



Clinical Workbook

Designed and written by
Train IT Medical for AH&MRC

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Introduction

Purpose of this guide

This guide provides clinical staff with the knowledge and procedures required to effectively use Bp Premier within an Aboriginal Community Controlled Health Organisation (ACCHO). It is designed to support consistent clinical documentation, accurate patient record management, preventative health activities, chronic disease management, recalls and reminders, clinical coding, and other day-to-day clinical workflows.

The guide outlines standard workflows and best-practice procedures to assist clinicians in delivering high-quality, culturally safe, and patient-centred care while maintaining compliance with organisational policies, privacy legislation, RACGP Standards, accreditation and reporting requirements.

This document should be used as both a training resource for new clinical staff and a reference guide for experienced users performing clinical activities within Bp Premier.

Intended Audience

This guide is intended for clinical staff working within an Aboriginal Community Controlled Health Organisation (ACCHO), including:

- General Practitioners (GPs)
- General Practice Registrars
- Nurses and Nurse Practitioners
- Aboriginal Health Workers and Aboriginal Health Practitioners
- Allied Health Professionals
- Visiting Specialists and other authorised clinical users

The guide assumes users have basic computer skills but limited experience using Bp Premier. It focuses on the clinical functions of the system and does not cover practice administration, appointment management, billing, Medicare claiming, or other workflows performed primarily within the administrative functions.

Software version

The guide is current for the Spectre SP1 revision edition of the Bp Premier software. As software functionality is updated periodically, some screens and features may differ slightly depending on your practice's installed version and configuration.

Topic 1 – Recording essential clinical data

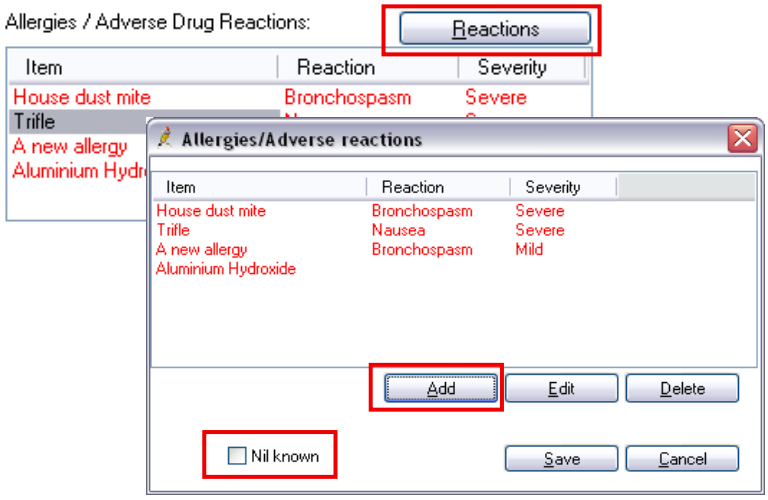
Health summary data

Adding allergies and adverse reactions

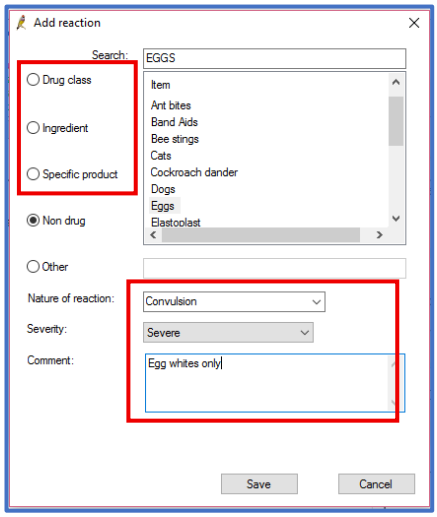
The currently 'Allergy/Adverse Drug Reactions' information will appear in red on the top left of the patient screen.

Important: If the patient has no allergies or adverse reactions, tick 'Nil Known' to indicate the patient has been asked about allergies.

To add or edit 'Allergies/Adverse reactions':



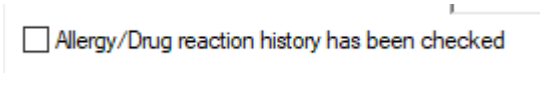
1. Open the patient record **(F2)**
2. Click on the **Reactions** button.
3. Select **Add** and select from the dropdown list according to:
   - Drug Class
   - Ingredient
   - Specific Product
   - Non Drug
   - Other
4. Select the **Nature of the Reaction**
5. Enter the **Severity and any relevant comments**
6. Select **Save.**



Note: You must use 'Drug Class', 'Ingredient, or 'Specific product' method when searching and choose an item from the dropdown list to generate automatic alerts when a medication is prescribed. If you add a medication name via the 'Other' method, then **no** automatic alerts will be triggered.

TIP: Tick the 'Nil Known' checkbox to indicate that the patient has been asked about their allergies but does not have any known allergies.

TIP: You can notate that you have updated allergy/drug reaction data when prescribing by ticking the checkbox 'Allergy/Drug reaction history has been checked'.

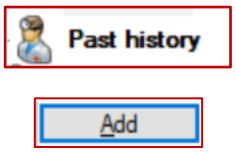


Adding Past Medical History:

1 Open the patient record **(F2).**

2 Select the '**Past history'** tab.

3 Select the **'Add'** button in the top left of the window.



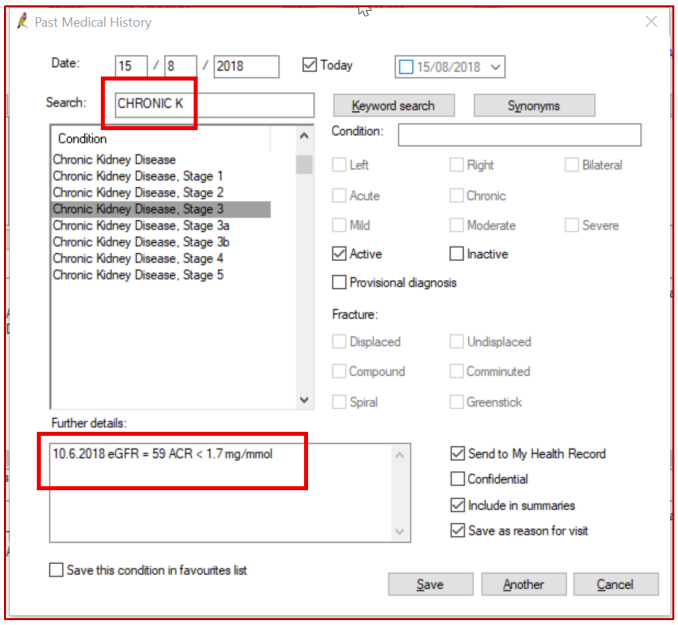
4 **Enter the date** the condition was first diagnosed in the date field. If a specific date is not known, enter the Year it was first diagnosed.

5 **Enter the first few characters** of the condition in the '**Search**' field then **double click** on the relevant diagnosis to select.

6 Tick '**Active'** to indicate the condition is current.

7 Tick '**Send to My Health Record'** as appropriate.

8 Tick **'Include in Summaries'** to include the diagnosis on health summaries.



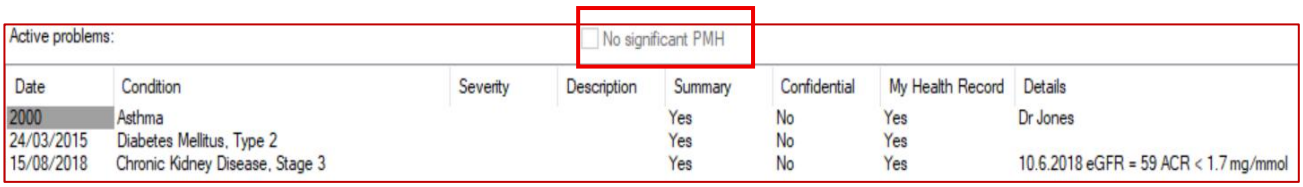
9 Tick '**Confidential**' to indicate that the diagnosis is not to be shared.

10 Tick '**Save as Reason for Visit'** if applicable.

11 Enter any relevant comments in the **Further Details** section as required.

12 **Save**.

Note: Tick 'No significant PMH' if there is no past medical history to record.



Recording immunisations

In Bp Premier the relevant immunisation schedule will appear according to the age of the patient.
To access immunisation data within the patient record:

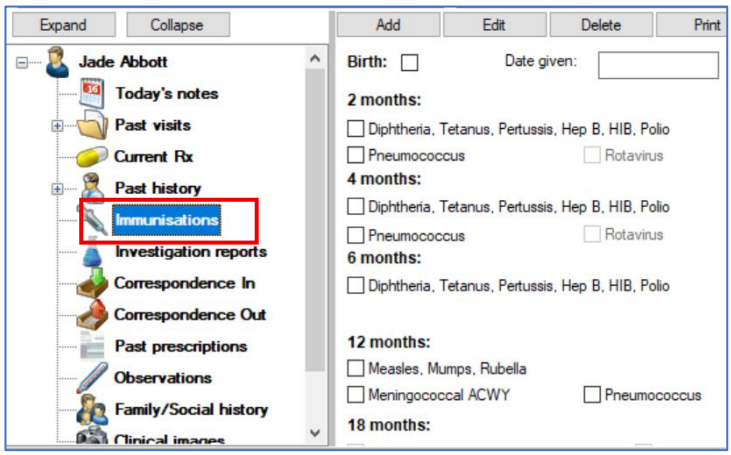
Adding a childhood immunisation

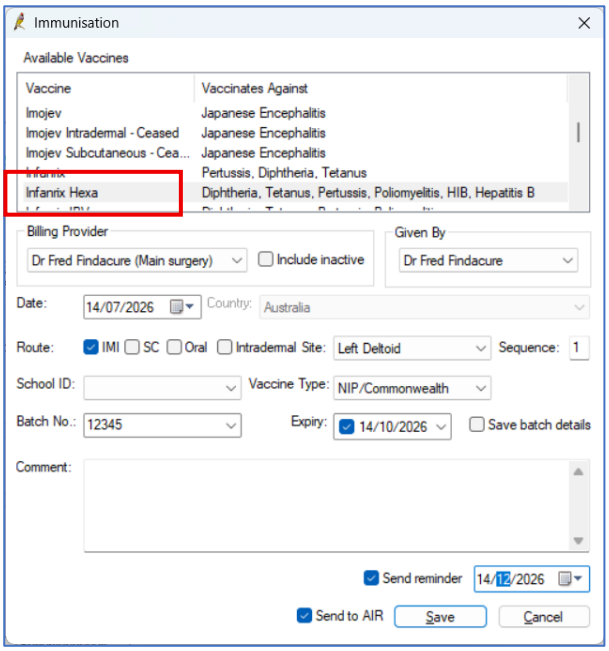
1 Open the patient record **(F2)**

2 Click on **Immunisation** tab

3 **Tick the checkbox** for the vaccine/s being given. The immunisation schedule will appear.

If the patient is eight years old or less, the screen shows the childhood immunisation schedule to the left of the Vaccines given list. Vaccinations for which the child patient is too young will be disabled.





4 Select the **vaccine/s** from the list.

5 The **Billing provider and Given by** fields default to the logged-in user, but can be changed.

6 Select the **Site and Route** of administration

7 Enter the **Sequence number** for the vaccination (if applicable)

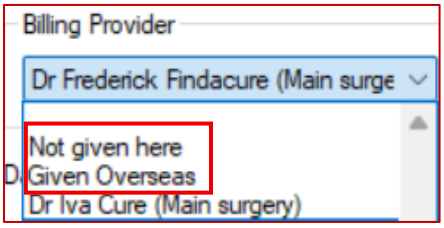
8 Enter a Batch No. & expiry date.

9 Enter Serial No. and School ID if applicable.

10 Select the **Vaccine Type**

11 **Save.**

Note: If updating a patient's immunisation record it is possible to select "Not given here" or 'Given overseas' in the Billing Provider drop-down list. This will allow you to record the vaccination in Bp Premier but will not send to AIR.



Adding an adult immunisation

1 Open the patient record **(F2)**

2 Click on **Immunisations** tab

3 Select **Add.**

4 Select the **vaccine/s from the list**.

5 The **Billing provider** and **Given by** fields default to the logged-in user, but can be changed.

6 Select the **Site and Route** of administration

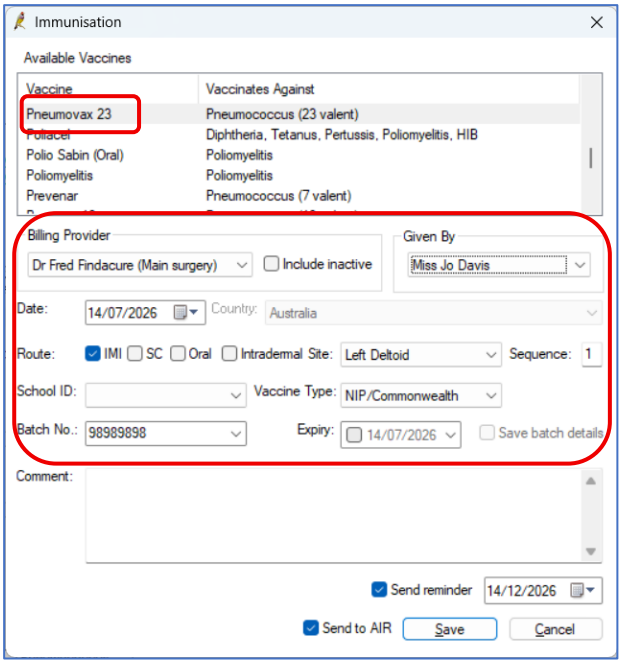
7 Select the **Sequence number** for the vaccination (if applicable)

8 **School ID** (If applicable)

9 Enter a **Batch No. & expiry date**.

10 Select the **Vaccine Type**

11 Tick **Send to AIR** to ensure this encounter is sent to the AIR automatically.



12 Tick **Send Reminder** & enter a reminder date (if applicable)

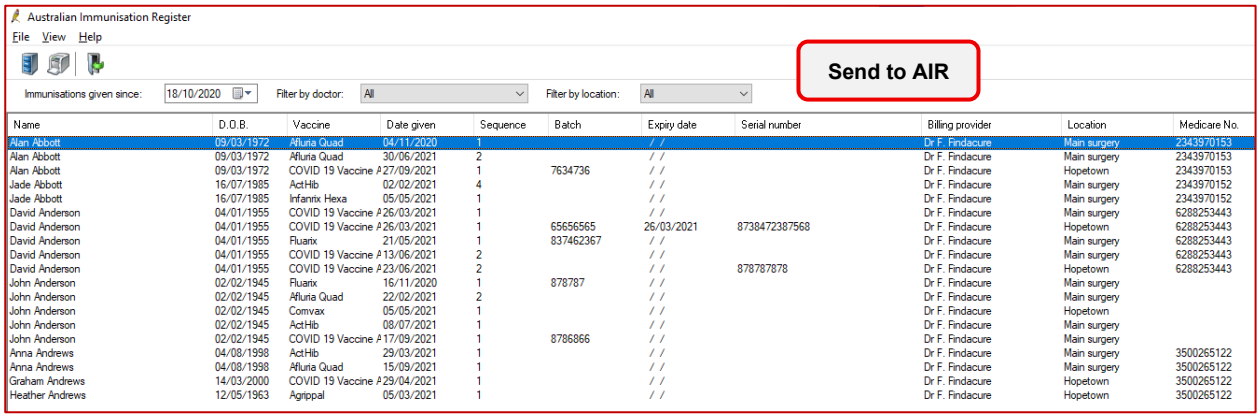
13 **Save.**

Send Immunisation records to AIR

Immunisation data will send directly to AIR without manual intervention (if configured). However it is a good idea to check for any immunisation records not sent to AIR as follows:

1 Select **Utilities > Australian Immunisation Register** (to see list of unsent vaccine records)

2 Select **Send to AIR**

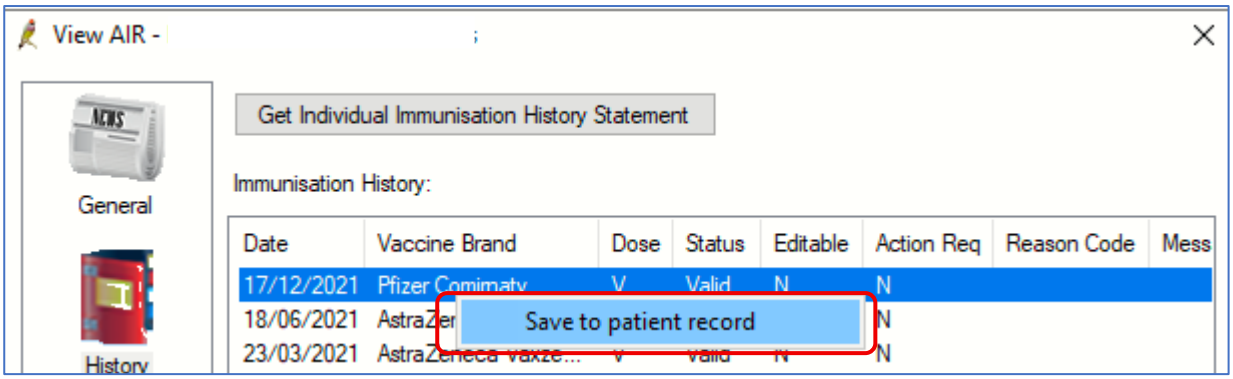


Download immunisation records from AIR

To check the list of vaccinations on AIR and download vaccination records to the patient file in Bp Premier:

1. Open the patient record **(F2)**
2. Click on **Immunisations** tab
3. Select **View AIR**
4. Select **History** button
5. **Highlight a vaccine in the list**
6. **Right Click** > Select **Save to patient list**





Recording risk factors

Adding Alcohol Intake

From the patient record:

1 Select **Open > Alcohol & Smoking History**

2 **Tick checkbox** if non-drinker OR

3 Enter **no. of days per week** alcohol is consumed

4 **Standard drinks per day** consumed

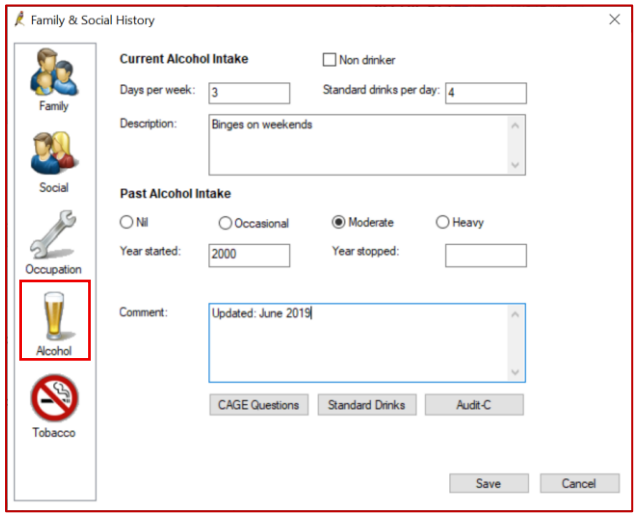
5 Enter a Description (if necessary)

6 Select **Past Alcohol intake**

7 **Year started and stopped**

8 **Any relevant comments**

9 **Save**

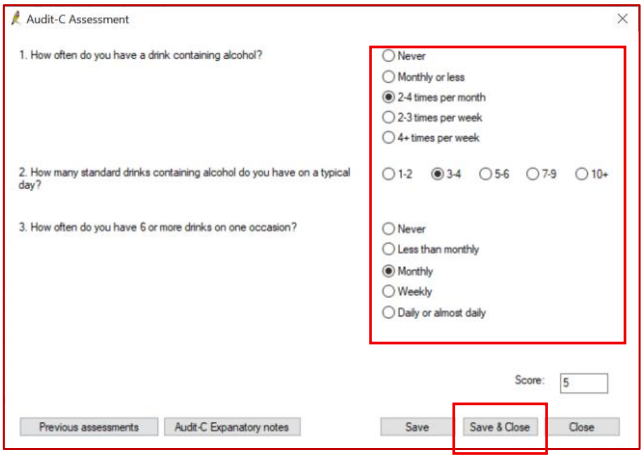


To perform a scored assessment of alcohol consumption and to access previous assessments for this patient.

10 Click on **Audit-C**

11 **Select answers to questions 1, 2 and 3.**

12 **Save & Close**



Recording a Smoking Assessment

From the patient record

1 Select **Open > Alcohol & Smoking History**

2 Click **Tobacco** icon

3 Select **Smoking Status**

4 Select **product & enter quantity per day**

5 Enter **Year started** smoking

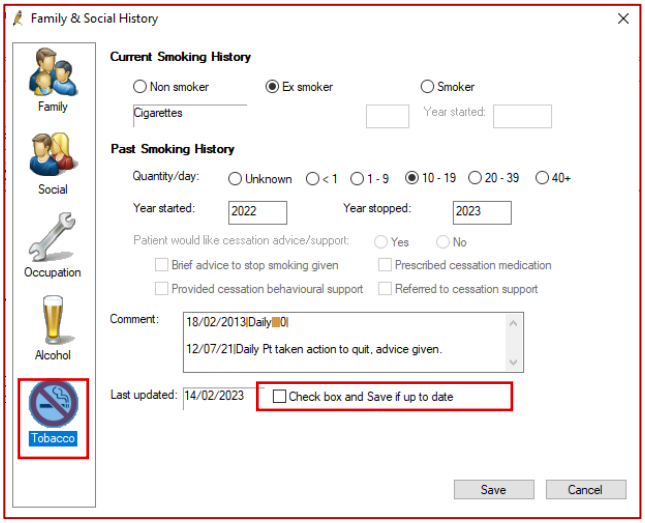
6 Select **support options** as required.

7 Enter any relevant **comments**

8 **Save.**

TIP: Doubleclick on the word 'tobacco' or alcohol at the top of the patient record and it will quickly take you straight to the relevant screen.

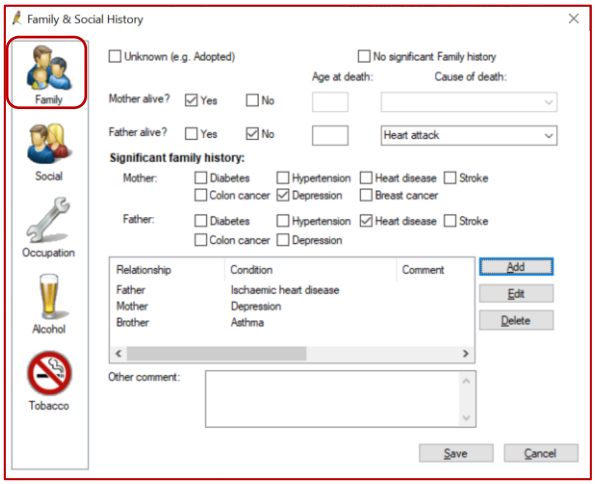
TIP: If smoking status has not changed since the last assessment, tick 'Check box and save if up to date' to



record that the information has been asked and answered.

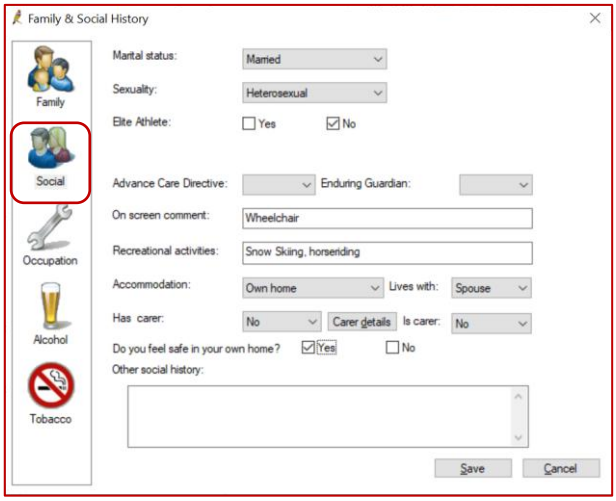
Recording Family History

1. Select **Open > Family History**
2. Tick **Unknown** if the patient's history is not known
3. Tick **No significant family history** if nothing chronic or significant to record
4. **Mother Alive?** Yes or No. If no, enter age at death and select cause of death
5. **Father Alive?** Yes or No. If no, enter age at death and select cause of death
6. **Significant Family History**: Tick relevant conditions for both mother and father from the available list of checkboxes.
7. Use **Add** to enter details about significant medical conditions for other family members
8. Enter any relevant **comments**
9. **Save.**



TIP: Tick 'Unknown' or 'No Significant History' if applicable to record that this information has been asked about and answered by the patient.

Recording Social History



1. Select **Open > Social History**
2. Select **Marital Status**
3. Select **Sexuality**
4. Tick **Elite Athlete** Yes/No
5. Select if an **Advance Care Directive or Enduring Guardian** is in place
6. Enter any **On Screen Comments** to appear in the demographics section of the clinical record in RED.
7. Enter recreational activities as applicable
8. Select **Accommodation and Carer status**
9. Tick Yes / No to '**Do you feel safe in your own home?'**
10. Add any **additional comments relevant to social history**
11. **Save.**

Recording cancer screening test results

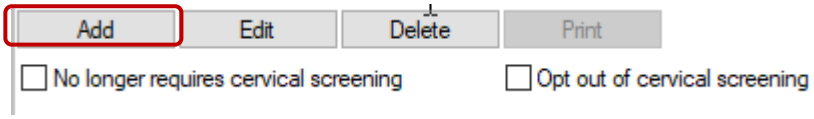
Record Cervical Screening test results (CST)

Cervical screening data must be entered manually into Best Practice in order for it to be recognised in search queries. Since there is no national standard coding system for Cervical Screening in Australia, the results don't automatically populate this area of the patient record. The test result must appear in the Cervical Screening section (ie after being manually added from either the Inbox or the results section in the patient record.

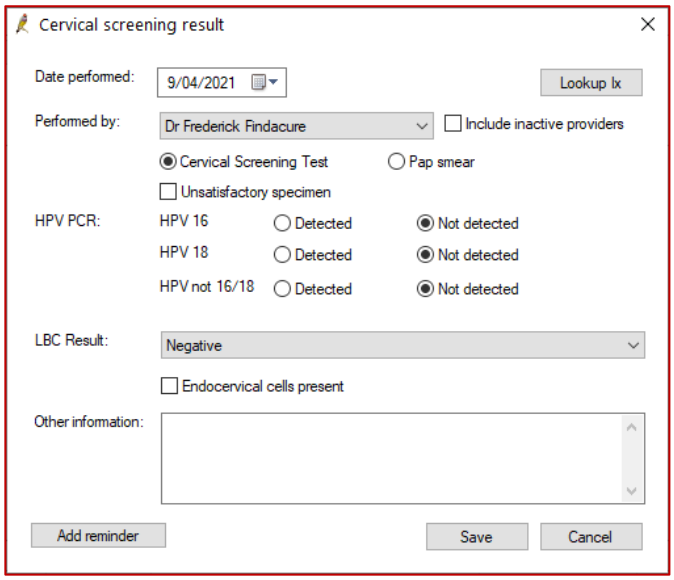
From the Patient Record:

1 Select the **Cervical Screening** section on the menu (left of patient screen)

2 Select the **Add** button and enter the following detail:



- Date Performed:
- Performed By:
- Test Type: CST or PAP
- Tick if **Unsatisfactory specimen**
- HPV PCR details
- LBC Result:
- Tick if Endocervical Cells Present



3 Enter any comments in Other Information

4 **Add a reminder** as required for further/future screening

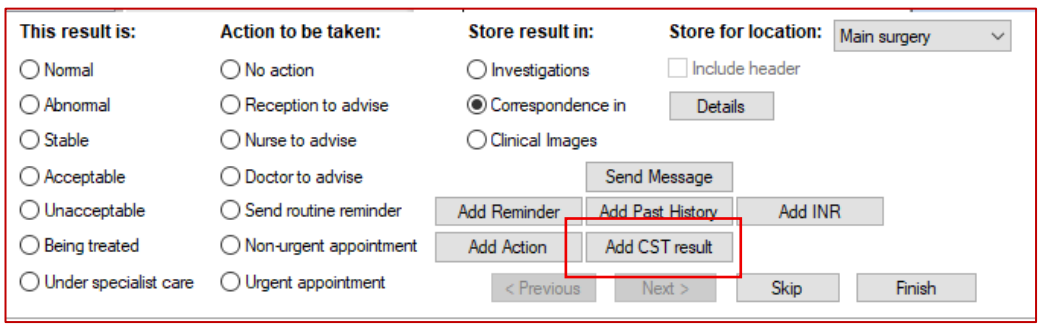
5 Select the **Save** button.

Enter CST results from the Inbox:

1 Select the result in the list and action as per the practice protocol (ie Select the relevant action to be taken)

2 Select the **Add CST result** button and enter the test results data as per the instructions above.

3 **Save**



Record Bowel Screening Test Results (FOBT)

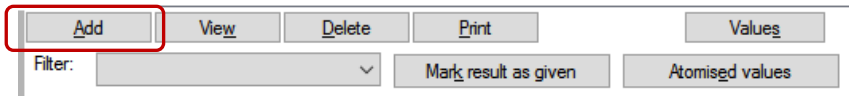
Bowel Screening data must be entered manually into BP Premier in order for it to be recognised in search queries. The test name must contain 'FOBT' for it to be recognised as a Bowel screening test. The test result can be entered from the Patient record.

From the Patient Record:

1 Select the **Investigation Reports** item on the menu (left of patient screen)



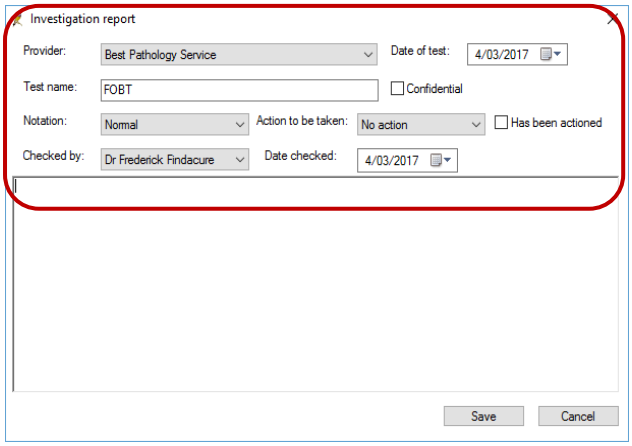
2 Select the **Add** button



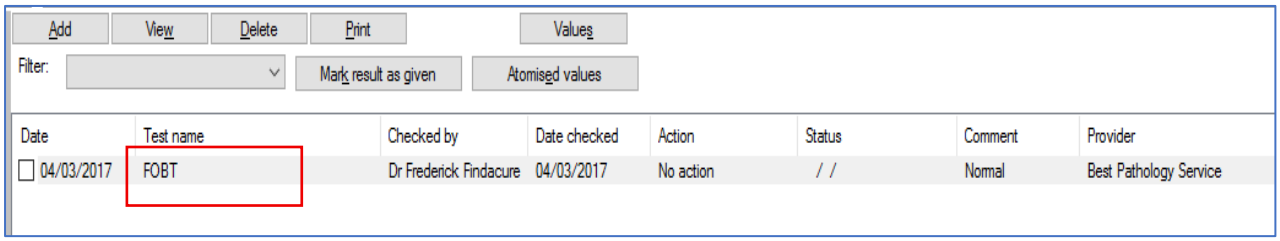
3

4 Enter the details of the FOBT Screening test:

- Provider
- Test name = ***FOBT***
- Date of test:
- Notation:
- Action to be taken (as per practice protocol)
- Tick Has Been actioned if already processed
- Checked By
- Date Checked
- Comments (if necessary)



5 Select the **Save** button.

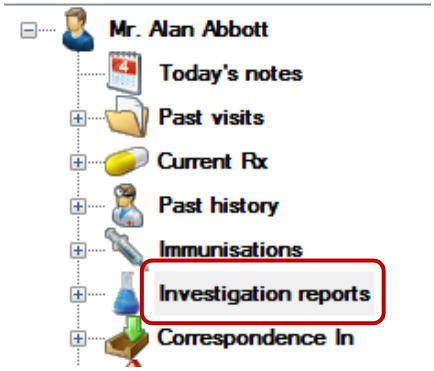


Recording Mammogram Results

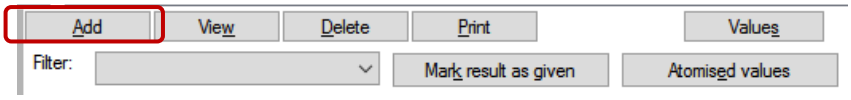
Breast Screening data must be entered into the Investigation Reports area in BP Premier in order for it to be recognised in search queries. The test name should be entered as 'Breast Mammogram Screening'. The test result can be entered from the Patient record.

From the Patient Record:

1 Select the **Investigation Reports** item on the menu (left of patient screen)

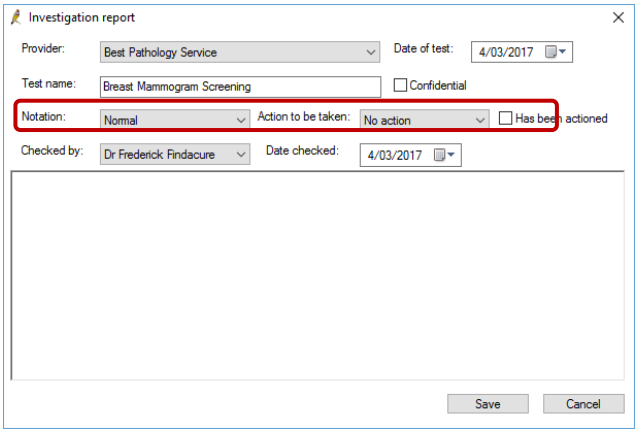


2 Select the **Add** button



3 Enter the details of the Mammogram Screening test:

- Provider
- Test name = Breast Mammogram Screening
- Date of test:
- Notation:
- Action to be taken
- Has Been actioned
- Checked By
- Date Checked
- Comments (if necessary)



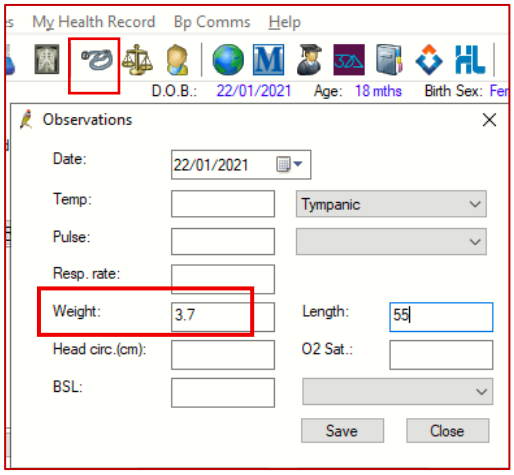
4 Select the **Save** button.



Recording Baby Birth Weights

Observations are recorded using the **Clinical > Observations**  item in Bp Premier.

It is important to record ALL baby birth weights accurately in Bp Premier for the data to flow through to the various reports that use this information.



1 Open the baby's patient record **(F2)**

2 Select **Clinical > Observations**

3 **Change the date displayed on this screen to match the baby's date of birth. – this step is essential**.

4 Enter the **baby's weight (in kg),** length etc

5 Select '**Save'.**

To link a mother's and baby's record in Bp Premier from the mother's obstetric record:

1 Open the **mothers patient record (F2)**

2 Select the '**Obstetric History**' tab

3 **Highlight** the relevant pregnancy from the list

4 **Double click to open and update**

5 Record the **Finish Date** (this will be the birth date) the **Outcome** and any complications

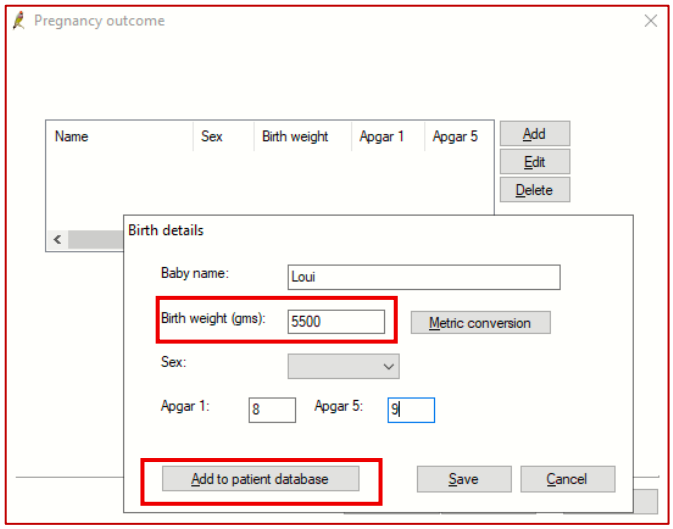
6 **Next**

7 Enter the **delivery details**

8 **Next**

9 Select **Add**

10 Enter **Baby's name** (if known) and birthweight, Sex, Apgar scores



11 Click '**Add to patient database'**

12 Complete the **patient details (child) on the patient demographic page**.

13 Select **'Save'**.

Topic 2 – Data Cleansing

Archiving patient records

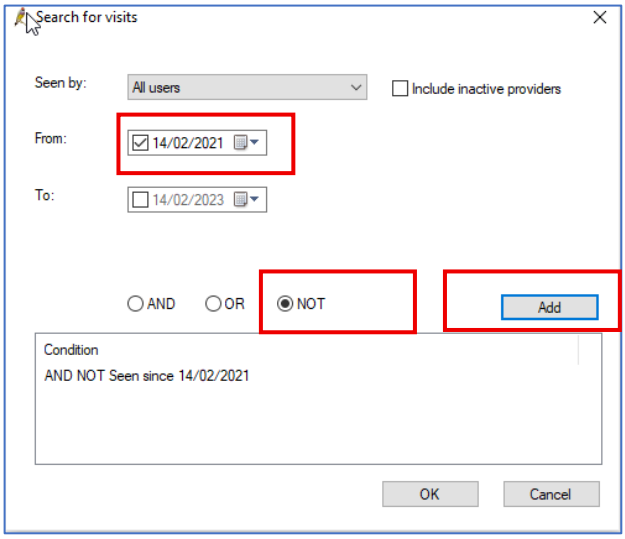
Marking patients as inactive in bulk

You may wish to **search** your patient database and mark those patients who you have not seen for many years as inactive.

Marking patients as inactive is a relatively simple process as is reactivating them again.

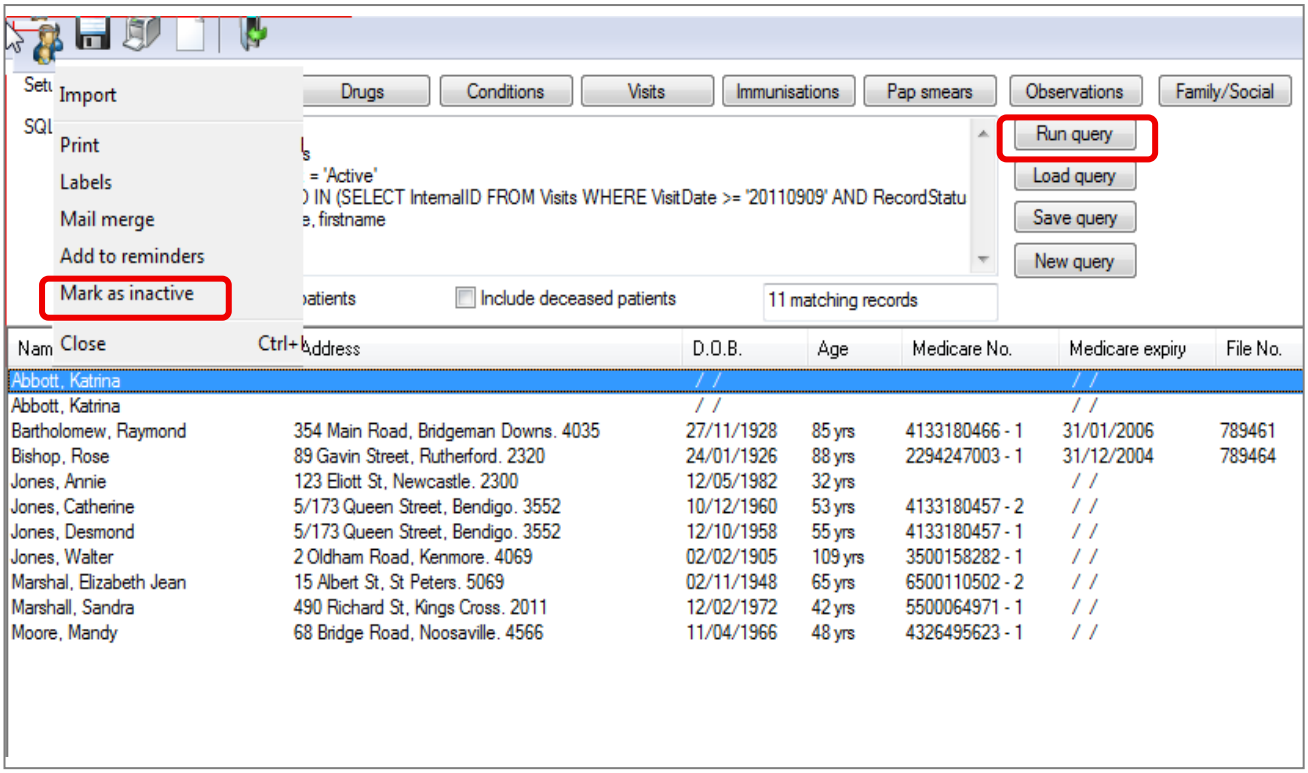
By marking patients as inactive you are removing them from view when you **search** the database, their information is not included in standard patient searches and you won't send them recall letters.

This activity is called archiving and is an important aspect of database cleansing as it has a significant impact on reporting including nKPI data. Therefore you should regularly archive inactive patients and only re-activate a patient when they visit again.

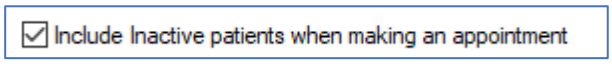


1. From the **Main Screen**, select **Utilities>Search**.
2. Select the **Visits button**
3. **Enter the From date –** this date will be used to select ALL patients who have not visited since this date.
4. **Select 'NOT' to search for patients NOT seen since the date selected above. This step is essential.**

   Tip: You can type directly on top of the year date to **change**
5. Press '**Add**' button
6. Click **OK** then
7. **Select Run Query**
8. Select (highlight) all patients that you want to inactivate in the onscreen list. (Use Shift and arrow keys to select multiple patients).
9. Select **File>Mark as Inactive**.
10. Select **Yes to confirm**



TIP: Ensure you can see 'inactive' patients easily in the Appointment Book. Go to Setup > Configuration > Appointments and tick 'Include inactive patients when making an appointment'.

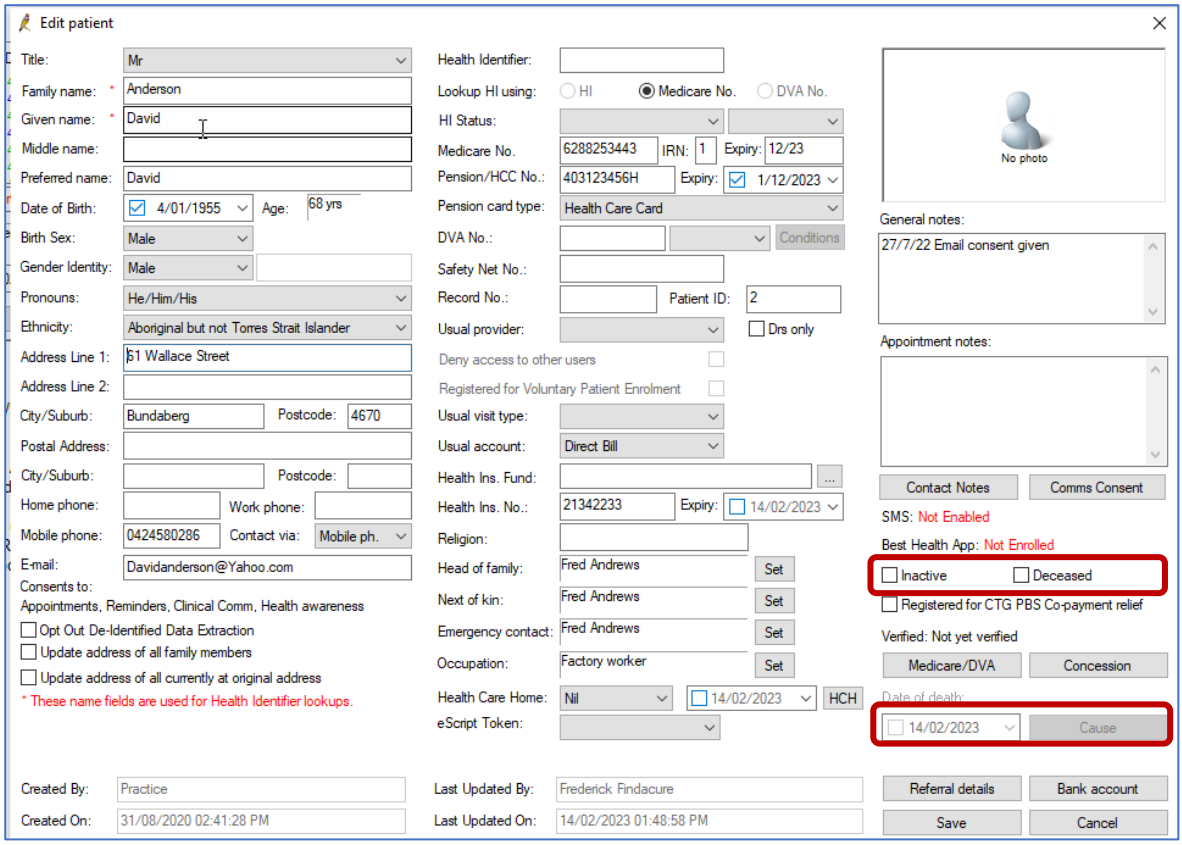


Marking individual patient records as inactive (or deceased)

If one patient or family inform you they are moving away or no longer visiting the practice, you may wish to individually inactivate the patient record/s.

To mark patients as inactive from the Main Screen:

1. Go to the **Main Screen**, **Open** (F2).
2. **Search for the patient** whom you wish to mark as inactive.
3. **Double click** to Open the Edit patient screen.
4. Tick the box marked '**Inactive**' or **Deceased** as required.
5. Add date of death and cause of death if known for deceased patients.
6. **Save**.



Updating health summary data

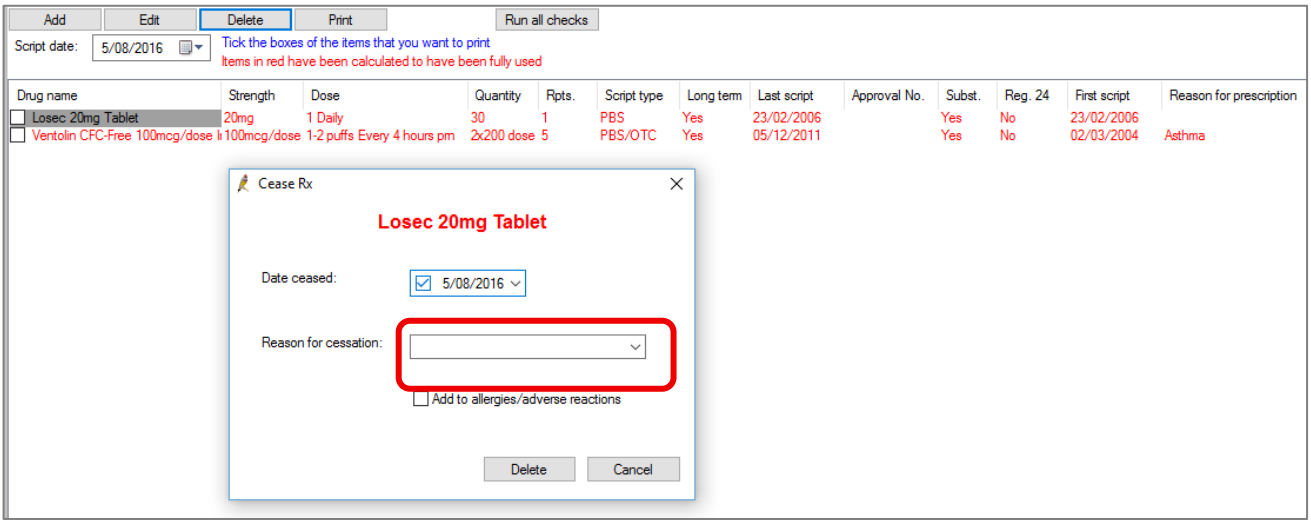
Updating the Medication List

It is vital the medication list (Current Rx) section of the patient record is accurate. The information in the current medication list is shared with other providers via the Health Summary and therefore should be kept up to date.

To cease a **medication in the list**

1. **Select the patient (F2)**
2. Select **Current Rx**
3. **Select a medication** from the list
4. **Hit the delete key** on your keyboard. You will be prompted to select a reason for cessation.
5. **Select a reason** from the drop-down list
6. **Delete**

Note: If a prescription is marked as 'once-only', when the date has been reached for that medication to have finished, Bp Premier will move the script to the Past prescriptions area. Long term medications that have been fully utilised will display in red in the Current medications list to prompt the prescriber to remove or represcribe them.



Clean up Past Medical History

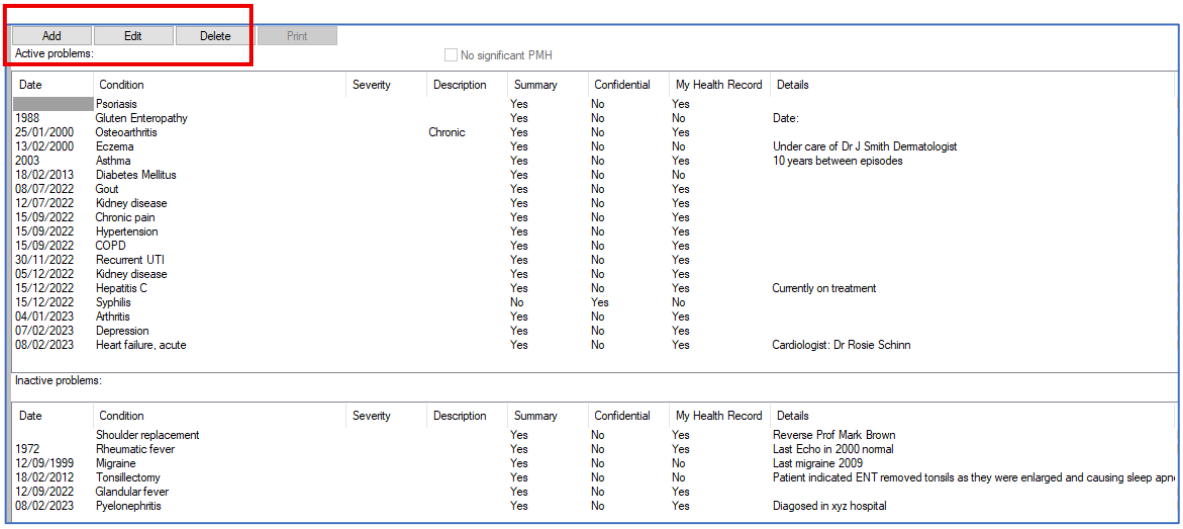
Clinical coding refers to diagnoses being added using the **Past history** screen in Bp Premier by selecting from a coded list rather than using free text.

Add or **Delete** to update the Past History section to reflect:

- Chronic conditions
- Significant events in the patient's medical history

Edit to update for relevance / remove duplicated entries and to add helpful additional detail eg. Who diagnosed that condition, detail of surgery etc.

Add, Edit or Delete to update the Past History list



Date	Condition	Severity	Description	Summary	Confidential	My Health Record	Details
	Psoriasis			Yes	No	Yes	
1988	Gluten Enteropathy			Yes	No	No	Date:
25/01/2000	Osteoarthritis		Chronic	Yes	No	Yes	
13/02/2000	Eczema			Yes	No	No	Under care of Dr J Smith Dermatologist
2003	Asthma			Yes	No	Yes	10 years between episodes
18/02/2013	Diabetes Mellitus			Yes	No	No	
08/07/2022	Gout			Yes	No	Yes	
12/07/2022	Kidney disease			Yes	No	Yes	
15/09/2022	Chronic pain			Yes	No	Yes	
15/09/2022	Hypertension			Yes	No	Yes	
15/09/2022	COPD			Yes	No	Yes	
30/11/2022	Recurrent UTI			Yes	No	Yes	
05/12/2022	Kidney disease			Yes	No	Yes	
15/12/2022	Hepatitis C			Yes	No	Yes	Currently on treatment
15/12/2022	Syphilis			No	Yes	No	
04/01/2023	Arthritis			Yes	No	Yes	
07/02/2023	Depression			Yes	No	Yes	
08/02/2023	Heart failure, acute			Yes	No	Yes	Cardiologist: Dr Rosie Schinn

Date	Condition	Severity	Description	Summary	Confidential	My Health Record	Details
	Shoulder replacement			Yes	No	Yes	Reverse Prof Mark Brown
1972	Rheumatic fever			Yes	No	Yes	Last Echo in 2000 normal
12/09/1999	Migraine			Yes	No	No	Last migraine 2009
18/02/2012	Tonsillectomy			Yes	No	No	Patient indicated ENT removed tonsils as they were enlarged and causing sleep apn
12/09/2022	Glandular fever			Yes	No	Yes	
08/02/2023	Pyelonephritis			Yes	No	Yes	Diagosed in xyz hospital

Topic 3 – Practice Systems

Actions, Reminders and Recalls

Bp Premier includes a range of built-in practice management tools that help healthcare teams deliver safe, organised and proactive patient care. These tools support practices to manage clinical follow-up, monitor preventive health activities, communicate with patients and ensure that important tasks are completed in a timely manner. When used consistently, they improve continuity of care, reduce the risk of missed follow-up and help practices meet clinical, accreditation and quality improvement requirements.

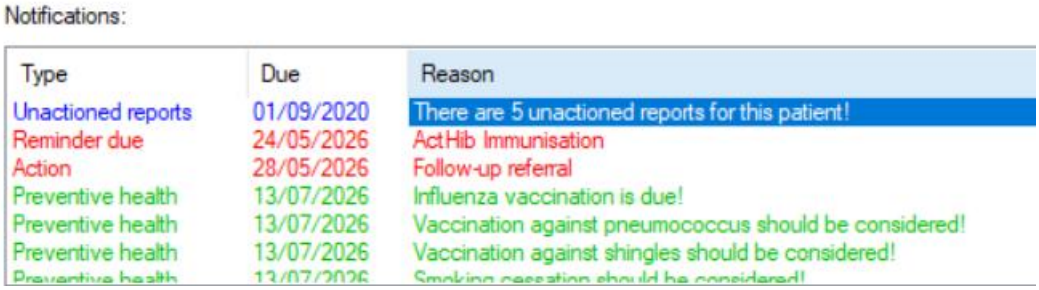
This topic explains how Bp Premier uses Actions, Recalls and Reminders to manage patient follow-up and practice workflows. Although these features have different purposes, they work together to ensure that clinical tasks, preventive health activities and patient reviews are identified, tracked and completed. Understanding when and how to use each tool is essential for maintaining accurate patient records, supporting effective team communication and delivering high-quality patient care.

Actions

Similar to a post-it note on a hard copy patient file, actions will alert you to items flagged for follow up with the patient (clinical or social) when they next visit in the Notifications area of the record.

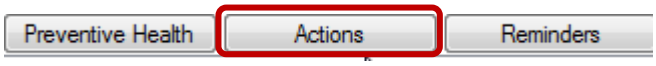
Examples include:

- Discuss smoking
- Recheck BSL
- Follow-up referral to dietician



Adding an Action:

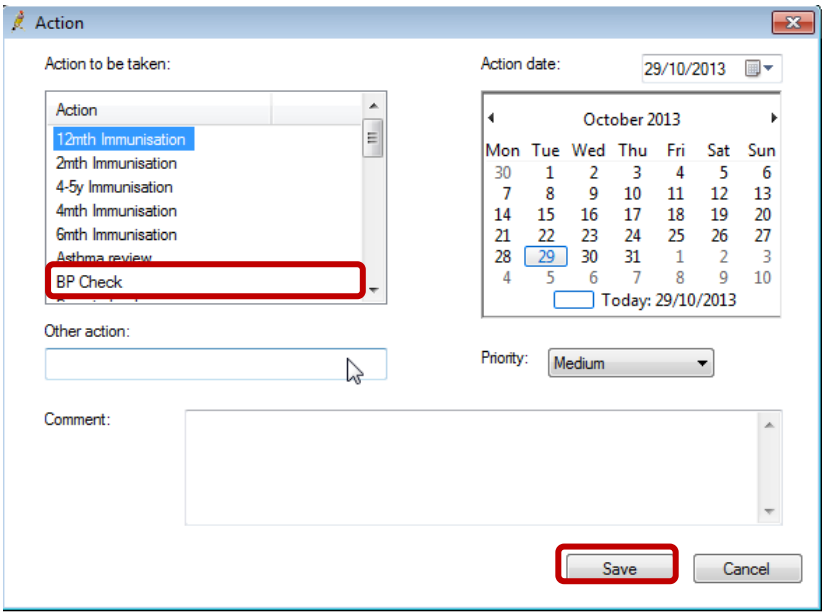
1 Open a patient record and click on the **Actions** button



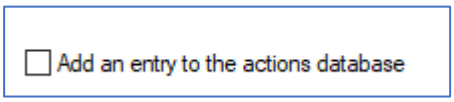
2 Click on **Add New**

3 Select from the list of actions or type your own **Action description** in the **Other Action** field.

4 **Save.**



TIP: Tick the box when saving Referrals or saving Pathology or Radiology requests to 'Add an entry to the Actions database'. This can help you track significant referrals and requests.

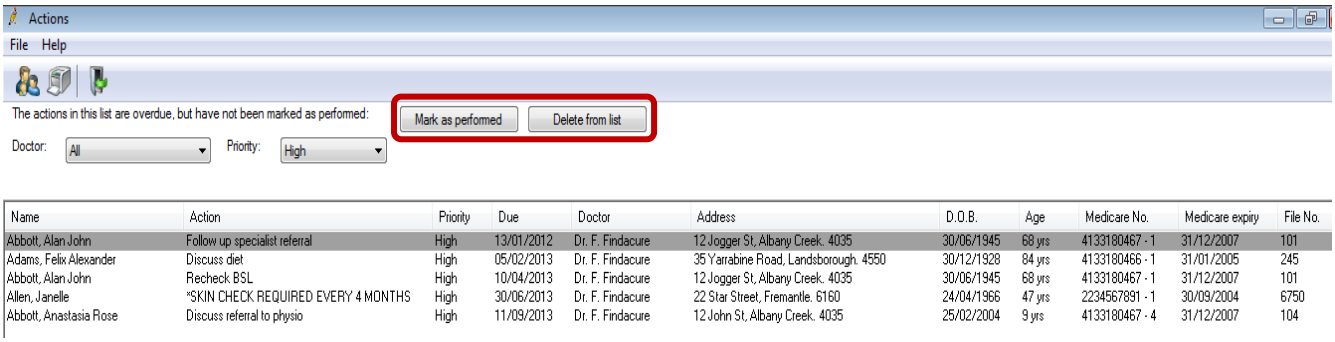


Marking Actions as performed

Check the **Notifications area** in the middle of the patient screen regularly and keep it up-to-date by deleting or completing actions that have been resolved. For example, when you do the repeat BSL testing, double-click on the Action and select 'Mark as Performed' or delete when complete.

Following up Outstanding Actions

You can view the outstanding actions you have for all your patients from the Main Screen. Click on **Clinical > Actions**. Use the **Mark as performed** and **Delete from list** buttons to manage the list.

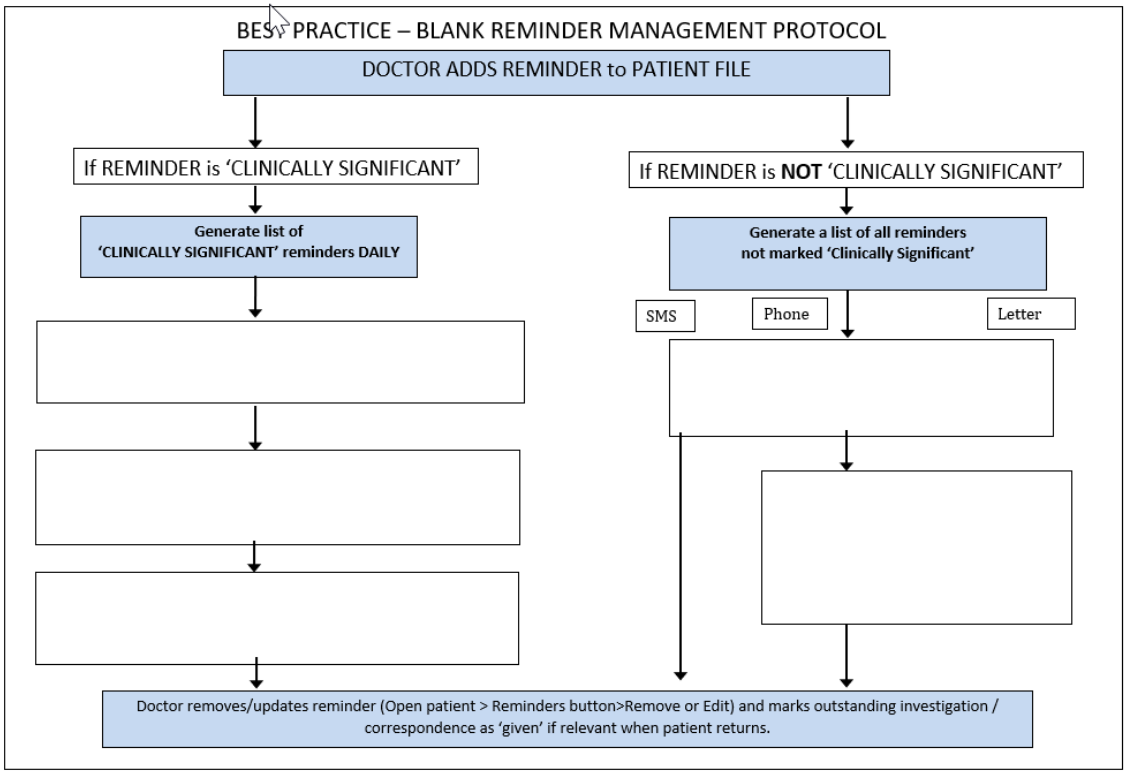


TIP: Doctors can access this list weekly (filtering by own name) and 'Mark as performed' or 'Delete from list' as appropriate.

Reminders

Designing a reminder protocol

Agree and document a reminder management protocol for the practice team to follow. See the sample protocol below as an example of what this might look like for your practice.



The RACGP Standards for General Practices (5th edition) refers to reminders as occurring when a patient is added to a recommended preventive activity list that is managed on a periodic basis to help manage preventive care.

> **Indicator**
>
> **C4.1▶A** Our patients receive appropriately tailored information about health promotion, illness prevention, and preventive care.

Each practice will need to design a system which effectively differentiates between their general preventive reminders and their true recalls (ie those that are clinically significant).

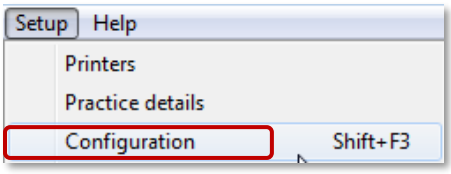
See Appendix 1 for more sample reminder management protocols

Creating an Effective Reminder List

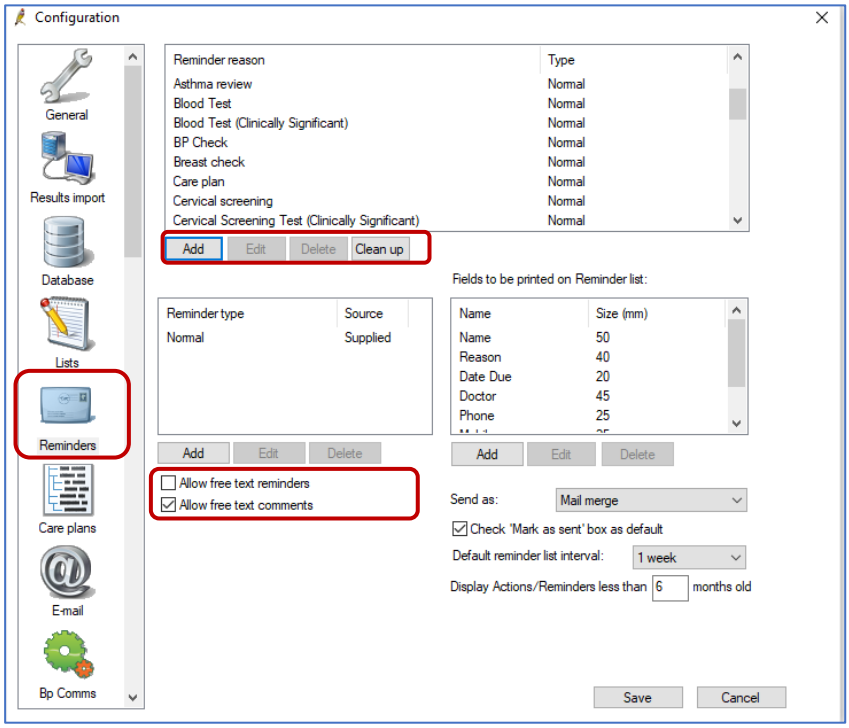
The first step to creating an effective recall and reminder system is often to create a clear list of recall and reminder reasons.

1 From the Main Screen of Bp Premier select '**Setup' > 'Configuration**'

2 Select the '**Reminders**' icon from the left column



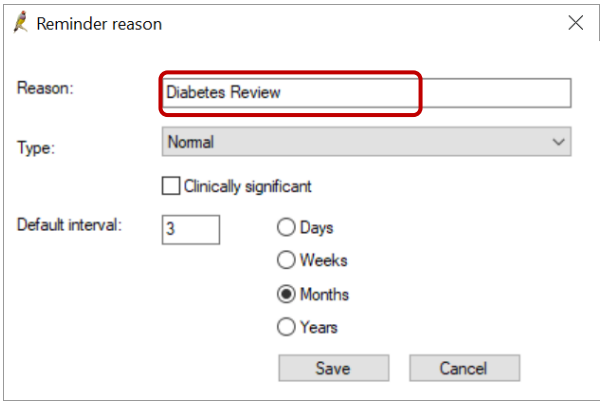
3 Use **Add, Edit, Delete** buttons to create an effective list.



TIP: Once you have an effective list, untick 'Allow free text reminders' and Tick 'Allow free text comments' as this will allow clinicians to add detail to help identify the reason for the reminder in the future eg which particular blood tests etc.

Adding new reminder reason to the list:

1. Select the '**Add**' button in the 'Reminder reason' section on the top.
2. Enter a **New Reminder Reason**
3. Select a **Reminder** Type if you want to group reminders together for the purposes of handling them separately to others. Eg Chronic Disease Management.
4. Tick '**Clinically Significant'** if a label is required to indicate there may be a risk of harm to the patient if not followed up. This allows the practice to separate the 'clinically significant recalls' from the preventative health reminders that may be processed separately when generating reminder lists, SMS and letters.
5. Press '**Save**' button

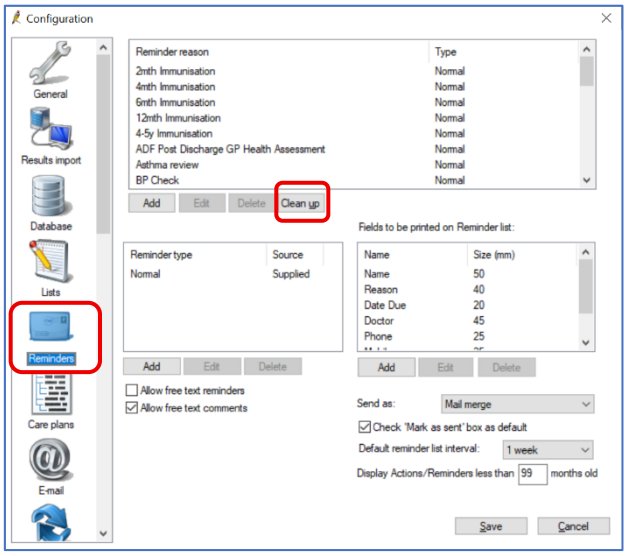


The reminder reason will be added to your reminder reasons list.

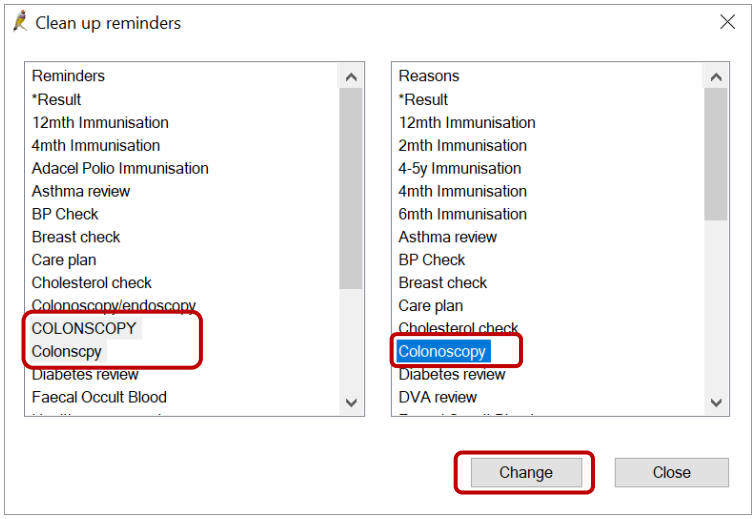
Reminder List Bulk Clean Up

It is common for similar labels to end up on the reminder list. The first step to cleaning this up is to edit the list of available reasons and then merge old reason codes into valid reason codes on the newly defined list.

To access the Reminder List clean up facility;



1. From the Main screen of BP Premier, select **Setup > Configuration**
2. Select the **'Reminders'** icon in the column on the left.
3. After editing the list of available reminder reasons in the list, select the **Clean Up** button.
4. **Highlight the entries in the left hand column** that you want to merge with an entry in the right hand column.
5. Select the **'Change'** button to effect the merge.



TIP: You can merge multiple entries at once. This can be done by Holding down the Shift or Control keys while selecting the entries with the mouse.

TIP: A key factor in helping ensure an effective reminder system is to keep this list manageable. Clearly define your reminders and ensure all staff understand the practice 'system'.

Add View & Modify Patient Reminders

In the patient record:

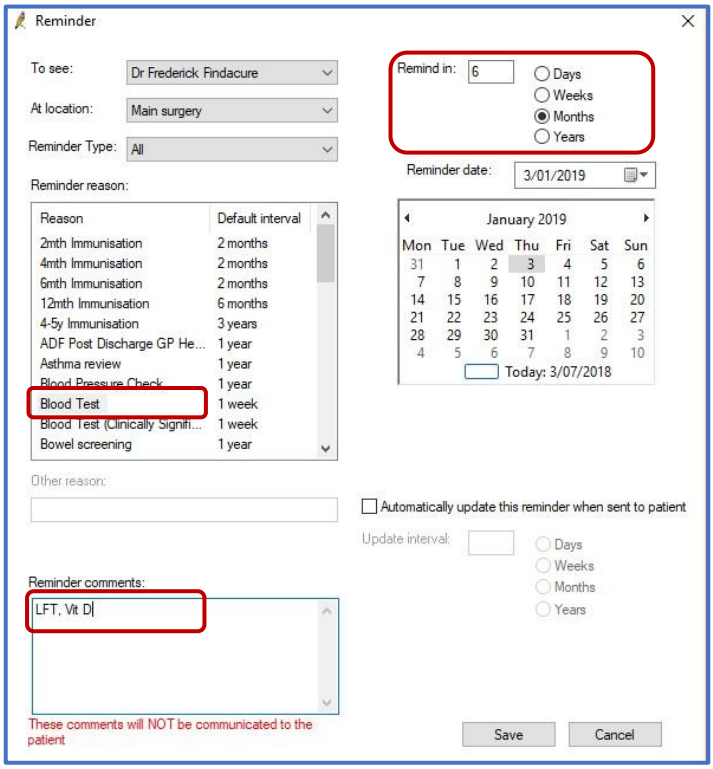
1. Open the patient record **(F2)**
2. Click on the **Reminders** button. If the patient has a Reminder that is overdue or due in the next 30 days, it will show up in blue in the Notifications area.



3. Choose '**New**'



4. Select a **Reason from the list**.
5. Select the **Due date** required.
6. Add any relevant **reminder comments** that can be used to provide additional detail when viewing the reminder at a later date. *These will not be communicated to the patient*.
7. **Save.**



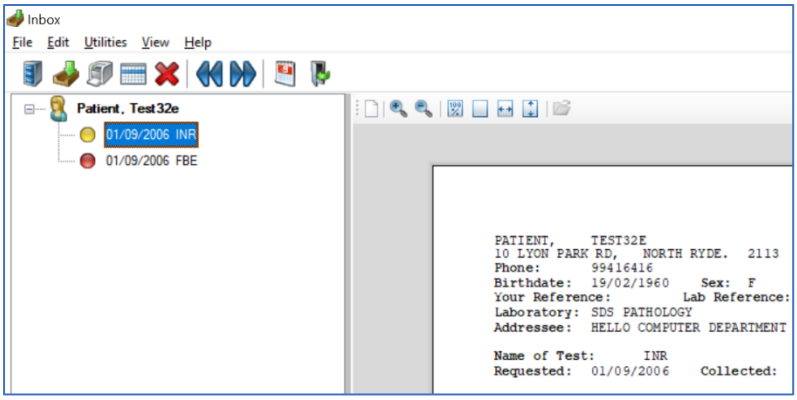
TIP: It is possible to filter the reminder reason list by 'Reminder Type'. The type can be used to differentiate reminders that have been grouped together under a given Type eg Chronic Disease Clinic, Travel Clinic etc. To add types, go to Setup > Configuration > Reminders.

From the Inbox:

1 Open the Inbox **(F3)**



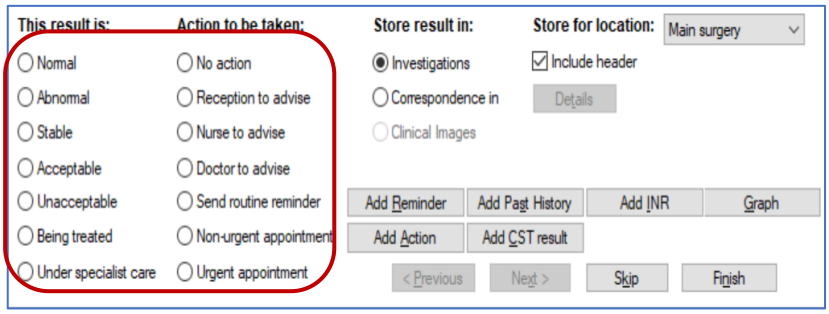
2 **Select the item / test result**



3 Go to '**This result is'** section and choose the appropriate response.

eg. Normal, Abnormal, Stable etc

4 Under '**Action to be taken'** select the relevant action (according to your practice protocol).

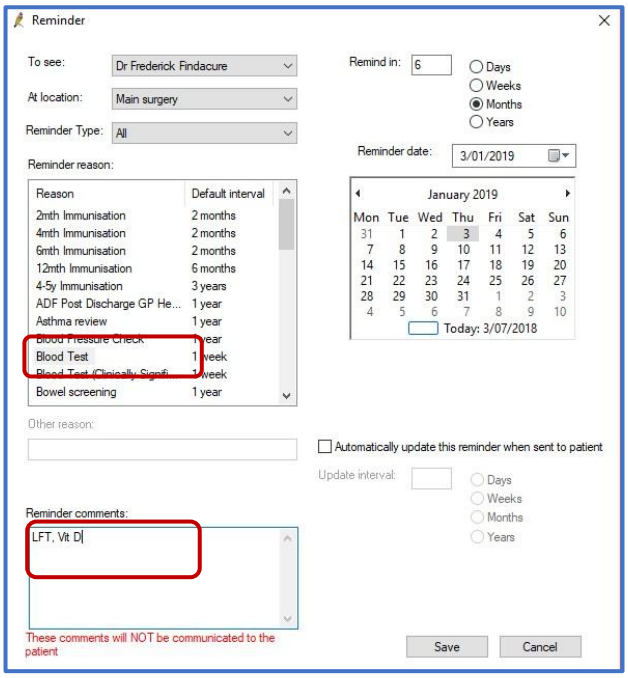


5 Click on the '**Add Reminder' b**utton.

The reminder window will be presented.

6 Choose an applicable '**Reminder reason'** from the list.

7 From the '**Remind In**' section select the appropriate reminder interval or choose a due date



8 Add any relevant **reminder comments**

These comments can be used to provide additional detail when viewing the reminder at a later date. *These will not be communicated to the patient*

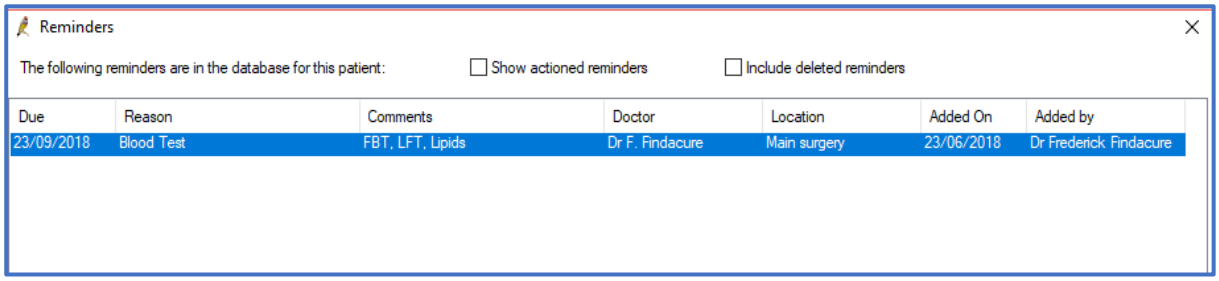
9 Press **'Save'** button

Practice staff can then mail merge these patient records with a relevant reminder letter, phone or send an SMS message to notify patients when their reminder falls due.

Viewing and editing reminders

From the patient screen:

1 Select the **Reminders** button



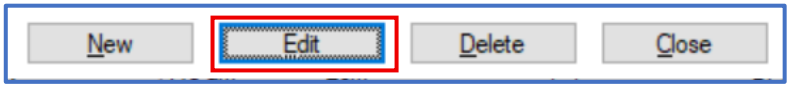
A list of reminders added to a patient record can be viewed. Due dates, reasons and comments can also be seen for each reminder, if entered.

2 **Highlight** the reminder to be edited

3 Select the **Edit** button

4 **Edit** the reminder detail

5 **Save**.



Note: Tick the **Show actioned** and **Include deleted reminders** boxes to view reminders in these categories.

Generate patient reminders

1 From the main screen select the **Open Reminders List** icon



2 Click the **Select patients** button



3 Tick all **Reasons** to include

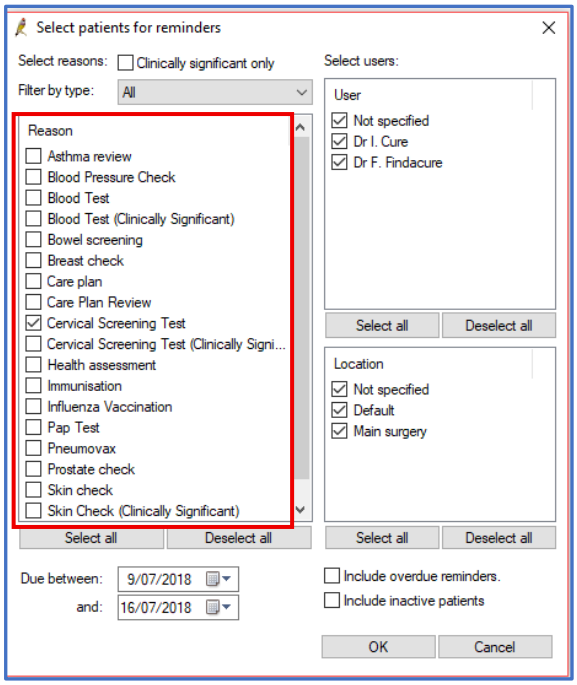
4 Tick all **Users** to generate reminders for

5 Tick to select which **Locations** to generate reminders for (if applicable)

6 Select a **due date** range to include

7 Choose whether to include overdue reminders and reminders on inactive patient records.

8 **OK**

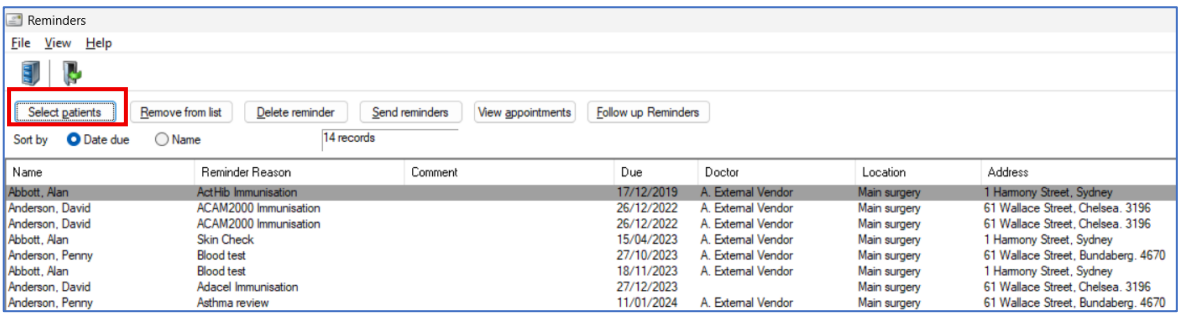


A list of reminders that meet the criteria will be displayed on the screen.

Once you have generated the list you can choose to **open, print or save** (click on the file dropdown menu for these selections).

You can also remove reminders from the list (**Remove from List** button) and delete reminders (**Delete Reminder** button).

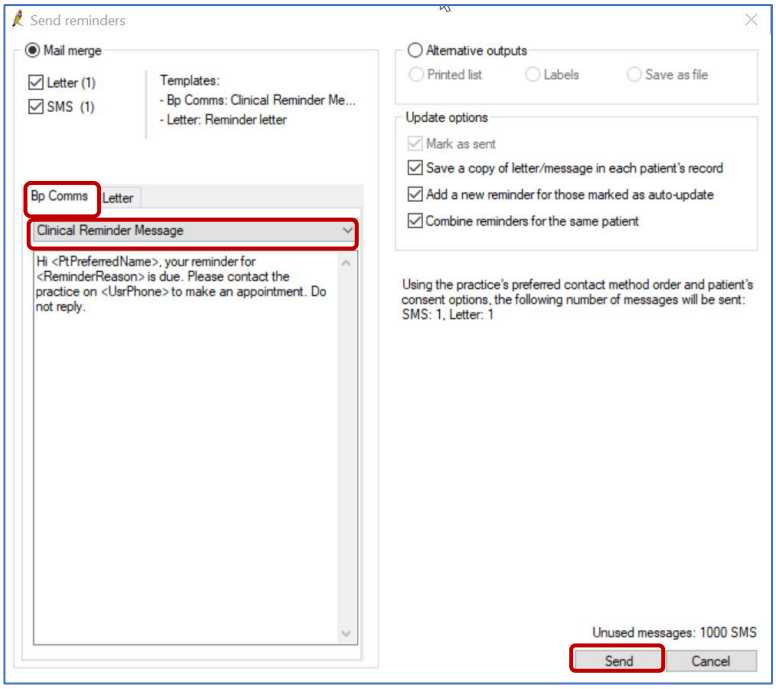
Selecting the '**Clinically Significant only'** checkbox will mean that only reminders with this indicator will be included in the list that is generated. This feature enables clinically significant reminders to be easily identified and managed separately to other reminders.



Name	Reminder Reason	Comment	Due	Doctor	Location	Address
Abbott, Alan	ActHib Immunisation		17/12/2019	A. External Vendor	Main surgery	1 Harmony Street, Sydney
Anderson, David	ACAM2000 Immunisation		26/12/2022	A. External Vendor	Main surgery	61 Wallace Street, Chelsea. 3196
Anderson, David	ACAM2000 Immunisation		26/12/2022	A. External Vendor	Main surgery	61 Wallace Street, Chelsea. 3196
Abbott, Alan	Skin Check		15/04/2023	A. External Vendor	Main surgery	1 Harmony Street, Sydney
Anderson, Penny	Blood test		27/10/2023	A. External Vendor	Main surgery	61 Wallace Street, Bundaberg. 4670
Abbott, Alan	Blood test		18/11/2023	A. External Vendor	Main surgery	1 Harmony Street, Sydney
Anderson, David	Adacel Immunisation		27/12/2023		Main surgery	61 Wallace Street, Chelsea. 3196
Anderson, Penny	Asthma review		11/01/2024	A. External Vendor	Main surgery	61 Wallace Street, Bundaberg. 4670

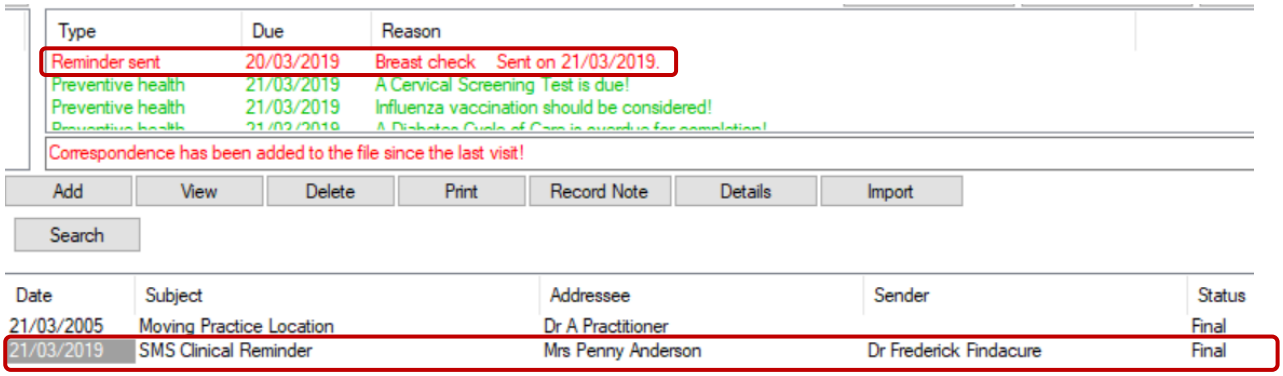
Send patient reminders

After selecting the patients that are due to receive a reminder(above):

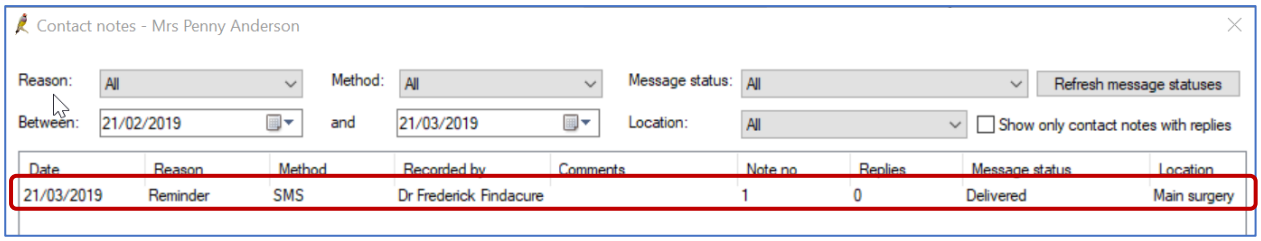


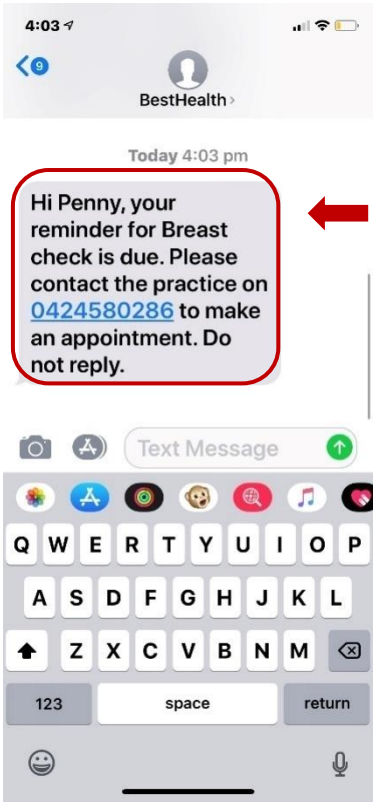
1. Choose **Send Reminders**
2. Choose **Bp Comms** tab
3. Select a **message template from the drop-down list.**
4. Select the **Letter tab** and **select a letter template.**
5. Tick '**Save a copy of letter/message in each patient's record'**
6. Tick '**Add a new reminder for those marked as auto-update'** as applicable.
7. Tick '**combine reminders for the same patient'** as applicable.
8. **Edit** the message detail if required.
9. Press '**Send**'.

The messages will be sent directly to the patient's mobile number and letters will be sent to the default printer. If you have ticked to save a copy in the patient's record, a copy will be filed under Correspondence Out and a Reminder Sent notification will also be visible on the screen (under Notifications) to show the status of the reminder message (ie sent).



Additionally, a contact note will have been automatically added to the patient record when the SMS was generated. This can be viewed in patient demographics > Contact Notes.



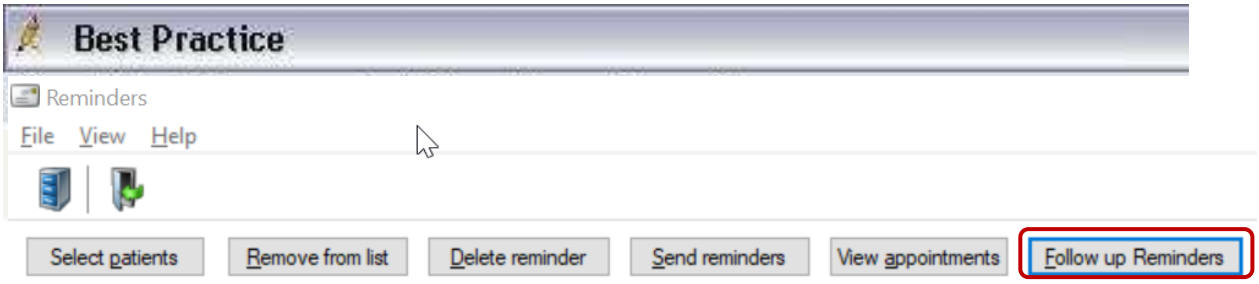


This is an example of what the patient sees when the message is received on their phone.

Following up Recalls and Reminders

The follow up reminders screen shows all reminders that have been sent previously but not marked as completed by default (All unactioned). You can view sent reminders and send a second follow up reminder letter/SMS as follows:

1 Re-open the **Reminders List** from the Main Screen.



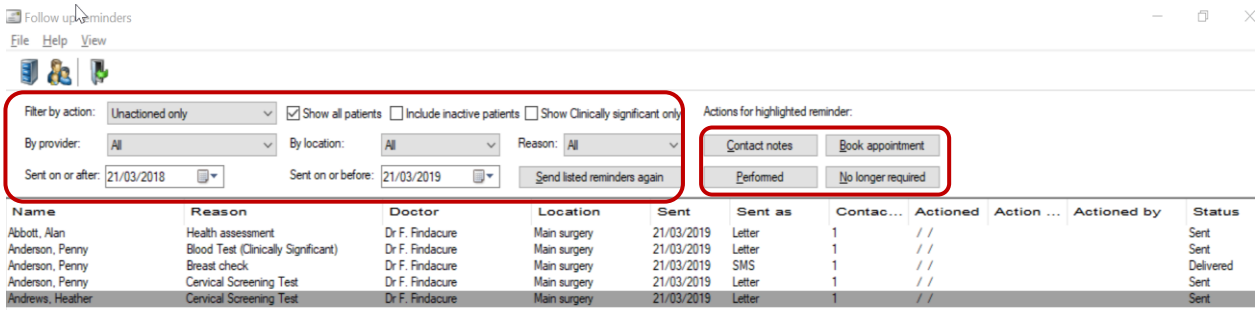
2 Select **Follow up reminders** button to generate a list.

3 Select Filter by action: **Unactioned only**

4 Select a **date range** (based on date previously sent)

5 Filter by **Doctor, Location and Reminder Reason** as required

6 Select **Send listed reminders again** to reopen the send screen and proceed to sending a letter or SMS, or phoning the patient as per practice protocol.

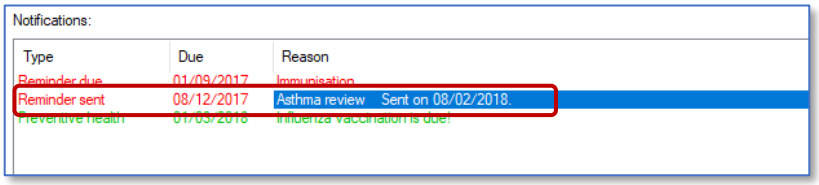


The following options are also available on the Follow up reminders screen:

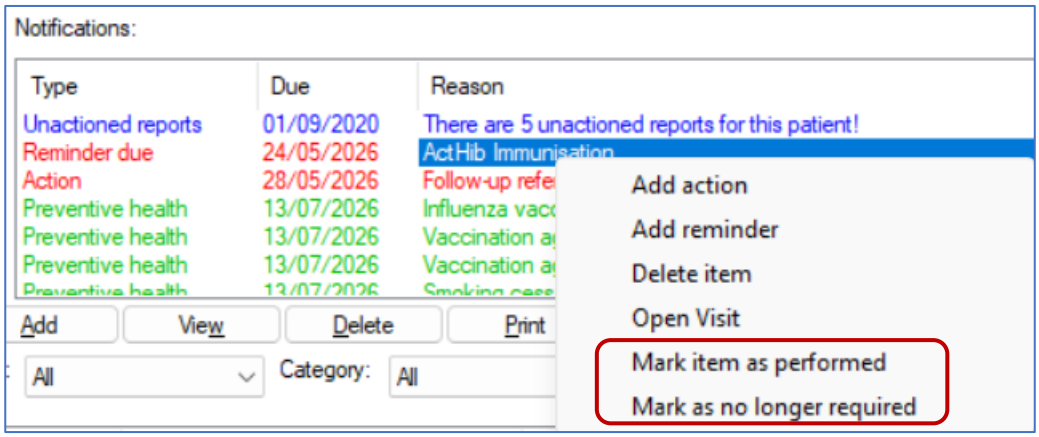
- Select the '**Performed'** button if patients on the list have returned for the item indicated as the reminder reason.
- Select '**No longer required'** button if the reminder is no longer needed and no further follow up is necessary.
- Use '**Contact Notes'** button to record details of any patient contact regarding a reminder.
- Use '**Book Appointment'** button to view and book an appointment for the patient.

Removing reminders from the patient record

When the patient visit and the patient record is opened, there will be an entry in the Notifications window in RED alerting the clinician that a reminder notification was sent to this patient on a specified date.



1. Open the patient record **(F2)**
2. Find the '**Reminder Sent'** notation in the 'Notifications' window.
3. Once the service has been performed, you need to remove or update the reminder
4. **Highlight** the reminder in the list and **right click.**
5. Select '**Mark as performed' or 'Mark as no longer required'.**



The reminder will be closed with a status of 'performed' or deleted and will be removed from the Notifications display area on the patient record.

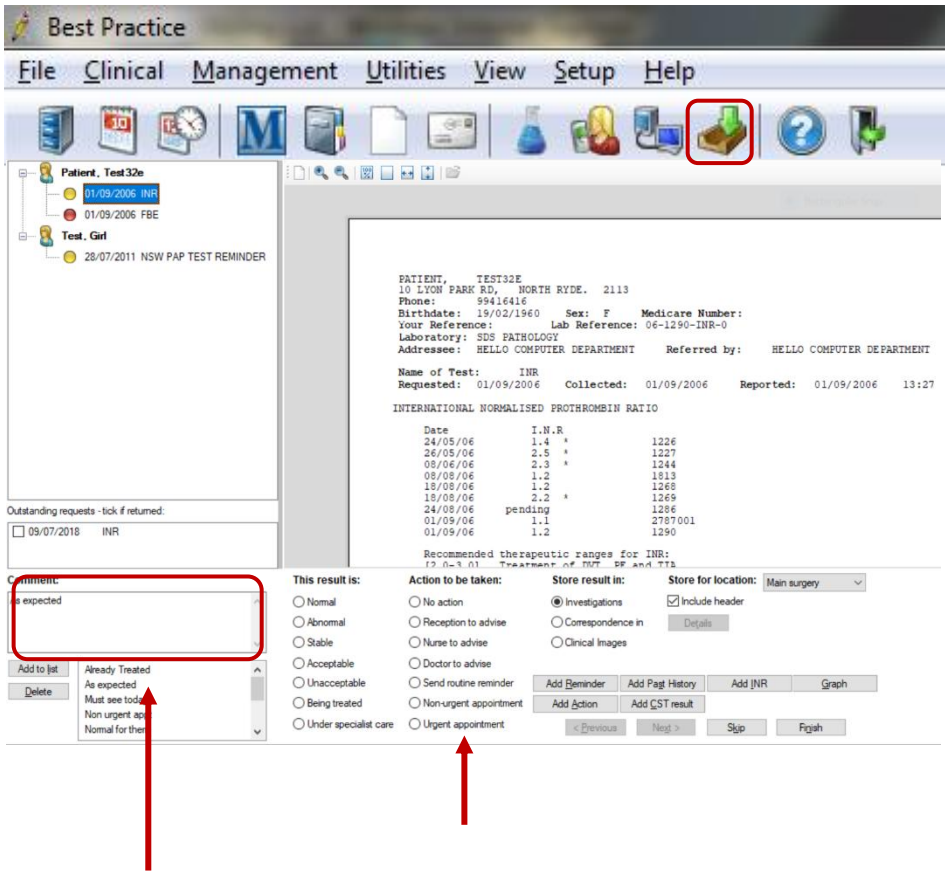
Recalling patients from the Inbox

Results, Scanned or imported new Correspondence

The **Inbox** contains scanned or imported documents as well as electronically received pathology and radiology results. In addition the Inbox will now hold electronically received documents such as discharge summaries, specialist letters etc.

The Inbox needs to be checked and cleared regularly (several times each day). Over time there should be fewer additional incoming hard copies and faxed documents.

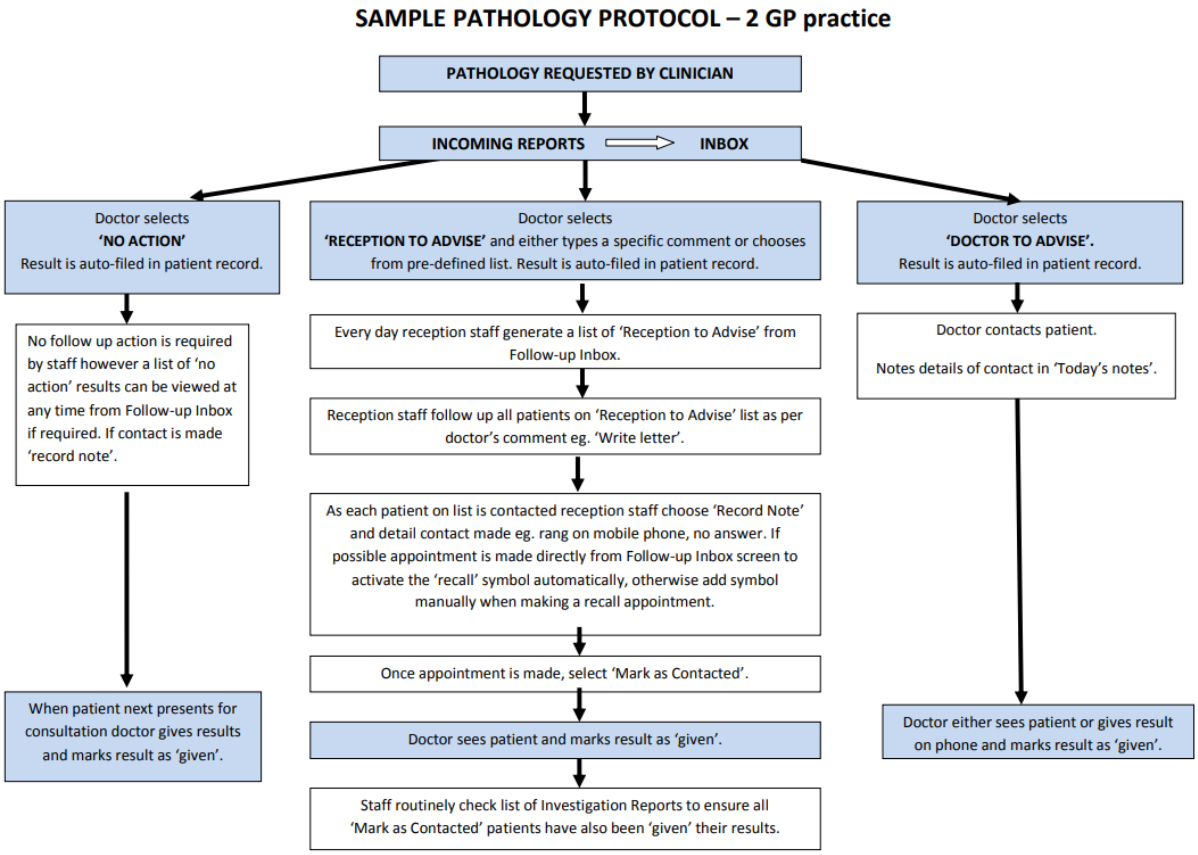
To access the Inbox click on the tray with green arrow icon from the main screen or View> In-box (or F3).



Note the 'Comment' box and the multiple choices in the 'Action to be taken' list. A clear practice protocol should be in place for an effective follow-up system.

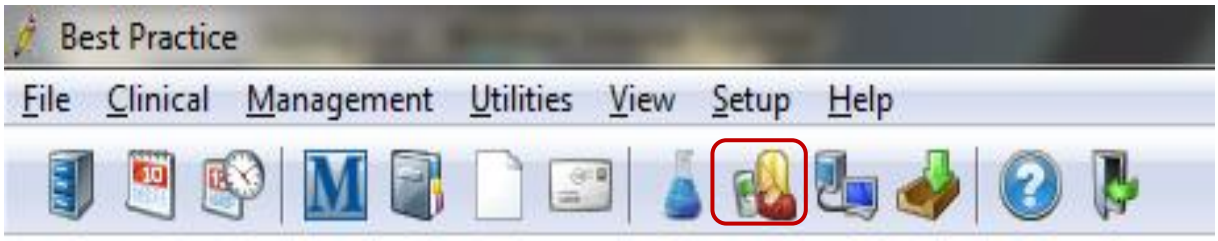
Designing a Practice 'System' for managing incoming correspondence

Hold a team meeting to decide and clearly document which choices clinicians will select and how they will be followed up.



Each practice will design a system which effectively differentiates between incoming correspondence requiring no further action, non-urgent follow up and urgent follow up with the patient based on the clinical significance of each result or incoming document.'

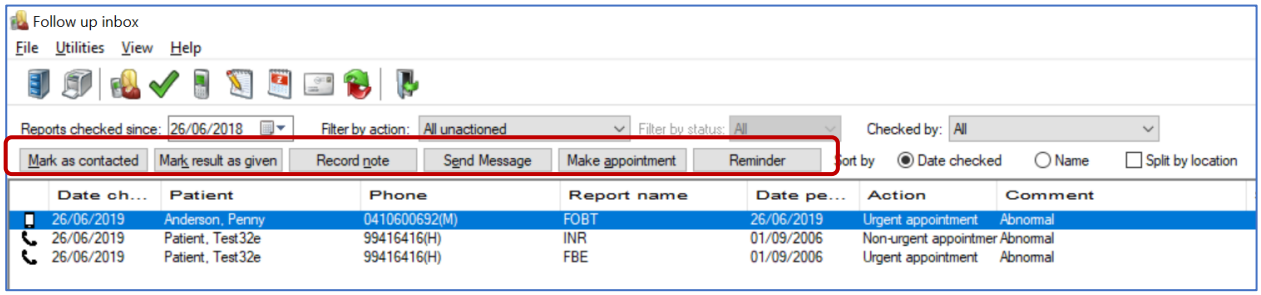
See Appendix 2 for more sample results/correspondence management protocols



The 'Follow Up In-box' is designed to help with contacting patients needing about results/incoming correspondence. Use 'Filter by Action' and follow-up according to comments and practice protocol.

Available options include:

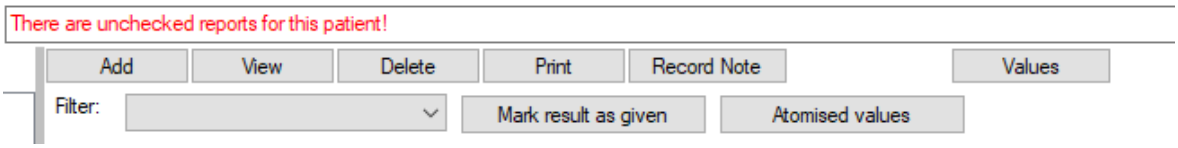
- Mark as Contacted,
- Mark Result as Given,
- Record Note,
- Send Message (SMS),
- Make Appointment
- Add a Reminder



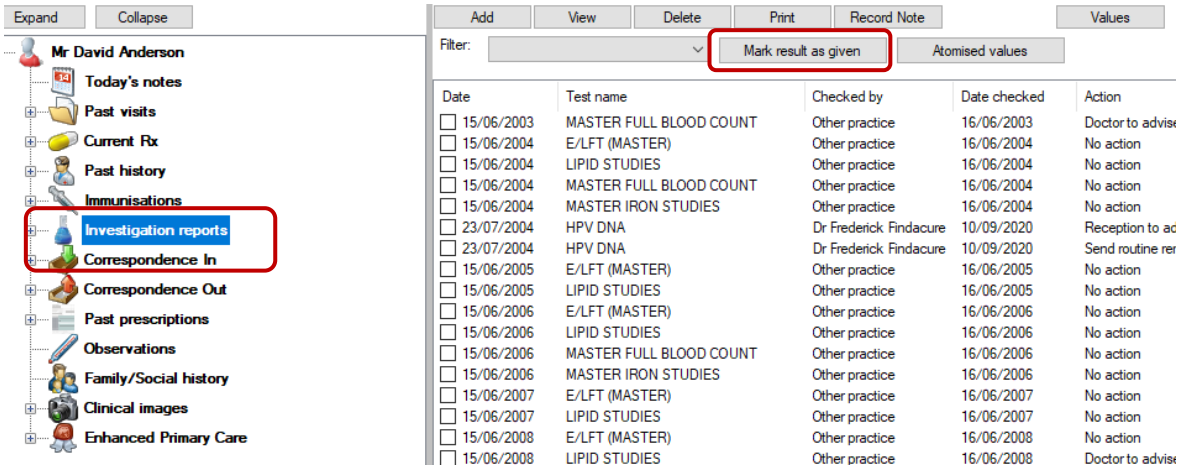
Tip: Regularly access this list and filter the list to see correspondence where the patient has been 'contacted' but not marked as 'notified' and follow up as appropriate.

Marking results as given

Results can be marked as given from the ‘Follow Up In box’ and from the Investigation and Correspondence In sections on the patient record. This step is the final step in the patient follow up process after which further follow up ceases. It also serves as an audit trail.



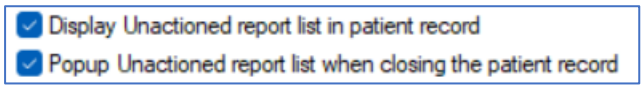
1 Select **Investigation Reports**

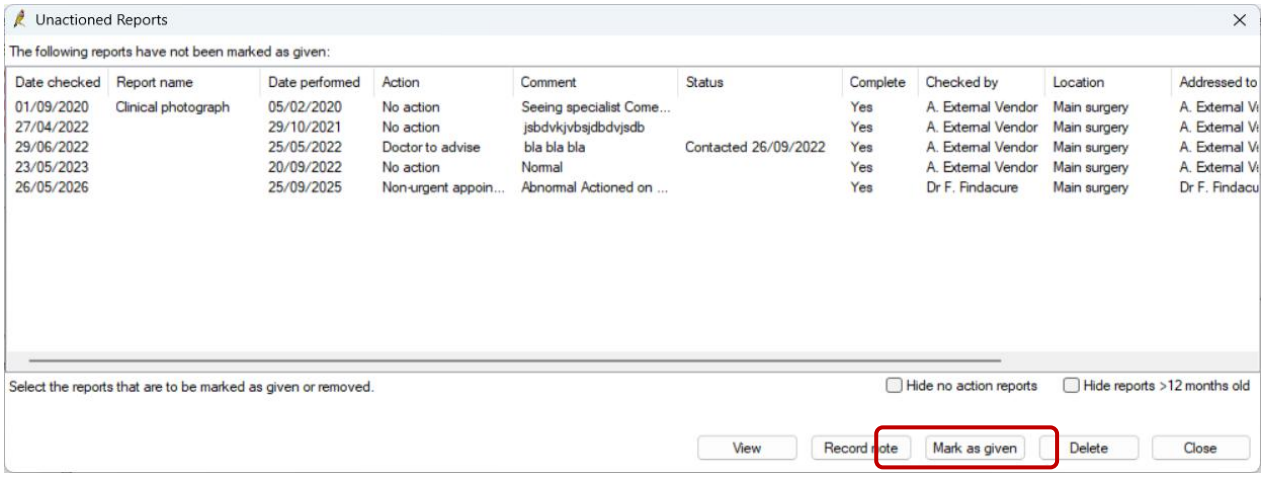


2 **Tick the checkbox** to select a result.

3 Select **Mark result as given** once discussed with the patient.

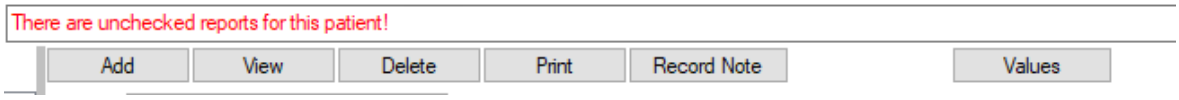
To see a list of all unactioned reports in Bp Premier on closing the patient record, go to Setup > Preferences and tick these options:





This acts as a reminder to the clinician to mark off any outstanding results before closing the file. Review the list before finalising the visit and Mark results as given once communicated to the patient.

TIP: If you see the red notation ‘There are unchecked reports for this patient’ click on Clinical > Unchecked Reports (or Alt F11) to access the results directly from the Inbox.

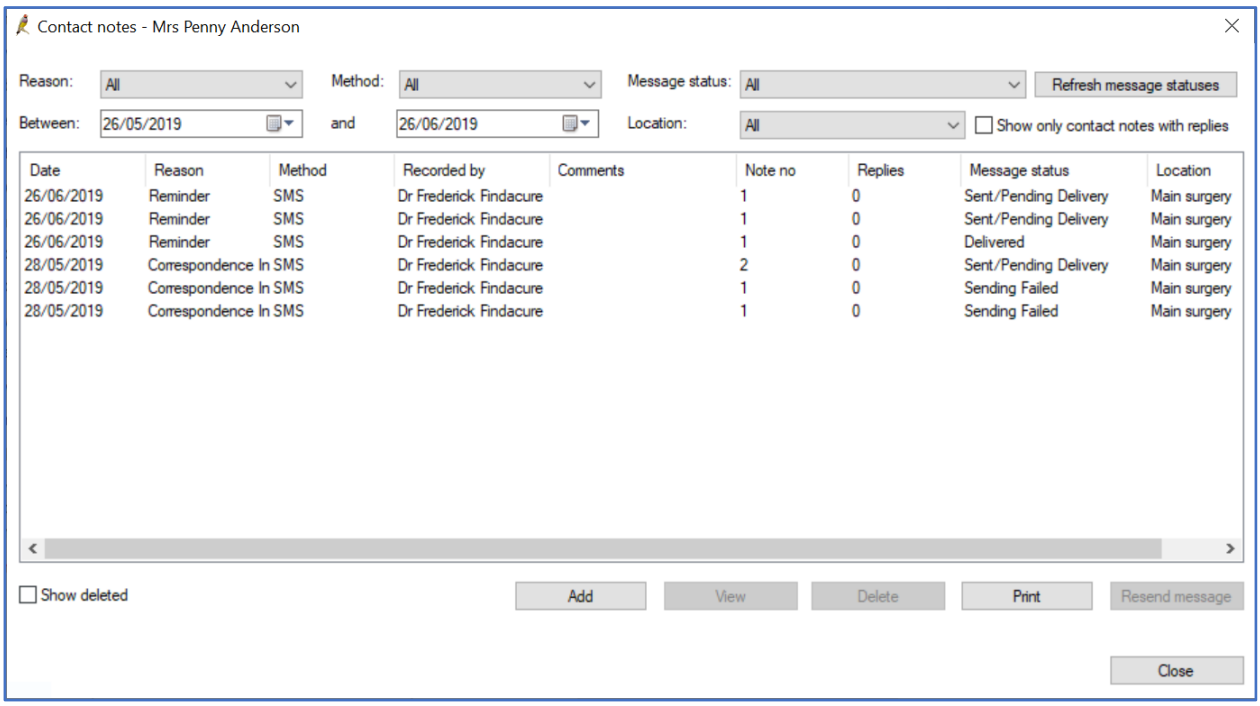


Using Contact notes

Contact Notes are used to record patient communications/contact attempts including SMS, email, phone, letter and they include the outcome of the contact attempt.

Contact notes can be manually or automatically generated in a patient record and can be accessed via a number of screens including the patient demographic screen, appointment book, reminders and follow up reminders window, inbox, patient list and via the clinical record.

A contact note is automatically created when a mail merge is done (generating either a letter or SMS) from both the reminder and follow up reminder lists and the follow up inbox when patient notifications are sent. Subsequent contact attempts can be added to a contact note to track all activity relating to patient reminders and recalls.



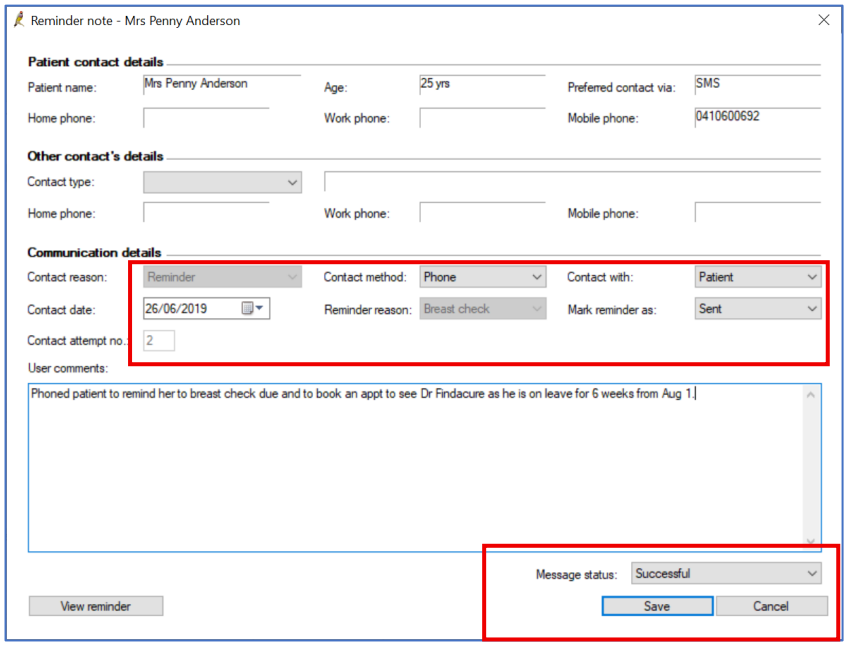
TIP: To find automatically generated contact notes, go to either the patient record and select View>Contact Notes or via the source screen (e.g. Inbox Follow Up) select the item in the list and select ‘Record note’.

Adding a new contact note:

Contact notes that have been generated via an automated process (such as follow up to an incoming test result or reminder) may require subsequent follow up attempts for the same item. (eg. phone call) and this can be recorded against the original contact note.

To add a new note (to an existing note) from the patient record:

1. From the main screen select **View > Contact Notes**
2. Filter by Reason etc to locate the note > View
3. Select **Add**.
4. **Other contacts details** should only be used if the person contacted is NOT the patient and they are listed as Emergency contact, Next of Kin or carer).
5. Select a **contact reason and method**.
6. Enter a **comment** as required.
7. Select **a message status**.
8. **Save.**



TIP: When adding a new contact note to an existing note than has been automatically generated, the contact attempts will automatically increase by 1 each time a new contact note is added and saved.

Topic 4 - Documents and templates

Generating and sending letters

Generating a letter



1 Select the **New Letter** icon within a patient record.

2 Select **Templates > Use template** from the drop-down menu.

3 Select the template from the list (select from **All**, **Custom or Supplied** categories),

4 **Open**

5 If prompted for information, add data, select > **Next** then **Insert**

6 Review the completed letter or document and make any changes required.

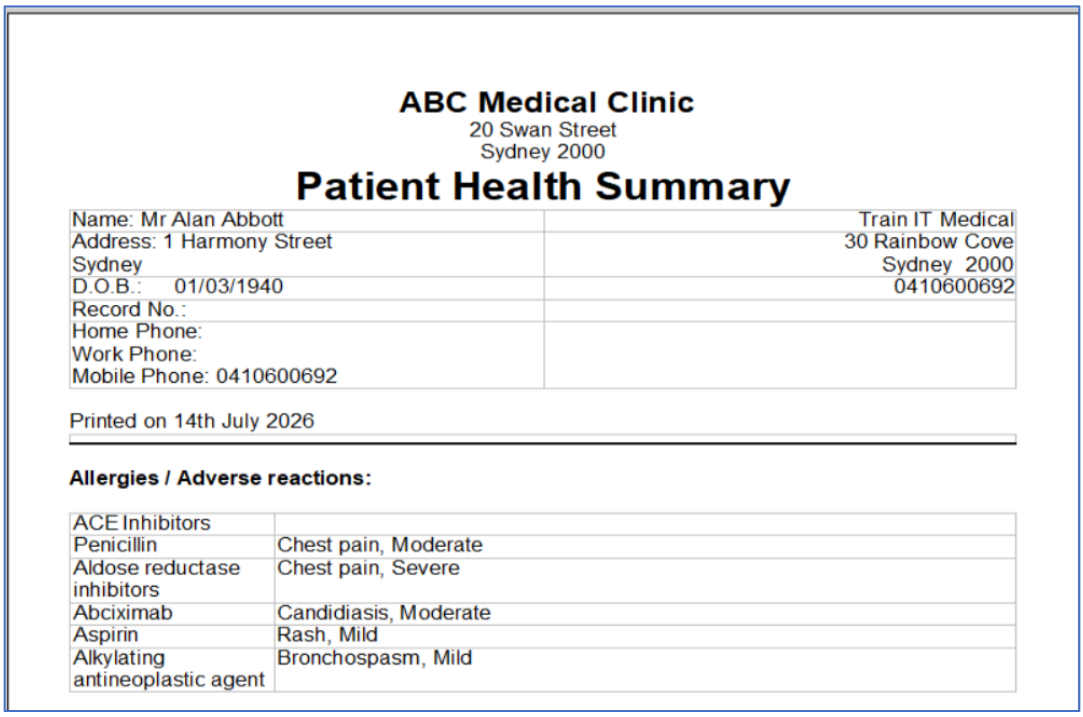


7 To print the letter, select **File > Print**

8 Save the letter in the patients record by selecting **File > Save**

9 Complete the **letter details**

10 Click **File > Save**.



ABC Medical Clinic
20 Swan Street
Sydney 2000

Patient Health Summary

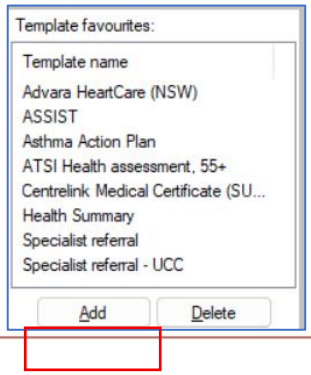
Name: Mr Alan Abbott	Train IT Medical
Address: 1 Harmony Street Sydney	30 Rainbow Cove Sydney 2000
D.O.B.: 01/03/1940	0410600692
Record No.:	
Home Phone: Work Phone: Mobile Phone: 0410600692	

Printed on 14th July 2026

Allergies / Adverse reactions:

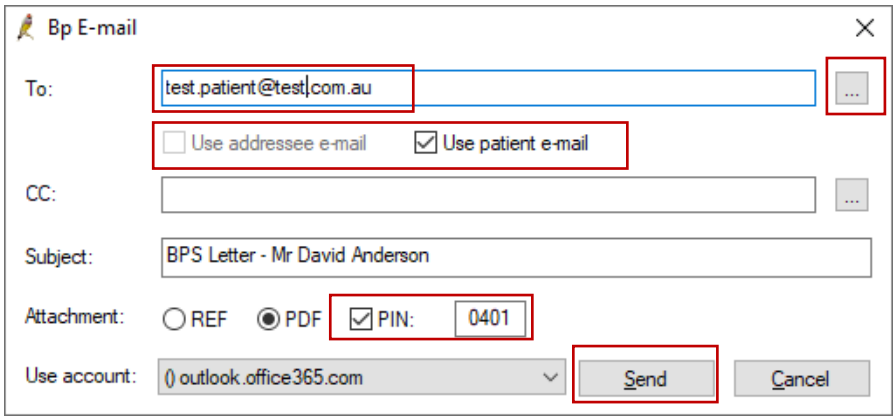
ACE Inhibitors	
Penicillin	Chest pain, Moderate
Aldose reductase inhibitors	Chest pain, Severe
Abciximab	Candidiasis, Moderate
Aspirin	Rash, Mild
Alkylating antineoplastic agent	Bronchospasm, Mild

TIP : Add commonly used templates to your list of Favourites so they are easy to find and use in the WordProcessor. **Click Add** and select the template from the list to add to favourites.



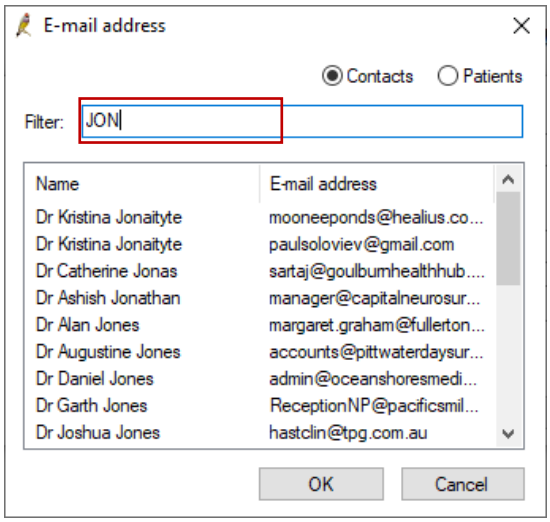
Send a letter via email:

1. **Open a letter** (double click on the letter in Correspondence Out)
2. Select '**Send mail'** 
3. To send to the patient, tick '**Use patient email'**. The email address recorded in the patient details screen will be used.
4. To send to the addressee on the letter, **tick 'Use addressee email'**
5. If there is no patient/addressee email address recorded, type it **in the To: field.**

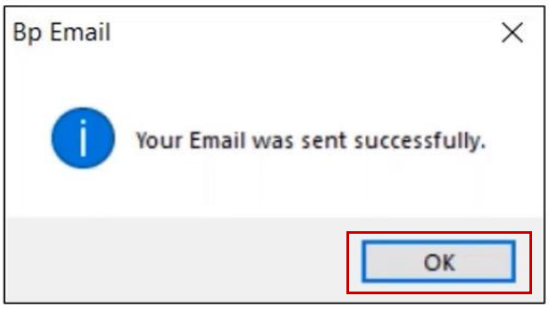


6. To send to a contact, other than the patient or addressee**, click on the**  **button and search for the contact in the database.**

7. **Highlight** the recipient and select **OK.**
8. Select **Send.**
9. Once the email has been successfully sent the following message will display:
10. Click **OK to confirm**



Note: If you included a PIN Number, the recipient will need to know the PIN number to open the attachment (document) on receipt. The PIN number will default to the patients Date of Birth in the format 'DDMM'**.**



Note: Emails sent from the Word Processor will automatically generate an entry in Todays Notes.

Note: the outgoing email body text can be configured in **Setup > Configuration > Email**

Note: Set the default PIN setting for outgoing emails in **Setup > Preferences > General > 'Default to PIN protected patient emails'**

Modifying and importing templates

Modify an existing template



1. Select the **New Letter** icon within a patient record.
2. Select **Templates** from the dropdown menu then choose **Edit Template.**
3. **Select the template** to be modified **> Open**
4. **Make the required changes to the template**.
5. Save the template by selecting **File > Save as** and entering a name for the template (e.g. Podiatry referral)
6. Tick the box to make available to all users.
7. **Save**

Import a Template

1. **Download a template** from an external source and save the file as an .rtf file (Use 'Save As). Do not open the document.
2. **Right-mouse click** on the file link and select **Save Link As**.
   Navigate to the folder or location on the hard drive of the computer where you want to save the file (eg desktop) and select **Save**. Do not Open it once saved, it must be **imported** into Bp Premier.



3. To import the template, open Bp Premier Wordprocessor by clicking on the Letter icon.
4. Select **Template > Import Template**.
5. **Find and select the template file (.rtf) to be imported**, **> Open.** This will import the template.
6. **Modify the layout if required**
7. Save the template by selecting **File > Save as**
8. Type in a new name for the template and tick on **All Users** depending on who is to have access to the template.
9. Select **Save.**

This will save the template under the **Custom** tab.

Topic 5 – Digital Health

My Health Record

Accessing the Patient's My Health Record

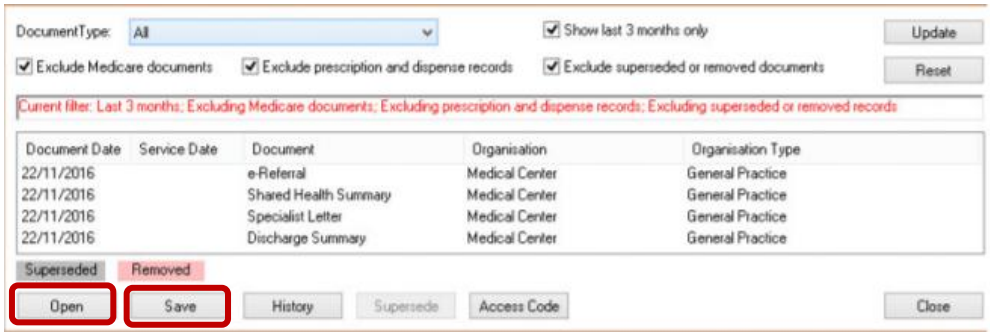
You are able to access your patient's My Health Record to view and download documents if:

- Their Individual Healthcare Identifier (IHI) has been validated in your system.
- The My Health Record icon in the top right of the patient window is Orange or Green.

1 **Click the My Health Record icon** in the top right of the patient window.



The My Health Record document list will appear e.g. Shared Health Summary, Event Summary, Discharge Summary etc.

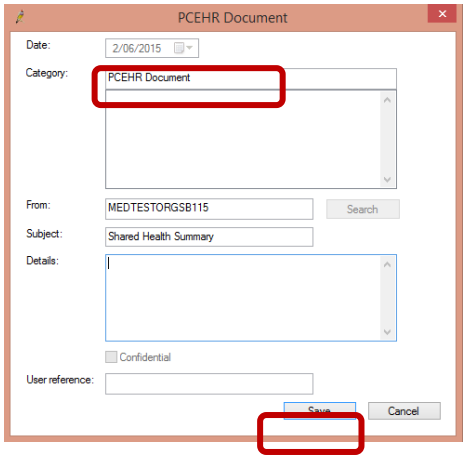


2 **Select the document** you wish to view and double click or select **Open** (in the bottom left corner) to View.

3 **To Save the document** to the patients local medical record, highlight it and select Save.

4 A popup box will appear for you to add file Details and/or a User Reference as preferred

5 **Save**.



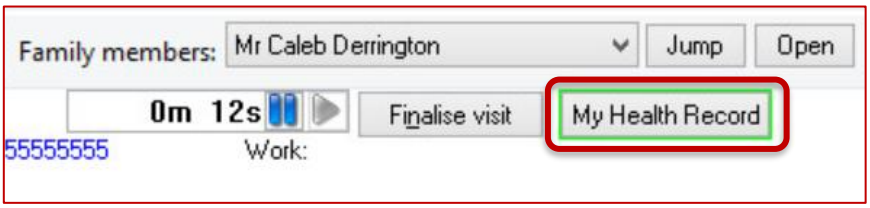
The document will be saved in the **Correspondence In** section of the patient's local medical record.



An Auto-notation is added to the patient record in Todays notes.

Adjusting Filters in My Health Record

1 For registered patients, The My Health Record button will have a green border in the demographics section of your patient record. To access, **click on the My Health Record button.**



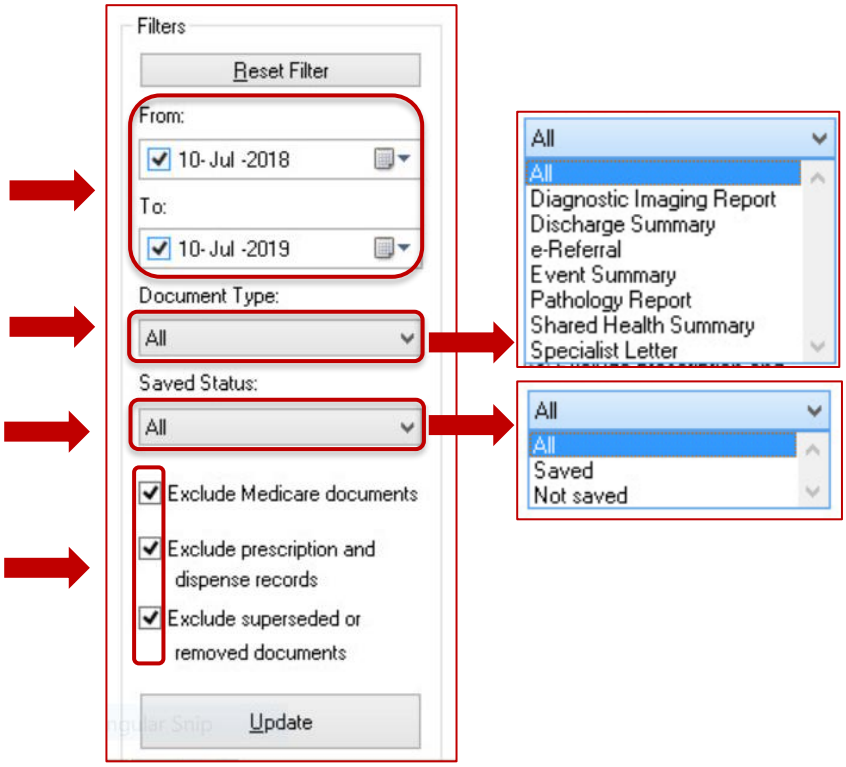
2 To enable faster retrieval of relevant documents you can change the filters.

3 Click on the **From and To dates** to change the document date filters.

4 Click the **Document Type Filter** to select a single document type to be displayed.

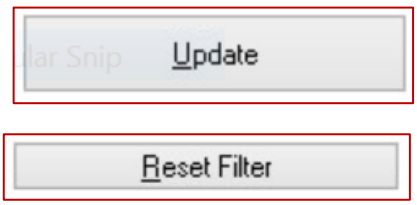
5 Tick the **Saved Status Filter** to see only documents with a particular status.

6 **Click to untick the document exclusion filters** to display documents not included in the default display.



7 Select **Update** to apply the filter selection changes.

8 To **Reset** all filters back to the default settings, select '**Reset Filter**'.





Shared Health Summary
1-Mar-2013

SCHOEMAN, Bram (Mr.) DoB 9-Sep-1968 (44y) SEX Male IHI 8003 6056 7979 3550

START OF DOCUMENT

Best Practice Clinic no 3

Author Dr. Frederick Findacure (General Medical Practitioner)
Phone 05645613121

Adverse Reactions

Adverse Reactions

Substance/Agent	Manifestation
Bee venom	• Anaphylaxis

Medications

Reviewed Medications - Exclusion Statement

Exclusion Statement
None known

Medical History

Medical History - Procedures - Exclusion Statement

Exclusion Statement
None Supplied

Medical History - Problem Diagnosis - Exclusion Statement

Exclusion Statement
None Supplied

Immunisations

Immunisations - Administered Immunisations

Date Time	Medicine	Vaccine Sequence Number
21 Mar 2012	Fluvax	

Administrative Observations

Field	ResultValue
Date of Birth is Calculated From Age	False
Date of Birth Accuracy Indicator	AAA
Age Accuracy Indicator	True
Age	44
Medicare Benefits	2950141771 (Medicare Card Number)

ADMINISTRATIVE DETAILS

Patient

Name	Mr. Bram SCHOEMAN
Sex	Male
Indigenous Status	Torres Strait Islander but not Aboriginal origin
Date of Birth	9-Sep-1968 (44y)
IHI	8003 6056 7979 3550
Entitlements	2950141771 (Medicare Benefits)
Home Address	40 Fairway Outlook, Arana Hills, Australia
Postal Address	PO Box 51, Arana Hills, 4054, Australia
Phone	41417890 (Home) 41418954 (Workplace) 0417854322 (Mobile Contact)
Email	test@testing.com.au (Home)

Author

Name	Dr. Frederick Findacure (General Medical Practitioner)
Organisation	Best Practice Clinic no 3
Work Place	1 Brian Road, Adelaide, SA, 5000, Australia
Phone	05645613121 (Mobile Contact)
Email	julie.dietrich@bpsoftware.com.au (Workplace)

Clinical Document Details

Document Type	Shared Health Summary
Creation Date/Time	1 Mar 2013 16:32+1000
Date/Time Attested	1 Mar 2013 16:32+1000
Document ID	34949bd0-c3c9-4ad3-b29d-b4897130a63a
Completion Code	Final

END OF DOCUMENT

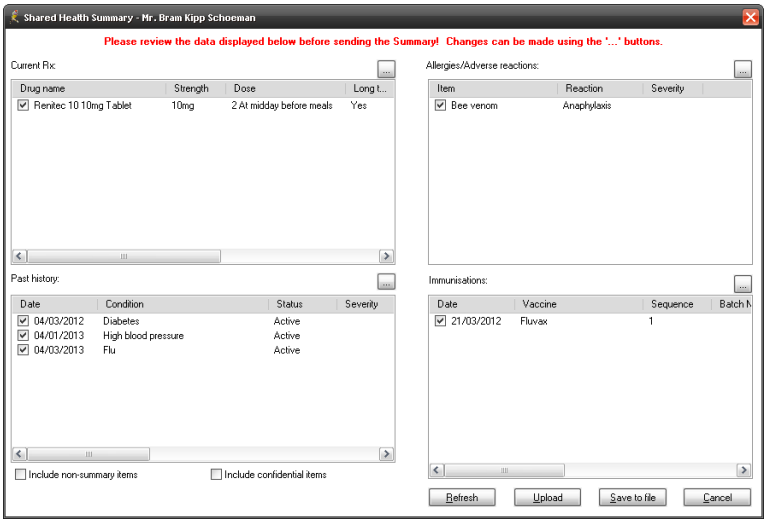
TIP: To access further hands-on training using dummy patient records on the My Health Record system, access the On Demand Training Environment at www.digitalhealth.gov.au

Uploading a Shared Health Summary to My Health Record

1 From the patient record, select **My Health Record** > **Shared health Summary**



2 **The Shared Health Summary will automatically populate** with information from the patient's local medical record.

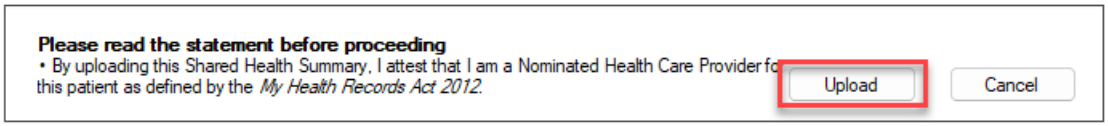


3 Review the information and verify it is correct.

4 **Tick / untick** the items to include

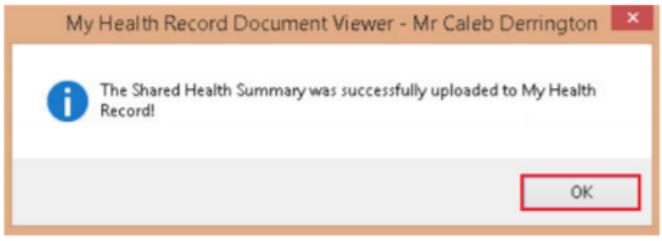
5 **Preview**

6 Attest to the information at the bottom of the screen, then select **Upload**.



A pop-up appears confirming that the Shared Health Summary has been successfully uploaded to My Health Record.

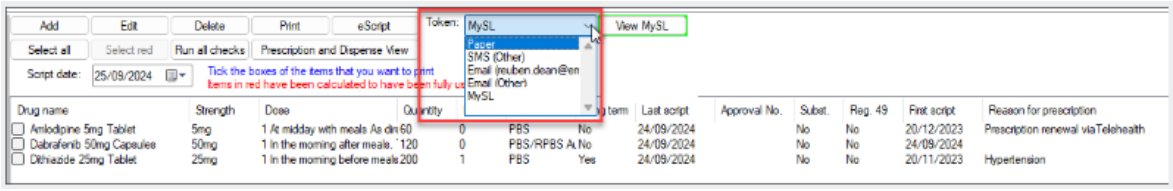
7 Select **OK**.



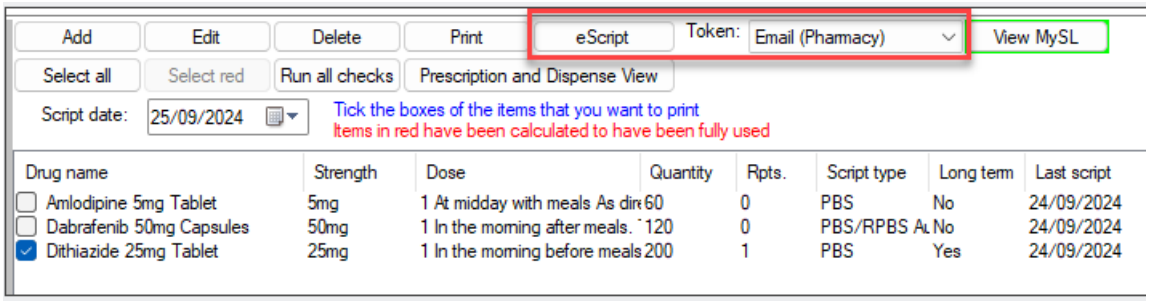
Actions:
A Shared Health Summary was uploaded to the My Health Record!

Generate and send eScripts

1. **Select Rx from the patient record and create a prescription as per usual** (the script will have tick in the Current Rx screen to indicate that it has not yet been printed)
2. **Tick the check box next to the drug that you want to send an electronic prescription token for.** You can select multiple scripts; all selected scripts will be sent by the same method Select eScript



- Select the method for sending the electronic prescription token from the **Token** drop-down menu. Options are:
- **Paper** – Prints the token on a blank sheet of paper
- **SMS (default)** - Sends the token to the phone number in the patient demographics.
- **SMS (Other)** - Sends the token to a phone number entered by the prescriber, eg a carer
- **Email (default)** - Sends the token to the email address in the patient demographics.
- **Email (Other)** - Sends the token to an alternate email address entered by the prescriber.
- **Email (Pharmacy)** - Sends the token to the email address of the patient's preferred pharmacy



- **App** - Send the token to the Best Health App if the patient is enrolled.
- **MySL** - The token is sent to the patient's MySL record

3. Click **eScript** to send
4. If you selected **SMS(Other)**or **Email (Other)**,enter the phone number or email address to send to. Enter the **mobile number** with no spaces or an **email address**, and click **Continue**.
5. If you selected **Email (Pharmacy)**, follow the prompts to select the pharmacy to send to.
6. Select **Send**

Note: A contact note is recorded for every electronic prescription sent via SMS

Topic 6 - Quality Improvements

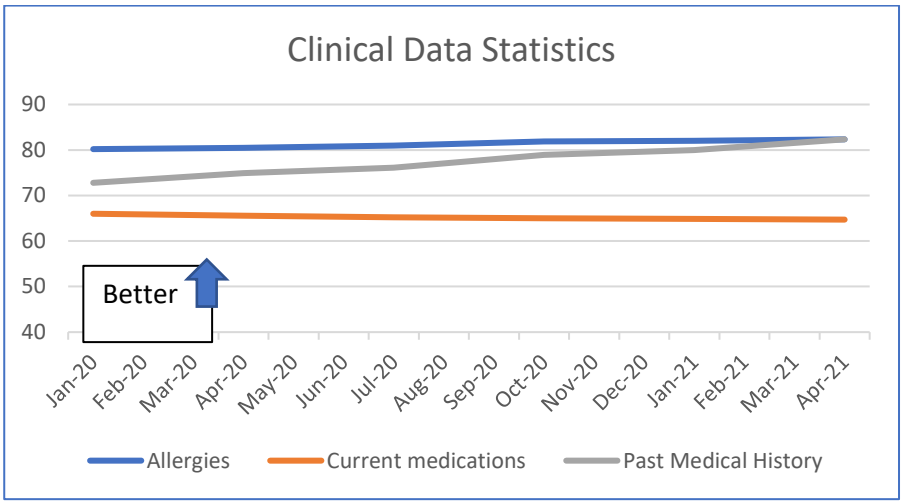
Using data for improvement

Regular data quality measurements

Regular measuring, monitoring and analysis of key metrics is important to helping you understand whether your practice improvement activities are working successfully. Visual displays of data can be helpful to prompt discussion and further improvements among the team.

One idea is to identify key performance metrics for your practice and focus on making improvements to these metrics over time by monitoring their progress on a graph – see below.

Sample 1 – Monitoring key metrics over time (including baseline)



Regular data quality measurements

Regular measuring, monitoring and analysis of key metrics is important to helping you understand whether your practice improvement activities are working successfully. Visual displays of data can be helpful to prompt discussion and further improvements among the team.

One idea is to identify key performance metrics for your practice and focus on making improvements to these metrics over time by monitoring their progress on a graph – see below.

nKPIs & baseline data using database searches.

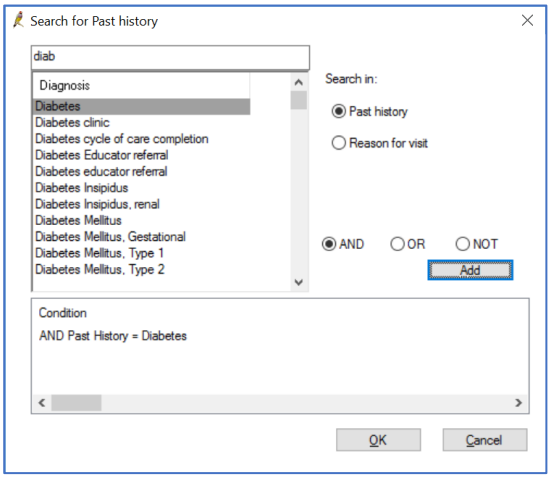
The search function in BP Premier has capacity to further help us identify patients at risk and streamline preventive health management approaches. Bp Premier comes with a separate database search utility. Search Bp **Utilities from the m**ain menu and use your usual login and password.

Tip: If this option is not available on your screen, your user id does not have permission to run this utility. You will need to log in as a user with higher access and edit the permissions on your user id to give you access to 'Search Clinical data'.

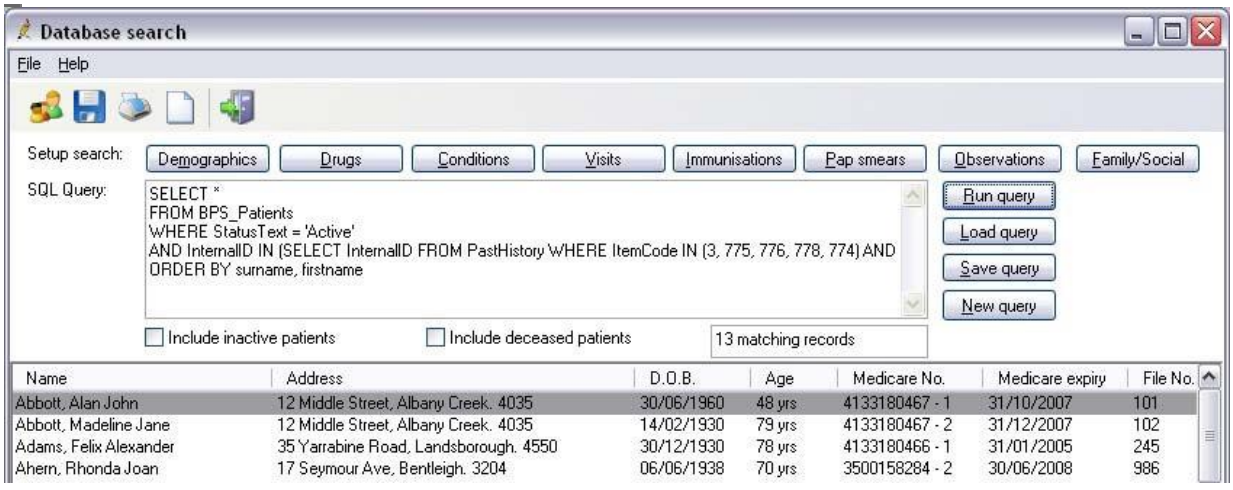
Searches can be filtered by '**Demographics'**, '**Drugs'**, '**Conditions'**, '**Visits'**, '**Immunisations'**, '**Observations'** and '**Family/Social'** items or a combination of these items.

Below is an example of a query to list all patients who are recorded as having diabetes.

1. Select **Utilities > Search**
2. Select the area you would like to search by clicking on one of the setup search buttons. In this example, click on Conditions and type 'Diabetes' into the diagnosis field.
3. Click **Add** button and you will see that a 'condition' has appeared in the condition section at the bottom of the screen.
4. **Double click** on the required highlighted condition from the past history list to select it and select "OK".
5. This will return you to the original **Database Search** screen and you will see that there is additional text in the 'SQL query box'.



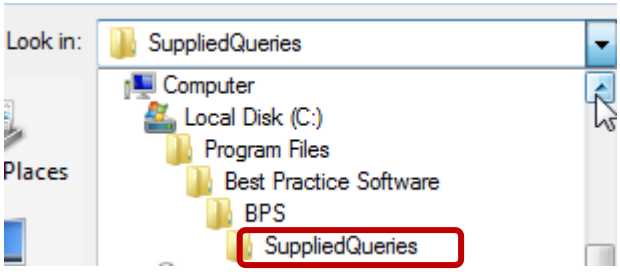
6. Click the Run Query button and the query will be executed and will display the list of patients who meet the criteria.



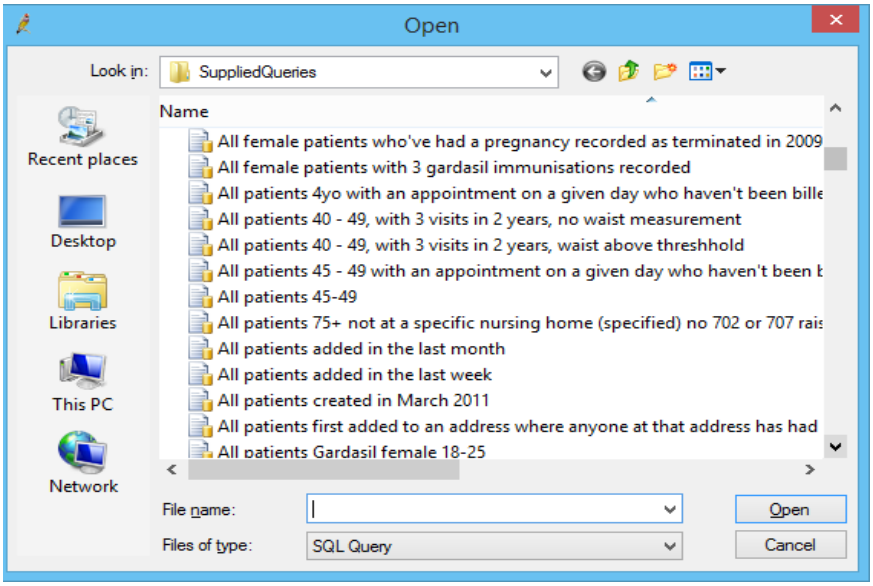
There are many other fields that we can run queries on.

TIP: In Bp Premier it is possible to search on either 'Past History' or 'Reason for Visit' by selecting the appropriate radio button. Searching 'Reason for Visit' can give you data that can be helpful for assessing common presentations.

Data Queries/Searches



Select 'Load Query' to see the variety of additional queries that are now available with Bp Premier. These have been specially written following requests from other practices. If at first they don't appear, follow this file path to tell your computer to find the 'Supplied Queries' folder. In future it will remember that's where they are stored.



Run advanced database searches:

1. Select **Utilities > Search**
2. Select **'Load Query'**
3. **Locate the query to be used and highlight to select**.
4. Select '**Open**'
5. Select '**Run Query**'

A list of patients who match the search criteria will display on the results screen.

TIP: You could create your own practice-specific queries, save them in the Supplied Queries folder and run the same queries on a regular basis using the 'Save Query' button.

Here are some IDEAS and SAMPLES OF QI Activities/PDSAs



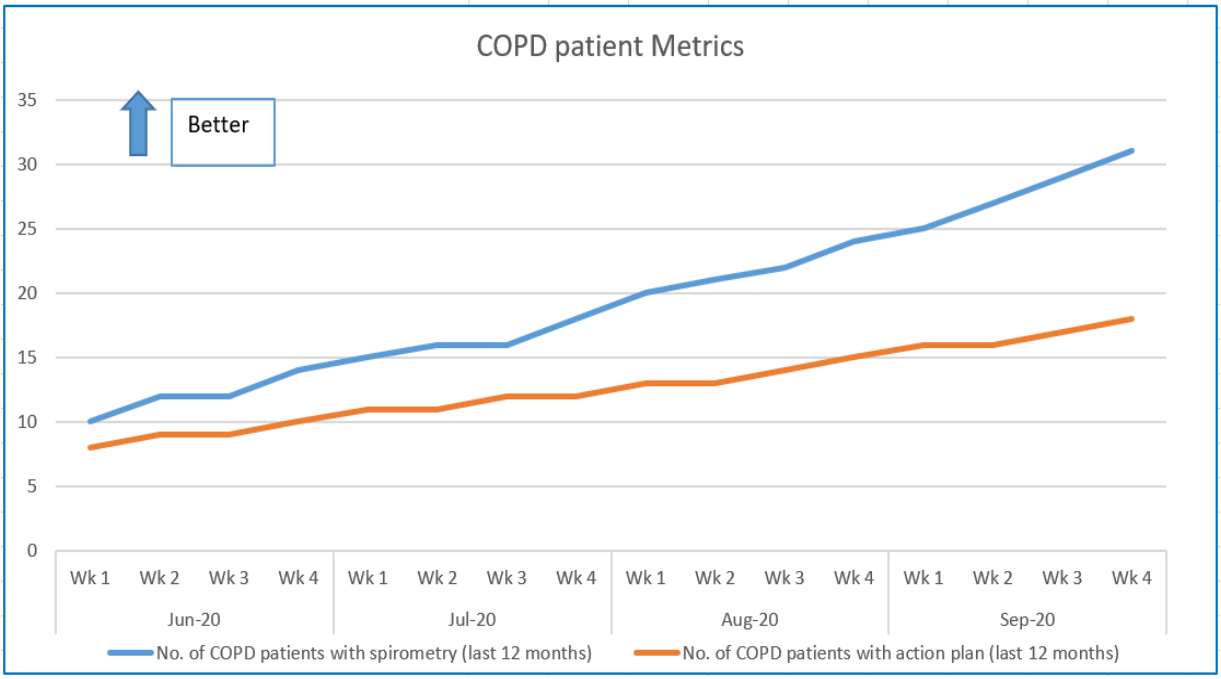
Sample 1 - COPD Quality Improvement Activity/PDSA

1. What is our goal?

Improve the ongoing management of patients with COPD through a patient centred, team-based approach.

2. How will we measure our progress?

1. Increase the number of patients with COPD who have an action plan by 25% by end of 2020.
2. Increase the number of patients with COPD with recorded spirometry results by 40% within 6 months.



Next steps:	Team members:
• Build a register of patients with COPD (look for indicated diagnosis). • Implement spirometry recording integration in clinical software. • Source a suitable COPD action plan template for clinical software. • Recall patients with COPD and no action plan / spirometry recorded for last 12 months	Data collection/reporting: Recall Management: Spirometry Integration: Templates:

Sample 2 - Data Quality – Recording allergies and adverse reactions

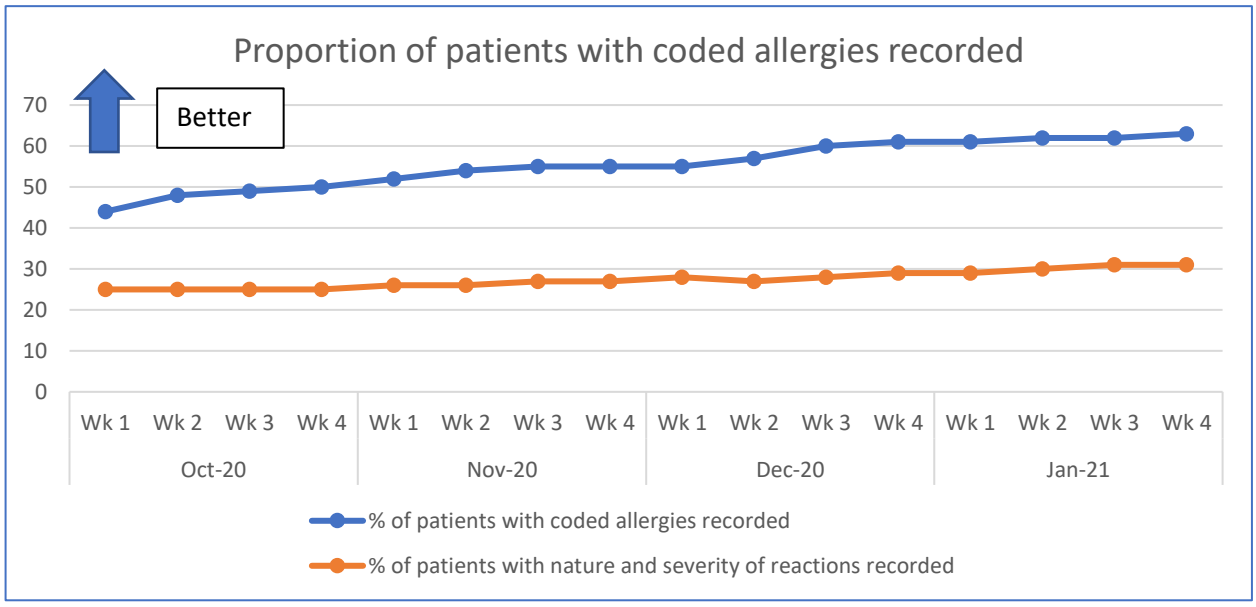
1. What is our goal?

Improve the recording of 'allergies and adverse reactions' in clinical software. Benefits:

- Improved safety for patients when prescribing medications (when coding is used and nature / severity of the reaction is included).
- Better compliance with RACGP accreditation standards (data quality).
- Improved comprehensibility of the patient record for other clinicians with whom the record is shared for ongoing treatment.
- Improved ability to search for patients with specific allergies, no known allergies and nothing recorded.

2. How will we measure progress?

1. Improve measure – proportion of patients with either coded 'allergy' or 'adverse reaction' data recorded or 'Nil known' checked will increase significantly in 3 months – date to be specified.
2. Quality measure – proportion of patients with 'nature' and 'severity' of reaction recorded will increase by 10% by DATE.



Ideas currently being trialled:

- Print a health summary for patients when they next present to check and update their allergy information.
- Provide training to clinical staff to record essential clinical data items for every consultation including the benefits of coding allergies.
- Print a list of all patients with No Allergies recorded and add an action to their record to flag when they next attend.
- Prepare a checklist of essential clinical data to be displayed in front of each clinician.

Team members –

Recording Metrics:

Determine baseline - current level of recording of coded allergies.

1. Consider tracking % of patients with no allergies recorded and Nil known not checked.
2. Track progress over time by measuring each month and tracking on a chart/graph.

Sample 3 – My Health Record – Uploading health summaries for vulnerable patients

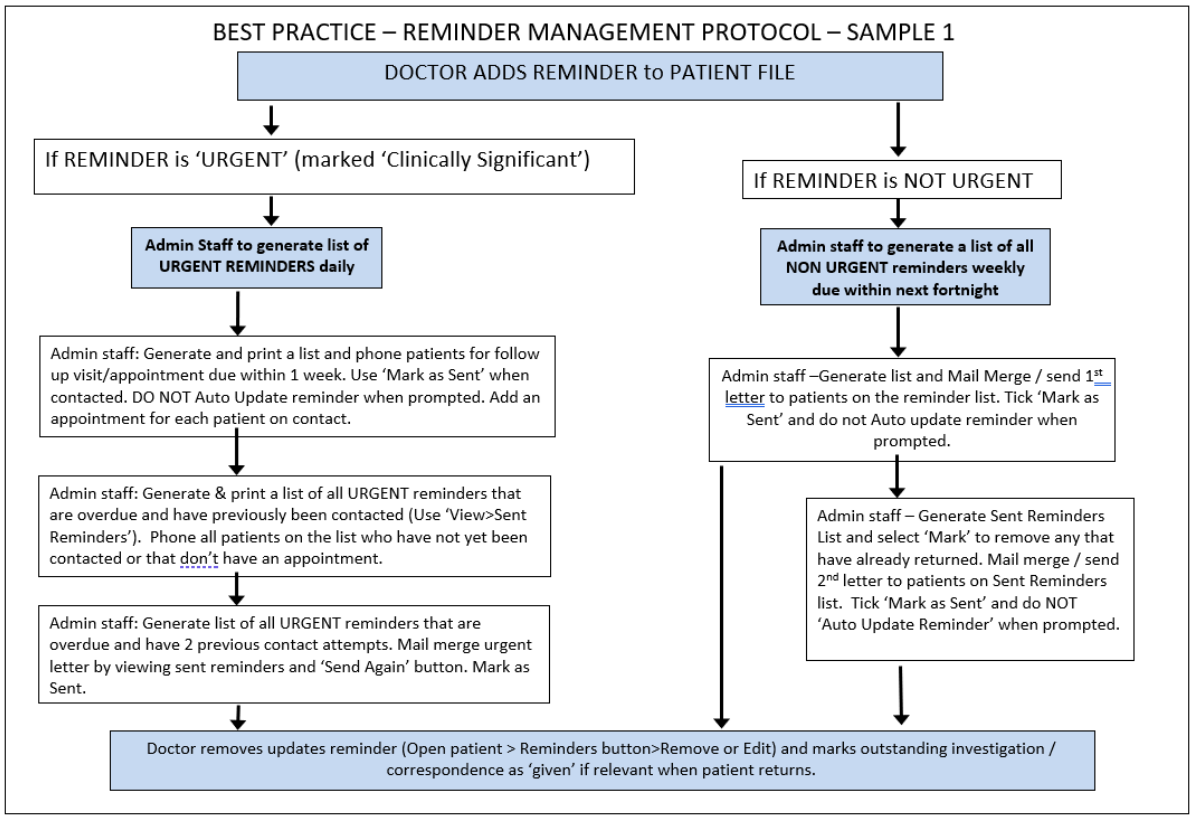
Step 1. The 3 Fundamental Questions

1. What are we trying to accomplish? **(By answering this question you will develop your goal for improvement)**
Improve the management of vulnerable patients through the use of digital health and in particular the use of My Health Record (as a method to share information) with a focus on vulnerable patients.
2. How will we know that a change is an improvement? **(By answering this question you will develop measures to track the achievement of your goal)**
The total number of Shared Health Summaries for 'vulnerable patients' uploaded to My health Record will increase by 10% each month for the next 6 months.
3. What changes can we make that can lead to an improvement? – list your ideas for change **(By answering this question you will develop the ideas you would like to test to achieve your goal)**
Idea 1 – Team meeting to define 'vulnerable' patients by agreeing criteria we will use to identify and flag patients in our software and to develop a plan of action. Idea 2 – Establish a register of 'vulnerable' patients Idea 3 – Review the register and check whether patients have registered for My Health Record and have a recent Shared Health Summary uploaded. Idea 4 – Retrain clinical staff on use of My Health Record Idea 5 - Book a telehealth consultation with GP and each vulnerable patient on the register Idea 6 – Upload a Shared Health Summary (as required) to ensure the most up-to-date information is available to other healthcare providers. Idea 7 – For patients that have opted out, ask if they would like to opt in and explain the benefits. Idea 8 – If GPMP in place, RN/AHW to follow up by telehealth to check on patients welfare periodically and upload new SHS as health summary information changes.

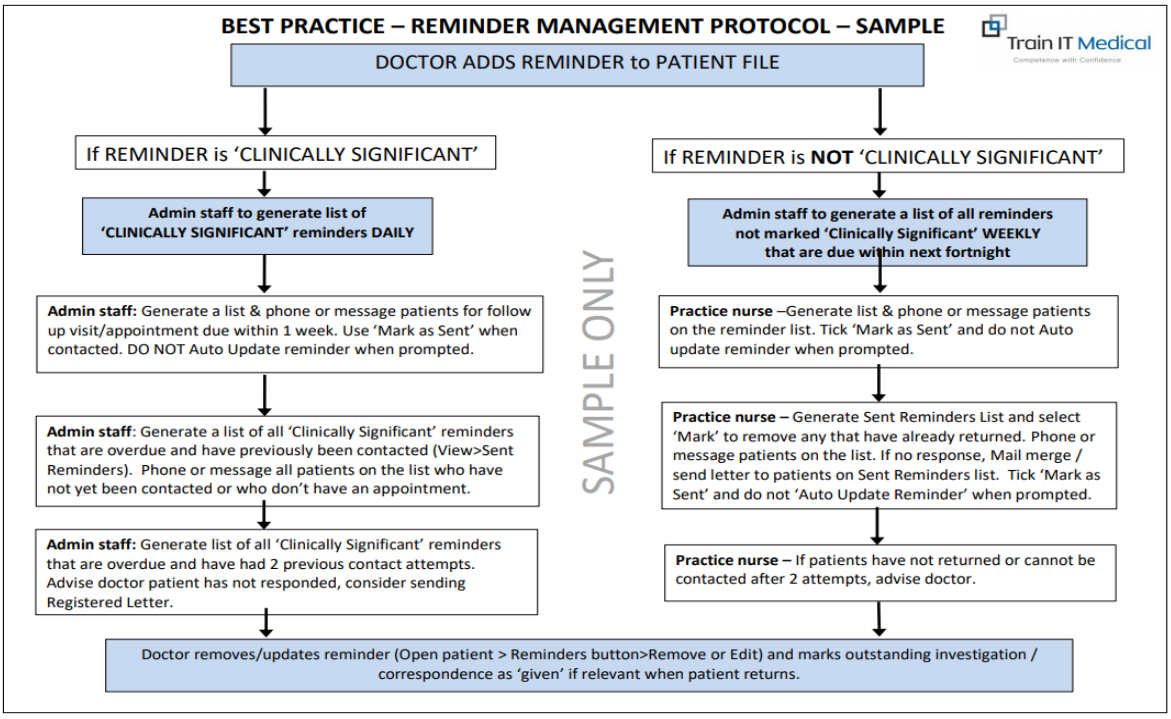
One Improvement idea I will share / trial

Appendix

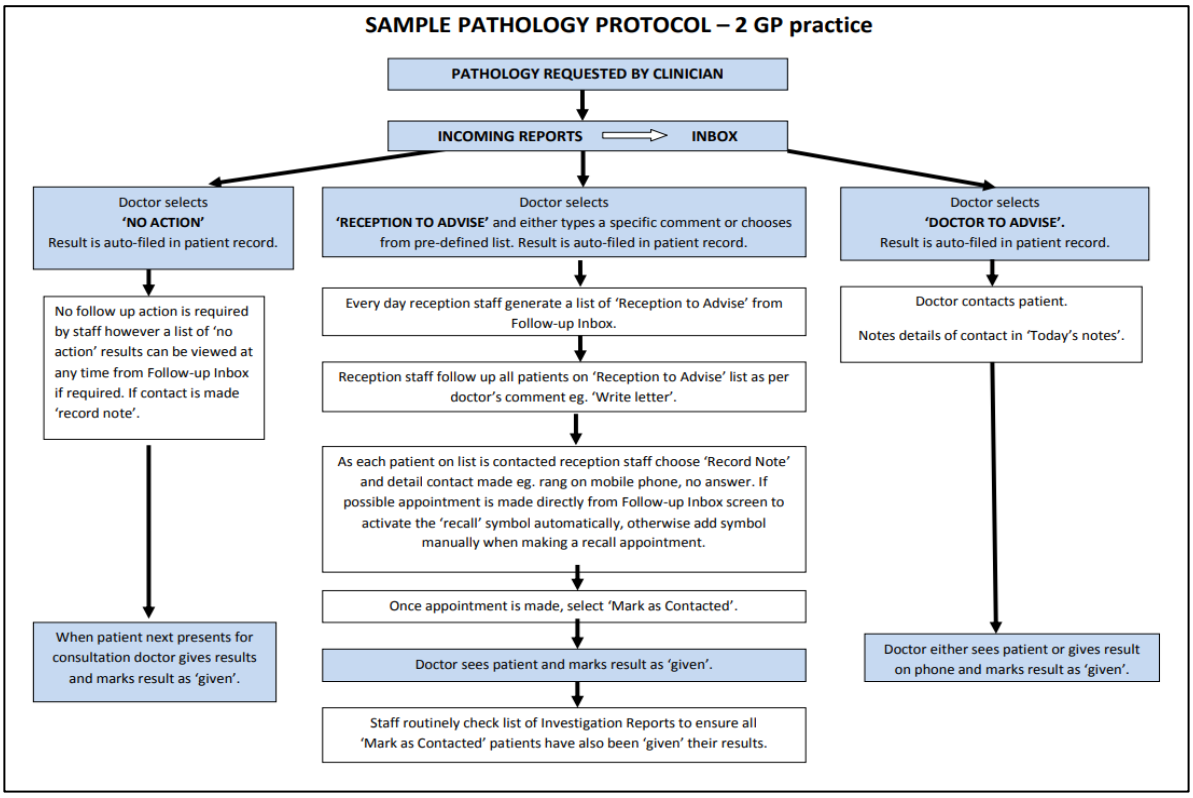
Sample 1 – Reminder Management Protocol



Sample 2 – Reminder Management Protocol



Sample 3 - Correspondence Management Protocol



Sample 4 – Correspondence Management

