Indigenous primary health care: PI08a-Number of regular clients with a chronic disease who have received a Team Care Arrangement (MBS Item 723), 2012

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Identifying and definitional attributes

Metadata item type:	Indicator
Indicator type:	Output measure
Short name:	PI08a-Number of regular clients with a chronic disease who have received a Team Care Arrangement (MBS Item 723), 2012
METEOR identifier:	432545
Registration status:	Health, Superseded 23/02/2012
Description:	NOTE: THIS PERFORMANCE INDICATOR HAS BEEN SUPERSEDED BY ITS EQUIVALENT FOR 2013, WITHOUT BEING MADE A STANDARD. Number of regular clients who are Indigenous, have a chronic disease and who have received a Team Care Arrangement (MBS Item 723) 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Indicator set:	Indigenous primary health care key performance indicators (2012) Health, Superseded 23/02/2012

Collection and usage attributes

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

'Regular client' refers to a client of an OATSIH-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 OATSIH-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 (Department of Health and Ageing 2011). Team Care Arrangements, for the purpose of this indicator, are defined in the MBS (Item 723).

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 who have received a Team Care Arrangement (MBS Item 723) 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 2012-14

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 2012-14

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 2012-14

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 2012-14

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 2012-14

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 2012-14

Representational attributes

Representation class: Count

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 (AIHW)

Origin: Department of Health and Ageing (DoHA)
Department of Health and Ageing 2011. Department of Health and Ageing, Canberra. Viewed 27 May 2011,

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

Relational attributes

Related metadata references:

Has been superseded by Indigenous primary health care: PI08a-Number of regular clients with a chronic disease who have received a Team Care Arrangement (MBS Item 723), 2013

Health, Superseded 21/11/2013

Indigenous, Superseded 21/11/2013

See also Indigenous primary health care: PI08b-Proportion of regular clients with a chronic disease who have received a Team Care Arrangement (MBS Item 723), 2012

Health, Superseded 23/02/2012