



Annual Diabetes Review

Report 2015

It is estimated that approximately 257,000 people have diagnosed diabetes in New Zealand.¹ An annual diabetes review allows for assessment of glycaemic control and earlier detection of, and intervention for, diabetes related complications. It also creates an opportunity to regularly review and assess individual treatment plans and enable support if required. Additionally, the information gained from diabetes follow-up provides up to date data for diabetes registers, which in turn drives improvements in diabetes service delivery.²

Each DHB is responsible for their own diabetes care improvement package, which is a community and primary care-based programme and therefore services and initiatives differ between regions.

This report uses data from the pharmaceutical collection and laboratory claims collection to provide an update on diabetes monitoring between March, 2014 and March, 2015 in general practice in New Zealand.

Regular checks for the management of diabetes

The New Zealand quality standards for diabetes care state that: "People with diabetes should be offered, as a minimum, an annual assessment for the risk and presence of diabetes-related complications and for cardiovascular risk. They should participate in making their own care plans, and set agreed and documented goals/targets with their health care team."³

The table below suggests the assessments that should be conducted at least annually. The frequency of these may vary depending on the individual patient's risk of complications.^{2,5}

	Assess at least Annually	If moderate to high risk of complications
HbA _{1c}	✓	✓ 3 monthly
Blood Pressure	at every visit	
Lipid profile	✓	
Feet	✓	✓ 3 monthly
Retina check	✓	
Albumin / Creatinine ratio	✓	✓ 6 monthly
eGFR	✓	
BMI / Weight	✓	
Teeth and gums	✓	
Healthy lifestyle advice	✓	

Increasing uptake of the annual diabetes review⁴

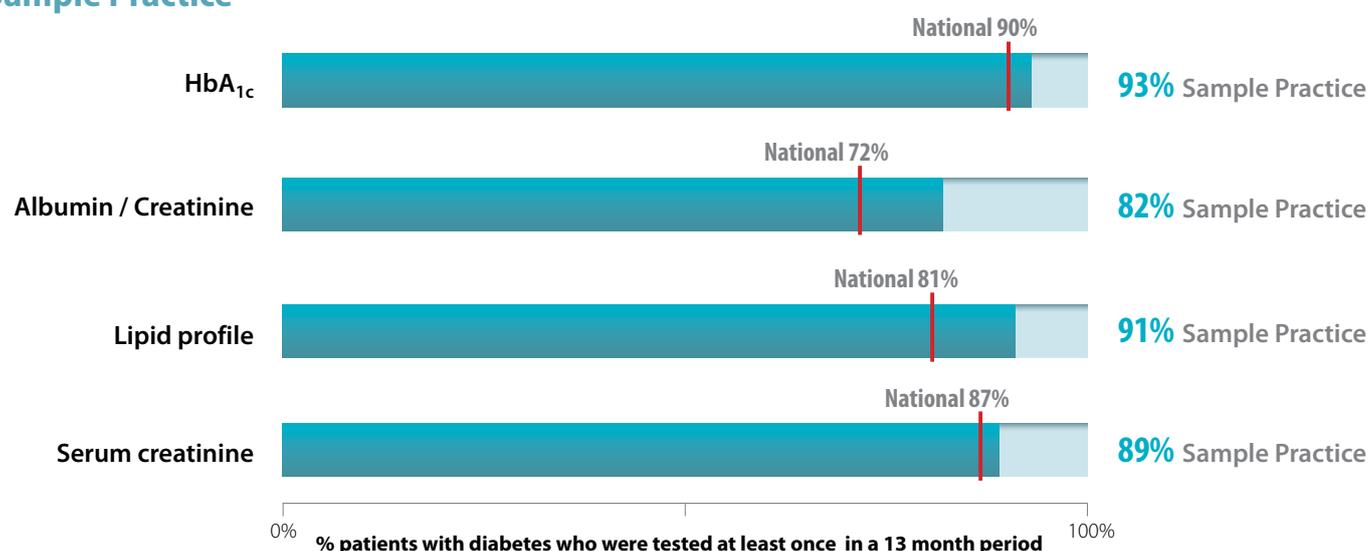
Strategies to increase the number of people with diabetes who receive annual follow-ups include:

- **Send out a recall letter or create an electronic alert:** Recall alerts can be created for patients overdue for an annual assessment
- **Create a diabetes register:** An electronic diabetes register allows analysis of a practice's population, which can highlight patients who are overdue for review and those not achieving treatment targets
- **Elect a chronic conditions "champion":** Allocate specific roles for members of the primary care team to oversee aspects of the diabetes programme and patient recall
- **Promote patient awareness:** High visibility posters, leaflets and advertising in the practice may encourage patients to attend annual assessments
- **Text alert reminders:** Text alerts are a simple, cheap and non-intrusive way to remind patients when their annual assessments are due

Monitoring

The results below show whether tests of HbA_{1c}, microalbumin (to calculate an albumin/creatinine ratio), serum creatinine (to calculate eGRF) and serum cholesterol (lipid profile) are being requested at least annually for patients with diabetes, both nationally and at your practice. The data in this report is for all registered patients dispensed either insulin, oral diabetes medicine or testing strips between March, 2014 and March, 2015.

Sample Practice



1. Ministry of Health (MOH). Virtual Diabetes Register. MOH, 2014. Available from: www.health.govt.nz (Accessed July, 2015).
 2. New Zealand Guidelines Group. New Zealand Primary Care Handbook. 2012. Available From: www.health.govt.nz (Accessed July, 2015).
 3. Ministry of Health. Quality Standards for Diabetes Care Toolkit. Wellington: Ministry of Health, 2014.
 4. bpac^{nz}. Diabetes follow-up. Best Practice Journal 2011; 39. Available from: www.bpac.org.nz (Accessed July, 2015).
 5. Health Mentor Online. Diabetes resources for healthcare professionals. Available from: www.pro.healthmentoronline.com. (Accessed July, 2015).