

Indigenous primary health care: PI07a-Number of regular clients with a chronic disease for whom a GP Management Plan (MBS Item 721) was claimed, 2015-2017

Exported from METEOR (AIHW's Metadata Online Registry)

© Australian Institute of Health and Welfare 2024

This product, excluding the AIHW logo, Commonwealth Coat of Arms and any material owned by a third party or protected by a trademark, has been released under a Creative Commons BY 4.0 (CC BY 4.0) licence. Excluded material owned by third parties may include, for example, design and layout, images obtained under licence from third parties and signatures. We have made all reasonable efforts to identify and label material owned by third parties.

You may distribute, remix and build on this website's material but must attribute the AIHW as the copyright holder, in line with our attribution policy. The full terms and conditions of this licence are available at <https://creativecommons.org/licenses/by/4.0/>.

Enquiries relating to copyright should be addressed to info@aihw.gov.au.

Enquiries or comments on the METEOR metadata or download should be directed to the METEOR team at meteor@aihw.gov.au.

Indigenous primary health care: PI07a-Number of regular clients with a chronic disease for whom a GP Management Plan (MBS Item 721) was claimed, 2015-2017

Identifying and definitional attributes

| | |
|-----------------------------|---|
| Metadata item type: | Indicator |
| Indicator type: | Output measure |
| Short name: | PI07a-Number of regular clients with a chronic disease for whom a GP Management Plan (MBS Item 721) was claimed, 2015-2017 |
| METEOR identifier: | 686434 |
| Registration status: | Health! , Superseded 17/10/2018 Indigenous , Superseded 17/10/2018 |
| Description: | Number of regular clients who are Indigenous, have a chronic disease and for whom a GP Management Plan (MBS Item 721) 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. The development of a GP Management Plan is one way in which the client and primary health care provider can ensure appropriate care is coordinated. |
| Indicator set: | Indigenous primary health care key performance indicators (2015-2017) Health! , Superseded 17/10/2018 Indigenous , Superseded 17/10/2018 |

Collection and usage attributes

Computation description: Count of regular clients who are Indigenous, have a chronic disease and for whom a GP Management Plan (MBS Item 721) 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.

GP Management Plan (MBS Item 721): 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 (DoH 2014). GP Management Plans, for the purpose of this indicator, are defined in the MBS (Item 721).

Presented as a number.

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 only

Numerator: Calculation A: Number of regular clients who are Indigenous, have Type II diabetes and for whom a GP Management Plan (MBS Item 721) 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 NBEDS 2017–18](#)

Guide for use

Type II diabetes only.

Data Element / Data Set

[Person—GP Management Plan \(MBS Item 721\) indicator, yes/no code N](#)

Data Source

[Indigenous primary health care data collection](#)

NMDS / DSS

[Indigenous primary health care NBEDS 2017–18](#)

Data Element / Data Set

[Person—Indigenous status, code N](#)

Data Source

[Indigenous primary health care data collection](#)

NMDS / DSS

[Indigenous primary health care NBEDS 2017–18](#)

Guide for use

The implementation start date for this data element in the Indigenous primary health care NBEDS 2017-18 is 1 December 2017.

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 NBEDS 2017–18](#)

Guide for use

The implementation start date for this data element in the Indigenous primary health care NBEDS 2017-18 is 1 December 2017.

- 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—age, total years N\[NN\]](#)

Data Source

[Indigenous primary health care data collection](#)

NMDS / DSS

[Indigenous primary health care NBEDS 2017–18](#)

Data Element / Data Set

[Person—sex, code X](#)

Data Source

[Indigenous primary health care data collection](#)

NMDS / DSS

[Indigenous primary health care NBEDS 2017–18](#)

Guide for use

The implementation start date for this data element in the Indigenous primary health care NBEDS 2017-18 is 1 December 2017.

Representational attributes

- Representation class:** Count
- Data type:** Real
- Unit of measure:** Person
- Format:** N[N(6)]

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: PI07a-Number of regular clients with a chronic disease for whom a GP Management Plan \(MBS Item 721\) was claimed, 2015-2017](#)

[Health!](#), Superseded 25/01/2018

[Indigenous](#), Superseded 27/02/2018

Has been superseded by [Indigenous primary health care: PI07a-Number of regular clients with a chronic disease for whom a GP Management Plan \(MBS Item 721\) was claimed, 2018-2019](#)

[Health!](#), Superseded 16/01/2020

[Indigenous](#), Superseded 14/07/2021

See also [Indigenous primary health care: PI07b-Proportion of regular clients with a chronic disease for whom a GP Management Plan \(MBS Item 721\) was claimed, 2015-2017](#)

[Health!](#), Superseded 17/10/2018

[Indigenous](#), Superseded 17/10/2018