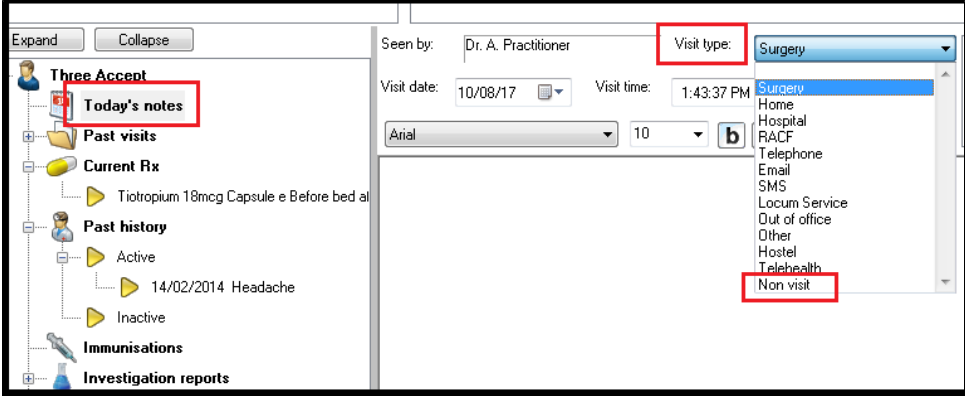


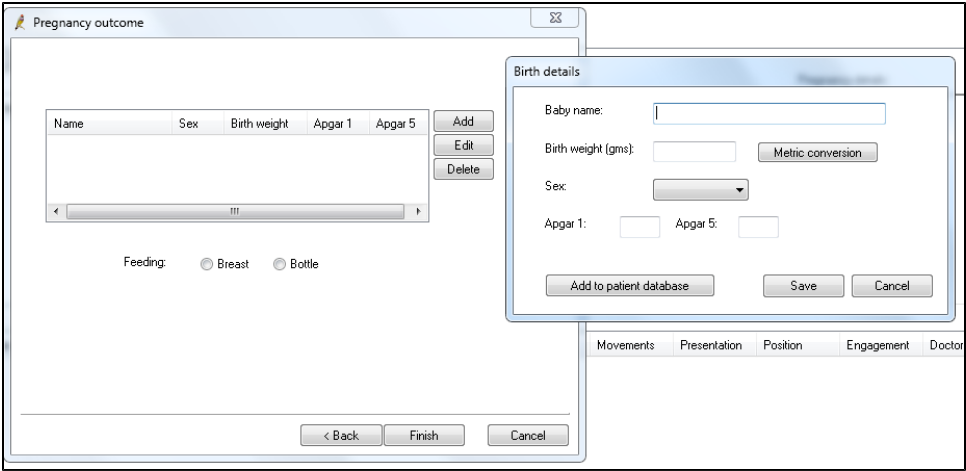
# General Data Category Mappings BP

D e m o g r a p h i c	Best Practice Data Mapping
G e n d e r	Open > Demographics screen > Sex
E t h n i c i t y	<div>Open &gt; Demographics screen &gt; Drop down list for Aboriginal / TSI</div> <div><div><div>Sex:Female</div><div>Ethnicity:Aboriginal but not Torres Strait Islander</div><div>Address Line 1:Australian, non indigenous</div><div>Address Line 2:Aboriginal but not Torres Strait Islander</div><div>City/Suburb:Torres Strait Islander but not Aboriginal</div><div>Postal Address:Both Aboriginal and Torres Strait Islander</div></div></div> <div>When 'Other' is chosen, BP gives additional options for ethnicity. Only one option can be chosen:</div> <div><div><div>Ethnicity</div><div>Acehnese</div><div>Afghan</div><div>African American</div><div>Afrikaner</div><div>Akan</div><div>Albanian</div><div>Algerian</div><div>American</div><div>Amhara</div><div>Anglo-Burmese</div></div><div><div>OK</div><div>Cancel</div></div></div>

D V A	Open > Demographics screen > DVA No. has a value
A g e	Open > Demographics screen > DOB
L a s t V i s i t / A c t i v i t y	<p>After entering notes on the 'Today's notes' tab, the visit will appear on the 'Past Visits' tab</p> <p>CAT will check the most recent date in the list</p> <p><b>Visits flagged as Type = Non Visit are excluded.</b></p> <p>Last Visit = the most recent date recorded</p> <p>Active = 3 or more visits recorded in the last 2 years</p> <p>Note: The past visits screen in Best Practice can be used by practices to record non clinical contacts, for example, when a recall letter is sent. T must be flagged a type <b>Non Visit</b> to be excluded by CAT.</p> 
P o s t c o d e	Open > Demographics screen > Postcode
F a m i l y H i s t o r y	<p>Main Patient Screen &gt; Family &amp; Social History</p> <p>any information entered on this form will be counted as family history information</p>
A l l e r g y	Main Patient Screen > Allergies / Adverse Drug Reactions Box
A l l e r g y R e c o r d e d	An Allergy Item is present

N o K n o w n A l l e r g i e s	The 'Nil Known' check box is checked
N o t h i n g R e c o r d e d	No Allergy Items are present and the 'Nil Known' check box is unchecked
S m o k i n g	Main Patient screen > Open > Alcohol and Smoking History > Tobacco
S m o k i n g C e s s a t i o n	<p>Patient would like cessation advice yes/no will be mapped to:</p> <ul style="list-style-type: none"> <li>• Yes = Ready to Quit</li> <li>• No = Not Ready to quit</li> </ul>
D a i l y S m o k e r	Smoker = Smoker is selected
I r r e g u l a r S m o k e r	This option is not captured in Best Practice
E x S m o k e r	Smoker = Ex-Smoker is selected

N e v e r S m o k e d	Smoker = Never smoked is selected
N o t h i n g R e c o r d e d	Smoker has nothing selected
R e v i e w D a t e	This will be the date something in the 'Family & Social History' section is changed. It is not possible to isolate Smoking changes.
A l c o h o l	Main Patient screen > Open > Alcohol and Smoking History > Alcohol Frequency = days a week patient usually drinks alcohol
D r i n k e r	Frequency = any except Never
N o n D r i n k e r	Frequency = Never
N o t h i n g R e c o r d e d	Alcohol tab has nothing selected
R e v i e w D a t e	This will be the date something in the 'Family & Social History' section is changed. It is not possible to isolate Alcohol changes.

M e a s u r e m e n t s  / P a t h o l o g y *	Best Practice Mapping
B M I	Patient Record >Main Patient Screen > Observations screen
W a i s t	Patient Record >Main Patient Screen > Observations screen
B i r t h  w e i g h t	<p>For the Maternal Health Care report, CAT can extract the birth weight of the child from two sources. One is the child's record, which needs the v and the date backdated to the child's birthday - this will be picked up under the 'Patient Record' report.</p> <p>For the Mother's Antenatal report the birth weight of the child has to be recorded in the mother's record. Under the 'Past Pregnancy' on the 'Obs tab after adding the pregnancy outcome, BP will show a field for the birth weight of the child born.</p> 
B S L F	<p>Patient Record &gt;Main Patient Screen &gt; Observations screen</p> <p>OR</p> <p>Patient Record &gt; Main Patient screen &gt; Enhanced Primary Care &gt; Diabetes Cycle of Care screen.</p> <p>OR</p> <p>Pathology HL7 results with LOINC codes 14771-0, 14996-3</p>
C h o l e s t e r o l	<p>Lipids data :</p> <p>Patient Record &gt; Main Patient screen &gt; Enhanced Primary Care &gt; Diabetes Cycle of Care screen.</p> <p>OR</p> <p>Pathology HL7 results</p>

H DL	OR manually entered result
L DL	
T r i g l y c e r i d e s	
C r e a t i n e	<p>Patient Record &gt; Main Patient screen &gt; Enhanced Primary Care &gt; Diabetes Cycle of Care screen.</p> <p>OR</p> <p>Pathology HL7 results</p> <p>OR manually entered result</p>
U r i n a r y c r e a t i n e	Pathology HL7 results with LOINC code 14683-7
M i c r o a l b u m i n	<p>Patient Record &gt; Main Patient screen &gt; Enhanced Primary Care &gt; Diabetes Cycle of Care screen.</p> <p>OR</p> <p>Pathology HL7 results</p>
A C R ( M i c r o a l b u m i n C r e a t i n e R a t i o)	<p>Listed in the BP database as an ACR result (with the BP pathology code 17)</p> <p>OR one of these LOINC codes: 32294-1,30000-4,9318-7,14959-1</p> <p>OR one of these result names: Alb/Cre, Alb/Creat, Albumin/Creatinine, Albumin/Creatinine Ratio, Urinary Albumin/Creatinine Ratio, Urinary Alb Ratio, Microalbumin Ratio</p> <p>OR manually entered result</p>

H b A 1c	<p>Patient Record &gt; Main Patient screen &gt; Enhanced Primary Care &gt; Diabetes Cycle of Care screen.</p> <p>OR</p> <p>Pathology HL7 results</p> <p>OR manually entered result</p> <p>OR</p> <p>Additional test name 'Blood haemoglobin A 1 c'</p>
BP	<p>Patient Record &gt; Main Patient screen either</p> <ul style="list-style-type: none"> <li>- opening the Observations screen, or</li> <li>- opening the Enhanced Primary Care &gt; Diabetes Cycle of Care screen.</li> </ul>
R e s p i r a t o r y - S p i r o m e t r y	<p>Clinical &gt; Respiratory function</p> <p>OR</p> <p>Today's Notes &gt;History and Examination &gt; Respiratory &gt; Calculator &gt; FEV1 and FVC</p> <div>  Please note that currently only POST results are extracted by CAT4 </div>
I NR	<p>Clinical &gt; INR Manager</p>
P h y s i c a l A c t i v i t y	<p>Clinical &gt; Physical Activity Prescription</p> <p>The prescription must be printed for it to be saved.</p> <p>A selected 'current physical activity level' of moderate or active meets the physical activity guidelines, otherwise they do not meet the guidelines</p> <p>We report Inactive as sedentary, Moderate and Active as sufficient.</p>
F O BT	<p>Pathology HL7 results with LOINC code 2335-8, 27396-1, 14563-1, 14564-9, 14565-6, 12503-9, 12504-7, 27401-9, 27925-7, 27926-5, 57905-2, 6,56491-4,29771-3</p> <p>or with test names Faecal Occult Blood ,Faecal occult blood screening, Faecal Occult Blood Test, FOB, FOBT, Occult blood – faeces, Stool occ OCCULT BLOOD, faecal human haemoglobin, Insure FOBT, FOBT1, FOBT2, FOBT3, FOB1, FOB2, FOB3, Faecal Occult Blood1, Faecal Occi Faecal Occult Blood3, BOW, IFOBT, OCCULT BLOOD (OCB-0), OCCULT BLOOD (OCB-1), OCCULT BLOOD (OCB-2), OCB NATIONAL SCF FHB, FAECAL BLOOD, %FOBT%, %OCCULT%, Faecal Immunochemical Test, FAECAL HAEMOGLOBIN</p> <p>FOBT test orders are extracted with any of the test names above. The % indicates a wild card search which will pick up any test name with FOE in the name.</p>
e G FR	<p>Pathology HL7 results with LOINC code 33914-3</p> <p>OR</p> <p>Calculation (Refer Clinical Audit User Guide – Part 2 Functionality)</p>

P a p S m e a r	Best Practice Mapping
	Female Patient Record > Main Patient Screen > Cervical Smears tab (Manual entry or Pathology HL7 results)
R e c o r d e d	A smear test is listed
S m e a r D a t e	Date of most recent entry
B e s t P r a c t i c e P a p S m e a r H L 7 M a p p i n g T E S T N A M E	CCSR CERVICAL CONVENTIONAL SMEAR CERVICAL CYTOLOGY CERVICAL SMEAR CERVICAL SMR CYTOLOGY GYNAECOLOGICAL CYTOLOGY GYNAECOLOGICAL (PAP-0) GYNAE CYTOLOGY GYNAECOLOGICAL CYTOLOGY GYNEA CYTOLOGY NON SCREENING PAP NON SCREENING SMEAR PAN-O PAP PAP (BALLARAT) PAP (GEELONG) PAP NS PAP SMEAR PAP SMEAR (PAN-0) PAP SMEAR +/- THIN PREP PAP SMEAR OLD PAP SMEARS PAP TEST PAP-0 (PAP SMEAR) PAPFU PAPR



Best Practice Eligible	<p>PAPR NS</p> <p>THIN PREP ONLY</p> <p>THINP</p> <p>VAG SM</p> <p>VAGINAL SMR</p> <p>VAULT CYTOLOGY</p> <p>VAULT SMEAR</p> <p>Practices should check the test names appearing in the results tab and advise PCS if there is a test name that should be added to this list.</p>
Pap Smear Ineligible	<p><b>Best Practice Mapping</b></p>
	<p>Cervical Smears screen - tick-box 'Not Required' checked</p> <p>Coded condition of Hysterectomy: see Diagnosis Codes Screening Tests</p>



If you are not receiving your results electronically, you will have to enter the test results manually using one of the names specified in the guides. Please check the links below for details. Also please note that CAT4 can't pick up mammogram test from your conditions or past - it has to be a test name!

Mammogram results are not sent electronically in all states, but if test names are entered manually into the results tab CAT4 will pick up that the done. The following test names are recognised:

- Breast Mammogram Screening
- Bilateral Mammography
- Ultrasound Breast Bilateral
- Wesley Breast Clinic Consultation Report
- Mammogram
- Mammogram-normal
- Breast Mammography
- Mammography - Bilateral
- Mammogram BreastScreen NSW
- Screening Mammogram - BreastScreen Queensland

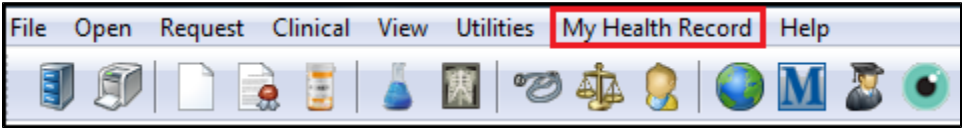
To manually add a mammogram result click on the 'Add' button under the 'Investigation report' tab, then enter one of the test names from above the other fields. CAT4 will only extract the test name and date but no outcome/result.

### Best Practice Mapping

Past History screen > Checks the condition selected on history items, where Conditions are selected from a coded list.

Refer to Appendix C-1 for a list of conditions mapping to each CAT condition.

### Best Practice Mapping

M e d i c a t i o n	<p>Current Rx screen &gt; Checks the Drugs listed as current medications, where Drugs are selected from a coded list.</p> <p>Refer to Appendix C-2 for a list of medications mapping to each CAT medication.</p>
M e d i c a t i o n C o u n t	<p>Current Rx screen &gt; Counts All Drugs listed as current medications</p>
M y H e a l t h R e c o r d s t a t u s	<p>To update a patient's MHR status from unknown the 'My Health Record' menu needs to be accessed in BP. If no one has clicked on 'My Health CAT4 will list the status as 'unknown'.</p>  <p>The screenshot shows a horizontal menu bar with the following items: File, Open, Request, Clinical, View, Utilities, My Health Record, and Help. Below the text labels are corresponding icons: a server tower, a printer, a document, a document with a red circle, a pill bottle, a beaker, a human torso, a stethoscope, a balance scale, a person icon, a globe, a large blue letter 'M', a graduation cap, and a magnifying glass over an eye.</p>

\* Refer to pathology note at the start of this manual and Appendix