



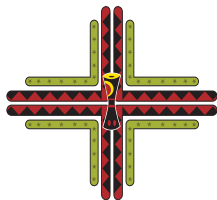
MedicalDirector®

nKPI

Data Reference Manual
for Medical Director

JANUARY 2023





TAIHS

Townsville Aboriginal &
Islander Health Service

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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
- Nurses/AWA
- GPs

Improvement Strategies

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

Action

- The birthweight is to be taken from the baby's client record where available
- Where a baby does not have a separate client record, the mother's record may be used as a source of birth details
- The date of the weight recorded must match the babies' date of birth.

Numerator

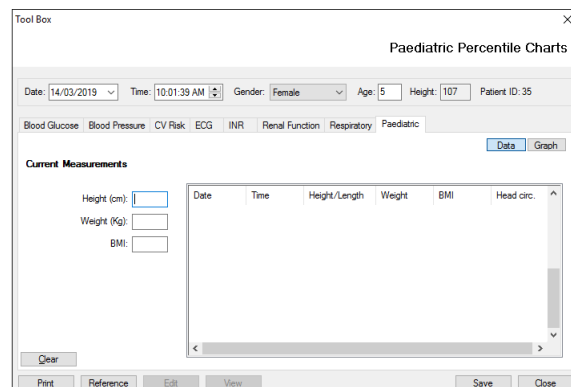
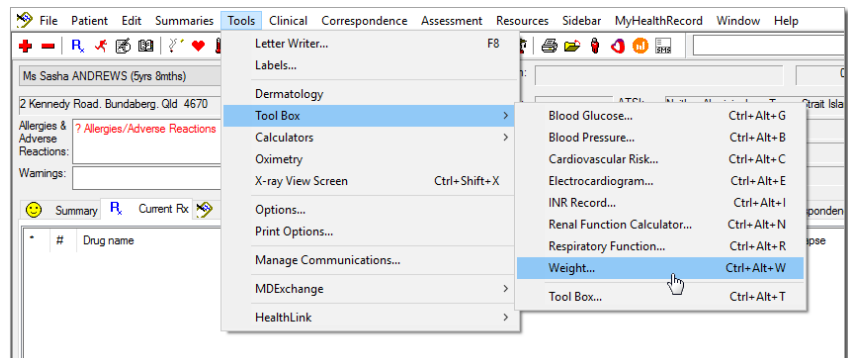
- Number of Indigenous babies born in the 12 months up to the census date who attended the organisation more than once whose birth-weight was recorded.

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. Open a patient's record
2. Select on Tools > Toolbox > weight
3. Paediatric percentile charts will be displayed
4. Enter a value for weight (Modify patient's date of birth)
5. Click 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 (less than 2,500 grams)
- normal (2,500 grams to less than 4,500 grams)
- high (4,500 grams and over).

Current %

| | |
|--------------------|-------|
| National Current % | 13.2% |
| National Target % | n/a |

Primary Responsibility

- New Directions
- Nurses/AWA
- GPs

Improvement Strategies

- Referrals to new Directions
- Antenatal visits follow ups
- Strong linkages with local hospital and health services Data entry field

Action

- The birthweight is to be taken from the baby's client record where available.
- Where a baby does not have a separate client record, the mother's record may be used as a source of birth details.
- 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 birthweight=

Numerator

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

Data Entry Field

1. Open a patient's record
2. Select on Tools > Toolbox > weight
3. Paediatric percentile charts will be displayed
4. Enter a value for weight (Modify patient's date of birth)
5. Click Save

Disaggregation

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

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 Current % | 0–4yrs 37% +25yrs 52% |
| National Target % | 0–4yrs 39% 25yrs & 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

- Patient must have had at least one MBS claim where the ‘date lodged’ falls in the previous 12 or 24 months
- The claim is required to be transmitted to Medicare and the payment report requested and returned.

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

n/a

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 patients)

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
- Nurses/AWA
- GPs

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
 - 12 months up to the census date

Denominator

- Number of Indigenous regular patients with Type 2 diabetes.

Data Entry Field

1. Click Result
2. Click Add
3. In subject field key HbA1
4. In results key readings (or example 7.8%)
5. Click 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 results (Type 2 Diabetes patients)

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 \leq 7%) 39% |
|--------------------|---------------------------|

Primary Responsibility

- Nurses
- AHW
- GPs

Improvement Strategies

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

Action

- Only Type 2 diabetes is considered
- 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
- 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:
 - 6 months up to the census date
 - 12 months up to the census date

Denominator

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

Data Entry Field

1. Open a patient's record
2. Select on Clinical > Diabetes Record
3. The Diabetes Follow up window appears
4. Click Add values > The Diabetes Record window appears
5. Input a value for HbA1c (either % or mmol/mol)
6. Click 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
- Nurses

Improvement Strategies

- Appoint Chronic Disease Team Leader
- Expand Integrated Team Care team
- Follow up MBS item 813000 visits

Action

- Do not include patients with type 1 diabetes, secondary diabetes, gestational diabetes mellitus (GDM), previous GDM, impaired fasting glucose or impaired glucose tolerance
- Do not include patients who have only had a GP Management Plan review (Medicare Item 732) within the recording period.

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

- The method for creating and processing a 715 claim can be seen in PI03
- A history of Type 2 Diabetes may be added to the patient file by following the method outlined in PI05.

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

- Patient's smoking status is recorded in the smoking tab in the patient's details menu
- Results arising from measurements conducted outside of the organisation that are known by the organisation should be included.

Numerator

- The number of regular Indigenous aged over 11 have had their smoking status recorded in the 24 months up to the census date.

Denominator

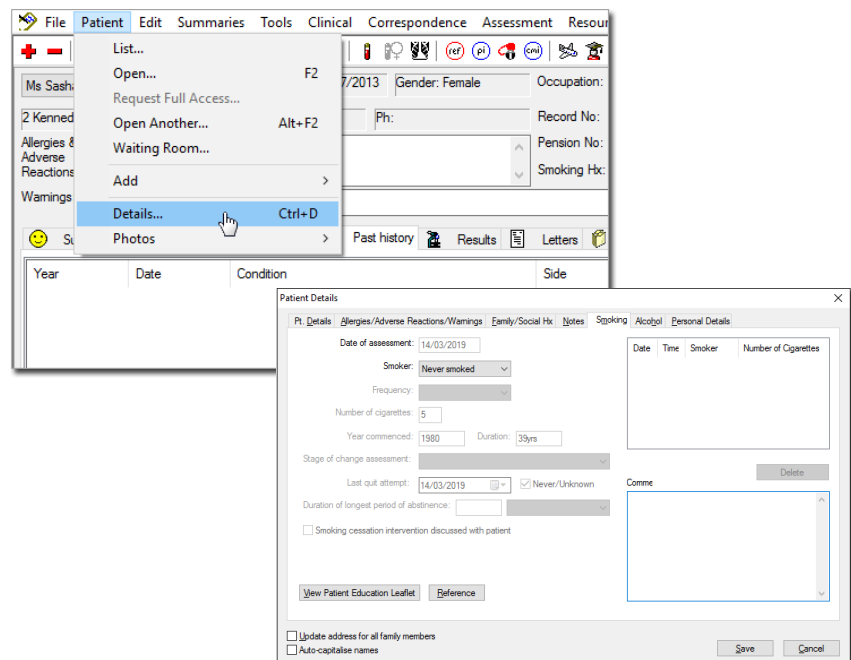
- The number of your regular Indigenous patients were there in each age and gender group.

Data Entry Field

1. Open a patient's record
2. Select Patient > Details
3. Select the Smoking tab
4. Set smoking status via the Smoker dropdown
5. Click 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 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
- Never smoked

There's no agreement on how long a person needs to have quit smoking to be considered an ex-smoker rather than a smoker—what is put on the record is a clinical judgement. To be counted as having ever smoked, the person must have smoked more than 100 cigarettes in total (or equivalent).

Current %

| | |
|--------------------|-----|
| National Current % | 52% |
| National Target % | 40% |

Primary Responsibility

- Clinic staff
- New Directions
- TIS

Improvement Strategies

- Continue to benchmark for TIS
- AHW include in screenings

Action

- Where an Indigenous regular patient's tobacco smoking status does not have an assessment, date assigned within the Patient Information Record System (PIRS), smoking status as recorded in the PIRS should be treated as current (that is, as having been updated within the previous 24 months)
- Results arising from measurements conducted outside of the organisation that are known by the organisation should be included.

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. Open a patient's record
2. Select Patient > Details
3. Select the Smoking tab
4. Set smoking status via the Smoker dropdown
5. Click 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**

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
- Never smoked

There's no agreement on how long a person needs to have quit smoking to be considered an ex-smoker rather than a smoker—what is put on the record is a clinical judgement. To be counted as having ever smoked, the person must have smoked more than 100 cigarettes in total (or equivalent).

Current %

| | |
|--------------------|-----|
| National Current % | 50% |
| National Target % | 37% |

Primary Responsibility

- New Directions
- Nurses/AWA
- GPs

Improvement Strategies

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

Action

- Counts clients with a recorded smoking status, who recorded 3 or more visits within the previous 2 years
- Includes live births and still births if the birthweight is at least 400 grams OR the gestational age was 20 weeks or more
- Include only the most recent smoking status recorded prior to the completion of the latest pregnancy. Where a smoking status does not have an assessment date assigned within the CIS, smoking status should not be counted
- Include results arising from measurements conducted outside of the organisation that are known by the organisation.

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

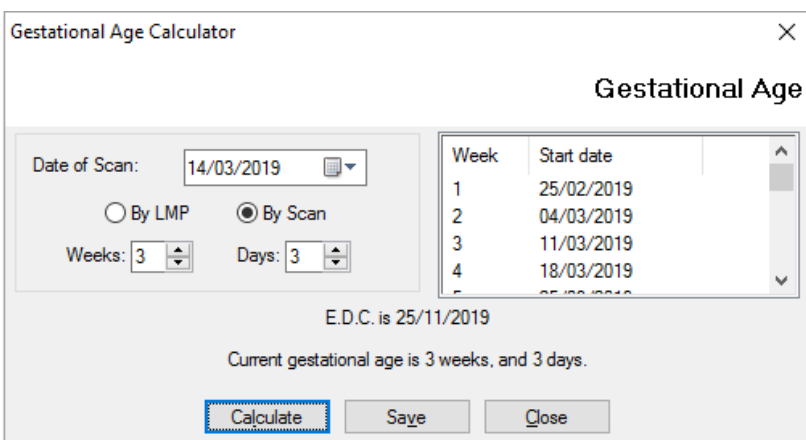
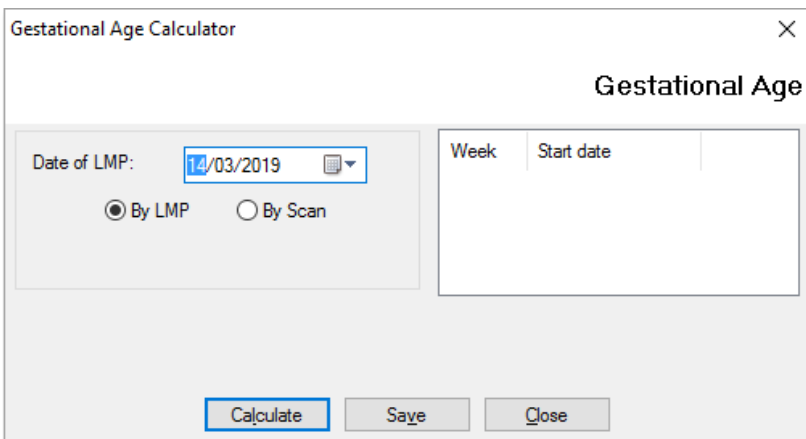
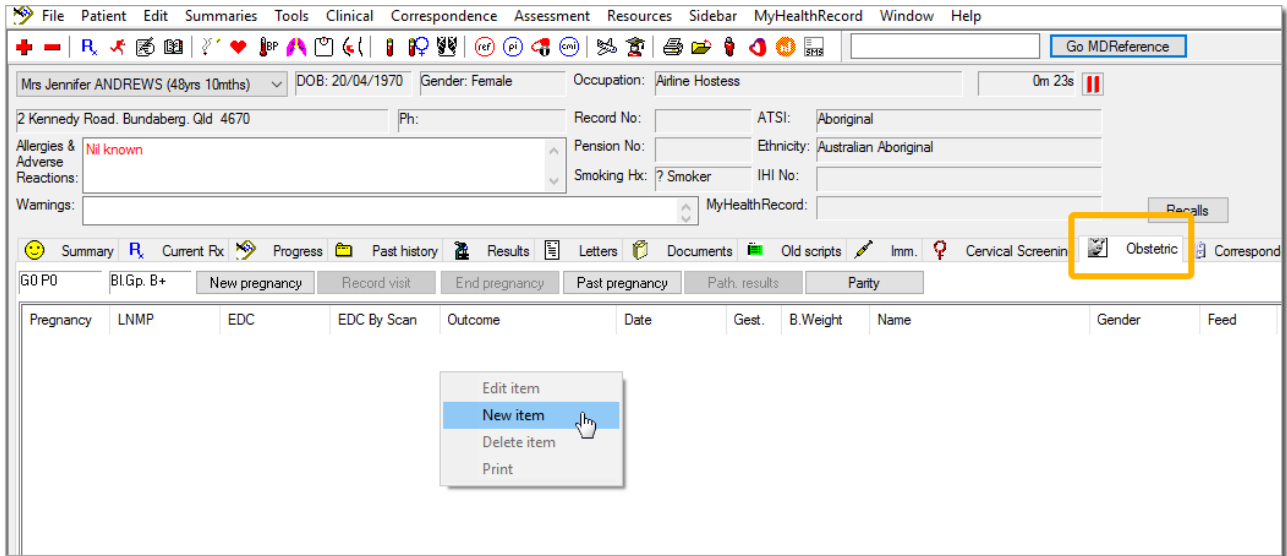
- Number of female Indigenous regular clients who gave birth in the 12 months up to the census date who had their smoking status recorded during pregnancy.

Data Entry Field

1. Open a female patient's record
2. Select the Obstetric tab
3. Right-click in the white space to add a New Item
4. Input the value for Date of LMP or gestational age by scan and click save
5. Add smoking status as per PI09

Disaggregation

- **Age:** Less than 20 years, 20–34 years, 35 and over
- **Gender:** Male and Female
- **Smoking status results**



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)
- Normal weight (>=18.50 but <=24.99)
- Overweight (>=25 but <=29.90)
- Obese (>=30)

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% |
| National Target % | n/a |

Primary Responsibility

- AWA
- GPs
- Nurses

Improvement Strategies

- Screening updated
- Offer nurse or MBS item 81300 follow up
- Diet education

Action

- Only the most recent BMI is considered
- Only weight measurements recorded in the last 24 months are considered
- Only height measurements recorded since the patient turned 18 are considered
- If any of the above conditions are not met, then the patient is excluded from the calculation.

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.
- Number of Indigenous regular clients aged 18 and over.

Denominator

Data Entry Field

Use height and weight measured based on the following rules:

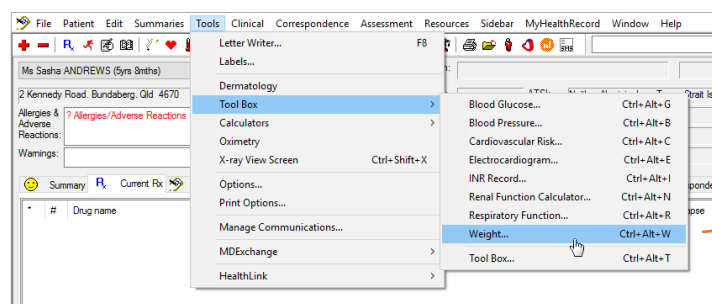
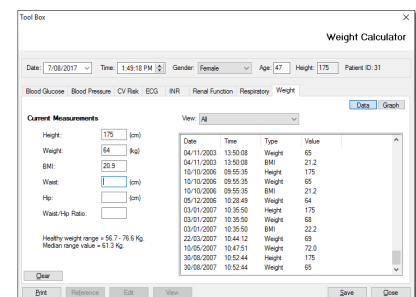
- A height taken since age 25 or taken within the previous 24 months for patients aged 15–26 years.
- A weight taken within the previous 24 months.

The BMI needs to be recorded in the Weight Calculator per the below steps:

1. Open a patient's record
2. Select Tools > Tool Box > Weight
3. Input height and weight values
4. Click Save

Disaggregation

- **Age:** 18-24 years, 25-34 years, 35-44 years, 45-54 years, 55-64 years, 65 years and over
- **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 less than 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 weeks or later 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 Current % | 42.2% |
| National Target % | 60% |

Primary Responsibility

- GPs
- Nurses/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 birthweight 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

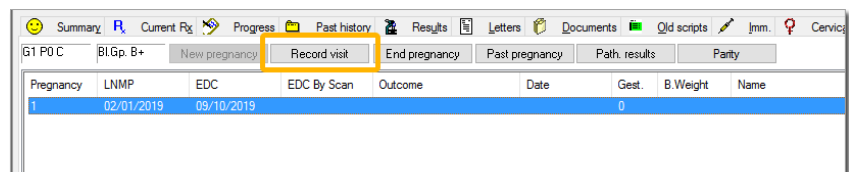
- Number of female Indigenous regular clients who gave birth in the 12 months up to the census date.

Data Entry Field

1. Select a pregnancy record from the list.
2. Click Record Visit
3. Input the date as the visit date
4. Click Save

Disaggregation

- **Age:** Less than 20, 20-34, 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



Antenatal record

Date: Weight:

B.P. Systolic: Diastolic:

Oedema: Urine:

Size (weeks) Calc: Clin:

Fundal height (cm): Foetal heart:

Presentation:

Comments:

Influenza immunisation (aged 6 months and over)

Description:

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

Current %

| | |
|--------------------|-----|
| National Current % | n/a |
|--------------------|-----|

Primary Responsibility

- Clinic Staff

Improvement Strategies

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

Action

- Patient's Influenza Immunization status is defined in the 'Immunization record' under the code 'flu' or description 'Influenzae'. If this is present in the patient's file, the date between the immunization date and date of reporting is calculated. If this date difference is ≥ 12 months, the record is included.

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

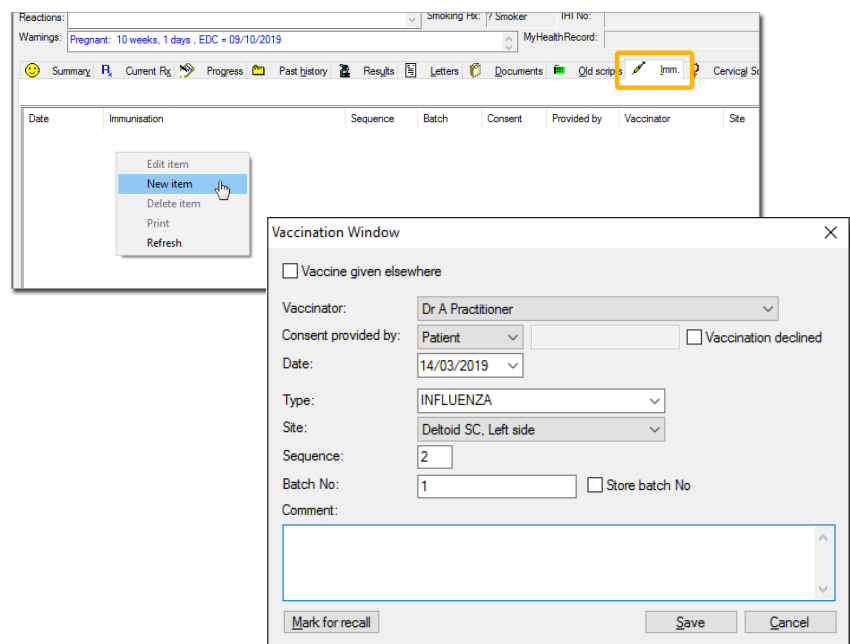
- Number of Indigenous regular clients aged 6 months and over.

Data Entry Field

1. Open a patient's record.
2. Select the Immunization tab
3. Right-click in the white space to add a New Item
4. Enter date, type (Influenza) site and sequence
5. Click Save

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

- Nurses/AHW
- GPs
- New Directions

Improvement Strategies

- Screening updated
- Staff nKPI education

Action

- Alcohol consumption status recorded is defined as patients for whom an Audit-C measurement exists.

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. Open a patient's record.
2. Select Assessment > Audit-C
3. The Audit-C Assessment is presented
4. Input data and click 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

The screenshot shows a medical software interface. The top menu bar includes 'File', 'Patient', 'Edit', 'Summaries', 'Tools', 'Clinical', 'Correspondence', 'Assessment', 'Resources', 'Sidebar', 'MyHealthRecord', 'Window', and 'Help'. The 'Assessment' menu is open, showing options like 'Asthma Action Plan...', 'Audit-C...', 'Care Plan...', 'Edinburgh Postnatal Depression...', 'Geriatric Depression...', 'Health Assessment...', 'Medication Review...', 'Mini Mental State Examination...', 'Pain Assessment...', 'Physical Activity...', 'ATSI Health Assessment...', 'Hamilton Rating Scale for Depression...', 'QLD Workers' Compensation Certificate...', 'ADF Post-Discharge GP Health Assessment...', and 'Distress (K10) Assessment...'. The 'Audit-C...' option is highlighted.

The main window displays patient details for Mrs. Jennifer Andrews (51 yrs, 10mths), DOB: 20/04/1967, Gender: Female, 2 Kennedy Road, Bundaberg, Qld 4670. Below this, there are sections for 'Allergies & Adverse Reactions' (Nil known) and 'Warnings' (Pregnant: 10 weeks, 1 days, EDC = 09/10/2019). A 'Summary' tab is selected, showing a table with columns for 'Date', 'Immunisation', and 'Sequence'.

The 'Patient Details' window is open, showing the 'Audit-C Assessment' form. The 'Date of assessment' is 10/11/2016. The form includes questions about alcohol consumption frequency and quantity. The 'Audit-C Total Score' is 9. The form also includes a 'Patient concerned about drinking?' section and a 'Comments' field. The 'Save' button is visible at the bottom right.

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:

- 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 % | 46% |
|--------------------|-----|

Primary Responsibility

- Nurses/AHW
- GPs
- New Directions

Improvement Strategies

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

Action

- AUDIT-C result recorded as defined in PI16.
- The score is defined as the result recorded for the AUDIT-C assessment.

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. Open a patient's record.
2. Select Assessment > Audit-C
3. The Audit-C Assessment is presented
4. Input data and click 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**

Patient Details

Pr: Details | Allergies/Adverse Reactions/Warnings | Family/Social Hx | Notes | Smoking | Alcohol | Personal Details

Date of assessment: 10/11/2016

| Date | Time | Score | Concerns | Comments |
|------------|----------|-------|------------|----------|
| 10/11/2016 | 10:55:22 | 9 | Don't know | No |
| 10/11/2016 | 09:53:28 | 2 | Don't know | No |

Audit-C Assessment

1. How often do you have a drink containing alcohol?

Never Monthly or less 2-4 times a month

2-3 times a week 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

1 or 2 3 or 4 5 or 6

7 to 9 10 or more

3. How often do you have six or more drinks on one occasion?

Never Less than monthly Monthly

Weekly Daily or almost daily

Audit-C Total Score: 9

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

Patient concerned about drinking?

Yes No Don't know

[View Alcohol Guidelines](#) [Reference](#) [New Assessment](#)

Currently displaying data from assessment performed on 10/11/2016. Click 'New Assessment' to conduct a new assessment.

Update address for all family members
 Auto-capitalise names

[Save](#) [Cancel](#)

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); or
- only an albumin/creatinine ratio (ACR); or
- both an eGFR and an ACR; or
- only an ACR test result recorded
- neither an eGFR nor an ACR test result recorded.

Current %

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

Primary Responsibility

- Nurses
- GPs
- AHW

Improvement Strategies

- Screening updated
- Clinic staff training
- Staff nKPI education

Action

- Type 2 Diabetes recorded as outlined in PI05.
- History of CVD recorded is defined as patients with a condition listed as at least one of the below:
- ACR or other micro albumin test result recorded is defined as patients whose records contain at least one of the following:
 - o Pathology results containing one of the following LOINC codes: '14959-1', '32294-1', '30001-2', '30000-4', '9318-7'.
 - o A manually recorded ACR measurement of type: 'MALB', 'MALBUN' or 'MALDATE'.
- eGFR recorded is defined as patients whose records contain at least one of the following:
 - o Pathology results containing one of the following LOINC codes: '33914-3', '62238-1'.
 - o A manually recorded eGFR measurement of type: 'EGFR'.

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.

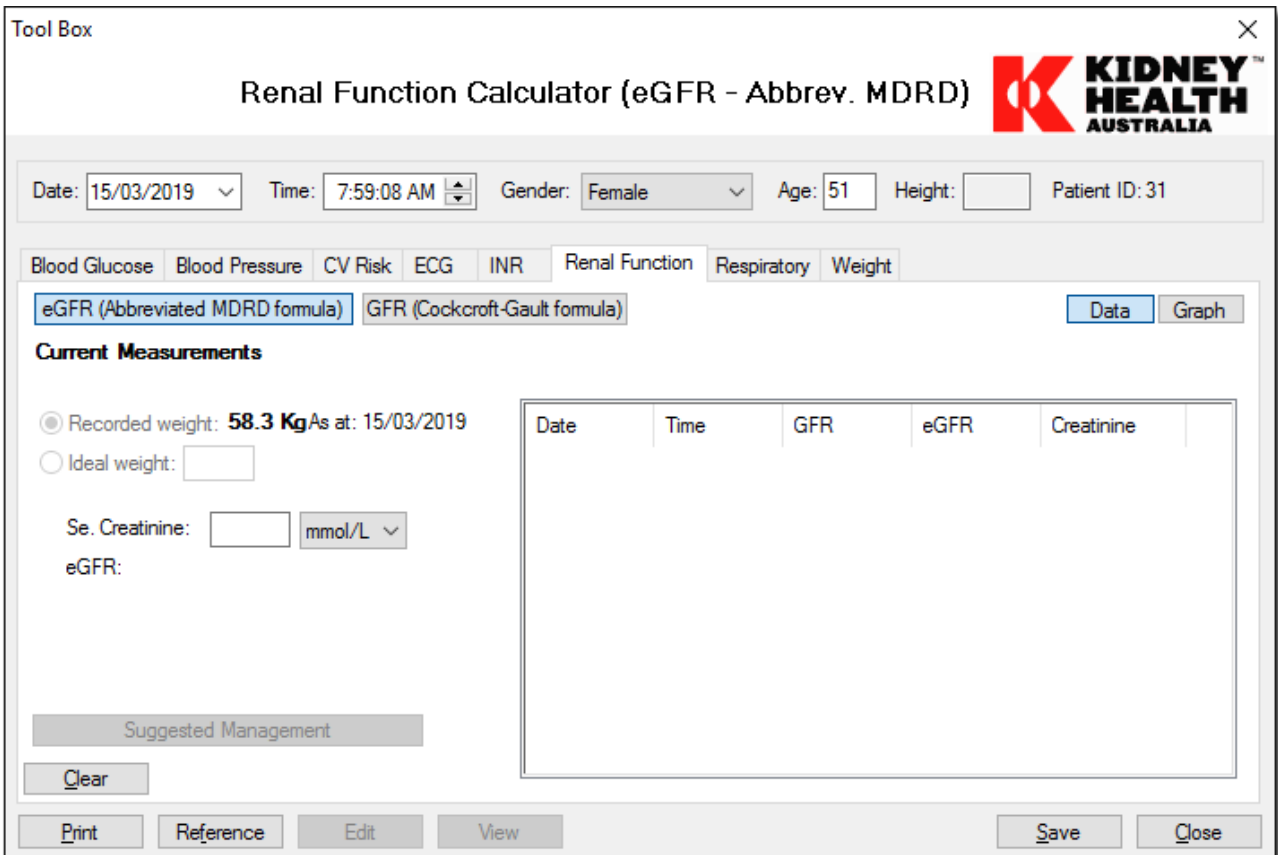
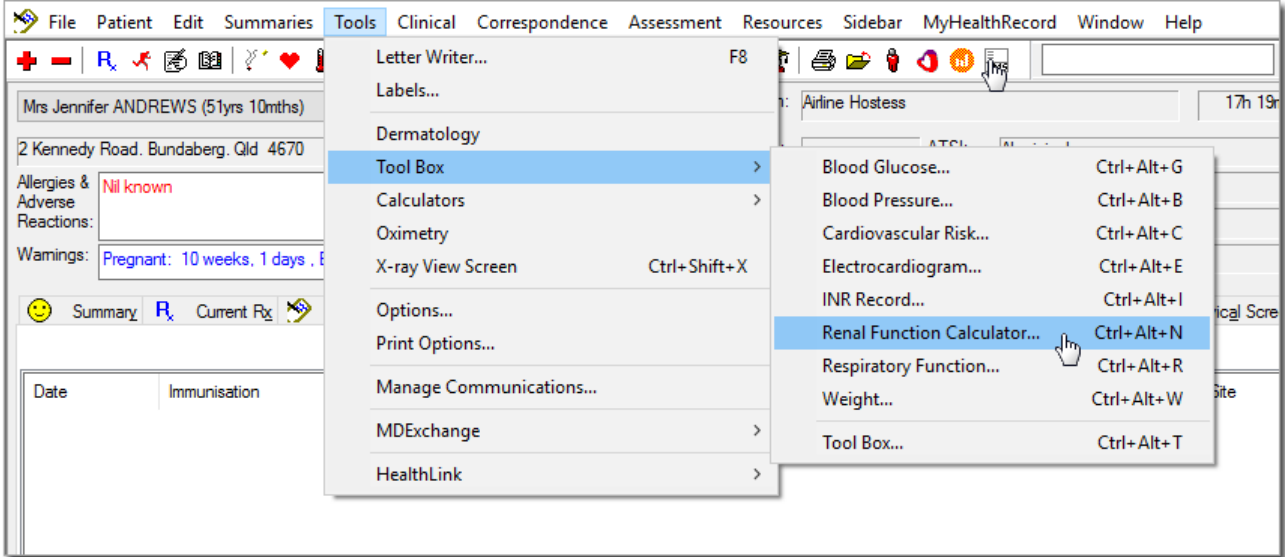
Data Entry Field

1. Open a patient's record.
2. Select Tools > Tool Box > Renal Function Calculator
3. The Renal Function Calculator window appears
4. Enter a value for creatine to generate eGFR value and click Save

Disaggregation

- **Age:** 18–24 years, 25–34 years, 35–44 years, 45–54 years, 55–64 years, and 65 years and over
- **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 recorded (Type 2 Diabetes or CVD)



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 ≥ 60 mL/min/1.73m² and:
 - ACR < 3.5 mg/mmol (females)
 - ACR < 2.5 mg/mmol (males).
- **Low risk**—eGFR ≥ 45 mL/min/1.73m² and < 60 mL/min/1.73m² and either:
 - ACR < 3.5 mg/mmol (females)
 - ACR < 2.5 mg/mmol (males);
 OR eGFR ≥ 60 mL/min/1.73m² and either:
 - ACR ≥ 3.5 mg/mmol & ≤ 35 mg/mmol (females)
 - ACR ≥ 2.5 mg/mmol & ≤ 25 mg/mmol (males).
- **Moderate risk**—eGFR ≥ 45 mL/min/1.73m² and < 60 mL/min/1.73m² and either:
 - ACR ≥ 3.5 mg/mmol & ≤ 35 mg/mmol (females)
 - ACR ≥ 2.5 mg/mmol & ≤ 25 mg/mmol (males);
 OR eGFR ≥ 30 mL/min/1.73m² and < 45 mL/min/1.73m² and either:
 - ACR < 35 mg/mmol (females)
 - ACR < 25 mg/mmol (males).
- **High risk**—eGFR ≥ 30 mL/min/1.73m² and either:
 - ACR > 35 mg/mmol (females)
 - ACR > 25 mg/mmol (males);
 OR eGFR less than 30 mL/min/1.73m² and any ACR result for both females and males.

Current % Kidney test, eGFR ≥ 60 ml/min/1.73 m²

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

Primary Responsibility

- GPs
- Nurses
- IHPs

Improvement Strategies

- Screening updated
- Clinic staff training
- Staff nKPI education

Action

- 'Type 2 diabetes' – specifically excludes Type 1 diabetes, secondary diabetes, gestational diabetes mellitus (GDM), previous GDM, Impaired fasting glucose, and impaired glucose tolerance.
- The report only considers the most recently recorded eGFR test result per patient.
- The report only considers the most recently recorded ACR test result per patient.
- Results taken from relevant pathology results. If your organisation does not have a system for adding pathology results to patient records, ensure the results have been included in the correct fields for this nKPI.
- For correct data entry please see PI05.
- 'ACR' refers to an albumin/creatinine ratio, or other micro albumin urine test result.

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

- eGFR results may be added manually through the Renal Function Calculator or via HL7 file as described in PI18
- Type 2 Diabetes can be recorded via the method shown in PI05.

Disaggregation

- **Age:** 18–24 years, 25–34 years, 35–44 years, 45–54 years, 55–64 years, and 65 years and over
- **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

- GPs
- Nurses
- AHW

Improvement Strategies

- Screening updated
- Clinical staff training
- External education

Action

- CVD recorded per **PI18**
- Smoking status recorded per **PI09**
- Diabetes recorded per **PI05**
- Absolute CV risk is defined as patients with a measurement type of 'ACVRISK'. These results are collated into low, medium, and high by the below calculations:
 - $0 \leq \text{measurement value} < 10$: set element value as 3 (low).
 - $10 \leq \text{measurement value} \leq 15$: set element value as 2 (medium).
 - $15 < \text{measurement value}$: set element value as 1 (high).
- High-Density Lipoprotein Cholesterol recorded is defined as patients with a measurement type of 'LIPIDDATE' or 'HDL'.

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.

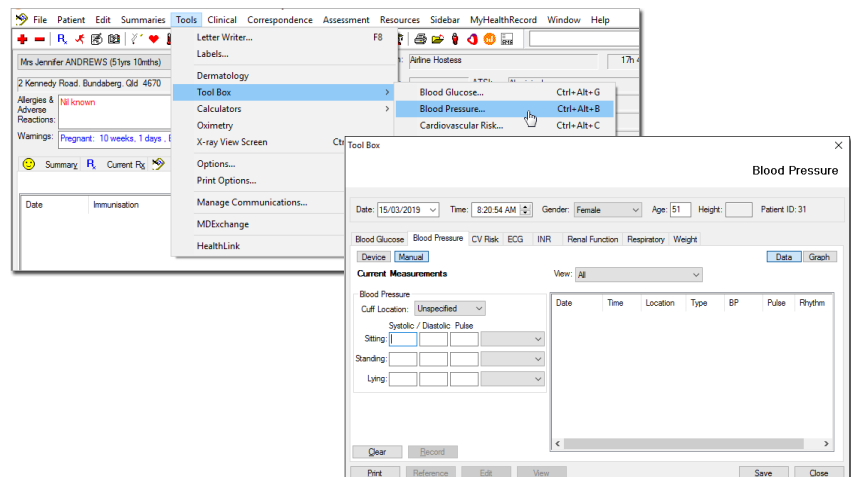
Data Entry Field

Record blood pressure

1. Open a patient's record.
2. Select Tools > Tool Box > Blood Pressure
3. The blood pressure manual appears
4. Enter values for blood pressure and then click save.

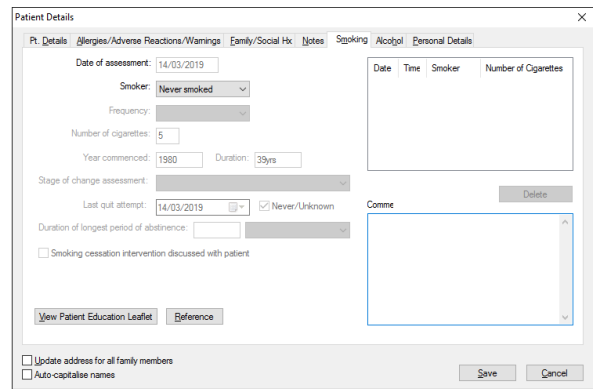
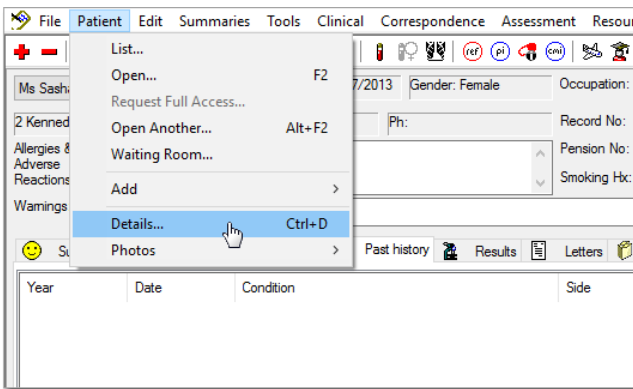
Disaggregation

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



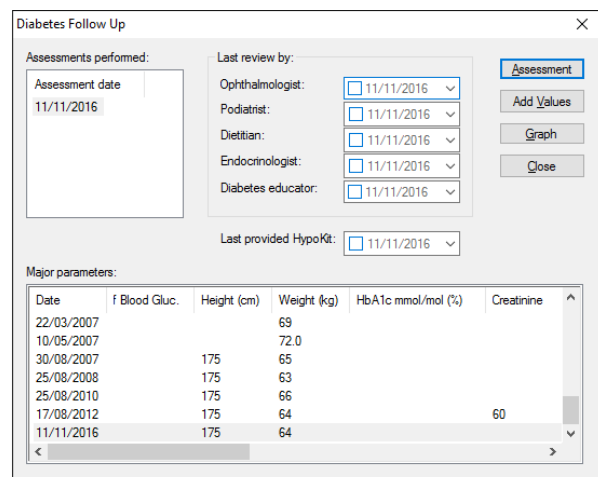
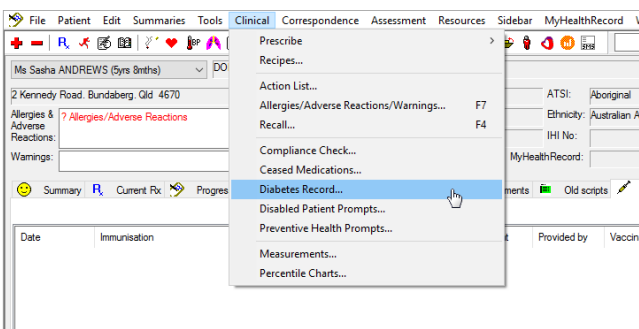
Record smoking status

1. Open a patient's record.
2. Select Patient > Details
3. Select the Smoking tab
4. Select the smoking status from the Smoking drop-down list and click Save.



Record Total Cholesterol and HDL

1. Open a patient's record.
2. Select Clinical > Diabetes Record
3. The Diabetes Follow Up window appears
4. Click Add Value. The Diabetes record window appears
5. Enter values for total cholesterol and HDL, then click Save.



CVD risk assessment result

Description:

Proportion of Indigenous regular clients aged 35-74 with no known cardiovascular disease (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% |
|--------------------|-----|

Primary Responsibility

- GPs
- Nurses
- AWH

Improvement Strategies

- Screening updated
- Clinical staff training
- External education

Action

- CVD recorded per **PI18**
- Absolute CVD risk assessment recorded per **PI20**
- Only the most recently recorded result from an absolute CVD risk assessment. This means that if a patient has had several assessments, then include only the results from the most recent test.

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. From within the clinical Window, select Clinical > Diabetes Record — the Diabetes Follow Up window appears
2. An assessment may be conducted, or alternatively values may be added directly
3. From within the Clinical Window, select Tools > Toolbox > Blood Pressure — The Blood Pressure module appears, record Blood Pressure from within this window

Disaggregation

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

Diabetes Assessment

Investigations

Has the patient had the following investigations in the last 12 months:

Fasting Blood Glucose: Value: mmol/L

Fasting lipids:

Total Cholesterol: Triglycerides:

HDL: LDL:

Glycated Hb (HbA1c): Value: mmol/mol

Upper limit of normal range: mmol/mol

Microalbumin: Value: mg/L

Units: mg/L ug/min mg/24hr ratio

Upper limit of normal range:

Tool Box

Blood Pressure

Date: Time: Gender: Age: Height: Patient ID: 31

Current Measurements View:

Blood Pressure

Cuff Location:

Systolic / Diastolic Pulse

Sitting:

Standing:

Lying:

| Date | Time | Location | Type | BP | Pulse | Rhythm |
|------|------|----------|------|----|-------|--------|
| | | | | | | |

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 % | 28% |
|--------------------|-----|

Primary Responsibility

- Nurses/AHW
- GPs
- New Directions

Improvement Strategies

- Women wellness clinic
- Screening updated
- Staff nKPI education

Action

- Cervical screening as recorded a record present in the 'Cervical Screening' tab.
- No history of hysterectomy is defined as patients whose medical file does not contain the below DOCLE codes:

cxyz Hysterectomy
 cxyz Surgery – Uterus – Hysterectomy
 cxyz Uterus – removal of
 cxyz Hysterectomy – Abdominal
 cxyz Hysterectomy – Vaginal
 cxyz Vaginal Hysterectomy
 cxyz Hysterectomy – Vaginal with vaginal repair

cxyz Hysterectomy – Laparoscopic
 cxyz Laparoscopic hysterectomy
 cxyz Hysterectomy – ovary(ies) spared
 cxyz Hysterectomy – Subtotal
 cxyz Hysterectomy – Total
 cxyz Subtotal hysterectomy
 cxyz Hysterectomy & BSO – Abdominal

Numerator

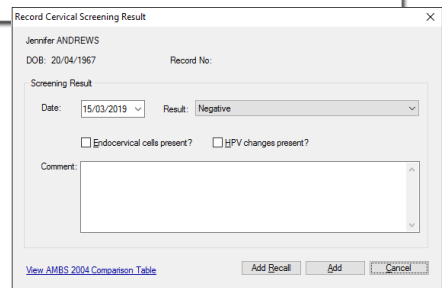
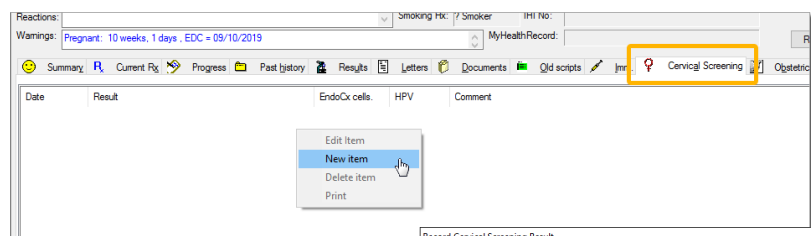
- Number of female Indigenous regular clients aged 25-74, who have not had a hysterectomy and who have had a cervical screening (human papillomavirus (HPV)) test within the previous 5 years where the test occurred on or after 1 December 2017.

Denominator

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

Data Entry Field

1. Open a female patient's record.
2. Select the Cervical screening tab.
3. Right-click in the white space and select New Item.
4. The Record Cervical Screening Result window appears. Enter the date of the result, select the result from the drop down and tick the 'Endocervical cells present?' and/or HPV changes present?' checkboxes as required.
5. Click Add.



Disaggregation

- **Age:** 25-34 years, 35-44 years, 45-54 years, 55-64 years, 65-74 years
- **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

- GPs
- Nurses
- AHW

Improvement Strategies

- Screening updated
- Equipment regularly calibrated
- Staff nKPI education

Action

- Type 2 Diabetes recorded as per PI05
- Blood pressure measurement recorded as per patient's whose file's contain measurements of types 'Systolic' and 'diastolic' as recorded in the 'Blood pressure' toolbox.

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

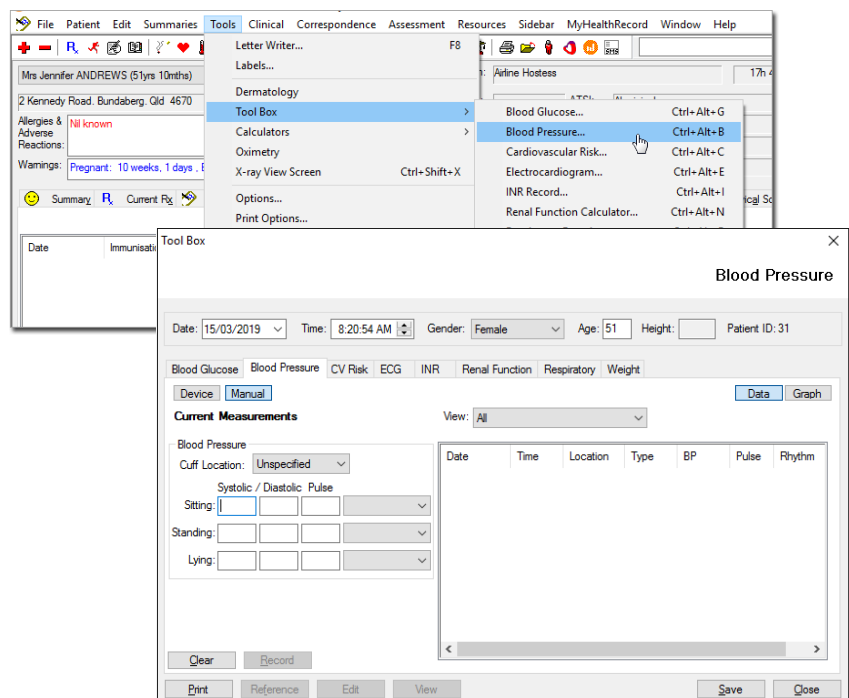
- Number of Indigenous regular clients with Type 2 diabetes.

Data Entry Field

1. Open a patient's record
2. Select Tools > Tool Box > Blood Pressure
3. The Blood Pressure module appears
5. Enter values for Systolic and Diastolic and click 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% |
|--------------------|-------|

Primary Responsibility

- GPs
- Nurses
- AHW

Improvement Strategies

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

Action

- Type 2 Diabetes as recorded in PI05
- Blood pressure recorded per PI23
- Only the most recently recorded blood pressure test result. This means that if a patient has had their blood pressure measured several times in the past 6 months, then include only the results from the most recent measurement.

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. Open a patient's record
2. Select Tools > Tool Box > Blood Pressure
3. The Blood Pressure module appears
5. Enter values for Systolic and Diastolic and click Save.

Disaggregation

- **Age:** 35–44 years, 45–54 years, 55–64 years, and 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.

Current %

| | |
|--------------------|-----|
| National Current % | n/a |
|--------------------|-----|

Primary Responsibility

- GPs
- Nurses
- AHW

Improvement Strategies

n/a

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 – Australian Institute of Health and Welfare \(aihw.gov.au\)](#)

Action

- Patients with either a Chlamydia or Gonorrhoea test result recorded is defined as patients whose records contain a pathology result with a relevant LOINC code.

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.

Data Entry Field

n/a

Disaggregation

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



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