**NSW MINISTRY OF HEALTH ABORIGINAL HEALTH KPIs**

**POPULATION HEALTH PROGRAM**

**Program Objective:**

To improve health outcomes for the Aboriginal community by delivering core preventative and public health initiatives, including early identification and management of chronic disease risk factors.

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| **Indicator Title** | **Indicator Description** |
| **Smoking Assessments** | Proportion of regular Aboriginal clients aged 15 years and older whose smoking status has been recorded.ANDProportion of regular Aboriginal clients aged 15 years and older whose most recent smoking status has been recorded as:- current smoker, OR- ex-smoker, OR- never smoked.ANDOf those regular Aboriginal clients aged 15 years and older with a smoking status recorded as a current or ex-smoker, the proportion that had a MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) claimed in the past 12 months.  |
| **Smoking Cessation** | Proportion of regular Aboriginal clients aged 15 years and older who are recorded as a current smoker, who have a recorded smoking cessation intervention within the past 12 months. |
| **Healthy weight** | Proportion of regular Aboriginal clients aged between 2 and 18 years who had their height and weight measured and recorded (on the same occasion) within the last 12 months AND the proportion that were above a healthy weight (overweight or obese). ANDProportion of regular Aboriginal clients aged 18 years and older who had a weight recorded within the last 12 months AND the proportion that were above a healthy weight (overweight or obese).  |
| **Absolute Risk** | Proportion of regular Aboriginal clients aged 35 to 74 years that are not coded with a diagnosis matching the cardiovascular disease (CVD) definition who have had the following information recorded:- smoking status, AND- systolic blood pressure result recorded within the previous 24 months, AND- total cholesterol result recorded within the previous 24 months, AND- High Density Lipoprotein (HDL) cholesterol result recorded within the previous 24 months.ANDProportion of regular Aboriginal clients aged 35 to 74 years without Cardiovascular Disease who have had an Absolute Risk Assessment within the last 12 months.ANDProportion of regular Aboriginal clients aged 35 to 74 years without a diagnosis of CVD, who have had an absolute CVD risk assessment within the previous 12 months, with results categorised as:- high (greater than 15% chance of a cardiovascular event in the next 5 years), OR- moderate (10-15% chance of a cardiovascular event in the next 5 years), OR- low (less than 10% chance of a cardiovascular event in the next 5 years).ANDOf those with an absolute CVD risk assessment with a result categorised as high, the proportion that have been prescribed BP and lipid lowering drug treatment in accordance with clinical guidelines. |
| **Kidney Function Testing** | Proportion of regular Aboriginal clients aged 30 years and over who have had both an estimated Glomerular Filtration Rate AND a urinary Albumin/Creatinine Ratio recorded within the previous 24 months. |
| **Diabetes Key Measurables** | Proportion of regular Aboriginal clients with Type II Diabetes with all key measurables recorded within the required timeframes.*Note: Key measurables are:- two (2) Blood Pressure (BP) measurements recorded within the previous 12 months- a HbA1c measurement recorded within the previous 12 months- a total cholesterol or Low Density Lipoprotein (LDL) measurement recorded within the previous 12 months- an ACR or other urinary micro albumin recording within the previous 12 months- an estimated Glomerular Filtration Rate (eGFR) recording within the previous 12 months- a recorded smoking status.* |
| **Diabetes HbA1C** | Proportion of regular Aboriginal clients with Type II Diabetes whose HbA1C measurement result recorded in the previous 12 months was less or equal to 7% (less than or equal to 53mmol/mol). |
| **GP Management Plans** | Proportion of regular Aboriginal clients with Type II diabetes with a GP Management Plan (MBS Items 721) claimed within the previous 24 monthsANDProportion of regular Aboriginal clients with cardiovascular disease for whom a GP Management Plan (MBS Item 721) was claimed within the previous 24 months. |
| **GP Management Plan Reviews** | Proportion of regular Aboriginal clients with Type II diabetes or cardiovascular disease for whom a GP Management Plan (MBS Item 721) was claimed 12-24 months prior to the end of the reporting period, that had a review (MBS Item 732) conducted:- zero times- once- two or more times. |
| **Health Checks** | The proportion of regular Aboriginal clients for whom an MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) was claimed within the previous 12 months (reported for clients aged under 15 years and clients aged 15 years and older). |
| **Team Care Arrangements** | The proportion of regular Aboriginal clients with Type II diabetes for whom a Team Care Arrangement (MBS item 723) was claimed within the previous 24 monthsANDProportion of regular Aboriginal clients with cardiovascular disease for whom a Team Care Arrangement (MBS Item 723) was claimed within the previous 24 months. |
| **Team Care Arrangement Reviews** | Proportion of regular Aboriginal clients with Type II diabetes or cardiovascular disease for whom a Team Care Arrangement (MBS Item 723) was claimed 12-24 months prior to the end of the reporting period, that had a review (MBS Item 732) conducted:- zero times- once- two or more times |
| **Child Immunisation** | Number and proportion of regular Aboriginal children attending your organisation who are fully immunised at:• 12 to less than 24 months• 24 to less than 36 months• 60 to less than 72 months |
| **Influenza Vaccination Pregnancy** | Proportion of female Aboriginal clients coded as being pregnant during the last 12 months who were vaccinated against influenza.  |
| **Influenza Vaccination Children** | In the previous 12 month period, proportion of Aboriginal children aged between 6 months and less than 5 years vaccinated against influenza.  |
| **Influenza Vaccination Adults** | In the previous 12 month period, proportion of Aboriginal clients aged over 15 years who were vaccinated against influenza. |
| **Pertussis** | Proportion of female Aboriginal clients coded as being pregnant and in the third trimester during the last 12 months who received a pertussis vaccination during pregnancy.  |
| **Hepatitis B**  | Proportion of regular Aboriginal clients born before May 2000 who are recorded as ever being tested for Hepatitis B infection.  |
| **Hepatitis B treatment** | Proportion of regular Aboriginal clients with chronic Hepatitis B infection who have had a HBV DNA viral load and liver function tests in the past 12 months. |
| **Hepatitis C**  | Proportion of regular Aboriginal clients aged over 18 years and HCV RNA positive who have received DAA treatment within the last 12 monthsANDProportion of regular Aboriginal clients aged over 18 years and HCV RNA positive who initiated DAA treatment between 12 and 24 months prior to the end of the reporting period that have achieved sustained virological suppression. |
| **STI**  | Proportion of regular Aboriginal clients aged 15-30 years (inclusive) who were tested for Chlamydia and/or Gonorrhoea within the last 12 monthsANDProportion of regular Aboriginal clients aged 15-30 years (inclusive) who were tested for Chlamydia and/or Gonorrhoea and Syphilis within the last 12 months. |
| **STI/HIV Tests** | Proportion of regular Aboriginal clients (any age) with a positive Chlamydia and/or Gonorrhoea and/or Syphilis result in the last 12 months who received an HIV test within 30 days of the first positive result. |

**POPULATION HEALTH PROGRAM: DRUG AND ALCOHOL**

**Program Objective:**

To reduce the impact of alcohol and drugs on the Aboriginal community through provision of culturally sensitive screening, treatment and support.

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| **Indicator Title** | **Indicator Description** |
| **AUDIT-C** | Proportion of regular Aboriginal clients aged 15 or over who have had an AUDIT-C result recorded within the previous 12 months with a 'positive' score (>=4 for men, >=3 for women) |
| **Alcohol Condition** | Proportion of regular Aboriginal clients coded with a relevant alcohol related condition that have an alcohol related referral. |
| **Drug and/or Alcohol Support Plan** | Proportion of regular Aboriginal clients with a coded drug and/or alcohol condition in the quarter with a care plan in place.  |

**MENTAL HEALTH PROGRAM**

**Program Objective**:

To improve the mental health and wellbeing of Aboriginal people by working collaboratively and in partnership with local health and support organisations to provide culturally sensitive and safe mental health assessment, treatment, support and information.

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| **Indicator Title** | **Indicator Description** |
| **GP Mental Health Plan** | Proportion of regular Aboriginal clients with an identified high impact mental illness/es who have had a GP Mental Health Plan (2700, 2701, 2715, 2717) claimed in the last 24 monthsANDProportion of regular Aboriginal clients with an identified low impact mental illness/es (without an identified high impact mental illness) who have had a GP Mental Health Plan (2700, 2701, 2715, 2717) claimed in the last 24 months. |
| **GP Mental Health Plan Review** | Proportion of regular Aboriginal clients with an identified high impact mental illness/es who have had a GP Mental Health Plan (2700, 2701, 2715, 2717) claimed 12-24 months prior to the end of the reporting period, that had a review (MBS Item 2712) conducted:- zero times- once- two or more timesANDProportion of regular Aboriginal clients with an identified low impact mental illness/es (without an identified high impact mental illness) who have had a GP Mental Health Plan (2700, 2701, 2715, 2717) claimed 12-24 months prior to the end of the reporting period, that had a review (MBS Item 2712) conducted:- zero times- once- two or more times |

**DRUG & ALCOHOL RESIDENTIAL REHABILITATION PROGRAM**

**Program Objective**:

To reduce the impact of alcohol and other drugs on the Aboriginal community through providing culturally sensitive residential-based care and support for Aboriginal people engaging in or recovering from substance abuse, including links to support services.

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| **Indicator Title** | **Indicator Description** |
| **Bed Occupancy** | Bed occupancy during the quarter expressed as a proportion of bed nights occupied divided by the available bed nights for the quarter.  |
| **Exit Plans** | Proportion of clients leaving the residential program in the quarter with a documented drug and/or alcohol exit plan. |
| **Follow Up** | Proportion of clients who exited the residential program in the previous quarter that your organisation attempted to contact in this quarter.ANDOf those clients, the proportion that your organisation was successful in contacting.ANDOf those clients that were able to be contacted, the proportion who reported progress in line with their exit plan. |