Diabetes Annual Review/Year of Care

Introduction and Background

Diabetes is associated with a range of complications that are a major cause of disability, morbidity and mortality, including vision loss, lower-limb amputation, renal and cardiovascular disease. With the prevalence of type 2 diabetes in Aotearoa New Zealand predicted to increase by 70 – 90% in the next 20 years, the burden of diabetes complications on patients and the healthcare system will also increase.

A regular review of patients with diabetes is essential to prevent or delay the onset of diabetes complications and slow their progression, thus

- Every patient with type 2 diabetes should be reviewed at least annually; more frequent review may be indicated depending on the patient's risk factors;
- The main components of a diabetes review are an examination of the feet, assessing cardiovascular disease (CVD) risk, requesting HbA_{1c}, lipid levels, renal and liver function tests, assessing mental health and general wellbeing, and ensuring retinal photo screening is up to date;
- The cornerstone of managing CVD risk and preventing or delaying microvascular complications are lifestyle interventions, optimising glycaemic control, blood pressure and lipid levels; pharmacological treatment is often indicated depending on the patient's risk factors and individualised treatment targets.

Purpose

To provide funding support that enables a yearly review for people with diabetes including screening, monitoring and managing complications for both diabetes and cardiovascular disease.

The Annual Review

The basic components of an annual diabetes review are included in the Mōhio CVD/Diabetes form. In clinical practice, these may be reviewed at different times, and all should be performed at least once per year. More frequent review may be indicated depending on the patient indicators, and/or Type of Diabetes and/or other co-morbidities (for example high risk patients may need to be seen more frequently e.g. every three months, or where measurements are not at target. However, Auckland PHO funds for **one** Diabetes Annual Review per year).

Diabetes Foot & Eye Screening & Referrals

Diabetes Foot Screening and Management/Podiatry Services

See diabetes foot screening and risk stratification

https://www.aucklandpho.co.nz/_files/ugd/0cdff8_c9f88b59c3234503a08661013e1aae37.pdf

- **Low Risk**: annual screening
- **Moderate or High-Risk** stratification can be referred to the Auckland PHO Community Diabetes Podiatry Service. See link for information on diabetes foot screening.

Further information about the Auckland PHO Community Diabetes Podiatry Service

https://www.aucklandpho.co.nz/_files/ugd/0df4f8_66b8314afb1c45ad8d4b796173437c5f.pdf

Patients with Active Diabetes Foot Disease/Complications
Refer to Auckland Regional Health Pathways

Diabetes Retinal Photo Screening
See Eye disease in diabetes for referral criteria

Equity

Māori and Pacific peoples have a higher incidence of type 2 diabetes and have worse health outcomes associated with the disease, compared with European people.

Many of the contributing factors are related and, in general, are likely to be due to inequities in standard of care, including access to medicines, medicines management, education and access to diabetes management services.

The Auckland PHO funded Diabetes Annual Review ensures there is a system/funding that aims to mobilise screening and management reviews and is targeted at all patients (and particularly Māori and Pacific peoples) with a diagnosis of type 1 and type 2 diabetes.

Funding

- $50.00 exclusive of GST
- An additional $10 exclusive of GST for a CVD management review for people with diabetes whose CVD Risk is ≥ 15%
- Note that if there is doubt that the patient will not access Labtests consider undertaking phlebotomy on site and claim via DFP

Business Rules

The patient must be enrolled:

- type 1 or type 2 diabetes
- all ages
- all ethnicities

At least 11-month period since last claim for a Diabetes Annual Review

Quality System Indicator Targets

- 90% of enrolled patients with diabetes have received a Diabetes Annual Review, and
- HbA1c Glycaemic control – 80% of enrolled patients (aged 15 – 74 years) latest HbA1c is less than or equal to 64mmmol/mol recorded in the last 15 months
- Blood pressure control – 80% of enrolled patients (aged 15 – 74 years) latest systolic blood pressure is <140 mmHg
- CVD Management
  - CVD Secondary Prevention:**70% of enrolled eligible patients (25 – 74 years) with known CVD who are on triple therapy (statin+ BP lowering agent+ antiplatelet/anticoagulant). Exclusion: history of haemorrhagic stroke)**

- CVD Primary Prevention: **70% of enrolled patients (25 – 74 years) whose most recently recorded CVD risk score is ≥15% are on dual therapy (statin + BP lowering agent.)**

Exclusions: History of prior CVD and other conditions identified as "clinically high".

These Quality System Indicator Targets were agreed to by the Northern Region Clinical Governance Forum.
https://www.aucklandpho.co.nz/_files/ugd/0df4f8_af611d8d63fb41129d52ccb60c2f4ebe.pdf

Note that reporting ages and associated age funding across some indicators are different.

Contact

For troubleshooting, please contact support@mohio.co.nz,
or Auckland PHO Clinical and Quality Manager, Siobhan Matich
siobhan@aucklandpho.co.nz

See next page for information about the Mōhio CVD + Diabetes Form
For further information about the **CVD and Diabetes Mōhio Form** click here.

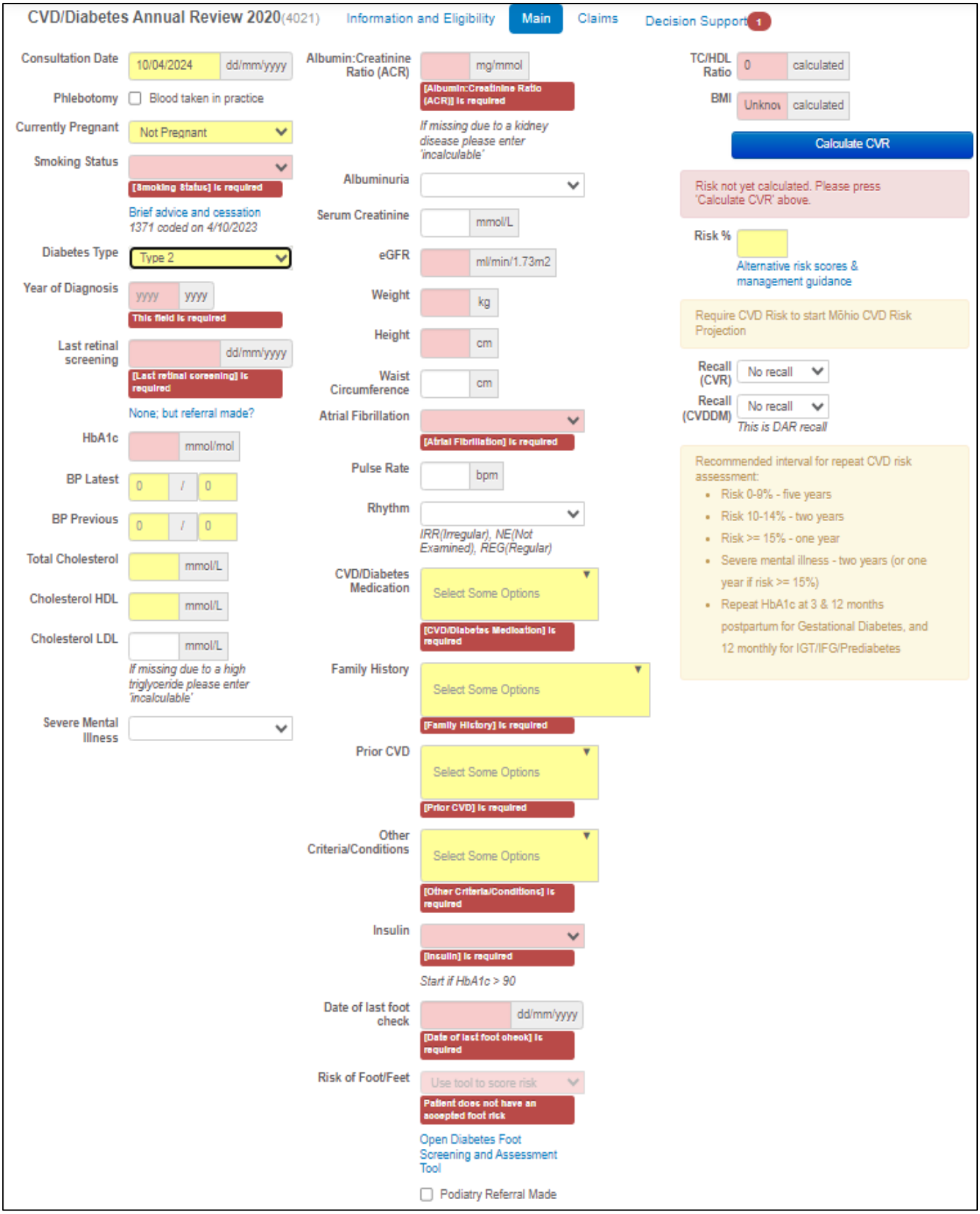
For further information on Auckland PHO's CVD Risk and Management Funding programme click here.

Mōhio CVD + Diabetes Form

The Mōhio CVD and Diabetes Forms were integrated into one form in December 2023. The updated form integrates the 2018 Consensus Statement and combines a diabetes review (from the age of diagnosis) with a CVD risk assessment (from 18 years of age).

All yellow and pink highlighted fields are mandatory, and most will auto populate if the information is available in the PMS.

The Form will write back recalls and other screening or measurement information not currently in the PMS.


CVD/Diabetes Annual Review 2020(4021)
Information and Eligibility
Main
Claims
Decision Support 1
Consultation Date
10/04/2024
dd/mm/yyyy
Phlebotomy
Blood taken in practice
Currently Pregnant
Not Pregnant
Smoking Status
[Smoking Status] is required
Brief advice and cessation
1371 coded on 4/10/2023
Diabetes Type
Type 2
Year of Diagnosis
yyyy
yyyy
This field is required
Last retinal screening
dd/mm/yyyy
[Last retinal screening] is required
None; but referral made?
HbA1c
mmol/mol
BP Latest
0
/
0
BP Previous
0
/
0
Total Cholesterol
mmol/L
Cholesterol HDL
mmol/L
Cholesterol LDL
mmol/L
If missing due to a high triglyceride please enter 'incalculable'
Severe Mental Illness
Albumin:Creatinine Ratio (ACR)
mg/mmol
[Albumin:Creatinine Ratio (ACR)] is required
If missing due to a kidney disease please enter 'incalculable'
Albuminuria
Serum Creatinine
mmol/L
eGFR
ml/min/1.73m2
Weight
kg
Height
cm
Waist Circumference
cm
Atrial Fibrillation
[Atrial Fibrillation] is required
Pulse Rate
bpm
Rhythm
IRR(Irregular), NE(Not Examined), REG(Regular)
CVD/Diabetes Medication
Select Some Options
[CVD/Diabetes Medication] is required
Family History
Select Some Options
[Family History] is required
Prior CVD
Select Some Options
[Prior CVD] is required
Other Criteria/Conditions
Select Some Options
[Other Criteria/Conditions] is required
Insulin
[Insulin] is required
Start if HbA1c > 90
Date of last foot check
dd/mm/yyyy
[Date of last foot check] is required
Risk of Foot/Feet
Use tool to score risk
Patient does not have an accepted foot risk
Open Diabetes Foot Screening and Assessment Tool
Podiatry Referral Made
TC/HDL Ratio
0
calculated
BMI
Unknow
calculated
Calculate CVR
Risk not yet calculated. Please press 'Calculate CVR' above.
Risk %
Alternative risk scores & management guidance
Require CVD Risk to start Mōhio CVD Risk Projection
Recall (CVR)
No recall
Recall (CVDDM)
No recall
This is DAR recall
Recommended interval for repeat CVD risk assessment:
Risk 0-9% - five years
Risk 10-14% - two years
Risk >= 15% - one year
Severe mental illness - two years (or one year if risk >= 15%)
Repeat HbA1c at 3 & 12 months postpartum for Gestational Diabetes, and 12 monthly for IGT/IFG/Prediabetes