Data quality guide for Communicare
Introduction

This guide has been created to assist health service staff to improve and correct data quality in electronic clinical records in the Communicare system.

The focus of this guide is to improve key performance indicator (KPI) data. However it is not the only or most important purpose. Good data enables good patient care. When clinical information is recorded correctly, health providers can easily find correct diagnoses and other important information in the clinical record such as BPs, HbA1cs, or when the last Pap test was done and the results.

Correct demographic data ensures a correct population denominator. This is important not only for KPIs, but when other reports and recall lists are run. Often these reports are run for your current patients, excluding past patients and/or visitors. Patients will ‘fall through the cracks’ if they are classified incorrectly as past or transient patients. Correct demographics data is also important for accreditation and to enable efficient follow up.

Acknowledgements

Thank you to the staff of the Northern Territory Aboriginal health services who have generously shared their time, knowledge and experience of good data to make this guide. Thank you also to the Communicare helpdesk staff.

Collated by the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT), 2015.

We would be pleased to have a collaborative approach to ongoing improvement of this guide. If you have anything to add to this guide – corrections, edits, tips or additions – please send to margaret.cotter@amsant.org.au so we can continue to share knowledge to improve all clinical records and data.
General tips

External sources
Use external sources to help in validating data such as biographics, and accessing clinical information. These include:

- HPOS - Health Professional Online Services
  - Good for Medicare numbers and Medicare information
- MeHR
- PCeHR/My Health Record
- RHD Register - NT Rheumatic Heart Disease Register
gin/index.aspx
- CDC - NT Centre for Disease Control
  - For immunisations
- Pap Smear Register

Training
- Comprehensive training for staff in Communicare use is crucial for good data quality.
- Involve data quality staff in training to help identify and reduce common errors in Communicare use/data entry.

See here for some tips on training. (Appendix page 15).

Report function in Communicare
Maximise the report functionality by using:

- The Search function in Reports
- The Scheduled reports
- The Advanced function in the search window accessed from the Clinical Record or Patient Biographics icons on the main toolbar. Particularly useful for data cleaning.
- The patient query (Report | Patients | Patient query)

Click here for more information on using reports (Appendix page 16).
Ending consultations
Ensure that every encounter/consult is ‘finished’ correctly at the end of each reporting period. Records not ended correctly means that those contacts and some of the data in them will not be counted.

Click here for more information (Appendix page 23).

Recall management
Good recall management is crucial to good data quality (as well as good clinical care). How health services manage the recall system will vary to what works for that service, as well as size, capacity, staffing and organisation.

See here for tips to manage recalls (Appendix page 24).

Medicare management
Good Medicare management will assist in good KPIs as well as increased income generation – with the main aim of improving patient care.

See here for tips on managing Medicare (Appendix page 25).

Notes and pop up alerts
You can use Administration notes and pop up alerts (found under the Administration tab in Biographics) to remind staff for specified information.

Click here for more tips (Appendix page 26)

Relationships and data
- Good relationships with all staff – clinical, administrative, GPs, managers, executive, clerical, ancillary and executive – is crucial to good data management. Involving the whole team will improve data quality.
- The presentation of data is important – data should be presented in a way that is accessible and understandable for all staff.

Know your population
- Know your database/population by accessing regularly (daily if capacity exists)
- Trend data is useful including trends on denominators.
Biographics

- Correct biographics are essential for good data quality. Checking and correcting biographics can be done by clinicians and administrative staff, every time a record is opened, and on a regular basis e.g. weekly if capacity exists.

- Thorough training is very important here, ensuring that everyone who adds a new patient adds all relevant information. Minimum information is: Name, DOB, Gender, Aboriginality (never Not Applicable), locality and a contact person and their contact details. The last is especially important for children.

- Correct patient status has a large impact on data quality and depends on accurate personal details including address (if patient status is set to be automatic). A patient’s address determines status as a current patient, or as transient/visitor, for both in Communicare and for the NTAHKPIs. It is important for all staff to have a thorough understanding of how Communicare classifies patients as current, transient or past.
### Biographics - reports to help correct data

<table>
<thead>
<tr>
<th>Area</th>
<th>Resource</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duplicate names</td>
<td>Database consistency check</td>
<td>Accessed from Tools on the main tool bar. 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, preferably by faxing or e-mailing the report. If the report contains any data in the Table Name or Field Name columns then there is something to investigate.</td>
</tr>
<tr>
<td>Name, DOB, sex, Aboriginality</td>
<td>Report Patients Biographics added</td>
<td>Lists biographic details of new patients added to the Communicare database since a selected date. The username of the provider who added the patient is also displayed.</td>
</tr>
<tr>
<td>No DOB or sex</td>
<td>Report Patients Patients without DOB or sex</td>
<td>Lists all patients who do not have a date of birth or sex recorded.</td>
</tr>
<tr>
<td>Reversed names</td>
<td>Report Patients With names reversed</td>
<td>Lists all patient names where the reversed names are recorded for another patient. Use this report to check that a patient has not been incorrectly recorded.</td>
</tr>
<tr>
<td>Names with characters/numbers instead of letters</td>
<td>Report Patients Names with illegal characters</td>
<td>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.</td>
</tr>
<tr>
<td>Same DOB, same Medicare number</td>
<td>Report Patients Patients with Same DOB, Medicare number</td>
<td>Lists details of patients with identical dates of birth and Medicare card. Use it to find possible duplicate patients with different names. Note that twins sharing the same Medicare card will be reported also.</td>
</tr>
<tr>
<td>Aboriginality</td>
<td>Report Patients Biographics filter</td>
<td>Very useful report – in the parameters choose Aboriginality unknown to get a list of patients with Aboriginal status not recorded.</td>
</tr>
<tr>
<td>Birth weights (recorded)</td>
<td>Report National KPI PIO1</td>
<td>This report will list all babies with and without birth weight recorded.</td>
</tr>
<tr>
<td>Birth weights (recorded correctly)</td>
<td>Report Patients Birth details Audit</td>
<td>This report 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.</td>
</tr>
</tbody>
</table>
Patient status

Errors in patient status can occur for several reasons and can affect your KPIs as well as other reports and recall lists you may use to help manage patient care.

**Current patient:**

If you choose to use the manual system instead, it is recommended to do a community census on a regular basis (quarterly or annual) to update the address and patient status.

The following information relates to automatic patient status functionality.

If you use the automated updating of patient status it is important to train your staff to check the address on every presentation in order to maintain accuracy (and for accreditation purposes, and for general good practice). It is also important to teach staff not to change patient status manually. Patient status does not occur immediately, after, e.g. changing an address to outside the locality – it occurs overnight.

See the Communicare help menu under ‘Automatic patient status change’ for further details on this functionality.

**Mode of contact**

If a clinical record is opened in a mode of contact when the patient is not present, for example as “Millennium Health Service (Aboriginal Health Service)” when it should be “Administration – no client contact”, this will be counted as a contact. This can occur e.g. when reviewing pathology or documents, or to record attempts to contact, or for a variety of reasons. It can make a patient ‘current’ even if the patient has not been seen for several years. A patient may not have been seen in 2 years but could be counted as a regular client in your nKPIs, and a current patient for the NTAHKPIs.

Ensure staff training includes the importance of using the correct mode. It is helpful to use the Service Recording to check the day’s work, to ensure correct mode, and that all notes and follow up have been correctly recorded and performed (and Medicare claimed).

**Patient status and key performance indicators**

Further discussion on patient status can be found under the KPI section. The definition of a regular or current patient affects your KPIs and also your work as it can define which patients you will follow up and/or offer screening and health assessments.
## Useful reports to check patient status

<table>
<thead>
<tr>
<th>Area</th>
<th>Resource</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correct mode used</td>
<td>Report</td>
<td>Lists the users that had accessed the clinical record and if a service is recorded, as well as progress notes. This report also useful for general assessment of staff use of Communicare, for training purposes, and for inappropriate viewing of clinical records</td>
</tr>
<tr>
<td>Patient status – manual changes</td>
<td>Audit logs</td>
<td>Shows all changes (manual or automatic) to a patient's status recorded between two dates. Use it to see who might be manually adjusting a patient's status or which changes have been made automatically.</td>
</tr>
<tr>
<td>Patient status – check current patients</td>
<td>Patients</td>
<td>This report can assist in picking up errors in classifying patient status as current</td>
</tr>
<tr>
<td>Patient status – check past patients</td>
<td>Patients</td>
<td>This report can assist in picking up errors in classifying patients status as past</td>
</tr>
</tbody>
</table>
Key Performance Indicators (KPIs)

- The draft or complementary reports for both the NTAKPIS and the national KPIs are very useful tools to help manage and improve patient care.
- The draft reports also provide a chance to clean the data if needed.
- Located at Report|National KPI and Report|NT KPI
- Run the draft KPI reports regularly, e.g. monthly if capacity exists (so there are no surprises in June and December).
- Alternatively run KPI reports in, say, May and October, giving you a month to catch up with outstanding work before the end of the reporting period.
- Also use these reports to cross-check with your recall lists to retrieve patients “lost in the cracks” (e.g. patients with no HBA1C recorded may have had a diabetes follow-up recall cancelled inadvertently, but will be listed in the draft KPI report).
- Develop ‘hit lists’ from these, for patients not recorded for those particular KPI reports.
- Determine priority patients with GPs, health service managers, portfolio/program holders, and other relevant staff such as diabetic educators
- For weights, BMI, BP, smoking status, alcohol status, Hb, HbA1c, Pap test results, Influenza immunisation:
  - Enable these qualifiers to appear on the Qualifier Summary
  - Apply the currency function for these qualifiers. This highlights the date in the qualifier summary, of values after a specified date, as a reminder to attend to these items if not done in that specified period:

<table>
<thead>
<tr>
<th>Qualifier</th>
<th>Value</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hb (Haemoglobin)</td>
<td>140 g/L</td>
<td>02/02/2011</td>
</tr>
<tr>
<td>Smoking status</td>
<td>Current smc...</td>
<td>29/05/2014</td>
</tr>
</tbody>
</table>

  - Use pop up alerts to remind staff to measure and record these values.
- The report: Report|Reference tables|Reports and comments... choosing National_KPI and NT_KPI are useful to run for the definition of each KPI and details of where the data comes from, in Communicare. Attached here (Appendix page 27)
- Running the KPI reports regularly will help with ensuring data is accurate and to follow up care with patients. There are other reports that can also assist in improving KPI data, and some of these are listed on the following page. See the report definitions in Communicare for the exact description of each report.
Reports (additional to the KPI reports) to assist in improving KPI data and patient care

<table>
<thead>
<tr>
<th>Topic</th>
<th>Report</th>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal care &amp; birth weights</td>
<td>Report</td>
<td>Pregnancy</td>
<td>Current antenatal list (Run monthly)</td>
</tr>
<tr>
<td></td>
<td>Report</td>
<td>Pregnancy</td>
<td>Outcomes</td>
</tr>
<tr>
<td></td>
<td>Report</td>
<td>Patients</td>
<td>Birth details audit</td>
</tr>
<tr>
<td>Immunisations</td>
<td>Report</td>
<td>Immunisations</td>
<td>Report for CDC-NT</td>
</tr>
<tr>
<td></td>
<td>Report</td>
<td>Immunisations</td>
<td>Annual Fluvax List NT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child health</td>
<td>Report</td>
<td>Recalls</td>
<td>Healthy Under 5s Checks</td>
</tr>
<tr>
<td></td>
<td>Report</td>
<td>Recalls</td>
<td>Child Health Check Chart</td>
</tr>
<tr>
<td></td>
<td>Report</td>
<td>Procedures</td>
<td>GAA record sheet NT</td>
</tr>
<tr>
<td></td>
<td>Report</td>
<td>Healthy 4 Life</td>
<td>EI 41 Child Health Checks</td>
</tr>
<tr>
<td>Health checks</td>
<td>Report</td>
<td>Recalls</td>
<td>Health check management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CDMPs</td>
<td>Good Medicare management – see <a href="#">here</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>Report</td>
<td>Clinical Record</td>
<td>Conditions and qualifier analysis</td>
</tr>
<tr>
<td></td>
<td>Report</td>
<td>Clinical Record</td>
<td>Patients with Dx but no item etc.</td>
</tr>
<tr>
<td></td>
<td>Report</td>
<td>ABCD 12170</td>
<td>Clinical Audit protocol</td>
</tr>
<tr>
<td>CKD &amp; eGFR</td>
<td>Report</td>
<td>Conditions</td>
<td>Diabetes &amp; hypertension measures</td>
</tr>
<tr>
<td>Cervical screening/Pap tests</td>
<td></td>
<td></td>
<td>Renal conditions &amp; eGFR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Differences between the NT AHKPIs and the national KPIs:

<table>
<thead>
<tr>
<th></th>
<th>NT AHKPIs</th>
<th>National KPIs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who is counted in the KPIs?</strong></td>
<td>Based on your definition of current patient, which for Communicare users can be a manual or automatic status. If automatic, this means a patient who lives in your local area and has visited your health service at least once in the prescribed time which is determined by the setting your service makes in Communicare—often 2 or 3 years.</td>
<td>Use a RACGP/AIHW definition of a regular client, which is a patient, regardless of place of residence, who has visited your health service at least 3 times in 2 years. Therefore the nKPIs will not include some of your current patients (if they were seen by you less than 3 times in 2 years), and will include all visitors who were seen at your clinic 3 times in 2 years</td>
</tr>
<tr>
<td><strong>Patient status — current patient/regular client</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Birth weights</strong></td>
<td>• Includes multiple births</td>
<td>• Excludes multiple births</td>
</tr>
<tr>
<td></td>
<td>• Counts babies born to resident mothers</td>
<td>• Counts all babies recorded at the health service</td>
</tr>
<tr>
<td><strong>Health checks</strong></td>
<td>• Includes alternative health checks (where health checks have been completed but not signed off by a doctor with a Medicare item 715 claim)</td>
<td>• Counts only MBS item 715 claimed</td>
</tr>
<tr>
<td></td>
<td>• Include people with coronary heart disease and type 2 diabetes</td>
<td>• Include children aged 0-4 years</td>
</tr>
<tr>
<td></td>
<td>• Count MBS items 721 &amp; 723 (GPMP &amp; TCA)</td>
<td></td>
</tr>
<tr>
<td><strong>Immunisations</strong></td>
<td>Count children ages:</td>
<td>Count children ages:</td>
</tr>
<tr>
<td></td>
<td>• 6-&lt;12 months;</td>
<td>• 1-&lt;2 years;</td>
</tr>
<tr>
<td></td>
<td>• 1-&lt;2 years;</td>
<td>• 2-&lt;3 years;</td>
</tr>
<tr>
<td></td>
<td>• 2-&lt;6 years</td>
<td>• 3-&lt;6 years</td>
</tr>
<tr>
<td></td>
<td>Second indicator to measure timeliness of immunisations for children under 12 months</td>
<td></td>
</tr>
<tr>
<td><strong>HbA1c tests</strong></td>
<td>Count from age 15 years and over</td>
<td>Count all ages from 0 years</td>
</tr>
<tr>
<td><strong>CDMPs</strong></td>
<td>• Include people with coronary heart disease and type 2 diabetes</td>
<td>• Count only people with type 2 diabetes</td>
</tr>
<tr>
<td></td>
<td>• Count MBS items 721 &amp; 723 (GPMP &amp; TCA)</td>
<td>• Count only MBS item 721 (GP management plan)</td>
</tr>
<tr>
<td><strong>Diabetes – BP control</strong></td>
<td>Count from age 15 years and over</td>
<td>Count all ages from 0 years</td>
</tr>
<tr>
<td><strong>Cervical screening</strong></td>
<td>Includes all women between the age of 20-69 years, so some women who have had hysterectomies and do not require cervical screening will be counted</td>
<td>Excludes women who have had hysterectomies and had this recorded in Communicare, so some women who have had hysterectomies but still require vault screening, will not be counted</td>
</tr>
<tr>
<td><strong>CV risk (coming)</strong></td>
<td>Based on CARPA STM, starting at age 20 and adds 5% for Indigenous status</td>
<td>Based on Framingham and starting from age 35</td>
</tr>
</tbody>
</table>

Data quality guide for Communicare. November 2015 Version 2.0
National KPI regular client:

- In many cases experience shows that this can increase the number of chronic disease patient shown as “current” by around 50% in a remote clinic, many of whom will only have attended for tablets rather than receiving regular care items such as CDMPs etc.

- It can be useful to run the nKPI reports in Communicare twice, once with the AIHW regular client definition, and again using the Communicare current patient definition. This will allow visibility of the difference in the reports when the different definition of regular patient is used and will often be useful when commenting on your nKPIs.

- Using the Communicare current patient definition may be more useful in using the nKPI data for CQI as it reflects your ‘real’ resident population more accurately.
Accreditation

These reports can assist in improving data related to accreditation standards. The use of administration notes or pop up alerts could be used to remind staff to complete these fields.

<table>
<thead>
<tr>
<th>Area</th>
<th>Resource</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse reaction</td>
<td>Report, Clinical</td>
<td>No formal allergy status recorded</td>
</tr>
</tbody>
</table>
| Adverse reaction, social & family history, emergency contact | Report, Encounter analysis | Accreditation audit  
This report shows all patients seen by a provider between two dates where any of the following has still not been recorded:  
1. Allergy status (either an allergy or ‘nil known’ not recorded)  
2. Social and family history (one of both missing)  
3. Emergency contact (name and phone missing - i.e. if there is a number or a name then this is considered OK) |
| Social and family history                 | Report, Clinical  | Social and family history analysis and patients                             |
The PCeHR/My Health Record and data quality

The relationship between data quality in your organisation and the effective use of the PCeHR/MHR requires:

- Accurate and up-to-date patient identification and demographic information in your Communicare system before patient IHIs can be downloaded, and;
- The correct IHI is required before patient clinical information can be shared in the PCeHR/MHR system; and
- Accurate and up-to-date clinician, staff and organisation identification information is required for your HPI-I and HPI-O(s), and;
- These must be established correctly in your health service before patient clinical information can be shared.
- Accurate and up-to-date patient clinical information is required in your CIS for the safe sharing of health summaries and other clinical documents, such as eReferrals.
- The sharing (outgoing and incoming) of inaccurate data may lead to adverse patient outcomes.

The Shared Health Summary is a critical component of the eHealth record system. It is maintained by a patient’s usual health service (via a clinician in the role of being their Nominated Healthcare Provider); it is a "clinically reviewed" summary of your patient’s health status at a point in time. The Shared Health Summary is likely to be the first clinical document a healthcare provider views. Additionally, its content is drawn from patient data in your CIS, so it is imperative that data in it is of the highest possible quality.

A Shared Health Summary or Event Summary can be manually created when in a patient’s clinical record or automatically generated at the end of a consult. A patients PCeHR can be accessed from their clinical record within Communicare.

In the near future it is expected that ePIP payments will be based on meaningful use of the PCeHR including sending and viewing of clinical documents in the PCeHR.
Appendix – tips and further information

Communicare training and use – tips

- Ensure consistent training for every staff member
- Offer refresher/follow up training soon after the initial training.
- As a training tool, audit staff shortly after commencing to ensure correct use (ensuring staff are reassured that it is performed for training needs only): Report|Encounter Analysis|Provider Data Audit will show, for each provider who provided service during a selected period, the number of "Contacts" and the number of clinical items and the number of progress notes recorded (aiming for at least 1:1:1). Use this report to audit provider’s data recording
- Courtesy of Nganampa Health, these tools are used there as training resources:

![](Nganampa Basic CC USER AUDIT.docx)

![](Nganampa Advanced CC Training.docx)

- Make use of the resources provided by Communicare. The website http://www.communicaresystems.com.au/ has a variety of resources – note that you require a login to access these. Resources include:
  - How to guides (many)
  - Training videos (a few)
  - Helpdesk - by phone, email or live chat
- Use the help menu in Communicare, accessed from the toolbar or any part of Communicare: Help or
- A user guide may be of use. AMSANT has developed one, adapted from a manual created by Central Australian Aboriginal Congress. This is freely available on request.
- Make use of your AMSANT Communicare support staff, Clinton Franklin and Margaret Cotter (clinton.franklin@amsant.org.au and margaret.cotter@amsant.org.au). They are available to provide initial training in Communicare use for any NT ACCHO staff.

Return to top of document
Report function in Communicare – tips

1. Use the **Search Reports** function in Reports. This allows you to save reports to a favourite list so you can easily find reports you have found useful. It also provides quick and easy access to report definitions.

1.1 Use the Search window or the tree to find reports you want. Once you add reports to your favourites, click on **Show Favourites** to list these reports.

Return to main document
Reports – tips (cont.)

2. Use the **Scheduled reports** function to automatically email relevant reports to relevant staff daily, weekly, monthly or annually – whatever period is useful for that particular report. These reports run between 8.30pm and midnight so should not slow your system during main clinic hours.

![Scheduled Reports](image)

3. Use the **Advanced** function in the search window accessed from the **Clinical Record** or **Patient biographics** icon on the main toolbar. This function runs reports providing quick access to patient records when undertaking data cleaning.

![Advanced Search](image)

_Return to main document_
Reports – tips (cont.)

3.1. Choose required report, eg. **Biographics Added** to produce a list of patients missing Aboriginality status.

![Patient Biographics Added](image)

3.2. Select required parameters and click OK:

![Add or change patient clinical record](image)

3.3 Note: use this function through **Patient Biographics** for biographics information, or the **Clinical Record** for clinical information that requires correcting. In these reports patient names are usually listed, but if not (such as here in this example), double clicking on the patient will bring up a patient record.

![Add or change patient biographic details](image)
3.4. You can now correct missing information:

4. **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. This report should be used when none of the other reports can produce the results you require.
- The disadvantage of this report is that the query cannot be saved - you need to re-enter the same data into the fields to run the same report again.
- Located at **Report|Patients|Patient query**. The screenshots here shows how to enter the example described in the Communicare help menu in *How to make a query* (Copyright (c) HEALTHCONNEX Friday, 27 March 2015).

4.1 Specify the search conditions

- Select a data item, e.g. "Patient Age"
- Select a Relational operator, e.g. ">" (greater than)
- Enter a value, e.g. "50"
- Click the **Add** button to add the condition to the list of conditions to be used in the search.
Patient query (cont.)

The example here would select patients who are over 50 years of age.

![Patient Query interface image]

After the first condition has been added, the **logical operator** list box will appear.

Therefore, if additional conditions are added you must also:

- Select a logical operator, e.g. "and"
- Select a data item, e.g. "Residence"
- Select a relational operator, eg "=" (equals)
- Select a value, eg "Northern Region"

Click the **Add** button to add the condition to the list of conditions to be used in the search.
Patient query (cont.)

The example would now select patients who are over 50 years of age AND live in the Northern Suburbs.

Clinical Item data can be used to refine the search criteria even further and the results can also be inverted in the Results options.

For example to find all patients with diabetes;Type 2:

Alternatively, to find all patients without diabetes, perform the same query and select "Invert clinical item" selection on the Results tab.

Return to main document
Patient query (cont.)

4.2. Select the type of results.

The type of results can be specified on the results tab. The results of the search may be either a simple count of the number of patients found or a list of the patient names.

4.3. Click the Search button

After one or more search conditions have been added, the search button can be clicked. Note: Ensure items are added before clicking the search button.
Ending consults correctly - tips

Ensure that every consult is ‘finished’ correctly at the end of each reporting period. Check your Service Recording regularly & frequently – e.g. at the end of each day or week depending on capacity. Ensure records are “finished” – not “paused”, “waiting” or “started”. Records not ended correctly means that those contacts and some of the data in them will not be counted. It also lengthens the time for reports to run.

The Service Recording is also useful to quickly check that:

- Data has been entered correctly
- All tasks completed e.g. pathology ordered, referrals created, recalls set, progress notes completed
- Relevant Medicare has been claimed
- Correct mode has been used. Incorrect use of mode will affect contact and encounter data, and can make patients ‘current’, even if not seen in past 2 years, if their record has been accessed in incorrect mode of patient contact.

Return to main document
Recall management – tips

♦ Create a shortlist of manual recalls
♦ Create a recall user guide for staff
♦ Disable recalls
♦ Request reports to be created at Communicare, to suit your health service.
  Examples are:
  o Your most urgent follow up recalls
  o By portfolio/program e.g. Children’s/Under 5’s, women health, men’s health, chronic conditions etc.
♦ Create your own SQL reports. Training is available by Communicare.

Useful recall reports:

<table>
<thead>
<tr>
<th>Report</th>
<th>Recalls</th>
<th>Recalls due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recalls</td>
<td>Recalls due</td>
<td>multi-select</td>
</tr>
<tr>
<td>Recalls</td>
<td>Completion rate</td>
<td></td>
</tr>
<tr>
<td>Recalls</td>
<td>Completion rate</td>
<td>automated recalls</td>
</tr>
<tr>
<td>Recalls</td>
<td>Cancelled recalls</td>
<td></td>
</tr>
<tr>
<td>Recalls</td>
<td>Due except</td>
<td>selected recall type</td>
</tr>
<tr>
<td>Recalls</td>
<td>Health check</td>
<td>management</td>
</tr>
<tr>
<td>Recalls</td>
<td>Healthy Under 5s</td>
<td>checks</td>
</tr>
<tr>
<td>Patients</td>
<td>Without selected</td>
<td>recall</td>
</tr>
</tbody>
</table>

Return to main document
Medicare tips

- Good Medicare management is a large complex topic in its own right and these are just some brief suggestions. Medicare management can:
  - increase revenue for health services
  - improve KPIs and data quality, and
  - enhance patient care.

- Often the employment of an experienced Medicare officer will generate their own wage plus more. In many instances, it is simply a matter of claiming Medicare for work that is already being done by health services. When Medicare officers work as part of a clinical team, patient care can be improved by helping to ensure correct recalls and referrals are in place, and to enable appropriate follow up.


These are some reports that are helpful in managing Medicare.

<table>
<thead>
<tr>
<th>Report</th>
<th>Patients</th>
<th>Invalid Medicare details</th>
<th>Run weekly or monthly depending on size of health services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report</td>
<td>Patients</td>
<td>Medicare cards about to expire</td>
<td>choose parameters of Document type = letter and Template type = PIP - Registration and Consent</td>
</tr>
<tr>
<td>Report</td>
<td>Electronic claims</td>
<td>Check items and claims</td>
<td>This report shows all the records visible in the Bulk Bills Status window (paid claims and discarded claims are excluded). The report adds details of patient Medicare card status and any error messages that are reported when attempting to send. The report has no print layout - it is designed to be exported to Excel for analysis. Use the report to assist in the maintenance and monitoring of the Bulk Bill Status for claiming purposes.</td>
</tr>
<tr>
<td>Report</td>
<td>Electronic claims</td>
<td>(Several useful reports)</td>
<td></td>
</tr>
</tbody>
</table>

Data quality guide for Communicare. November 2015 Version 2.0
Administration notes and pop up alerts - tips

♦ Found under the Administration tab in Biographics
♦ Administration notes can be used by administration staff to e.g. update Next of Kin (NOK) details—these leave a notepad icon next to the patient's name in the search window and Service recording
♦ Pop up alerts can be used to remind staff for particular data. It is useful to initial & date these. A report is available to review popup alerts for their currency.
♦ It is advised not to record any sensitive information in either of these notes.

Return to main document
Key performance indicators - definitions

Where does the data come from? Definitions for the NTAHKPIs and national KPIs in Communicare

Northern Territory Aboriginal Health Key Performance Indicators (NTAHKPIs)

The website for the NTAHKPIs includes documents which may be useful including a full definition of each KPI (under System documents)


National key performance indicators

The AIHW have a website for the nKPIs, including brief definitions of each indicator, and a user guide for the nKPIs:


The current (though little outdated) user guide is here:

2015 nkpi user guide.pdf

The detailed definitions of the nKPIs are a little hard to find. They are on the Meteor site (Metadata online Registry – there is a link on the AIHW site). The 2015 indicator set can be found here:

http://meteor.aihw.gov.au/content/index.phtml/itemId/584983

Return to main document
Pregnancy data – tips

- Check records to ensure gestations are in sequence:

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
<th>Gestation</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/07/2007</td>
<td>antenatal check-up</td>
<td>24</td>
</tr>
<tr>
<td>01/06/2007</td>
<td>antenatal check-up</td>
<td>20</td>
</tr>
<tr>
<td>01/05/2007</td>
<td>antenatal check-up</td>
<td>16</td>
</tr>
<tr>
<td>03/04/2007</td>
<td>antenatal check-up</td>
<td>22</td>
</tr>
</tbody>
</table>

- Also check that pregnancies are numbered correctly and sequentially:

<table>
<thead>
<tr>
<th>Current Pregnancy</th>
<th>Obstetric History</th>
<th>Past Pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Pregnancy</td>
<td></td>
<td>Past Pregnancy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preg No</th>
<th>Date of Delivery</th>
<th>Gestation</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>12/10/2005</td>
<td>33</td>
<td>termination of pregnancy</td>
</tr>
<tr>
<td>2</td>
<td>22/07/2002</td>
<td>33</td>
<td>normal vaginal delivery of a liveborn</td>
</tr>
<tr>
<td>1</td>
<td>07/04/2003</td>
<td>33</td>
<td>termination of pregnancy</td>
</tr>
</tbody>
</table>

Return to main document