



Best Practice  
An evolution in medical software

# nKPI

Data Reference Manual  
for Best Practice

OCTOBER 2022



# Table of Contents

---

## nKPI:

• 01	Birthweight recorded.....	1
• 02	Birthweight result (Low, normal or high).....	2
• 03	Indigenous Health Assessment completed.....	3
• 05	HbA1c recorded (Type 2 Diabetes).....	4
• 06	HbA1c results (Type 2 Diabetes).....	5
• 07	Chronic Disease Management Plan prepared (Type 2 Diabetes).....	6
• 09	Smoking status recorded .....	7
• 10	Smoking status result.....	8
• 11	Smoking during pregnancy.....	9
• 12	Body mass index (BMI) (overweight or obese) .....	10
• 13	First antenatal care visit .....	11
• 14	Influenza immunisation .....	12
• 16	Alcohol consumption recorded .....	14
• 17	Audit-C result recorded .....	15
• 18	Kidney function test recorded (Type 2 Diabetes or CVD).....	16
• 19	Kidney function test result (Type 2 Diabetes or CVD).....	17
• 20	Cardiovascular disease (CVD) risk assessment.....	18
• 21	Absolute CDV risk assessment result.....	19
• 22	Cervical screening recorded .....	20
• 23	Blood pressure recorded (Type 2 Diabetes).....	21
• 24	Blood pressure result (Type 2 Diabetes clients) .....	22
• 25	Sexually transmissible infections (Type 2 Diabetes clients).....	23

# Birthweight recorded

## Description:

Proportion of Indigenous babies born in the 12 months up to the census date who attended the organisation more than once whose birth weight was recorded.

### Current %

National Current %	73.7%
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

## Action

- Birth weights are obtained from the Birth weights are obtained from the infant's record
- All births in last 12 months are considered whether infant was a regular client or not
- The infant must have at least one recorded visit to the health service
- Only live births.

## Numerator

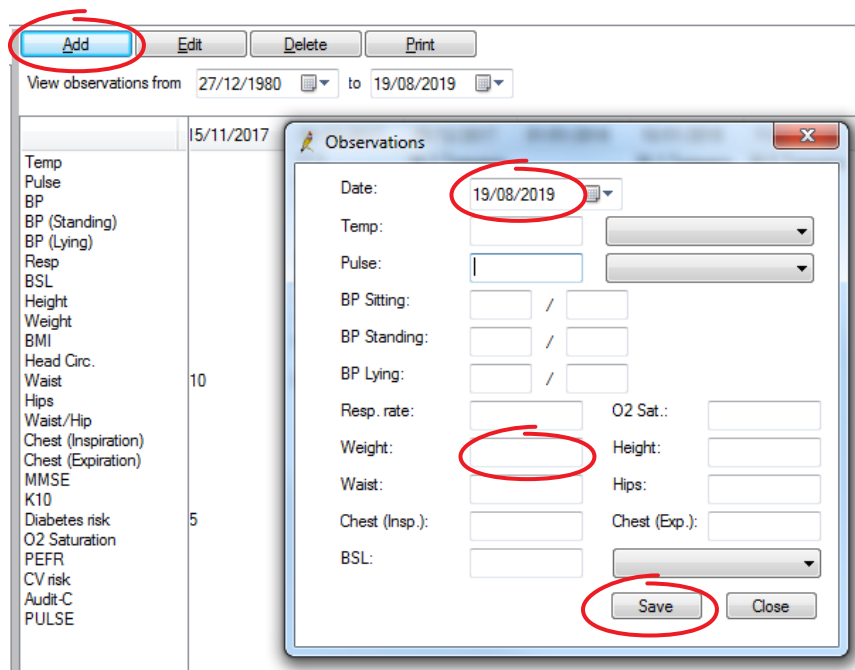
- Number of Indigenous babies born in the 12 months up to the census date who attended the organisation more than once whose birthweight was recorded.

## Denominator

- Number of Indigenous babies born in the 12 months up to the census date who attended the organisation more than once.

## Data Entry Field:

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



# Birthweight result (Low, normal or high)

## Description:

Proportion of Indigenous babies born in the 12 months up to the census date who attended the organisation more than once and whose birth weight result was:

- low (< 2,500 grams)
- normal (2,500 grams <4,500 grams)
- high (>4,500 grams).

### Current %

National Current %	Low 13.2%
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

## Action

- Birth weights are obtained from the infant's record.
- All births in the last 12 months are considered, whether the infant was a regular client or not.
- The infant must have at least one recorded visit to the health service.
- Exclude babies with unknown birth weight.

## Numerator

- Number of Indigenous babies born in the 12 months up to the census date who attended the organisation more than once whose birth weight result was within specified categories.

## Denominator

- Number of Indigenous babies born in the 12 months up to the census date who attended the organisation more than once whose birth weight was recorded.

## Data Entry Field

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

## Disaggregation

- **Birthweight result:**  
Low, normal, high.

The screenshot shows a software interface for entering observations. At the top, there are buttons for 'Add', 'Edit', 'Delete', and 'Print'. Below these is a date range selector: 'View observations from 27/12/1980 to 19/08/2019'. A list of observation types is on the left, including Temp, Pulse, BP, BSL, Height, Weight, BMI, Head Circ., Waist, Hips, etc. The 'Weight' field is highlighted with a red circle. An 'Observations' dialog box is open, showing a 'Date' field set to '19/08/2019' (circled in red), a 'Weight' field (circled in red), and a 'Save' button (circled in red). Other fields in the dialog include Temp, Pulse, BP (Sitting, Standing, Lying), Resp. rate, O2 Sat., Height, Hips, Chest (Insp./Exp.), and BSL.

# Indigenous Health Assessment completed

## Description:

Proportion of Indigenous regular clients with a current completed Indigenous health assessment, consisting of:

- Proportion of Indigenous regular clients aged 0–14 with an Indigenous health assessment (In-person MBS items: 715, 228; Telehealth MBS items: 92004, 92016, 92011, 92023) completed in the 12 months up to the census date.

AND

- Proportion of Indigenous regular clients aged 15 and over with an Indigenous health assessment (In-person MBS items: 715, 228; or Telehealth MBS items: 92004, 92016, 92011, 92023) completed in the 24 months up to the census date.

### Current %

National	0–4yrs 37%
Current %	25yrs & over 52%
National	0–4yrs 39%
Target %	25yrs & over 63–74%

### Primary Responsibility

- Clinic staff

### Improvement Strategies

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

## Action

- A patient is deemed to have received an MBS Health Assessment if a service has the MBS item selected for claiming, regardless of whether it has been submitted or paid.

## Numerator

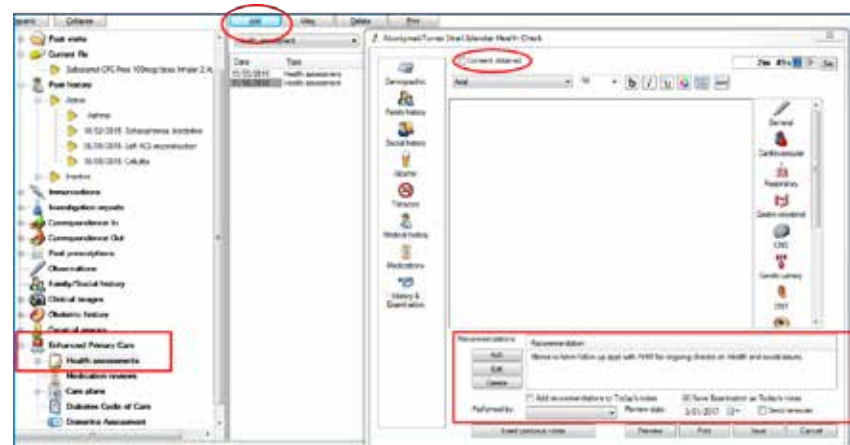
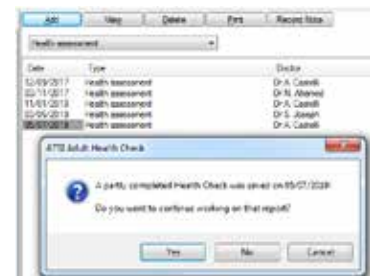
- **Calculation A:** Ages 0–14—Number of Indigenous regular clients who had an Indigenous health assessment completed in the 12 months up to the census date.
- **Calculation B:** Ages 15 and over—Number of Indigenous regular clients who had an Indigenous health assessment completed in the 24 months up to the census date.

## Denominator

- Number of Indigenous regular clients.

## 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 715/228/92004/92016/92011/92023
9. Reception to complete billing which will be sent to Medicare.



## Disaggregation

- **Age:** 0–4 years, 5–14 years, 15–24 years, 25–34 years, 35–44 years, 45–54 years, 55–64 years, 65 years and older
- **Gender:** Male and Female
- **Type of health assessment:** In-person MBS-rebated Indigenous health assessment, telehealth MBS- rebated Indigenous health assessment

## HbA1c recorded (Type 2 Diabetes clients)

### Description:

Proportion of regular clients with Type 2 diabetes and who have had an HbA1c measurement result recorded.

Proportion of Indigenous regular clients who have either:

- Type 2 diabetes and who have had an HbA1c measurement result recorded within the previous 6 months
- Type 2 diabetes and who have had an HbA1c measurement result recorded within the previous 12 months.

#### Current %

National Current %	6 mths 52%
National Target %	6 mths 69%

#### Primary Responsibility

- New Directions
- Nurse/AHW
- GP

#### Improvement Strategies

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

### Action

- Only Type 2 diabetes is considered.
- Any qualifier with a system code of HBA and units of % or a system code of HBM and units of mmol/mol is considered an HbA1c measurement.
- Clinicians must record HbA1c results correctly. They should not enter a % result in the HbA1c qualifier or a mmol/mol result in the HbA1c (%) qualifier

### Numerator

- Number of Indigenous regular clients with Type 2 diabetes who had HbA1c measurement result recorded in the 6 months up to the census date.

### Denominator

- Number of Indigenous regular patients with Type 2 diabetes.

### 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			26.0			
eGFR						
Hb						
HbA1c					10	
HbA1c (%)		14.2		9		15
HDL				25		
LDL						
Microalbuminuria						
Triglycerides						
UAE						

### Disaggregation:

- **Age:** 0–4 years, 5–14 years, 15–24 years, 25–34 years, 35–44 years, 45–54 years, 55–64 years, 65 years and older
- **Gender:** Male and Female
- **Duration:** 6 months and 12 months

# HbA1c results (Type 2 Diabetes clients)

## Description:

Proportion of Indigenous regular clients with Type 2 diabetes whose HbA1c measurement result was within a specified level.

Number of Indigenous regular clients who have Type 2 diabetes and who have had an HbA1c measurement result recorded within the previous 6 or 12 months.

### Current %

National Current %	(6 mths ≤7%) 39%
--------------------	---------------------

### Primary Responsibility

- Nurse
- AHW
- GP

### Improvement Strategies

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

## Action

- Only Type 2 diabetes is considered.
- Any qualifier with a system code of HBA and units of % or a system code of HBM and units of mmol/mol is considered an HbA1c measurement.
- Only the most recent HbA1c measurement result for each time period is considered

## Numerator

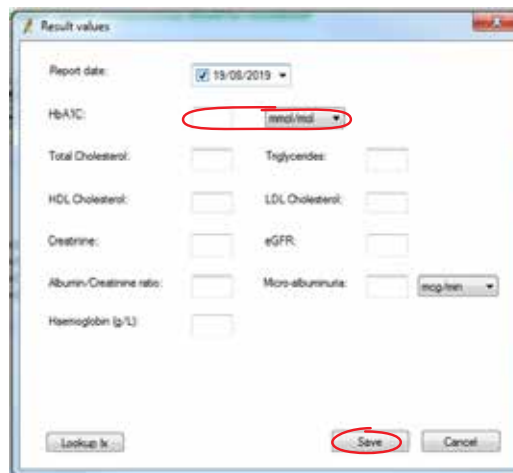
- Number of Indigenous regular clients with Type 2 diabetes who had HbA1c measurement result recorded in the:
  1. 6 months up to the census date
  2. 12 months up to the census date.

## Denominator

- Number of Indigenous regular patients with Type 2 diabetes who had an HbA1c measurement result recorded in the:
  1. 6 months up to the census date
  2. 12 months up to the census date.

## Data Entry Field

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



## Disaggregation

- **Age:** 0–4 years, 5–14 years, 15–24 years, 25–34 years, 35–44 years, 45–54 years, 55–64 years, 65 years and older
- **Gender:** Male and Female
- **Duration:** 6 months and 12 months
- **HbA1c measurement result**

# Chronic Disease Management Plan prepared

## Description:

Proportion of Indigenous regular clients with a chronic disease (Type 2 diabetes) for whom a chronic disease management plan (In-person MBS items: 721, 229; Telehealth MBS items: 92024, 92068, 92055or 92099).

Proportion of Indigenous regular clients who have Type 2 diabetes and who have received a GP Management Plan (MBS Item 721) within the previous 24 months up to the census date.

### Current %

National Current %	56%
--------------------	-----

### Primary Responsibility

- GPs
- AHW
- Nurse

### Improvement Strategies

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

## Action

- A patient is deemed to have received a GP Management Plan if a service has the MBS item checked for claiming, regardless of whether it has been submitted or paid.

## Numerator

- Number of Indigenous regular clients with Type 2 diabetes for whom an included chronic disease management plan was prepared in the 24 months up to the census date.

## Denominator:

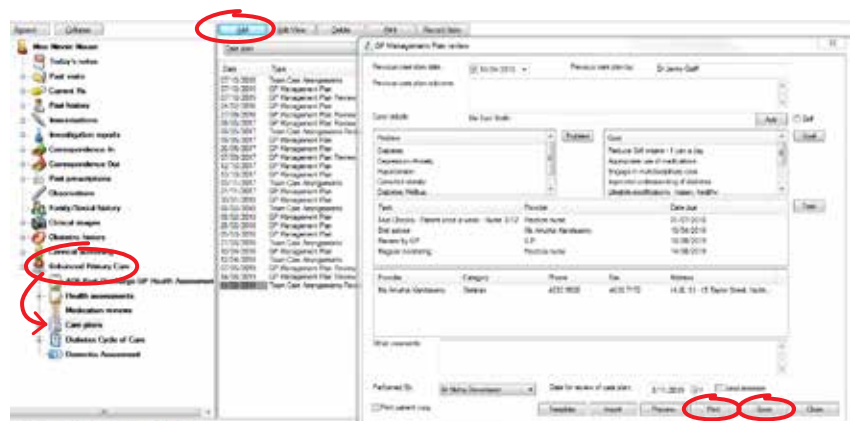
- Number of Indigenous regular clients' patients with Type 2 diabetes.

## 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.

## Disaggregation

- **Age:** 0–4 years, 5–14 years, 15–24 years, 25–34 years, 35–44 years, 45–54 years, 55–64 years, 65 years and older
- **Gender:** Male and Female
- **Type of chronic disease management plan**





# Smoking status recorded

### Description:

Proportion of Indigenous regular clients aged 11 and over whose smoking status was recorded in the 24 months up to the census date.

#### Current %

National Current %	83%
--------------------	-----

#### Primary Responsibility

- 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

### Action

- 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.

### Numerator

- Number of Indigenous regular clients aged 11 and over who had their smoking status recorded in the 24 months up to the census date .

### Denominator

- Regular, Indigenous patients aged 11 years and over.

### Data Entry Field

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

### Disaggregation

- **Age:** 11–14 years, 15–24 years, 25–34 years, 35–44 years, 45–54 years, 55–64 years, 65 years and older
- **Gender:** Male and Female

The screenshot shows a software interface for entering patient data. On the left, a vertical menu has icons for Family, Social, Occupation, Alcohol, and Tobacco. The Tobacco icon is highlighted with a red circle. The main window is titled 'Family & Social History'. Under 'Current Smoking History', there are radio buttons for 'Non smoker', 'Ex smoker', and 'Smoker' (which is selected). Below this, there is a dropdown for 'Cigarettes', a text box for 'Cigarettes per day' (containing '15'), and a text box for 'Year started' (containing '2018'). The 'Past Smoking History' section has radio buttons for 'Quantity/day' (Unknown, <1, 1-9, 10-19, 20-39, 40+). Below that are text boxes for 'Year started' and 'Year stopped'. There are also radio buttons for 'Patient would like cessation advice/support:' (Yes, No) and 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 status result

## Description:

Proportion of Indigenous regular clients aged 11 and over whose smoking status was recorded in the 24 months up to the census date was:

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

### Current %

National Current %	52%
National Target %	40%

### Primary Responsibility

- All clinic staff
- New Directions
- TIS

### Improvement Strategies

- Continue to benchmark for TIS
- AHW include in screenings

## Action

- For 'current smoker' – add together 'daily smoker', 'weekly smoker' and 'irregular smoker'.

## Numerator

- Number of Indigenous regular clients aged 11 and over who had a specified smoking status result in the 24 months up to the census date.

## Denominator

- Number of Indigenous regular clients aged 11 and over who had their smoking status recorded in the 24 months up to the census date.

## Data Entry Field

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

## Disaggregation

- **Age:** 11–14 years, 15–24 years, 25–34 years, 35–44 years, 45–54 years, 55–64 years, 65 years and older
- **Gender:** Male and Female
- **Smoking status results.**

Family & Social History

**Current Smoking History**

Non smoker
  Ex smoker
  **Smoker**

Cigarettes: [dropdown] 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

# Smoking during pregnancy

## Description:

Proportion of female Indigenous regular clients who gave birth in the 12 months up to the census date whose smoking status result during pregnancy was:

- 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

- Include only the most recent smoking status recorded prior to the completion of the latest pregnancy. Where an Indigenous regular client's tobacco smoking status does not have an assessment date assigned in the CIS, smoking status should not be counted.

## Numerator

- Number of female Indigenous regular clients who gave birth in the 12 months up to the census date who had a specified smoking status result recorded during pregnancy.

## Denominator

- Number of female Indigenous regular clients who gave birth in the 12 months up to the census date who had their smoking status recorded during pregnancy.

## 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

## Disaggregation

- **Age:** Less than 20, 20–34 years, 35 and over
- **Gender:** Females only
- **Smoking status result.**

# Body Mass Index (BMI) (overweight or obese)

## Description:

Proportion of Indigenous regular clients aged 18 and over who had their Body Mass Index (BMI) classified as underweight, normal weight, overweight, obese, and not calculated in the 24 months up to the census date.

- Underweight (<18.50 kg/m<sup>2</sup>)
- Normal weight (>=18.50 kg/m<sup>2</sup> but <=24.99 kg/m<sup>2</sup>)
- Overweight (>=25 kg/m<sup>2</sup> but <=29.90 kg/m<sup>2</sup>)
- Obese (>=30 kg/m<sup>2</sup>)

If there is no BMI recorded or it was recorded more than 24 months ago, the BMI is classified as 'not calculated'.

### Current %

National Current %	71%
--------------------	-----

### Primary Responsibility

- AHW
- GP
- Nurse

### Improvement Strategies

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

## Action

- Only the most recent measurement result with a system code of BMI in the previous 24 months is considered.
- Only include clients with both height and weight recorded whose BMI was classified using a height measurement taken since the client turned 18 years old and a weight measurement taken within the previous 24 months. The 'not calculated' category includes clients with neither height nor weight recorded, as well as those with invalid height and/or weight recorded.

## Numerator

- Number of Indigenous regular clients aged 18 and over who had a specified BMI classification recorded in the last 24 months up to the census date.

## Denominator

- Number of Indigenous regular clients aged 18 and over.

## Data Entry Field

1. BMI Calculator
2. Enter details
3. Save.

## Disaggregation

- **Age:** 18–24 years, 25–34 years, 35–44 years, 45–54 years, 55–64 years, 65 years and older
- **Gender:** Male and Female
- **BMI result.**

# First antenatal care visit

## Description:

Proportion of female Indigenous regular clients who gave birth in the 12 months up to the census date who:

- had gestational age of >11 weeks recorded at their first antenatal care visit
- had gestational age of 11–13 weeks recorded at their first antenatal care visit
- had gestational age of 14–19 weeks recorded at their first antenatal care visit
- had gestational age of ≤20 recorded at their first antenatal care visit
- did not have gestational age recorded at their first antenatal care visit
- did not attend an antenatal care visit.

### Current %

National	(before 13 wks)
Current %	42.2%
National Target %	60%

### Primary Responsibility

- GP
- Nurse/AHW
- New Directions

### Improvement Strategies

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

## Action

- Percentages may not add up to 100%.
- Live births and stillbirths; if the birth weight was at least 400 grams or the gestational age was 20 weeks or more.

## Numerator

- Number of female Indigenous regular clients who gave birth in the 12 months up to the census date and who had a specified gestational age recorded at their first antenatal care visit.

## Denominator

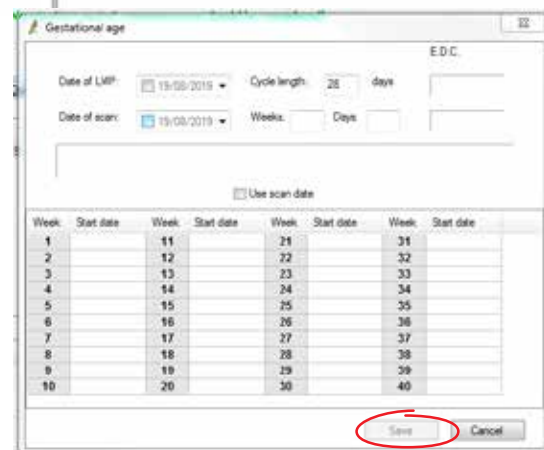
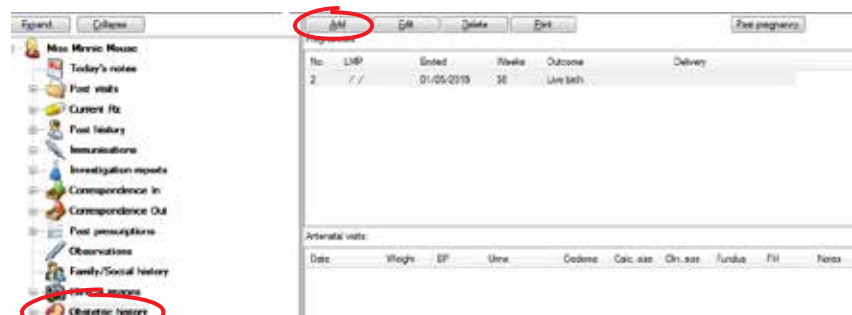
- Number of female Indigenous regular clients who gave birth in the 12 months up to the census date.

## Data Entry Field

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

## Disaggregation

- **Age:** Less than 20, 20–34 years, 35 and over
- **Gender:** Females only
- **Gestational age group:** Less than 11 weeks, 11–13 weeks, 14–19 weeks, and 20 weeks or later, no result recorded



# Influenza immunisation

## Description:

Proportion of Indigenous regular clients aged 6 months and over who are immunised against influenza within the previous 12 months.

### Current %

National Current %	N/A
--------------------	-----

### Primary Responsibility

- Clinic Staff

### Improvement Strategies

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

## Action

- Do not include Indigenous regular clients in the numerator if they have not been vaccinated, regardless of the reason.

## Numerator:

- Number of Indigenous regular clients aged 6 months and over who were immunised against influenza in the 12 months up to the census date.

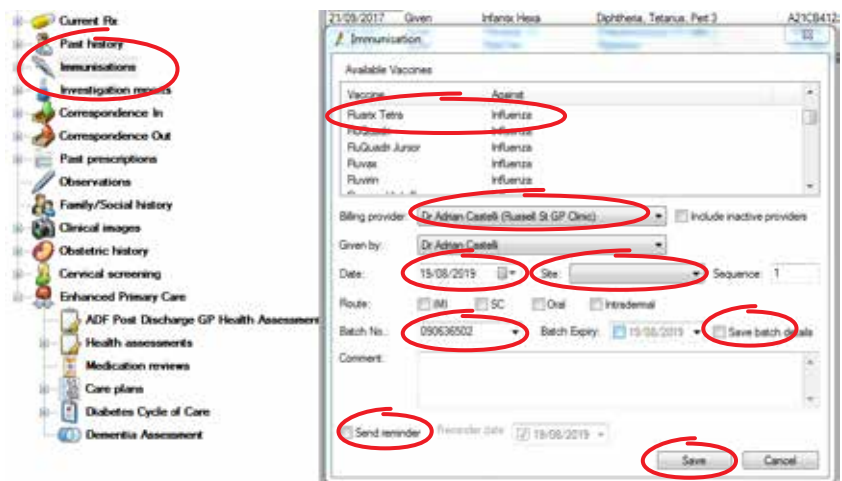
## Denominator

- Number of Indigenous regular clients aged 6 months and over.

## Data Entry Field

### IMMUNISATIONS ADMINISTERED AT THE 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 Batch Number
10. Save



# Influenza immunisation

## IMMUNISATIONS **NOT** ADMINISTERED AT THE 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. Send reminder
9. Save

The screenshot shows the 'Immunisation' form with the following details:

- Available Vaccines:**

Vaccine	Against
Fluarix Tetra	Influenza
FluQuadri	Influenza
FluQuadri Junior	Influenza
Fluvax	Influenza
Fluvirin	Influenza
- Billing provider:** Not given here
- Given by:** (empty)
- Date:** 19/08/2019
- Site:** (empty)
- Sequence:** 1
- Route:**  IMI  SC  Oral  Intradermal
- Batch No.:** (empty)
- Batch Expiry:** 19/08/2019
- Comment:** (empty)
- Send reminder:**  Reminder date: 19/08/2019

## Disaggregation

- **Age:** 6 months – 4years, 5–14 years, 15–24 years, 25–34 years, 35–44 years, 45–54 years, 55–64 years, and 65 years and over
- **Gender:** Male and female.

# Alcohol consumption recorded

## Description:

Proportion of Indigenous regular clients aged 15 and over whose alcohol consumption status was recorded in the 24 months up to the census date.

### Current %

National Current %	65%
--------------------	-----

### Primary Responsibility

- Nurse/AHW
- GP
- New Directions

### Improvement Strategies

- Screening updated
- Staff nKPI education

## Action

- Patients must have had a qualifier with a system code of ALC or ALP recorded to be included
- Central qualifiers are Alcohol Consumption Level and Alcohol Consumption During Pregnancy.

## Numerator

- Number of Indigenous regular clients aged 15 and over whose alcohol consumption status was recorded in the 24 months up to the census date.

## Denominator

- Number of Indigenous regular clients aged 15 and over.

## Data Entry Field

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

## Disaggregation

- **Age:** 15–24 years, 25–34 years, 35–44 years, 45–54 years, 55–64 years, and 65 years and over
- **Gender:** Male and Female.



# Audit-C result recorded

## Description:

Proportion of Indigenous regular clients aged 15 and over who had an AUDIT-C with result recorded in the 24 months up to the census date of:

- ≥4 males and ≥3 females; or
- <4 males and <3 females.

### Current %

National Current %	≥4 (Males) or ≥3 (Females) 46%
--------------------	-----------------------------------

### Primary Responsibility

- Nurse/AHW
- GP
- New Directions

### Improvement Strategies

- Alcohol education
- Clinical staff updated on tool
- Staff nKPI education

## Action

- Any numeric qualifier with an export code of AUDITC is considered an AUDIT-C result. For example, in Check up; alcohol; AUDIT-C, the three Alcohol audit interview questions must have a value and the Alcohol AUDIT-C total must be calculated. These four qualifiers can be added to any clinical item to augment data collection.
- Do not include results from any other alcohol use screening tool.

## Numerator

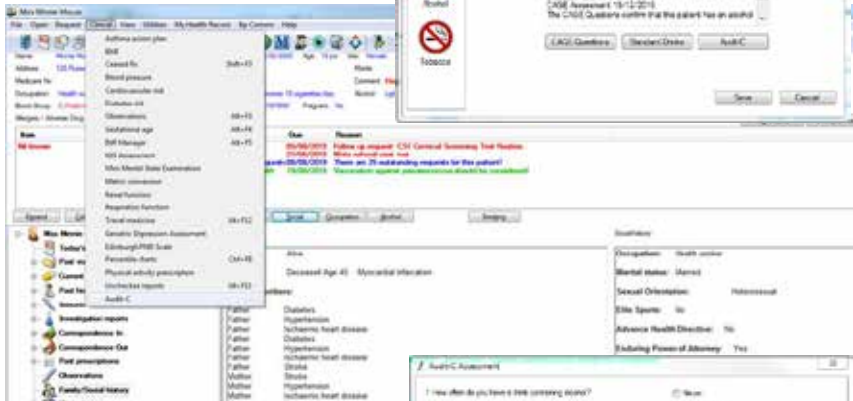
- Number of Indigenous regular clients aged 15 and over who had a specified AUDIT-C score in the 24 months up to the census date.

## Denominator

- Number of Indigenous regular clients aged 15 and over who had an AUDIT-C result recorded.

## Data Entry Field

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



## Disaggregation

- **Age:** 15–24 years, 25–34 years, 35–44 years, 45–54 years, 55–64 years, and 65 years and over
- **Gender:** Male and Female
- **AUDIT-C result.**

	15-24	25-34	35-44	45-54	55-64	65+	Male	Female
Compendium In	121	76	110	88	83	21	105	26
Compendium Out	43	28	110	74	83	21	105	26
Past presentations	28							
Observations								
Family/Social History								
Clinical history								
Clinical summary								
Enhanced Patient Care								

## Kidney function test recorded (Type 2 Diabetes or CVD)

### Description:

Proportion of Indigenous regular clients aged 18 and over with Type 2 diabetes and/or cardiovascular disease (CVD) who had a kidney function test recorded in the 12 months up to the census date, consisting of:

- only an estimated glomerular filtration rate (eGFR)
- only an albumin/creatinine ratio (ACR)
- both an eGFR and an ACR
- only an ACR test result recorded
- neither an eGFR nor an ACR test result recorded.

#### Current %

National Current %	Type 2 Diabetes 62% CVD 59%
--------------------	--------------------------------

#### Primary Responsibility

- Nurse
- GP
- AHW

#### Improvement Strategies

- Screening updated
- Clinic staff training
- Staff nKPI education

### Action

- ACR results are identified as belonging to a qualifier with the system code of ACR and eGFR results are identified as belonging to a qualifier with the system code of GFE. Both laboratory and manually entered results are included.
- Do include results from all relevant pathology tests.
- In the 'Type 2 diabetes and/or CVD' category, count clients with either or both conditions once only. For example, count a client with both Type 2 diabetes and CVD once, not twice.

### Numerator

- Number of Indigenous regular clients with Type 2 diabetes or with CVD or Type 2 diabetes and/or CVD who had a specified kidney function test result recorded in the 12 months up to the census date.

### Denominator

- Number of Indigenous regular clients with Type 2 diabetes, CVD, Type 2 diabetes and/or CVD.

### Data Entry Field

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

### Disaggregation

- **Age:** 18–24 years, 25–34 years, 35–44 years, 45–54 years, 55–64 years, 65 years and older
- **Gender:** Male and Female
- **Chronic disease:** Type 2 diabetes, Cardiovascular disease, either or both above
- **Test:** an eGFR only, an ACR only, both an eGFR and an ACR, neither an eGFR nor an ACR.

# Kidney function test result (Type 2 Diabetes or CVD)

## Description:

Proportion of Indigenous regular clients with Type 2 diabetes and/or cardiovascular disease (CVD) who had both an estimated glomerular filtration rate (eGFR) and albumin/creatinine ratio (ACR) result recorded in the 12 months up to the census date, categorised as normal/low/moderate/high risk.

### KIDNEY FUNCTION TEST RISK RESULTS CATEGORIES

- **Normal risk**—eGFR  $\geq 60$  mL/min/1.73m<sup>2</sup> and:
  - ACR  $< 3.5$  mg/mmol (females)
  - ACR  $< 2.5$  mg/mmol (males).
- **Low risk**—eGFR  $\geq 45$  mL/min/1.73m<sup>2</sup> and  $< 60$  mL/min/1.73m<sup>2</sup> and either:
  - ACR  $< 3.5$  mg/mmol (females)
  - ACR  $< 2.5$  mg/mmol (males);

OR eGFR  $\geq 60$  mL/min/1.73m<sup>2</sup> and either:

  - ACR  $\geq 3.5$  mg/mmol &  $\leq 35$  mg/mmol (females)
  - ACR  $\geq 2.5$  mg/mmol &  $\leq 25$  mg/mmol (males).
- **Moderate risk**—eGFR  $\geq 45$  mL/min/1.73m<sup>2</sup> and  $< 60$  mL/min/1.73m<sup>2</sup> and either:
  - ACR  $\geq 3.5$  mg/mmol &  $\leq 35$  mg/mmol (females)
  - ACR  $\geq 2.5$  mg/mmol &  $\leq 25$  mg/mmol (males);

OR eGFR  $\geq 30$  mL/min/1.73m<sup>2</sup> and  $< 45$  mL/min/1.73m<sup>2</sup> and either:

  - ACR  $< 35$  mg/mmol (females)
  - ACR  $< 25$  mg/mmol (males).
- **High risk**—eGFR  $\geq 30$  mL/min/1.73m<sup>2</sup> and either:
  - ACR  $> 35$  mg/mmol (females)
  - ACR  $> 25$  mg/mmol (males);

OR eGFR less than 30 mL/min/1.73m<sup>2</sup> and any ACR result for both females and males.

Current % Kidney test, eGFR  $\geq 60$  mL/min/1.73 m<sup>2</sup>

National Current %	Type 2 82%, CVD 76%
--------------------	---------------------

### Primary Responsibility

- GPs
- Nurses
- IHPs

### Improvement Strategies

- Screening updated
- Clinic staff training
- Staff nKPI education

## Action

- Count is of people, not tests.
- Clients must have both a valid eGFR AND a valid ACR test result recorded to be categorised as normal/low/moderate/high risk.
- Consider only the most recent eGFR and ACR tests. This means that if a client has had several tests, include only the results from the most recent tests.
- Results from all relevant pathology tests.

## Numerator

- Number of Indigenous regular clients with Type 2 diabetes or with CVD or Type 2 diabetes and/or CVD who had a specified kidney function test result recorded in the 12 months up to the census date.

## Denominator

- Number of Indigenous regular clients with Type 2 diabetes, CVD, Type 2 diabetes and/or CVD.

## Data Entry Field:

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

The screenshot shows a 'Result values' form with various fields for laboratory tests. The 'eGFR' field is highlighted with a red circle. At the bottom right, the 'Save' button is also circled in red.

## Disaggregation

- **Age:** 18–24 years, 25–34 years, 35–44 years, 45–54 years, 55–64 years, 65 years and older
- **Gender:** Male and female
- **Chronic disease:** Type 2 diabetes, Cardiovascular disease, either or both above
- **Risk result category**

## CVD risk assessment factors

### Description:

Proportion of Indigenous regular clients aged 35-74 with no known cardiovascular disease (CVD) who had all the necessary factors assessed in the 24 months up to the census date to enable CVD risk assessment. These risk factors are:

- Tobacco smoking
- Diabetes assessment
- Systolic blood pressure
- Total cholesterol and HDL cholesterol levels
- Age
- Sex

### Current %

National Current %	49%
--------------------	-----

### Primary Responsibility

- GP
- Nurse
- AHW

### Improvement Strategies

- Screening updated
- Clinical staff training
- External education

### Action

- Patients must have a sex and date of birth.
- Patients must have the following recorded in the previous 24 months:
  - Smoking status (reference qualifier with system code of SMO or SMP).
  - Systolic blood pressure (numeric qualifier with system code of BPS).
  - Either total cholesterol and HDL (numeric qualifiers with system codes of CHO and HDL) or cholesterol/HDL level (numeric qualifier with system code of CHR).
- Do not include Indigenous regular clients with CVD

### Numerator

- Number of Indigenous regular clients aged 35-74 without known CVD who had all the necessary factors assessed in the 24 months up to the census date to enable CVD risk assessment.

### Denominator

- Number of Indigenous regular clients aged 35-74 without know CVD.

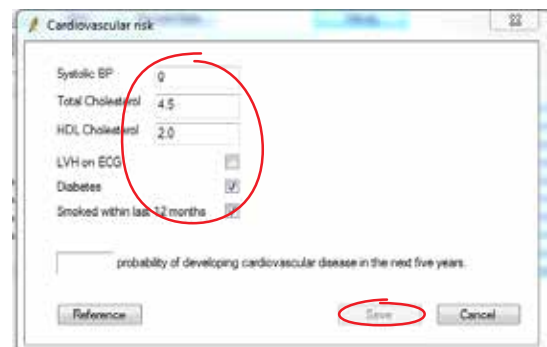
### Data Entry Field

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



### Disaggregation

- **Age:** 35-44 years, 45-54 years, 55-64 years, 65 years and older
- **Gender:** Male and Female



# Absolute CVD risk assessment results

## Description:

Proportion of Indigenous regular clients aged 35 to 74 with no known CVD who had an absolute CVD risk assessment recorded in the 24 months up to the census date as:

- 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 %	30% (High)
National Target %	

### Primary Responsibility

- GP
- Nurse
- AHW

### Improvement Strategies

- Screening updated
- Clinical staff training
- External education

## Action:

- Patients must have a sex and date of birth.
- Do not include Indigenous regular clients with CVD.
- Only the most recently recorded result from an absolute CVD risk assessment. This means that if a client has had several assessments, include only the results from the most recent assessment.
- Patients must have a record of their cardiovascular risk (high, moderate, or low) recorded within the previous 24 months.

## Numerator

- Number of Indigenous regular clients aged 35 to 74 who had a specified absolute CCVD risk assessment recorded in the 24 months up to the census date.

## Denominator

- Number of Indigenous regular clients aged 35-74 without known CVD who had an absolute CVD risk assessment result recorded.

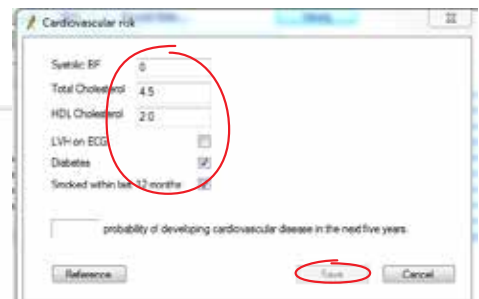
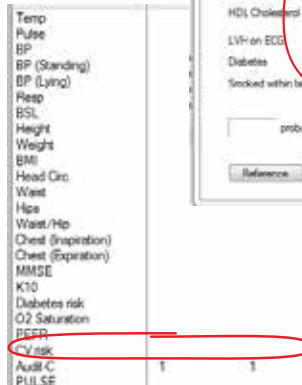
## Data Entry Field

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



## Disaggregation

- Age: 35–44 years, 45–54 years, 55–64 years, 65–74 years
- Gender: Male and Female
- CVD risk assessment



# Cervical screening recorded

## Description:

Proportion of female Indigenous regular clients aged 25–74 who have not had a hysterectomy and who had a cervical screening human papillomavirus (HPV) test within the 5 years up to the census date where the test occurred on or after 1 December 2017.

Proportion of female Indigenous regular clients aged 25–74, who have not had a hysterectomy and who have had a cervical screening (human papillomavirus (HPV)) test within the previous 5 years.

### Current %

National Current % (previous 2 years)	28%
---------------------------------------	-----

### Primary Responsibility

- Nurse/AHW
- GP
- New Directions

### Improvement Strategies

- Womens wellness clinics
- Screening updated
- Staff nKPI education

## Action

- A cervical screening result is any incoming electronic pathology result identified as being a cervical screening where its laboratory description contains CST, HPV, LBC, CERVICAL SCREEN, GYNAECOLOGICAL CYTOLOGY or NCSP.
- A cervical screening request is a pathology request which has a keyword of CST, HPV, or LBC.
- A cervical screening clinical item is a completed item of any class with the export code of CST, HPV or LBC.
- A cervical screening qualifier is any qualifier which is a Yes/No qualifier with the export code of CST, HPV or LBC where the response recorded was Yes.
- Do not include Indigenous regular clients whose last screening was more than 5 years ago or before 1 December 2017.

## Numerator

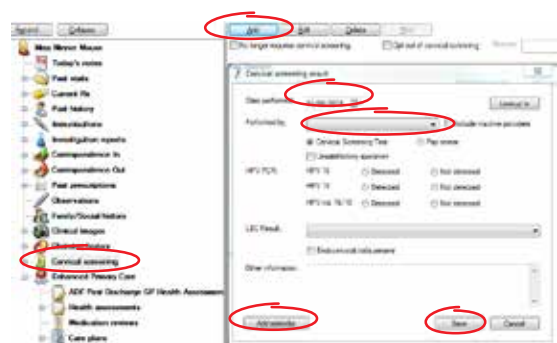
- Number of female Indigenous regular clients aged 25–74, who have not had a hysterectomy and who have had a cervical screening (human papillomavirus (HPV)) test within the previous 5 years where the test occurred on or after 1 December 2017.

## Denominator

- Number of female Indigenous, regular client aged between 25 – 74 who have not had a hysterectomy.

## 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



## Disaggregation

- **Age:** 25–34 years, 35–44 years, 45–54 years, 55–64 years, 65 years and older
- **Gender:** Female

# Blood pressure recorded (Type 2 Diabetes)

## Description:

Proportion of Indigenous regular clients with Type 2 diabetes who had a blood pressure measurement result recorded in the 6 months up to the census date.

Proportion of regular clients who are Indigenous, 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 %	66.2%
National Target %	70%

### Primary Responsibility

- AHW
- Nurse
- GP

### Improvement Strategies

- Screening updated
- Equipment regularly calibrated
- Staff nKPI education

## Action

- Only Type 2 diabetes is considered (any ICD code of T90). Type 1 diabetes, secondary diabetes, gestational diabetes mellitus (GDM), previous GDM, impaired fasting glucose, impaired glucose tolerance is not included.

## Numerator

- Number of Indigenous regular clients with Type 2 diabetes who had their blood pressure measurement result recorded in the 6 months up to the census date.

## Denominator

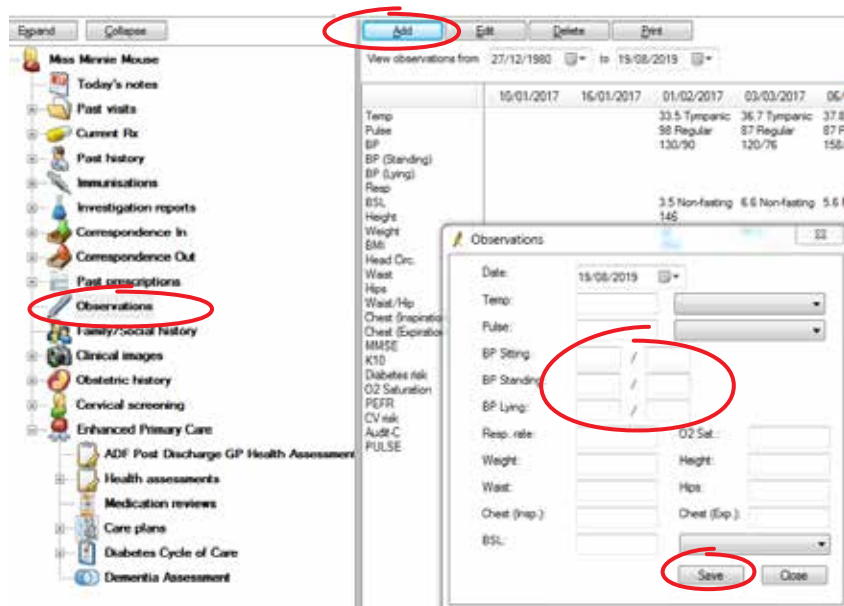
- Number of Indigenous regular clients with Type 2 diabetes.

## Data Entry Field

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

## Disaggregation

- **Age:** 0–4 years, 5–14 years, 15–24 years, 25–34 years, 35–44 years, 45–54 years, 55–64 years, 65 years and older
- **Gender:** Male and Female



# Blood pressure result (Type 2 Diabetes)

## Description:

Proportion of Indigenous regular clients with Type 2 diabetes whose blood pressure measurement result, recorded in the 6 months up to the census date, was less than or equal to 140/90 mmHg.

### Current %

National Current %	41.3%
National Target %	

### Primary Responsibility

- AHW
- Nurse
- GP

### Improvement Strategies

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

## Action

- Only Type 2 diabetes is considered (any ICD10 code of T90). Type 1 diabetes, secondary diabetes, gestational diabetes mellitus (GDM), previous GDM, impaired fasting glucose, impaired glucose tolerance is not included. For more information, see System codes.
- The patient does not have a blood pressure measurement of less than or equal to 140/90 mmHg if either the systolic or diastolic reading is above the threshold (140 and 90 respectively).
- Only the most recent blood pressure measurement result in previous 6 months is considered.

## Numerator

- Number of Indigenous regular clients with Type 2 diabetes who had a recorded blood pressure of 140/90 mmHg or less in the 6 months up to the census date.

## Denominator

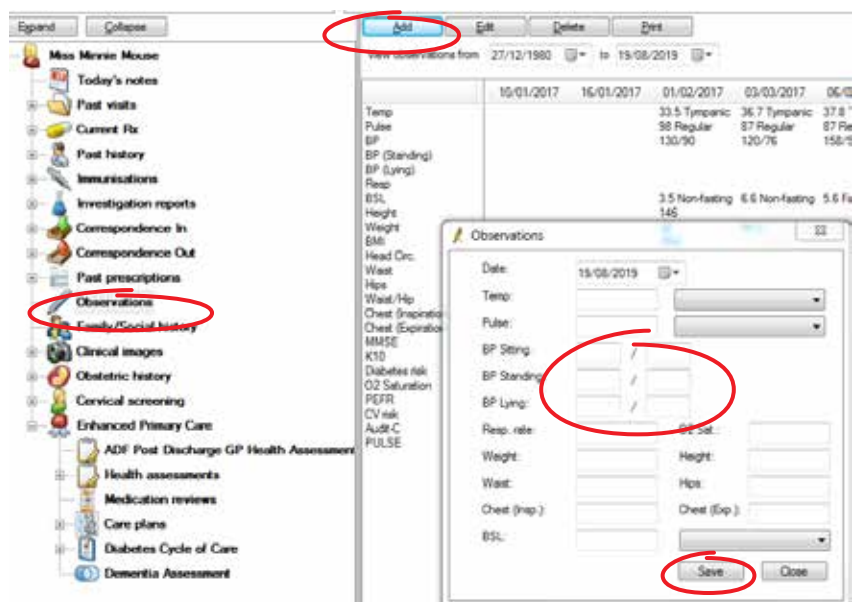
- Number of Indigenous regular clients with Type 2 diabetes who had their blood pressure measurement result recorded in the 6 months up to the census date.

## Data Entry Field

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

## Disaggregation

- **Age:** 0–4 years, 5–14 years, 15–24 years, 25–34 years, 35–44 years, 45–54 years, 55–64 years, 65 years and over
- **Gender:** Male and Female





# Sexually transmissible infections

## Description:

Proportion of Indigenous regular clients aged 15–34 who were tested for one or more sexually transmissible infections (STIs) (Chlamydia and/or gonorrhoea) within the previous 12 months.

### Primary Responsibility

- AHW
- Nurse
- GP

### Evidence for the National current %

[National Key Performance Indicators for Aboriginal and Torres Strait Islander Primary Health Care: results to June 2018, An overview of nKPI results to June 2018.](#)

## Action

- Consider only tests where the result is recorded in the Clinical Information System (CIS). Do not include tests that have been requested but a result has not been recorded.
- Ensure that your data are from the correct time period, as specified in the indicator description.
- Count is of people, not tests.
- Consider only the most recent test.

## Numerator

- Number of Indigenous regular clients who were tested for chlamydia and/or gonorrhoea within the previous 12 months.

## Denominator

- Number of Indigenous regular clients.

## Disaggregation

- **Age:** 15–19 years, 20–24 years, 25–29 years, 30–34 years, 35–39 years,
- **Gender:** Male and Female







36 Russell Street  
South Brisbane Q 4101

P: 07 3328 8500

[qaihc.com.au](http://qaihc.com.au)

