



Northern Territory Aboriginal Health

Key Performance Indicator Information System



Australian Government
Department of Health and Ageing



Northern Territory Government

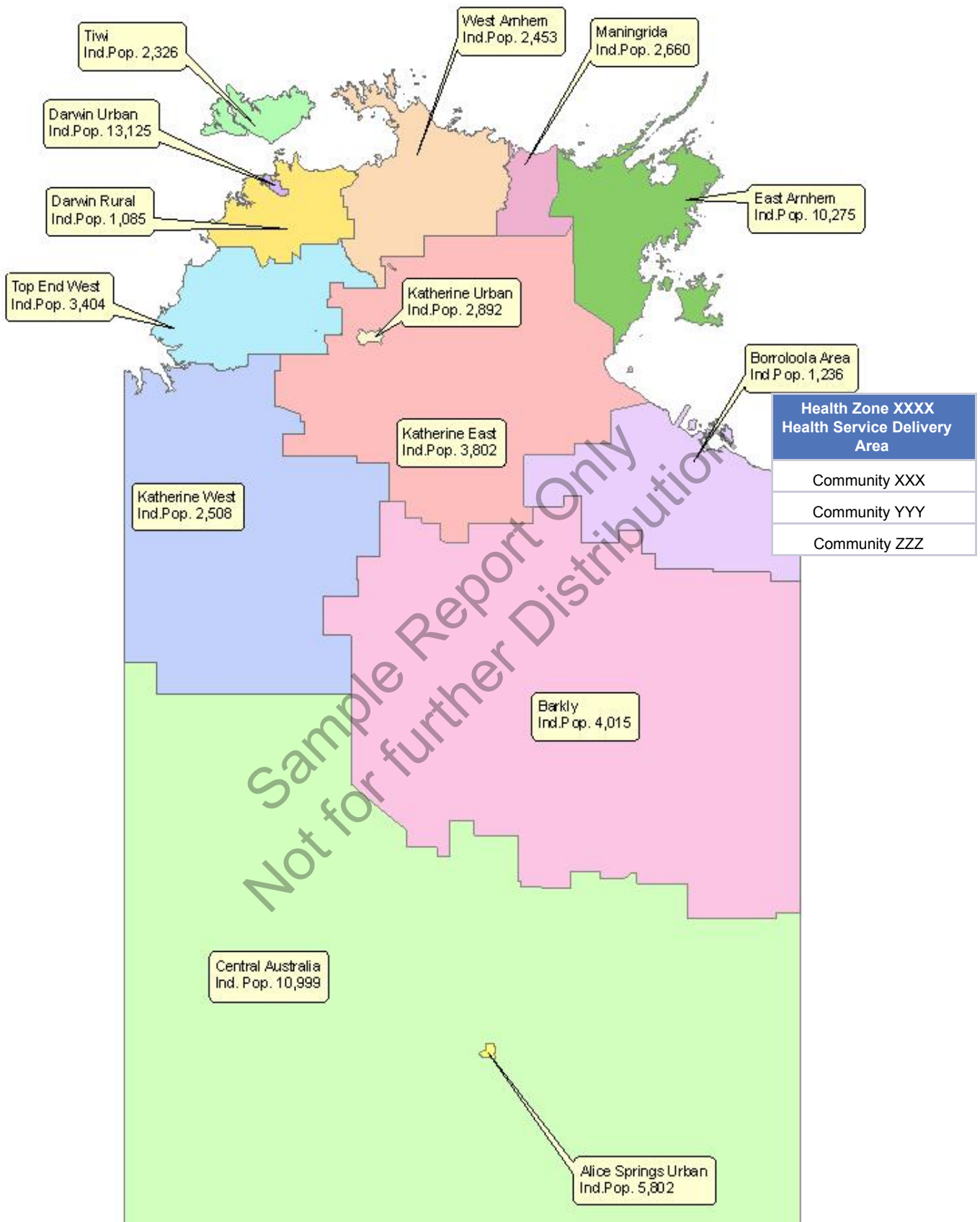
Health Service Delivery Area Report for Health Zone XXXXX

FINAL RELEASE

For Report Period 01/01/2009 to 31/12/2009

Sample Report Only
Not for further Distribution

Northern Territory Health Service Delivery Areas.**



** The Northern Territory Health Service Delivery Areas are also the Northern Territory OATSIH Planning Regions that took effect from 1 July 2008.

Note: The population statistics shown are 2006 Preliminary Estimated Resident Population (ERP), with a total Indigenous population of 66,582. This should be compared with the Final 2006 Estimated Resident Population statistics contained in the Australian Bureau of Statistics publication 3238.0.55.001 Experimental Estimates of Aboriginal and Torres Strait Islander Australians, June 2006, released 19 August 2008. In this publication, there was an estimate of 64,005 Aboriginal and Torres Strait Islander people at June 2006 in the Northern Territory.

Document Control

This document is managed on behalf of the NT Aboriginal Health Forum for the NT Aboriginal Health Key Performance Indicator System Team.

The metadata pages provide descriptions of the general format and calculations used in the production of the Health Service Delivery Area Report for Health Zone XXXXX.

Release Details:

Ver	Date	Reason for change	Ref	Description of change
V1.0.6	8/3/2010	Address confusion over representation of graph percentages that calculate denominators against a community instead of a cohort.	All	Applied cohort percentage calculation to all tables and charts.
V1.0.5	9/2/2010	Address of final issues identified through final peer review prior to 2009 calendar year delivery.	All	Applied consistent style to all charts and tables. All chart percentages calculated against total of community. Non Indigenous count removed from 1.7 and 1.8. Calculation errors identified and resolved.
V1.0.4	1/2/2010	Application of feedback from CQI process. Add calendar year functionality.	All - minor release only	Early distribution with limited issues addressed.
V1.0.3	20/10/2009	Final Release - Distributed to DHF and ACCHO's.		Incorporating feedback from DHF, OATSIH and AMSANT review of the 'First Release Report V1.0.1 and V1.0.2
V1.0.2	4/9/2009	Distributed to DHF for CQI and format and layout feedback.		Minor calculation errors identified by ACCHO's resolved.
V1.0.1a	21/8/2009	First Release - Distributed to DHF.		Blank page added.
V1.0.1	14/8/2009	First Release - Distributed to ACCHO's		Incorporating feedback from Preliminary Release
V1.0.0	31/7/2009	Preliminary Release - Distributed to ACCHO's who could deliver data		Incorporating feedback from consultation draft
V.0.1.0	8/4/2009	Consultation draft circulated to the AHF		N/A

Report Document Structure

Section	Description
Report Document Information	Acknowledgements
	Introduction
	Data Quality and Use
	Confidentiality and distribution
	Known Data Quality Issues
NT AHKPI Quantitative Reports (1.1 to 1.12)	Indicator Graphs
	Interpretation
	Data Tables
Metadata	Data Description
	KPI Detail

Sample Report Only
Not for further Distribution

Acknowledgements

The significance of this report is that it has been made possible due to an extensive team collaboration by many persons from many organisations. This team includes doctors, nurses, health centre managers, administrators, data managers, systems analysts and programmers. Thanks are extended to the whole team who have turned a concept into this HSDA report. Most importantly, this report would not be possible without the efforts of data input into various information systems by health services staff who perform the day to day work of data collection and data entry. A huge thank you has to go to these people who tirelessly feed the systems with data and without which this report would not be possible. This important collaborative effort of members of the NT Aboriginal Health Forum continues.

Sample Report Only
Not for further Distribution

Introduction

Background

The Northern Territory Aboriginal Health Forum (NT AHF), that comprises representatives from the Commonwealth Department of Health and Aging (DoHA), Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) and the Northern Territory Department of Health and Families (DHF), have developed this set of Key Performance Indicators (KPI's). The NT wide health jurisdiction Aboriginal Health Key Performance Indicators system (NT AHKPI) is capturing and measuring primary health care data consistently across the variety of NT remote Primary Health Care service providers. The objective of the NT AHKPI system is to contribute to improving primary health care services for Indigenous Australians in the Northern Territory by building capacity at the service level and the system level to collect, analyse and interpret data that will:

1. Inform understanding of trends in individual and population health outcomes;
2. Identify factors influencing these trends; and
3. Inform appropriate action, planning and policy development

This report provides a Health Services Delivery Area level analysis of the suite of KPIs. Full KPI definition can be found at:

<http://www.nt.gov.au/health/ahkpi/Reports/KPIdefinition.pdf>

Sample Report Only
Not for further Distribution

IMPORTANT NOTE FOR READERS OF THIS REPORT

Data Quality and Use

The NT AHKPI Report data quality will vary across health services depending on their experience in using data and indicators and the capacity of their information systems. This report is intended to be used to measure ongoing continuous quality improvements in processes for health data collection and analysis across the diverse and challenging environment that the remote communities of the Northern Territory operate in.

This report is NOT for public distribution as the quality of the jurisdiction wide information collected is being extensively reviewed by the members of the NT Aboriginal Health Forum. Through this rigorous validation process, data quality and collection methods will continue to be analysed and improved.

The format of this report is also under review and subject to change. Timeline graphs are to be included in future releases.

Confidentiality and Distribution

As noted above, there are important data quality issues to consider in determining how to use this report.

'All NT AHKPI data collected through health service organisations operational information systems are the property of the health service organisations. Access to data will not be granted without the consent of the individual Aboriginal Medical Services and will only be released to individuals/organisations following approval by the NT AHKPI Steering Committee' in accordance with the NT AHKPI system Data Management Strategy and Protocols, December 2008.

The NT AHF in consultation with member organisations will decide the format and timing of public data release from the NT AHKPI system at a point in the future when the data are of sufficient quality.

Known Data Quality Issues for Health Zone XXXX Health Service Delivery Area Data

Specific system issues, data anomalies included here.

Sample Report Only
Not for further Distribution

AHKPI 1.1 Number of Episodes of Health Care and Client Contacts

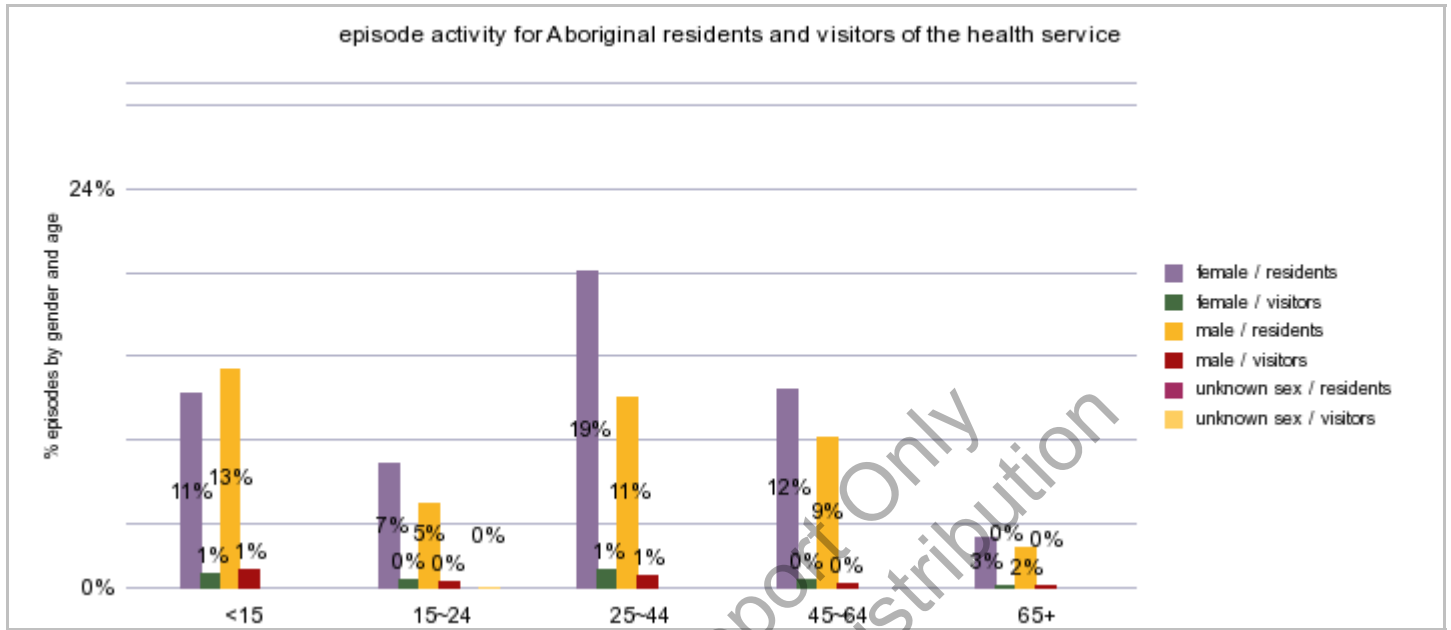
Health Zone XXXX

1.1a Number of episodes of health care

Total number of episodes of care for calendar year ending 2009

36,929

Episodes of care shows the number of episodes of care for one person (generally coded in one day as an episodic event) using the health service.



1.1b Number of client contacts

Total number of client contacts for calendar year ending 2009

43,940

Client contacts shows the workload of the health service staff. For example: in one day a child attends for a health review and is seen by the Aboriginal health worker (1 contact) then the GP (1 contact). This is one episode of care but two client contacts.

Key comments

Percentages displayed on the chart are based on Aboriginal episodes of care (residents and visitors) by gender and age group/ total Aboriginal episodes of care (residents and visitors).

This indicator shows the number of episodes of care for people coming to the HSDA, and contacts reflects the workload the HSDA undertakes. It shows use of the health services by males and females, age group, indigenous status and whether the person is a resident or visiting each community.

Visitors can increase the workload as health staff spend time accessing their records from other services.

Health Zone XXXX

AHKPI 1.1a Number of Episodes of Health Care

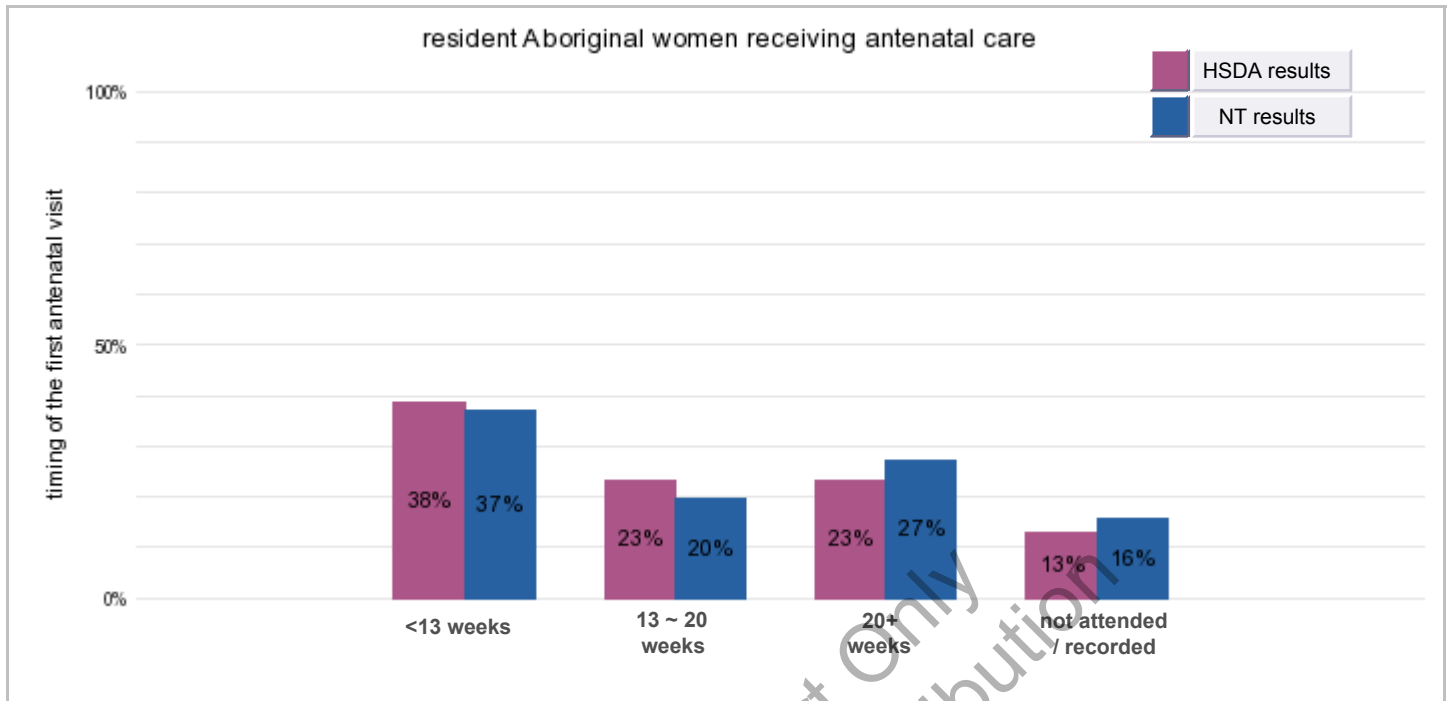
Number of episodes of health care and client contacts

all episodes	residents of the HSDA						visitors to the HSDA						all episode totals
	age group					totals	age group					totals	
	<15	15~24	25~44	45~64	65+		<15	15~24	25~44	45~64	65+		
<i>total episodes</i>	7,998	4,031	10,868	7,603	1,627	32,127	907	655	1,824	1,229	187	4,802	36,929
<i>% total episodes</i>	21.7%	10.9%	29.4%	10.7%	4.4%	87.0%	2.5%	1.8%	4.9%	3.3%	0.5%	13.0%	100.0%
men	4,387	1,623	4,231	3,654	786	14,681	480	301	878	651	131	2,441	17,122
	11.9%	4.4%	11.5%	9.9%	2.1%	39.8%	1.3%	0.8%	2.4%	1.8%	0.4%	6.6%	46.4%
women	3,611	2,408	6,637	3,949	841	17,446	427	353	944	578	56	2,358	19,804
	9.8%	6.5%	18.0%	10.7%	2.3%	47.2%	1.2%	1.0%	2.6%	1.6%	0.2%	6.4%	53.6%
unknown sex	0	0	0	0	0	0	0	1	2	0	0	3	3
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Aboriginal episodes	<15	15~24	25~44	45~64	65+		<15	15~24	25~44	45~64	65+		
<i>total episodes</i>	6,329	3,196	7,823	5,347	1,383	24,078	669	283	614	207	38	1,811	25,889
<i>% total episodes</i>	17.1%	8.7%	21.2%	14.5%	3.7%	65.2%	1.8%	0.8%	1.7%	0.6%	0.1%	4.9%	70.1%
men	3,358	1,297	2,939	2,292	611	10,497	364	115	249	59	32	819	11,316
	9.1%	3.5%	8.0%	6.2%	1.7%	28.4%	1.0%	0.3%	0.7%	0.2%	0.2%	2.2%	30.6%
women	2,971	1,899	4,884	3,055	772	13,581	305	167	365	148	6	991	14,572
	8.0%	5.1%	13.2%	8.3%	2.1%	36.8%	0.8%	0.5%	1.0%	0.4%	0.0%	2.7%	39.5%
unknown sex	0	0	0	0	0	0	0	1	0	0	0	1	1
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
non Aboriginal episodes	<15	15~24	25~44	45~64	65+		<15	15~24	25~44	45~64	65+		
<i>total episodes</i>	1,618	827	3,000	2,212	243	7,900	232	365	1,168	996	146	2,907	10,807
<i>% episodes</i>	4.4%	2.2%	8.1%	6.0%	0.7%	21.4%	0.6%	1.0%	3.2%	2.7%	0.4%	0.4%	29.3%
men	990	318	1,283	1,324	175	4,090	115	184	607	577	99	1,582	5,672
women	628	509	1,717	888	68	3,810	117	181	559	419	47	1,323	5,133
unknown sex	0	0	0	0	0	0	0	0	2	0	0	2	2
unknown status episodes	<15	15~24	25~44	45~64	65+		<15	15~24	25~44	45~64	65+		
<i>total episodes</i>	51	8	45	44	1	149	6	7	42	26	3	84	233
<i>% episodes</i>	0.1%	0.0%	0.1%	0.1%	0.0%	0.4%	0.0%	0.0%	0.1%	0.1%	0.0%	0.2%	0.6%
men	39	8	9	38	0	94	1	2	22	15	0	40	134
women	12	0	36	6	1	55	5	5	20	11	3	44	99
unknown sex	0	0	0	0	0	0	0	0	0	0	0	0	0

AHKPI 1.2 First Antenatal Visit

Timing of first antenatal visit for regular clients delivering Indigenous babies.

Health Zone XXXX



Key comments

Percentages displayed on the chart are based on resident Aboriginal women attending a first antenatal visit by timing / total recorded resident Aboriginal women who gave birth in the reporting period.

This indicator shows the number and proportion of regular clients who are residents who gave birth to Aboriginal babies who attended for a first antenatal visit before 13 weeks gestation. Early presentation in pregnancy allows any problems to be identified and managed more effectively and it is recommended that most women attend in the first trimester. Women attending after 20+ weeks have less opportunity to maintain healthy behaviours in pregnancy, receive all the recommended care, and minimise risk.

Early presentation for pregnancy care is promoted by the health service providing regular antenatal clinics, pregnant women knowing who to talk to about their pregnancy and with midwives, Aboriginal health workers and community workers promoting the benefits of early attendance.

Health Zone XXXX

AHKPI 1.2 First Antenatal Visit

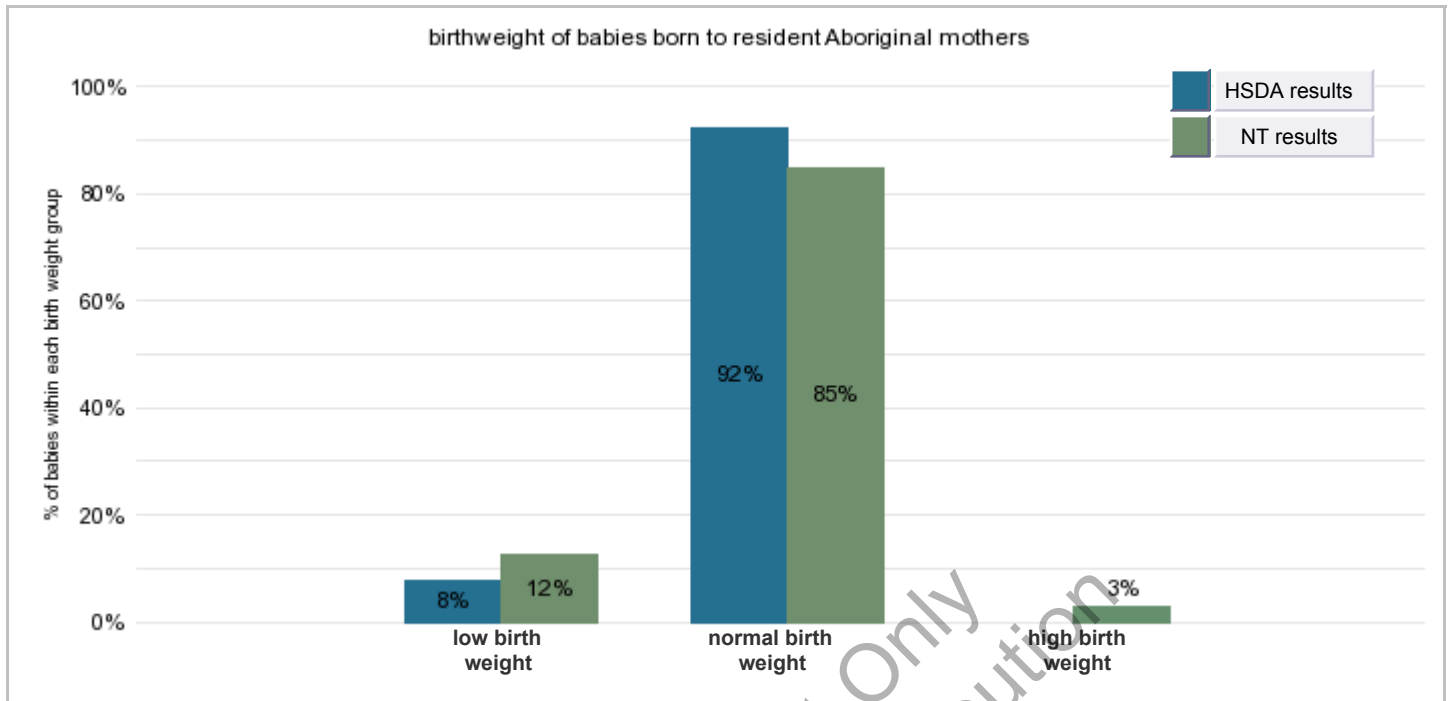
Timing of first antenatal visit for regular clients delivering Indigenous babies.

mothers delivering babies (Aboriginal and non Aboriginal)	mothers age group			totals
	< 20	20~34	35+	
total mothers	5	37	4	46
% mothers	10.9%	80.4%	8.7%	100.0%
attending a first antenatal visit	5	31	4	40
% attending a first antenatal visit	10.9%	67.4%	8.7%	87.0%
attended less than 13 weeks	0	16	3	19
% attended less than 13 weeks	0.0%	34.8%	6.5%	41.3%
attended between 13 and 20 weeks	3	8	1	12
% attended between 13 and 20 weeks	6.5%	17.4%	2.2%	26.1%
attended later than 20 weeks	2	7	0	9
% attended later than 20 weeks	4.3%	15.2%	0.0%	19.6%
not recorded as attending or did not attend	0	5	0	5
% not recorded as attending or did not attend	0.0%	10.9%	0.0%	10.9%
Aboriginal mothers delivering babies	mothers age group			totals
	< 20	20~34	35+	
total Aboriginal mothers	4	34	1	39
% Aboriginal mothers	10.3%	87.2%	2.6%	84.8%
attending a first antenatal visit	4	28	1	33
% attending a first antenatal visit	100.0%	82.4%	100.0%	84.6%
attended less than 13 weeks	0	14	1	15
% attended less than 13 weeks	0.0%	41.2%	100.0%	38.5%
attended between 13 and 20 weeks	2	7	0	9
% attended between 13 and 20 weeks	50.0%	20.6%	0.0%	23.1%
attended later than 20 weeks	2	7	0	9
% attended later than 20 weeks	4.3%	20.6%	0.0%	23.1%
not recorded as attending or did not attend	0	5	0	5
% are not recorded as attending or did not attend	0.0%	20.6%	500.0%	12.8%
non Aboriginal mothers delivering babies	mothers age group			totals
	< 20	20~34	35+	
total non Aboriginal mothers	1	3	3	7
% total non Aboriginal mothers	14.3%	42.9%	42.9%	15.2%
attending a first antenatal visit	1	3	3	7
% attending a first antenatal visit	100.0%	100.0%	100.0%	100.0%
attended less than 13 weeks	0	2	2	4
% attended less than 13 weeks	0.0%	66.7%	66.7%	57.1%
attended between 13 and 20 weeks	1	1	1	3
% attended between 13 and 20 weeks	100.0%	33.3%	33.3%	42.9%
attended later than 20 weeks	0	0	0	0
% attended later than 20 weeks	0.0%	0.0%	0.0%	0.0%
not recorded as attending or did not attend	0	0	0	0
% are not recorded as attending or did not attend	0.0%	0.0%	0.0%	0.0%
unknown Aboriginal status mothers delivering babies	mothers age group			totals
	< 20	20~34	35+	
total unknown Aboriginal status mothers	0	0	0	0
% unknown Indigenous status mothers	0.0%	0.0%	0.0%	0.0%
attending a first antenatal visit	0	0	0	0
% attending a first antenatal visit	0.0%	0.0%	0.0%	0.0%
not recorded as attending or did not attend	0	0	0	0
% not recorded as attending or did not attend	0.0%	0.0%	0.0%	0.0%

AHKPI 1.3 Birth Weight

Number and proportion of low, normal and high birth weight Indigenous babies

Health Zone XXXX



Key Comments

Percentages displayed on the chart are based on babies born to resident Aboriginal mothers by birth weight group / total of all babies born to resident Aboriginal mothers.

Please note when considering this chart that there are limitations to the data collected for this KPI. Although the mothers Indigenous status is captured at the babies birth, current systems do not collect the fathers Indigenous status. It is possible that there is a group of babies missing from this indicator who have Indigenous fathers and non Indigenous mothers.

Low birth weight is associated with both prematurity and poor growth in pregnancy. There are a number of factors that may contribute to low birth weight including maternal infection, risk factors such as smoking, alcohol consumption, drugs resulting in baby's poor weight gain and growth. It is associated with higher risks of disease for the infant. High birth weight is often associated with diabetes in pregnancy and post term babies.

Health Zone XXXX

AHKPI 1.3 Birth weight

Number and proportion of low, normal and high birth weight Indigenous babies

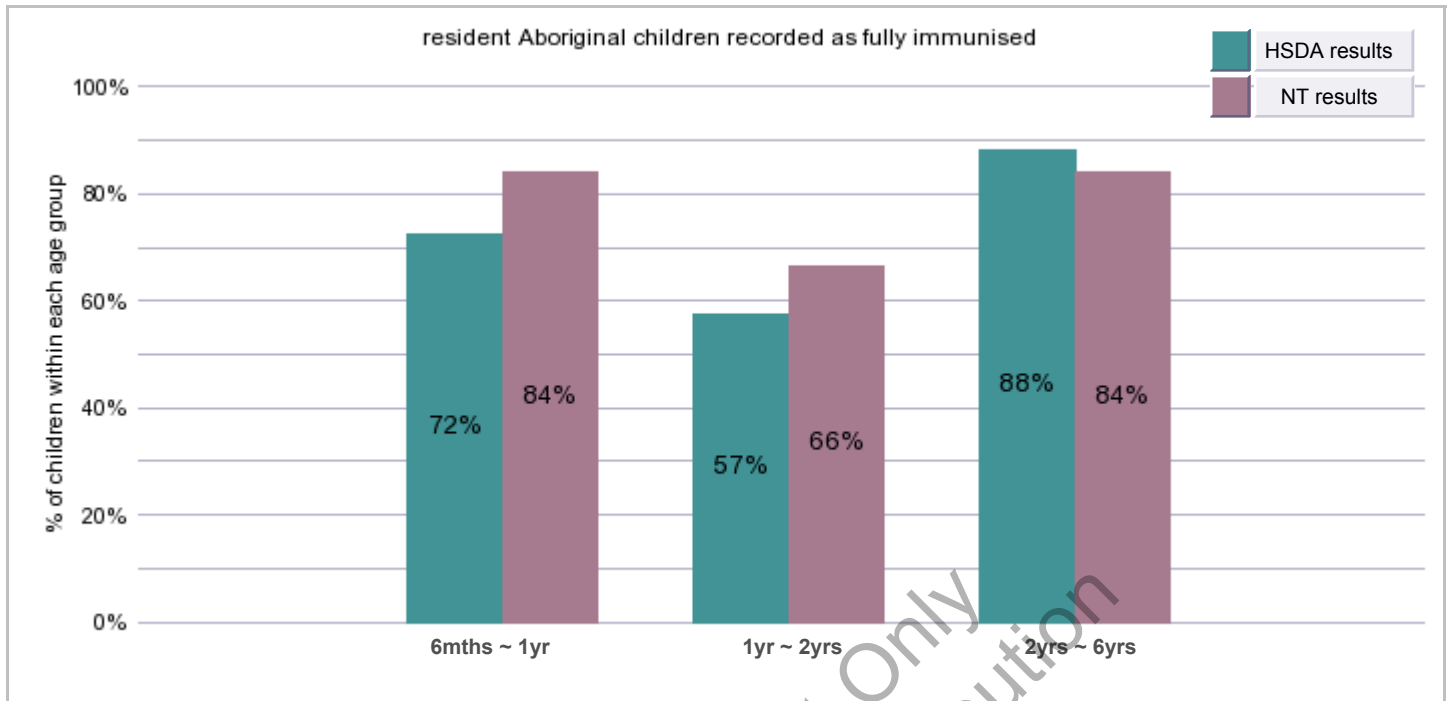
all babies (Aboriginal and non Aboriginal mothers)	mothers age group			totals
	< 20	20~34	35+	
total babies born	5	39	4	48
% babies born	10.4%	81.3%	8.3%	100.0%
low birth weight	0	5	1	6
% low birth weight babies	0.0%	12.8%	25.0%	12.5%
normal birth weight	5	34	3	42
% normal birth weight	100.0%	87.2%	75.0%	87.5%
high birth weight	0	0	0	0
% high birth weight	0.0%	0.0%	0.0%	0.0%
babies born to Aboriginal mothers	mothers age group			totals
	< 20	20~34	35+	
total babies born	4	34	1	39
% babies born	10.3%	87.2%	2.6%	81.3%
low birth weight	0	2	1	3
% low birth weight	0.0%	5.9%	100.0%	7.7%
normal birth weight	4	32	0	36
% normal birth weight	100.0%	94.1%	0.0%	92.3%
high birth weight	0	0	0	0
% high birth weight	0.0%	0.0%	0.0%	0.0%
babies born to non Aboriginal mothers	mothers age group			totals
	< 20	20~34	35+	
total babies born	1	5	3	9
% babies born	11.1%	55.6%	33.3%	18.8%
low birth weight	0	3	0	3
% low birth weight	0.0%	60.0%	0.0%	33.3%
normal birth weight	1	2	3	6
% normal birth weight	100.0%	40.0%	100.0%	66.7%
high birth weight	0	0	0	0
% high birth weight	0.0%	0.0%	0.0%	0.0%

Sample Report Only
Not for further Distribution

AHKPI 1.4 Fully Immunised Children

Number and proportion of Indigenous children fully immunised at 1, 2 and 6 years of age

Health Zone XXXX



Key comments

Percentages displayed on the chart are based on resident Aboriginal children by age group recorded as fully immunised / total of all resident Aboriginal children by age group.

Counting rules for immunisation status should be noted when considering this graph. The coverage is measured with a time lag to allow for delayed immunisations using the same calculation as for the national ACIR reports that is also used by Healthy for Life. This means children due for vaccinations at birth are assessed and reported as fully immunised at 8 months. Please refer to the 1.4 Metadata page for all calculations used to assess and report a child's immunisation status.

Health Zone XXXX

AHKPI 1.4 Fully Immunised Children

Number and proportion of Indigenous children fully immunised at 1, 2 and 6 years of age

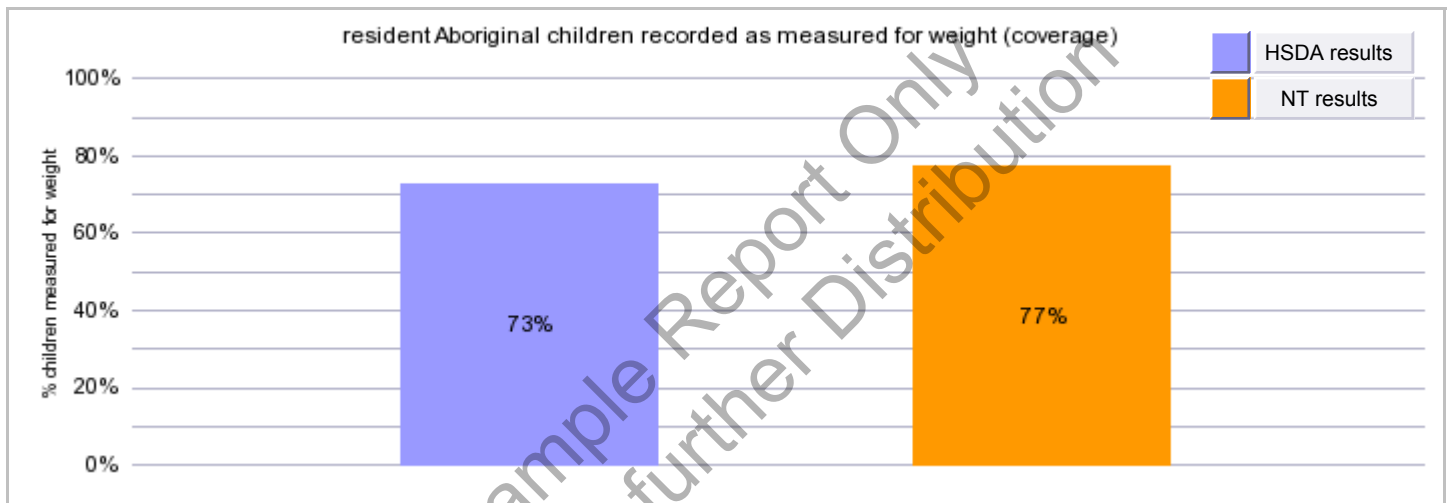
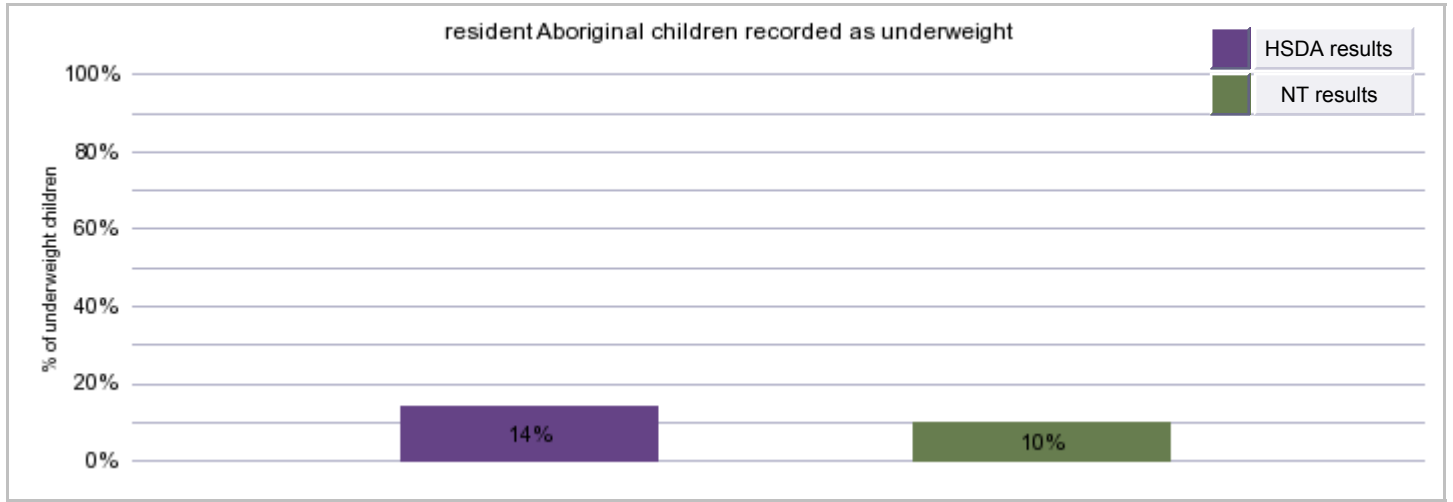
resident Aboriginal children between 6 mths and 6 yrs	childrens age group			Totals
	6 mths to 1 year	1 year to 2 years	2 years to 6 years	
total resident Aboriginal children	29	47	178	254
% resident Aboriginal children	11.4%	18.5%	70.1%	100.0%
total fully immunised	21	27	157	205
% fully immunised	72.4%	57.4%	88.2%	80.7%

Sample Report Only
Not for further Distribution

AHKPI 1.5 Underweight Children

Number and proportion of children less than 5 years of age who are underweight

Health Zone XXXX



Key Comments

Underweight percentages displayed on the chart are based on resident Aboriginal children less than 5 years recorded as being underweight / total all resident Aboriginal children less than 5 years of age recorded as being measured for weight.

Coverage percentages displayed on the chart are based on resident Aboriginal children less than 5 years recorded as being measured for weight / total recorded resident Aboriginal children less than 5 years of age.

Health Zone XXXX

AHKPI 1.5 Underweight Children

Number and proportion of children less than 5 years of age who are underweight

resident children less than 5 years of age (Aboriginal and non Aboriginal)

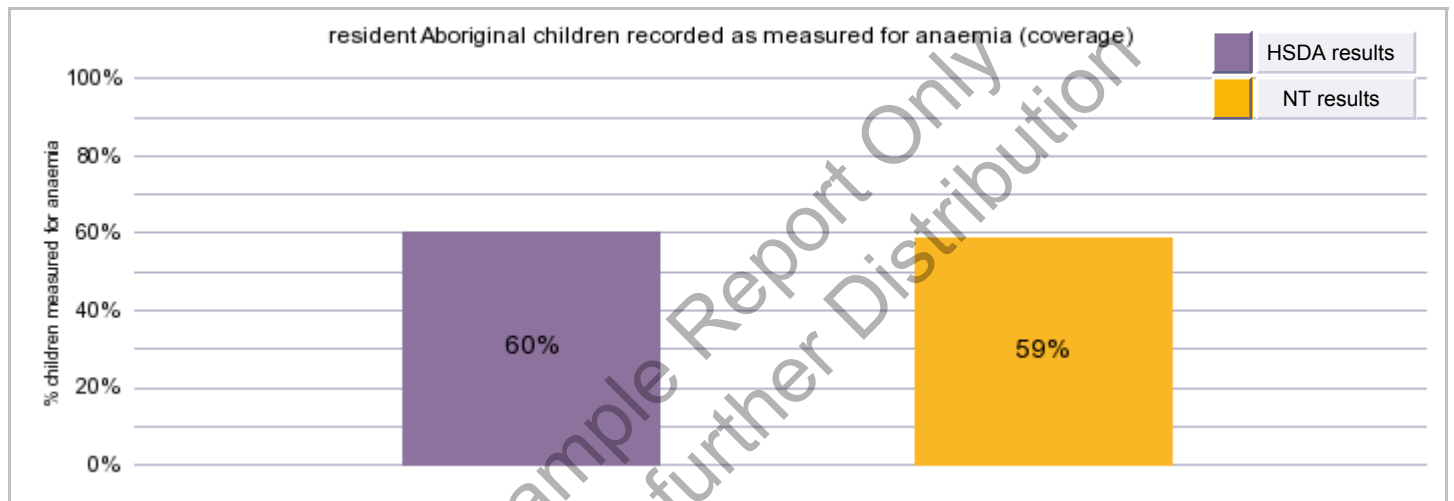
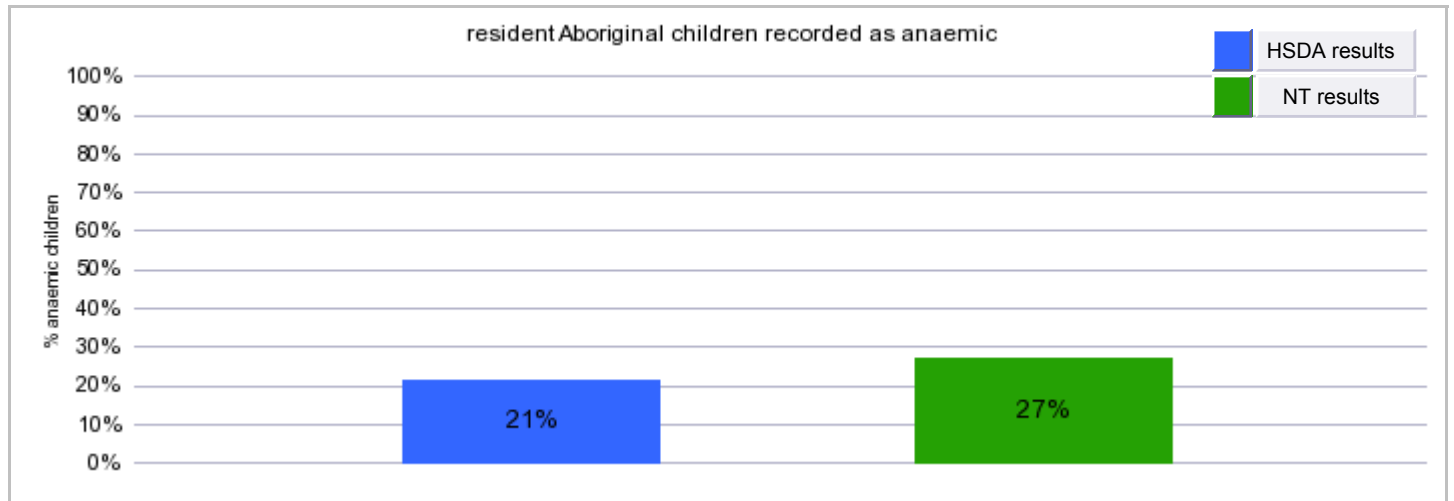
total resident children	378
% resident children	100%
total underweight	25
% underweight	10.7%
measured for weight (coverage)	233
% measured for weight (coverage)	61.6%
resident Aboriginal children less than 5 years of age	
total resident Aboriginal children	213
% resident Aboriginal children	56.3%
total underweight	22
% underweight	14.2%
measured for weight (coverage)	155
% measured for weight (coverage)	72.8%
resident non Aboriginal children less than 5 years of age	
total resident non Aboriginal children	158
% resident non Aboriginal children	41.8%
total underweight	3
% underweight	4.0%
measured for weight (coverage)	75
% measured for weight (coverage)	47.5%
resident unknown Aboriginal status children less than 5 years of age	
total resident unknown Aboriginal status children	7
% total resident unknown Aboriginal status children	1.9%
total underweight	0
% underweight	0.0%
measured for weight (coverage)	3
% measured for weight (coverage)	42.9%

Sample Report Only
Not for further Distribution

AHKPI 1.6 Anaemic Children

Number and proportion of children between 6 months and 5 years of age who are anaemic

Health Zone XXXX



Key Comments

Anaemia percentages displayed on the chart are based on resident Aboriginal children between 6 months and 5 years recorded as having anaemia / resident Aboriginal children between six month and 5 years recorded as being measured for anaemia.

Coverage percentages displayed on the chart are based on resident Aboriginal children between 6 months and 5 years recorded as being measured for anaemia / total recorded resident Aboriginal children between six month and 5 years.

The % of children with anaemia (usually iron deficiency) reflects maternal anaemia, low birth weight, poor growth and recurrent infection.

Health Zone XXXX**AHKPI 1.6 Anaemic Children****Number and proportion of children between 6 months and 5 years of age who are anaemic****resident children between 6 months and 5 years of age (Aboriginal and non Aboriginal)**

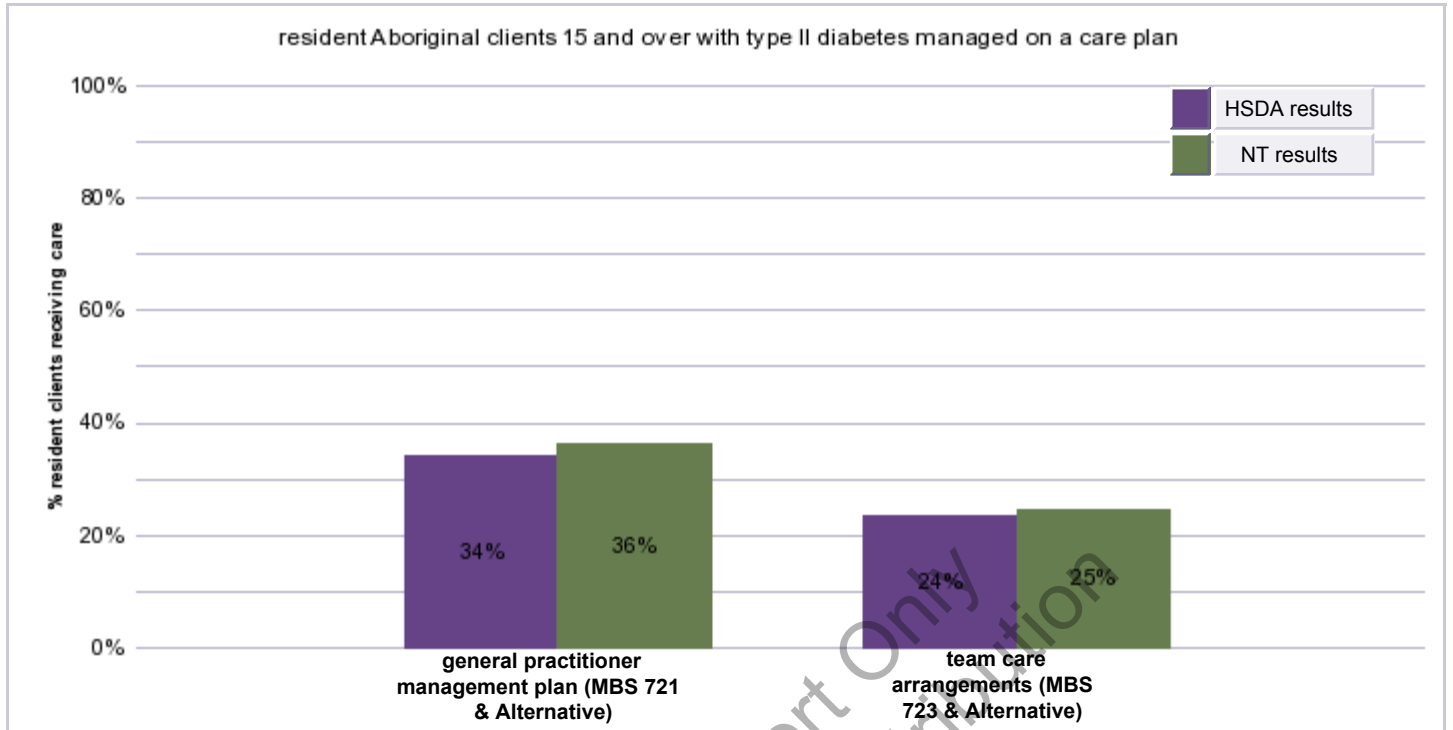
total resident children	357
% resident children	100%
total anaemic	29
% anaemic	17.7%
measured for anaemia (coverage)	164
% measured for anaemia (coverage)	45.9%
resident Aboriginal children between 6 months and 5 years of age	
total resident Aboriginal children	202
% resident Aboriginal children	56.6%
total anaemic	26
% anaemic	21.3%
measured for anaemia (coverage)	122
% measured for anaemia (coverage)	60.4%
resident non Aboriginal children between 6 months and 5 years of age	
total resident non Aboriginal children	149
% resident non Aboriginal children	41.7%
total anaemic	3
% anaemic	7.3%
measured for anaemia (coverage)	41
% measured for anaemia (coverage)	27.5%
resident unknown Aboriginal status children between 6 months and 5 years of age	
total resident unknown Aboriginal status children	6
% resident unknown Aboriginal status children	100.0%
total anaemic	0
% anaemic	0.0%
measured for anaemia (coverage)	1
% measured for anaemia (coverage)	16.7%

Sample Report Only
Not for further Distribution

AHKPI 1.7 Chronic Disease Management Plan

Clients who are residents aged 15 years and over who have been diagnosed with Type II Diabetes who have a chronic disease management plan

Health Zone XXXX



Key Comments

Percentages displayed on the chart are based on resident Aboriginal clients 15 years and over recorded as having type II diabetes and managed on a chronic disease care plan by care plan type / total resident Aboriginal clients aged 15 years and over recorded as having type II diabetes.

This indicator gives an indication of how well the HSDA is managing people with diabetes. Chronic disease care plans are an important way to document team based care tailored for the individual patient. Care plans show that the HSDA has developed organised systems and has sufficient resources to deliver quality care for chronic disease.

Health Zone XXXX

AHKPI 1.7 Chronic Disease Management Plan

Clients who are residents aged 15 years and over who have been diagnosed with Type II Diabetes who have a chronic disease management plan

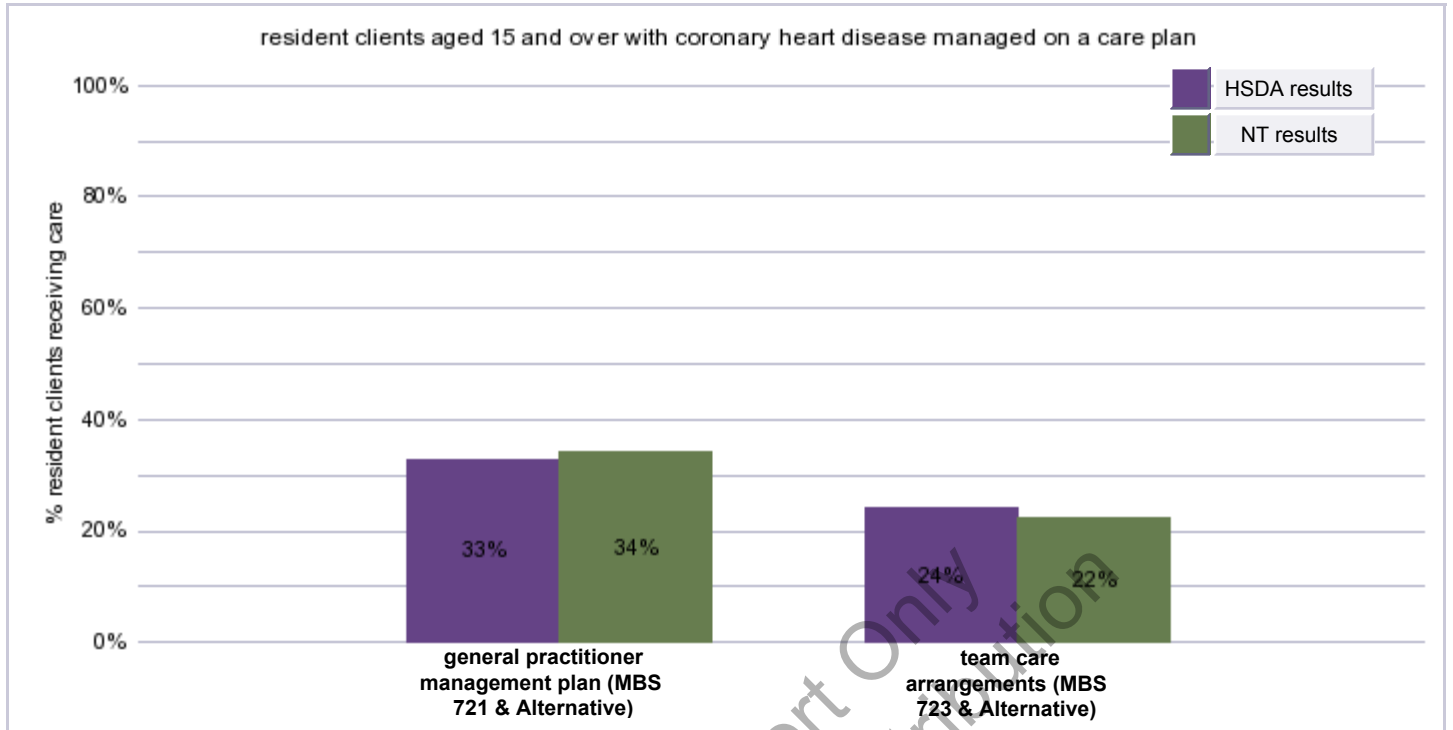
Aboriginal residents 15 years and over	clients age group				totals
	15-24	25-44	45-64	65+	
recorded as having Type II Diabetes	3	94	123	21	241
% recorded as having Type II Diabetes	1.2%	39.0%	51.0%	8.7%	100.0%
men	2	30	53	9	94
% men	2.1%	31.9%	56.4%	9.6%	39.0%
women	1	64	70	12	147
% women	0.7%	43.5%	47.6%	8.2%	61.0%
sex unknown	0	0	0	0	0
% sex unknown	0.0%	0.0%	0.0%	0.0%	0.0%
receiving care under a chronic disease management plan ~ General Practitioner Management Plan and/or Team Care Arrangements					
under a general practitioner management plan (MBS or Alternative)	0	30	49	3	82
% under a general practitioner management plan (MBS or Alternative)	0.0%	31.9%	39.8%	14.3%	34.0%
men	0	8	15	1	24
% men	0.0%	26.7%	28.3%	11.1%	25.5%
women	0	22	34	2	58
% women	0.0%	34.4%	48.6%	16.7%	39.5%
sex unknown	0	0	0	0	0
% sex unknown	0.0%	0.0%	0.0%	0.0%	0.0%
under team care arrangements (MBS & Alternative)	0	26	28	3	57
% under team care arrangements (MBS & Alternative)	0.0%	27.7%	22.8%	14.3%	23.7%
men	0	6	9	1	16
% men	0.0%	20.0%	17.0%	11.1%	17.0%
women	0	20	19	2	41
% women	0.0%	31.3%	27.1%	16.7%	27.9%
sex unknown	0	0	0	0	0
% sex unknown	0.0%	0.0%	0.0%	0.0%	0.0%

Sample Report Only
Not for further Distribution

AHKPI 1.7 Chronic Disease Management Plan

Clients who are residents aged 15 years and over who have been diagnosed with Coronary Heart Disease who have a chronic disease management plan

Health Zone XXXX



Key Comments

Percentages displayed on the chart are based on resident Aboriginal clients 15 years and over recorded as having coronary heart disease and managed on a chronic disease care plan by care plan type / total resident Aboriginal clients aged 15 years and over recorded as having coronary heart disease.

This indicator is to measure how well the HSDA is managing people with coronary heart disease (CHD). Care plans either claimed through Medicare or an electronic or paper care plan that includes similar criteria to a Medicare claim, suggest your clinic has organised systems to deliver quality care for chronic disease.

Health Zone XXXX

AHKPI 1.7 Chronic Disease Management Plan ~ coronary heart disease

Clients who are residents aged 15 years and over who have been diagnosed with coronary heart disease who have a chronic disease management plan

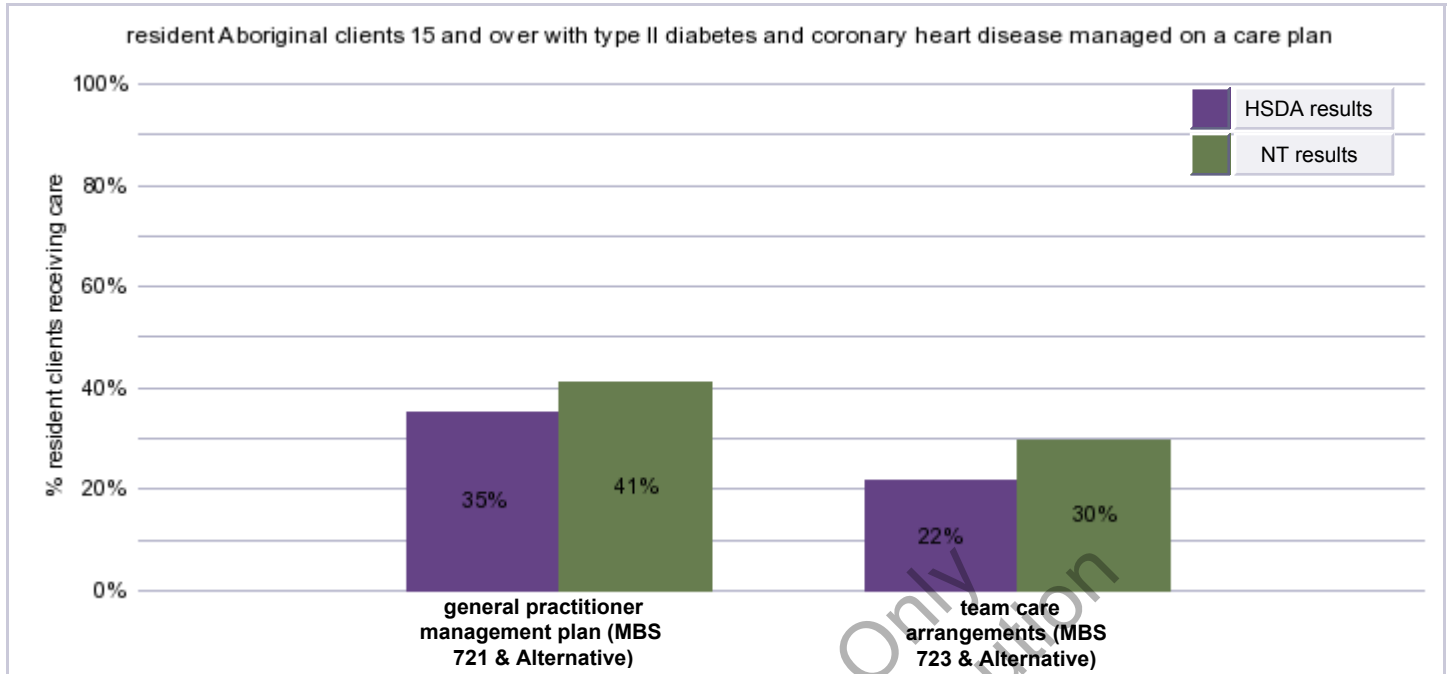
Aboriginal residents 15 years and over	clients age group				totals
	15~24	25~44	45~64	65+	
recorded as having coronary heart disease	1	24	49	5	79
% recorded as having coronary heart disease	1.3%	30.4%	62.0%	6.3%	100.0%
men	0.01	14	29	4	48
% men	2.1%	29.2%	60.4%	8.3%	60.8%
women	0	10	20	1	31
% women	0.0%	32.3%	64.5%	3.2%	39.2%
sex unknown	0	0	0	0	0
% sex unknown	0.0%	0.0%	0.0%	0.0%	0.0%
receiving care under a chronic disease management plan ~ General Practitioner Management Plan and/or Team Care Arrangements					
under a general practitioner management plan (MBS or Alternative)	0	8	17	1	26
% under a general practitioner management plan (MBS or Alternative)	0.0%	33.3%	34.7%	20.0%	32.9%
men	0	5	6	0	11
% men	0.0%	35.7%	20.7%	0.0%	22.9%
women	0	3	11	1	15
% women	0.0%	30.0%	55.0%	100.0%	48.4%
sex unknown	0	0	0	0	0
% sex unknown	0.0%	0.0%	0.0%	0.0%	0.0%
under team care arrangements (MBS & Alternative)	0	7	11	1	19
% under team care arrangements (MBS & Alternative)	0.0%	29.2%	22.4%	20.0%	24.1%
men	0	4	4	0	8
% men	0.0%	28.6%	13.8%	0.0%	16.7%
women	0	3	7	1	11
% women	0.0%	30.0%	35.0%	100.0%	35.5%
sex unknown	0	0	0	0	0
% sex unknown	0.0%	0.0%	0.0%	0.0%	0.0%

Sample Report Only
Not for further Distribution

AHKPI 1.7 Chronic Disease Management Plan

Clients who are residents aged 15 years and over who have been diagnosed with Type II Diabetes and Coronary Heart Disease who have a chronic disease management plan

Health Zone XXXX



Key Comments

Percentages displayed on the chart are based on resident Aboriginal clients 15 years and over recorded as having type II diabetes and coronary heart disease and managed on a chronic disease care plan by care plan type / total resident Aboriginal clients 15 years and over recorded as having type II diabetes and coronary heart disease.

This indicator is to measure how well the HSDA is managing people who have both diabetes and CHD. These 2 conditions were chosen as they cause significant burden of disease for Aboriginal people. Care plans either claimed through Medicare or an electronic or paper care plan that includes similar criteria to a Medicare claim, suggest the HSDA has organised systems to deliver quality care for chronic disease.

Health Zone XXXX

AHKPI 1.7 Chronic Disease Management Plan ~ diabetes and coronary heart disease

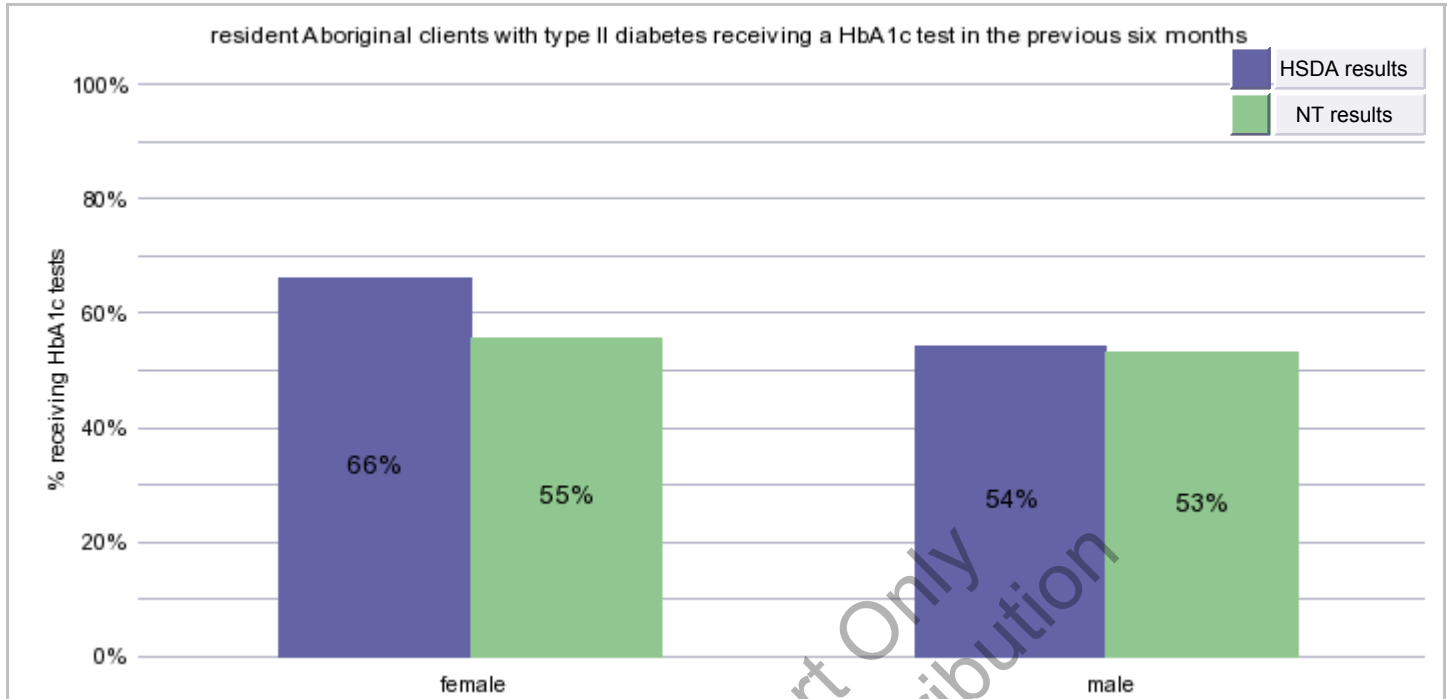
Clients who are residents aged 15 years and over who have been diagnosed with coronary heart disease who have a chronic disease management plan

Aboriginal residents 15 years and over	clients age group				totals
	15~24	25~44	45~64	65+	
recorded as having diabetes and coronary heart disease	0	7	27	3	37
% recorded as having diabetes and coronary heart disease	0.0%	18.9%	73.0%	8.1%	100.0%
men	0	3	15	3	21
% men	0.0%	14.3%	71.4%	14.3%	56.8%
women	0	4	12	0	16
% women	0.0%	25.0%	75.0%	0.0%	43.2%
sex unknown	0	0	0	0	0
% sex unknown	0.0%	0.0%	0.0%	0.0%	0.0%
receiving care under a chronic disease management plan ~ General Practitioner Management Plan and/or Team Care Arrangements					
under a general practitioner management plan (MBS or Alternative)	0	1	12	0	13
% under a general practitioner management plan (MBS or Alternative)	0.0%	2.7%	32.4%	0.0%	35.1%
men	0	1	3	0	4
% men	0.0%	33.3%	20.0%	0.0%	19.0%
women	0	0	9	0	9
% women	0.0%	0.0%	75.0%	0.0%	56.3%
sex unknown	0	0	0	0	0
% sex unknown	0.0%	0.0%	0.0%	0.0%	0.0%
under team care arrangements (MBS & Alternative)	0	0	8	0	8
% under team care arrangements (MBS & Alternative)	0.0%	0.0%	29.6%	0.0%	21.6%
men	0	0	2	0	2
% men	0.0%	0.0%	13.3%	0.0%	9.5%
women	0	0	6	0	6
% women	0.0%	0.0%	50.0%	0.0%	37.5%
sex unknown	0	0	0	0	0
% sex unknown	0.0%	0.0%	0.0%	0.0%	0.0%

AHKPI 1.8 HbA1c Tests

Number and proportion of resident clients aged 15 years and over with Type II Diabetes who have had an HbA1c test in the last 6 months

Health Zone XXXX



Key Comments

Percentages displayed on the chart are based on resident Aboriginal clients recorded as having type II diabetes and receiving an HbA1c test in the previous six months by gender / total resident Aboriginal clients recorded as having type II diabetes by gender.

This indicator measures one process of care for diabetes. Measurement of HbA1c once in 6 months is a minimum standard for good diabetes care. The guideline recommendation is for every 3 months so this allows a time lag.

Health Zone XXXX

AHKPI 1.8 HbA1c Tests

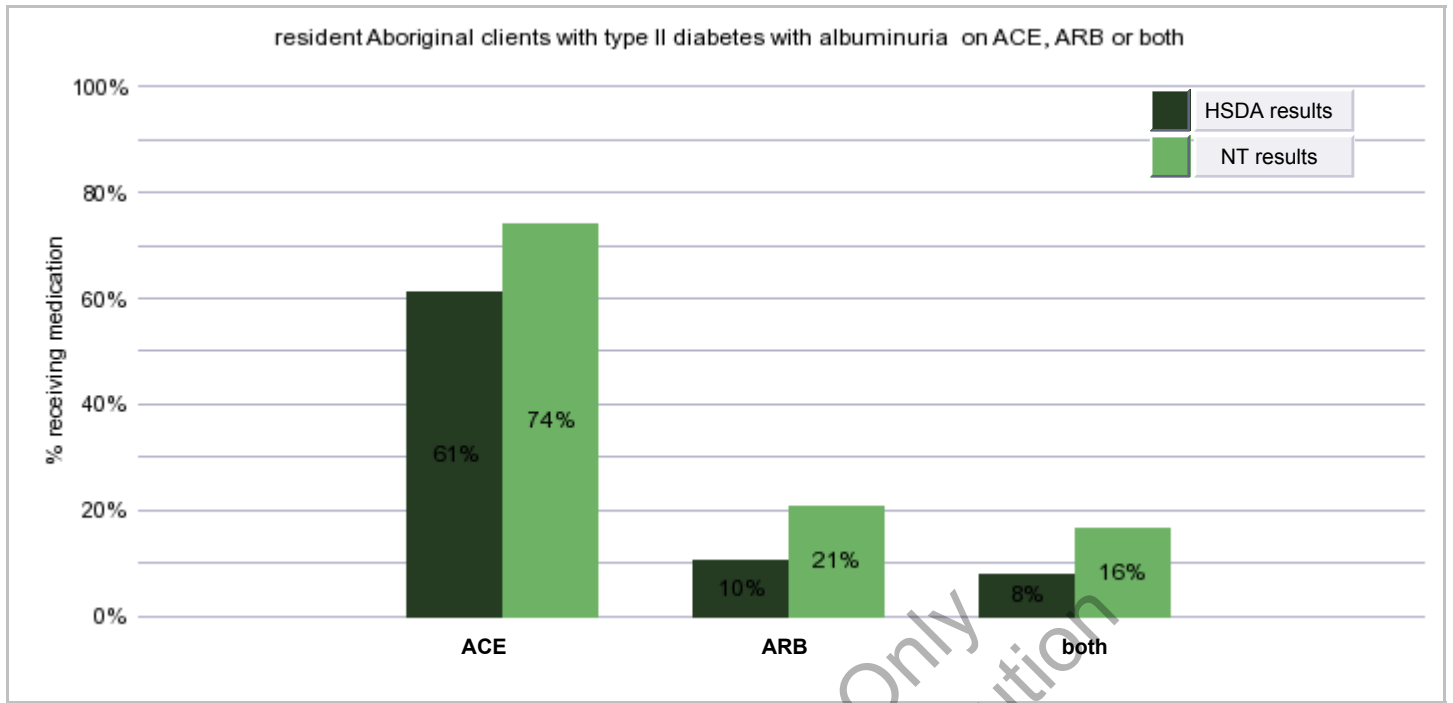
Number and proportion of resident clients aged 15 years and over with Type II Diabetes who have had an HbA1c test in the last 6 months

Aboriginal clients 15 years and over with type II diabetes	client's age group				total
	15~24	25~44	45~64	65+	
Aboriginal clients with type II diabetes	3	94	123	21	241
% Aboriginal clients with type II diabetes	1.2%	39.0%	51.0%	8.7%	100.0%
men with diabetes	2	30	53	9	94
women with diabetes	1	64	70	12	147
unknown sex with diabetes	0	0	0	0	0
Aboriginal clients having a HbA1c test in the last six months	3	52	80	13	148
% Aboriginal clients having a HbA1c test in the last six months	100.0%	55.3%	65.0%	61.9%	61.4%
men having a HbA1c test	2	15	29	5	51
% men having a HbA1c test	100.0%	50.0%	54.7%	55.6%	54.3%
women having a HbA1c test	1	37	51	8	97
% women having a HbA1c test	100.0%	57.8%	72.9%	66.7%	66.0%
unknown sex having a HbA1c test	0	0	0	0	0
% unknown sex having a HbA1c test	0.0%	0.0%	0.0%	0.0%	0.0%

Sample Report Only
Not for further Distribution

AHKPI 1.9 ACE Inhibitor and/or ARB

Number and proportion of diabetic patients with albuminuria who are on ACE inhibitor and/or A
Health Zone XXXX



Key Comments

Percentages displayed on the chart are based on resident Aboriginal clients recorded as having type II diabetes with albuminuria who are currently on ACE and/or ARB treatment by treatment type / total resident Aboriginal clients recorded as having type II diabetes with albuminuria.

This indicator is a measure of quality of care for diabetes. The majority of Aboriginal people with diabetes have albuminuria. Recommended treatment to control BP and reduce progression of kidney disease is an ACE inhibitor medication. Some people cannot tolerate this drug and should be prescribed an ARB as an alternative. Some people will require both drugs to achieve good BP control.

Health Zone XXXX**AHKPI 1.9 ACE Inhibitor and/or ARB****Number and proportion of diabetic patients with albuminuria who are on ACE inhibitor and/or ARB**

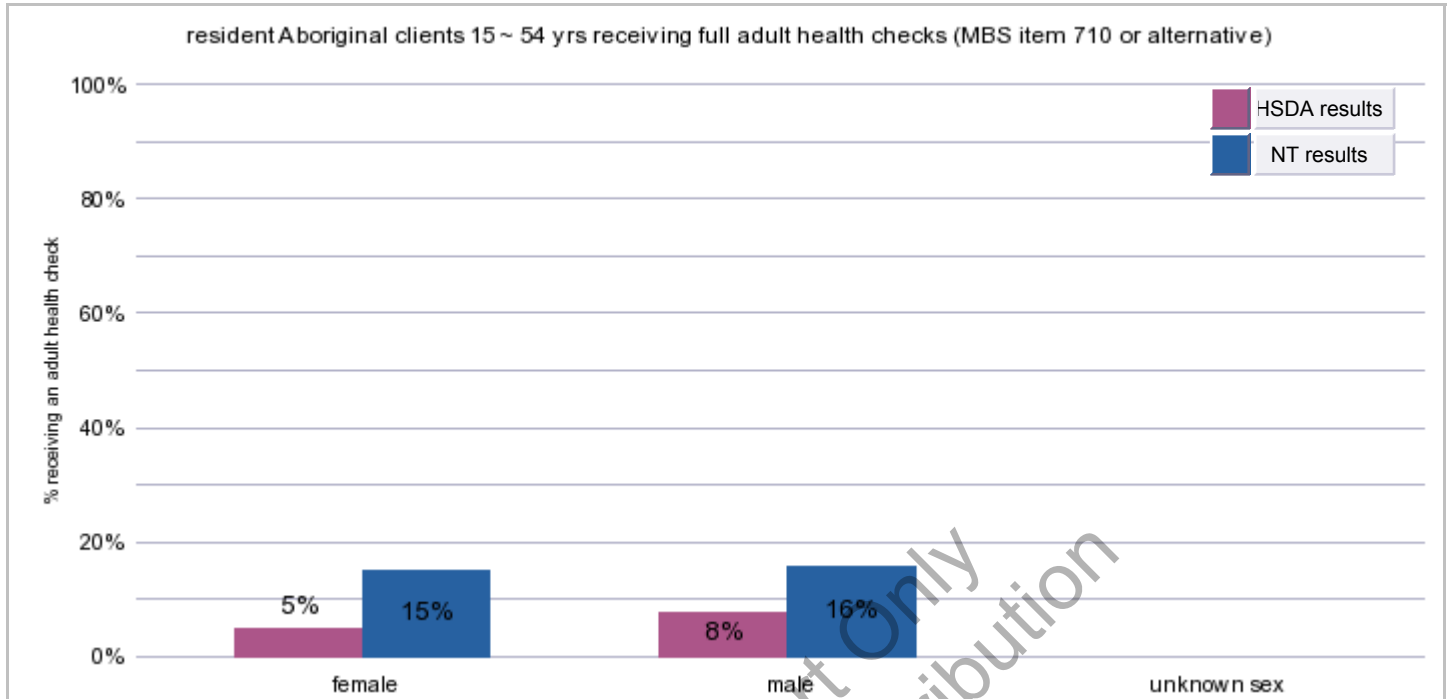
residential clients (Aboriginal and non Aboriginal) 15 years and over recorded as having type II diabetes with albuminuria	total
residential clients (Aboriginal and non Aboriginal) recorded as having albuminuria	139
% on an ACE inhibitor	60.4%
%s on an ARB	10.1%
% on an ACE inhibitor and ARB	7.2%
residential Aboriginal clients 15 years and over recorded as having type II diabetes with albuminuria	
residential Aboriginal clients recorded as having albuminuria	126
% residential Aboriginal clients recorded as having albuminuria	90.6%
total receiving ACE inhibitors	77
% receiving ACE inhibitors	61.1%
total receiving ARB's	13
% receiving ARB's	10.3%
total receiving both (ACE inhibitors and ARB's)	10
% receiving both (ACE inhibitors and ARB's)	7.9%
residential non Aboriginal clients 15 years and over recorded as having type II diabetes with albuminuria	
residential non Aboriginal clients recorded as having albuminuria	13
% residential non Aboriginal clients recorded as having albuminuria	9.4%
total receiving ACE inhibitors	7
% receiving ACE inhibitors	53.8%
total receiving ARB's	1
% receiving ARB's	7.7%
total receiving both (ACE inhibitors and ARB's)	0
% receiving both (ACE inhibitors and ARB's)	0.0%

Sample Report Only
Not for further Distribution

AHKPI 1.10 Adult Aged 15 ~ 54 Health Check

Number and proportion of Indigenous resident clients aged 15 ~ 54 years who have had full adult health check

Health Zone XXXX



Key Comments

Percentages displayed on the chart are based on resident Aboriginal clients 15 to 54 years recorded as having received a full adult health check by gender /total resident Aboriginal clients aged 15 to 54 years by gender.

Due to very high rates and early onset of chronic disease, early detection of problems through adult health checks is strongly recommended.

Health Zone XXXX

AHKPI 1.10 Adult Aged 15 ~ 54 Health Check

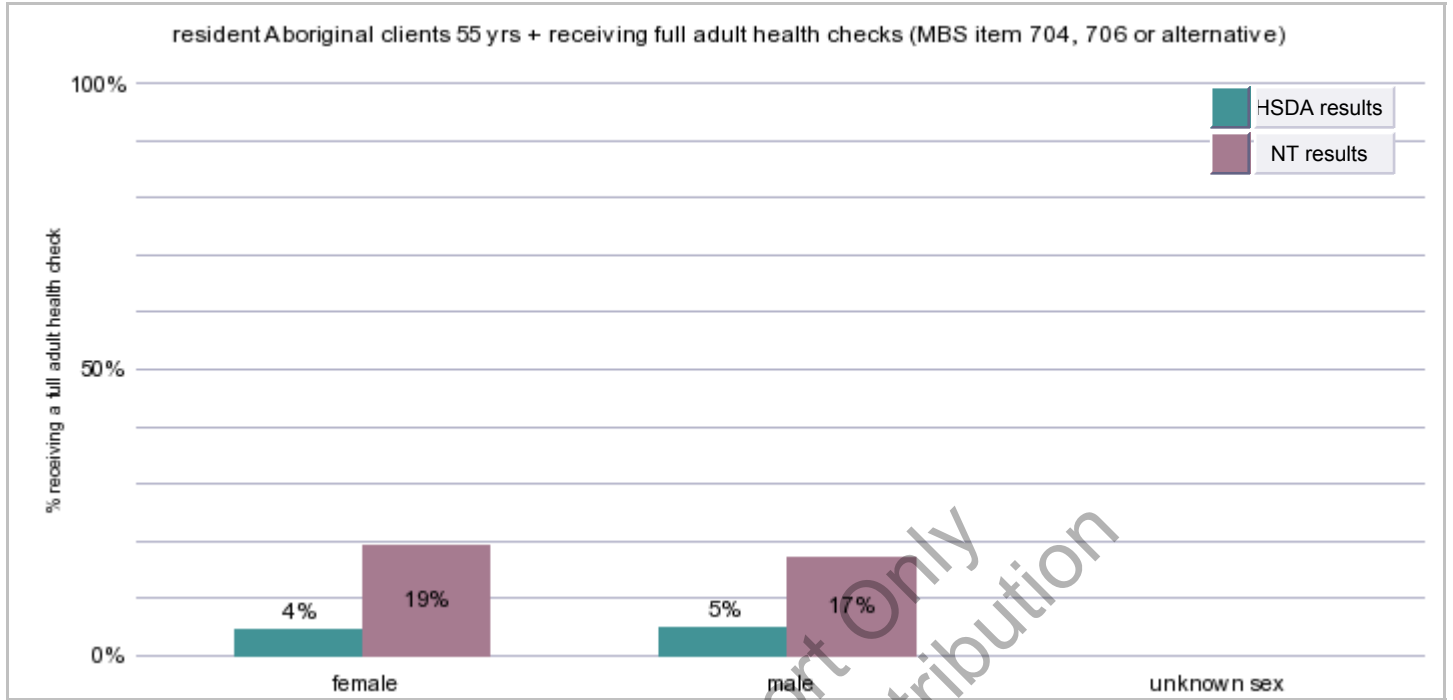
Number and proportion of Indigenous resident clients aged 15 to 54 years who have had full adult health check

residential Aboriginal clients 15 ~ 54 years	age group			Total
	15~24	25~ 45	45 to < 55	
total residential Aboriginal clients 15 to 54 years	467	733	217	1,417
% residential Aboriginal clients 15 to 54 years	33.0%	51.7%	15.3%	100.0%
men	230	342	114	686
% men	49.3%	46.7%	52.5%	48.4%
women	237	391	103	731
% women	50.7%	53.3%	47.5%	51.6%
unknown sex	0	0	0	0
% unknown sex	0.0%	0.0%	0.0%	0.0%
residential Aboriginal clients 15 to 54 years receiving a full adult health check ~ MBS item 710 or a recognised alternative health check				
total receiving an adult health check	20	54	12	86
% receiving an adult health check	4.3%	7.4%	5.5%	6.1%
% men	3.5%	10.5%	7.0%	7.6%
% women	5.1%	4.6%	3.9%	4.7%
% unknown sex	0.0%	0.0%	0.0%	0.0%
residential Aboriginal clients 15 ~ 54 receiving full adult health checks ~ MBS item 710 health checks				
total receiving an MBS item 710 full adult health check	20	54	12	86
% receiving an MBS item 710 full adult health check	4.3%	7.4%	5.5%	6.1%
men	8	36	8	52
% men	3.5%	10.5%	7.0%	7.6%
women	12	18	4	34
% women	5.1%	4.6%	3.9%	4.7%
unknown sex	0	0	0	0
% unknown sex	0.0%	0.0%	0.0%	0.0%
residential Aboriginal clients 15 ~ 54 receiving a full adult health check ~ recognised alternative health checks				
total receiving an alternative adult health check	0	0	0	0
% receiving an alternative adult health check	0.0%	0.0%	0.0%	0.0%
men	0	0	0	0
% men	0.0%	0.0%	0.0%	0.0%
women	0	0	0	0
% women	0.0%	0.0%	0.0%	0.0%
unknown sex	0	0	0	0
% unknown sex	0.0%	0.0%	0.0%	0.0%

AHKPI 1.11 Adult Aged 55 and over Health Check

Number and proportion of Indigenous resident clients aged 55 years and over who have had full adult health checks

Health Zone XXXX



Key Comments

Percentages displayed on the chart are based on resident Aboriginal clients 55 years and over recorded as having received a full adult health check by gender / total resident Aboriginal clients aged 55 years and over by gender.

Due to very high rates and early onset of chronic disease, early detection of problems through adult health checks is strongly recommended.

A majority of Aboriginal people over 55 years have established chronic disease. Many clinics provide regular checks for "old people". The adult health check for this age group is more a comprehensive assessment of their chronic disease and issues such as vision, hearing, mobility and social supports.

Health Zone XXXX

AHKPI 1.11 Adult Aged 55 and over

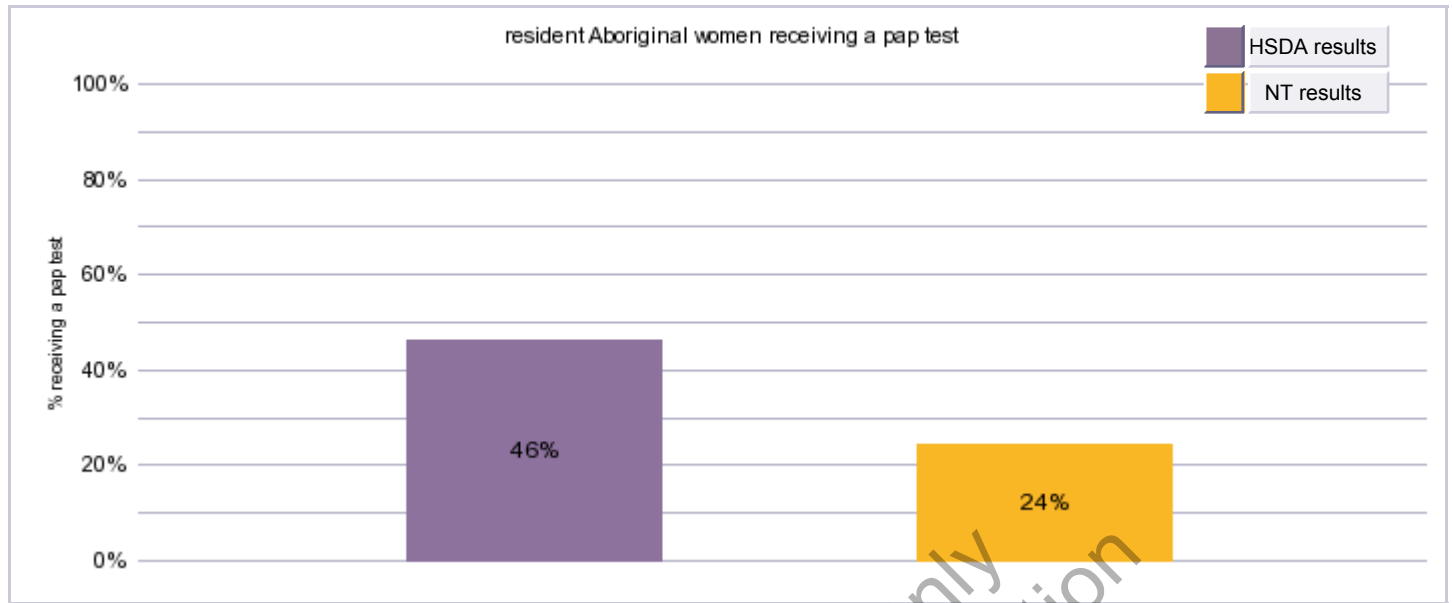
Number and proportion of Indigenous resident clients aged 55 and over who have had full adult health check

residential Aboriginal clients 55 years and over	age group		Total
	55~64	65+	
total residential Aboriginal clients 55+	112	62	174
% residential Aboriginal clients 55+	64.4%	35.6%	100.0%
men	55	29	84
% men	49.1%	46.8%	48.3%
women	57	33	90
% women	50.9%	53.2%	51.7%
unknown sex	0	0	0
% unknown sex	0.0%	0.0%	0%
residential Aboriginal clients 55+ receiving a full adult health check ~ MBS item 704, 706 or a recognised alternative health check			
total receiving an adult health check	5	3	8
% receiving an adult health check	4%	5%	4.6%
% men	3.6%	6.9%	4.8%
% women	5.3%	3.0%	4.4%
% unknown sex	0.0%	0.0%	0.0%
residential Aboriginal clients 55+ receiving full adult health checks ~ MBS item 704, 706 health checks			
total receiving an MBS adult health check	5	3	8
% receiving an MBS adult health check	4.5%	4.8%	4.6%
men	2	2	4
% men	3.6%	6.9%	4.8%
women	3	1	4
% women	5.3%	3.0%	4.4%
unknown sex	0	0	0
% unknown sex	0.0%	0.0%	0.0%
residential Aboriginal clients 55+ receiving a full adult health check ~ recognised alternative health checks			
total receiving an alternative adult health check	0	0	0
% receiving an alternative adult health check	0.0%	0.0%	0.0%
men	0	0	0
% men	0.0%	0.0%	0.0%
women	0	0	0
% women	0.0%	0.0%	0.0%
unknown sex	0	0	0
% unknown sex	0.0%	0.0%	0.0%

AHKPI 1.12 pap Smear Tests

Number and proportion of resident women who have had at least one pap test during the last two years.

Health Zone XXXX



Key Comments

Percentages displayed on the chart are based on resident Aboriginal women aged 18 - 70 years who have received pap test in the last 2 years / total resident Aboriginal women recorded as aged 18 to 70 years.

Pap smears are a recommended screening test (with a screening interval of 2 years) for women, which can often be combined with the adult health check for a comprehensive check. Since 1991, pap smear screening has increased significantly in the NT and the rates of cervical cancer and deaths from cervical cancer have decreased dramatically. Over 15 years, deaths from cervical cancer for Aboriginal women reduced by 92%. This indicator is looking at the prevalence of resident clients in the community who had a pap smear and not just those who have had a pap smear at the centre. It is quite possible that resident clients have had a pap smear elsewhere.

Health Zone XXXX

AHKPI 1.12 pap Smear Tests

Number and proportion of resident women who have had at least one pap test during the last two years.

residential women aged 18 ~ 70 years	Total
total residential women	1,411
receiving a pap test	476
% receiving a pap test	33.7%
residential Aboriginal women aged 18 ~ 70 years	Total
total residential Aboriginal women	740
% residential Aboriginal women	52%
receiving a pap test	343
% who have had a pap test	46.4%
residential non Aboriginal women aged 18 ~ 70 years	Total
total residential non Aboriginal women	652
% residential non Aboriginal women	46%
receiving a pap test	131
% who have had a pap test	20.1%
residential women of unknown Aboriginal status aged 18 ~ 70 years	Total
total residential women with unknown Aboriginal status	19
% residential women with unknown Aboriginal status	10.5%
receiving a pap test	2
% who have had a pap test	11%

Sample Report Only
Not for further Distribution

Data Description

Report Name

KPI 1.1 Number of episodes of health care and client contacts

Sourced From

PCIS, IDCT, Communicare and Ferret

KPI Alias

Episodes of Health Care and Client Contacts

KPI Detail

This report details the activity load of the health service by measuring the number of episodes of health care and the number of client contacts with health professionals recorded during a reporting period.

A bar chart displays the proportion of activity load by gender and age group. A table details the breakdown by residential status, indigenous status, gender and age group.

Episode of Health Care

Are contacts between an individual client and a health service, within one day, by one or more staff, in order to provide health care.

Client Contacts

Are the numbers of health professionals who have had contact with a client during an episode of health care. A client may have one or many contacts with health professionals within an episode of care.

Sample Report Only
Not for further Distribution

Data Description

Report Name

KPI 1.2 Timing of first antenatal visit for regular clients delivering Indigenous babies

Sourced From

Caresys Midwives, Communicare & Ferret

KPI Alias

First antenatal visit for regular clients delivering Indigenous babies.

KPI Detail

This report details the number and proportion of resident clients who gave birth to Aboriginal babies and the timing of their first antenatal visit.

A bar chart displays the comparison between the health centre and the Northern Territory results of the proportion of the timing of mothers attending their first antenatal visits. A table details the timing of the first antenatal visit by mothers Aboriginal status and age group.

Aboriginal baby	An Aboriginal baby is a baby with at least one parent who identifies as Aboriginal and can be born to mothers who are either Aboriginal or non-Aboriginal.
First antenatal visit	The definition of a "first antenatal visit" is the clinical assessment according to the "Women's Business Manual".

Sample Report Only
Not for further Distribution

Data Description

Report Name

KPI 1.3 Number and proportion of low, normal and high birth weight Indigenous babies

Sourced From

Caresys Midwives, Communicare & Ferret

KPI Alias

Birth Weight

KPI Detail

Included in this report is a comparison of babies birth weights within the community reported against the average of babies birth weights for all communities participating in the NTAHKPI reports.

A bar chart displays the comparison between the health centre and the Northern Territory results of the proportion of low, normal and high birthweights. A table details the birthweight breakdown by mothers Aboriginal status and age group.

Birth weight	Birth weight is defined as the first weight of the baby obtained after birth as per the National Health Data Dictionary.
Low birth weight	Low birth weights are defined as babies born weighing less than 2500 grams.
Normal birth weight	Normal birth weights are defined as babies born weighing between 2500 grams and 4499 grams.
High birthweight	High birth weights are defined as babies born weighing 4500 grams or over.

Sample Report Only
Not for further Distribution

Data Description

Report Name

KPI 1.4 Number and proportion of Indigenous children fully immunised at 1, 2 and 6 years of age

Sourced From

Community Care Information System, Communicare & Ferret

KPI Alias

Fully Immunised Children

KPI Detail

This report details immunisation rates amongst Aboriginal children aged 6 mths to 6 years. Immunisation rates are measured against the National Immunisation Program (0 - 4 years). For current Immunisation Schedule see "<http://www.medicareaustralia.gov.au/provider/patients/acir/schedule.jsp>". Immunisation counting rules are detailed below.

Included in this report is a comparison of fully immunised children within the community reported against the average of fully immunised children for all communities participating in the NTAHKPI reports across the Northern Territory.

A bar chart displays the comparison between the health centre and the Northern Territory results of the proportion of resident Aboriginal children by age group who are recorded as fully immunised. A table details the immunisation rates by Aboriginal status and age group.

Fully Immunised at six months to less than 1 year of age	6 months to less than 8 months and have received all immunisations that are due at birth
	8 months to less than 10 months and have received all immunisations that are due by 2 months of age
	10 months to less than 1 year and have received all immunisations that are due by 4 months of age
Fully Immunised at 1 year to less than 2 years of age	1 year to less than 18 months and have received all immunisations that are due by 6 months of age
	18 months to less than 2 years and have received all immunisations that are due by 12 months of age
Fully immunised at 2 years to less than 6 years	2 years to less than 4 years and 6 months and have received all immunisations that are due by 18 months of age
	4 years and 6 months to less than 6 years and have received all immunisations that are due by 4 years of age

Sample Report Only
Not for further distribution

Data Description

Report Name

KPI 1.5 Number and proportion of children less than 5 years of age who are underweight

Sourced From

Growth Assessment and Action, Communicare & Ferret

Report Alias

Underweight Children

KPI Detail

This report details the number and proportion of resident children less than 5 years of age who are recorded as underweight and measured for weight by Aboriginal status.

This report shows recorded underweight and coverage rates. Note that underweight rates are based on total weight/total measured. Coverage rates are based on total measured/total resident children less than 5 yrs.

Two bar chart displays the comparison between the health centre and the Northern Territory results of the proportion of resident Aboriginal children less than 5 years of age who are recorded as underweight and being measure for weight.

Underweight	Underweight children are defined as children who are -2 standard deviations away from the mean weight for age.
Standard deviations	Also known as Z scores, are derived from methodologies defined by the USA National Centre for Health Statistics.

Sample Report Only
Not for further Distribution

Data Description

Report Name

KPI 1.6 Number and proportion of children between 6 months and 5 years of age who are anaemic

Sourced From

Growth Assessment and Action, Communicare & Ferret

KPI Alias

Anaemic Children

KPI Detail

This report details the number and proportion of resident children between 6 months and 5 years of age who are recorded as anaemic and measured for anaemia by Aboriginal status.

This report shows recorded anaemia and coverage rates. Note that anaemia rates are based on total anaemic/total measured. Coverage rates are based on total measured/total resident children aged 6mths to 5 yrs.

Two bar chart displays the comparison between the health centre and the Northern Territory results of the proportion of resident Aboriginal children between 6mths and 5 years of age who are recorded as anaemic and being measure for anaemia.

A table details the anaemic and coverage rates of resident children 6mths to 5 yrs by Aboriginal status.

anaemia

The number and proportion of children who are residents, who are ≥ 6 months and < 5 years of age and whose haemoglobin level is less than 110 g/L (WHO definition).

Sample Report Only
Not for further Distribution

Data Description

Report Name

KPI 1.7 Number and proportion of resident clients aged 15 years and over with Type II Diabetes and/or Coronary Heart Disease who have a chronic disease management plan

Sourced From

PCIS, IDCT, Communicare & Ferret

KPI Alias

Diabetics on Chronic Disease Management Plan

KPI Detail

This report details the number and proportion of Aboriginal clients 15 years old and over who are recorded as having diabetes and/or coronary heart disease and who are receiving chronic disease care under a recognised care plan. Chronic diseases and the appropriate management plans covered are detailed below.

A bar chart displays the comparison between the health centre and the Northern Territory results of the proportion of resident Aboriginal clients aged 15 years and over who are recorded as having type II diabetes and/or coronary heart disease and receiving care through a recognised chronic disease care plan (MBS item 721, 723 or alternative 721, 723).

A table details the number and proportion of resident Aboriginal clients by care plan type, gender and age group receiving care through a recognised chronic disease care plan.

Chronic disease	Included in this category are Ischaemic heart disease and Type II diabetes only.
Ischaemic heart disease	Based on NPCC Guidelines Ischaemic heart disease includes myocardial infarction, angina, unstable angina pectoris, revascularisation as evidenced by angioplasty with or without a stent and coronary artery bypass surgery. Ischaemic heart disease primary feature is insufficient blood supply to the heart itself. The two major clinical forms are heart attack and angina.
Type II Diabetes	Type II diabetes includes the common major form of diabetes but does not include: Type I diabetes, Gestational diabetes mellitus, Secondary diabetes, Impaired fasting glycemia or Impaired glucose tolerance.
MBS 721 (GPMP) care plan	Provides a rebate for a GP to prepare a management plan for a patient with a chronic medical condition. The GP assesses the patient, agrees management goals, identifies actions to be taken by the patient, identifies treatment and ongoing services to be provided, and documents these and a review date in the GP Management Plan.
MBS 723 (TCA) care plan	Provides a rebate for incorporated services for a client with a chronic medical condition provided by a multidisciplinary care team, including: <ul style="list-style-type: none"> • Aboriginal health care workers • Registered Nurses • Diabetes educators, etc A GP Management Plan and Team Care Arrangements, together, broadly equate to an EPC multidisciplinary.
Alternative 721 (GPMP) care plan	Alternative Chronic Disease Management Plan in the form of General Practitioner (or equivalent) Management Plan that cannot be claimed and includes a number of items in clinical guidelines and protocols for developing an alternative GPMP.
Alternative 723 (TCA) care plan	Alternative Chronic Disease Management Plan in the form of Team Care Arrangement's that cannot be claimed and includes a number of items in clinical guidelines and protocols for developing an alternative Team Care Arrangements.

Data Description

Report Name

KPI 1.8 Number and proportion of resident clients aged 15 years and over with Type II Diabetes who have had an HbA1c test in the last 6 months.

Sourced From

PCIS, IDCT, Communicare & Ferret

KPI Alias

Diabetics who have had a HbA1c test in previous 6 months.

KPI Detail

This report details the number and proportion of resident Aboriginal clients aged 15 years and over recorded as having type II diabetes and receiving a HbA1c test in the last 6 months by gender and age group.

A bar chart displays the comparison between the health centre and the Northern Territory results of the proportion of resident Aboriginal clients aged 15 years and over recorded as having type II diabetes and receiving a HbA1C test within the previous 6 months.

A table details the number and proportion of resident Aboriginal clients recorded as having type II diabetes and receiving a HbA1c test within the previous six months by gender and age group.

HbA1c

Glycosylated haemoglobin (HbA1c) is an index of average blood glucose level for the previous 2 to 3 months and is used to monitor blood sugar control in diabetic people.

Sample Report Only
Not for further Distribution

Data Description

Report Name

KPI 1.9 Number and proportion of diabetic patients with albuminuria who are on ACE inhibitor and/or ARB

Sourced From

PCIS, IDCT, Communicare & Ferret

Report Alias

Diabetic patients with Albuminuria and on ACE/ARB

KPI Detail

This report details the number and proportion of resident clients aged 15 years and over recorded as having type II diabetes with albuminuria and receiving ACE/ARB medication.

A bar chart displays the comparison between the AMS and the Northern Territory results of the proportion of resident Aboriginal clients aged 15 years and over recorded as having type II diabetes and albuminuria and receiving ACE/ARB medication.

A table details the numbers and percentages of resident clients (Aboriginal and non Aboriginal) recorded as having type II diabetes and albuminuria receiving ACE/ARB medication by Aboriginal status.

Albuminuria	More than normal amounts of a protein called albumin in the urine. Albuminuria (urine ACR >3.4) may be a sign of kidney disease, a problem that can occur in people who have had diabetes for a long time.
ACE	An ACE Inhibitor is a type of medication that lowers blood pressure by blocking Angiotensin Converting Enzyme. This enzyme usually helps create a chemical called Angiotensin that causes high blood pressure, and so blocking the enzyme stops this production and lowers blood pressure. Drugs included are: Ramipril and Perindopril.
ARB	Angiotensin receptor blockers (ARB's) medication helps to modulate the renin-angiotensin system which has a role in maintaining the bodies overall blood pressure and the volume of blood in the body. Drugs included are: Candesartan and Irbesartan.

Sample Report Only
Not for further Distribution

Data Description

Report Name

KPI 1.10 Number and proportion of Indigenous resident clients aged 15 to 54 years who have had full adult health check

Sourced From

PCIS, IDCT, Communicare & Ferret

KPI Alias

15 to 54 years full adult health check

KPI Detail

This report details the number and proportion of resident Aboriginal clients aged 15 to 54 years who are recorded as having a complete adult health check (MBS item 710 or or alternative).

A bar chart displays the comparison between the health centre and the Northern Territory results of the proportion of resident Aboriginal clients aged 15 to 54 years who are recorded as having received a recognised full adult health check.

A table details the numbers and percentages of resident Aboriginal clients 15 to 54 years who are recorded as having a full adult health check by health check type, gender and age group.

MBS Item 710	<p>This item applies to an Aboriginal and/or Torres Strait Islander person between 15 years and 54 years of age (inclusive). It complements the existing voluntary annual health assessment, available to Aboriginal and Torres Strait Islander people aged 55 years and over.</p> <p>An Aboriginal and Torres Strait Islander Adult Health Check means the assessment of an Aboriginal and/or Torres Strait Islander patient's health and physical, psychological and social function, and whether preventive health care, education and other assistance should be offered to that patient, to improve the patient's health and physical, psychological or social function.</p>
Alternative Adult Health Check (710)	<p>Alternative adult health check in the form of an MBS 710 that cannot be claimed and includes a number of items in clinical guidelines and protocols for developing an alternative adult health check.</p>

Sample Report Only
Not for further Distribution

Data Description

Report Name

KPI 1.11 Number and proportion of Indigenous resident clients aged 55 and over years who have had a full adult health check

Sourced From

PCIS, IDCT, Communicare & Ferret

KPI Alias

55 years and over who have full adult health check

KPI Detail

This report details the number and proportion of resident Aboriginal clients aged 15 to 54 years who are recorded as having a complete adult health check (MBS item 704, 706 or alternative).

A bar chart displays the comparison between the health centre and the Northern Territory results of the proportion of resident Aboriginal clients aged 55 years and over who are recorded as having received a recognised full adult health check.

A table details the numbers and percentages of resident Aboriginal clients 55 years and over who are recorded as having a full adult health check by health check type, gender and age group.

MBS Item 704	Medicare Item 704 is for an older age health assessment (55 yrs +) conducted for an Aboriginal and/or Torres Strait Islander person at a GP/DMO/RMP's consulting rooms.
MBS Item 706	Medicare Item 706 is for the same service conducted at somewhere other than a GP/DMO/RMP's consulting room, a hospital, or a residential aged care facility.
Alternative 704 Adult Health Check	Alternative Adult Health Check in the form of an MBS 704 that cannot be claimed and includes a number of items in clinical guidelines and protocols for developing an alternative Adult Health Check.
Alternative 706 Adult Health Check	Alternative Adult Health Check in the form of an MBS 706 that cannot be claimed and includes a number of items in clinical guidelines and protocols for developing an alternative Adult Health Check.

Sample Report Only
Not for further Distribution

Data Description

Report Name

KPI 1.12 Number and proportion of resident women who have had at least one pap test during the last two years.

Sourced From

PCIS, IDCT, Communicare & Ferret

Report Alias

pap tests

KPI Detail

This report details the number and proportion of resident women (Aboriginal and non Aboriginal) aged 18-70 years who are recorded as having had at least one pap smear test during the previous two years.

A bar chart displays the comparison between the health centre and the Northern Territory results of the proportion of resident Aboriginal women aged 18 to 70 years who have had a pap test in the previous 2 years.

A table details the number and proportion of resident women (Aboriginal and non Aboriginal) aged 18 to 70 years who have had a pap test by Aboriginal status within the previous 2 years.

pap Test

The Papanicolaou test (also called pap smear, pap test, cervical smear, or smear test) is a screening test used in gynecology to detect premalignant and malignant (cancerous) processes in the ectocervix. Significant changes can be treated, thus preventing cervical cancer.

Sample Report Only
Not for further Distribution