

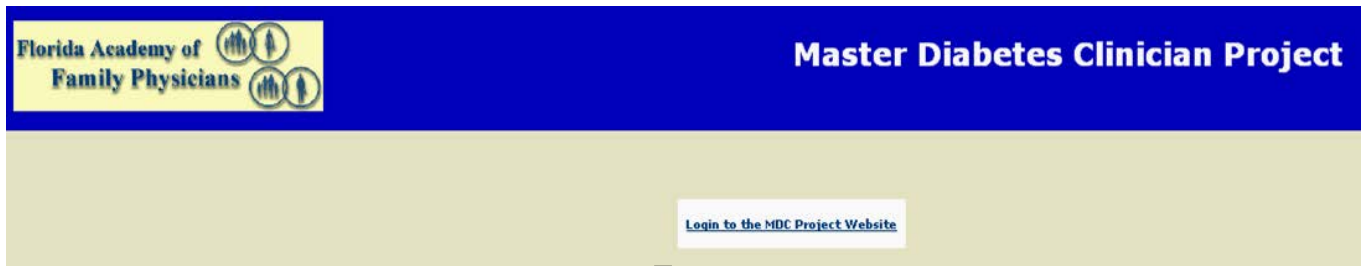
Users Manual

Internet Registry of the Diabetes Master Clinician Program FAFP

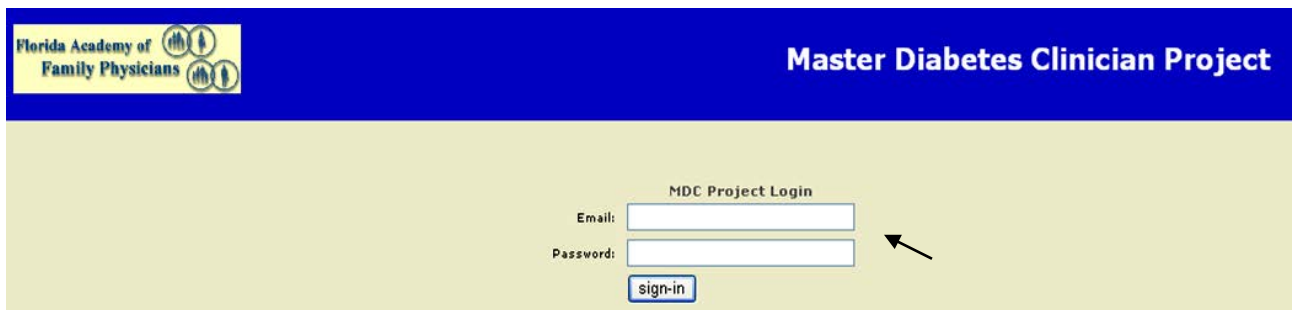
Prepared by Ed Shahady MD

The following instructions will help the user understand how to access and use the diabetes registry of the DMCP.

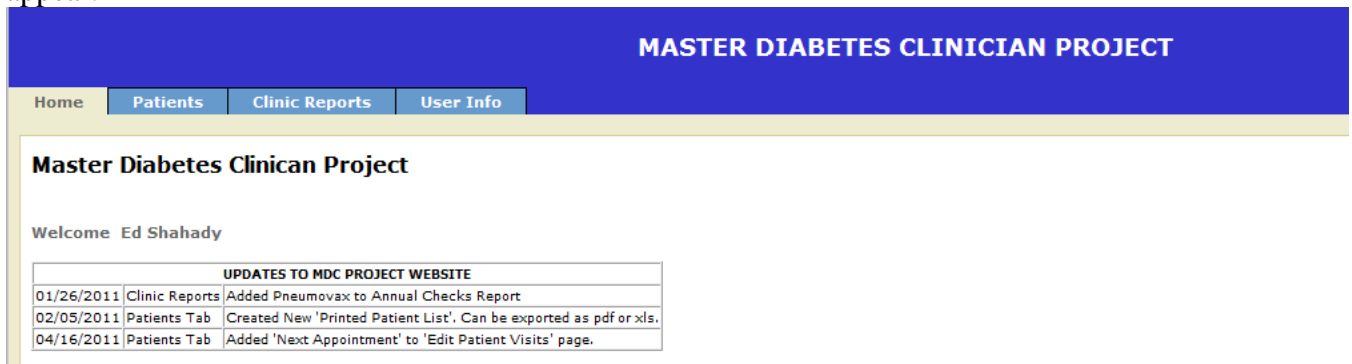
Log on to the internet through your browser. Usually it is internet explorer but each office may have its own unique set up. Once into the internet type in **www.mdcproject.org** on the line for internet addresses and click on go or touch the key Enter on your keyboard. The page that opens will look like this.



Point your cursor to logon and click the mouse. The next screen will appear.

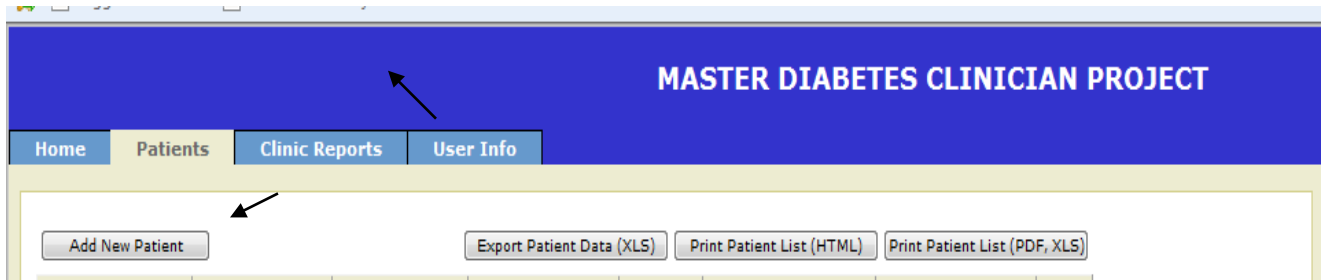


Enter your email address and password. This information will be given to you by Dr. Shahady or another member of the teaching team. The email address may not be your actual email address. A member of your team will be shown how to change the password. After you enter your email and password click on sign in and the following screen will appear.



The name of the clinic or one of the clinicians will be there not that of Dr. Shahady. Also note the name of Sean Nickerson. He is our IT consultant who manages the technical aspects of the registry. Initially you should contact Dr. Shahady for technical help (850-443-1230). If you are not able to contact Dr. Shahady then call Sean for help. The registry has been 99% free of problems and the others are usually easily resolved.

Next point your mouse to Patients at the top of the page and click. The following screen will appear.



Initially no patients will appear on the screen but as you add patients their information will appear automatically. Other items above will be discussed under reports.

Point your mouse to the box titled add a new patient and click.

The following screen will appear.

Fill in the information requested. For names be sure to start with a **Capital Letter** and then use lower case. (e.g. Smith) Be sure the dates are entered as suggested above. Month and day should always have 2 numbers and year 4 numbers e.g. June the second 1938 is 06/02/1938 (note slashes are always forward). When moving from field to field use the tab button or your mouse. **DO NOT HIT THE ENTER KEY** as it kicks you out of the database. If you do by mistake you may have to start over if the back button on your browser does not return you to the page. Assign a medical record number. Some practices

have one assigned. If not create one starting with the number 1 and increasing as you go. **Do not use social security numbers.** Be sure to enter sex and ethnicity by using the dropdown boxes. Use the clinician field if there is more than one clinician in the practice. Use numbers or letters like 101 and A, fewer errors are made when numbers or letters are used rather than names to identify the clinician. Insurance provider and number are optional fields. The delete account button is used when a patient is no longer in the practice.

After all data is entered click the mouse on save and add new patient. Do not click the enter button. This will take you out of the system and require reentry. If all the information you entered disappears you have successfully entered the patient. If the date has not been entered correctly a message letting you know the format needs changed will appear. **After you have saved the information click on return to patient list.** The following screen will appear

The screenshot shows the 'MASTER DIABETES CLINICIAN PROJECT' interface. At the top, there are navigation tabs: Home, Patients, Clinic Reports, and User Info. Below the tabs, there are buttons for 'Add New Patient', 'Export Patient Data (XLS)', 'Print Patient List (HTML)', and 'Print Patient List (PDF, XLS)'. The main area displays a patient list for 'Doe, Sue' with ID 'ab44'. Below the patient name, there are several action buttons: 'Edit Patient Info', 'Edit Patient Visits', 'New Visit', 'Clinician Report Card', 'Patient Report Card', and 'Graph'. An arrow points to the 'New Visit' button.

You may need to go to the bottom of the screen and click on the letter of the alphabet for the patient's last name.

Point the mouse to **new visit** for the patient (Sue Doe) click and next screen appears.

The screenshot shows the 'New Patient Visit for Sue Doe' form. It contains several sections:

- Visit Date:** A text input field.
- Weight:** A text input field followed by 'lbs.'.
- Height:** A text input field followed by 'inches'.
- BP:** Two text input fields for blood pressure.
- Daily ASA:** A checkbox.
- Current Smoker:** A checkbox.
- Attended Group Visit:** A checkbox.
- Next Appt:** A text input field.

Lab Tests:

- HbA1c: Text input field.
- Total Cholesterol: Text input field.
- LDL: Text input field.
- HDL: Text input field.
- Triglycerides: Text input field.

Yearly Checks:

Test	Status	Next Test Due	Most Recent Test
Eye Check	OVERDUE		
Foot Check	OVERDUE		
UMA Check	OVERDUE		
Flu Shot	OVERDUE		

Lifetime Shots:

- Pneumovax: A checkbox labeled 'Completed'.

At the bottom of the form, there is a button labeled 'Save & Add New Visit'.

To find diabetes related visits go to the pages where lab data is stored. Use these dates to begin your data entry. The dates for the lab data may vary from the visit data but this is **not** your legal record so you can combine data from visits as long as they have occurred within 8 weeks of each other. This helps because many patients obtain their tests before

or after their visits. Fill in all the fields that you can for data you can find. Some of the fields are just check boxes. Give credit only if the test is documented on the chart. **For eye tests this is a dilated eye exam that has been performed by an optometrist or ophthalmologist.** Ordering the test is not sufficient. If the chart notes that it was done or a letter from the eye doctor is in the chart give credit for the eye test. For certain tests like HBA1C, LDL, HDL, triglycerides the number should be entered. HBA1C requires a decimal point e.g. do not enter 7 enter 7.0. For others like urine microalbumin just check to note that it was done. **Foot exam credit is given if the note states that the feet were inspected and the patient could or could not feel touch. A monofilament or tuning fork may have been used to also check for sensation.** Do not give credit for a foot exam unless touch, monofilament or vibratory sense is noted in the chart. Give credit for ASA (aspirin) if the note says the patient takes aspirin daily. If the patient takes drugs named plavix also give credit for ASA. Click save and add new visit when done and if the screen goes blank you can add another visit or click return to the patient list. For initial data entry enter up to 3 visits that occurred in the last 18 months and have lab data. If only one or two visits have lab data then two visits is enough.

Once returned to the patient list you now have several options. You can click on the Edit Patient Info button and edit the demographic data. The following screen will appear.

Doe, Sue	ab44	Edit Patient Info	Edit Patient Visits	New Visit	Clinician Report Card	Patient Report Card	Graph
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[Return to Patient List](#)

Patient Information

First Name

Middle Name

Last Name

Birthdate (mm/dd/yyyy)

Medical Record #

Sex

Ethnicity

Clinician

Insurance Provider

Insurance Number

Delete Account (Accounts delete nightly at 1:00 am.)

If the patient leaves the practice or expires they should be removed by clicking the delete account button. Save your edit and then click on return to patient list.

Once back to the patient list you can also edit the past visits by clicking on the Edit Patient Visits button.

Doe, Sue	ab44	Edit Patient Info	Edit Patient Visits	New Visit	Clinician Report Card	Patient Report Card	Graph
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The following screen will appear. The patient is now John Doe and has data entered.

Return to Patient List

John Doe Age: 70 Sex: Male Medical Record #: 444444

Height inches

Pneumovax: Completed
 2nd Pneumovax: (When patient is over 65)

	<input type="button" value="-Edit-"/>	<input type="button" value="-Edit-"/>
Date	07/08/05	05/22/05
Weight	222	220
BMI	27	27
BP	160/99	150/88
EyeCheck	True	True
FootCheck	True	False
HbA1c	8.0	7.5
Total Chol	199	333
LDL	133	188
HDL	33	33
Non-HDL	166	300
Triglycerides	345	222
U Micro Alb	True	True
FluShot	False	False
Daily ASA	False	True
Group Visit	True	False
Current Smoker	False	False

If you want to delete the visit just click delete. If you want to edit click on Edit for the 05/22/05 and the next screen appears that will permit edited information.

Return to Patient List

John Doe Age: 70 Sex: Male Medical Record #: 444444

Height inches

Pneumovax: Completed
 2nd Pneumovax: (When patient is over 65)

	<input type="button" value="-Edit-"/>
Date	07/08/05
Weight	222
BMI	27
BP	160/99
EyeCheck	True
FootCheck	True
HbA1c	8.0
Total Chol	199
LDL	133
HDL	33
Non-HDL	166
Triglycerides	345
U Micro Alb	True
FluShot	False
Daily ASA	False
Group Visit	True
Current Smoker	False

Visit Date:

Weight: lbs.

Height: inches

BP: /

Eye Check: Completed

Foot Check: Completed

HbA1c:

Total Cholesterol:

LDL:

HDL:

Triglycerides:

Urine Micro Albumin:

Flu Shot:

Daily ASA:

Attended Group Visit:

Current Smoker:

Update any information and be sure to click on save. The screen will return to the

previous page and the information should be updated.

Reports for a Patient Visit

Report for the Clinician—click on Clinician Report Card

Doe, John	444444	Edit Patient Info	Edit Patient Visits	New Visit	Clinician Report Card	Patient Report Card	Graph
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The following screen will appear.

Return to Patient List
Format for Printing

MDCP Medical Record for John Doe

Age: 73 Sex: Male Medical Record #: 444444

	Goal	Dec 2011	May 2011	Nov 2010
Weight		222	220	210
BMI		27	27	26
BP	<= 130/80 Best < 120/80	160/99	150/88	150/88
Tests				
HbA1c	< 7 Best < 6	8.0	7.5	8.2
Total Cholesterol	< 200	199	333	256
LDL	< 100 Best < 70	133	188	152
HDL	> 40	33	33	34
Non-HDL	< 130 Best < 100	166	300	222
Triglycerides	< 150	345	222	289
Medication				
Daily ASA	Take daily	No	Yes	No
Smoking				
Current Smoker		No	No	No
Smoking Cessation Counseling		No	No	No
Other				
Group Visit		Yes	No	Yes

Important Yearly Activities	Goal	Status	Next Test Due	Most Recent Test
Eye Check	1 time a year	Completed	12/7/2012	12/8/2011
Foot Check	1 time a year	Completed	12/7/2012	12/8/2011
Urine Micro Albumin	1 time a year	Completed	12/7/2012	12/8/2011
Flu Shot	1 time a year	OVERDUE	11/30/2011	11/30/2010

Special Vaccine	Goal	Status
Pneumovax (to prevent a special pneumonia - twice if first was given before age 65)	2nd	1st Shot Completed 2nd Shot Completed

Do not print this page as it will be too small. Click on Format for Printing and a new screen will appear. You can then print that page.

If it does not appear it may be that you are not allowing pop-ups on your internet site. You usually can disable this at the top of your screen. After the new screen appears click on file and print to obtain a print out that can be used for the chart. This form is placed on the chart at the time of the visit for the clinician to review. The best way now to return back to your patient is to click the back button at the top of your screen. This returns you to the prior page. If you click on the return to patient visit page you will be at the start of the alphabet.

Once back to your patient list click on Patient Report Card.

Doe, John	444444	Edit Patient Info	Edit Patient Visits	New Visit	Clinician Report Card	Patient Report Card	Graph
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The following screen will appear.

[Return to Patient List](#)
[Format for Printing](#)
[en Español](#)

Patient Report Card for John Doe

Age: 73 Sex: Male MR #: 444444

	Goal	Dec 2011	May 2011	Nov 2010
Weight		222	220	210
BP	Less than or equal to 130/80 Best 120/80	160/99	150/88	150/88
Tests				
HbA1c (Sugar for 3 months)	Less than 7 Best if 6	8.0	7.5	8.2
LDL (Lousy or bad cholesterol)	Less than 100 Best if 70	133	188	152
HDL (Happy or good cholesterol)	Greater than 40	33	33	34
Triglycerides (another bad fatty substance)	Less than 150	345	222	289
Medication				
Aspirin or Anti-coagulant (to prevent heart attacks)	Take daily	No	Yes	No
Important Yearly Activities	Goal	Status	Next Test Due	Most Recent Test
Eye Check (to prevent blindness)	1 time a year	Completed	12/7/2012	12/8/2011
Foot Check (to check for numbness and sores)	1 time a year	Completed	12/7/2012	12/8/2011
Urine Micro Albumin (to check for kidney failure)	1 time a year	Completed	12/7/2012	12/8/2011
Flu Shot (to prevent flu)	1 time a year	OVERDUE	11/30/2011	11/30/2010
Special Vaccine	Goal	Status		
Pneumovax (to prevent a special pneumonia: given once in a lifetime - twice if first was given before age 65)	2 nd	1st Shot Completed 2nd Shot Completed		

This is the most helpful report in the registry. It is given to the patient by the nurse or the medical assistant. The patient sees this before the clinician enters the room. This report card empowers the patient by making them aware of their diabetes goals, the reasons why they are important and how well they are doing in reaching their goals. The patient takes the report with them as a reminder. This page is printed by first clicking on format similar to the Clinician Report Card. **Also note that the report is available in Spanish.**

By now you have noticed the banners at the top of the page. You can use them instead of returning to the patient list to find all the sites for data entry and report printing.

[Home](#) [Patients](#) [Clinic Reports](#) [User Info](#)

[Edit Patient Info](#) [Edit Patient Visits](#) [New Visits](#) [Clinician Report Card](#) [Patient Report Card](#)

[Return to Patient List](#) [Format for Printing](#)
[en Español](#)

Population Practice Reports

The prior reports informed the patient about their level of achieving diabetes quality goals. The next set of reports informs the practice and individual clinicians about their level of achieving diabetes quality goals. These reports are available by clicking on clinic reports the top of the page (arrow above)

This will produce the following screen. (Report is from the sample clinic) Note the banner on the left. The first screen displayed below is a summary of quality goals for the practice on the most recent tests entered into the registry.

Most Recent Tests	Dr. Sample Clinic's Clinic					
Clinician Report #1	Patients Meeting ADA Goals On Most Recent Tests					
Clinician Report #2	Clinic ID		HbA1c	LDL	BP	HbA1c & LDL & BP
HbA1c	1	Percentage Met Goals	34%	21%	61%	10%
LDL		47	29	86	13	136
Non-HDL		138	137	141		
Triglycerides	All Clinics	Percentage Met Goals	57%	61%	57%	23%
Blood Pressure		10413	10643	10692	3933	
Smoking		18282	17502	18723	17045	
Annual Checks	GOALS		<7.0	<100	SP<=130	

	Goals	All Clinics	Clinic's Average
# of Patients		18767	142
# of Visits		94289	240
Weight		213	175
BMI		34	30
Waist Range		42	34
B/P	<=130/80	131/76	135/81
EyeCheck	Once a year	29 %	15 %
FootCheck	Once a year	39 %	17 %
HbA1c	<7 (<6 Best)	7.3	7.5
Total Chol	<200	173	201
LDL	<70	95	125
HDL	(M: >40 F: >50)	45	50
Non-HDL	<100	128	151
Triglycerides	<150	168	199
U Micro Alb	Once a year	39 %	17 %
Pneumovax	Once	55 %	57 %
FluShot	Once a year	25 %	14 %
Daily ASA	100%	53 %	68 %
Attended Group Visit		2 %	9 %

Click on the above links for more population reports

This report informs the practice about their degree of achievement of diabetes standards of care. This screen also has reports about the degree of achievement for each clinician as well as reports that demonstrates which of their patients are not achieving goal for HbA1c, LDL, Non-HDL, Blood Pressure, immunizations and yearly checks.

For example by clicking on Clinician Report 1 the following report is available.

Clinician Report #1	Patients Meeting ADA Goals On Most Recent Tests					
Clinician Report #2	Clinic		HbA1c	LDL	BP	HbA1c & LDL & BP
HbA1c	Clinic 106	Percentage Met Goals	74%	73%	58%	34%
LDL		111	104	87	47	138
Non-HDL		149	143	151		
Triglycerides	All Clinics	Percentage Met Goals	57%	61%	57%	23%
Blood Pressure		10413	10643	10692	3933	
Smoking		18282	17502	18723	17045	
Annual Checks	GOALS		<7.0	<100	SP<=130	

A						
Clinician		HbA1c	LDL	BP	HbA1c & LDL & BP	
A	Percentage Met Goals	70%	68%	50%	24%	
	37	34	27	12		
	53	50	54	49		
GOALS		<7.0	<100	SP<=130		

B						
Select a clinician . . .						
A		HbA1c	LDL	BP	HbA1c & LDL & BP	
B	Percentage Met Goals	74%	75%	74%	41%	
	26	27	26	14		
	35	36	35	34		
GOALS		<7.0	<100	SP<=130		

The drop down box is used to display the information for each clinician. Clinician report 2 has additional information about each clinician.

Clinician Report #1	Goals	All Clinics	All Clinicians	406	408	420	432	485
Clinician Report #2								
HbA1c	# of Patients	18767	2012	259	447	423	489	192
LDL	# of Visits	94289	9595	1172	1400	1729	2711	1318
Non-HDL	Weight	213	222	220	215	220	226	220
Triglycerides	BMI	34	34	34	33	34	35	36
Blood Pressure	Waist Range	42						
Smoking	B/P	<=130/80	131/76	127/77	130/77	129/77	128/77	123/75
Annual Checks	EyeCheck	Once a year	29 %	28 %	2 %	2 %	4 %	49 %
	FootCheck	Once a year	39 %	33 %	4 %	0 %	16 %	68 %
	HbA1c	<6	7.3	7.1	7.1	7.2	7.3	6.9
	Total Chol	<200	173	165	165	170	160	168
	LDL	<70	95	89	91	90	92	85
	HDL	(M: >40 F: >50)	45	45	44	44	44	46
	Non-HDL	<100	128	120	121	121	126	114
	Triglycerides	<150	168	155	158	161	167	145
	U Micro Alb	Once a year	39 %	38 %	8 %	11 %	21 %	73 %
	Pneumovax	Once	55 %	63 %	42 %	30 %	69 %	78 %
	FluShot	Once a year	25 %	25 %	0 %	2 %	1 %	46 %
	Daily ASA	100%	53 %	54 %	37 %	49 %	58 %	79 %

The next reports aid the clinician with discovering which specific patients are at significant risk because their numbers are very high. These reports help the clinician and staff practice population based medicine. These lists can be used to see if patients have not made recent visits, invite to group visits, make reminder phone calls and send reminder letters or emails. The reports for HbA1c, LDL, BP, Non-HDL, and Triglycerides provide lists of patients at high risk, average risk, those at goal and no test performed. The following table is a list of patients for HbA1c. This report is from the test site and all patient names are fictitious.

Most Recent Tests	Dr. Sample Clinic's Clinic					
Clinician Report #1	Most Recent HbA1c					
Clinician Report #2	Clinic	Very High (>9)	High (>=7 & <=9)	Target (<7)	# Patients Not Tested	# Patients Tested
HbA1c	1	9	82	47	31	169
LDL						
Non-HDL						
Triglycerides						
Blood Pressure						
Smoking						
Annual Checks						

Very High HbA1c On Most Recent Test			
<input type="button" value="Very High"/> <input type="button" value="High"/> <input type="button" value="Target"/> <input type="button" value="Not Tested"/> <input type="button" value="ALL"/>			
	MR Number	Patient	Most Recent HbA1c
+		Haqer, Kevin	12.3
+	89493	Jones, Bubba	10.0
+	333-45-3333	jones, mary	10.0
+	000000000	Pants, Meanie	12.0
+	b98t	T, Mr	12.7
+	012	Tucker, Samantha	12.0
+	d14	Vandross, Felicia	14.0
+	444991212	Vulgamore, Lula	13.0
+	2456	White, Snow	10.0

By identifying high risk patients the clinician and staff can develop additional strategies

to help these patients achieve their goals. The high risk patients are ideal for inviting to group visits. The report for smoking provides lists as indicated in the screen shot below.

Clinic	Smokers Without Counseling	Smokers w/ Counseling	Smokers w/ Counseling Latest Visit	Smokers	Non Smokers	Patients
1	28	23	17	51	91	142

Reports can also be generated to see which of you patients have not had their immunizations or yearly checks like a dilated eye exam or a complete foot exam. Point your mouse to annual checks and click. The following screen appears. Use the drop down box to choose an indicator. All patients who have not had an indicator performed in the last 365 days will be displayed. For Pneumovax it will list those who have never had the immunization. The names are fictitious.

Here is how you can download all your patients to an excel spreadsheet. This will allow you to analyze any aspect of the diabetic patients in your practice. You could also do this periodically and compare your progress. If you know how to use a spreadsheet you could create statistical relationships.

After you enter the registry go to the patient page. The following is from our Test Page

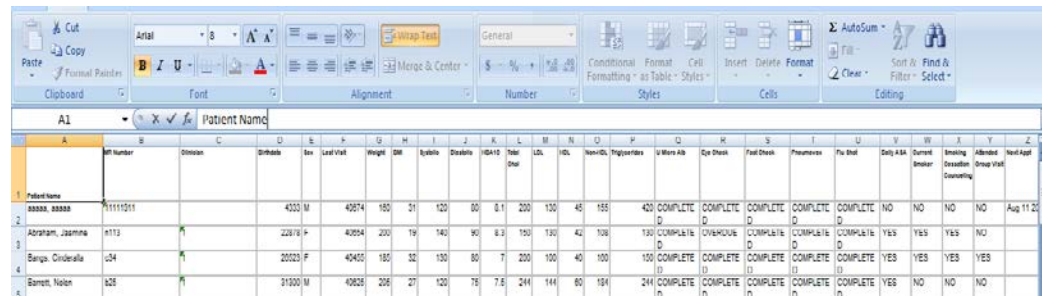
Now click on patients. The following screen will appear. Click on export patient data xls.



The following page will appear. Click on the Excel Icon



And now you can save the spreadsheet and sort and manipulate



You can also down load other reports of your complete patient list and also the list for each clinician by clicking on the following areas.



Who sees your data?

Your data will never be shown to others in a way that identifies you or your patients. Because this is a demonstration project aggregate data will be shared publicly for educational purposes. This will include published articles and educational seminars. The aggregate data will also be shown to funding agencies to obtain further funding for the project.

If you have questions or suggestions please contact me at eshahady@att.net