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**Are we there yet? Closing the gap in indigenous health in Australia:  
Monitoring clinical performance in Aboriginal and Islander community  
control health services in Queensland**

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## **Are we there yet? Closing the gap in indigenous health in Australia: Monitoring clinical performance in Aboriginal and Islander community control health services in Queensland**

### **Abstract**

Abstract presented at the World Congress of Cardiology, Dubai, United Arab Emirates, 18-21 April 2012.

### **Keywords**

control, we, there, yet, closing, gap, indigenous, services, health, queensland, australia, monitoring, clinical, performance, aboriginal, islander, community

### **Disciplines**

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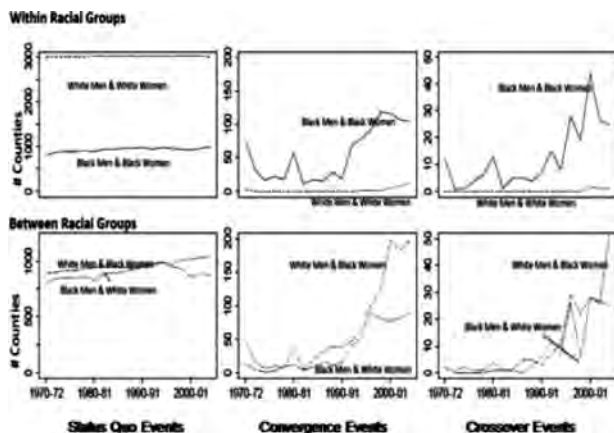
Panaretto, K. S., Button, S., Carson, A., Leon, D., Schibasaki, R., Wason, G., Baker, D. & Ring, I. (2012). Are we there yet? Closing the gap in indigenous health in Australia: Monitoring clinical performance in Aboriginal and Islander community control health services in Queensland. *Circulation: Journal of the American Heart Association*, 125 (19), E890-E890.

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largest for BW-WM (51), followed by BW-BM and WW-BM (each with 25 CR events) and lowest for WW-WM (1).

Image/graph 1:



**Conclusion:** In an increasing number of counties, HD mortality rates in women are becoming similar to or higher than rates for men. This finding suggests that environmental factors can override female biological protectiveness for HD. The actual causes of these trends are uncertain and deserve definitive examination.

#### P675 Are we there yet? closing the gap in indigenous health in Australia: monitoring clinical performance in aboriginal and Islander Community control health services in Queensland

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**Introduction:** Aboriginal people in Australia continue to experience a high burden of chronic disease, including cardiovascular disease. Aboriginal Medical Services (AMSs) are a significant component of the effort to reduce this burden and must be supported to deliver the highest quality care. **Objectives:** To evaluate clinical health care performance in Queensland Aboriginal and Islander Health Council (QAIHC) member Aboriginal Medical Services (AMSs) in Australia. **Methods:** In October 2009, AMSs in Queensland began to use a standard indicator set, the QAIHC Core Indicators, to monitor recorded prevalence and management performance on a number of key risk factors, clinical care activities and chronic diseases. Data is extracted monthly from clinic electronic medical record systems (EMRs) and submitted to a web based portal for services to review their performance over time and benchmarked. A copy of the data is also sent to the QAIHC data repository to allow agreed secondary analysis to occur. In July 2011 longitudinal data was analysed to examine trends in the number of participating services, proportion of patients with current recording of key health care activities and the prevalence of risk factors and cardiovascular disease. **Results:** From October 2009 to July 2011, AMSs sending data for the QAIHC Core Indicators increased from 6 to 15 participants; the number of patients for whom data was captured increased from 10,800 to 26,004 of whom 19,634 (75.5%) were regular Indigenous patients in July 2011. The aggregated performance of participating services was consistent and excellent on the recording of a number of number of key risk factors and health care activities (for example tobacco use, blood pressure) and poor for others, with some improvement over time. Performance Variation in performance between services was greatest for care planning and health check activity. Hypertension was identified in a total of 2567 (19.2%) regular Indigenous adult patients, with a range in prevalence of 12–36% across the 15 services. The care delivered for hypertension was universally good. **Conclusion:** The prevalence of hypertension is high in the Aboriginal Community in Australia, its management by AMSs across Queensland meeting best practice standards. Indicator sets built into existing information systems provides useful timely information for Aboriginal Medical Services. Lessons learnt should enable a similar system to be implemented in AMSs across Australia in 2012.

#### Cardiovascular research output and actual citation impact of Argentina, India, and South Africa: a bibliometric approach

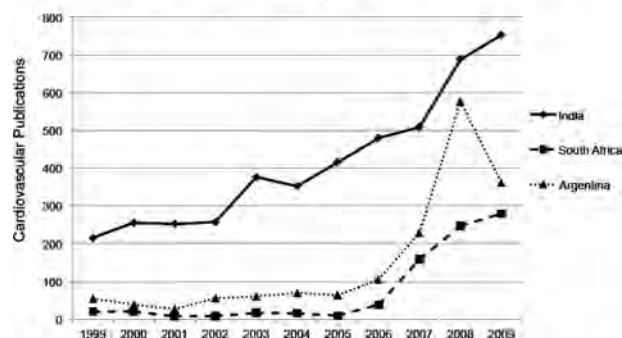
Mark D. Huffman<sup>1,\*</sup>, Gerald S. Bloomfield<sup>2</sup>, Lisandro Colantonio<sup>3</sup>, V.S. Ajay<sup>4</sup>, Poornima Prabhakaran<sup>5</sup>, Grant Lewison<sup>6</sup>, Dorairaj Prabhakaran<sup>4</sup>

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**Introduction:** Global cardiovascular research output and research quality appears to be increasing, particularly in low- and middle-income countries. However, there are limited objective data evaluating these potential trends. **Objectives:** To evaluate the cardiovascular research output and research quality of three middle-income countries: Argentina, India, and South Africa between 1999 and 2009. **Methods:** We created a bibliometric filter to capture cardiovascular research articles published in the *Web of Science* based on specialist journals and title words. Two co-authors with expertise in cardiovascular medicine (MDH, GSB) tested and refined this filter to achieve >90% precision and recall of cardiovascular research papers. We determined the research output of three countries (Argentina, India, South Africa) and estimated research quality from their mean actual citation impact (ACI) from 1999 to 2006. **Results:** Argentina published 1,657 cardiovascular research papers, India 3,403, and South Africa 838 between 1999 and 2009 in the *Web of Science*, with a substantial increase in production over that time period, particularly after 2006 (Figure 1). Five-year mean ACI values between 1999 and 2006 were 3.1 (SE = 0.4) for Argentina, 2.4 (SE = 0.3) for India, and 6.2 (SE = 0.9) for South Africa.

Image/graph 1:

Figure 1. Web of Science Cardiovascular Publications by Country (1999-2009)



**Conclusion:** These data provide objective evidence that cardiovascular research output has substantially increased in Argentina, India, and South Africa over the past decade. Potential reasons for these increases include increased number of journals published in *Web of Science*, increasing interest in cardiovascular research, increased availability of local resources for research, and increased in research output associated with more international collaborators. The potential reasons for these increases, as well as reasons for differences in ACI across the three countries, merit further investigation.

#### The level of HDL in patients with CAD comparing to patients with normal coronary in the Arab and eastern population comparing to the western population

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**Introduction:** It is well known that elevated LDL has a significant risk factor for developing CAD. There is a large number of studies to confirm that association, however, low HDL has been proposed as a risk factor for CAD but there is only limited number of data in that regard, especially in the Middle East. **Objectives:** To evaluate the prevalence of low HDL in patients with CAD by angiogram comparing to the level of HDL of patients with normal coronary. The analysis includes the ethnicity and sex of the subject. **Methods:** Chart review and angiogram review of all patients who underwent coronary angiogram at a single center in Dubai. Every patient who underwent angiogram will retrieve his/her lipid profile which was done just before or after angiogram. Also included in the study are the demographic data of the patients. The patients were divided into Easterns and Westerns. The Eastern group includes people from the Middle and Far East. The Western includes Europeans and Americans. **Results:** The total number of patients in the study was 635. 473 were males, and 162 were females. 444 were Easterns, 191 were Westerns. Mean age for males was 54, and 61.7 for females. Mean age for Easterns was 56.7, and 54 for Westerns. For subjects with normal coronary the mean LDL, HDL values for Easterners: 2.95, 1.25, Westerners: 3.10, 1.39 (p=0.4, 0.067). For subjects with abnormal coronary the mean LDL, HDL values for Easterners: 2.82, 1.10, Westerners: