Communicare

nKPI

Data Reference Manual for Communicare

Based on version 19.2

APRIL 2021

QAIHC
Queensland Aboriginal and Islander Health Council

This guide refers to Clinical Items and Reports that are included with a 'standard install' of Communicare, but which may either be disabled or modified in your version.

There may also be additional service-preferred items which are used for recording some of this data, so please consider liaising with your Communicare Administrator or Data Coordinator to see if this document requires local adjustments.

Also, for detailed assistance with particular KPI indicator codes and issues, please either call Communicare Systems Helpdesk, or log a job with their online 'Jira' Helpdesk system.

For assistance with Pen CAT, please contact Pen CAT, or your local NACCHO Affiliate (QAIHC, AH&MRC, AHCSA, TAC, VACCHO, AMSANT, AHCWA, WNAHCS) or PHN if they are your usual support for this.

Support Contacts

Communicare

JIRA Job-Logging system:
jira.telstrahealth.com/servicedesk/customer/portal/
E: support@communicare.telstrahealth.com
Helpline: 1800 798 441

PEN CAT4

pencs.com.au/support/
E: support@pencs.com.au
Helpline: 1800 762 993

NACCHO affiliate link:

naccho.org.au/naccho-affiliates

PHN Directory by state/territory

health.gov.au/internet/main/publishing.nsf/Content/PHN-Contacts

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nKPI: PI01

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	69%
National Target	n/a

Service 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 Communicare.

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.

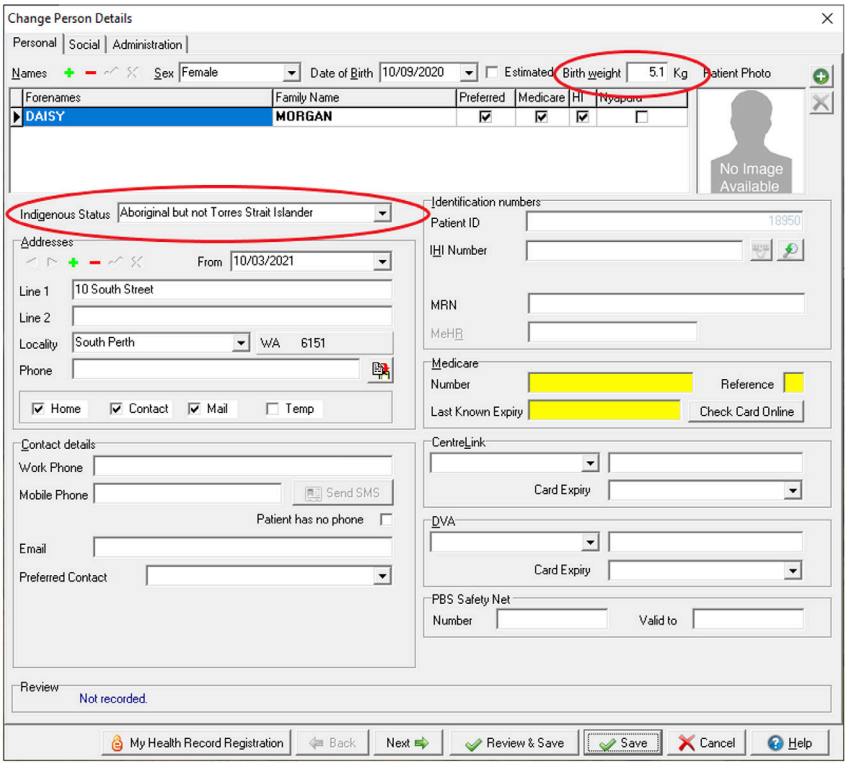
Run the report query 'Reports/Patients/Births'.

Set the dates to appropriate timeframe.

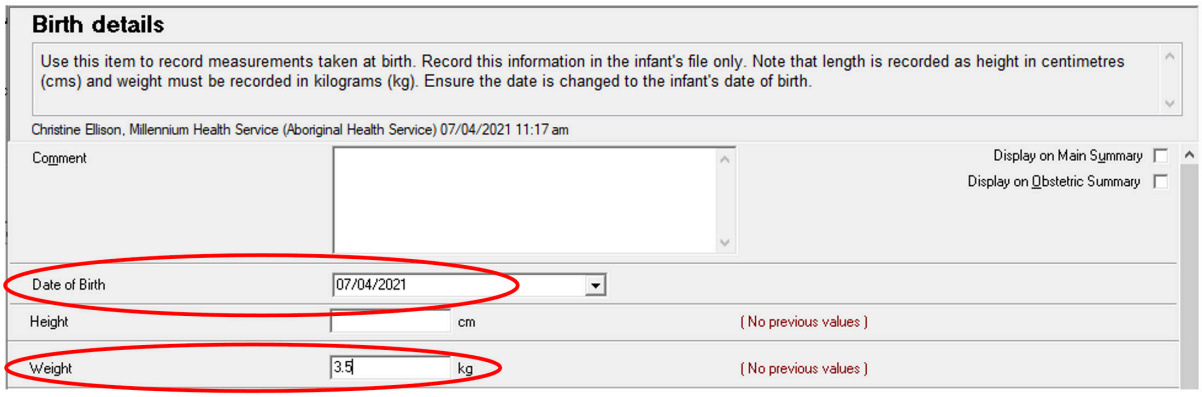
Find any babies with no recorded weight.

Data Entry Field:

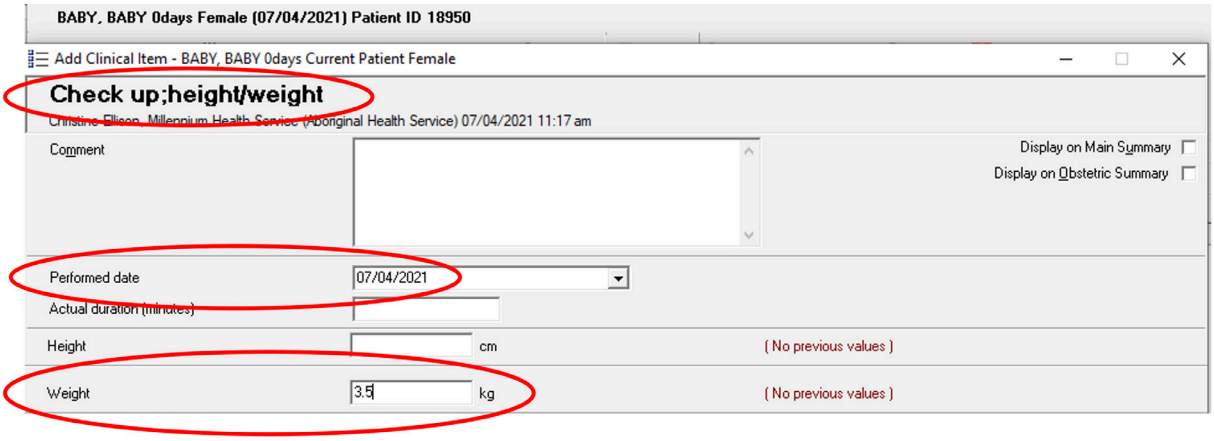
1. Open the baby's 'Patient Biographics'.
2. Enter weight into 'Birth weight' box at top of window.
3. Ensure 'Indigenous Status' is set correctly.
4. Save/exit.



Birthweight can also be found if a weight is recorded on the day of birth. For example:



Or this one, noting the weight is recorded on date of birth.



nKPI: PI02

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

Service 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 birth weights 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 kilograms in the mother's obstetric record (note: the birthweight is entered as kgs in the baby's medical file).

Data Entry Field:

Follow instructions for PI01.

nKPI: PI03

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%

Service 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:

Each patient is to be contacted at least three times and notes added into the patient file.

Data Entry Field:

No snapshot required—see improvement strategies (PIO checks 715s due).

nKPI: PI04

Fully immunised children

Description:

Number and proportion of Aboriginal and/or Torres Strait Islander 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%

Service 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** (note: must record 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.

Immunisation data in Communicare unfortunately does not rely on the specific immunisations recorded. This is due to different immunisation schedules in states and territories—it would be a very expensive indicator and complex to manage this and keep it accurate. Instead it relies on the recalls for age specific immunisations.

FOR EXAMPLE:

- Review—immunisation—6 months of age
- Review—immunisation—12 months of age
- Review—immunisation—18 months of age
- Review—immunisation—4 years of age

Firstly, this relies on these recalls being enabled, usually as automatic, on registration recalls. If no recall protocol is used, then an overestimate of immunised children will occur.

The nKPI for this indicator relies on these recalls being completed, or the absence of any overdue recalls for these or for any immunisation (other than any influenza vaccine).

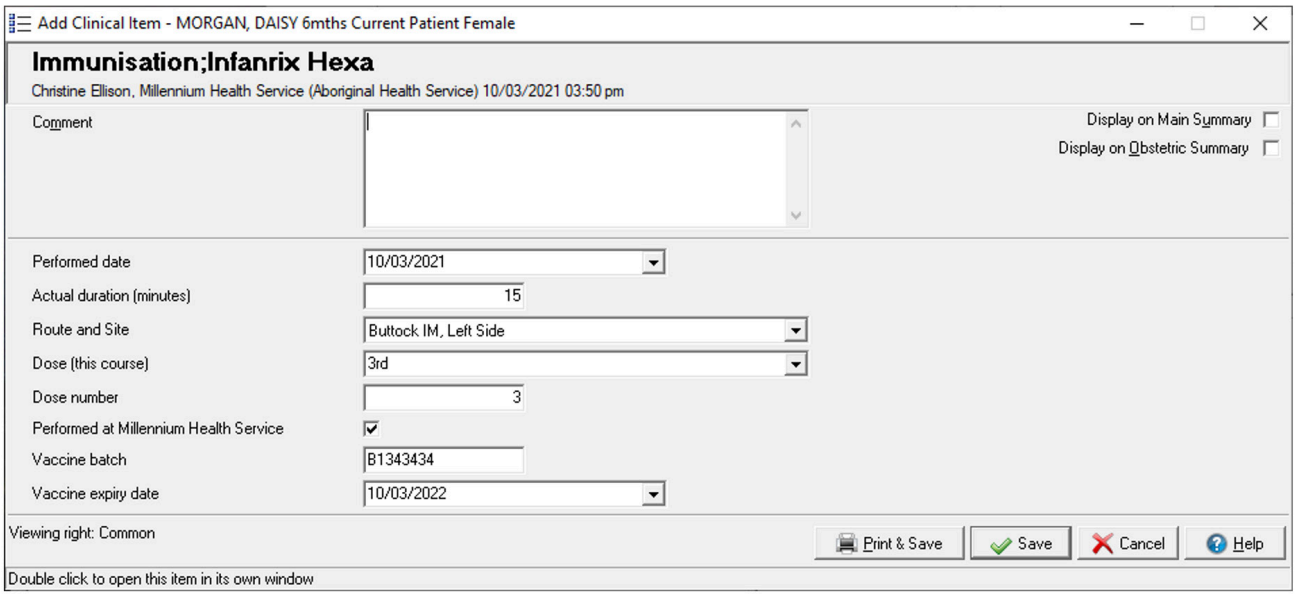
Data Entry Field:

IMMUNISATIONS ADMINISTERED AT THE CLINIC

1. From clinical record add clinical item for relevant immunisation from either the 'Immunisation' shortcut menu at the bottom of the window, or from 'Clinical Item' button at top-left of window, and searching for 'Immunisation' in the keywords search tab. Select relevant Immunisation from list.
2. Fill in all required fields.
3. Make sure 'Performed at [clinic name] 'tick-box is ticked.
4. Save/exit.

IMMUNISATIONS NOT ADMINISTERED AT THE CLINIC

1. Follow the same instructions above for 'Immunisations administered at the clinic', but DO NOT tick the 'Performed at [clinic name]' tick-box.
2. Write in the Comment box where the vaccination was given, and where you obtained this information.
3. Save/exit.



nKPI: PI05

HbA1c recorded (T2 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 months 53%
National Target	6 months 69%

Service Responsibility

- IHPs
- GPs
- Nurses

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:

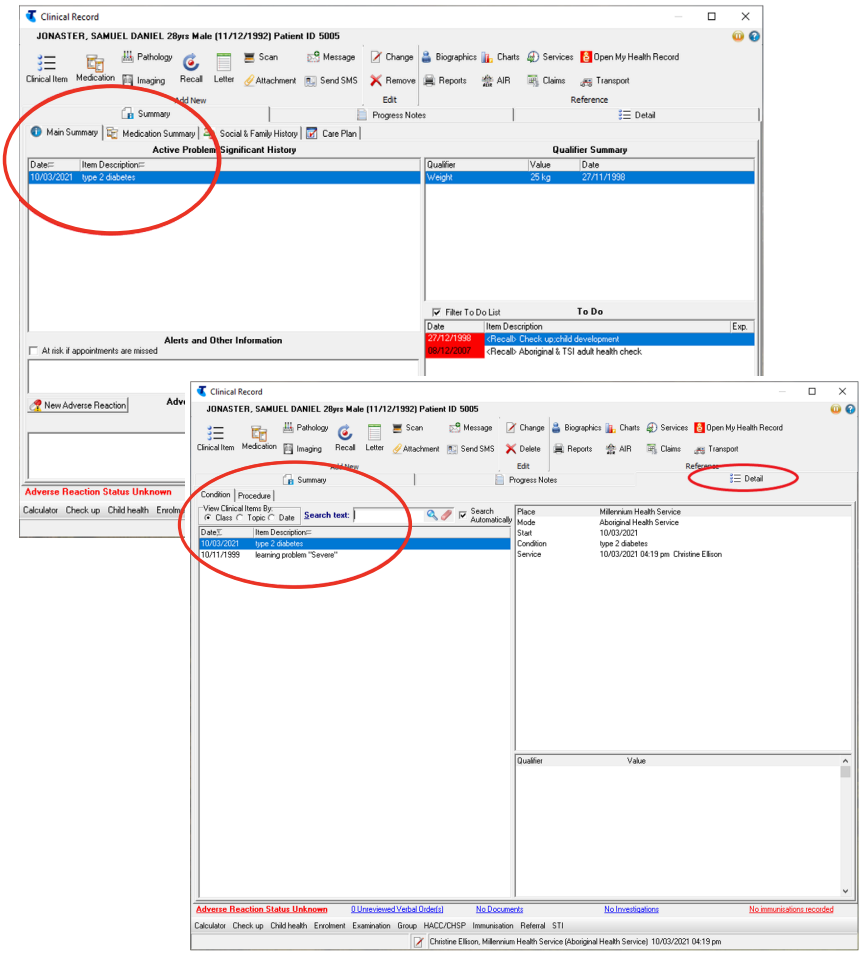
All Aboriginal and/or Torres Strait Islander clients attending the clinic who have diabetes or at risk of diabetes are to have a HbA1c recorded every 6 months.

Data Entry Field:

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

1. Open patient clinical record.
2. Add any clinical item that records HbA1c eg. clinical item 'Test;HbA1c' or Cycle of care for diabetes.
3. Fill in the HbA1c % or HbA1c mmol/mol as required.
4. Save/exit.

If the patient is diabetic there should be a diagnosis/condition listed in their clinical record, Main Summary, in the 'Active Problem/Significant History' panel, and/or under the 'Details' tab, viewing by 'Class' and on the 'Condition' Tab.



nKPI: PI06

HbA1c results (T2 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	< or = 7% 35%

Service 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

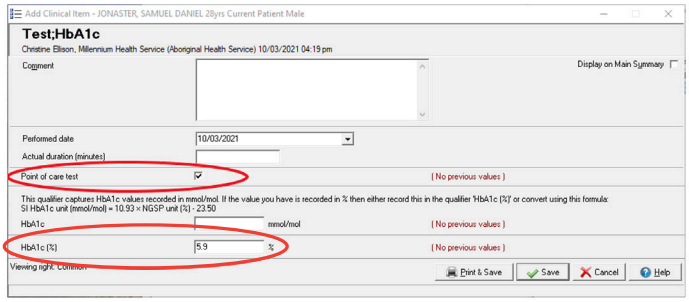
Action:

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.

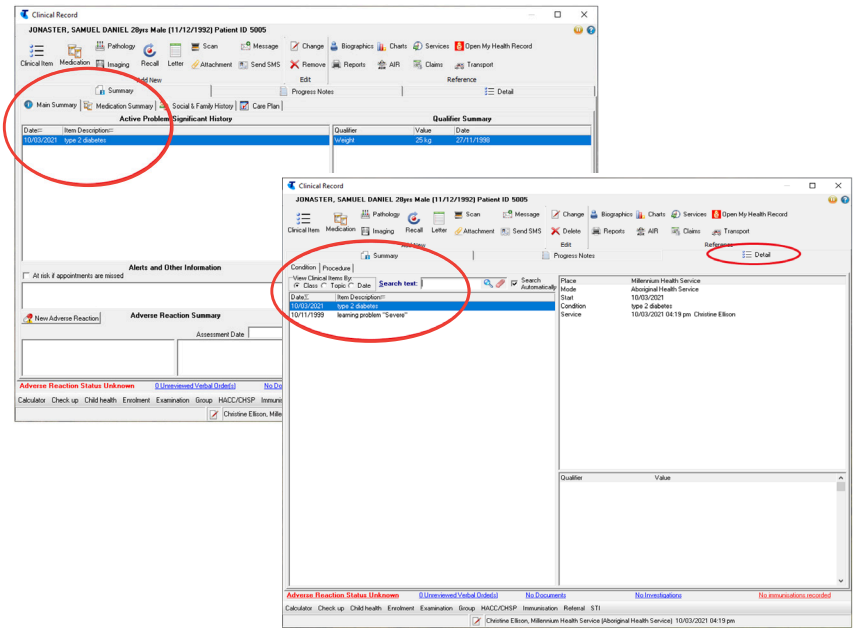
Data Entry Field:

When utilising the PoC Testing machine you must enter the results in the results field and tick the 'Point of care test' box.

1. Open patient clinical record.
2. Add any clinical item that can record a HbA1c eg. 'Test;HbA1c'.
3. Fill in the HbA1c % or HbA1c mmol/mol as required.
4. Save/exit.



If the patient is diabetic there should be a diagnosis/condition listed in their Clinical Record, Main Summary, in the 'Active Problem/ Significant History' panel, and/or under the 'Details' tab, viewing by 'Class' and on the 'Condition' tab.



nKPI: PI07

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

Service Responsibility

- IHPs
- GPs
- 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 GP Management Plan.

Data Entry Field:

No snapshot required—see improvement strategies (PIO checks 721s due).

nKPI: PI08

Team Care Arrangements (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	48%
National Target	n/a

Service Responsibility

- IHPs
- Nurses
- GPs

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.

Data Entry Field:

No snapshot required—see improvement strategies (PIO checks 723s due).

nKPI: PI09

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

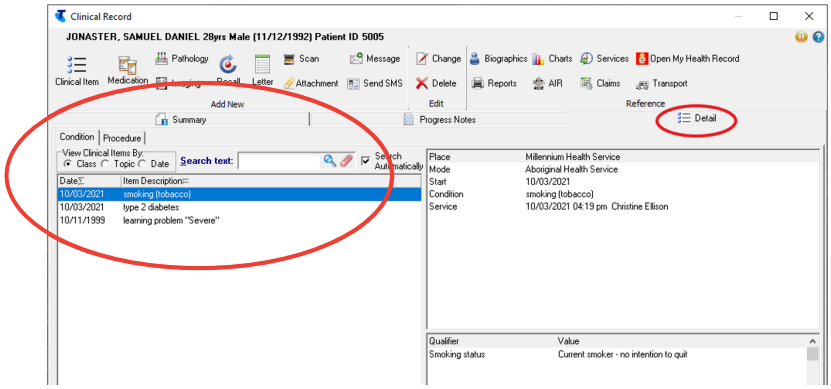
- Include in IHP screening and assessment
- Include in Nurse screening and assessment
- Data extraction shows clients with no smoking status recorded for follow up

Evidence Base

Tobacco in Australia—Facts & Issues

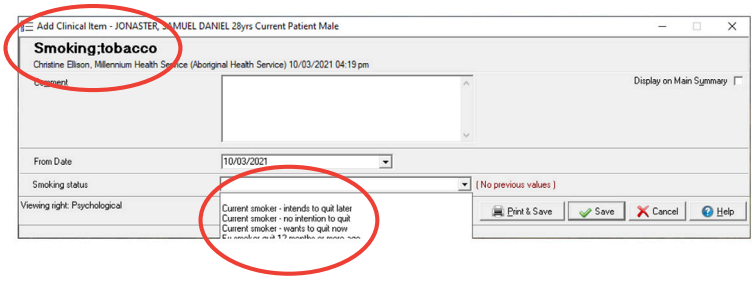
Action:

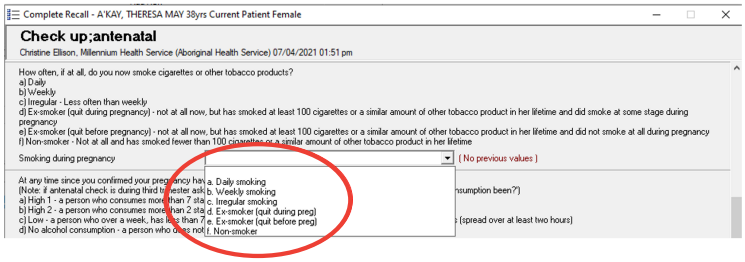
All Aboriginal and/or Torres Strait Islander clients attending the clinic have their smoking status recorded during screening. Patients must have had a qualifier recorded with a system code of 'SMO' or 'SMP' to be included—central qualifiers are 'Smoking status' and 'Smoking during pregnancy'. If the patient is a smoker, there should be a diagnosis/condition listed in their clinical record, Main Summary, in the 'Active Problem/Significant History' panel, and/or under the 'Details' tab, viewing by 'Class' and on the 'Condition' tab.



Data Entry Field:

1. Open patient Clinical Record.
2. Add the 'Smoking Status' qualifier by using any available 'Smoking Clinical' item to the patient file. The **smoking status** qualifier is found in many clinical items, such as health checks, examinations, cycle of care for diabetes, etc. and others.
3. Save/exit.





nKPI: PI10

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 and other details recorded during the screening.

Data Entry Field:

Follow instructions for PI09.

nKPI: PI11

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 and other details recorded during the screening.

Data Entry Field:

Follow instructions for PI09.

nKPI: PI 12

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

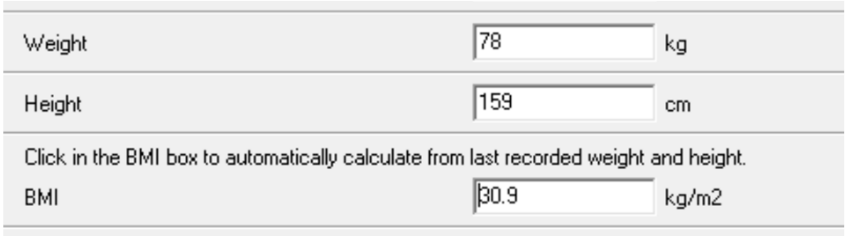
Overweight and Obesity

Action:

All Aboriginal and/or Torres Strait Islander clients attending the clinic have their height, weight and waist circumference recorded during screening.

Data Entry Field:

1. Open clinical record.
2. Add a clinical item that can record, height weight and BMI—this is in many clinical items such as health checks and examinations such as 'Exam;pre-consult...' from shortcut menu at bottom or 'Clinical Item' button at top.
3. Enter weight and height, click in the "BMI" box to calculate.
4. Save/exit.



nKPI: PI13

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:

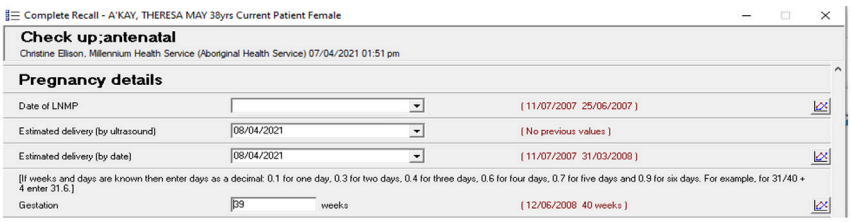
When an Aboriginal and/or Torres Strait Islander client has a confirmed pregnancy test, the obstetric record is to be commenced in the Communicare clinical record window/Obstetrics tab and an antenatal check completed at that visit. Note that not all fields need to be completed for this to be counted.

Data Entry Field:

1. Open clinical record.
2. Select Obstetrics tab.
3. Once new pregnancy/pregnancy confirmed has been completed and saved, an antenatal check should be completed—either visible after new pregnancy has been saved, or selected from the clinical item list or a quick access button.
4. Enter either 'Date of LNMP'/'Estimated delivery [by ultrasound]' then click in 'Estimated delivery [by date]' to calculate delivery date, and then click in 'Gestation' to calculate Gestation.

   OR

5. Enter your calculated 'Estimated delivery [by date]' and then click in 'Gestation' to auto-calculate Gestation.
6. Save/exit.



nKPI: PI14

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').

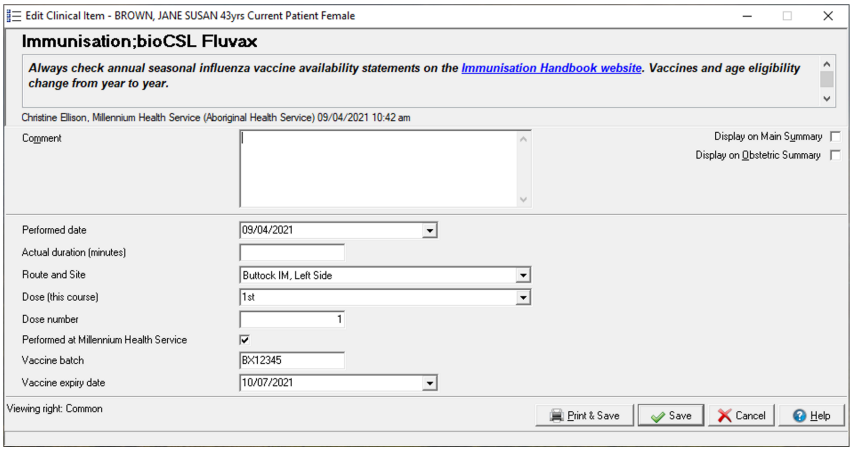
Data Entry Field:

IMMUNISATIONS ADMINISTERED AT THE CLINIC:

1. From clinical record, add clinical item for relevant Fluvax immunisation (name may change) from either the 'Immunisation' shortcut menu at the bottom of the window, or from 'Clinical Item' button at top-left of window, and searching for 'Immunisation' in the 'Keywords' search tab. Select relevant Immunisation from list.
2. Fill in all required fields.
3. Make sure 'Performed at [clinic name]' tick-box is ticked.
4. Save/exit.

IMMUNISATIONS NOT ADMINISTERED AT THE CLINIC:

1. Follow the same instructions above for 'Immunisations Administered at the clinic', but DO NOT tick the 'Performed at [clinic name]' tick-box.
2. Write in the Comment box where the vaccination was given, and where you obtained this information.
3. Save/exit.



nKPI: PI 15

Influenza immunisation (T2 diabetes and COPD clients)

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	n/a

Primary Responsibility

- All clinic staff
- AHWs
- Nurses
- GPs

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. From clinical record add clinical item for relevant Fluvax immunisation (name may change) from either the 'Immunisation' shortcut menu at the bottom of the window, or from 'Clinical Item' button at top-left of window, and searching for 'Immunisation' in the 'Keywords' search tab. Select relevant immunisation from list.
2. Fill in all required fields.
3. Make sure 'Performed at [clinic name]' tick-box is ticked.
4. Save/exit.

IMMUNISATIONS NOT ADMINISTERED AT THE CLINIC:

1. Follow the same instructions above for 'Immunisations administered at the clinic', but DO NOT tick the 'Performed at [clinic name]' tick-box.
2. Write in the Comment box where the vaccination was given, and where you obtained this information.
3. Save/exit.

nKPI: PI16

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	n/a

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

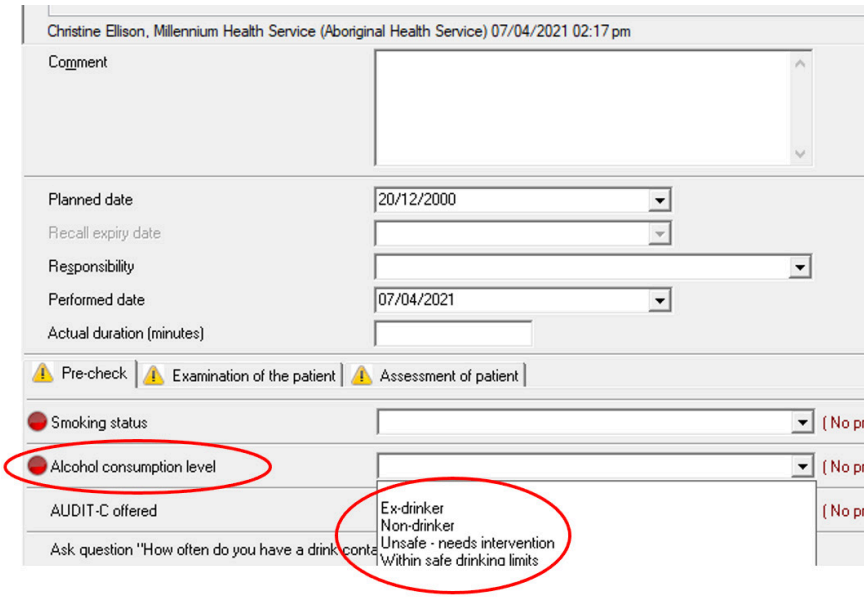
Substance use among Aboriginal and Torres Strait Islander People

Action:

All clients have their alcohol consumption status recorded during screening.

Data Entry Field:

1. Open clinical record.
2. Complete a clinical item that can record alcohol consumption level such as health checks or examinations. Alcohol consumption level during pregnancy also records this, found in antenatal checks.
3. Save/exit.



nKPI: PI17

Alcohol results recorded

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	n/a
National Target	n/a

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

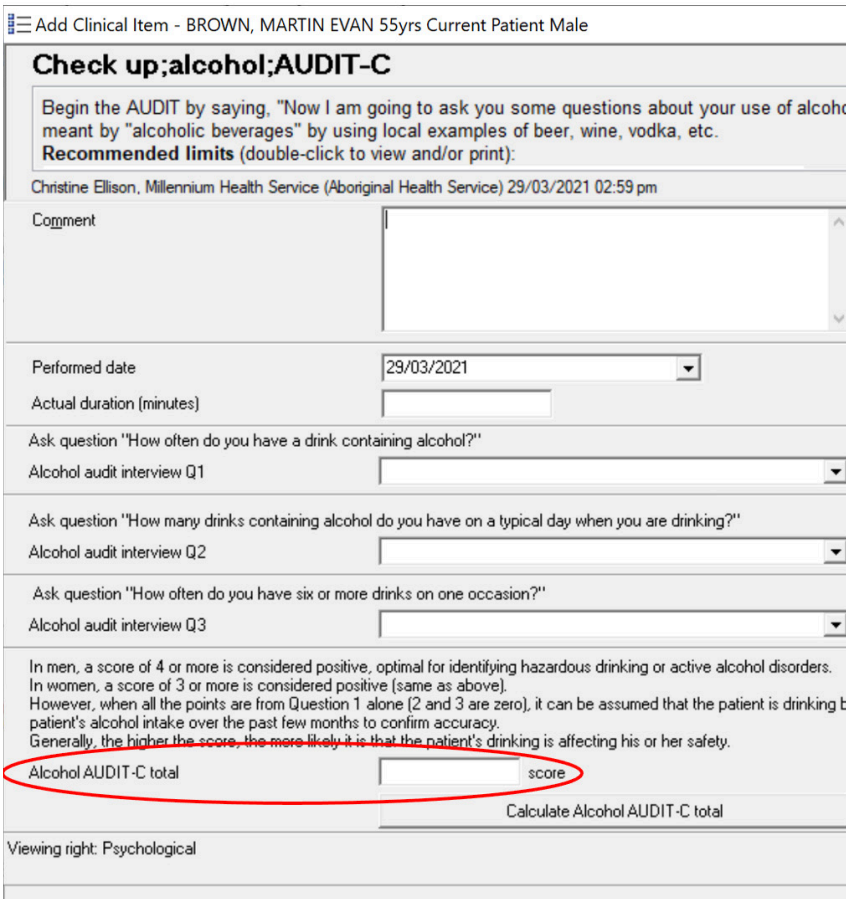
Effectiveness of the AUDIT-C as a Screening Test for Alcohol Misuse in Three Race/Ethnic Groups

Action:

All clients have their alcohol consumption status recorded during.

Data Entry Field:

1. Open clinical record.
2. Complete clinical item 'Check up;alcohol;AUDIT-C'—the data in Alcohol AUDIT-C Total is counted for this KPI.
3. Save/exit.



nKPI: PI18

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	n/a

Primary Responsibility

- IHPs
- GPs
- Nurses

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

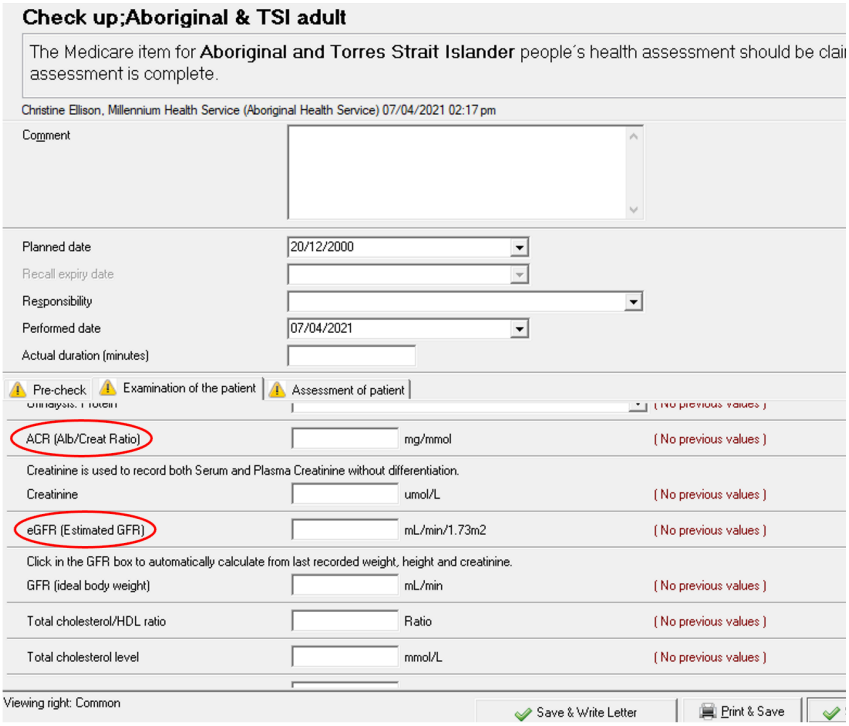
Action:

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

Data Entry Field:

1. Open clinical record.
2. Complete a clinical item eg. 'Glomerular filtration rate' that records ACR and eGFR, such as health checks or examinations.
3. Ideally these fields are auto-populated from pathology results but may need manual entry.
4. Save/exit.

ACR results from Pathology Labs (Westerns etc.) are automatically recorded.



nKPI: PI19

Kidney function test result (Type 2 diabetes or CVD)

Description:

Option 1

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 ≥ 60
- 60 ≥ 45
- 30 ≥ 45
- 30 ≥ 15
- < 15

Option 2

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
- 25 ≥ 2.5
- > 25

Option 3

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
- 35 ≥ 3.5
- > 35

Current %	
National Current	38%
National Target	

Primary Responsibility

- IHPs
- Nurses
- GPs

Improvement Strategies

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

Evidence Base

Cardiovascular risk profile ATSI

Action:

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

Data Entry Field:

Follow instructions for PI18.

nKPI: PI20

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%
National Target	

Primary Responsibility

- IHPs
- GPs
- Nurses

Improvement Strategies

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

Evidence Base

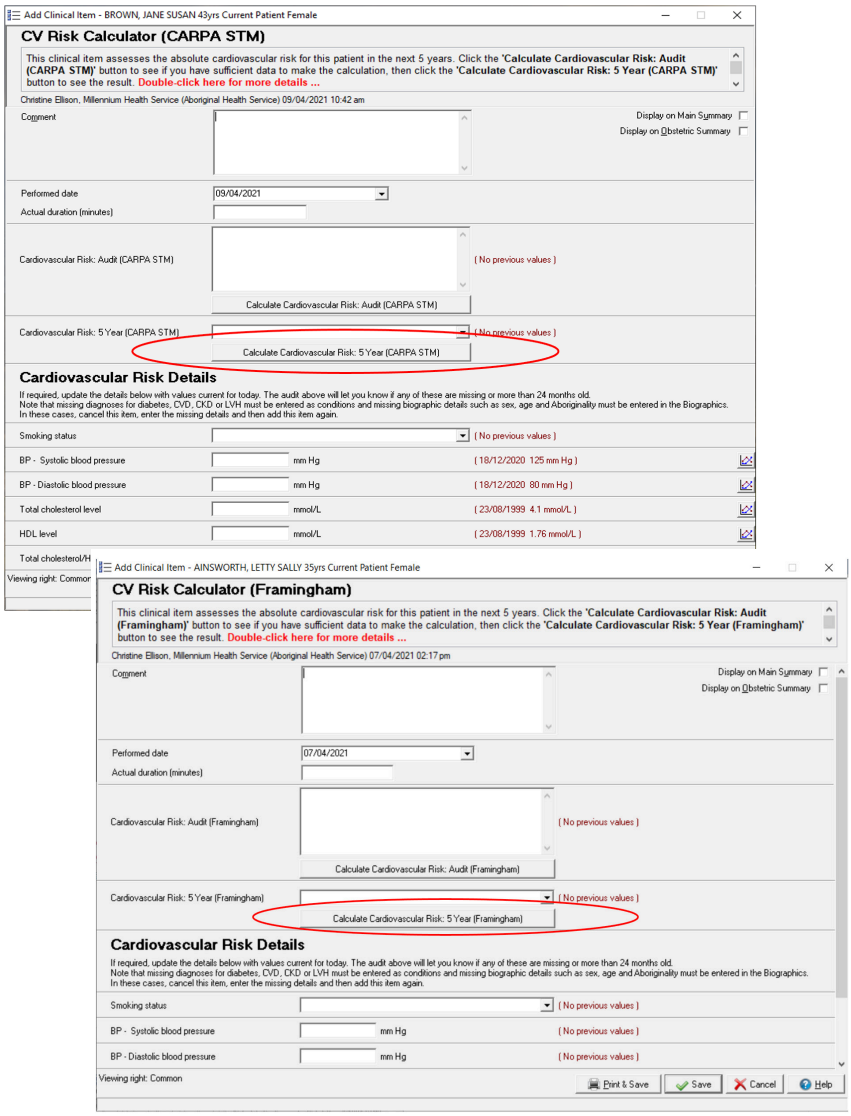
Cardiovascular risk profile ATSI

Action:

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

Data Entry Field:

1. Open clinical record
2. Complete clinical item 'CV Risk Calculator (CARPA STM)' or 'CV Risk Calculator (Framingham)'. This can be done automatically by clicking on the **'Cardiovascular Risk; 5-year (CARPA SMT)'** field (if all factors are recorded), or it can be entered manually e.g. if a person is high risk clinically.
3. Save/exit.



nKPI: PI21

Absolute cardiovascular 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

- IHPs
- Nurses
- GPs

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 entered into their clinical file (the result appears with observations as CV risk).

Data Entry Field:

Follow instructions for PI20.

nKPI: PI22

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%
National Target	n/a

Primary Responsibility

- IHPs
- Nurses
- GPs

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*** *see page 105: Prevention and early detection of cervical cancer.*

Action:

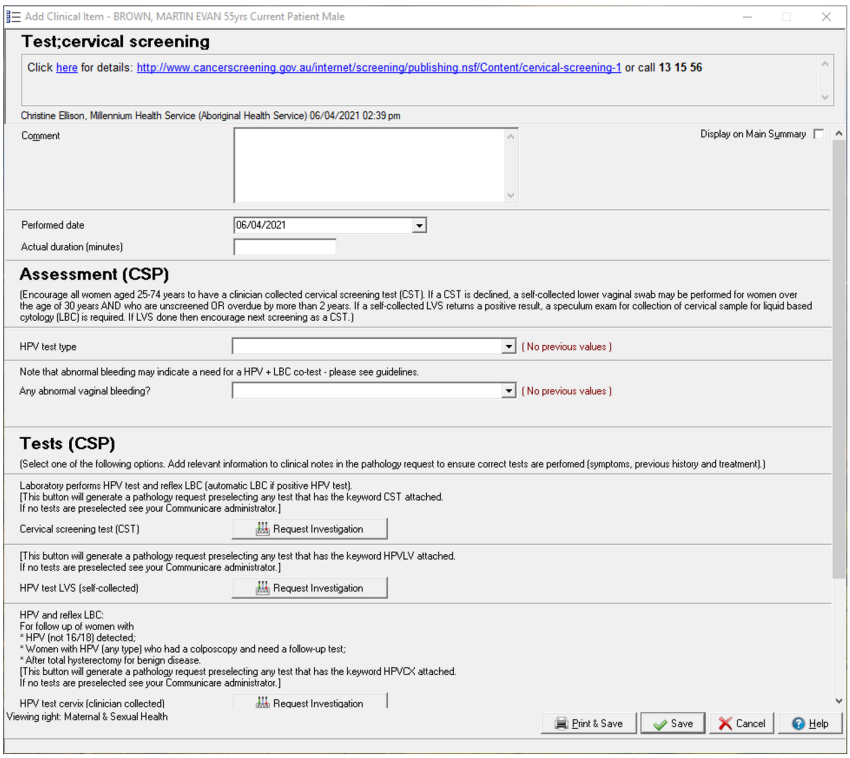
All female clients aged 25–74 years are to be asked during screening when they had their last cervical screening, or to check the clinical record or the National Cancer Screening Register for their last cervical screen.

If unknown the patient is to be offered the opportunity to have a cervical screen done at clinic, or mark performed by as 'not performed here'.

Data Entry Field:

Data is collected from electronic pathology tests that contain 'CST', 'HPV', LBC', 'Cervical Screening', 'Gynaecological Cytology' or 'NCSP'; cervical screening request with a keyword of 'CST', 'HPV' or 'LBC'; or a clinical item for cervical screening.

1. Open clinical record.
2. Complete clinical item 'Test;cervical screening', or any clinical item with the qualifier 'HPV test type'.
3. Save/exit.



nKPI: PI23

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

- IHPs
- Nurses
- GPs

Improvement Strategies

- Data recording training for staff
- Regular calibration of equipment

Evidence Base

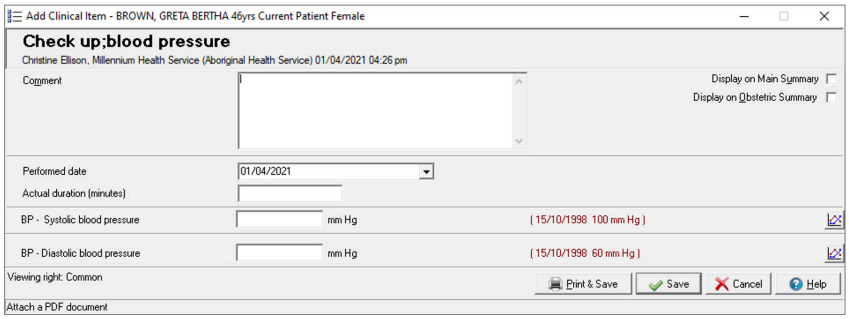
High Blood Pressure Facts and Figures

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. Open clinical record.
2. Complete clinical item 'Check up;blood pressure' or any clinical item with the qualifiers of BP—systolic blood pressure and BP—diastolic blood pressure (eg in health checks).
3. Save/exit.



nKPI: PI24

Blood pressure <or =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

- IHPs
- Nurses
- GPs

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:

Follow instructions for PI23.

nKPI PENCAT EXTRACTIONS for auditing and improvement cycles

PI01 & PI02

- Report Tab
- Maternal Health Care, baby birth weight, patient record tab
- *Set the filter as follows:*
  - Ethnicity tab—select Indigenous
  - Date Range (results): select results <=12months
  - Recalculate

PI03

- MBS Tab, Count
- *Set the filter as follows:*
  - Ethnicity tab select Indigenous

For 0–4 Age

- Select Active (3 x in 2yrs)
- General Tab, End Age = 4
- Date Range (results): select results <=12months
- Recalculate

For 25 and Above Age

- General tab, start age = 25, select Active (3 x 2yrs)
- Date range (results): select results <=24months
- Recalculate

PI04

- Report Tab
- Immunisations, Child, Child nKPI Essential Immunisations tab
- *Set the filter as follows:*
  - Ethnicity tab, select Indigenous
  - General tab, select Active (3x in 2yrs)
  - Recalculate

PI05 & PI06

- Report Tab
- Pathology, HbA1c Tab
- *Set the filter as follows:*
  - Ethnicity tab, select Indigenous
  - General tab, select Active (3x in 2yrs)
  - Conditions tab, select Diabetes Type II ticked

6 months

- Date range (results): select results <=6months
- Recalculate

12 months

- Run the report again to select results <=12months
- Recalculate

PI07

- Report Tab
- MBS Items, select the 721 segment
- *Set the filter as follows:*
  - Ethnicity tab, select Indigenous
  - General tab, select Active (3x in 2yrs)
  - Conditions tab, select Diabetes Type II ticked

24 months

- Date Range (results): select results <=24mths
- Recalculate

12 months

- Run the report again to select results <=12mths
- Recalculate

PI08

- Report Tab
- MBS Items, select the 723 segment
- *Set the filter as follows:*
  - Ethnicity tab, select Indigenous
- General tab, select Active (3x in 2yrs)
- Conditions tab, select Diabetes Type II ticked

24 months

- Date Range (results): select results <=24mths
- Recalculate

PI09 & PI10

- Report Tab
- Smoking Tab
- *Set the filter as follows:*
  - Ethnicity tab, select Indigenous
  - General tab, start age 15, select Active (3x in 2yrs)
  - Recalculate

PI11

- Report Tab
- Smoking Tab
- *Set the filter as follows:*
  - Ethnicity tab, select Indigenous
  - General tab, start age 15, select Active (3x in 2yrs)
  - Conditions tab, select other, select pregnant yes
  - Recalculate

PI12

- Report Tab
- Measures, BMI
- *Set the filter as follows:*
  - Ethnicity tab, select Indigenous
  - General tab, start age 25, select Active (3x in 2yrs)
  - Date Range (results): select results <=24mths
  - Recalculate

PI13
- Report Tab
- Maternal Health Care, antenatal visits, size in weeks at first visit tab
- *Set the filter as follows:*
  - Ethnicity tab, select Indigenous
  - General tab, Gender Female, select Active (3x in 2yrs)
  - Recalculate

PI14
- Report Tab
- Immunisations Tab
- *Set the filter as follows:*
  - Ethnicity tab, select Indigenous
  - General tab, Start age = 50, select Active (3x in 2yrs)
  - Recalculate

PI15
- Report Tab
- Immunisations and Influenza
- *Set the filter as follows:*
  - Ethnicity tab, select Indigenous
  - General tab, Start age = 15, End age = 49 select Active (3x in 2yrs)
  - Conditions tab, select Diabetes Type II and COPD
  - Recalculate

PI16 & PI17
- Report Tab
- Alcohol Tab
- *Set the filter as follows:*
  - Ethnicity tab, select Indigenous
  - General tab, Start age = 15, select Active (3x in 2yrs)
  - Date Range (Results) tab, select <=24mths
  - Recalculate

PI18 & PI19
- Report Tab
- Pathology tab, eGFR, ACR, Microalbumin tabs
- *Set the filter as follows:*
  - Ethnicity tab, select Indigenous
  - General tab, Start age = 15, select Active (3x in 2yrs)
  - Conditions tab, Diabetes Type II and Cardiovascular Disease (CVD) ticked
  - Date Range (Results) tab, select <=24mths
  - Recalculate

PI20
- Report Tab
- CV Event Risk
- *Set the filter as follows:*
  - Ethnicity tab, select Indigenous
  - General tab, start age 35, End age = 74, select Active (3x in 2yrs)
  - Conditions tab, Cardiovascular Disease "No" ticked
  - Date Range (Results) tab, select <=24mths
  - Recalculate

PI21
- Report Tab
- CV Event Risk
- *Set the filter as follows:*
  - Ethnicity tab, select Indigenous
  - General tab, start age 35, End age = 74, select Active (3x in 2yrs)
  - Conditions tab, Cardiovascular Disease "No" ticked
  - Date Range (Results) tab, select <=24mths
  - Recalculate
  - General tab, Start age = 20, End Age = 69
  - Gender Female, select Active (3x in 2yrs)
  - Conditions tab, select other, select pregnant yes
  - Recalculate

PI22
- Report Tab
- Screening, Pap Smear tab
- Pap smear done date
- *Set the filter as follows:*
  - Ethnicity tab, select Indigenous
  - General tab, Start age = 20, End age = 69
  - Gender Female, Select Active (3x in 2yrs)
  - Recalculate

PI23
- Report Tab
- Measures, BP Tab
- *Set the filter as follows:*
  - Ethnicity tab, select Indigenous
  - General tab, Select Active (3x in 2yrs)
  - Conditions tab, Diabetes type II selected
  - Date Range (Results) tab, select <=6mths
  - Recalculate

PI24
- Report Tab
- Measures, BP Tab
- *Set the filter as follows:*
  - Ethnicity tab, select Indigenous
  - General tab, Select Active (3x in 2yrs)
  - Conditions tab, Diabetes type II selected
  - Date Range (Results) tab, select <=6mths
  - Recalculate

Notes

Notes

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