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

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: PI08a-Number of regular clients with a chronic disease for whom a Team Care Arrangement (MBS Item 723) was claimed, 2015-2017

Identifying and definitional attributes

Metadata item type:	Indicator
Indicator type:	Output measure
Short name:	Pl08a-Number of regular clients with a chronic disease for whom a Team Care Arrangement (MBS Item 723) was claimed, 2015-2017
METEOR identifier:	663939
Registration status:	<u>Health</u> , Superseded 25/01/2018 <u>Indigenous</u> , Superseded 27/02/2018
Description:	Number 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Indicator set:	Indigenous primary health care key performance indicators (2015-2017) Health, Superseded 25/01/2018 Indigenous, Superseded 27/02/2018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:	Count 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 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
Computation:	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. Numerator only
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.

-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

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

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:	Count
Data type:	Real
Unit of measure:	Person

Indicator conceptual framework

Framework and	<u>Continuous</u>
dimensions:	

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

Source and reference attributes

Australian Government Department of Health

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: PI08a-Number 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 <u>Indigenous primary health care: PI08a-Number of regular</u> 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: PI08b-Proportion 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