ATLAS Indigenous Primary Care Surveillance & Research Network

ATLAS is a national surveillance and research network that is currently focused on collecting deidentified primary care data relating to sexually transmissible infection (STI) and blood-borne virus (BBV) testing and control. ATLAS is now extending its scope to include surveillance of vaccine-preventable diseases (VPDs).

The ATLAS network is led by Professor James Ward, Director of the University of Queensland's Poche Centre for Indigenous Health. It is funded by grants from the Australian Government Department of Health, Medical Research Future Fund and National Health and Medical Research Council.

ATLAS was developed in partnership with the Aboriginal Community-Controlled Health Organisation (ACCHO) sector in five 'clinical hubs': in the Kimberley (Western Australia), Cape York (Far North Queensland), Southeast Queensland, New South Wales and South Australia. We are now working to expand the network to include ACCHOs in Victoria and the Northern Territory. More than 40 ACCHOs and Indigenous communities are currently involved in the collaboration and expanding the network is a key objective for this funding cycle.

Why is the ATLAS network needed?

Despite years of public health work, the burden of STIs and BBVs among Indigenous populations remains much higher than for non-Indigenous populations. To reduce this disparity, a better understanding of the extent to which STIs and BBVs are occurring within Indigenous communities is needed, including information on local epidemics, patterns of infection, health care access, testing and positivity rates, timeliness of treatment and follow-up. ATLAS is now working to expand its surveillance capabilities to include VPDs and other infectious diseases that disproportionately affect Indigenous communities.

What is the benefit of being involved?

Participation in the ATLAS network will:

1. Enable ACCHOs to have a more thorough understanding of clinical activity and contribute to Continuous Quality Improvement activities within the service and region, with support from the ATLAS team.
2. Provide regular data on a set of best-practice surveillance indicators and access to a near-real time secure online data dashboard (see below).
3. Provide behavioural data collected by survey to complement clinical data.
4. Provide evidence to support interventions aimed at reducing the burden of STIs, BBVs and VPDs and informing policy and guidelines.
5. Provide opportunities for staff to strengthen capacity in STI, BBV and VPD control and management.

What does the project involve?

Health services providing primary care to a predominantly Aboriginal and Torres Strait Islander client population are invited to participate in each of the two main components of the surveillance program, (i) provision of deidentified clinical data and (ii) a periodic behavioural survey.

Participation in the ATLAS network will involve providing access to de-identified client records relating to STI, BBV and other infectious disease testing, treatment and care. This will typically use GRHANITE™, a data extraction tool that is installed alongside the health service's patient information management software (PIMS). GRHANITE is used widely across multiple health settings including general practice, sexual health services and hospitals. GRHANITE can operate with CommuniCare, Medical Director, Best Practice and MMEx PIMS and requires minimal resources. **Identifiable data or data unrelated to the ATLAS program is not extracted from the health service.** Data collected from health service PIMS remain the property of the service.

Initial data is collected retrospectively from 1 January 2016 to the date of participation initiation for all clients who attended the health service, then at regular (usually weekly) intervals thereafter.

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Anonymous behavioural surveys are also collected from a sample of clients aged 15–29 years old who attend the health service, led by the health services with support from the ATLAS team. Survey data will be collected over a short period annually, in each of the network's health services. The anonymous behavioural data collected helps contextualise the clinical surveillance data collected.

ATLAS is strongly committed to maintaining genuine and ongoing engagement with participating health services and key stakeholders, in our project governance processes and research activities, and relevant Human Research Ethics Committees have oversight of our work in all of the regions of the network.

Data outputs

Currently, the deidentified clinical data collected by the ATLAS network is used to produce surveillance reports detailing 12 key STI and BBV performance measures for each health service, every six months:

1. **STI Testing Rate**: Proportion of clients tested for STIs (chlamydia, gonorrhoea, trichomonas, syphilis and HIV) during the reporting period
2. **STI Testing Coverage**: Proportion of clients tested for STIs at least once in a 12-month period
3. **STI Test Positivity**: Proportion of clients with at least one positive STI test in a 12-month period
4. **Completeness of STI Testing**: Proportion of positive chlamydia and/or gonorrhoea and/or trichomonas tests followed by testing for syphilis and HIV within 30 days of the date of initial specimen collection
5. **STI Treatment Interval**: Time (days) from date of positive STI (chlamydia, gonorrhoea, trichomonas) investigation request to date of treatment
6. **STI Retesting Rate**: Testing approximately three months (60 to 120 days) following treatment for an initial positive STI (chlamydia/gonorrhoea/trichomonas) result
7. **STI Repeat Positivity Rate**: Positive retesting for chlamydia/gonorrhoea at approximately three months (60 to 120 days) following treatment for an initial positive chlamydia/gonorrhoea result
8. **Hepatitis B Virus Testing and Positivity Rate**: Proportion of clients receiving a hepatitis B virus test and among those testing negative, the proportion subsequently vaccinated.
9. **Hepatitis C Virus Testing and Positivity Rate:** Proportion of clients tested for the hepatitis C virus and among those testing positive, the proportion subsequently tested for RNA or viral load.
10. **Hepatitis C Virus Treatment Uptake**: Proportion of clients prescribed Direct Acting Antiviral (DAA) treatment
11. **Hepatitis C Virus Sustained Virological Response** (SVR): Proportion of clients who, after having been prescribed Direct Acting Antiviral (DAA) treatment, achieve an undetectable viral load
12. **Human Papillomavirus (HPV) Screening Rate**: Proportion of female clients screened for human papillomavirus (HPV) in line with national guidelines

These data and performance measures also form the basis for **a secure online data dashboard**, through which health services can access their own data to produce customised analyses and outputs, to focus on local priorities and concerns. Access to the ATLAS dashboard is limited to authorised accounts and support for use of the dashboard in knowledge dissemination and CQI is provided by the ATLAS team. The dashboard data tables are updated weekly, giving near real-time access to the surveillance network and analyses.

Register your interest in participating in the ATLAS project by contacting:

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