Proportion of clients with Type II Diabetes and/or coronary heart disease with a chronic disease management plan

Key performance indicators 2017/18 – attribute sheets

Identification and definitional attributes	
Short name:	Chronic Disease Management Plan
Indicator type:	SDA; Annual Report, BP3
Description:	The proportion of remote resident Aboriginal clients aged 15 years and over who have been diagnosed with type II diabetes and/or coronary heart disease and who have a chronic disease management plan or alternative chronic disease management plan in a two year period.
Definition:	Sum of the number of remote resident Aboriginal clients aged 15 years and over with type II diabetes and/or coronary heart disease who have a chronic disease management plan or alternative chronic disease management plan during the two year coverage period, divided by the total number of remote resident Aboriginal clients aged 15 years and over with type II diabetes and/or coronary heart disease. Presented as a percentage (%).
Rationale:	Preventable chronic diseases are responsible for a significant burden of disease for Aboriginal people and if poorly controlled increase hospitalisations and impact quality of life. Care plans are the foundation for providing appropriate long term care and increases are indicative of improved primary health care service delivery.
Calculation attributes	
Calculation:	(Numerator ÷ Denominator) x 100
Inclusions and exclusions:	Calculation includes all clients who are identified as residents of a Health Service and who are recorded as Indigenous and have diabetes type II and/or chronic heart disease who have received chronic disease management plan or alternative chronic disease management plan within the period. Inclusions for numerator and denominator: • Client having a chronic disease management plan o [MBS Billing Item] is equal to '721' o [Health Event Date] is in two year coverage period o If a client has more than one MBS Item during a period, count only once. • Client having an alternative chronic disease management plan o [MBS Billing Item] is equal to '723' OR '732' OR o [Health Event] equal to 'TEAM CARE ARRANGEMENT' o Not having a valid [MBS Billing Item] is equal to '721' within two year coverage period o [Health Event Date] is within two year coverage period o If a client has more than one event for an item during a period, count only once. • Client with type II diabetes and/or coronary heart disease o [ICPC Code] is a valid Diabetes Type II code OR Chronic Heart Disease Code o [Rank of Problem Status] equal to 1 (latest) o [Problem Status] is confirmed

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A resident client is a person who is identified as ‘belonging’ in the community serviced by the government managed Health Centre, who usually resides in the community and has been present in the community for at least six months of the reporting period.

[Resident Status] equal to ‘resident’ or null
[Usual Health Centre] is a PCIS remote community health centre

Age groups are calculated at end of the reporting period. Client’s residential status and Indigenous Status are according to the end of the reporting period.

[Age at Report End Date] is greater than or equal to 15 years
[Indigenous Status] equal to Indigenous

Exclusions:

Non-government managed Health Centres

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<tr><td>Numerator:</td><td>Sum of the number of remote resident Indigenous clients with type II diabetes and/or coronary heart disease who have a chronic disease management plan or alternative chronic disease management plan</td></tr>
<tr><td>Numerator variable/universe object</td><td>Numerator data elements:
Primary Health Care
<table>
<tr><th>Data element</th><th>Universe Object</th></tr>
<tr><td>GPMP</td><td>MBS Billing Item</td></tr>
<tr><td>Problem</td><td>ICPC Code</td></tr>
<tr><td>Problem Rank</td><td>Rank by Problem Status Date</td></tr>
<tr><td>Problem Status</td><td>Problem Status</td></tr>
<tr><td>Residency Status</td><td>Residency Status</td></tr>
<tr><td>Indigenous Status</td><td>Indigenous Status Desc</td></tr>
<tr><td>Locality</td><td>Usual Clinic Name</td></tr>
</table></td></tr>
<tr><td>Denominator:</td><td>Sum of the number of remote resident Indigenous clients with type II diabetes and/or coronary heart disease</td></tr>
<tr><td>Denominator variable/universe object</td><td>Denominator data elements:
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</table></td></tr>
<tr><td>Target:</td><td>TEHS; 90% CAHS; 90%</td></tr>
<tr><td>Target tolerances:</td><td>Green (Performing): ≥90%
Amber (Performance concern): >87 – <90%
Red (Not performing): ≤87%</td></tr>
<tr><td>Scope:</td><td>Health Services</td></tr>
<tr><td colspan="2">Reporting and data attributes</td></tr>
<tr><td>Standard report name:</td><td>BI Report: SDA Dashboard - Shared SDA Reporting</td></tr>
</table>

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Standard report location:	Public Folders / Shared Folders / Shared Performance and Reporting / SDA Automation / Completed Reports
Business intelligence universe:	SDA Reporting.unx
Reporting level:	This indicator can be represented as a whole of health total, or disaggregated by: Health Service Disaggregation data elements: **Variable** — **Universe Object** Health Service — Usual Clinic Name
Data source:	Remote Health Data Collection via the "Primary Health Care" universe and Communicare operating reports.
Period available:	The historical period available is from 01/07/2011.
Reporting frequency:	Monthly [✓] Quarterly [ ] Annually [ ]
Timeliness:	Data is available for reporting four days after the end of month.
Unit of measure:	Percentage (%)
Known data issues and limitations:	The data for the last completed month may have minor variations as data updates are completed.
Relational and compliance attributes	
Related national benchmark, target, relevant METeOR references or reporting:	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 METeOR identification: 589006 http://meteor.aihw.gov.au/content/index.phtml/itemId/589006
Accountability attributes	
Data custodian:	Manager, Primary Health Care Reporting
Data steward:	Chief Data Officer
Data owner:	Senior Director, System Performance and Grants