



Best Practice
An evolution in medical software

nKPI

Data Reference Manual for Best Practice

SEPTEMBER 2019



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Birthweight recorded

Description:

Number and proportion of Aboriginal and/or Torres Strait Islander babies born within the previous 12 months whose birthweight has been recorded at the primary health care service.

Current %

National Current %	69%
National Target %	100%

Primary Responsibility

- New Directions
- Nurse/AHW
- GP

Improvement Strategies

- Data entry training with staff
- New Directions to follow up clients
- Seek hospital discharge summary

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 birth weight 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. Observations
2. Add
3. Enter date as birth date
4. Enter weight in kilograms (kgs)
5. Save

The screenshot shows the MD software interface. At the top, there are buttons for 'Add', 'Edit', 'Delete', and 'Print'. Below these, a date range is set from 27/12/1980 to 19/08/2019. On the left, a list of observation fields is shown, including Temp, Pulse, BP, Height, Weight, etc. The 'Weight' field is highlighted with a red circle. On the right, the 'Observations' window is open, showing a form with fields for Date, Temp, Pulse, BP, Height, Weight, etc. The 'Date' field is set to 19/08/2019, and the 'Weight' field is circled in red. At the bottom of the window, the 'Save' button is circled in red.

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 %	Low 13%
National Target %	n/a

Primary Responsibility

- New Directions
- Nurse/AHW
- GP

Improvement Strategies

- Referrals to New Directions
- Antenatal visit follow ups
- Strong linkages with local hospital and health services

Evidence Base

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

Action:

The 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. In the mother's obstetric record the birthweight is entered as grams, in the baby's file it is entered as kilograms (kgs). Incorrect entry will provide incorrect data.

Data Entry Field:

1. Observations
2. Add
3. Enter date as birth date
4. Enter weight in kilograms (kgs)
5. Save

The screenshot shows the 'Observations' data entry form. The 'Add' button at the top is circled in red. Below it, the date range is set from 27/12/1980 to 19/08/2019. The 'Date' field in the form is set to 19/08/2019 and is circled in red. The 'Weight' field is also circled in red. The 'Save' button at the bottom right is circled in red. The form includes fields for Temp, BP, Resp, BSL, Height, Weight, BMI, Head Circ., Waist, Hips, and various clinical indicators like Diabetes risk, O2 Saturation, PEFR, CV risk, Audit-C, and PULSE.

Health assessment (MBS item 715)

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, **aged 0–4 years** and for whom a Medicare Benefits Schedule (MBS) Health Assessment for Aboriginal and Torres Strait Islander People was claimed within the previous 12 months AND number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, **aged 25 years and over** and for whom an MBS Health Assessment for Aboriginal and Torres Strait Islander People was claimed within the previous 24 months.

Current %

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

Primary Responsibility

- All clinic staff

Improvement Strategies

- ICHW to assist families to clinics
- Separate program/clinic data in BP
- Continue to develop new incentive shirts

Evidence Base

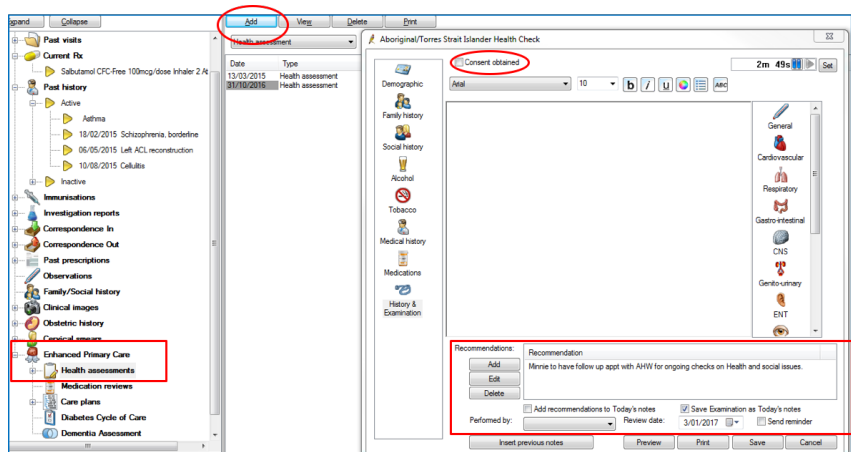
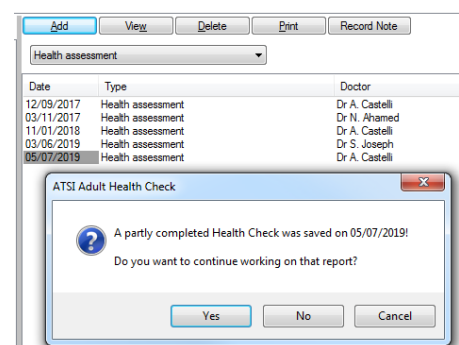
[Item 715 Medicare Fact Sheet](#)

Action:

- The data looks for all Aboriginal and/or Torres Strait Islander patients who have had a MBS item 715 billed in the past 12 months in both the 0–4 and over 25 years age brackets.
- All Aboriginal and Torres Strait Islander patients attending the clinic must be offered the opportunity to have a MBS item 715 health assessment completed.
- The patient eligibility must be checked with Medicare before billing the MBS item 715 (an MBS item 715 can only be billed once every 10 months). A pop up screen will appear in BP if the patient has had an MBS item 715 here in the previous 10 months.

Data Entry Field:

1. Enhanced Primary Care
2. Health Assessment
3. Add (check for pop up box)
4. Complete
5. Tick for patient consent
6. Complete all sections
7. Add recommendations including follow up with AHW
8. GP to bill MBS item 715
9. Reception to complete billing which will be sent to Medicare.



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
- Nurse/AHW
- GP

Improvement Strategies

- ICHW follow up on unvaccinated children
- Partner with research groups
- BP links with AIR to translate data

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

Data Entry Field:

Administered at clinic

1. Immunisation
2. Add
3. Select vaccine
4. Select Provider
5. Select Site
6. Enter Date
7. Enter Batch Number
8. Tick Send reminder
9. Tick Save batch details
10. Save

Not given at clinic

1. Immunisation
2. Add
3. Select vaccine
4. Select Provider 'NOT GIVEN HERE'
5. Enter Date
6. Do not save Batch Number
7. Enter comments
8. Save

HbA1c recorded (Type 2 Diabetes clients)

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, have Type 2 Diabetes and who have had a HbA1c measurement result recorded at the primary health care service within the **previous 6 months** AND number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, have Type 2 Diabetes and who have had an HbA1c measurement result recorded at the primary health care service within the **previous 12 months**.

Current %

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

Primary Responsibility

- GP
- AHW
- Nurse

Improvement Strategies

- Screening updated
- DCC updated every visit
- Increase nurse visits

Evidence Base

[Journal of Diabetes Research Study](#)

Action:

All Indigenous clients attending the clinic who have diabetes or at risk of diabetes are to have a HbA1c recorded **every 6 months**.

Data Entry Field:

1. Investigation reports
2. Values
3. Enter in HbA1c level
4. After entering HbA1c – Atomised values will allow it to be graphed

	03/2015	20/04/2015	03/11/2015	22/02/2016	29/06/2016	27/09/2016
ACR		3.6				
Cholesterol				12		
Creatinine			36.0			
eGFR						
HB						
HbA1c					10	
HbA1c (SI)		14.2		9		1.5
HDL				25		
LDL						
Microalbuminuria						
Triglycerides						
UAE						

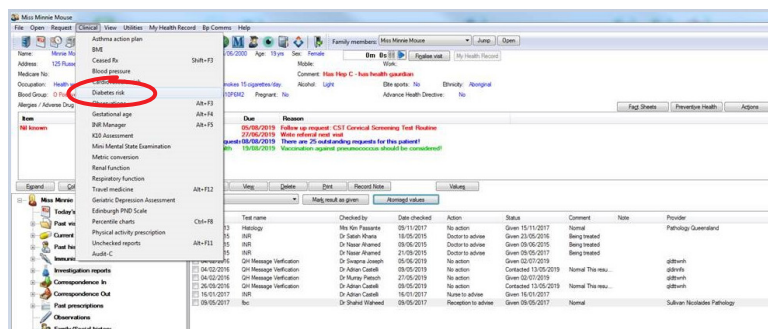
HbA1c recorded (Type 2 Diabetes clients)

Action:

Clients at risk must have a diabetes risk assessment completed and saved on file **every 12 months**.

Data Entry Field:

1. Clinical Tab
2. Diabetes Risk
3. Complete Question
4. Save



Diabetes risk calculator

Age group: Under 35 years

Gender: Female

Ethnicity: Aboriginal

Where were you born? [Dropdown]

Has any first degree relative been diagnosed with diabetes (type 1 or type 2)? ☒ Yes ☐ No

Has there ever been a high blood glucose detected? ☐ Yes ☐ No

Is an antihypertensive being taken? ☐ Yes ☐ No

Does the patient currently smoke any tobacco products on a daily basis? ☒ Yes ☐ No

How often does the patient eat vegetables or fruit? [Dropdown]

Does the patient do at least 2.5 hours of physical activity per week? ☐ Yes ☐ No

Waist measurement: [Input] cm

Points: 0

Print Save Cancel

Result:

Appears in Observations; Diabetes risk; and records the score and date.

	15/11/2017	01/12/2017	05/12/2017	01/01/2018	10/01/2018	11/01/2018	12/01/2018	17/01/2018	18/01/2018	14/02/2018	26/04/2019	29/04/2019	09/05/2019	24/06/2019	25/06/2019
Temp	37.2	36.3 Tympanic	36.3 Tympanic	36.3 Tympanic	36.5 Tympanic	36.5 Tympanic	36.5 Tympanic	36.5 Tympanic	36.7	36.8 Tympanic	36.9 Tympanic	36.5 Tympanic	36.9 Tympanic	36.9 Tympanic	36.0 Tympanic
Pulse	84	88 Regular	88 Regular	88 Regular	88 Regular	90 Regular	95 Regular	98 Regular	98	98	98	98	98	98	98
BP	120 Systolic	133/88			120/80	120/80	125/80	125/85	132/88	117/76	122/80	120/80	120/80	117/81	117/86
BP (Standing)															
BP (Lying)															
Resp	20														
BSL	4.2	7.1 Non-fasting			5.6 Non-fasting	5.4	6.5 Non-fasting		6.2 Non-fasting	6.8 Non-fasting	8.9 Non-fasting	5.9 Non-fasting	5.6 Non-fasting		
Height	169	165			165	168		175	174	160.5	160.5	165	170	165.0	165.0
Weight	123	76.40		3.62	85.6	98.5		85	105	90	85	85	100	68.50	68.50
BMI	43.1	28.1			31.4			27.8	34.7	34.9	110	31.2	34.6	25.2	25.2
Head Circ.															
Waist	10	89								108.5					
Hips															
Waist/Hip															
Chest (Inspiration)															
Chest (Expiration)															
MMSE															
KPI															
Diabetes risk	5		98		98	98	97		98	98	98	97	98	98	98
O2 Saturation															

HbA1c results (Type 2 Diabetes clients)

Description:

Number and proportion of regular Aboriginal and/or Torres Strait Islander clients who have 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

- GP
- AHW
- Nurse

Improvement Strategies

- Diabetes education
- Recall diabetic patients
- DCC updated at every visit

Evidence Base

[Diabetes the silent pandemic](#)

Action:

All Indigenous clients attending the clinic who have diabetes or at risk of diabetes are to have a HbA1c recorded every 6 months.

Data Entry Field:

1. Investigation reports
2. Values
3. Enter in HbA1c level
4. Save

Result values

Report date: 19/08/2019

HbA1c: [] mmol/mol

Total Cholesterol: [] Triglycerides: []

HDL Cholesterol: [] LDL Cholesterol: []

Creatinine: [] eGFR: []

Albumin/Creatinine ratio: [] Micro-albuminuria: [] mcg/min

Haemoglobin (g/L): []

Lookup ix Save Cancel

GP management plan (MBS item 721)

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, have a chronic disease (Type 2 Diabetes), and for whom a GP Management Plan (GPMP) (MBS Item 721) was claimed within the previous 24 months.

Current %

National Current % 51%

National Target %

Primary Responsibility

- GPs
- AHW
- Nurse

Improvement Strategies

- Appoint Chronic Disease Team Leader
- Expand Integrated Team Care team
- Followup MBS item 81300 visits

Evidence Base

[Care Planning for Chronic Diseases](#)

Action:

All Aboriginal and/or Torres Strait Islander clients who have a chronic disease should be offered a GP Management Plan (GPMP).

Data Entry Field:

1. Enhanced Primary Care
2. Care Plan
3. Add (check for pop up box, select GPMP)
4. Complete Care Plan
5. Add recommendations including referrals to allied health if required and follow up with AHW
6. Print a copy for the patient to sign to ensure that they understand the plan you have created and they agree
7. Save a final (untick save as draft)
8. GP to bill MBS item 721
9. Reception to complete billing which will be sent to Medicare.

The screenshot shows the 'GP Management Plan review' window. On the left, a tree view shows 'Enhanced Primary Care' selected. The main area displays a table of care plans. At the bottom, the 'Print' and 'Save' buttons are circled in red. The 'Add' button at the top is also circled in red.

Team Care Arrangement (MBS item 723)

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, have a chronic disease (Type 2 Diabetes) and for whom a Team Care Arrangement (TCA) (MBS Item 723) was claimed within the previous 24 months.

Current %

National Current % 48%

National Target %

Primary Responsibility

- GP
- AHW
- Nurse

Improvement Strategies

- Appoint Chronic Disease Team Leader
- Expand Integrated Team Care team
- Followup MBS items 10987 and 81300

Evidence Base

[Care Planning for Chronic Diseases](#)

Action:

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

Data Entry Field:

1. Enhanced Primary Care
2. Care Plan
3. Add (check for pop up box, select TCA)
4. Complete all areas
5. Add recommendations including referrals to allied health if required and follow up with AHW
6. Print a copy for the patient to sign to ensure that they understand the plan you have created and they agree
7. Save a final (untick save as draft)
8. GP to bill MBS item 723
9. Reception to complete billing which will be sent to Medicare.

Smoking status recorded

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, **aged 15 and over**, and whose smoking status has been recorded at the primary health care service.

Current %

National Current %	80%
National Target %	

Primary Responsibility

- All clinic staff
- New Directions
- TIS

Improvement Strategies

- Continue to benchmark for TIS
- AHW include in screenings
- Extract clients who have no data for follow up

Evidence Base

[Prevalence of Tobacco use among ATSI](#)

Action:

All clients attending the practice are to have their smoking status recorded during screening. This is to be checked and updated at each visit.

Data Entry Field:

1. Family & Social History
2. Tobacco
3. Enter details
4. Save

The screenshot shows a software interface for 'Family & Social History'. On the left is a sidebar with icons for Family, Social, Occupation, Alcohol, and Tobacco. The Tobacco icon is circled in red. The main area contains the following fields:

- Current Smoking History:** Radio buttons for Non smoker, Ex smoker, and Smoker (selected). A dropdown for Cigarettes, a text field for Cigarettes per day (15), and a text field for Year started (2018).
- Past Smoking History:** Radio buttons for Quantity/day: Unknown, < 1, 1 - 9, 10 - 19, 20 - 39, 40+.
- Patient would like cessation advice/support:** Radio buttons for Yes (selected) and No.
- Checkboxes:** Brief advice to stop smoking given, Prescribed cessation medication, Provided cessation behavioural support, and Referred to cessation support (checked).
- Comment:** A text area containing the text: 'client stopped smoking for 6 months and has just started taking it up again'.
- Buttons:** 'Save' and 'Cancel' buttons at the bottom right. The 'Save' button is circled in red.

Smoking status result

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, **aged 15 and over**, and whose smoking status has been recorded as one of the following:

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

Current %

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

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

Primary Responsibility

- All clinic staff
- New Directions
- TIS

Improvement Strategies

- Continue to benchmark for TIS
- AHW include in screenings

Evidence Base

[Prevalence of Tobacco use among ATSI](#)

Action:

All clients attending the practice are to have their smoking status recorded during screening. This is to be checked and updated at each visit.

Data Entry Field:

1. Family & Social History
2. Tobacco
3. Enter details
4. Save

The screenshot shows a software interface for 'Family & Social History'. On the left is a sidebar with icons for Family, Social, Occupation, Alcohol, and Tobacco. The Tobacco icon is circled in red. The main area is titled 'Current Smoking History' and contains three radio buttons: 'Non smoker', 'Ex smoker', and 'Smoker'. The 'Smoker' button is selected and circled in red. Below these are fields for 'Cigarettes' (a dropdown menu), 'Cigarettes per day' (set to 15), and 'Year started' (set to 2018). There is also a 'Past Smoking History' section with a 'Quantity/day' dropdown and several radio buttons for ranges from '< 1' to '40+'. Below that are fields for 'Year started' and 'Year stopped'. A section for 'Patient would like cessation advice/support:' has 'Yes' selected. There are checkboxes for 'Brief advice to stop smoking given', 'Prescribed cessation medication', 'Provided cessation behavioural support', and 'Referred to cessation support'. A 'Comment' text area contains the text 'client stopped smoking for 6 months and has just started taking it up again'. At the bottom right, there are 'Save' and 'Cancel' buttons, with the 'Save' button circled in red.

Smoking during pregnancy

Description:

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

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

Current %

National Current %	50%
National Target %	37%

Primary Responsibility

- New Directions
- Nurse/AHW
- GP

Improvement Strategies

- Expand reach of TIS — targeted
- AHW include in screenings
- Partner with New Directions

Evidence Base

[Tobacco smoking during pregnancy](#)

Action:

All clients attending the practice are to have their smoking status recorded during screening. This is to be checked and updated at each visit.

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

Family & Social History

Current Smoking History

☐ Non smoker ☐ Ex smoker ☒ Smoker

Cigarettes: Cigarettes per day: 15 Year started: 2018

Past Smoking History

Quantity/day: ☐ Unknown ☐ < 1 ☐ 1 - 9 ☐ 10 - 19 ☐ 20 - 39 ☐ 40+

Year started: Year stopped:

Patient would like cessation advice/support: ☒ Yes ☐ No

☐ Brief advice to stop smoking given ☐ Prescribed cessation medication

☐ Provided cessation behavioural support ☒ Referred to cessation support

Comment: client stopped smoking for 6 months and has just started taking it up again

Save **Cancel**

Body Mass Index (BMI) (overweight or obese)

Description:

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

Current %

National Current %	70%
--------------------	-----

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

Primary Responsibility

- AHW
- GP
- Nurse

Improvement Strategies

- Screening updated
- Offer nurse or MBS item 81300 followup
- Diet education

Evidence Base

[Overweight and Obesity](#)

Action:

All clients attending the practice have their height, weight and waist circumference recorded during screening. This is to be checked and updated at each visit.

Data Entry Field:

1. BMI Calculator
2. Enter details
3. Save

First antenatal care visit

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, who gave birth within the previous 12 months and who had gestational age recorded at their first antenatal care visit with results 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

- GP
- Nurse/AHW
- New Directions

Improvement Strategies

- Doctor education on importance
- Clinic staff education
- New direction education

Evidence Base

[Antenatal Care](#)

Action:

When a client has a confirmed pregnancy test the obstetric record is to be commenced in the BP clinical file at that visit.

Data Entry Field:

1. Obstetric History
2. Add
3. Complete details to predict the gestational age
4. Save

The screenshot shows a patient record for 'Miss Minnie Mouse'. The 'Add' button is circled in red. The left sidebar shows 'Obstetric history' selected. The main area displays a table with columns: No., LMP, Ended, Weeks, Outcome, Delivery. A row shows '2 / / 01/05/2019 38 Live birth'. Below this is a section for 'Antenatal visits' with columns: Date, Weight, BP, Urine, Oedema, Calc. size, Clin. size, Fundus, FH, Notes.

The 'Gestational age' form has fields for 'Date of LMP' (19/08/2019), 'Cycle length' (28 days), and 'Date of scan' (19/08/2019). There is a checkbox for 'Use scan date'. Below is a table with columns: Week, Start date, Week, Start date, Week, Start date, Week, Start date. The table is filled with weeks 1 through 40. The 'Save' button is circled in red.

Influenza immunisation (50 years and over)

Description:

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

Current %

National Current %	34%
National Target %	64%

Primary Responsibility

- All Clinic Staff

Improvement Strategies

- Dedicated Flu Days
- Partner with local hospital
- Offer incentives

Evidence Base

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

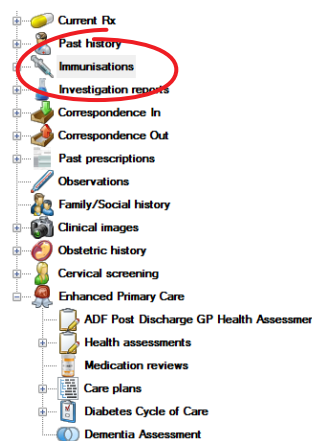
Action:

- All clients aged 50 and over are to be offered a Flu vaccine.
- Vaccines are usually available from March to September each year.
- All immunisations are to be entered into the file even if they were not administered at the clinic (just note as 'not given here').

Data Entry Field:

IMMUNISATIONS ADMINISTERED AT THE CLINIC:

1. Immunisations
2. Add
3. Select Vaccine
4. Select Provider
5. Select Site
6. Enter Date
7. Enter Batch Number
8. Tick Send reminder
9. Tick Batch Number
10. Save



IMMUNISATIONS NOT ADMINISTERED AT THE CLINIC:

1. Immunisations
2. Add
3. Select Vaccine
4. Select Provider 'NOT GIVEN HERE'
5. Enter Date
6. Do not save Batch Number
7. Enter comments
8. Send reminder
9. Save

Influenza immunisation (Type 2 Diabetes or COPD)

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, aged 15–49, are recorded as having type 2 diabetes or chronic obstructive pulmonary disease (COPD) and are immunised against influenza.

Current %

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

Primary Responsibility

- AHW
- Nurse
- GP

Improvement Strategies

- Dedicated Flu Days
- Partner with local hospital
- Offer incentives

Evidence Base

[Vaccination for COPD Immunisation](#)

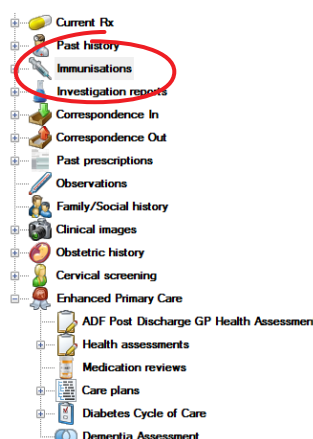
Action:

- All diabetic and COPD clients are to be offered and recommended to have a Flu vaccine
- Vaccines are usually available from March to September each year.
- All immunisations are to be entered into the file even if they were not administered at the clinic (just note as 'not given here').

Data Entry Field:

IMMUNISATIONS ADMINISTERED AT THE CLINIC:

1. Immunisations
2. Add
3. Select Vaccine
4. Select Provider
5. Select Site
6. Enter Date
7. Enter Batch Number
8. Tick Send reminder
9. Tick Batch Number
10. Save



IMMUNISATIONS NOT ADMINISTERED AT THE CLINIC:

1. Immunisations
2. Add
3. Select Vaccine
4. Select Provider 'NOT GIVEN HERE'
5. Enter Date
6. Do not save Batch Number
7. Enter comments
8. Send reminder
9. Save

Alcohol consumption recorded

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, aged 15 and over, and who have had their alcohol consumption status recorded at the primary health care service within the previous 24 months.

Current %

National Current %	57%
National Target %	

Primary Responsibility

- Nurse/AHW
- GP
- New Directions

Improvement Strategies

- Screening updated
- Staff nKPI education

Evidence Base

[Alcohol use among Indigenous people](#)

Action:

All clients, aged 15 and over, attending the practice are to have their alcohol consumption recorded during screening. This is to be checked and updated at each visit.

Data Entry Field:

1. Family & Social History
2. Alcohol
3. Enter details
4. Save

Family & Social History

Current Alcohol Intake ☐ Non drinker

Days per week: 1 Standard drinks per day: 1

Description: Social drinker - approx 1/12

Past Alcohol Intake

☐ Nil ☐ Occasional ☐ Moderate ☒ Heavy

Year started: Year stopped:

Comment: CAGE Assessment 12/10/2016
There is no indication that this patient has an alcohol dependency problem!
CAGE Assessment 19/12/2016
The CAGE Questions confirm that this patient has an alcohol

CAGE Questions Standard Drinks Audit-C

Save Cancel

Kidney function test recorded (Type 2 Diabetes or CVD)

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, aged 15 and over, who are recorded as having type 2 diabetes and have had an estimated glomerular filtration rate (eGFR) recorded AND/OR an albumin/creatinine ratio (ACR) or other microalbumin test result recorded within the previous 12 months.

AND

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, aged 15 and over, who are recorded as having 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

- Nurse
- GP
- AHW

Improvement Strategies

- Screening updated
- Clinic staff training
- Staff nKPI education

Evidence Base

[Chronic Kidney disease ATSI](#)

Action:

All Diabetic and CVD clients are to have the eGFR recorded AND/OR an ACR or other microalbumin test result recorded. This is to occur at least once in a 12 month period.

Data Entry Field:

1. Investigation Reports
2. Values
3. Complete details
4. Save.

The screenshot shows a 'Result values' form with the following fields:

- Report date: 19/08/2019
- HbA1C: [] mmol/mol
- Total Cholesterol: []
- Triglycerides: []
- HDL Cholesterol: []
- LDL Cholesterol: []
- Creatinine: []
- eGFR: []
- Albumin/Creatinine ratio: []
- Micro-albuminuria: [] mcg/min
- Haemoglobin (g/L): []

Buttons at the bottom: Lookup ix, Save, Cancel. The 'Save' button is circled in red.

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 ≥ 60
- 60 ≥ 45
- 30 ≥ 45
- 30 ≥ 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
- 25 ≥ 2.5
- > 25

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
- 35 ≥ 3.5
- > 35

Current %

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

Primary Responsibility

- GPs
- Nurses
- IHPs

Improvement Strategies

- Screening updated
- Clinic staff training
- Staff nKPI education

Action:

All Diabetic and CVD clients are to have the eGFR recorded AND/OR an ACR or other microalbumin test result recorded. This is to occur at least once in a 12 month period.

Data Entry Field:

1. Investigation Reports
2. Values
3. Complete details
4. Save.

Result values

Report date: 19/08/2019

HbA1C: mmol/mol

Total Cholesterol: Triglycerides:

HDL Cholesterol: LDL Cholesterol:

Creatinine: eGFR:

Albumin/Creatinine ratio: Micro-albuminuria: mcg/min

Haemoglobin (g/L):

Lookup lx Save Cancel

Cardiovascular disease(CVD) risk assessment

Description:

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

Current %

National Current %	38%
National Target %	

Primary Responsibility

- GP
- Nurse
- AHW

Improvement Strategies

- Screening updated
- Clinical staff training
- External education

Evidence Base

[Cardiovascular risk profile ATSI](#)

Action:

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

Data Entry Field:

1. Clinical Tab
2. Cardiovascular risk
3. Complete Details
4. Save

The screenshot shows a patient record for 'Miss Minnie Mouse'. The 'Clinical' tab is selected, and the 'Cardiovascular risk' sub-tab is highlighted with a red circle. Other tabs visible include 'Asthma action plan', 'BME', 'Ceased Rx', 'Blood pressure', 'Observations', 'Gestational age', 'BVR Manager', 'K20 Assessment', and 'Mini Mental State Examination'. Patient details include Name: Miss Minnie Mouse, Address: 125 Plaza, Medicare No., Blood Group: O Positive, and various other clinical data points.

The screenshot shows the 'Cardiovascular risk' data entry form. Fields include Systolic BP (0), Total Cholesterol (4.5), HDL Cholesterol (2.0), LVH on ECG (checkbox), Diabetes (checkbox), and Smoked within last 12 months (checkbox). A red circle highlights the 'Save' button at the bottom right. The form also includes a 'Reference' button and a text field for 'probability of developing cardiovascular disease in the next five years'.

Absolute CVD risk assessment result

Description:

Number and proportion of Aboriginal and/or Torres Strait Islander regular clients, aged 35–74, and 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 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%
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National Target %	
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Primary Responsibility

- GP
- Nurse
- AHW

Improvement Strategies

- Screening updated
- Clinical staff training
- External education

Evidence Base

[Absolute Cardio Risk resources](#)

Action:

Clients that are 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:

1. Clinical Tab
2. Cardiovascular risk
3. Complete Details
4. Save

Temp	
Pulse	
BP	
BP (Standing)	
BP (Lying)	
Resp	
BSL	
Height	
Weight	
BMI	
Head Circ.	
Waist	
Hips	
Waist/Hip	
Chest (Inspiration)	
Chest (Expiration)	
MMSE	
K10	
Diabetes risk	
O2 Saturation	
PEFR	
CV risk	
Audit-C	1
PULSE	1

Cervical screening recorded

Description:

Number and proportion of female regular clients who are Aboriginal and/or Torres Strait Islander, aged 20–69, who have not had a hysterectomy and who have had a cervical screening within 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

- Nurse/AHW
- GP
- New Directions

Improvement Strategies

- Womens wellness clinics
- Screening updated
- Staff nKPI education

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 patients aged 20-69 years are to be asked during screening when they had their last pap smear
- If unknown the patient is to be offered the opportunity to have a pap smear done at the clinic. Mark performed by as 'Not performed here'.

Data Entry Field:

1. Cervical Screening
2. Add
3. Date Performed
4. Performed by – enter provider details or 'Not performed here'
5. Add reminder
6. Save

Blood pressure recorded (Type 2 Diabetes)

Description:

Number and proportion of regular clients who are Aboriginal and/or Torres Strait Islander, have Type 2 Diabetes and who have had a blood pressure measurement result recorded at the primary health care service within the previous 6 months.

Current %

National Current %	68%
National Target %	70%

Primary Responsibility

- AHW
- Nurse
- GP

Improvement Strategies

- Screening updated
- Equipment regularly calibrated
- Staff nKPI education

Evidence Base

[Measured High blood Pressure](#)
[Summary of ATSI health](#)

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. Observations
2. Add
3. Enter BP Details
4. Save

The screenshot shows the nKPI software interface. In the top toolbar, the 'Add' button is circled in red. The left sidebar shows the 'Observations' menu item circled in red. The main window displays a table of observations for 'Miss Minnie Mouse' with columns for dates and various measurements like Temp, Pulse, BP, etc. A 'Save' button is also circled in red at the bottom right of the form.

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

Description:

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

Current %

National Current %	43%
National Target %	

Primary Responsibility

- AHW
- Nurse
- GP

Improvement Strategies

- DCC updated each visit
- Screening updated
- Staff nKPI education

Evidence Base

[BP](#)
[BP 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. Observations
2. Add
3. Enter BP Details
4. Save

The screenshot shows the nKPI system interface for a patient named Miss Minnie Mouse. The left sidebar contains a list of medical history categories, with 'Observations' highlighted. The main area displays a table of observations from 27/12/1980 to 19/08/2019. The 'Add' button is circled in red. Below the table, the 'Observations' form is open, showing fields for Date (19/08/2019), Temp, Pulse, BP Sitting, BP Standing, BP Lying, Resp. rate, Weight, Height, Waist, Hips, Chest (Insp.), Chest (Exp.), BSL, and O2 Sat. The 'Save' button is also circled in red.



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