



MedicalDirector®

nKPI

Data Reference Manual
for Medical Director

MARCH 2025





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 % (as of June 2023)

National Current %	77%
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

- Ensure all babies (ie. any child aged 2 years or younger) registered with ACCHO have a birth weight recorded.
- 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.
- The birthweight is to be sourced from the baby's client record or hospital records where available.
- Where the birthweight is not recorded in the baby's client record, the mother's record may be used as a source of birth details.
- Only live births are to be counted.

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. 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 % (as of June 2023)

National Current %	low 12%
National Target %	not set

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 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).
- Do not include babies who were still born.
- The number of babies in each weight category should add up to the number of babies 'With birth weight recorded'.

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 % (as of June 2023)

National Current %	0-14 years – 35%, 15-24 years – 41%, 25-54 years – 43% 55+ years – 54%
National Target %	0-14 years – 69%, 15-24 years – 69%, 25-54 years – 63% 55+ years – 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

- The data looks for all Aboriginal and/or Torres Strait Islander patients who have had a MBS item 715 (or equivalent) 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 or equivalent (an MBS item 715 can only be billed once every 10 months).

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

Within Pracsoft waiting room

- Waiting room
- Record visit
- Select Practitioner
- Issue a Bulk Bill account from the invoice to drop down
- Enter item number 715 or equivalent
- Select Voucher

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.

Indigenous Health Assessment completed

Record Visit

File View

Patient name: ANDERSON, David Seen by: AP - Dr A Practitioner Location: Surgery

Consult time: 2:57:21 PM

Consult date: 20/05/2024

Invoice to: Bulk Bill

Service details

Visit Date	Item No	Description	Fee	Gap	Fee Rate	GST Rate	GST Amount	Text
20/05/2024	715	Professional attendance by a general...	\$224.40	\$0.00	Schedule Fee	0.00	\$0.00	
20/05/2024	75870	Bulk Bill metropolitan areas	\$24.25	\$0.00	Schedule Fee	0.00	\$0.00	

\$248.65 \$0.00 \$0.00

☐ In hospital ☐ Apply incentive

Add Delete Up Down

Payment options (F12)

☐ Pay now Full Payment

☒ Pay later Gap Payment

Visit options

☒ Remove from Waiting Room ☐ Non visit

☐ Non patient account ☐ Aftercare

Print options

☒ Print voucher ☒ Print preview

☐ Print PC1 Copies: 1

Hold Voucher Account Cancel

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 % (as of June 2023)

National Current %	previous 6 mths – 50% previous 12 mths – 66%
National Target %	previous 6 mths – not set previous 12 mths – 69%

Primary Responsibility

- New Directions
- Nurses/AWA
- GPs

Improvement Strategies

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

Action

- All indigenous clients attending the clinic who have diabetes or at risk of diabetes are to have a HbA1c recorded every 6 months.
- Clients at risk must have a diabetes risk assessment completed and saved on file every 12 months.

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

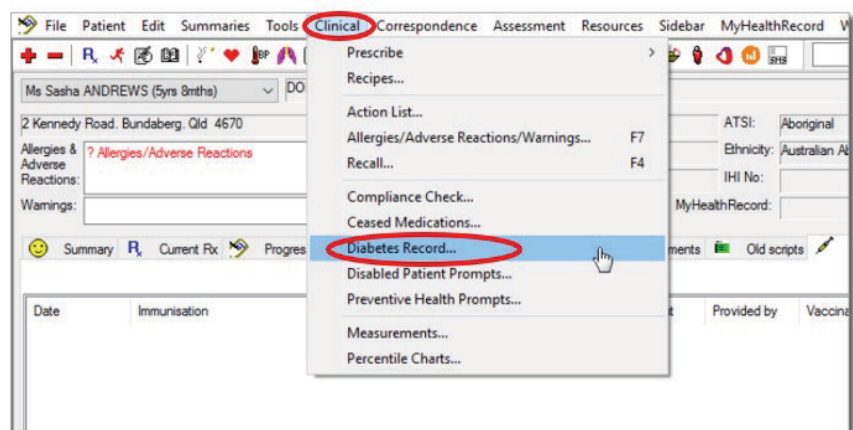
- Number of Indigenous regular patients with Type 2 diabetes.

Data Entry Field

1. Clinical
2. Diabetes Record
3. Add values
4. Input HbA1c
5. 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 recorded (Type 2 Diabetes patients)

Diabetes Follow Up

×

Assessments performed:

Assessment date

Last review by:

Ophthalmologist:

☐ 14/03/2019

Podiatrist:

☐ 14/03/2019

Dietitian:

☐ 14/03/2019

Endocrinologist:

☐ 14/03/2019

Diabetes educator:

☐ 14/03/2019

Last provided HypoKit:

☐ 14/03/2019

Assessment

Add Values

Graph

Close

Major parameters:

Date	f Blood Gluc.	Height (cm)	Weight (kg)	HbA1c mmol/mol (%)	Creatinine	Pr

<

>

Diabetes record

Date:

Parameters		Urinalysis	
Weight (kg)	<input type="text"/>	Protein	<input type="text"/>
Systolic BP	<input type="text"/>	Blood	<input type="text"/>
F Blood Gluc.	<input type="text"/>	Glucose	<input type="text"/>
Total Chol.	<input type="text"/>	Ketones	<input type="text"/>
Triglycerides	<input type="text"/>	Leucocytes	<input type="text"/>
Height (cm)	<input type="text"/>	Bilirubin	<input type="text"/>
Diastolic BP	<input type="text"/>		
HbA1c (mmol/mol)	<input type="text"/>		
HDL	<input type="text"/>		
Creatinine	<input type="text"/>		

Last review by:

Ophthalmologist	<input type="text" value="14/03/2019"/>	Podiatrist	<input type="text" value="14/03/2019"/>
Dietitian	<input type="text" value="14/03/2019"/>	Endocrinologist	<input type="text" value="14/03/2019"/>
Diabetes educator	<input type="text" value="14/03/2019"/>		

Last Provided HypoKit:

Save **Close**

HbA1c results (Type 2 Diabetes patients)

Description:

Proportion of Indigenous regular clients with Type 2 diabetes whose HbA1c measurement result, recorded within either the previous six months or 12 months, was categorized as one of the following:

- less than or equal to 7% (less than or equal to 53 mmol/mol);
- greater than 7% but less than or equal to 8% (greater than 53 mmol/mol but less than or equal to 64 mmol/mol);
- greater than 8% but less than 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).

Primary Responsibility

- Nurses
- AHW
- GPs

Improvement Strategies

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

Action

- All Indigenous clients attending the clinic who have diabetes or are at risk of diabetes are to have an HbA1c recorded every 6 months.
- Only the most recently reported result from an HbA1c test. This means that if a First Nations regular client has had several tests, include only the result from the most recent test.

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

- Same as 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
- **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, 92055) was prepared within the previous 24 months.

Current % (as of June 2023)

National Current %	51%
National Target %	not set

Primary Responsibility

- GPs
- AHW
- Nurses

Improvement Strategies

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

Action

- All Aboriginal and Torres Strait Islander patients who have a chronic disease should be offered a GP Management Plan.

Include

- All Aboriginal and Torres Strait Islander patients who have a chronic disease should be offered a GP Management Plan.

Numerator

- A note in the submission comments if your organisation does not claim included MBS items but provides an equivalent level of care, such as a comprehensive management plan that cannot be claimed through the MBS.

Denominator

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

Data Entry Field

Within Pracsoft waiting room

1. Waiting room
2. Record visit
3. Select Practitioner
4. Issue a Bulk Bill account from the invoice to drop down
5. Enter item number 721 or equivalent
6. Select Voucher

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**

Record Visit

File View

Patient name: ANDERSON, Penny Seen by: AP - Dr A Practitioner Location: Surgery

Consult time: 3:49:33 PM

Consult date: 20/05/2024

Invoice to: Bulk Bill

Service details

Visit Date	Item No	Description	Fee	Gap	Fee Rate	GST Rate	GST Amount	Text
20/05/2024	721	Attendance by a general practitioner ...	\$152.50	\$0.00	Schedule Fee	0.00	\$0.00	
20/05/2024	75870	Bulk Bill metropolitan areas	\$24.25	\$0.00	Schedule Fee	0.00	\$0.00	

\$176.75 \$0.00 \$0.00

☐ In hospital ☐ Apply incentive

Payment options (F12)

☐ Pay now ☐ Full Payment ☐ Pay later ☐ Gap Payment

Visit options

☒ Remove from Waiting Room ☐ Non visit ☐ Non patient account ☐ Aftercare

Print options

☒ Print voucher ☐ Print PC1 ☐ Print preview

Copies: 1

Hold Voucher Account Cancel

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 % (as of June 2023)

National Current %	71%
National Target %	not set

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

The screenshot shows the nKPI software interface. The 'Patient' menu is open, and the 'Details...' option is highlighted. The 'Smoking' tab is selected in the 'Patient Details' window. The 'Smoking' tab contains fields for 'Date of assessment', 'Smoker' (dropdown), 'Frequency', 'Number of cigarettes', 'Year commenced', 'Duration', 'Stage of change assessment', 'Last quit attempt', 'Duration of longest period of abstinence', and 'Smoking cessation intervention discussed with patient'. The 'Smoker' dropdown is set to 'Never smoked'. The 'Date of assessment' is 14/03/2019. The 'Number of cigarettes' is 5. The 'Year commenced' is 1980. The 'Duration' is 39ys. The 'Stage of change assessment' is 'Never/Unknown'. The 'Last quit attempt' is 14/03/2019. The 'Duration of longest period of abstinence' is empty. The 'Smoking cessation intervention discussed with patient' checkbox is unchecked. The 'Save' button is visible at the bottom right.

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 Smokers % (as of June 2023)

National Current %	47%
National Target %	not set

Primary Responsibility

- Clinic staff
- New Directions
- TIS

Improvement Strategies

- Continue to benchmark for TIS
- AHW include in screenings

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.

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 Smokers % (as of June 2023)

National Current %	42%
National Target %	not set

Primary Responsibility

- New Directions
- Nurses/AWA
- GPs

Improvement Strategies

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

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.
- Live births and stillbirths if the birthweight was at least 400 grams or the gestational age was 20 weeks or more.
- Include only the most recent smoking status recorded before the completion of the latest pregnancy. Where a First Nations regular client's tobacco smoking status does not have an assessment date assigned in Medical Director, 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.

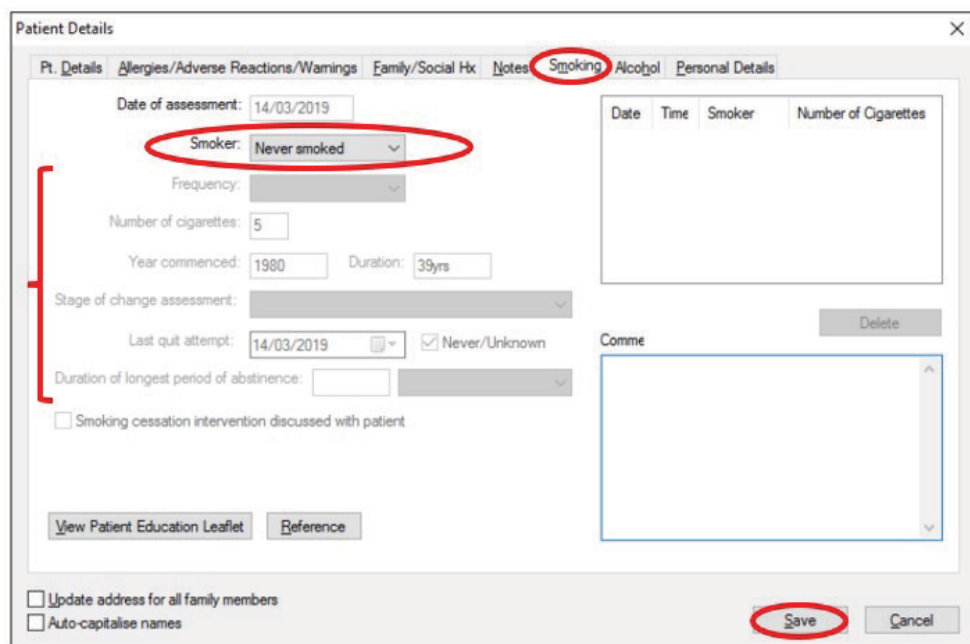
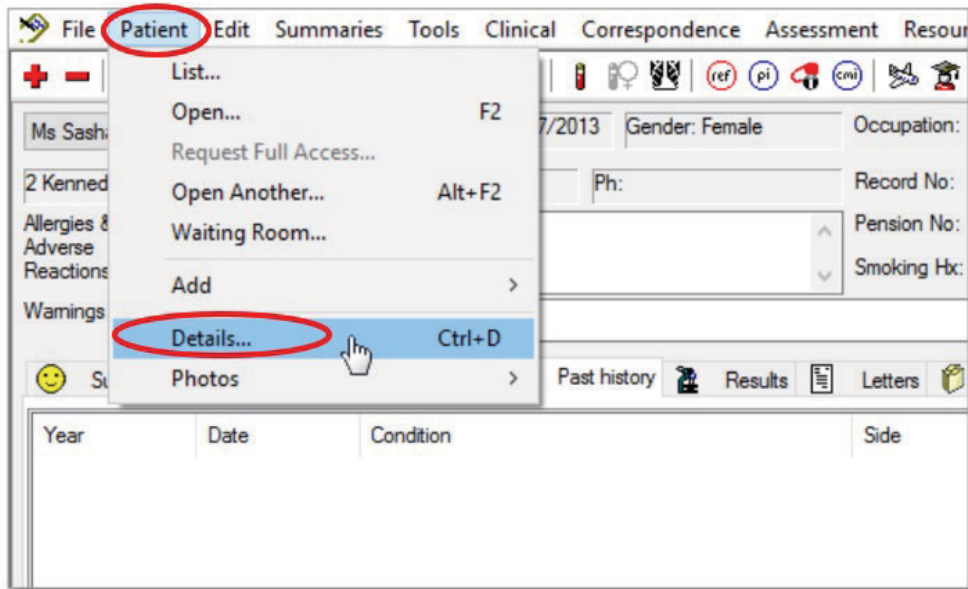
Data Entry Field

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:** Females only
- **Smoking status results**

Smoking during pregnancy



Body Mass Index (BMI) (overweight or obese)

Action

- All clients attending the practice are to have their height, weight and waist circumference recorded during screening.
- This is to be checked and updated at each visit.
- Only the most recently recorded BMI measurement.
- This means that if the client had their BMI recorded more than once within the previous 24 months, include only the most recently recorded result.
- 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.
- A note in the submission comments if BMI is substantially more likely to be recorded for certain groups of clients than others, such as those with diabetes.
- A note in the submission comments if BMI is more likely to be recorded if a client looks underweight, overweight or obese (this could result in the apparent proportion of underweight, overweight or obese clients being higher than it actually is).

Current Overweight or Obese % (as of June 2023)	
National Current %	43%
National Target %	not set

Primary Responsibility
<ul style="list-style-type: none"> • AWA • GPs • Nurses

Improvement Strategies
<ul style="list-style-type: none"> • Screening updated • Offer nurse or MBS item 81300 follow up • Diet education

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.

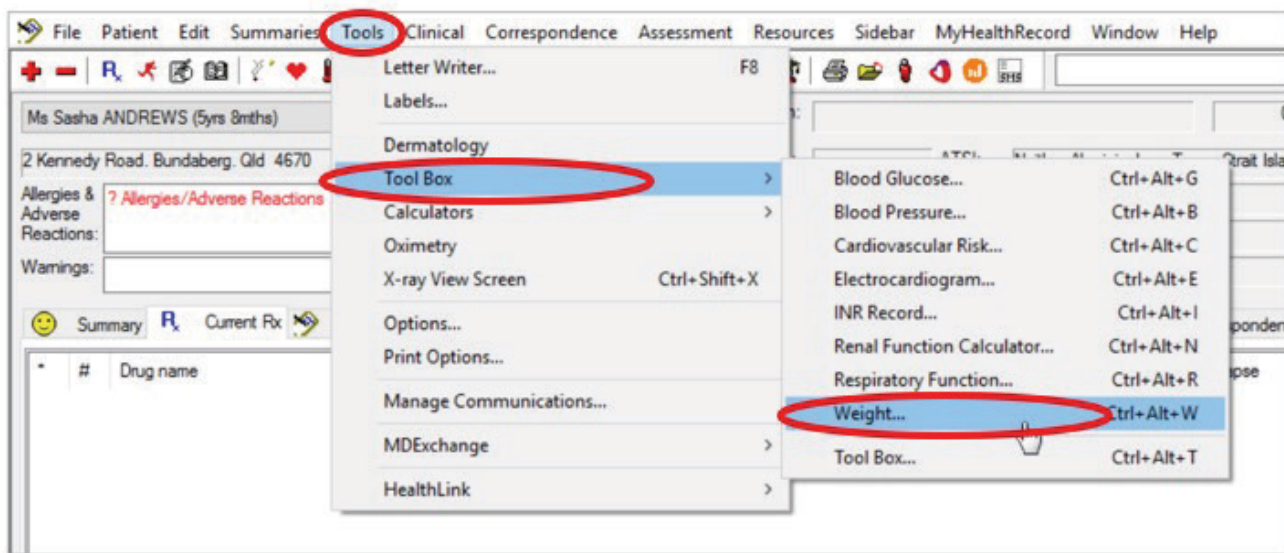
Data Entry Field

1. Tools
2. Toolbox
3. Weight
4. Input height and weight values.
5. 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**

Body Mass Index (BMI) (overweight or obese)



Tool Box

Weight Calculator

Date: 7/08/2017 Time: 1:49:18 PM Gender: Female Age: 47 Height: 175 Patient ID: 31

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

Data Graph

Current Measurements

View: All

Height: 175 (cm)
 Weight: 64 (kg)
 BMI: 20.9
 Waist: (cm)
 Hip: (cm)
 Waist/Hip Ratio:

Healthy weight range = 56.7 - 76.6 Kg.
 Median range value = 61.3 Kg.

Clear

Date	Time	Type	Value
04/11/2003	13:50:08	Weight	65
04/11/2003	13:50:08	BMI	21.2
10/10/2006	09:55:35	Height	175
10/10/2006	09:55:35	Weight	65
10/10/2006	09:55:35	BMI	21.2
05/12/2006	10:28:49	Weight	64
03/01/2007	10:35:50	Height	175
03/01/2007	10:35:50	Weight	68
03/01/2007	10:35:50	BMI	22.2
22/03/2007	10:44:12	Weight	69
10/05/2007	10:47:51	Weight	72.0
30/08/2007	10:52:44	Height	175
30/08/2007	10:52:44	Weight	65

Print Reference Edit View **Save** Close

First antenatal care visit

Description:

Proportion of female Indigenous regular clients who gave birth in the 12 months up to the census date and who had gestational at their first antenatal care visit with results either:

- Before 11 weeks
- 11 to 13 weeks
- 14 to 19 weeks
- 20 weeks or later
- No result recorded
- Did not attend an antenatal care visit

Current Before 11 weeks % (as of June 2023)

National Current %	33%
National Target %	not set

Primary Responsibility

- GPs
- Nurses/AHW
- New Directions

Improvement Strategies

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

Action

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

The screenshots illustrate the data entry process in the MyHealthRecord system. The first image shows the patient record for Mrs. Jennifer ANDREWS (43yrs 10mths) with a red box around the 'Obstetric' tab. The second image shows the 'Gestational Age Calculator' dialog box with 'Date of LMP' set to 14/03/2019 and 'By LMP' selected. The third image shows the 'Gestational Age Calculator' dialog box with 'Date of Scan' set to 14/03/2019 and 'By Scan' selected, showing a calculated gestational age of 3 weeks and 3 days.

Influenza immunisation (aged 6 months and over)

Description:

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

Current % (as of June 2023)

National Current %	20%
National Target %	64%

Primary Responsibility

- Clinic Staff

Improvement Strategies

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

Action

- All clients 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').

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 Immunisation tab
3. Right-click in the white space to add a New Item
4. Select Vaccinator
5. Enter date, type (Influenza) site and sequence
6. Click mark for recall
7. 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

The screenshot shows the MyHealthRecord interface. At the top, there are tabs for Summary, Rx, Current Rx, Progress, Past history, Results, Letters, Documents, Old scripts, and Imm. The Imm. tab is selected. Below the tabs is a table with columns: Date, Immunisation, Sequence, Batch, Consent, Provided by, Vaccinator, and Site. A right-click context menu is open over the table, showing options: Edit item, New item (highlighted), Delete item, Print, and Refresh. In the bottom right, the 'Vaccination Window' is open. It contains the following fields:

- ☐ Vaccine given elsewhere
- Vaccinator: Dr A Practitioner
- Consent provided by: Patient
- ☐ Vaccination declined
- Date: 14/03/2019
- Type: INFLUENZA
- Site: Deltoid SC, Left side
- Sequence: 2
- Batch No: 1
- ☐ Store batch No
- Comment: (empty text area)

 At the bottom of the window are buttons for 'Mark for recall', 'Save', and 'Cancel'.

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 % (as of June 2023)

National Current %	55%
National Target %	not set

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.

Include

- Any record of alcohol consumption. This could include a record of:
 - whether the First Nations regular client consumes alcohol
 - the amount and frequency of the First Nations regular client's alcohol consumption
 - the results of tests such as the AUDIT or AUDIT-C.

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 the nKPI 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..., and Geriatric Depression... The 'Audit-C...' option is selected. The patient details for Mrs Jennifer ANDREWS (51yrs 10mths) are displayed. The Audit-C Assessment form is open, showing the following questions and answers:

- 1. How often do you have a drink containing alcohol?
 - ☐ Never
 - ☒ Monthly or less
 - ☐ 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 or 8
 - ☐ 9 or more
- 3. How often do you have six or more drinks on one occasion?
 - ☐ Never
 - ☐ Less than monthly
 - ☒ Monthly
 - ☐ Weekly
 - ☐ Daily or almost daily

The Audit-C Total Score is 9. The form also includes a 'Save' button and a 'Cancel' button.

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 % (as of June 2023)

National Current %	Type 2 – 62% CVD – 62%
National Target %	Type 2 – not set CVD – not set

Primary Responsibility

- Nurses
- GPs
- AHW

Improvement Strategies

- Screening updated
- Clinic staff training
- Staff nKPI education

Action

- Diabetic and CVD patients are to have the eGFR recorded AND/OR
 - an albumin/creatinine ratio (ACR) or other microalbumin test result recorded.
- This is to occur at least once in a 12 month period.

Include

- Results from all relevant pathology tests. If your organisation does not have a good system for adding pathology results to client records, you will need to make sure they have been included in the correct field.
- In the 'type 2 diabetes and/or CVD' category, count clients with either or both of these 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.

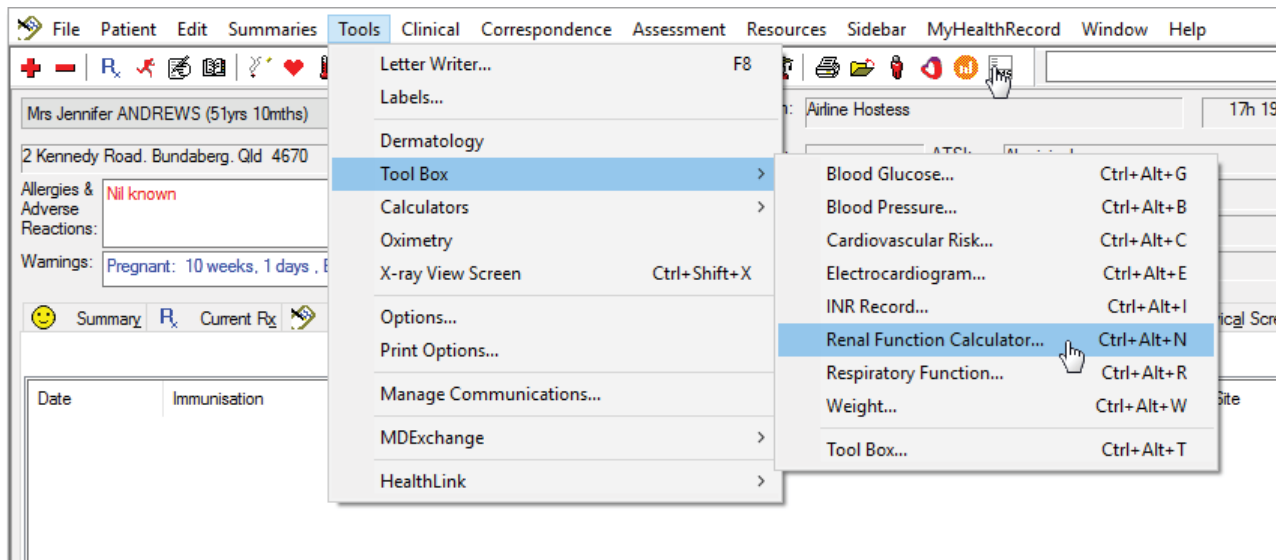
Data Entry Field

1. 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)



Tool Box

Renal Function Calculator (eGFR - Abbrev. MDRD) 

Date: 15/03/2019 Time: 7:59:08 AM Gender: Female Age: 51 Height: Patient ID: 31

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

eGFR (Abbreviated MDRD formula) **GFR (Cockcroft-Gault formula)** **Data** **Graph**

Current Measurements

☒ Recorded weight: **58.3 Kg** As at: 15/03/2019

☐ Ideal weight:

Se. Creatinine: mmol/L

eGFR:

Suggested Management

Clear

Date	Time	GFR	eGFR	Creatinine
------	------	-----	------	------------

Print **Reference** **Edit** **View** **Save** **Close**

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 High Risk Result % (as of June 2023)

National Current % – 23%	National Target % – not set
--------------------------	-----------------------------

Primary Responsibility

• GPs • Nurses • IHPs

Improvement Strategies

• Screening updated • Clinic staff training
• Staff nKPI education

Action

- Diabetic and CVD patients are to have the eGFR recorded AND/OR
 - an albumin/creatinine ratio (ACR) or other microalbumin test result recorded.
- This is to occur at least once in a 12-month period.

Include

- 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

- 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 % (as of June 2023)

National Current %	48%
National Target %	not set

Primary Responsibility

- GPs
- Nurses
- AHW

Improvement Strategies

- Screening updated
- Clinical staff training
- External education

Action

- 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'.

Include

- Information on diabetes status from the most recent record for the client, regardless of how old that record is.

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.

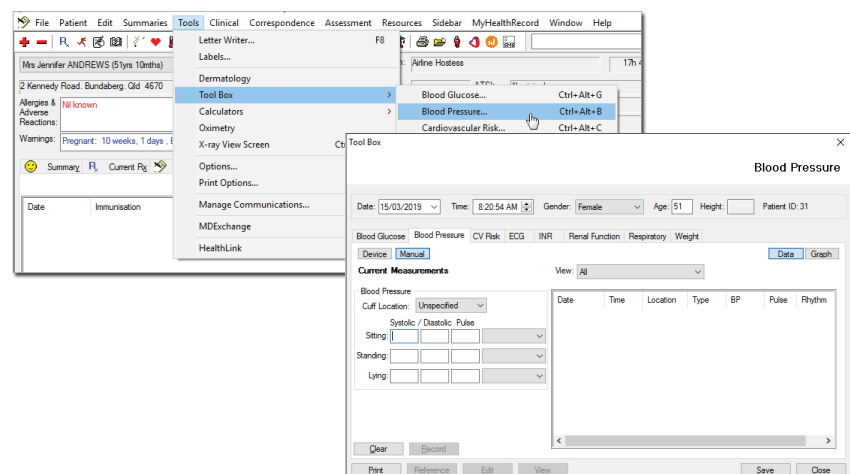
Denominator

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

Data Entry Field

Record blood pressure

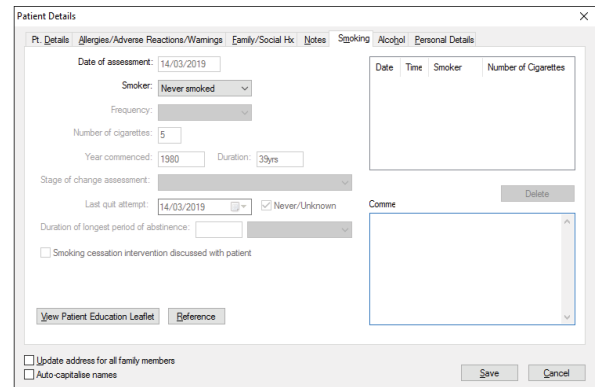
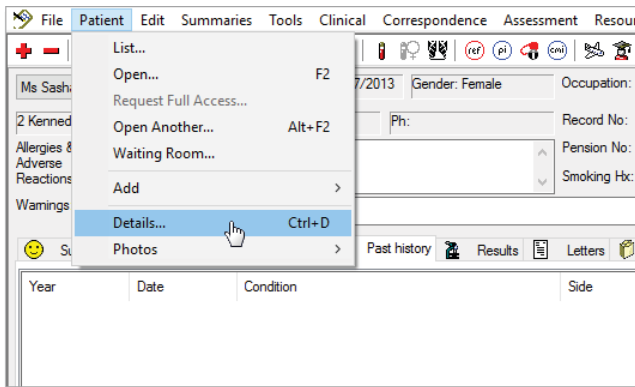
1. Open a patient's record.
2. Select Tools > Tool Box > Blood Pressure
3. The blood pressure manual appears
4. Enter values for blood pressure and then click save.



CVD risk assessment factors

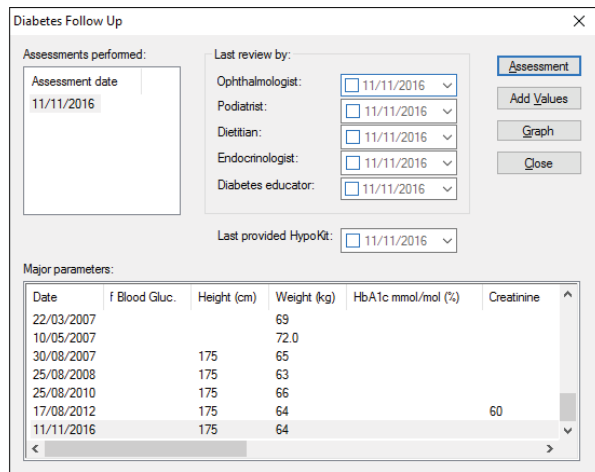
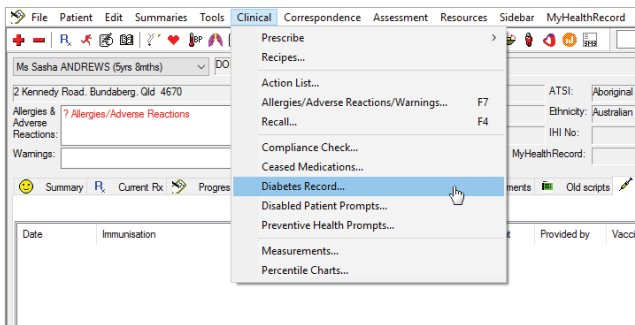
Record smoking status

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.



Disaggregation

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

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 % (as of June 2023)

National Current %	35%
National Target %	not set

Primary Responsibility

- GPs
- Nurses
- AWH

Improvement Strategies

- Screening updated
- Clinical staff training
- External education

Action

- Clients that are suspected of having any CVD risk factors must have a cardiovascular risk assessment entered into their Medical Director file.
- The result appears with observations as CV risk.
- 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

Same as PI20

Disaggregation

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

CVD risk assessment result

Diabetes Assessment

Investigations

Has the patient had the following investigations in the last 12 months: [View](#)

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:

[< Back](#)
[Next >](#)
[Cancel](#)

Tool Box

Blood Pressure

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

[Blood Glucose](#)
[Blood Pressure](#)
[CV Risk](#)
[ECG](#)
[INR](#)
[Renal Function](#)
[Respiratory](#)
[Weight](#)

[Device](#)
[Manual](#)
[Data](#)
[Graph](#)

Current Measurements View:

Blood Pressure

Cuff Location:

Systolic / Diastolic Pulse

Sitting:

Standing:

Lying:

Date	Time	Location	Type	BP	Pulse	Rhythm

[Clear](#)
[Record](#)

[Print](#)
[Reference](#)
[Edit](#)
[View](#)
[Save](#)
[Close](#)

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 % (as of June 2023)

National Current %	42%
National Target %	not set

Primary Responsibility

- Nurses/AHW
- GPs
- New Directions

Improvement Strategies

- Women wellness clinic
- Screening updated
- Staff nKPI education

Action

- All female patients aged 25-74 years are to be asked during screening when they had their last cervical screen.
- If unknown the patient is to be offered the opportunity to have a cervical screen done at the clinic.

Include

- HPV tests where the sample is either collected by a health practitioner or self-collected.

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. Add recall if required.
6. Click Add.

Disaggregation

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

The screenshot shows the nKPI system interface. The top navigation bar includes tabs for Summary, Current Rx, Progress, Past history, Results, Letters, Documents, Old scripts, and a 'Cervical Screening' tab which is highlighted with a yellow box. Below the navigation bar, a context menu is open with options: Edit item, New item (highlighted with a blue bar and a mouse cursor), Delete item, and Print. In the foreground, the 'Record Cervical Screening Result' window is displayed for patient Jennifer ANDREWS (DOB: 20/04/1967). The window contains fields for Date (15/03/2019), Result (Negative), and checkboxes for 'Endocervical cells present?' and 'HPV changes present?'. There is also a large text area for 'Comment'. At the bottom of the window are buttons for 'Add Recall', 'Add', and 'Cancel'.

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 % (as of June 2023)

National Current %	63%
National Target %	70%

Primary Responsibility

- GPs
- Nurses
- AHW

Improvement Strategies

- Screening updated
- Equipment regularly calibrated
- Staff nKPI education

Action

- Every patient who has an active diagnosis of Type 2 diabetes must have a blood pressure recorded at every visit
- 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 <= 140/90 mmHg %
(as of June 2023)

National Current %	66%
National Target %	not set

Primary Responsibility

- GPs
- Nurses
- AHW

Improvement Strategies

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

Action

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

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.

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

Ear Health

Description:

Number and proportion of Indigenous regular clients aged 0–14 years who have a completed ear health check recorded in the previous 12 months.

Include

- **Checks recorded in:** an ear health section of a CIS module — checks as defined by the conditions/diagnoses and ear health check procedures terms and codes specified in the ear condition coding framework (Solving Health 2024).
- Checks that have been conducted outside the First Nations-specific primary health care organisation within the previous 12 months, by any provider type such as ear health checks conducted by visiting health professionals or audiologists.
- If it cannot be determined in the CIS which part of the check was completed (that is, appearance, or movement, or both appearance and movement), count all parts as completed.

Numerator

- **Calculation A:** Number of First Nations regular clients aged 0–14 who have a completed check of the appearance of both ear canals and eardrums recorded within the previous 12 month
- **Calculation B:** Number of First Nations regular clients aged 0–14 who have a completed check of the movement of both eardrums (tympanic membrane) recorded within the previous 12 months
- **Calculation C:** Number of First Nations regular clients aged 0–14 who have a completed check of the appearance of both ear canals and eardrums AND a completed check of the movement of both eardrums recorded within the previous 12 months

Denominator

- **Calculation A:** Number of First Nations regular clients aged 0–14
- **Calculation B:** Number of First Nations regular clients aged 0–14
- **Calculation C:** Number of First Nations regular clients aged 0–14

Data Entry Field

- If it cannot be determined in the CIS that a check was performed at all (that is, that any part was completed), do not count any part as completed.
- Ensure that your data are from the correct time period, as specified in the indicator description.
- Count is of people, not ear health checks.
- Consider only the completed test.
- Please provide a comment if your numerator is zero.

Disaggregation

- **Age:** 0–11 months, 12–23 months, 24–35 months, 36–59 months, 5–9 years, 10–14 years
- **Gender:** Male and Female



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