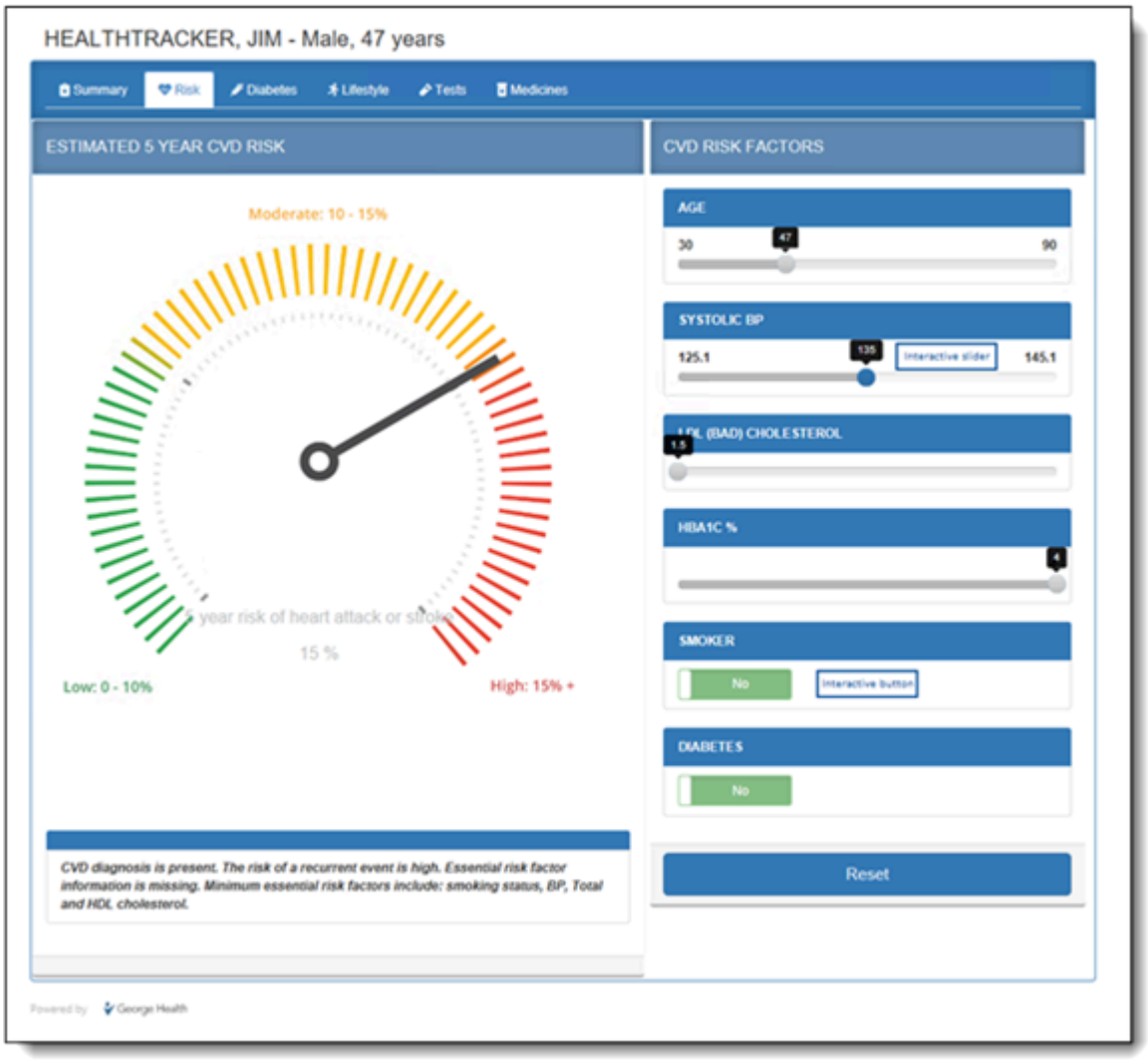
Summary



The **Summary** tab displays the following information for the patient:

- An estimated 5-year CVD risk percentage and recommendation.
- Current CV medications.
- CV-related medical conditions both past and family history related conditions.
- Current smoking status and recommendation.
- Current weight related data and recommendation.
- Current blood pressure related data and recommendation.
- Current cholesterol related data and recommendation.
- Current kidney related data and recommendation.
- Current diabetes related data and recommendation.

Risk



The **Risk** tab presents the estimated cardiovascular disease risk for the patient.

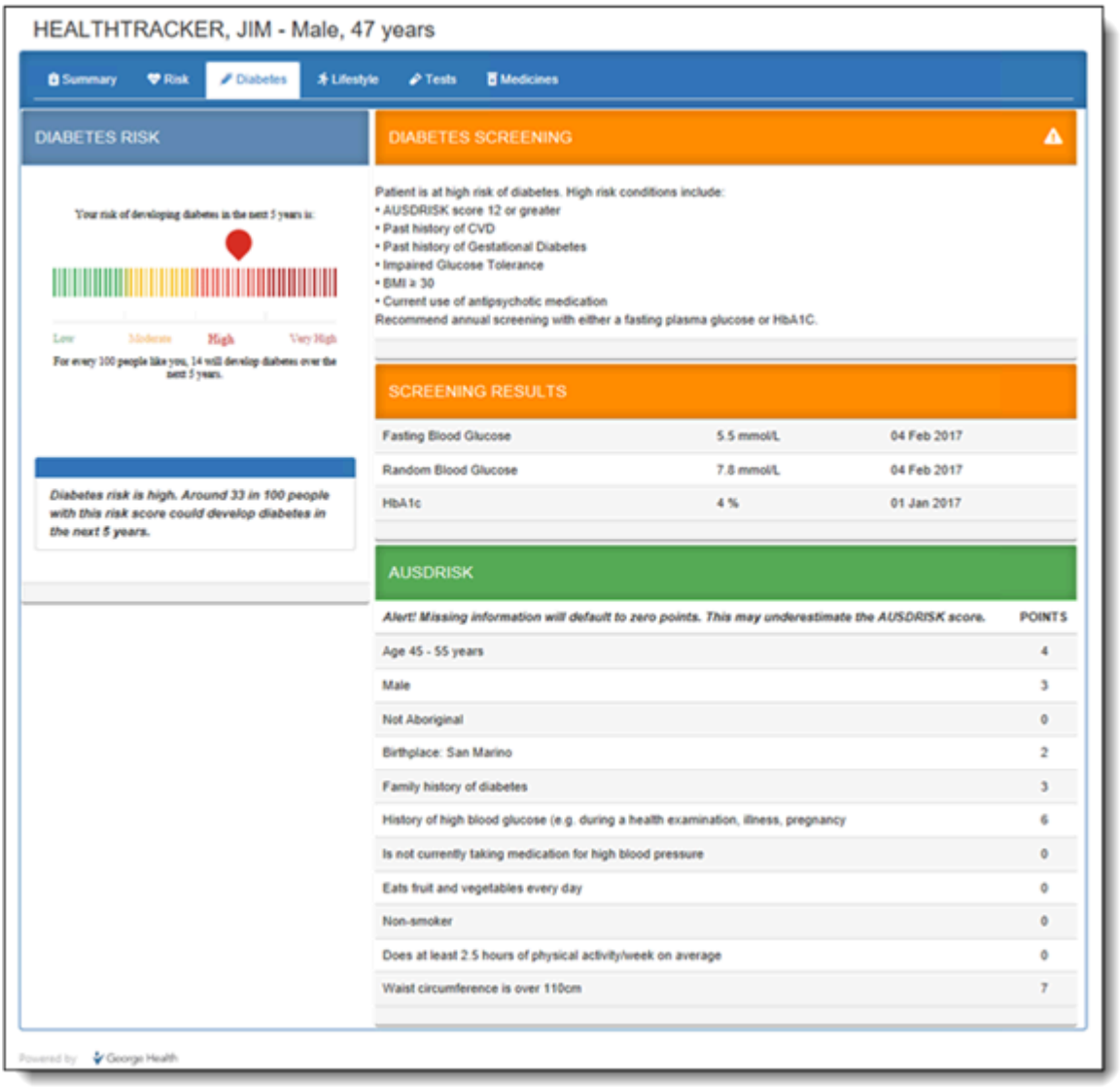
Adjust the risk factors such as Age, SBP, Cholesterol (LDL), HbA1c, Smoking status and Diabetes and observe the impact on a patient's risk percentage and any associated recommendations. The risk dial sliders for SBP, Cholesterol (LDL) and HbA1c qualifiers can only be lowered.

Conditions are also implied to control the behaviour and value of each qualifier. The availability of the sliders for each qualifier depends on other qualifier values:

- Age
    - The range should be from 30 to 90 years
    - If patient has CVD or a clinically high-risk condition, slider should be disabled.
- Systolic BP
    - Only enable when SBP is above 110mmHg
    - Show current value as upper limit
- Cholesterol (LDL)
    - Only enable when LDL is above 1.5mmol/L
    - Show current value as upper limit

- Smoker
    - This is a simple on and off slider
    - Only enable when the patient is a current smoker
- Diabetes
    - This is a simple on and off slider
    - Only enable when the patient has diabetes
- HbA1c
    - Only enable when the patient has diabetes and HbA1c is above 6%
    - Show current value as the upper limit

Diabetes



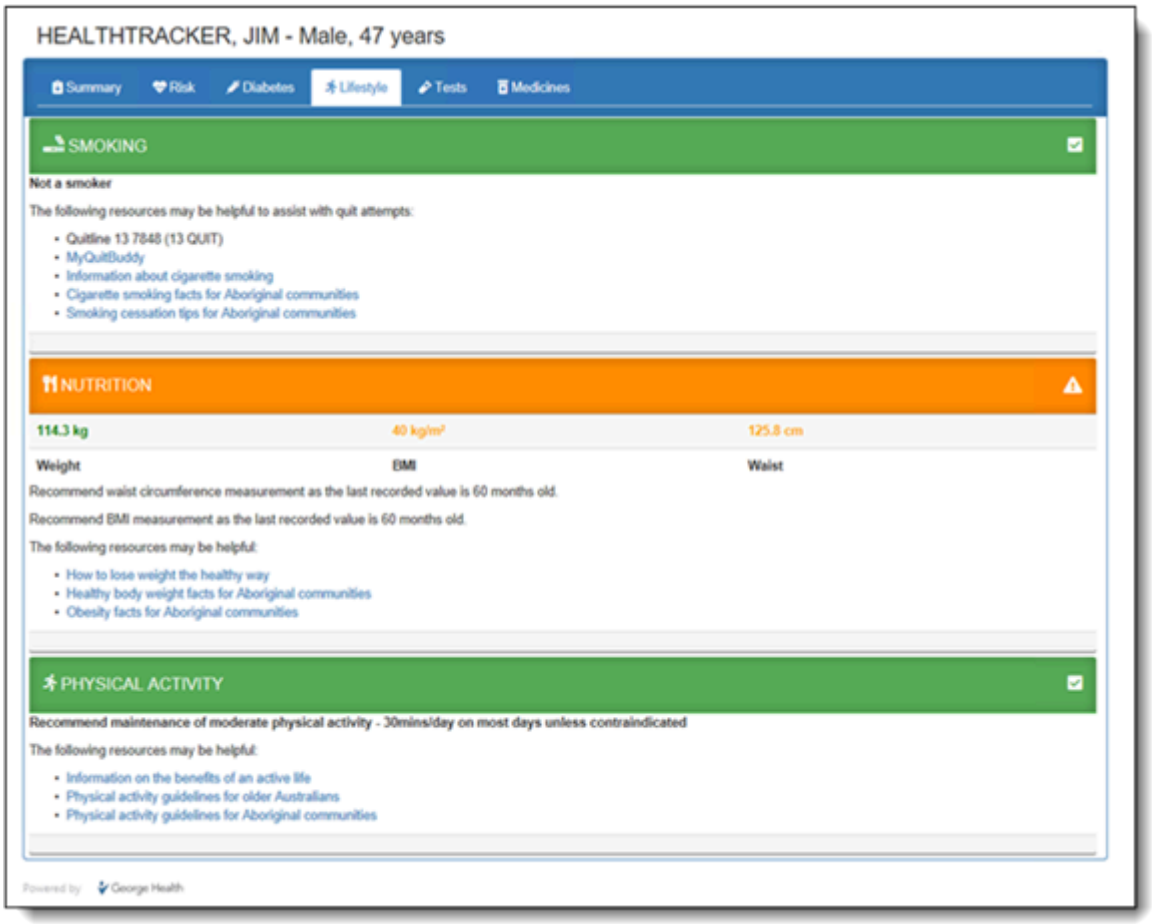
The contents of the **Diabetes** tab depends on whether the patient has Diabetes or not.

- If a patient has diabetes, the **Diabetes management** page shows the diagnosis record and any recommendations including medicines that will help in managing the diabetes level. It also includes recommendations for:
    - Retinopathy
    - Foot Assessment

- Foot Risk Calculator result
- Neuropathy

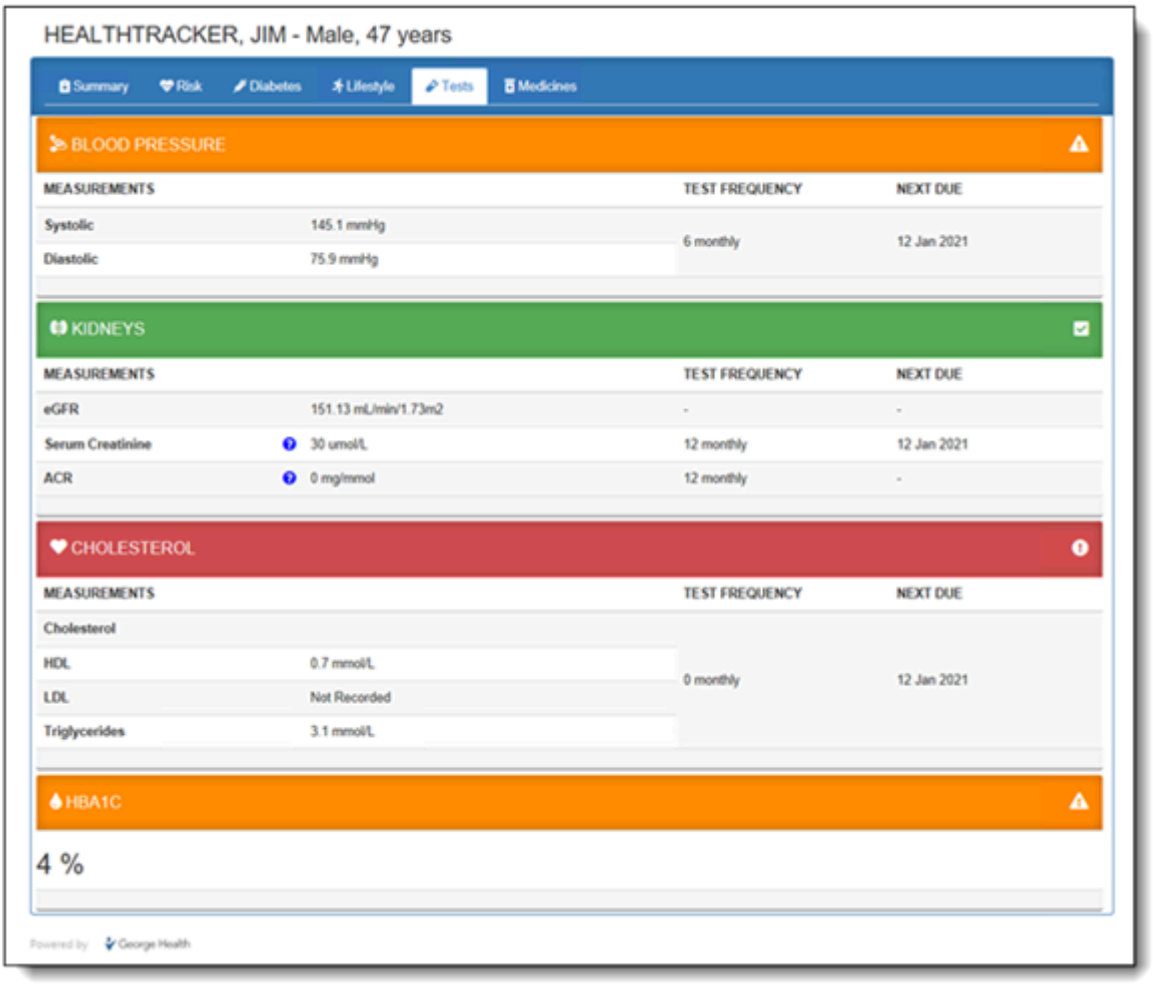
- If a patient has not been diagnosed with Diabetes, the **Diabetes screening** page is displayed which describes the patient's diabetes risk, screening results and the relevant AUSDRISK points. It provides a 5-year diabetes risk calculation and recommendation. It also includes the following information:
  - Diabetes Screening recommendation
  - Diabetes screening results
  - Diabetes risk points which are based on the following criteria:
    - Age
    - Sex
    - Aboriginal and Torres Strait Islander (Australia)
    - Birthplace
    - Family history of Diabetes
    - Family history of High blood glucose
    - High Blood pressure medication
    - Fruits and Vegetable consumption
    - Smoking status
    - Physical exercise
    - Waist measurement

Lifestyle



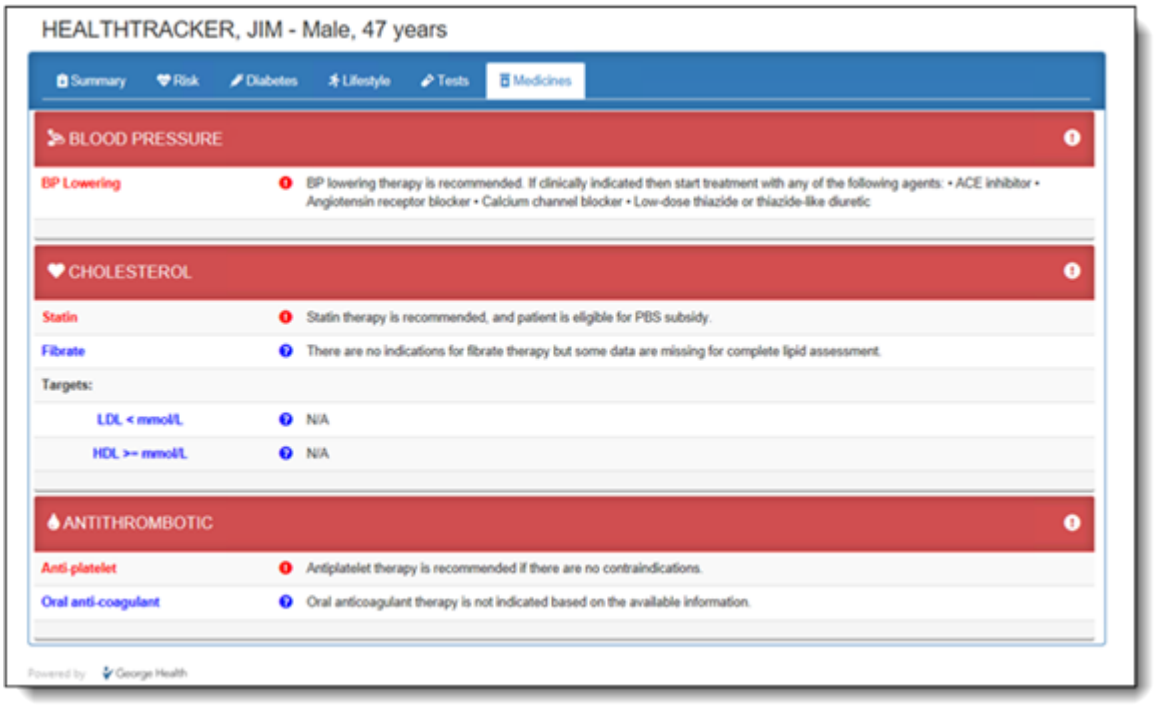
The **Lifestyle** tab describes the patient's lifestyle and provides recommendations about smoking status, diet, and physical activity.

Tests



The **Tests** tab describes the patient's latest blood pressure, kidney, cholesterol and HBA1C test results and the recommended follow up test date.

Medicines



The **Medicines** tab describes the recommended medications based on the patient's conditions and qualifiers, related to the following:

- Blood Pressure - assessment for BP lowering is done based on patient's current medication related to BP.
- Cholesterol - assessment for Statin, Fibrate, Target LDL and Target HDL are done based on patient's current medication related to Cholesterol.
- Antithrombotic - assessment for Anti-platelet and Oral anti-coagulant are done based on patient's current medication related to HbA1c.

MeHR

My Electronic Health Record Service (MeHR) allows Communicare users to submit details of a patient's health record and consultations to a central repository. Registered users also have access to this repository.

Administration

The Admin screen shows the MeHR administration functions. To display the Admin window, select **File > MeHR Administration**

Bulk Update - this function updates the MeHR repository with the home health centre of all patients who have a MeHR ID and whose patient status is 'Current Patient'.

Only click **Send Patient Details** when instructed to do so by MeHR. The My Electronic Health Record Help Desk phone number is 1800 247 430.

My Electronic Health Record Printable Forms

- **Help > Forms > MeHR > MeHR Health Professional Access** - print a blank form for access to the My Electronic Health Record, complete and return to MeHR.
- **Help > Forms > MeHR > MeHR Consumer Registration** - print a blank form to register your patient for the My Electronic Health Record or to re-register as an adult (over 16 years old) for the Shared Electronic Health Record. Remember to also print off the MeHR Better Healthcare Information Sheet and give to all patients who register (see below).
- **Help > Forms > MeHR > MeHR Better Healthcare Information Sheet** - print this information sheet and give to your patients when they register for the My Electronic Health Record. This is to inform them of what they are signing up for, what rights they have and what actions they can take if they are concerned or unhappy with the My Electronic Health Record.

Security Note

MeHR's security model does not support Communicare's Viewing Rights. Granting access to MeHR to users with limited Viewing Rights may result in those users seeing restricted information in the MeHR. Furthermore, CHP's generated by users with limited Viewing Rights may result in restricted information being inadvertently posted to the MeHR. Communicare recommends that users who access the MeHR should have full Viewing Rights.

MeHR eRegistration

The purpose of MeHR eRegistration is to introduce electronic patient registration with MeHR *(on page 824)*, allowing for the immediate transfer of a patient's Current Health Profile *(on page 776)* and Event Summaries *(on page 776)*. During eRegistration MeHR can generate a registration form pre-filled with some of the patient's details, to be printed and given to the patient to complete. The completed form must still be mailed off, but upon verification of patient signature they can be added as a temporary registration. While in this status MeHR can receive clinical data on the patient as normal, but the shared records may not be accessed by anyone until the completed form is received and the patient switched to an active registration.

eRegistration Triggers

When the functionality is enabled there will be four automatic triggers where the user will be prompted to follow the eRegistration process:

- Patient Appointment Arrival - When a patient has a booked appointment and their arrival has been recorded by clicking the  button in Service Recording *(on page 86)*.
- Patient Walk-In - When a patient has walked in without an appointment and a new service of type 'Walk-In' or 'Extra' has been created for them in Service Recording *(on page 86)*.
- Patient Service Start - When a new service has been started by opening the Clinical Record *(on page 112)* for a patient. (Mostly applicable to clinics where patients do not always see a receptionist first.)
- Patient Creation - When a new patient has been created. This may be useful even if the patient is not present, as a search can be run to see if they have a pre-existing HCID (My Electronic Health Record ID).

In each case there will be a status check performed (unless the patient previously declined to register), and if they are not registered the eRegistration web form will be displayed to continue the process.

When searching a patient, the MeHR Registration Status will be displayed in the patient search dialog along with other details about the patient.

These automatic triggers can be enabled and disabled for a user group with the 'MeHR eRegistration Auto-Prompt' system right in the User Groups window, or for all users with the 'MeHR eRegistration Auto-Prompt' module in the System Parameters window. If the automatic triggers are disabled, eRegistration will still be functional and accessible manually but there will be no automatic prompts.

Navigating the eReg Web Form

When the MeHR eRegistration web page appears, follow the steps displayed to determine the outcome (which will generally end in a button to click). There are 4 basic results:

- Patient is registered with MeHR and their new HCID (My Electronic Health Record ID) is saved in Communicare. The form filled out by the patient is posted to MeHR.
- Patient is found to already be registered with MeHR (via the search function) so their existing HCID is saved in Communicare.
- Patient declined to register, so no more triggered prompts will appear for them.
- User closed the form without performing any actions so no changes are saved and eRegistration will be triggered again in future.

Manual eRegistration

The eRegistration button will be available if MeHR eRegistration *(on page 774)* is enabled and the patient does not have a known HCID (MeHR ID). Clicking the eRegistration button will allow you to register the selected patient with MeHR. Hovering over the MeHR area will display the patient's current MeHR status.

If a patient has changed their mind and wishes to register with MeHR, the process can be manually initiated.

- In the Patient Biographics *(on page 30)* window, on the 'Personal' tab, click 'eRegistration'. This window will not automatically trigger eRegistration as the patient may not be present).
- In the Clinical Record, click 'Red Kanga' ('MeHR Profile' when the patient is not registered).

If MeHR to My Health Record Transition *(on page 779)* is enabled, the eRegistration button will never be available.

Module Setup and Administration

The MeHR eRegistration module must be enabled in System Parameters *(on page 811)* in order to be used. The main MeHR module must also be enabled and configured as appropriate. MeHR eRegistration can then be enabled for specific User Groups *(on page 842)*. Note that users do not require the eRegistration System Right if they only need access to view MeHR; it simply adds the additional option of registration and activates the automatic triggers as described above.

NT MeHR Patient Search results

This screen shows the matching results from the MeHR repository for a patient search performed in Communicare.

This screen can be accessed from the Patient Search screen when clicking the New Patient button.

The result set can be shortened by refining the search criteria and performing the search again.

Click 'New Patient' to add a new patient from scratch. Click 'Select Patient' to add a new patient with the selected patient details pre-populated in the add patient screen. Click 'Cancel Search' to abandon the patient search and add new patient process.

MeHR Current Health Profile

In the Current Health Profile window, select the patient encounters and clinical items to send to MeHR.

To display the **Current Health Profile** window, in the patient clinical record, click Blue Envelope **View and/or amend Current Health Profile**.

Viewing the CHP

If the user ticks a patient encounter that was previously unticked then a medical event summary (MES *(on page 776)*) is sent to the Secure Electronic Health Record repository for the newly ticked patient encounter.

If the user unticks a patient encounter that was previously ticked and has been sent to the MeHR repository then a Deactivate Medical Event Summary message is sent to the MeHR repository.

Current Health Profile Data

The MeHR Current Health Profile contains the following information.

Table 261. MeHR Current Health Profile

MeHR Data	Communicare Data
Adverse Reactions	Drug & Non-Drug. All adverse reactions. Always sent in CHP.
Alerts	Whatever is contained in the Alerts and Other Important Information field. Always sent in CHP.
Risk Factors	All of the Patients Risk Factors. Always sent in CHP.
Conditions	All condition class clinical items displayed in the **Clinical Items Summary**
Current Medications	All records displayed in the **Medication Summary**
Immunisations Given	All immunisations recorded
History of Disease	All history class clinical items recorded
Presenting Reason	20 most recent clinical records marked as **Reason of Encounter**
Procedures	20 most recent procedures recorded
Observations	3 most recent qualifiers of each type
Progress Notes	20 most recent progress notes

Note:
Information that can not be displayed due to a user's security restrictions is not included in the Current Health Profile.

Sending the patient encounter to MeHR

The CHP is also sent to MeHR repository along with a medical event summary (MES *(on page 776)*) every time a patient encounter is completed or paused and the user has chosen to send the patient encounter to the MeHR repository.

MeHR Event Summary

The MeHR Event Summary contains the following information.

Table 262. MeHR Event Summary Data

MeHR Data	Communicare Data
Drug Allergy / Other Information	All information recorded in the "Drug Allergy or Other Important Information" box in the Main Summary
Conditions	All condition class clinical items added and marked for **Display on Summary** in the current service
Current Medications	Medications prescribed or repeated in the current service
Immunisations Given	All immunisations recorded in the current service
History of Disease	All history class clinical items recorded in the current service
Presenting Reason	Clinical records marked as **Reason of Encounter** in the current service
Procedures	All procedures recorded in the current service
Observations	All qualifiers recorded in the current service
Progress Notes	All progress notes recorded in the current service

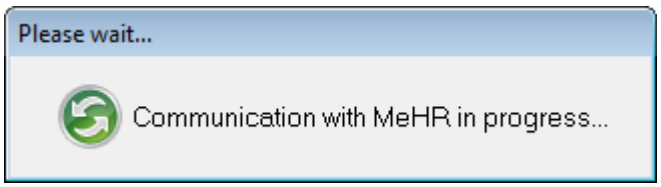
MeHR Notifications

Use MeHR Notifications to enable the user to receive notifications of medical changes from the MeHR repository for patients whose current home health centre is the default home health centre.

To display MeHR Notifications, select **Patient > MeHR Notifications**.

The user also has the ability to change the home health centre if they wish to see notifications for patients whose home health centre is not the default home health centre: click **Change Home Health Centre**.

MeHR eMessage Wait Dialog



This dialog indicates when communications are taking place between Communicare and MeHR. Some MeHR functions will still be handled in the background without such notice; this is shown primarily when we need to request and wait for data that may result in the triggering of additional functionality such as patient eRegistration. The maximum amount of time to wait is determined by the eMessage Timeout setting under MeHR *(on page 824)* in System Parameters. If the timeout period is exceeded an error will be thrown and the waiting dialog will disappear.

HCID Import Wizard

Use the HCID Import wizard to import and update multiple HCIDs using a file provided by MeHR.

HCID Import

To access the wizard, select **Tools > HCID Import**. This option is only available when the MeHR module has been enabled in the system.

CSV File

The wizard will prompt you to select a CSV (comma separated values) file. This file should contain the following values separated by commas (single line per patient):

```
Communicare_Patient_ID,HCID,Date_of_Birth
```

where the birth date is formatted `DD/MM/YYYY`.

For example:

```
3098,1234,12/09/1946
4067,1235,01/03/1985
6436,1236,04/11/2001
```

Validation and Errors

The Date of Birth and Patient ID will be validated before the HCID is updated - the Patient ID and birth date must match what is currently in the system.

On completion, any records rejected or that failed to update will be shown and saved to a log file. The log file is called HCID_import.log and is located in the Communicare program directory.

Uploading results to MeHR

Pathology and imaging results can be uploaded from Communicare to MeHR automatically.

To upload results, the following criteria must be met:

- MeHR module must be enabled on **File > System Parameters > System** tab and the correct details set on the **MeHR** tab
- Argus must be set up and working
- The patient must be registered with MeHR

Results received in any of the following formats are uploaded to MeHR:

- Plain text
- PDF
- HTML

To ensure that pathology results are uploaded to MeHR, use the following workflow:

1. In the patient's clinical record, check that their  MeHR profile is green.

   If it is not, in the  **Patient Biographics**, on the **Personal** tab, check the number in the **MeHR** field and that the patient shows as `Registered`.
2. In the registered patient's clinical record, when you add a pathology or imaging investigation request, in the **Add Investigation Request** window, ensure that **Send this investigation's results to MeHR** is set.
3. When you close the service, in the **Service exit** window, ensure that **Send to MeHR** is set.
4. When you receive the result and open it from  **Documents and Results**, in the **Match and Review Result** window, ensure that you match the pathology result to the investigation request created in step 2 *(on page 778)*.

The result is queued to save to MeHR:

- When the **CCareQueue_ehr** process runs, the result is saved to outgoing documents.
- When the **CCareQueue_argus** process runs, the result is sent to MeHR.

After the result has been sent to MeHR, clinicians can view the result on the MeHR portal.

MeHR Antenatal Reports

Communicare sends antenatal information to MeHR via Antenatal Reports, Event Summaries and Current Health Profile documents.

The 'Confirmed Pregnancy' clinical item has a tickbox, 'Send Antenatal Reports', which determines where data for this pregnancy is sent to the MeHR. This tickbox is also shown in Antenatal Check-up clinical items, but as read-only, reflecting the value set in the Confirmed Pregnancy clinical item for the same pregnancy number. Either all the data concerning a pregnancy is sent to the MeHR, or no data.

If this tickbox is ticked:

- All data that has been entered for this pregnancy (in the Confirmed Pregnancy and Antenatal Check-up clinical items), will be sent to the MeHR.
- All Event Summaries for past services that contained data for this pregnancy will be sent to the MeHR.
- All data for this pregnancy will be included in CHP documents, and cannot be removed.
- At the end of any service containing data for this pregnancy, an Event Summary, Antenatal Report, and Current Health Profile will be sent to the MeHR. This cannot be overridden.

If this tickbox is unticked:

- All data that has been entered for this pregnancy (in the Confirmed Pregnancy and Antenatal Check-up clinical items), will be removed from the MeHR.
- All Event Summaries for past services that contained data for this pregnancy will be removed from the MeHR.
- All data for this pregnancy will be removed from CHP documents, and cannot be readded.
- At the end of any service containing data for this pregnancy, no document will be sent to the MeHR. This cannot be overridden.

MeHR to My Health Record Transition

Use the MeHR to My Health Record Transition module to aid the transition of patients from the MeHR to the My Health Record.

The MeHR to My Health Record Transition module can be enabled in System Parameters *(on page 811)*.

This module can only be enabled if both the MeHR and My Health Record modules are enabled, and cannot be enabled in conjunction with MeHR Administration and MeHR e-Registration Auto-Prompt.

Enabling this module will limit MeHR functionality in various areas of the system. For more information, see:

- System Parameters - MeHR *(on page 824)*
- Clinical Records *(on page 112)*
- Biographics *(on page 30)*
- Closing a Clinical Record *(on page 95)*
- My Health Record Patient Record *(on page 783)*

My Health Record

A My Health Record is a secure, electronic record of a patient's medical history, stored and shared in a network of connected systems, which brings key health information from a number of different systems together and presents it in a single view.

Communicare has attained full My Health Record compliance from the National E-Health Transition Authority (NEHTA).

My Health Record access

The My Health Record repository can be accessed by authorised healthcare providers.

To register for access to the My Health Record repository and for more information, contact the Department of Health and Ageing at http://www.ehealth.gov.au

Accessing a My Health Record in Communicare

To upload documents to, or download documents from the My Health Record, the following modules must be enabled on the **File > System Parameters > System** tab:

- `My Health Record Access`
- `My Health Record Assisted Registration`

Before enabling My Health Record access, the following information needs to be obtained and set up.

Table 263. My Health Record access requirements

Entity	Requirement	Description
Organisation	Valid HPI-O	Recorded on **File > Organisation Maintenance > General** tab
Encounter Place	Valid HPI-O	Recorded in the **HPI-O Number** field for the encounter place in **File > Reference Tables > Encounter Place**
Provider	Valid HPI-I	**File > Providers** Set against the correct log on username.
Provider	Belongs to a user group with the `My Health Record Access` system right enabled	**File > User Groups** The My Health Record's security model does not support Communicare's viewing rights. Communicare recommends that only users who have full Viewing Rights should access the My Health Record.

After you have collected and set up this information, contact Communicare Support to arrange installation of the My Health Record module.

In the Offline Client, you can generate My Health Record documents, but they are not uploaded to the My Health Record until after you are back online and have synchronised to the online client.

The Demo version of Communicare connects to the test My Health Record Service. Searches and validation cannot be done on real patients, providers or organisations using the Demo version.

Patient registration and consent

When you add a new patient to Communicare, you can also register them for My Health Record.

For Communicare to upload information to a patient's My Health Record, the patient must:

- Have a valid IHI recorded on the **Personal** tab of their biographic record

  Communicare validates a patient's IHI when it uploads documents to the My Health Record repository.

- Be registered in Communicare for a My Health Record

  From any tab in a patient's biographic record, click  **My Health Record Registration** to open the My Health Record Assisted Registration *(on page 788)* window.

- Have consented to upload information to the My Health Record, for more information, see My Health Record Upload Consent *(on page 787)*

  Set a patient's consent or refusal on the **Administration** tab of their biographic record.

  If a patient opts out of uploading records to the My Health Record, clinicians are warned when they generate My Health Record documents and **Do not send reports to My Health Record** is set in pathology and imaging requests.

For patients who are registered with My Health Record, the  **Open My Health Record** icon in their clinical record displays a green background.

Using My Health Record in Communicare

To access a patient's My Health Record information, in Communicare, in the patient's clinical record:

- Click  **Open My Health Record > View Health Record Overview** or  **Prescription & Dispense View**.
- In the Medication Summary, click  **View My Health Record Medications**

If the patient has set an access code, they will need to supply it so that the clinician can view the patient's record.

Uploading medications to My Health Record

Prescribed medications and medication orders are uploaded automatically to the My Health Record within 5 minutes if consent has been given.

To exclude a particular medication from being uploaded to the My Health Record, deselect **Consent to send to My Health Record** when prescribing.

Uploading documents to a My Health Record in Communicare

If a patient has an IHI, you can generate and upload the following documents to My Health Record:

- eDischarge Summary
- eReferral
- Shared Health Summary
- Event Summary

To generate and upload a document from Communicare:

1. In the clinical record, click **Open My Health Record > Generate a** *document*. For example, **Generate a Shared Health Summary**.
2. In the document, select the elements that you want to include in the document. Ensure that you do not include sensitive data.
3. Click **Save and Upload to My Health Record**.

An entry is added to the **Progress Notes** tab in the clinical record to show that a document was generated.

The document will be queued and will upload to My Health Record when the background process is next run.

Until they are sent, documents are listed on the **Documents and Results > Outgoing** tab with a status on `Pending`. Any processing errors are also displayed here.

If a patient's IHI is not valid, you will see an error such as `Patient doesn't have a valid IHI`.

> **Tip:**
> If you resolve a problem that was stopping a document being sent, such as a network error or IHI validation, to upload the document to My Health Record, on the **Documents and Results > Outgoing** tab, right-click the document with an error and select **Resend Document**.

In the Offline Client, documents are not uploaded to the My Health Record until after you are back online, have synchronised to the online client and the background process has run.

For more information, see Clinical Document Architecture (CDA) *(on page 327)*.

Health Record Overview

The Health Record Overview (HRO) is a summary of a patient's data stored in their My Health Record.

> **Note:**
> The Health Record Overview is not a complete view of the individual's health information, as it contains only the information that has been uploaded to the My Health Record.

The Health Record Overview consists of the following sections:

- Documents available on the My Health Record since the last Shared Health Summary - lists any documents that have been loaded to the patient's My Health Record since the last Shared Health Summary was uploaded. Since the majority of information on the Health Record Overview shows what was included in the patient's last Shared Health Summary, it is important to show what has been added since, and is therefore additional to this information. These documents are listed at the top of the HRO window. Double-click on these documents to preview them.

- Shared Health Summary - shows the data from the last Shared Health Summary that was uploaded for the patient, and consists of the following subsections:
    - Current and Past Medical History - shows Problems, Diagnoses, and Procedures
    - Allergies & Adverse Reactions
    - Medicines
    - Immunisations
- My Health Record View Links - these are unavailable if information exists for the view in the patient's My Health Record. See https://www.nehta.gov.au/implementation-resources/clinical-documents for more detailed descriptions of what these views contain.
    - Patient Document List *(on page 783)*- lists all CDA documents in the patient's My Health Record, with options for filtering, uploading, and so on
    - Pathology Index View *(on page 784)*- lists Pathology Reports in the patient's My Health Record, with options to filter and preview these reports
    - Diagnostic Imaging Report View *(on page 785)*- lists Diagnostic Imaging Reports in the patient's My Health Record, with options to filter and preview these reports.
    - Personal Health Summary - a summary of personal health information entered on the My Health Record by the patient themselves or an authorised representative.
    - Advance Care Directive Custodian - Advance Care Directive Custodian contact details.
    - Health Check Assessment Schedule *(on page 785)*- questionnaires completed by a parent of an authorised representative at scheduled intervals to help monitor a child's growth and development.
    - Prescription and Dispense View - see My Health Record Prescription and Dispense View *(on page 790)*.
    - Medicare Overview *(on page 785)* - information regarding Medicare and Department of Veterans Affairs benefits, pharmaceutical benefits, childhood immunisation and organ donor status.
- Documents Available on the My Health Record in the last 12 months - double-click on these documents to preview them.

Patient Document List

Displays information about the patient and any clinical documents that have been added to the patients My Health Record.

Documents displayed in blue also exist in the Communicare database. This form presents three tabs, Home, Views and Document (provided the patient has documents).

To load the patient's Prescription and Dispense View *(on page 790)*, click  Medications.

To upload a document from Communicare to the My Health Record, click  **Upload**. See Select a Document *(on page 786)*. You can only upload a document if:

- You were the author of the document
- The HPI-O recorded in Communicare matches the HPI-O of the document

When you view a patient's My Health Record there may be some documents not visible due to security. To view these documents the patient can elect to provide you with an access code which, when entered, will make these documents appear. To display any patient-restricted documents, click  **Enter LDAC** and enter the code.

MeHR Profile

If the MeHR to My Health Record Transition *(on page 779)* module is enabled, the MeHR Profile button is visible. If the patient has an MeHR, it will show as green and open the MeHR viewing window. If the patient does not have an MeHR the button will show as red.

Document List preferences

You can customise the types of documents and a date range for displaying the patients documents.

- **Document Types** - these are all of the documents that can be stored against a My Health Record. This will default to display all documents, or the documents that you selected last time.
- **From Date** - defaults to either 60 days previously or the interval in days used the last time.
- **To Date**- defaults to today.

Once you have selected the document types and a date range click  **Refresh** to refresh the list of My Health Record documents displayed.

When you close the My Health Record Patient Record window, these settings will be saved and used the next time you open the My Health Record Patient Record form.

Views tab

This tab allows you to customise the appearance of the documents list. See Grid Views *(on page 961)*.

Document tab

This tab allows you to maintain the patient's My Health Record documents.

To attach a read-only view of the currently selected document to the My Health Record, click  **Preview**. See Viewing Documents *(on page 786)*.

To view the selected document's history, click  **History**.

To remove the currently selected document from the My Health Record, click  **Remove**. See Removing Documents *(on page 786)*. You can only remove a document if:

- You were the author of the document
- The HPI-O recorded in Communicare matches the HPI-O of the document

To replace a document in the My Health Record with a new document from Communicare, click **Supersede**. See Select a Document *(on page 786)*. You can only supersede a document if:

- You were the author of the document
- The HPI-O recorded in Communicare matches the HPI-O of the document
- The document types match, that is you can only replace an eReferral with another eReferral

Pathology Index View

The My Health Record Pathology Index View shows a filterable list of CDA pathology report documents.

The following functions are available

- Start Date, End Date: - filter the documents included in the view, based on their specimen collection date. The End Date always defaults to today's date.
- Refresh - retrieve data based on the dates set.
- Print - print the document list.
- Preview - double-click a list item, or click Preview to display an individual pathology report in the list

Diagnostic Imaging Report View

The My Health Record Diagnostic Imaging Report View shows a filterable list of CDA diagnostic imaging report documents.

The following functions are available

- Start Date, End Date - filter the documents included in the view, based on their imaging date. The End Date always defaults to today's date.
- Refresh - retrieve data based on the dates set.
- Print - print the document list.
- Preview - double-click a list item, or click Preview to display an individual diagnostic imaging report in the list.

Health Check Assessment Schedule

Shows questionnaires completed by a parent or an authorised representative at scheduled intervals to help monitor a child's growth and development.

The My Health Record Health Check Assessment Schedule is opened as a CDA document on the My Health Record Document Viewing window.

The following functions are available:

- From Date, To Date - filter the data included in the view. The To Date always defaults to today's date.
- Refresh - retrieve data based on the dates set.
- Print - print the document displayed.

Medicare Overview

Shows information regarding Medicare and Department of Veterans Affairs benefits, pharmaceutical benefits, childhood immunisation and organ donor status.

The My Health Record Medicare Overview is opened as a CDA document on the My Health Record Document Viewing window.

The following functions are available:

- From Date, To Date - filter the data included in the overview. The To Date always defaults to today's date.
- Refresh - retrieve data based on the dates set.
- Print - print the document displayed.

Limited Document Access Code (LDAC)

When you view a patient's My Health Record there may be some documents missing due to security.

To view these documents, the patient can elect to provide you with an access code which when entered will give you access to these documents.

To enter the code and display the patient-restricted documents, click **Enter LDAC**.

The **Prescription and Dispense** view of the Patient Controlled Electronic Health Repository may also require a Limited Document Access Code. If the LDAC code was previously entered for the patient, you will not be prompted to enter it again.

Access Code

When attempting to access a My Health Record the repository may require you to enter an access code.

You should ask your patient yo supply you with their access code. Then to continue to the patient's record, enter the access code and click **OK**.

If you require emergency access to a patient's records and don't have the access code, click **Request Emergency Access**.

Once you have obtained access to a patient's My Health Record using an access code, you may not need to enter an access code again to access that patient's My Health Record.

Select a Document

This displays a list of documents that have been created in Communicare but not yet uploaded to a My Health Record.

Preview Document

You can preview a document by clicking the Preview button and this will open the document in a read only view.

Upload Document

You can select a document for uploading to a My Health Record. To do this selected a document and then click the Upload button

Viewing Documents

My Health Record documents are temporarily downloaded and displayed for viewing.

To print a document, click **Print**.

Removing Documents

If required, you can remove documents from the My Health Record repository.

Documents can be removed from a My Health Record repository, provided:

- You were the author of the document
- The HPI-O in Communicare matches the HPI-O of the document

To remove a document from a My Health Record:

1. Click  **Remove**.
2. You will be prompted for a removal reason. Select one of the reasons and click **OK**.

Communicare will attempt to remove the document.

To reinstate a document once it has been removed, its authoring organisation must contact the PCHER System Operator.

My Health Record Not Found

The **My Health Record Not Found** window is when a My Health Record cannot be found for the current patient.

This could mean either:

- The patient does not have a My Health Record
- The patient's My Health Record is restricted and an access code is required

If the patient has a restricted My Health Record, click **Enter Access Code** and enter the access code in the Access Code Prompt *(on page 786)* to gain access to the patient's My Health Record.

My Health Record Upload Consent

My Health Record and National Prescription and Dispense Repository (NPDR) are opt-out systems. However, patient upload consent may still be required before a document can be uploaded to a patient's My Health Record.

By default, the My Health Record upload consent status for each patient is set to `not asked`, that is, neither Yes nor No. However, a background process is run nightly that checks if a patient has an active My Health Record accessible to the organisation and if their status is `not asked` sets that patient's upload consent status to Yes. For more information, see CCareQueue_Pcehr in Background Processes *(on page 950)*.

When an upload to My Health Record is attempted, Communicare checks if patient consent has been obtained. If consent has not been obtained, a window is displayed requesting patient consent before the upload can continue. If the patient grants consent, enter your Communicare login password and then the upload can occur.

Removing My Health Record upload consent

To remove consent on  **Patient Biographics > Administration** tab, set **Patient consents to My Health Record uploads** to `No`.

You may also need to remove consent in the following situations:

-  **Medication > Add Medication** - on the **Write a Prescription** tab, **Consent to send to My Health Record** is automatically set if the patient has a My Health Record. Deselect this option to prevent medication information from being uploaded to My Health Record and NPDR.
-  **Medication > Add Medication** - on the **Create a Medication Order** tab, **Consent to send to My Health Record** is automatically set if the patient has a My Health Record and **Upload medication order to eRx** is set on **File > System Parameters > Clinical** tab. Deselect this option to prevent medication information from being uploaded to My Health Record and NPDR.
-  **Imaging** and  **Pathology** - from the **Add Investigation Request** window, pathology and imaging information is automatically uploaded to My Health Record if the patient has registered for a My Health Record, unless **Do not send reports to My Health Record** is set.
- Service exit - when you exit a clinical record after a service encounter, if the patient has a My Health Record and they have given upload consent, the following options are automatically set:
    - **Send Event Summary to My Health Record**
    - **Send Shared Health Summary to My Health Record**

My Health Record Assisted Registration

Register new patients with My Health Record if they are not already registered.

Communicare checks if a patient with that IHI already exists in the My Health Record and warns you if they do. Do not register a patient more than once.

To register a new patient with My Health Record:

1. In the new patient's biographic record, click **My Health Record Registration**.
2. In the **My Health Record Assisted Registration** window, information about the patient is displayed in the **Patient** pane.

   > **Tip:**
   >
   > Click **Change Details** to edit patient details in the Patient Biographics *(on page 30)* window.

3. If a child is being registered, click **Select Guardian** and select a parent or guardian with a valid IHI number from the Communicare patient list. The guardian's information that is relevant to the registration is added to the **Guardian** pane.

   The guardian's IHI number is validated before allowing them to be selected or saved. Even though it is not required for a child registration that the guardian and child share the same Medicare Number, the patient search will default to a search based on the patient's Medicare Number. To edit the guardian's patient record, click **Change Details**. To remove the guardian from the registration, click **Clear Guardian**.

4. In the **Opt in Information Sharing** pane, for each type of information, set **Yes** or **No** depending on whether the patient agrees to share that information with My Health Record.
   - Future MBS - Future Medicare Benefits Scheme information
   - Past MBS - Past Medicare Benefits Scheme information. This is only available for selection if the patient is sharing Future MBS information.
   - Future PBS - Future Pharmaceutical Benefits Scheme information
   - Past PBS - Past Pharmaceutical Benefits Scheme information. This is only available for selection if the patient is sharing Future PBS information.
   - AODR - Australian Organ Donor Register information
   - AIR - Australian Immunisation Register information
5. The Identity Verification Code (IVC) indicates that the patient's identity has been verified. The IVC is required the first time a person accesses their My Health Record online. In the **Identity Verification Code Delivery Method** (IVC) pane, choose how the IVC will be delivered to the patient. Select from:
   - **None** - the patient will not be able to access their record online. They may call a helpline at the Department of Health and Ageing to gain access at a later date
   - **Email** - the patient will be sent their IVC in an email to the email address provided. The email address field from the patient record is used. Any changes in the **Email Address** field here are not saved back to their patient record.
   - **SMS** - the patient will be sent their IVC in a text message to the mobile number provided. The mobile number from the patient record is used. Any changes in the **Mobile No** field here are not saved back to their patient record.
   - **Response** - the IVC is shown on-screen in Communicare when the registration is successful. The user should take a note of the code and pass this to the patient.

6. From the **Identity Verification Method** list in the **Evidence of Identification** pane, select the way in which the patient's identity was verified.
7. In the **Declaration** pane, set if the patient agrees with the terms and conditions for My Health Record registration and use. The declaration wording varies depending on whether a guardian is involved in the registration.
8. Click **Send Registration Details to My Health Record**.

Communicare validates the patient, guardian, and registration data.

If the data is valid, the registration is sent to the My Health Record, and you will either receive a confirmation that the registration has been successful, or an error message.

If the IVC Delivery method was set to **Response** and the registration is successful, the Identity Verification Code is displayed.

If a patient is successfully registered with My Heath Record, the **Open My Health Record** icon in their clinical record displays a green background.

If any of the following conditions are not met, Communicare will not register a patient with My Health Record and will list the validation errors:

- The patient has a valid identifier - the patient requires either an IHI, Medicare Card and Reference No, or DVA No. If they have an IHI, no further demographic details are required for the application.
- The patient has sufficient demographic information - if the patient does not have an IHI, in addition to the identifier, they also need the following information recorded in their biographics: Family Name, Forename, Date of Birth, Sex, and Indigenous Status. *Not Stated* is counted as a valid value for My Health Record registration.
- The guardian has a valid identifier - the guardian requires either an IHI or Medicare Card and Reference No. If they have an IHI, no further demographic details are required for the application.
- The patient and guardian have the same Medicare No - this is required even if the patient or guardian are using an IHI for their identifier.
- A patient under 14 years of age may only register with a guardian.
- The patient must be younger than 18 years to register with a guardian - if the patient is 18 years or older, the guardian should be removed.
- The guardian must be at least 14 years older than the patient.
- The declaration is agreed.
- All the opt in information sharing options are filled in, none can be left as `Blank`.
- An Identification Verification Code Delivery Method has been specified, along with email address or mobile number if needed.
- An Identity Verification Method has been selected.

Correct any errors.

National Prescription and Dispense Repository

You can view patient medication data on My Health Record through Communicare.

Access the National Prescription and Dispense Repository (NPDR) through the My Health Record.

If the patient gives consent, you can upload patient medication data to the patient's My Health Record via eRx *(on page 249)*.

Accessing NPDR in Communicare

- Ensure that Electronic Transfer of Prescriptions *(on page 249)* is enabled. To verify that ETP is enabled, select **File > System Parameters > Clinical** tab. The eRx adapter URL should be valid. If not, see ETP *(on page 249)* for instructions on registering for the service.
- Ensure that the Accessing My Health Record in Communicare *(on page 780)* module is enabled, and that the user has access. To enable My Health Record, select **File > System Parameters > System** tab and set **My Health Record Access**.

Sending the Medication Details to NPDR

From the prescription details window, accessed through the clinical record, you can send medication details to NPDR.

The medication details are not sent until the ETP *(on page 249)* Prescription is printed.

Viewing Medication Details

To display the **My Health Record Prescription and Dispense View**, either:

- In the **Patient eHealth Record** window, click **View Medications**
- In the clinical record, on the **Summary > Medication Summary** tab, click  **View My Health Record Medications**.

For more information, see My Health Record Prescription and Dispense View *(on page 790)*.

If the My Health Record access code *(on page 785)* has already been entered once on the clinical record to access the My Health Record or My Health Record Prescription and Dispense View, you won't be prompted for this again.

My Health Record Prescription and Dispense View

The My Health Record **Prescription and Dispense View** is opened as a CDA document in the My Health Record Document Viewing window. Documents loaded to eRx *(on page 249)* with consent to be sent to the My Health Record are presented as CDA documents.

The document view displays a summary of both prescribed and dispensed items with links to more information. Click an individual prescription or dispense event item to display further drug information. Click this information to display the full eHealth Prescription Record.

You can customise the information displayed in this window:

- Set the date range for which you'd like medicines displayed. Medicines prescribed on or after the **From Date** to the **To Date** are listed. The From Date defaults to either 60 days previously or the interval in days used the last time the view was used. The To Date defaults to today.
- For records with multiple medications, select an option from the **Group By** list to group the medications according to your preference:
    - Prescription - default view
    - Generic Name

- PBS Item Code
- Brand Name

If you change the date range, click **Refresh** to download the CDA from My Health Record again.

Print this document if required

Stopped medications

If a medication that has been sent to My Health Record is stopped, cancelled or deleted, the medication is listed as `cancelled` in the **Prescription and Dispense View** view.

National Cancer Screening Register

Communicare integrates with the National Cancer Screening Register (NCSR).

The NCSR stores a single electronic record for each person in Australia participating in the national cervical, bowel or lung screening programs.

The NCSR provides two portals:

- Participant Portal - people who are involved in the cervical, bowel or lung screening programs can access this portal through their MyGov account. The NCSR sends invitations, reminders and results to participants and these are displayed on the participant portal.
- Healthcare Provider Portal - view a history of screening results and manage your patient's participation in the cervical, bowel or lung screening programs

Communicare integrates with the Healthcare Provider Portal to:

- Display alerts from the NCSR in Communicare
- Allow the healthcare provider to access participant data, manage your patient's participation in the cervical, bowel or lung screening programs, update details such as patient information, program forms and so on

The NCSR is not supported in the Offline client.

The following clinicians can access the NCSR:

- Healthcare professionals with a Medicare provider number
- Nurses and medical practice or lab staff without a Medicare provider number acting as a delegate of a healthcare provider with a Medicare provider number
- Providers with a Register Identifier Number – a unique number used to authenticate screening test providers not eligible for a Medicare provider number

For more information about the NCSR, see NCSR (www.ncsr.gov.au).

Enable NCSR integration

Before you can access the NCSR from Communicare, the integration must be enabled.

Your practice must be registered with the NCSR before you can enable National Cancer Screening Register functionality. Before you can register your practice, you must have the following information set up:

- A Responsible Officer with an individual PRODA account
- Your organisation must have an Healthcare Provider Identifier–Organisation (HPI-O) number - this must be the HPI-O that has been used to register for the organisation's National Authentication Service for Health (NASH) certificate
- The Responsible Officer has registered the organisation in PRODA
- The Responsible Officer has linked the NCSR as a Service Provider to the organisation in PRODA

For more information, including guides to support you through the registration process, see https://ncsr.gov.au/integrations/communicare.

After the registration process is complete, System Administrators can enable the NCSR integration in Communicare.

To enable the NCSR integration in Communicare, as an administrator:

1. Add your organisation's NCSR NASH certificate to Communicare in **File > Reference Tables > Certificates**.
2. Enable the module:
    a. Select **File > System Parameters**.
    b. On the **System** tab, in the module list, set **NCSR Integration**.
    c. On the **Web Services** tab, in the **National Cancer Screening Register (NCSR)** pane:
        - In the **URL** field, enter the URL of the NCSR API
        - From the **Certificate** list, select your organisation's NCSR NASH certificate
    d. Click **Save** and enter the authority code provided by Communicare Support *(on page)*.
3. If you want to allow nurses and medical practice or lab staff to access the NCSR as delegates of a healthcare provider with a Medicare provider number, in **File > Reference Tables > Encounter Place**, select the provider from the **Default NCSR Provider** list.
4. Set the system rights for the user groups you want to be able to access the NCSR:
    a. In Communicare, select **File > User Groups**.
    b. In the **User Group Maintenance** window, select the user group in the **User Group Name** list to which you want to grant access to the NCSR. For example, `Doctors`.
    c. On the **System Rights** tab, set **NCSR Integration**.
    d. Click **Save**.

When Communicare is next started, for users who belong to a group that has the NCSR system right enabled, NCSR alerts are displayed in the banner of a patient's clinical record if that patient is matched to the NCSR database. Users can also link to the NCSR Hub from the patient record.

Access NCSR from Communicare

For healthcare providers who belong to a group that has the `NCSR Integration` system right enabled and who have a valid provider number, or who are delegates of the healthcare provider, a count of current alerts for patients matched in the NCSR database is displayed in the matching patient's clinical record in Communicare.

The following clinicians can access the NCSR:

- Healthcare professionals with a Medicare provider number
- Nurses and medical practice or lab staff without a Medicare provider number acting as a delegate of a healthcare provider with a Medicare provider number
- Providers with a Register Identifier Number – a unique number used to authenticate screening test providers not eligible for a Medicare provider number

Communicare users who belong to a user group with the `NCSR Integration` system right enabled, but who don't have a provider number and are not delegates of the healthcare provider, see an error message similar to the following when they attempt to access the NCSR:

```
You cannot access NCSR because you don't have a Medicare provider number
 and no default provider has been specified for the encounter site
```

Patient banner

In Communicare V21.2 and later, alerts from the NCSR are displayed in the patient banner. For example:

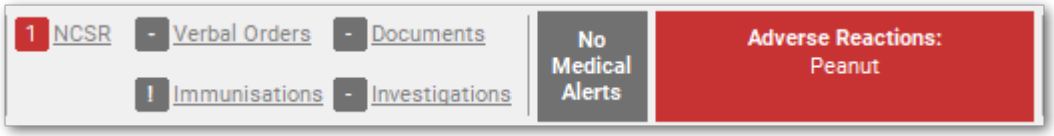


Table 264. NCSR alerts in patient banner

Banner display	Description
-	No match for this patient was found in the NCSR database. **Important:** If a patient cannot be matched but should be, check the NCSR Healthcare Provider Portal for any alerts. Do not assume that if no alerts are displayed in Communicare, the patient does not have any alerts from NCSR.
0	The patient record was matched to a record in the NCSR database, but there are no alerts to display for this patient.
1	The patient record was matched to a record in the NCSR database, and there are alerts to review for this patient.
!	The user belongs to a user group with the `NCSR Integration` system right enabled, but doesn't have a Medicare provider number and is not a delegate of the healthcare provider. Hover over the icon to display details of the error.

Viewing patient information in NCSR

If you belong to a user group that has the `NCSR Integration` system right enabled, you can view a patient's NCSR record if the patient is matched in the NCSR database.

Important:
If a patient cannot be matched but should be, check the NCSR Healthcare Provider Portal for any alerts. Do not assume that if no alerts are displayed in Communicare, the patient does not have any alerts from NCSR.

To display a patient's NCSR record, in the clinical record, either:

- In the patient banner, click **NCSR**
- In the toolbar, select **Go To > NCSR Hub**

Downloading information from NCSR

To download a patient's record from the NCSR, click **Download**.

All files downloaded on a given day are saved to your `Downloads` folder with the same name, for example, `exportDataFri Jul 16 2021.pdf`.

> **Tip:**
> The next download from the NCSR on the same day will overwrite the previous download. If you want to keep the download, save it with the date and the patient's name to your server or upload it to Communicare.

Matching patients

Not all patients will have information in the NCSR database. Only those people in Australia participating in cervical, bowel or lung screening are included.

Communicare provides the following data to the NCSR so that patients can be matched:

- Name
- Sex
- Date of birth
- Medicare number
- IHI number
- DVA number

If a patient does not have an identifying number such as a Medicare number, they are unlikely to be matched.

NCSR Hub

Use the NCSR Hub to gain visibility of your patient's screening status and to prompt important discussions about cancer screening.

Providers and practice staff can use the NCSR Hub to:

- Access screening information, including patients' screening history and results, overdue and follow-up alerts.
- Submit demographic and clinical updates to the NCSR.
- Record program test kits issued to patients during a consultation or kits ordered for deliver to a patient's address to facilitate bowel screening test completion.

Review the following step-by-step video guide for using the NCSR Hub integration with Communicare to support patient participation in bowel and cervical screening.

https://app.screencast.com/FfbXw1Xhp6wwW/e

HealthLink SmartForms

Communicare integrates with HealthLink SmartForms to enable you to send structured eReferrals.

Relevant data, such as patient and medication information from the patient's Communicare record is automatically added to the form you select. The latest observations from Communicare are added to the forms. Information added automatically from Communicare is generally, but not always editable, depending on the form.

Note:

SmartForms are developed and maintained by HealthLink. The formatting of HealthLink SmartForms is controlled by HealthLink. Discuss any concerns you have about the presentation of the SmartForms with HealthLink Support.

Access to SmartForms is provided by HealthLink based on each Communicare site's HealthLink customer ID. The HealthLink customer ID determines the HealthLink SmartForms available to your organisation. If the required HealthLink SmartForm is not visible, contact HealthLink to have the form added to your HealthLink customer ID account.

Configure Communicare to use HealthLink SmartForms

To use HealthLink SmartForms, your organisation must have a HealthLink account and your Communicare instance must be configured to access the forms.

Register your organisation with HealthLink at HealthLink Support. Remember the EDI code and password provided to you.

Users who belong to the **System Administrators** user group can configure Communicare to use HealthLink Aduro SmartForms.

To configure your Communicare instance to use HealthLink SmartForms:

1. In **File > System Parameters > Secure Messaging** tab, enter the HealthLink EDI code and password. For more information, see System Parameters - Secure Messaging *(on page 824)*.
2. In **File > User Groups > System Rights** tab, set **HealthLink SmartForms** for the user groups that need access to the forms. For example, Doctors, Registered Nurses.
3. Open your firewall for the port specified in System Parameters - Secure Messaging *(on page 825)*.

For more information, contact Communicare Support.

Send HealthLink SmartForms

Send eReferrals and other forms from Communicare using HealthLink SmartForms.

Your Communicare instance must be configured *(on page 795)* to integrate with HealthLink SmartForms.

HealthLink SmartForms allow organisations receiving eReferrals or other forms to standardise the data required.

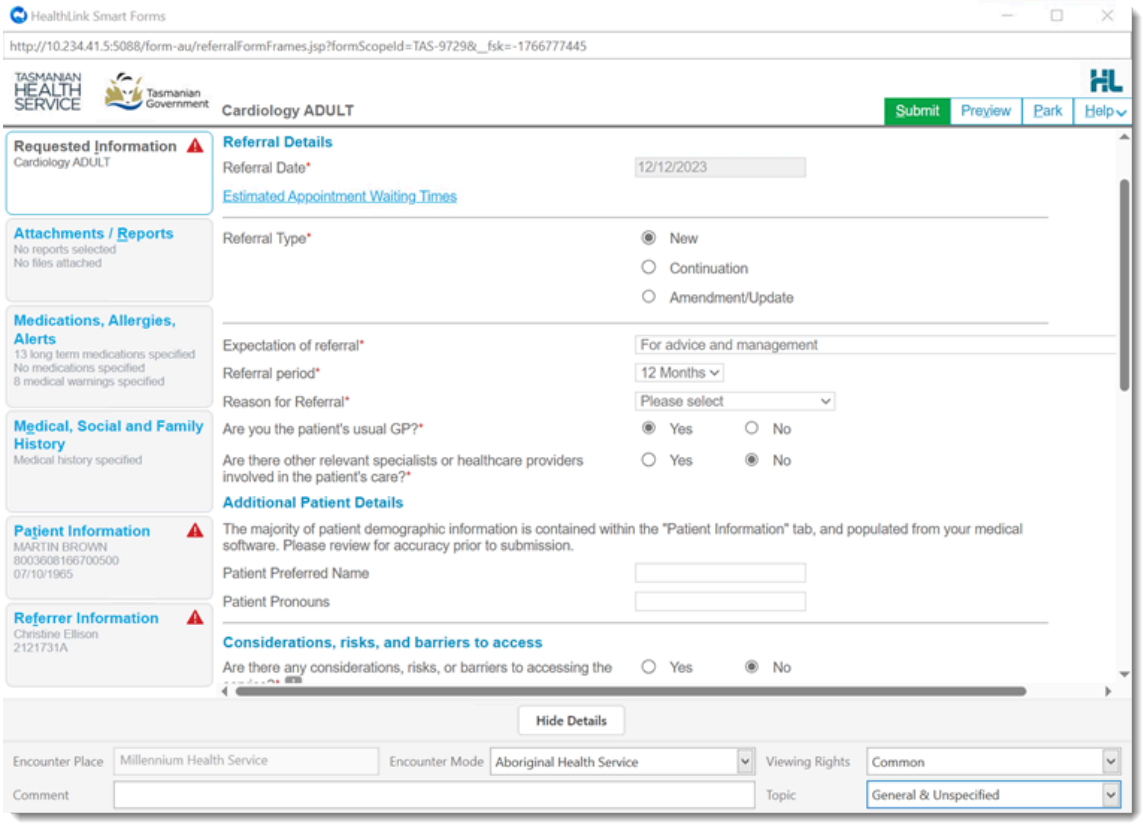
Each HealthLink SmartForm contains:

- Default data set by HealthLink
- Data imported from Communicare
- Fields to be completed manually by the clinician

Only users who belong to a user group with the **HealthLink SmartForms** system right enabled can work with SmartForms. Users without this system right can still view saved or submitted SmartForms.

To send a form from Communicare using a HealthLink SmartForm:

1. In a patient's clinical record in Communicare, select **Go To >** **HealthLink SmartForms**.
2. From the HealthLink SmartForms directory, select the required form.
3. Complete the eReferral form.



   - In the form, complete the mandatory fields.
   - Review the data imported from Communicare and update it if required. For more information, see HealthLink SmartForms Data Mapping *(on page 798)*.
   - Attach documents and reports as required. For more information, see Documents *(on page 799)*.
4. The current encounter and document properties are added to the SmartForm. To display the properties associated with the SmartForm, click **Show Details**. Edit these details if required.
   - From the **Encounter Mode** list, select an alternative encounter mode.
   - To limit who can view the document, from the **Viewing Rights** list, select a user group so that only users who belong to the selected group can view the SmartForm.
   - To sort the SmartForms into topics, from the **Topic** list, select a topic.
   - In the **Comment** field, enter a comment.

     The comment is added to the document properties and is used to identify the document in Communicare. Comments are limited to 40 characters.

     > **Tip:**
     > Copy the form name to the comment field to help with later identification of the form.

5. If you can't complete the form immediately, click **Park** to save it to Communicare, from where you can resume it later.

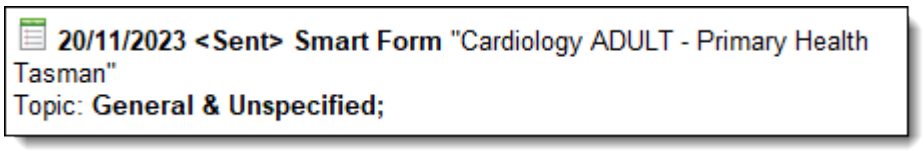
6. Click **Submit**.
7. When you submit or park and close the form, if you haven't added a comment already, include one in the space provided and click **Yes**.

Submitted forms are sent securely to the recipient and a summary of the information sent in the form is displayed as HTML or a PDF. This summary is also saved to Communicare. Print the summary if required.

> **Note:**
> HealthLink SmartForms do not use the Communicare default printer settings set in Printer Assignments *(on page 618)*.

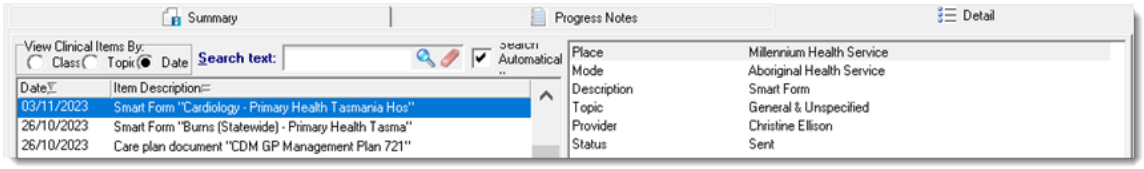
If the form fails to send, it is saved and parked and an error message from HealthLink is displayed.

In Communicare, submitted forms are listed in the patient's clinical record, on the **Progress Notes** tab, prefixed with `<Sent> SmartForm "comment"`.

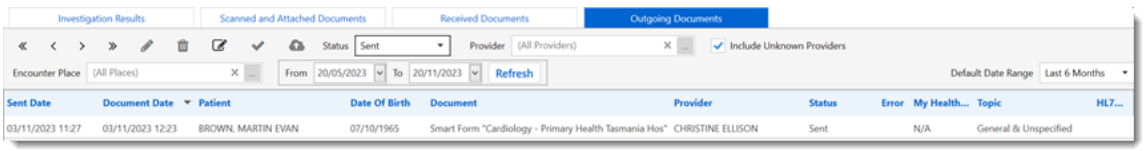


Submitted forms are also displayed in the following locations with the document name `SmartForm "comment"` and a status of `Sent`. For example `SmartForm "Cardiology - Primary Health Tasmania"`.

- The patient's clinical record, on the **Detail > Document** tab.



- **Documents and Results > Outgoing Documents** tab.



> **Tip:**
> To display an HTML or PDF summary of the SmartForm sent, double-click the SmartForm in the list.

  Incomplete, parked forms are listed with a status of `Saved`.

- Viewing rights are respected. Only clinicians who belong to the set user group can view the document.

For some recipients, forms are sent asynchronously using SMD. Forms sent asynchronously show a status of:

- `Pending` until an acknowledgement message is received.
- `Sent` when an acknowledgement message is received with a successful state.
- `Error` if a form is rejected or fails. To deliver the form to the recipient using an alternative method, open the form and print it to PDF.

Tip:
To open a sent SmartForm, double-click it on the **Progress Notes** or **Detail** tab.

If you parked an incomplete form or a form failed to send, from Communicare, resume it. For more information, see Edit HealthLink SmartForms *(on page 799)*.

HealthLink SmartForms Data Mapping

Data in Communicare is mapped to fields in HealthLink SmartForms.

Data mapping

Data mapping of note between Communicare and HealthLink SmartForms is as follows:

- For medications, Healthlink SmartForms display medications on the current medications list only, including the following:
  - Where there are multiple, regular prescriptions for the same medication, only the latest regular prescription.
  - Regular medications that are marked as stopped but with expiry date in the future.
  - Regular medication orders.
  - Regular medication history records.
- For some Healthlink SmartForms if the responses do not meet the criteria for referral submission, you cannot submit the form. To cancel the form and return to the clinical record, click **X**Close.
- Data that exceeds the validation period set for a HealthLink SmartForm is not included in the form. For example, height recorded in Communicare 10 years ago is not included in the HealthLink SmartForm.
- A provider's AHPRA number recorded in the **Registration Number** field *(on page 918)* in Communicare is mapped to the **Medical Registration Number** in HealthLink SmartForms.
- The organisation's phone number is used as the provider's work phone number.
- The HPI-O for the encounter place is used in HealthLink SmartForms. If there is no HPI-O set on the encounter place, the organisation's HPI-O is used.
- The most recent address for a patient recorded in biographics in Communicare with **Mail** set is used as the patient's postal address in HealthLink SmartForms.
- Some fields, such as, `Referral Type`, `Expectation of referral`, and `Referral period` are set to default values which you may want to adjust.
- For some data, all information from Communicare is listed and you must select the data to include. For example for `Current Medical Conditions` and `Relevant Past History`. If no data is selected, the information is excluded from the SmartForm and the receiving provider may not have the relevant information required to make an informed assessment of the submitted SmartForm.
- Investigation requests and results are not included in **Patient Problem** and **Patient Past History** in forms.
- Alert clinical items or structured alerts if enabled, are listed in **Medical, Social and Family History > Relevant Past History**.
- Social and Family History from Communicare is listed on the **Medical, Social and Family History** tab.

- For Social History, in the **Relevant Past History** section, `Social History` is displayed in the **Description** column and the information from Communicare is included in the **Comments**.
- For Family History, in the **Family History** section, `Family History` is displayed in the **Description** column and the information from Communicare is included in the **Comments**. Only the most recent information from **Family History** is included in the HealthLink SmartForm.

Documents

Attach documents and reports as required. On the **Attachments/Reports** tab, select documents to add to the SmartForm. The default list of documents is provided by the form's author. If the required document is not listed:

- To search for documents stored in the patients Communicare Clinical Record, select **Browse for patient document**.
- To search for documents stored elsewhere in your local computer's file system, select **Browse for local files**.

CDA documents such as Shared Health Summary or Event Summary cannot be attached to a SmartForm. Most CDA files can be retrieved from My Health Record.

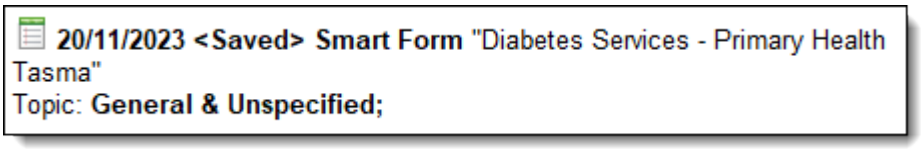
Edit HealthLink SmartForms

While editing a HealthLink SmartForm, you can save the form to Communicare in its unsubmitted state, and continue editing it later. This process is also known as parking and resuming a SmartForm.

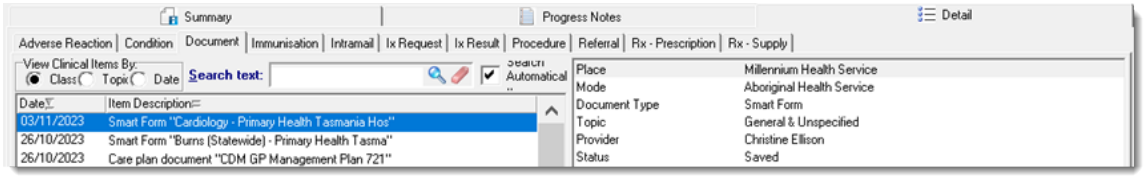
Your Communicare instance must be configured *(on page 795)* to integrate with HealthLink SmartForms.

Incomplete, parked HealthLink SmartForms are saved to the patient's clinical record:

-  **Progress Notes** tab, prefixed with <Saved> `SmartForm "`*`comment`*`"`.



- **Detail > Document** tab, named with `SmartForm "`*`comment`*`"`, and with a status of `Saved`.



Incomplete, parked HealthLink SmartForms are also listed in  **Documents and Results > Outgoing Documents** tab with a status of `Saved`.

Only users who belong to a user group with the **HealthLink SmartForms** system right enabled can work with SmartForms. Users without this system right can still view saved or submitted SmartForms.

Only users who belong to a user group with the **HealthLink SmartForms** system right enabled can work with SmartForms. Users without this system right can still view saved or submitted SmartForms.

Note:
Only the provider who initiated a SmartForm can resume it.

Data updated in the patient's Communicare clinical record since a HealthLink SmartForm was parked is not automatically updated in the reopened form, but can be added. For example, current, regular medications that have been updated and finalised are not listed in `Current medications` in the resumed SmartForm, but can be selected from the `Browse for more medications` list; similarly, select once off medications from `Past Relevant Medications`. Only those Medications that have a script number are included in HealthLink SmartForms.

To resume editing an unsubmitted form:

1. In Communicare, on the **Progress Notes** or **Detail > Document** tab, double-click a SmartForm with a status of `Saved` to open it.
2. In **HealthLink SmartForms**, complete the form. Ensure you include data updated since the form was parked.
3. Any attachments you added before you parked the form are not saved. Attach these documents again.
4. The current encounter and document properties are added to the SmartForm. To display the properties associated with the SmartForm, click **Show Details**. Edit these details if required.
    - From the **Encounter Mode** list, select an alternative encounter mode.
    - To limit who can view the document, from the **Viewing Rights** list, select a user group so that only users who belong to the selected group can view the SmartForm.
    - To sort the SmartForms into topics, from the **Topic** list, select a topic.
    - In the **Comment** field, enter a comment.

      The comment is added to the document properties and is used to identify the document in Communicare. Comments are limited to 40 characters.

      Tip:
      Copy the form name to the comment field to help with later identification of the form.
5. Click **Submit**.

Submitted forms are sent securely to the recipient and a summary of the information sent in the form is displayed as HTML or a PDF. This summary is also saved to Communicare. Print the summary if required.

Note:
HealthLink SmartForms do not use the Communicare default printer settings set in Printer Assignments *(on page 618)*.

Delete HealthLink SmartForms

You can delete a saved or submitted HealthLink SmartForm from Communicare, just as you can with any other document.

Documents are removed from display but are not deleted from the database.

Only users who belong to a user group with the **HealthLink SmartForms** system right enabled can work with SmartForms. Users without this system right can still view saved or submitted SmartForms.

To delete a HealthLink SmartForm:

1. In a clinical record, select the SmartForm:
    - On the **Progress Notes** tab for the current service.
    - On **Detail > Document** tab.
2. Click **Delete**.
3. In the **Delete Document** window, enter an explanation for why you are deleting the SmartForm.
4. Click **OK**.

A progress note is created, prefixed with `<Deleted> SmartForm "comment"` and displayed on the **Progress Notes** tab.

Tip:
When you close a patient record, you cannot ignore the service if you created a SmartForm, even if you did not enter any information or deleted the form. A SmartForm is automatically saved to the database when it is first created, which updates the clinical record.

Titanium & ISOH

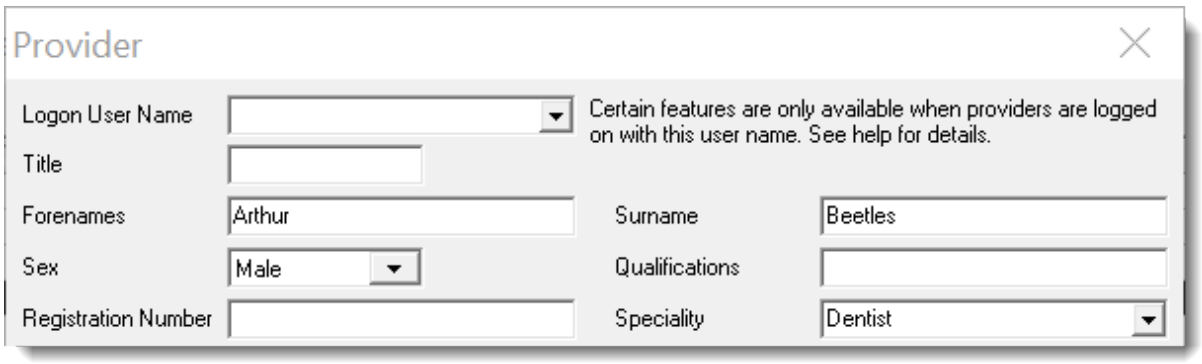
Communicare can interface with the Information System for Oral Health (ISOH) or Titanium.

Note:
A standard activation fee and additional charges apply. For more information, contact Communicare Support *(on page)*.

Dental appointments can be managed in Communicare and patient demographic information can then be uploaded to ISOH or Titanium into their demographic data fields.

Communicare sends appointment information to ISOH and Titanium based on the provider who is assigned to the appointment session template in the Communicare appointment book. Only those appointments for a provider with a speciality containing the word `Dentist` or `Dental` are exported.

Provider specialities are specified in the **File > Providers > Speciality** field.



The provider specialities that will interface with ISOH and Titanium are:

- `Dental Assistant`
- `Dental Hygienist`
- `Dental Prosthetist`
- `Dental Specialist`
- `Dental Technician`
- `Dental Therapist`
- `Dentist`

The interface between Communicare and Titanium also requires that the provider key used by Communicare for the relevant provider is registered in Titanium. To access this key:

1. In Communicare, select **File > Providers**.
2. In the Provider table, right-click and select **Show Hidden Columns**.

3. Note the provider key displayed in the **Provider No** column for each provider that you want to have an interface between Communicare and Titanium.
4. Send these provider key values to Titanium.

Communicare set up

Patient data is exported from Communicare to an HL7 file for ISOH or Titanium to import.

The export utility service is configured by Communicare Support. Support can set customisations in `App.config`, such as **PatientExportMode** to export only those patients with a dental booking created or modified since the last export, rather than all patients.

After it is configured, patient data is saved to `c:\PatientExportFiles` in HL7 format.

ISOH or Titanium Integration

Once Communicare is configured to export data, the Communicare Administrator for your health service should contact Titanium support and ask them to update the configuration for Titanium to import the messages created by Communicare. This integration work is not undertaken by Communicare.

You will receive an email from Communicare containing the following information:

- Server name
- IP address
- Communicare patient export folder

Troubleshooting

If after Communicare and ISOH or Titanium have been configured, there is no data exported to `c:\PatientExportFiles`, check that any appointment session you expected to be exported has been allocated to a provider with one of the specialities listed above. If the appointment sessions are correctly allocated and you are still not receiving the appointments into the `c:\PatientExportFiles` folder, contact Communicare Support for further assistance.

Virtual health monitoring

Communicare can be configured to integrate with virtual health monitoring applications such as My Care Manager (MCM).

MCM telemonitoring collects data, both actively and passively, from medical devices such as weighing scales, blood glucose monitors, thermometers, blood pressure monitors and pulse oximeters.

Observations recorded in MCM are added to Communicare as investigation results and appear in  **Documents and Results** in the same way as results from a pathology lab. If required, Communicare Support can configure Communicare to automatically review results that are in the normal range for all patients. With this configuration, MCM observations are added to  **Documents and Results > Investigation Results** tab with a **Review Status** of `Reviewed`.

Communicare remains the source of truth for patient details and updates MCM with any changes.

Communicare uses the following information to match a patient:

- Medicare number
- Date of birth
- Sex
- Patient name

MCM sends the following observations:

- Blood glucose
- Blood pressure
- Oxygen saturation
- Pulse
- Respiratory rate
- Temperature
- Weight

Patient virtual health monitoring status

If your health service is registered for virtual health monitoring with a service such as MCM, and a patient is being monitored, set their monitoring status in their biographics.

On the  **Patient Biographics > Administration** tab, from the **Virtual Health Monitoring** list, select the patient's status. Select from the following options:

- `Active` - the patient is being monitored
- `Inactive` - the patient is not being monitored
- `Suspended` - the patient is normally monitored, but monitoring is suspended. This can be for various reasons, such as, the patient is in hospital care, is away from home, and so on.

Hiding normal monitoring results

Virtual health monitoring applications generate many results for each patient. So that important clinical information is not obscured, you can configure Communicare to hide normal results on the **Detail** tab for all clinical records.

Before you can hide normal monitoring results in clinical records, Communicare Support must have first enabled integration with your virtual health monitoring application and added it as a source.

Note:
If you hide normal results from your virtual health monitoring application in the clinical record for one patient, normal results are hidden in the clinical records of all patients.

To hide normal monitoring results for all patients:

1. Open the clinical record of any patient.
2. On the **Detail** tab, on any of the following tabs, right-click the Item pane and select **Hide normal results from monitoring system >** *monitoring source*:
    - **Class > Ix Result**
    - **Topic > Investigations**
    - **Date**

    For example, select **Hide normal results from monitoring system > MCM**.

Only those results from your virtual health monitoring application with an abnormal flag are listed on the **Detail** tab in the clinical records of all patients.

This setting is saved in your user profile and is applied when you open any clinical record in future.

You can toggle this setting on and off. To display all results, repeat the procedure above and deselect the virtual health monitoring source.

WACHS Features

This topic provides help for WACHS-related features.

These features are available only when the **WACHS Features** module is enabled. Contact Communicare Support to enable the this module.

PAS Alerts

The alerts received from PAS through the EMPI integration are displayed as read-only text in the **Main Summary** of the clinical record. Any PAS alerts are also included in the Patient Summary.

Service Record & Billing

Both Medicare and Private claims are disabled when the WACHS Features module is enabled: you can't create and submit Medicare or Private claims and claim buttons and Invoice-related fields are disabled. However, you can select MBS items in the **Service Record** window and the **Details** tab.

On the **Details** tab of the **Service Record** window, use the **Indirect** column to record any indirect time (in minutes) for the service by the provider.

On the **WACHS** tab of the **Service Record** window record WACHS-specific information about the service in the following fields:

- Service Delivery Mode (mandatory)
- Clinic Category (mandatory)
- Outcome (mandatory)
- NDMS Code (mandatory)
- Tier 2 Code (mandatory)
- Service Type (mandatory)
- Claim Type
- NDIS Service
- Direct Units
- Indirect Units
- Employee Status (mandatory)
- Care Type (mandatory)
- Payment Class
- Main Reason for Visit (mandatory)
- Other Reason for Visit 1
- Other Reason for Visit 2
- Other Reason for Visit 3
- Discharge Status
- Closing Comments

Clinical Record

When you add an item to a patient's Medication History, the **Confirm Medication** window is not displayed. Ensure that you check previously prescribed medications with all allergy and adverse drug reaction information.

Adverse Reaction Assessment Status

From the **Main Summary** of the clinical record, select the Assessment Status manually for Adverse Reactions from the following options:

- **<blank>** - Selected by default
- None Known
- Known
- Unable to assess
- Unknown

Note: If Nil Known is selected, then None Know is automatically selected.

Patient Biographics

The following fields are required:

- Medicare Reference number
- Marital Status
- Country of Birth
- Residential Status
- Interpreter Required

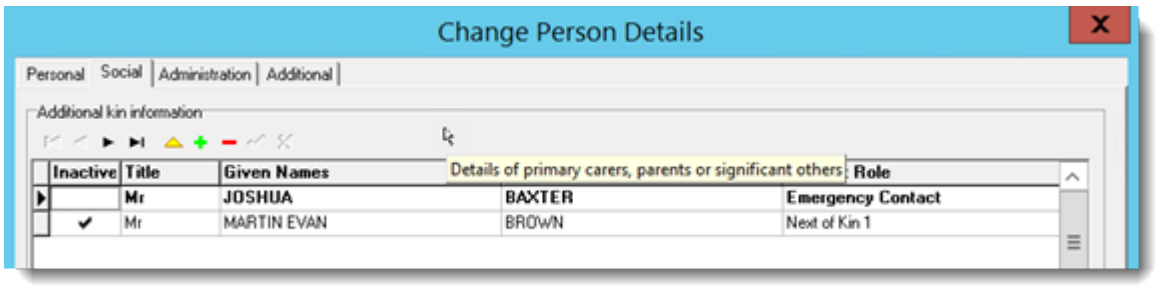
Patient Kin

On the **Social** tab of the patient's biographic window, when you add a patient's kin, the following fields are available:

- Title - kin title (mandatory)
- Family name - kin family name (mandatory)
- Given name - kin given name (mandatory)
- Relationship - kin relationship to the patient (mandatory)
- Address - address of the patient kin
- Home Phone - kin home phone number
- Business Phone - kin business phone number
- Mobile - kin mobile phone number
- Email - kin email address
- Contact Role - kin role
- Inactive - determines whether the kin is active or not
- Inactive date - If the kin is inactive then you can enter the inactive date
- Preferred Phone - preferred phone option.

> **Note:**
>
> The Contact Role must be unique across all kin for the current patient, except for a Contact Role of `Other`.

Active kin are displayed in bold and listed before inactive kin. For example:



Patient Unmerge

The Communicare Patient Unmerge functionality is to undo two incorrectly merged patient records. To access the Patient Unmerge functionality, the **Patient Deletion** system right is required.

Tip:
Review the patient record you select thoroughly before proceeding with unmerge.

Print a patient summary to use as a reference for comparison following the unmerge.

Note:
Unmerge will only proceed if no changes subsequent to the incorrect merge are identified in the merged patient record. A change for the purposes of unmerge is any information recorded during a patient encounter or service including viewing the clinical record, or a change made to an incoming referral, appointment or patient document.

Any other changes made to the patient record, for example changes to biographic information, are ignored and the unmerge process proceeds. Ensure you take account of this type of information prior to the unmerge and decide what actions to take after the unmerge.

If the unmerge does proceed, the merged patient record is unmerged to two separate patient records.

If the unmerge process fails, contact Communicare Support *(on page 973)* who will investigate the complexity surrounding the unmerging of two patient records with you on a case by case basis. Possible options, if any, can then be discussed. If there are any possible changes that can be made to enable unmerging of the patient records, Communicare will require you to submit an authorised change request.

On unmerge, the details for the following fields will be restored to what they were prior to the merge that had been incorrectly undertaken.

Note:
Review all patient data in the resulting patient records to ensure that the data are correct.

- Patient Biographics, including:
  - Sex
  - Skin
  - Date of birth
  - Place of birth
  - Patient death details
  - Medicare details
  - Birth Weight
  - Forenames
  - Surnames
  - Address
  - Phone
  - Work Phone
  - Mobile Phone
  - Email
  - Has No Phone checkbox
  - Aboriginality
  - Kin Type and Name
  - Nyaparu

    - Special Check Box
    - Special Lookup
    - MRN
    - Popup Alert - retains both
    - Admin Notes - retains both
    - Safety Net details
    - DVA details
    - Patient current status
    - Emergency contact details
    - IHI - including IHI history
    - Birth indicator
    - Patient Kin
- Patient Recalls - during unmerge, all recalls (including the deleted ones), are restored and assigned to their source and destination records respectively.

> **Note:**
> Any duplicate automated recalls that existed prior to the merge will leave a duplicate in the destination patient record on unmerge which needs to be manually removed. For example, if both patients who were merged had an automated recall for an 8 week Child Health Check Up, on unmerge the source record will have the same recall but the destination one will have two recalls for an 8 week Child Health Check Up.

- Pregnancy
- Conditions / Diagnosis
- Transport
- Patient Organisation Consent
- Documents
- Patient Encounter
- Investigation Request and Results
- Patient Measurements
- Incoming Referrals
- Patient Death Cause Factor
- Private Billing Account Holder
- Patient Claim
- Medication - all medication records that belong to the source patient are reallocated back to the source patient. If a regular medication has expired since the incorrect merge it will appear as expired following the unmerge. Information about once-off medications that expired between the merge and unmerge will be available only on the **Details** tab.
- Patient Alias
- Patient File Number
- Patient Prescription
- Patient Invoice

DAA Type

DAA types in medications are restricted to only `DAA`.

HIH Patient Search

Displays the matching results from the Health Integration Hub (HIH) Web Service before you can add a new Patient to Communicare.

To display this window, in **Patient Search**, click **New Patient**.

To decrease the number of results returned, refine the search criteria and repeat the search.

To add a new patient from scratch, click **New Patient**.

To add a new patient with the selected patient details pre-populated in the add patient screen, click **Select Patient**.

Cardiovascular Risk

Record cardiovascular risk in Communicare.

Record cardiovascular risk in Communicare using one of the following clinical items:

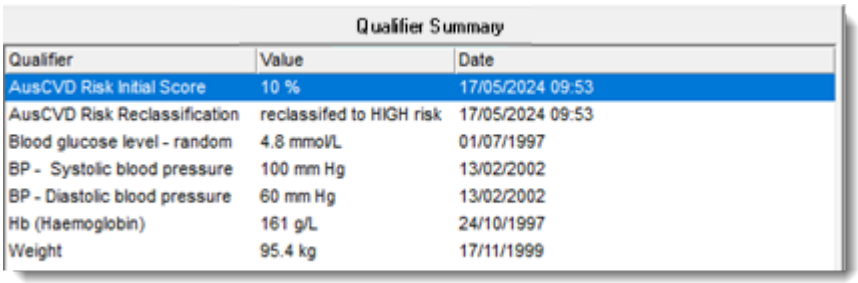
- **CV Risk Calculator (CARPA STM)** - used by the NT for NKPI reporting.
- **CV Risk Calculator (Framingham)** - used by other states for NKPI reporting.
- **CV Risk Calculator (AusCVDRisk)** - use to record the results from the CVD Risk Guideline and Calculator (AusCVDRisk) so that the output is stored in a patient's clinical record and is available for reporting.

> **Note:**
> The `CVD Risk Calculator (AusCVDRisk)` clinical item, used to capture the output of the online AUSCVDRisk calculator for the patient's record, is not currently used for NKPI reporting.

AusCVDRisk

Before you use the Australian cardiovascular disease risk calculator | AusCVDRisk, add the **CV Risk Calculator (AusCVDRisk)** clinical item to the patient's clinical record in Communicare. The qualifiers required by the AusCVDRisk online calculator are listed on the **Investigations as required** tab making it much easier to complete the calculator. The qualifiers will display the most recent values recorded for the patient in Communicare.

After you have added data to AusCVDRisk tool, record the output on the **Results of Calculator** tab. Both the `AusCVD Risk Initial Score` and `AusCVD Risk Reclassification` are added to the clinical record, **Main Summary > Qualifier Summary**.



Qualifier Summary

Qualifier	Value	Date
AusCVD Risk Initial Score	10 %	17/05/2024 09:53
AusCVD Risk Reclassification	reclassifed to HIGH risk	17/05/2024 09:53
Blood glucose level - random	4.8 mmol/L	01/07/1997
BP - Systolic blood pressure	100 mm Hg	13/02/2002
BP - Diastolic blood pressure	60 mm Hg	13/02/2002
Hb (Haemoglobin)	161 g/L	24/10/1997
Weight	95.4 kg	17/11/1999

> **Tip:**
> By default, the **CV Risk Calculator (AusCVDRisk)** clinical item is not included in a short cut menu. For information about adding it to a menu, see Clinical Item Keywords and Shortcuts *(on page 889)*.

Administration

Communicare Administrators can tune the way in which Communicare works at your health clinic.

Refer to the following sections for further information about configuring Communicare, tools to assist you with Communicare administration and tasks that you need to perform regularly.

System Administration

System administration functions affect all Communicare users and should be used with care.

Communicare System Administrator users have system and database administration functions that include changing the database, modifying audit logs, accessing and backing up the database, and granting other users access (including System Administrator access).

Use the System Administrators group with caution. System Administrator is a position of great trust and responsibility since this role allows the user to do just about anything within Communicare and the Communicare Database. Accordingly:

- Never put anyone in this group who does not have to be a System Administrator
- Limit the number of users who have System Administrator access to reduce risk
- Ensure you have appropriate safeguards and confidentiality arrangements in place with individuals who are provided with System Administrator access, and that they are appropriately trained
- Do not grant System Administrator access where a user is not authorised to perform system administration functions

System administration functions are designed for IT system administrators to support and maintain Communicare for your organisation. Misuse of system administration functions may result in permanent data loss or changes, or unauthorised access to data if not properly managed. System administrator permissions should not be used as a mechanism to provide data to third parties.

If you are unsure about something, contact your local Communicare Administrator or Communicare Support before making changes or additions.

System Parameters

If you belong to the `System Administrators` user group, you can configure Communicare by setting system parameters.

Note:
Disabling system parameters may result in existing patient data becoming inaccessible to users. However, the data remains on the database. System parameters should be changed only by Administrators who understand the consequences of the changes. Changing system parameters may result in functions described in the help not being available at your installation.

All system parameters affect the entire Communicare system and all workstations attached. For example, if Appointments are disabled by deselecting that system parameter from a particular workstation, Appointments are disabled for all workstations.

To change system parameters:

1. Select **File > System Parameters**.
   If you do not belong to the `System Administrators` user group, you cannot see the **System Parameters** menu item.

2. Update the required parameters.
3. Click **Save**.
4. In the **Enter Authority Code** window, enter your authority code and click **OK**.

> **Note:**
> Because of the extensive and serious consequences that changes to organisation parameters can cause, this code is provided only to Communicare Administrators. The authority code should not be shared.

System Parameters - General

The **General** tab shows parameters related to your organisation in a read-only mode, and is visible only to users without administrative access rights.

See Organisation Parameters - General *(on page 835)* for a description of the parameters that are visible on this tab.

System Parameters - System

Set the modules included in your Communicare and other system settings on the **System** tab.

The following system parameters are available on the **System** tab.

Table 265. System tab parameters

Parameter	Description
Module Name	Set a module to enable it for your organisation. Modules are major components of Communicare. Most enabled modules are only accessible by users if they belong to a user group with the necessary system rights. However, Transport Management, EPD Address Book Integration and Online Appointment Booking are accessible by all users when enabled. **Note:** Some modules are dependent on other modules. For example, **Medications Management** can be enabled only if **Prescribing** is enabled. You cannot enable some modules without an authorisation code. Contact Communicare Support for the code.
Startup Settings	• **Version warning** - set to add a warning for all users when they log in if the software is more than 12 months old. • **Offline - Enable Discard Data** - set to enable data synchronisation clients to discard their changes when synchronising data. If this option is not set, **Discard Data** is not available for data sync clients.

Table 265. System tab parameters (continued)

Parameter	Description
Patient information	• **Select all Event Summary clinical data items by default** - set to select all clinical data items by default when the Event Summary is generated for the MEHR and My Health Record for the first time in the service. • **Patient automatic search** - set to enable search results to be automatically displayed when users type details in patient search fields. • **Patient phonetic search** - set to enable Communicare to attempt to match search terms based on pronunciation.
Error Logging	Whenever an error occurs, details about the problem are automatically collected and stored securely on the appliance server. No patient data is collected, only usernames, the computer name, and various details about the environment and network. This information allows the Communicare Technical and Development teams to find solutions to problems faster. At regular intervals, these error logs are bundled together and sent to Communicare Support to assist in diagnosing and resolving active problems. • **Send Error Logs** - set to enable Communicare to send error logs and CCDailySvc execution logs to the recipients listed in **E-mail recipient(s)**. If the Communicare administrator does not want this data to be sent to Communicare, deselect this option. However, Communicare strongly recommends that this option is left enabled because the logs can be invaluable in resolving active problems quickly. • **E-mail recipient(s)** - list the addresses that the logs will be sent to when **Send Error Logs** is set. Additional addresses can be separated by a comma, semi-colon or new-line. Emails are sent using the settings specified in Organisation Parameters - Email Server *(on page 839)*.
Datasets	Lists the datasets that have been imported using the CENTRAL update program. Select the datasets that your organisation requires. If you make changes, run the CENTRAL update program to apply the changes

Communicare Modules

Communicare modules determine the functionality available in your Communicare instance.

Unless otherwise stated the modules are core modules, central to the operation of Communicare.

Table 266. Communicare Modules

Module	Description
Address Book Integration - ADHA PDS	Deprecated in V22.2.
Address Book Integration - EPD	Enables the EPD address book which uses Argus, an online provider directory of medical sites, services and practitioners. Consider using the combined address book *(on page 335)* instead. **Tip:** Before enabling this module, first configure Argus and the EPD web service (URL and API Key). For more information, see EPD web service configuration *(on page 826)*.

Table 266. Communicare Modules (continued)

Module	Description
Address Book Maintenance	Enables a local address book where your health service can store local address book entries. If the EPD or PDS Address Book Integration modules are also enabled, local address book entries are linked to the Enterprise Provider Directory or Provider Directory Service.
Adverse Reaction Administration	Enables controls to delete or update adverse reactions in patient records.
Appointments	Optional - V18.3 and later Enables appointment scheduling.
Biographics	Enables recording of personal information about a patient.
Birth Notifications	Western Australian Country Health Service only - V18.4 and later Enables birth notifications to be managed in a single list. Requires set up by a Communicare Implementation Consultant. Contact Communicare Support for further information.
Clinic Attendance	Deprecated. Replaced with Service Recording.
Clinical Records	Enables all Clinical Item and Recall recording for patients.
Clinical Reporting	Enables patient summary and hard-coded reports related to clinical patient information.
Communications	V21.1 and later Enables Communicare to send SMS messages and appointment reminders using Telstra Health's SMS gateway (TH Messaging) instead of Burst. For more information, see Enable SMS *(on page 66)*.
Data Entry Wizard	Enables the Data Entry Wizard that allows users to enter a clinical item into multiple patient records simultaneously.
Document Scanning	Enables users to scan documents from Documents and Results and the clinical record
Electronic Claims	Optional - V18.3 and later Enables your health service to make electronic claims with Medicare Australia
Electronic Documents	Enables users to create outgoing documents from the 'Documents and Results' and the clinical record, and see incoming documents.

Table 266. Communicare Modules (continued)

Module	Description
EMPI Search	Optional Enables searching for patient details before adding them to Communicare using an Enterprise Master Patient Index. This feature is available only to customers who have developed integrations to their EMPI with the Telstra Health Implementations team. If you would like to integrate your EMPI, contact our implementations through contact Communicare Support.
Information Sharing Consent Maintenance	Enables recording that a patient has given or denied consent to allow access to their clinical record by other organisations. Applies only if a single database is shared between organisations.
Information Sharing Consent Recording	Enables recording of whether a patient has withdrawn consent or has never been asked to allow access to their clinical record by other organisations. Applies only if a single database is shared between organisations.
Intramail	Optional - V18.3 and later Enables sending secure internal electronic messages within Communicare.
Investigations	Enables Pathology and Imaging, so users can request investigations and receive results electronically.
Management Reporting	Enables the Query Builder and non-clinical SQL reports.
Medication View	Enables viewing of medication history, management, prescribing,
Medications Management	Prescribing must also be enabled. Allows sites to manage Imprest, consolidated orders, administer and supply medication, and work with Verbal Medication Orders.
MeHR	NT sites only Integrates Communicare with the My eHealth Record.
MeHR Administration	NT sites only Integrates Communicare with the My eHealth Record.
MeHR e-Registration Auto-Prompt	NT sites only Integrates Communicare with the My eHealth Record.
MeHR to My Health Record Transition	NT sites only Integrates Communicare with the My eHealth Record. This is preferred module. When set, this option disables the other MeHR modules.
My Health Record Access	Integrates Communicare with MHR
My Health Record Assisted Registration	Integrates Communicare with MHR

Table 266. Communicare Modules (continued)

Module	Description
NCSR Integration	V21.2 and later Integrates Communicare with the National Cancer Screening Register (NCSR). **Tip:** After enabling this module, on the **Web Services** tab, specify the URL of the NCSR API and your organisation's NASH certificate. For more information, see Web Services > National Cancer Screening Register (NCSR) *(on page 828)*.
Online Appointment Booking	Optional - V18.3 and later Enables external online appointment booking services to interface with Communicare to book appointments.
Patient Add	Enables adding patients to patient biographics so Patient Add system rights can be applied to user groups.
Patient Deletion	Enables deleting patients from Communicare so Patient Deletion system rights can be applied to user groups.
Patient Edit	Enables editing patients in patient biographics so Patient Edit system rights can be applied to user groups.
Prescribing	Allows prescribing of medication, adding medication history and creation of a medication request. Medication requests combine multiple medications on one prescription. This system module can be enabled as a stand alone.
Private Billing	Optional - V18.3 and later Enables your health service to bill patients privately.
Reference Tables	Enables system reference tables which form a basic dictionary of information used throughout Communicare.
Report Administration	Enables report administration. customisation and modification.
Security on Alerts	Was Alerts and Other Information Control. Enables Communicare Administrators to restrict access to view the medical alerts section of the clinical record to users with the Alerts and Other Information system right for their user group.
Service Recording	Enables consultations to be recorded or viewed
SMS Messaging	Optional Enables your health service to send SMS messages to patients

Table 266. Communicare Modules (continued)

Module	Description
Structured Alerts	Optional Alert clinical items are not recorded in the free text alerts area in the **Main Summary** tab of Clinical Records. To replace the free text alerts area with a generated list of all Alert clinical items and their current state, enable Structured Alerts. **Note:** Alerts entered in free text are not migrated to Alert clinical items automatically. If you would like to migrate your existing alerts, contact Communicare Support before you enable this module. Communicare's Professional Services team will scope and implement this feature as a separate, paid service.
Structured Contacts	Optional Enables your health service to record extra kin information on the **Social** tab of Patient Biographics. **Note:** Do not enable this option without first contacting Communicare Support. Existing data may be lost if it is not first migrated. If your health service would like to use structured contacts, contact Communicare Support. Communicare's Professional Services team will scope and implement this feature as a separate, paid service.
Third Party CDA	Optional - V20.2 and later Enable only for large health services that use a private repository instead of sending CDA documents like the Event Summary and Shared Health Summary to My Health Record directly. For the additional configuration required, see Configuring use of a private CDA repository *(on page 333)*. **Note:** Ensure that you also deselect the **My Health Record Access** module.
Transport Management	Optional - V18.3 and later Enables your health service to plan transport arrangements for attendance at your clinic and also track the transport outcomes.
Transport Services	Deprecated. Replaced with Transport Management.

System Parameters - Clinical

Use the **Clinical** tab to control the information included in clinical items, records and so on.

The following system parameters are available on the **Clinical** tab.

Table 267. Clinical tab parameters

Parameter	Description
Clinical Item Attributes	Control the availability of optional attributes (data fields) on the clinical record • **Alcohol** - set to record alcohol factors for conditions • **Actual Duration** - set to enable users to record an actual duration in minutes for a clinical item • **Episode** - set to enable episode of care, for example, First, New, Ongoing • **Reason for Encounter** - set to add a checkbox to each clinical item where clinicians can indicate if this item is the reason for the encounter. The first item recorded as a reason for the encounter for a service is the default reason for encounter. If the **Reason for Visit** is also set, the reason for the encounter is added to the **Reasons for Visit** list in the Progress Notes. • **Always record date and time** - set to ensure that both the date and time are recorded for all clinical items and their qualifiers, even if **Date only** is set for a clinical item type. Use to update existing clinical items so that the time can be recorded.
Investigation Options	Control the availability of optional attributes (data fields) on investigation print-outs, for example, pathology requests: • **Bulk Assignment Request Form** - enable to print a label on investigation request forms and remove the need for doctors to sign the request forms. Before enabling this parameter, check with your pathology lab that they can accept such a request form. See also the option to allow investigation requests on behalf of another claiming provider.
Clinical Record Features	Control the availability of the following major features of the patient clinical record: • **Free text medication** - determines how both chronic medications and acute medications are entered. Deselect to allow users to select specific medication types from those defined in the Communicare database. Enable if you don't want your users to be able to select medication types and to force them to enter text describing the medication (either chronic or acute). • **Summary Items By Default** - enable to add clinical items on the patient summary page automatically without user intervention, using a pre-selected setting for the clinical item type. If your organisation has large sets of clinical terms (such as ICPC-2 PLUS) deselect this option. • **Obstetrics Summary By Default** - enable to add clinical items to the obstetrics summary page automatically without user intervention, using a pre-selected setting for the clinical item type. If your organisation has large sets of clinical terms (such as ICPC-2 PLUS) deselect this option. • **Allow Tabs in Clinical Items** - set to enable tabs to be shown in clinical items. To find out how to show tabs in a clinical item see Clinical Item Type Properties. • **Reason For Visit** - set to enable clinicians to specify the main reasons for a patient's visit to the health service in the progress notes. If both **Reason For Visit** and **Reason For Encounter** are set, **Reason For Encounter** is displayed in the clinical item. Items set as **Reason For Encounter** are listed in the first available slot in the **Reason For Visit**. ◦ **Reason For Visit Lookup** - the name of the general lookup table used to specify reasons for visit that are specific to your health service. For example, **Checkup**, **Followup**, **Treatment** and so on.

Table 267. Clinical tab parameters (continued)

Parameter	Description
Clinical Summary Style	Determine the style of the Summary on both the Clinical Record and the Patient Summary Report: • **Simple** - enable to display the Date, Class, Status, Description and Comment for all items selected to appear on the Summary. • **Consolidated** - enable to display the Occurrence (how many times), First date, Last date and Description for clinical item types selected to appear on the Summary.
Medication Labels	Set up options for printing supply labels: • **Enable label printing** - set to enable printing of supply labels • **Print Labels by default** - set to print labels by default for all new medication orders if Medication Management is not enabled. • **Default label count** - sets the default number of labels to be printed during supply or when supply labels are reprinted

Table 267. Clinical tab parameters (continued)

Parameter	Description
Prescribing Options	Determine how medications can be prescribed at your organisation: • **Brand Prescribing** - set to display and prescribe drugs by brand name. • **Generic Prescribing** - set to display and prescribe drugs by generic name. To meet the requirements of the Active Ingredient Prescribing legislation (2019), set to **Generic Prescribing**. Also set **Show generics in drug browser** to ensure consistency with generic prescribing. • **Generic Prescribing Mandatory** - set to force a prescriber to prescribe only generic medications. This setting may be used to meet the requirements of the Active Ingredient Prescribing legislation (2019), however using this option will have implications when prescribing drugs included on the LMBC, where a clinician may determine that a brand is clinically relevant. • **Enforce choice of once off/short course or regular medication** - set to require prescribers to select either once off or regular medications. • **Make Once off/Short Course prescription duration mandatory** - set to require prescribers to enter a duration for once off or short course prescriptions. • **Print prescription by default** - set whether prescriptions are automatically marked for printing or not when finalising prescriptions. If set, in the **Finalise Prescriptions** window, valid PBS prescriptions are set to print by default. In either case the prescriber may override the default and choose not to print. • **Use Health Centre Prescription defaults** - set for new medications to be made regular by default with an until date of 365 days. Note: If Enforce Choice is selected as well as Health Centre Prescription by default Enforce Choice will override Health Centre Prescription. • **Show generics in Drug Browser** - set to allow prescribers to view generic medications by default when browsing the MIMS Drug Browser. • **Use default prescription repeats** - set to automatically add the maximum repeats allowed by PBS to the **Repeats** field when prescribing. • **Show Prescribers Comments** - set to print comments on the prescription. • **Use RTPM Service**- set to allow prescription information for controlled substances to be sent to the Real Time Prescription Monitoring service in your state. Configure the RTPM service used on the Web Services *(on page 826)* tab. • **Require password on adverse reaction prescribing** - set to require clinicians to enter a password if they attempt to prescribe a medication for which the patient has an adverse reaction of any allergic reaction type recorded. If the clinician continues with the prescription, the action is logged in `user_log`. A password is required by default. • **Upload medication order to eRx** - set to select **Consent to send to My Health Record** by default when creating medication orders.

System Parameters - Patient

Use the **Patient** tab to control the information required for patient biographics and search.

The following system parameters are available on the **Patient** tab.

Table 268. Patient tab parameters

Parameter	Description
Address Type	Set data entry for addresses to one of the following options: • Standard - use in urban or rural contexts where a person has a conventional postal address • Locality - use when patients live in remote communities or similar, where a conventional address is not used, such as Joan Smith, Jigalong.
Default Community	Set the default community to help speed up data entry.
Inactivity years	See Automatic Patient Status Change.
Patient Indicator	Select a clinical item group to highlight in gold on the Details panel in the Patient Search for any patient with a clinical item belonging to that group.
IHI Revalidation Period	Set the number of hours that the IHI remains usable with each patient's My Health Record without requiring validation with the HI Service.
Enable Patient Photo	Set whether the patients' photos are displayed.
Enable Extended Identifiers	Set whether to store additional patient identifiers against a patient, which can also be used in the Patient search to find a patient. This is useful when you have more than one MRN or want to use identifiers from other systems, such as a hospital system.
Single Field Patient Search	Set whether one or multiple fields can be used to search for a patient.
Skin	Set whether a patient's skin group can be recorded
Telephone numbers	Set whether a patient's telephone numbers can be recorded
Preferred language	Set whether a patient's preferred language can be recorded.
Language spoken at home	Set whether the patient's language that they speak at home can be recorded
Country of birth	Set whether a patient's birth country can be recorded.
Birthplace	Set whether a patient's birth place can be recorded.
Marital status	Set whether a patient's marital status can be recorded.
Occupation	Set whether a patient's occupation can be recorded.
Special	Define the optional special purpose data items displayed on the **Administration** tab: • Special Checkbox - enter the description you want to appear beside the check box. Use the check box to limit the selection of patients on most reports. For example, use the check box to identify patients participating in a particular health promotion program. You could then run a report that includes only those patients. Leave the description blank if you do not want the check box to appear. • Special Lookup - enter the description you want to appear beside the Special Lookup check box. Use the check box to create an additional list in the UI of extra options and a reference table. Leave the description blank if you do not want the Lookup list to be displayed.
User-defined Terms	• Nyaparu term - enter the term used for Nyaparu or similar • MRN term - enter the text used for the MRN field caption. • Display MRN in Clinical Record - set to display the MRN caption and MRN in the title bar when a clinical record is displayed. • Existing file - set a name for the field used to record an alternative file number for a patient. For example, Paper file no.

Table 268. Patient tab parameters (continued)

Parameter	Description
Special Check	Use to customise the **Special Patient Check** field, that allows for important checks which must be confirmed before the user can open the patient's Clinical Record. Set the following: • Caption - set the name or type of check being used, for example, Patient Consent Check • Message - a question with a Yes/No answer, indicating that access to the Clinical Record is prevented until the Special Check is confirmed. Contact Communicare Support to change this message.

Special Patient Check

If the special patient check functionality is enabled you see additional information.

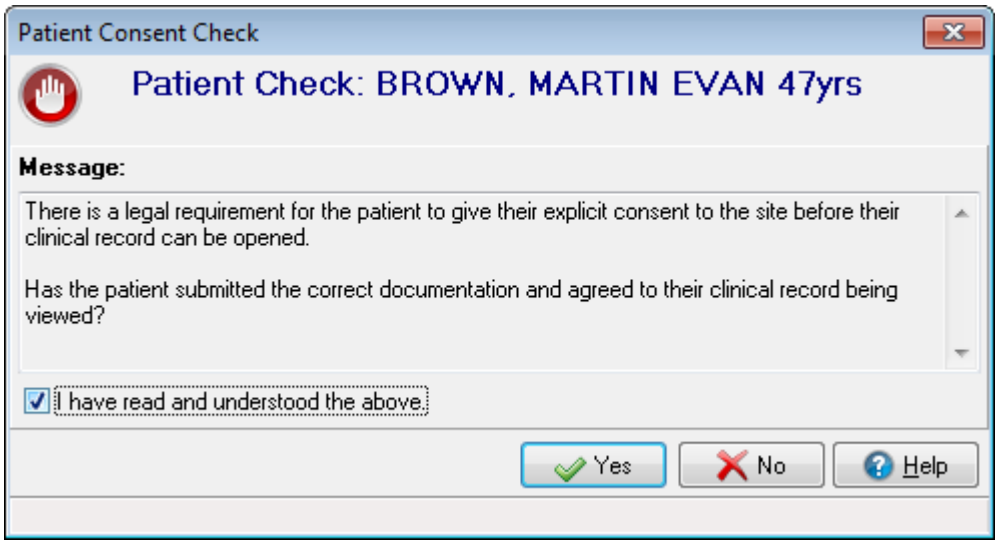
Special Patient Check

If the special patient check functionality has been enabled in **System Parameters > Patient**, this form will appear for unconfirmed patients whenever the Clinical Record is accessed. Unconfirmed patients are those patients who have not yet had the patient check or who have had the patient check denied.

The user must confirm or deny the check using the Yes and No buttons. The Yes button can only be clicked once the user has read and accepted the message.

The Clinical Record will only be shown if the check is confirmed.

For example:



Undo Patient Confirmation Status

If the patient check was confirmed in error for one or more patients, the status can be reset via Patient Biographics *(on page 30)*. Simply un-tick the special patient check checkbox and the patient will be changed to a status of unconfirmed.

Resetting Patient Check

If the patient check functionality is to be reused for another purpose, contact Communicare Support to help reset patient data. In addition, the patient check message can only be changed after it has been approved and updated by our technical team.

System Parameters - Appointments

Use the **Appointments** tab to set appointment horizons, grace periods and online bookings.

The following system parameters are available on the **Appointments** tab.

Table 269. Appointments System Parameters

Parameter	Description
General Appointment Settings	• Default Appointment Horizon Days - for each Appointment Session Template, the number of days ahead that your organisation can book an appointment. Enter a value from 0 to 373 inclusive, or null. • Grace period for late appointments (minutes) - patients who are late for an appointment by more that the Grace Period are normally queued after those who arrived on time. If you want to use this functionality, enter a value in minutes.
Online Appointment Booking Settings	If the Online Appointment Booking module is enabled, set which program rights are available for appointments for online appointment booking services.

System Parameters - Devices

Use the **Devices** tab to control printers and scanners.

The system parameters available on the 'Devices' tab provide a way to adjust printer and scanner settings.

Table 270. Devices tab System Parameters

Parameter	Description
Printers	• Available Printers - a list of currently configured Microsoft Windows printers. To specify positioning adjustments for one of these printers select it from the list. To adjust settings for a printer not in the list, type the full URL of the printer. • System Printers - a table of printers with positioning adjustments. Offsets apply to the following printed documents: ◦ Patient Labels ◦ Prescriptions ◦ Investigation Requests
Scanners	• Color - select the appropriate setting for scanned images, but be aware that using colour will increase the size of documents stored in the database. • Resolution - select the appropriate setting for scanned images, but be aware that the higher the resolution, the larger the size of documents stored in the database.

Table 270. Devices tab System Parameters (continued)

Parameter	Description
Maximum Document Size	The maximum size in KB allowed when attaching or creating a document in Communicare and the maximum size allowed when adding an image qualifier. **Note:** Note: The maximum document size affects database size, which in turn affects the size of backups and the time required to synchronise offline (data synchronisation) clients. Backups may grow beyond the capacity of Communicare's Appliance Server's built-in removable (CD or DVD) media. In this case you are responsible for creating an alternative off-site back-up. Refer to Communicare Support for more information about backups.

Mouse Cursor Disabled Functions

This is used to change the balance between appearance and performance on the client computer. It has nothing to do with database performance.

- None - all cursor functions are enabled. This will configure Communicare for best appearance.
- Basic - most cursor functions are disabled. This will configure Communicare for better performance over the satellite. This will also disable flat buttons and hot-tracking.
- Complete - all cursor functions are disabled. This will configure Communicare for best performance over the satellite. This will also disable flat buttons and hot-tracking.

Adjusting the printing position

You can adjust the printing position for a prescription, label or request.

To adjust the printing position:

1. Select **File > System Parameters**, **Devices** tab.
2. In the **Available Printers** list, select the required printer.
3. In the **System Printers** table, in the **Top Offset** and **Left Offset** fields enter an adjustment to the page position in mm, to a precision of 0.1 mm.
4. Click **Save**.

Print a test prescription, label or request. Repeat steps 2-4 until you are satisfied with the outcome.

System Parameters - Electronic Claims

Use the **Electronic Claims** tab to set addresses for electronic claims.

If your organisation bulk bills Medicare for services, enter details for Medicare Australia on the **Electronic Claims** tab.

Table 271. Electronic Claims system parameters

Parameter	Description
Recipient	The email address to where claims are sent. The default value is ebus@medicareaustralia.gov.au
Server	The Medicare Australia server address to where the connection is established. The default value is mcoe.humanservices.gov.au/pext

System Parameters - MeHR

Use the **MeHR** tab to set MeHR details.

Use the **MeHR** tab to configure how Communicare interacts with MeHR.

The MeHR module interacts with the Northern Territory's MeHR implementation and supports the My Electronic Health Record. From the Clinical Record, Communicare:

- Sends Event Summaries from every consultation to MeHR
- Sends Current Health Profiles for a patient
- Gets the current patient registration status with MeHR. Only registered patients can have their data sent to MeHR.
- Displays current shared clinical data for the patient from MeHR. Only registered clinicians can access this data.

All clinicians must be registered with MeHR to access patient clinical data from MeHR.

Some MeHR features will not be available if the MeHR to My Health Record Transition *(on page 779)* module is enabled.

Table 272. MeHR tab System Parameters

Parameter	Description
General settings	• MeHR HSD ID - repository address ID for secure messaging • Use initial Current Health Profile (CHP) - set to display the first CHP for every client • Current Health Profile sends all Events - set to send all prior events with the CHP • 'Send to MeHR' popup prompt - set to prompt users to send patient details to meHR rather than sending automatically
Advanced settings	• Notify of Medical Changes feature - set to receive notifications from MeHR for patient your patients whose details have changed, if your organisation is their home health centre • Patient Search on Add Patient - set to search the MeHR repository in addition to the Communicare database when you add a new patient • Use HRN in MeHR matching - set to include the patient's HRN when requesting data from MeHR • eMessage Timeout (seconds) - enter a period in seconds, to wait for a response from MeHR before timing out

The MeHR Help Desk phone number is 08 8973 8642.

System Parameters - Secure Messaging

Use the **Secure Messaging** tab to set the server details for your secure messaging vendor.

Communicare uses either Argus or HealthLink or both to send and receive secure messages. Use the **File > System Parameters > Secure Messaging** tab to provide the required details for your chosen secure messaging vendor.

Note:
If you want to enable secure messaging in Communicare, contact Communicare Support for further information.

Table 273. Secure Messaging parameters

Vendor	Parameter	Description
Argus Configuration - deprecated	**Server Address**	Enter the hostname or IP address of the Argus server.
	Server Port	Enter the port number of the Argus server. The default is `60000`.
HealthLink	**EDI/Mailbox**	Enter the EDI code for your organisation provided by HealthLink. This code identifies your organisation in outgoing, secure messages.
	Password	Enter the password for your organisation's HealthLink account.
	Forms Engine URL	Enter the URL of the Aduro Forms Engine.
	Forms Engine Port	Enter the port number for communication with the Aduro Forms Engine. The default is port `5088`.
	Session Expiry	Enter when the Aduro Forms Engine session will end if there is no activity. The default is `720` minutes (12 hours).

See Secure Messaging *(on page 341)* for more information.

System Parameters - Web Services

Use the **Web Services** tab to configure the addresses of the web services used in Communicare.

Security certificates for the web services are maintained on Organisation Parameters - Certificates *(on page 841)*.

Table 274. Web Services parameters

Pane	Parameters & Description
Secure Message Exchange	If you search online provider directories or use secure messaging using the combined address book, Communicare Support will complete the following for your health service: • Set **Enable Secure Message Exchange**. • In the **URL** field, the web address of the Secure Message Exchange. • From the **Certificate** list, select a certificate. The certificate determines which online provider directories the health service can access. Only those organisations in Communicare with a NASH org certificate are listed. For more information, see Certificates *(on page 857)*.
Healthcare Identifiers (HI) Service	Set **Enable HI Service** and enter the web service address of the HI Service, either: • Production URL: `https://www3.medicareaustralia.gov.au/pcert/soap/services/` • Test URL (for use in the Demo only): `https://www5.medicareaustralia.gov.au/cert/soap/services/`
Electronic Transfer of Prescriptions (ETP)	The path to the eRx Adapter software that enables ETP, entered by Communicare when this module is enabled.

Table 274. Web Services parameters (continued)

Pane	Parameters & Description
Enterprise Provider Directory (EPD) Service	Deprecated. Details were used with Argus for the EPD address book, Argus is now end-of-life.
Communicare Web Service	Specify the address of the Communicare web service. For example, `https://web-services.communicaresystems.com.au:9000`
My Health Record Service	Specify the web service address of the My Health Record Service, either: • Production URL: `https://services.ehealth.gov.au:443` • Test URL (for use in the Demo only): `https://services.svt.gw.my-healthrecord.gov.au`
Real-Time Prescription Monitoring (RTPM) Service	Specify the address of the RTPM web service `https://api.prescriptionmonitor-ing.gov.au/` and the RTPM API key. **Tip:** This web service is used by all states. You may also need to allow a fire-wall exception for the IP addresses associated with this URL. For more in-formation, see RTPM firewall exceptions *(on page 941)*.
EMPI Search	Specify the web service address of the EMPI search service.
Clinical Decision Support (CDS)	Deprecated, do not set this option. The CDS service is no longer available. Com-municare instead uses the MIMS database installed locally.

Table 274. Web Services parameters (continued)

Pane	Parameters & Description
Services Australia	In V21.3 and later, settings required to connect to Service Australia's web services. Set **Enable Services Australia** to use these settings. • General settings: ◦ **System Identifier** - the name of the OPV API, for example, `communicare.resourcemanagement` ◦ **Device Identifier** - the foreign key for the system identifier. This is the global PRODA device ID setting for your organisation. ◦ **Identifier** - the name of the Communicare server instance, for example, `CCAREQA05` • **Medicare Endpoint** - for integration with Medicare Online: ◦ **URL** - the URL of the Telstra Health Services Australia API, for example, `https://ap-dev-servicesaustralia-api-th.azurewebsites.net` ◦ **Namespace** - the namespace for Services Australia objects, for example, `sp-dev-servicesaustralia-sb-th.servicebus.windows.net` • **Immunisation Endpoint** - for integration with the AIR: ◦ **URL** - the URL of the Telstra Health AIR API, for example, `https://ap-dev-servicesaustralia-immunisation-th.azurewebsites.net/` • **API Credentials** : ◦ **Client ID** - the ID assigned to your health service by Telstra Health, provided by Communicare Support ◦ **Client Secret** - an authorisation key from Telstra Health, provided by Communicare Support ◦ **Authentication URL** - the URL used to authenticate access to Services Australia. ◦ **Scope** - the API endpoint scope which defaults to `api://{clientId}/.default` • **Message Bus Credentials**: ◦ **Client ID** - the ID assigned to your health service by Telstra Health, provided by Communicare Support ◦ **Client Secret** - an authorisation key from Telstra Health, provided by Communicare Support ◦ **Authentication URL** - the URL used to authenticate access to Services Australia. ◦ **Scope** - the message bus scope which defaults to `https://servicebus.azure.net/.default` **Tip:** The default timeout for calls to Services Australia is 5000 milliseconds. If you would like this changed, contact Communicare Support.

Table 274. Web Services parameters (continued)

Pane	Parameters & Description
SNOMED Terminology	Specify the settings of the SNOMED terminology server, used to validate SNOMED codes assigned to clinical items. • **Browser Location** - the web application to browse SNOMED terminology. Default: `https://ontoserver.csiro.au/shrimp` • **FHIR Validation Service** - the URL used to access a FHIR terminology server. Default: `https://api.healthterminologies.gov.au/integration/R4/fhir` • **Authentication URL** - the URL used to authenticate access to the FHIR terminology server. Leave this field blank if your terminology server does not require authentication. Default: `https://api.healthterminologies.gov.au/oauth2/token` • **Client ID** - the ID assigned by the FHIR terminology server. • **Client Secret** - an authorisation assigned by the FHIR terminology server. Your health service can use one of the following terminology servers: • National Clinical Terminology Server (NCTS) provided by Australian Digital Health Agency (ADHA). Register at https://www.healthterminologies.gov.au/ • A terminology server provided by Telstra Health • A terminology server hosted by your organisation or a third party
National Cancer Screening Register (NCSR)	Specify your organisation's National Cancer Screening Register (NCSR) registration details: • **URL** - the URL of the NCSR API • **Certificate** - your organisation's NASH certificate **Tip:** First upload the certificate to **File > Reference Tables > Certificates**. **Tip:** Before you can specify NCSR settings, on the **System** tab, first enable the `NCSR Integration` module.

Table 274. Web Services parameters (continued)

Pane	Parameters & Description
Script Exchange	In V22.1 and later, settings required to enable Electronic Transfer of Prescriptions (ETP) and connect to an ETP service, such as eRx, using Telstra Health **Script Exchange**. Contact Communicare Support to register for ePrescribing. • General settings: ◦ **System Identifier** - the customer code emailed to you when you registered for ePrescribing with Telstra Health, for example, `CCARE05` ◦ **Identifier** - the authoring system foreign key emailed to you when you registered, for example, `CPHS-123` ◦ **Queue Name** - the queue used to communicate with Script Exchange emailed to you when you registered, for example, `CCareQueue_-ScriptExchange/Classic-<CustomerCode>-<Environment>-01` ◦ **Namespace** - the namespace for Script Exchange objects, for example, `sb-aue-classic-scriptexchange-th.servicebus-.windows.net` ◦ **Client ID** - the ID emailed to you when you registered. ◦ **Client Secret** - an authorisation key emailed to you when you registered. ◦ **Authentication URL** - the URL used to authenticate access to eRx script exchange, for example, `https://login.microsoftonline-.com/...`. **Note:** The default timeout for ePrescribing is 15 seconds. If you would like this changed, contact Communicare Support

System Parameters - HealthTracker

Use the **Health Tracker** tab to configure the HealthTracker web services settings used in Communicare to communicate with the George Institute HealthTracker API.

Table 275. George Institute web services settings

Setting Name	Default Value	Type	Description
Issuer	Telstra Health	String	The account issuer registered to George Institute HealthTracker Platform. This is supplied by George Institute.
Name	Communicare	String	The account name registered to George Institute HealthTracker Platform. This is supplied by George Institute.
Subject	`healthtracker@health.telstra.com`	String	The account subject (usually the company email address) registered to George Institute HealthTracker Platform. This is supplied by George Institute.

Table 275. George Institute web services settings (continued)

Setting Name	Default Value	Type	Description
Web Service URL	Test - `https://health-tracker-test.georgeinstitute.org` Production - `https://healthtracker.georgeinstitute.org`	String	The Service URI of the HealthTracker API. Enter the correct George Institute HealthTracker web service for your environment.
Riskdial Web Service URL	Test - `https://riskdial-test.georgehealth.com` Production - `https://riskdial.george-health.com`	String	The Service URI of the CVD Risk Dial API. Enter the correct George Institute HealthTracker web service for your environment.
Diabetes Riskdial Web Service URL	Test - `https://riskdial-test.georgehealth.com/diabetes` Production - `https://riskdial.george-health.com/diabetes`	String	The Service URI of the Diabetes Risk Dial API. Enter the correct George Institute HealthTracker web service for your environment.
Application ID	Test - `b710e-bcf-47be-42f8-6ba5-08d621d1b063` Production - contact Communicare Support for details	GUID	The application identifier is provided by George Institute as a result of the registration process to consume the HealthTracker API. Enter the correct value for your environment.
HealthTracker Main API Ruleset ID	Test - `3df672ac-5f3e-4f8e-4db4-08d62296dd8d` Production - contact Communicare Support for details	GUID	An identifier provided by George Institute and used by HealthTracker to process the overall patient health risk and assessment. This is supplied by George Institute and depends on which environment is used.
CVD Riskdial Ruleset ID	Test - `8290b0c4-24d2-4655-4803-08d6660db1a6` Production - contact Communicare Support for details	GUID	An identifier provided by George Institute and used by HealthTracker Cardio Vascular Disease risk dial component of the application. This is supplied by George Institute and depends on which environment is used.
Diabetes Riskdial Ruleset ID	Test - `d75e-f9b8-f460-4ad2-716a-08d6ae6f3164` Production - contact Communicare Support for details	GUID	An identifier provided by George Institute and used by the HealthTracker Diabetes risk dial component of the application. This is supplied by George Institute and depends on which environment is used.

Table 275. George Institute web services settings (continued)

Setting Name	Default Value	Type	Description
RSA Key		Blob	The RSA keypair contains the public key (shared between Communicare and HealthTracker) and the private key. The keypair is used for signing the JWT required for authorising Communicare to consume HealthTracker API endpoints. This is provided by George Institute during the registration process to the HealthTracker Platform.

System Parameters - Appearance

Use Appearance system parameters to control the text displayed in the Login and other windows.

The following settings are available on the **Appearance** tab.

Table 276. Appearance System Parameters

Parameter	Description
Login Message	Use to display important text unique to your health service on the login window. In the **Login Message** field, enter text to display in the Communicare login window in the **Important** text area.
Medication Confirmation	Use to display a **Confirm Medication** window when providers add or repeat medications when prescribing or creating a medication order. For example, to warn providers if clinical record information might be incomplete. If any text is entered in the **Medication Confirmation** field, when providers add or repeat a medication in the patient's Clinical Record the **Confirm Medication** window is displayed. If the provider clicks **Confirm**, the **Drug Browser** window is displayed and providers can add or repeat medications. **Confirm** is displayed only once for a session and applies to all medications added or repeated during the session. After you click **Confirm**, the **Confirm Medication** window is not displayed again until a new session begins. If the provider clicks **Cancel** instead of **Confirm**, the **Drug Browser** window is not displayed and providers cannot add or repeat medications. The **Confirm Medication**window is displayed each time they attempt to add or repeat a medication until **Confirm** is selected. The **Confirm Medication** window is not displayed when providers select **Add Medication History.** If the **Medication Confirmation** field is left blank, no confirmation window is displayed.

System Parameters - Integration

The **Integration** tab contains settings related to integration with other systems.

Table 277. Integration parameters

Parameter	Description
Enable Integration Events	For Enterprise customers, if you need to integrate data from Communicare with other, external systems, set **Enable Integration Events** to record an event whenever a patient is inserted, modified, deleted, or merged. **Note:** Requires an nServiceBus licence.
CDA options	• **Private repository name** - when the `Third Party CDA` module is set, enter the repository name used for large health services that use a private repository for CDA documents like the Event Summary and Shared Health Summary, instead of sending records directly to My Health Record. For example, enter `The Viewer and to MHR if allowed and it exists`.This name is used in the **Service exit** window, appended to the **Send Event Summary** and **Send Shared Health Summary** options. • **Private repository short name** - enter a name up to 30 characters to be used together with the **Private repository name**. For example, enter `The Viewer & MHR`. This name is used in the **Event Summary** and **Shared Health Summary** windows, appended to the **Save and Upload** button. • **Include patient contact details** - deselect if you don't want to include patient addresses and phone numbers in the generated XML CDA documents. Patient contact details are not displayed in the rendered summaries, but are included in the XML source if this option is set.

System Parameters - Prescription Forms

Use the **Prescription Forms** tab to enable custom prescriptions, medication requests and consolidated orders and set the templates used by these features.

Custom prescriptions

Custom prescription forms print to blank paper using the template you select. By default, Communicare prints to PBS Script preprinted forms.

To enable custom prescription forms:

1. Select **File > System Parameters > Prescription Forms** tab.
2. In the **Custom Prescription Options** section, set **Use Custom Prescription Forms**.
3. From the **Standard Template** list, select the prescription template appropriate to your health service.
4. If required, from the **S8 Template** list, select a template for S8 prescriptions.
5. Click **Save**.

Tip:
Do a test print of a prescription to ensure that it is printing correctly.

Medication requests

Medication requests combine multiple medications on one prescription. Medication requests print to blank paper using the template you select and can only be reprinted by a user with a prescriber number and at least `Once off /Short Course` Prescribing Rights. By default, medication requests are not enabled.

> **Tip:**
> Before enabling medication requests, ensure that you have imported a medication request template. If you are using rural prescribing, import an appropriate Health Centre Prescription template. For more information, see Communicare Templates *(on page 957)*.

To enable medication requests:

1. Select **File > System Parameters > Prescription Forms** tab.
2. In the **Medication Request Options** section, set **Enable Medication Request**.
3. For those health services that want to customise the name *Medication Request* in Communicare, enter alternative details in the following fields:
    - **Name** - enter a name up to 30 characters long
    - **Plural Name** - enter a name up to 33 characters long
    - **Information Text** - enter text of up to 140 characters long
    - **Selection Information Text** - enter text of up to 140 characters long

    > **Note:**
    > *Medication Request* will be updated in the Medication Summary, in medication requests, when finalising requests and in progress notes. It will not be updated in System Modules, System Parameters or the product documentation. In progress notes, historical entries will not be updated to the new name.

4. From the **Medication Request Template** list, select the appropriate medication request template that you have previously imported.
5. If your health service wants to create medication requests by default when a provider finalises new medications in a patient's clinical record, set **Create medication request by default**.
6. If you want to show or hide medications included in a request for which there is no inventory, set **Show Out of Stock Inventory**. If you don't enable this option, all active medication requests are displayed whether there is any inventory in stock or not.
7. If you want to print S8 prescriptions on a separate page to any other medications included in a medication request, set **Print S8 prescriptions on a separate page**.

    > **Note:**
    > Ensure you set this option for Health Centre Prescriptions.

8. Click **Save**.
9. Contact Communicare Support for today's security code. In the **Enter Authority Code** window, enter the code and click **OK**.

Communicare closes for the changes to take effect. When you next start Communicare, medication requests are enabled for your health service:

- The **Medication Requests** button is visible on the **Medication Summary**
- Medication requests are included in the **Finalise** window
- If you enabled **Create medication request by default**, medication requests are created when a provider finalises medications if a pickup location is set in the clinical record. Regular medications are also added to the medication request and selected by default.
- If you enabled **Show Out of Stock Inventory**, an  Options button is added to the **Administer and Supply Medication** window in the **Requested Medications** section.
- When you print a medication request, it will use the Communicare default printer

> **Tip:**
> If patients will be able to collect their medications from a pickup location separate to their encounter place, ensure you set **Medication Pickup Location** for the pickup encounter place. For more information, see Adding and Editing Encounter Places and Modes *(on page 872)*.

Consolidated orders

Consolidated orders are groups of medication requests that can be requested from an external pharmacy for your patient-specific inventory. If medication requests are enabled for your health service, you can also enable consolidated orders.

> **Tip:**
> Before enabling consolidated orders, ensure that you have imported a consolidated order template. For more information, see Communicare Templates *(on page 957)*.

To enable consolidated orders:

1. Select **File > System Parameters > Prescription Forms** tab.
2. In the **Consolidated Order Options** section, set **Enable Consolidated Order**.
3. From the **Consolidated Order Template** list, select the appropriate consolidated order template that you have previously imported.
4. Click  **Save**.
5. Contact Communicare Support for today's security code. In the **Enter Authority Code** window, enter the code and click **OK**.

Communicare closes for the changes to take effect. When you next start Communicare, consolidated orders are enabled for your health service.

Next, set the `Consolidated Order - Manage` system right for the user groups that need to access consolidated ordering. For more information, see User Groups *(on page 842)*.

Pregnancy interactions

You can change the level of interaction warnings displayed when you add a new medication to the clinical record of a pregnant patient or start a pregnancy in the patient's clinical record.

- To include interaction warnings for medications that belong to an ADEC category but do not have specific ADEC or general text recorded in MIMS, in the **Interactions** section, set **Include non-specific category interactions**.
- To exclude interaction warnings for medications that belong to ADEC category A, B1 and B2 and do not have any specific text, in the **Interactions** section, set **Exclude minor non-specific pregnancy interactions**.

  If both options are set, interaction warnings for medications that do not have specific ADEC or general text recorded in MIMS, and that are not in ADEC category A, B1 or B2 are displayed.

Organisation Maintenance

Configure Communicare for your organisation by setting organisation parameters. Changes to organisation parameters affect the Communicare system for the organisation and all workstations.

> **Warning:**
> Disabling organisation parameters may result in existing patient data becoming inaccessible. However, the data remains in the database. Organisation parameters should only be changed by knowledgeable people, such as Communicare Administrators. Changing organisation parameters may mean that functions described in the online help are not available at your installation.

To change organisation parameters:

1. Select **File > Organisation Maintenance**.
2. Select the organisation you want to modify and double-click it.
3. Update the required parameters.
4. Click **Save**.
5. In the **Enter Authority Code** window, enter your authority code and click **OK**. Because of the extensive and serious consequences that changes to organisation parameters can cause, this code is only provided to Communicare Administrators who should not share it.

Organisation Parameters - General

Use the **General** tab to configure general parameters for your practice.

Table 278. General Organisation Parameters

Parameter	Description
Name of Practice Address Line 1 Locality Phone Fax	Your organisation's details that appear on reports. Print any report to see how these details are displayed.
ABN	Your organisation's Australian Business Number
ETP eRx Entity ID	The Entity ID provided by eRx that identifies your organisation to eRx.

Table 278. General Organisation Parameters (continued)

Parameter	Description
HPI-O Number	The current Healthcare Provider Identifier - Organisation (HPI-O) number assigned to your organisation. This field may appear with different coloured backgrounds depending on its status. For ePrescribing, your encounter place must have a HPI-O number and be connected to the HI Service. You may not be able to enter an HPI-O number if the HI Service module is switched off. See Healthcare Identifier Service *(on page 632)* for more detail on availability, as well as the rules that govern when an HPI-O Number search or validation is triggered. This identifier is used when creating any CDA document to define the Custodian, or owner, of the document. For all other functions that require an HPI-O, such as My Health Record access, the HPI-O against the Encounter Place is used. To validate a previously entered HPI-O Number with Medicare, click  Revalidate HPI-O. The validation updates the last checked date against the HPI-O Number and may result in a new status or new number. To display a history of HPI-O Numbers assigned to the organisation, click  View HPI-O History. See Viewing Healthcare Identifier History for more detail.
HPD Practice Name	The organisation name associated with your organisation's HPI-O in the Healthcare Provider Directory (HPD). This field can only be populated after the validation of an HPI-O, and is read only. If the Organisation name in Communicare is different from the name recorded in the HPD, you will be prompted to allow this value to be set to the value in the HPD. Organisations that have a different name recorded in Communicare from the name registered in the HPD can make use of this. For example, a service operating under the auspice of another.
Clinic Hours	Set the clinic days and start and end time. The clinic hours are used to determine if a service is an after hours service or not.

Table 278. General Organisation Parameters (continued)

Parameter	Description
Setup the Letter Head	Use to set up your own letterhead in the 'Letter Writer' window. Follow these guidelines: • Don't define page margins here - the actual letter will have its own margins • Restrict your letterhead to 630 pixels wide - if you are designing a letterhead rather than using an existing one, create a table with 2 columns and 1 row, 630 pixels wide, with no border, no cell padding, no cell spacing and no cell borders • Insert your logo into the left cell (left aligned) • Type your address in the right cell (right aligned) • Add the required variables from the right pane • Put a carriage return (ENTER) after the table so that users will be able to start typing under the letterhead
Results Folder Name	The name of the folder where investigation results for the organisation are placed for importing into Communicare. This must be unique for each organisation. For example: `\\APPSERVERNAME\Results\ORGFOLDERNAME\`

Organisation Parameters - Medicare Claims

Use the **Medicare Claims** tab to configure Medicare bulk billing, printing and batch claim parameters.

Table 279. Medicare Claims Organisation Parameters

Parameter	Description
Type of Medicare Assignment Form	Select whether the Medicare Assignment Form will be printed on preprinted, tractor-fed forms or on plain paper. **Tip:** **Plain paper (online claiming)** can only be printed when using the Electronic Claims module.
Assignment Form Copies	If you selected **Plain paper (manual claiming)**, set which copies of the Assignment Form are printed. If you don't set either option, only the Medicare copy is printed. If you selected **Plain paper (online claiming)**, you don't print a copy for Medicare Australia so you need at most two copies. Communicare will always print the Practice copy, set **Print Patient Copy** if you also want to print the patient copy.
Batch Claims	If your organisation wants to group multiple Medicare claims or AIR uploads into a single submission, set **Enable Batch Claims**. Each item in a batch is assigned the same claim ID.

Table 279. Medicare Claims Organisation Parameters (continued)

Parameter	Description
Incentive Items	If your practice is in a rural or remote location, and a patient is under 16 or has a CentreLink or Health Care Card, your health service may be eligible to claim additional bulk billing incentives. To have Communicare automatically prompt you to include additional MBS incentive items for eligible patients when completing a service, add values to all three of the **Incentive Items** fields for the same item type: • **Medical** - for example, for MM 6 `75857` • **Radiology** - for example, for MM 6 `64994` • **Pathology** - for example, for MM 6 `75863` **Tip:** Leave all fields blank if you don't want to be prompted to include additional MBS incentive items. If your health service doesn't use and can't claim one of the three categories, for example, Radiology, enter `0` for that category. **Note:** Values for MBS incentive items can also be added for particular encounter places. Values added for MBS incentive items for the encounter place *(on page 872)* override values specified for the organisation *(on page 838)*. **Tip:** To find the incentive items you need, find your location using the Modified Monash Model and match your location to the code. For example, at 1 January 2022: Item type / MM 3-4 / MM 5 / MM 6 / MM 7 MBS Item / Benefit / MBS Item / Benefit / MBS Item / Benefit / MBS Item / Benefit GP: 75855 / $10.50 / 75856 / $11.15 / 75857 / $11.80 / 75858 / $12.50 Diagnostic Imaging: 64992 / $9.85 / 64993 / $10.45 / 64994 / $11.05 / 64995 / $12.15 Pathology: 75861 / $9.85 / 75862 / $10.45 / 75863 / $11.05 / 75864 / $12.15 For more information, see Services Australia - Rural bulk billing incentives changes.

Organisation Parameters - Electronic Claims

Use the **Electonic Claims** tab to configure parameters used to send Bulk Billing claims electronically to Medicare Australia. Ensure that your practice is registered with Medicare before configuring this module.

Table 280. Electonic Claims Organisation Parameters

Parameter	Description
Location ID	The Location ID registered with Medicare Australia for the encryption certificates used to send Electronic Claims. Communicare Support provides each site with a location ID. If you have only one Location ID, maintain it from here. If you have multiple locations, use the Encounter Place maintenance form.
Crypto Store	The path to the Medicare Australia Crypto store file on the Communicare server. The Crypto Store holds the certificates for the Location ID and it is used when creating an online claiming session. To load a different Crypto Store: 1. Click  Ellipsis, locate your Crypto store file and load it into Communicare. 2. Restart all Communicare clients before using Medicare Australia's online claiming. If you don't restart Communicare, the Electronic Claims module uses the old Crypto Store.
Password	The password for the Medicare Australia Crypto Store.
Always print DB4 assignment form before submitting the Bulk Bill Claim	Set to print the DB4 form once for every claim before submitting it. If you don't set this option, Communicare doesn't print the DB4 form automatically and you will have to print it using 'Print Medicare Assignment form' in the Service Recording window.

Organisation Parameters - Email Server

Use the **Email Server** tab to configure local email server parameters.

The values here are used by the blat email tool to:

- Email reports from the Communicare Report Scheduler on completion
- Email notifications about PRODA device expiry
- Email side loader notifications
- Email daily service logs to the recipient specified in System Parameters - System *(on page 811)*

Table 281. Email server Organisation Parameters

Parameter	Description
Name	The name or IP address of your SMTP server. • For Microsoft 365, the default is `smtp.office365.com` • For Outlook, the default is `smtp-mail.outlook.com` • For Gmail, the default is `smtp.gmail.com`

Table 281. Email server Organisation Parameters (continued)

Parameter	Description
Port number	The port number used by your SMTP email server. • For Microsoft 365, the port is `587` • For Outlook.com, the port is `587` • For Gmail, the default port is `465` for SSL. For unauthenticated email, the default is `25`.
Login	For authenticated email, where the server requires a username and password, your username. • For Microsoft 365, your full Microsoft 365 email address, for example, `name@yourdomain.com` • For Outlook, your full Outlook.com email address, for example, `name@outlook.com` • For Gmail, your full gmail.com email address, for example, `name@gmail.com` For unauthenticated email, leave this field blank.
Password	For authenticated email, where the server requires a username and password, the password associated with your email address. For unauthenticated email, leave this field blank.
Sender	The email address that appears as the sender. Many servers will not send a message without a sender and spam filters may identify the email as spam if there is no sender.

Note:
To receive emails from Communicare in Gmail, you may need to customise your settings:

- In **Settings > Forwarding and POP/IMAP**:
  - Enable POP for all mail
  - Enable IMAP and in addition to the defaults, set **Immediately delete the message forever**.
- In your Google account settings, **Security** tab, for **Third-party apps with account access**, allow **Less secure apps**.

Organisation Parameters - Investigations

Use the **Investigations** tab to configure parameters for investigations to enable workers without a provider number to request investigations.

Table 282. Investigations Organisation Parameters

Parameters	Description
blank field	Name of investigations at your practice. For example, `Investigation Requests`.

Table 282. Investigations Organisation Parameters (continued)

Parameters	Description
Allow Investigation Request on Behalf of another claiming provider	When requesting an investigation, a Medicare provider number is required. Set this option to enable providers with a provider number, but without **Ix Claimant** set in their provider details for an encounter place to make a request on behalf of another provider. For more information, see Providers *(on page 920)*.
Default Investigation Provider	If the **Allow Investigation Request on Behalf of another claiming provider** option is set, select the default provider for all new investigation requests at your organisation.

Organisation Parameters - Secure Messaging Configuration

Use the **Secure Messaging** tab to configure Argus to send documents securely.

Table 283. Secure Messaging Organisation Parameters

Parameters	Description
Username	The username that you use to access the Argus web service
Password	The password that you use to access the Argus web service

Note:
For all Argus related enquries and support, contact Argus on (03) 5335 2221.

Organisation Parameters - Certificates

Use the **Certificates** tab to configure security certificates used to connect to the web services used in Communicare.

The web service addresses for the certificates are maintained on Systems Parameters - Web Service Configuration *(on page 825)*.

Table 284. Certificates Organisation Parameters

Parameters	Description
HI Certificate	Select the security certificate that will be used to connect to the HI service. HI Service certificates are maintained in the Communicare Certificates Store *(on page 857)*. Contact the Department of Human Services to register and obtain a certificate: • Email - hiservice@humanservices.gov.au • Phone - 1300 550 115
Assist Reg Certificate	Select the Certificate used to access the My Health Record for Assisted Registration. All My Health Record Certificates attached to encounter places that belong to your organisation are listed here. My Health Record certificates are maintained in the Communicare Certificates Store *(on page 857)*.

Organisation Parameters - SMS Server

Use the **SMS Server** tab to record configuration settings for the SMS Web Service.

Note:
These details are normally entered by the Communicare Implementation team when they configure your site to use SMS messaging. Communicare Administrators should not need to change these settings.

Table 285. SMS server organisation parameters

Parameters	Description
API Key	The SMS Service API Key
API Secret	The SMS Service API Secret
Caller ID	The SMS sender displayed on every SMS message that is sent out from your organisation, limited to 11 characters in length.

User Groups

Users of the Communicare system are organised into groups. Rights to access various parts of Communicare are given to these groups of users.

A user may only belong to one user group. If a user requires a unique set of system rights or clinical item rights, create a new user group.

To display and maintain user groups for your organisation, select **File > User Groups**.

Typical user groups are:

- Doctors
- Health Workers
- Receptionists
- Registered Nurses
- System Administrators

All users in the **System Administrators** group can add, delete and change other users' details. Changes to users and user groups, including when a system right is added or removed from a user group, are logged.

Finding existing users & user groups

To search for any user group, in the **Locate Group** field, enter a search phrase.

To search for any username regardless of their user group, in the **Locate User** field, enter a search phrase. As you type in this box the search will highlight a user from any group that matches the search alphabetically as it progresses (i.e. if you are looking for SMITHP then the first keystroke will find the first user starting with 'S' ordered alphabetically, then the first user starting 'SM' and so on).

Adding new user groups

To add a new user group:

1. Select **File > User Groups**.
2. Above the **User Group Name** grid, click ✚Add Group.
3. In the **Add a new user group** window, enter a descriptive name for the new user group and click **OK**.

4. Set **Provider** to mark a user group as a provider group. A provider group means that the users belonging to this group provide health services to clients. If you want to use the responsibility feature in the recalls, you must mark the user groups appropriately.
5. Click **Save**.

Results:

The new user group is added to the **User Group Name** list. You can now add users and rights to the user group.

Renaming user groups

To rename a user group:

1. In the **User Group Name** grid, double-click the required user group.
2. In the **Change user group details** window, enter a new name for the user group and click **OK**.
3. Click **Save**.

Deleting user groups

User groups cannot be deleted unless the group is empty. The user group can be emptied by dragging the existing users into a new group or deleting the user from the group directly.

To delete a user group:

1. In the **User Group Name** grid, highlight the user group.
2. Click Remove Group.
3. Click **Save**.

Adding users to user groups

> **Note:**
> Use the System Administrators group with caution. Never put anyone in this group who does not have to be a System Administrator. System Administrator is a position of great trust and responsibility since this role allows the user to do just about anything within Communicare and the Communicare Database.

To add users to a user group:

1. Select **File > User Groups**.
2. On the **Users** tab, click Add User.
3. In the **User Name** field, enter a unique username for the user, using uppercase characters. For example, `ELLISONC`. Usernames in the System Administrators group can contain only alpha-numeric characters and cannot contain any of the following characters: `\, /, :, *, ?, ", <, >, |, '`
4. In the **Password** and **Confirm Password** fields, enter and confirm a password that will be used by that user to access Communicare. User passwords can be 8-255 characters long.
5. If you want the user to have access to Communicare immediately, set **Active**.
6. If you have entered a temporary password that you want the user to change at their next login, set **Can change password**. For Administrators, if you change your password, you cannot reset user passwords until you restart Communicare. For information about SSO, see User Maintenance *(on page 847)*.
7. Click **Save**.

Moving users between groups

To move users from one group to another, on the **Users** tab, click and drag the username to the required user group in the **User Group Name** grid.

Deleting users from user groups

To delete a user:

1. On the **Users** tab, click  Remove User.
2. Click **OK**.

User Group Rights

For each user group, set the following rights:

- System rights
- Viewing rights
- Program rights
- Formulary rights
- Scope of Practice

System Rights

System access rights define which of Communicare's modules can be accessed by a group of users. Modify the system access rights of a User Group on the **File > User Groups**, **System Rights** tab.

System access rights for the typical user groups are shown in the following table.

For more information, see System rights *(on page 923)*.

Table 286. System Access Rights

System Right	Doctors	Health Workers	Receptionists	Registered Nurses	System Administrators
Address Book Maintenance	Y				Y
Adverse reaction Administration	Y				
AIR Patient Integration					
AIR Patient Integration Update					
Alerts and Other Information					
Appointments	Y		Y	Y	Y
Appointments Administration	Y				Y
Billing	Y		Y		Y
Billing Administration					Y
Biographics	Y	Y	Y	Y	Y

Table 286. System Access Rights (continued)

System Right	Doctors	Health Workers	Receptionists	Registered Nurses	System Administrators
Birth Notifications					
Clinical Records	Y	Y		Y	Y
Clinical Reporting	Y	Y		Y	Y
Consolidated Order - Manage					
Data Entry Wizard	Y	Y	Y	Y	Y
Document Scanning	Y	Y	Y	Y	Y
Electronic Documents	Y	Y	Y	Y	Y
HealthLink SmartForms	Y			Y	Y
Imprest Management	Y				Y
Investigations	Y			Y	Y
Management Reporting	Y			Y	Y
MeHR					
MeHR Administration					
MeHR e-Registration Auto-Prompt					
Medication History	Y			Y	Y
Medication View	Y			Y	Y
Medications Administer	Y			Y	Y
Medications Supply	Y			Y	Y
My Health Record Access	Y				Y
My Health Record Assisted Registration	Y				Y
NCSR Integration					
Patient Add	Y	Y	Y	Y	Y
Patient Deletion			Y		Y
Patient Edit	Y	Y	Y	Y	Y
Patient Status Administration	Y	Y	Y	Y	Y
Prescribing - Full	Y				Y
Prescribing - Once Off/ Short Course	Y			Y	Y
Provider Administration	Y				Y
Reference Tables	Y				Y
Referral Management					
Report Administration					Y
S100 Management (WACHS only)	Y				

Table 286. System Access Rights (continued)

System Right	Doctors	Health Workers	Receptionists	Registered Nurses	System Administrators
Service Recording	Y	Y	Y	Y	Y
SMS Administration					
SMS Messaging	Y	Y	Y	Y	Y
Transport Services					

Viewing Rights

Viewing Rights *(on page 903)* define which Clinical Item Types *(on page 885)* a group of users may access. These rights are enforced by the database itself so are effective even when using SQL tools such as QueryBuilder.

One enabled viewing right can be set as a default for progress notes access. If no default is set, the progress notes' default viewing right is General or Common if one exists, otherwise the first viewing right given to this group.

Viewing rights for the typical user groups are shown in the following table.

Table 287. Viewing Rights

Viewing Right	Doctors	Health Workers	Receptionists	Registered Nurses	System Administrators
Care Plan	Y			Y	Y
Common	Y	Y		Y	Y
Highly Sensitive Information	Y				Y
Home and Community Care	Y	Y		Y	Y
Investigations View	Y			Y	Y
Maternal & Sexual Health	Y			Y	Y
Psychological	Y			Y	Y
Social Problems	Y	Y		Y	Y

Program Rights

A group of users can be given rights to access services performed as part of a program. Rights allow full access to both reading and recording. The list of available programs is maintained in the **Encounter Program** window.

Program rights for the typical user groups are shown in the following table.

Table 288. Program Rights

Program Right	Doctors	Health Workers	Receptionists	Registered Nurses	SystemAdministrators
Child Health	Y	Y		Y	Y
Link Up Program	Y				Y
Sexual Health	Y			Y	Y
Social and Emotional Well-being	Y				Y

Formulary Rights

If a group has been granted the Prescribing right they can be restricted in the drugs they are able to prescribe. By default, <All Products> is set, which means that all drugs are available to be prescribed. However, you can set a formulary as the default for the selected user group. This determines which formulary is selected by default when a user is prescribing or browsing MIMS drug data and limits the drugs displayed in the Drug Browser, and that can be prescribed, to those listed in the formulary.

Note:
If a user with a Prescriber Number, such as a Nurse Practitioner, has a Scope of Practice and Formulary rights which include all formularies, they can see and create medications orders. The Formulary rights do not limit what they can prescribe, only the medication orders they can create.

Formulary rights for the typical user groups are shown in the following table.

Table 289. Formulary Rights

Formulary Right	Doctors	Health Workers	Receptionists	Registered Nurses	System Administrators
<All Products>	Y				Y
Midwife	Y			Y	Y
Nurse Practitioner	Y			Y	Y
Optometrist	Y				Y

Scope of Practice

Set one or more formularies to include in a user group's Scope of Practice. The Scope of Practice sets the medications that members of a user group can prescribe without requiring a verbal order.

All formularies *(on page 861)* that have **Use as Scope of Practice** set are listed on the **Scope of Practice** tab.

Before you can link user groups to formularies, first complete the following configuration:

1. Define the medications included in a formulary and set **Use as Scope of Practice**. See Formularies *(on page 861)* for more information.
2. For individual providers, set **Use Scope of Practice**. See Editing Providers *(on page 921)*

Adding a new user

To add a new user to Communicare, you first add them to a user group and then assign additional access.

Communicare organises users into groups. All rights to access Communicare modules and information are allocated to User Groups *(on page 842)*.

If your Communicare user groups have been synchronised to Active Directory, for information about SSO, see Active Directory integration *(on page 849)*.

Note:
Use the **System Administrators** group with caution. Never put anyone in this group who does not have to be a System Administrator. System Administrator is a position of great trust and responsibility: this role allows the user to do just about anything within Communicare and the Communicare Database including:

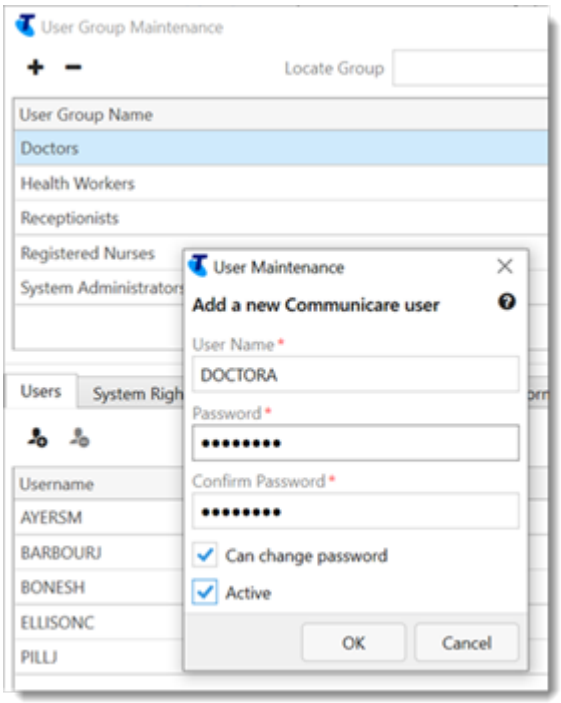
- Change or modify any part of the database.
- Bypass audit mechanisms and audit logs.
- Backup and restore the database, including across the network.

Tip:
You can create a user to provide database access to a third party, such as a data analytics provider. For example, Outcome Health POLAR. Provide the username and password you create to the third party.

Typically you would not create a partner account in the **System Administrators** user group. However, other user groups have limited access to certain database tables, views and stored procedures, so third party applications may encounter errors when used with a limited user if they were designed assuming administrator access.

To add a new user:

1. Select **File > User Groups**.
2. In the **User Group Name** list, select the user group that the new user will belong to.
3. On the **Users** tab, click Add User.



4. In the **User Maintenance** window, in the **User Name** field, enter a unique username for the user. Usernames in the System Administrators group can contain only alpha-numeric characters. Usernames cannot contain any of the following characters: `\, /, :, *, ?, ", <, >, |, '`.

Tip:
Try to keep the new username consistent with the existing naming convention for your organisation. For example, *`lastnamefirstnameinitial`*, such as `ELLISONC`.

5. In the **Password** and **Confirm Password** fields, enter and confirm a password that will be used by that user to access Communicare.
6. If you have entered a temporary password that you want the user to change at their next login, set **Can change password**. For Administrators, if you change your password, you cannot reset user passwords until you restart Communicare.
7. If you want the user to have access to Communicare immediately, set **Active**.
   A user cannot be activated if the number of allowable active users in the license agreement is exceeded. For further assistance, contact Communicare Support.
8. Click **Save**.

The new user is added to the list of users on the User Group Maintenance *(on page 842)* window. Here, you can move users from one group to another and delete users.

The system rights *(on page 923)*, viewing rights *(on page 903)*, program rights *(on page 876)*, formulary rights *(on page 861)*, and scope of practice *(on page 278)* for the selected user group all apply to the new user.

If the new user is anyone who provides healthcare for a patient, such as, a doctor, health worker, or nurse, now add them as a provider *(on page 921)*.

If you set **Can change password** in step 6 *(on page 849)*, to reset their password, users can select **File > Change Password**.

To reset a user's password, at step 2 *(on page 848)*, double-click a user, then repeat steps 4 *(on page 848)*-8 *(on page 849)*.

Active Directory integration

Communicare user groups can be synchronised to an Active Directory group so that a user's Microsoft Windows and Communicare logins can be managed from one location and users can use single sign-on.

Before you ask Communicare Support to enable Active Directory integration, consider the following:

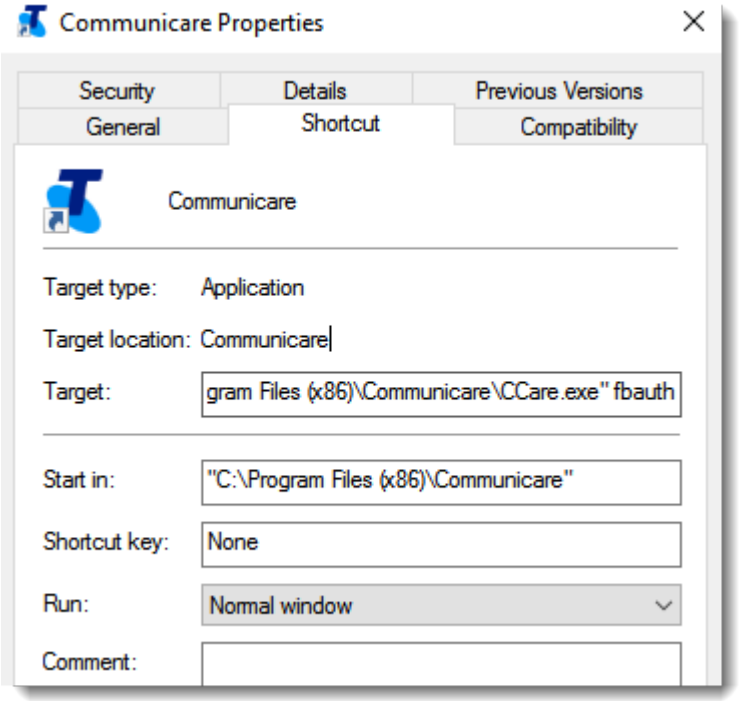
- Usernames cannot be longer than 31 characters, including the domain name and a backslash.
- All staff using Communicare will need to be included in an Active Directory group. Active Directory synchronisation will hide the username and password field in Communicare to allow for single sign-on functionality.
- Existing users will lose any local Communicare settings and favourites, which will return to default settings, including:
  - Words added to the spellcheck dictionary
  - Report parameters
  - Report favourites list
  - Default Provider, Encounter Place, Mode, Program
  - Tools menu – Show Hints, Button Captions, Show status bar
  - `Recently Used` clinical items on the Clinical Item search window
  - Appointment Book filters
  - Patient Search filters
  - Last selected options on qualifier and centile charts
  - Last selected filter on the clinical record Detail tab
  - Prescription defaults
  - Non-public dosage instructions
  - Window dimensions (if resized)
  - User medication favourites list

- Printer Assignments
- Existing Intramail messages sent only to these users and not saved to progress notes

If single sign-on has been enabled by Communicare Support, additional options will be visible in **File > User Groups** to help manage the integration with Active Directory.

After Active Directory has been enabled, complete the following steps:

1. So that you can synchronise your own group to Active Directory, to login to Communicare for the first time after the upgrade, right-click on the Communicare shortcut and add `fbauth` to the target parameters. This allows you to login in using your Communicare username and password.

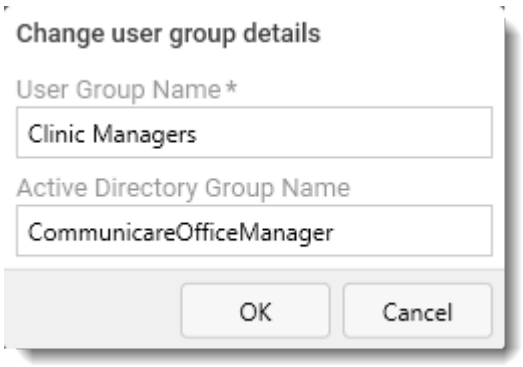


> **Remember:**
> Remove this parameter from the shortcut once you have synchronised the Active Directory group containing your Windows user name.

2. Double-click the Communicare shortcut and login as a user with administrator rights as usual.
3. Synchronise your Communicare user group with Active Directory:
   a. Select **File > User Groups**.
   b. In the **User Group Maintenance** window, click ✚Add or double-click a user group.

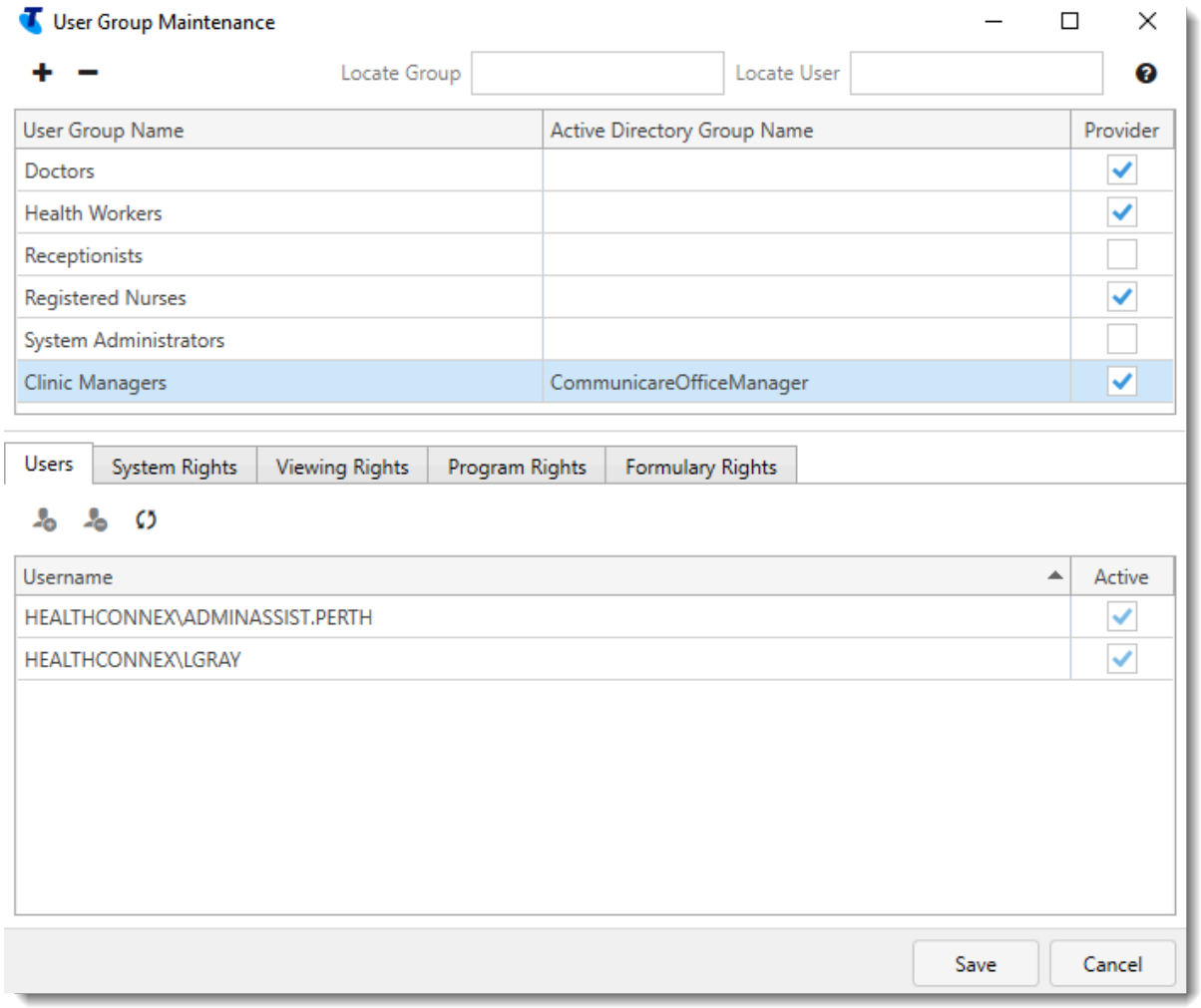
> **Note:**
> A synchronised user group should not contain any uses who aren't Active Directory users. If you are synchronising a previously existing Communicare user group, any remaining non-Active Directory usernames should be deleted.

   c. Enter the user group name and the corresponding Active Directory group exactly as it appears in Windows and click **OK**.



   d. Click Synchronise (above the group's user list) or click **Save**.
4. Log out of Communicare, remove the `fbauth` parameter you added to the shortcut in step 1, and log back in using your Windows credentials.
5. Reassign any provider records that were associated with a Communicare username to their Active Directory username. In **File > Providers**, in the **Logon User Name** field, enter the Active Directory username. For example, `HEALTHCONNEX\LGRAY`.
6. Advise users that they can now reassign their printer assignments in **File > Printer Assignments** and add any previous favourites, dosage instructions, and so on.

Any groups that are modified are automatically synchronised and all users belonging to the specified Active Directory group are created in Communicare and listed on the **Users** tab. Users created based on Active Directory users will be in the form `DOMAIN\\USERNAME`. The 31 character limit for usernames in Communicare still applies and includes the domain prefix.



Note:

Users in nested groups will not be brought into Communicare.

Although Active Directory users can belong to multiple groups, a Communicare user may only exist in a single group. Thus, if a user belongs to multiple mapped groups, they will only reside in the last group to be synchronised.

In groups that are mapped to Active Directory, the Active Directory users cannot be manually removed, moved to another group, or edited.

To synchronise Communicare user groups to Active Directory in subsequent logins, you need only complete step 3 *(on page 850)*.

Note:

After a user group is synchronised to an Active Directory group, the users must be maintained in Active Directory. Functions such as adding, deleting, changing passwords and making users inactive are disabled in Communicare for this group.

Note:
If you clear an Active Directory group name from a Communicare user group, the members of that group will be removed.

A background process can be enabled to automatically synchronise all Active Directory user groups with Communicare. The default is once daily 4:00pm - 4:30pm. Ideally, the synchronisation should be just before your scheduled Communicare backup runs.

Reference Tables

The system reference tables form a basic dictionary of information used throughout the system.

The list of Transport Modes for example, is a reference table. It tells Communicare what the transport modes names are. Communicare will allow you to select a mode of transport from that list. You can't record a transport mode that is not on the list. From time to time you may need to add records to the list.

There are two types of Reference Table maintenance form, those with one grid and those with two. The single grid forms have a single set of navigation buttons *(on page 21)* and adding or editing a record may be done in the grid (Public Holidays) or in a separate dialog box (Automated Recall Types). Those forms with two grids also have a single set of navigation buttons. It is important to click in the grid you wish to edit before selecting the appropriate navigation button. All of the forms with two grids are edited in the grid.

It is very important that reference table records are not changed to mean something different. It is always OK to correct an error, for example a misspelling, but a record must NEVER be changed so that its meaning is changed. For example, you should not change the record for "Royal Flying Doctor Service" to read "Plane". If you did make such a change, all transfers ever made by "RFDS" would appear as "Plane" instead. This may cause confusion if other air services are used or limit future transport statistics.

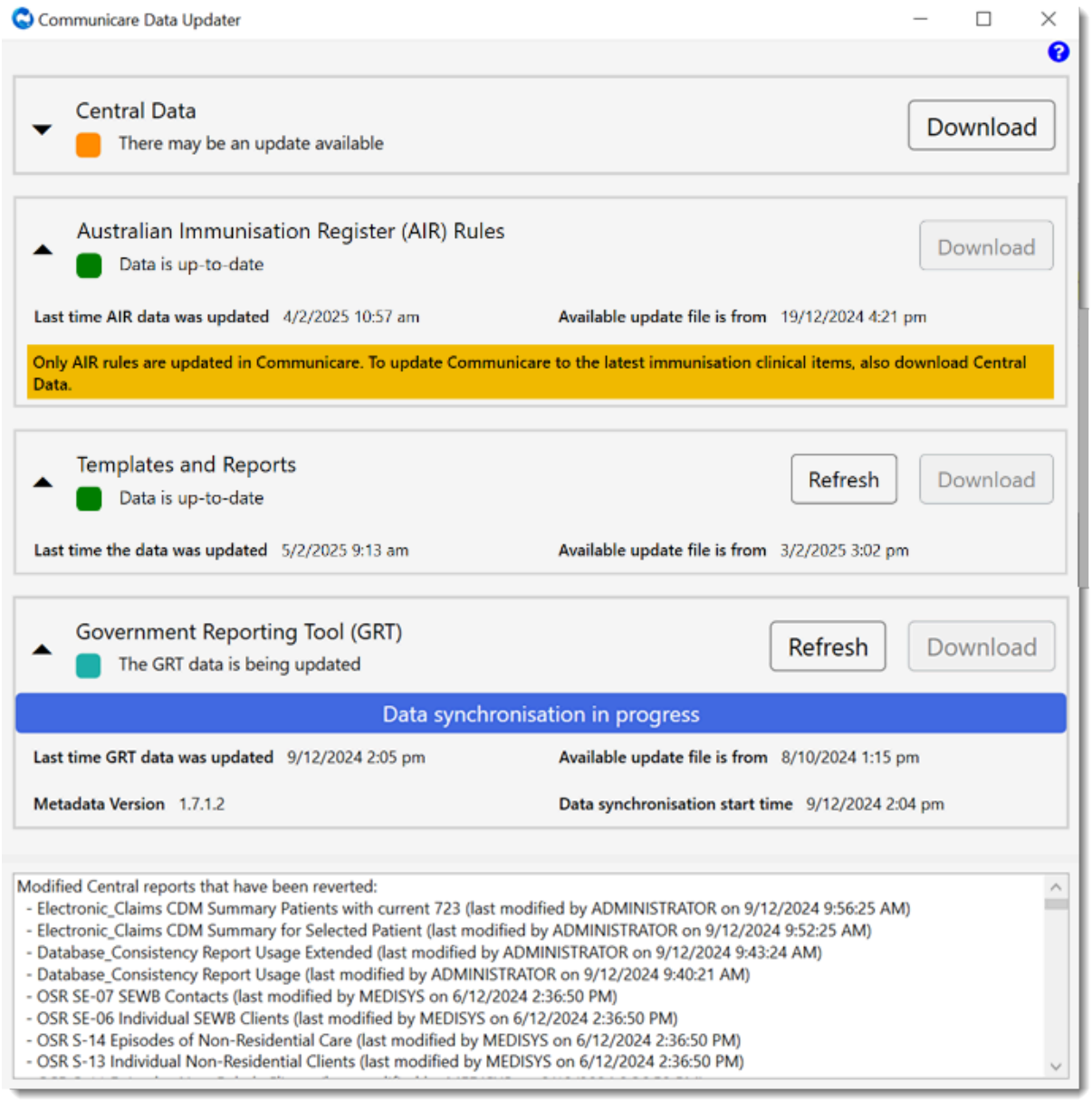
Typically, you need System Administrator rights to work with reference tables.

Communicare Data Updater

Use the Communicare Data Updater to update Central items and other clinical data, AIR rules, templates and reports, and the GRT.

Users who belong to the **System Administrators** user group can use the Data Updater to update any of the following data:

- Central Data items, including immunisation clinical items
- Australian Immunisation Register (AIR) Rules
- Templates and reports data
- Government Reporting Tool (GRT)



Update each data set by itself or in combination with other selected other data sets.

The frequency at which you run the Communicare Data Updater depends on the data that you need to update. Ideally run the Data Updater out of hours so that other users are not affected.

The Communicare Data Updater checks for the last time and date that each type of data was changed in the Communicare database and sets an update status, from the following:

- Dark red - your data is old. Update now.
- Orange - your data is irregular and there may be an update. Run the Data Updater and attempt an update.
- Teal - your data is being updated in the background which may take several hours. To see the latest status, click **Refresh** to
- Green - your data is current. No further action is required.

- Blue - the status of your data is unclear. Try again later or contact Communicare Support.
- Red - cannot connect to the Communicare service. Try again later or contact Communicare Support.

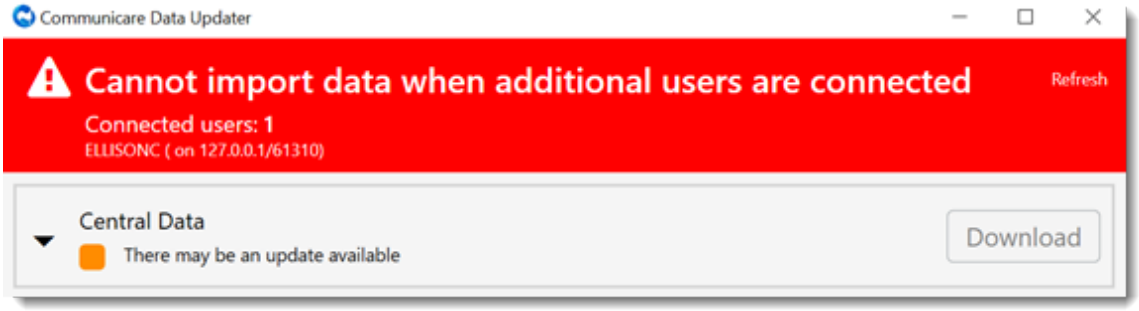
Update Central Data

Use the Communicare Data Updater to update Central items and optionally AIR rules or template and report data to the latest version.

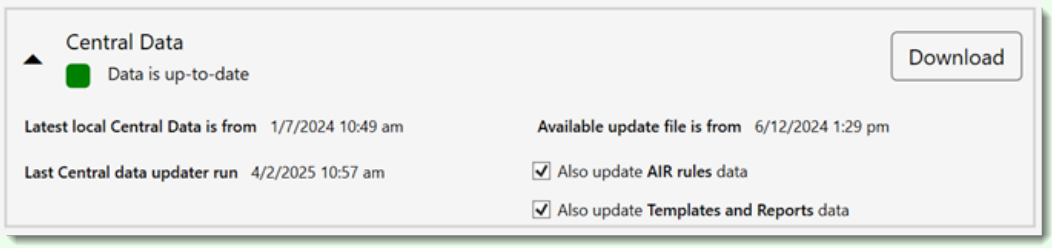
> **Tip:**
> To update immunisation clinical items, update Central data.

To update central and other clinical data:

1. Ensure nobody is logged into the Communicare server or clients, except you as the administrator.
2. On the Communicare server, select **File > Reference Tables > Update Clinical Data**.
3. If other users are logged in, the user and their computer name are listed in a banner. Before proceeding with the update, ensure that those users are logged out, then click **Refresh** in the banner.



4. Check the status.

> **Tip:**
> Select the caret to display when the local and central data was last updated.
>
> 
>

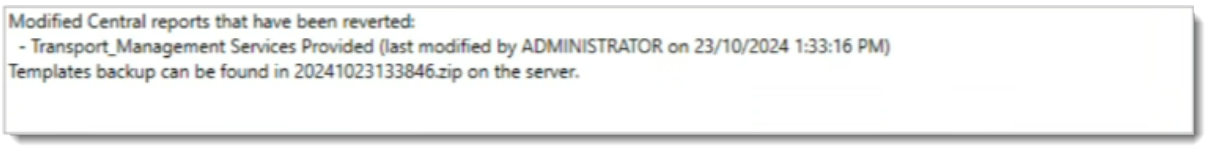
5. To update Central data, AIR rules and templates and report data simultaneously, set **Also update AIR rules data** and **Also update Templates and Reports data**. Alternatively, deselect these options to update only central data.
6. Click **Download**.

> **Tip:**
> If required, to update only the AIR rules or the Templates and reports data, run the downloads from their separate tiles.

7. Enter your username and password.

The data files are downloaded from our server and the Import Central Data tool is run automatically. Your version of the data files is updated.

For Central items that had been updated locally, the items are archived on the server and information about those items that have been reverted to Central is displayed in the Data Updater.



Update GRT and nKPI reports

Use the Communicare Data Updater to update the GRT and the associated nKPI reports to the latest version.

To update the GRT and nKPI reports:

1. Log in to Communicare as an administrator.
2. On the Communicare server, select **File > Reference Tables > Update Clinical Data**.
3. If other users are logged in, the user and their computer name are listed in a banner. Before proceeding with the update, ensure that those users are logged out, then click **Refresh** in the banner.
4. Check the status.

> **Tip:**
> Select the caret to display when the GRT was last updated.

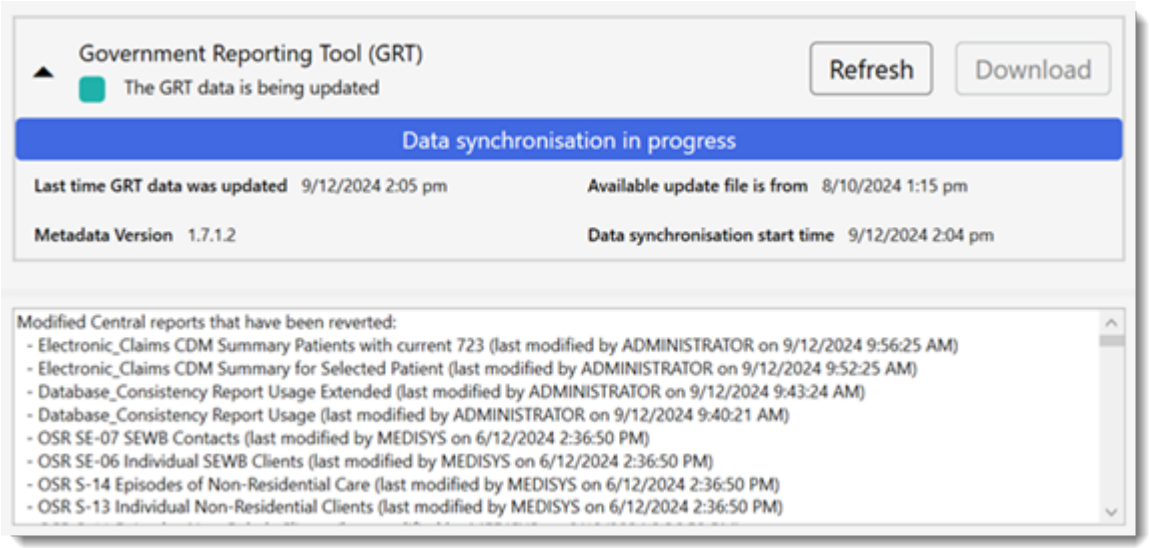
5. To update report data simultaneously, set **Also update Templates and Reports data**. Alternatively, deselect this option to update only GRT data.
6. Click **Download**.
7. Enter your username and password.

The GRT scripts and report templates are downloaded from our server and your database is updated. The synchronisation may take many hours depending on your internet connection.

You may close the Data Updater and do other work in Communicare while the GRT data is downloading: the synchronisation will continue in the background.

To check the progress of the update, open the Data Updater and on the GRT tile, click **Refresh**.

A teal background indicates that the GRT is still be being updated.



A green tile indicates that the update is complete.

Certificates

The **Certificates Maintenance** window lists all of the currently installed certificates used in various places in Communicare, including for Services Australia (IHI, OPV, AIR, Medicare and so on), My Health Record, and ePrescribing.

Certificates expire every two years. Administrators should receive an updated certificate from the third party, such as Services Australia and renew the old certificate before it expires.

You can review certificate expiry dates in **File > Reference Tables > Certificates**. The following information is displayed for certificates in the **Certificates Maintenance** window:

- **Name** - a unique name for the certificate specified by the user.
- **Type** - the type of the certificate specified by the user, usually `NASH Org Certificate` or `HI Org Certificate`.
- **HPI-O** - the HPI-O in the certificate. This is populated automatically by Communicare if the certificate contains an HPI-O. For example, if the certificate type is *NASH PKI Certificate for Healthcare Provider Organisation*, also known as a *NASH Org* certificate.
- **Expiry Date** - the expiry date of the certificate. Renew your certificate before this date.
- **Description** - a description for the certificate specified by the user.

Working with certificates

To add a new certificate:

1. In **File > Reference Tables > Certificates**, click Add. A new row is added to the list of certificates.
2. Select the new row, and in the **Required Information** pane, provide the certificate information:
    a. In the **Name** field, enter a unique name for the certificate.
    b. In the **Certificate** field, click Ellipsis and select the certificate you want to add to Communicare.

c. If the certificate is password-protected, in the **Password** field, enter the password required to access the certificate.
d. From the **Certificate Type** list, select what type of certificate this is.

3. In the **Optional Information** pane, when you attach a certificate and add a password, the subject distinguished name is included in the **Subject** field. To copy the name to your clipboard for use in configuring connected services such as **SecureMessageExchange**, in the **Subject** field, click **...**.
4. Click **Save**.

To edit a certificate:

1. In **File > Reference Tables > Certificates**, select an existing certificate.
2. In the **Required Information** pane, edit the any information that has changed.
3. Click **Save**.

Certificate Parameters

Certificate Parameters are displayed when you edit an existing certificate or attempt to add a new certificate from the **Certificate Maintenance** window.

Table 290. Certificate parameters

Field	Description
Name	The unique name of the certificate
Certificate	The certificate file to load into Communicare
Password	The password for the certificate
Certificate Type	The type of the certificate.
Description	The description for the certificate.

Certificate Types

The HI Org Certificate is a NASH PKI Site Certificate which delegates access to the Healthcare Identifiers (HI) Service.

Note:
In V21.2 and earlier, in some cases, the HI Org Certificate could be the Medicare Site PKI. In V21.3 and later, the HI Org Certificate is always the NASH PKI.

Certificates are validated when you save any changes to ensure that the password is the correct password for the certificate. If the certificate contains an HPI-O, it is stored alongside the certificate in Communicare.

Appointment Facilities

A facility is an object that is needed on an exclusive basis for an appointment.

Normally a facility is a room, but it can also be something else such as a piece of test equipment.

The facility is associated with an Encounter Place to indicate the place where the facility is to be found. If required, create a new encounter place or mode before you create a facility to associate with it. For more information, see Adding and Editing Encounter Places and Modes *(on page 872)*.

To add a new facility:

1. Select **File > Reference Tables > Appointment Facilities**.
2. In the **Facility Maintenance** window, check that the facility you need is not in the list.
3. Click  Add.
4. In the new row, from the **Place and Mode** list, select the encounter place and mode for which the facility is used.
5. In the **Description** field, enter the name of the new facility.
6. Click  **Save**.

The facility is now available for use in an appointment session template. For more information, see Appointment Session Templates *(on page 910)*.

Requirements

Requirements are services or objects that may be needed for particular patient appointments and services, such as Fasting Bloods, Test Results, Transport, X-Rays.

When an appointment is booked all defined requirements are listed with a comment. Those making the booking can select the requirements that apply and add a comment about each requirement. For example, add a comment of `Knock on back door` to **Transport**.

When a service is created or edited if a requirement is selected, the  Requirements icon is displayed in the  **Service Recording** window. The **Requirements** tab at the bottom of the  **Service Recording** window shows the requirements details for the selected patient.

Note:

If used in conjunction with the  **Transport Management** module, selecting the **Transport** requirement creates a transport booking assumed to be from the patient's home address, to the place of the appointment with a drop-off time of the time of the appointment. Deselecting the **Transport** requirement does not cancel the booking.

Instead cancel the booking from  **Transport Management**.

Public Holidays

Public holidays identify normal working days (or part days) that the practice will be closed.

Appointments are not generated for the period that the practice is closed. Sessions are not added to the Appointment Book automatically and manual sessions cannot be added.

Public holidays are also used in the calculation of normal working hours for some reports.

By default, the start date and time of the holiday is the first minute of the selected date and the end date and time defaults to the last minute of the end date. Typically this is the same as the start date, that is, most holidays are full, single days.

As long as your site does not routinely see patients on public holidays, enter national and state public holidays for the new year as early as possible, and before the default horizon days has automatically added sessions to the Appointment Book. If they are observed at your site, also include cultural holidays such as NAIDOC Week, or site-specific holidays such as Staff Picnic Day.

Note:
A public holiday cannot be entered for a period in which appointments sessions already exist, except for cancelled sessions. If you attempt to create a holiday where sessions exist an error message is displayed.

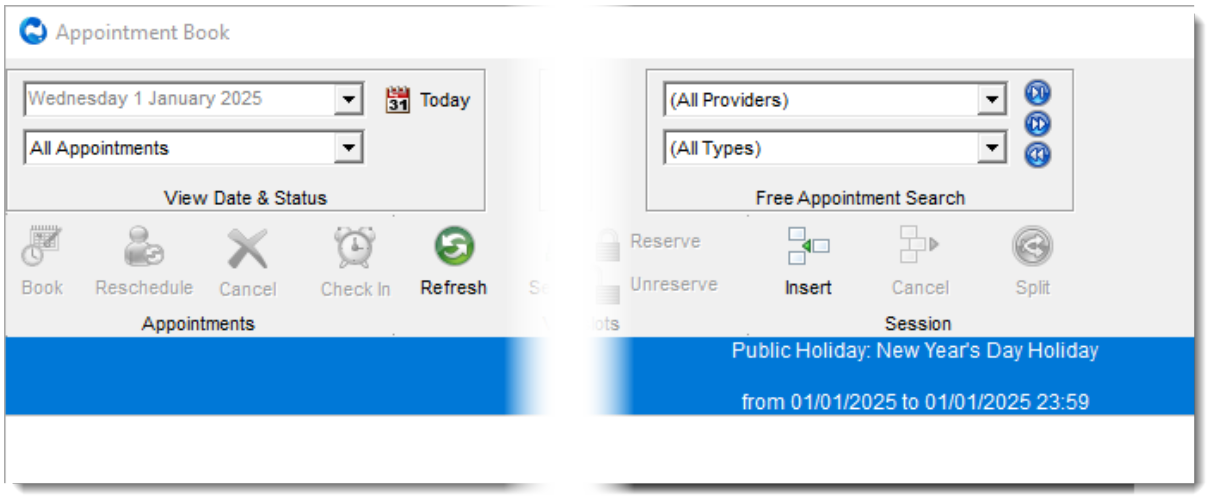
To add a public holiday to the appointment book:

1. Select **File > Appointments > Public Holidays**.
2. In the **Public Holiday Maintenance** window, click Add.

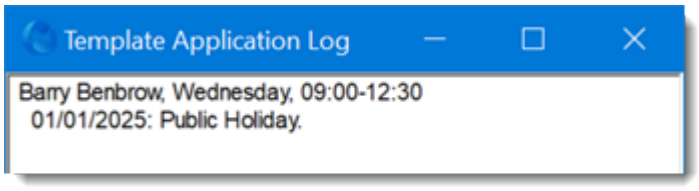
   Tip:
   You can position the mouse anywhere; holidays are sorted by date after they have been saved.

3. In the row added, enter the name of the holiday and the start and end date.
4. Repeat steps 2-3 to continue adding holidays for the whole year.
5. Click **Save**.
6. Restart Communicare.

The public holidays are reserved in the appointment book. When you go to the date of the reserved public holiday in the appointment book, a banner is displayed with details of the holiday.



You can now insert new sessions into your appointment book. If you attempt to insert sessions into a reserved public holiday, an error is displayed in the Template Application Log.



MIMS Database Import

If your site uses the `Prescribing Full` or `Prescribing Once off/short course` module, `Adverse Reactions` or browses the MIMS drug database, update MIMs monthly.

Before following these steps, delete any old MIMS files. Delete any file called `drugdata.exe` and any folder called `Drugdata`.

MIMS Pharamaceutical Data may be imported into Communicare from a file downloaded from the Communicare website. The import includes the following MIMS datasets:

- Abbrev
- AllergyAlert
- CMI
- DrugAlert
- Full
- HealthAlert
- Images
- Interact
- LinkAMT
- Tables

To update MIMS:

1. Download the most recent drug data file from Communicare User Portal - Help and Support:
    a. Log on to Communicare User Portal with your username and password (register online if you do not have these).
    b. On the **Help and Support** tab, in the **MIMS** tile, click **Download**.
    c. Accept the conditions and click **Download**.
    d. When the archive file has successfully downloaded, it automatically runs and prompts you for a location to which it should be extracted. Extract the drug data to the workstation on which Communicare is installed.

    > **Note:**
    > Ensure that the data is extracted to a local drive. If you extract the data to a network drive, the subsequent import will fail.

2. Import the drug data:
    a. Select **File > Reference Tables > Import MIMS Pharmaceutical Data**.
    b. In the **Import MIMS** window, follow the instructions to import the drug data. The process can take up to half an hour depending on your network. Please do not use your computer for other tasks until the import is complete.

The MIMS data is updated.

If you are unsure about any of the above steps, contact Communicare Support.

Formularies

Use the **Formulary Maintenance** window to manage medication lists or formularies.

Formularies are used to limit medications available to particular provider specialties, such as Midwives and Nurse Practitioners or to allow other providers to create medication orders for particular medications. Formularies are used:

- To constrain medications listed in the Drug Browser to those listed in the formulary. Typically these are once off medications used to treat acute conditions.
- To define a Scope of Practice, medication orders outside of which require a Verbal Order. You can set one or more formularies to use as Scope of Practice.
- To support management functions such as reporting and stock control.

To create a new formulary:

1. Select **File > Reference Tables > Formulary**.
2. In the **Formulary Maintenance** window, click **New**.
3. On the **Details** pane, in the **Formulary Name** field, enter a name for the new formulary.
4. If you want to allow providers to be able to create medication orders for medications listed in the formulary without the requirement for a verbal order, set **Use as Scope of Practice**.
5. In the **Organisation** field, enter your organisation name.
6. In the **Encounter Place** list, set your encounter place, for example Millenium Health Service.
7. In the left panel, select **Drugs** to switch from the formulary details to drug selection pane.
8. In the medications list, select the medications you want to include in this formulary. Set **Only show formulary drugs** to restrict the list to those drugs you have added to the formulary.
9. Click  Save.

By default, new formularies are created in draft mode. While a formulary is in draft mode, it cannot be enabled for use or be exported. To use the formulary, it must first be published.

Publishing a formulary

A draft formulary can be edited or published. Once published, the current version of that formulary cannot be further modified.

To publish a draft formulary:

1. Select **File > Reference Tables > Formulary**.
2. In the the **Formulary Maintenance** window, select the draft formulary.
3. Click  Publish.
4. Click **Close**.

The formulary is enabled and the current MIMS issue date of the Communicare system is recorded against the formulary. The formulary is now available to assign to user groups *(on page 847)* and for use in Scope of Practice *(on page 842)*.

Editing a formulary

You can edit a draft formulary or a published formulary.

If you edit a published formulary, a new, draft version of that formulary is created, which allows the existing version to remain in use until the new version is published.

To edit a published formulary:

1. Select **File > Reference Tables > Formulary**.
2. In the the **Formulary Maintenance** window, select the published formulary and click  Edit.

3. On the **Details** pane, you cannot edit the formulary name, but can edit any other details as required.
4. On the **Drugs** pane, edit the medications included in the formulary if required.
5. Click Save.

The new, draft version of the formulary is saved. You can now publish the version when required. When the new version is published, all previous versions of that formulary are disabled.

Disabling a formulary

When published, a formulary is enabled by default.

To disable a formulary to restrict its use:

1. Select **File > Reference Tables > Formulary**.
2. In the the **Formulary Maintenance** window, in the list of formularies, for the formulary you want to disable, deselect **Enabled**.
3. Click **Close**.

Importing and exporting formularies

Any published formulary can be exported as a file that can be distributed to other health organisations using Communicare. Receiving organisations can import the file and review the formulary before choosing to save it.

Formularies created by another organisation cannot be edited, but the list of medications that they contain can be copied into a new formulary.

Locality

The **Locality** reference table is a list of places used in patient addresses. It is initially populated with over 14,000 localities used by Australia Post when your Communicare server is installed.

To display the **Locality** window, select **File > Reference Tables > Locality**.

Adding localities and postcodes

You can manually add new localities as they emerge and add localities for a local community. All localities must have a postcode.

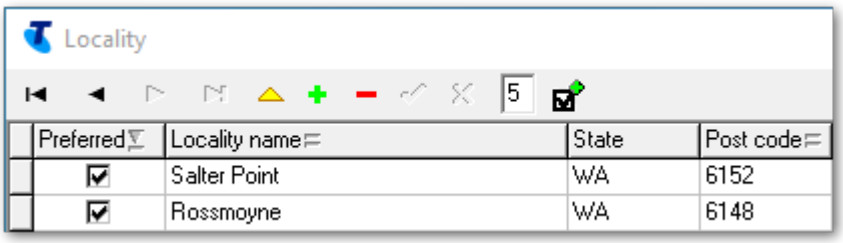
You can modify any locally created localities, but you cannot modify or delete the official, Australia Post localities that were originally imported.

If the postcode for a locally created suburb changes, modify the postcode. The postcode for patients at this locality is updated automatically.

Marking preferred localities

Mark localities as preferred to limit the visible choices of locality in the patient biographics form and save time for users. Using preferred localities helps reduce the risk of mistakenly choosing places with similar place names.

To mark multiple localities as preferred, in the **Locality** window, select the localities, right-click and select **Preferred**.



To automatically set localities as preferred based on how often they have already been used, enter a value (the default is 5) in the field on the toolbar and click Add Preferred. **Preferred** is set for all localities used at least that number of times.

Locality Group

A locality group is where several localities are combined for reporting purposes. Locality groups can be defined for overlapping areas. For example, the following locality groups could be defined for your city or town:

- North of the river
- South of the river
- Inner city
- Suburban
- Northern suburbs
- Southern suburbs
- Etc.

The Locality Group Maintenance function allows creation of new locality groups, deletion of existing locality groups and changes to existing locality groups. Two grids are displayed; the upper grid lists existing locality groups, the lower grid lists the localities included in the current locality group (i.e. the one selected in the upper grid).

Add a new locality group by clicking on the locality group (upper) grid and then clicking on the add button. A blank Locality Group Name appears in the locality group grid. Type the name of the new locality group. Start the name with an upper case letter to ensure it appears in the correct sort position, eg 'My locality group'.

Add a new locality to an existing locality group by clicking on the lower grid and then clicking on the Add button. Click on a locality to add it to the current locality group.

Health Service Area

The locality group called Health Service Area is a special group that cannot be deleted. It must contain all the localities that define the health service's coverage. This group drives two important functions in Communicare: firstly, the automated patient status *(on page 933)* feature looks at this group to determine whether a past patient who has been seen should be changed to current (if their locality is in the health service area) or transient (if it is not); secondly, several reports look at this group to determine which clients 'belong' to the health service.

Patient Skin

Skin types (names) relevant to your patients or region.

Patient Group Maintenance

Use the **Patient Group Maintenance** window to define the groups that a patient can belong to and the behaviour of those groups.

To display the **Patient Group Maintenance** window, select **File > Reference Tables > Patient Groups**.

The types of group available are listed in the Group Type table. You cannot edit this table. Group types may have the following settings:

- **Has Provider** - if a group type has **Has Provider** set, a provider must be selected for the group.
- **Continuous** - if a group type is continuous, after a patient is added to the group, they may move to other groups of the same type, but may not exit until death. Consider the `Patient Status` group type for example. A patient may start as a Temporary patient, become a Current patient, then a Past patient, then perhaps a Temporary patient once more. The patient is always a member of one Patient Status or other.
- **Unique** - if a group type is unique, a patient may belong to only one unique group at a time. Consider again the `Patient Status` group type for example. Clearly, a patient cannot be a Current Patient and a Past Patient at the same time.

If no setting is selected, there are no restrictions on the group.

To add a new patient group:

1. In the Group Type table, select the group type for the new group. For example, `Inclusive Care Program`.
2. In the Group table, click  Add to insert a new row.
3. In the highlighted row, in the **Group Name** column, enter a name for the new group.
4. In the **Definition** column, click  Ellipsis. In the **Group Definition** window, enter a description for the group and click **OK**.
5. Set **Enabled**.
6. Click  **Save**.

You can now add patients to the new group on the  **Patient Biographics > Administration**tab. For more information, see Biographics - Administration *(on page 37)*.

To edit a patient group:

1. In the Group Type table, select the group type to which the patient group belongs.
2. In the Group table, click  Edit.
3. Edit the required fields and click  **Save**.

If you delete a patient group, it is disabled rather than being deleted.

Encounter Place

An encounter place can take one of two forms.

An encounter place can be either:

- A Service Encounter Place, where patient contacts occur
- An Administrative Encounter Place, a concept that defines a group of encounter places for administrative or reporting purposes

Service Encounter Places

A Service Encounter Place identifies either:

- The physical place at which a service is delivered. It is usually a clinic (for example, Millennium Health Service Clinic) but may also be a non-clinic location at which services are delivered (for example, Fremantle Prison). In both cases, this is where the provider and the consumer are when the service is delivered. Use encounter places in this way when it is necessary to report by specific places (for example, specific prisons).
- The physical place from which a service is delivered. For example, Millennium Health Service Clinic or Eastern Branch Clinic. This is where the provider has come from in order to deliver the service, and is usually the place of employment, where the service is being provided from. Use encounter places in this way when it is not necessary to report by specific places. For example, Client's homes.

Note: Places are sometimes used as subdivisions of a health organisation, for example, General Clinic and Dental Clinic. In this case, do not define places that overlap with each other. For example, if Millennium Health service has two subdivisions, General and Dental, do not also define Millennium Health Service as a third encounter place. Reporting is done for the whole of health service and also by encounter place. If both subdivisions and branch clinics are defined as encounter places, it may not be possible to do aggregate reporting for a subdivided clinic. Consider using programs *(on page 876)* as an alternative to encounter places for subdivisions.

Administrative Encounter Places

An Administrative Encounter Place identifies either:

- An administrative area to which a subset of Encounter Places belongs
- A reporting region to which a subset of Encounter Places belongs

An Administrative Encounter Place may comprise further, smaller Administrative Encounter Places with as many levels as required.

All Administrative Encounter Places must comprise at least one Administrative Encounter Place or Service Encounter Place for the places to be meaningful. No place may belong to another Service Encounter Place. Places may belong to at most one Administrative Encounter Place.

User Interface

Encounter places are displayed in the status bar: *Encounter Place (Encounter Mode) Program*

For example: `Millennium Health Service (Aboriginal Health Service) (No program selected)`

Encounter Mode

Every Encounter Place must have one or more encounter modes associated with it before it can be used to record services.

In the following discussion, two types of Service Encounter Places are referenced.

- The physical place at which a service is delivered.
- The physical place from which a service is delivered.

See Encounter Place *(on page 865)* for more information.

Note:
All services are assumed to be "face to face" unless implied otherwise by the mode.

Encounter Modes

An Encounter Mode identifies either:

- The means of delivering a health service. For example "Telephone".
- The type of physical place at which a health service is delivered. For example, "School". The entire encounter place is "West Leeming Primary School (School)" to identify services delivered at the school.

Use physical places at which a service is delivered with either the means of delivering the service or the type of place at which the service is delivered. For example:

- Millennium Health Service Clinic (Telephone)
- Millennium Health Service Clinic (Aboriginal Health Service)

Use physical places from which the provider travels to deliver a service with the type of place where the service is delivered. For example:

- Millennium Health Service Clinic (School), i.e. the Millennium Health Service Clinic is not a school but the service is delivered at a school.

Examples of Common Places and Modes

Table 291. Common encounter places and modes

Description	Encounter Place	Encounter Mode
The physical place at which a service is delivered and the means of delivering a health service	Millennium Health Service Clinic	Administration - no client contact
	Millennium Health Service Clinic	Telephone
The physical place at which a service is delivered and the type of physical place at which a health service is delivered	Millennium Health Service Clinic	Aboriginal Health Service
	Fremantle Prison	Prison*
	Leeming Primary School	School
	Leeming Senior High School	School
The physical place from which a service is delivered an the means of delivering a health service	Millennium Health Service Clinic	Mobile Clinic
	Millennium Health Service Clinic	Outreach
The physical place from which a service is delivered and the type of physical place at which a health service is delivered	Millennium Health Service Clinic	Client's Home
	Millennium Health Service Clinic	Prison*
	Millennium Health Service Clinic	School

* Some combinations are mutually exclusive. For example, use only one of the following combinations, not both:

- A specific prison and the mode of Prison
- A place of health service and mode of Prison

Types of Modes

Communicare provides the following encounter modes:

Table 292. Types of encounter mode

Means of delivery	Type of physical place
Administration - client contact	Aboriginal Health Service
Administration - no client contact	Client's Home
Clinical administration – client contact	Commercial setting (eg pharmacy)
Clinical administration – no client contact	Community Health Centre
Clinic - Consult	Community Services Centre
Inreach	Court
Mobile Clinic	Day Aged Care Centre
Other	Day Procedure Centre (Free-standing)
Outreach	Dental Room
Telehealth - Provider	Dispensary - no client contact
Telehealth - Recipient	Drug and Alcohol Agency
Telehealth Video	Health Care Practitioner Office (any discipline)
Telephone	Health Service
	Hospital - All types
	Hospital - Emergency Department
	Hospital - General Practice
	Hostel
	Nursing Home
	Other (also a means of delivery, read "Other type of place")
	Prison
	Renal Dialysis Centre (Free-standing)
	Respite Care Facility (non-Hostel or Nursing Home)
	School
	Supported residential accommodation

Other encounter modes:

- `Contact Attempt Unsuccessful - no client contact` is a special encounter mode which is neither type of place nor means of delivery.

Modes

Typically, health services use only a few modes for each encounter place, configured by the Communicare Administrator.

Use the following table to help determine which encounter modes to use.

Table 293. Encounter modes

Encounter Mode	Consultation Delivery	Description	Included in reports	Automated patient status updates?
Aboriginal Health Service	In person	Use to record a clinical consultation where the patient attended the clinic.	nKPI and OSR	Yes
Administration - client contact	Administrative - in person	Use to record that although the health service has seen the patient it was not for a clinical reason.	None	Yes
Administration - no client contact	None	Use to record administrative work for a patient.	None	No
Clinical administration – client contact	Administrative - in person	Client contact that is more clinically focused than `Administration - client contact`.	nKPI and OSR **Note:** Inclusion in reports may be affected by provider type.	Yes
Clinical administration – no client contact	None	Clinical administration, for example: • Updating clinical history - allergies, past medical, surgical. Gynae history, family and social history • Referrals – child health, dietitian, allied health, social work, GP, OT, exercise physiologist, pharmacist • Applications – My Aged Care, MASS, Centrelink, Lions Club equipment • Immunisations – history, data entry, documentation verification • Pathology – follow up and organising treatment • Notifications – schools, GP, hospital, discharge planners • Discharge planning	None	No
Client's Home	In person	Use to record where workers from the health service deliver services at the client's home. Use instead of creating a separate encounter place for each client.	nKPI and OSR	Yes

Table 293. Encounter modes (continued)

Encounter Mode	Consultation Delivery	Description	Included in reports	Automated patient status updates?
Clinic - Consult	In person	Use to record a clinical consultation where the patient attended the clinic.	nKPI and OSR	Yes
Commercial setting (eg pharmacy)	In person	Use to record where workers from the health service deliver services at a business such as a pharmacy. Use instead of creating a separate encounter place for each business.	nKPI and OSR	Yes
Community Health Centre	In person	Use at community health centres to record a clinical consultation where the patient attended the health service.	nKPI and OSR	Yes
Community Services Centre	In person	Use to record where workers from the health service deliver services at a Community Services Centre. Use instead of creating a separate encounter place for each centre.	nKPI and OSR	Yes
Contact Attempt Unsuccessful - no client contact	None	Use to record attempted contact.	None	No
Court	In person	Use to record where workers from the health service deliver services at court. Use instead of creating a separate encounter place for each court.	nKPI and OSR	Yes
Day Aged Care Centre	In person	Use to record where workers from the health service deliver services at a day aged care centre. Use instead of creating a separate encounter place for each centre.	nKPI and OSR	Yes
Day Procedure Centre (Free-standing)	In person	Use at day procedure centres to record a clinical consultation where the patient attended the centre.	nKPI and OSR	Yes
Dental Room	In person	Use to record a clinical consultation where the patient attended a consulation in the dental room.	nKPI and OSR	Yes
Dispensary - no client contact	None	Use to record dispensary work for a patient.	None	No
Drug and Alcohol Agency	In person	Use at drug and alcohol agencies to record a clinical consultation where the patient attended the health service.	nKPI and OSR	Yes
Health Care Practitioner Office (any discipline)	In person	Use to record a clinical consultation for a health care practitioner that does not fit any other category.	nKPI and OSR	Yes

Table 293. Encounter modes (continued)

Encounter Mode	Consultation Delivery	Description	Included in reports	Automated patient status updates?
Health Service	In person	Use for non-indigenous health services to record a clinical consultation where the patient attended the health service.	nKPI and OSR	Yes
Hospital - All types	In person	Use in hospitals to record a clinical consultation where the patient attended the hospital.	nKPI and OSR	Yes
Hospital - Emergency Department	In person	Use in hospital EDs to record a clinical consultation where the patient attended the ED.	nKPI and OSR	Yes
Hospital - General Practice	In person	Use in hospital-based general practices to record a clinical consultation where the patient attended the practice.	nKPI and OSR	Yes
Hostel	In person	Use to record where workers from the health service deliver services at a hostel. Use instead of creating a separate encounter place for each hostel.	nKPI and OSR	Yes
Inreach	In person	Use to record inreach consultations.	nKPI and OSR	Yes
Mobile Clinic	In person	Use to record where workers from the health service go out in a mobile clinic to deliver services. Use instead of creating a separate encounter place.	nKPI and OSR	Yes
Nursing Home	In person	Use to record where workers from the health service deliver services at a nursing home. Use instead of creating a separate encounter place for each centre.	nKPI and OSR	Yes
Other	In person	Use to record where workers from the health service deliver services at a service encounter or physical place that is not otherwise described, read "Other means" or "Other service delivery mode".	nKPI and OSR	Yes
Outreach	In person	Use to record where workers from the health service go out into the community to deliver services. Use instead of creating a separate encounter place.	nKPI and OSR	Yes
Prison	In person	Use to record where workers from the health service deliver services at a prison. Use instead of creating a separate encounter place for each prison.	nKPI and OSR	Yes

Table 293. Encounter modes (continued)

Encounter Mode	Consultation Delivery	Description	Included in reports	Automated patient status updates?
Renal Dialysis Centre (Free-standing)	In person	Use to record where workers from the health service deliver services at a freestanding renal dialysis centre. Use instead of creating a separate encounter place for each centre.	nKPI and OSR	Yes
Respite Care Facility (non-Hostel or Nursing Home)	In person	Use to record where workers from the health service deliver services at a respite care facility. Use instead of creating a separate encounter place for each facility.	nKPI and OSR	Yes
School	In person	Use to record where workers from the health service go to a school to deliver services. Use instead of creating a separate encounter place for each school or youth club.	nKPI and OSR	Yes
Supported residential accommodation	In person	Use to record where workers from the health service deliver services at supported residential accommodation. Use instead of creating a separate encounter place for each centre.	nKPI and OSR	Yes
Telehealth Video	Video conferencing	Use to record services where the contact between the Communicare provider and the patient was using video conferencing.	nKPI and OSR	Yes
Telehealth - Provider	Telephone or by another device such as a computer, with or without video	Use to record remote telehealth consultations during the COVID-19 pandemic.	nKPI and OSR	Yes
Telehealth - Recipient	Facilitator only	Use where a consultation happened between a provider elsewhere and a patient, such as between a specialist and patient at a hospital, and the Communicare provider only facilitated the contact by providing a room and remote conferencing equipment.	nKPI and OSR	Yes
Telephone	Telephone	Use to record a clinical consultation performed over the telephone between the Communicare provider and the patient.	nKPI and OSR	Yes

Adding and Editing Encounter Places and Modes

Create a Service Encounter Place and associate it with one or more encounter modes *(on page 866)*.

Adding Encounter Places

To add an Encounter Place:

1. Select **File > Reference Tables > Encounter Place**.
2. In the **Encounter Place** pane, click  Add.
3. In the **Description** field, enter the name or a description of the Encounter Place.
4. Enter address information for the Encounter Place. The address details for each Encounter Place are used in letters when the clinic address is selected, and on prescription forms. The address defined in the system parameters is displayed by default.
5. Select whether this is a **Service Encounter Place** or **Administrative Encounter Place**.
   For more information, see Encounter Place *(on page 865)*.
6. If you are using medication requests, and patients will be able to collect their medications from this location, set **Medication Pickup Location**.
7. If required, from the **Belongs To** list, select the parent Administrative Encounter Place. Selecting a parent Encounter Place places the current Encounter Place immediately below the parent in the encounter place hierarchy.
   If a parent Administrative Encounter Place is selected, you can filter service recording and appointments by a group of Encounter Places. Some reports can also be filtered by group.
8. For the NT only, for Service Encounter Places:
   a. If required, from the **Locality Group** list, select a locality group. This effectively makes this encounter place the home health centre for all patients whose locality belongs to the locality group assigned to this encounter place.
      - Locality groups may be assigned to only one encounter place.
      - A patient may have only one home health centre, which means localities may not overlap where more than one of the locality groups they belong to are assigned to an encounter place.
   b. If this encounter place uses MeHR, in the **MeHR Site ID** field, enter the identifier for this Encounter Place used when data is sent to MeHR.

      This is available only if the `MeHR module` is enabled and the user belongs to a user group for which `MeHR` and `MeHR Administration` system access rights are enabled.
   c. In the **DHF Health Service Code** field, enter the code used for the NT Health Key Performance Indicator Data Export.
9. For Service Encounter Places:

   a. If required set **Record Storage** to indicate that paper patient records are stored at this encounter place. This encounter place will be available for selection as a record storage site in Biographics.

   b. If required, in the **HIC Minor Location ID** field, enter the identifier used for this Encounter Place when claims are sent to Medicare.
      This number is generated and provided by Communicare. The field is available only if the Electronic Claims module is enabled and the user belongs to a user group for which Electronic Claims and Electronic Claims Administration system access rights are enabled.

   c. If required, in the **Device Identifier** field, enter a PRODA device ID for this encounter place that overrides the global PRODA Device ID for the organisation set in Services Australia system parameters *(on page 827)*. This device ID will be used for online claiming.

   d. If your practice is in a rural or remote location, and a patient is under 16 or has a CentreLink or Health Care Card, your health service may be eligible to claim additional bulk billing incentives. To have Communicare

automatically prompt you to include additional MBS incentive items for eligible patients when completing a service, add values to all three of the **Incentive Items** fields for the same item type:

- **Medical** - for example, for MM 6 `75857`
- **Radiology** - for example, for MM 6 `64994`
- **Pathology** - for example, for MM 6 `75863`

> **Note:**
> Values for MBS incentive items can also be added for particular encounter places. Values added for MBS incentive items for the encounter place *(on page 872)* override values specified for the organisation *(on page 838)*.

If no values are specified for the encounter place, the incentive items for the organisation *(on page 838)* are used. If no values are specified for either the encounter place or the organisation, the automatic addition of extra MBS incentive items to claims is disabled.

> **Tip:**
> To find the incentive items you need, find your location using the Modified Monash Model and match your location to the code. For example, at 1 January 2022:

Item type	MM 3-4		MM 5		MM 6		MM 7	
	MBS Item	Benefit	MBS Item	Benefit	MBS Item	Benefit	MBS Item	Benefit
GP	75855	$10.50	75856	$11.15	75857	$11.80	75858	$12.50
Diagnostic Imaging	64992	$9.85	64993	$10.45	64994	$11.05	64995	$12.15
Pathology	75861	$9.85	75862	$10.45	75863	$11.05	75864	$12.15

> For more information, see Services Australia - Rural bulk billing incentives changes.

e. If this encounter place is a hospital, in the **Hospital Facility ID** field, enter the identifier used for Inpatient claiming. Ensure that the identifier entered is a valid Hospital Provider Number.

f. If required, in the **Location Code** field, enter a location code.
This code is not used in standard Communicare reports, but can be extracted for SQL reports and used for any location coded dataset.

g. If required, in the **Facility Code** field, enter the Facility Code for the Encounter Place.
This code is not used in standard Communicare reports, but can be extracted for SQL reports and used for any facility coded dataset.

h. If required, from the **Facility Type** list, select the type of ANZSIC healthcare facility.

i. If required, in the **AIR Provider No** field, enter a provider number to be used for all claims recorded against this encounter place.
This value overrides the Default AIR Provider and the provider numbers of the clinicians who recorded and claimed the immunisation. For more information, see Australian Immunisation Register (Online Claiming) *(on page 433)*.

j. If required, from the **Default AIR Provider** list, select the provider number for the provider who will be used for all AIR claims created for this encounter place, unless an **AIR Provider No** has been recorded. Only providers who have a current DOH Provider Number against this encounter place are listed.

k. If required, from the **Default NCSR Provider** list, select a healthcare provider with a Medicare Provider Number (MPN), for whom nurses and medical practice or lab staff will act as a delegate when accessing the NCSR.

10. For WA only, if required, in the **Establishment Code** field, enter the code assigned by the WA Department of Health.
11. From the **HPI-O Number** list, select the current Healthcare Provider Identifier - Organisation number assigned to the encounter place by Medicare.

    Click  Revalidate HPI-O to validate a previously entered HPI-O Number with Medicare, which will update the last checked date against the HPI-O Number and may result in new statuses or even a new number. See Healthcare Identifier Service *(on page 632)* for more information. Some functions such as My Health Record and CDA documents require HPI-O numbers to match the HPI-O in NASH Org Certificate *(on page 857)*.
12. Click **Close**.

The new Encounter Place is added to the **Encounter Place** list in the **Encounter Places** window.

Next, add at least one Encounter Mode to the Encounter Place.

Adding Encounter Modes to Encounter Places

To add encounter modes to an Encounter Place:

1. In the **Encounter Places** window, select the Encounter Place you're working with.
2. In the **Encounter Mode** pane, click  Add.
3. In the new row, from the **Encounter Mode** list, select an encounter mode. See Encounter Mode *(on page 866)* for more information.
4. If your health service has a receptionist and you want to be able to record when patients arrive for appointments, set **Arrival Times**. Times are recorded in the **Service Record Maintenance** window.
5. If actual times of arrival, service start and service end are not to be recorded, set **Dates Only**.
6. Set **Enabled**.
7. Click **Save**.

Editing Encounter Modes

You can edit whether you want to record times of arrival, service start and service end for an encounter mode, or disable the encounter mode.

To add encounter modes to an Encounter Place:

1. In the **Encounter Mode** pane, select the encounter mode you want to change.
2. If required, set or deselect **Arrival Times** or **Dates Only**.
3. If required, deselect **Enabled**.
4. Click **Save**.

Encounter Program

An encounter program is a special program that is conducted within a health service. The program may have external funding but is administered within the health service and the health service is required to report separately on the activities of providers who are part of the program.

All encounters (services) between a provider and a patient have a single Encounter Place and a single Encounter Mode. In addition, some encounters are associated with a special program, for example, *Bringing Them Home*.

Access to specific programs and their details is restricted by user group.

To add a new program:

1. In **File > Reference Tables > Encounter Program**, click Add.
2. In the **Program Name** column, enter the name of the program, for example *Child Health*.
3. In the **Definition** column, click Ellipsis and in the **Definition** window, enter a program description and click **OK**.
4. In the **Export Code** column, enter an export code for use in reports.
5. Click **Save**.

The new program is added.

In most circumstances, you won't want to set a default program for your health service.

However, if required you can set a program as the default for your health service. To set a particular program as your default:

1. In the main toolbar, double-click the status bar.
2. In the Provider, Place and Mode selection window, from the 'Program' list select the program you want to use as a default.
3. Click Close.

The status bar displays the program.

If your user group has the required program rights enabled, you can record that a service is part of a particular program if required. Administrators set the program rights for user groups that enable users to access and edit particular programs. See User Groups *(on page 842)* for more information.

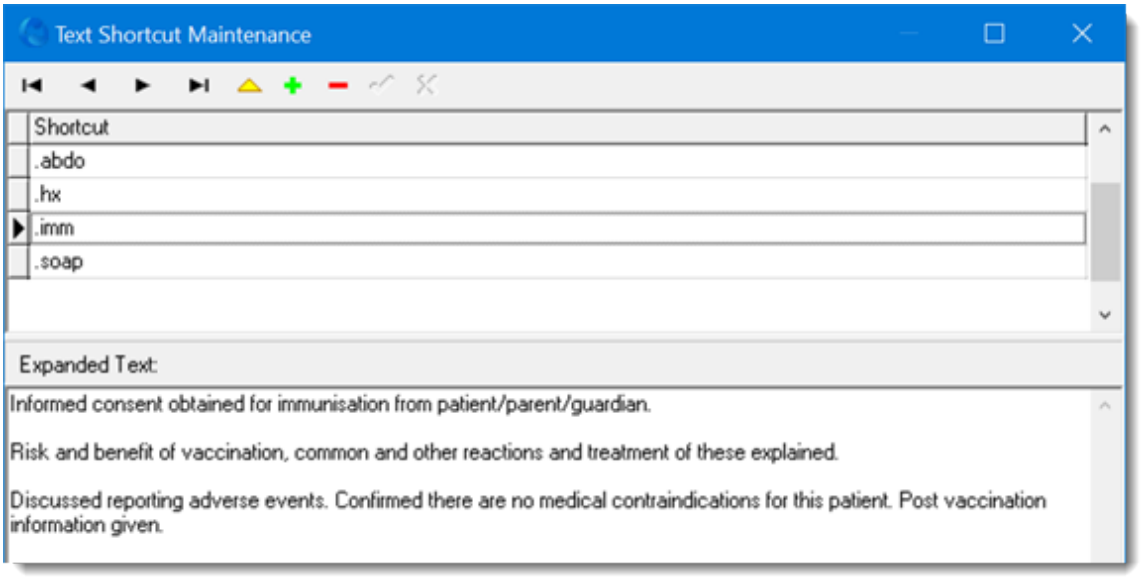
Text Shortcuts

Add or modify the text shortcuts for commonly used blocks of text available in Communicare. Text shortcuts can be used by clinicians in progress notes and letters.

Only users belonging to a user group with the **Reference Tables** system access right can edit the list of text shortcuts.

To edit the available text shortcuts:

1. Select **File > Reference Tables > Text Shortcuts**.



2. In the **Text Shortcut Maintenance** window, the **Shortcut** pane lists the shortcuts available on your system. Select a shortcut to display the text that will be substituted in a progress note or letter in the **Expanded Text** pane.
3. If required, in the **Expanded Text** pane, edit the text that will be substituted for the shortcut.

> **Note:**
> Don't add text that is a shortcut identifier, such as `.hx`, into the expanded text.

4. If required, add a new shortcut:
    a. Click Add.
    b. In the new **Shortcut** row, type a unique name for the shortcut of up to 10 characters.

> **Tip:**
> Shortcuts cannot contain spaces. To avoid unintentional use of a shortcut when typing progress notes and letter items, use a naming convention. For example, start the shortcut with a `.` character or other identifier, such as `/` or `,`.

    c. In the **Expanded Text** section, add the text that will be substituted for the shortcut.

    Your expanded text can contain up to 1024 characters.

5. Click **Save**.

For information about using text shortcuts in progress notes and letters, see Using Text Shortcuts *(on page 142)*.

Dosage instructions

Use the **Dosage Instruction** window to review abbreviations or short codes for use when prescribing and add new abbreviations.

There are three types of abbreviation in Communicare, indicated with the following colours:

- Black - default abbreviations that can be edited by the Communicare Administrator and are available to everybody
- Red - abbreviations that are only available to the user who created them. Only the user who created the abbreviations can edit them.
- Blue - abbreviations created by a user that have been made public and are available to all other users. Only the user who created the abbreviations can edit them.

Add any abbreviation or short code that your clinicians like to use when prescribing, for example, `BD` for *twice a day*, or `CF` for *with food*.

To add a new abbreviation:

1. Select **File > Reference Tables > Dosage Instructions**.
2. Click  Add.
3. In the new row:
    a. In the **Abbreviation** column, enter the new abbreviation. For example, `BD`.
    b. In the **Text** column, enter the full text that will be displayed in the dosage instructions. For example, `twice a day`.
    c. To also make the abbreviation available to other Communicare users, set **Public**.
4. Click **Save and Close**.

When prescribing, your clinicians can now use the abbreviation in the **Dosage Instructions** field and the full text is printed.

Medicare Benefits Schedule Shortlist

Because the Medicare Benefits Schedule (MBS) is so big, you can control the order in which Medicare Benefits Schedule (MBS) items are displayed in Communicare and add short descriptions that are meaningful to your context.

In the **File > Reference Tables > Medicare Benefits Schedule > Shortlist MBS Items** window, you can set the items you are likely to require to make selection easier when using the schedule. Selected items are listed first.

Each shortlisted item must be given a short description, which you will see in selection lists when using the MBS.

You can also specify an item order. The selected MBS items are sorted into order sequence: give frequently used items low numbers to make then appear near the top of lists without the need to scroll.

To edit the text in the **Short Description** or **Item Description** fields, click three times and enter the updated text.

To increase the row height, increment the number in the **Row height** field.

Note:
Items that have subsequently been deleted by Medicare Australia are shown in grey. If a deleted item is currently shortlisted, it is displayed in red: remove these items from the shortlist.

Medicare Benefits Schedule Search

The Medicare Benefits Schedule (MBS) items can be quickly searched in order to make a selection, when browsing by category and maintaining the shortlist is not relevant to you.

The simpler item search window may be accessed from locations such as the Service Record dialog when you need to find and add a claim item that is not shortlisted.

Click the button in the view column to display the full MBS Item description of the selected item.

Double clicking an item or pressing 'Enter' will select it and exit the window.

Medicare Benefits Schedule Import

Communicare is initially supplied with the MBS already loaded. Updated versions can be obtained from the Portal.

To update the MBS version that Communicare uses:

1. Download the most recent MBS data file from Communicare User Portal - Help and Support:
    a. Log on to Communicare User Portal with your username and password (register online if you do not have these).
    b. On the **Help and Support** tab, in the **MBS** tile, click **Download**. An archive with the XML file is downloaded to your computer.
    c. Extract the XML file to your computer.
2. In Communicare, select **File > Reference Tables > Medicare Benefits Schedule > Import MBS**
3. Follow the instructions to download the file and import into Communicare.

Note:
If you are running in a Citrix client environment, directories mounted on a client device, including CD-ROM, DVD or a USB memory stick may not be available to users unless Citrix is configured for client drive mapping. Please refer to Citrix documentation or ask for their support to configure client drive mapping.

Private Billing Configuration

Use **File > Reference Tables > Private Billing** options to modify the fee schedule *(on page 879)* and private billing types *(on page 881)* used by the **Private Billing** module.

Private Billing Schedules

Add fee schedules for private billing.

Use **File > Reference Tables > Private Billing > Fee Schedule** to list private billing fee items and the corresponding linked MBS items for private billing.

Link a fee item to a Medicare Benefits Schedule (MBS) item so a patient can claim a Medicare refund for the linked MBS item. For example, a Private practice short consult can be linked to MBS Item 3 - Brief Consult Level A. You can link a maximum of 2 MBS items to each fee item.

For each fee item, you can set a different fee for each billing type. For example, a private practice might charge $50 for a Standard Consultation to an individual and $75 for Workers Compensation because of the administrative tasks involved.

If you didn't add your MBS Favourites when you activated the **Private Billing** module, add each billing item individually.

To add a fee item:

1. Select **File > Reference Tables > Private Billing > Fee Schedule**.
2. In the **Fee Schedule** window, click ✚Add.
3. In the **Fee Schedule Details** window, in the **Item Code** field, enter a code for the fee item which can be a combination of characters and numbers.

4. In the **Descriptor** field, enter an item name.
5. If you want to link the fee item to an MBS item, in the **MBS Item Number** field, click Ellipsis and select the related MBS item from the **MBS Browser** window. The MBS schedule fee is added to the **Schedule Fee** field.
6. Add a billing type:
    a. Click Add.
    b. From the **Billing Type Name** list, select a billing type. If the required billing type is not listed, add it. See Billing Types *(on page 881)* for more information.
    c. Set the fee for the item. Either:
        - In the **Item Fee** field, enter the private fee.
        - If the private fee is linked to the MBS fee, set **Schedule Fee**. If you set this option, and the private fee is linked to an MBS item, the fee is automatically updated to the latest MBS Schedule Fee when you do an MBS Import.
    d. If the item incurs the GST, set **Taxable**. If set, a 10% GST is calculated from the amount set for the Item Fee (ensure that the Item Fee includes the 10% GST). The private billing invoice displays the GST component for the selected billing type of the fee item.
7. Repeat step 6 for each billing type associated with the fee item.
8. Click Save.

The new fee item is added to the fee schedule.

In the **Fee Schedule** window, you can search for a fee item using any text displayed in the **Fee Schedule** window. In the **Search** field, enter an item code, descriptor, MBS item number or schedule fee to limit the items listed. Delete the search phrase to display all items again.

If you added your MBS Favourites when you activated the **Private Billing** module, you can edit these records to add a private billing fee. You can also update fee items that you have added. To update a fee item:

1. Select **File > Reference Tables > Private Billing > Fee Schedule**.
2. In the Fee Schedule window, double-click the fee item you want to update.
3. In the Fee Schedule Details window, click in any field you want to edit and update the value.
4. If required, to remove a billing type, select it in the Billing Type table, and click Remove.
5. Click Save.

If a fee item is not in use by another record, you can delete it so that the item cannot be used for future billing. To delete a fee item:

1. Select **File > Reference Tables > Private Billing > Fee Schedule**.
2. In the Fee Schedule window, select the fee item you want to remove.
3. Click Remove.
4. In the confirmation window, click **Yes**.

The fee item remains in the database so that there is no impact on existing records that are linked to that fee item.

To view deleted fee items, in the **Fee Schedule** window, set **Show Deleted**.

Billing Types

The Billing Type is a lookup list of all the entities to whom service charges can be billed. For example, Private Individual, Private Health Insurance, WorkCover, Department of Veterans Affairs and so on.

Create at least one private billing type. If required, add other billing types, such as WorkCover as an organisation.

To add a new billing type:

1. Select **File > Reference Tables > Private Billing > Billing Type**.
2. In the **Billing Type** window, click Add.
3. In the newly created row, in the **Billing Type Name** column, enter a name. For example, `Private`.
4. In the **Billing Type** column, select either **Individual** or **Organisation**. For example, `Individual`.
5. If the service incurs the GST, set **Taxable**. When set, a GST of 10% is automatically added to the invoice for this billing type.
6. If required, repeat steps 2-5 to add other billing types. For example, `WorkCover` as an `Organisation`.
7. Click Save.

For each billing type that is an organisation, there must be a record in the address book. To add organisations for private billing to the address book, select **File > Address Book** and click **Add New**. For more information, see Add and edit an address *(on page 339)*.

To edit a billing type:

1. Select **File > Reference Tables > Private Billing > Billing Type**.
2. In the **Billing Type** window, select the row for the billing type you want to edit.
3. Edit the required values.
4. Click Save.

If a billing type is not in use by another record, you can delete it so that the item cannot be used for future billing. To delete a billing type:

1. Select **File > Reference Tables > Private Billing > Billing Type**.
2. In the **Billing Type** window, select the row for the billing type you want to delete.
3. Click Remove.
4. In the confirmation window, click **Yes**.
5. Click Save.

The billing type remains in the database, so there is no impact on existing records that are linked to that billing type.

To view deleted billing types, in the **Billing Type** window, set **Show Deleted**.

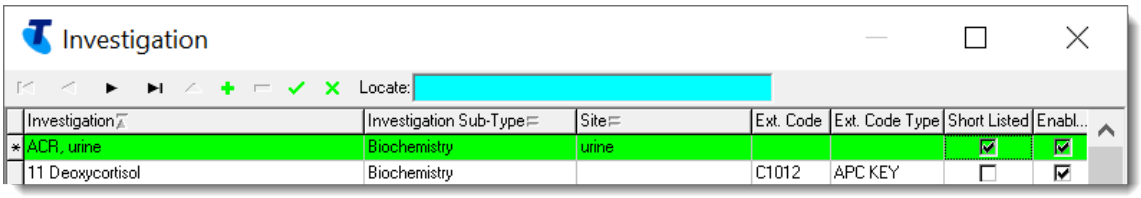
Investigations

Investigations can be requested by a provider from within a patient's clinical record. Use the **Investigation** reference table to define investigations.

New investigations can be created and existing investigations disabled or updated.

To add a new investigation:

1. Select **File > Reference Tables > Investigations > Investigations**.
2. In the **Investigation** window, click Add.



3. In the blank row:
   - In the **Investigation** field, enter the name of the new investigation. Start the investigation name with an uppercase letter to ensure it appears in the correct sort position.
   - From the **Investigation Sub-Type** list, select a subtype, for example `Biochemistry`.
   - In the **Site** field, enter a site if required, for example `serum`.
   - Leave the **Ext. Code** and **Ext. Code Type** fields blank. These columns relate to the initial import of pathology types and are no longer required.
   - For commonly used investigations, set **Short Listed**, so that they appear in the short list in the request window and can be easily selected.
   - If you want the investigation to be available immediately, set **Enabled**.
4. Click **Save**.

The new investigation is added.

Add at least one keyword to each investigation so that it can be found by clinicians.

> **Remember:**
> Also include any common abbreviations used for the investigation as keywords.

1. Select **File > Reference Tables > Investigations > Investigation Keywords**.
2. In the **Keyword** grid, select a suitable keyword, or add a new keyword if there is nothing suitable.
3. In the **Investigation** grid, add the investigation you just created.
4. Repeat steps 2-3 until you've added all suitable keywords.
5. Click **Save**.

For more information, see Investigation Keywords *(on page 882)*.

Investigation Keywords

Investigations that are commonly ordered together can be grouped in Communicare using investigation keywords.

To display the list of investigations grouped by keyword, select **File > Reference Tables > Investigations > Investigation Keywords**.

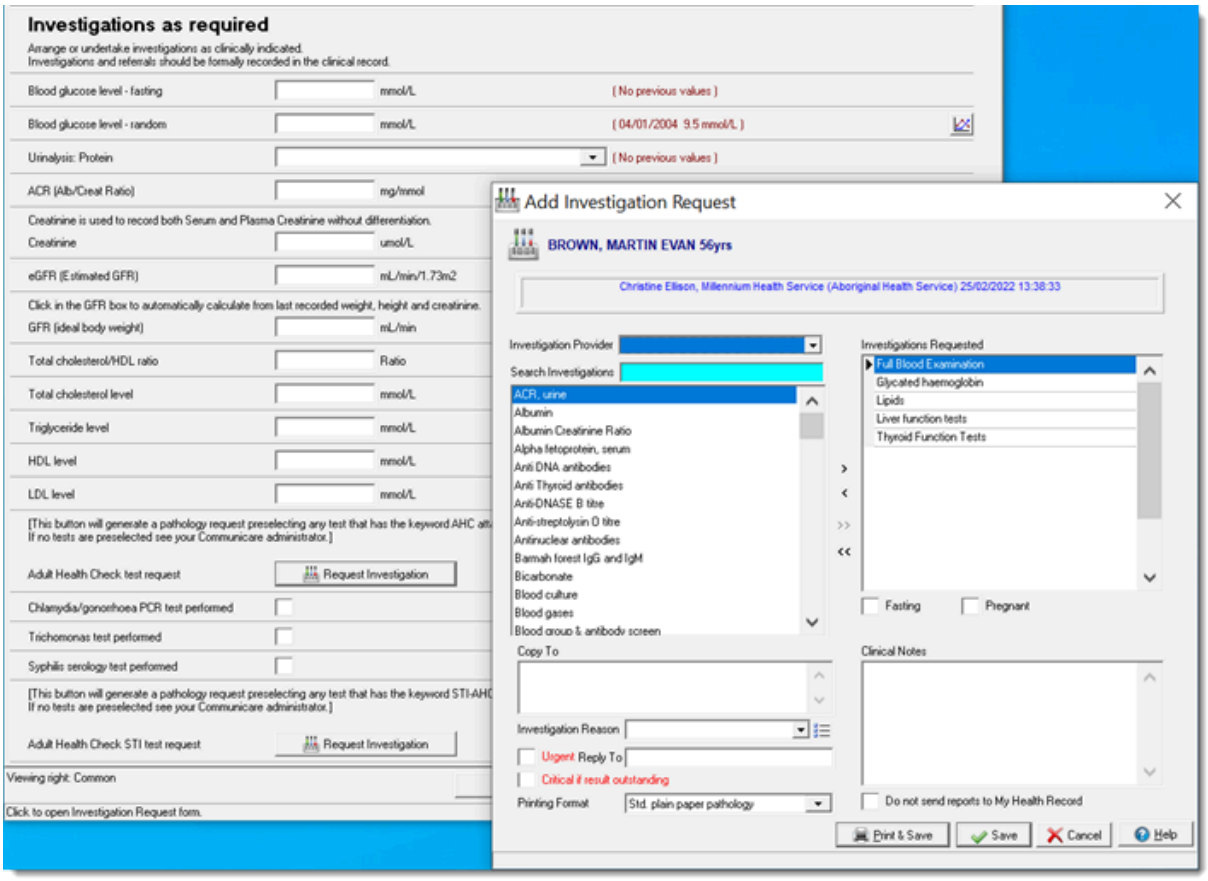
Investigation keywords are used throughout Communicare. For example:

- From **Pathology** or **Imaging** in the clinical record, clinicians can use the investigation keyword to search for a set of investigations.
- Administrators can add an investigation keyword as a qualifier to a clinical item so that clinicians can order all investigations with a particular investigation keyword from the clinical item.

> **Tip:**
> Do not mix pathology and imaging in one investigation keyword. If you do, clinicians will have to edit any request that uses that keyword because pathology and imaging investigations use different request forms.

AHC investigation request in Check up;Aboriginal & TSI adult clinical item

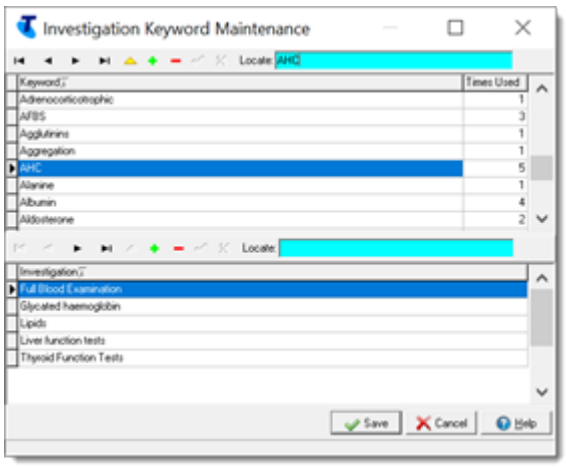
The **Check up;Aboriginal & TSI adult** clinical item includes a **Request Investigation** button for **Adult Health Check test request**. When clinicians click this button, the associated tests are automatically selected in the **Add Investigation Request** window.



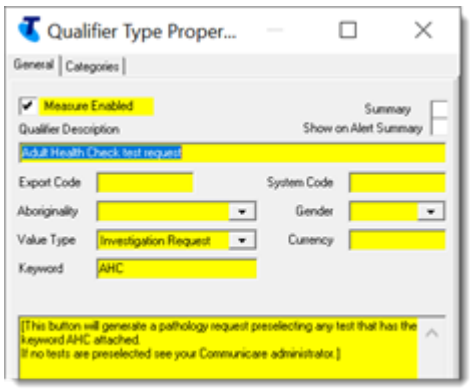
How these tests are associated with the clinical item:

- In **File > Reference Tables > Investigations > Investigation Keywords**, the investigation keyword *AHC* is created which groups the relevant investigations.

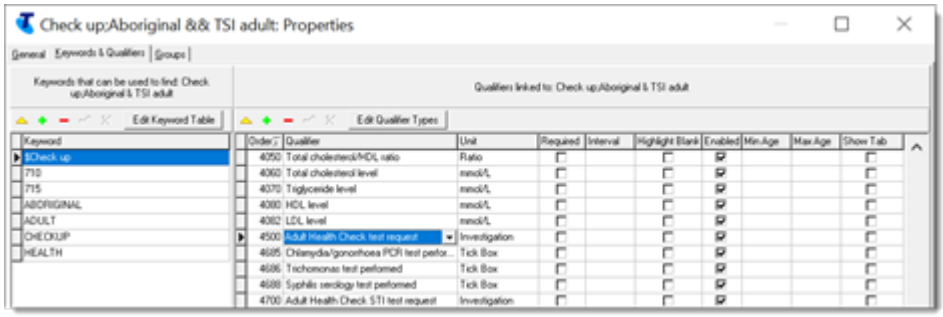
> **Note:**
> These are all pathology tests only.



- In **File > Reference Tables > Investigations > Qualifier Types**, the *Adult Health Check test request* qualifier type is created and the *AHC* investigation **Keyword** is added to it. It is also give a **Value Type** of `Investigation Request`.



- In **File > Reference Tables > Investigations > Clinical Item Types > Keywords & Qualifiers** tab, the *Adult Health Check test request* qualifier type is added to the clinical item.



Clinical Item Maintenance

Clinical items are an essential building block for providing a care pathway with the clinical record workflow.

Clinical items are developed using standards and guidelines that inform the care pathway and the data that must be recorded.

At a minimum, Communicare uses ICPC-2 PLUS for central clinical items. Clinical items for enterprise customers are also linked to SNOMED CT codes.

Using clinical items, clinicians can record a clinical event in a patient's record using structured data. Clinical items incorporate qualifiers to ask relevant clinical questions and record responses in a structured way.

Before editing or adding clinical items, you should understand the impact on related clinical record workflow building blocks:

- Recalls - a clinical item that has a planned date that has not been actioned yet. A recall is listed in the patient's clinical record in the **To Do** list. It can be triggered from a clinical item or a particular qualifier (in addition to other ways in which a recall can be triggered.)
- Reports - measure the programs and services provided; enable proactive recall follow-up; enable easy reporting to government organisations.

  Scheduled reports - a way of sending structured data to people for information or action.
- Imaging and pathology - requesting and reviewing
- Charts - measurements recorded as qualifiers in a clinical item can be charted. For example, INR, qualifier or centile charts.
- Medications - prescribe, chart, administer and supply
- Letters - a way of collating structured and unstructured data recorded in the patient's clinical record into a single letter.
    - Care Plans - a type of letter template that can be revised as care needs change. A patient can have one care plan for each topic.
- Medicare - a way of generating revenue for the programs and services provided.

Clinical Item Type

A clinical item type is a predefined value that a clinical item for a patient can take.

For example, 'Glue ear' is defined as a clinical item type, so a patient can be recorded as having glue ear by adding the 'glue ear' clinical item to the patient's clinical record.

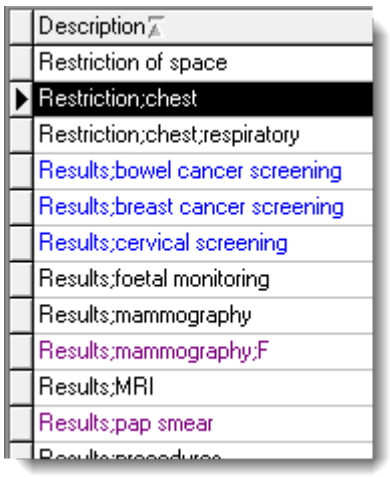
To display the **Clinical Item Type Maintenance** window, select **File > Reference Tables > Clinical Item Types**.

In the **Clinical Item Type Maintenance** window:

- To find a clinical item type, whether disabled or not, in the **Locate** field, enter a search term.
- To find an enabled clinical item type, click  Clinical Terms Browser.
- To display the properties of a clinical item type or edit it, double-click the item, or click  Edit Row.
- To disable an item, in the **Properties** window, deselect **Enabled**.
- To hide all disabled clinical items, set **Hide Disabled**.

Clinical Item Colour Coding

In the **Clinical Item Type Maintenance** window, clinical item types are colour coded.



- Black - ICPC-2 PLUS terms
- Blue - other items distributed by Communicare, referred to as Central items
- Purple - local terms
- Grey - all inactive terms

Clinical Item Type Properties

Clinical items have a set of structured properties that define the information that can be included in a clinical item, group items, link the item to ICPC-2 PLUS and SNOMED, and enable Communicare to perform advanced calculations and reporting, enable recalls and referrals, control access, and so on.

To display **Clinical Item Type Properties**, in the **Clinical Item Type Maintenance** window, double-click an item or select an item and click Edit.

Note:
Items with a record number of 1,000,000,000 or greater are centrally maintained by Communicare and have only limited local editing rights.

General tab

On the **General** tab, set the basic properties of a Clinical Item Type, including:

- **Formal Terms** - enter the name or rubric for the item, which is used to give a detailed and exact definition of what the item means and when it should be used. For example, `?Pregnancy` or `Abrasion;corneal`.
- **Natural language** - a more natural description of the term. It can be used in letters, for example, where a more user-friendly term is required.
- **Definition** - describe the clinical item unambiguously, so that misuse through misunderstanding does not occur. The definition may contain drawings and pictures.
- **Class** - select what sort of thing the item is. For example, a record of a `Procedure` that has been performed, or a `Condition` that has been diagnosed.
- **Topic** - select the topic, that is an arbitrary classification which helps organise a patient's clinical information.
- **Recallable** - determines if the item can be used as a recall. This option is only visible for items with a class of `Procedure`, `Immunisation` or `Referral`.

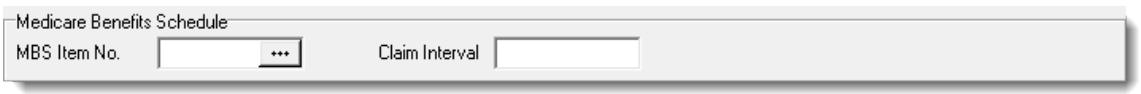
- **Allow Recall Expiry** - determines if a user can set a future expiry date for a recall of this type that when passed removes the recall from the patient's record. This option is only visible for items with a class of `Procedure`, `Immunisation` or `Referral`.
- **Enabled** - determines if the item can be added to a Clinical Record. Deselecting this option does not remove the item from patient files, but the item can't be used to record new information. Centrally disabled items cannot be enabled locally.
- **Cost** - optional value used for reporting and analysis.
- **Viewing Right** - right required to view the clinical item.
- **Record for occurrence** - record a clinical item with a date and time, or as date only. The default is date only.

> **Tip:**
> To enable multiple observations to be recorded for a qualifier in a day, set to **Date and Time**.

- **Serial Number Mandatory** - for items with a class of `Immunisation`, set to require clinicians who administer a vaccine to record the serial number of that vaccine in the clinical item. Once enabled, clinicians must include a serial number in the clinical item for any new immunisations of that type performed at the health service.

Click **Advanced** to display the following options:

- **Export Code** - a code that may be used when exporting data to another system. For example, it is used when exporting data to the CCDM, in which case it holds an ICPC code. For more information, see Export codes *(on page 907)*.
- **System Code** - an internal code used by Communicare to identify items that are used in calculations. Leave blank unless instructed otherwise. For more information, see System codes *(on page 905)*.
- **Record No.** - Communicare's internal reference number.
- **Critical Referral** - enabled when a Referral type item is added or edited. Use to set the item as critical. The standard referrals report can report on these items.
- **Item Interval** - the interval required since the last completed clinical item in order to be able to complete the new clinical item. It is used to allow a clinic to define a required period in which an item should be completed. The item can only be completed at the end of the required interval. If an attempt is made to complete this item during the item interval, the item generates a recall with the comment `Cannot complete before DD-MON-YYYY`.
- **Letter Type** - the letter type to be used when adding this clinical item to the patient's record. If not set, **Save & Write Letter** is not visible.
- **Rule Code** - used to identify a program which has enrolment and exit behaviour, such as pregnancy and drug and alcohol programs. For more information, see Rule codes *(on page 908)*.
- **Picture** - add a picture for the clinical item type to the **Picture** tab of the **Clinical Terms** Browser. The image must in the format bmp, ico, emf or wmf and be no larger than 60x60 pixels. You must also add an image for the related Clinical Item Topic.
- **Medicare Benefits Schedule**:

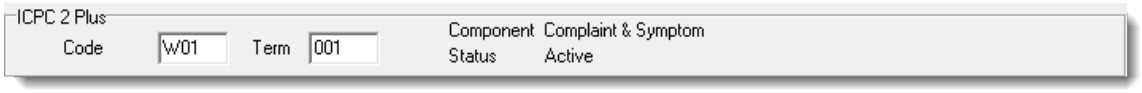


  - **MBS Item No.** - the MBS item to be claimed when the clinical item is completed. If there is a number entered here, only a provider with a Provider Number will be able to complete this item, and on completion, the specified item is automatically selected for the provider to claim electronically. If an item is completed by

a provider who doesn't have a Provider Number, the item generates a recall with the comment `Only a doctor can complete this`.

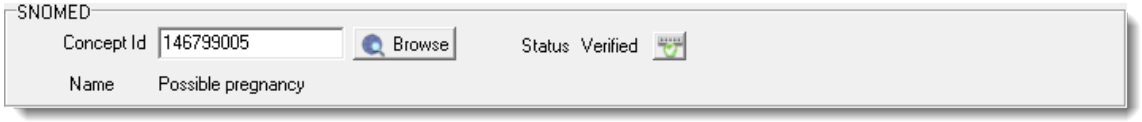
- **Claim Interval** - the interval for the MBS item, used when Medicare Australia says that the MBS item cannot be claimed more often than the Claim Interval. If an attempt is made to complete this item by a provider with a Provider Number within the claim interval, the MBS item is not automatically selected for claiming.

- **ICPC 2 Plus**:



  - **Code** and **Term** - ICPC-2 PLUS code for this term. If a clinical item doesn't have a complete code, it doesn't appear on reports that look for this code and decision support is not available.

- **SNOMED**:



  - **Concept Id** and **Name** - mapping between the ICPC-2 PLUS code and the equivalent SNOMED concept. The SNOMED concept ID is validated using the SNOMED terminology server specified in Web Services > SNOMED Terminology *(on page 828)*. When you enter a valid concept ID of 6-18 digits, Communicare connects to the terminology server, pulls the correct concept name from the server and updates the concept name and status.

    - **Browse** - click to connect to the terminology server configured for your organisation where you can search for the relevant concept ID.
    - Validate Status - click to validate the concept ID and update the concept name and status from the terminology server. Only verified concept IDs have a concept name: invalid concept IDs cannot be saved.

  If a clinical item doesn't have a SNOMED concept ID, it doesn't appear on reports that look for this concept ID.

  Central items mapped to SNOMED CT are mapped centrally; map only local clinical items using these settings.

Keywords & Qualifiers tab

The keywords grid lists the terms that can be used to locate this item or adds the clinical item to a shortcut button. For more information, see Clinical Item Keywords and Shortcuts *(on page 889)*.

The qualifiers *(on page 897)* grid lists any qualifiers that are linked to this item. Qualifiers add additional meaning to a Clinical Item Type. A Clinical Item Type can have any number of qualifiers associated with it. For example, the clinical item `Pregnancy;confirmed` may have associated qualifiers such as `Date of LNMP`, `Gestation`, `Foetal heart rate`, and so on.

The qualifier types table shows the following information:

- **Order** - a number used to sort the qualifiers
- **Qualifier** - qualifier term
- **Unit** - units in which the qualifier is measured, for example, Date, weeks, bpm.
- **Required**:

    - Qualifiers cannot be marked as Required if the clinical item type is not recallable, nor can they be used if the clinical item type is a referral.
    - If a qualifier is not required, it cannot have a required interval.
    - When a clinical item is recallable and has required qualifiers, making the item not recallable clears the required flag on the qualifiers.
    - When designing a clinical item that has required qualifiers, note that the behaviour of that qualifier does not commence until the day after the qualifier was enabled. To see the effective date, right-click and select **Show Hidden Columns**.
- **Highlight Blank** - set to highlight a qualifier when it has no data. This is useful to draw attention to important values on very long forms.
- **Enabled** - use to hide a qualifier that has been used in the past, but is no longer needed. No patient data is lost and the data is visible when older items are edited. However, the qualifier will not appear for use in the future. Disabled qualifiers are displayed in grey.
- **Min Age** and **Max Age** - determine whether the qualifier should be shown in the clinical item. A patient who is below the minimum age or above the maximum age will not have the qualifiers shown when that item is added.
- **Show Tab** - determines whether this qualifier should appear on the clinical item as a new tab. Note that this field can only be set for qualifiers that are of the Unit type `Title`.
    - This field only applies when the **Allow Tabs in Clinical Items** system parameter is on. This field cannot be changed for qualifiers on centrally maintained clinical items.
    - Title type qualifiers do not collect data. They are displayed in bold in this window to facilitate design.
    - Where a qualifier is sex-specific, the row is coloured pink or blue depending on the sex. Qualifiers with a sex that does not match that of the patient are not displayed when the clinical item is added.

To edit a qualifier, click **Edit Qualifier Types**.

Keywords can be added, deleted or changed in the top grid. The bottom grid displays all the clinical item types that use the keyword selected in the top grid. The bottom grid can be used to add or delete clinical item types to a keyword. See Clinical Item Keywords *(on page 889)* for more information.

Tip:
For a recall to be included in the manual recall lists, for a clinical item type with a class of `Procedure`, `Immunisation` or `Referral`:

- To include the item in the manual recall list in the clinical record, add the keyword `$Recall`
- To include the item in the manual recall list for incoming results, add the keyword `$IxRecall`

To edit a keyword, click **Edit Keyword Table**.

Groups tab

The **Groups** tab shows the groups to which the clinical item type belongs, for reporting and analysis purposes.

To add groups and edit or delete existing groups, click **Edit Groups Table**.

Clinical Item Keywords and Shortcuts

Clinical item keywords help you locate clinical item types or define shortcuts to clinical items.

For example, the words 'Glue', 'Otitis', 'Media' and 'OM' could all be keywords for the term 'Glue ear'. This enables the clinical term to be found easily without knowing the exact wording.

You can add the following shortcuts:

- Shortcuts to commonly-used clinical items from patients' clinical records.
- Shortcuts for manual recalls, either from
    - Patients' clinical records
    - Investigation results

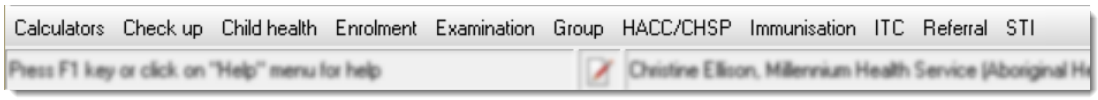
To display the keywords used in Communicare, select **File > Reference Tables > Clinical Item Keywords**.

In the **Keyword Maintenance** window, keywords are listed in the top pane with special, shortcut keywords listed first. Select a keyword to list the clinical items that use that keyword in the lower pane. Keywords are colour-coded:

- Black - ICPC-2 PLUS terms
- Blue - other items distributed by Communicare
- Purple - local terms

Special shortcut keywords

All keywords starting with the dollar ($) sign, except recall keywords) are added to the shortcut bar at the bottom of the clinical record as Clinical Item categories. You can define any number of clinical item shortcut categories, however, you should restrict the number of buttons to those that will fit into a single row of buttons on the smallest screen resolution used by any user. This should ideally be about 8-12 buttons.



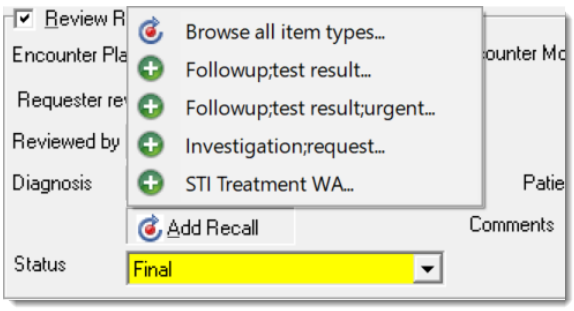
In the **Keyword Maintenance** window, select a shortcut keyword and add any clinical item that you want included in that category on the shortcut bar in the clinical record. For example, to the `$Referral` keyword, add clinical items such as `Referral;cardiologist`, `Referral; counsellor` and so on. The number of clinical items included in a category is displayed in the **Times Used** column.

Alternatively, in **File > Clinical Item Type > Keywords & Qualifiers** tab, add the shortcut keyword *(on page 888)* to a clinical item. New clinical items added to a shortcut keyword will be added to the shortcut in the clinical record and listed in the **Keyword Maintenance** window.

Recall shortcut keywords

Use the keyword `$Recall` to add items to which it is attached to the **Recall** button of the clinical record. The item is treated as a manual recall.

You can also link manual recalls to investigation results. Use the `$IxRecall` keyword to add recall items to the **Add Recall** button of the **Match and Review Result** window.



Working with keywords

To work with keywords for a Clinical Item Type:

1. To display the **Keyword Maintenance** window, select **File > Reference Tables > Clinical Item Keywords**.
2. In the **Locate** field, enter the keyword you want to work with.

Use the top grid to select the keyword that you want to work with. You can also add, delete or change keywords.

The bottom grid displays all clinical item types that use the keyword selected in the top grid. Use the bottom grid to add clinical item types to a keyword or remove them from a keyword. Linked Qualifiers item are disabled rather than deleted.

Clinical Item Definitions

A definition is a full description of what a clinical item actually means and possibly notes on how and when it should be used.

Definitions may include drawings, pictures, sounds, animations, or any other OLE Objects as well as rich text.

> **Tip:**
> You cannot update central definitions maintained by Communicare. Instead clone the item and add a definition to that item.

To maintain local definitions:

1. Select **File > Reference Tables > Clinical Item Types**.
2. From the **Clinical Item Type Maintenance** window, double-click a clinical item type.
3. In the **Properties** window, in the **Definition** field, update the definition.
4. Click **Save**.

In the **Clinical Item** browser, Definition is displayed for any clinical item that includes a definition.

Clinical Item Topics

Communicare uses topics to organise clinical items into health or medically related categories.

All clinical items must have an associated topic. Clinicians can organise documents into suitable topics if they are flagged as being a 'document' topic.

A topic is analogous with ICPC2-Plus chapters.

The following are example topics:

- Blood, Blood form Organs & Immune Mechanism
- Cardiovascular
- Digestive
- Ear
- Endocrine, Metabolic and Nutritional
- etc.

Maintaining local topics

To maintain local topics:

1. Select **File > Reference Tables > Clinical Item Topics**.
2. To work with a particular topic, double-click it in the Topic list.
3. To add a picture for the topic to the 'Picture' tab of the Clinical Terms Browser, double-click in the 'Picture' field and select the image that you want to upload. The image must in the format bmp, ico, emf or wmf and be no larger than 60x60 pixels. You must also add images for related Clinical Item Types.
4. If the topic is suitable for adding documents, set 'Allows document assignment'.
5. Click 'Save'.

Results

Clinical Item Topics are listed in the Clinical Terms Browser on the 'Topic' tab.

If an image has been added for both Clinical Item Topics and Clinical Item Types, the topic is displayed in the left pane.

Colour Coding

- Black - ICPC-2 PLUS terms
- Blue - other items distributed by Communicare
- Purple - local terms

Clinical Item Groups

Clinical Item Groups define collections of Clinical Item Types that have some common characteristic.

Groups can be very useful for analysing Clinical Data or setting up recalls. For example, a group could be created to link all Endocrine-related diseases. The Endocrine Group could then be used to report or analyse all Endocrine-related diseases in a single step, rather than reporting each disease separately.

Any number of groups may be defined and a Clinical Item Type may belong to any number of groups.

Clinical Item Groups are colour-coded:

- Black - ICPC-2 PLUS terms
- Blue - other items distributed by Communicare
- Purple - local terms

In a clinical item, the **Groups** tab shows the groups to which the clinical item type belongs, for reporting and analysis purposes.

Tip:
Ensure that you add a definition and describe exactly what the group is intended to be used for. If you don't add a definition, the group may be misunderstood and misused at some time in the future.

To add a Clinical Item Group:

1. Select **File > Reference Tables > Clinical Item Group**.

   Alternatively, in a clinical item, on the **Groups** tab, click **Edit Groups Table**.
2. In the **Clinical Item Type Group Maintenance** window, click Add row.
3. In the new row, add a clinical item group name.
4. Click Ellipsis and in the **Group Definition** window, add a description for the group and click **OK**.
5. Click **Save**.

The Clinical Item Group is created. You can now add a Clinical Item Type *(on page 895)* to the group.

Clinical Item Group Keywords

Some reports in Communicare use the clinical item groups browser. Add Clinical Item Group Keywords to help you locate clinical item groups.

To manage the keywords associated with a clinical item group:

1. Select **File > Reference Tables > Clinical Item Group Keywords**.
2. Define your keywords in the upper grid and associate these keywords with groups using the bottom grid.
   There are restrictions on the editing of ICPC-2 PLUS groups and group keywords, but you can add local keywords to an ICPC-2 PLUS group, and add ICPC-2 PLUS keywords to a local group.

Clinical Item Classes

A clinical item class is a grouping of clinical item types that have common properties and attributes (data values).

These common properties include a description, comment and date. All are linked to a patient and a service provider with the exception of incoming, unmatched or unreviewed documents, and results and automated recalls not yet edited by a service provider.

Clinical item classes are system defined. Some classes are only available if specific modules are enabled in the **System Parameters** window.

Communicare records the following classes of clinical items.

Classes used for local clinical items

The following classes can be used for clinical items:

- `Admission` - use to record admissions elsewhere. Record the place admitted using the Address Book to find entries flagged as Admission Place.
- `Condition` - use to record symptoms, complaints, infections, neoplasms, injuries, congenital anomalies and other diagnoses.

- `History` - use to record items such as 'history of [condition]' and 'family history of [condition]' rather than actual diagnoses for the patient or family members.
- `Immunisation` - use to record actual immunisations and vaccinations, whether performed by the provider or performed elsewhere. Use to record batch numbers, expiry dates, route and site, serial numbers and so on. Immunisations are recallable. Recalls for immunisations can be cancelled.
- `Procedure` - use to record any activity performed on or for the patient. This may include clinical procedures, examinations and health checks, but also such activities as 'advice and education' and program-specific activity, such as HACC activities. Procedures are recallable. Recalls for procedures can be cancelled.
- `Referral` - use to record formal referrals both outgoing and incoming. Referral can also be configured to manage incoming referrals. Record the referral source or destination using the Address Book to find entries flagged as Referral Place. Other attributes include appointment dates (for external agencies) and a date the referral was deemed to be complete. Referrals are recallable. Both recalls for and initiated but not yet complete referrals can be cancelled.
- `Alert` - use to record structured and codified alerts about a patient that staff of the health service need to know. If your health service uses structured alerts, details from clinical items with this class are displayed *(on page 124)* in the patient record on the **Summary > Main Summary > Alerts** pane. The status of the alert can be any of the following:
  - `Active` - the alert is current and requires consideration by the health service
  - `Inactive` - the alert is no longer current but may have an impact on future encounters
  - `Resolved` - the alert is closed and no longer requires consideration by the health service
  - `Entered In Error` - the alert was documented in error, either because the history was reported incorrectly or it was entered in error

The following classes may be used, but should not be used if the Prescribing module is enabled:

- `Acute medication` - used when Prescribing is not used, to document giving medication for acute conditions
- `Chronic medication` - used when Prescribing is not used, to document giving medication for chronic conditions

Classes not used for local clinical items

The following single central items have a specific purpose and cannot be used for local clinical items:

- `Ix Result` - *Investigation Result* used to link to incoming pathology and radiology results
- `Ix Request` - *Investigation Request* used to link to outgoing pathology and radiology requests recorded formally in Communicare
- `SMS` - *SMS Message* used to record SMS messages formally in Communicare
- `Adverse reaction` - *Adverse Reaction*, used to link to adverse reactions recorded formally in Communicare.

Classes that are not actual clinical items

The following classes are used to record information in the database:

- `Prescription` - prescriptions are recorded in the database with this class
- `Supply` - formal supplies are recorded in the database with this class
- `Administer` - formal administering are recorded in the database with this class
- `Document` - documents created in or imported into Communicare are recorded in the database with this class, including scanned documents, incoming and outgoing letters, uploads and downloads to My Health Record, and so on
- `Email` - formal intramail messages are recorded in the database with this class

The classes `Prescription`, `Supply` and `Administer` are prefixed with `Rx -`.

Create a Clinical Item

Trained Administrators can create new clinical items if required.

Has the following information been considered?

Table 294. New clinical item considerations

Dependencies	Consideration
Clinical workflow	Has the clinical item been considered in the context of an entire clinical workflow?
Central	Is there already a clinical item distributed by Communicare that serves this purpose?
Clinical Item	What speciality can complete the clinical item? (Is the clinical item restricted, for example, to a nurse, doctor, aboriginal health worker.)
	Are there MBS Item codes associated with the clinical item?
	Are there any system codes, rules codes or export codes associated with the clinical item?
	Are there links within the clinical item description, for example to peak bodies?
	Does the clinical item contain local versions of centrally maintained qualifiers? For example, otoscopy.
	Have you considered naming conventions?
	Are there investigation qualifier types used in the clinical item?
	What measurements should be included in the clinical item?
	Is there a shortcut keyword associated with the clinical item?
Automated Recalls	Are automated recall rules required?
Letter Templates	Are letter templates required?
Reports	Are specific reports needed to support the clinical item workflow reporting requirements?
	Are associated scheduled reports required?

Fastpath:
If the clinical item you need is similar to another, you can clone *(on page 896)* that clinical item and customise it.

To create a new clinical item:

1. Select **File > Reference Tables > Clinical Item Types**.
2. In the **Clinical Item Type Maintenance** window, click Add.
3. On the **General** tab, complete the required information.
   For more information, see General tab *(on page 886)*.
4. On the **General** tab, click **Advanced** and complete the required information.
   For more information, see General tab *(on page 886)*.
5. On the **Keywords & Qualifiers** tab, in the **Keywords...** pane, select the keywords that you want to use for this clinical item.

The keywords *(on page 889)* grid lists the terms that can be used to locate this item. To add or edit keywords groups, click **Edit Keyword Table**. For more information, see Clinical Item Keywords and Shortcuts *(on page 889)*.

6. On the **Keywords & Qualifiers** tab, in the **Qualifiers...** pane, add the qualifiers that make up this clinical item. For more information, see Keywords & Qualifiers tab *(on page 888)*.

> **Tip:**
> You can add a qualifier to multiple clinical item types simultaneously. For more information, see Adding qualifiers to multiple clinical items *(on page 902)*.

   To add or edit qualifier types, click **Edit Qualifier Types**. For more information, see Create and Edit Qualifiers *(on page 897)*.
7. On the **Groups** tab, select any groups to which you want the clinical item to belong for reporting and analysis. To add groups and edit or delete existing groups, click **Edit Groups Table**. For more information, see Clinical Item Groups *(on page 892)*.

Clone a Clinical Item

You can make copy of an existing clinical item and customise it for your health service.

To make an identical copy of a clinical item:

1. In the **Clinical Item Types Maintenance** window, right-click the required item and select **Clone Selected Item**.

   The new clinical item is identical to the original in every way but is inactive. You can only enable it by either disabling the item you cloned from or by renaming the new item.
2. Rename the cloned item and change it to suit your needs.

> **Note:**
> You can't change the class of a cloned item.

You can also use this function when you want to modify a Central item in some way: clone the Central item, disable the Central item, enable and edit your local copy. When naming your local item, you should append something unique to your description, such as the initials of the clinic. This approach helps you identify your local items and prevents any potential future naming conflicts with Communicare Central items.

If you clone a Central item, when Communicare is updated in future, the Central item is again created with the same name:

- During a Communicare update, the Central import would find your item and disable it to allow the Communicare item to be added in an enabled state. You would need to disable our item and enable yours again in this case.
- If your local item is identical to the Communicare Central item with the same name and same qualifiers, the update would overwrite your local item with the Communicare Central item. You would not know this had happened unless you went to make further changes to your local item after the event. At this stage you would need to clone it again.
- If your local item is different from the Communicare Central item with the same name but different qualifiers, the update would leave the item as-is and ask you what you want to do. If your local item has a different name from any in Central, it is left as-is.

Qualifier Types

Qualifiers add additional meaning to a clinical item, for example to add observations, dates and to request investigations.

A clinical item can have any number of qualifiers associated with it. For example, the clinical item **Blood Pressure** may have two qualifiers associated; systolic and diastolic.

To view, add or change qualifiers, select **File > Reference Tables > Qualifier Types**.

To locate a specific qualifier, enter the qualifier description in the **Locate** field at the top of the form. Scroll to view the complete list of available qualifiers.

Qualifiers are colour coded:

- Black - ICPC-2 PLUS terms
- Blue - other items distributed by Communicare
- Purple - local terms
- Grey - all disabled terms

You can add qualifiers to one or multiple clinical items, clone qualifiers, edit qualifiers and remove them from clinical items if required. For more information, see Create and Edit Qualifiers *(on page 897)*.

Qualifier usage

To see which clinical item types have the qualifier attached, right-click and select **Qualifier Usage**. If the clinical item type is disabled it will show `(item disabled)`. If the qualifier is disabled on an enabled clinical item type it will show `(qualifier disabled)`. See also Special Qualifiers *(on page 161)*.

Create and Edit Qualifiers

You can add qualifiers to one or multiple clinical items, clone qualifiers, edit qualifiers and remove them from clinical items if required.

Before you add a qualifier, review the properties and values required.

Table 295. Qualifier Properties

Property	Description
Qualifier Description	Name of the qualifier. This should uniquely identify the data even when the qualifier is reported on without the context of the clinical item to which it is attached.
Summary	Set to add this qualifier type to the Qualifier Summary *(on page 125)* on the **Main Summary** in a patient's clinical record. This shows the latest date and value for this qualifier for that patient. If this setting is changed for a qualifier that already has a lot of data, saving the change may take a few moments because patient data is being processed.
Show on Alert Summary	If your health service uses structured alerts, set to add this qualifier to structured Alerts *(on page 123)* on the **Main Summary** in a patient's clinical record. Qualifiers are added as extra columns. If a clinical item with a class of `Alert` is added to the patient's record, the qualifier values are also displayed in the alert.
Export Code	The code used to facilitate identification of qualifiers for reporting purposes.

Table 295. Qualifier Properties (continued)

Property	Description
System Code	A code used to facilitate specific behaviours in the Communicare program. Nothing should be entered here without consultation with Communicare to confirm the behaviours that will arise for that code. Unrecognised codes will have no effect.
Aboriginality	Determines whether this qualifier is only for persons of a particular Aboriginality. Leave blank if it should be applicable to everyone. This cannot be changed once the qualifier has been created.
Sex	Determines whether this qualifier is only for persons of a particular sex. Leave blank if it should be applicable to everyone. This cannot be changed once the qualifier has been created.
Value Type	Determines the way in which the qualifier appears in the clinical item. For more information, see Table 296: Value Types *(on page 898)*.
Currency	The period of time that the qualifier will be current or up-to-date. If a qualifier is added to a patient's qualifier summary, it will be current for the amount of time specified here. If a qualifier is older than its currency period, the date value is highlighted in red in the qualifier summary list. If you leave this field blank, the qualifier will always be treated as current.
Units	The units in which the qualifier is measured.
Min Value	The minimum possible value for this qualifier.
Summary Order	Qualifiers listed on the **Qualifier Summary** in the patient's clinical record, for which Summary *(on page 897)* is set are sorted alphabetically by default. To order the qualifiers displayed on the **Qualifier Summary**, enter the number 1 or higher. Qualifiers with a summary order of `1` are listed first. If there is more than one qualifier with the same summary order priority, they are sorted alphabetically. **Tip:** To prioritise the display order, space the qualifiers. For an example, see Table 297: Summary Order value example *(on page 900)*. If no sorting is required, leave the field blank.
Max Value	The maximum possible value for this qualifier.
Definition	This section is displayed above the qualifier on the clinical item when a user is entering data. It can be used to clarify the measurement description or to add specific instructions as to when and how the qualifier is to be used.

When adding a new qualifier, you are required to select the type of value it should store. This cannot be changed once the qualifier has been created.

Table 296. Value Types

Type	Description
`Address Book Lookup`	Allows the user to select an address book record that is available for secure communications from the Communicare address book.
`Date`	Value is any valid format date.
`Date Time`	Value is any valid format date and 24 hour time.

Table 296. Value Types (continued)

Type	Description
`Drawing`	A preset template image to draw on for examinations and so on. This qualifier type is not currently user-definable. Contact Communicare Support for requests for further drawing qualifiers.
`Dropdown list`	A single value can be selected from a predefined list. Define the options in the lower grid. For more information, see Dropdown List Qualifiers *(on page 901)*.
`Free text`	Values can be any short text to a maximum of 40 characters.
`Image`	An image file can be loaded into the clinical item. Supported file types are: • JPEG (*.jpg;*.jpeg) • Windows Bitmap (*.bmp) • Icon files (*.ico) • Windows Metafiles (*.emf;*.wmf) • GIF (*.gif) • Portable Network Graphics (*.png)
`Investigation Request`	Select to include a button in the clinical item that opens the **Add Investigation Request** window. The investigation keyword included in the **Keyword** field identifies one or more investigation requests. Clicking the button generates an investigation request with the identified tests associated with the investigation keyword automatically selected. When the clinical item is saved there is a record that the investigation request was generated from that clinical item. In future this will allow results of specific tests to be matched to the item (say, antenatal check) that generated the request. For more information, see Investigation Keywords *(on page 882)*.
`Memo`	Value is an unlimited amount of free text.
`Numeric`	Values can be numbers, including decimals. Units must be defined. Specifying a range of values: numeric qualifiers can have maximum and minimum values defined. This will prevent users from entering values below the minimum or above the maximum. If the user enters a value outside the range, they are warned. For example, `Hb (Haemoglobin) (g/L) must be between 18 and 220`. Users must correct the data before they can save the clinical item.
`Person`	A person (patient) in the Communicare database.
`Tick box`	A check box that can be set. Defaults to unselected.
`Time`	Value is any 24 hour format time.
`Title`	A section header. Does not collect patient data.
`Yes, No`	Values can be `Yes`, `No` or blank (not stated). Defaults to blank.

To prioritise the display order of qualifiers in the Qualifier Summary *(on page 125)*, space the qualifiers using the values you specify in the **Summary Order** field.

Table 297. Summary Order value example

Group	Summary Order value	Qualifier type
Investigations	100	Hb (Haemoglobin)
	110	ACR (Alb/Creat Ratio)
	120	HbA1c
	130	HDL Level
	140	LDL Level
	150	Total cholesterol level
	160	INR (International Normalised Ratio)
	170	Target: INR (range)
Observations	200	BP – Systolic blood pressure
	210	BP – Diastolic blood pressure
	220	Weight
	230	BMI
	240	Waist circumference
	250	Waist/Height ratio
	260	Blood glucose level - random
Lifestyle	300	Smoking status
	310	Exercise Level
	320	Alcohol consumption level
	330	Alcohol AUDIT-C total
	340	Diet Assessment
Screening	400	Prostate cancer screening still required
	410	Breast cancer screening still required
	420	Cervical screening still required
	430	Opted out Bowel Cancer Screening Clinic
	440	Opted out Cervical Screening Clinic
	450	Opted out of Bowel Cancer Screening NCSR
	460	Opted out of Breast Screening Clinic
	470	Opted out of BreastScreen Program
	480	Opted out of Cervical Screening NCSR

To add a qualifier:

1. Select **File > Reference Tables > Qualifier Types**.
2. In the **Qualifer Type Maintenance** window, click  Add and add qualifier properties, as described in Table 295: Qualifier Properties *(on page 897)*.
3. Click **Save**.

Editing qualifiers

To edit a qualifier:

1. Select **File > Reference Tables > Qualifier Types**.
2. In the **Qualifer Type Maintenance** window, click  Edit.
3. Edit the required qualifier properties, as described in Table 295: Qualifier Properties *(on page 897)* .
4. Click  **Save**.

Cloning qualifiers

> **Note:**
> When a qualifier is cloned, only the data that you can edit in **Qualifier Type Properties** is cloned. Related Charts, Clinical Items and Recalls are not cloned.

To clone a qualifier to use as the basis for another qualifier:

1. Select **File > Reference Tables > Qualifier Types**.
2. In the **Qualifer Type Maintenance** window, right-click on a qualifier in the qualifiers list and select **Clone Selected Item**.
3. Open the new qualifier and edit its properties.
4. Click  **Save**.

The cloned qualifier is coloured purple to denote that it is a local qualifier.

Dropdown List Qualifiers

List items can be enabled and disabled, which allows records of historical item selection to be maintained, while not offering these historical items for future selection.

List items can be enabled and disabled as many times as necessary. By default, new dropdown items are enabled when inserted.

Additional Text

If a dropdown list item has its 'Additional Text' box ticked, this means that when it is selected, the user will have the option to supply additional information. This is of use if none of the other items on the dropdown are appropriate. For example, an item of 'Other' could be available from the dropdown, and when selected it would allow for a more appropriate value to be specified.

Colour Coding

In both the **Qualifier Type Maintenance** and **Qualifier Type Properties** windows, disabled dropdown items appear greyed-out in the grids.

Relationship to Clinical Items

When a dropdown qualifier has been linked to a clinical item, the following behaviour occurs:

- If the clinical item is added, only enabled list items will be available for selection. Disabled items are hidden from the list.
- If a previously-inserted clinical item is edited, and a disabled list item is currently selected, this selection will be maintained (all other disabled items will be hidden, however). If another item is selected and this selection is saved, the disabled item will no longer appear in the list.
- If an item selected from the dropdown qualifies for additional text, then at the point of selection a text box will appear below the dropdown with the label 'Please specify'. This field is optional and will allow the user to give more information if appropriate. If another item which does not qualify for additional text is subsequently selected, the label and text box will be hidden again, and any text that had been entered in the text box deleted.

Reporting

The report **Reference Tables > Clinical Item Type Details** will not display disabled list items which are linked to the clinical item type.

Adding qualifiers to multiple clinical items

You can add new qualifiers to multiple clinical items from the **Qualifier Types** window.

To add a qualifier to multiple clinical item types:

1. Select **File > Reference Tables > Qualifier Types**.
2. In the **Qualifer Type Maintenance** window, right-click and select **Bulk Application**.
3. In the **Clinical Terms Browser**, search for the clinical items to which you want to add the clinical qualifier. Select all that apply.
4. Click **Select**.

The qualifier will be added after any existing qualifiers if it does not already exist on that item.

Removing qualifiers from multiple clinical items

You can also remove a qualifier from multiple clinical items.

To remove the qualifier from multiple clinical items:

1. Right-click and select **Bulk Removal**.
2. In the **Clinical Terms Browser**, search for the clinical items from which you want to remove the qualifier. Select all that apply.
3. Click **Select**.

The qualifier is removed if it exists on that item.

Special Lookup Table Maintenance

If the Special Lookup 1 has been given a name (for example, Faction Colour) in the System_Parameters (Patient tab) then the menu **File > Reference Tables > Faction Colour** will be displayed. Any number of entries can then be made which will appear on the drop down list on the Special tab of the patient Biographics window.

Special Lookup is one of the Report Selection Options *(on page 456)* available on most reports.

Transport Mode

Your modes of transport used when the patient is admitted or referred. eg:

Ambulance, Clinic Bus, RFDS, etc.

Chart Types

Chart Types define the sort of patient data that can be plotted together on a Qualifier_Chart. Any number of chart types can be defined.

The chart type maintenance window has two panes.

* Chart Name * The top pane is where chart names are maintained. Chart names should be unique, clear and unambiguous.

* Qualifiers * The bottom pane defines the Qualifier Types *(on page 897)* that are to be graphed together on the chart.

* One line is added to the chart for each qualifier.

* Only numeric qualifiers can be graphed.

* Any number of qualifiers can appear on a chart, though only two different

measurement units can appear on a single chart. This is because the first unit

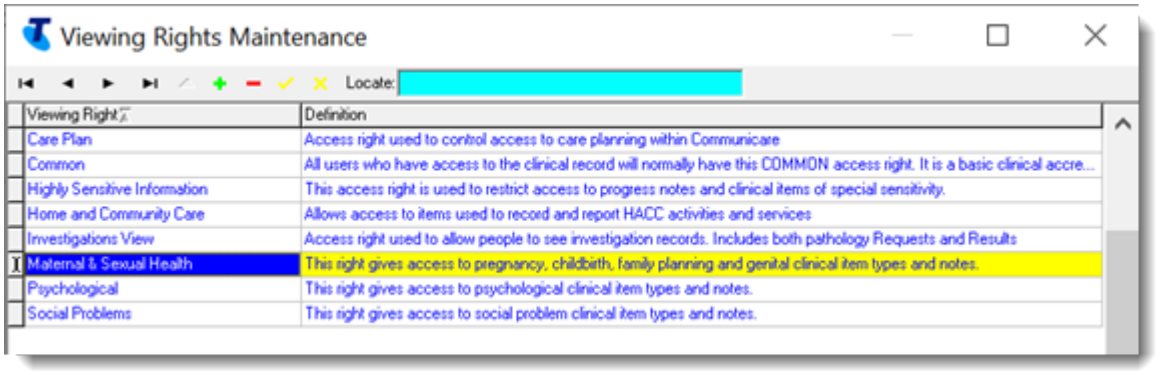
is placed on the left 'Y' axis and the second one (if any) is placed on the

right 'Y' axis.

Viewing Rights

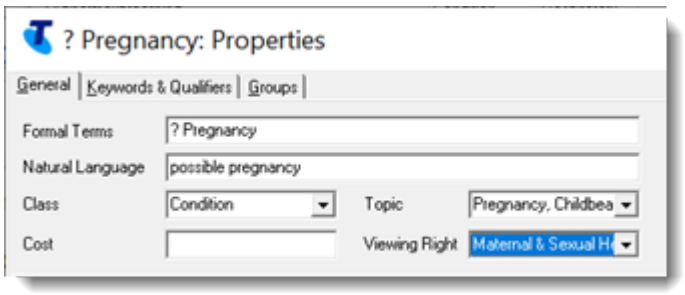
Viewing Rights define access levels to clinical data for each user group.

Define Viewing Rights for your health service in **File > Reference Tables > Viewing Rights**.



Make sure you add a description in the **Definition** column and fully define exactly what each right is intended to be used for. Failure to do so may result in the right being misunderstood and consequently misused at some time in the future.

After a right has been defined, you can link any number of Clinical Item Types *(on page 885)* to it. Select the required value from the **Viewing Right** list for each clinical item.



Add viewing rights to user groups to define access levels to clinical data.

Users can allocate a suitable viewing right to individual progress notes and documents, such as a letters, investigation results or HealthLink SmartForms. The viewing right defaults to **Common**. If a user does not have the viewing right assigned to a document, they won't be able to see that progress note or document.

Colour Coding

- Black - ICPC-2 PLUS terms
- Blue - other items distributed by Communicare
- Purple - local terms
- Grey - all disabled terms

SNOMED CT Import

Communicare uses SNOMED CT-AU terminology to capture clinical data.

SNOMED CT-AU is the Australian extension to SNOMED CT, and includes the international resources along with all Australian-developed terminology for use in Australian health care settings. New versions of the SNOMED CT-AU are released monthly.

> **Tip:**
> If your site uses Adverse Reactions, ensure you update SNOMED CT-AU at least every six months.

Update the SNOMED CT-AU version on both the Communicare server and any clients.

To update your version of SNOMED CT-AU in Communicare:

1. Delete any old SNOMED CT-AU release bundle files.
2. Get the release bundle file from the Communicare User Portal - Help and Support:
    a. Log on to Communicare User Portal with your username and password (register online if you do not have these).
    b. On the **Help and Support** tab, in the **SNOMED** tile, click **Download**. An archive file is downloaded to the `Downloads` folder on your computer.
3. Import the release bundle file:
    a. On a workstation with Communicare installed, run SNOMED CT Import. Select **File > Reference Tables > Import SNOMED CT-AU Data**.
    b. Select the downloaded SNOMED CT-AU archive file in your `Downloads` folder.

c. Click **Start** to begin the import process.

> **Note:**
> Do not use your computer for other tasks until the import is complete.

If you are unsure about any of the above steps, contact Communicare Support.

Reference Table Codes

Communicare reference tables use a variety of codes to identify and manage clinical data.

Finding and recording codes

Your Communicare Administrator can use the Clinical Item Types *(on page 885)* and Qualifier Types *(on page 897)* reference tables to see and edit codes.

For example, to display clinical item type properties:

1. Select **File > Clinical Item Type**.
2. In the **Clinical Item Type Maintenance** window, double-click a clinical item or select an item and click Edit.
3. On the **General** tab, click **Advanced**.

System codes

These codes of three characters are used to identify specific data in certain reference tables. Often the system code is not accessible to local users (for example, in defining patient status or other patient group types) but the following tables have access to the code:

- Clinical Item Types (for example, PRE identifies all clinical items that record relevant aspects of a pregnancy).
- Qualifiers, and the separate elements of reference type qualifiers (for example, HBA recognises an HbA1c value; SMO recognises a smoking status and its drop-down references have system codes such as S for a current smoker, E for an ex-smoker and N for a non-smoker or a person who has never smoked).

The system code can be used for:

- Program behaviour (for example, the automated patient status update uses system codes when adjusting a patient's current status).
- High level recognition (for example, when calculating BMI automatically the program looks for an existing weight and height for that patient by using the system codes for weight (WKG) and height (HCM)).
- Reporting (see export codes below).

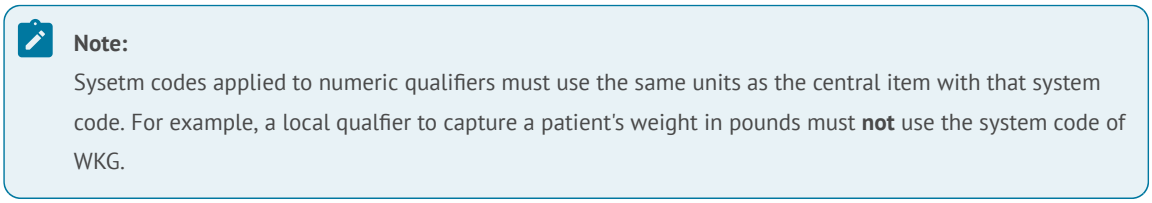
Important clinical item system codes:

- AHC - identifies an adult Aboriginal health check (used by H4L and NT KPI to identify a completed adult health check for a patient who does not have an appropriate MBS claim).
- CHC - identifies a child Aboriginal health check (used by H4L and NT KPI to identify a completed child health check for a patient who does not have an appropriate MBS claim).
- CHI - Child Health Check Intervention (NT). No longer in use.
- CMA - identifies an aged care resident check.

- CPA - identifies a GP management plan (used by H4L and NT KPI to identify a completed management plan for a patient who does not have an appropriate MBS claim).
- CPD - identifies a care plan document (Communicare use only).
- EHC - identifies an over 75s check.
- OHC - identifies an over 55s Aboriginal health check.
- PRE - identifies pregnancy related items. In association with a rule code that has a PR prefix the 'pregnancy number' attribute is revealed on the clinical item.
- SFH - identifies changes and additions to the social and family history tab (Communicare use only).
- TCA - identifies team care arrangements (used by H4L and NT KPI to identify completed team care arrangements for a patient who does not have an appropriate MBS claim).

Important qualifier system codes:

- Pregnancy qualifiers:
    - EDD (estimated date of delivery)
    - EDU (EDD by ultrasound)
    - FHR (foetal heart rate)
    - GST (gestation)
    - LMP (last menstrual period)
    - PGR (gravida)
    - PMI (number of miscarriages)
    - PPA (parity)
    - PRA (indigenous status of father)
    - PRD (date of delivery)
    - PRF (baby's feeding method)
    - PRH (fundal height)
    - PRL (duration of labour)
    - PRN (baby's name)
    - PRP (baby's place of birth)
    - PRS (baby's sex)
    - PRW (baby's birthweight)
    - PTE (number of terminations)
    - RPP (previous pregnancies - Communicare use only).
- X as a prefix - STI results (Communicare use only).
- [Various numeric qualifiers] - important numeric qualifiers are identified by system codes:



Note:
Sysetm codes applied to numeric qualifiers must use the same units as the central item with that system code. For example, a local qualfier to capture a patient's weight in pounds must **not** use the system code of WKG.

    - ACR (ACR)
    - ALB (albumin)
    - BGF (fasting glucose)
    - BGR (random glucose)
    - BPD (diastolic BP)
    - BPS (systolic BP)

    - BMI (body mass index - will appear on centile chart)
    - CHO (cholesterol)
    - CHR (total cholesterol/HDL ratio)
    - CRU (creatinine in micromols per litre)
    - CRM (creatinine in millimols per litre)
    - GFE (estimated GFR)
    - GFI (GFR based on ideal body weight)
    - HBA (HbA1c)
    - HBH (haemoglobin)
    - HCC (head circumference - will appear on centile chart)
    - HCM (height - will appear on centile chart)
    - HDL (HDL)
    - INR (INR)
    - LDL (LDL)
    - OXY (oxygen saturation)
    - PCR (protein creatine ratio)
    - PSA (PSA)
    - RSP (respiratory rate)
    - TMP (temperature)
    - TRG (triglycerides)
    - UPD (urine protein dipstick)
    - WCM (waist circumference)
    - WKG (weight - will appear on centile chart).
- [Risk factors reference type qualifiers] - important risk factors are identified by system codes:
    - ALC (alcohol consumption)
    - ALP (alcohol consumption in pregnancy)
    - IDP (illicit drug use in pregnancy)
    - IDU (illicit drug use); SMO (smoking status)
    - SMP (smoking status in pregnancy). The smoking references also have system codes (E for ex-smoker statuses, S for current smoker statuses and N for non-smokers and never-smoked.
- History:
    - RFH (family history - Communicare use only)
    - RSH (social history - Communicare use only)

Export codes

These codes of up to eight characters are used to identify specific data in certain reference tables. Often the export code is not accessible to local users (for example, in defining Aboriginal type or other patient group types) but the following tables have access to the code:

- Clinical Item Types (for example, the export code PAPSMEAR is used to identify items that record that a pap smear has been done: NT KPI reports use this data to determine if a woman has a current pap smear).
- Qualifiers, and the separate elements of reference type qualifiers (for example, the ANFPP and HACC data export reports use export codes to identify data they require).

The export code is used for:

- Data export and reporting.
- Identifying immunisation types with AIR codes to allow automated upload to the Australian Immunisation Register.

Important clinical item export codes:

- BICILLIN - identifies a clinical item that is evidence of an LA Bicillin injection or equivalent having been done.
- PAPSMEAR - identifies a clinical item that is evidence of a pap smear having been done.
- BREAST - identifies a clinical item that is evidence of a breast screening or check having been done.
- DA-, DR- (as prefixes) - Drug and Alcohol.
- HA- (as prefix) - Home and Community Care.
- [AIR codes] - Immunisation types that have an allocated AIR code. For example, BCG, FLUVAX, PNEUMO, ASTCOV. Codes are listed in AIR vaccine code formats.
- STI- (as prefix) - STI screening and treatment related data.
- TS- (as prefix) - Tackling Smoking data.
- MCH-GRP - Maternal and Child Health group activities.
- HP-GRP - Health Promotion group activities.

Important qualifier export codes:

- CI- (as prefix) - NT Intervention data.
- DA - (as prefix) - Drug and Alcohol data.
- CS, DM, EL, EN, FP, HA, HC, HH, IB, PR, RL (as prefixes) - ANFPP data.
- HA- (as prefix) - Home and Community Care.
- HS- (as prefix) - Headspace.
- STI- (as prefix) - STI screening and treatment related data.
- TARG- (as prefix) - qualifier that sets a target value for a patient rather than an actual value (e.g. TARG-INR).
- TSR- (as prefix) - Tackling Smoking referrals.
- WRF - New Warfarin dose.

Special codes for cardiovascular risk calculator qualifiers:

- CVR-R05C - this should be used for a dropdown box used to capture the risk category of CVD within the next 5 years using the CARPA STM method. Dropdown references should use a system code of H for high, M for moderate, L for low and U for unknown.
- CVR-R05F - this should be used for a dropdown box used to capture the risk category of CVD within the next 5 years using the Framingham method. Dropdown references should use a system code of H for high, M for moderate, L for low and U for unknown.
- CVR-N05C - this should be used for a numeric qualifier that captures the percentage risk of CVD within the next 5 years using the CARPA STM method.
- CVR-N05F - this should be used for a numeric qualifier that captures the percentage risk of CVD within the next 5 years using the Framingham method.

Rule codes

Rule codes apply only to clinical item types and have the format LL-NNNN.

LL is a two character code to identify a program with enrolment and exit behaviour. The prefixes usually relate to a specific dataset. Important rule code prefixes include:

- PR - pregnancy related behaviours
- HA - Home and Community Care
- DA, DR - Drug and Alcohol
- HS - Headspace

Note:
Contact Communicare Support for advice when considering setting up a local enrolment-exit protocol.

NNNN is one of a set of suffixes:

- ENROL (this item is used to start a period of enrolment during which a patient can have 'action' type items added). An item of this type cannot be added if it has already been added to a patient's clinical record unless there is an 'exit' item (see below) recorded between the two enrolments.
- EXIT (this item is used to end a period of enrolment). It can only be added to a patient's clinical record if there is an 'enrolment' type item of the same prefix (LL) that has not been exited.
- ACT (this item can only be added between an enrolment and an exit of the same prefix).

Pregnancy items have their own behaviour. The prefix is 'PR' and the suffixes are:

- START (this item will be treated as a start of a pregnancy and will appear on the 'New Pregnancy' button of the Obstetrics tab). There can only be one clinical item of a specific pregnancy number for a specific patient and the system will check if there is already a start to, say, pregnancy 3 by looking for other items with the rule code 'PR-START'.
- END (this item will end a pregnancy of the same pregnancy number and will appear on the 'End Pregnancy' and 'Past Pregnancy' buttons of the Obstetrics tab. It can also be used to record past pregnancies). It is possible to record multiple ends to a single pregnancy in the case of multiple births. This item will cause a pregnancy to end and thus, unless the woman has a pregnancy start of a later pregnancy number, the woman will not be shown as currently pregnant.
- CHECK (this item will qualify as an antenatal check and will appear on the 'Antenatal Check' button of the Obstetrics tab).
- HIST (used uniquely for an item to record the current pregnancy history of gravida, parity, miscarriages and terminations).
- STAT (an item that records supplementary detail about a current or past pregnancy). For example, a pregnancy can be started and then later found to be a multiple pregnancy. The item 'Pregnancy;multiple' has the rule code 'PR-STAT' to be able to associate it with the same pregnancy number as the 'Pregnancy;confirmed' for that patient.

ICPC 2 Plus codes

There are two values stored in the clinical item table for ICPC-2 PLUS codes: **Code** and **Term**. For example, Diabetes Mellitus has a Code of `T90` and a Term of `002`. This data is supplied by the ICPC-2 PLUS central import. Where users have an analagous clinical item, the ICPC Code should be entered appropriately to identify this clinical item to various reports that look for the ICPC Code.

For example, the Healthy for Life reports *(on page 472)* identify diabetic patients as those with a clinical item code of `T90`.

Known codes

Your administrator can run the following report to identify system codes and rule codes in your database:**Report > Reference Tables > System Codes and Rule Codes**

Note:
Items and qualifiers with a number of less than 1000000000 are local items and care should be taken to validate any system code or rule code associated with these elements.

ICPC codes can be seen and queried using:

- **Report > Reference Tables > Clinical Item Types**
- **Report > Reference Tables > Clinical Item Groups**

Export codes are usually specific to particular datasets.

Appointment Session Templates

Appointment Session Templates identify when appointments can be made, in a general way. They are used as a template for creating the sessions *(on page 61)* into which appointments are actually booked.

Prerequisites

Before you can add a session template, the following details must be configured in Communicare:

- Providers, select **File > Providers**
- Rooms and facilities, select **File > Appointments > Appointment Facilities**
- Session types, select **File > Appointments > Session Types**

You should also complete the Appointment Template Worksheet for each provider for whom you want to schedule appointments. To display the worksheet, select **Help > Forms > New Appointment Template Worksheet**. Download or print the worksheet as required.

To create a new appointment session template:

1. Select **File > Appointments > Session Templates**.
2. In the **Session Templates** window, click ✚Add.
3. From the **Provider** list, select the provider you are creating templates for. You cannot include a provider in more than one session simultaneously, that is provider overlaps are not allowed.
4. From the **Facility** list, select the room you want to assign to the provider.
5. If you want to allow the room booking to overlap with bookings in other templates, set **Allow Facilities Overlap**.
6. If you want to limit this booking to a program, from the Session Program list, select a program.
7. From the **Session Type** list, select a session type. The session type defines whether walkins are allowed and may provide a default number of horizon days, which can differ from the system defined default.
8. From the **Day of Week** list, select one of the following options:
    - Manual - the template is not used to automatically generate sessions. Manual sessions can be inserted manually into the appointment book for any day of the week provided no Provider or Facility conflicts exist.
    - Sunday, Monday, Tuesday, ... - the template can be used to automatically create sessions on a repeating basis. For example, every Monday, every second Monday, every third Monday and so on.
9. If you selected a day of the week, in the **Recurrence Pattern** section:
    a. From the **Repeat Value** list, select how often you would like this session to repeat.
    b. From the **Effective date** calendar, select the earliest date that the appointments generated from this template can be made. If no date is entered, the current date is used. If the sessions are fortnightly or further apart, ensure that you set this date correctly for the first occurrence.

c. In the **Horizon days** field, enter the number of days into the future to automatically create sessions. The number in brackets indicates the value that will be used if nothing is entered here. The maximum value allowed is 373 days.
d. The **Horizon date** displays last time appointments generated up to and including this date. Next time generation will start from the next day.
e. If sessions have been cancelled for the period between today and the Horizon date, you can force the overnight process to recreate them by resetting the date. The effect is that it will commence from 'today' instead of the day after the last run.

10. In the **Start Time** field, enter a start time for the session.
11. In the **End Time** field, enter a finish time for the session.
12. For session types that allow walk-in appointments, in the **Last Walkin** field, enter the number of minutes before the end of the session that walk-in patients will be accepted into the session.
13. Click **Save**.

After adding a session template, a Timeslot Template *(on page 916)* is created automatically and the Timeslot Template *(on page 916)* window is displayed. Click 'Save' to save the timeslots and enable the session template.

The session duration and end time are reduced if necessary so that session duration is an integer multiple of default timeslot duration.

The nightly Communicare process will generate new appointment sessions based on the information entered in the Recurrence Pattern section. There is no last Horizon Date so new appointments are created overnight, up to the Horizon Date.

If there are missing sessions or you want the appointments generated immediately, right-click on the enabled session template and select 'Apply to appointments book'. See Appointment_Session_Template_Application *(on page 912)* for more information.

Cloning session templates

You can make an identical copy of an appointment session template.

To clone a template:

1. Select **File > Appointments > Session Templates**.
2. In the **Session Templates** window, right-click the template you want to clone and select **Clone Selected Item**.
3. In the Confirmation window, click **Yes**.

A duplicate template is created, which is identical but is not enabled.

Editing session templates

You can edit a session template if required. When editing templates, changes will only be reflected in the appointments book after the last Horizon Date.

To edit a session template:

1. Select **File > Appointments > Session Templates**.
2. In the **Session Templates** window, double-click the template you want to edit.
3. In the **Confirmation** window, click **Yes** to confirm that you want to disable the template.

4. In the **Session Template** window, edit the required details. Start time and duration may not be edited. Instead, edit the Timeslot Template *(on page 916)* to change end time and duration of a session template.
5. Set **Enabled**.
6. Click **Save**.

Editing session template timeslots

You can edit the start time and duration of timeslots for a session template if required.

To edit timeslots:

1. Select **File > Appointments > Session Templates**.
2. In the **Session Templates** window, right-click the template whose timeslots you want to edit and select **TimeSlots**.
3. In the **Timeslots** window, edit the required start times and duration, or set **Reserved** for some timeslots.
4. Click **Save**.

Deleting session templates

Session templates are disabled rather than deleted.

To disable a session template:

1. Select **File > Appointments > Session Templates**.
2. In the **Session Templates** window, select the template you want to disable.
3. Click Delete.
4. In the **Warning** window, click **OK**.

Filtering

To filter the session templates by provider:

In the **Session Template** window, from the **Provider** list, select the provider whose session templates you want to work with.

To display all session templates again, delete the provider or select `All Providers`.

Appointment Encounter Program

Assigning an Encounter Program to the Appointment Template ensures that all future Sessions generated will have the same Encounter Program.

This allows filtering of Appointment Sessions when they are of a sensitive nature eg. Sexual Health, as users will only be able to view the Session in the Appointment Book if they have the appropriate rights to the Encounter Program *(on page 876)*.

Appointment Session Template Application

You can force Communicare to generate appointment timeslots in the appointment book according to the details of the template, rather than waiting for the nightly process.

To generate appointment timeslots:

1. Select **File > Appointments > Session Templates**.
2. In the **Session Templates** window, right-click the template that you want to apply and select **Apply to appointments book**.
3. In the **Select Date Range** window, from the **From** calendar, select when you want to apply the session template from.
4. From the **To** calendar, select the Appointment Horizon date. This option is only enabled if the horizon date is set (indicating that the Appointments Generator has previously run).
5. Click **OK**.

The selected template is used to generate appointment timeslots in the appointment book according to the details of the template.

Any sessions that would overlap with existing session providers or facilities are skipped.

The outcome is displayed in the Template Application Log. For example, "The number of inserted sessions is 26".

Details of all skipped sessions are also listed with the reason the session was skipped. For example, "Provider overlap".

Appointment Session Type

An appointment session type defines attributes that are common to a class of Appointment Sessions *(on page 61)*. Every session has a type.

The session type defines:

- The name (description) of the session, e.g. "Antenatal Clinic". Names are case-sensitive.
- The Session Booking Type
- Whether walk-in patients are allowed
- Appointment horizon days to override the system defined value (optional). The maximum value allowed is 373 days.
- Whether online appointment bookings *(on page 64)* are allowed for the session

Session Booking Type

Session booking types determine how appointments are scheduled and booked.

The session booking types are:

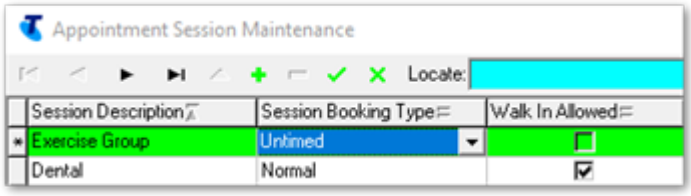
- Normal - appointments are made for this session in the usual way.
- Untimed - appointments can be made, but all appointments are given the same start time, which is the start time of the session. This is useful when a number of patients are to be seen for the same thing and the duration is expected to be short. For example, influenza immunisations and antenatal clinics.
- Walk-in Only - appointments cannot be made for this session, it is kept free for walk-in patients only.

Example group session

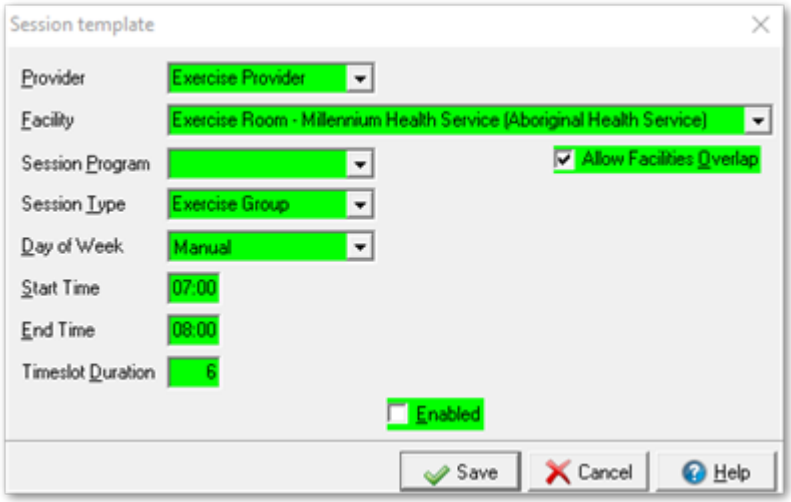
This session type is for scenarios where patients are all asked to turn up at the same time and are then seen one after the other, for example for influenza immunisations.

However it can also be used to create a fixed length group session into which you can book multiple people. For example, a daily session for an exercise group with a maximum of 10 people.

1. If you don't already have one, set a facility:
    a. Select **File > Reference Tables > Appointment Facilities**.
    b. In the **Facility Maintenance** window, click ✚Add and enter the following information:
        - **Place and Mode** - `Millenium Health Service`
        - **Description** - `Exercise Room`
    c. Click **Save**.
2. Add the group session type:
    a. Select **File > Appointments > Session Types**.
    b. In the **Appointment Session Maintenance** window, click ✚Add.



    c. In the new row, in the **Session Description** column, enter `Exercise Group`. This description is displayed in each timeslot when you add the session to the appointment book.
    d. From the **Session Booking Type** list, select `Untimed`. All appointments are given the same start time.
    e. Click **Save**.
3. Add the session template:
    a. Select **File > Appointments > Session Templates**.
    b. In the **Session template** window, from the **Provider** list, select who will be conducting the exercise session.
    c. Click ✚Add.

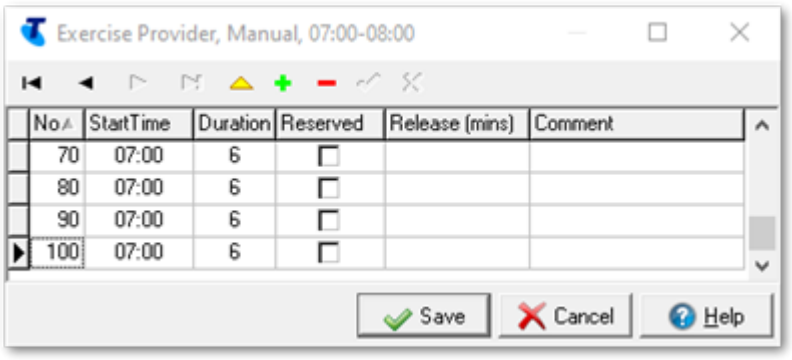


    d. In the **Session template** window, from the **Facility** list, select the facility specified in step 1, `Exercise Room`.
    e. If you want more than one appointment provider in the same room at the same time, set **Allow Facilities Overlap**.
    f. From the **Session Type** list, select the session type specified in step 2, `Exercise Group`.
    g. Enter a start time, end time and timeslot duration.

> **Note:**
> Restrict the session length by setting the duration according to the number of participants in the session: divide the length of the session by the number of particpants. For example, for a 60 minute session, set **Timeslot Duration** to 6 minutes for 10 people, 5 minutes for 12 people and so on.

h. Click **Save**.

4. Add the timeslots:
    a. In the Appointment Timeslot template window, add the number of timeslots available, either press cursor down or click ✚Add and enter `20`.



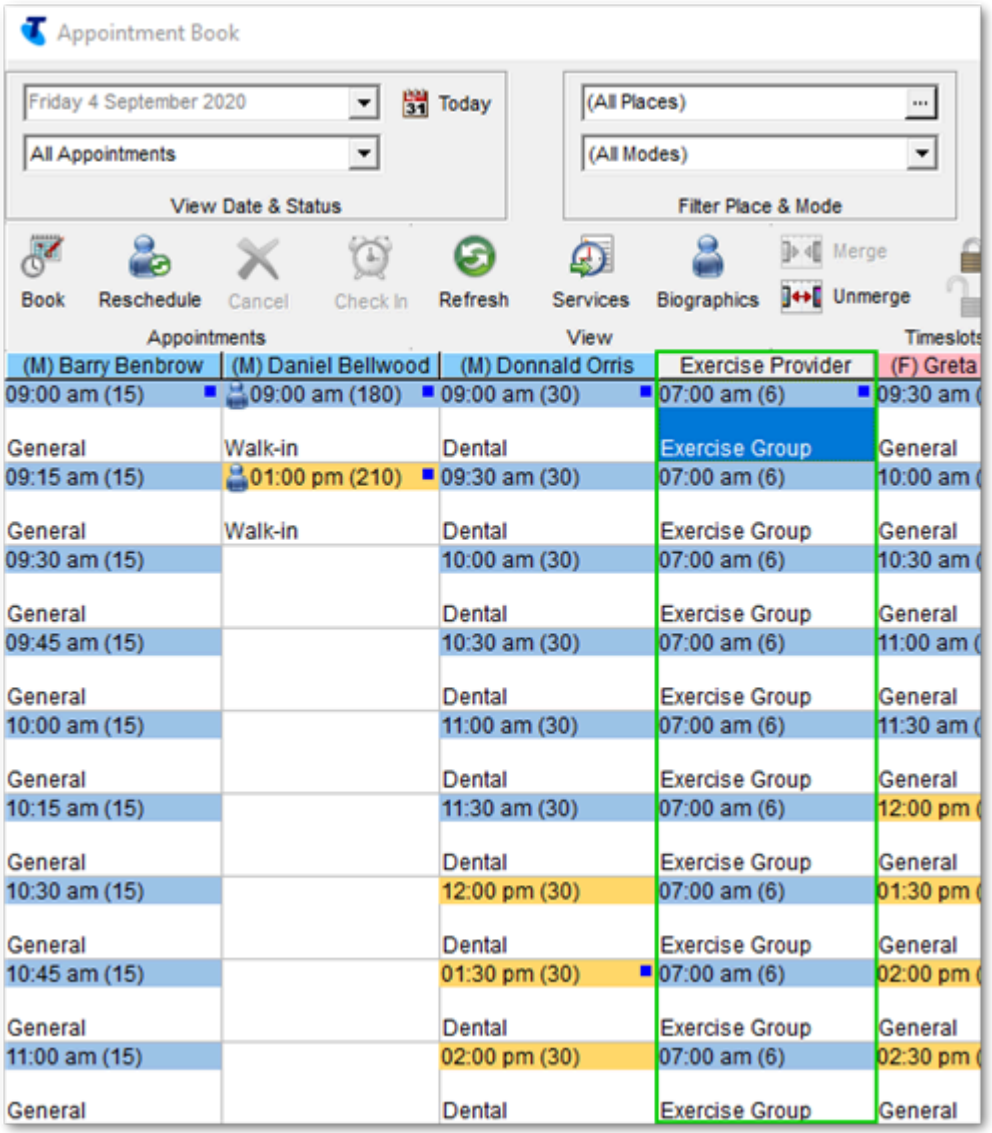
    b. Repeat 8 times, incrementing the number. All appointments have the same start time and duration.
    c. Click **Save**.
5. Enable the session template:
    a. Double-click the session template you've been working with (specified in step 4).
    b. Set **Enabled**.
    c. Click **Save**.

If the session is a weekly repeating session it is added to the appointment book automatically.

If the session is manual, add the session to the appointment book:

1. In the main toolbar, click **Appointments Book**.
2. In the **Appointment Book**, go to the required day and click **Insert**.
3. In the **Session Templates List**, select the provider specified in step 1, `Exercise Provider`.
4. Click **OK**.

The exercise group is added to the appointments book.



You can now book a group of up to 10 people into a 7am exercise group, in the exercise room.

Appointment Timeslot Template

Use the Appointment Timeslot template to edit the timeslots that belong to a session.

To display the Appointment Timeslot template window, select **File > Appointments > Session Templates** then right-click a session template and select **TimeSlots**.

The Timeslot Template window:

- Displays the identity of the owning session at the top of the form, that is provider, day of week, start time, repeat start, repeat value.
- Displays details of each timeslot, including calculated starting time.
- As timeslots are added, deleted or changed the session end time is adjusted and displayed.
- Provider or facility overlaps are not allowed.

- Reserved timeslots are times intended for non-contact periods that cannot be booked. Set either a reserved timeslot or a release time, not both. Enter a comment for reserved appointment slots if required. Comments are displayed in the appointment book, but ignored if the slot is not reserved.
- If a release time is entered, the slot cannot be booked more than this number of minutes before it starts. Set either a reserved timeslot or a release time, not both.

Provider's Planned Absence

This form is used to record planned provider absences such as holidays. The daily process service *(on page 932)* will not organise appointments for a provider for these dates.

Public holidays *(on page 859)*, when all providers are on holiday, can be set at **File > Appointments > Public Holidays**.

To record a planned provider absence:

1. Reschedule any existing appointments that have already been booked during the planned period of absence.
2. Manually cancel any sessions that exist during the period of absence:
    a. In the **Appointment Book**, right-click the session and select **Cancel Session**.
    b. In the **Session Cancellation** window, enter `SESSION`.
    c. Click **OK**.
3. Select **File > Appointments > Provider Planned Absences**.
4. In the **Provider Planned Absences Maintenance** window, click ✚Add.
5. From the **Provider** list, select the provider's name from the list.
6. Enter a start and end date for the period of absence.
7. Click **Save**.

Providers

The **Providers** window lists clinicians who have been added to Communicare as providers at your health service.

A provider is anyone who provides health care for a patient (such as, a doctor, health worker, nurse, and so on) who may or may not be a billing entity. Specifically, a service provider is defined by Medicare.

Table 298. Provider fields

Field	Description
Logon User Name	The username used to associate a user with this provider at logon time. If a provider has a Logon User Name assigned, the following security restrictions apply: • When the user logs on to Communicare, this provider is automatically selected as the default provider and cannot be changed • Progress Notes for this provider can only be written if the provider logs on to Communicare with this Logon User Name • Providers without a Logon User Name cannot prescribe electronic prescriptions • Providers without a Logon User Name cannot make electronic claims • If a provider has an HPI-I, it will only be usable in Communicare if the provider is also logged into Communicare with their selected Logon User Name

Table 298. Provider fields (continued)

Field	Description
Provider personal details	• **Title** - the provider's title • **Forenames** - the given name of the provider • **Surname** - the family name of the provider • **Sex** - the sex of the provider • **Indigenous Status** - the provider's Indigenous status • **Date of Birth** - the provider's date of birth The provider's full name is required for ePrescribing. You cannot add two providers with the same name.
Provider professional details	• **Qualifications** - the qualifications of the provider. Required for ePrescribing. • **AHPRA Number** - the Australian Health Practitioner Regulation Agency registration number of the provider. To check a provider's AHPRA registration number and that they are safe to practise, visit the AHPRA website. • **Speciality** - the specialty or occupation of the provider. A provider is associated with a single speciality. If a provider's speciality type is changed then all retrospective progress notes reflect this change. For example, if a nurse writes notes as an Enrolled Nurse and then becomes a Registered Nurse, the old notes will indicate that they are now a Registered Nurse. • **Prescriber Number** - the provider's prescriber number. Without a prescriber number, the provider can't print prescriptions or prescribe medications. Required for ePrescribing. • **SIRA Approval Number** - the provider's State Insurance Regulatory Authority approval number. • **HPI-I Number** - the current Healthcare Provider Identifier - Individual number assigned to the provider. The box may have a different background colour depending on the provider's status. For more information, see HI Service *(on page 632)*. ◦ You may not be able to enter HPI-I Numbers if the `HI Service` module is switched off. See HI Service *(on page 632)* for more detail on availability, as well as the rules that govern when an HPI-I Number search or validation is triggered. ◦ To validate a number with Medicare, click Validate. The last checked date is updated, and a new status or number may be assigned. ◦ To display a history of HPI-I Number's assigned to the provider, click History. For more information see Viewing Healthcare Identifier History *(on page 635)*. ◦ HPI-I is required for ePrescribing. • **Student** - set to identify a provider as a student practitioner. Students are identified in progress notes in the clinical record together with their speciality if available. • **Transport Driver** - set to identify that the provider is also a driver of transport. • **Cultural Awareness Training Given** - select whether cultural awareness training has been given to the provider or not
Show Medicare Claim Tab	Set to always show the **Medicare Claim** tab when this provider closes a clinical record for a service.
Allow online appointment bookings	Set if the provider allows appointments to be booked online.

Table 298. Provider fields (continued)

Field	Description
Enable and disable providers	To enable a provider, in the **Enable Date** field, enter a date from which the provider will be active in Communicare. When the provider leaves your health service, to disable a provider, in the **Disable Date** field, enter a date from which the provider cannot access Communicare.
Enable ePrescribing	Set to enable a provider to participate in ePrescribing.
Notes	Enter any relevant notes about the provider.
Verbal Order	To enable Verbal Order options, the `Medications Management` module must be enabled. Configure individual providers to require verbal orders when creating medication orders for particular medications, according to their scope of practice, for particular Schedule classifications and at particular encounter places. A Verbal Order is required if: • A provider attempts to create a medication order for a medication that is not included in their Scope of Practice • A provider attempts to create a medication order for a medication that is part of a restricted Schedule classification (S1, S2, S3, S4, S5, S6, S7, S8, S9, Unscheduled) • A provider attempts to create a medication order at a selected encounter place Specify medications for which a provider can create a medication order using either Schedules, Scope of Practice or both. Set the following: • To enable a provider to create medication orders for medications listed in their Scope of Practice without needing a Verbal Order, set **Use Scope of Practice**. • **S1**, **S2**, **S3**, **S4**, **S5**, **S6**, **S7**, **S8**, **S9**, **Un-Scheduled** - set one or more options to require that any medication order created for medications included in the selected Schedule requires a Verbal Order. For example, if a nurse needs to be able to prescribe S1, S2 and S3 medications without a Verbal Order, deselect **S1**, **S2** and **S3** and set **S4**-**S9**. • To require a Verbal Order only for particular encounter places, select the required Encounter Place. **Tip:** If you deselect an encounter place, the provider does not require a Verbal Order at that encounter place. If you want a provider to always require a verbal order at all encounter places,for **Encounter Places**, set **Select All**.

Table 298. Provider fields (continued)

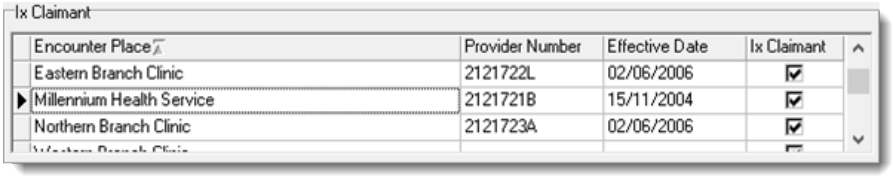
Field	Description
Ix Claimant	Provider numbers for Medicare Online Claiming can be associated with providers by encounter place.  Ix Claimant Encounter Place / Provider Number / Effective Date / Ix Claimant Eastern Branch Clinic / 2121722L / 02/06/2006 / ☑ Millennium Health Service / 2121721B / 15/11/2004 / ☑ Northern Branch Clinic / 2121723A / 02/06/2006 / ☑ This allows a provider to claim using different provider numbers based on the place they are providing services from. Claims cannot be submitted against this provider number at the relevant encounter place before the effective date. For the current encounter place, provide the following information: • **Provider Number** - an eight character Medicare identifier by which a provider is referenced, typically six numbers followed by two letters, for example, `123456AB`. **Tip:** If your provider number contains fewer than six numbers, it is considered invalid and the following error is displayed: `Invalid provider number`. Prefix shorter provider numbers with zeroes to make them six numbers long, for example, `012345AB`. • **Effective Date** - the date at which the specified provider number became effective for the current provider. The effective date must not be in the future. **Note:** Providers should ensure that their details are finalised with Medicare before the effective date is reached. • **Ix Claimant** - if the provider has a Medicare Provider Number for the encounter place, set to allow the current provider to request investigations for the encounter place. ◦ An investigation request can only be requested by, or on behalf of a provider who has **Ix Claimant** set for an encounter place. ◦ Providers who have a Medicare Provider Number and have **Ix Claimant** set for an encounter place, are not given the option to order investigations on behalf of another provider. If a provider with a Medicare Provider Number needs to order tests on behalf of another provider, do not set **Ix Claimant**. ◦ If this field is not enabled, the provider will only be able to request an investigation on behalf of another provider if **Allow Investigation Request on behalf of another claiming provider** is set in Organisation maintenance. For more information, see Organisation Maintenance *(on page 840)*.

Table 298. Provider fields (continued)

Field	Description
Electronic Claims	When a provider provides a service, only that provider can submit their claims, with the following exceptions: • **Payee Provider** - the delegated doctor whose provider number is attached to the health service bank account where the Electronic Claims deposits are made. **Note:** If the provider being edited is the payee provider, this field should be left blank. • **Delegated User** - another user authorised to submit claims on behalf of this provider. This user must be a Communicare Logon User and can be anyone with `Billing` system rights in Communicare. All Communicare System Administrators can also resubmit a bulk bill in case of transmission failures. If a personal token must be used to sign all claims made by this provider, also set **Sign the Claims using the PKI Token**.

Editing Providers

Use the **Provider** window to configure providers for your health service.

A provider is anyone who provides health care for a patient (such as, a doctor, health worker, nurse, and so on) who may or may not be a billing entity. Specifically, a service provider is defined by Medicare.

Communicare Administrators can enable and disable providers, restrict providers to a scope of practice, schedule or encounter place, and edit details of a provider, including the provider's name, speciality, provider number and so on.

Add, edit the details of, or delete providers as required.

You must have the `Provider Administration` system right to access and modify any provider record.

To work with providers:

1. Select **File > Providers**.
2. In the **Providers** window:
   - To edit a provider, select the provider in the list and click Edit.
   - To add a new provider, click Add.
   - To delete a provider, select the provider in the list and click Delete.
   - Providers who have a Disabled Date in the past are set as inactive and are greyed-out. To hide all providers who are inactive, set **Hide Disabled**.
3. Edit the required field. For more information on the information required for providers, see Table 298: Provider fields *(on page 917)*
4. Click **Save**.

Medicare Number Import

Patient Medicare numbers can be imported directly from files provided by Medicare Australia.

Patients are identified by Family Name, First Name, Second Initial, Date of Birth and Sex for the update of Medicare numbers. Expiry dates are then updated according to Medicare number.

Contact the Medicare Australia EDI Help Desk by phone on 1300 550 115 to request the supply of Medicare patient data.

To run the import, select **File > Import Medicare Number File** and follow the on-screen instructions.

Details of patients in the import files who could not be identified and those with duplicate (non-unique) Medicare numbers can be reported at the end of the import process.

Patient Import

Patient information may be imported into Communicare from either a csv file or Medicare Australia's Medicare data files.

To run the import simply select menu **File > Import Patient Biographic's File...** and follow the on screen instructions.

Details of import process will be reported at the end of operation and saved in Patient_Import.log in the Communicare program folder.

CSV File Import

The format of the csv file is defined in PatientImport.xls which can be found in the Communicare program folder. A csv file can be created from PatientImport.xls by using Excel's 'Save As' command.

It is best not to edit the PatientImport.xls file in the Communicare program folder because it will be overwritten by any Communicare upgrade. Instead, copy it to a working folder and edit it there. .

Dates must be formatted as dd/mm/yyyy.

*Medicare Australia's Medicare Data File Import * Contact the Medicare Australia EDI Help Desk by phone on 1300 550 115 to request the supply of Medicare patient data files. One file is supplied for each provider, containing details of each provider's patients.

These files contain Name, Date of Birth, Sex and Medicare card number only. No address information is contained in these files. Each imported patient's address is left blank, except for locality, which is set to the 'Default Community' according to System_Parameters.

Communicare Security

Communicare's security scheme is designed to be easy to maintain yet effective. It works on 3 layers: SYSDBA, ADMINISTRATOR, MEDISYS.

Only members of the System Administrators group can grant or maintain user rights and privileges.

Firebird Authentication

All Communicare data are held in a Firebird database. Access is denied without a valid Firebird username and password. The username and password supplied when Communicare is started is passed to the Firebird server for authentication. If authentication fails, Communicare prompts you to try again a limited number times.

This security layer applies regardless of the data enquiry tool used. That is, the same username and password is applicable to Communicare, Windows Interactive SQL or any other third party data analysis tools used to access Communicare data.

In order to maintain your Communicare database there are several system usernames and passwords that we maintain. For more information, see System Passwords *(on page 931)* .

Application Level Security

Users are organised into user groups. Access rights are granted to user groups.

Access to Communicare modules, for example, Management Reports, Clinical Record, is controlled by the Communicare application and the user groups and system rights.

This security layer applies only to Communicare.

For more information, see User Groups *(on page 842)*.

Database Enforced Security

Users are organised into user groups. Access rights are given to user groups only.

Access to Patient Clinical records and Clinical Item Type data is controlled according to user group membership.

This security layer applies regardless of the data enquiry tool being used. That is, the same username and password is applicable to Communicare, 'Windows Interactive SQL' or any other third party data analysis tools used to access Communicare data.

This scheme allows specific users to view sensitive data, for example, STD results, whilst hiding the same data from other users.

For more information, see User Groups *(on page 842)*.

Other Security Considerations

Refer to the HQBird and Firebird documentation for further information about securing Firebird. Particular attention should be paid to restricting access to:

- Firebird backup and backup media, so that unauthorised users cannot restore their own copies of Communicare data.
- The folder where the Communicare database resides.
- Firebird folders, usually `C:\\HQbird`.
- The server temporary file folder, usually the **TMP** environment variable defines where Firebird stores temporary files.

System rights

System rights determine which areas of Communicare can be accessed by a user. System rights are set when defining User Groups *(on page 842)*.

The System Rights themselves cannot be created, edited or deleted.

Unlike System Parameters, which determine which menus and buttons are visible to a user, System Rights determine which of these items are enabled.

The System Rights are described below.

Address Book Maintenance

Gives members of the User Group the right to insert, update or delete records from the Address Book and to search the EPD or PDS.

For more information, see Address Book *(on page 335)*.

Adverse Reaction Administration

Gives members of the User Group the right to update and delete Adverse Reactions from patient's Clinical Records. For more information, see Adverse Reaction Maintenance *(on page 255)*.

AIR Patient Integration

Gives members of the user group the right to view a patient's immunisation information recorded in the AIR. The information displayed from the AIR is dependent on the user's AIR provider number.

If an AIR provider number is set for the organisation, all Communicare users can view a patient's immunisation information if the AIR provider number has access to the AIR.

AIR Patient Integration Update

Gives members of the user group the right to edit a patient's immunisation information displayed in Communicare from the AIR. This right enables users to:

- Add a special risk group
- Add a planned catch up
- Edit indigenous status
- Edit vaccine history
- Add medical contraindications
- Add natural immunities

Alerts and Other Information

Gives members of the User Group the right to access information in the **Alerts and Other Information** pane in the Clinical Record and retrieve this information by using the letter item in Letter Writer. This User Group setting is available when the **Security on Alerts** module is enabled.

Warning:
There may be important information recorded in the **Alerts and Other Information** section that providers must see. There may be consequences to restricting users from being able to view this information which should be considered before turning on this module. Communicare shall not be liable for any unintended consequences.

Note:
Information displayed in the **Alerts and Other Information** pane may be included in some reports and this option does not prevent users viewing the information in reports. System administrators should consider the reporting rights of users with restricted access to alerts and other information.

For more information, see Alert Information *(on page 122)*.

Appointments

Gives members of the User Group the right to use the Appointments facility to book patients in for future appointments or record services provided for 'walk-in' patients.

The `Biographics` system right is included with this system right by default.

For more information, see Appointments *(on page 54)*.

Appointments Administration

Gives members of the User Group the right to access the appointments Session Types, Session Templates and Provider Planned Absences from the Appointments menu.

Billing

Gives members of the User Group the right for both Private Billing and to make electronic Medicare claims using online claiming. See Online Claiming - Electronic Claims *(on page 422)*.

`Billing` and `Billing Administration` rights are available when **Private Billing** or **Electronic Claims** modules are enabled.

When `Billing` and `Billing Administration` system rights are enabled, these system rights are applied to both **Private Billing** and **Electronic Claims** functionality if enabled.

Billing Administration

Gives members of the User Group the right to reset Bulk Bill Claims. For more information, see Bulk Bills Status (Online Claiming) *(on page 423)*.

It also gives members of the User Group the right to process Private billing.

Biographics

Gives members of the User Group the right to view, record or edit personal data, family data and special or administrative information. The user can also print Patient Labels. This user right is included by default if `Clinical Records`, `Appointments`, `Service Recording`, `Prescribing`, `Medication View`, `Patient Add` or `Patient Edit` is included. All personal data can be edited by users with this right, with the exception of date of birth, sex and preferred name. These values can be set when there is currently no value specified, but if there is already saved data, the `Patient Edit` right is required in addition to the `Biographics` right to edit it. See Biographics *(on page 30)* for more details.

Birth Notifications

Gives members of the User Group the right to access the Birth Notifications facility. The Birth Notifications system right is available only when the **Birth Notifications** module is enabled.

For more information, see Birth Notifications *(on page 346)*.

Clinical Records

Gives members of the User Group the right to view and use patients' clinical records. Items that users can see will depend on the Clinical Item Access Rights granted to the user. Users with this right can also record patient death.

The `Biographics` system right is included with this system right by default.

See Clinical Records *(on page 112)*.

Clinical Reporting

Members of the User Group with this system right can run the patient summary report and hard-coded reports related to clinical patient information such as immunisations due. With the `Management Reporting` right, the user can use Query Builder and run SQL reports. For more information, see Clinical Reporting *(on page 483)*.

Consolidated Order - Manage

Members of the User Group with this system right can manage consolidated orders, review new and changed medication requests, determine order quantities, submit consolidated orders to suppliers and receive inventory. Consolidated orders are part of the **Medications Management** module.

Data Entry Wizard

Gives members of the User Group the right to access the data entry wizard. For more information, see Data Entry Wizard *(on page 165)*.

Document Scanning

Gives members of the User Group the right to scan documents. For more information, see Managing Documents *(on page 314)*.

Electronic Documents

Gives members of the User Group the right to create documents outside of the Clinical Record. Inside the Clinical Record all users can create documents regardless of this system right. When using the Documents and Results form, this system right is required in order to have access to all documents under Received Documents tab. Users with no Electronic Documents system right can see only the reviewed documents list but can't access it. Members of this group will also be able to see documents with no viewing right attached - both in the clinical record and also in the Documents and Results form. For more information, see Managing Documents *(on page 314)*.

HealthLink SmartForms

Gives members of the User Group the right to create, modify and delete HealthLink SmartForms. Users without this system right can still view saved or submitted SmartForms. Fore more information, see HealthLink SmartForms *(on page 794)*.

Imprest Management

Gives members of the User Group the right to manage the imprest functionality. The Imprest Management system right is available only when the Medications Management module is enabled.

Information Sharing Consent Maintenance

Gives members of the User Group the right to record that a Patient has given or denied consent to allow access to their Clinical Record to an Organisation who didn't originally record the data. For more information, see Information Sharing Consent *(on page 41)*.

Information Sharing Consent Recording

Gives members of the User Group the right to record that a patient has withdrawn consent or has never been asked to allow access of their Clinical Record to an Organisation who didn't originally record the data. For more information, see Information Sharing Consent *(on page 41)*.

Investigations

Gives members of the User Group the right to request, manage and review pathology results. For more information, see Investigations *(on page 299)*.

Management Reporting

Gives members of the User Group the right to run hard-coded reports related to management reporting such as admissions *(on page 477)* and to use the Patient Query *(on page 533)* tool to produce reports. Management reports tend to be concerned with analysing the whole population base rather than reporting on specific patients. Some of these reports can take some time to complete. With the Clinical Reporting right the user can use Query Builder *(on page 576)* and run SQL reports. For more information, see Management Reporting *(on page 453)*.

Medication History

Any user who belongs to a user group with `Medications History` system right can view, record, edit or delete a patient's Medication History, regardless of formulary or prescribing rights. The Medications History system right is available only when the **Medications View** module is enabled.

Medication View

Gives members of the User Group the right to view the Medication Summary tab in the Clinical Record, and to browse the MIMS Pharmaceutical Database.

The `Biographics` system right is included with this system right by default.

Medications Administer

Gives members of the User Group the right to view, record, edit or delete the administer details. The `Medications Administer` system right is available only when the **Medications Management** module is enabled.

Medications Dispense

Deprecated.

Medications Supply

Gives members of the User Group the right to view, record, edit or delete the supply details for a medication. The Medications Supply system right is available only when the **Medications Management** module is enabled.

MeHR

Gives members of the User Group the right to participate in MeHR *(on page 773)* and register patients with MeHR electronically if they do not have a MeHR ID.

MeHR Administration

Gives members of the User Group the right to use MeHR administration functions.

MeHR e-Registration Auto-Prompt

Access to this functionality will enable automatic checks and prompts for registration at certain points if a patient's registration status is unknown. This System Right cannot be given without the MeHR right. For more information, see MeHR eRegistration *(on page 774)*.

My Health Record Access

Gives members of the User Group the right to access the **My Health Record Access** module. For more information, see My Health Record *(on page 780)*.

My Health Record Assisted Registration

Gives members access to the My Health Record Assisted Registration window, via Patient Biographics. For more information, see My Health Record Assisted Registration *(on page 788)*.

NCSR Integration

Providers who belong to a user group with this system right can view NCSR alerts and link to the NCSR hub. The NCSR `Integration` system right is available only when the **NCSR Integration** module is enabled.

Patient Add

Gives members of the User Group the right to add new patients.

The `Biographics` system right is included with this system right by default.

Patient Deletion

Gives members of the User Group the right to delete patients from the database and merge duplicate patient records. Allocate this right with care. Only fictitious patients should be deleted, instead use merge for duplicated patients. For more information, see Patient Deletion *(on page 49)*.

Patient Edit

Gives members of the User Group the right to edit date of birth, sex and preferred name. If a user does not have this right they may only set these values if there is currently no value specified.

The `Biographics` system right is included with this system right by default.

Patient Status Administration

Gives members of the User Group the right to change the Patient Status and to view and edit patient group membership information on the **Administration** tab.

Prescribing - Full

Gives members of the User Group the right to write a prescription and create a medication order, and to use the MIMS Pharmaceutical Database. A Provider must have a Prescriber Number in order to write a prescription. The Prescribing - Full system right is available only when the Prescribing Module *(on page 812)* is enabled.

The `Biographics` system right is included with this system right by default.

For more information, see Prescribing *(on page 223)*.

Prescribing - Once Off/Short Course

Gives members of the User Group the right to create a once off prescription or medication order and use the MIMS Pharmaceutical Database. A Provider must have a Prescriber Number in order to prescribe. If Prescribing Once Off/ Short Course is enabled without Prescribing Full then members of this user group are only allowed to prescribe or create medication orders for once off/Short Course medications. They can view both once off/Short Course and regular

medications, but modify only once off/Short Course medications. In order for users to see Medication Requests in the clinical record, Prescribing once off/short course needs to be enabled. To gain access to Prescribing Once Off/Short Course system right, Prescribing module needs to be enabled.

The `Biographics` system right is included with this system right by default.

For more information, see Prescribing *(on page 223)*.

Provider Administration

Gives members of the User Group the right to access Provider maintenance form and modify any provider record and their details.

Reference Tables

Gives members of the User Group the right to edit the various Reference Tables. See Reference Tables *(on page 853)*. This is also the right required to create and edit document templates - see Template Maintenance *(on page 957)*.

Referral Management

Gives members of the User Group the right to manage incoming referrals, that is, allows the users of the group to edit referral status, referral priority, and so on. The `Referral Management` system right is available only when the **Referral Management** module is enabled.

Report Administration

Users with `Report Administration` system rights can save new customised reports for future use, or save modifications to existing customised reports.

Service Recording

Gives members of the User Group the right to access the Service Recording facility.

The `Biographics` system right is included with this system right by default.

For more information, see Service Recording *(on page 86)*.

SMS Administration

Users with `SMS Administration` system rights can set up and manage the appointment templates used with Telstra Health's SMS gateway (TH Messaging) in **Tools > Manage SMS Appointment Reminders**.

SMS Messaging

Users with `SMS Messaging` system rights can use either Telstra Health's SMS gateway (TH Messaging) or Burst to send SMS messages to patients. Users can also send appointment reminders to multiple patients automatically using Telstra Health's SMS gateway (TH Messaging).

Transport Services

Gives members of the User Group the right to access the **Transport Services** module. For more information, see Transport Services *(on page 81)*.

Report Access

Access to reports in Communicare is controlled using a variety of system rights and viewing rights.

Access to hard-coded reports

Hard-coded reports  are part of the Communicare program and as such cannot be imported, exported or modified without a Communicare upgrade. Access to these reports is controlled thus:

- The Appointments right gives access to hard-coded reports on the Appointments menu.
- The Management Reporting right gives access to hard-coded reports on the Admissions, Encounter Analysis, Population Analysis, Procedures and Referrals menus and also the Births, Deaths, Patient Card Numbers and Patient Query reports on the Patients menu.
- The Clinical Reporting right gives access to hard-coded reports on the Conditions, Immunisations, Medications and Recalls menus and also the Patient Summary report on the Patients menu.
- The Biographics right gives access to the hard-coded Patient Labels report on the Patients menu.
- System Administrators only have access to the Headspace export report on the Headspace menu.
- All users have access to the heard-coded reports on the Reference Tables menu.

Access to SQL reports

Access to central SQL reports  and local SQL reports  requires both Management Reporting and Clinical Reporting rights. In addition, if the SQL report has a defined viewing right then that right must belong to the user and if the SQL report has a specific system right then that right must belong to the user (e.g. Appointments SQL reports may have a requirement for the Appointments system right as well as the reporting rights). If the SQL report is disabled or was created by a user who has made it 'not public' then it cannot be seen by other users.

Access to Query Builder reports

Query Builder reports  are not maintained by Communicare and as such are all local reports. These are based on models which determine the access. If the Query Builder report was created by a user who has made it 'not public' then it cannot be seen by other users.

See Access Control for Query Builder reports *(on page 930)* for more details. See Also User Groups *(on page 842)*.

Access Control for SQL reports

In order to access SQL reports *(on page 581)* a user must have both the Management Reporting right and the Clinical Reporting right.

In addition, each SQL report may have a separate viewing right and/or system right that may prevent a user without these rights from running those reports.

The Report Administration right is required to be able to edit, create, import and export SQL reports *(on page 581)*. See Also User Groups *(on page 842)*.

Access Control for Query Builder reports

Access to Query Builder reports is controlled by a combination of system rights and data models.

To be able to edit, create, import and export Query Builder *(on page 576)* reports, users must belong to a user group that has the `Report Administration` system right.

By default, System Administrators have access only to reports based on the `Users` data model.

To access reports in a particular area, based on a particular data model, users must also have the additional rights described below. For more information, see Data Models *(on page 578)* and User Groups *(on page 842)*.

Table 299. System rights required for access to Query Builder reports

Data model	System right required
`Appointment`	**Appointments**, **Management Reporting**
`AppointmentTemplate`	**Appointments**, **Management Reporting**
`Demographics`	**Biographics**
`ClinicalRecord`	**Clinical Reporting**
`Services`,	**Management Reporting**

Note:
Query Builder reports cannot be accessed if they are placed on a non-Query Builder report menu that is disabled because of a user's System Rights.

System Passwords

Communicare maintains some system accounts and passwords and backup archive passwords.

The following system accounts and passwords are maintained by Communicare:

- **SYSDBA** - used for database metadata changes during upgrades and some data maintenance tasks. This user does not access your database using Communicare, but can access the database using server maintenance tools.
- **CCUSER** - used by the server's daily maintenance tasks performed throughout the day, such as Medicare claiming and card checking, pathology result processing, and so on. This password cannot currently be changed.
- **CCSERVER** - a system-level administrator user account for integration with the application service. The default should be customised for each health service.
- **CCSYNC** - used by data synchronisation tasks after changes made on data synchronisation laptops are uploaded.
- **CENTRAL** - used to create data in the central distribution database. This user does not access your database but is displayed as the created user of central clinical items and qualifiers.
- **MEDISYS** - this is the only username that may be used to access your database using Communicare. It is used by Communicare Support when investigating issues or on request to support your health service. Activity performed by this user is logged in the same way as all users of Communicare. In addition we keep our own records of authorised access.

Additionally the **BACKUPZIP** account and password are used to protect your backup archive zip files.

Changing system passwords

Normally Communicare Support sets and maintains system passwords. However, on request, we can reset these passwords if you are concerned about potential data breaches or because you have a formal password policy.

Important:
In most circumstances you should not update system passwords, otherwise the normal functioning of the database may be impaired. However, if you do reset these passwords yourself, it is essential that you inform Communicare. Communicare Support must know these passwords, or our ability to support you will be compromised.

To change a system password:

1. On the Communicare server, run *Communicare_install*/ccPasswordsEditor.exe.
2. In the **Enter Password** window, enter your SYSDBA password and the daily code from Communicare Support.
3. In the **Passwords** window, for the password you want to update, click **Change**.
4. In the **Choose New Password** window, enter and confirm the new password.

   Passwords must not include the following characters: `>, =, %, |, &, ^, '(Single quote), "(Double quote), (space)`.
5. Click **OK**.

Daily Process Service

The Daily Process Service is a Windows NT Service which can automatically run a variety of database tasks each day. For example, it will generate sessions *(on page 61)* and timeslots *(on page 60)* from the session templates *(on page 910)* and timeslot templates *(on page 916)*.

- It is normally run only on the Server computer.
- It runs each day (at midnight by default). The time can be set in services.ini under the Communicare folder.
- Run CcDailySvc /install to self register as a service. Startup is Automatic.

Appointments

The generation of appointments takes into account the following:

- It sets the Horizon Date to indicate last date generated.
- Dates before a Provider enable date or on or after Provider disable date will not generate sessions.
- A session will not be generated if either the start or end (start+duration) of the session would overlap with either a public holiday or a planned absence for the designated provider.
- A success message is output to the application log on every execution which includes brief statistics of the sessions generated.

Backups

The service will also run the CD Backup process (at 6AM by default). The time can be set in services.ini under the Communicare folder.

Automatic Recalls

The service also deletes invalid recalls. This includes recalls generated for patients who were under the maximum age when the recall was generated but who are now older than the maximum age.

Patient Status

This service also updates any patient whose status has not been changed manually. The rules are outline in the topic Automatic Patient Status Change *(on page 933)*.

Daily Process Application

The Daily Process Application is provided for demonstration use only. Production system should use the daily process service *(on page 932)* instead.

Automatic Patient Status Change

Every night the server will check the Inactivity years in system parameters and use it to change a patient's status after the specified number of years, based on the existence of contact services and patient address.

A contact service is defined as any service with a mode that does not contain the words "no client contact" or "telephone". Changes to this value will not take effect until the Daily Process is run.

> **Note:**
> Blank Inactivity years will effectively disable the automatic status change facility.

Inactivity years is the number of years as set in the system parameters.

New patients are treated as if they were "serviced" on the day they were recorded for the purpose of status updates. This means a new patient will have a status of either current or transient.

Automatic status change

These are the rules to be followed when changing the status automatically:

- A health service may determine a patient inactivity period in years ('n'). This can be anything they want but is usually 2 or 3.
- If an inactivity year has been entered, the patient status change is automatic.
- If n is not set, all patient statuses must be determined manually.
- Statuses of Fictitious Patient or Non Patient are never changed automatically.
- If n has been set, a health provider may set a patient's status manually if they want and their decision will be respected for n years after they set this status. When a new patient is added it is assumed to be a manual status that has been set at that time.
- If n has been set and a patient's status has not been manually set or adjusted in the previous n years then the following changes are implemented automatically every evening after the database restarts:

- If the patient has at least one contact service either booked, cancelled, waiting, withdrawn, started, paused or completed, excluding telephone calls, within the previous n years, and they live in the region defined in the database as the Health Service Area, then their status remains or is changed to Current Patient.
- If the patient has at least one contact service either booked, cancelled, waiting, withdrawn, started, paused or completed, excluding telephone calls, within the previous n years, and they do not live in the region defined in the database as the Health Service Area, then their status remains or is changed to Transient Patient.
- If the patient has no contact services either booked, cancelled, waiting, withdrawn, started, paused or completed, excluding telephone calls, within the previous n years, then their status remains or is changed to Past Patient.

- In rare cases a health service may implement additional statuses of Banned 30 days and Banned 60 days. These are automatically set to Current after the appropriate period.

Table 300. Rules for status change

	Current Status	Status manually changed in the last Inactivity years	Was Serviced in the last Inactivity years[2]	Lives in Health Service Area[3]	New Status
1	-	Yes	-	-	No Change
2	Past	No	Yes	Yes	Current
3	Past	No	Yes	No	Transient
4	Transient	No	Yes	Yes	Current
5	Transient	No	No	-	Past
6	Current	No	No	-	Past
7	Current	No	Yes	No	Transient

Terminal Server and Communicare

The Communicare client can be installed on a Terminal Server.

Note:
As of Windows Server 2008 R2, Terminal Services / Terminal Server have been renamed to Remote Desktop Services / Remote Desktop Server. This article will continue to refer to them as Terminal Services / Terminal Server.

Install the client in the usual way from the Communicare Server Install share (i.e. `\\\\CCAREXYZ\\Install`).

Upgrading the Communicare Client on a Terminal Server

Because of the way Terminal Servers are used to serve applications to multiple users concurrently, there are some peculiarities with how applications must be installed and upgraded. The server must be put into "Install Mode" before installing a program, and then must be returned to "Execute Mode" afterwards.

This also applies to installing and upgrading Communicare. Most importantly, the upgrade MUST BE PERFORMED MANUALLY - say NO to any invitation to upgrade to the new version and cancel the Communicare log-on.

2. *Was Serviced* means the patient has at least one contact service. The addition of an appointment even if the patient did not turn up is counted as a service because the booking implies intent to become a patient of the health service.
3. *Lives in service area* means the patient's home address locality is listed in the Health Service Area locality group *(on page 864)*.

Instead, use Windows Explorer to browse to the install share - `\\\\CCAREXYZ\\Install\\CCare` (where *CCAREXYZ* is the name or IP address of the Communicare Server) and run the file `setup.exe`, accepting all the defaults. Windows Server should recognize the file name as an installer and will automatically put the system into Install Mode while it is running. It will also change it back afterwards.

Alternatively, you can install using **Control Panel > Add/Remove Programs** and browse to the location. This is guaranteed to put the server into Install Mode.

Automatically Upgrade using Batch Script

The following script can be used to automatically install Communicare on a Terminal Server. Copy and paste this into a text file, and save as AutoUpgradeCommunicare.cmd on the server desktop. Make sure *CCAREXYZ* is replaced with the name or IP address of the Communicare Server before running the script.

The script will show the task manager so that any users currently logged on (or who have not disconnected properly) can be notified and logged off. The script will temporarily stop users from being able to log-on during the upgrade (to prevent them from using incorrect configurations), and will put the server in Install Mode. Communicare will be installed silently using the current configuration. Once installed, the server is returned to Execute Mode.

```
@echo off

echo.
echo ################################################################################
echo #                                                                              #
echo #  IMPORTANT: Check that no-one has an active session on the system.     #
echo #             Use task manager to send them a message and log them off.  #
echo #                                                                              #
echo ################################################################################
echo.
taskmgr

:: Stop any new connections to the server.
change logon /disable

:: Put server into install mode.
change user /install

echo Installing Communicare...
:: Install the latest version of Communicare from the server.
"\\CCAREXYZ\Install\CCare\Setup.exe" /silent

:: Put server back into normal execute mode.
change user /execute

:: Allow connections again.
change logon /enable

echo.
echo Done!
```

```
pause
```

Configuration Notes

Communicare can use between 32MB to 256MB RAM. It also requires at least 512KB in Session Heap RAM. Old terminal servers like 2000 and 2003 might allocate only 512KB of Heap RAM per Window Station. We recommend 1MB per Window Station in Session Heap. This can be modified using the Windows registry.

This setting is controlled by `CurrentControlSet/Control/Session Manager/SubSystem`. The actual value is **Windows** and should contain something like this:

```
... SharedSection=1024,3072,512 ...
```

The 3rd value is the session heap and it should be changed to at least 768. Recommended value is 1024.

```
... SharedSection=1024,3072,1024 ...
```

Backup Regimes

Backups of your Communicare database are critical for business continuity in the event of a disaster. Communicare is automatically backed up to the server nightly. Your site should take regular backups of these backups.

> **Important:**
> Exercise care with your backups. The most recent Communicare backup is an important resource for your health service in the event of technical failure, cyber attack or disaster. If the Communicare server is destroyed, you won't be able to restore your data without a backup. For more information, see Disaster Recovery *(on page 938)*. Historical backups may also be an important reference, for example, for point-in-time medico-legal investigations.

You are responsible for:

- Checking that the backups occur as scheduled.
- Taking a copy of the backup and storing it on a server separate to the Communicare database.
- Regularly storing a copy of the backup offsite.
- Asking Communicare to adjust the time of the backup if you require a different time. The default is 5pm local time.
- Asking Communicare to configure the backup to be copied to a network share if you would prefer this method.
- If you use an external storage device, changing it regularly.
- Asking Communicare to change the number of monthly backups kept if required. The default is six months.

Backups

Communicare servers have an automated system for writing zipped and password protected backups to the server. The database and the security database (containing usernames and passwords) are both backed up in this way.

The hard drive stores daily backups for the last week, weekly backups for the last month and monthly backups for the last six months.

> **Tip:**
> Communicare keeps a detailed log of the last 14 backups on the server.

Communicare uses the following naming convention for backup files, where *XXXX* is a 3-5 letter code identifying your database and `YYYYMMDDHHMMSS` is the date and time at which the backup finished:

- Daily:
  - `XXXX_D1-7_YYYYMMDDHHMMSS.zip`, for example, `DEMO_D7_20200101170032`
  - `SECURITY2_D1-7_YYYYMMDDHHMMSS.zip`
- Weekly:
  - `XXXX_W1-4_YYYYMMDDHHMMSS.zip`, for example, `DEMO_W4_20200101170047`
  - `SECURITY2_W1-4_YYYYMMDDHHMMSS.zip`
- Monthly, up to 6 months:
  - `XXXX_M01-06_YYYYMMDDHHMMSS.zip`, for example, `DEMO_M06_20200101170044`
  - `SECURITY2_M01-06_YYYYMMDDHHMMSS.zip`

You may also find some legacy backup files from database upgrades and a previous database regime with an alternative naming convention.

Important:
Regularly check the contents of the `Backup` folder on the server. In the Windows Explorer, open `\\CCAREXYZ\Backup` (where *CCAREXYZ* is the name of your Communicare server) and look at the files.

- Order the files by **Date modified** and look at the files for yesterday. There should be a large database file and a smaller security file.
- If there are no files in the `Backup` folder, contact Communicare Support immediately.

Backing up over a network

Your site should be taking regular backups of the daily, weekly and monthly backups.

Network administrators can back up the entire contents of the `Backup` folder or be selective.

Backup files can also be copied (mirrored) to a network share if required. Contact Communicare Support for further assistance.

Backing up using an external storage device

If you are using an external storage device to store backups, use one of the following strategies:

- New storage device daily

  By inserting a new storage device every day you will always have the previous day's work. At any time you can restore a database from any previous day. Simply label each backup with the date and store safely. This is the best strategy for securely backing up your database.

- New storage device weekly

  The previous week's nightly backups are stored on one storage device. You will have the same facility to restore a database from any previous day, but in the event of a catastrophe you will not necessarily have the previous day's backup. However, you will have a backup of no more than 7 days old.

- One storage device

The external storage device will always contain only one backup which will be the most recent.

- Set of storage devices, cycled

  Use five (or seven) storage devices labeled Monday, Tuesday, Wednesday, and so on. Rotate them daily. At any stage you will have a backup for any day of the previous week. Periodically take a copy of one of the storage devices as permanent backup.

Note:

If a backup cannot be written to the external storage device, that day's backup is kept and will be written the next time there is a suitable storage device in the drive. If you employ a system of changing the device every day but miss a day, the next day's backup will contain the missing backups.

If no storage device is found for seven days, only the most recent seven days' backups will be copied when a suitable storage device is inserted.

Disaster Recovery

In the event of disaster, call Communicare Support on **1800 798 441** and follow these steps to recover your data.

Important:
As soon as Communicare is installed at your health service, you should have a backup regime in place. For information about backing up your Communicare database, see Backup Regimes *(on page 936)*.

In the event of disaster, either the database must be recovered or the most recent backup must be obtained. Without the database or a backup, you won't be able to restore your data. These are the options available to restore your data in order of preference:

1. If there is access to the server's file system, the database file may be recoverable by Communicare Support. Support can backup and copy the database.
2. If the database is inaccessible, the latest backup may still be accessible. The data will be 0-24 hours old depending on the time of day that the server problem was encountered.
3. If the server has been destroyed completely, the latest backup copy stored separately to the Communicare server will be required. If you copy your backup to a separate server daily, the data will be 0-24 hours old depending on the time of day that the server problem was encountered. If you copy your backup less frequently, the backup will be older than one day.
4. If the entire building has been lost, the latest backup stored offsite will be required.
5. If a synchronisation client has survived, this may be used to recover the database. The database will be as current as the last time the offline client was synchronised.

Note:
If you have a computer, the latest backup and an internet connection available immediately, the time to get the database up and running after a disaster may be as little as 60 to 90 minutes. Extra time will be needed if any of these requirements are not met. Extra time may also be needed for large or complex installations and in the event of disasters where multiple health services are affected simultaneously.

To recover your database:

1. Determine which of the above scenarios applies to you.
2. Configure a Windows computer to allow remote access for Communicare Support. If a computer is available, installing and configuring the remote control software should take no longer than 5-10 minutes. If no internet or phone connection is available, move the computer to a place where there is either an internet or phone connection.
3. Call Communicare Support on **1800 798 441**.
4. Communicare Support will access the replacement computer and install Communicare. If Communicare cannot be copied from the old server, it will need to be downloaded over the internet. This can take about 1 hour with a good internet connection.
5. Communicare Support will restore the latest backup. This will take approximately 5-15 minutes, or longer depending on the size of the database and the specification of the server.

If there is a local network available, clients can connect to this replacement computer and use Communicare almost immediately.

File Transfer

Communicare demos and updates are available from the Communicare User Portal - Help and Support tab.

Firewall Configuration

Antivirus

When virus scanners do real-time, on-access scans of the database, there is potential for serious performance penalties and corruption of the database file itself. Therefore, certain areas must be excluded from all scanning (whether it be scheduled or real-time).

Exclude the following folders, including all files and subfolders from all virus scans.

Tip:
Use `C:\\Program Files\\` or `C:\\Program Files (x86)\\` as appropriate.

- Communicare folder: `C:\\Program Files (x86)\\Communicare\\`
- Firebird Server folder: `C:\\HQbird`
- Argus folder (if Argus is installed): `C:\\Program Files (x86)\\Argus\\`
- Database folder: `D:\\`

If possible, exclude the following file extensions from being scanned:

- Firebird database files: `*.FDB`, `*.GDB`

Note:
If these exclusions are not possible with the virus scanner, do not use it on the appliance server.

Firewall Exceptions

Some Communicare and third party processes rely on external connections to function.

Table 301. Required firewall and proxy exceptions

Process	Description	Protocol	Source IP	Source Port	Destination IP	Destination port
Firebird SQL	Allow a Communicare Client to connect to a Communicare Server. Mandatory for most basic configuration.	TCP	Communicare Client IP	Random	Communicare Server IP	3050 and 3051
Shared Folders	Access to the Communicare Server shared folders. All Communicare Shared folders are read-only with the exception of 'Results' if that exists. Everyone can connect to a Communicare shared folder without a password or username.	TCP and UDP	Client IP	Random	Communicare Server IP	135...139 and 445 (Not all ports are always required, but should be configured)
Medicare Australia	Mandatory for online claiming only.	TCP	Communicare Client IP and Server	Random	`mcoe.humanservices.gov.au`	http (80)
Medicare Australia	Mandatory for online claiming only.	TCP	Communicare Client IP and Server	Random	`www2.medicareaustralia.gov.au/pext`	https (443)
Medicare Australia - AIR	Mandatory for AIR web page only.	TCP	Communicare Client IP and Server	Random	`www1.medicareaustralia.gov.au`	https (443)
Health Identifier Service	Mandatory for online claiming only.	TCP	Communicare Client IP and Server	Random	`www3.medicareaustralia.gov.au`	https (443)
My Health Record	Mandatory for MHR	TCP	Communicare Client IP and Server	Random	`services.ehealth.gov.au`	https (443)
eRx	Mandatory for electronic prescriptions	TCP	Communicare Client IP	Random	`APPSERVERNAME:3440/StandardAdapterService.svc/outbound` where *APPSERVERNAME* is the name of the Appliance Server or VM on which Communicare is installed	3440
Shared Electronic Health Records - My eHealth Record (MeHR)	All NT Communicare Clients must be able to make outgoing connections to the NT HealthConnect repository	TCP	Communicare Client IP and Server	Random	`repository.healthconnect.nt.gov.au`	8080

Table 301. Required firewall and proxy exceptions (continued)

Process	Description	Protocol	Source IP	Source Port	Destination IP	Destination port
Secure Electronic Messaging System - Argus 6	For the Communicare server to use a SEMS it must connect to an Argus server or run an Argus server on the Communicare server.	TCP	Communicare Server IP	Random	Argus server	60000 (or as set up on Argus server)
HealthLink - Secure Message Delivery	The port number for communication with HealthLink for secure message delivery.	TCP	Communicare Client IP and Server	Random		
HealthLink Aduro SmartForms	The port number for communication with the HealthLink Aduro Forms Engine.	TCP				5088
National Health Services Directory		TCP	Communicare Server IP and Communicare Client IP	Random	`humanservices-directory.vic.gov.au`	https (443)
National Health Services Directory		TCP	Communicare Server IP and Clients	Random	`www.connecting-care.com`	https (443)
SMS Messaging	Allow the Communicare server to send SMS messages.	TCP	Communicare Server IP	Random	`webservices.communicaresystems.com.au`	9000
Communicare FTP Server	Passive mode settings.	TCP	Communicare Server IP	Random	`ftp.healthconnex.com.au` (`101.172.166.96`)	22
Communicare Remote Support	Remote support using Team Viewer.	TCP	Communicare Server IP	Random	`teamviewer.com`	80, 443 & 5938
QH VIEWER	For North West Hospital Health Services, QLD only	TCP	Communicare Client IP and Server	Random	`eds.health.qld.gov.au`	https (443)
Real Time Prescription Monitoring (RTPM) Service	The address of the RTPM web service	TCP	Communicare Client IP and Server	Random	`https://api.prescriptionmonitoring.gov.au/` You may also need to allow a firewall exception for the IP addresses associated with this URL. Contact eRx for further information.	https

Table 301. Required firewall and proxy exceptions (continued)

Process	Description	Protocol	Source IP	Source Port	Destination IP	Destination port
SNOMED Terminology Browser Location	Access to link clinical item terms to SNOMED terms using the CSIRO Shrimp Server	TCP	Communicare Server IP and Communicare Client IP	Random	`https://ontoserver.csiro.au/shrimp` (`150.229.0.213`)	https (443)
SNOMED Terminology FHIR Validation Service	Allow linked SNOMED terms on clinical items to validate.	TCP	Communicare Server IP and Communicare Client IP	Random	`https://stu3.ontoserver.csiro.au/fhir` (`52.62.60.39`)	https (443)

Upgrades

Communicare upgrades are performed remotely by Communicare Support at a time arranged with the system administrator.

System Administrator: before a Communicare upgrade

Before a Communicare upgrade, complete the following steps:

1. Download the latest demo from the Communicare User Portal - Help and Support tab.
2. Study the appropriate Release Notes.
3. Familiarise yourself with the changes, including changes to ICPC-2 PLUS terms (see www.fmrc.org.au) and any new reports that have been added.
4. Prepare your staff for the changes that they will see after the upgrade: this may involve inviting key staff to test the changes.
5. Request an upgrade on the Communicare User Portal - Help and Support tab.

Communicare Support will contact you about the timing of the upgrade. The upgrade will be performed by Communicare Support staff.

Important:
If you are upgrading to Communicare V21.1 and later, ensure that you recall all laptops with an offline client installed and synchronise them with the core Communicare database before the upgrade occurs. Data from Communicare V19.2 and earlier that is not synchronised before the upgrade will be lost.

During the upgrade, no users can be connected to Communicare. If you use Remote Desktop Connection or similar, you will need to log on to the Remote Desktop to upgrade the client version of Communicare before users of the Remote Desktop can use Communicare.

System Administrator: after a Communicare upgrade

After a Communicare upgrade, be available for staff in case there are any issues with the Communicare upgrade on a workstation. For example, some users' login credentials may not allow them to run an installation program.

Communicare Client Upgrades

After the server has been upgraded, Communicare clients automatically detect that an upgraded version is available on your network. If an upgraded version is available, Communicare displays a message while it is starting up. You should choose to upgrade Communicare as, occasionally, running an old version will cause errors. In case of errors just close Communicare, restart it and accept the upgrade. Depending on your network connection speed, the upgrade will normally only take a minute or two to complete, after which Communicare will start.

Users who do not have the rights to install software should seek the assistance of the network administrator who will need to log on to complete the upgrade.

Upgrading the Communicare Client on a Remote Desktop

See Terminal Server and Communicare *(on page 934)*.

Reports and Templates upgrade

Whenever the server computer is upgraded to a newer version of Communicare, the latest reports and templates will be imported into the database. If you have created reports or templates with exactly the same name as a new report or template in the upgrade, your report or template will be overwritten. However, all of the existing reports and templates are backed-up on the server in a folder under the `SavedQueries` folder. Rename the required reports and import them back into the Communicare database.

Database Connection Settings

Client Database Server, Path and Schema cache directory details are setup by the installation program and should not normally require adjustment.

The Database Server and Path information is copied from ccSetup.ini (which is located with the Setup.exe on the server) by the installation program (Setup.exe). If the server name or database path is changed then ccSetup.ini should be edited and the installation program (Setup.exe) re-run on each workstation.

Central Data

Communicare maintains and distributes a specific set of Clinical Item definitions. Centrally maintained Clinical Item definitions are referred to as *central* items.

The central items may be for one or more specific projects such as the Aboriginal Family Futures Project or may be used to maintain and distribute standard code sets such as ICPC-2 PLUS or ICD-10. Recalls and generic protocols are also included so that central control may be exercised over recalls. This allows central distribution of immunisation schedules, for example.

Your administrator can configure a unique set of additional Clinical Item definitions for your site which are retained when Central data is updated. Use reports such as **Reference Tables > Clinical Item Types Added** to help maintain your local, unique Clinical Item definitions when central Clinical Item definitions are added and updated.

Central data items are updated regularly and distributed automatically with each new version of Communicare. Alternatively, administrators can use the Communicare Data Updater to update Central data as required.

Note:

- Central datasets have their own access groups. For any site users, including the administrator, to use or even see the Central items, users must be added to these groups.
- If there is a conflict in a description between a Central item and a site item, the site item will generally be deleted if not in use, otherwise the site description will be changed by appending `[1]`, `[2]`, `[3]` and so on to the site description. Conflicts are listed in the Action window. Your administrator should amend the site description as soon as possible to avoid any confusion.
- To change the Central datasets included in your Communicare instance, set the datasets required in the **Datasets** list on the **System Parameters > System** tab and run the Data Updater. Contact Communicare Support for help.

Datasets

Communicare includes some datasets by default. Other datasets are optional and are available on request.

For optional datasets, a standard activation fee and additional charges may apply. For more information, contact .Communicare Support.

In the **Datasets** table on the **System Parameters > System** tab, the following datasets are available:

- **Communicare Infrastructure** - do not deselect this dataset. It is used by Communicare internally and many parts of Communicare depend on it.
- **Communicare Value Added** - additional clinical item types not yet included in ICPC-2 PLUS such as custom check-ups and EPC items. This dataset is required for antenatal care reporting. It contains the Fagerstrom clinical item.
- **ICPC-2 Plus** - contains all supported ICPC-2 PLUS clinical terms and groupers.
- **Immunisation Age Based Reviews** - defines regular immunisation reviews based on age.
- **Immunisation Vaccines** - a list of vaccines by brand name. We distribute both ICPC-2 PLUS 'generic' immunisation types and Communicare 'brand' vaccine dataset. The latter dataset is fully coded with AIR codes to facilitate the electronic transmission of AIR details to AIR. We usually recommend that health services adopt the 'brand' dataset and disable all but a few of the 'generic' dataset. It is the health service's decision whether to record brand or generic names. In the case of influenza, ICPC-2 PLUS distributes both `Immunisation;flu` and `Immunisation;influenza`. They are analogous and either can be used. The Communicare dataset distributes `Immunisation;Fluvax`, `Immunisation;Vaxigrip`, and others as they become available. `Immunisation;ADT` is the ICPC-2 PLUS item and `Immunisation;ADT` vaccine is the Communicare item. `Immunisation;Q fever` is the ICPC-2 PLUS item and `Immunisation;Q fever vaccine` is the Communicare item. You will also see `Immunisation;BCG`, `Immunisation;CDT` and `Immunisation;Triple antigen` as both ICPC-2 PLUS and Communicare items. We strongly recommend using the Communicare 'brand' vaccine dataset.
- Various program, project, local and national initiative datasets. For example:
  - `Australian Nurse-Family Partnership` (ANFPP) - participating health services should contact the Australian Nurse Family Partnership Program for details. Any required reports will be distributed directly by the ANFPP. For more information, see Australian Nurse-Family Partnership Program *(on page 378)*.
  - `Drug and Alcohol Treatment Service` (DATS) - this dataset is required for residential drug and alcohol services that need to submit data using the National Minimum Dataset. There are variations for NSW. For more information, see Drug and Alcohol Treatment Service *(on page 380)*.

- `Flinders Care Plan` - Flinders Model of Chronic Disease Care Management as adapted for Closing the Gap which includes My Health Story and Living Well Smoke Free. If you require Flinders Care Plan support, contact the Flinders Model team at http://flindersprogram.com.au or phone (08) 8404 2607. For more information, see Flinders Care Plan *(on page 382)*.
- `HACC and CHSP` - these datasets (there is a separate dataset for Victoria) satisfy data collection for HACC or the CHSP using the export reports. Submission details can be obtained from HACC. Use either the `HACC and CHSP` or the `HACC and CHSP (Victoria)` dataset, but not both. For more information, see Home Support Programs *(on page 383)*.
- `Headspace` - participating health services will need to export data using the headspace export program. Submission details will be provided by headspace. For more information, see Headspace *(on page 393)*.
- `Healthy Under 5 Kids` (HU5K) - this program is a Northern Territory Government, Department of Health (DoH) initiative. This program incorporates a series of age specific child health checks which include growth assessment and the childhood vaccination schedule. AMSANT and DoH have jointly worked to make this program available through the Communicare system. For information relating to data and electronic health record system functionality, contact AMSANT. For queries relating to the Healthy Under 5 Kids program please contact NT DoH, Child & Youth Health Strategy Unit. For more information, see Healthy Under 5 Kids *(on page 395)*.
- `iSISTAQUIT` (implement Supporting Indigenous Smokers To Assist Quitting) - is a multi-component intervention aimed at improving health providers' provision of smoking cessation care to pregnant Aboriginal and Torres Strait Islander women, funded by the Commonwealth Government. This program is currently restricted. For more information, see iSISTAQUIT *(on page 401)*.
- `NT Child Health Check Initiative` - this program has now ceased.
- `RACGP Aboriginal & TSI Health Check` - combined annual Aboriginal and Torres Strait Islander health check developed in conjunction with the RACGP and NACCHO. For more information, see RACGP Aboriginal & TSI Health Check *(on page 412)*.
- `RHD and acute rheumatic fever` - Northern Territory RHD and acute rheumatic fever protocol items. For more information, see RHD and acute rheumatic fever *(on page 412)*.
- `Tackling Smoking` - participating health services should import this dataset and request the accompanying reports. For more information, see Tackling Smoking *(on page 420)*.
- `STRIVE` - participating health services should import this dataset and request the accompanying reports. In addition, to facilitate the recognition of local laboratory codes used for some STI results, health services should request the import of the codes used by their specific STI pathology lab. For more information, see STRIVE *(on page 420)*.
- `The George Institute` - The George Institute Health Assessment and Recommendations. For more information, see HealthTracker *(on page 762)*.

Terms Conversion

Together with your Implementation Consultant, when your site goes live with Communicare, a clinician with Administrator user privileges can use the Terms Converter tool to convert local terms into centrally maintained terms, for example, ICPC-2 PLUS terms.

Communicare reports return data based on clinical items and qualifiers. It cannot report on local terms that have not been converted to centrally maintained terms. Centrally maintained terms enable consistency in the reporting and recording of diagnosis. Chronic disease diagnoses which are reported heavily in nKPI reports are the first priority. Common conditions and immunisations are also important.

For example, the following multiple descriptions of local terms can be converted to a single ICPC-2 PLUS term.

Table 302. Example local terms that can be converted to a central term

Previous terms	ICPC-2 PLUS term
Type Two Diabetes	Diabetes; Type 2
NIDDM	
Non-Insulin-dependant diabetes	
Diabetes Mellitus Type II	
Maturity onset diabetes mellitus	
DM2	

Note:
Terms conversion is a delicate task and should only be undertaken under the guidance of a Communicare health informatics specialist.

Local terms are those which have not been distributed by the central data update program and have not been assigned an ICPC code. Migrated clinical items of conditions and procedures are local terms.

Some of the Term Converter functions may be used to convert between local terms.

Terms are only converted where the qualifiers match exactly. Consequently, most local terms with qualifiers are not converted.

Prerequisites

After conditions and procedures have been migrated to Communicare, run the term converter.

Terms Converter Functions

Run the following functions where required in the order listed:

1. **Auto Convert Local Qualifiers to Central Qualifiers by System Code** - converts local qualifiers to central qualifiers based solely on SYS_CODE. The qualifiers should have equivalent units and be of the same type for the conversion to succeed. Unsuccessful conversions are reported. On completion of this function, patient qualifiers are linked to the central qualifier types.
2. **Auto Convert Local Qualifiers to Central Qualifiers by Description** - scans all local qualifiers and attempts to match them to central qualifiers with identical descriptions and units. Strings of the form [n] at the end of local descriptions are ignored. Conversion success and any unit mismatches are reported. On completion of this function, patient qualifiers are linked to the central qualifier types.
3. **Convert Used Local Terms by Description and Class** - scans local Condition, Procedure and Referral terms that have been used in patient clinical records and changes the patient record to use identical central terms. Matching is done on the basis of description (the actual terms) and subtype. Strings of the form [n] at the end of local descriptions are ignored.
4. **Disable Local Conditions, Procedures Referrals and Immunisations** - disables all local Condition, Procedure, Referral and Immunisation terms. Terms in the Pathology topic and terms used in enabled automated recalls are bypassed by this process, that is, they remain enabled. When all conversion activity is complete, you may need to enable terms not represented by Central Terms again, particularly newly created terms that have not yet been used. Unused disabled local terms are deleted by a later process.

5. Delete Unused Disabled Local Terms - deletes all disabled, unused, local terms. No statistics are reported. Ensure that any newly created clinical items, that may not have been used in a patient record yet, have have been enabled before you run this function.
6. **Delete Unused Local Qualifier Types** - deletes all unused local qualifiers. No statistics are reported.
7. **Convert Local Conditions, Procedures and Referrals to Selected Conditions, Procedures, Referrals and Immunisations** - lists local terms. Use the Terms browser to select local terms and match them to equivalent central terms. Patient clinical records are updated to use the central terms and the original terms are deleted. Conversion statistics and failures are reported. You can also use these functions to convert local terms to other local terms.
8. **Convert Other/Elsewhere Localities to Selected Localities** - allows invalid locality names to be converted to valid locality names and address line 2 cleared. During data conversion from a legacy system, patient addresses recorded with invalid locality names are imported to the 'Other/Elsewhere' locality and the invalid locality name is placed in address line 2. Valid localities are those in Communicare's locality reference table, which contains over 17,000 Australia Post locality names, plus any others added by your Communicare Administrator. After the data conversion has been completed, run this function. This data cleaning is important, because address localities are used to group patients, for example, to identify those living within a health service area.
9. **Correct Terms Gender** - alters ICPC terms to correlate to the patient's sex. For example, the term **Mammography;F** is changed to **Mammography;M** where recorded for male patients. This function works for any terms that end with **;F** or **;M**.
10. **Convert Topics** - lists all local terms with local topics. Use this window to update local topics to central topics. Using central topics for local terms is preferred, but local special purpose topics are acceptable provided they do not cause ambiguity with central topics.

Converting terms

For sites using a Terminal Server, the site administrator must publish the `TermsConverter.exe` so that it is available for users to access.

To convert terms, you must belong to the System Administrators user group.

Follow these recommendations when converting terms:

- 'Measures imported from source software' - do not convert local items with this description to ICPC-2 PLUS terms. This description is applied to any local clinical items that could not be uniquely identified during migration
- Local items with qualifiers - local items containing qualifiers should not be converted, unless the ICPC-2 PLUS item has exactly the same qualifiers. Qualifiers are listed in the bottom table in the Terms Conversion window. If you try to convert a local item with qualifiers, a message is displayed stating that the data will be retained but the qualifier will not be available for ongoing data entry. If you click 'Yes':
    - If the qualifier is not a central qualifier, the process will complete as planned.
    - If the qualifier already exists as a central qualifier, the conversion cannot be completed and an error message is displayed stating that Centrally Maintained items cannot be edited.
- Local terms that exist in Communicare only as a qualifier cannot be converted. For example, Pulse rate is a qualifier in Communicare but not a clinical item.
- Local terms that are useful. For example, Assessment;Smoking;MD is a clinical item created to migrate a list of qualifiers which are mapped from the source to Communicare. These terms should not be converted.
- Clinical items that can be converted to items with required fields should not be converted. Clinical items such as Aboriginal Health Checks could be converted to the matching ICPC-2 PLUS item and be counted for reporting purposes, however the required fields would remain incomplete. If these terms are converted, an additional process is required to adjust the effective date of the required qualifiers so that outstanding recalls or incomplete clinical

items aren't created. Alternatively, add a system code or export code for reporting, but leave the items disabled and instead use the correct ICPC-2 PLUS items.

- Clinical items that cannot be converted due to patient sex - some local terms cannot be converted in one step because the ICPC-2 PLUS items are sex-specific. For example, a Mammogram local term cannot be converted in one step because the ICPC-2 PLUS item is Mammogram:M or Mammogram:F and the local term will have been used for a mixture of both sex patients. To complete term conversion for sex-specific terms:
    1. Convert the local term to a central term. For example, **MAMMOGRAM** to **Mammography;F**.
    2. In the **Terms Conversion** window, click **Correct Terms Gender**. This function checks the sex recorded for patients and for example, changes **Mammography;F** to **Mammography;M** when the patient is male.

To run the terms converter:

1. Select **Start > Communicare > Terms Converter** or run `TermsConverter.exe` from the Microsoft Windows command line.
2. To complete terms conversion for migrated data, in the **Terms Conversion** window, click **Convert Local Conditions and Procedures to Selected Terms**.
3. The **NON-ICPC Coded Clinical Items View** lists all local non-ICPC-2 PLUS coded clinical items used at your site. Click **Used** to sort the terms by the number of times they are used.
4. To open the **Clinical Terms Browser** with a list of suggested matching ICPC-2 PLUS central clinical terms for the local item, double-click the local item in the top list. The **Clinical Terms Browser** uses the first word of the local term to suggest possible central term equivalents. The clinician may need to search manually to find the correct clinical item to match to. For example, for the locally migrated term `Metabolic Bone Disease`, the browser returns a list based on the word *Metabolic*. In the **Clinical Terms Browser**, the clinician searches instead for the word *bone*, and selects `Disease;bone`.
5. In the the **Clinical Terms Browser**, select the correct central term and click **Select**.
6. In the confirmation window, check that the terms you are converting from and to are correct, and if so, click **Yes**.

> **Note:**
> After a term has been converted from a local term to a centrally maintained term, you cannot undo this process. The **Information** window displays how many records have been updated and of what type.

7. Repeat steps 4-6 for all local terms that you want to convert to central terms.
8. To finish the conversion process, close the **NON-ICPC Coded Clinical Items View** and in the **Terms Conversion** window, click **Save** to commit the changes to the database.

Results

The items that have been successfully converted are no longer listed in the **Terms Conversion** window.

Run **Correct Terms Gender** to fix sex-specific clinical items.

Validation

To check terms conversion and validate that the correct changes have occurred:

1. Choose a local migrated clinical item from the list before you complete terms conversion, for example, *Dressing Change*.
2. In **File > Reference Tables > Clinical Item Types**, look up `Dressing change`. The item is not enabled.
3. If you try to delete the row for `Dressing change`, you will get an error message stating that the item is in use.

4. Complete the terms conversion.
5. In **File > Reference Tables > Clinical Item Types**, look up `Dressing change` and attempt to delete the item. The system will now delete the clinical item type as it is no longer is use.

To validate term conversion in a clinical record:

1. Choose a local clinical item from the list before conversion. For example, *CKD (Chronic Kidney Disease) Stage 5*.
2. To identify a patient with that clinical item, run **Report > Patients > With Selected Clinical Item**.
3. Open the patient record and find the selected clinical item and then close the record.
4. In the **Terms Conversion** window, open the local term and convert it to a central term. For example, `CKD (Chronic Kidney Disease) Stage 5` to `Disease;kidney;chronic;stage 5`.
5. Open the same patient record. The clinical record will now display the new ICPC-2 PLUS clinical item. The **Detail** tab displays the local term in the **Converted from** field.

Notes Qualifier Conversion Errors

Local qualifiers may exist on central items because of prior conversion work. When a local term is converted to a central term, local qualifiers are copied to the central term and disabled. This process allows the conversion to proceed without data loss. You will be able to view the old qualifier data, though no new data can be added using the disabled local qualifiers.

Auto Convert Local Qualifiers to Central Qualifiers by System Code and **Auto Convert Local Qualifiers to Central Qualifiers by Description** may fail as a result of these local qualifiers on central items. The message displayed is `Unable to delete local Qualifier nn. May be used on a CENTRAL item`.

This failure occurs because the terms converter does not have the ability to put a central qualifier on a central item. In other words, this is a necessary failure. It is not a problem provided that reporting is done using system codes. Reports should always use system_code rather than a primary key or description when it is available.

This scenario can only occur when the terms are converted before the qualifiers are converted, which is not the usual sequence. However it has occurred where terms were converted, then in a later central update, new central qualifiers were introduced, for example Height and Weight, which then conflicted with local qualifiers.

CAT Export Tool

Use the CAT Export Tool to export datasets defined by the Improvement Foundation from Communicare as XML. These XML datasets can then be loaded into PEN CS' Clinical Audit Tool (CAT).

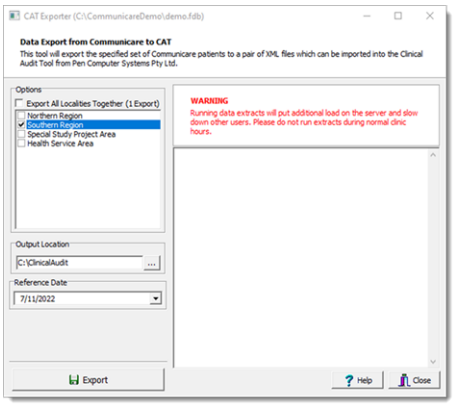
Running the CAT Export will generate a pair of XML files: a de-identified data XML file and a link XML file to re-identify the data should the organisation require this. Each linked XML file is unique to each export created and cannot be used with other de-identified XML files.

Restriction:

- Running data extracts will put additional load on the server and slow down other users. Please do not run extracts during normal clinic hours.
- Offline (data sync) client installations will run the export from the offline database. Data will only be as up-to-date as the last sync date.

To run the CAT Export tool:

1. From your computer's **Start** menu, select **Communicare > CAT Export**.



2. Select the localities for which you want to export data. Select either:
   - **Export All Localities Together** to generate a pair of XML files containing all the data from all localities. The file names for this pair will contain the `ALL_LOCALITIES` string.
   - Individual localities for which you want to generate data. A pair of XML files containing the data for that locality only are generated. The file names for these files contains the locality name.
3. In the **Output Location** field, enter the folder where the generated XML files are saved. If the PEN Clinical Audit Tool is installed, this location defaults to the data location specified by the tool.
4. From the **Reference Date** calendar select a date from which you want to export. This field defaults to today's date.
5. Click **Export**.

The export may take some time to complete. When the operation has successfully completed, `Export successful` is displayed in green text above the **Export** button.

For information on using PEN CS' Clinical Audit Tool, see CAT4 User Guide.

Background Processes

Communicare runs a number of server-side background processes that integrate with various external services.

You cannot edit the configuration of these processes. However, if you require variations, such as to schedule backups for a different time, or to change the frequency with which the results folder is checked, contact Communicare Support.

Table 303. Background processes

Process	Example Frequency	Description
CCareQueue_ADSync	Daily, 4-4:30pm	If Windows based authentication is on, synchronises all Communicare user groups to the mapped AD groups.
CCareQueue_Appoint-ments	Daily	Executes any stored procedure in the database with the prefix DAILY_ and generates appointment sessions and timeslots. For example, up-dating patient status, cancelling expired recalls, cleaning up log files and temporary holding tables, validating patient records and encounter records.
ccareQueue_Argus	Every 10 mins, 9am-8pm	Processes Argus incoming and outgoing secure messages. If a site uses Argus, both ccareQueue_Argus and ccareQueue_Argus_Nightly should be enabled.

Table 303. Background processes (continued)

Process	Example Frequency	Description
ccareQueue_Argus_-Nightly	Nightly, 9pm-12am	As for ccareQueue_Argus, but the command runs without a time limit. If a site uses Argus, both ccareQueue_Argus and ccareQueue_Argus_Nightly should be enabled.
CCareQueue_Communications	Configurable	In V21.1 and later, runs on a schedule to process the SMS appointment reminder templates and send both direct SMS messages and bulk SMS messages to patients identified in an SMS appointment reminder template using Telstra Health's SMS gateway (TH Messaging). The scheduler finds and executes SMS appointment reminder templates. The following scheduler options are set by the Communicare Implementation team in `Communicare_installation\CCareQueue_Communications\appsettings.json`: • **AppointmentRunJobStartTime** - time at which the scheduler starts daily. Default: 7:00 AM • **AppointmentRunJobEndTime** - time at which the scheduler stops running daily. Default: 10:00 PM • **AppointmentRunIntervalMinutes** - interval at which the scheduler runs. Default: 15 minutes • **AppointmentRunWindowMinutes** - window of time that the scheduler searches for an appointment template to run at each interval. Default: 30 minutes
CCareQueue_DataSync	Every 3 mins, 7am-8pm	Processes incoming datasync files from the results folder.
CCareQueue_EHR	Every 10 mins, 9am-8pm	In the Northern Territory, processes My E-Health Record (MeHR) documents that are in the order queue and loads them into the Argus database.
CCareQueue_Etp	Every 5 mins, 8am-8pm	Deprecated in V22.1 and replaced with Script Exchange *(on page 829)*. Was used to send electronic prescriptions to the original eRx ETP service using the client adapter.
CCareQueue_Eureka-Logs	Daily	Prunes logs from the drop folder that are older than 30 days.
CCareQueue_FullBack-up	Daily, weekly, monthly	Runs the Communicare internal backup at 5pm by default.
CCareQueue_HIC	Hourly, 9am-12pm & 2am	Performs some Online Claiming functions, including: • 9am-12pm, requests processing and payment reports for sent claims • 2am, sends all valid immunisation records to AIR
CCareQueue_HSDSync	Daily, 9-11pm	Synchronises National Human Services Directory (NHSD) linked addresses from the Communicare address book with the NHSD via Argus.
CCareQueue_Mehr	Daily, 8-11:59pm	Checks that the patient is registered on MeHR

Table 303. Background processes (continued)

Process	Example Frequency	Description
CCareQueue_Pcehr	Daily, 8-11:59pm	Looks up patients to see if they have registered for My Health Record. The process finds all patients with an IHI number but no My Health Record, then for each one: • Searches for an active My Health Record for the patient, which must also be accessible to the organisation • If a My Health Record is found for the patient: ◦ Updates PATIENT.HAS_PCEHR to True ◦ If the My Health Record Consent is currently `Not Asked`, sets the My Health Record Consent to `Yes` ◦ If the My Health Record Consent is already `Yes` or `No`, no change is made
CCareQueue_PcehrUpload	Every 5 mins, 8am-10pm	Uploads My Health Record documents to My Health Record from the order queue. Documents awaiting upload are listed in **Documents and Results > Outgoing Documents** tab with a `Pending` status.
CCareQueue_Reports	Daily	Runs queued reports.
CCareQueue_Results	Every 3 mins, 7am-8pm	Processes incoming results from the results folder, including PIT and HL7 files.
CCareQueue_RunAIR	Every 30 mins, 12:15am-2am	Allows immunisations to be sent to AIR. This command tells CCareQueue_HIC to run the AIR claims only at a certain time, for example, at midnight.
CCareQueue_RunHIC	Every 60 mins, 9:30am-8pm	Tells CCareQueue_HIC to run all HIC commands except the AIR feed. If a site does not claim, this is not used.
CCareQueue_SendLog	Daily, 3:10-3:20am	Sends the daily service logs by email using the Blat email tool. For more information, see Organisation Parameters - Email Server *(on page 839)*. Set permission to send logs and the recipients in System Parameters - System *(on page 811)*. Schedule all other processes to end before the send log starts.

Table 303. Background processes (continued)

Process	Example Frequency	Description
CCareQueue_SMD	configurable	• Processes incoming results from the results folder, including HL7 files. • Controls the interval at which outgoing and incoming messages are sent and received • For the combined address book: ◦ Controls how often the online provider directory service is checked for updates to entries saved to the local address book. For example, by default, specialties and service types are updated from the provider directory service every 7 days. ◦ Specifies if the terms used are synchronised with SNOMED CT. ◦ Specifies the URL used for the Specialty terms. Default: `http://snomed.info/sct?fhir_vs=ecl/<223366009` ◦ Specifies the URL used for the Service Type terms. Default: `http://snomed.info/sct?fhir_vs=ecl/<224930009` **CCareQueue_SMD** is not configured to run automatically during installation of Communicare, and is instead configured by the Implementation team during set up. When `CCareQueue_Smd.config.json` is configured, a new line is added to `Services.ini` to enable **CCareQueue_SMD** to run at a regular interval. `CCareQueue_Smd.default.config.json` contains the default configuration which can be customised in `CCareQueue_Smd.config.json`.
CCareQueue_SMS	Every 5 mins, 8am-8pm	Processes SMS messages.
PrepareReports	Daily, 7pm-8:15pm	Checks the scheduled reports database and determines which reports will be run by RunReports1 and in what order.
RebootPC2	Daily, 3:20am	Reboots the server every 24 hours. On servers that are not allowed to reboot, instead use RestartDailySvc.
RestartDailySvc	Daily, 3:20am	Restarts the service daily for sites where the server cannot be rebooted.
RunReports1	Daily, 10:20pm-12am	Runs the scheduled reports prepared by PrepareReports.

Communicare Logs

Adjust the level of detail recorded in Communicare logs if required.

There are two main applications required to use Communicare and take advantage of all its most advanced features.

- `Communicare` - the main application installed on each client machine
- `Communicare.Classic.Service` - a service installed on the Communicare server machine, which the main application talks to for certain functionality, such as ePrescribing & HealthLink SmartForms

Each executable generates local log files, the content of which can vary depending on the log file configuration.

Communicare Administrators can adjust the log size and log detail of each application if required.

- For `Communicare`, the `Communicare.exe.config` settings file and the `logs` folder can be found in the folder that the Communicare application was installed into, typically `C:\Program Files (x86)\Communicare`.
- For `Communicare.Classic.Service`, the `appsettings.json` settings file and `logs` folder can be found in the folder that the service was installed into, typically `C:\Program Files (x86)\Communicare\Communicare.Classic.Service`.

> **Warning:**
> If you change the logs to capture HTTP requests and HealthLink SmartForms are in use, the log files will capture patient data, including patient identity information.

For more information, contact Communicare Support.

Tools

Use these tools to help manage Communicare.

Database Consistency Check

The Database Consistency Check checks the Communicare database and produces a report showing any data problems found.

If any problems are found that cannot be addressed they should be reported immediately to Communicare Support. If the report contains any data in the **Table Name** or **Field Name** columns, there is something to investigate.

The types of inconsistencies checked are either those that can arise from time to time due to environmental issues or historical data that was allowed to exist at some time but is now not allowed.

The following inconsistencies may be reported.

Table 304. Data inconsistencies

Section	Error	Description
Structure incomplete	Structure Incomplete. Please edit this patient's biographic details.	Errors in this section arise if a patient's **Biographics** window was open and the database connection was lost without the changes being saved. For each patient reported, in **Patient Search**, click **Change Details**, edit the details in some way and click **OK**. For example, add 'X' to the patient's name then remove it. A message is displayed identifying the inconsistency for you to deal with.
Patient Measurements Update	Patient qualifier type mismatch	Reported if a patient has a value for a qualifier that is inconsistent with the current definition of that data. For example, if there is a list of qualifiers but a patient has a numeric result recorded instead, they are reported. To fix these, contact Communicare Support.
	Patient qualifier with wrong gender	Reported if a patient has a value for a qualifier that should only be recorded in a patient of the other sex. Consult the clinical record and either correct the sex or delete the data.

Table 304. Data inconsistencies (continued)

Section	Error	Description
Unstarted Services with Progress Note		Errors in this section arise if there are services that have not started but have a progress note. This can happen if there is a conflict with data synchronisation, whereby an appointment is completed offline but is cancelled online at a later time but prior to synchronisation.
Withdrawn Services	Withdrawn service with incorrect status	A service may be reported as both withdrawn and, say, started. Edit the service details.
Services not validated	Please edit Service Record on	These services have some inconsistent data. Typically this is a data synchronisation problem, where conflicting details were recorded on the live database and a synchronised client. Edit the service details to correct.
Multiple Medication Items	Multiple Chronic Meds with Free Text Med enabled	Reported if more than one Chronic Medication type clinical item is enabled and Free Text Medication is also enabled. To correct this either disable all Chronic Medication type clinical items except one or disable Free Text Medication.
	Multiple Acute Meds with Free Text Med enabled	Reported if more than one Acute Medication type clinical item is enabled and Free Text Medication is also enabled. To correct this either disable all Acute Medication type clinical items except one or disable Free Text Medication.
Communicare Templates	Letterhead exceeds 50Kb maximum. Please edit letterhead	Edit the organisation letterhead. Communicare Support can advise on techniques for doing this.
Duplicate Places	Duplicate Encounter Place	Two or more encounter places of the same name. Rename encounter places so they are unique.
Unreferenced Encounter Programs		Reported if there are references to encounter programs that do exist. Contact Communicare Support to investigate as this may result in encounters being wrongly hidden or exposed.
Localities with Invalid Postcodes	Invalid Locality Postcode	Locally added localities should all have a postcode of four digits 0000 - 9999.
Item Properties No Longer Allowed	Illegal Qualifier Reference Type	Qualifiers that are not lists should not have dropdown references defined. You may need the help of Communicare Support.
	...should not be recallable	For example, recallable clinical items which are not Procedures or Conditions. To correct the clinical items, go to **File > Reference Tables > Clinical Item Types**.
	Invalid recall type responsibility	Reported if there are recall rules where the responsible user group no longer has the rights to see the item being recalled. Fix in the patient record or contact Communicare Support.
	... should not have required qualifiers	Referral type clinical items are not allowed to have required qualifiers. To correct the clinical items, go to **File > Reference Tables > Clinical Item Types**.
Recalls with Invalid Responsibility	Invalid recall responsibility	Reported for patients with clinical items that are the responsibility of a user group that cannot see those clinical items any more. Correct the clinical record or contact Communicare Support.

Table 304. Data inconsistencies (continued)

Section	Error	Description
Morbidity Types with invalid unique description	Possible duplicate	Reported for clinical items that have an invalid description, possibly because a Central data import introducing amended terms.
Multiple Identical Morbidity Types		Reported if there are ten or more disabled clinical item types of the same description. This may be an indication of accidental processing of a data synchronisation file that contains errors. Contact Communicare Support to remove unused duplicates.
Multiple Starts to Same Pregnancy		Reported if there is more than one start to the same pregnancy. This can happen if there is a conflict with data synchronisation, whereby a new pregnancy is started offline and is also started online prior to synchronisation.
Multiple Mothers or Fathers		Reported if there is more than one father or more than one mother recorded in a patient's biographics. This can happen if there is a conflict with data synchronisation whereby a mother or father is recorded offline and is also recorded online prior to synchronisation.
Duplicate Patients		Reported if two patient records have the same name, date of birth and sex. This can happen if there is a conflict with data synchronisation whereby a new patient record is recorded offline and is also recorded online prior to synchronisation.
Orphan Summary Qualifiers		Reported if there is a latest qualifier value in the qualifier summary where the qualifier itself no longer exists. This can happen if there is a conflict with data synchronisation whereby a new summary qualifier value is recorded offline but the same clinical item is edited later prior to synchronisation without that qualifier being recorded.
Orphan Qualifiers		Reported if there is a qualifier value attached to a clinical item that is in a state of being a recall or cancelled. This can happen if there is a conflict with data synchronisation whereby a new qualifier value is recorded offline but the same clinical item is edited later online prior to synchronisation by being cancelled.
Irregular Enrolment Sequences		Reported when enrolment and exit items do not appear in the correct sequence with any action items for the same program, e.g. HACC. This can happen if there is a conflict with data synchronisation whereby an enrolment, exit or action item is recorded offline and is also recorded online prior to synchronisation.
Rogue Tables, Views and Stored Procedures	Table/View/Stored procedure created by USERNAME	These tables, views and stored procedures have been created locally and are not authorised. You will need to contact the support team to have them removed. If possible, talk to the user who created them to determine why they were created. Whilst these items remain, the database is potentially unstable and the consequences may range from poor performance to failed upgrades in the future.

Reset Communicare Default Settings

This is a useful option to restore accessibility and ease of use in Communicare.

It will clear your personal customisations. For example, windows will return to their original size and placement, report date ranges will return to their default settings, and more.

To reset defaults, select **Tools > Reset Communicare Default Settings**.

Show Help Hints

When enabled it allows small, yellow help tips to be displayed when the mouse cursor pauses over objects on the screen.

To enable help hints, select **Tools > Show Help Hints**.

Licence Administration

Licence Administration

Set the Communicare Licence Key & Licence Service URL provided by Communicare Support.

The Licence Administration window contains the following sections.

Licence Key Data

This displays your current registered licence key. The licence key defines the maximum number of users that can legitimately run Communicare at a single point in time. The current licensing status is displayed on the Communicare Login form under the section 'Licensing'. If the licensing message is displayed in RED, then you are running more instances of Communicare than you are licensed to. If the licensing message is displayed in black, then you are legitimately within the limits of your licence agreement.

Licence Service URL

The Licence Service URL defines the path to the licensing service that Communicare uses to verify licensing information. The licensing service will run in the background on the same server where Communicare is installed.

The licensing service is setup and configured by Communicare. If you want to review your licensing agreement or have an issue with the licensing system, contact Communicare Support.

Communicare Templates

Use the **Communicare Templates** window to manage the templates used in Communicare.

To work with templates, you must have `Reference Table` system rights. Only Communicare Administrators can edit system templates.

Note:

SQL Report and SMS templates cannot be imported from here. SQL Report templates must be imported from **Tools > SQL Report Editor** or **Report > Search Reports**.

SMS templates must be imported from **Tools > Send batch SMS**.

Use the **Communicare Templates** window to import Word and PDF-based templates such as Invoice, Imprest, Pathology and Imaging templates. These templates cannot be edited from here. Contact Communicare Support for further information.

You can import or export a template and add, modify or delete a template.

To edit a template in Communicare using the **Letter Writer**:

1. Select **Tools > Communicare Templates**.
2. In the **Communicare Templates** window, double-click a template or select the template and click Edit.
3. In the **Document Template** window, click **Edit Document Template**.
4. Make your changes in the **Letter Writer**.

See Document Templates *(on page 958)* for more information.

Alternatively, you can import a template you created outside of Communicare, or export and modify a template and import it back into Communicare.

To export a template, in the **Communicare Templates** window, select a template and click **Export**.

To import a Communicare document template in XML file format, in the **Communicare Templates** window, click **Import**.

To find a template, in the **Search Text** field, enter part of the template name you are looking for. Communicare filters the list of templates to those with a name containing the characters you entered.

To delete a template, select a template and click Delete.

Document Templates

Use the **Document Template** window to create and edit the templates used in Communicare that are not imported.

Open the **Document Template** window from the **Communicare Templates** window.

To create a new template in Communicare using the Letter Writer:

1. Select **Tools > Communicare Templates**.
2. In the **Communicare Templates** window, click Add document template.
3. In the **Document Template** window, in the **Template Name** field, enter a unique name.
   If you modify a template owned by MEDISYS, give the template a new name so that the next upgrade does not overwrite your changes.
4. In the **Template Description** field, enter information about how the template should be used.
5. From the **Document Type** list, select the document type.

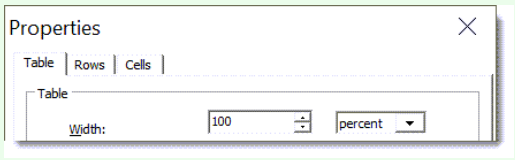
   By default a new template is a Letter. Once added, it can be selected from the **Letter Editor** in the clinical record. Alternatively, select:
   - `Care plan template` - for use as patient care plans. Access from the from the **Care Plan** tab of the clinical record.
   - `Discharge Summary Letter` - for use with hospital discharge summaries. These documents are linked to clinical items with this document type selected in **File > Reference Tables > Clinical Item Types**, **Advanced** section, **Letter Type** field.

- `Health check report` - for use with health checks. These documents are linked to clinical items with this document type selected in **File > Reference Tables > Clinical Item Types**, **Advanced** section, **Letter Type** field.
- `Paper based clinical form` - typically, you should use clinical items to record data that can be used throughout Communicare. However, occasionally you may prefer to collect information in this document.
- `Referral letter` - for use with referrals. These documents are linked to clinical items with this document type selected in **File > Reference Tables > Clinical Item Types**, **Advanced** section, **Letter Type** field.
- `System template` - these templates are used in the system for various tasks. For example, details sent to MeHR.

6. From the **Viewing Right** list, select a viewing right, that determines which users can see and use this template.
7. From the **Default Topic** list, select a category.
8. If you want to share the template with anyone with the appropriate viewing rights, set **Public**. Otherwise only the owner, the user who created the template, can see it.
9. Click **Edit Header** or **Edit Footer** to open the **Letter Writer** and add the required header and footer information. Headers and footers appear on every page of a letter or other document.

> **Tip:**
> You won't see the header or footer when you add a document to a clinical record, but these are visible when you print the document.

10. To add content to the document template, click **Edit Document Template**. This opens the **Letter Writer**. Set the page layout and add text, data objects (on the right) or other items.

> **Tip:**
> - If you want more control over the layout, put your text and items into tables. You can remove the borders to make the table invisible.
> - To make the new document template fit within the default page width, set tables to 100% wide, rather than a fixed number of pixels so that you don't lose the right hand margin when the document is printed. To do this:
>   a. Add a table.
>   b. Right-click anywhere in the table and select **Table Properties**.
>   c. On the **Table** tab, in the **Width** fields, set `100% percent`.
>
> 
>
>
> - Remember that the data objects will resize when an actual letter is created. For example, a patient's name may be long or short.
> - Page layout settings such as page orientation and page margins may not be retained.
> - If you want an interactive check box, use the menu item **Insert - Check Box** rather than the data object **Miscellaneous - Tickbox**. It will appear on the template as a check box rather than a data object. If your template is for a Care Plan, use the check box.

11. To save the layout, close the **Letter Writer**. If the template is ready for use, set **Enabled**.
12. Click **Save**.

The template is now saved and ready for use by users with appropriate access rights.

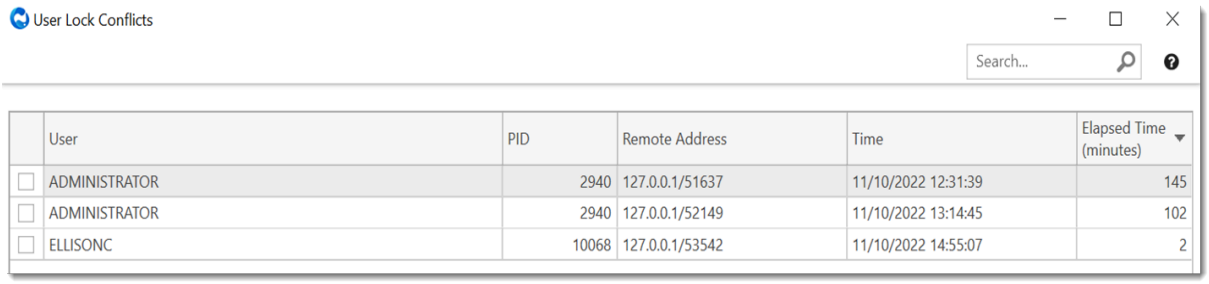
Tip:
If a document template is updated, it is also updated in any document you open that was created previously.

User Lock Conflicts

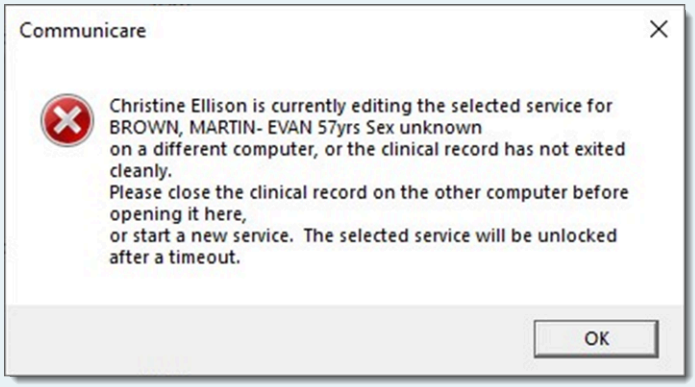
Sometimes there are data entry conflicts and the database is locked to protect the integrity of the clinical record.

Use **Tools > User Lock Conflicts** to manage user lock conflicts. Only System Administrators can access this window.

The **User Lock Conflicts** window lists all the active connections to the database other than the current, logged in user.



Note:
An entry in the **User Lock Conflicts** window does not necessarily indicate that there is a problem. If you see a user in the list, you should not clear their session unless they are getting messages advising that the record is locked.
For example:



User lock conflicts can occur in the following circumstances:

- When multiple users attempt to edit the same information
- If a single user has multiple sessions on different computers
- If there are network problems

Note:
Only use unlock to resolve user conflicts as a last resort.

To resolve a user lock conflict:

1. Ask the user with the user lock to log off before proceeding. It is easier for the user to close Communicare prior to clearing the lock conflicts.

   > **Warning:**
   > Do not clear a lock conflict without talking to the user. The unlock will affect their active service and will disconnect them from whatever work they are completing at the time. Do not proceed until the user is ready to close Communicare and for the lock conflict to be cleared.

2. Select the user in the **User Lock Conflicts** window.
3. Click **Unlock**.

The user is disconnected from the database, the user lock is resolved and the user lock conflict is cleared.

THe user should now be able to log in again.

Grid Views

Grid views allow you to customise the look and feel of a grid in Communicare.

If a form contains a Microsoft style Ribbon with a View tab then the grid on that form can have it's look and feel customised.

Views Tab

This tab allows the user to customise the appearance of the documents list. See Grid Views.

View All Columns

Click the All Columns button to have all available columns presented in the grid list.

View Standard View

Click the Standard View button to set the view of the grid to the standard view.

View No Columns

Click the No Columns button to have all columns removed from the grid.

Save the current view

Click the Save button to save the current grid view layout. Any customisations that you have made to the grid will be saved. See Saving a Grid View *(on page 964)*.

Maintain Views

Click the Maintain Views button to view/maintain all defined views that the user has access to. See Grid View Maintenance *(on page 963)*.

Custom Views

This is the list of custom views that the user has access to for customising the current grid. Click on the appropriate view to apply that view to the gird. Custom grid views have differing icons based on their availability and distribution.

-  - a grid view that is available to all users
-  - a grid view that is distributed with Communicare
-  - a grid view that was created by the currently logged in user and is only available to that user

Customising a Grid

Grids can be customised in a variety of ways:

- Sorting
- Grouping
- Filtering
- Customising columns

Sorting

Sort Data

- Click a column header. The Up and Down Arrows indicate ascending and descending sort orders respectively. Click the column again to change the sort order.
- Right-click a column header and select Sort Ascending or Sort Descending from the context menu that will appear.

Unsort Data

- Click a column header while holding down the CTRL key.
- Right-click a column header and select Clear Sorting from the context menu.

Grouping

Group Data

- Drag a column header from the column header panel to the group panel.
- Right-click a column header and select Group By This Column from the context menu.

Ungroup Data

- Drag a column header from the group panel to the column header panel.
- Right-click a grouping column's header and selecting UnGroup from the context menu.
- To remove grouping by all columns, right click the group panel and select Clear Grouping from the context menu.

Change Group Order

- To change group order, move a grouping column header to another position within the group panel.

Filtering

- Right-click a column header and select Filter Editor... from the context menu. From here you can apply a filter condition to filter the data in the grid.

Column Customisation

Displaying Hidden Columns

- Open the Customization Form by right-clicking a column header and selecting Column Chooser.
- Drag the required column/band from the Customization Form onto the column/band header panel and drop it at a specific position.

Hiding Columns

- Click a column header/band header and drag it onto the grid control's cell area, until the cursor changes its image to a big 'X'. Then drop the header.
- Drag and drop a column/band header onto the Customization Form if it's open.

Rearranging Columns

- To reorder columns, drag and drop a column header to a new position.

Resizing Columns

- Drag the right edge of the target column/band header.
- To change a column's width so that it displays its contents compactly in their entirety, do one of the following.
    - Double-click the right edge of the column header.
    - Right-click the column's header and select Best Fit.
- To change the widths of all columns so that they display their contents in the best possible way, right-click the header of any column and select Best Fit (all columns).

Changing the Column Title

- Right-click a column header and select Change Column Title... from the context menu. A dialog appears allowing to to customise the caption. Click the Apply Button or hit Enter to apply your new title.

Grid View Maintenance

Maintaining Grid Views

This form allows the user to maintain the grid views that they have access to.

Edit

Click the Edit button to edit the title or settings of a grid view.

Delete

Click the Delete button to remove a grid view.

Views Tab

This tab allows the user to customise the appearance of the list of grid views. See Grid Views *(on page 961)*.

Saving a Grid View

This form allows a user to save the current grid view.

- **View Name** - the name of the view. This must be unique to a grid.
- **View Settings > Administrator Settings** - If the user is a member of the Communicare System Administrators User Group they will have access to the following administrator settings:
    - **Publish this view to all users** - set to make this view available to all users in Communicare.
    - **Make this view the standard view for all users** set to make this view the standard view for all users, whenever they click **Standard View**

You can customise the grid views distributed with Communicare. When saving these customisations you will be required to enter a new name for the grid view, and the Communicare distributed grid view will be unchanged. If you decide that you want the grid view to mirror the Communicare distributed grid view again click the Restore Communicare View button

Regular Administrator Tasks

There are several regular maintenance tasks for the Communicare Administrator to perform.

As required

- Reboot the Communicare server. This may be required when, for example, electronic pathology results are not being processed.
    1. Make sure there are no users using Communicare.
    2. Press the power button on the Communicare server only once, do not hold the button in.
    3. Wait for the lights to go out. If the lights do not go out, hold the power button in until the lights go out which can take 5-6 seconds. Only do this if the server refuses to shut down normally.
    4. Wait a few seconds and press the power button again to turn the server on and wait for the lights to stop blinking.
- Run the Communicare Data Updater to update Central items and other data.

Daily

- Maintain the backup procedure *(on page 936)* for your site:
    - Ensure that the previous night's backup is on the server.
    - Ensure your IT company is maintaining a redundant copy of the backup off-site.
- Check the Scheduled Reports all ran successfully the previous night.
    - Run the **Report > Database Consistency > Scheduled Reports Monitor** report for 'yesterday'.
    - Move scheduled reports between days as required if there is not enough time for all reports to be run on a given evening (**Tools > Scheduled Reports**).
- If you use Communicare to make Medicare claims:
    - First thing in the morning, open **File > Online Claiming > Bulk Bill Claims** tab.
        - During the day act on the previous day's claim messages. See Daily Medicare Tasks *(on page 104)* for more information.
    - At a convenient time, run the Payment Report for all claims. This may take some time depending on the number of claims currently awaiting payment.
- If your site uses the offline client, check that data synchronisation successfully completed for all laptops. Report any problems to Communicare Support.

- Your Communicare Administrator should check `\\Communicare_installation\Results` for any files older than 24 hours. If there are old files, report the problem to Communicare Support.
- Check the Communicare User Portal - News page for the latest updates to Communicare, especially during extreme events such as a pandemic.

Weekly

- If you use Communicare to make Medicare claims, run **Report > Electronic Claims > By Period** entering dates for the previous week. Each claim will have a status.
- Run **Tools > Database Consistency Check** and act on the results. Any patients identified (for example, as duplicates) may cause the Daily Process Service to fail. For more information, see Database Consistency Check *(on page 954)*.
- Check `\\Communicare_installation\Results` on the Communicare server for any electronic pathology results that may not been processed. (The default location for the results is on the server at `C:\Program Files(x86)\Communicare\Results`.) Report these to Communicare Support immediately.

  If your site uses a Communicare Appliance Server, the default location is a shared folder called `Results` on the server. For example, if your server is called `ccareabcd`, the results are to be placed in `\\ccareabcd\\Results`.
- If you use secure messaging, check Documents and Results Outgoing Documents *(on page 302)* for any errors

Monthly

> **Note:**
> Updates that are usually monthly may instead be released as required during extreme events such as a pandemic.
>
> - If you use Communicare to prescribe, download the MIMS monthly data from the Communicare Client Portal
> - If you use Communicare to make Medicare claims, download MBS monthly updates
> - If you use Communicare with SNOMED, download SNOMED
> - If you use HDP, download the updated User Guide if available
> - Check that your Automated Recalls still apply and are working as required in **File > Reference Tables > Automated Recall Types**

The Communicare User Portal - Help and Support tab shows the latest updates. To download datasets from the Communicare User Portal:

1. Log into Communicare User Portal with your Communicare User Portal username and password (not your Communicare login). Register in the portal if you do not have a login.
2. From the Communicare User Portal - Help and Support tab, for the required update, click **Download**.
3. Accept the licence and click **Download**.
4. Follow the instructions to download the file and import it into Communicare.

Two monthly

- Run the OSR reports for the current year (i.e. with the 'end of year to report' as the end of the current financial year) and report any unusual or unexpected results. For example, running the reports at the start of October and multiplying figures by four should give you a projection for the next year.
- Run the National KPI reports with a 'report date' of today (these reports are mainly running totals) and investigate any unusual or unexpected results.

Four monthly

Communicare Support can test your backup to ensure that it can be restored and is capturing the data required. If you would like your backup tested, contact Communicare Support. You will have to arrange delivery of your backup to Communicare.

Note:
Backup testing is a separate, paid service.

Six monthly

- Raise a request with Communicare Support to upgrade to the latest version of Communicare if you have not done so within the last six to twelve months. Before the upgrade, review the Release Notes *(on page 973)* and instruct users accordingly.

Annually

- Check that the Health Service Area Locality Group lists all localities for your health service area. The automatic patient status change *(on page 933)* looks at this group to determine if a past patient who has been seen should become 'Transient' or 'Current'. You may find the report at **Report > Reference Table > Localities Not in Health Service Area** useful.
- Review your clinical items and qualifiers.

Communicare Upgrades

For more information, see Upgrades *(on page 942)*.

When adding a new client computer

- From the new client navigate through My Network Places to the shared folder on the Communicare server called Install. Run the file `setup.exe` that is in the folder called `CCare` (or possibly `Communicare`).

Requesting a new Communicare report

To request a new SQL report for your system:

1. Select **Help > Forms > Report Request Form**.
2. Print the form and fill in the details.
3. Have the form signed by your CEO or Communicare Administrator.
4. Scan the form and attach it to a support request.

Receiving Medicare Australia notices

Medicare will automatically e-mail you notices about outages and other issues affecting online Medicare claiming if you register with them.

To register, call 1300 550 115, give them your minor ID and ask them to register an email address for notifications.

General Non-Communicare Maintenance

For more information, see Important Non-Communicare Maintenance *(on page 967)*.

On arrival and departure of staff

You must maintain who has access to Communicare at your site.

On arrival of new staff

- Add the new person to an appropriate user group at **File > User Groups** and give them a password. This will allow them to log on to Communicare with appropriate rights.
- Add the new person as a provider at **File > Providers** and add their details. This will allow them to record services in their name.
- Train the new person in the use of Communicare. The new person should be trained appropriately according to their job description. Allowing untrained users access to Communicare may compromise the integrity of your data.
- Create an Appointments Session Template at **File > Appointments > Session Templates** if they will be requiring appointment slots and you use Communicare for appointments.
- To print a worksheet that will help you collect the required information before you create the session templates, go to **Help > Forms > New Appointment Template Worksheet**.

On departure of staff

- Remove their username from their user group at **File > User Groups**.
- Add a disable date to their provider record at **File > Providers**.
- Disable or delete their Appointments Session Template at **File > Appointments > Session Templates**.

Important non-Communicare Maintenance

Various non-Communicare maintenance tasks are the responsibility of the Communicare Administrator. They are essential to ensure the smooth running of Communicare.

Internet Access and Remote Communications

Internet access is required by Medicare Online Claiming, many pathology lab download programs, secure email, MeHR (formerly NT Health Connect) and for remote access by Communicare to maintain the server and software. It is the responsibility of the Communicare Administrator to make sure that this access is maintained.

In addition, the phone line access to the server must be maintained by the Communicare Administrator for use in an emergency. This includes making sure that the line is not disconnected because it is rarely used.

PRODA device registration

When you receive an email from Communicare warning that your PRODA device registration will expire soon, go to the PRODA portal and renew your device registration. Typically the PRODA device registration will expire every 6 months.

Important:
Renew the registration when you receive the email. If the device registration expires, your site won't be able to make claims from, or be paid by Medicare.

E-mail and E-Mail Accounts

For secure e-mail and report scheduling the Communicare server is usually allocated an e-mail account on the local e-mail server (usually communicare@...). This e-mail account and those of scheduled report recipients must be in working order and maintained. We recommend that the account allocated to the Communicare server has an automatic reply sent to anyone who might send a message to that account explaining that this account is not monitored and no further reply will be forthcoming. It might also suggest that e-mails are sent to the Communicare Administrator at the site.

If the e-mail server is down for any reason then scheduled reports will not be delivered.

Pathology Download Software

This is usually installed on a site's local server (not the Communicare server) and occasionally on a workstation. The software may use an internet connection or a dial-up and may be scheduled to run automatically or manually. Some programs require that the computer is left logged on. Initially the software will be set up to place pathology results into a shared folder on the Communicare server. This software should be maintained in consultation with the pathology lab who can advise you on its maintenance and upgrades.

Licence Fees Payable to External Organisations

Separate from the Communicare annual support and maintenance costs are fees payable to other organisations.

- MIMS Pharmaceutical Data - annual fees are payable to MIMS for the regular updates of the list of medications. The amount depends on the number of doctors prescribing. Sites that do not have the prescribing module enabled do not need to pay these fees. Without an up-to-date licence we cannot update the MIMS database. Contact Client Services:
  Toll Free: 1800 800 629
  Phone: +61 2 9902 7700
  Fax: +61 2 9902 7771
  Email: subscriptions@mims.com.au
- ICPC Clinical Terms Data - annual fees are payable to the National Centre for Classification in Health for use of the ICPC-2 PLUS coding system. This allows detailed reporting and coding of conditions and procedures. Most sites use this system and it is mandatory for all sites that report to Healthy for Life, NPCC, ABCD, and so on. Only some very small specialist clinics do not use this coding system. Without an up-to-date licence we cannot update the ICPC-2 PLUS clinical items. For information about ICPC-2 PLUS, contact ICPC-2 PLUS Enquiries:
  Telephone: +61 2 9351 9772
  Email: ncch@sydney.edu.au

Hardware

Workstations: Workstations should be in good working order and be connected to the same network as the Communicare server.

Printers: Printers should be available to users and be in good working order. All workstations should have a default printer defined and accessible to all users.

Scanners: Where Communicare's scanning function is enabled, users with the right to scan should have access to a scanner in good working order. Local scanners connected via USB are the easiest to use.

Communicare conducted a survey of users to find out what scanners were being used to scan documents into Communicare. Though we have not tested and do not endorse any of the following products the following brands and types of local (not networked) scanners were being used successfully:

- A-Vision flatbed scanner with automatic document feeder 'used thousands of times and works well'
- Konica Minolta BizHub flatbed scanner with automatic document feeder
- Canon LIDE 60 and 70
- Canon Canoscan LID60 Flatbed
- Ricoh flatbed
- Ricoh flatbed with automatic document feeder

Administrator only tasks

These tasks can only be performed by users in the System Administrators user group:

- System parameter changes - high level enabling of modules and global preferences. Occasional use.
- Updating MIMS Pharmaceutical Database (although this is usually done when COMMUNICARE upgrades a site). Monthly updates outside of an upgrade must be performed by the Administrator.
- Recording or amending information under another provider name - this may be required when a user who is no longer available has recorded some erroneous information in a patient clinical record that may compromise the care of that patient.
- Usernames, passwords, access rights - necessary when users join and leave the service or when a user's requirements change.
- Clinical item templates and automated recall protocols - any change to data collection items and associated recall protocols.
- Scheduled reports - any automatic report scheduling and e-mailing of results to recipients.
- Database Consistency checks - done by COMMUNICARE when upgrading but recommended to be done occasionally by a local administrator.

All other tasks can be performed by users who have appropriate system and viewing rights.

Printable Forms

You can print forms from Communicare.

All printable forms can be opened using the **Help > Forms** menu in Communicare.

Some printable forms are specific to MeHR. Below is a brief description of them:

- MeHR Health Professional Access Form - Print a blank form for access to the My Electronic Health Record, complete and return to MeHR.
- MeHR Consumer Registration Form - Print a blank form to register your patient for the My Electronic Health Record or to re-register as an adult (over 16 years old) for the Shared Electronic Health Record. Remember to also print off the MeHR Better Healthcare Information Sheet and give to all patients who register (see below).
- MeHR Better Healthcare Information Sheet - Print this information sheet and give to your patients when they register for the My Electronic Health Record. This is to inform them of what they are signing up for, what rights they have and what actions they can take if they are concerned or unhappy with the My Electronic Health Record.

Adding custom forms

If required, you can add custom forms to Communicare.

You can add files to the *`Communicare Directory`*`\Distributable Documents\Custom` folder to be displayed in Communicare, including PDFs, Microsoft Word files, shortcuts and web links.

Note:
You cannot add executable files, or shortcuts or links to executable files, to Communicare. The following table lists files that cannot be added.

Table 305. Executable files that cannot be added to Communicare

File extension	Description
BAT	Batch File
BIN	Binary Executable
CMD	Command Script
COM	Command File
CPL	Control Panel Extension
EXE	Executable
GADGET	Windows Gadget
INF1	Setup Information File
INS	Internet Communication Settings
INX	InstallShield Compiled Script
ISU	InstallShield Uninstaller Script
JOB	Windows Task Scheduler Job File
JSE	JScript Encoded File
LNK	File Shortcut - `LNK` files can be added as long as they do not link to an executable file.
MSC	Microsoft Common Console Document
MSI	Windows Installer Package
MSP	Windows Installer Patch
MST	Windows Installer Setup Transform File
PAF	Portable Application Installer File
PIF	Program Information File
PS1	Windows PowerShell Cmdlet
REG	Registry Data File
RGS	Registry Script
SCR	Screensaver Executable
SCT	Windows Scriptlet
SHB	Windows Document Shortcut
SHS	Shell Scrap Object

Table 305. Executable files that cannot be added to Communicare (continued)

File extension	Description
U3P	U3 Smart Application
VB	VBScript File
VBE	VBScript Encoded Script
VBS	VBScript File
VBSCRIPT	Visual Basic Script
WS	Windows Script
WSF	Windows Script
WSH	Windows Script Preference

Applications installed on the workstation are used to open the files.

It is your responsibility to author, validate and distribute these files.

You can override a standard Communicare form with one of your own. If there is an identical form within the *Communicare Directory*`\Distributable Documents\Custom` folder to one within the *Communicare Directory*`\Distributable Documents\Communicare` folder, the form in the `Custom` folder will take precedence. Custom forms will not be erased when Communicare is upgraded.

Tip:
Do not add files to *Communicare Directory*`\Distributable Documents\Communicare` directly. These files are deleted each time Communicare is upgraded.

To add custom forms and shortcuts to Communicare:

1. Create *Communicare Directory*`\Distributable Documents\Custom`, where *Communicare Directory* is the directory to which Communicare has been installed, usually `C:\Program Files (x86)\Communicare`.
   The folder structure within this directory translates into menu items, with subfolders forming submenus. For example, if you add *Communicare Directory*`\Distributable Documents\Custom\Help\Forms\ReadMe\ReadmeFile.pdf`, `ReadMe` is added as a submenu to the **Help > Forms > ReadMe** menu, within which will be a new menu item **ReadMeFile**.
2. Add the required files or shortcuts to the new folder.
   Add any type of file that you can open, but do not use special characters in the filename. To add a link to a web page, either:
   - Create a shortcut automatically - in Windows Explorer, drag the address bar icon from a web page into the folder
   - Create a new shortcut manually:
     a. In Windows Explorer, right-click and select **New > Shortcut**.
     b. In the **Type the location of the item** field, paste the URL for the required web page and click **Next**.
     c. In the **Type a name for this shortcut** field, enter the name which will be displayed in the menu, and click **Finish**.
3. Restart Communicare.

Note:

Add the files to the *`Communicare Directory`*`\Distributable Documents\Custom` folder for each workstation. If Communicare is accessed using a terminal service, you need to add the file only to the terminal server where Communicare is installed.

Refer to your local IT support for assistance with the distribution of the form files.

Support

If you run into problems using Communicare, you can always get help from us.

For help and support, go the Communicare User Portal - Help and Support tab for general information and further links.

If you still need help, create a support request and we'll get back to you.

Include as much information in the request as you can and follow these guidelines:

- If you include patient information, for patient confidentiality, use the Patient ID instead of the patient's name.
- If you include screenshots, ensure that you conceal both the patient's name and date-of-birth.

Fastpath:
For urgent problems or issues with using the portal, call `1800 798 441` to speak to a support team member.

If reporting a problem, before contacting us, try to replicate the problem. It also helps to write down the problem and the circumstances under which it occurred.

Release Notes

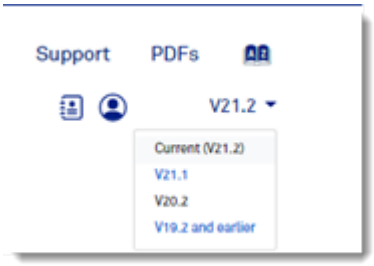
Release notes for all versions of Communicare are available on the Knowledge Centre.

To open the release notes for the latest version of Communicare:

1. On the Communicare User Portal > Help and Support https://communicare-portal.telstrahealth.com/help-and-support/ tab, in the **Knowledge Centre** tile, click **Learn More**.
2. In the Knowledge Centre https://communicare-portal.telstrahealth.com/knowledge/, from the main menu, select **Support > Release Notes >** *required release notes version*.

Tip:
Release notes for the latest version are listed first.

If you are using an older version of Communicare and want to refer to release notes for that version, the release notes are included with the latest version. However, to display the complete Knowledge Centre for your version of Communicare, in the Knowledge Centre, on the right side of the main menu, select your version of Communicare.



Quick links to release notes

- V23.1
- V22.4
- Older versions

Training

If you want someone to teach you how to use Communicare, from beginners to advanced users, try our training.

We can organise someone to come to you, or you can access our eLearning.

> **Tip:**
> Check our eLearning site regularly for our invaluable *Tips and Tricks*.

Request Remote Assistance

Run Teamviewer for quick support or request remote assistance.

Requesting Remote Assistance will allow Communicare Support to have a live view of your screen so we can help you better.

To run remote assistance, when instructed by Communicare Support, in Communicare, select **Help > Request Remote Assistance**.

In order to invoke Request Remote Assistance, on your keyboard, press `CTRL+F2`.

Glossary

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Notices, acknowledgements and attributions

Notices

Words mentioned in this book that are known to be trademarks, whether registered or unregistered, have been capitalised or use initial capitals. Terms identified as trademarks include Microsoft®, Microsoft Windows®.

This software uses some third-party code (C) 2012 Arnaud Bouchez provided by Synopse - http://synopse.info - under Mozilla Public License 1.1; modified source code is available at http://SoftwareCompany.com/MPL.

Approval has been granted by the Tasmanian Government to use Communicare Version 22.1 as an electronic prescription system in Tasmania.

If using the Australian Immunisation Register integration: *Participating health professionals may utilise the services and information provided including personal information only in accordance with National (Privacy Act 1988, Health Insurance Act 1973, Australian Immunisation Register Act 2015 and other relevant legislation), State or Territory legislation, Policy and Guidelines.*

In Communicare V21.3 and later, to support Services Australia interactions, your patients' relevant personal information is encrypted and sent from your Communicare server to Services Australia web services via Communicare Next Generation. The data is retained by Communicare Next Generation. Communicare Next Generation is hosted on Microsoft Azure cloud services, in highly secure data centres based in Australia (Sydney, Canberra, Melbourne) which meet the Australian Standards for Information Security. Microsoft has been awarded Certification for Protected data in Australia. For more information about how Telstra Health manages personal information, see our privacy policy.

In Communicare V22.1 and later, to support ePrescribing interactions, your patients' relevant personal information is encrypted and sent from your Communicare server to an ETP service, such as eRx, via Communicare Next Generation. The data is retained by Communicare Next Generation. Communicare Next Generation is hosted on Microsoft Azure cloud services, in highly secure data centres based in Australia (Sydney, Canberra, Melbourne) which meet the Australian Standards for Information Security. Microsoft has been awarded Certification for Protected data in Australia. For more information about how Telstra Health manages personal information, see our privacy policy.

In Communicare V22.1 and later, for printed PBS prescriptions, your patients' relevant personal information is encrypted and sent from your Communicare server to an ETP service, such as eRx, via Communicare Next Generation. The data is retained by Communicare Next Generation. Communicare Next Generation is hosted on Microsoft Azure cloud services, in highly secure data centres based in Australia (Sydney, Canberra, Melbourne) which meet the Australian Standards for Information Security. Microsoft has been awarded Certification for Protected data in Australia. For more information about how Telstra Health manages personal information, see our privacy policy.

In Communicare V22.2 and later, for outgoing messages, your patients' relevant personal information is encrypted and sent from your Communicare server to the recipient via Communicare Next Generation (Secure Message Exchange). The data is retained by Communicare Next Generation. Communicare Next Generation is hosted on Microsoft Azure cloud services, in highly secure data centres based in Australia (Sydney, Canberra, Melbourne) which meet the Australian Standards for Information Security. Microsoft has been awarded Certification for Protected data in Australia. For more information about how Telstra Health manages personal information, see our privacy policy.

Acknowledgements

NPS MedicineWise, Specifications for national Key Performance Indicators and Online Services Reporting. Sydney: NPS MedicineWise, 2021

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