

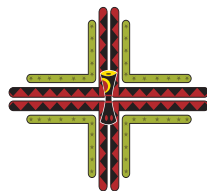


MedicalDirector®

nKPI

Data Reference Manual
for Medical Director

SEPTEMBER 2019



TAIHS

Townsville Aboriginal &
Islander Health Service

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Birthweight recorded

Description:

Number and proportion of Aboriginal and/or Torres Strait Islander babies born within the previous 12 months with a birthweight recorded.

Current %

National Current %	73%
National Target %	n/a

Primary Responsibility

- New Directions Team
- MCH Nurse / IHP
- MCH Manager
- MCH GPs

Improvement Strategies

- Data entry training for staff
- MCH Team to follow up with clients
- GP to access Viewer for birthweights
- Strong linkages with THHS

Evidence Base

[AIHW Report – 'Birthweight of babies born to Indigenous mothers'](#)

Action:

Ensure all babies (ie. any child aged 2 years or younger) registered with AICCHO have a birthweight recorded in MD. Birthweight is defined as the first weight of a baby obtained after birth and must be recorded with the same date as the baby's birth date. The weight must be entered as kilograms (kgs). For example, 5.46kgs if the birthweight was 5460 grams (gms) and must be entered using the date of birth.

Data Entry Field:

1. Click on weight calculator
2. Enter date as birth date
3. Enter weight in kilograms (kgs)
4. Save

MedicalDirector Clinical 3.172 - [Ms Child Test (19yrs 7mths)]

File Patient Edit Summaries Tools Clinical Correspondence Assessment Resources Sidebar MyHealthRecord Window Help

[Ms Child Test (19yrs 7mths)] Gender: Female Occupation: 7m 5s

551 Rinders St. Townsville. Qld. 4810 Ph: 45678912 (home) Record No: T0010448 ATSI: Aboriginal - CTG

Penion No: Ethnicity: Australian Aboriginal

Smoking Hc: Never smoked IHI No: Warnings: MyHealthRecord: IHI not recorded as of 10/09/2019

Summary Current Rx Progress Past history Results Letters Documents Old scripts Imm. Cervical Screening Obstetric Correspondence

Consultation date: 10/09/2019 Visit type: Practice Admin

Tuesday September 10 2019 12:03:19 Mph Support Officer - Susan Habener Visit type: Practice Admin

Tool Box

Weight Calculator

Date: 10/09/2019 Time: 12:06:28 PM Gender: Female Age: 19 Height: 195.0 Patient ID: 17991

Blood Glucose Blood Pressure CV Risk ECG INR Renal Function Respiratory Weight

Current Measurements View: All

Height: 195.0 (cm) Weight: 195.0 (kg) BMI: 32.9

Waist: (cm) Hip: (cm) Waist/Hip Ratio:

Weight must be greater than 10kg for BMI calculation.

Date	Time	Type	Value
07/01/2010	15:32:11	Height	135
07/01/2010	15:32:11	Weight	30
21/01/2010	11:07:28	Height	100
21/01/2010	11:07:28	Weight	20
08/06/2010	08:59:47	Height	72
08/06/2010	08:59:47	Weight	2.3
23/06/2010	09:00:28	Height	73
23/06/2010	09:00:28	Weight	2.6
13/01/2011	15:12:16	Height	125
13/01/2011	15:12:16	Weight	22
14/01/2011	17:15:10	Weight	78
07/02/2011	09:52:27	Height	190
07/02/2011	09:52:27	Weight	82
27/06/2012	15:15:21	Weight	10
26/11/2012	14:40:13	Height	130
26/11/2012	14:40:13	Weight	30
15/01/2013	15:15:12	Weight	15
08/05/2013	15:15:04	Weight	20
28/05/2013	15:14:38	Weight	10
19/02/2014	11:32:11	Weight	7.8
08/07/2014	14:43:52	Height	195.0
08/07/2014	14:43:52	Weight	125.0
08/07/2014	14:43:52	BMI	32.9

Clear Print Reference Edit View Save Close

History Examination Reason Review

Birthweight result (Low, normal or high)

Description:

Number and proportion of Aboriginal and/or Torres Strait Islander babies born within the previous 12 months whose birthweight results were categorised as one of the following:

- low (less than 2,500 grams)
- normal (2,500 grams to less than 4,500 grams)
- high (4,500 grams and over).

Current %

National Current %	12%
National Target %	n/a

Primary Responsibility

- New Directions Team
- MCH Nurse / IHP
- MCH Manager
- MCH GPs

Improvement Strategies

- MCH referrals
- Data entry training for staff
- MCH Team antenatal follow up
- Strong linkages with THHS

Evidence Base

[AIHW Report – 'Birthweight of babies born to Indigenous mothers'](#)

Action:

This indicator looks at all birthweights entered and inserts them into each category. To ensure that the data is accurate the weight must be entered correctly (incorrect entries will provide incorrect data). Enter the birthweight in grams in the mother's obstetric record (NB. The birthweight is entered as kgs in the baby's medical file).

Data Entry Field:

1. Click on Obstetric tab
2. Click on pregnancy to be ended
3. Click on end pregnancy
4. Complete as much information as possible.

MedicalDirector Clinical 3.172 - [First Test (32yrs 3mths)]

File Patient Edit Summaries Tools Clinical Correspondence Assessment Resources Sidebar MyHealthRecord Window Help

First Test (32yrs 3mths) DOB: 30/05/1987 Gender: Female Occupation: 0m 32s

Record No: ATSI: Aboriginal
Pension No: Ethnicity: Australian Aboriginal
Smoking Hx: 15 Daily IHI No: MyHealthRecord: [not recorded as of 10/09/2019]

Warnings: Pregnant: 8 weeks, 6 days EDC = 15/04/2020

Summary Current Rx Progress Past history Letters Documents Old scripts Imm Cervical Screening Obstetric Correspondence

Pregnancy 1 UNMP 08/02/2019 10/07/2019

Past Obstetric History

Pregnancy No. 2 Finish date: 10/09/2019 Gestation (wks): 8

Outcome: [dropdown] Para Termination Miscarriage

Notes: [text area]

Labour

Stage 1: [text] Stage 2: [text] Stage 3: [text]

Episiotomy/tear: [text]

Baby

Name: [text]

Birth weight (gms): [text] Gender: [dropdown] Feeding: Breast Bottle

Apgar 1: [text] Apgar 5: [text]

Save Cancel

Health assessment (MBS item 715)

Description:

1. Number and proportion of Aboriginal and/or Torres Strait Islander active clients aged 0–4 years who had a 715 claimed within the previous 12 months.
2. Number and proportion of Aboriginal and/or Torres Strait Islander active clients aged 25 years and over who had a 715 claimed within the previous 24 months

Current %

National Current %	0–4yrs 33% +25yrs 46%
National Target %	0–4yrs 69% +25yrs 63–74%

Primary Responsibility

- New Directions Team
- MCH Nurse / IHP
- MCH Manager
- MCH GPs

Improvement Strategies

- Use Proda/Toggle to check if patients are due for 715
- T-shirt 715 incentive
- Opportunistic 715s performed

Evidence Base

[Item 715 Medicare Fact Sheet](#)

Action:

- All immunisations are to be entered into the file even if they were not administered at this clinic (NB. Must note as 'not given here')
- Reminders for immunisations are to be entered into each patient file with a designated nurse in charge for recalling overdue
- Each patient is to be contacted at least 3 times and notes added into the patient file.

Fully immunised children

Description:

Number and proportion of Indigenous children who are regular clients, and who are 'fully immunised' aged:

- 12 months to less than 24 months
- 24 months to less than 36 months
- 60 months to less than 72 months;

Current %

National Current %	74%
National Target %	88%

Primary Responsibility

- New Directions Team
- MCH Nurse / IHP
- MCH Manager
- MCH GPs

Improvement Strategies

- Data entry training for staff
- Child Health to follow up on unvaccinated children (Boots on the Ground)
- MD linkage with AIR for data transfer

Evidence Base

[Immunisation: Reducing health inequality for Indigenous Australians](#)

Action:

- All immunisations are to be entered into the file **even if they were not administered at this clinic** (NB. Must note as 'not given here')
- Reminders for immunisations are to be entered into each patient file with a designated nurse in charge of recalling overdue patients
- Each patient is to be contacted at least three times and notes added into the patient file.

Data Entry Field:

IMMUNISATIONS ADMINISTERED AT THE CLINIC

1. Select immunisation
2. Right click mouse/ new item
3. Select Vaccinator
4. Select vaccine from the boxes
5. Select Date
6. Enter batch number
7. Select Site
8. Press OK
9. Select Provider
10. Press OK
11. Press Save

MedicalDirector Clinical 3.17.2 - [Ms Child Test (19yrs 7mths)]

File Patient Edit Summaries Tools Clinical Correspondence Assessment Resources Sidebar MyHealthRecord Window Help

Ms Child Test (19yrs 7mths) | DOB: 20/01/2000 | Gender: Female | Occupation: | 19m 45s

551 Flinders St, Townsville, Qld 4810 | Ph: 45678912 (home) | Record No: T0010448 | ATSI: Aboriginal - CTG

Allergies & Adverse Reactions: DOG HAIR | Pension No: | Ethnicity: Australian Aboriginal

Smoking Hx: Never smoked | IHI No: | MyHealthRecord: IHI not recorded as of 10/09/2019

Summary | Current Rx | Progress | Past history | Results | Letters | Documents | Old scripts | Imm | Cervical Screening | Obstetric | Correspondence

Date	Immunisation	Sequence	Batch	Consent	Provided by	Vaccinator	Site	Comment
11/09/2007	ACELLULAR DTP	0	0906			Dr. Vivienne Manassis	Buttock SC, Left side	
07/02/2011	ENGRIX BIPEDIAITRIC	1	H3449	Consented	Parent	Dr Lisa Oliver	Deltoid IM, Right side	
02/07/2013	priorixtra	1	a3333	Consented	Parent	Child Health Nurse ...	Deltoid IM, Left side	
07/02/2014	biclin		12345	Consented	Parent	Emily Marshall on be...	Buttock IM, Right side	
24/07/2019	FLUVAX					Given elsewhere	Deltoid IM, Left side	

Vaccination Window

☐ Vaccine given elsewhere ☒ Send to AIR

Vaccinator: Child Health Nurse

Consent provided by: Patient

Date: 10/09/2019

Type: BOOSTRIX

Site: Deltoid SC, Right side

Sequence:

Batch No: AC37B313BD ☐ Store batch No

Comment:

Mark for recall Save Cancel

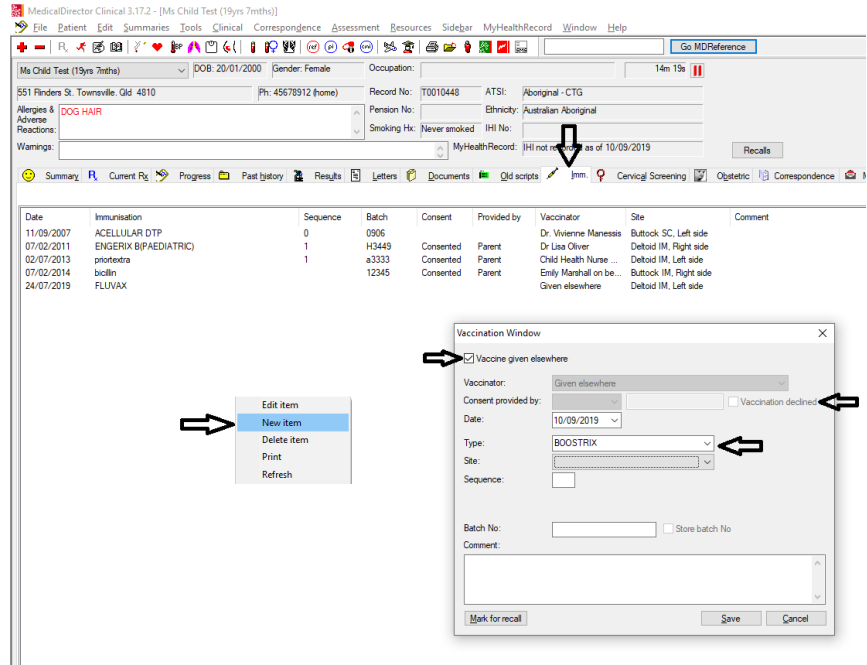
Fully immunised children

IMMUNISATIONS NOT ADMINISTERED AT THE CLINIC

1. Select immunisation
2. Right click mouse/ new item
3. Tick Box **Vaccine given elsewhere**
4. Select vaccine from the boxes
5. Select Date
6. Do not save batch number
7. Press OK

VACCINATION DECLINED

1. Select immunisation
2. Right click mouse/ new item
3. Tick Box **Vaccination declined**
4. Select vaccine from the boxes
5. Select Date
6. Do not save batch number
7. Press OK



HbA1c recorded (Type 2 Diabetes clients)

Description:

1. Number and proportion of active Aboriginal and/or Torres Strait Islander clients diagnosed with Type 2 Diabetes with a HbA1c measurement recorded within the previous **6 months**.
2. Number and proportion of active Aboriginal and/or Torres Strait Islander clients diagnosed with Type 2 Diabetes with a HbA1c measurement recorded within the previous **12 months**.

Current %

National Current %	6 mths 53%
National Target %	6 mths 69%

Primary Responsibility

- IHPs
- Nurses
- GPs

Improvement Strategies

- Data entry training for staff
- Patient screening updated each visit
- 73840 MBS Items for PoC claimed
- DACC updated every visit

Evidence Base

[Diabetes Queensland – Diabetes Annual Cycle of Care](#)

Action:

All Aboriginal and/or Torres Strait Islander clients attending the clinic who have diabetes or at risk of diabetes are to have a HbA1c recorded every 6 months.

Data Entry Field:

When utilising the PoC Testing machine you must enter the results.

1. Click Result
2. Click Add
3. In subject field key HbA1c.
4. In results key readings for example 7.8%
5. Save.

Results must be recorded into Diabetes Record.

1. Click on Clinical
2. Select Diabetes Record
3. Select Add Values
4. Keys results into HbA1c Box
5. Save

HbA1c results (Type 2 Diabetes clients)

Description:

Number and proportion of active Aboriginal and/or Torres Strait Islander clients diagnosed with Type 2 Diabetes with a HbA1c measurement result, recorded within either the previous 6 months or 12 months categorised as one of the following:

- < or = 7% (less than or equal to 53 mmol/mol)
- >7% but < or = 8% (greater than 53 mmol/mol but less than or equal to 64 mmol/mol)
- > 8% but < 10% (greater than 64 mmol/mol but less than 86 mmol/mol) or greater than or equal to 10% (greater than or equal to 86 mmol/mol)

Current %

National Current %	<=7% 35%
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Primary Responsibility

- IHPs
- Nurses
- GPs
- Chronic Care Coordinator

Improvement Strategies

- Data entry training for staff
- Diabetes education
- Recalls
- 73840 MBS Items for PoC entered accordingly
- DACC updated every visit

Evidence Base

[Diabetes the silent pandemic](#)

Action:

All Aboriginal and/or Torres Strait Islander clients attending the clinic who have diabetes or at risk of diabetes are to have a HbA1c recorded every 6 months.

Data Entry Field:

When utilising the PoC Testing machine you must enter the results.

1. Click Result
2. Click Add
3. In subject field key HbA1c.
4. In results key readings for example 7.8%
5. Save.

Results must be recorded into Diabetes Record.

1. Click on Clinical
2. Select Diabetes Record
3. Select Add Values
4. Keys results into HbA1c Box
5. Save

GP management plan (MBS item 721)

Description:

Number and proportion of active Aboriginal and/or Torres Strait Islander clients diagnosed with a chronic disease for whom a GP Management Plan (GPMP) (MBS Item 721) was claimed within the previous 24 months.

Current %

National Current %	51%
National Target %	n/a

Primary Responsibility

- GPs
- IHPs
- Nurses

Improvement Strategies

- Use Proda/Toggle to check if clients with chronic disease are eligible for 721
- GPMP to be updated or review item 732 at least 6 monthly (3 monthly for non-stable clients)
- Ensure MBS items 10987 and 81300 are actioned and claimed
- Expand responsibilities of the nursing team to support Care Plan development (when funding for more PHN nursing positions become available)

Evidence Base

[Education guide - Chronic disease GP Management Plans and Team Care Arrangements](#)

Action:

All Aboriginal and/or Torres Strait Islander clients diagnosed with a chronic disease should be offered a GPMP.

Team Care Arrangement (MBS item 723)

Description:

Number and proportion of active Aboriginal and/or Torres Strait Islander clients diagnosed with a chronic disease for whom a Team Care Arrangement (TCA) (MBS Item 723) was claimed within the previous 24 months.

Current %

National Current %	51%
National Target %	n/a

Primary Responsibility

- GPs
- IHPs
- Nurses

Improvement Strategies

- Use Proda/Toggle to check if clients with chronic disease are eligible for 721
- GPMP to be updated or review item 732 at least 6 monthly (3 monthly for non-stable clients)
- Ensure MBS item 10987 and 81300 are actioned and claimed
- Expand responsibilities of the nursing team to support Care Plan development (when funding for more PHN nursing positions become available)

Evidence Base

[Education guide - Chronic disease GP Management Plans and Team Care Arrangements](#)

Action:

All Aboriginal and/or Torres Strait Islander clients diagnosed with a chronic disease should be offered a TCA.

Smoking status recorded

Description:

Number and proportion of active Aboriginal and/or Torres Strait Islander clients, aged 15 and over, with a smoking status recorded.

Current %

National Current %	80%
National Target %	n/a

Primary Responsibility

- IHPs
- Nurses

Improvement Strategies

- Include in IHP screening and assessment
- Include in Nurse screening and assessment
- Data extraction shows clients with no smoking status recorded for follow up

Evidence Base

[Tobacco in Australia – Facts & Issues](#)

Action:

All Aboriginal and/or Torres Strait Islander clients attending the clinic have their smoking status recorded during screening.

Data Entry Field:

1. Patient
2. Details
3. Smoking
4. Enter details
5. Save

Medical Director Clinical 3.17.2 - (First Test (32yrs 3mths))

File Patient Edit Summaries Tools Clinical Correspondence Assessment Resources Sidebar MyHealthRecord Window Help

Go MDReference

1987 Gender: Female Occupation: 13m 41s

Record No: ATSI: Aboriginal

Pension No: Ethnicity: Australian Aboriginal

Smoking Hx: 15 Daily IHI No:

Details... Ctrl+D

Family History

Diabetes - Mum and Dad

Rheuma - Mum

Hypertension - Grandfather

Cancer - Grandmother

Past History

Year	Date	Condition
2019	10/09/2019	HT (Hypertension)

Smoking

Date of assessment: 21/08/2019

Smoker: Smoker

Frequency: Daily

Number of cigarettes: 15

Year commenced: 2000 Duration: 13yrs

Stage of change assessment: Unsure thinking of quitting in the next 6 months

Last quit attempt: 15/08/2019

Duration of longest period of abstinence: Never/Unknown

Smoking cessation intervention discussed with patient

Comments: 120 pack yrs. Mostly cigarettes but also rolls. 21/08/2019 NI changes

Save

Smoking status result

Description:

Number and proportion of active Aboriginal and/or Torres Strait Islander clients, aged 15 and over, with a smoking status recorded as one of the following:

- current smoker
- ex-smoker or
- never smoked.

Current %

National Current %	53%
--------------------	-----

National Target %	40%
-------------------	-----

Primary Responsibility

- IHPs
- Nurses

Improvement Strategies

- Include in IHP screening and assessment
- Include in Nurse screening and assessment
- Data extraction shows clients with no smoking status recorded for follow up
- Smoking status recorded/ details updated at each visit

Evidence Base

[Tobacco in Australia – Facts & Issues](#)

Action:

- All Aboriginal and/or Torres Strait Islander clients attending the clinic have their smoking status recorded during screening.
- Checked and updated at each visit.

Data Entry Field:

1. Patient
2. Details
3. Smoking
4. Enter details
5. Save

The screenshot shows the Medical Director software interface. The main window displays the 'Patient Details' tab, which includes fields for Patient ID, Gender, Occupation, Record No., Pension No., Smoking Hx, and IHI No. The 'Smoking Hx' field is highlighted, and a dropdown menu is open showing '15 Daily'. The 'Patient Details' tab is also visible, showing fields for Date of assessment, Smoker status, Frequency, Number of cigarettes, Year commenced, Duration, Stage of change assessment, Last quit attempt, and Duration of longest period of abstinence. The 'Smoking' tab is active, showing a 'Comments' field with the text '~20 pack yrs Mostly cigarettes but also rolls 21/08/2019 NI changes'. A 'Save' button is visible at the bottom right of the 'Smoking' tab.

Smoking during pregnancy

Description:

Number and proportion of active Aboriginal and/or Torres Strait Islander clients, **aged 15 and over**, who gave birth within the previous 12 months and whose smoking status recorded as one of the following:

- current smoker
- ex-smoker or
- never smoked.

Does not collect changes in smoking status during pregnancy.

Current %

National Current %	50%
National Target %	37%

Primary Responsibility

- IHPs
- Nurses

Improvement Strategies

- Include in IHP screening and assessment
- Include in Nurse screening and assessment
- Data extraction shows clients with no smoking status recorded for follow up
- Smoking status recorded/ details updated at each visit

Evidence Base

[Tobacco smoking during pregnancy](#)

Action:

All Aboriginal and/or Torres Strait Islander clients attending the clinic have their smoking status recorded during screening.

Data Entry Field:

Pregnancy must be activated in Obstetric tab, not just in condition.

1. Patient
2. Details
3. Smoking
4. Enter details
5. Save

Body Mass Index (BMI) (overweight or obese)

Description:

Number and proportion of active Aboriginal and/or Torres Strait Islander clients, **aged 25 and over**, who have had their BMI classified as overweight or obese within the previous 24 months.

Current %

National Current %	70%
National Target %	n/a

Primary Responsibility

- IHPs
- Nurses

Improvement Strategies

- Include in IHP screening and assessment
- Offer IHP 81300 or Nurse 10987 follow up for Nutrition and Diet education
- Refer to Dietitian

Evidence Base

[Overweight and Obesity](#)

Action:

- All Aboriginal and/or Torres Strait Islander clients attending the clinic have their height, weight and waist circumference recorded during screening.
- Checked and updated at each visit.

Data Entry Field:

1. Progress notes
2. Examination
3. Insert both height and weight values – BMI will automatically update
4. Save

The screenshot shows the MedicalDirector Clinical 3.17.2 interface. The patient is Gordon St. Garbutt, DOB 30/05/1987, Female. The examination form is open, showing the following data entry fields:

- Height: 163 (cm)
- Weight: 57.3 (kg)
- BMI: 21.57

The BMI field is highlighted with a red box and an arrow. The form also includes sections for blood pressure, hydration, and other clinical observations. The patient's details, including DOB (30/05/1987) and gender (Female), are visible at the top.

First antenatal care visit

Description:

Number and proportion of active Aboriginal and/or Torres Strait Islander clients who gave birth within the previous 12 months and who had gestational age recorded at their first antenatal care visit with result either:

- less than 13/40 weeks
- 13/40 weeks to less than 20/40 weeks
- at or after 20/40 weeks or
- no result.

Current %

National Current %	37%
National Target %	60%

Primary Responsibility

- IHPs
- Nurses
- MCH GPs
- New Directions Team

Improvement Strategies

- Data entry training for staff
- Clinic staff education
- Patient education and resources

Evidence Base

[Antenatal Care for Aboriginal and Torres Strait Islander Women](#)

Action:

When an Aboriginal and/or Torres Strait Islander client has a confirmed pregnancy test, the obstetric record is to be commenced in the MD clinical file at that visit. Must enter consult in Obstetric tab not in progress notes.

Data Entry Field:

1. Obstetrics
2. New Pregnancy
3. Complete details to predict the gestational age
4. Save

The screenshot shows the MedicalDirector Clinical 3.17.2 interface. The 'New pregnancy' tab is selected. A 'Gestational Age Calculator' dialog box is open, showing the 'Date of LMP' as 16/09/2019 and 'Week' as 13. The 'Calculate' button is highlighted. The background shows patient details for 'Gordon St. Garbutt, Qld 4814' and various clinical fields like 'ATSI: Aboriginal', 'Ethnicity: Australian Aboriginal', and 'Smoking Hx: 15 Daily'.

Influenza immunisation (50 years and over)

Description:

Number and proportion of active Aboriginal and/or Torres Strait Islander clients, aged 50 and over, who are immunised against influenza.

Current %

National Current %	34%
National Target %	64%

Primary Responsibility

- All Clinic Staff
- Nurses
- GPs
- IHPs

Improvement Strategies

- Data entry training for staff
- Dedicated Flu Shot Days
- Partnering with THHS
- Offer incentives
- All clients are offered Flu Vaccine

Evidence Base

[Immunisation: Reducing health inequality for Indigenous Australians](#)

Action:

All immunisations are to be entered into the file even if they were not administered at this clinic (just note as 'not given here').

Data Entry Field:

IMMUNISATIONS ADMINISTERED AT THE CLINIC:

1. Immunisations
2. Right click mouse/new item
3. Vaccinator name
4. Date
5. Select Vaccination from drop down box
6. Site
7. Sequence
8. Batch number
9. Mark for recall
10. Save

1. Immunisations
2. Right click mouse/new item
3. Tick box vaccine given elsewhere
4. Select vaccination from type
5. Sequence
6. Do not save batch number
7. Save

Influenza immunisation (Type 2 Diabetes or COPD)

Description:

Number and proportion of active Aboriginal and/or Torres Strait Islander clients, aged 15–49, are recorded as having Type 2 Diabetes or COPD and are immunised against influenza.

Current %

National Current %	T2 Diabetes 34% COPD 35%
National Target %	

Primary Responsibility

- AHW
- Nurse
- GP

Improvement Strategies

- Data entry training for staff
- Dedicated Flu Shot Days
- Partnering with THHS
- Offer incentives
- All Diabetic and COPD clients are offered Flu Vaccine

Evidence Base

[RACGP Clinical Guidelines COPD](#)

Action:

All immunisations are to be entered into the file even if they were not administered at this clinic (just note as 'not given here').

Data Entry Field:

IMMUNISATIONS ADMINISTERED AT THE CLINIC:

1. Immunisations
2. Right click mouse/new item
3. Vaccinator name
4. Date
5. Select vaccination from Type drop down box
6. Site
7. Sequence
8. Batch number
9. Mark for recall
10. Save

IMMUNISATIONS NOT ADMINISTERED AT THE CLINIC:

1. Immunisations
2. Right click mouse/new item
3. Tick box vaccine given elsewhere
4. Select vaccination from type
5. Sequence
6. Do not save batch number
7. Save

Alcohol consumption recorded

Description:

Number and proportion of active Aboriginal and/or Torres Strait Islander clients, **aged 15 and over**, who have had their alcohol consumption status recorded within the previous 24 months.

Current %

National Current %	57%
National Target %	0

Primary Responsibility

- IHPs
- Nurses
- GPs

Improvement Strategies

- Include in IHP screening and assessment
- Include in Nurse screening and assessment
- Data extraction shows clients with no alcohol status recorded or details recorded for follow up
- Alcohol status recorded/ details updated at each visit

Evidence Base

[Substance use among Aboriginal and Torres Strait Islander People](#)

Action:

All clients, aged 15 and over, have their alcohol consumption status recorded during screening.

Data Entry Field:

1. Patient
2. Details
3. Alcohol
4. Enter details
5. Save

Medical Director Clinical 3.17.2 - [First Test (42yrs smths)]

File Patient Edit Summaries Tools Clinical Correspondence Assessment Resources Sidebar MyHealthRecord Window Help

List... Open... F2 Request Full Access... Open Another... Alt+F2 Waiting Room... Add Details... Ctrl+D Summary Photos History Results Letters Patient Details

Patient Details

Pt. Details Allergies/Adverse Reactions/Warnings Family/Social Hx Notes Smoking Alcohol Personal Details

Date of assessment: 16/08/2019

Audit-C Assessment

1. How often do you have a drink containing alcohol?
☐ Never ☒ Monthly or less ☐ 2-4 times a month
☐ 2-3 times a week ☐ 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?
☒ 1 or 2 ☐ 3 or 4 ☐ 5 or 6
☐ 7 to 9 ☐ 10 or more

3. How often do you have six or more drinks on one occasion?
☒ Never ☐ Less than monthly ☐ Monthly
☐ Weekly ☐ Daily or almost daily

Audit-C Total Score: 1

In men a score of 4 or more and in women a score of 3 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders. The guidelines to reduce health risks from drinking alcohol provide further assessment and treatment options.

Patient concerned about drinking?
☐ Yes ☒ No ☐ Don't know

View Alcohol Guidelines Reference New Assessment

Currently displaying data from assessment performed on 16/08/2019. Click 'New Assessment' to conduct a new assessment.

☐ Update address for all family members
☒ Auto-capitalise names

Save Cancel

Alcohol consumption result

Description:

Number and proportion of active Aboriginal and/or Torres Strait Islander clients, **aged 15 and over**, who have had an AUDIT-C result recorded in the previous 24 months with a score of:

- greater than or equal to 4 in males and 3 in females; or
- less than 4 in males and 3 in females

Current %

National Current %

National Target %

Primary Responsibility

- IHPs
- Nurses
- GPs

Improvement Strategies

- Clinical staff updated on AUDIT-C assessment tool
- Alcohol patient education and resources
- Alcohol status to be updated at each visit

Evidence Base

[Effectiveness of the AUDIT-C as a Screening Test for Alcohol Misuse in Three Race/Ethnic Groups](#)

Action:

All clients, aged 15 and over, have their alcohol consumption status recorded during screening.

Data Entry Field:

1. Patient
2. Details
3. Alcohol
4. Enter details
5. Save

The screenshot shows the Medical Director Clinical 5.17.2 software interface. The top menu bar includes File, Patient, Edit, Summaries, Tools, Clinical, Correspondence, Assessment, Resources, Sidebar, MyHealthRecord, Window, and Help. The main window displays the Patient Details form for a patient named Gordon St. Garb. The form includes fields for Gender (Female), Occupation, Record No., Pension No., Smoking Hx (15 Daily), and MyHealthRecord. The Alcohol assessment section is highlighted, showing the Audit-C Assessment questions and the resulting score of 1. The Audit-C Assessment questions are: 1. How often do you have a drink containing alcohol? (Never, Monthly or less, 2-4 times a month, 2-3 times a week, 4 or more times a week); 2. How many standard drinks containing alcohol do you have on a typical day? (1 or 2, 3 or 4, 5 or 6, 7 to 9, 10 or more); 3. How often do you have six or more drinks on one occasion? (Never, Less than monthly, Monthly, Weekly, Daily or almost daily). The Audit-C Total Score is 1. The form also includes a section for Patient concerned about drinking (Yes, No, Don't know) and buttons for View Alcohol Guidelines, Reference, and New Assessment. The bottom of the form has checkboxes for Update address for all family members and Auto-capitalise names, and Save and Cancel buttons.

Kidney function test recorded (Type 2 Diabetes or CVD)

Description:

Number and proportion of active Aboriginal and/or Torres Strait Islander clients, **aged 15 and over**, diagnosed with Type 2 Diabetes and have had an Estimated Glomerular Filtration Rate (eGFR) recorded and/or an albumin/creatinine ratio (ACR) or other micro-albumin test result recorded within the previous 12 months.

AND

Number and proportion of active Aboriginal and/or Torres Strait Islander clients aged 15 and over diagnosed with Cardiovascular Disease (CVD) and have had an eGFR recorded within the previous 12 months.

Current %

National Current %	Type 2 67% CVD 63%
National Target %	Type 2 69%

Primary Responsibility

- IHPs
- Nurses
- GPs

Improvement Strategies

- Clinic staff training
- Screening updated as required
- eGFR and ACR must occur at least once in a 12 month period

Evidence Base

[Chronic Kidney disease ATSI](#)

Action:

Diabetic and CVD clients have eGFR and/or an ACR or other micro-albumin test result recorded.

Data Entry Field:

1. Click Result
2. Click Add
3. In subject field key ACR
4. In results key readings for example A/C = 15.3 mg/mol, Albumin 178.0 mg/L, Creatinine = 11.6 mmol/L
5. Save.

Specimens sent to Pathologists are automatically recorded

MedicalDirector Clinical 3.17.2 - [First Test (32yrs 3mths)]

File Patient Edit Summaries Tools Clinical Correspondence Assessment Resources Sidebar MyHealthRecord Window Help

First Test (32yrs 3mths) DOB: 30/05/1987 Gender: Female Occupation: 42m 16s

1 Gordon St, Garbutt, Qld 4814 Ph: Record No: ATSI: Aboriginal

Allergies & Adverse Reactions: Nil known Pension No: Ethnicity: Australian Aboriginal

Smoking Hx: 15 Daily IHI No: MyHealthRecord: IHI not recorded as of 10/09/2019

Warnings:

Summary Current Rx Progress Past history Results Letters Documents Qld scripts Cervical Screening

Preview - Full - Hide Preview Clear Filters Move Location Document Details Send SMS Scan Import Print Add Delete Search Clear

Add Investigation Result

Start Patient: Test, First
1 Gordon St, Garbutt 4814
Birthdate: 30/05/1987 Age: 32 yrs Gender: F
Your Reference: 46906

Subject: ACR

Date Requested: Tuesday, 10 September 2019
Date Collected: Tuesday, 10 September 2019

Result:
A/C = 15.3 mg/mol, Albumin 178.0 mg/L, Creatinine = 11.6 mmol/L

Action Add Recall Save Cancel

Your Reference: QML Reference: 17-64859056 Sender/Provider: QML Pathology

CUMULATIVE SERUM BIOCHEMISTRY

Date	17/01/17	03/02/17	28/02/17	04/04/17	03/05/17
Time	00:00	13:25	10:00	11:37	13:25
Lab No	55092785	64042831	64183047	64183315	64859056
Sodium	134	134	137	136	mmol/L (137-147)
Potass.	4.1	5.0	4.5	3.7	mmol/L (3.5-5.0)
Chloride	98	99	99	97	mmol/L (96-109)
Bicarb	23	25	30	29	mmol/L (25-33)
An.Gap	17	15	13	14	mmol/L (4-17)
Gluc	17.3	19.0	20.2	9.8	mmol/L (3.0-7.7)
Urea	13.2	11.1	7.0	9.2	mmol/L (2.5-8.0)
Creat	140	111	107	101	umol/L (60-130)
eGFR	50	66	69	74	mL/min (over 59)

Previous Next Reassign Patient Reassign Recipient Notify Cumulative Results Action Add Recall View

Kidney function test result (Type 2 Diabetes or CVD)

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, aged 15 and over, are recorded as having type 2 diabetes or cardiovascular disease (CVD) and who have had an estimated glomerular filtration rate (eGFR) recorded within the previous 12 months with a result of (ml/min/1.73m²):

- ≥ 90
- $90 \geq 60$
- $60 \geq 45$
- $45 \geq 30$
- $30 \geq 15$
- < 15

or

**Number and proportion of regular clients who are male, Aboriginal and/or Torres Strait Islander, aged 15 and over, who are recorded as having type 2 diabetes and who have had an albumin/creatinine ratio (ACR) recorded within the previous 12 months with a result of (mg/mmol):

- < 2.5
- $2.5 \geq 2.5$
- > 2.5

or

**Number and proportion of regular clients who are female, Aboriginal and/or Torres Strait Islander, aged 15 and over, who are recorded as having type 2 diabetes and who have had an albumin/creatinine ratio (ACR) recorded within the previous 12 months with a result of (mg/mmol):

- < 3.5
- $3.5 \geq 3.5$
- > 3.5

Current %

National Current %	Type 2 67% CVD 63%
National Target %	Type 2 69%

Primary Responsibility

- GPs
- Nurses
- IHPs

Improvement Strategies

- Clinic staff training
- Screening updated as required
- eGFR and ACR must occur at least once in a 12 month period

Evidence Base

Action:

Diabetic and CVD clients have eGFR and/or an ACR or other micro-albumin test result recorded.

Data Entry Field:

1. Click Result
2. Click Add
3. In subject field key ACR
4. In results key readings for example A/C = 15.3 mg/mol, Albumin 178.0 mg/L, Creatinine = 11.6 mmol/L
5. Save.

Specimens sent to Pathologists are automatically recorded

MedicalDirector Clinical 3.17.2 - (First Test (32yrs 3mths))

File Patient Edit Summaries Tools Clinical Correspondence Assessment Resources Sidebar MyHealthRecord Window Help

First Test (32yrs 3mths) DOB: 30/05/1987 Gender: Female Occupation: 42m 16s

11 Gordon St. Garbutt. Qld 4814 Ph: Record No: ATSI: Aboriginal

Allergies & Adverse Reactions: Nil known Pension No: Ethnicity: Australian Aboriginal

Smoking Hx: 15 Daily IHI No: MyHealthRecord: IHI not recorded as of 10/09/2019

Warnings:

Summary Current Rx Progress Past history Results Letters Documents Old scripts Cervical Screening

Preview - Full Hide Preview Clear Filters Move Location Document Details Send SMS Scan Import Print Add Delete Search Clear Search

Add Investigation Result

Start Patient: Test First
1 Gordon St. Garbutt 4814
Birthdate: 30/05/1987 Age: 32 yrs Gender: F
Your Reference: 46906

Subject: ACR

Date Requested: Tuesday, 10 September 2019
Date Collected: Tuesday, 10 September 2019

Result:
A/C= 15.3 mg/mol, Albumin 178.0 mg/L, Creatinine= 11.6 mmol/L

Action Add Recall Save Cancel

Cardiovascular disease(CVD) risk assessment

Description:

Number and proportion of active Aboriginal and/or Torres Strait Islander clients, **aged 35–74**, with no known cardiovascular disease, with information available to calculate their absolute CVD risk.

Current %

National Current %	38%
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National Target %	
-------------------	--

Primary Responsibility

- GPs
- Nurses
- IHPs

Improvement Strategies

- Clinic staff training in CVD Risk Assessment, patient education and resources

Evidence Base

[Cardiovascular risk profile ATSI](#)

Action:

Clients suspected of having any CVD risk factors must have a cardiovascular risk assessment.

Data Entry Field:

1. Tools Tab
2. Tool Box Tab
3. Cardiovascular Risk Tab
4. Relative CVD Risk Calculator Tab
5. Complete Details
6. Save

7.2 - [First Test (32yrs 3mths)]

Summary Tools Clinical Correspondence Assessment Resources Sidebar MyHealthRecord Window Help

Letter Writer... F8

Labels...

Dermatology

Tool Box

Calculators

Oximetry

X-ray View Screen Ctrl+Shift+X

Options...

Print Options...

Manage Communications...

MDExchange

HealthLink

Go MDReference

1h 18m 7s

Recalls

Cervical Screening

Search

Clear Search

Refresh

Send To MyHealthRecord

Remove From

Cardiovascular Risk Calculator

Date: 10/09/2019 Time: 3:32:40 PM Gender: Female Age: 32 Height: 152 Patient ID: 45906

Blood Glucose Blood Pressure CV Risk ECG INR Renal Function Respiratory Weight

Absolute CVD Risk Calculator Relative CVD Risk Calculator

Current Measurements

Blood Pressure (mmHg)

Systolic: 130 Diastolic: 70

Cigarettes/Day: 15 Cholesterol:

The cardiovascular risk for this patient based on age and gender is in the 1st percentile.

Date Time Type Risk (Percentile)

This is a calculator only. Click the Save button to save the percentile risk. Double-click a record within the table on right side to view individual measurements.

Clear

Print Reference Edit View Save Close

Absolute CVD risk assessment result

Description:

Number and proportion of active Aboriginal and/or Torres Strait Islander clients, aged 35–74, with no known history of cardiovascular disease (CVD), who have had an absolute CVD risk assessment recorded within the previous 2 years and whose CVD risk was categorised as one (1) of the following:

- high (greater than 15% chance of a cardiovascular event in the next 5 years)
- moderate (10%–15% chance of a cardiovascular event in the next 5 years)
- low (less than 10% chance of a cardiovascular event in the next 5 years).

Current %

National Current %	36%
National Target %	n/a

Primary Responsibility

- GPs
- Nurses
- IHPs

Improvement Strategies

- Data recording training for staff
- Clinical staff training (Interpreting CVD Risk)

Evidence Base

[Absolute Cardiovascular Disease Risk Management](#)

Action:

Clients suspected of having any CVD risk factors must have a cardiovascular risk assessment.

Data Entry Field:

1. Tools Tab
2. Tool Box Tab
3. Cardiovascular Risk Tab
4. Relative CVD Risk Calculator Tab
5. Complete Details
6. Save

The screenshot shows the nKPI software interface. The 'Tools' menu is open, and the 'Cardiovascular Risk' option is selected. The 'Cardiovascular Risk Calculator' window is displayed, showing patient details (Date: 10/09/2019, Time: 3:32:40 PM, Gender: Female, Age: 32, Height: 152, Patient ID: 46906) and current measurements (Blood Pressure: 130/70 mmHg, Total Cholesterol, HDL Cholesterol, Smoking Status, Diabetes, ECG LVH). A color-coded risk bar is shown at the bottom, ranging from green (Low) to red (High).

Cervical screening recorded

Description:

Number and proportion of active Aboriginal and/or Torres Strait Islander female clients, **aged 20–69**, who have not had a hysterectomy and who have had a cervical screening with the previous 2 years, 3 years and 5 years.*

Current %

National Current %	30%
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National Target %	
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Primary Responsibility

- GPs
- Nurses
- IHPs

Improvement Strategies

- Data recording training for staff
- Up-skill additional clinical staff to be certified to perform cervical screening

Evidence Base

[Summary of cervical cancer among Indigenous women](#)

* Cervical Screening record does not reflect current guidelines. You can download the National Guide to a preventive health assessment [here](https://www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Resources/National-guide-3rd-ed-Sept-2018-web.pdf). <https://www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Resources/National-guide-3rd-ed-Sept-2018-web.pdf> see page 105: Prevention and early detection of cervical cancer.

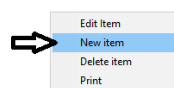
Action:

All female clients, aged 20–69 years, are to be asked during screening when they had their last cervical screening. If unknown the patient is to be offered the opportunity to have a cervical screening done at TAIHS or mark performed by as 'not performed here'.

Data Entry Field:

1. Pap Test
2. Right click mouse (new item)
3. Enter details
4. Comments (not performed here)
5. Add reminder
6. Save

The screenshot shows the MyHealthRecord software interface. The 'Cervical Screening' tab is selected, and a red arrow points to it. The interface displays patient details such as Gender (Female), Occupation, Record No., ATSI (Aboriginal), Pension No., Ethnicity (Australian Aboriginal), Smoking Hx (15 Daily), and IHI No. The 'MyHealthRecord' section shows 'IHI not recorded as of 10/09/2019'. The 'Recalls' section shows 'EndoCx cells: No', 'HPV: No', and 'Comment: due in 2 years'.



The screenshot shows the 'Record Cervical Screening Result' dialog box. The 'Date' is 10/09/2019, 'Result' is Negative, and 'Comment' is 'Not performed here'. The dialog box also includes checkboxes for 'Endocervical cells present?' and 'HPV changes present?'. At the bottom, there are buttons for 'Add Recall', 'Add', and 'Cancel'.

Blood pressure recorded (Type 2 Diabetes)

Description:

Number and proportion of active Aboriginal and/or Torres Strait Islander female clients who have Type 2 Diabetes and who have had a blood pressure measurement recorded within the previous 6 months.

Current %

National Current %	68%
National Target %	70%

Primary Responsibility

- GPs
- Nurses
- IHPs

Improvement Strategies

- Data recording training for staff
- Regular calibration of equipment

Evidence Base

[High Blood Pressure Facts and Figures](#)

Action:

Every patient who has an active diagnosis of Type 2 Diabetes must have a blood pressure recorded at every visit.

Data Entry Field:

1. Examination
2. Enter BP Details
3. Save

Blood pressure $\leq 130/80$ mmHg (Type 2 Diabetes)

Description:

Number and proportion of active Aboriginal and/or Torres Strait Islander female clients who have Type 2 Diabetes and whose blood pressure measurement result, recorded within the previous 6 months, was less than or equal to 130/80 mm/Hg.

Current %

National Current % 43%

National Target %

Primary Responsibility

- GPs
- Nurses
- IHPs

Improvement Strategies

- DACC updated at each visit
- BP taken and recorded at every visit

Evidence Base

[High Blood Resources](#)

Action:

Every patient who has an active diagnosis of Type 2 Diabetes must have a blood pressure recorded at every visit.

Data Entry Field:

1. Examination
2. Enter BP Details
3. Save

The screenshot shows the MedicalDirector Clinical 3.17.2 interface. The 'Examination' tab is active, and the 'Blood Pressure' section is highlighted. The 'Blood Pressure' section includes fields for 'Cuff Location' (set to 'Unspecified'), 'Body Position' (set to 'Sitting'), 'Systolic/Diastolic' (with input fields for mmHg), and 'Pulse' (with a dropdown menu). There are also checkboxes for 'Hydration' (Normal or % dehydrated) and 'Blood Group' (with a dropdown menu). The 'Colour' section includes checkboxes for 'Anaemia', 'Jaundice', 'Central cyanosis', and 'Peripheral cyanosis'. The 'Other' section includes checkboxes for 'Finger clubbing', 'Spider naevi', 'Bruising', and 'Thinned skin'. The 'Save' button is visible at the bottom right of the 'Examination' tab.



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