First Nations-specific primary health care: PI19a-Number of First Nations regular clients with a selected chronic disease who have a kidney function result within a specified category, December 2023

Exported from METEOR (AIHW's Metadata Online Registry)

First Nations-specific primary health care: PI19a-Number of First Nations regular clients with a selected chronic disease who have a kidney function result within a specified category, December 2023

Identifying and definitional attributes

Metadata item type: Indicator

Indicator type: Output measure

Short name: PI19a-Number of First Nations regular clients with a selected chronic disease who have a kidney function result within a specified category, December 2023

METEOR identifier: 788056

Registration status: Indigenous, Standard 25/02/2024

Description: Number of **First Nations regular clients**, aged 18 and over with:

- type 2 diabetes
- cardiovascular disease (CVD)
- type 2 diabetes AND/OR CVD

whose estimated glomerular filtration rate (eGFR) and albumin/creatinine ratio (ACR) recorded within the previous 12 months was categorised as:

- normal risk
- low risk
- moderate risk
- high risk.

Rationale: First Nations people have very high levels of kidney disease due to a range of risk factors and antecedents. Kidney disease contributes substantially to the high burden of ill health experienced by First Nations people. Tests of a person's urine and blood can identify most cases of chronic kidney disease when the disease is in its early stages, enabling treatment to prevent or slow down the progression. eGFR and ACR are accepted as the best measures of kidney disease.

Indicator set: Aboriginal and Torres Strait Islander specific primary health care national key performance indicators December 2023
Indigenous, Standard 25/02/2024

Collection and usage attributes

Population group age from: 18 years and over.

Computation description: Number of First Nations regular clients aged 18 and over with:

- type 2 diabetes
- CVD
- type 2 diabetes AND/OR CVD

who had both an eGFR (mL/min/1.73m²) and an ACR (mg/mmol) result recorded within the previous 12 months categorised as:

- Normal risk:
  - Males: eGFR ≥60 and ACR <2.5
  - OR
  - Females: eGFR ≥60 and ACR <3.5.
- Low risk:

    - Males:
        - eGFR ≥60 and ACR 2.5–25 OR
        - eGFR 45–<60 and ACR <2.5
    - OR
    - Females:
        - eGFR ≥60 and ACR 3.5–35 OR
        - eGFR 45–<60 and ACR <3.5.

- Moderate risk:
    - Males:
        - eGFR 45–<60 and ACR 2.5–25 OR
        - eGFR 30–<45 and ACR ≤25
    - OR
    - Females:
        - eGFR 45–<60 and ACR 3.5–35 OR
        - eGFR 30–<45 and ACR ≤35.

- High risk:
    - Males:
        - eGFR ≥30 and ACR >25 OR
        - eGFR <30 and any ACR result
    - OR
    - Females:
        - eGFR ≥30 and ACR >35 OR
        - eGFR <30 and any ACR result.

Presented as a number.

Count is of people, not tests.

Consider only the most recent eGFR and ACR tests.

Calculated separately for the specified chronic disease and risk categories.

Clients must have both a valid eGFR and a valid ACR test recorded to be included in this indicator. It is acknowledged that this will undercount those with high risk who could be classified based on the result of either an eGFR or an ACR test.

Valid test result recorded: A valid test result is a numeric value that can be used to classify test results into the specified risk categories. Negative, non-numerical and null values are not considered to be valid results. It is acknowledged that inclusion of only valid test results may undercount the number of tests that were conducted, for example, because of known issues with pathology recording and uploading.

Kidney function tests result: Categorisation refers to the risk of progressing to end stage kidney disease and the need for kidney replacement therapy (for example, dialysis or transplantation).

Type 2 diabetes AND/OR CVD includes clients with:

- type 2 diabetes only
- CVD only
- type 2 diabetes and CVD.

Count clients with either or both of these conditions once only. For example, count a client with both type 2 diabetes and CVD once, not twice.

Computation: Numerator only.

Numerator:

Calculation A: Number of First Nations regular clients aged 18 and over with type 2 diabetes who had both an eGFR and an ACR result recorded within the previous 12 months which indicated normal risk.

Calculation B: Number of First Nations regular clients aged 18 and over with type 2 diabetes who had both an eGFR and an ACR result recorded within the previous 12 months which indicated low risk.

Calculation C: Number of First Nations regular clients aged 18 and over with type 2 diabetes who had both an eGFR and an ACR result recorded within the previous 12 months which indicated moderate risk.

Calculation D: Number of First Nations regular clients aged 18 and over with type 2 diabetes who had both an eGFR and an ACR result recorded within the previous 12 months which indicated high risk.

Calculation E: Number of First Nations regular clients aged 18 and over with CVD who had both an eGFR and an ACR result recorded within the previous 12 months which indicated normal risk.

Calculation F: Number of First Nations regular clients aged 18 and over with CVD who had both an eGFR and an ACR result recorded within the previous 12 months which indicated low risk.

Calculation G: Number of First Nations regular clients aged 18 and over with CVD who had both an eGFR and an ACR result recorded within the previous 12 months which indicated moderate risk.

Calculation H: Number of First Nations regular clients aged 18 and over with CVD who had both an eGFR and an ACR result recorded within the previous 12 months which indicated high risk.

Calculation I: Number of First Nations regular clients aged 18 and over with type 2 diabetes AND/OR CVD who had both an eGFR and an ACR result recorded within the previous 12 months which indicated normal risk.

Calculation J: Number of First Nations regular clients aged 18 and over with type 2 diabetes AND/OR CVD who had both an eGFR and an ACR result recorded within the previous 12 months which indicated low risk.

Calculation K: Number of First Nations regular clients aged 18 and over with type 2 diabetes AND/OR CVD who had both an eGFR and an ACR result recorded within the previous 12 months which indicated moderate risk.

Calculation L: Number of First Nations regular clients aged 18 and over with type 2 diabetes AND/OR CVD who had both an eGFR and an ACR result recorded within the previous 12 months which indicated high risk.

Numerator data elements:

Data Element / Data Set

Person—diabetes mellitus status, code NN

Data Source

Aboriginal and Torres Strait Islander specific primary health care national Key Performance Indicators (nKPI) data collection

NMDS / DSS

Aboriginal and Torres Strait Islander specific primary health care NBEDS December 2023

Guide for use

Type 2 diabetes only.

Data Element / Data Set

Person—age, total years N[NN]

Data Source

Aboriginal and Torres Strait Islander specific primary health care national Key Performance Indicators (nKPI) data collection

NMDS / DSS

Aboriginal and Torres Strait Islander specific primary health care NBEDS December 2023

Guide for use

Aged 18 and over only.

Data Element / Data Set

Person—cardiovascular disease recorded indicator, yes/no code N

Data Source

Aboriginal and Torres Strait Islander specific primary health care national Key Performance Indicators (nKPI) data collection

NMDS / DSS

Aboriginal and Torres Strait Islander specific primary health care NBEDS December 2023

Data Element / Data Set

Person—Indigenous status, code N

Data Source

Aboriginal and Torres Strait Islander specific primary health care national Key Performance Indicators (nKPI) data collection

NMDS / DSS

Aboriginal and Torres Strait Islander specific primary health care NBEDS December 2023

Guide for use

First Nations only.

Data Element / Data Set

Person—sex, code X

Data Source

Aboriginal and Torres Strait Islander specific primary health care national Key Performance Indicators (nKPI) data collection

NMDS / DSS

Aboriginal and Torres Strait Islander specific primary health care NBEDS December 2023

Guide for use

Male and female only.

Data Element / Data Set

Person—chronic kidney disease risk, categories code N

Data Source

Aboriginal and Torres Strait Islander specific primary health care national Key

Performance Indicators (nKPI) data collection

NMDS / DSS

Aboriginal and Torres Strait Islander specific primary health care NBEDS December 2023

Data Element / Data Set

Person—regular client indicator, yes/no code N

Data Source

Aboriginal and Torres Strait Islander specific primary health care national Key Performance Indicators (nKPI) data collection

NMDS / DSS

Aboriginal and Torres Strait Islander specific primary health care NBEDS December 2023

Guide for use

Regular clients only.

Disaggregation:

1. Sex:
a) Male
b) Female.

2. Age group:
a) 18–24 years
b) 25–34 years
c) 35–44 years
d) 45–54 years
e) 55–64 years
f) 65 years and over.

Disaggregation data elements:

Data Element / Data Set

Person—age, total years N[NN]

Data Source

Aboriginal and Torres Strait Islander specific primary health care national Key Performance Indicators (nKPI) data collection

NMDS / DSS

Aboriginal and Torres Strait Islander specific primary health care NBEDS December 2023

Guide for use

Aged 18 and over only.

Data Element / Data Set

Person—sex, code X

Data Source

Aboriginal and Torres Strait Islander specific primary health care national Key Performance Indicators (nKPI) data collection

NMDS / DSS

Aboriginal and Torres Strait Islander specific primary health care NBEDS December 2023

Guide for use

Male and female only.

Comments: Census date for reporting is 31 December 2023.

Representational attributes

Representation class: Count

Data type: Real

Unit of measure: Person

Format: N[N(6)]

Indicator conceptual framework

Framework and dimensions: Effective/Appropriate/Efficient

Data source attributes

Data sources:

Data Source

Aboriginal and Torres Strait Islander specific primary health care national Key Performance Indicators (nKPI) data collection

Frequency

6 monthly

Data custodian

Australian Institute of Health and Welfare.

Accountability attributes

Reporting requirements: Funding agreements between the Department of Health and Aged Care and the organisations funded under the Indigenous Australians' Health Programme (IAHP).

Organisation responsible for providing data: First Nations-specific primary health care organisations or maternal and child health programs/services funded by the Department of Health and Aged Care under its IAHP, referred to as **funded organisations**.

Accountability: Australian Institute of Health and Welfare/Department of Health and Aged Care

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Kidney Health Australia (2020) *Chronic Kidney Disease (CKD) management in primary care*, 4th edn, Kidney Health Australia, Melbourne, accessed 20 December 2021.

Relational attributes

Related metadata references:

Supersedes Indigenous-specific primary health care: PI19a-Number of Indigenous regular clients with a selected chronic disease who have a kidney function result within a specified category, June 2023
Indigenous, Superseded 25/02/2024

Has been superseded by First Nations-specific primary health care: PI19a-Number of First Nations regular clients with a selected chronic disease who have a kidney function result within a specified category, June 2024
Indigenous, Qualified 17/04/2024

See also First Nations-specific primary health care: PI19b-Proportion of First Nations regular clients with a selected chronic disease who have a kidney function result within a specified category, December 2023
Indigenous, Standard 25/02/2024