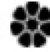
Northern Territory Aboriginal Health

Key Performance Indicator Information System

Australian Government
Department of Health and Ageing



Northern Territory Government

NT AHKPI PROMPT SHEET

For the Health Centre Community Report

Version 1.0.0

July 2010

Document Approval

The NTAHKPI Clinical Reference Group have delivered this Prompt Sheet in order to assist community health services staff in applying Continuous Quality Improvement to their AHKPI Initial Release Report(s).

This document version is the approved reference for this system from the date indicated.

The document is a managed document. For identification of amendments, each page contains a release number and a page number. Changes will only be issued as complete replacement. Recipients should remove superseded versions from circulation.

This document has been reviewed by the NTAHKPI Clinical Reference Group and “Approved by” indicates endorsement for release. Prior to release all system changes have been reviewed and tested.

Action	Name	Position	Date
Prepared by	Melissa Roberts	NTAHKPI Secretariat, Clinical Reference Group, CQI Coordinator, AMSANT.	15/7/10
Reviewed by	AHKPI CRG Members		15/7/10
Approved by	Dr Andrew Bell	NTAHKPI Chair, Clinical Reference Group, Katherine West Health Services, AMSANT.	15/7/10

Standard Management Report Specification Acceptances

This document version is authorised for release once all signatures have been obtained.

	Name	Title	Signature	Date
Prepared for Acceptance	Melissa Roberts	NTAHKPI Secretariat, Clinical Reference Group, CQI Coordinator, AMSANT.		15/7/10
Accepted for Release	Dr Andrew Bell	NTAHKPI Chair, Clinical Reference Group, Katherine West Health Services, AMSANT.		15/7/10

Associated Documents

Doc	Name	File Name
1	NT Aboriginal Health Key Performance Indicators Definitions, (Endorsed for use by NT Aboriginal Health Forum, Final approval pending agreement to adopt OATSIH qualitative definitions for Domains Two to Four), December 2008, Version 1.3.1	KPIdefinition.pdf
2	NT Aboriginal Health Forum, Key Performance Indicator System, Data Management Strategy and Protocols, for Data Receiving, Privacy, Release and an Overarching Governance Structure, (Approved by NT AHF for Trialling), December 2008, Version 1.1.2	DataManagementStrategyProtocol.pdf
3	NT Aboriginal Health Key Performance Indicator System, Health Centre Report for Community, (Approved by the NT CRG, July 2010, V 1.1.1)	AHKPI V1.1.1.pdf

Document Control

Release Details

Ver.	Date	Reason for Change	Document /Para Ref	Made By	Description of Change
1.0.0	15/7/10	First Release	ALL	M Roberts	First Release of prompt sheet for July 2010 NTAHKPI Financial Year Release

Document Distribution

(List of recipients)

Ver	Date Sent	Sent To	
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NT AH KPI Prompts against each KPI

Background

This prompt sheet has been developed to assist community clinics/health services and Health Service Delivery Area staff in assessing their Initial Release Report(s) for completeness and accuracy and to add comment or explanations to each of the NT AH KPIs. There may be some significant clinical and environmental factors which you are aware of which may have contributed to your KPI outcome data. You have the opportunity to enter any comments and explanations and resubmit these comments in the text block so that it can be included in the 'Known Data Quality Issues section.

This prompt sheet can also be used for clinical teams to analyse their final report and consider continuous quality improvement activities to improve. There may be some simple systematic changes that could be made within your clinic or community environment which could then improve access or providing health care, to work toward improving Aboriginal health outcomes.

Your Continuous Quality Improvement Facilitator for your HSDA can assist you in analysing your reports and facilitating continuous quality improvement activities with your team.

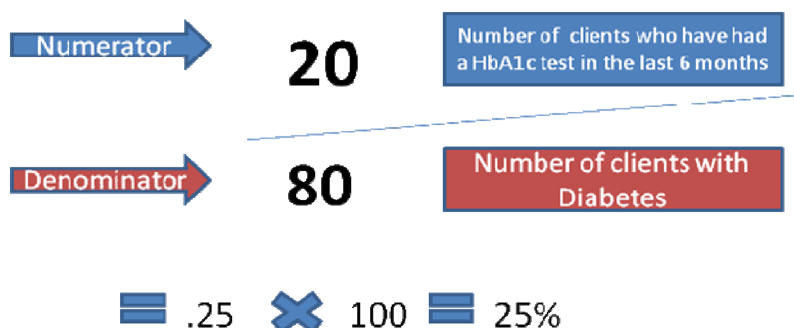
You may also consider running other reports in your PIRS to further analyse your data to pin point issues or factors which may be contributing to your KPI outcomes.

When analysing your data at the initial release stage or for continuous quality improvement purposes, consider referring to the NT AH KPI Definition document and key comments in your report. The definition and comments against each of the KPIs will provide further guidance to understand the KPI rationale, counting rules and information to consider when analysing your KPI outcome data.

General Prompt Notes

- Do you understand the NT AHKPI query and how the data is being extracted from your PIRS?
- In some services, staff reporting on the NT AHKPIs may have better technical knowledge than practitioners, and should be able to explain to staff what clinical data is being extracted and how proportions and percentages are calculated (e.g. proportion of children who are anaemic). It is important to understand the numerators and denominators which calculates the percentages and the denominator is highlighted against each KPI below.

Think about a simple equation to get a percentage



- In larger clinics/services it is important that data analysis is done with managers and practitioners working within NTKPI focused areas such as maternal and child health, chronic disease and preventative health. It is important to contextualize the information so that it can tell a story.

- If you get an unexpected result consider whether the data is accurate, or if there has been significant clinical factors or community and environmental factors which may have contributed to the KPI outcome. Reasons why it may not be accurate include :
  - Are patients being coded accurately as current, transient and past? Misclassifying visitors as current patients will reduce your performance as you will not necessarily have provided comprehensive health care during the period for these visitors e.g. two HbA1c, or children's immunization record may not be complete.
  - Has there been a change of staff? Has staff had appropriate training in PIRS?
  - Is data being coded in the right place? E.g. are qualifiers (appropriate fields for numeric and text data to be coded) being used for coding appropriately rather than adding values within the progress notes?

- Do you have a good system to ensure patient status is maintained? (For Communicare users if you have a system to manually change the patient status then it is recommended you disable the 'inactivity years' found in the system parameters patient tab).

- Change in PIRS usage; shift from paper based to electronic PIRS could significantly affect data quality

- If you think that this is a real change rather than reflecting inaccurate data , consider reasons for this change:
  - E.g. staffing and program changes, workload in acute care affecting time spent on recall/reminder and check ups.

- Key comments in the report might give further prompts on data presentation and interpretation.

Small numbers

Interpreting small numbers

It is important that you do not over interpret small numbers particularly in indicators such as low birth weights, under weight children and anaemia. Numbers can vary due to random fluctuation and this is especially likely when the numbers are small. For instance if you have 2 anaemic children in one reporting period and then four in the next period, this does not necessarily mean that there is a clinical or public health reason for this change even though the numbers have doubled : it could just be due to chance. However, if you had twenty underweight children in one reporting period and forty in the next, there would be more cause for concern as with these bigger numbers, it is more likely that there is an underlying reason for the change e.g. less effective follow up of children who are anaemic.

Identifying individuals

When you show this data to the community or board, be aware that presenting small numbers may risk identifying individuals even though this data is meant to be " de-identified (i.e. it doesn't refer to individuals and can not be traced back to individuals). For instance if you present that you only had 2 underweight babies in the last reporting period, community members may try to work out who these babies are. This may affect the privacy of these families. .

NTAHKPI Prompts against each KPI		
1.1a and 1.1b	**Episodes of Care and Contacts**	• If the number of episodes of care and contacts is different to expected consider the following? • Could this just be fluctuation due to chance i.e. it is not a trend? • Is this change what you expected due to data cleansing or quality improvement activities? • Data quality issues to consider include: • Have you gone from a manual system to electronic health record and coding of health information? • Has there been a change in electronic coding? • Is the proportion of contacts and episodes classified as unknown Indigenous status improving? Are there reasons for this? Data cleansing initiative? • Have there been more or less visitor clients this period? If so, is there a reason for this? • Consider doing a brainstorm with staff about possible factors for change in activity e.g. practitioner position increased or vacant during period, community numbers up and down due to cultural reasons/ bereavement/ unusual weather, epidemic of diseases. • Is the gender mix normal or within x% or has there been a change in gender ratios? • What about the proportion of people seen in different age groups? • Possible reasons for changes in age or sex breakdown could include male health program commenced, focused activities e.g. to increase child health checks/ adult health checks/youth outreach.

1.2	**First Antenatal Visit**	Some questions may not be relevant depending on the size of your community and how well you know your community. • Is the total of all mothers (denominator) reflective of the clients who have had a baby in the reporting period? (clients who have a status of being a regular client and who have had a baby in the reporting period) • If there are more clients than expected? Have visitors been counted? • If there are more clients attending late is this reflective of your resident clients or have visitors (who are receiving most of their care elsewhere) been coded as a regular client wrongly. • If less than expected has the end of the pregnancy been coded? • Is the ‘not recorded as attending’ or ‘did not attend’ data increased or decreased? Is there a reason for this? • Has there been a change in staff? Or no women’s health practitioner/midwife or GP to attend to antenatal care, and coding has been inadequate in the PIRS. • Is recording of maternal care being performed electronically or are manual records still being kept?
1.3	**Birth weights**	• Compare your number of babies born (denominator) against the number of mothers in query 1.2. If there is a large difference what might be the reason? E.g. no discharge summaries so no weights have been recorded. Babies birth details not correct? Mothers end pregnancy not recorded appropriately? • Comparing community low birth weights and NT data may be misleading because of the small numbers of births e.g. one low birth weight out of 4 births is 25%. • Was there a number of sets of twins which could skew your data? • Has there been some significant factors in this reporting period that may have contributed to low birth weight babies? Was there a number of premature babies (>20 <37 weeks gestation) or twins which could account for more low birth weights than normal? • Babies above 4500gm may indicate mothers with diabetes in pregnancy or prolonged term babies => 42 weeks gestation. • Has there been an Indigenous status missing from either the mother or father which may exclude baby’s birth weight not being included in the counting of the query? • (For Communicare users running the Pregnancy outcome query for the same reporting period will give you more details about the birth of babies and mothers gestation and pregnancy details)

1.4	**Fully Immunised Children**	• Is the number of resident children reported (denominator) reflective of your known population of resident children in the community? If more than expected consider if visitor clients have been included. • Consider factors that may have affected performance e.g. staff shortage or staff changes, changing demands for acute care affecting program delivery. • Note: a leeway of 6mths is given to allow for a child to be immunized at a given age. Therefore even if your data is good, you could still have large proportion of young children who are significantly late for immunisation.
1.5	**Underweight children**	• Is the number of children under 5yrs reported in the report (denominator) reflective of your known population of resident children under 5yrs in the community. If not consider if visitor clients have been included. • Has there been any significant factors which may have contributed to the increase or decrease of underweight children e.g. child health checks focused activity, no staffing to provide child health checks, high number of new born babies (prem or under weight), broken equipment. • Lack of PIRS training and weights incorrectly coded in PIRS. • Aboriginality not coded appropriately in PIRS.
1.6	**Anaemic children**	• Is the number of children between 6mths and 5yrs reported in the report (denominator) reflective of your known population of resident children 6mths and 5yrs in the community? If not consider if visitor clients have been included? • Is the proportion of children who have been tested for anaemia consistent with what you expect, and is the number of children who are anaemic what you expected. If not what factors might influence the testing rate e.g. equipment availability,only testing when anaemia is suspected or in all children, staff training etc. • Have Hb's been entered correctly into the PIRS? • Has there been any significant other clinical or environmental factors which may have contributed to the increase or decrease of anaemic children during the reporting period e.g. child health checks focused activity, no staffing to provide child health checks. Is there a high number of new born babies (prem or under weight), infections or faulty orbroken equipment?

<table>
<tr><td>1.7</td><td>Chronic disease management plan
Clients with Type II Diabetes
Clients with CHD
Clients with both Type II diabetes and CHD</td><td>Is the number of clients 15yrs and over with Type II diabetes/CHD/both reported (denominator) reflective of your known population of resident clients with Type II Diabetes/CHD/both? If not consider if visitor clients have been included. If the numbers are not what you expect then consider if practitioners are diagnosing diabetes correctly /screening for it regularly and whether they are misclassifying diabetes as glucose intolerance,.
Is the male and female gender distribution reflective of your clients with Type II Diabetes/CHD/both?
Does the number of care plans reported seem to be accurate?, if not consider your system and why there might be over or under reporting, e.g. Medicare claiming has not been done, or alternative care plans have not been coded appropriately to be counted in the query.
Has there been significant clinical factors which may contribute to over or under reporting such as staffing, training, using manual systems, or care planning is not captured electronically to be counted?</td></tr>
<tr><td>1.8</td><td>HbA1c Tests</td><td>Is the number of clients 15yrs and over with Type II diabetes (denominator) reflective of your known population of resident clients with Type II Diabetes? If not consider if visitor clients have been included, and if diabetes is being coded correctly and diagnosed accurately.
Are registers up to date or do they need to be reviewed?
Do you think that the number of HbA1c tests in the last 6 months seem to be reflective of the care provided. If not consider if the denominator is accurate?
Consider data quality issues, e.g. point of care results not entered into the appropriate place
Consider clinical factors which may have impacted on the result of this KPI, e.g. staffing, training in point of care machine, machines broken.</td></tr>
<tr><td>1.9</td><td>ACE inhibitor and/or ARB</td><td>Is the number of clients 15yrs and over with Type II diabetes with albuminuria (denominator) reflective of your known population of resident clients with Type II Diabetes with albuminuria? If not consider data quality /coding and clinical issues such as the rate of screening for albuminiuria.
Do you believe that the number of clients 15yrs and over with Type II diabetes with albuminuria on an ACE inhibitor and/or ARB (numerator) is reflective of this client group. If not consider if visitor clients have been included, are medication charts are up to date?
Think about the number of patients who aren’t on an ACE or ARB, is that what you would expect given that a small proportion of patients may not be able to take these drugs safely?
Consider if practitioners are following CARPA e.g. albuminuria is checked annually, and if diabetes care and medications is reviewed in accordance with CARPA.
Are recalls for patient review and care in place?</td></tr>
</table>

1.10	**Adult aged 15-54 health check**	• Is the number of clients 15-54 yrs reported (denominator) reflective of your known population of resident clients 15-54yrs? If not consider if visitor clients have been included. • Is the male and female gender distribution reflective of your 15-54yr clients? • Is the number of AHC reported likely to be accurate, if not consider data quality and clinical issues. Data quality issues include Medicare claiming has not been done, or alternative AHC have not been coded appropriately to be counted in the query. • Has alternative AHC been given the appropriate system code allocated to the clinical item? • Has there been significant factors which may contribute to over or under reporting such as staffing, training, manual systems and AHC are not captured electronically to be counted, focus program on doing AHC? • Note: Medicare changes have been introduced from 1st May with new Medicare items. Medicare item 715 should be added to the query but the old item (710) is still included). Is your PIRS version up to date with updated query? Check with your system administrator.
1.11	**Adult aged 55yrs and over Health Check**	• Is the number of clients 55 yrs and over reported (denominator) reflective of your known population of resident clients 55yrs and over? If not consider if visitor clients have been included. • Is the male and female gender distribution reflective of your 55yrs and over clients? • Is the number of AHC reported seem to be accurate, if not consider your system and why there might be over or under reporting. e.g. Medicare claiming has not been done, or alternative AHC have not been coded appropriately to be counted. • Has there been significant factors which may contribute to over or under reporting such as staffing, training, manual systems and AHC are not captured electronically to be counted, focus program on doing AHC? • Note: Medicare changes have been introduced from 1st May with new Medicare items. Medicare item 715 should be added to the query but the old item (704 & 706) is still included). Is your PIRS version up to date with updated query? Check with your system administrator.

1.12	Pap Smear Test	- Is the number of women between the age of 18 and 69 yrs reflective of the resident female clients in the community at the end of the reporting period (denominator)? If not consider if visitor clients have been included. - Do you believe that the number of women who have had a pap smear in the last 2yrs reported is reflective of your practice or is it under or over reported? - Are there significant factors which may contribute to the report such as: - Investigation requests are not coded through the PIRS system at your clinic. (This is the way the query counts for the time being) - No trained women's health practitioner to perform pap smears. - Note: the counting of this query may change in the future as smaller remote clinic are not requesting investigations electronically. In the meantime consider your pap smear coding system and how you might code (and back date) pap smears done elsewhere. - By coding pap smears done elsewhere you will get a more accurate coverage rate of the women in your health service area.