Specialist Medical and Surgical Services

Diabetes Annual Review

Tier 3 Service Specification

November 2024

Health New Zealand
Te Whatu Ora

Contents

1. Status

Approved to be used for mandatory nationwide description of services to be provided.

MANDATORY ☒ RECOMMENDED ☑

These are centralized and recommended specifications to be used by Districts for purchasing services, they may be used to enable providers to transition to meeting a Mandatory specification over time. Districts are expected to move to a mandatory specification when renewing or varying an agreement].

2. Review History

Review History	Date
Published on NSFL	October 2011
Working Party Review of: **Free Annual Review for People with Diabetes (Dec 2003**) Amendments: removed introduction, edited content, updated Service Definition, Access, Key Inputs, Purchase Unit Code table and Additional Reporting Requirements.	August 2011
Amendments: removed references to “Free” in title and purchase unit code, changed status of the service specification from Mandatory, added reference to the Diabetes Care Improvement Packages.	April 2013
Content moved to updated Health New Zealand format	November 2024
Consideration for next Service Specification Review	Within five years

Note: In 2024 a programme of work moved all Service Specifications to Health New Zealand branded templates. No amendments were made to the body text or content of the Service Specification, so references to DHB, Ministry of Health or other pre-2022 reforms vocabulary will still exist. A larger programme of work to review and revise all Service Specifications is planned for late 2024 to early 2025.

3. Introduction

The tier three service specification for Diabetes Annual Review (the Service) must be used in conjunction with the tier one Specialist Medical and Surgical Services service specification and the tier two Diabetes Services service specification.

If this service is delivered as part of component of the Diabetes Care Improvement Package (COGP0051) then the COGP0006 purchase unit code must be used for counting purposes.

4. Service Definition

This service specification describes the Annual Review and defines the information to be collected from the Annual Review, specifies how that information will be managed and to which organisations it will be reported. The information collected during the Annual Review is provided in Appendix A.

The purpose of the Service is to:

- provide an opportunity for a diabetes-specific review and management plan for individuals with diabetes (the Individual), supported by electronic collection of clinical data to encourage the optimal evidence-based management of patients with diabetes[1]
- encourage self-management[2] for Individuals through the use of a care plan, with the support of their families and whānau (where desired), and in partnership with health professionals and community resources[3]
- General Practice is responsible for ensuring that the Individual has had their Annual Review completed and that the reporting data has been transferred to the Primary Health Organisation (PHO) / District.

The Individual may receive the majority of their care in the primary health care setting and/ or as appropriate, some care / treatment in a District's specialist diabetes service. Note that some Individuals may choose not to participate in the Annual Review.

The Annual Review:

- ensures that each Individual (who is enrolled with a PHO) has received during the preceding 12 months, all tests / examinations indicated by clinical guidelines
- systematically screens for the risk factors and complications of diabetes and cardiovascular disease
- promotes early detection and intervention, during the following 12 months
- coordinates:

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[1] Where appropriate, an opportunistic Annual Review, regardless of the setting, may be undertaken when an Individual is in care for another condition or diabetes. The result will be communicated to the Individual's General Practitioner.

[2] Individuals with long term conditions having greater control in looking after themselves.
[3] National Health Committee. 2007. *Meeting the needs of people with Chronic Conditions: Hapai te Whanau mo ake ake tonu*. Wellington: Ministry of Health.

  - any indicated tests or examinations that have not been undertaken, to be completed within the recommended timeframe in the clinical guidelines
  - and refers the Individual into specialist care or to other services (if required)
- ensures the Individual's care plan is updated and sets goals for the Individual for the following 12 months
- provides information to the PHO to collate electronically
- undertakes a cardiovascular risk assessment annually for all at risk[4] Individuals to assist them and their families to self-manage their disease. The risk assessment commences from the date of the Individual being diagnosed of diabetes and is undertaken at the time of the Annual Review.

5. Service Objectives

5.1 General

The objectives of this Service are to:

- improve the quality of diabetes healthcare for the Individual with diabetes and their ability to self-manage their condition
- decrease the barriers for Individuals to accessing high quality care for Māori, Pacific people and other high risk groups.
- ensure high quality of diabetes services for the population through the collection of information in the diabetes register to support analysis to monitor, evaluate and improve the quality of diabetes services.
- collect and collate information in the diabetes register to ensure ongoing monitoring, evaluation and the subsequent improvement in the quality of diabetes healthcare services for populations across a variety of delivery settings.

5.2 Māori Health

Refer to the tier two Diabetes Services service specification.

5.3 Pacific Health

Refer to the tier two Diabetes Services service specification.

[4] New Zealand Guidelines Group. New Zealand Primary Care Handbook 2012. 3rd ed. Wellington: New Zealand Guidelines Group; 2012.

6. Service Users

All Individuals who are eligible for public funding[5] and who have a confirmed clinical diagnosis of diabetes.

7. Access

The Service will seek to address identified barriers to accessing diabetes services by facilitating transport or other support services as required. Service staff may accompany Individuals and their family and whānau to appointments with other services.

7.1 Entry criteria

All Individuals with a confirmed diagnosis of diabetes who agree to participate in their Annual Review.

When an Individual moves / changes domicile the Service provider will refer the Individual, with a management plan to their new diabetes Annual Review Provider on request by the new medical practitioner. They will ensure, by the timeliness of referral and the information provided, that the Individual's Annual Review 'pattern' and quality of care are maintained.

7.2 Exit criteria

Refer to the tier two Diabetes Services service specification.

7.3 Time

The Annual Review will ensure that:

- tests and examinations for risk factors and complications of diabetes and accompanying cardiovascular disease have been undertaken within the timeframes specified in clinical guidelines[6] and
- an agreed care plan has been developed with the Individual for treatment and self-management for the coming 12 months.

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[5] Eligibility criteria: Not all people who are referred or present to the Service are eligible for publicly funded services. Refer to website: http://www.moh.govt.nz/eligibility for more eligibility information

[6] Guidelines on Type 2 Diabetes May/ June 2011, See New Zealand Guidelines Group (NZGG) website (http://www.nzgg.org.nz) form the basis for identifying complications and agreeing a treatment plan.

8. Service Components

8.1 Processes

The role of the PHO primary care team (PHCT), including Māori Service Providers, is to undertake an Annual Review that includes the provision of, and coordination of tests and examinations for Individuals.

The PHCT is responsible for collecting the required Annual Review information. If an Annual Review is completed at an outpatient clinic located within a District (or the equivalent), then the information (including the minimum data set), is to be sent to the Individual's General Practitioner, as agreed with the District.

The health professional completing the Annual Review will provide the Individual with advice on diabetes management, update their treatment plan, and counsel the Individual where appropriate, eg, about smoking cessation.

The aspects of the Service to be delivered at PHCT level are as follows:

8.1.1 Annual Review

Not all tests and examinations will be undertaken at the time of the Annual Review. The indicated tests and examinations need to have been undertaken within the timeframes indicated in the clinical guidelines 5, and for arrangements to be made for any outstanding tests to be completed. The results recorded in the dataset must be the most recent results and must be from tests / examinations undertaken within the timeframe(s) indicated in the clinical guidelines. The agreed minimum dataset (refer Appendix A) is sent to the PHO for analysis, reporting, monitoring and evaluation.

The Annual Review must include:

- information about the Service that is provided to the Individual [6], to forward identifiable clinical information to their PHO, District (and possibly other service providers) for the purpose set out in this service specification
- a review of the Individual's current achievement against their previous care plan
- undertaking a comprehensive assessment of the Individual including a review of current diabetes and cardiovascular status (Appendix A)
- ensuring that the Individual has been referred for retinopathy screening within recommended timeframes (as indicated in the *National Diabetes Retinal Screening Grading System and Referral Guidelines [2006])*
- ensuring that when the Individual has been referred to another service, as part of a comprehensive multi-disciplinary team approach, that the Individual receives care and support that best meets their diabetes-related needs. In this case, the health service should ensure, through the timeliness of referral and the information provided, that the individual's Annual Review 'pattern' is maintained
- the following must be considered during the Annual Review:
  - adequate time should be allowed for explanations and discussion
  - cultural needs of the Individuals will be recognised especially for Individuals whose first language is other than English.

8.1.2 Care Plan

Following the review of care received by the Individual during the previous 12 months, an updated care plan will be developed with the Individual to set their personal goals for the next 12 months for enhanced self-care, including their care and treatment.

The care plan is completed in a manner appropriate to the needs, skills, resources and priorities of the Individual that optimises the Individual's ability to self-manage in order to gain good clinical outcomes. Copies of this care plan are to be provided to the Individual and recorded in their clinical notes as described in section 9.2.

The care plan will also include as appropriate:

- feedback on the Annual Review of test results to the Individual (and their family and whānau, if appropriate) that reflect the Individual's diabetes management, eg, HbA1c blood test for blood sugar profiling
- updated prescriptions to reflect any treatment changes indicated by the Annual Review
- plans for referral to specialist services and / or other treatment providers eg, podiatry, dietary, renal, retinal or support services
- the provision of adequate information about diabetes and its treatment, including a list of any medication changes, if appropriate[7]
- information on cardiovascular risk
- agreed, culturally appropriate self-management plan
- green prescriptions referral
- smoking status assessed using the ABC tool. If the person identifies as currently smoking, information is provided on cessation treatment options, including nicotine replacement therapy.

8.2 Settings

Staff may work with patients, whānau, iwi, and other members of the community in private homes, marae, and other community settings as appropriate. The Service may be provided in an appropriate District setting / site or be provided through primary health care organisation (PHO) practices.

8.3 Key Inputs

An Annual Review of care received during the preceding 12 months for all Individuals will be provided by a General Practitioner, Registered Primary Health Care Nurse or

[7] This is an essential part of good care, and should be given in the context of a patient's needs and preferences. This will assist services in meeting their obligations under the Code of Health and Disability Services Consumers' Rights 1996 (the Code), a regulation under the Health and Disability Commissioner Act 1994.

Nurse Practitioner. Health professionals employed to implement the Service are regulated by the Health Practitioners Competence Assurance Act 2003.

In addition; staff employed to implement this Service should have access to clinical peer review (where necessary).

For other requirements for clinical and support health care personnel refer section 6.5 tier two Diabetes Services service specification.

9. Service Linkages

Refer to the tier two Diabetes Services service specification.

10. Exclusions

People who do not have a confirmed clinical diagnosis of diabetes.

11. Quality Requirements

11.1 General

The Service must comply with the Provider Quality Standards described in the Operational Policy Framework or, as applicable, Crown Funding Agreement Variations, contracts or service level agreements.

11.2 Effectiveness

Where appropriate, and within a primary health care setting, an Individual's family members deemed at high risk of developing type 2 diabetes should be entered onto a screening recall system with appointments at recall intervals as indicated by the NZGG guidelines for type 2 diabetes management[8]. They should also be offered risk reduction and health promotion interventions and information aimed at reducing their risk of developing diabetes or pre diabetes.

[8] The New Zealand Guidelines Group. 2003 *The Treatment of Type 2 Diabetes*. Wellington.

12. Purchase Units

Purchase Units are defined in Health New Zealand's Nationwide Service Framework Purchase Unit Data Dictionary[9]. The following Purchase Units apply to this service:

Specific reporting requirements apply at tier three service specifications.

Purchase Code	PU Description	PU Definition	PU Measure	PU Measure Definition	National Collections
COGP0006	Annual Diabetes Check Review	Diabetes annual review check available to all individuals with a diagnosis of type 1 or type 2 or another specific type of diabetes (no copayment may be charged to the patient)	Attendance	Number of attendances to a clinic/department/ acute assessment unit or domiciliary.	Get Checked version 2.

The PHOs use 'Get Checked' version 2 for their data collection.

13. Reporting Requirements

13.1 Additional Reporting Requirements

Reporting by PHO	Reporting by District	Reporting to LDT, or equivalent service Frequency	Reporting to LDT, or equivalent service Date
• Primary Health Care (PHC) practices to Primary Health organisation (PHO) Monthly • PHO to PHC practices 6 Monthly	All reporting as detailed in the contract Appendix A and B.	Annually	by 20th July

The Service provider will monitor and report, annually or as required, to the Districts on the ongoing development and efficacy of the Services. This will include detailed assessments of Service delivery and the impact the Services have in achieving its goals, objectives, and functions.

[9] www.nsfl.health.govt.nz

The primary care Service Provider must be able to demonstrate how the analysis of the information contained in the diabetes database is used to encourage continuous quality improvement.

Note: PHOs may require aligned practices to provide more information than is defined in Appendix A. This specification defines the minimum information requirements.

13.2 Primary Care Practice Reporting to Primary Health Organisation

Monthly, primary health care practices are required to report the non-identifiable information electronically, (defined in the minimum dataset in Appendix A) to the PHO to which they are aligned, for each non-identifiable Individual that has received this Service. The information is to be stored electronically using the data definitions in appendix A, as agreed with the District.

If an Annual Review is done by a health professional at an outpatient clinic, located within a District (or the equivalent), then the information (including the minimum data set), is to be sent to the individual's General Practitioner, as agreed with the District.

13.3 Primary Health Organisation Reporting to Primary Care Practice

PHOs must undertake an analysis of the information contained in the diabetes database as a part of quality improvement processes and provide feedback to their primary health care practices six-monthly. This analysis may be facilitated by the District.

13.4 District Information provided to the Local Diabetes Team

The District must provide an aggregated non-identifiable dataset to Local Diabetes Team (or an equivalent service) annually, as locally agreed by the District, by the 20th July to enable them to analyse population health information and recommend strategies to improve the quality of diabetes services. The aggregated dataset is defined in Appendix B.

14. Glossary

Not required

15. Appendices

15.1 Appendix A – MINIMUM DIABETES / CVD DATA SET[10]

These items should be recorded in the Primary Health Organisation (PHO) database

1. Provider Details Type Element

1.1 Provider Identifier

Definition:	Code for provider (GP or Nurse) doing annual check. Initially the Registration number for the GP or nurse.
Requirement:	Required

1.2 Provider Identifier Type

Definition:	The Identifier Type links the Provider Identifier to the specific register or numbering system that an organisation uses to identify its members. An organisation may have a number of registers and each is required to have a unique Identifier Type. It is the register from which the person identifier number is allocated.
Requirement:	Required

1.3 NameTitle

Definition:	Title is an honorific form of address preceding a name, used when addressing a person. This may include Mr, Mrs, Miss, Dr, Professor etc.
Requirement:	Optional

1.4 GivenName

Definition:	The provider's GIVEN identifying name.
Requirement:	Required

1.5 MiddleNames

Definition:	The provider's second and further given names or initials thereof.
Requirement:	Optional

1.6 Surname

Definition:	The provider's Family Name as distinguished from her/his given and second and subsequent name(s).
Requirement:	Required

1.7 Locum

Definition:	Is the Provider a locum?
Requirement:	Optional

[10] Diabetes Get Checked / CVD XML Schema and Dataset. Implementation Guide Version 4

2. Patient Identification Type Element

2.1 Patient External ID

Definition:	This must be a valid NZHIS HCU number (NHI)
Requirement:	Required

2.2 Surname

Definition:	The patient's family name as distinguished from her/his given and second and subsequent names.
Requirement:	Required

2.3 Given Name

Definition:	The patient's first GIVEN identifying name.
Requirement:	Required

2.4 Second Name or Initials

Definition:	The patient's second and further given names or initials thereof.
Requirement:	Optional

2.5 Date of Birth

Definition:	Used to confirm ID, and calculate age
Requirement:	Required

2.6 Gender

Definition:	Required for CVD risk
Requirement:	Required
Verification rules:	"F" = Female "M" = Male "U" = Unknown/other

2.7 PHO Registration Status

Definition:	Patient's current enrolment status with the PHO at the time of the review.
Requirement:	Required
Verification rules:	"E" = Enrolled "R" =Registered "C" =Casual

2.8 Permanent Address Line 1

Definition:	First line of the patient's address
Requirement:	Optional

2.9 Permanent Address Line 2

Definition:	Second line of the patient's address

Requirement:	Optional

2.10 Permanent Address Suburb

Definition:	Suburb of the Patient's address
Requirement:	Optional

2.11 Permanent Address City

Definition:	City of the Patient's address
Requirement:	Optional

2.12 Permanent Address Post Code

Definition:	The numeric descriptor for a postal delivery area, aligned with the locality, suburb or place for the address.
Requirement:	Optional

2.13 Permanent Address Country

Definition:	Country of the Patient's address
Requirement	If blank, New Zealand will be assumed value

2.14 Contact Phone

Definition:	Area code and phone number
Requirement:	Optional

2.15 Prioritised Ethnicity

Definition:	Use PMS systems for recording ethnicity. If only one ethnicity code is provided it should be prioritised ethnicity. Ethnicity must be provided to 2 digits, with 5 digit ethnicity recorded only if already implemented in the PMS system.
Verification rules:	11=New Zealand European/Pakeha 12=Other European 21=New Zealand Maori 31=Samoan 32=Cook Island Maori 33=Tongan 34=Niuean 35=Tokelauan 36=Fijian 37=Other Pacific Islands (not listed) 30=Pacific Island not further defined 43=Indian 43112=Fijian Indian 441=Sri Lankan

	44414=Pakistani 44412=Bangladeshi 44411=Afghani 44413=Nepalese 44415=Tibetan 42=Chinese 442=Japanese 443=Korean 41=Southeast Asian 40=Asian not further defined 51=Middle Eastern 52=Latin American / Hispanic 53=African 54=Other 10=European Not Further Defined 44=Other Asian (Code 44) 444=Other Asian (Code 444)

2.16 Ethnicity2

Definition:	As above. Only included if present in PMS data tables.
Requirement:	Optional

2.17 Ethnicity3

Definition:	As above
Requirement:	Optional

2.18 Healthcare District

Definition:	Code for patient's District Health Board. PMS will only include this if already present in PMS data tables. Same format and content as in HL7 Standard Capitation-Based Funding Electronic Registers v3.09
Verification rules:	NLD Northland NWA Waitemata CAK Auckland SAK Counties Manukau WKO Waikato LKS Lakes BOP Bay of Plenty TRW Tairawhiti

	HWB Hawkes Bay TKI Taranaki MWU MidCentral WNI Whanganui CAP Capital and Coast HUT Hutt WRP Wairarapa NLM Nelson Marlborough WCO West Coast CTY Canterbury SCY South Canterbury OTA Otago SLD Southland

2.19 Geo Code

Definition:	Geographical Code for the meshblock of the patient's usual residential address, in the format defined by Statistics New Zealand and used by Primary Health Organisations. Nillable (*see Introduction, page 4*) if not already present in PMS data tables.
Requirement:	Required

2.20 Deprivation Quintile

Definition:	Deprivation Quintile for geocoded meshblock of patient at time of annual review. Nillable *(see Introductio*n*, page 4*) if not already present in PMS data tables.
Requirement:	Required

2.21 PHO ID

Definition:	PerOrg ID.
Requirement:	Optional
Verification rules:	6 digit PerOrg number If patient is not enrolled at PHO themselves, please default the PHOID the practice is part of.

2.22 Care Plus Enrolment Status

Definition:	Records if patient is enrolled in "Care Plus" or not.
Requirement:	Required

2.23 Care Plus Enrolment Start Date

Definition:	The date upon which a particular person becomes eligible for Care Plus.
Requirement:	Required

2.24 Care Plus Enrolment End Date

Definition:	This is the expiry date of Care Plus eligibility for that particular person as submitted by the Provider.
Requirement:	Required

3. Patient Consent Type Element

3.1 Sequence Number

Definition:	Number of repeats of this segment
Requirement:	Required

3.2 Sharing of Information Consent

Definition:	Consent confirming the patient's wish to be included in the service or have information forwarded as in data element 6.3 below (TypeOfConsent).
Requirement:	Optional

3.3 Type of Consent

Definition:	For people to request that a copy of their information is sent to another service or a mailing list.
Requirement:	Optional

4. Clinical Data Cardiovascular Element

4.1 Date of Review

Definition:	Default is day of data entry
Requirement:	Required

4.2 Height

Definition:	Height of patient without shoes (cm).
Requirement:	Required

4.3 Weight

Definition:	Weight of patient dressed without shoes (kg)
Requirement:	Required

4.4 Waist Circumference

Definition:	Taken midway between lower rib margin and the iliac creat to the nearest 1 cm
Requirement:	Optional

4.5 Smoking History

Definition:	Is the patient a smoker?

Requirement:	Required
Verification rules:	0 = No - never (default) 1 = No - quit over 12 months ago 2 = No - quit within 12 months 3 = Yes - up to 10 / day 4 = Yes - 10-19 / day 5 = Yes - 20+ / day

4.6 Type Of Diabetes

Definition:	Type of Diabetes
Requirement:	Required
Verification rules:	0 = No diabetes 1 = Type 1 2 = Type 2 (incl type 2 on insulin) 3 = Type unknown 4 = Gestational 6 = Other known type 7 = IGT / IFG 9 = Diabetes status unknown

4.7 History Of Acute Coronary Syndrome

Definition:	Is there a history of acute coronary syndrome?
Requirement:	Optional
Verification rules:	0 = No (default) 1 = Yes

4.8 Angina-AMI

Definition:	Is there a history of Angina AMI?
Requirement:	Required
Verification rules:	0 = No (default) 1 = Yes

4.9 PTCA-CABG

Definition:	Is there a history of PTCA-CABG?
Requirement:	Required
Verification rules:	0 = No (default) 1 = Yes

4.10 Stroke-TIA

Definition:	Is there a history of Stroke-TIA?
Requirement:	Required
Verification rules:	0 = No (default) 1 = Yes

4.11 Peripheral Vessel Disease

Definition:	Is there a history of Peripheral Vessel Disease?
Requirement:	Required
Verification rules:	0 = No (default) 1 = Yes

4.12 Family History of Early Cardiovascular Disease

Definition:	Is there family history of ischaemic heart disease or ischaemic stroke occurring in first degree male relative before age 55 years or first degree female relative before age 65 years?
Requirement:	Required
Verification rules:	0 = No (default) 1 = Yes

4.13 Genetic Lipid Disorder

Definition:	Is there a history of genetic lipid disorder? (As defined in NZ Guidelines Group Guidelines)
Requirement:	Required
Verification rules:	0 = None (default) 1 = Familial hypercholestrolaemia 2 = Familial defective apoB 3 = Familial combined hypercholesterolaemia 4 = Other genetic lipid disorder

4.14 Established Renal Disease

Definition:	Is there established renal disease?
Requirement:	Required
Verification rules:	0 = No nephropathy 1 = Confirmed microalbuminuria 2 = Overt diabetic nephropathy 3 = Non diabetic nephropathy 9 = Not established / not known (default)

4.15 Atrial Fibrillation

Definition:	Is Atrial fibrillation present (should be confirmed by ECG).
Requirement:	Required

Verification rules:	0 = No (default) 1 = Yes

4.16 Diagnosed Metabolic Syndrome

Definition:	If diabetes type = 0, 7, or 9, is there diagnosed metabolic syndrome?
Requirement:	Optional
Verification rules:	0 = No (default) 1 = Yes

4.17 Pregnant

Definition:	If gender = "F", is the patient pregnant?
Requirement:	Conditional
Verification rules:	0 = No (default) 1 = Yes

4.18 Stolic Blood Pressure Today

Definition:	Today’s sitting Systolic Blood Pressure (mm Hg)
Requirement:	Required

4.19 Diastolic Blood Pressure Today

Definition:	Today’s sitting Diastolic Blood Pressure (mm Hg)
Requirement:	Required

4.20 Systolic Blood Pressure Previous

Definition:	Previous Systolic Blood Pressure Sitting (mm Hg)
Requirement:	Optional

4.21 Diastolic Blood Pressure Previous

Definition:	Previous Diastolic Blood Pressure Sitting (mm Hg)
Requirement:	Optional

4.22 Fasting Glucose

Definition:	Fasting Glucose reading.
Requirement:	Optional

4.23 Fasting Glucose Date

Definition:	Date of Fasting Glucose reading.
Requirement:	Optional

4.24 Total Cholesterol

Definition:	Cholesterol reading
Requirement:	Optional

4.25 Total Cholesterol Date

Definition:	Date of total cholesterol reading
Requirement:	Optional

4.26 HDL Cholesterol

Definition:	HDL Cholesterol reading
Requirement:	Optional

4.27 Triglyceride

Definition:	Triglyceride reading
Requirement:	Optional

4.28 Serum Creatinine

Definition:	Serum Creatinine reading expressed to nearest Umol/L.
Requirement:	Optional

4.29 Serum Creatinine Date

Definition:	Date of Serum Creatinine reading.
Requirement:	Optional

4.30 eGFR

Definition:	Reported by labs with, and calculated from, serum creatinine (ml/min). If normal may be reported as ">60 ml/min".
Requirement:	Optional

4.31 Urine Albumin To Creatine Ratio

Definition:	Urine Albumin to Creatine ratio reading if clinically indicated - (mg/mmol Creatinine)
Requirement:	Optional

4.32 Urine ACR Date

Definition:	Date of Urine Albumin to Creatinine Ratio reading.
Requirement:	Optional

4.33 Dipstick Test For Microalbuminuria

Definition:	Dipstick test result for Microalbuminuria if clinically indicated and lab urine albumin:creatinine ratio not practicable
Requirement:	Optional
Verification rules:	0=Negative 1=Positive 2=Not Done

4.34 Albumin Protein Stick Test

Definition:	Result of Albumin Protein Stick Test
Requirement:	Optional

Verification rules:	0=Negative 1=Positive 2=Not Done 3= Not Required 9=Unknown

4.35 Aspirin

Definition:	Is patient being treated with Aspirin?
Requirement:	Required
Verification rules:	0 = No (default) 1 = Contra-indicated / not tolerated 2 = Yes 3 = Unknown

4.36 Clopidogrel

Definition:	Is patient being treated with Clopidogrel?
Requirement:	Optional
Verification rules:	0 = No 1 = Contra-indicated / not tolerated 2 = Yes 3 = Unknown

4.37 Warfarin

Definition:	Is patient being treated with Warfarin?
Requirement:	Optional
Verification rules:	0 = No 1 = Contra-indicated / not tolerated 2 = Yes

4.38 ACE Inhibitor

Definition:	Is patient being treated with ACE Inhibitor?
Requirement:	Required
Verification rules:	0 = No (default) 1 = Contra-indicated / not tolerated 2 = Yes

4.39 A2 Receptor Antagonist

Definition:	Is patient being treated with A2 Receptor or Antagonist?
Requirement:	Required

Verification rules:	0 = No (default) 1 = Contra-indicated / not tolerated 2 = Yes

4.40 BetaBlocker

Definition:	Is patient being treated with betablocker?
Requirement:	Required
Verification rules:	0 = No (default) 1 = Contra-indicated / not tolerated 2 = Yes

4.41 Thiazide

Definition:	Is patient being treated with Thiazide?
Requirement:	Required
Verification rules:	0 = No (default) 1 = Contra-indicated / not tolerated 2 = Yes

4.42 Calcium Antagonist

Definition:	Is patient being treated with Calcium Antagonist?
Requirement:	Required
Verification rules:	0 = No (default) 1 = Contra-indicated / not tolerated 2 = Yes

4.43 Other Anti HypertensiveMedication

Definition:	Is patient being treated with other Anti-hypertensive medication (other than ACEI, A2RA, beta blocker, thiazide, or calcium antagonist)?
Requirement:	Required
Verification rules:	0 = No (default) 1 = Contra-indicated / not tolerated 2 = Yes

4.44 Statin

Definition:	Is patient being treated with Statin?
Requirement:	Required
Verification rules:	0 = No (default) 1 = Contra-indicated / not tolerated 2 = Yes

4.45 Fibrate

Definition:	Is patient being treated with Fibrate?
Requirement:	Required
Verification rules:	0 = No 1 = Contra-indicated / not tolerated 2 = Yes

4.46 Other Lipid Lowering Medication.

Definition:	Is patient being treated with other lipid lowering medication (other than statin or fibrate)
Verification rules:	0 = No 1 = Contra-indicated / not tolerated 2 = Yes

4.47 Nicotine Replacement Therapy

Definition:	Is patient being treated with nicotine replacement therapy if smoking history >2 (ie current smoker)?
Verification rules:	0 = Never Offered. (Default) 1 = Offered but declined 2 = Prescribed previously 3 = Currently on NRT 4 = Prescribed today 5 = Contra-indicated / not tolerated

4.48 Green Prescription

Definition:	Has a Green Prescription been offered to patient?
Requirement:	Optional
Verification rules:	0 = Never Offered. (Default) 1 = Offered but patient declined 2 = Prescribed today 3 = Currently (<6 months) on Green Rx and more active than previously 4 = Currently (<6 months) on Green Rx but NOT more active now 5 = Prescribed > 6 months ago and more active now 7 = Contra-indicated (eg medical risk, disability)

5. Diabetes Clinical Data Element

5.1 Year Of Diabetes Diagnosis

Definition:	Date as Year, if unknown = 9999
Requirement:	Required

5.2 HbA1c

Definition:	HbA1c reading. Expressed to one decimal place (%).
Requirement:	Required

5.3 HbA1c Date

Definition:	Date of HbA1c reading.
Requirement:	Optional

5.4 Date Last Retinal Screening

Definition:	Date of last retinal examination or ophthalmologist review. If only year known then only use CCYY.
Requirement:	Required

5.5 Retinal Screening Interval

Definition:	Planned interval between retinal screening or ophthalmologist appointment (from last report).
Requirement:	Optinal
Verification rules:	1=Every 2 years (default) 2=Every Year 3=Every 6 months 4=Other 5= Not required (eg blind) 6= Not known

5.6 Eye Referral Today

Definition:	Has patient been given an eye referral today?
Requirement:	Optional
Verification rules:	0 = No 1 = No - in screening programme 2 = No - under ophthalmologist care 3 = Yes to retinal screening programme

	4 = Yes to ophthalmologist 5 = Not required (eg blind)

5.7 Visual Acuity Left

Definition:	Corrected / pin-hole
Requirement:	Optional

5.8 Visual Acuity Right

Definition:	Corrected / pin-hole
Requirement:	Optional

5.9 Retinopathy Worst Eye

Definition:	Retinopathy result for Worst Eye.
Requirement:	Optional
Verification rules:	R0 = None R1 = Minimal *(< 5 microaneurysms or dot haemorrhages)* R2 = Mild *(> 4 microaneurysms and dot haemorrhages. Exudates > 2DD from centre of macula*) R3 = Moderate *(Any features of Mild. Blot or larger haemorrhages. Up to 1 Quadrant of Venous Beading*) R4 = Severe *(One or more of: definite IRMA, 2 quadrants or more of venous beading, or 4 quadrants of blot or larger haemorrhages*) R5 = Proliferative *(One or more of: Neovascularisation, Sub Hyaloid or Vitreous Haemorrhage, Traction Retinal Detachment or Retinal Gliosis*) RT = Stable treated retinopathy PO = Pregnant no retinopathy or macular disease P1 = Pregnant minimal retinopathy, no macular disease P2 = Pregnant more than minimal retinopathy and/or macular disease QI = Clarity / view inadequate NS = Never screened U = Unknown

5.10 Maculopathy Worst Eye

Definition:	Maculopathy result for worst eye
Requirement:	Optional
Verification rules:	M0 = None M1 = Minimal M2 = Mild *(Microaneurysms and haemorrhages within 1DD*)

	M3 = Mild+ *(Exudates and or thickening within 2DD but > 1DD)* M4 = Moderate *(Exudates or retinal thickening within 1DD)* M5 = Severe *(Exudates or retinal thickening involving the foveola)* MT = Stable, treated macular disease QI = Clarity / view inadequate U = Unknown

5.11 Feet Sensation

Definition:	Microfilament or vibration perception threshold. May be on a linked sub-form for foot examination.
Requirement:	Optional
Verification rules:	0=Not examined 1=Normal 2=Abnormal (Left) 3=Abnormal (Right) 4=Abnormal (BOTH)

5.12 Feet Circulation

Definition:	Diminished or absent pulses. May be on a linked sub-form for foot examination.
Requirement:	Optional
Verification rules:	0=Not examined 1=Normal 2=Abnormal (Left) 3=Abnormal (Right) 4=Abnormal (BOTH)

5.13 History Diabetic Foot Ulcer

Definition:	Is there history of diabetic foot ulcer?
Requirement:	Optional
Verification rules:	0=No 1=Yes

5.14 Current Diabetic Foot Ulcer

Definition:	Is there a current diabetic foot ulcer?
Requirement:	Optional
Verification rules:	0=No 1=Yes

5.15 Other Criteria For High Risk Foot

Definition:	Is there other criteria for high risk foot? May be on a linked sub-form for foot examination.
Requirement:	Optional
Verification rules:	0=No 1=Yes

5.16 Previous Diabetic Lower Limb Amputation

Definition:	Is there a previous diabetic lower limb amputation? May be on a linked sub-form for foot examination.
Requirement:	Optional
Verification rules:	0=No 1=Yes - Left 2=Yes - Right 3=Yes – Bilateral

5.17 Diet LifestyleTherapy Only

Definition:	Is patient being treated with diet lifestyle therapy only?
Requirement:	Required
Verification rules:	0 = Prescribed Rx (default) 1 = Diet / lifestyle only

5.18 Hypoglycaemic Attacks

Definition:	Is there a history of hypoglycaemic attacks?
Requirement:	Optional
Verification rules:	0=Never 1=Less than 1 per month 2=Less than 1 per week 3=More than 1 per week

5.19 Blood Glucose Self Monitoring

Definition:	Is the patient self monitoring for blood glucose?
Requirement:	Optional
Verification rules:	0 = Never 1 = < 1 test / day 2 = 1-2 tests / day 3 = 2-3 tests / day 4 = 4+ tests / day

5.20 Insulin

Definition:	Is patient being treated with insulin?
Requirement:	Required
Verification rules:	0 = No (default) 1 = Nocturnal only 2 = Once daily 3 = Twice daily

	4 = Multiple injections 5 = Insulin pump 6 = Other insulin (eg prn) 9 = Not used (for decision support)

5.21 Metformin

Definition:	Is patient being treated with Metformin?
Requirement:	Required
Verification rules:	0 = No (default) 1 = Contra-indicated / not tolerated 2 = On maximum tolerated dose 3 = Yes

5.22 Sulphonylurea

Definition:	Is patient being treated with Sulphonylurea?
Requirement:	Required
Verification rules:	0 = No (default) 1 = Contra-indicated / not tolerated 2 = On maximum tolerated dose 3 = Yes

5.23 Glitazone

Definition:	Is patient being treated with Glitazone?
Requirement:	Required
Verification rules:	0 = No (default) 1 = Contra-indicated / not tolerated 2 = On maximum tolerated dose 3 = Yes

5.24 Acarbose

Definition:	Is patient being treated with Acarbose?
Requirement:	Required
Verification rules:	0 = No (default) 1 = Contra-indicated / not tolerated 2 = On maximum tolerated dose 3 = Yes

15.2 APPENDIX B: Aggregated Diabetes Annual Review

AGGREGATED DIABETES ANNUAL REVIEW "GET CHECKED" DATA TO BE REPORTED TO LOCAL DIABETES TEAMS BY DISTRICT HEALTH BOARDS ANNUALLY [11]

	Number receiving DAR vs. Expected prevalence (%)	Number receiving DAR	Number receiving DAR not recorded yet	Number receiving DAR with retinal screening in last 2 years	Number receiving DAR with foot checks recorded in past 12 months	Number receiving DAR with HB1AC >8	Number receiving DAR and coded as smokers	Number receiving DAR with micro-albumunia on Ace inhibitors	Number receiving DAR and on statins	Number receiving DAR and CVR recorded in the last 12 months	Number with CVR ≥15 (of CVR recorded in the last 12 months]	Number receiving DAR with NZ Dep Quintile >5
Māori												
Pacific Island												
Other												
South Asian												

[11] Data for claims paid in that quarter