The QAIHC Core Indicators

Overview of Development and Technical Details

Queensland Aboriginal and Islander Health Council

July 2014

Version 3

TABLE OF CONTENTS

1 Introduction **3**

1.1 Introduction *3*

1.2 Indicator Purpose *3*

1.3 Background *3*

1.4 Development Methodology *4*

1.5 Data collection, Reporting or Feedback *4*

2 Core Indicators **6**

2.1 Indicators *6*

2.2 Definition of terms *7*

2.3 Acronyms *8*

3 Technical Details **9**

4 Future indicator development and review **34**

4.1 Technical Details – Workforce Indicators *35*

4.2 Technical Details – STI Indicators *42*

Appendix 1 – References **49**

1 INTRODUCTION

1.1 Introduction

In August 2008 the Queensland Aboriginal and Islander Health Council (QAIHC) released a set of 25 core indicators for use by Aboriginal and Islander Community Controlled Health Services (AICCHSs) in Queensland – *the QIAHC Core Indicators*. Beginning in 2008 a system has been built to extract, use and report on these indicators at local, regional and state levels. Software has been developed with continued evolution to extract the necessary data from Medical Director, Communicare and Best Practice, the EMR's used in the majority of AICCHSs in Queensland. Services can monitor their data in real-time and QAIHC produces several reports annually including the Benchmarking and External reports. This journey has seen this set of indicators extended, some indicators revised and some dropped from the set.

Queensland (Qld) has a large Indigenous population of 146,000 Aboriginal and Torres Strait Islander persons. This represents 3.6% of the total Qld population and 28.3% of the national Aboriginal and Torres Strait Islander population. QAIHC supports 27 member AICCHSs across Queensland to deliver comprehensive, primary health care to their communities. These organisations receive a mix of funding from the Commonwealth and State governments and additionally bill Medicare, Australia's national health insurance scheme, for services delivered by their clinical care teams. The services have community elected boards, leading the delivery of multidisciplinary comprehensive primary health care.

This document provides the technical specifications and implementation notes for the revised set of indicators current in July 2014.

1.2 Indicator Purpose

The purpose of the *QAIHC core indicators* is to provide an overview of the performance of individual services and of the sector as a whole. The indicators address the following issues:

- Is the catchment population being reached?
- Are clients receiving the core services?
- Are these services being delivered properly?
- What is the prevalence of various risk factors within the client population?
- Does they service have the resources and staff to deliver the services and are they optimising capture of available funding? The *QAIHC core indicators* provide an overview of the quality of care and the health status of clinic patient populations. The indicator set includes measures of workload and access; health determinants; risk loads; prevention; chronic disease care; maternal and child health; and workforce

1.3 Background

The Centre for Clinical Research Excellence (CCRE) Health Information Project (2008) developed a comprehensive set of 86 health performance indicators for the Aboriginal and Islander community controlled primary health care sector. These indicators could be used for a variety of purposes, from supporting local service quality improvement initiatives to sector wide advocacy through demonstrating the effectiveness and efficiency of the sector. It was not the intention that this full set of indicators would be used at any one time; instead subsets of the indicators could be selected for use to meet

particular purposes. A subset of 25 indicators was designated as the QAIHC Core Indicators.

1.4 Development Methodology

The overall approach in the development of the original set was to draw on existing indicators. The rationale for this was twofold - to allow the potential for comparison with other organisations and to draw on the existing evidence base.

- A review of existing Australian and international indicator sets and frameworks was carried out to identify suitable indicators and to identify gaps that needed to be addressed in developing a comprehensive set of indicators.
- Indicators to address the identified gaps were developed by the project team. This produced an expanded set of potential indicators comprehensively covering the Queensland community controlled Primary Health Care sector.
- The expanded set of indicators was reviewed by the Health Information Advisory Group, an expert panel convened by the CCRE Health information Project. The Advisory Group modified the definitions of some indicators, added a small number of extra indicators and endorsed the set.

QAIHC has a small Data Management Unit, within its Preventative Health Unit, which has led the implementation of the health information strategy, manages the data and leads the attendant quality improvement program for the 23 services with medical clinics where 21 of these are AICCHS. The AICCHSs have been integrally involved in the work in both advisory, testing and participatory capacities and provide members to a continuing, advisory lead clinician (LCG) group. Data definitions were established in the CRE work. The indicators are reviewed annually by the LCG, which is multi-disciplinary, including CEOs, Aboriginal Health Workers, nurses and general practitioners.

The main report documenting the full indicator set maps all of the indicators against their sources and provides background discussion on the selection of the indicators. This document: *Health Information Project, Queensland Community Control Health Services, Performance Indicators, QAIHC, 2008* is available from the QAIHC website.

1.5 Data collection, Reporting or Feedback

Participating services send aggregated whole of service data on the first Wednesday of every month for the:

- *QAIHC core indicators*
- *APCC measures*

to the qiConnect data repository, managed by the Improvement Foundation, Adelaide. The data extraction is automated, drawn from the service clinical IT systems using the PEN CAT tool. The data is fed back to services through the Australian Primary Care Collaborative (APCC) web portal, via the QAIHC 'pages' and a copy is left on the services' servers. A copy of the data for all participating services is downloaded from the IF warehouse to a QAIHC data repository monthly also.

The monthly data collection thus represents a 'live' whole of service patient snapshot. That is the data is extracted for all patients on the EMR and the indicators are reported

for 3 user groups: all patients, recent patients and regular patients stratified by ethnicity. The patient group varies from month to month, as does the number of services submitting data. The data is derived from daily delivery of clinical care – there are no patient sub groups defined by having a completed health check for example, inclusion is defined by attendance for care at the clinic.

2 CORE INDICATORS

2.1 Indicators

Table 1 below shows the current 23 core indicators, in the four domains of:

- Access and workload
- Health determinants, risk and prevention
- Chronic disease care
- Maternal and child health

Table 1 QAIHC Core Indicators July 2014

Access and Workload		
AW_01	Numbers of clients seen: Total, adults, children	1
AW_02	Client contacts by staff categories	2
Health determinants, risk and prevention		
HD_01	Recording of smoking status *and* smoking prevalence	3
HD_02	Recording of alcohol consumption *and* prevalence of 'at risk' alcohol consumption	4
HD_03	Recording of weight circumference *and* prevalence of overweight and obesity by waist circumference	5
HD_04	Recording of height and weight *and* prevalence of overweight and obesity by BMI	6
HD_05	Recording of physical activity and level of physical activity	7
HD_06	Indigenous health assessments: adults 15-54 years *and* 55 years and over	8
HD_07	Indigenous health assessments: children 0-<=5 years *and* 6 to 14 years	9
Chronic Disease Care		
CD_01	Proportion of clients with Type II diabetes compared to expected proportion of Indigenous clients with Type II diabetes	10
CD_02	Type II diabetic clients on GP management plan	11
CD_03	Type II diabetic clients glycaemic control: HbA1c testing *and* values	12
CD_04	CHD clients on GP management plan	13
CD_05	Hypertension screening *and* proportion of clients with hypertension compared to expected proportion of Indigenous clients with hypertension	14
CD_06	Clients with hypertension on ACE or Angiotension II inhibitor medication	15
CD_07	Risk of renal disease: eGFR *and* ACR testing *and* values	16
Maternal and child health		
MC_01	Indigenous women who gave birth *and* number who attended antenatal care at the service	17
MC_02	Timing of first antenatal visit for Indigenous women	18
MC_03	Adequate antenatal care for Indigenous women	19
MC_04	Preterm births to Indigenous women	20
MC_05	Low and high birth weight babies born to Indigenous women	21
MC_06	Recording of weight and height *and* under-weight and under-height children aged less than or equal to 5 years	22
MC_07	Recording of weight and height *and* under-weight and over-weight children aged 6 to 14 years	23

2.2 Definition of terms

Key terms used in the Technical Details are defined below. Client-based indicators may be calculated for the following groups of clients:

Term	Definition
Recent:	Recent attenders are patients that have had a visit in the last 6 months
Recent Active:	A patient who has had 3 visits or more in the last 2 years including at least 1 visit in the 6 months prior to the date of data extraction and submission.
All Patients:	All Patients is restricted to patients that have had a visit in the last 2 years. *From June 2012 MD and BP users are able to extract archived and deceased patients that have had a visit in the last 2 years. If the practice has elected to include archived patients then these will be included in the above populations provided they still meet the visit criteria. Hence the patient totals will vary depending on your preference selection.
Adult:	Unless otherwise stated, a person 15 years or older
Child:	Unless otherwise stated, a person 0 -14 years
Indigenous:	Aboriginal and/or Torres Strait Islander patients.
Visit:	A visit is any patient contact that has been recorded in the progress notes.
QAIHC Average:	For each indicator, the QAIHC average is the sum of the numerators for all services divided by the sum of the denominators for all services. For example for smoking, the sum of the numerators (number of smokers) for all services is 5,818; the sum of the denominators (the population with smoking status recorded) for all services is 11,800. Therefore, the QAIHC average is 5,818 divided by 11,800 which is 0.49 or 49%.
QAIHC Standard:	The performance standard proposed by QAIHC for each of a range of clinical activities.
QAIHC Target:	Target QAIHC suggests to be worked towards by all services.
Population Prevalence:	Measures the amount of a condition in a population at a given point in time.
Screening Gap:	This refers to the patients who have been in seen by the clinical team and have not been screened for the indicator. For example for smoking, the screening gap is the proportion of patients who were not asked or did not have their information on tobacco use recorded. This should trend to 0% as all patients should be asked about risk factors and have their information updated regularly.
Treatment Gap:	This refers to patients who should be on a particular treatment but are not. This applies to the hypertension indicator only which assesses how many people identified as having hypertension and are on an ACE or AR2 medication. This should trend to 0% as nearly all patients should be on the correct medication. Treatment Gaps are also reported for GPMPs.

Term	Definition
SEIFA:	The Socio-Economic Index For Areas 2006 (SEIFA) is derived from the 2011 Census of Population and Housing, and provides a range of measures to summarise aspects of the level of socio-economic wellbeing in an area. These measures include: advantage / disadvantage; economic resource; and education / occupation.
BMI:	Body Mass Index is calculated from Weight (kg) / [Height (m) ^{2}]

2.3 Acronyms

ACR: Albumin to Creatinine Ratio
AGPAL: Australian General Practice Accreditation Limited
AICCHS: Aboriginal and Islander Community Controlled Health Service
APCC: Australian Primary Care Collaborative
BMI: Body Mass Index
BP: Blood Pressure
BSL: Blood Sugar Level
CAT tool: PEN Clinical Audit Tool
CQI: Continuous Quality Improvement
eGFR: Glomerular Filtration Rate
EMR: Electronic Medical Record
GPMP: GP Management Plan
HbA1c: Blood glucose concentration. Also known as A1c, glycohaemoglobin and glycated haemoglobin.
IF: Improvement Foundation
MBS: Medical Benefits Schedule
MD: Medical Director
Pracsoft: Practice Management system for billing and appointments
QAIHC: Queensland Aboriginal and Islander Health Council
QIC: Quality Improvement Council
qiConnect: Quality improvement web portal by the Improvement Foundation
RACGP: Royal Australian College of General Practitioners
SNAP: Smoking, nutrition and physical activity
STI: Sexually transmitted infection

3 TECHNICAL DETAILS

Domain: Access and Workload	
AW_01	
Indicator	**Number of clients seen**
Rationale	A measure of access to the health service by the local population and of service size
Description	Numbers in client groups[#] seen in the 6 months prior to the reporting date.
Calculation:	Numerators: Numbers in client groups[#] Denominators: n/a Disaggregation: Indigenous and non-Indigenous Adults and children
Data source	Numerators from EMR
Implementation notes	[#] 'All patients', 'recent attenders', 'recent active attenders'.
References	1

Domain: Access and Workload	
AW_02	
Indicator	**Client contacts by staff categories**
Rationale	Measure of workload and staffing
Description	Numbers and proportions of contacts with client groups[#] in the 6 months prior to the reporting date by staff category: • GP • Dietician • Midwife • Podiatrist • Psychologist • Registered nurse • Aboriginal Health Worker • Medical Student
Calculation	Numerators: Numbers of contacts in each staff category for each client group[#] Denominators: Total numbers of contacts for each client group[#] Disaggregation: Indigenous and non-Indigenous
Data source	EMR
Implementation notes	[#] 'All patients', 'recent attenders', 'recent active attenders'
References	None

Domain: Health determinants, risk and prevention	
HD_01	
Indicator	**Recording of smoking status *and* smoking prevalence**
Rationale	Tobacco use is the leading contributor to the burden of disease in the Indigenous community, accounting for 12.1% of the total burden [Vos 2007]. *Close the Gap* nominates a target of an annual reduction of 2% in the prevalence of tobacco use until 2020 [HREOC 2008]. Smoking status is included in an adult health assessment.
Description	a) Numbers and proportions in client groups# with smoking status recorded* b) Numbers and proportions in client groups# with smoking status recorded who were recorded as: - Smoker - Non-smoker - Ex-smoker
Calculation	a) Numerators: Numbers in client groups# with smoking status recorded/not recorded Denominators: All adults in client groups# Disaggregation: Indigenous and non-Indigenous b) Numerators: Numbers in client groups# with smoking status recorded who were recorded as: - Smoker - Non-smoker - Ex-smoker Denominators: All adults in client groups# with smoking status recorded Disaggregation: Indigenous and non-Indigenous
Data source	EMR
Implementation notes	# 'All patients', 'recent attenders', 'recent active attenders' * Smoking status is currently not dated in the EMR so recording period is not applicable; measure relates to the reporting date.
References	2, 3

Domain: Health determinants, risk and prevention	
HD_02	
Indicator	**Recording of alcohol consumption *and* prevalence of 'at risk' alcohol consumption**
Rationale	Alcohol consumption is the leading risk factor for injury burden in Indigenous Australians, contributing significantly also to mental health disorders [Vos 2007]. Over the period 2000-04 in Queensland, Western Australia, South Australia and the Northern Territory, Aboriginal and Torres Strait Islander males died from alcohol related causes at 7 times the rate of non-Indigenous males. Females died from causes related to alcohol use at 10 times the rate of non-Indigenous females [AIHW 2006]. Alcohol consumption is included in an adult health assessment.
Description	a) Numbers and proportions of adults in client groups# with alcohol consumption recorded* b) Numbers and proportions of adults in client groups# with alcohol consumption recorded who were recorded as: - Non drinker - Low risk - At risk
Calculation	a) <u>Numerators</u>: Numbers of adults in client groups# with alcohol consumption recorded/not recorded^ <u>Denominators</u>: All adults in client groups# <u>Disaggregation</u>: Indigenous and non-Indigenous b) <u>Numerators</u>: Numbers of adults in client groups# with alcohol consumption recorded who were recorded as: - Non drinker - Low risk - At risk <u>Denominators</u>: All adults in client groups# with alcohol consumption recorded <u>Disaggregation</u>: Indigenous and non-Indigenous ***Definition*** *At risk* – either drinks more than 2 standard drinks on a regular occasion or drinks 6 or more standard drinks on any occasion *Low risk* - a drinker who does not meet the risk criteria This is slightly less conservative than the 2009 NHMRC Guidelines which identify: *At risk* – either drinks more than 2 standard drinks on any day (Guideline 1) or drinks more than 4 standard drinks on any one occasion (Guideline 2) *Low risk* - a drinker who is not *at risk.*
Data source	EMR
Implementation notes	# 'All patients', 'recent attenders', 'recent active attenders' * Alcohol status is currently not dated in the EMR so recording period is not applicable; measure relates to the reporting date. ^ This excludes services using Communicare who do not have the capability to submit alcohol related data.
References	3, 4, 5

Domain: Health determinants, risk and prevention	
HD_03	
Indicator	**Recording of waist circumference *and* prevalence of obesity by waist circumference**
Rationale	Obesity is the second highest risk factor contributing to the burden of chronic disease in Indigenous Australians, accounting for 11.4 % of risk [Vos 2007]. Screening and brief intervention are key prevention activities that have been identified in the National Chronic Disease Strategy to improve nutrition, physical activity and levels of obesity that can be undertaken in adequately resourced AICCHSs.
Descriptions	a) Numbers and proportions of adults in client groups# whose waist circumference was recorded in the past 12 months b) Numbers and proportions of adults in client groups# whose waist circumference was recorded in the past 12 months whose most recent waist circumference measurement was recorded as: Males: - 94cm – 102cm - > 102 cm Females: - 80cm – 88cm - > 88cm
Calculation	a) Numerators: Numbers of adults in client groups# whose waist circumference was recorded/not recorded in the past 12 months Denominators: All adults in client groups# Disaggregation: Indigenous and non-Indigenous Males and females b) Numerators: Numbers of adults in client groups# whose waist circumference was recorded in the past 12 months whose most recent waist circumference measurement was recorded as: Males: - 94cm – 102cm - > 102 cm Females: - 80cm – 88cm - > 88cm Denominators: All adults in client groups# whose waist circumference was recorded in the past 12 months Disaggregation: Indigenous and non-Indigenous Males and females ***Definition*** For most people, a waist measurement higher than the following is associated with increased risk of chronic disease. *Increased risk:* Men: more than 94 centimetres Women: more than 80 centimetres *Greatly increased risk:* Men: more than 102 centimetres Women: more than 88 centimetres
Data source	EMR
Implementation notes	# 'All patients', 'recent attenders', 'recent active attenders' Waist measurement is considered a better indicator of risk than BMI, but BMI is more likely to be recorded.
References	3, 6

Domain: Health determinants, risk and prevention	
HD_04	
Indicator	**Recording of weight and height *and* prevalence of obesity by BMI**
Rationale	Obesity is the second highest risk factor contributing to the burden of chronic disease in Indigenous Australians, accounting for 11.4 % or risk [Vos 2007]. Screening and brief intervention are key prevention activities that have been identified in the National Chronic Disease Strategy to improve nutrition, physical activity and levels of obesity that can be undertaken in adequately resourced AICCHSs.
Description	a) Numbers and proportions of adults in client groups# whose weight and height were recorded in the past 12 months b) Numbers and proportions of adults in client groups# whose weight and height were recorded in the past 12 months whose most recent BMI was: - Less than 20 - Equal to or greater than 20 to less than or equal to 25 - Greater than 25 to less than or equal to 30 - Greater than 30
Calculation	a) <u>Numerators</u>: Numbers of adults in client groups# whose weight and height were recorded/not recorded in the past 12 months <u>Denominators</u>: All adults in client groups# <u>Disaggregation</u>: Indigenous and non-Indigenous Males and females b) <u>Numerators</u>: Numbers adults in client groups# whose weight and height were recorded in the past 12 months whose most recent BMI was: - <20 - =>20 - <=25 - > 25 - <=30 - >30 <u>Denominators</u>: All adults in client groups# whose weight and height were recorded in the past 12 months <u>Disaggregation</u>: Indigenous and non-Indigenous Males and females ***Definitions*** <20 – underweight =>20 - <=25 – normal weight > 25 - <=30 - overweight >30 - obese
Implementation notes	# 'All patients', 'recent attenders' 'recent active attenders' Waist measurement is considered a better indicator of risk than BMI but BMI is more likely to be recorded.
References	3

Domain: Health determinants, risk, prevention	
HD_05	
Indicator	**Recording of physical activity *and* level of physical activity**
Rationale	Physical inactivity is the third most important risk factor (accounting for 8.4% of total risk) associated with the burden of chronic disease the Aboriginal and Torres Strait Islander population [Vos 2007]. Indigenous Australians in urban areas were 1.5 times as likely as other Australians to report their level of physical activity as sedentary in 2004-05 [AHMAC 2006]. Increasing levels of physical activity through with screening and brief interventions is a key component of the National Chronic Disease Strategy [NCDS 2006].
Description	a) Numbers and proportions of adults in client groups# whose physical activity level was recorded in the past 2 years b) Numbers and proportions of adults in client groups# whose physical activity level was recorded in the past 2 years whose most recent physical activity level was recorded as: - meeting physical activity guideline - not meeting physical activity guideline
Calculation	a) Numerators: Numbers of adults in client groups# whose physical activity level was recorded/not recorded in the past 2 years Denominators: All adults in client groups# Disaggregation: Indigenous and non-Indigenous Males and females b) Numerators: Numbers of adults in client groups# whose physical activity level was recorded in the past 2 years whose most recent physical activity level was recorded as: - meeting physical activity guideline - not meeting physical activity guideline Denominator: All adults in client groups# whose physical activity level was recorded in the past 2 years Disaggregation: Indigenous and non-Indigenous Males and females
Implementation notes	# 'All patients', 'recent attenders', 'recent active attenders' Physical activity level is assessed in the adult health assessment.
References	3, 7, 8

Domain: Health determinants, risk and prevention	
HD_06	
Indicator	**Indigenous health assessments: adults 15-54 years *and* 55 years and over**
Rationale	Adult Health Checks facilitate the prevention, early detection and intervention for chronic diseases that cause considerable morbidity and early mortality. *Close the Gap* nominates a target of 80% of all eligible Indigenous adults having one health check every 2 years [HREOC 2008]. This is a sensitive indicator of the service's delivery of preventative primary health care to its adult clients.
Description	Numbers and proportions of Indigenous adults in client groups# aged a) 15 to 54 years and b) equal to or greater than 55 years who have had an Indigenous health assessment in the past 2 years*.
Calculation	Numerators: Numbers of Indigenous adults in client groups# aged a) 15-54 years and b) => 55 years who have had an Indigenous health assessment in the past 2 years* Denominators: All Indigenous adult in client groups# aged a) 15-54 years and b) => 55 years Disaggregation: None
Implementation notes	# 'All patients', 'recent attenders', 'recent active attenders' * The health assessment is an annual service for both age groups. Post-May 2010 Item number 715; pre-May 2010 MBS Item numbers 704, 706, 710
References	2, 9

Domain: Health determinants, risk, prevention	
HD_07	
Indicator	**Indigenous health assessments: children <=5years *and* 6-14 years**
Rationale	This is a sensitive indicator of the service's delivery of preventative primary health care for its child clients. Indigenous health assessments for children include review of growth, immunisation and nutritional status.
Description	Numbers and proportions of Indigenous children in client groups# aged a) less than or equal to 5years and b) 6 to 14 years who have had an Indigenous child health assessment in the past 2 years.#
Calculation	Numerators: Numbers of Indigenous children in client groups# aged a) <=5years and b) 6-14 years who have had an Indigenous health assessment in the past 2 years* Denominators: All Indigenous children in client groups# aged a) <=5years and b) 6-14 years Disaggregation: None
Implementation notes	# 'All patients', 'recent attenders', 'recent active attenders' * The health assessment is an annual service for both age groups. Post-May 2010 Item number 715; pre-May 2010 MBS Item numbers 704, 706, 710
References	9

Domain: Chronic Disease Care	
CD_01	
Indicator	**Proportion of clients with Type II diabetes compared to expected proportion of Indigenous clients with Type II diabetes**
Rationale	Diabetes is the most common chronic disease in the Indigenous community, with a prevalence of between 15-30%. It causes significant morbidity and mortality. Diabetes and cardiovascular disease are the main contributors to the health gaps between Indigenous and non-Indigenous Australians over the age of 35. This indicator provides a measure of access to the service by its client population and the completeness of the service's screening activities.
Description	a) Numbers and proportions of adults in client groups# diagnosed with Type II diabetes* b) Expected proportions of Indigenous clients with Type II diabetes
Calculation	a) Numerators: Numbers of adults in client groups# diagnosed with Type II diabetes* Denominators: All adults in client groups# Disaggregation: Indigenous and non-Indigenous b) Expected proportions of Indigenous clients with Type II diabetes (15%) Disaggregation None
Data source	a) EMR b) Lead Clinician Group consensus based on best available evidence
Implementation Notes	# 'All patients', 'recent attenders', 'recent active attenders' * Diabetes TypeII ICPC Codes: T90 002 diabetes mellitus T90 005 non insulin dependant diabetes T90 007 adult onset diabetes T90 009 type 2 diabetes T90 016 type 2 diabetes treated with insulin
References	3

Domain: Chronic Disease Care	
CD_02	
Indicator	**Diabetic clients on GP Management Plan**
Rationale	Diabetes is responsible for a significant burden of disease for Aboriginal and Torres Strait Islander people. Good control in the community setting prevents hospitalisations and complications such as renal disease. GP Management Plans provide a structured best practice framework to guide long-term care and an increase in usage demonstrates improved health service delivery. *Close the Gap* nominates a target of 100% of clients with diabetes having regular review of the cycle of care [HREOC 2008] which could be expected to be delivered via a GP Management Plan 721.
Description	Numbers and proportions of adults in client groups[#] diagnosed with Type II diabetes* who had a GP Management Plan[@] done in the past 12 months
Calculation	Numerators : Numbers of adults in client groups[#] diagnosed with Type II diabetes* who had a GP Management Plan[@] done in the past 12 months Denominators: All adult in client groups[#] diagnosed with Type II diabetes* Disaggregation: Indigenous and non-Indigenous
Data source	EMR
Implementation notes	[#] 'All patients', 'recent attenders', 'recent active attenders' * Diabetes TypeII ICPC Codes T90 002 diabetes mellitus T90 005 non insulin dependant diabetes T90 007 adult onset diabetes T90 009 type 2 diabetes T90 016 type 2 diabetes treated with insulin [@] MBS item 721
References	2

Domain: Chronic Disease Care	
CD_03	
Indicator	**Diabetic clients glycaemic control: HbA1c testing *and* values**
Rationale	Glycosylated haemoglobin (HbA1c) is an index of average blood glucose level for the previous 2 to 3 months and is used to monitor blood sugar control in diabetic people. Although not as sensitive as OGTT in the diagnosis of diabetes, HbA1c is a practical marker of diabetes risk in population-based surveys. It appears to be a marker of the increased risk of developing atherosclerosis, myocardial infarction, strokes, cataracts and loss of the elasticity of arteries, joints and lungs. The US Diabetes Control and Complications Trial and the UK Prospective Diabetes Study have established that the risk of diabetic complications is strongly associated with previous hyperglycaemia and that any reduction in HbA1c is likely to reduce the risk of complications.Glycaemic control is related to the risk of the development of macro- and microvascular complications. *Close the gap* nominates a target of 70% of known diabetics having an HbA1C of < 8% [HREOC 2008].
Description	a) Numbers and proportions of adults in client groups# diagnosed with Type II diabetes* whose HbA1c was recorded in the past 12 months b) Numbers and proportions of adults in client groups# diagnosed with Type II diabetes* whose HbA1c was recorded in the past 12 months whose most recent HbA1c level was recorded as: - less than or equal to 7% - greater than 7% to less than or equal to 10% - greater than 10%
Calculation	a) Numerators: Numbers of adults in client groups# diagnosed with Type II diabetes* whose HbA1c was recorded/not recorded in the past 12 months Denominators: All adults in client groups# diagnosed with Type II diabetes* Disaggregation: Indigenous and non-Indigenous b) Numerators: Numbers of adults in client groups# diagnosed with Type II diabetes* whose HbA1c was recorded in the past 12 months whose most recent HbA1c level was recorded as: - <=7% - >7% - <=10% - > 10% Denominators: All adults in client groups# diagnosed with Type II diabetes* whose HbA1c was recorded in the past 12 months Disaggregation: Indigenous and non-Indigenous ***Definitions*** HbA1c less than or equal to 7.0% - good glycaemic control; HbA1c greater than 7.0% to less than or equal to 10.0%- impaired glycaemic control; HbA1c greater than 10.0% - poor glycaemic control
Data source	EMR
Implementation Notes	# 'All patients', 'recent attenders', 'recent active attenders' * Diabetes TypeII ICPC Codes: T90 002 diabetes mellitus T90 005 non insulin dependant diabetes T90 007 adult onset diabetes T90 009 type 2 diabetes T90 016 type 2 diabetes treated with insulin
References	2

Domain: Chronic Disease Care	
CD_04	
Indicator	**Coronary heart disease clients on GP Management Plan**
Rationale	Coronary heart disease (CHD) is the biggest contributor to the burden of chronic disease in the Indigenous community, accounting for 12%. Compared with other Australians, Aboriginal and Torres Strait Islander peoples have 3 times the rate of major coronary events such as heart attack and more than twice the rate of in hospital death [Mathur 2006]. GP Management Plans provide a structured best practice framework to guide long-term care and an increase in usage demonstrates improved health service delivery. *Close the Gap* nominates a target of 100% of clients with CHD having regular review of cycle of care activities for CHD [HREOC 2008], which could be expected to be delivered via a GP Management Plan 721.
Description	Numbers and proportions of adults in client groups# diagnosed with Coronary Heart Disease* who had a GP Management Plan@ done in the past 12 months
Calculation	Numerators: Numbers of adults in client groups# diagnosed with Coronary Heart Disease* who had a GP Management Plan@ done in the past 12 months Denominators: All adults in client groups# diagnosed with Coronary Heart Disease* Disaggregation: Indigenous and non-Indigenous
Data source	EMR
Implementation notes	# 'All patients', 'recent attenders', 'recent active attenders' * Coronary Heart Disease ICPC Codes: K41 005 Angiography; coronary K53 003 Angioplasty; artery; coronary K53 009 Stent(s); coronary K54 007 Graft; coronary Artery Bypass K74 001 Angina Pectoris K74 002 Pain; angina K74 003 Spasm; artery; coronary K74 004 Angina; unstable K74 006 Insufficiency; coronary K74 007 IHD with Angina K75 002 Infarction; myocardial; acute K75 004 Occlusion; coronary K75 013 Infarction; myocardial K75 014 Heart Attack K76 003 Coronary Artery Disease K76 005 Disease; atherosclerotic; heart K76 011 Disease; ischaem Heart; subacut K76 013 Coronary Heart Disease K76 014 Disease; ischaemic Heart K76 015 Disease; ischaem Heart; chronic K76 018 IHD Without Angina K84 009 Disease; heart @ MBS Item 721
References	2, 10

Domain: Chronic Disease Care	
CD_05	
Indicator	**Hypertension screening *and* proportion of clients with hypertension compared to expected proportion of Indigenous clients with hypertension**
Rationale	High blood pressure is a major risk factor for a range of cardiovascular diseases. The risk of disease increases as the level of blood pressure increases. Compared with other Australians, Aboriginal and Torres Strait Islander peoples have a similar attendance rate for hypertension and cardiac check-ups but much higher rates of ischaemic heart disease and heart failure [AHMAC 2006]. Screening frequency is based on the recommendations in *National Guide to Preventative Health Assessment* [NACCHO 2005].
Description	a) Numbers and proportions of adults in client groups# whose blood pressure was recorded in the past 12 months. b) Numbers and proportions of adults in client groups# (i) diagnosed with hypertension compared to (ii) expected proportion of Indigenous clients with hypertension. c) Numbers and proportions of adults in client groups# diagnosed with hypertension whose blood pressure was recorded in the past 6 months.
Calculation	a) Numerators: Numbers of adults in client groups# whose blood pressure was recorded in the past 12 months Denominators: All adults in client groups# Disaggregation: Indigenous and non-Indigenous b(i) Numerators: Numbers of adults in client groups# diagnosed with hypertension* Denominators: All adults in client groups# Disaggregation: Indigenous and non-Indigenous b(ii) Expected proportion of Indigenous clients with hypertension (10%) Disaggregation: None c) Numerators: Numbers of adults in client groups# diagnosed with hypertension whose blood pressure was recorded in the past 6 months Denominators: All adults in client groups# diagnosed with hypertension Disaggregation: Indigenous and non-Indigenous
Data source	EMR except for b(ii) – Lead Clinician Group consensus based on best available evidence
Implementation notes	# 'All patients', 'recent attenders', 'recent active attenders' * Hypertension ICPC Codes: K85 001 Elevated Blood Pressure K85 004 High Blood Pressure K85 007 Raised Blood Pressure K86 001 Hypertension; essential K86 004 Hypertension; uncomplicated K86 005 Hypertension K85 008 Hypertension; labile K87 002 Hypertension; renal disease K87 001 Hypertension; heart disease

	K87 003 Hypertension; nephropathy K87 004 Hypertension; malignant K87 005 Hypertension; LV hypertrophy K87 006 Hypertension; cardiorenal K87 007 Hypertensive encephalopathy K87 010 Hypertension; complicated K87 011 Hypertension; secondary
References	11, 12

Domain: Chronic Disease Care	
CD_06	
Indicator	**Clients with hypertension on best practice medication**
Rationale	Close the Gap recommends improving access and receipt of medications for management of elevated cardiac risk among Aboriginal people [HREOC 2008].
Description	Numbers and proportions of clients diagnosed with hypertension currently prescribed an ACE or A2 medication
Calculation	Numerators: Numbers of adults in client groups[#] diagnosed with hypertension* currently prescribed an ACE or Angiotensin II inhibitor medication[@] Denominators: All adults in client groups[#] diagnosed with hypertension Disaggregation: Indigenous and non-Indigenous
Data source	EMR
Implementation notes	[#] 'All patients', 'recent attenders', 'recent active attenders' * Hypertension ICPC Codes: K85 001 Elevated Blood Pressure K85 004 High Blood Pressure K85 007 Raised Blood Pressure K86 001 Hypertension; essential K86 004 Hypertension; uncomplicated K86 005 Hypertension K85 008 Hypertension; labile K87 002 Hypertension; renal disease K87 001 Hypertension; heart disease K87 003 Hypertension; nephropathy K87 004 Hypertension; malignant K87 005 Hypertension; LV hypertrophy K87 006 Hypertension; cardiorenal K87 007 Hypertensive encephalopathy K87 010 Hypertension; complicated K87 011 Hypertension; secondary These data are extracted from the current medications or prescription summary in the EMR.
References	2

Domain: Chronic Disease Care	
CD_07	
Indicator	**Risk of renal disease: eGFR *and* ACR testing *and* values**
Rationale	Aboriginal and Torres Strait Islander people suffer from renal disease at much higher rates than other Australians and it has reached epidemic proportions in some regions [Hoy et al 2005]. Renal disease is a complication of diabetes, hypertension and streptococcal infections and often goes unrecognized. It is a very serious condition that can lead to renal failure and dependency on dialysis. The eGFR test is used to screen for and detect early kidney damage and to monitor kidney status. The higher the filtration rate, the better the kidneys are working. The test detects kidney disease in its early stages more reliably than the creatinine test alone. ACR is the albumin:creatinine ratio. It is a useful measure of renal function in diabetic renal disease. Adult clients should be tested using both eGFR and ACR every 6 months. CKD guidelines, Kidney Health Australia
Description	a) Numbers and proportions of adults in client groups# whose eGFR was recorded in the past 6 months b) Numbers and proportions of adults in client groups# whose eGFR was recorded in the past 6 months whose most recent eGFR was recorded as: - greater than or equal to 90 mls/min - equal to or greater than 60 mls/min to less than 90 mls/min - less than 60 mls/min c) Numbers and proportions of adults in client groups# whose ACR was recorded in the past 6 months d) Numbers and proportions of adults in client groups# whose ACR was recorded in the past 6 months whose most recent ACR was recorded as: - greater than 3.5 mg/mmol - equal to or less than 3.5 mg/mmol
Calculation	a) Numerators: Numbers of adults in client groups# whose eGFR was recorded/ not recorded in the past 6 months Denominators: All adults in client groups# Disaggregation: Indigenous and non-Indigenous b) Numerators: Numbers and proportions of adults in client groups# whose eGFR was recorded in the past 6 months whose most recent eGFR was recorded as: - >= 90 mls/min - = >60 - < 90 mls/min - < 60 mls/min Denominators: All adults in client groups# whose eGFR was recorded in the past 6 months Disaggregation: Indigenous and non-Indigenous c) Numerators: Numbers of adults in client groups# whose ACR was recorded in the past 6 months Denominators: All adults in client groups# Disaggregation: Indigenous and non-Indigenous d) Numerators: Numbers and proportions of adults in client groups# whose ACR was recorded in the past 6 months whose most recent ACR was recorded as: - > 3.5 mg/mmol - <= 3.5 mg/mmol

	Denominators: All adults in client groups[#] whose ACR was recorded in the past 6 months Disaggregation: Indigenous and non-Indigenous ***Definitions*** eGFR >= 90 mls/min - normal - = >60 - < 90 mls/min – mild decrease - < 60 mls/min – moderate decrease suggestive of some kidney damage ACR - Women > 3.5 mg/mmol - clinically significant microalbuminuria - =< 3.5 mg/mmol – normal* ACR – Men ➢ 2.5 mg/mmol – clinically significant microalbuminuria ➢ =< 2.5 mg/mmol – normal *
Data source	EMR
Implementation Notes	[#] 'All patients', 'recent attenders', 'recent active attenders' * Queensland Chronic Disease Guidelines currently define microalbuminuria as: albumin:creatinine ratio >2.5mg/mmol (men) or >3.5mg/mmol (women) or albumin concentration >20mg/l. The parameters for this indicator will be considered in the next Core Indicators review by the Lead Clinicians Group.
References	13

Domain: Maternal and Child Health	
MC_01	
Indicator	**Indigenous women who gave birth *and* number who attended antenatal care at the service**
Rationale	The provision of antenatal care is a core primary health care responsibility of community controlled services. *Close the Gap* nominates a number of targets related to antenatal care including that all Indigenous women have access to appropriate mother and baby programs [HREOC 2008].
Description	a) Number of Indigenous females* in client groups# who gave birth in the past 6 months b) Number of Indigenous Indigenous females* in client groups# who gave birth in the past 6 months who attended at least one antenatal care visit at the service.
Calculation	a) Numerators: Numbers of Indigenous females* in client groups# who gave birth in the past 6 months Denominators: N/A Disaggregation: None b) Numerators: Numbers of Indigenous females* in client groups# who gave birth in the past 6 months who attended at least one antenatal care visit at the service Denominators: N/A Disaggregation: None
Data source	EMR
Implementation notes	* All females – does not filter on age # 'All patients', 'recent attenders', 'recent active attenders'
References	2

Domain: Maternal and Child Health	
MC_02	
Indicator	**Timing of first antenatal visit**
Rationale	The aim of antenatal care is to maximise the health outcomes of the mother and the baby. It aims to identify and manage risk factors or complications early, and to monitor progress with information and support during pregnancy. Evidence suggests Aboriginal and Torres Strait Islander mothers access antenatal services later in their pregnancy and less frequently than other mothers. Case studies of targeted programs suggest improved antenatal visiting can be achieved and that these can translate into improvements in health outcomes such as increased birth weight and reduced premature birth [AHMAC 2006]. *Close the Gap* nominates a target of 75% of all Indigenous pregnant women present for first antenatal assessment within the first trimester [HREOC 2008].
Description	Numbers and proportions of Indigenous females* in client groups# who gave birth in the past 6 months whose first antenatal visit was: - less than or equal to 13 weeks - greater than 13 weeks to equal to 20 weeks - greater than 20 weeks - not recorded
Calculation	Numerators: Numbers and proportions of Indigenous females* in client groups# who gave birth in the past 6 months whose first antenatal visit was: - <=13 weeks - >13 weeks – <= 20 weeks - > 20 weeks - not recorded Denominators: All Indigenous females* in client groups# who gave birth in the past 6 months Disaggregation: None
Data source	EMR
Implementation notes	* All females – does not filter on age # 'All patients', 'recent attenders', 'recent active attenders'
References	2, 11

Domain: Maternal and Child Health	
MC_03	
Indicator	**Adequate antenatal care for Indigenous women**
Rationale	The aim of antenatal care is to maximise the health outcomes of the mother and the baby. It aims to identify and manage risk factors or complications early, and to monitor progress with information and support during pregnancy. Evidence suggests Aboriginal and Torres Strait Islander mothers access antenatal services later in their pregnancy and less frequently than other mothers. Case studies of targeted programs suggest improved antenatal visiting can be achieved and that these can translate into improvements in health outcomes such as increased birth weight and reduced premature birth [AHMAC 2006].
Description	Numbers and proportions of Indigenous females* in client groups# who gave birth in the past 6 months whose antenatal visits numbered: - equal to or greater than 4 - less than or equal to 3 - no visit recorded
Calculation	Numerators: Numbers of Indigenous females* in client groups# who gave birth in the past 6 months whose antenatal visits numbered: - =>4 - <=3 - no visit recorded Denominators: All Indigenous females* in client groups# who gave birth in the past 6 months Disaggregation: None
Data source	EMR
Implementation notes	* All females – does not filter on age # 'All patients', 'recent attenders', 'recent active attenders'
References	None

Domain: Maternal and Child Health	
MC_04	
Indicator	**Proportion of preterm births to Indigenous women**
Rationale	The length of gestation is considered to be a key indicator of infant health, with pre-term birth being associated with poorer health outcomes in babies [AIHW 2007].
Description	Numbers and proportions of babies born[@] in the past 6 months to Indigenous females* in client groups[#] who were <= 36 weeks gestation
Calculation	Numerators: Numbers of babies born[@] in the past 6 months to Indigenous females* in client groups[#] who were <= 36 weeks gestation Denominators: All babies born[#] in the past 6 months to Indigenous females* in client groups[#] Disaggregation: None
Data source	EMR
Implementation notes	@ Includes live births only; also excludes births <= 20 weeks duration * All females – does not filter on age [#] 'All patients', 'recent attenders', 'recent active attenders' _____ An issue around antenatal care indicators is the question of whether the indicator refers to the Indigenous status of the mother or of the baby. The Healthy For Life definition for this indicators addresses this by requiring reporting of the indicators by two categories: • Indigenous baby born to indigenous mother • Indigenous baby born to non-indigenous mother This is difficult to report in practice as it requires linking mother and baby records, is intrusive in that can require asking the mother about the Indigenous status of the father, may have confidentiality issues in regards to reporting of small size denominators and is inconsistent with the reporting standards from the National Perinatal Data Collection. Hence this indicator is based on the Indigenous status of the mother.
References	14

Domain: Maternal and Child Health	
MC_05	
Indicator	**Low and high birth weight babies born to Indigenous women**
Rationale	The birth weight of an infant is a principal determinant of their chances of survival and good health in adulthood. Low birth weight is a risk factor for neurological and physical anomalies; infants weighing less than 2,500 grams are almost 40 times more likely to die within the first 28 days than of infants of normal birth weight [Reproductive Health Indicators Australia 2002]. *Close the Gap* nominates a target of a 50% reduction in the difference between Indigenous and non-Indigenous Australians' rates of preterm and low birth weight births [HREOC 2008].
Description	Numbers and proportions of babies born[@] in the past 6 months to Indigenous females* in client groups[#] who weighed: - < 2500 gms - 2500 - 4499 gms - => 4500 gms
Calculation	Numerators: Numbers of babies born[@] in the past 6 months to Indigenous females* in client groups[#] who weighed: - < 2500 gms - 2500-4499 gms - => 4500 gms Denominators: All babies born[@] in the past 6 months to Indigenous females* in client groups[#] Disaggregation: None
Data source	EMR
Implementation notes	[@] Live births only; also excludes births less than 20 weeks gestation. * All females – does not filter on age [#] 'All patients', 'recent attenders', 'recent active attenders' _____ An issue around antenatal care indicators is the question of whether the indicator refers to the Indigenous status of the mother or of the baby. The Healthy For Life definition for this indicators addresses this by requiring reporting of the indicators by two categories: • Indigenous baby born to indigenous mother • Indigenous baby born to non-indigenous mother This is difficult to report in practice as it requires linking mother and baby records, is intrusive in that can require asking the mother about the Indigenous status of the father, may have confidentiality issues in regards to reporting of small size denominators and is inconsistent with the reporting standards from the National Perinatal Data Collection. Hence this indicator is based on the Indigenous status of the mother.
References	2, 15

Domain: Maternal and Child Health	
MC_06	
Indicator	**Recording of weight *and* height *and* under-weight and under-height children aged less than 5 years**
Rationale	Weight and height are sensitive measures of growth in children.
Description	a) Numbers and proportions of children in clients groups# aged less than 5 years whose weight was recorded in the past 6 months b) Numbers and proportions of children in clients groups# aged less than 5 years whose weight was recorded in the past 6 months whose last recorded weight was: - significantly under-weight (less than 5th percentile) c) Numbers and proportions of children in clients groups# aged less than 5 years whose height was recorded in the past 6 months d) Numbers and proportions of children in clients groups# aged less than 5 years whose height was recorded in the past 6 months whose last recorded weight was: - significantly under height (less than 5th percentile)
Calculation	a) Numerators: Numbers of children in clients groups# aged less than 5 years whose weight was recorded/not recorded in the past 6 months Denominators: All children in clients groups# aged less than 5 years Disaggregation: Indigenous and non-Indigenous b) Numerators: Numbers of children in clients groups# aged less than 5 years whose weight was recorded in the past 6 months whose last recorded weight was: - significantly under-weight (less than 5th percentile) Denominators: All children in clients groups# aged less than 5 years whose weight was recorded in the past 6 months Disaggregation: Indigenous and non-Indigenous c) Numerators: Numbers of children in clients groups# aged less than 5 years whose height was recorded/not recorded in the past 6 months Denominators: All children in clients groups# aged less than 5 years Disaggregation: Indigenous and non-Indigenous d) Numerators: Numbers of children in clients groups# aged less than 5 years whose height was recorded in the past 6 months whose last recorded height was: - significantly under-height (less than 5th percentile) Denominators: All children in clients groups# aged less than 5 years whose height was recorded in the past 6 months Disaggregation: Indigenous and non-Indigenous
Data source	EMR
Implementation notes	# 'All patients', 'recent attenders', 'recent active attenders'
References	None

Domain: Maternal and Child Health	
MC_07	
Indicator	**Recording of height *and* weight *and* under-weight and over-weight children aged 5 to 14 years**
Rationale	Weight and height are sensitive measures of growth in children.
Description	a) Numbers and proportions of children in clients groups# aged aged 5 to 14 years whose weight and height were recorded in the past 6 months b) Numbers and proportions of children in clients groups# aged 5 to 14 years whose weight and height were recorded in the past 6 months whose last BMI was: - below 5th percentile for age - above 95th percentile for age
Calculation	a) Numerators: Numbers of children in clients groups# aged 5 to 14 years whose weight and height were both recorded/not recorded in the 6 months Denominators: All children in clients groups# aged 5 to 14 years Disaggregation: Indigenous and non-Indigenous b) Numerators: Numbers of children in clients groups# aged 5 to 14 years whose weight and height were both recorded in the 6 months whose last BMI was: - below 5th percentile of the WHO growth charts for age - above 95th percentile of the WHO growth charts for age Denominators: All children in clients groups# aged 5 to 14 years whose weight and height were both recorded in the 6 months Disaggregation: Indigenous and non-Indigenous
Data source	EMR
Implementation notes	# 'All patients', 'recent attenders', 'recent active attenders'
References	16

4 FUTURE INDICATOR DEVELOPMENT AND REVIEW

Enhancements to the *QAIHC Core Indicators* are the responsibility of the Lead Clinicians Group for the Community Controlled sector in Queensland. The LCG will:

a. Review the indicators periodically
b. Oversee development of additional indicators.

New domains for maternal and child health and sexually transmitted infections (STIs) are being developed. The development of STI indicators, listed below in table 3, is the most advanced and these should become operational in late 2014. In the *Chronic disease care* domain, future indicators might cover GP Management Plan review (732), and diabetes, CHD and hypertension HW/Nurse monitoring and support (10997). Domains for mental and dental health are being considered. Future indicators in the *Workforce* domain might cover unplanned staff turnover, FTE vacant positions, student placements and training position use. This data is also shown below in table 2 but due to difficulties of collection which cannot be automated at present these indicators remain aspirational.

Table 2 Aspirational Workforce Indicators

Workforce	
WF_01	Service accreditation
WF_02	Proportion of staff that are Indigenous by staff categories
WF_03	Proportion of permanent positions currently filled, FTE by position type
WF_04	Unplanned staff turnover
WF_05	Staff performance review
WF_06	Training position usage
WF_07	Student placement

Table 3 Sexually Transmitted Infections Indicators

Sexually Transmitted Infections	
STI_01	Chlamydia screening
STI_02	Gonorrhoea screening
STI_03	Health check and screening for STI
STI_04	Positive screening test – follow up testing full suite
STI_05	Positive screening test – follow up retesting
STI_06	HIV screening
STI_07	Syphilis screening

4.1 Technical Details – Workforce Indicators

Workforce	
WF_01	
Indicator	**Service accreditation**
Rationale	Accreditation status is a broad measure, providing an indication of the capability of services, based on their facilities, processes and staffing to provide quality health services. *Close the Gap* nominates a target of 80% of ACCHSs achieving accreditation status by 2013 [HREOC 2008].
Description	The service is accredited/enrolled for accreditation/not accredited
Calculation	The service is accredited/not accredited
Data source	Administrative records
Implementation notes	Accreditation of a service is assessed by an external organisation against international/Australian standards. Currently services seek organisation accreditation by ISO or QIC and practice accreditation with RACGP through AGPAL or GPA plus. Some services obtain both RACGP accreditation and ISO or QIC. There is no process currently in place to capture this data and remains an aspirational indicator
References	2

Workforce	
WF_02	
Indicator	**Proportion of staff who are Indigenous by staff categories**
Rationale	There is evidence that having Indigenous clinical staff increases the responsiveness of services and use of services by Indigenous clients. *Close the Gap* nominates a number of workforce related targets for AICCHSs [HREOC 2008]
Description	Numbers and proportions of staff who are Indigenous by the following staff categories: • Medical • Nursing (RN) • Nursing (EN) • AHW (all levels) • Allied Health
Calculation	Numerator For each clinical type, the number of staff who self identify as Indigenous weighted by each person's current FTE fraction. Denominator The number of occupied FTE of each clinical type on the report date, including project and contract positions.
Data source	
Implementation notes	There is no process currently in place to capture this data and remains an aspirational indicator
References	2

Workforce	
WF_03	
Indicator	**Proportion of permanent positions currently filled, FTE by position type**
Rationale	The proportion of vacant FTE positions is an effective indicator of existing service capacity and staff workload, as well as an important signifier of existing corporate memory. *Close the Gap* nominates a number of workforce related targets for AICCHSs [HREOC 2008]
Description	Numbers and proportions of permanent staff by FTE positions by the following staff categories: • Medical • Nursing (RN) • Nursing (EN) • AHW (all levels) • Allied Health
Calculation	Numerator The number of occupied FTE of each clinical type on the report date including project and contract positions by clinical type. Denominator The number of FTE positions (filled and unfilled) of each clinical type on the report date, including project and contract positions by clinical type.
Data source	
Implementation notes	There is no process currently in place to capture this data and remains an aspirational indicator
References	2

Workforce	
WF_04	
Indicator	**Unplanned staff turnover**
Rationale	A high level of turnover creates particular problems with continuity, corporate memory and the sort of incremental change over an appropriate timeframe required in chronic disease management. Productivity is lost when skilled staff leave and replacements need to be inducted and trained [NT KPI] *Close the Gap* nominates a number of workforce related targets for AICCHSs [HREOC 2008]
Description	Ratio of the number of staff who have left the service during the reporting period over the number of positions.
Calculation	Numerator Number of staff who have left the service during the reporting period Denominator The number of FTE positions (filled and unfilled)
Data source	
Implementation notes	There is no process currently in place to capture this data and remains an aspirational indicator
References	2

Workforce	
WF_05	
Indicator	**Staff performance review**
Rationale	The conduct of appropriate and timely staff performance evaluations can contribute to the development of staff skills and to performance management. By giving staff an opportunity for feedback, performance reviews can improve morale and contribute to increase staff retention. *Close the Gap* nominates a number of workforce related targets for AICCHSs [HREOC 2008]
Description	Percentage of staff that have been with the service for more than 12 months who have had a completed performance review in the previous 12 months
Calculation	Numerator The number of staff that have been with the service for more than 12 months who have had a completed performance review in the previous 12 months. Denominator The number of staff that have been with the service for more than 12 months
Data source	
Implementation notes	There is no process currently in place to capture this data and remains an aspirational indicator
References	2

Workforce	
WF_06	
Indicator	**Training position usage**
Rationale	The long term viability and effectiveness of the community controlled health services depends on having a skilled workforce sympathetic to the goals and priorities of the sector. *Close the Gap* nominates a number of workforce related targets for AICCHSs [HREOC 2008]
Description	Number of accredited and fill training positions broken down by clinical type: • Medical • Nursing (RN) • Nursing (EN) • AHW • Allied Health
Calculation	
Data source	
Implementation notes	There is no process currently in place to capture this data and remains an aspirational indicator
References	2

Workforce	
WF_07	
Indicator	**Student placement**
Rationale	The long term viability and effectiveness of the community controlled health services depends on having a skilled workforce sympathetic to the goals and priorities of the sector. *Close the Gap* nominates a number of workforce related targets for AICCHSs [HREOC 2008]
Description	Ratio of the total number of weeks of undergraduate student placement within the service vs the total number of working weeks for all service staff over the reporting period.
Calculation	Numerator Total number of weeks of undergraduate student placement within the service by Medical, Nursing and AHW. Denominator Total number of working weeks for all service staff over the reporting period
Data source	
Implementation notes	There is no process currently in place to capture this data and remains an aspirational indicator
References	2

4.2 Technical Details – STI Indicators

Sexually Transmitted Infections	
STI_01	
Indicator	**Chlamydia screening**
Rationale	Chlamydia was the most frequently reported notifiable condition for persons aged 15 years and older in 2011 *Kirby Institute 2011*
Description	Proportion of patients screened for Chlamydia aged 16 -29 (male and female) in the last 12 months
Calculation	Numerator: patients screened for Chlamydia in last 12 months aged 16-29 Denominator: patients aged 16-29 seen at least once in last 12 months Disaggregation: males, females, Indigenous, non-Indigenous
Data source	EMR
Implementation notes	'visit last 12 months' 'active and recent' Indicator being piloted in 2014
References	17

Sexually Transmitted Infections	
STI_02	
Indicator	**Gonorrhoea screening**
Rationale	In the past decade, rates of gonorrhoea have increased from 40 per 100,000 in 2001 to 65 per 100,000 in 2011. Men and women aged between 15 and 34 years accounted for nearly three quarters (74%) of total gonorrhoea diagnosis. Kirby Institute 2011
Description	Proportion of patients screened for Gonorrhoea aged 16 -34 (male and female) in the last 12 months
Calculation	Numerator: patients screened for Gonorrhoea in last 12 months aged 16-34 Denominator: patients aged 16-34 seen at least once in last 12 months Disaggregation: males, females, Indigenous, non-Indigenous
Data source	EMR
Implementation notes	'visit last 12 months' 'active and recent' Indicator being piloted in 2014
References	17

Sexually Transmitted Infections	
STI_03	
Indicator	**Health check and screening for STI**
Rationale	Adult Health Checks facilitate the prevention, early detection and intervention for diseases that cause considerable morbidity.
Description	Proportion of Aboriginal and Torres Strait Islander patients aged 16-34 screened for an STI (Chlamydia, gonorrhoea OR trichomonas) in the last 12 months who have had a health check in last 12 months
Calculation	Numerator: Aboriginal and Torres Strait Islander patients aged 16-34 who have had a health check in last 12 months AND have been screened for at least one STI (Chlamydia or gonorrhoea or trichomonas) in last 12 months Denominator: Aboriginal and Torres Strait Islander patients aged 16-34 who have had a health check (715) in last 12 months Disaggregation: males, females, Indigenous, non-Indigenous
Data source	EMR
Implementation notes	'visit last 12 months' 'active and recent' Indicator being piloted in 2014
References	

Sexually Transmitted Infections	
STI_04	
Indicator	**Positive screening test – follow up testing full suite**
Rationale	People who have tested positive for an STI should be offered full screening for other STIs and BBVs. AHMRC, 2013
Description	Proportion of patients who have been treated for an STI and followed up with a full suite of Sexually Transmitted Infection and BBV tests
Calculation	Numerator: patients who have had a syphilis and HIV test done within 3 months of a positive test for an STI Denominator: Total Patients with Positive screening for one STI (Chlamydia or Gonorrhoea or Trichomonas) in last 12 months: 16-34 years
Data source	EMR
Implementation notes	Screening for other STIs and BBV should follow local prevalence guidelines. For the purposes of this indicator, full screening includes testing for syphilis and HIV within 3 months of a positive result. At present it is not possible to extract a positive screening from pathology results. A positive screening is indicated based on treatment with CEFTRIAXONE OR PROBENECID: GONORRHOEA or AZITHROMYCIN: CHLAMYDIA or TINIDAZOLE: TRICHOMONIASIS. If any of these has been prescribed within 3 weeks of testing (including date of test) a positive screening will be counted.
References	18

Sexually Transmitted Infections	
STI_05	
Indicator	**Positive screening test – follow up retesting**
Rationale	It is recommended that retesting within 3 months of a positive STI result is performed to provide evidence of cure. AHMRC 2013
Description	Proportion of patients who have been treated for an STI and received a re-test (for the same STI) between one and four months post the date of treatment
Calculation	Numerator: patients who have had a positive test in the last 12 months and received a re-test between 1 and 4 months after the treatment date Denominator: Total Patients with Positive screening for one STI (Chlamydia or Gonorrhoea or Trichomonas) in last 12 months: 16-34 years
Data source	EMR
Implementation notes	See above
References	18

Sexually Transmitted Infections	
STI_06	
Indicator	**HIV screening**
Rationale	Rates of HIV diagnosis in 2013 were greater among Indigenous Australians (5.4 per 100 000) compared to the Australian-born non-Indigenous population (3.9 per 100 000). Kirby Institute 2014
Description	Proportion of patients screened for HIV in last 12 months
Calculation	Numerator: patients screened for HIV in last 12 months Denominator: patients seen at least once in past 12 months Disaggregation: male, female, Indigenous, non-Indigenous, age (16-34, 35 or over)
Data source	EMR
Implementation notes	'visit last 12 months' 'active and recent' Indicator being piloted in 2014
References	19

Sexually Transmitted Infections	
STI_07	
Indicator	**Syphilis screening**
Rationale	Rates among Aboriginal and Torres Strait Islander people are higher than for the non-Indigenous population at 25 per 100,000 compared with 5 per 100,000 respectively Kirby Institute 2011
Description	Proportion of patients screened for syphilis in last 12 months
Calculation	Numerator: patients screened for syphilis in last 12 months Denominator: patients seen at least once in past 12 months Disaggregation: male, female, Indigenous, non-Indigenous, age (16-34, 35 or over)
Data source	EMR
Implementation notes	'visit last 12 months' 'active and recent' Indicator being piloted in 2014
References	17

APPENDIX 1 – REFERENCES

#	Description	Link
1	Data is compared to estimated population data from OESR and/or ABS Census for GIS purposes and to estimate coverage/access of the Indigenous population in the region or appropriate catchment area.	http://statistics.oesr.qld.gov.au/qld-regional-profiles http://www.abs.gov.au/websitedbs/censushome.nsf/home/communityprofiles?opendocument&navpos=230
2	Human Rights and Equal Opportunity Commission. (2008) Close the Gap. National Indigenous Health Equality Targets.	https://www.humanrights.gov.au/publications/close-gap-national-indigenous-health-equality-targets
3	Vos T, Barker B, Stanley L, Lopez A. (2007) Burden of disease and injury in the Aboriginal and Torres Strait Islander peoples 2003. Centre for Burden of Disease and Cost-Effectiveness School of Population Health, The University of Queensland	http://www.lowitja.org.au/sites/default/files/docs/Indigenous-BoD-Summary-Report_0.pdf
4	AIHW 2006	http://www.aihw.gov.au/publication-detail/?id=6442467855
5	NHMRC 2009. Australian guidelines to reduce health risks from drinking alcohol	http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/ds10-alcohol.pdf
6	How to measure yourself	http://www.measureup.gov.au/internet/abhi/publishing.nsf/Content/How+do+I+measure+myself-lp
7	AHMAC 2006	Aboriginal and Torres Strait Islander Health Performance Framework 2006
8	National chronic disease strategy 2006	http://www.health.gov.au/internet/main/publishing.nsf/Content/pq-ncds-strat
9	Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715)	http://www.nmml.org.au/content/Document/Aboriginal%20and%20Torres%20Strait%20Islanders%20Fact%20Sheet.pdf
10	Mathur S, Moon L, Leigh S. (2006) Aboriginal Torres Strait Islanders with coronary heart disease – summary report. Canberra, AIHW	http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442454970
11	Aboriginal and Torres Strait Islander Health Performance Framework Report 2012. Canberra, DOHA.	http://www.health.gov.au/internet/main/Publishing.nsf/Content/F766FC3D8A697685CA257BF0001C96E8/$File/hpf-2012.pdf
12	National Aboriginal Community Controlled Health Organisation. (2012) National guide to a preventative health assessment in Aboriginal and Torres Strait Islander peoples. Melbourne, RACGP.	http://www.racgp.org.au/your-practice/guidelines/national-guide/
13	Hoy WE, Kondalsamy-Chennakesavan S, Scheppingen J, Sharma S, Katz I. A chronic disease outreach program for Aboriginal communities. *Kidney International* (2005) 68, S76–S82.	http://www.nature.com/ki/journal/v68/n98s/pdf/4496443a.pdf?origin=publication_detail
14	AIHW 2007. Australia's Babies. Australian Social Trends, 2007 Cat number: 4102.0	http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/3B2ACB4C166455CFCA25732F001C9207/$File/41020_Australia's%20babies_2007.pdf

15	Reproductive Health Indicators Australia 2002	http://www.aihw.gov.au/publication-detail/?id=6442467442
16	World Health Organisation Child Growth Standards	http://www.who.int/childgrowth/standards/en/index.html
17	The Kirby Institute 2011, Bloodborne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander People: Surveillance and Evaluation Report 2011	http://hiv.cms.med.unsw.edu.au
18	AHMRC 2013, STI & BBV manual.	http://www.ahmrc.org.au/index.php?option=com_docman&task=cat_view&gid=26&Itemid=45
19	Kirby Institute 2014, HIV in Australia Annual Surveillance Report 2014 Supplement	https://kirby.unsw.edu.au/sites/default/files/hiv/news/HIVASRsuppl2014_online.pdf