

# 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

## Identifying and definitional attributes

<b>Metadata item type:</b>	Indicator
<b>Indicator type:</b>	Indicator
<b>Short name:</b>	PI07b-Proportion of regular clients with a chronic disease for whom a GP Management Plan (MBS Item 721) was claimed, 2015-2017
<b>METEOR identifier:</b>	663937
<b>Registration status:</b>	<ul style="list-style-type: none"><li>• <a href="#">Health</a>, Superseded 25/01/2018</li><li>• <a href="#">Indigenous</a>, Superseded 27/02/2018</li></ul>
<b>Description:</b>	Proportion 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.
<b>Rationale:</b>	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.
<b>Indicator set:</b>	<a href="#">Indigenous primary health care key performance indicators (2015-2017)</a> <a href="#">Health</a> , Superseded 25/01/2018 <a href="#">Indigenous</a> , Superseded 27/02/2018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 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 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:**  $(\text{Numerator} \div \text{Denominator}) \times 100$

**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 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—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 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—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](#)

**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:

See also [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

Supersedes [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](#)

- [Health](#), Superseded 05/10/2016
- [Indigenous](#), Superseded 20/01/2017

Has been superseded by [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