Indigenous primary health care: PI08b-Proportion of regular clients with a chronic disease for whom a Team Care Arrangement (MBS Item 723) was claimed, 2015-2017

Exported from METEOR (AIHW's Metadata Online Registry)

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Identifying and definitional attributes

Metadata item type:	Indicator
Indicator type:	Indicator
Short name:	PI08b-Proportion of regular clients with a chronic disease for whom a Team Care Arrangement (MBS Item 723) was claimed, 2015-2017
METEOR identifier:	663942
Registration status:	Health!, Superseded 25/01/2018 Indigenous, Superseded 27/02/2018
Description:	Proportion of regular clients who are Indigenous, have a chronic disease and for whom a Team Care Arrangement (MBS Item 723) was claimed within the previous 24 months.
Rationale:	Effective management of chronic disease can delay the progression of disease, decrease the need for high-cost interventions, improve quality of life, and increase life expectancy. As good quality care for people with chronic disease can involve multiple health care providers across multiple settings, the development of multidisciplinary care plans is one way in which the client and primary health care provider can ensure appropriate care is arranged and coordinated.
Indicator set:	Indigenous primary health care key performance indicators (2015-2017) Health!, Superseded 25/01/2018 Indigenous, Superseded 27/02/2018

Collection and usage attributes

Computation description: Proportion of regular clients who are Indigenous, have a chronic disease and for whom a Team Care Arrangement (MBS Item 723) was claimed within the previous 24 months.

'Regular client' refers to a client of an Australian Government Department of Health-funded primary health care service (that is required to report against the Indigenous primary health care key performance indicators) who has an active medical record; that is, a client who has attended the Department of Health-funded primary health care service at least 3 times in 2 years.

Team Care Arrangement (MBS Item 723): The Chronic Disease Management (CDM) Medicare items on the Medicare Benefits Schedule (MBS) enable GPs to plan and coordinate the health care of patients with chronic or terminal medical conditions, including patients with these conditions who require multidisciplinary, team-based care from a GP and at least two other health or care providers (DoH 2014). Team Care Arrangements, for the purpose of this indicator, are defined in the MBS (Item 723).

Presented as a percentage.

Calculated separately for each chronic disease type:

A) Type II diabetes

Exclude Type I diabetes, secondary diabetes, gestational diabetes mellitus (GDM), previous GDM, impaired fasting glucose, impaired glucose tolerance.

B) Cardiovascular disease

C) Chronic obstructive pulmonary disease

D) Chronic kidney disease

At this stage, this indicator is only calculated for **Type II diabetes** as currently this is the only relevant chronic disease type with an agreed national definition.

Computation: (Numerator ÷ Denominator) x 100

Numerator: Calculation A: Number of regular clients who are Indigenous, have Type II diabetes and for whom a Team Care Arrangement (MBS Item 723) was claimed within the previous 24 months.

Numerator data elements:

Data Element / Data Set

Person—diabetes mellitus status, code NN

Data Source

Indigenous primary health care data collection

NMDS / DSS

Indigenous primary health care DSS 2015-17

Guide for use

Type II diabetes only.

Data Element / Data Set

Person—Indigenous status, code N

Data Source

Indigenous primary health care data collection

NMDS / DSS

Indigenous primary health care DSS 2015-17

Data Element / Data Set

Person—regular client indicator, yes/no code N

Data Source

Indigenous primary health care data collection

NMDS / DSS

Indigenous primary health care DSS 2015-17

Data Element / Data Set

Person—Team Care Arrangement (MBS Item 723) indicator, yes/no code N

Data Source

Indigenous primary health care data collection

NMDS / DSS

Indigenous primary health care DSS 2015-17

Denominator:

Calculation A: Total number of regular clients who are Indigenous and have Type II diabetes.

Denominator data elements:

Data Element / Data Set

Person—Indigenous status, code N

Data Source

Indigenous primary health care data collection

NMDS / DSS

Indigenous primary health care DSS 2015-17

Data Element / Data Set

Person—diabetes mellitus status, code NN

Data Source

Indigenous primary health care data collection

NMDS / DSS

Indigenous primary health care DSS 2015-17

Guide for use

Type II diabetes only.

Data Element / Data Set

Person—regular client indicator, yes/no code N

Data Source

Indigenous primary health care data collection

NMDS / DSS

Indigenous primary health care DSS 2015-17

Disaggregation:

1. Sex:
a) Male
b) Female

2. Age:
a) 0-4 years
b) 5-14 years
c) 15-24 years
d) 25-34 years
e) 35-44 years
f) 45-54 years
g) 55-64 years
h) 65 years and over

Disaggregation data elements:

Data Element / Data Set

Person—sex, code N

Data Source

Indigenous primary health care data collection

NMDS / DSS

Indigenous primary health care DSS 2015-17

Data Element / Data Set

Person—age, total years N[NN]

Data Source

Indigenous primary health care data collection

NMDS / DSS

Indigenous primary health care DSS 2015-17

Representational attributes

Representation class: Percentage

Data type: Real

Unit of measure: Person

Indicator conceptual framework

Framework and dimensions: Continuous

Data source attributes

Data sources:

Data Source

Indigenous primary health care data collection

Frequency

6 monthly

Data custodian

Australian Institute of Health and Welfare.

Accountability attributes

Further data development / collection required: Further work is required to reach agreement on national definitions for other chronic diseases including cardiovascular disease, chronic obstructive pulmonary disease and chronic kidney disease.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Australian Government Department of Health

Origin: DoH (Australian Government Department of Health) 2014. Chronic Disease Management (formerly Enhanced Primary Care or EPC) — GP services. Canberra: DoH. Viewed 28 October 2014,

http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement.

Relational attributes

Related metadata references:

Supersedes Indigenous primary health care: PI08b-Proportion of regular clients with a chronic disease for whom a Team Care Arrangement (MBS Item 723) was claimed, 2015
- Health!, Superseded 05/10/2016
- Indigenous, Superseded 20/01/2017

Has been superseded by Indigenous primary health care: PI08b-Proportion of regular clients with a chronic disease for whom a Team Care Arrangement (MBS Item 723) was claimed, 2015-2017
- Health!, Superseded 17/10/2018
- Indigenous, Superseded 17/10/2018

See also Indigenous primary health care: PI08a-Number of regular clients with a chronic disease for whom a Team Care Arrangement (MBS Item 723) was claimed, 2015-2017
- Health!, Superseded 25/01/2018
- Indigenous, Superseded 27/02/2018