



Train IT Medical

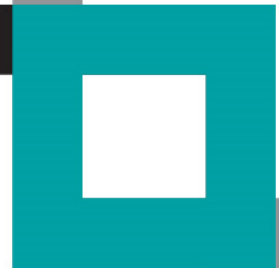
Leading Your Practice Into The Digital Future



Bp Premier

- Clinical -

Presented by Katrina Otto, Train IT Medical
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Agenda

1. Utilise new features in BP Premier (Lava edition)
2. Improve data quality
3. Meet accreditation requirements
4. Create edit and import templates
5. Improve chronic condition management

1.

Utilise new features of Bp
Premier (Lava)

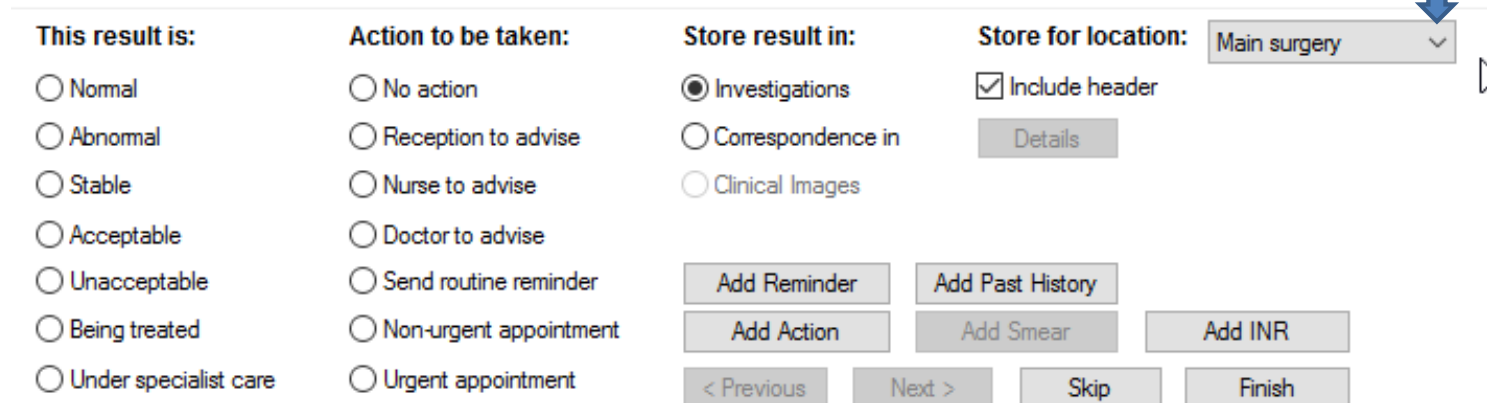
Bp  Premier

What's New in Bp Premier

1. Multiple location support & Multiple Provider numbers
2. Reports – were 150 now 50. Can drill for detail and export to Excel.
3. Inbox/Correspondence Management In and Out new features
4. Digital Health - My Health Record/Event Summaries & eReferral tracking
5. HealthShare Fact sheets
6. 'Run All Checks' Patient Record – checking against adverse reactions & pregnancy
7. National inpatient medication chart (4 page A4 version compliant with prescribing for inpatients usually rural and remote health service organisations).
8. Australian Defence Force – prompt for Health Assessments
9. Advanced Health Directive and Enduring Power of Attorney notification.

What's New – Inbox & Follow-Up

‘Store for location’ if dr would like to follow-up work to take place at another location.



The screenshot shows a medical software interface with four main sections: 'This result is:', 'Action to be taken:', 'Store result in:', and 'Store for location:'. A blue arrow points to the 'Store for location:' dropdown menu, which is currently set to 'Main surgery'.

This result is:	Action to be taken:	Store result in:	Store for location:
<input type="radio"/> Normal	<input type="radio"/> No action	<input checked="" type="radio"/> Investigations	Main surgery
<input type="radio"/> Abnormal	<input type="radio"/> Reception to advise	<input type="radio"/> Correspondence in	<input checked="" type="checkbox"/> Include header
<input type="radio"/> Stable	<input type="radio"/> Nurse to advise	<input type="radio"/> Clinical Images	<button>Details</button>
<input type="radio"/> Acceptable	<input type="radio"/> Doctor to advise	<button>Add Reminder</button>	<button>Add Past History</button>
<input type="radio"/> Unacceptable	<input type="radio"/> Send routine reminder	<button>Add Action</button>	<button>Add Smear</button>
<input type="radio"/> Being treated	<input type="radio"/> Non-urgent appointment	<button>< Previous</button>	<button>Add INR</button>
<input type="radio"/> Under specialist care	<input type="radio"/> Urgent appointment	<button>Next ></button>	<button>Skip</button>
			<button>Finish</button>

NB. Very important every practice designs their practice-wide protocol. Free samples and advice on this:
<http://trainitmedical.com.au/manuals-free-downloads/bp-software-resources-free-templates>

What's New – Inbox & Follow-Up

New prompt will appear on opening record when appointment made from Inbox Follow Up and will be visible in the patient record.

Mr. Brett Denton		
Type	Due	Reason
Follow up	09/08/2016	This appointment was booked to follow up an incoming report.
Preventive health	09/08/2016	A smoking history should be recorded!



What's New – Inbox Follow-Up

The Follow-up Inbox includes an additional combo box filter, giving users the ability to filter by status (Nil status, Contacted, Given, All) after filtering by action

Filter by action: Doctor to advise

Filter by status: Nil status

ione Rep

99905050(H), 097561238(M), CI-CC

Nil status

Contacted

Given

All

What's New – Correspondence

- Filter by sender
- Can now mark as given in Correspondence section.

Correspondence has been added to the file since the last visit! There are unchecked reports for this patient!

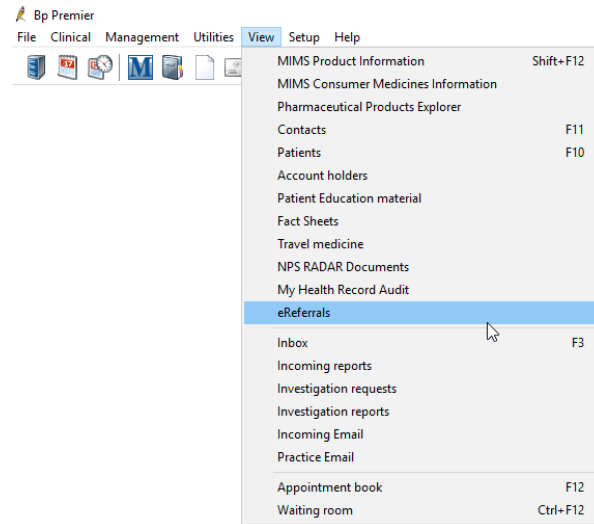
Add View Delete Print Details Scan

From: All Category: All Subject: All Mark as given Search details

All
Southern Radiology

Date	From	Category	Subject	Details
17/10/2016	Southern Radiology	Clinical photograph		

What's New – eReferrals




Log of all documents sent via Secure Messaging

The screenshot shows the 'eReferral Followup' window with a menu bar (File, Utilities, View, Help) and a toolbar. Below the toolbar, there are filters for 'Start date' (21/02/2016), 'Messaging provider' (All), and 'Status' (All). A checkbox for 'Hide positive acknowledgements' is also present. The main area displays a table with the following data:

Date	Patient	Provider	Addressee	Messaging Provider	Status	Details	Message ID
18/02/2016	Mr. Alan Abbott	Dr Frederick Findacure	Dr Heather Angel	HealthLink			BPS_20160228.2
18/02/2016	Mr. Alan Abbott	Dr Frederick Findacure	Dr Heather Angel	HealthLink			BPS_20160228.3

Preventive Health - Allergies

Details of when an allergy was recorded and last updated are now displayed after double clicking Allergies / Adverse drug reactions on the patient record

 Allergies/Adverse reactions ×

Item	Reaction	Severity
Dopamine antagonists		

Comment:

Recorded by: Dr Frederick Findacure on 17/10/2016

☐ Nil known

Add

Edit

Delete

Save

Cancel

What's New – My Health Record

1. Now called My Health Record
2. Runs overnight check on all patients with to check if patient has a My Health Record and puts a green box.
3. Now has Event Summaries.
4. Filters eg document type, last 3 months etc
5. Full name of patient now visible in window's title bar
6. Report added in Management reports to track for ePIP
7. Can now choose 'none known' or 'none supplied' for medications, allergies etc when creating a shared health summary.
8. Removal of 'consent to upload' button. Consent is implied when you click upload or non consent implied if choosing 'cancel'.

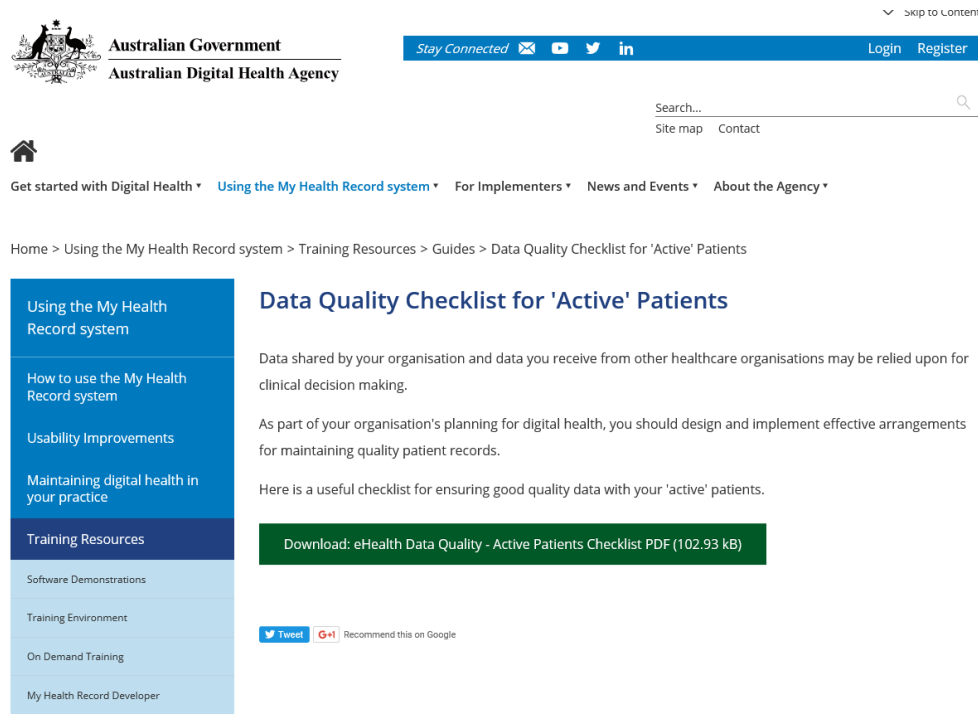


2.

Improve Data Quality



Download the 'Data Quality' Checklist



The screenshot shows the Australian Government Australian Digital Health Agency website. The header includes the agency logo, navigation links like 'Stay Connected' with social media icons, and 'Login' and 'Register' buttons. A search bar and links for 'Site map' and 'Contact' are also present. The main navigation bar lists various topics, with 'Using the My Health Record system' selected. The breadcrumb trail reads: Home > Using the My Health Record system > Training Resources > Guides > Data Quality Checklist for 'Active' Patients. The left sidebar contains a menu with items like 'Using the My Health Record system', 'How to use the My Health Record system', 'Usability Improvements', 'Maintaining digital health in your practice', 'Training Resources' (highlighted), 'Software Demonstrations', 'Training Environment', 'On Demand Training', and 'My Health Record Developer'. The main content area is titled 'Data Quality Checklist for 'Active' Patients' and contains text about data reliability and a link to download the checklist PDF (102.93 kB). Social sharing buttons for Twitter, Google+, and Google are at the bottom.

Australian Government
Australian Digital Health Agency

Stay Connected [Email] [YouTube] [Twitter] [LinkedIn] Login Register

Search...
Site map Contact

Get started with Digital Health ▾ Using the My Health Record system ▾ For Implementers ▾ News and Events ▾ About the Agency ▾

Home > Using the My Health Record system > Training Resources > Guides > Data Quality Checklist for 'Active' Patients

Using the My Health Record system

How to use the My Health Record system

Usability Improvements

Maintaining digital health in your practice

Training Resources

Software Demonstrations

Training Environment

On Demand Training

My Health Record Developer

Data Quality Checklist for 'Active' Patients

Data shared by your organisation and data you receive from other healthcare organisations may be relied upon for clinical decision making.

As part of your organisation's planning for digital health, you should design and implement effective arrangements for maintaining quality patient records.

Here is a useful checklist for ensuring good quality data with your 'active' patients.

Download: eHealth Data Quality - Active Patients Checklist PDF (102.93 kB)

[Twitter](#) [Google+](#) Recommend this on Google

<https://www.digitalhealth.gov.au/using-the-my-health-record-system/digital-health-training-resources/guides/879-data-quality-checklist-for-active-patients>

The 'Data Quality' Checklist

1

Demographics – are the contact details up-to-date?

- Double-click on the patient's telephone number to check & update details



2

Medication List – is the Current Meds list accurate?

- Right click to delete/cease medications no longer relevant (they can then be found in the Old/Past Scripts thereafter)
- If none, tick No medications



3

Past History List – does it contain only significant conditions that a hospital or specialist would need to know?

- Right click to edit, delete or add new
- If none, tick No significant past history (PMH) box



4

Allergies – have you also recorded adverse reactions?

- Double-click in allergies box and Add, Edit, Delete
- If none, tick No Known Allergies/Adverse Reactions/Nil Known



5

Immunisations – have immunisations been recorded?



Coding in Reason for Contact or Prescribing

Past History

Date: 1 / 6 / 2012 ☒ 1/06/2012

Condition: Shoulder replacement

Condition

- Shoulder replacement

☐ Left ☐ Right ☐ Bilateral

☐ Acute ☐ Chronic

☐ Mild ☐ Moderate ☐ Severe

☒ Active ☐ Inactive

☐ Provisional diagnosis

Fracture:

☐ Displaced ☐ Undisplaced

☐ Compound ☐ Comminuted

☐ Spiral ☐ Greenstick

Further detail:

Dr Ken Leouw - Port Macquarie Hospital

☒ Send to My Health Record

☐ Confidential

☒ Include in summaries



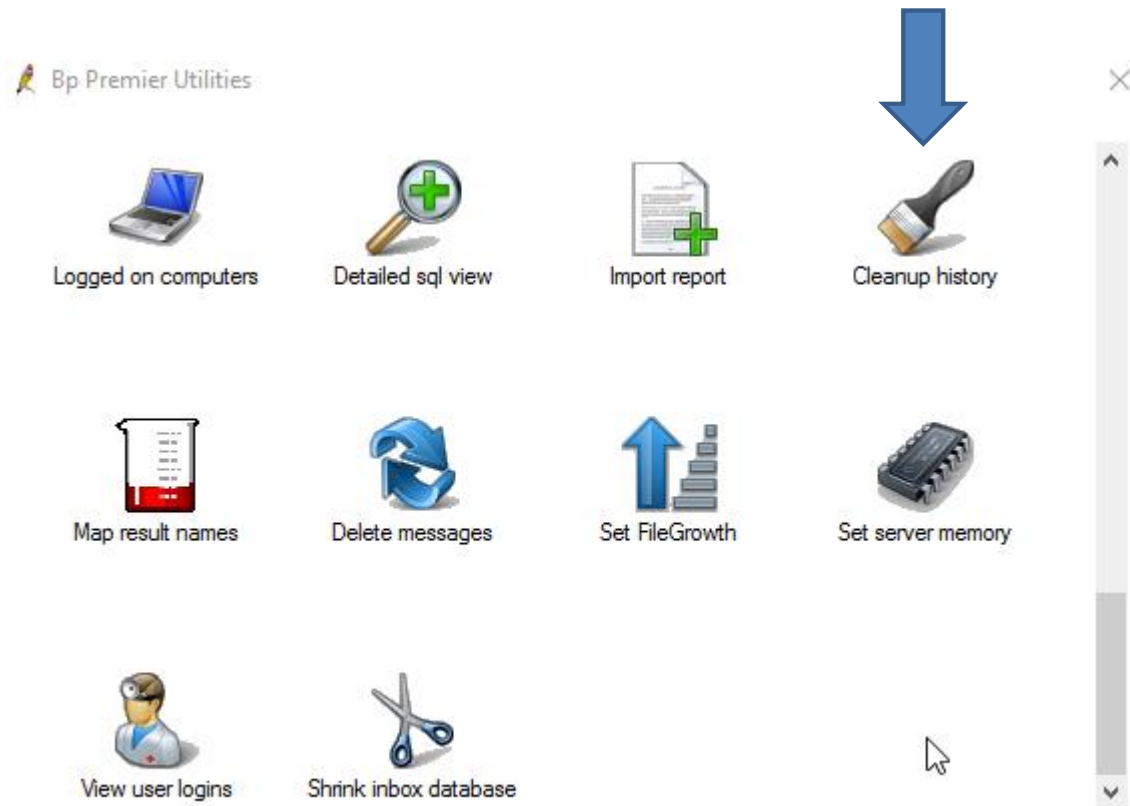
Year	Date	Condition	Side	Status	Summary	Confidential	Coded
1992	JUNE	Atrial Fibrillation		Active	Yes	No	Yes
1999	03/02/1999	Schizophrenia - borderline		Active	No	No	Yes
1999	12/02/1999	Migraine		Active	No	No	Yes
1999	25/02/1999	Urinary tract infection		Active	No	No	Yes
1999	10/08/1999	Anaemia - iron deficiency		Active	Yes	No	Yes
2005	04/05/2005	Hysterectomy & BSO - Abdominal		Inactive	Yes	No	Yes

“Consistent data **coding** systems
drive meaningful
quality improvement activities.”

1.7.1 Patient Health Records <http://www.racgp.org.au/your-practice/standards/standards4thedition/practice-services/1-7/patient-health-records/>

Data Cleansing & Coding

Clean up uncoded and free text data - Bp Premier Utilities.



Cleaning up uncoded items

Past History cleanup

Uncoded Past History terms:

Diab T2
Diabetes Mell.
Diabetis

DIAB Keyword

Condition

Diabetes
Diabetes clinic
Diabetes cycle of care completion
Diabetes Educator referral
Diabetes educator referral
Diabetes Insipidus
Diabetes Insipidus, renal
Diabetes Mellitus
Diabetes Mellitus, Gestational
Diabetes Mellitus, Type 1
Diabetes Mellitus, Type 2
Diabetes review

☐ Left ☐ Right ☐ Bilateral
☐ Acute ☐ Chronic
☐ Mild ☐ Moderate ☐ Severe

Fracture:

☐ Displaced ☐ Undisplaced
☐ Compound ☐ Comminuted
☐ Spiral ☐ Greenstick

Replace Close



User name:

Dr Frederick Findacure

Clone

Today's notes font:

Arial

10

Usual visit type:

Default temperature site:

Initial focus in Observations window:

☒ Pulse☐ Sitting BP☐ Allow blank notes☒ Prompt if no notes recorded☐ Enforce entry of Reason for Visit when closing patient record☒ Prompt for Reason for Visit when closing patient record☐ Don't start timer on opening record.☐ Don't record visit length.☒ Reason for visit at top of notes☐ Use SOAP headings for History and Examination☐ Load SOAP headings on opening notes☒ Display a My Health Record prompt in the Reminders box☒ Send reminder for influenza vaccination☐ Show 'Non visits' in Past Visit list☒ Display Outstanding requests in patient record☐ Use bold font for Allergies and On screen comment☒ Load PMH favourites on opening New PMH window☐ Expand Current Rx and PMH in tree view☒ Separate PMH into Active and Inactive in tree view☐ Expand Inactive PMH in tree view☒ Open the PMH window with the cursor in the date field☐ Popup Preventive Health list when opening patient record☒ Mark new PMH to be included in Shared Health Summaries☐ Display Event Summary window when closing patient record

Diagnosis window:

☒ Always 'Add to Past history'☒ Always 'Save as Reason for Visit'

Procedure window:

☒ Always 'Add to Past history'☒ Always 'Save as Reason for Visit'

Reason for Visit window:

☒ Always 'Add to Past history'

Past History window:

☒ Always 'Save as Reason for Visit'

Save

Save & Close

Close



General



Letters



Prescribing



Clinical



Pathology



Imaging

Update health summary when actioning correspondence



PATIENT, TEST32E	
10 LYON PARK RD, NORTH RYDE. 2113	
Phone: 99416416	
Birthdate: 19/02/1960	Sex: F Medicare Number:
Your Reference:	Lab Reference: 06-2788154-FBS-0
Laboratory: SDS PATHOLOGY	
Addressee: HELLO COMPUTER DEPARTMENT	Referred by: HELLO COMPUTER DEPARTMENT

Name of Test: FBE	
Requested: 01/09/2006	Collected: 01/09/2006 Reported: 01/09/2006 13:27

FULL BLOOD COUNT

	01/09/06	23/08/06	23/08/06	Range	
	2788154	1283	1282		
Haemoglobin	153	pending	127	(120 - 160)	g/L
RCC	5.18	* pending	4.09	(3.74 - 5.16)	x10 12/L
Haematocrit	0.481	* pending	0.393	(0.370 - 0.470)	
MCV	92.9	pending	96.1	(80.0 - 100.0)	fL
MCH	29.5	pending	31.1	(28.0 - 34.0)	pg
MCHC	318	pending	323	(310 - 360)	g/L
RDW	13.5	pending	13.0	(10.0 - 15.0)	%
White cells	5.0	pending	4.9	(4.0 - 11.0)	x10 9/L
Neutrophils	3.0		2.7	(2.0 - 7.5)	"
Lymphocytes	1.5		1.8	(1.0 - 4.0)	"
Monocytes	0.2		0.3	(0.2 - 1.0)	"
Eosinophils	0.3		0.1	(< 0.6)	"
Basophils	0.1		0.0	(< 0.2)	"
Platelets	234	pending	305	(150 - 400)	x10 9/L

1282 Blood count essentially normal.
 pending
 2788154 Blood count essentially normal.

3.

Meet Accreditation Requirements



RACGP Accreditation Standards

4th Standards for General Practices were released 2010
5th Standards currently in consultation phase until 30/9/16
due for release October 2017

<http://www.racgp.org.au/your-practice/standards/standardsdevelopment/>

Webinar on proposed changes:

<http://www.racgp.org.au/your-practice/standards/standardsdevelopment/webinar/>

Standards for Patient-Centred Medical Homes:

<http://www.racgp.org.au/your-practice/standards/standards-for-patient-centred-medical-homes/>

Accreditation Bodies



AGPAL · Accreditation for Practices

Indicators

- ▶ A. Our practice has a patient identification process using three approved patient identifiers and the practice team can describe how it is applied.

Explanation

Key points

- Correct patient identification is vital for patient safety and the maintenance of patient confidentiality
- Use at least three approved identifiers for each patient encounter or activity such as making appointments, writing prescriptions, writing referrals to other providers, giving results or entering results or correspondence into records
- Don't assume you have the correct patient record when treating familiar patients
- This criterion cross references to [Criterion 1.7.1 Patient health records](#).

Approved patient identifiers

All practice staff should be trained to check for approved patient identifiers as a matter of course.

Approved patient identifiers are those items of information accepted for use in patient identification and include

- patient name (family and given names)
- date of birth
- gender (as identified by the patient themselves)
- address

<http://www.racgp.org.au/your-practice/standards/standards4thedition/safety,-quality-improvement-and-education/3-1/patient-identification/>

Meeting Accreditation Standards for Digital Health



<http://www.digitalhealth.gov.au/using-the-my-health-record-system/digital-health-training-resources/webinars/1146-webinar-meeting-accreditation-standards-for-digital-health>

4.

Create, edit & import templates

Download detailed written instructions for importing templates from
<http://trainitmedical.com.au/manuals-free-downloads/bp-software-resources-free-templates>

Bp Premier

File Clinical Management Utilities View Setup Help



Bp Premier Word Processor - Untitled

File Edit View Insert Format Table Templates Utilities Help



Double click on an item in the list to insert it into the document.

- General
- Current user
- Addressee
- Referring Dr
- Other contact
- Patient
- Clinical

- New template
- Edit template
- Import template
- Export template
- Use template
- Edit letterhead
- Customise system templates



100% ▾

1 2 3 4

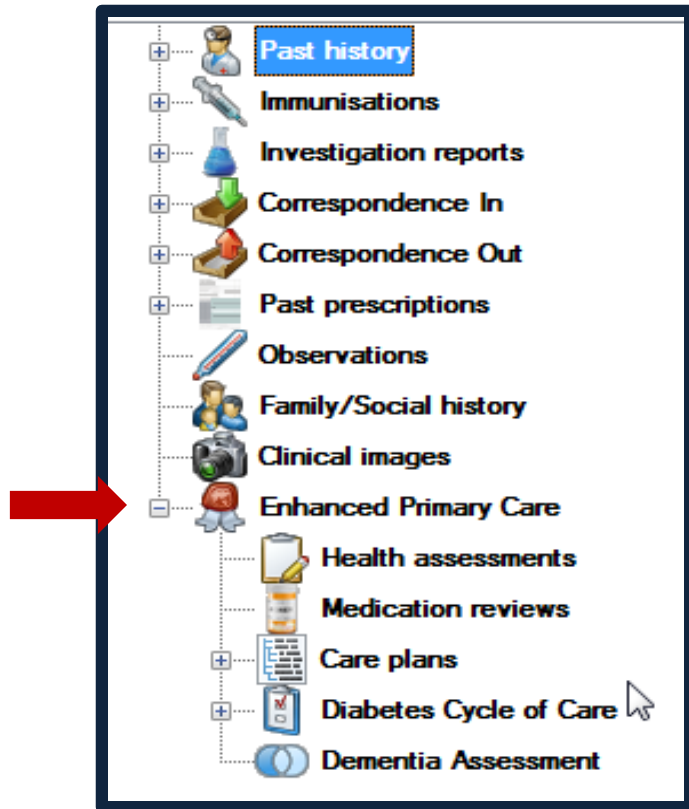
5.

Improve Chronic Condition Management

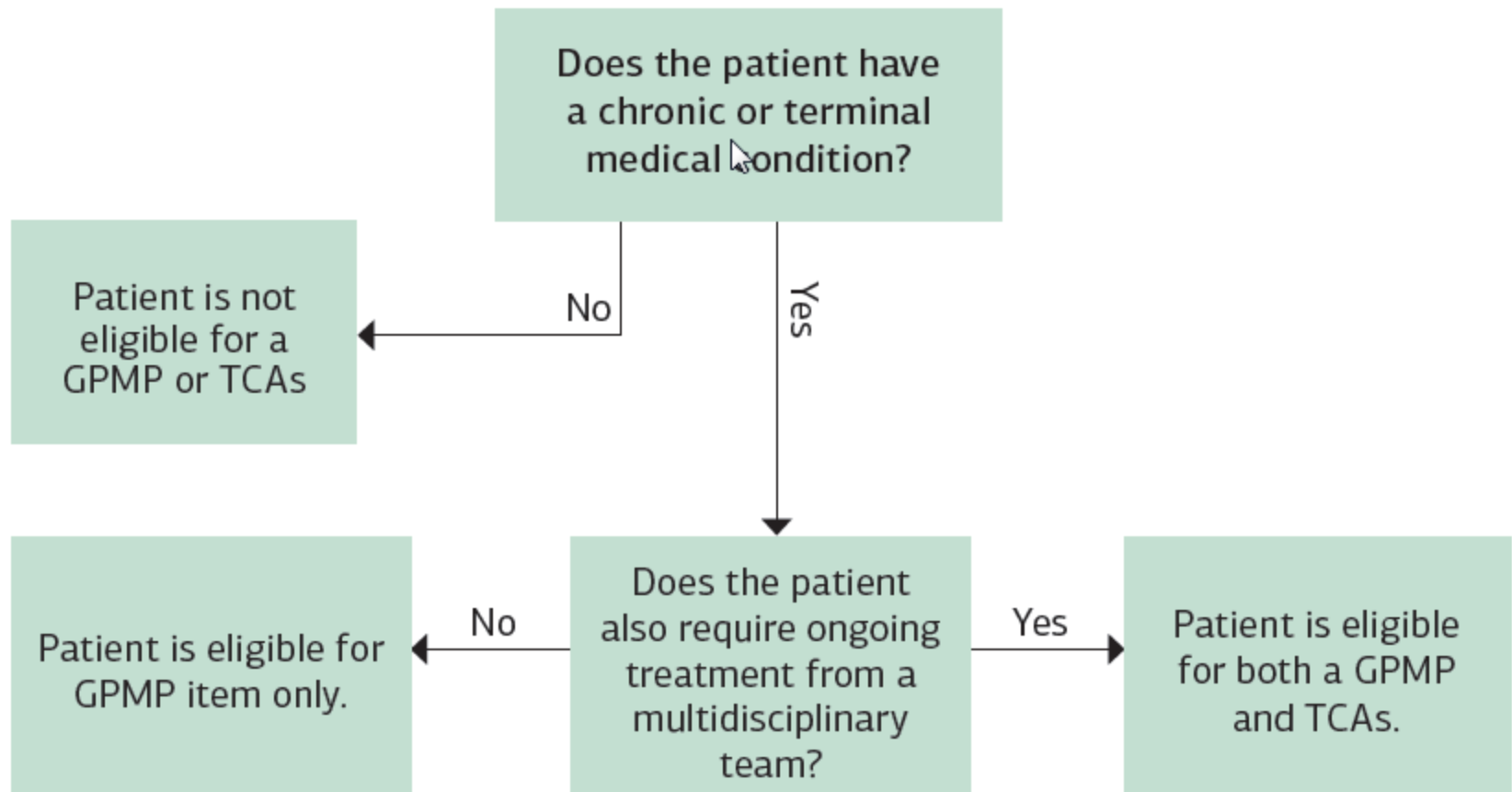


Free Medicare eLearning: <http://medicareaust.com/MBS/CDMForGPs/Welcome/index.html>

Using the EPC Section



1. Select the **'Enhanced Primary Care'** heading found in the "Patient Explorer Tree" on the left hand side of the main patient screen.
2. Expand the EPC heading, highlight Care Plan and press Add.



Chronic Disease Item Numbers

Item Number	Description	Frequency
721	Preparation of a GP Management Plan	Recommended every 2 years; minimum of 12 months
723	Preparation of a Team Care Arrangement	Recommended every 2 years; minimum of 12 months
732	Review of a GP Management Plan or Review of a Team Care Arrangement	Recommended every 6 months; minimum of 3months
729	Contribution to a multi disciplinary care plan prepared by another health care provider	Recommended every 6 months; earlier if clinically required
731	Contribution to a multi disciplinary care plan prepared by another health care provider for a resident in an aged care facility	Recommended every 6 months; earlier if clinically required

Chronic Disease Practice Nurse Item Numbers

Item Number	Description	Frequency
10997	Service provided by a person with a chronic disease by a Practice Nurse or Aboriginal & Torres Strait Islander Health Practitioner on behalf of / under supervision of a GP	Maximum of 5 per calendar year. Only relevant to patients already on a GP Management Plan, Team Care Arrangement or a Multidisciplinary Care Plan.

Health Assessments

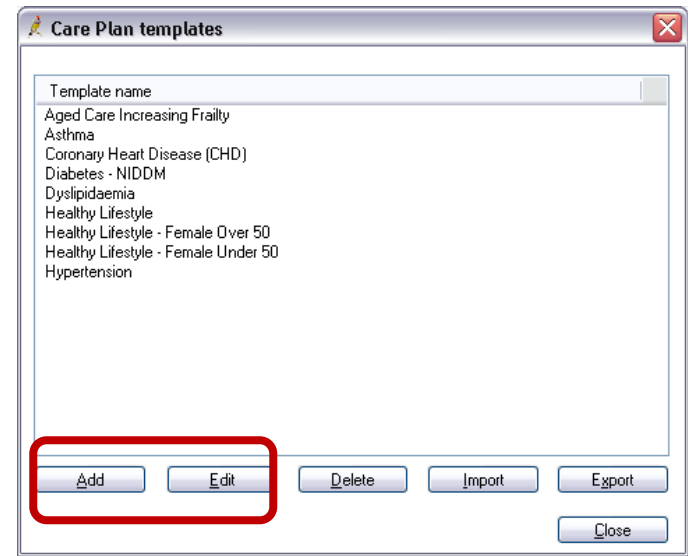
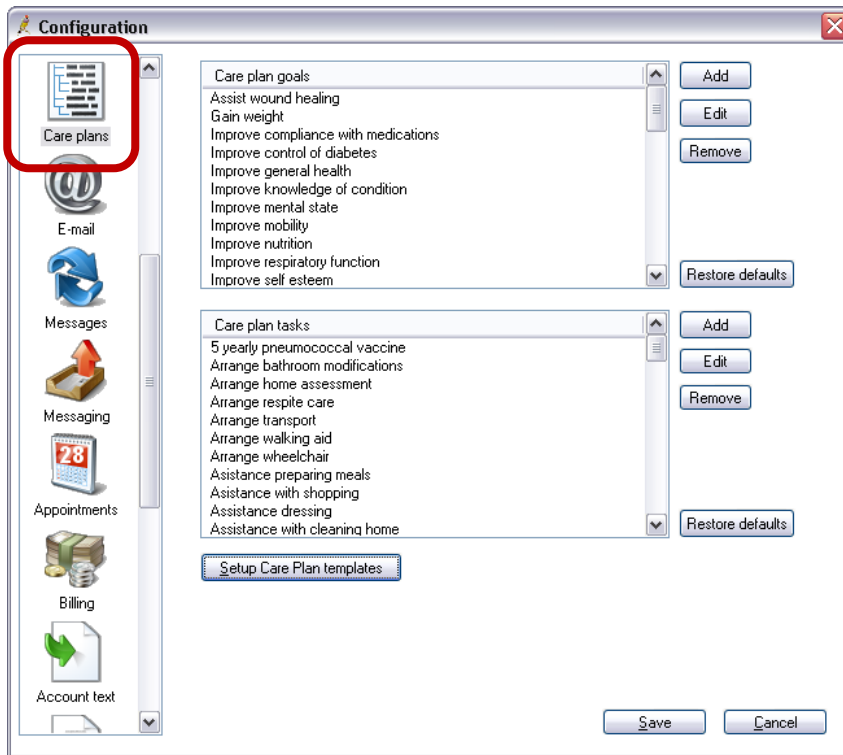
The time period includes the time taken by the doctor and the practice nurse to undertake a health assessment.

701	Brief Health Assessment < 30 minutes duration	12 monthly
703	Standard Health Assessment lasting more than 30 minutes but less than 45 minutes	12 monthly
705	Long Health Assessment lasting more than 45 minutes but less than 60 minutes	12 monthly
707	Prolonged Health Assessment lasting more than 60 minutes	12 monthly
715	Aboriginal and Torres Strait Islander people's health assessment	12 monthly

Diabetes Cycle of Care

Activity	Frequency/Description
Assess diabetes control by measuring HbA1c	At least once every cycle
Ensure that a comprehensive eye examination is carried out ^{††}	At least once every two years
Measure weight and height and calculate Body Mass Index (BMI) ^{†††}	At least twice every cycle
Measure blood pressure	At least twice every cycle
Examine feet	At least twice every cycle
Measure total cholesterol, triglycerides and HDL cholesterol	At least once every cycle
Test for microalbuminuria	At least once every cycle
Provide self-care education	Patient education regarding diabetes management
Review diet	Reinforce information about appropriate dietary choices
Review levels of physical activity	Reinforce information about appropriate levels of physical activity
Check smoking status	Encourage cessation of smoking (if relevant)
Review of medication	Medication review

Modifying Care Plan Templates for EPC Area



Reminders

Mr. Alan John Abbott

File Open Request Clinical View Help

Family members: [] Jump Open

Name: Alan Abbott D.O.B.: 30/06/1945 Age: 65 yrs Sex: Male 2h 24m 14s Finalise visit

Address: 12 Jogger St Albany Creek 4035 Phone: 07 50505050 Mobile: 0427556232 Work: 07 50509999

Medicare No: 4133180467 - 1 12/08 Record No.: 101 Pension No.: Comment: On warfarin

Occupation: Tobacco: Alcohol: Elite sports: Ethnicity: Aboriginal

Blood Group:

Allergies / Adverse Drug Reactions: Reactions

Item	Reaction	Severity
House dust mite	Bronchospasm	Severe
Tiniflu	Nausea	Severe
Aluminium Hydroxide		

Expand Collapse

01/03/2011 Depression

Inactive

Immunisations

Investigation reports

Correspondence In

Correspondence Out

Actions/Reminders: Preventive Health Actions Reminders

Type	Due	Reason
Reminder sent	23/06/2010	Full medical Sent on 16/06/2010.
Outstanding requests	17/03/2010	There are 2 outstanding requests for this patient!
Preventive health	04/03/2011	Vaccination against pneumococcus should be considered!

There are unchecked reports for this patient!



Add View Delete Print Values

Filter: [] Mark result as given Atomised values

Date	Test name	Checked by	Date checked	Action	Status
<input type="checkbox"/> 23/07/2004	HPV DNA	Dr. Frederick Findac...	01/03/2011	Nurse to advise	/ /

Katrina's Top 10 new features in:

1. Reports – can now drill down for detail within each report. Can now export to Excel.
2. Allergy audit – now shows when an allergy was last updated and by whom.
3. 'Run all checks' – checks for contraindications after adding a new allergy or pregnancy.
4. Results of diabetic foot exam now saved into today's notes so we can add more detail.
5. Follow-up Inbox – can check patients marked as 'contacted' about result but not 'given'.
6. HealthShare Fact Sheets – reactive with prompts following diagnosis or prescription.
7. Can move correspondence from 'Correspondence In' to 'Correspondence Out'
8. Can upload Event Summaries to the My Health Record System.
9. SMS reply symbols in appointment book.
10. The very helpful Online help!

 Confirmed attendance  Declined attendance  Neither declined or confirmed

Thanks for inviting me.

Let's keep in touch!

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