Northern Territory Aboriginal Health

Key Performance Indicator Information System

Health Centre Report for Community xxxx

PRE RELEASE REPORT

for the twelve month period ending 30/06/2010

Sample Report

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Document Control

This document is managed by the NT Aboriginal Health Key Performance Indicator system team on behalf of the NT Aboriginal Health Forum.

The metadata pages provides descriptions of the geneal format, text, data elements, queries and calculations used in the production of the Health Service Report for Community xxx .

Release Details:

Ver	Date	Reason for Changes	Ref	Description of change
V 1.1.2	15/07/10	Modified previous report as per CRG feedback from meeting on the 14th July 2010	ALL - Minor changes	KPI 1.1 - change title to trend of episode of care, moved 1.1b client count to end of page. ALL - changed "pop" to "n" on all the trend charts. ALL - modified table and chart order as per CRG instrution. KPI 1.9 - Updated lable "recorded on medication" to "on ACE and/or ARB". KPI.1.4 - Updated title to include age cohort.
V1.1.1	06/07/10	Modified previous report as per CRG feedback from meeting on the 1st July 2010	All	ALL - Changed trend line graph title for all KPI. ALL - added population figure in the trend graph next to year label. KPI 1.2 - excluded 20+ weeks from the trend graph. KPI 1.4 - created individual trend graph for each age group. KPI 1.7 - removed recorded on neither from bar graph and trend graph. KPI 1.9 - replaced "recorded on neither" with "recorded on medication" on the bar graph. Display only "recorded on medication" at the trend graph. KPI 1.10/1.11 - filter out “unknown sex” from the trend graph. KPI 1.12 - changed pie chart color.
V1.1.0	11/05/2010	Address the issues with previous report version. Improving report presentation.	All	Applied Y-axis value to be 100% through the report. Changed table presentation. Moved the total row to display at bottom. Removed % calculation for individual field. Moved meta data page from the back to the front of each KPI page. Moved know data issues and key comment to the front of each KPI page. KPI 1.3 – added indigenous babies birth weight pie chart. KPI 1.5 – combine 2 bar graphs into one graph. KPI 1.9 – added number of clients on neither ACE nor ARB data in the table and graph. ALL - added Trend graph for each KPI.
V1.0.6	08/03/2010	Address confusion over representation of graph percentages that calculate denominators against a community instead of for a cohort	All	Applied cohort percentage calculation to all tables and charts

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Release Details:				
Ver	**Date**	**Reason for Changes**	**Ref**	**Description of change**
V1.0.5	09/02/2010	Address of final issues identified through final peer review prior to 2009 calendar release.	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. Calculations errors identified and resolved.
V1.0.4	01/02/2010	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	04/09/2009	Distributed to DHF for CQI and format and layout feedback		Minor calculation errors identified by ACCHO's resolved
V1.0.1a	21/08/2009	First Release - Distributed to DHF		Blank page added.
V1.0.1	14/08/2009	First Release - Distributed to ACCHO's		Incorporating feedback from Preliminary Release.
V1.0.0	31/07/2009	Preliminary Release - Distributed to ACCHO's who could deliver data		Incorporating feedback from consultation draft.
V0.1.0	08/04/2009	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
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NT AHKPI Quantitative Reports	Data Description
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	KPI Key Comment interpretation
	KPI known data quality issues
	Indicator Graphs
	Trend Graphs
	Data Tables

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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.

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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 community level analysis of the suite of KPIs. Full KPI definations can be found at:
http://www.nt.gov.au/health/ahkpi/Reports/KPIdefinition.pdf

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IMPORTANT NOTE FOR READERS OF THIS REPORT

Data quality and use

The first of the biannual NT AHKPI reports was released in 2009. Data quality will vary across health services depending on their experience in using data and indicators and the capacity of their information systems. The 2009 report established a baseline 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. Furthermore it should be noted that some communities have a small population and interpretation of their data is questionable when small numbers have been used or when a large percentage of the population have not been measured (low coverage). Please remember these points when determining the validity of the data.

Confidentiality and distribution

As noted above, there are important data quality issues to consider in determining how to use this report. It contains important information about the community served by your health service. The NT AHKPI Steering Committee recommends that this report only be distributed and used within your organisation. The Steering Committee further recommends that, if you are considering releasing the report outside your organisation, you contact the NT AHKPI Data Custodian to discuss confidentiality, data quality, and interpretation issues specific to your report.

All NT AHKPI data collected through health service organisations operational information systems are the property of the health service organisations. Access to data stored in the central NTAHKPI repository will not be granted without the consent of the individual Aboriginal Community Controlled Health Organisation 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 General Issues for Community xxx

No specific data anomolies to assist interpretation of this KPI.

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AHKPI 1.1

Number of episodes of health care and client contacts

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, aboriginal 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.
Sourced From:	PCIS , IDCT, Communicare or Ferret

Sample Report

AHKPI 1.1 - 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 your health service, and contacts reflects the workload that your health centre undertakes. It shows use of the health service by males and females, age group, indigenous status and whether the person is a resident or visiting your community.

If there is a significant difference between male and females for other age groups, consider the population distribution in your community and how men use health services. Consider the number of visitors to your health centre. Visitors can increase the workload as health staff spend time accessing their records from other services.

AHKPI 1.1 - Known Data Quality Issues for Community xxx

No specific data anomolies to assist interpretation of this KPI.

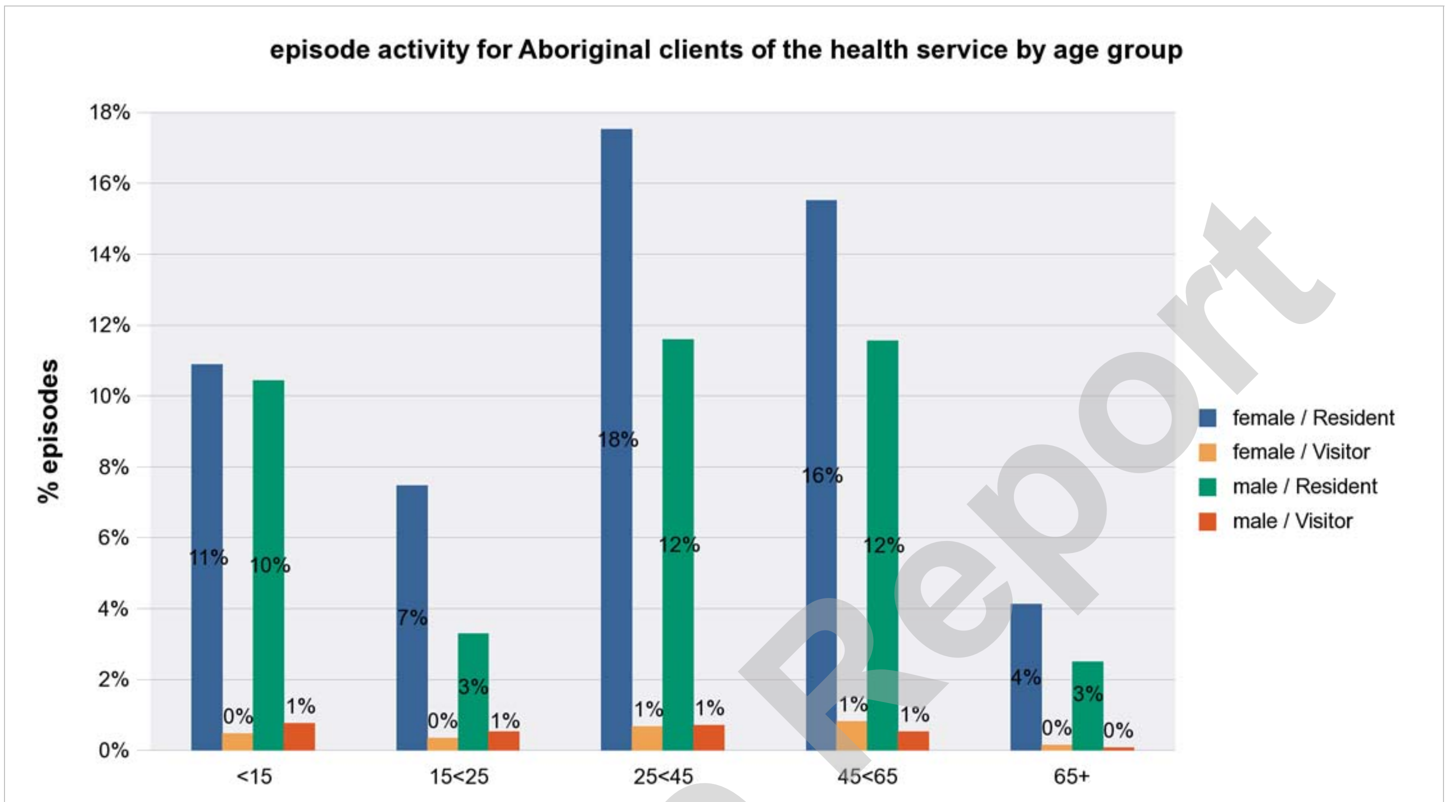
Sample Report

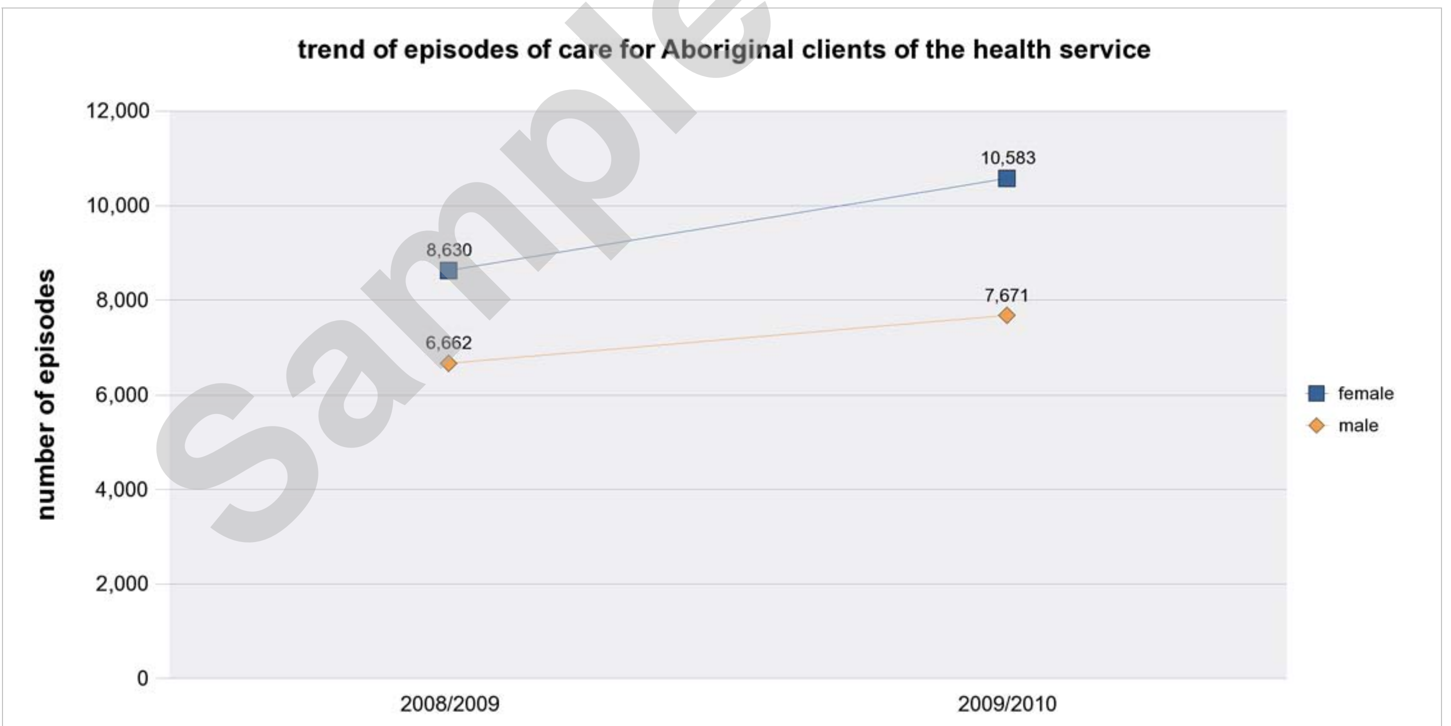
AHKPI 1.1 Number of episodes of health care and client contacts

Community xxxx for financial year ending 30/06/2010

1.1a Number of health care episodes	20,656

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.





Sample Report

1.1b Number of client contacts	28,317

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.

AHKPI 1.1 Number of episodes of health care and client contacts

Community xxxx for financial year ending 30/06/2010

NT AHKPI 1.1a Episodes of Health Care

Aboriginal Episodes	Resident					Total Resident	Visitor					Total Visitor	Total Episodes
	<15	15<25	25<45	45<65	65+		<15	15<25	25<45	45<65	65+		
female	1,987	1,364	3,198	2,831	752	10,132	88	63	123	151	26	451	10,583
male	1,905	601	2,118	2,111	457	7,192	138	97	131	98	15	479	7,671
Total Aboriginal Episodes	3,892	1,965	5,316	4,942	1,209	17,324	226	160	254	249	41	930	18,254
Total Aboriginal episodes as % of total	18.8%	9.5%	25.7%	23.9%	5.9%	83.9%	1.1%	0.8%	1.2%	1.2%	0.2%	4.5%	88.4%
Non-Aboriginal Episodes	Resident					Total Resident	Visitor					Total Visitor	Total Episodes
	<15	15<25	25<45	45<65	65+		<15	15<25	25<45	45<65	65+		
female	62	78	313	495	116	1,064	4	0	11	14	6	35	1,099
male	62	55	183	540	314	1,154	0	4	18	30	5	57	1,211
Total Non-Aboriginal Episodes	124	133	496	1,035	430	2,218	4	4	29	44	11	92	2,310
Total Non-Aboriginal episodes as % of total	0.6%	0.6%	2.4%	5.0%	2.1%	10.7%	0.0%	0.0%	0.1%	0.2%	0.1%	0.4%	11.2%
Unknown Status Episodes	Resident					Total Resident	Visitor					Total Visitor	Total Episodes
	<15	15<25	25<45	45<65	65+		<15	15<25	25<45	45<65	65+		
female	1	0	14	4	7	26	0	1	0	0	0	1	27
male	7	3	11	27	3	51	0	1	11	0	2	14	65
Total Unknown Status Episodes	8	3	25	31	10	77	0	2	11	0	2	15	92
Total Unknown Status episodes as % of total	0.0%	0.0%	0.1%	0.2%	0.0%	0.4%	0.0%	0.0%	0.1%	0.0%	0.0%	0.1%	0.4%
Total Episodes	Resident					Total Resident	Visitor					Total Visitor	Total Episodes
	<15	15<25	25<45	45<65	65+		<15	15<25	25<45	45<65	65+		
Total Episodes	**4,024**	**2,101**	**5,837**	**6,008**	**1,649**	**19,619**	**230**	**166**	**294**	**293**	**54**	**1,037**	**20,656**
% total episodes of care	**19.5%**	**10.2%**	**28.3%**	**29.1%**	**8.0%**	**95.0%**	**1.1%**	**0.8%**	**1.4%**	**1.4%**	**0.3%**	**5.0%**	**100.0%**

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AHKPI 1.2

Timing of first antenatal visit for regular clients delivering Aboriginal babies

KPI Alias:	First antenatal visit for regular clients delivering Aboriginal 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 ACCHO 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".
Sourced From:	Caresys Midwives, Communicare or Ferret

Sample Report

AHKPI 1.2 - 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.

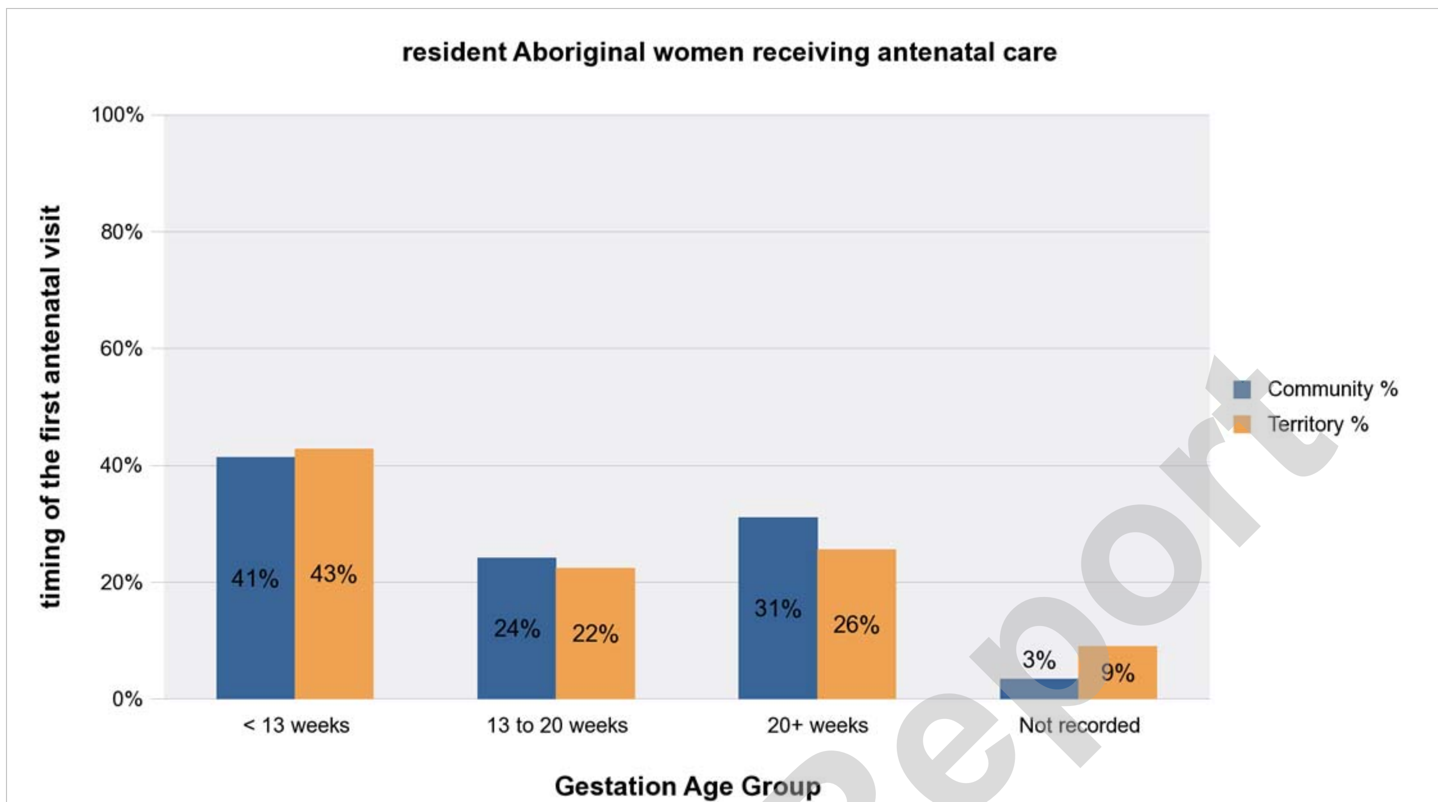
AHKPI 1.2 - Known Data Quality Issues for Community xxx

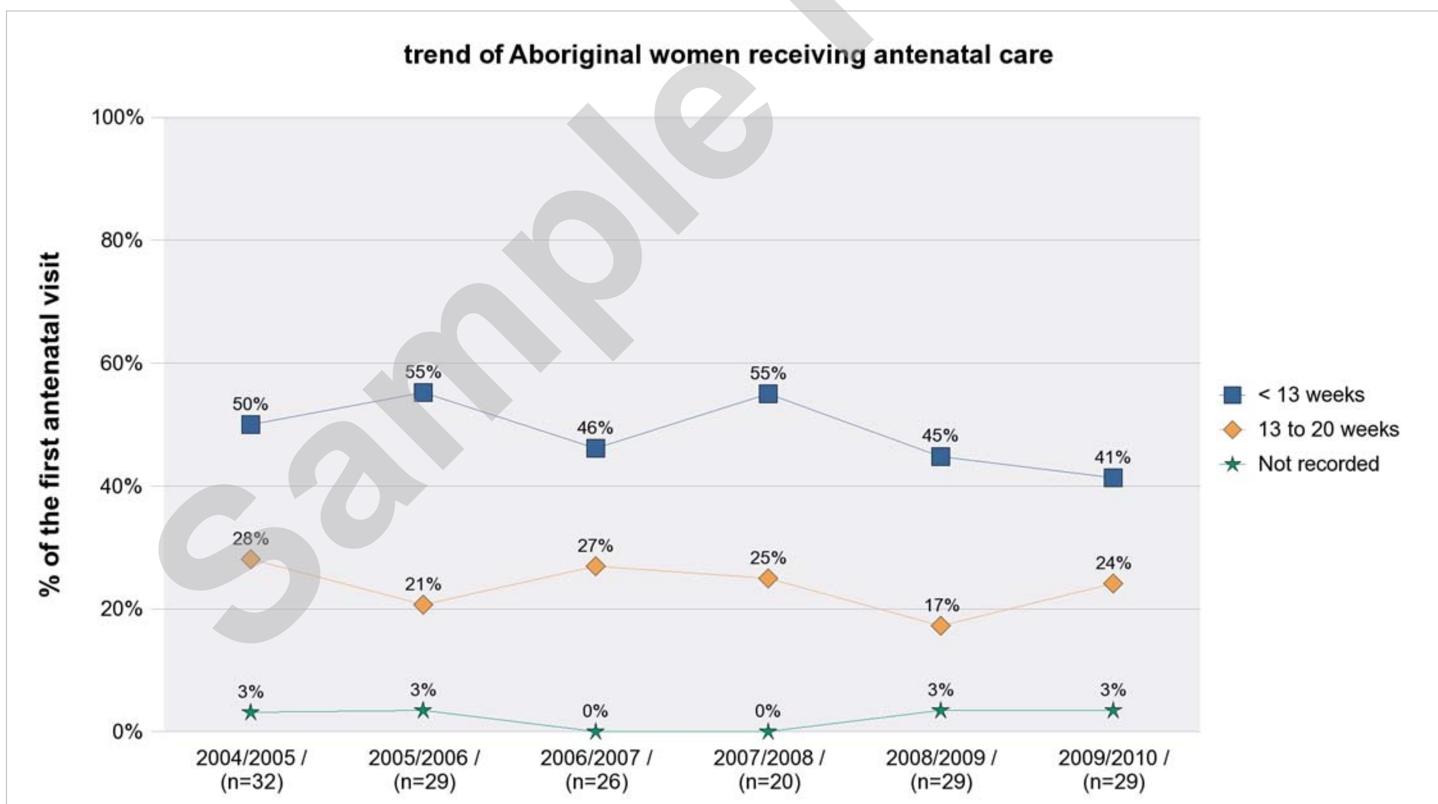
No specific data anomolies to assist interpretation of this KPI.

Sample Report

AHKPI 1.2 Timing of first antenatal visit for regular clients delivering Aboriginal babies

Community xxxx for financial year ending 30/06/2010





Sample Report

AHKPI 1.2 Timing of first antenatal visit for regular clients delivering Aboriginal babies

Community xxxx for financial year ending 30/06/2010

NT AHKPI 1.2 Timing of first antenatal visit				
Aboriginal mothers	Age of Mother			Total
	< 20 Years	20 to 34 Years	35+ Years	
First antenatal visit < 13 weeks	3	9	0	12
First antenatal visit 13 to 20 weeks	1	6	0	7
First antenatal visit 20+ weeks	3	5	1	9
First antenatal visit not recorded	0	1	0	1
Number of Aboriginal mothers	7	21	1	29
Total attending first antenatal visit	7	20	1	28
% attending a first antenatal visit	100.0%	95.2%	100.0%	96.6%
Non-Aboriginal mothers	Age of Mother			Total
	< 20 Years	20 to 34 Years	35+ Years	
First antenatal visit < 13 weeks	0	2	0	2
First antenatal visit 13 to 20 weeks	0	0	0	0
First antenatal visit 20+ weeks	0	0	0	0
First antenatal visit not recorded	0	0	0	0
Number of Non-Aboriginal mothers	0	2	0	2
Total attending first antenatal visit	0	2	0	2
% attending a first antenatal visit	0.0%	100.0%	0.0%	100.0%
Total mothers	Age of Mother			Total
	< 20 Years	20 to 34 Years	35+ Years	
Number of Aboriginal and non-Aboriginal mother	7	23	1	31
Total attending a first antenatal visit	7	22	1	30
% attending a first antenatal visit	100.0%	95.7%	100.0%	96.8%

Sample Report

AHKPI 1.3

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

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 hight 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.
Hight birthweight:	High birth weights are defined as babies born weighing 4500 grams or over.
Sourced From:	Caresys Midwives, Communicare or Ferret

Sample Report

AHKPI 1.3 - 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 Aboriginal status is captured at the babies birth, current systems do not collect the fathers Aboriginal status. It is possible that there is a group of babies missing from this indicator who have Aboriginal fathers and non Aboriginal 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.

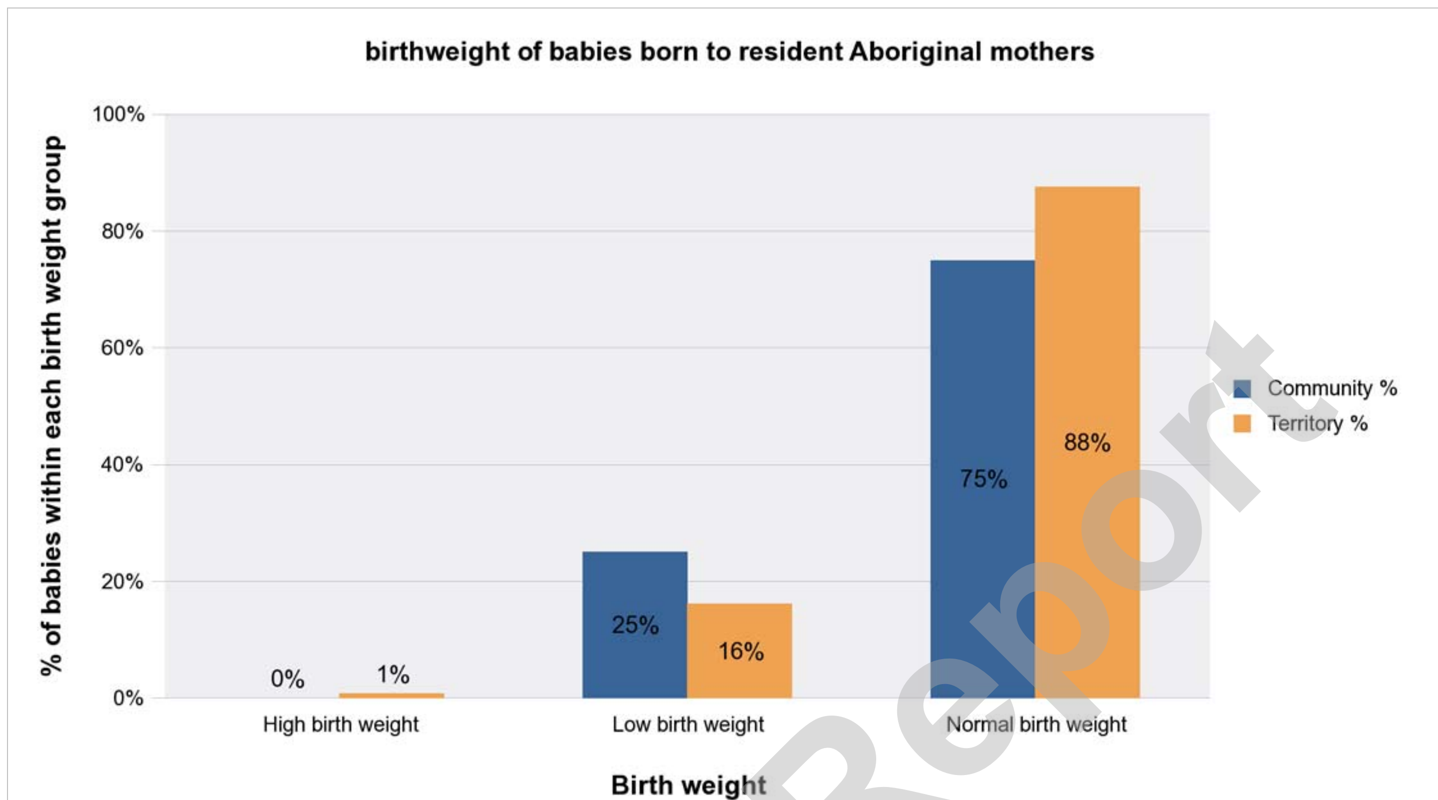
AHKPI 1.3 - Known Data Quality Issues for Community xxx

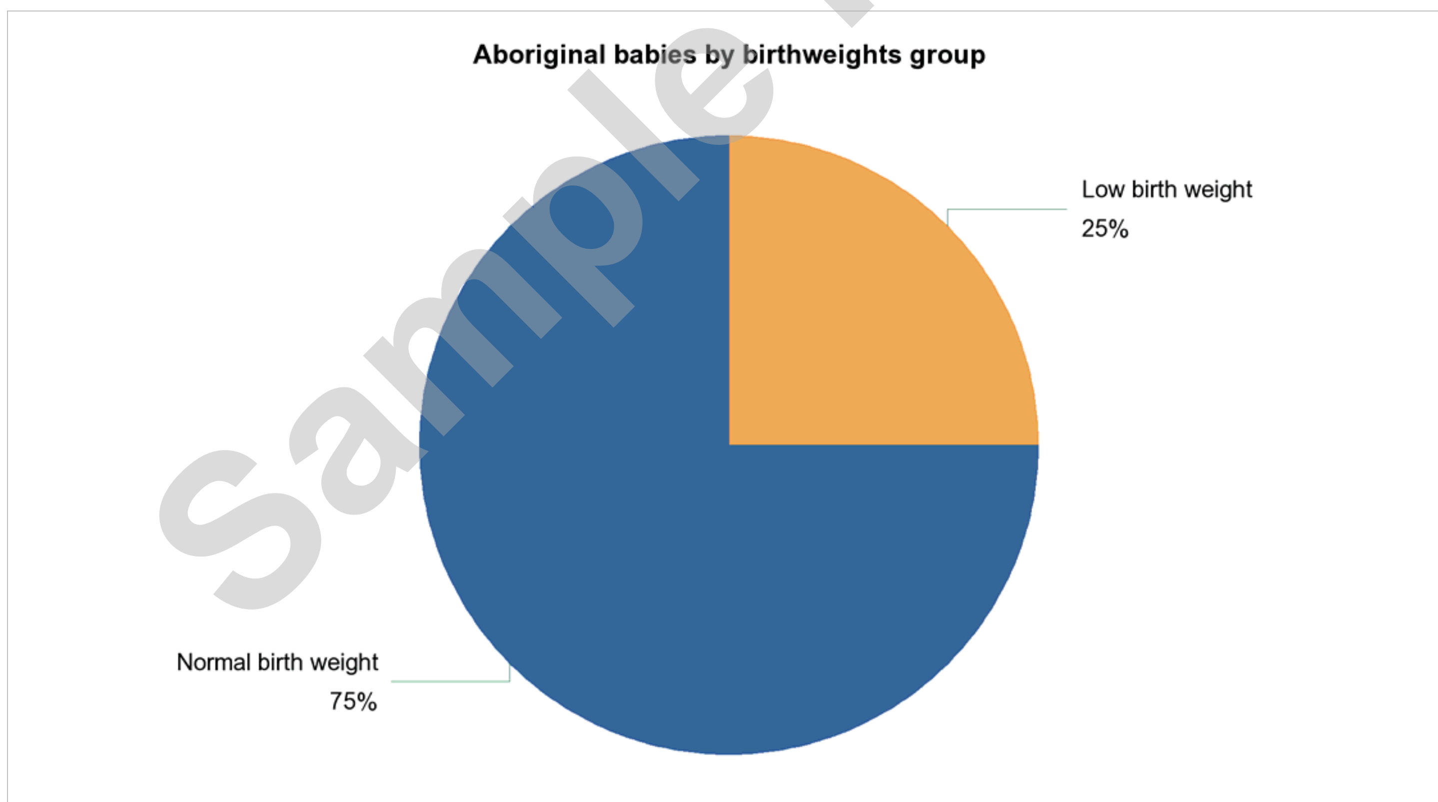
No specific data anomolies to assist interpretation of this KPI.

Sample Report

AHKPI 1.3 Number and proportion of low, normal and high birth weight Aboriginal babies

Community xxxx for financial year ending 30/06/2010





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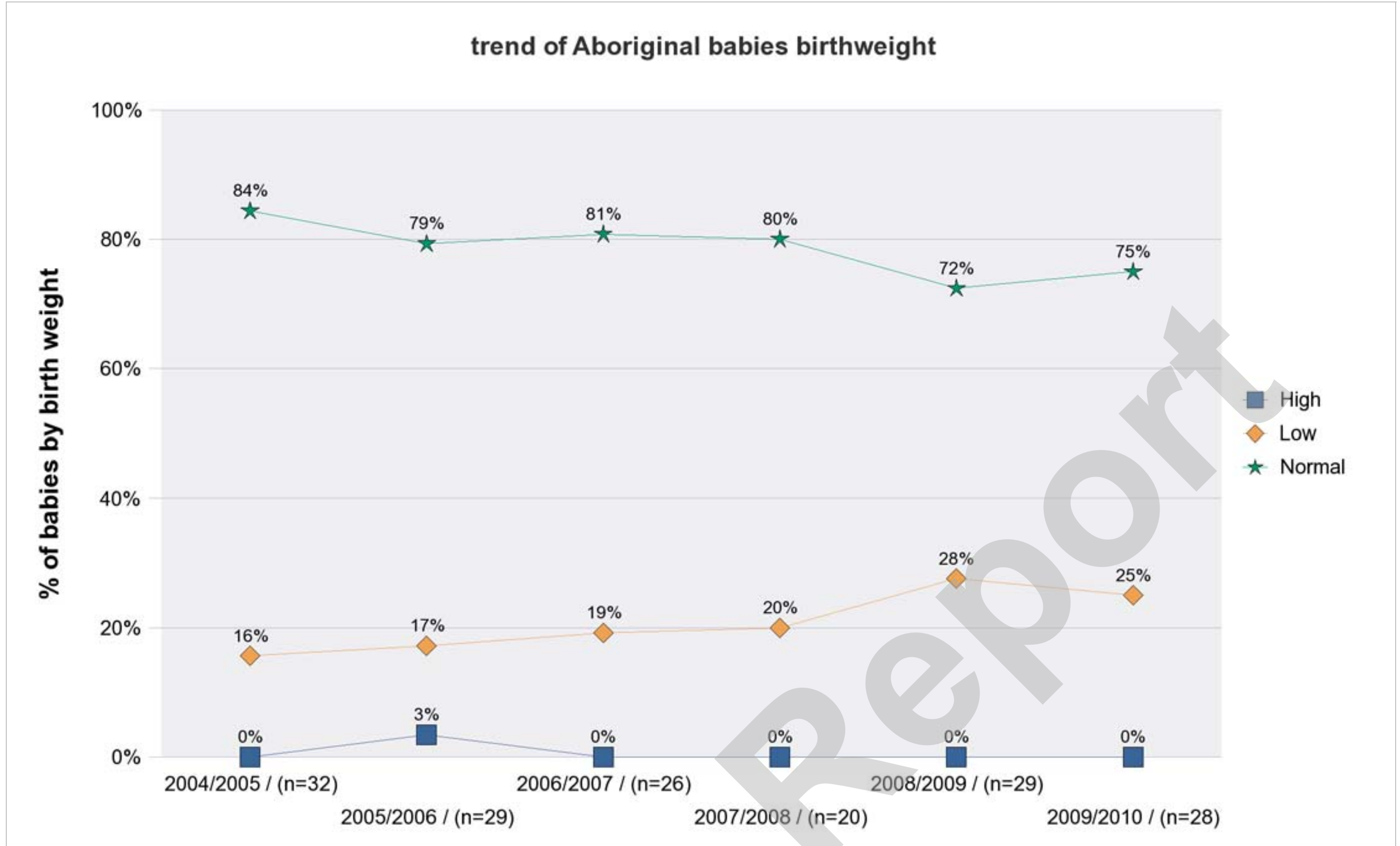
AHKPI 1.3 Number and proportion of low, normal and high birth weight Aboriginal babies

Community xxxx for financial year ending 30/06/2010



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NT AHKPI 1.3 Birth weight of babies

Aboriginal babies	Age of Mother			Total
	< 20 Years	20 to 34 Years	35+ Years	
Number of High birth weight babies	0	0	0	0
% high birth weight	0%	0%	0%	0%
Number of Low birth weight babies	2	5	0	7
% low birth weight	29%	25%	0%	25%
Number of Normal birth weight babies	5	15	1	21
% normal birth weight	71%	75%	100%	75%
Number of babies	7	20	1	28

Non-Aboriginal babies	Age of Mother			Total
	< 20 Years	20 to 34 Years	35+ Years	
Number of High birth weight babies	0	0	0	0
% high birth weight	0%	0%	0%	0%
Number of Low birth weight babies	0	0	0	0
% low birth weight	0%	0%	0%	0%
Number of Normal birth weight babies	0	2	0	2
% normal birth weight	0%	100%	0%	100%
Number of babies	0	2	0	2

Total babies	Age of Mother			Total
	< 20 Years	20 to 34 Years	35+ Years	
Number of babies	7	22	1	30

AHKPI 1.4

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

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 age between 6 months < 1 year:	6 months to less than 8 months and have received all immunisations that are due at birth. 8 months to less then 10 months and have received all immunisations that are due by 2 months of ages. 10 months to less than 1 year and have received all immunisations that are due by 4 months of ages.
Fully Immunised age between 1 year < 2 years:	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 < 6 years:	2 years to less then 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 then 6 years and have received all immunisations that are due by 4 years of age.
Sourced From:	Community Care Information System, Communicare or Ferret

Sample Report

AHKPI 1.4 - 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 Healthly for Life. This means children due for vaccinations at birth are assessed and reported as fully immunised at 8 months.

This indicator shows the proportion of children fully immunised at different stages. Check if your results seem correct for your baby clinic activity and population numbers. If lower coverage than expected, this could indicate data entry problems with your IT systems, or it may mean your health service needs to strengthen systems to ensure children are routinely checked and immunised when due.

e.g. Ensure that children who may have had immunisation done else have been recorded retrospectively on your system. We are measuring coverage rate of immunisation not just what you have done in your clinic. It is important to have a comprehensive child immunisation record. When checking a child's immunisation status with other clinics or the ACIR update your records. This will improve your outcome data for this indicator.

AHKPI 1.4 - Known Data Quality Issues for Community xxx

No specific data anomolies to assist interpretation of this KPI.

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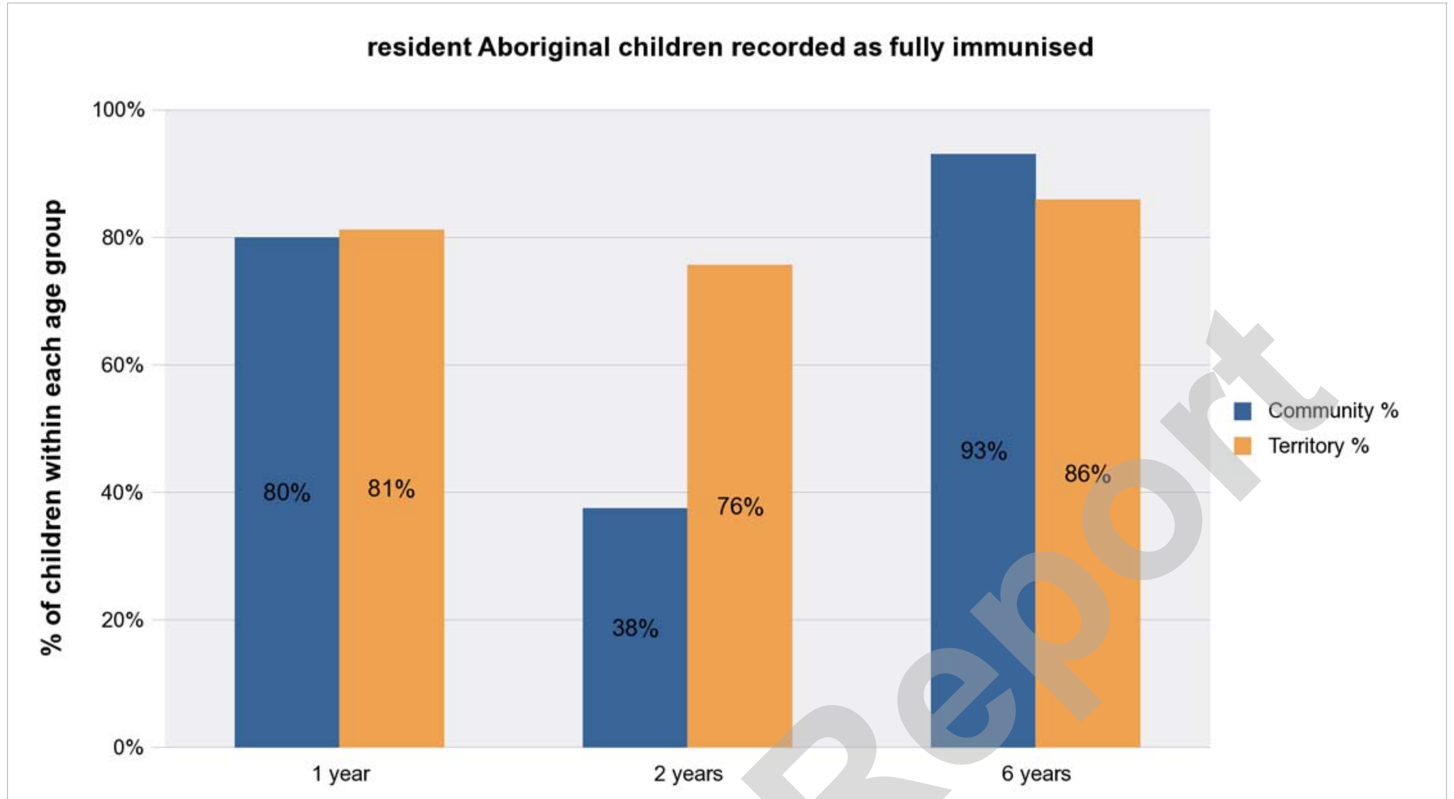
AHKPI 1.4 Number and proportion of Aboriginal children fully immunised at 1, 2 and 6 years of age

Community xxxx for financial year ending 30/06/2010



trend of 1 year old fully immunised Aboriginal children

% of children within each age group

100%
80%
60%
40%
20%
0%

67%
83%
100%
100%
44%
80%

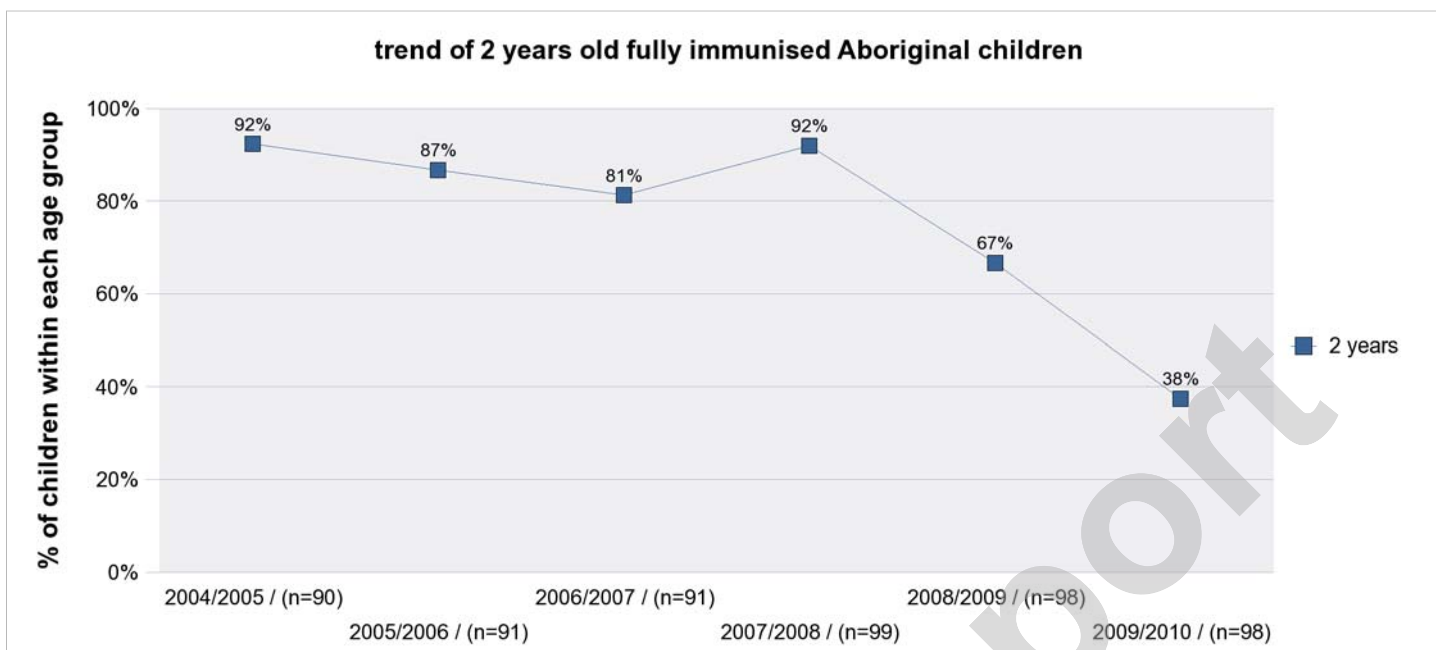
2004/2005 / (n=90)
2005/2006 / (n=91)
2006/2007 / (n=91)
2007/2008 / (n=99)
2008/2009 / (n=98)
2009/2010 / (n=98)

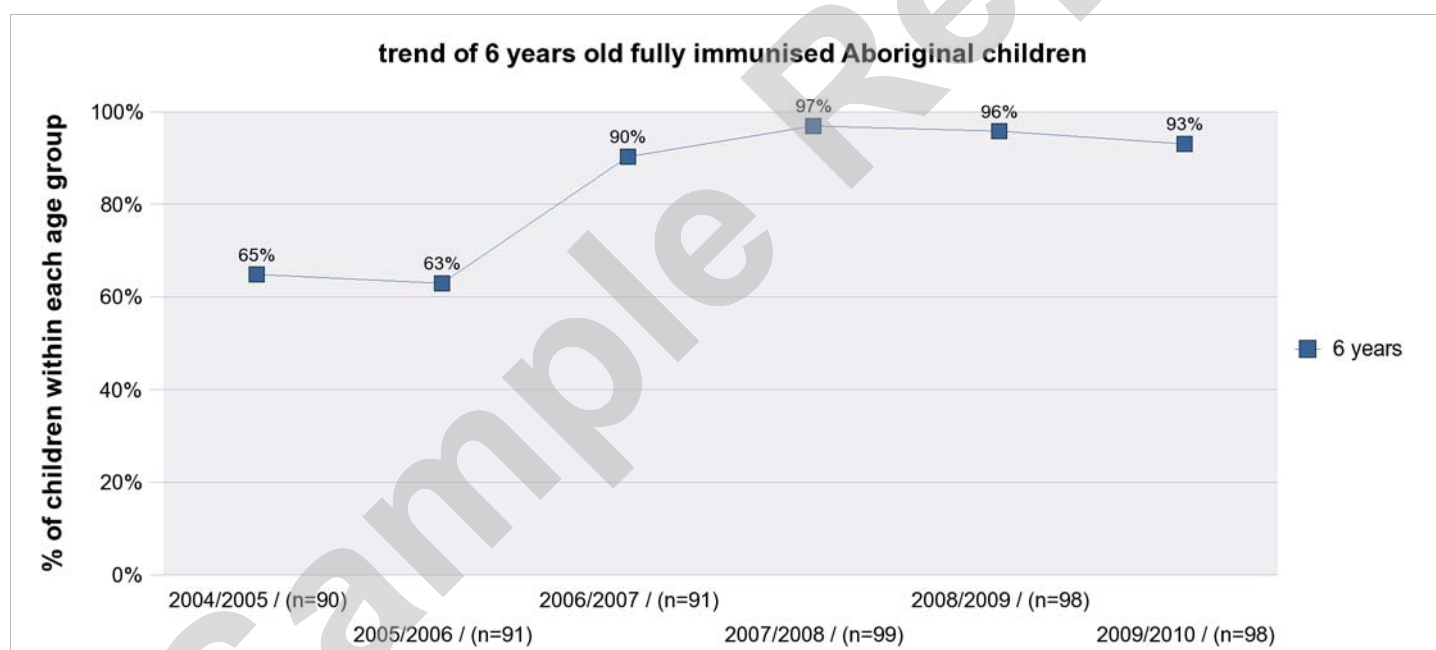
1 year

Sample Report

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

Community xxxx for financial year ending 30/06/2010





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NT AHKPI 1.4 Fully immunised children				
Fully Immunised Children	Age Group of Children			Total
	1 year	2 years	6 years	
Fully immunised children	8	6	67	81
% fully immunised children	80.0%	37.5%	93.1%	82.7%
Number of indigenous children	10	16	72	98

AHKPI 1.5

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

KPI 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 years. 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.
Sourced From:	Growth Assessment and Action, Communicare & Ferret

Sample Report

AHKPI 1.5 - 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.

Most clinics should have trend data for underweight children from your GAA reports.

The % of children underweight can reflect both low birth weight and poor growth during infancy. Check that the numbers of resident children is accurate and that the % of children measured is sufficient (usually 80% children measured) to provide a meaningful result.

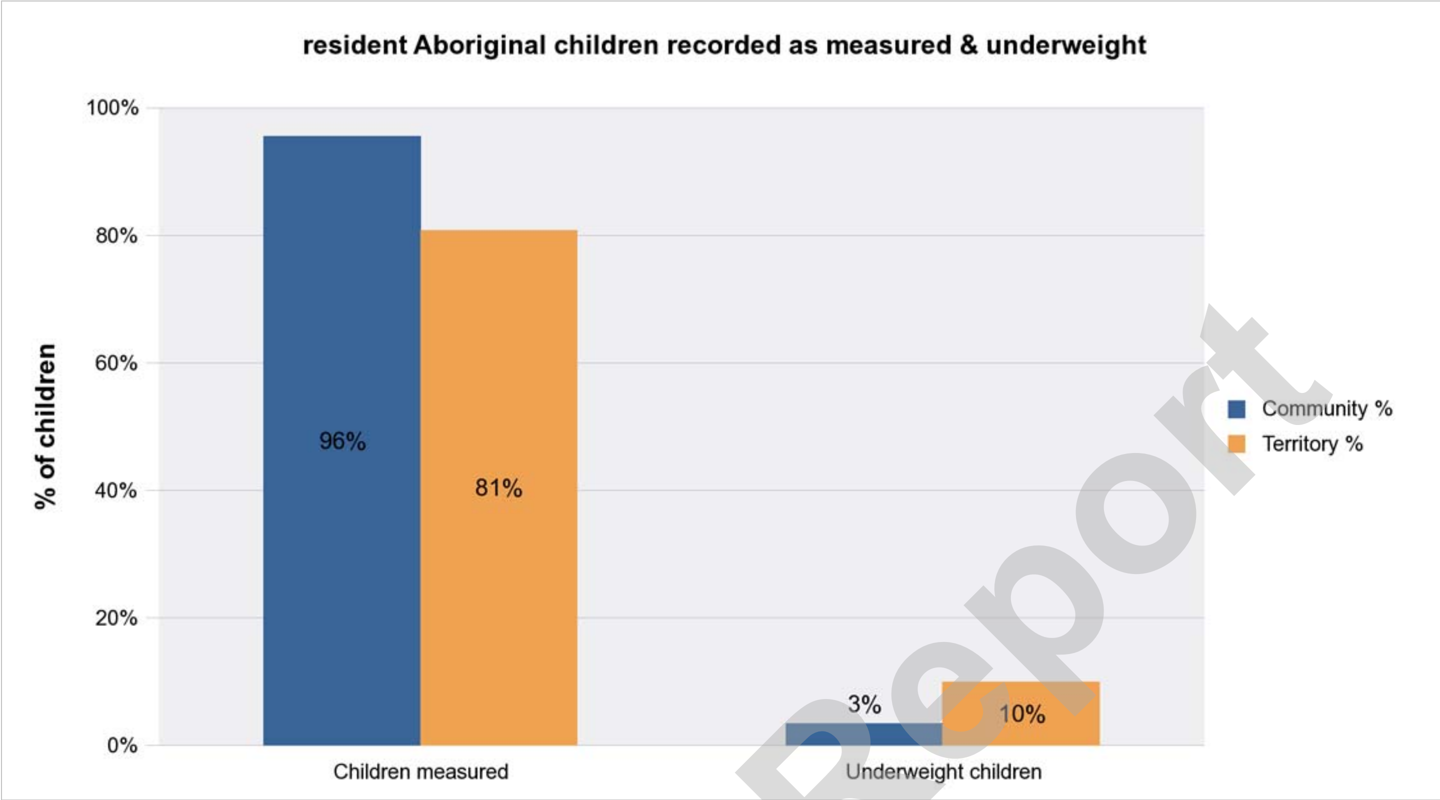
AHKPI 1.5 - Known Data Quality Issues for Community xxx

No specific data anomolies to assist interpretation of this KPI.

Sample Report

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

Community xxxx for financial year ending 30/06/2010



trend of Aboriginal children measured and underweight

% of children

100%
80%
60%
40%
20%
0%

85%
83%
56%
82%
73%
96%

10%
8%
0%
7%
11%
3%

2004/2005 / (n=71)
2005/2006 / (n=71)
2006/2007 / (n=73)
2007/2008 / (n=66)
2008/2009 / (n=99)
2009/2010 / (n=90)

Children measured
Underweight children

Sample Report

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

Community xxxx for financial year ending 30/06/2010

NT AHKPI 1.5 Underweight children	
Aboriginal Children	**Totals**
Number of aboriginal children in community	90
Children measured	86
% measured for weight	95.6%
Underweight children	3
% underweight	3.5%
Non-Aboriginal Children	**Totals**
Number of non-aboriginal children in community	4
Children measured	2
% measured for weight	50.0%
Underweight children	0
% underweight	0.0%
Unknown Status Children	**Totals**
Number of unknown status children in community	0
Children measured	0
% measured for weight	0.0%
Total Children	**Total**
Number of children in community	94

Sample Report

AHKPI 1.6

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

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.
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 110g/L (WHO definition).
Sourced From:	Growth Assessment and Action, Communicare or Ferret

Sample Report

AHKPI 1.6 - 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.

Most clinics should have trend data for anaemic children from your GAA reports.

The % of children with anaemia (usually iron deficiency) reflects maternal anaemia, low birth weight, poor growth and recurrent infection. Check the number of children is accurate for your community and that the proportion of children is sufficiently high (80%) to provide meaningful data.

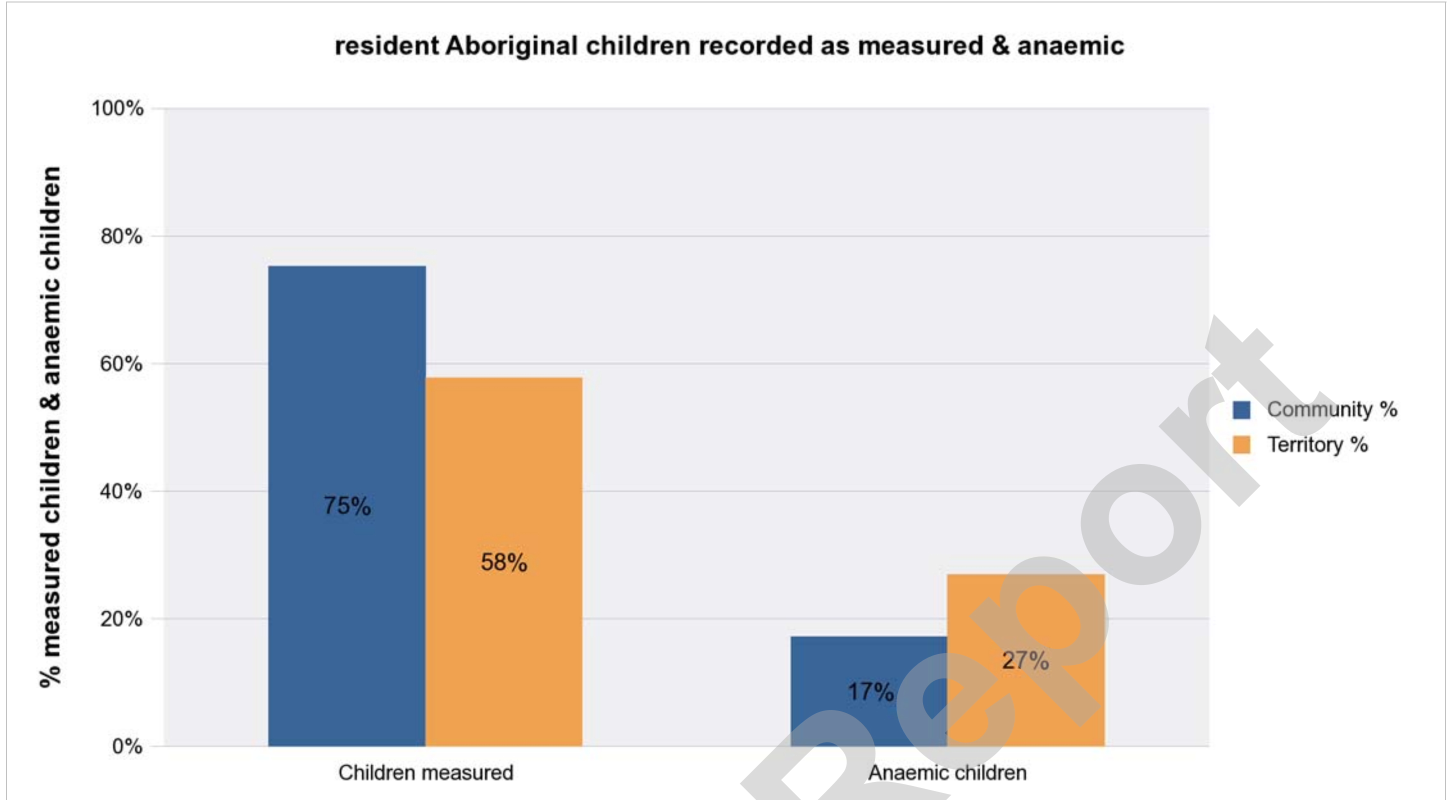
AHKPI 1.6 - Known Data Quality Issues for Community xxx

No specific data anomolies to assist interpretation of this KPI.

Sample Report

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

Community xxxx for financial year ending 30/06/2010



trend of Aboriginal children measured and anaemic

% of children

100%
80%
60%
40%
20%
0%

82%
80%
46%
81%
75%
75%
32%
35%
31%
34%
23%
17%

2004/2005 / (n=65)
2005/2006 / (n=64)
2006/2007 / (n=63)
2007/2008 / (n=62)
2008/2009 / (n=92)
2009/2010 / (n=85)

Children measured
Anaemic children

Sample Report

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

Community xxxx for financial year ending 30/06/2010

NT AHKPI 1.6 Anaemic children	
Aboriginal Children	**Totals**
Number of aboriginal children in community	85
Children measured	64
% measured for anaemia	75.3%
Anaemic children	11
% anaemic	17.2%
Non-Aboriginal Children	**Totals**
Number of non-aboriginal children in community	4
Children measured	2
% measured for anaemia	50.0%
Anaemic children	0
% anaemic	0.0%
Unknown Status Children	**Totals**
Number of unknown status children in community	0
Children measured	0
% measured for anaemia	0.0%
Total Aboriginal and non-Aboriginal Children	**Total**
Number of children in community	89

Sample Report

AHKPI 1.7

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

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 recoginsed 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: • 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.
Sourced From:	PCIS, IDCT, Communicare or Ferret

Sample Report

AHKPI 1.7 - Key comments

Clients with Type II Diabetes Graph

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 health service 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 health service has developed organised systems and has sufficient resources to deliver quality care for chronic disease. Think about how you might improve the number and quality of care plans for your diabetic patients

Clients with Coronary Heart Disease Graph

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 your clinic 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. Check the number of people with CHD is correct, and that the number of care plans or Medicare claims is being correctly identified by your IT system.
If you don't think the data is correct then there could be a problem with your coding or the PIRS query is not detecting chronic disease plans (or an alternative) that have been completed. This should trigger your service to investigate any disparities and the reasons for these.

Clients with Type II Diabetes and Coronary Heart Disease Graph

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 your clinic 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 your clinic has organised systems to deliver quality care for chronic disease. Check the number of people with diabetes and CHD is correct, and that the number of care plans or Medicare claims is being correctly identified by your IT system.

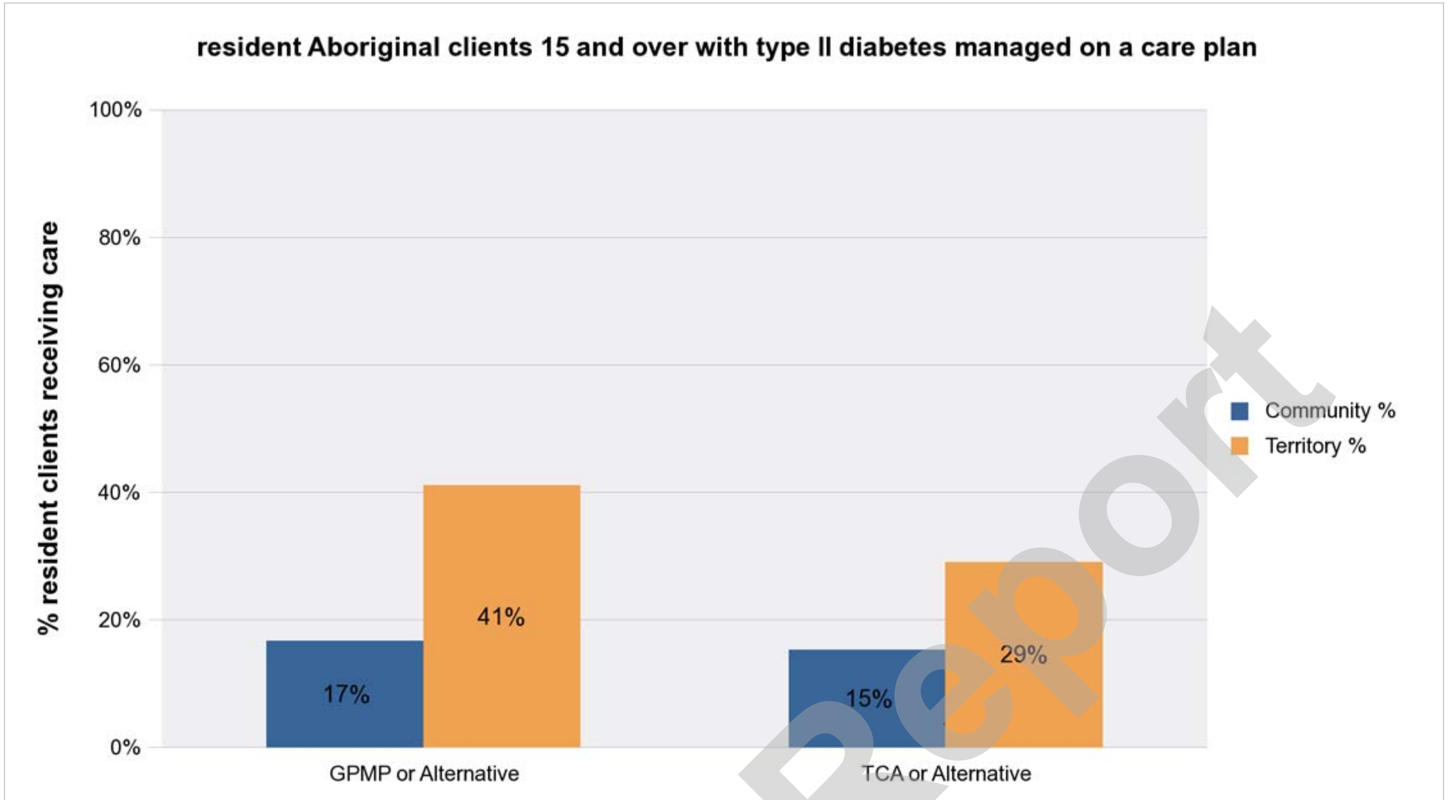
AHKPI 1.7 - Known Data Quality Issues for Community xxx

No specific data anomolies to assist interpretation of this KPI.

Sample Report

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

Community xxxx for financial year ending 30/06/2010



Sample Report

trend of Aboriginal clients with type II diabetes managed on a care plan

% resident clients receiving care
100%
80%
60%
40%
20%
0%
0%
0%
0%
0%
15%
13%
17%
15%
2004/2005 / (n=)
2005/2006 / (n=)
2006/2007 / (n=)
2007/2008 / (n=)
2008/2009 / (n=960)
2009/2010 / (n=988)
GPMP or Alternative
TCA or Alternative

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

Community xxxx for financial year ending 30/06/2010

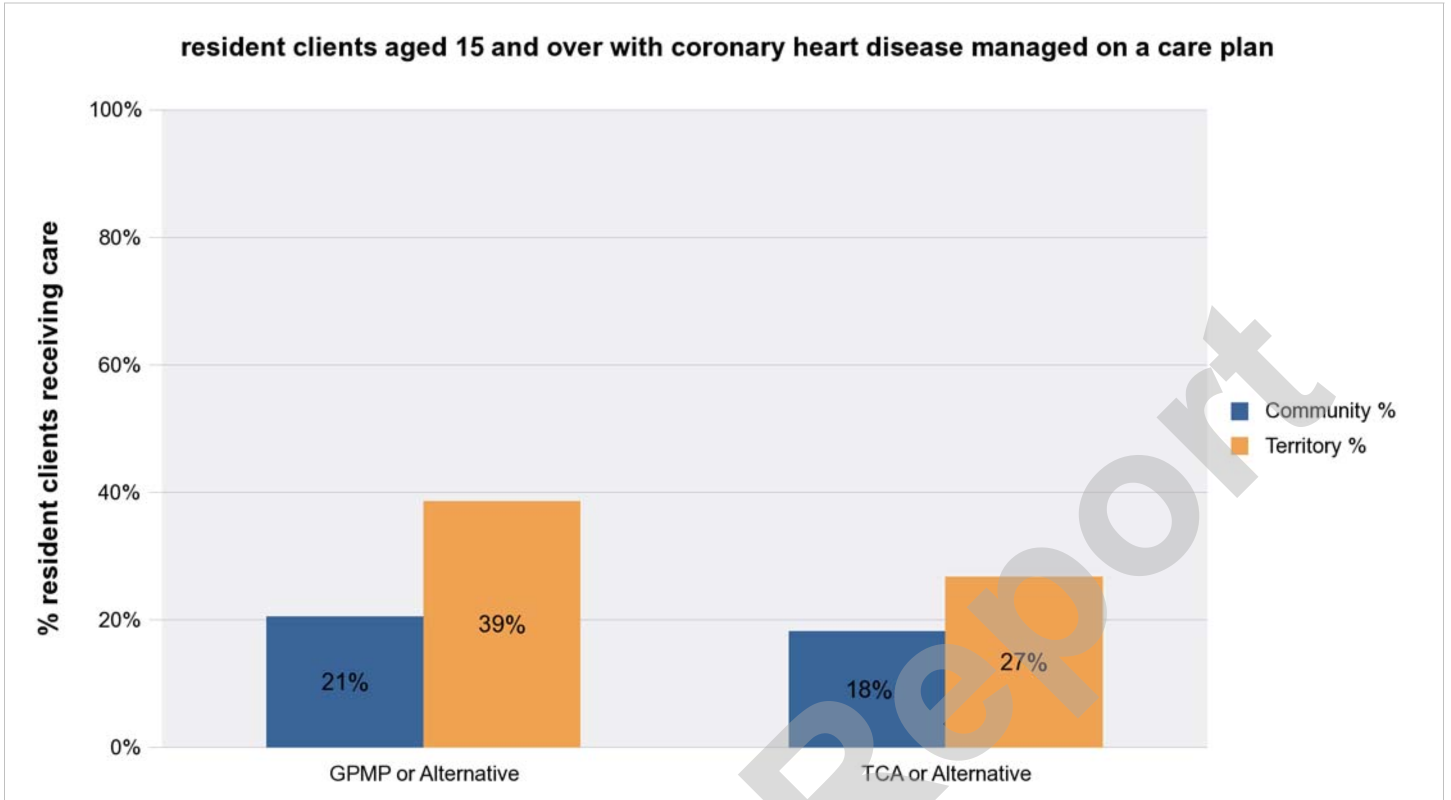
NT AHKPI 1.7 Clients with Type II Diabetes

Aboriginal Female Clients	Client Age Group				Totals
	15<25	25<45	45<65	65+	
Number on a GPMP or Alternative plan	4	15	56	21	96
% of clients on a GPMP or Alternative plan	22.2%	7.3%	17.6%	21.2%	15.0%
Number on a TCA or Alternative plan	4	14	51	22	91
% of clients on a TCA or Alternative plan	22.2%	6.8%	16.0%	22.2%	14.2%
Number of resident clients	18	206	318	99	641
Aboriginal Male Clients	**Client Age Group**				**Totals**
	15<25	25<45	45<65	65+	
Number on a GPMP or Alternative plan	0	13	43	13	69
% of clients on a GPMP or Alternative plan	0.0%	12.0%	22.4%	28.9%	19.9%
Number on a TCA or Alternative plan	0	12	38	10	60
% of clients on a TCA or Alternative plan	0.0%	11.1%	19.8%	22.2%	17.3%
Number of resident clients	2	108	192	45	347
All Aboriginal Clients	**Client Age Group**				**Totals**
	15<25	25<45	45<65	65+	
Total on chronic disease management plan	8	54	188	66	165
% on chronic disease management plan	20.0%	8.9%	19.4%	23.6%	16.7%
Total resident clients	20	314	510	144	988

Sample Report

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

Community xxxx for financial year ending 30/06/2010



trend of Aboriginal client with coronary heart disease managed on a care plan

% resident clients receiving care

100%
80%
60%
40%
20%
0%

0% 0% 0% 0% 23% 18% 21% 18%

2004/2005 / (n=)
2005/2006 / (n=)
2006/2007 / (n=)
2007/2008 / (n=)
2008/2009 / (n=205)
2009/2010 / (n=258)

GPMP or Alternative
TCA or Alternative

Sample Report

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

Community xxxx for financial year ending 30/06/2010

NT AHKPI 1.7 Clients with Coronary Heart Disease

Aboriginal Female Clients	Client Age Group				Totals
	15<25	25<45	45<65	65+	
Number on a GPMP or Alternative plan	0	4	16	12	32
% of clients on a GPMP or Alternative plan	0.0%	14.3%	21.6%	35.3%	23.4%
Number on a TCA or Alternative plan	0	4	16	11	31
% of clients on a TCA or Alternative plan	0.0%	14.3%	21.6%	32.4%	22.6%
Number of resident clients	1	28	74	34	137

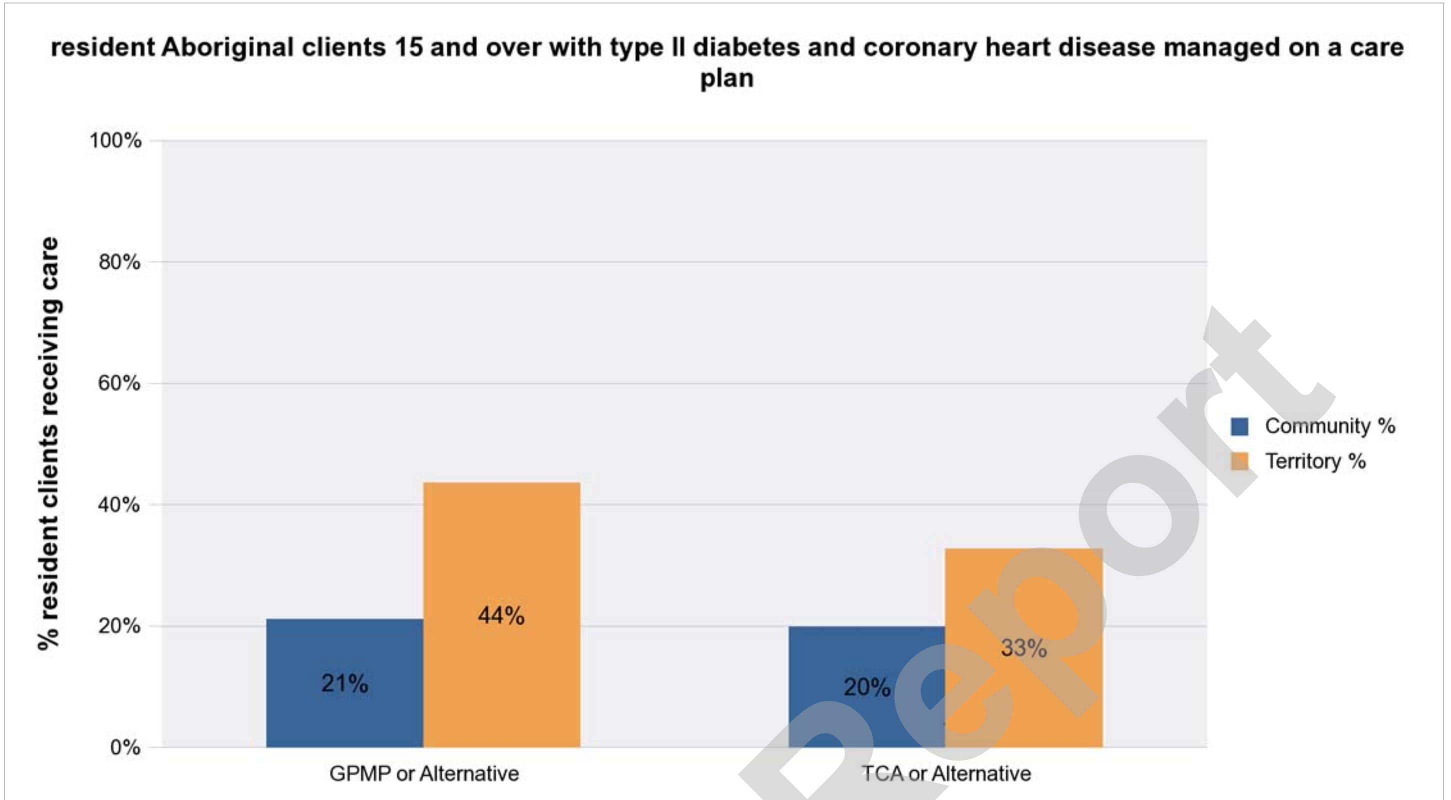
Aboriginal Male Clients	Client Age Group				Totals
	15<25	25<45	45<65	65+	
Number on a GPMP or Alternative plan	1	3	11	6	21
% of clients on a GPMP or Alternative plan	100.0%	12.5%	15.1%	26.1%	17.4%
Number on a TCA or Alternative plan	1	3	8	4	16
% of clients on a TCA or Alternative plan	100.0%	12.5%	11.0%	17.4%	13.2%
Number of resident clients	1	24	73	23	121

All Aboriginal Clients	Client Age Group				Totals
	15<25	25<45	45<65	65+	
Total on chronic disease management plan	1	7	27	18	53
% on chronic disease management plan	50.0%	13.5%	18.4%	31.6%	20.5%
Total resident clients	**2**	**52**	**147**	**57**	**258**

Sample Report

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

Community xxxx for financial year ending 30/06/2010



trend of Aboriginal clients with type II diabetes and coronary heart disease managed on a care plan

% resident clients receiving care

100%
80%
60%
40%
20%
0%

0% 0% 0% 0% 23% 17% 21% 20%

2004/2005 / (n=)
2005/2006 / (n=)
2006/2007 / (n=)
2007/2008 / (n=)
2008/2009 / (n=128)
2009/2010 / (n=156)

GPMP or Alternative
TCA or Alternative

Sample Report

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

Community xxxx for financial year ending 30/06/2010

NT AHKPI 1.7 Clients with Type II Diabetes and Coronary Heart Disease

Aboriginal Female Clients	Client Age Group			Totals
	25<45	45<65	65+	
Number on a GPMP or Alternative plan	2	12	6	20
% of clients on a GPMP or Alternative plan	14.3%	23.1%	31.6%	23.5%
Number on a TCA or Alternative plan	2	12	7	21
% of clients on a TCA or Alternative plan	14.3%	23.1%	36.8%	24.7%
Number of resident clients	14	52	19	85
Aboriginal Male Clients	**Client Age Group**			**Totals**
	25<45	45<65	65+	
Number on a GPMP or Alternative plan	1	8	4	13
% of clients on a GPMP or Alternative plan	11.1%	17.4%	25.0%	18.3%
Number on a TCA or Alternative plan	1	7	2	10
% of clients on a TCA or Alternative plan	11.1%	15.2%	12.5%	14.1%
Number of resident clients	9	46	16	71
All Aboriginal Clients	**Client Age Group**			**Totals**
	25<45	45<65	65+	
Total on chronic disease management plan	3	20	10	33
% on chronic disease management plan	13.0%	20.4%	28.6%	21.2%
Total recorded on neither plan	0	0	0	0
% recorded on neither plan	0.0%	0.0%	0.0%	0.0%
Total resident clients	23	98	35	156

Sample Report

AHKPI 1.8

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

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 HbAlc 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 month
Sourced From:	PCIS, IDCT, Communicare or Ferret

Sample Report

AHKPI 1.8 - 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. Check the number of people with diabetes is correct. If the % tested appears low this could be due to your IT system not capturing the pathology tests correctly.

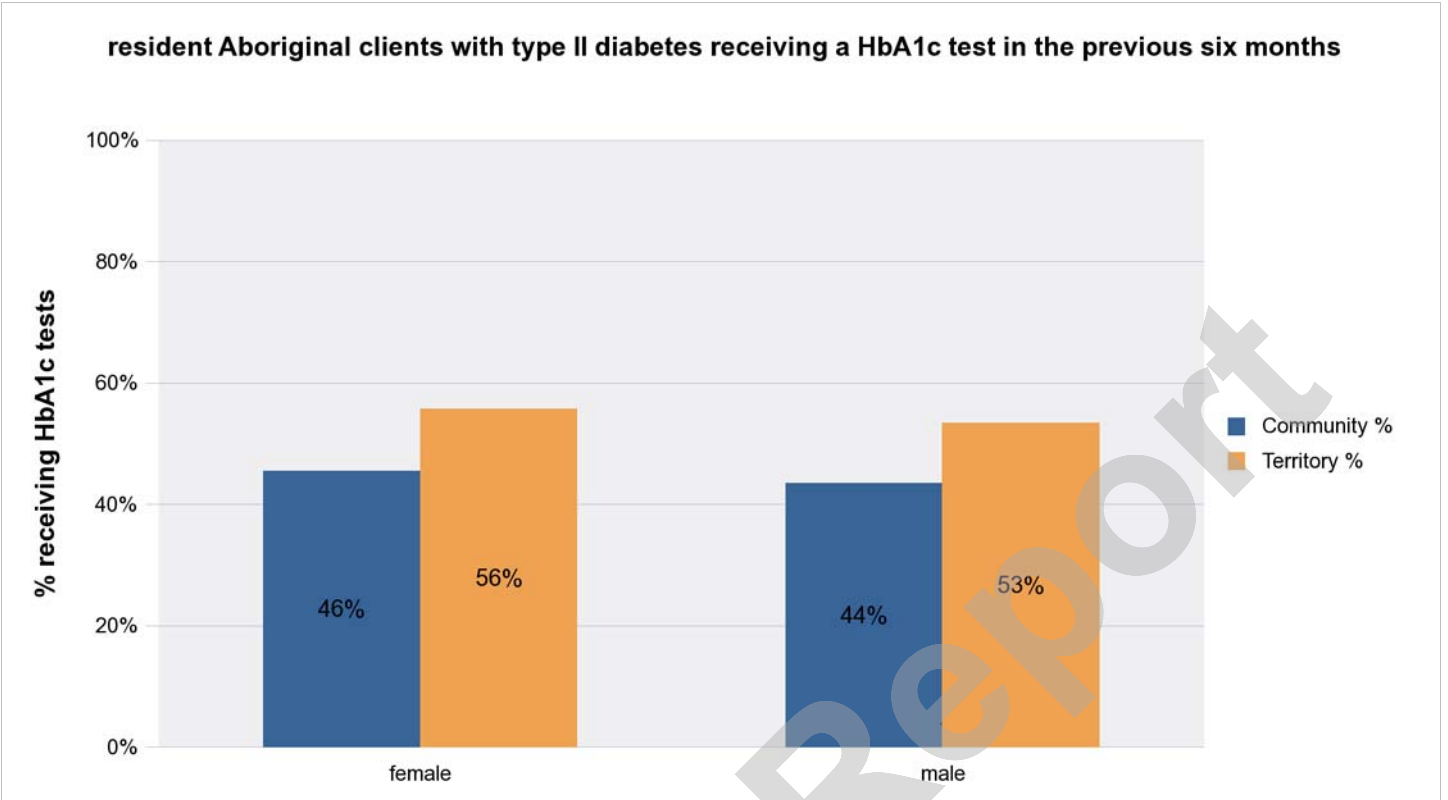
AHKPI 1.8 - Known Data Quality Issues for Community xxx

No specific data anomolies to assist interpretation of this KPI.

Sample Report

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

Community xxxx for financial year ending 30/06/2010



trend of Aboriginal clients with type II diabetes receiving a HbA1c test in the previous six months

% receiving HbA1c tests

100%
80%
60%
40%
20%
0%

0%
0%
0%
0%
45%
44%
46%
44%

2004/2005 / (n=)
2005/2006 / (n=)
2006/2007 / (n=)
2007/2008 / (n=)
2008/2009 / (n=960)
2009/2010 / (n=988)

female
male

Sample Report

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

Community xxxx for financial year ending 30/06/2010

NT AHKPI 1.8 Type II Diabetes Clients who had HbA1c Test					
Aboriginal Female Clients	Client Age Group				Totals
	15<25	25<45	45<65	65+	
Clients who had an HbA1c test	9	90	142	51	292
% who had an HbA1c test	50.0%	43.7%	44.7%	51.5%	45.6%
Number of clients with Type II Diabetes	18	206	318	99	641
Aboriginal Male Clients	Client Age Group				Totals
	15<25	25<45	45<65	65+	
Clients who had an HbA1c test	0	41	85	25	151
% who had an HbA1c test	0.0%	38.0%	44.3%	55.6%	43.5%
Number of clients with Type II Diabetes	2	108	192	45	347
All Aboriginal Clients	Client Age Group				Totals
	15<25	25<45	45<65	65+	
Clients who had an HbA1c test	9	131	227	76	443
% who had an HbA1c test	45.0%	41.7%	44.5%	52.8%	44.8%
Total clients with Type II Diabetes	**20**	**314**	**510**	**144**	**988**

Sample Report

AHKPI 1.9

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

KPI 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 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 albuminuria and receiving ACE/ARB medication. A table details the numbers and percentages of resident clients (Aboriginal and non Aboriginal) recoreded 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.
Sourced From:	PCIS, IDCT, Communicare or Ferret

Sample Report

AHKPI 1.9 - 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. Check the number of people with diabetes and albuminuria. Then check the number of people on the medications. Your IT system may not correctly capture or link the data.

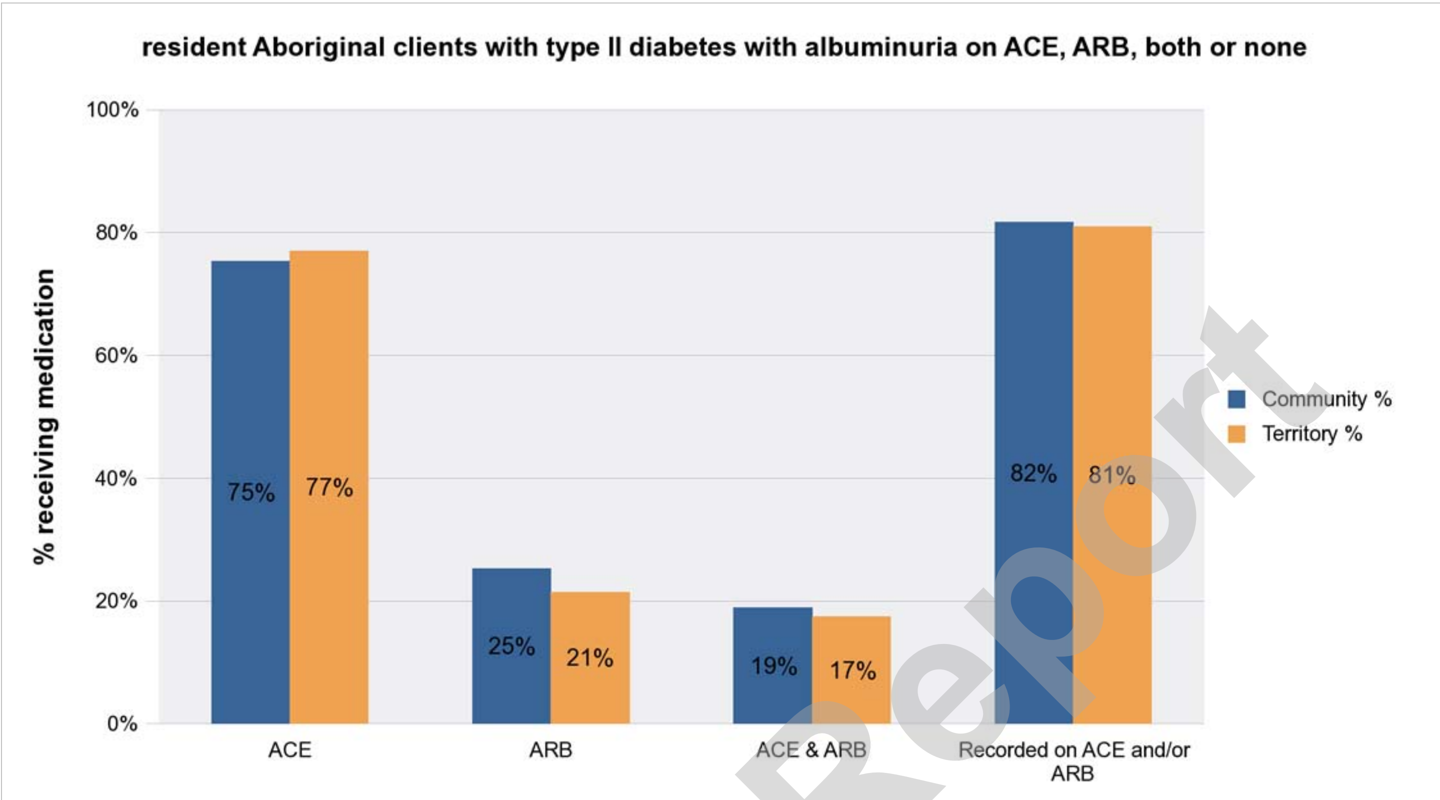
AHKPI 1.9 - Known Data Quality Issues for Community xxx

No specific data anomolies to assist interpretation of this KPI.

Sample Report

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

Community xxxx for financial year ending 30/06/2010



trend of Aboriginal clients with type II diabetes with albuminuria recored on medication

% of receiving medication

100%
80%
60%
40%
20%
0%

0% 0% 0% 0% 82% 82%

2004/2005 / (n=)
2005/2006 / (n=)
2006/2007 / (n=)
2007/2008 / (n=)
2008/2009 / (n=8,123)
2009/2010 / (n=317)

Recorded on ACE and/or ARB

Sample Report

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

Community xxxx for financial year ending 30/06/2010

NT AHKPI 1.9 Diabetic Clients with Albuminaria on ACE, ARB or both ACE & ARB	
Aboriginal clients	**Totals**
Number of aboriginal clients recorded as having albuminuria	317
Total of clients on ACE	239
	75.4%
Total of clients on ARB	80
	25.2%
Total of clients on ACE & ARB	60
	18.9%
Total of clients on Recorded on ACE and/or ARB	259
	81.7%
Non-Aboriginal clients	**Totals**
Number of non-aboriginal clients recorded as having albuminuria	5
Total of clients on ACE	3
	60.0%
Total of clients on ARB	1
	20.0%
Total of clients on ACE & ARB	0
	0.0%
Total of clients on Recorded on ACE and/or ARB	4
	80.0%
Residential clients (Aboriginal and Non Aborignal) recorded as having albuminuria	**Total**
Number of Aboriginal and non-Aboriginal clients	322

Sample Report

AHKPI 1.10

Number and proportion of Aboriginal clients aged 15 to 55 years who have had a full adult health check

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	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. 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.
Alternative Adult Health Check (710)	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.
Sourced From:	PCIS, IDCT, Communicare or Ferret

Sample Report

AHKPI 1.10 - 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. If the number of adult health checks is low, think about how to promote these checks in your community and how to manage workloads so that there is time for screening and prevention.

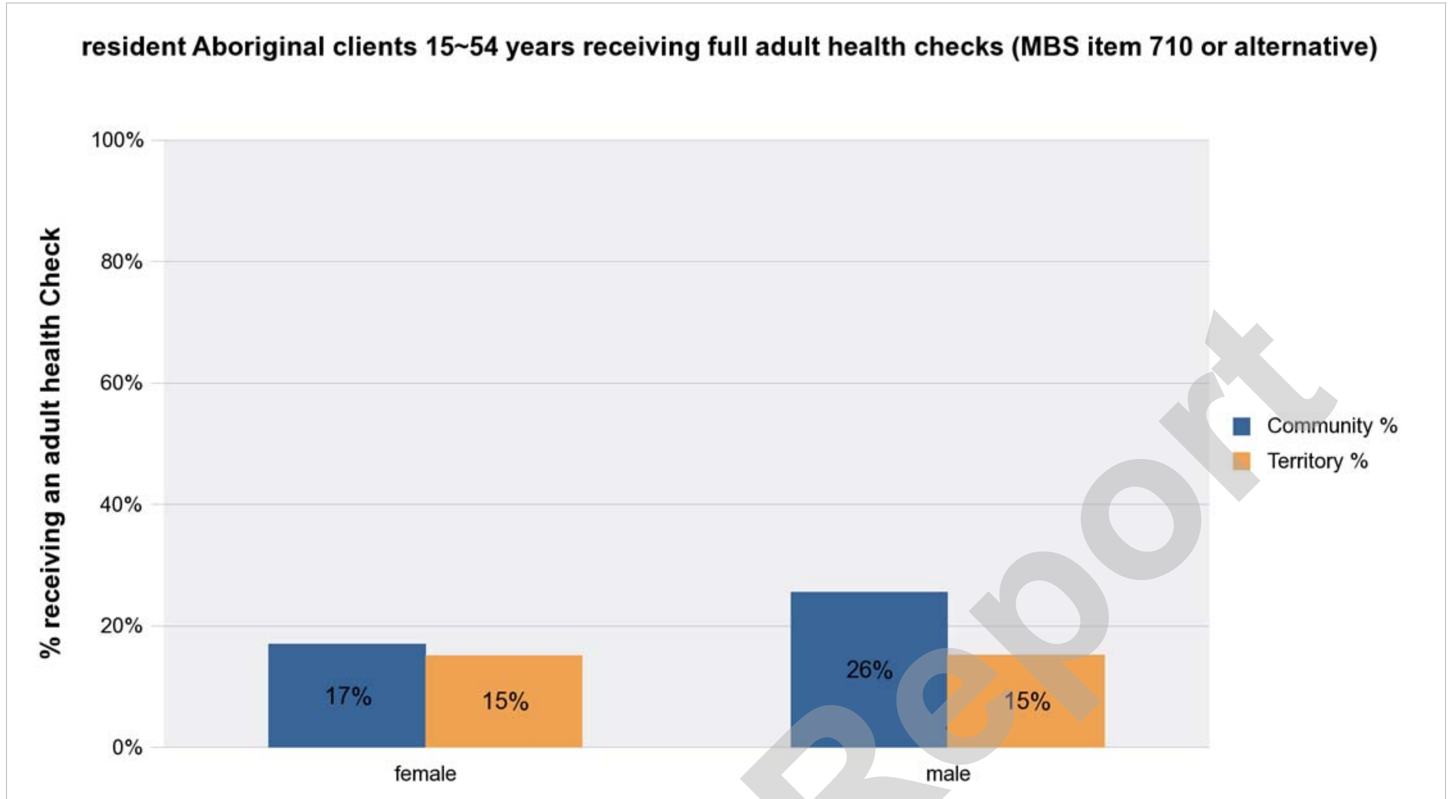
AHKPI 1.10 - Known Data Quality Issues for Community xxx

No specific data anomolies to assist interpretation of this KPI.

Sample Report

AHKPI 1.10 Number and proportion of Aboriginal clients aged 15 to 55 years who have had a full adult health check

Community xxxx for financial year ending 30/06/2010



Sample Report

trend of Aboriginal clients 15~54 years receiving full adult health checks

% receiving an adult health check

100%
80%
60%
40%
20%
0%

0%
0%
0%
0%
15%
7%
26%
17%

2004/2005 / (n=)
2005/2006 / (n=)
2006/2007 / (n=)
2007/2008 / (n=)
2008/2009 / (n=2,133)
2009/2010 / (n=1,988)

female
male

AHKPI 1.10 Number and proportion of Aboriginal clients aged 15 to 55 years who have had a full adult health check

Community xxxx for financial year ending 30/06/2010

NT AHKPI 1.10 Indigenous Clients having a Full Adult Health Check

Aboriginal Female Clients	Client Age Group 15<25	25<45	45<55	Totals
Number of clients receiving Alt MBS 710 health check	0	2	3	5
% of clients receiving Alt MBS 710 health check	0.0%	0.4%	1.6%	0.5%
Number of clients receiving MBS 710 health check	36	92	41	169
% of clients receiving MBS 710 health check	10.6%	18.6%	22.2%	16.6%
Number of resident clients	341	495	185	1,021
Aboriginal Male Clients	**Client Age Group** 15<25	25<45	45<55	Totals
Number of clients receiving Alt MBS 710 health check	1	3	1	5
% of clients receiving Alt MBS 710 health check	0.3%	0.6%	0.7%	0.5%
Number of clients receiving MBS 710 health check	68	124	50	242
% of clients receiving MBS 710 health check	21.2%	25.0%	33.3%	25.0%
Number of resident clients	321	496	150	967
All Aboriginal Clients	**Client Age Group** 15<25	25<45	45<55	Totals
Total receiving MBS 710 or alternative health check	105	221	95	421
% receiving MBS 710 or alternative health check	15.9%	22.3%	28.3%	21.2%
Total resident clients	662	991	336	1,989

Sample Report

AHKPI 1.11

Number and proportion of Aboriginal clients aged 55 years and over who have had a full adult health check in the past 12 months

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.
Sourced From:	PCIS, IDCT, Communicare or Ferret

Sample Report

AHKPI 1.11 - 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. If the number of adult health checks is low, think about how to promote these checks in your community and how to manage workloads so that there is time for screening and prevention.
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.

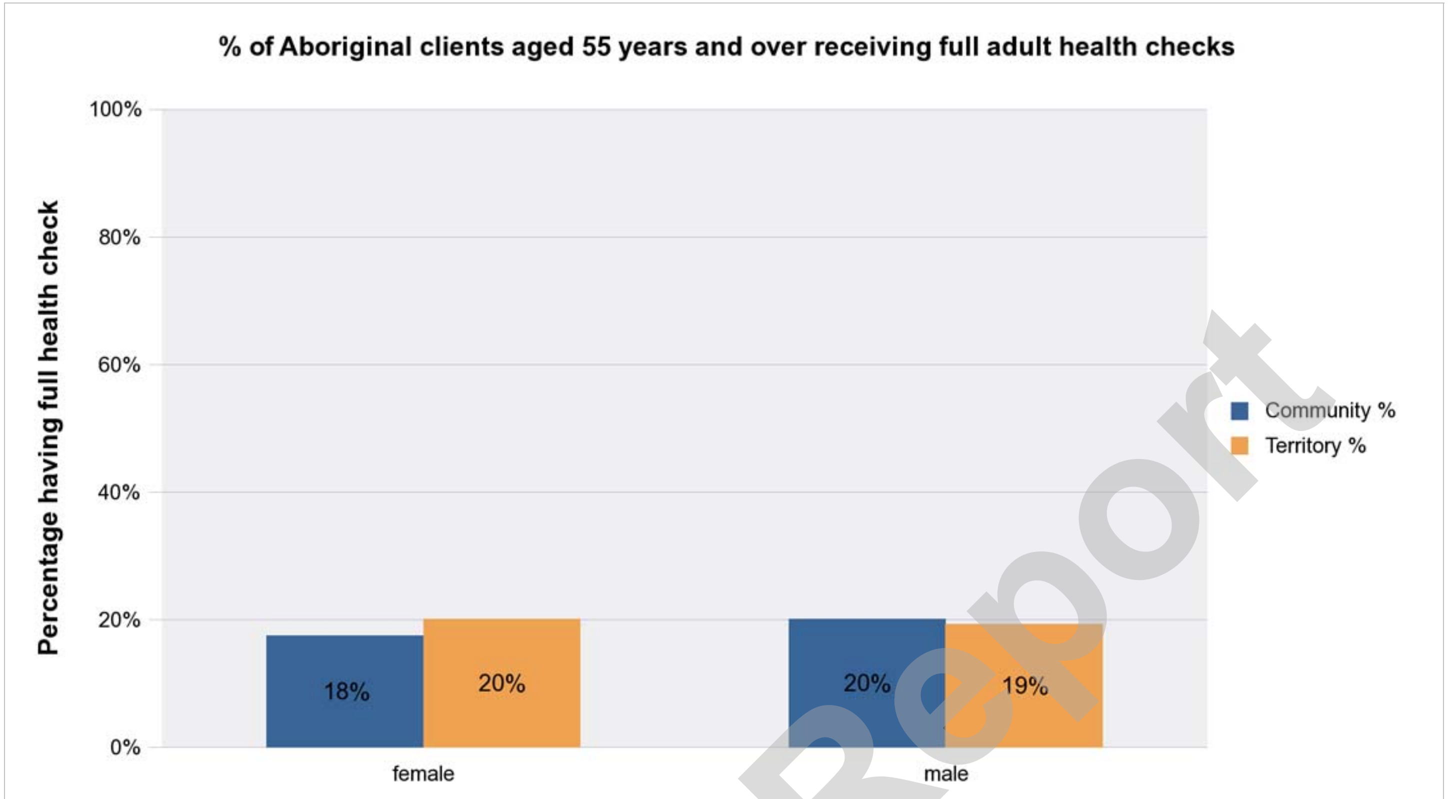
AHKPI 1.11 - Known Data Quality Issues for Community xxx

No specific data anomolies to assist interpretation of this KPI.

Sample Report

AHKPI 1.11 Number and proportion of Aboriginal clients aged 55 years and over who have had a full adult health check in the past 12 months

Community xxxx for financial year ending 30/06/2010



trend of Aboriginal clients aged 55 years and over receiving full adult health checks

% receiving an adult health check

100%
80%
60%
40%
20%
0%

0% 0% 0% 0% 13% 13% 20% 18%

2004/2005 / (n=) 2005/2006 / (n=) 2006/2007 / (n=) 2007/2008 / (n=) 2008/2009 / (n=341) 2009/2010 / (n=319)

female
male

Sample Report

AHKPI 1.11 Number and proportion of Aboriginal clients aged 55 years and over who have had a full adult health check in the past 12 months

Community xxxx for financial year ending 30/06/2010

NT AHKPI 1.11 Indigenous Clients having a Full Adult Health Check			
Aboriginal Female Clients	Client Age Group		Totals
	55<65	65+	
Number of clients receiving MBS 704 or Alternate health check	17	10	27
% of clients receiving MBS 704 or Alternate health check	19.3%	13.9%	16.9%
Number of clients receiving MBS 706 or Alternate health check	0	1	1
% of clients receiving MBS 706 or Alternate health check	0.0%	1.4%	0.6%
Number of Aboriginal female clients	88	72	160
Aboriginal Male Clients	Client Age Group		Totals
	55<65	65+	
Number of clients receiving MBS 704 or Alternate health check	20	12	32
% of clients receiving MBS 704 or Alternate health check	19.8%	20.7%	20.1%
Number of clients receiving MBS 706 or Alternate health check	0	0	0
% of clients receiving MBS 706 or Alternate health check	0.0%	0.0%	0.0%
Number of Aboriginal male clients	101	58	159
All Aboriginal Clients	Client Age Group		Totals
	55<65	65+	
Total clients receiving MBS 704, MBS 706 or alternate health check	37	23	60
% of clients receiving MBS 704, MBS 706 or alternate health check	19.6%	17.7%	18.8%
Total resident clients	189	130	319

Sample Report

AHKPI 1.12

Number and proportion of women who have had at least one pap test during reporting period

KPI 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.
Sourced From:	PCIS, IDCT, Communicare or Ferret

Sample Report

AHKPI 1.12 - Key comments

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 have had a pap smear at the centre. It is quite possible that resident clients have had a pap smear else where, it is important to understand that these women are in the denominator and therefore need to be in the numerator if you are trying to improve the data.
If the result is low then health centres need to check if clients had a pap smear elsewhere and code this retrospectively into their PIRS.
Understanding what the query is looking at and ensure that the query is just not looking at laboratory results but a clinical item recording that a pap smear has been done.

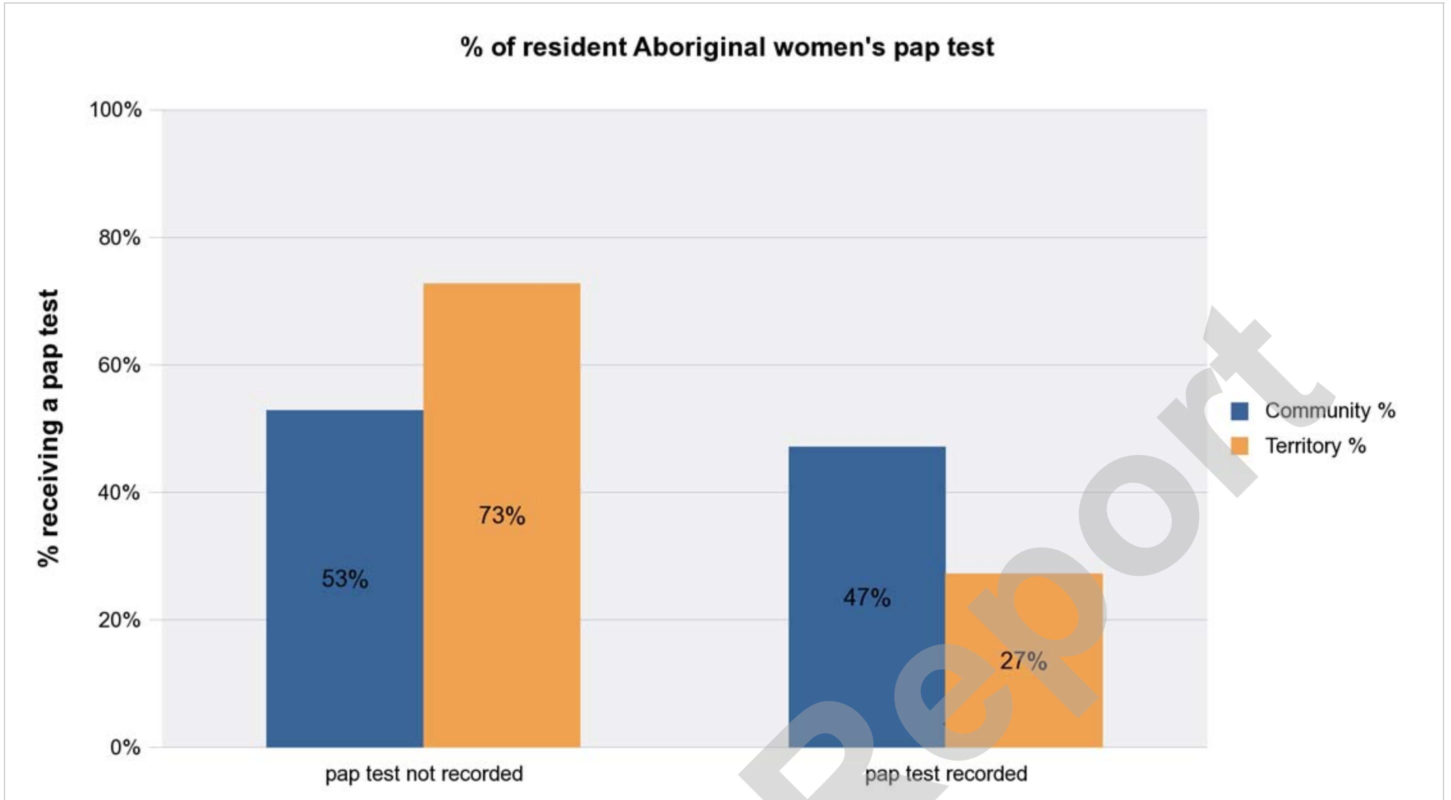
AHKPI 1.12 - Known Data Quality Issues for Community xxx

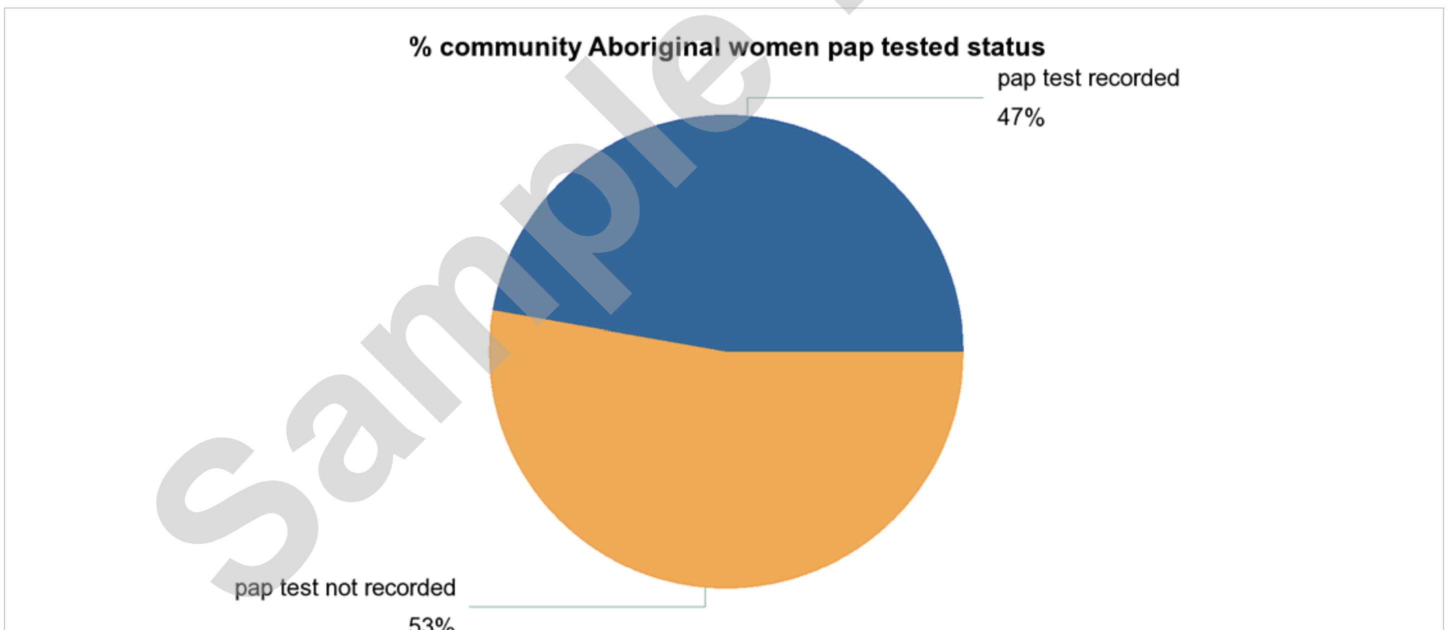
No specific data anomolies to assist interpretation of this KPI.

Sample Report

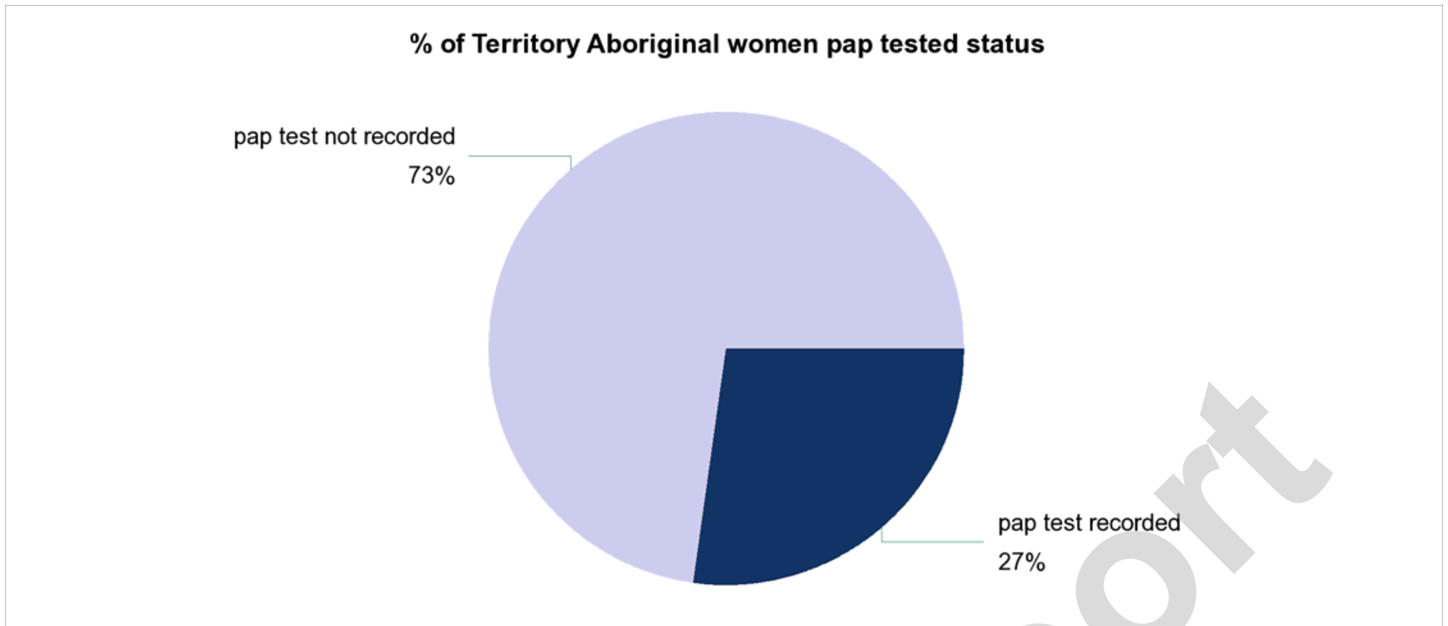
AHKPI 1.12 Number and proportion of women who have had at least one PAP test during reporting period

Community xxxx for financial year ending 30/06/2010





AHKPI 1.12 Number and proportion of women who have had at least one pap test during reporting period



trend of Aboriginal women pap test status

% pap test status

	2004/2005 / (n=152)	2005/2006 / (n=168)	2006/2007 / (n=357)	2007/2008 / (n=439)	2008/2009 / (n=454)	2009/2010 / (n=471)
pap test recorded	4%	8%	6%	33%	49%	47%

Sample Report

AHKPI 1.12 Number and proportion of women who have had at least one PAP test during reporting period

Community xxxx for financial year ending 30/06/2010

NT AHKPI 1.12 pap Smear Tests	
Aboriginal Women	**Totals**
Number of aboriginal women in community	471
pap test not recorded	249
	52.9%
pap test recorded	222
	47.1%
Non-Aboriginal Women	**Totals**
Number of non-aboriginal women in community	82
pap test not recorded	72
	87.8%
pap test recorded	10
	12.2%
Unknown Status Women	**Totals**
Number of unknown status women in community	18
pap test not recorded	17
	94.4%
pap test recorded	1
	5.6%
Total Women	**Total**
Number of Women in community	571

Sample Report