Appendix A: Complete indicator matrix

Notes for interpreting the indicator matrix:

At the foot of each indicator is an indicator assessment descriptor, such as [A/B; F3–5; P1]. For each indicator, the key to this assessment descriptor is:

A. Available or feasible at low cost with little development work.

B. Feasible, but needs development and some cost.

C. Not feasible at present.

Note: A/B implies 'Overlap' between A and B

F The frequency with which the indicator should be collected; for example, F1–2 = every 1–2 years

P The priority of the indicator wherever there are multiple questions in a column or more than one Indicator proposed for a column question; for example, P1 = first priority; P2 = second priority; and so on. Note: Pn/a= priority not applicable

Note: The cells of the indicator matrix containing the eleven priority indicators are shaded.

	Settings		
Continuum of care (NDSG questions)	**Health-care organisation (Funder-policy maker; service organisation)**	**Health-care practice (Levels of care—population health, primary, secondary and tertiary care; provider/service organisation)**	**Consumers**
1. Are we preventing or delaying the development of Type 2 diabetes? (process) These indicators relate to Type 2 diabetes.	**Q1** What programs/initiatives exist to prevent Type 2 diabetes or modify the prevalence of Type 2 diabetes risk factors? **1A.1.1 The type of programs and the proportion of the population reached by preventive programs.** **[B; F3–5; P1]** **1A.1.2 The number of characteristics and quality of programs/initiatives identified to prevent/delay the development of Type 2 diabetes or modify the prevalence of Type 2 diabetes risk factors.** *For each program/initiative identified:* • *Does it follow current evidence-based guidelines?* • *Is it ongoing?* • *What proportion of the at-risk population are offered preventive interventions? Or, if unavailable, what proportion of relevant services offer the preventive interventions?* **[A/B; F3–5; P2]**	**Q1** What is the trend in the prevalence of Type 2 diabetes risk factors? **1B.1.1 Prevalence of Type 2 modifiable diabetes risk factors over time:** • **overweight; overweight but not obese; obese. Based on: body mass index (BMI); and waist circumference** • **proportion of people not following Australian guidelines for physical activity** • **proportion of people not following Australian dietary recommendations.** **[A/B; F1–2; P1]**	**Q1** Are consumers aware of Type 2 diabetes risk factors and are they taking steps/actions to reduce their risk? **1C.1.1 The proportion of people at risk of Type 2 diabetes who correctly identify that they are at risk and who are taking steps/actions to reduce their risk.** **[B; F2–3; P1]**

(continued)

	Settings		
Continuum of care (NDSG questions)	**Health-care organisation (Funder-policy maker; service organisation)**	**Health-care practice (Levels of care—population health, primary, secondary and tertiary care; provider/service organisation)**	**Consumers**
1. Are we preventing or delaying the development of Type 2 diabetes? (process) These indicators relate to Type 2 diabetes.	**Q2** Is there a mechanism for monitoring the incidence of Type 2 diabetes and the prevalence of Type 2 diabetes risk factors? **1A.2.1 The number and characteristics of mechanisms for monitoring the incidence of Type 2 diabetes and the prevalence of Type 2 diabetes risk factors.** *For each mechanism/data source identified:* • *What is the type of mechanism/data source?* • *What is the scope and coverage of data collection?* • *What is the frequency of data collection?* • *Are data collected according to agreed national or international standards?* • *Is the data set routinely analysed and reported on?* **[A/B; F3–5; P3]**	**Q2** What is the trend in the incidence of Type 2 diabetes? **1B.2.1 Incidence rate of Type 2 diabetes over time.** **[B/C; F1–2; P2]**	**Q2** Are consumers aware of evidence-based healthy lifestyle choices? **1C.2.1 The proportion of people at risk of Type 2 diabetes who know what their evidence-based healthy lifestyle options are.** **[B; F2–3; P2]**

(continued)

	Settings		
Continuum of care (NDSG questions)	**Health-care organisation (Funder-policy maker; service organisation)**	**Health-care practice (Levels of care—population health, primary, secondary and tertiary care; provider/service organisation)**	**Consumers**
2. Is case detection occurring optimally? **(Screening for diabetes, that is, early detection)** These indicators relate to Type 2 and gestational diabetes.	**Q1** Are systems in place to screen at-risk individuals according to national standards for Type 2 diabetes? **2A.1.1 The proportion of health-care practitioners who have a system in place to opportunistically screen for Type 2 diabetes, and the characteristics of these systems.** **[B; F2-3; Pn/a]** *For each system identified:* • *Does it follow current evidence-based guidelines?* • *Is there a register / recall system?* • *Is it culturally appropriate?* • *Are primary care practices PIP-accredited?*	**Q1** What proportion of those with risk factors for Type 2 diabetes are being screened? **2B.1.1 The proportion of people at risk* of Type 2 diabetes who are being opportunistically screened, and the proportion of these undergoing appropriate opportunistic screening (as defined by current evidence-based guidelines).** ***refer NHMRC screening guidelines (NHMRC 2001)** **[B; F2-3; P1]**	**Q1** Are at-risk people aware of the need for screening for Type 2 diabetes and gestational diabetes? **2C.1.1 The proportion of at-risk people who are aware of the need for Type 2 diabetes and gestational diabetes screening.** **[B; F2-3; P n/a]**
2. Is case detection occurring optimally? **(Screening for diabetes, that is, early detection)** This indicator relates to Type 2 and gestational diabetes.		**Q2** What is the ratio of diagnosed to undiagnosed cases? **2B.2.1 The ratio of diagnosed to undiagnosed cases of Type 2 diabetes.** **[B/C; F3-5; P2]**	

(continued)

	Settings		
Continuum of care (NDSG questions)	**Health-care organisation (Funder-policy maker; service organisation)**	**Health-care practice (Levels of care—population health, primary, secondary and tertiary care; provider/service organisation)**	**Consumers**
3. Is access equitable? These indicators relate to Type 1, Type 2, and gestational diabetes.	**Q1** Do programs/initiatives/services for people at risk, or with diabetes, equitably target and reach: • Aboriginal and Torres Strait Islander people • people of culturally and linguistically diverse backgrounds • people with different socioeconomic status • people from different geographic areas? **3A.1.1 The number and characteristics of diabetes and at-risk programs, initiatives and services for:** • **Aboriginal and Torres Strait Islander people** • **people of culturally and linguistically diverse backgrounds** • **people with different socio-economic status** • **people from different geographic areas.** *For each program/initiative/service identified:* • *What is the focus of the program? (e.g. risk factor modification, self-management education)* • *What is the target population?* • *Does the program follow current evidence-based guidelines?* • *Is it ongoing?* • *To what extent is it culturally appropriate for all groups within the target population?* • *Are there any population groups who are missed or not reached?* **[B; F3–5; Pn/a]**	**Q1** Are Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, socioeconomically disadvantaged groups and people from diverse geographic areas able to access and use appropriate care (including screening) which is provided according to guidelines? **3B.1.1 The respective representation of Indigenous, culturally and linguistically diverse, socioeconomically disadvantaged, and geographically diverse groups in diabetes, at-risk and screening programs (compared with their estimated representation in the respective community**). **[B; F2–3; P1]**	**Q1** Are services accessible and presented in a culturally appropriate way? **3C.1.1 Ability for people to access services that are culturally suitable.** **[B; F2–3; P1]**

(continued)

	Settings		
Continuum of care (NDSG questions)	**Health-care organisation (Funder-policy maker; service organisation)**	**Health-care practice (Levels of care—population health, primary, secondary and tertiary care; provider/service organisation)**	**Consumers**
3. Is access equitable? These indicators relate to Type 1, Type 2, and gestational diabetes.	**Q2**	Do I have access to appropriate services to refer my patients to for the care of their diabetes? **3B.2.1 The respective number and characteristics of diabetes services available.** *For services that provide care for people with diabetes, what is/are the:* • *type of service?* • *cost to consumers?* • *hours of availability?* • *waiting times?* • *follow up?* • *outreach services?* • *levels of use for different population groups?* **[B; F2–3; P2]**	**Q2 What do I perceive to be the barriers to access—public and private?** **3C.2.1 Self-reported barriers to access to care.** **[B; F2–3; P2]**

(continued)

	Settings		
Continuum of care (NDSG questions)	**Health-care organisation (Funder-policy maker; service organisation)**	**Health-care practice (Levels of care—population health, primary, secondary and tertiary care; provider/service organisation)**	**Consumers**
4. Is care (prevention, early detection and management) provided according to guidelines? **(process)** These indicators relate to Type 1, Type 2, and gestational diabetes.	**Q1** For which aspects of diabetes prevention, early detection and management do guidelines exist? **4A.1.1The number and characteristics of diabetes guidelines identified.** **[A/B; F3–5; P1]** For each aspect of diabetes prevention, early detection and management for which guidelines exist: • *Are the guidelines Australian?* • *Are they evidence-based?* • *Have the guidelines been endorsed? If yes, by whom?* • When were they last updated and are they still considered current? • *Are they written or available in consumer-friendly language?* • *Describe the level of dissemination of these guidelines to health-care providers?* • *Have the guidelines been implemented/incorporated into diabetes programs/initiatives?* • *Are there mechanisms to audit diabetes prevention, early detection and management against the guidelines (in hospitals, diabetes centres and general practice)?*	**Q1** Is management recommended by guidelines being provided and received? **4B.1.1 The proportion of people with diabetes mellitus who have had an annual cycle of care (that is, have had recorded):** ***1. a foot examination within the last 12 months*** ***2. an eye exam within the last 2 years*** ***3. urinary albumin measured in the last year*** ***4. HbA1c measured in the last 6 months*** ***5. blood pressure measured in the last 6 months*** ***6. lipids measured in the last 12 months*** ***7. weight/BMI measured in the last 6 months.*** **[A; F1; P1]**	**Q1** Are consumers aware of evidence-based healthy lifestyle options? **4C.1.1 The proportion of people with diabetes who know what their evidence-based healthy lifestyle options are.** **[B; F3; P1]**

(continued)

Settings			
Continuum of care (NDSG questions)	**Health-care organisation (Funder-policy maker; service organisation)**	**Health-care practice (Levels of care—population health, primary, secondary and tertiary care; provider/service organisation)**	**Consumers**
4. Is care (prevention, early detection and management) provided according to guidelines? **(process)** These indicators relate to Type 1, Type 2, and gestational diabetes.	**4A.1.2 The proportion of programs to improve prevention, early detection and management that are consistent with guidelines.** **[A/B; F3–5; P2]**	**Q2 Are there systems to prompt for management according to these guidelines?** **4B.2.1 The proportion of GPs with Register / Recall Systems (by Divisions of GPs).** **[A; F1; P2]**	**Q2 Are consumers aware of the existence of guidelines?** **4C.2.1 The proportion of people with diabetes who are aware of the existence of guidelines for management.** **[B; F3; P2]**
5. Are we improving the quality of clinical management for people with diabetes? **(intermediate clinical outcomes, e.g. the percentage with HbA1c < 7.0%, the percentage with well-controlled BP)** These indicators relate to Type 1, Type 2, and gestational diabetes.	**Q1** Are there systems in place to assess quality of clinical management, and are they adequate? **5A.1.1 The adequacy of systems identified to assess quality of clinical management.** *For each system identified:* • *Does it follow current evidence-based guidelines?* • *Is it ongoing?* • *Does it cover identified population groups?* **[B; F2–3; P1]**	**Q1** What proportion of people with diagnosed diabetes meet the standards for adequate disease control (as defined in national guidelines) for: HbA1c; blood pressure; cholesterol; weight (BMI)? **5B.1.1 The proportion of people with diabetes that meet guideline targets for:** • ***HbA1c*** • ***blood pressure*** • ***cholesterol*** • ***weight/BMI.*** **[A/B; F2–3; Pn/a]**	**Q1** Do I have the knowledge to self-manage my diabetes? **5C.1.1 The proportion of patients who have attended a diabetes educator (for self-management education).** **[B; F2-3; P2]** **5C.1.2** **(a) The proportion of patients who are able to demonstrate that they understand the requirements for adequate self-care.** **(b) The proportion of patients who have a care plan that they and their health professional(s) have developed** **[B; F2–3; P1]**

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	Settings		
Continuum of care (NDSG questions)	**Health-care organisation (Funder-policy maker; service organisation)**	**Health-care practice (Levels of care—population health, primary, secondary and tertiary care; provider/service organisation)**	**Consumers**
5. Are we improving the quality of clinical management for people with diabetes? This indicator relates to Type 1, Type 2, and gestational diabetes.	**Q2** What programs are in place (education, training etc.) to improve the quality of clinical management? **5A.2.1 The number and characteristics of programs identified to improve the quality of clinical management.** *For each program identified:* • *Does it make use of current evidence-based or consensus guidelines (as appropriate)?* • *Is it ongoing?* • *What is the format of the program?* **[B; F2–3; P2]**		

(continued)

	Settings		
Continuum of care (NDSG questions)	**Health-care organisation (Funder-policy maker; service organisation)**	**Health-care practice (Levels of care—population health, primary, secondary and tertiary care; provider/service organisation)**	**Consumers**
6. Are we reducing the death rate and serious health effects of diabetes? **(hard clinical outcomes, e.g. mortality, prevalence and incidence of loss of vision, renal failure)** These indicators relate to Type 1, Type 2, and gestational diabetes.	**Q1** What systems are in place to assess the trends in morbidity and mortality from diabetes and its complications? **6A.1.1 The number and characteristics of existing data sources to assess the trends in morbidity and mortality from diabetes and its complications, and their connectivity.** *For each data source identified:* • *What is the type of data source?* • *What are the scope and coverage of the data collection?* • *What is the frequency of data collection?* • *Are data collected according to agreed national or international standards?* • *Is the data set routinely analysed and reported on?* • *What is the potential connectivity to other data sets?* **[A; F5; Pn/a]**	**Q1** What is the trend in diabetes-related mortality? **6B.1.1 The diabetes-related death rate over time, among:** • **the general population** • **Aboriginal and Torres Strait Islander people** • **people of culturally and linguistically diverse backgrounds** • **people of different socioeconomic status** • **people from different geographic areas.** **[A; F1–2; P1+]**	**Q1** Has my quality of life and/or health been affected by my diabetes? **6C.1.1 Quality of life of people with diabetes (measured by standardised questionnaire).** **[B; F3; P n/a]**

(continued)

Settings			
Continuum of care (NDSG questions)	**Health-care organisation (Funder-policy maker; service organisation)**	**Health-care practice (Levels of care—population health, primary, secondary and tertiary care; provider/service organisation)**	**Consumers**
6. Are we reducing the death rate and serious health effects of diabetes? This indicator relates to Type 1, Type 2 and gestational diabetes.		**Q2** What is the trend in diabetes prevalence, incidence, complications and comorbidities (including end-stage complications)? **6B.2.1 Prevalence and incidence of diabetes, its complications and comorbidities over time (by subgroup, as per indicator 4B.1.1):** • **diabetes** • **cardiovascular disease** • **visual loss** • **ESRD** • **non-traumatic amputation.** **[A/B/C; F1–2; P1-]**	
6. Are we reducing the death rate and serious health effects of diabetes? This indicator refers only to Type 1 because the duration of Type 2 is unreliable.		**6B.2.2** ***The proportion of people with Type 1 diabetes with complications, by duration of diabetes.*** **[B/C; F1–2; P4]**	
6. Are we reducing the death rate and serious health effects of diabetes? This indicator relates to Type 1, Type 2, and gestational diabetes.		**Q3** What is the life expectancy trend for people with diabetes? **6B.3.1 The diabetes-related life expectancy over time.** **[A/B; F1–2; P3]**	

Appendix B: National Health Priority Areas—diabetes indicators

1. Disease incidence and prevalence

1.1. Prevalence rates for Type 1 and Type 2 diabetes in:
- the general population
- the Indigenous population
- people from culturally and linguistically diverse backgrounds

1.2. Incidence rates for Type 1 and Type 2 diabetes in:
- the general population
- the Indigenous population
- people from culturally and linguistically diverse backgrounds

1.3. Gestational diabetes among women aged 20–44 years, by parity.

2. Risk factors for diabetes and associated complications

2.1. Prevalence rates for obesity and overweight (as measured by BMI) among people with Type 2 diabetes and in the general population

2.2. Rates for non-participation in regular, sustained, moderate aerobic exercise among people with Type 2 diabetes and in the general population

2.3. Prevalence rates for high blood pressure among people with Type 2 diabetes:
- ≥ 140 mm Hg systolic and/or 90 mm Hg diastolic and aged less than 60 years
- ≥ 160 mm Hg systolic and/or 90 mm Hg diastolic and aged 60 years or over and/or
- those on medication for high blood pressure.

2.4. Prevalence rates for high levels of lipoproteins among people with Type 1 and Type 2 diabetes:
- total cholesterol above 5.5 mmol/L
- high-density lipoproteins below 1.0 mmol/L

2.5. Prevalence rates for fasting hypertriglyceridaemia among people with Type 1 and Type 2 diabetes.

3. Diabetes complications

3.1. Proportion of people with end-stage renal disease with diabetic nephropathy as a causal factor

3.2. Incidence rate for eye disease among people with clinically diagnosed diabetes

3.3. Prevalence rate for foot problems among people with clinically diagnosed diabetes

3.4. Incidence rates for coronary heart disease and stroke among people with clinically diagnosed diabetes and in the general population.

4. Hospital separations for diabetes complications

4.1. Hospital separation rates for end-stage renal disease as the principal diagnosis with diabetes as an additional diagnosis

4.2. Hospital separation rates for coronary heart disease or stroke as the principal diagnosis with diabetes as an additional diagnosis

4.3. Hospital separation rates for conditions other than end-stage renal disease and coronary heart disease/stroke among people with diabetes as a principal diagnosis or an additional diagnosis.

5. Mortality

5.1. Death rates for diabetes in:

– general population

– Indigenous population

– people from culturally and linguistically diverse backgrounds

5.2. Death rates for coronary heart disease and stroke among people with diabetes in:

– general population

– Indigenous population

– people from culturally and linguistically diverse backgrounds.

6. Health status

6.1. Self-assessed health status of people with and without diabetes

7. Screening and management

7.1. Proportion of people with diabetes tested for glycosylated haemoglobin (HbA1c) level at least every 6 months

7.2. Proportion of pregnant women being tested for gestational diabetes.

Appendix C: List of jurisdictions and consumers consulted

Jurisdictions

New South Wales Department of Health
Department of Human Services, Victoria
Queensland Health
Department of Health, South Australia
Department of Health, Western Australia
Department of Health and Human Services, Tasmania
Australian Capital Territory Department of Health
Department of Health and Community Services, Northern Territory

Consumer representatives

Ms Karen Bect
Mr Trevor Corbell (Diabetes Australia)
Ms Sandra Hall
Mr Garry Horvai
Dr Lilian Jackson (Diabetes Australia)
Mr Cliff Newman
Mr Bruce Williams

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