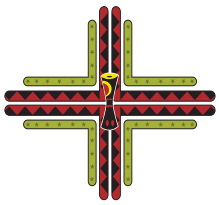
MedicalDirector®

nKPI

Data Reference Manual for Medical Director

MARCH 2025

QAIHC
Queensland Aboriginal and Islander Health Council



TAIHS

Townsville Aboriginal &
Islander Health Service

Table of Contents

nKPI:

nKPI: PI 01

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

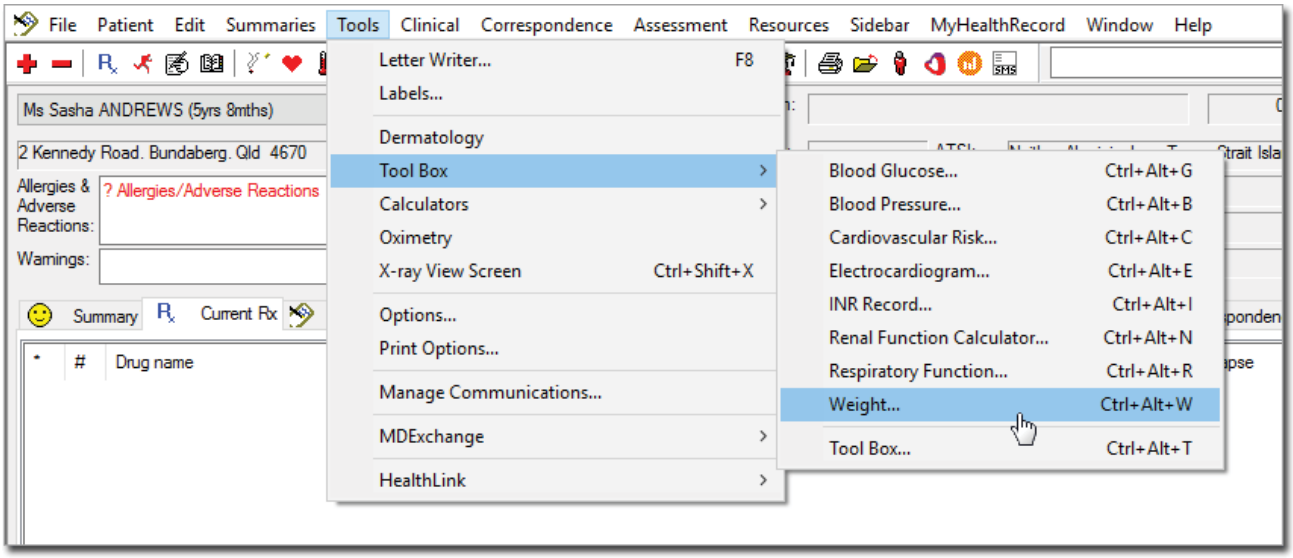
- Number of Indigenous babies born in the 12 months up to the census date who attended the organisation more than once whose birthweight was recorded.

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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Labels...
Dermatology
Tool Box
Calculators
Oximetry
X-ray View Screen Ctrl+Shift+X
Options...
Print Options...
Manage Communications...
MDExchange
HealthLink
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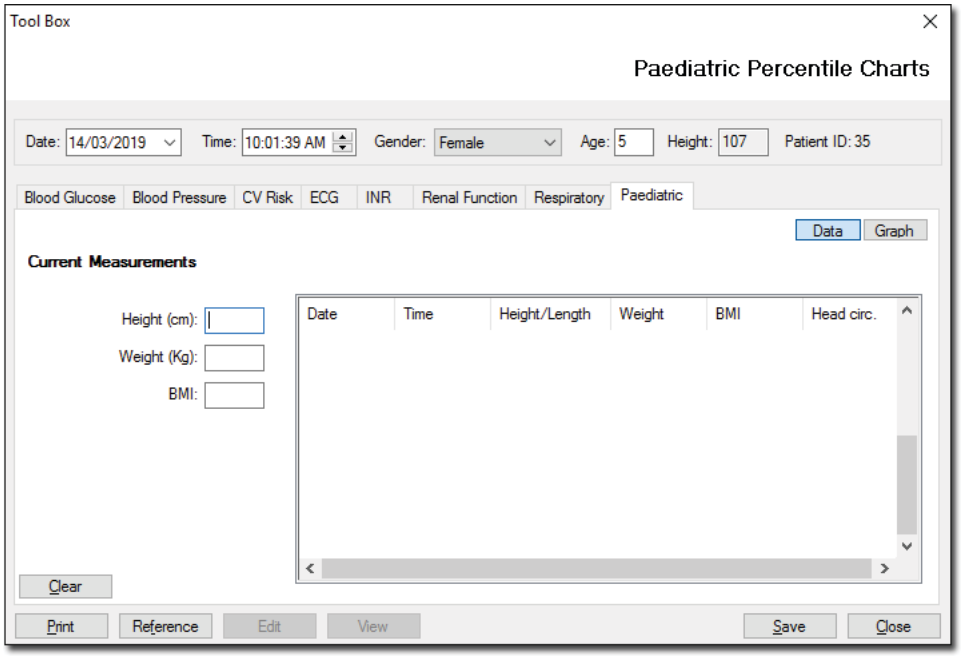
Blood Pressure... Ctrl+Alt+B
Cardiovascular Risk... Ctrl+Alt+C
Electrocardiogram... Ctrl+Alt+E
INR Record... Ctrl+Alt+I
Renal Function Calculator... Ctrl+Alt+N
Respiratory Function... Ctrl+Alt+R
Weight... Ctrl+Alt+W
Tool Box... Ctrl+Alt+T
Ms Sasha ANDREWS (5yrs 8mths)
2 Kennedy Road. Bundaberg. Qld 4670
Allergies & Adverse Reactions:
? Allergies/Adverse Reactions
Warnings:
Summary
Current Rx
Drug name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ECG
INR
Renal Function
Respiratory
Paediatric
Data
Graph
Current Measurements
Height (cm):
Weight (Kg):
BMI:
Date
Time
Height/Length
Weight
BMI
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Clear
Print
Reference
Edit
View
Save
Close

nKPI: PI 02

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

nKPI: PI03

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

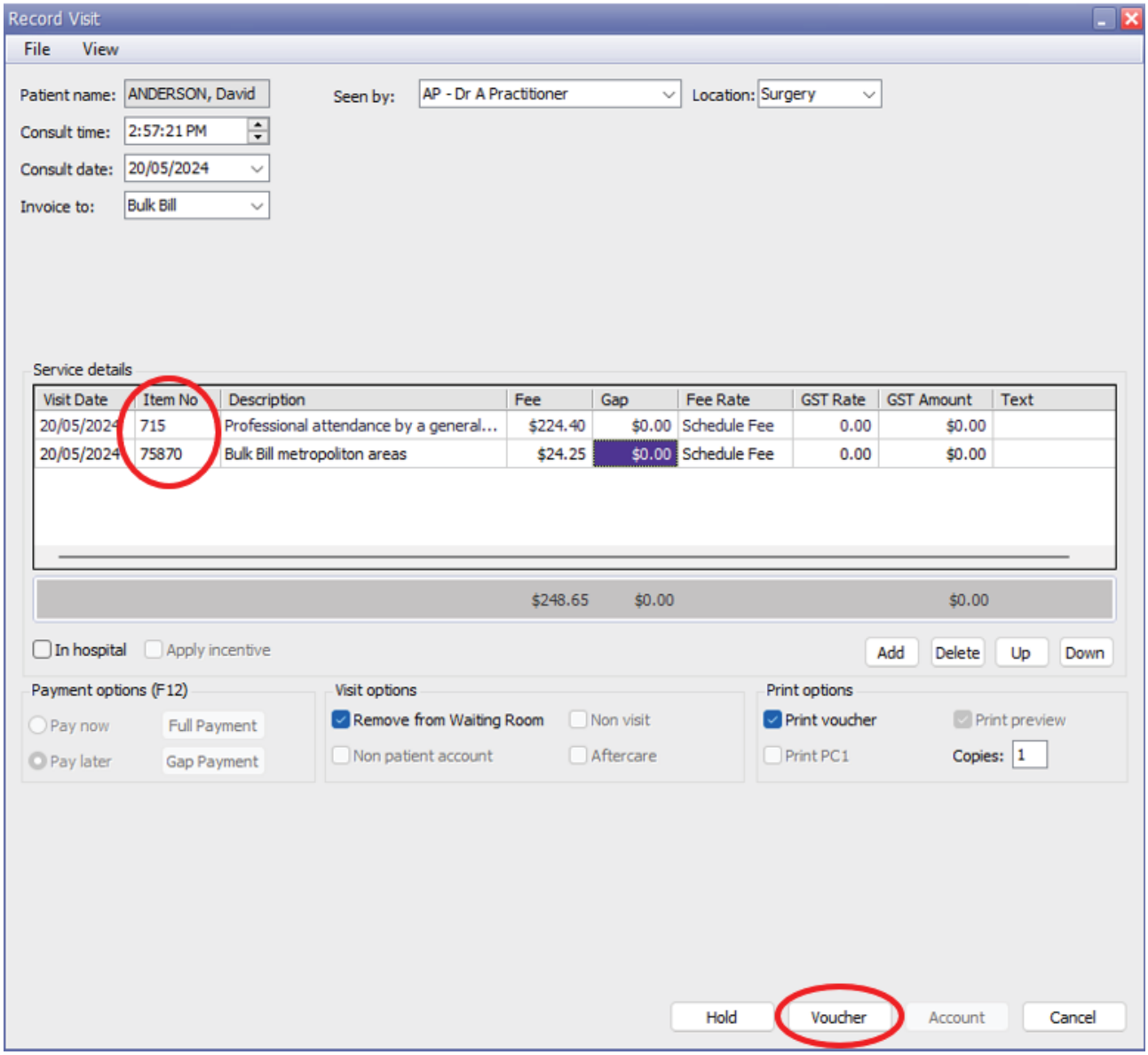
1. Waiting room
2. Record visit
3. Select Practitioner
4. Issue a Bulk Bill account from the invoice to drop down
5. Enter item number 715 or equivalent
6. Select Voucher

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 health Assessment:** In-person MBS-rebated Indigenous health assessment, telehealth MBS-rebated Indigenous health assessment.

nKPI: PI 03

Indigenous Health Assessment completed



nKPI: PI 05

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

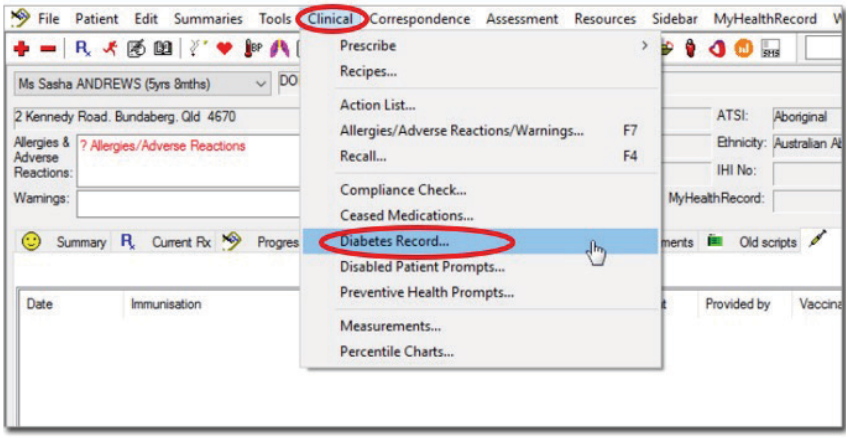
- Number of Indigenous regular patients with Type 2 diabetes.

Data Entry Field

1. Clinical
2. Diabetes Record
3. Add values
4. Input HbA1c
5. Save

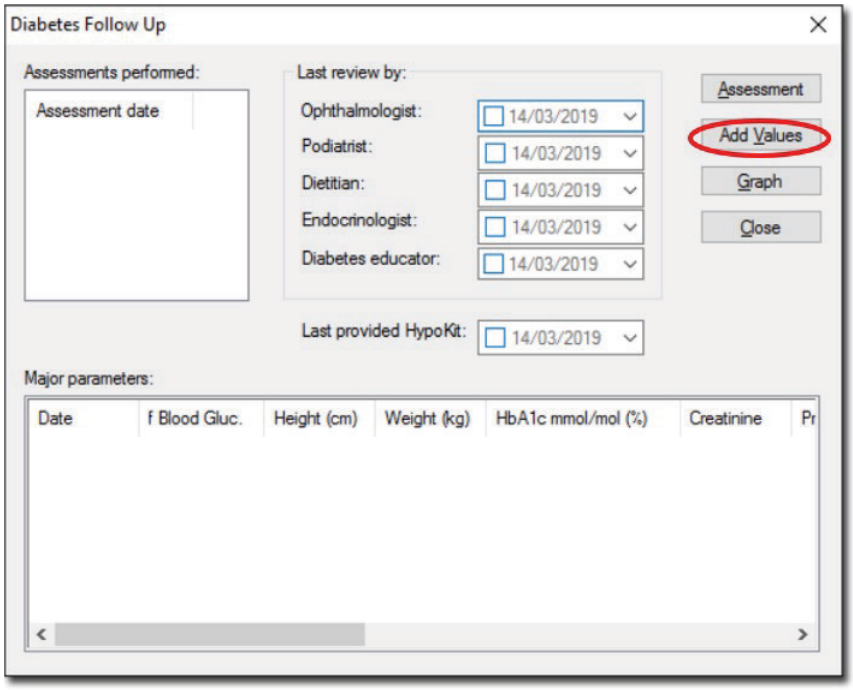
Disaggregation

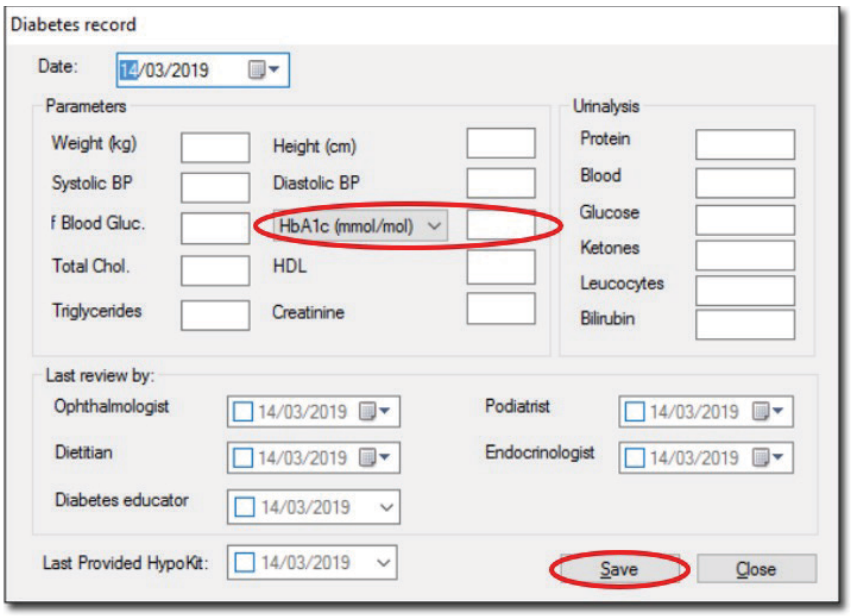
- **Age:** 0–4 years, 5–14 years, 15–24 years, 25–34 years, 35–44 years, 45–54 years, 55–64 years, 65 years and older
- **Gender:** Male and Female
- **Duration:** 6 months and 12 months



nKPI: PI05

HbA1c recorded (Type 2 Diabetes patients)





nKPI: PI06

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** PI**05**

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**

nKPI: PI 07

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.

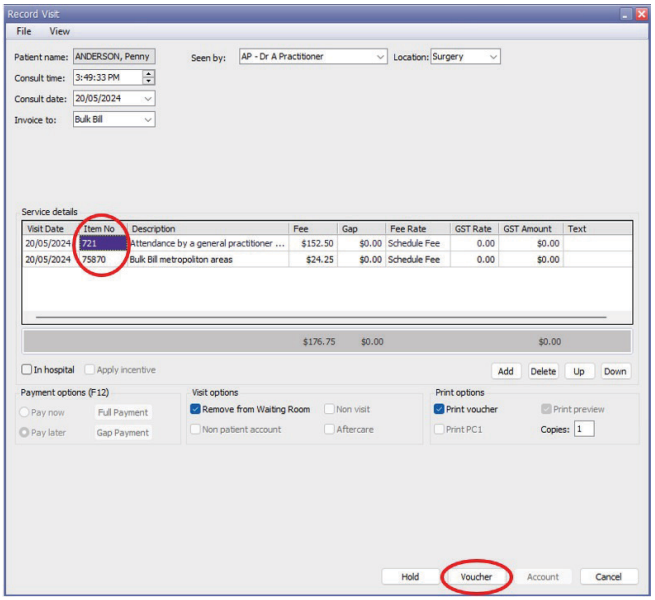
Data Entry Field

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**



nKPI: PI09

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 organsation 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

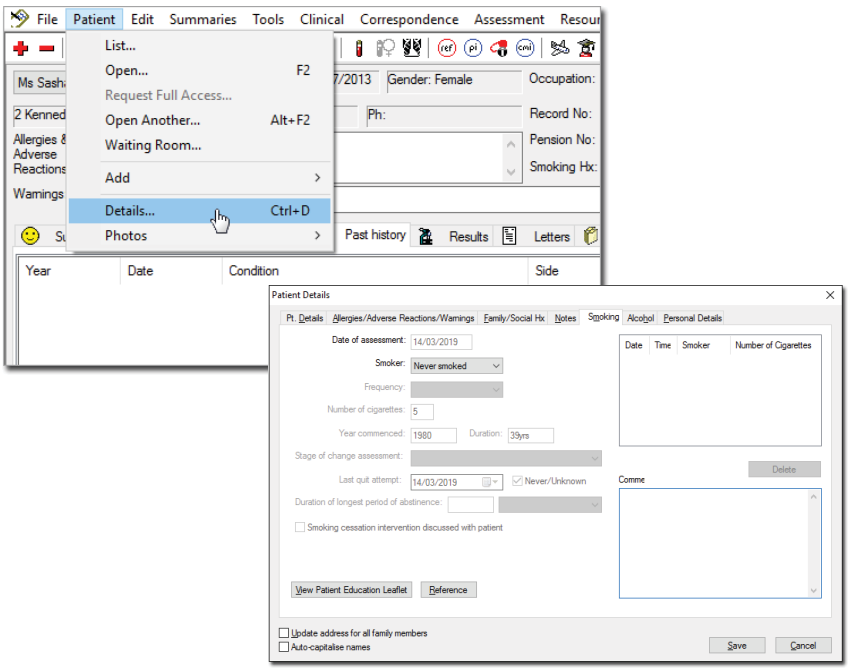
- The number of your regular Indigenous patients were there in each age and gender group.

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



nKPI: PI 10

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**

nKPI: PI 11

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

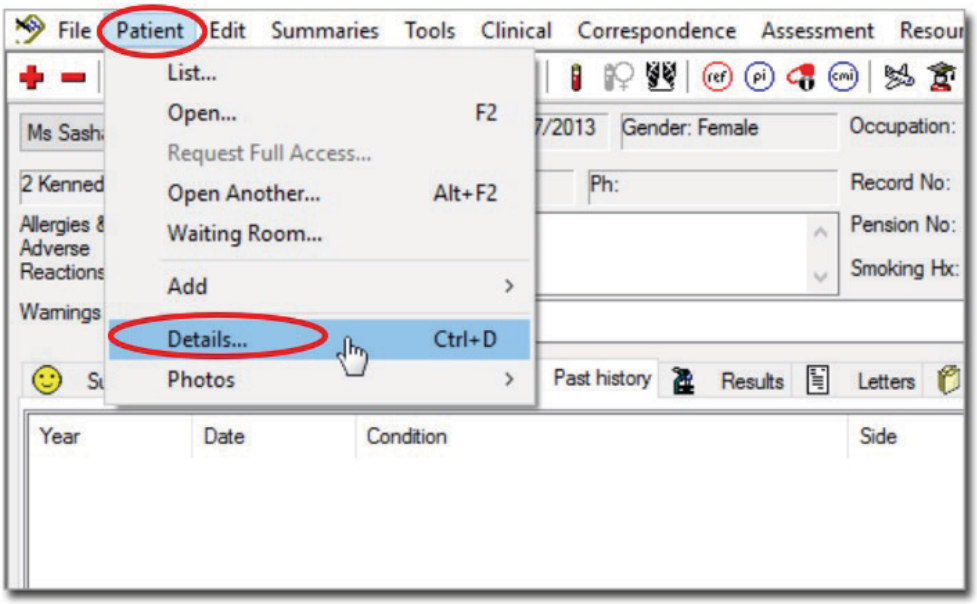
1. Open a female patient's record
2. Select the Obstetric tab
3. Right-click in the white space to add a New Item
4. Input the value for Date of LMP or gestational age by scan and click save
5. Add smoking status as per PI09

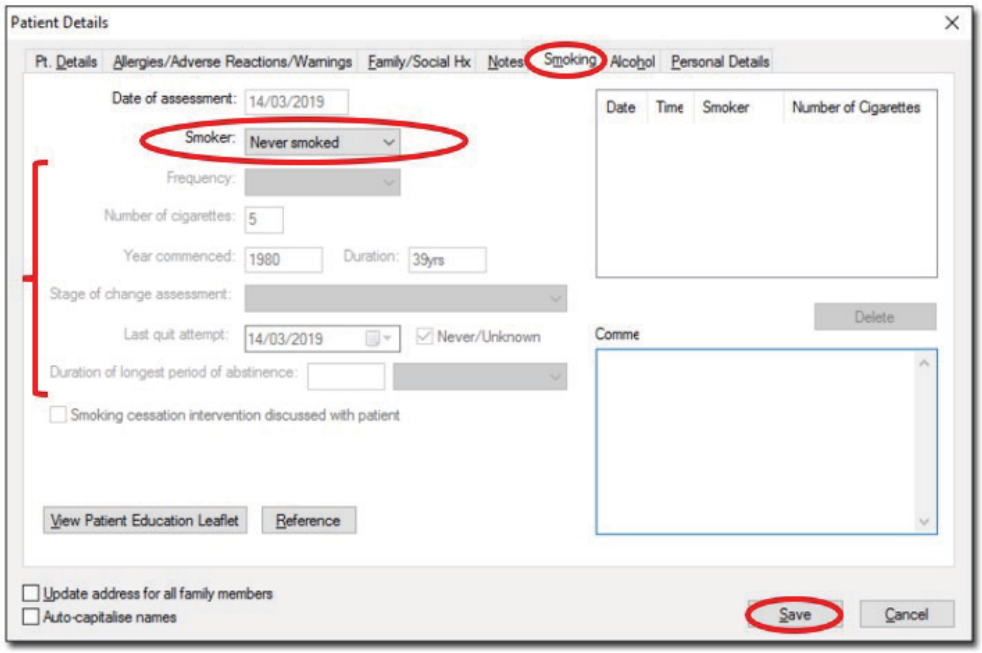
Disaggregation

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

nKPI: PI11

Smoking during pregnancy





nKPI: PI 12

Body Mass Index (BMI) (overweight or obese)

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

Primary Responsibility

- AWA
- GPs
- Nurses

Improvement Strategies

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

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).

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

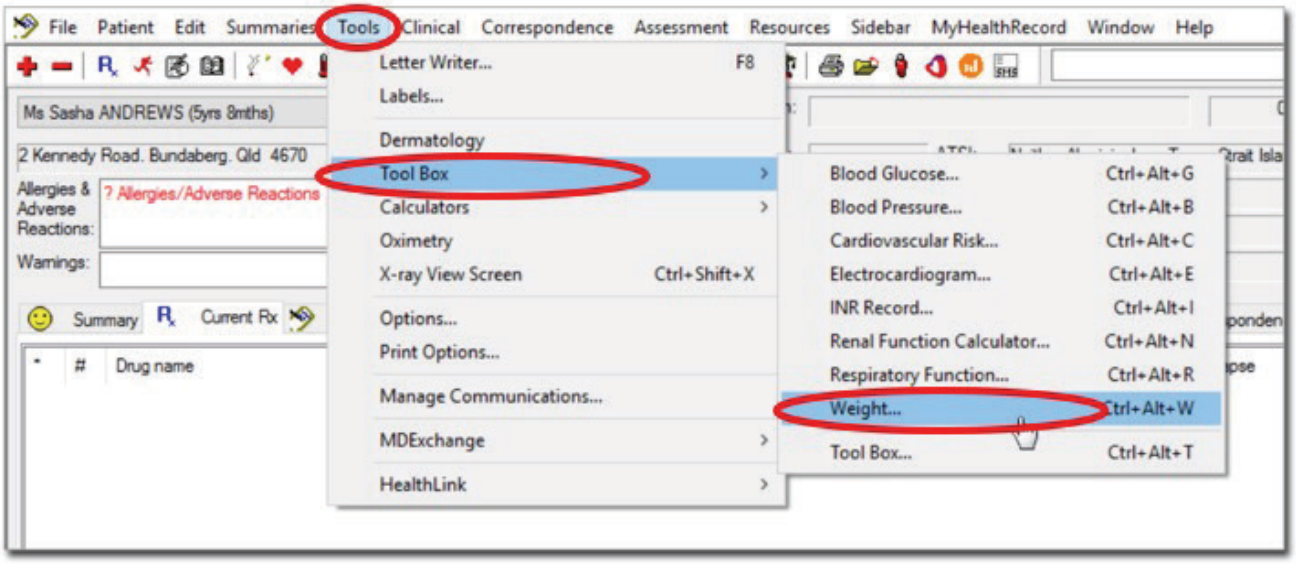
1. Tools
2. Toolbox
3. Weight
4. Input height and weight values.
5. Click Save

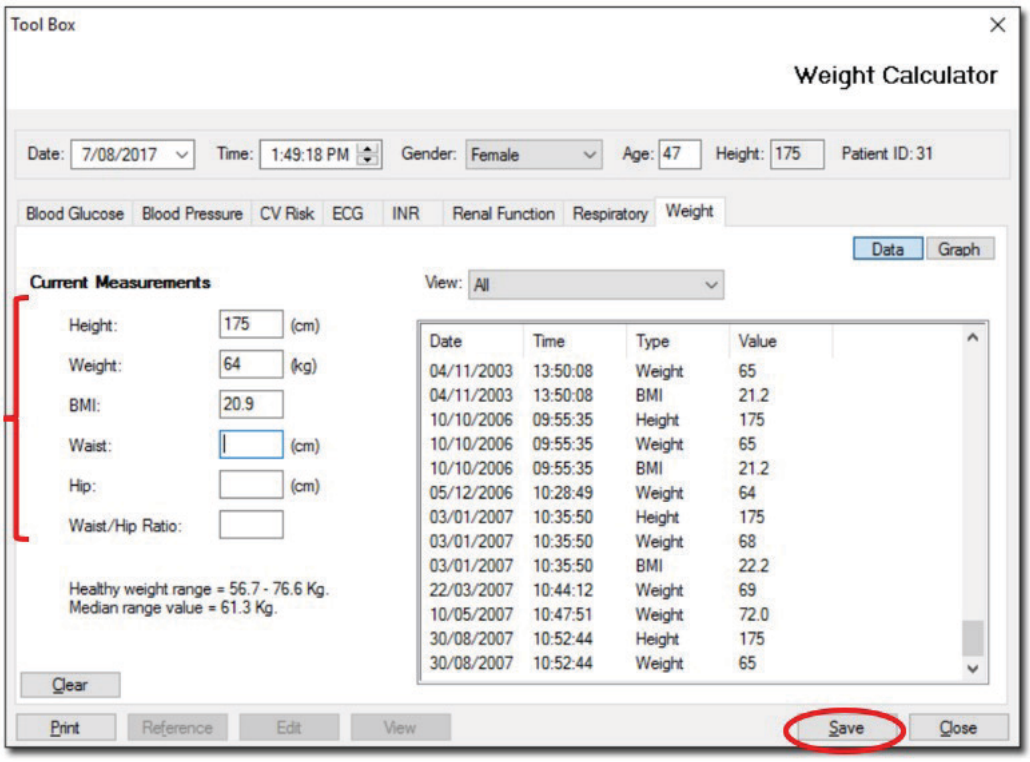
Disaggregation

- **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**

nKPI: PI 12

Body Mass Index (BMI) (overweight or obese)





nKPI: PI 13

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

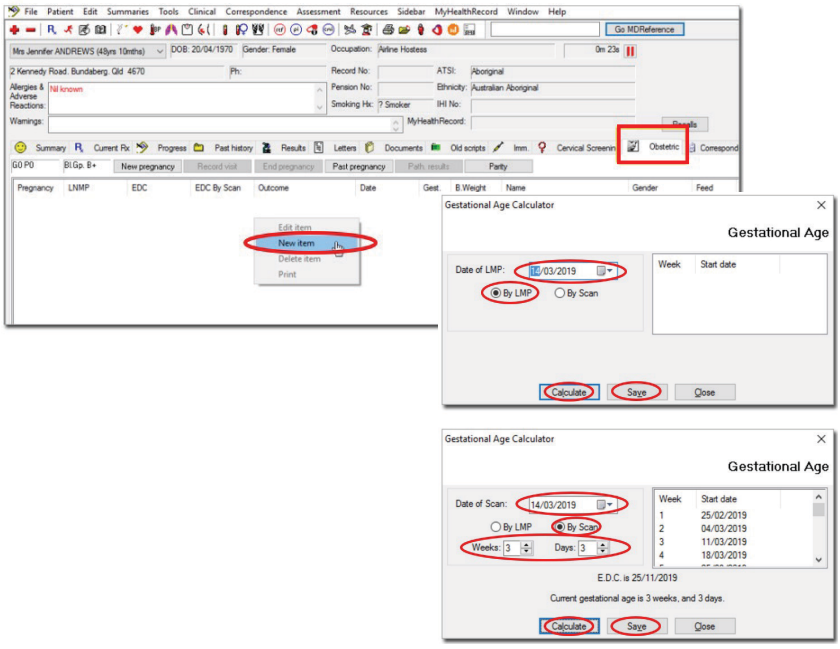
- Number of female Indigenous regular clients who gave birth in the 12 months up to the census date.

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



nKPI: PI 14

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

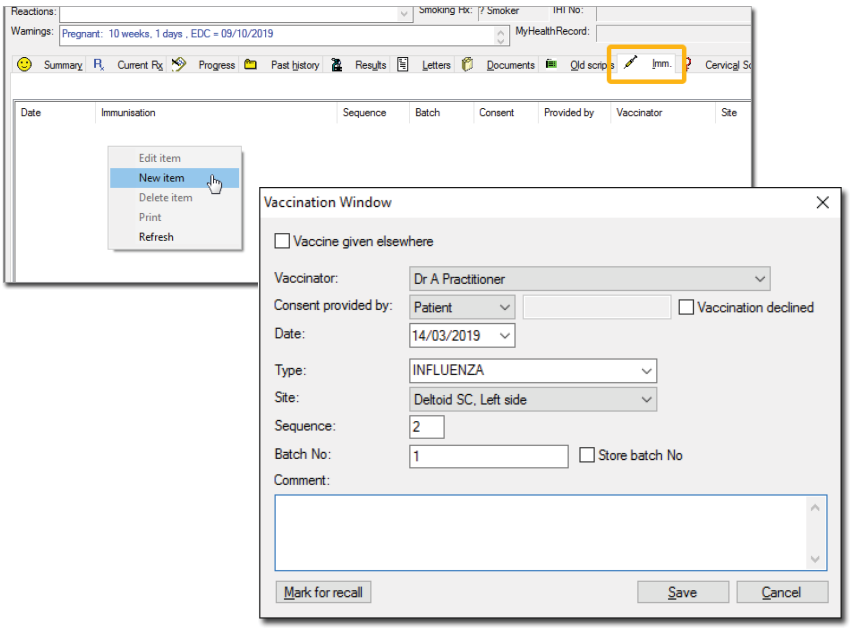
- Number of Indigenous regular clients aged 6 months and over.

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



nKPI: PI 16

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

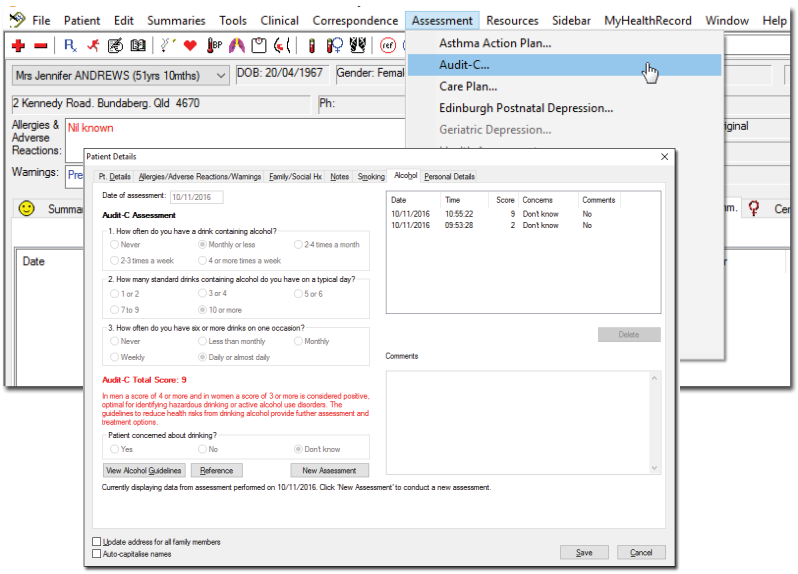
- Number of Indigenous regular clients aged 15 and over.

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



nKPI: PI 18

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

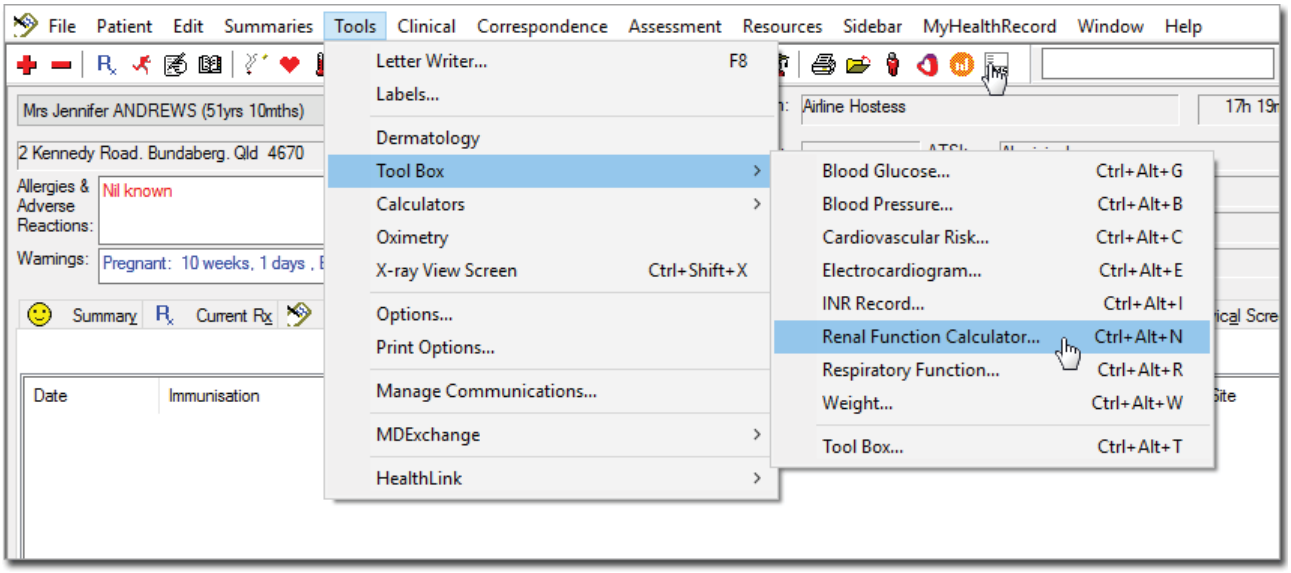
1. Open a patient's record.
2. Select Tools > Tool Box > Renal Function Calculator
3. The Renal Function Calculator window appears
4. Enter a value for creatine to generate eGFR value and click Save

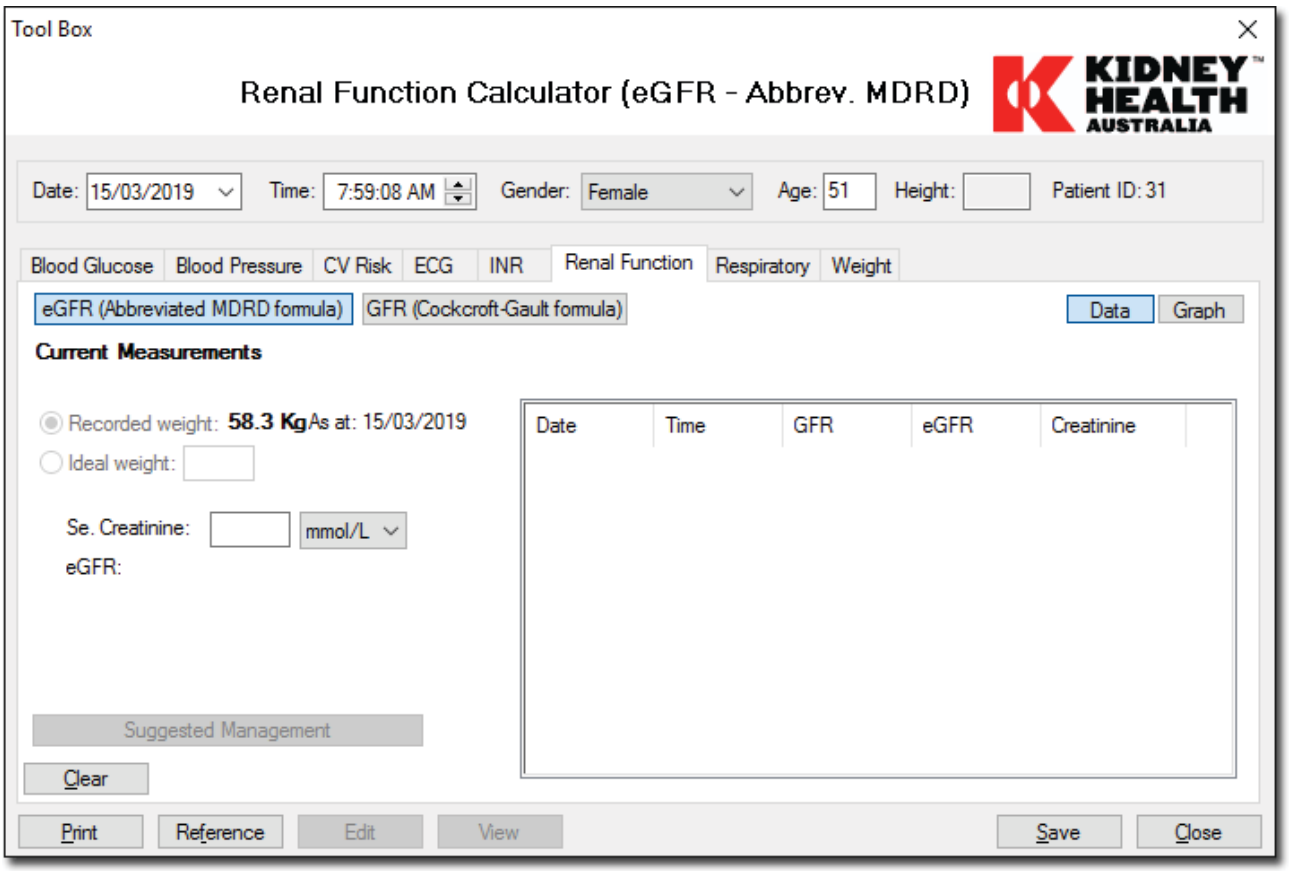
Disaggregation

- **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

nKPI: PI18

Kidney function test recorded (Type 2 Diabetes or CVD)





nKPI: PI 19

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 >35ml/mmol (females)
  - ACR >25mg/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**

nKPI: PI20

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 PI**09**
- Diabetes recorded per PI**05**
- 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 <= measurement value < 10: set element value as 3 (low).
  - 10 <= measurement value <= 15: set element value as 2 (medium).
  - 15 < 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.

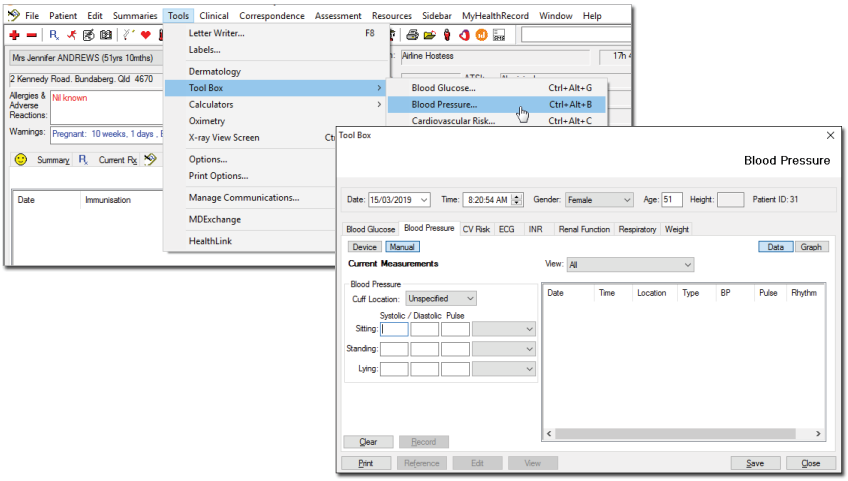
Denominator

- 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.

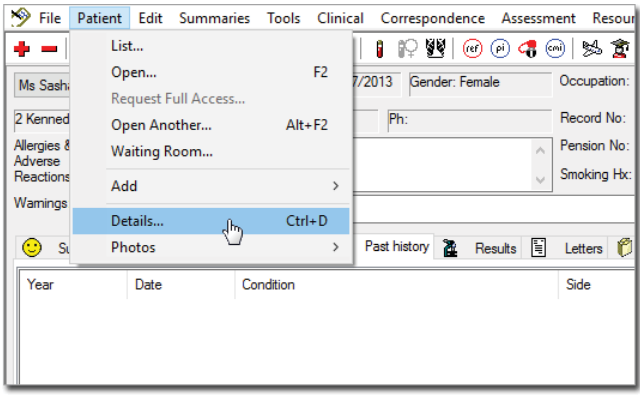


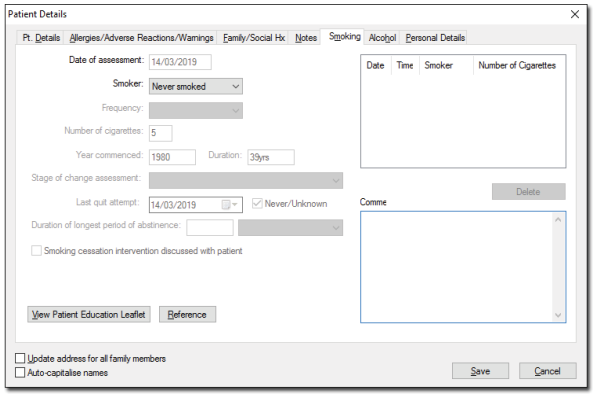
nKPI: PI20

CVD risk assessment factors

Record smoking status

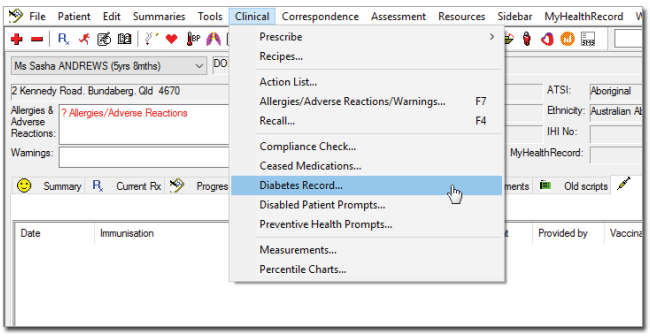
1. Open a patient's record.
2. Select Patient > Details
3. Select the Smoking tab
4. Select the smoking status from the Smoking drop-down list and click Save.

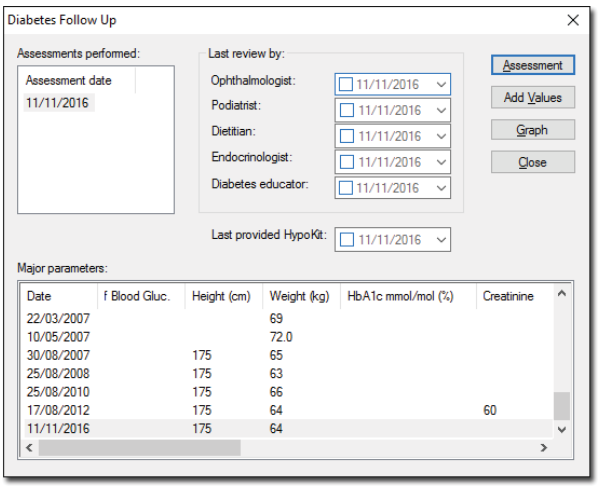




Record Total Cholesterol and HDL

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

nKPI: PI21

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

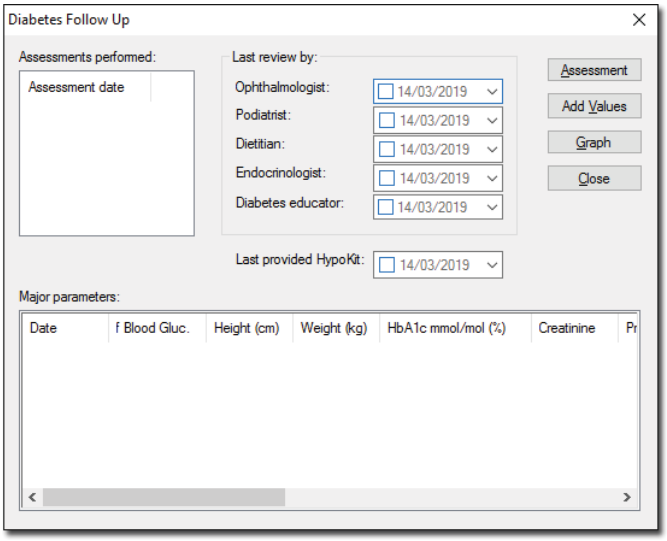
- Number of Indigenous regular clients aged 35-74 without known CVD who had an absolute CVD risk assessment result recorded.

Data Entry Field

Same as PI20

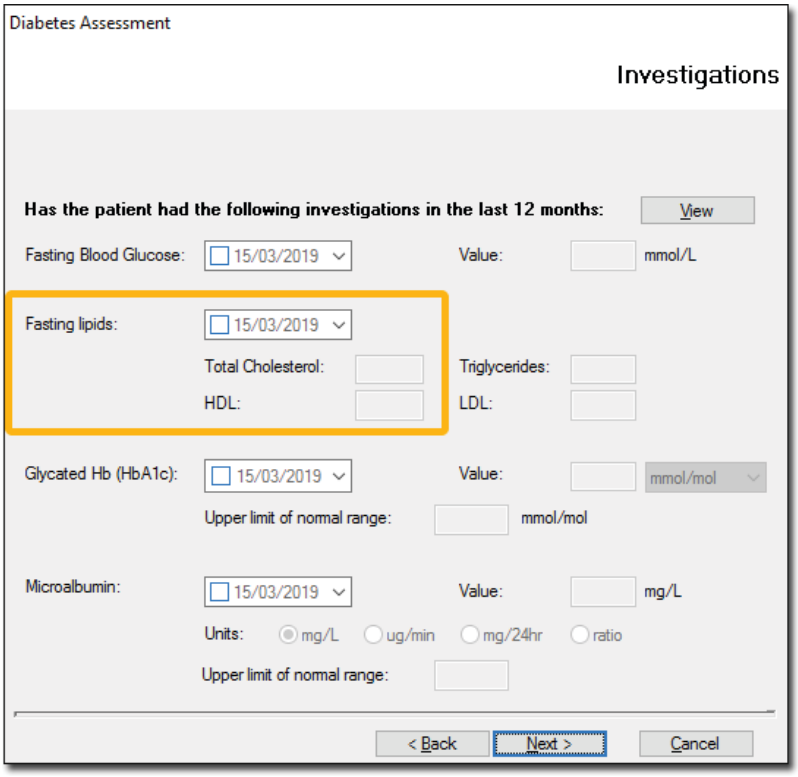
Disaggregation

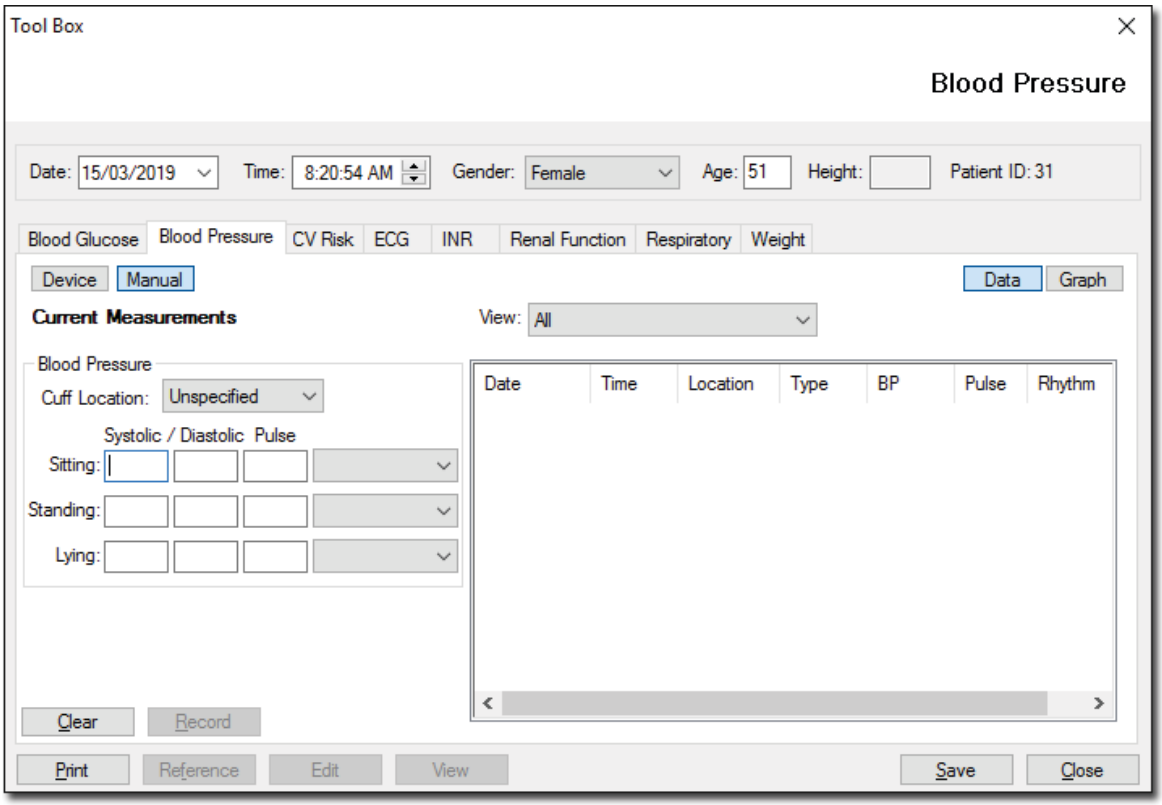
- **Age:** 35–44 years, 45–54 years, 55–64 years, and 65 years and over
- **Gender:** Male and Female
- **CVD risk assessment**



nKPI: PI21

CVD risk assessment result





nKPI: PI22

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 papilloma-virus (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

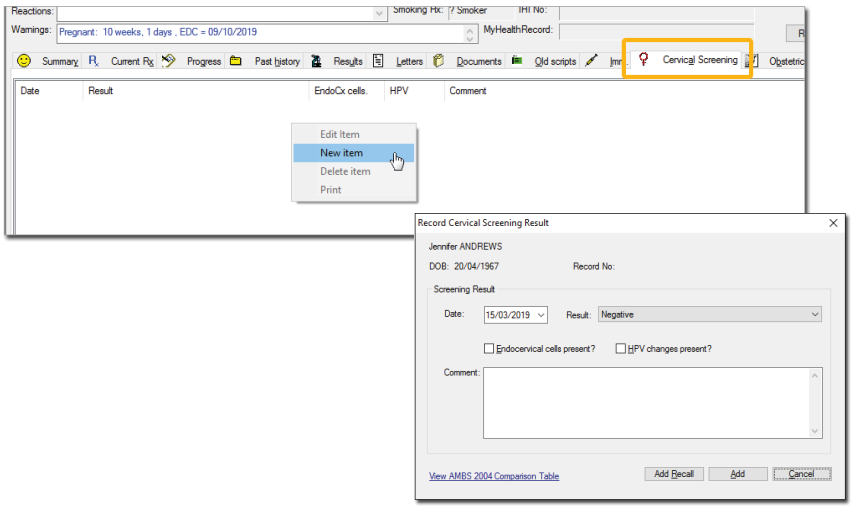
- Number of female Indigenous, regular client aged between 25–74 who have not had a hysterectomy.

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



nKPI: PI23

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

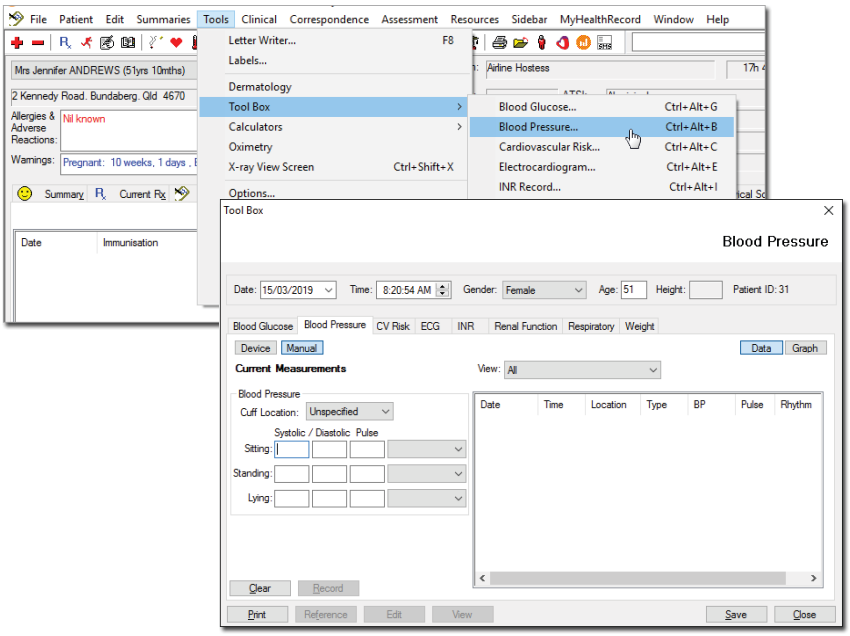
- Number of Indigenous regular clients with Type 2 diabetes.

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



nKPI: PI24

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

nKPI: PI25

Sexually transmissible infections

Description:

Proportion of Indigenous regular clients aged 15-34 who were tested for one or more sexually transmissible infections (STIs) (Clamydia 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

nKPI: PI26

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

Notes

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