

Improved Management of long term conditions (Diabetes)

Outcome

People living with diabetes are regarded as leading partners in their own care within systems that ensure they can manage their own condition effectively with appropriate support.

Measure

Primary Health Organisation (PHO) enrolled people aged 15 to 74 years with diabetes by most recent HbA1c level within the past 12 months

Type

Contributory measure

Relationship(s) to other frameworks

This is a DHB non-financial performance indicator (focus area 2) and aligns with actions in the 2015 – 2020 Diabetes plan 'Living well with Diabetes'.

Rationale

Good control of diabetes reduces long term complications

Eligible population

All people aged 15 to 74 years enrolled with the PHO

Measure status

Active

Numerator

Count of all enrolled people in the PHO aged 15 to 74 years with diabetes whose most recent HbA1c during the past 12 months is:

- Equal to or less than 64 mmol/mol
- Greater than 64 and less than or equal to 80 mmol/mol
- Greater than 80 and less than or equal to 100mmol/mol
- Greater than 100mmol/mol

Denominator

Count of enrolled people in the PHO aged 15 to 74 years with diabetes on the latest Ministry of Health Virtual Diabetes Register (currently 2015)

National target

Local target

Milestones to be decided by Alliance

Data Sources

- Laboratory test results
- VDR 2015

Data extracted from data sources

Data availability

- Laboratory test results are available through PHOs (via general practices)
- VDR 2015 is available through the Ministry of Health

Measure calculation process

Relationship(s) to other measures

Measure development notes

Patients coded with diabetes in the general practice registers can be used instead of the VDR once comparisons between the two have been completed and accuracy of general practice registers can be demonstrated. Actions to support delivery of Diabetes services and the Diabetes plan "Living Well with Diabetes" include:

- Prevention and early intervention, including mental health needs, to reduce the personal and social burden of disease
- Reducing disparities in health outcomes between different ethnic, socioeconomic, geographical and other disadvantaged groups
- Providing people centred services including for family and whanau when appropriate
- Being sustainable in the long term with consistent services across the country
- Achieving effective self-management including responding to people's demand for technology-enabled tools
- Information on evidence and test and evaluation promising interventions to improve our knowledge of what works for New Zealanders.