DiabetesManager®
HCP Web-Based Application

User's Manual

Version 1.1

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WellDoc™

DiabetesManager®

HCP Web-based Application

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Contents

Chapter 1: About this Guide

The DiabetesManager® system helps your patients manage their Diabetes. It allows them to record daily activities, such as blood glucose readings, exercise, and food consumption. This data is stored so that you and your patient can review their activity and make the necessary changes to optimize their healthcare. A team of diabetes specialists, educators, and people with diabetes developed DiabetesManager. DiabetesManager is a product of WellDoc™ Inc.

The healthcare provider (HCP) Web-based application provides a method for you to review your patients' logbook, medications, and other medical information as well as a method for private communication between you and your patient.

Two types of healthcare providers can utilise the DiabetesManager HCP Web-based application; a prescribing HCP (pHCP) and non-prescribing HCP (npHCP). You are a pHCP if you have a license to write prescriptions. You are a npHCP if you provide care to patients but are not licensed to write prescriptions.

This document describes how to use the DiabetesManager HCP Web-based application. All features are visible to all HCPs, but a few features may only be executed by pHCPs. The differences are noted within the manual.

In This Chapter

Key Features

DiabetesManager helps you manage your patients' diabetes. The application provides:

- Educational articles and diabetes tips for you to share with your patients
- A logbook that contains data such as blood glucose reading entered by your patients
- A message center for better communication between you and your patient
- Your patients personal health history

Understanding the DiabetesManager System

The HCP Web-based application is part of the DiabetesManager system. The system contains the following components:

- A mobile application for patients
- A web-based application for patients
- A web-based application for healthcare providers (HCP)
- A web-based application for account directors (AD)

Patients have a Web-based application and/or a mobile application for entry of information in to their logbook, access to the messaging center, access to the learning library, and their medical history. Account directors provide administrative support for the Web-based application activities of many healthcare providers.

Intended Audience

This guide is intended for use by healthcare providers that support people with diabetes. Basic knowledge of the internet and advanced knowledge of diabetes is assumed.

Conventions

The following conventions are used in this guide.

Convention	Description
Bold	Actions you should take such as text or data to be typed exactly or items to click.
Italics	Items to type for which you must supply a value.
Screen Name	Screen Names are in initial caps.

Getting Help

Context-sensitive help is available for many items. As you hover over an item, help items appear to guide you.

If you need further assistance, please contact WellDoc Inc. via e-mail at technicalsupport@welldocinc.com or call 888.MYDMHELP (888.693.6435). Telephone support is available 9:00 am to 5:00 pm EST Monday through Friday and is free of charge.

Chapter 2: Getting Started

The Web-based application provides an easy way for you to review your patient's logbook entries, add logbook entries for patients, forward literature about diabetes to patients, and communicate with your patients.

This chapter gets you started working with DiabetesManager and describes the user interface.

In This Chapter

System Requirements

DiabetesManager runs on most computers with their default settings. The requirements below are the minimum items needed to use the Web-based application on the internet.

- computer
- web browser
- internet connectivity
- keyboard for data entry
- Adobe® Acrobat® Reader

Browser Compatibility

DiabetesManager is compatible with:

- Microsoft® Internet Explorer (IE) versions 6.0 and 7.0
- Mozilla® Firefox® 2.0 and 3.0.

Browser Security

Medium (the default for IE) security settings are recommended. The method for changing this setting differs by browser. For IE, select the Security and Privacy settings within Internet Options to select the Medium setting.

System Updates

Acrobat Reader, Internet Explorer, and Mozilla Firefox are all free. If you do not currently have them on your system, you can download the latest free versions:

- Acrobat
  http://get.adobe.com/reader/
- Internet Explorer
  http://www.microsoft.com/windows/internet-explorer/default.aspx
- Firefox
  http://www.mozilla.com/en-US/firefox/ie.html

Screen Display

A minimum page resolution of 1024 X 768 pixels is recommend to avoid page scrolling when the application is maximized. The procedure to change default display setting differs by operating system. For example, in Microsoft Windows®, select the Display icon within your Control Panel.

Registration

You are invited to become a DiabetesManager healthcare provider when a patient has listed you as their healthcare provider or when an Account Director has sent you an invitation. You can be invited by a fax transmission or email message. If an Account Director has sent you an email invitation, click the link within the email to access your private registration page.

If you have received a fax transmission, generated when a patient adds or makes changes to their medication regimen, enter the link provided in the transmission in your web browser.

To begin registration:

1. Open the e-mail invitation sent to you from WellDoc Inc or type the address you received on a fax into your web browser. If you received a fax, go to step 3.

   It appears in your e-mail client inbox similar to the following:

2. Click the link within the e-mail to open your web browser to the linked page.
3. Follow the DiabetesManager Registration wizard through all the screens and enter as much information as you can.

   Registration for pHCPs and npHCPs is slightly different in that pHCPs have a few additional screens to fill out.

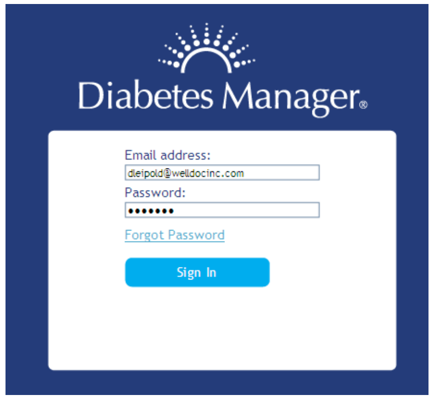
   The password you create must be 6-12 characters and contain one letter and one number. It is case sensitive, so if you type upper and lower case letters, it will have to be entered in exactly the same way at the login screen.

Logging In

Once registration is complete (see “Registration” on page 2-2), you can access DiabetesManager at anytime.

To access DiabetesManager:

1. Go to www.mydiabetes-manager.com.



   It is recommended that you bookmark this page in your web browser, so that you have quick and easy access to the application.

2. At the login screen, enter your e-mail address and your password.

   Your e-mail login is the same e-mail address at which you received your Registration notification. You set your password during registration.

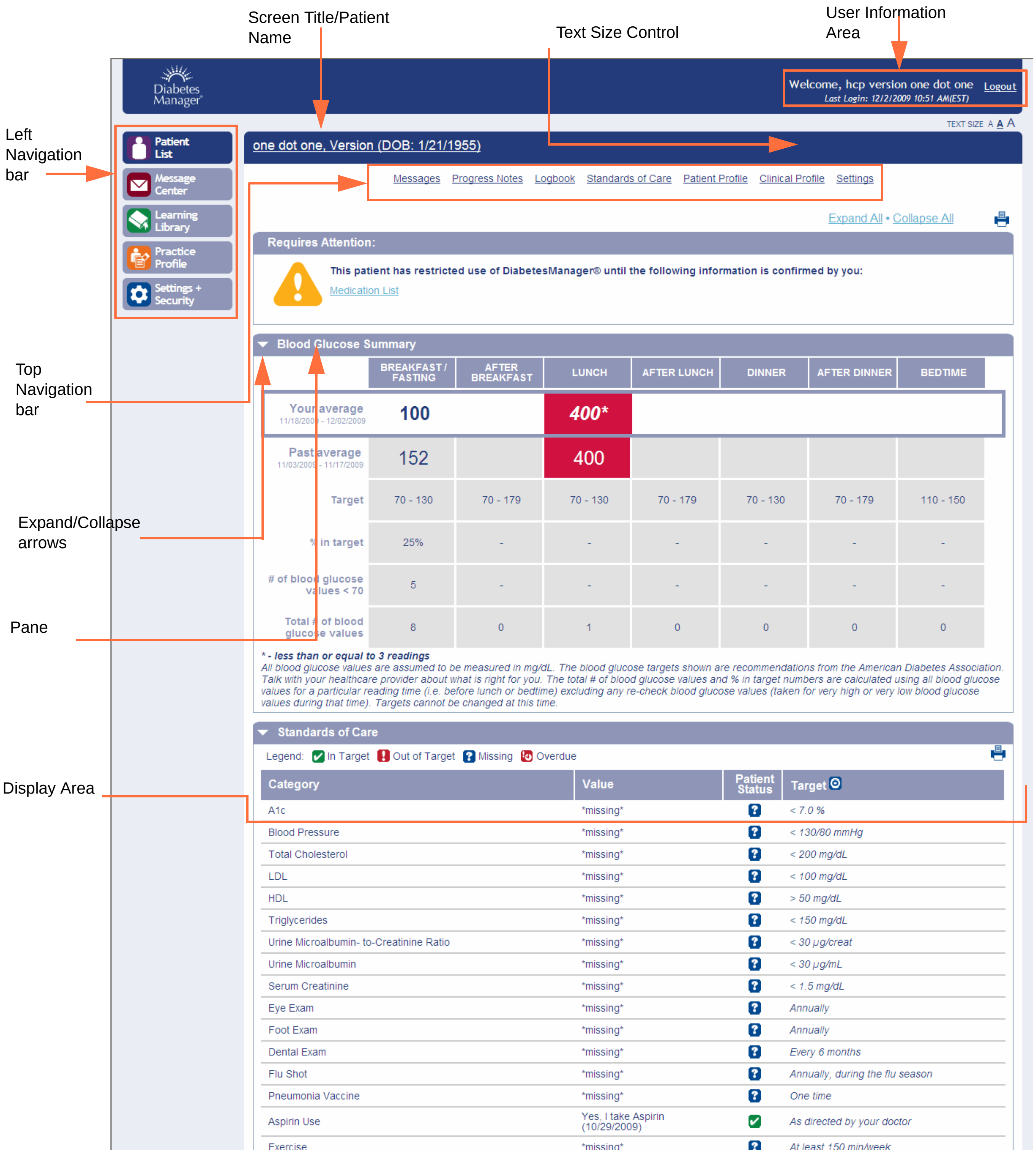
   If you have forgotten your password, click the **Forgot Password** link. Enter the answer to the security question (set during registration) and click **Submit**. A new temporary password is sent to your e-mail. Return to the login screen and enter your e-mail and the new password. You are prompted to create a new permanent password. If you have forgotten your e-mail address, please contact your account director.

   Upon successful login, the Patient List Screen is displayed.

Getting Started

Understanding the Interface

The DiabetesManager user interface is designed to be user friendly and easy-to-use. You can access all major features of the application from the left navigation bar.



Left Navigation Bar

The left navigation bar is the primary source of navigation throughout the application. Clicking on a menu button on this bar takes you to the main screen for that feature. When you click a menu, sub-menu items may also be displayed. The left navigation bar expands to display sub-menu items. You may then click these items to navigate to those topics.

Item	Description
Patient List	List all patients assigned to you or your practice.
Message Center	View, send, and receive messages from your patients or other HCPs.
Learning Library	Check out educational info that can help your patients take care of their diabetes and health.
Practice Profile	View contact information for you and your practice.
Settings + Security	Modify features of your account, such as web login.

Display Area

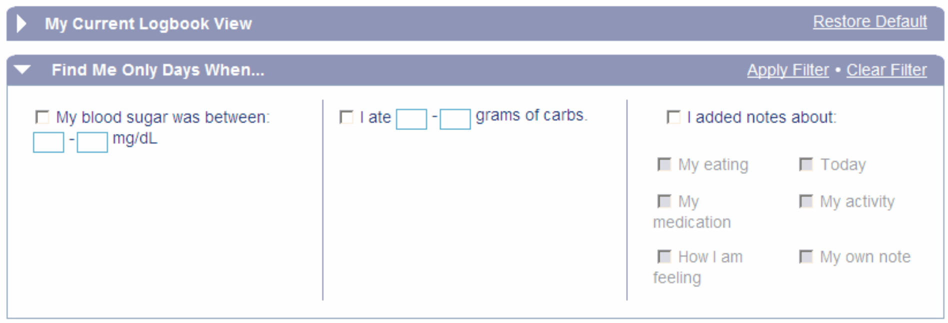
All of the application functionality is shown in the Display Area. Navigation with the Display Area is performed through a combination of links, buttons, and panes.

Screen Title

The title of the screen is shown across the top blue bar in the Display Area. When the screen level drills down into sub-items, the title name is hyphenated to help you keep track of your level.

Panes

Information is grouped into panes in the display area, Panes are separated by light blue bars that title each pane. A single pane may have sections within in. You can open or close panes using the expand and collapse arrows on the title bar for each pane.



Links

Learn More

You can click a link to go to a screen containing information about the link. Links are light blue and underlined.

Buttons

You can click a button to execute an action.

Icons

Icons are used to provide a pictorial clue for text. They can also be used to initiate a task. For example, the breakfast icon is displayed next to breakfast records and can not be clicked, while the pencil icon is an active icon that can be clicked to edit data in the row of a table. Text pops up when you hover over active icons to describe their functionality.

User Information Area and Logging Out

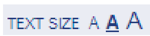
The User Information area displays the name of the person currently logged in, the start time and date of the current login, and provides a method for exiting the application. It is recommended to logout of the application when you are not using it, since access to your private health information is displayable within the application. When you logout, the Login screen is displayed.

If you exit your web browser with logging out, you are automatically logged out.

Top Navigation Bar

When in the Patient Summary Page, a Top Navigation bar helps you navigate through the patient's Web-based application. This bar mimics many of the options available in the Patient's Web-based application left navigation bar.

Changing the Display Text Size



You can use the Text Size Controller to increase or decrease the size of the text displayed in the DiabetesManager application. Click the "A" character that represents the desired text size.

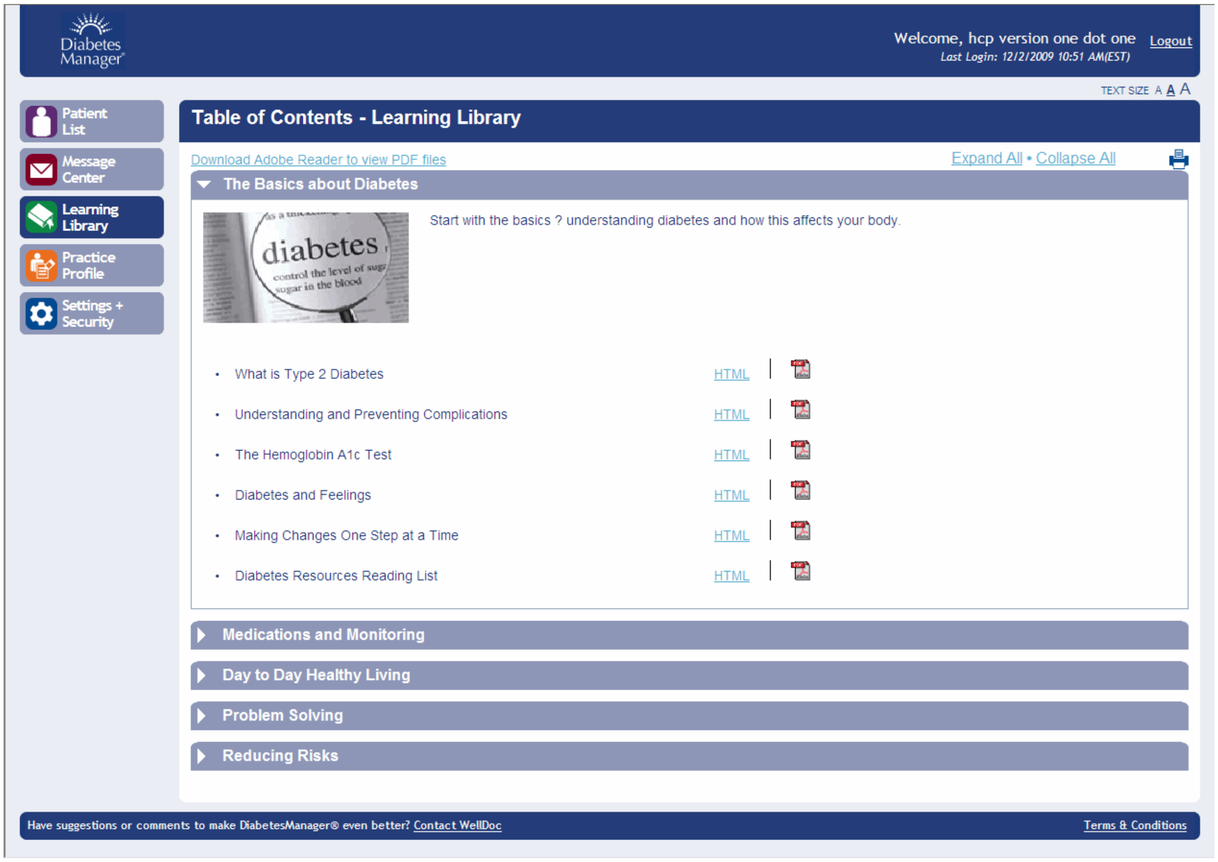
Learning Library

The learning library contains PDF files about nutrition, activity, hypoglycemia, hyperglycemia, sick days, coping with diabetes, and more. The library content was written by diabetes educators and is updated with information on a regular basis. This information is read-only. Visit the library occasionally as new articles are often added. You can tell your patients about particular articles your recommend they read.

To access Learning Library articles:

1. Click **Learning Library** on the left navigation bar.

   The Learning Library is displayed.



2. Navigate through the library and select the HTML or PDF version of the desired articles.

   The HTML version displays directly in your browser. The PDF version invokes Adobe Acrobat Reader and displays the article nicely formatted for printing.

Automated Curriculum

TBD

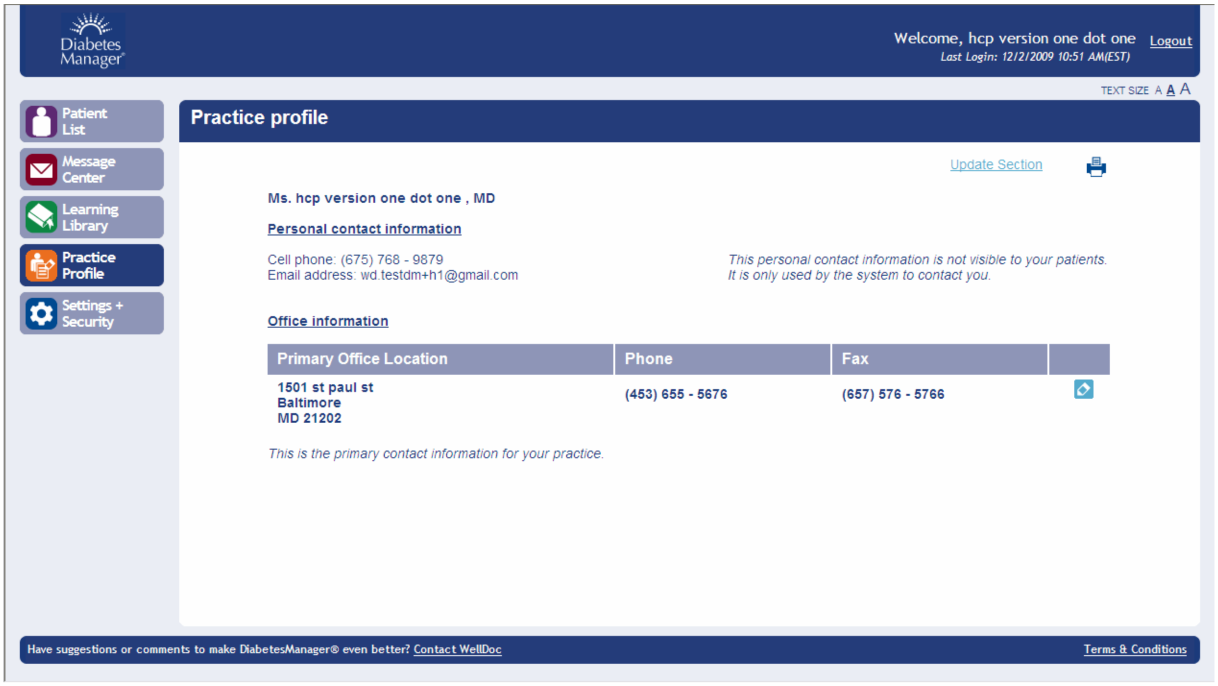
Practice Profile

The practice profile allows you to set personal or practice contact information. This information is displayed to users so that they can contact you.

To update the practice profile:

1. Click **Practice Profile** in the left navigation bar.

The Practice Profile screen is shown.



2. Click **Update Section**.
3. Enter the desired criteria.
4. Click **Save**.

Chapter 3: Settings and Security

The Settings + Security screen allows you to control your patients coaching messages, enable patient communication with you, and change your login password.

In This Chapter

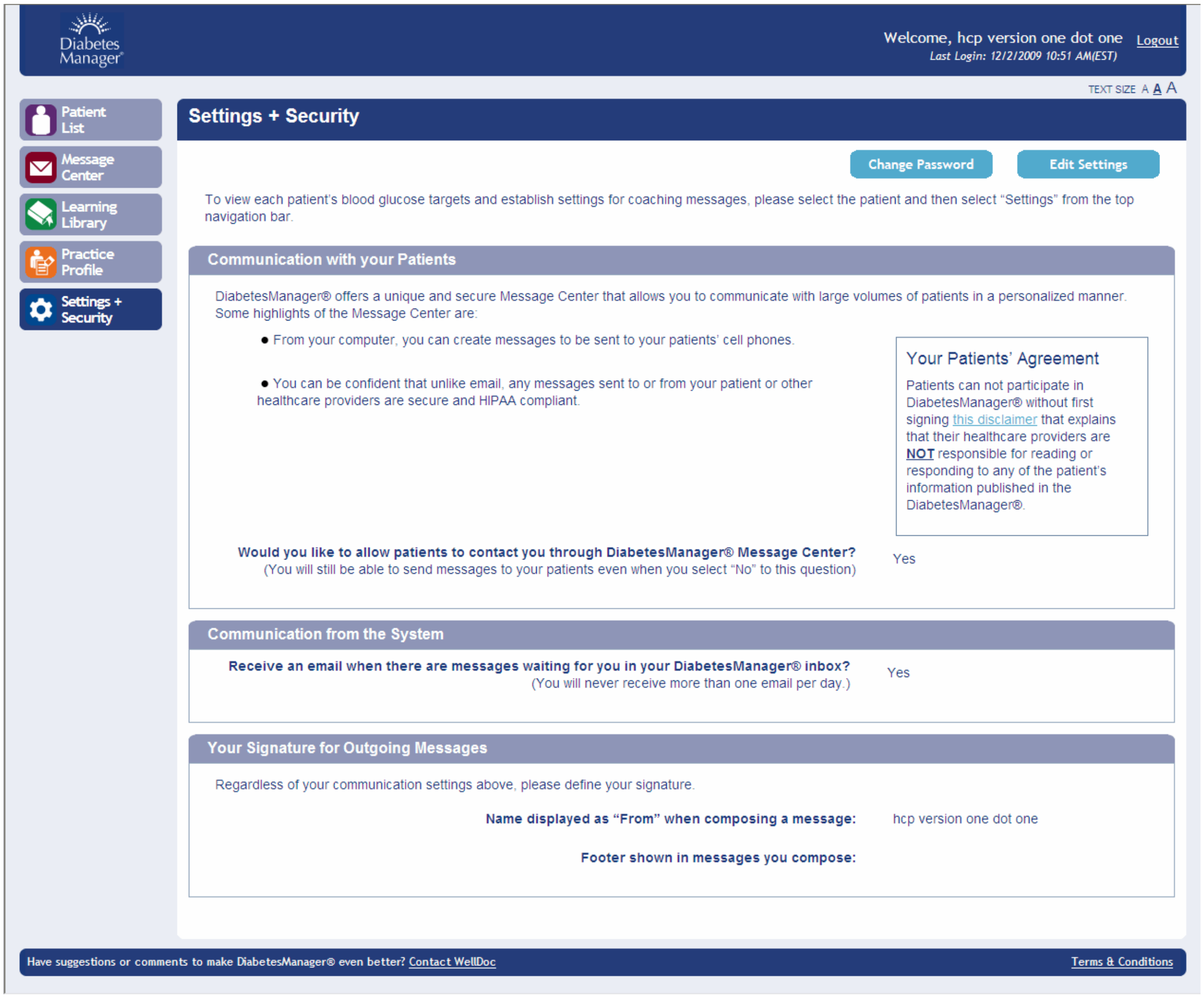
E-mail Notifications for Messages

When messages are in your DiabetesManager inbox, e-mail notifications can be sent to the e-mail address you provided to become a registered user. You will not receive more than one e-mail per day. If you do not wish to be notified, you can turn the system off.

To turn off e-mail notifications:

1. Click **Settings + Security** on the left navigation bar.

The Settings and Security page appears.



2. Click **Edit Settings**.

   The Update Settings dialog appears.

3. Select the **Off** radio button on the E-mail Reminders for Messages pane.

   If notifications have been turned Off and you wish to turn them back on, you can click the On radio button.

4. Click **Save**.

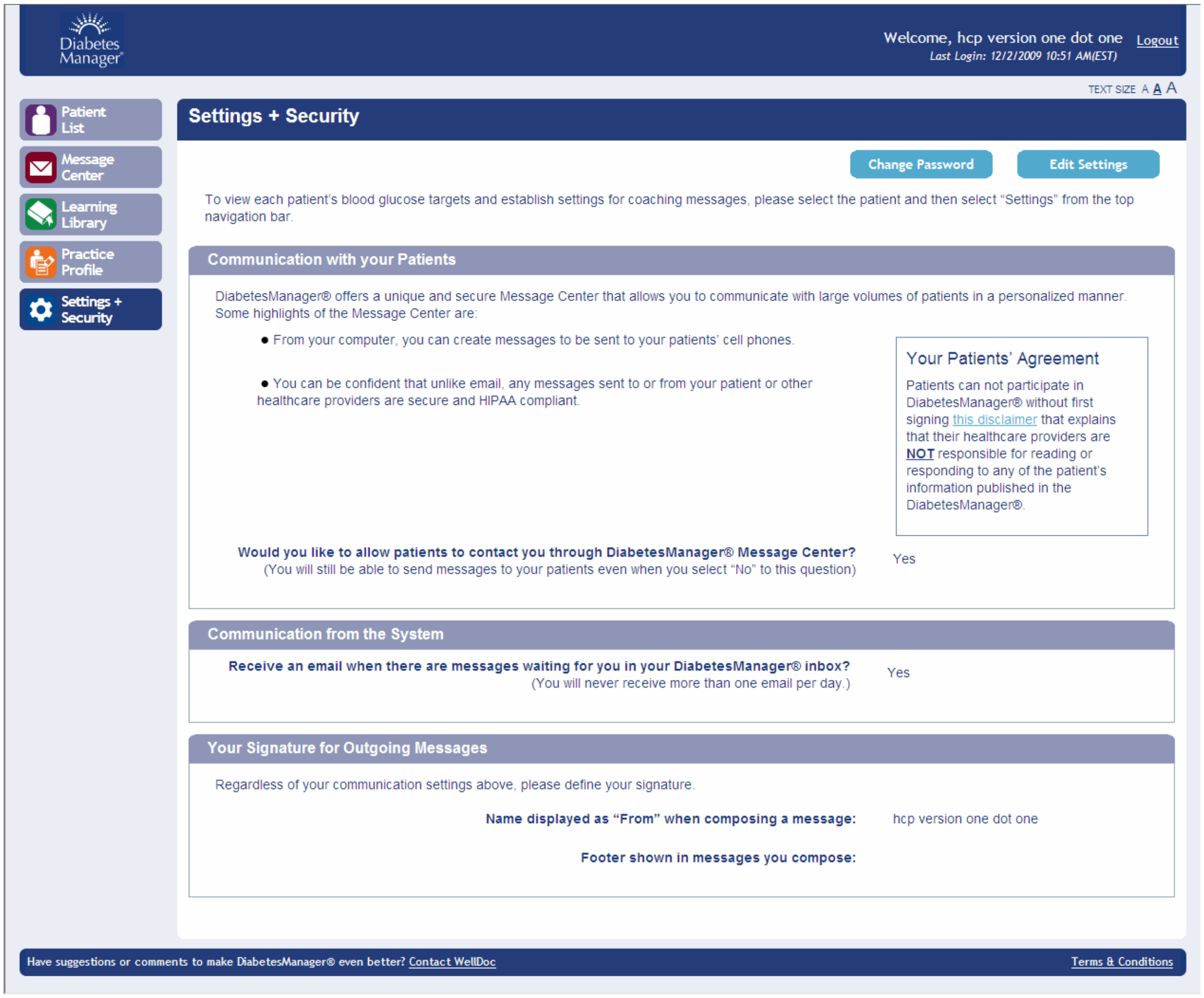
Patient Communication

You can allow patients to send you messages through the Message Center or disable this functionality for them. In either case, you can still send your patients messages through this secure center.

To turn off patient sending ability:

1. Click **Settings + Security** on the left navigation bar.

The Settings and Security page appears.



2. Click **Edit Settings**.

   The Update Settings dialog appears.

3. Select the **Off** radio button on the Communication with your Patients pane.

   If notifications have been turned Off and you wish to turn them back on, you can click the On radio button.

4. Click **Save**.

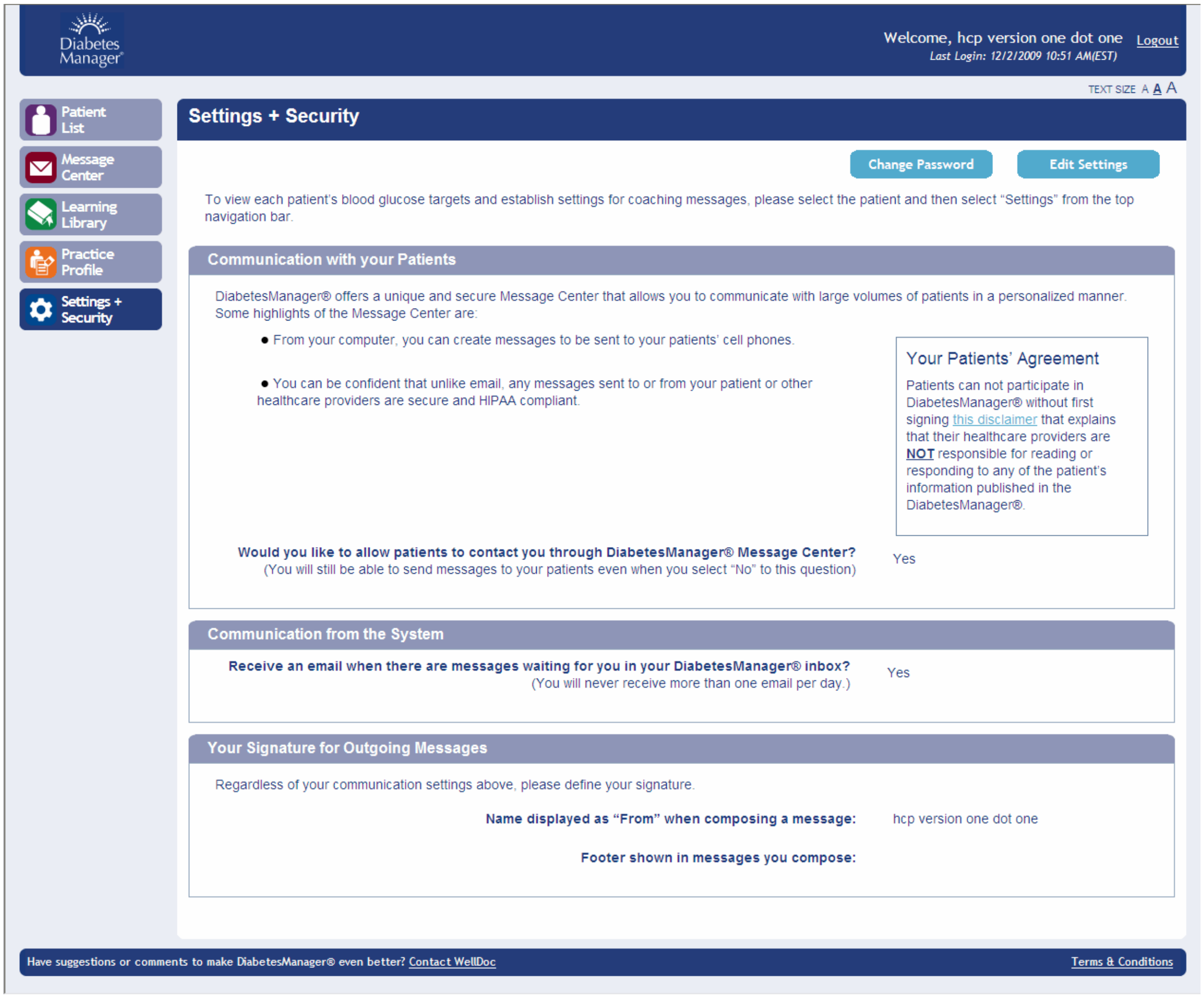
Message Signature

You can create a default signature that is appended at the bottom of all of your outgoing messages to patients.

To create a default signature:

1. Click **Settings + Security** on the left navigation bar.

The Settings and Security page appears.



2. Click **Edit Settings**.

   The Update Settings dialog appears.

3. Enter the desired information in the Your Signature for Outgoing Messages pane.
4. Click **Save**.

Changing Your Password

You can change the web-application login password. Your password is case-sensitive and must:

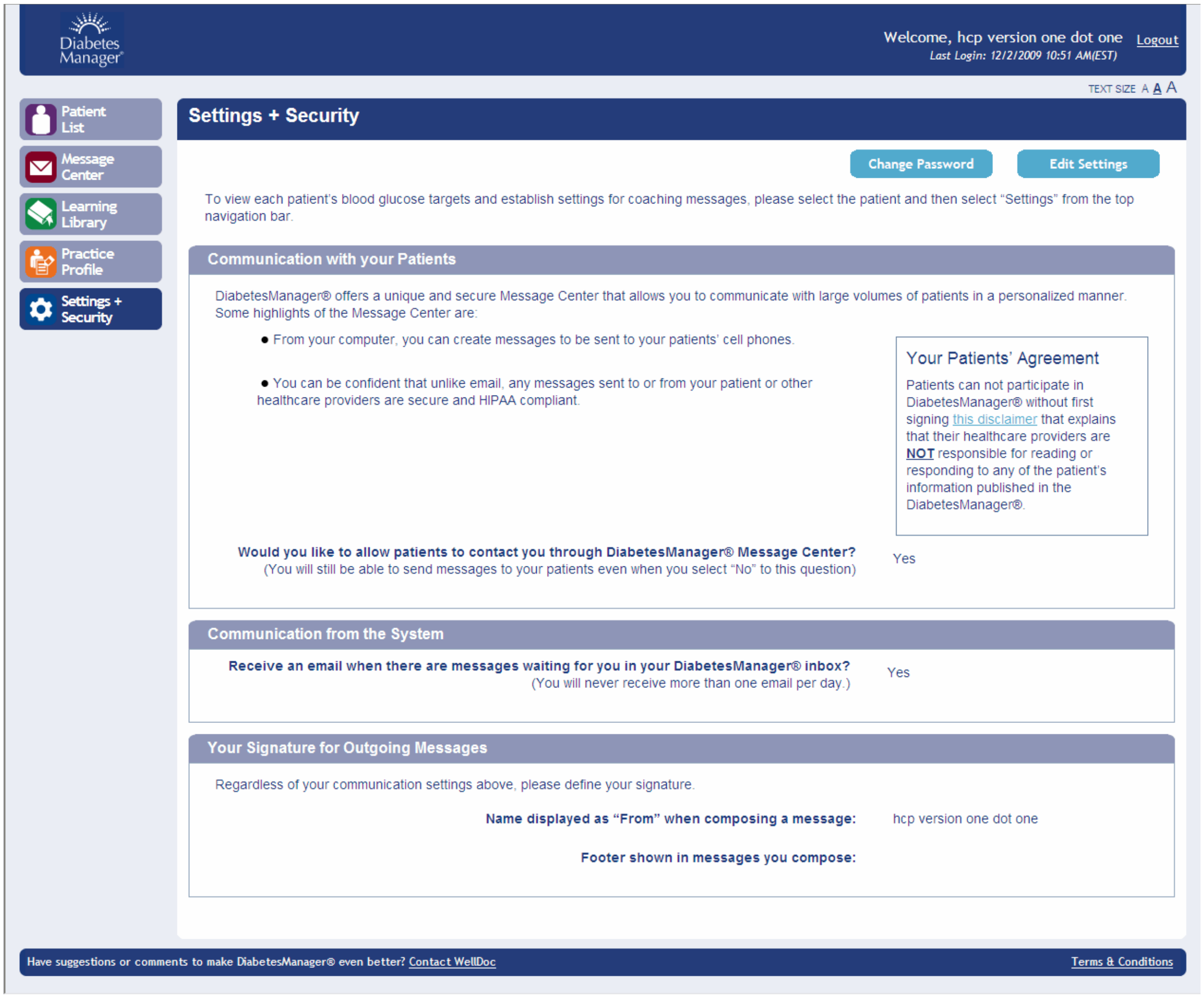
- Have 6 to 10 characters
- Have at least one letter
- Have at least one number
- Be easy for you to remember

Write down your new password and keep it in a safe place.

To change your password:

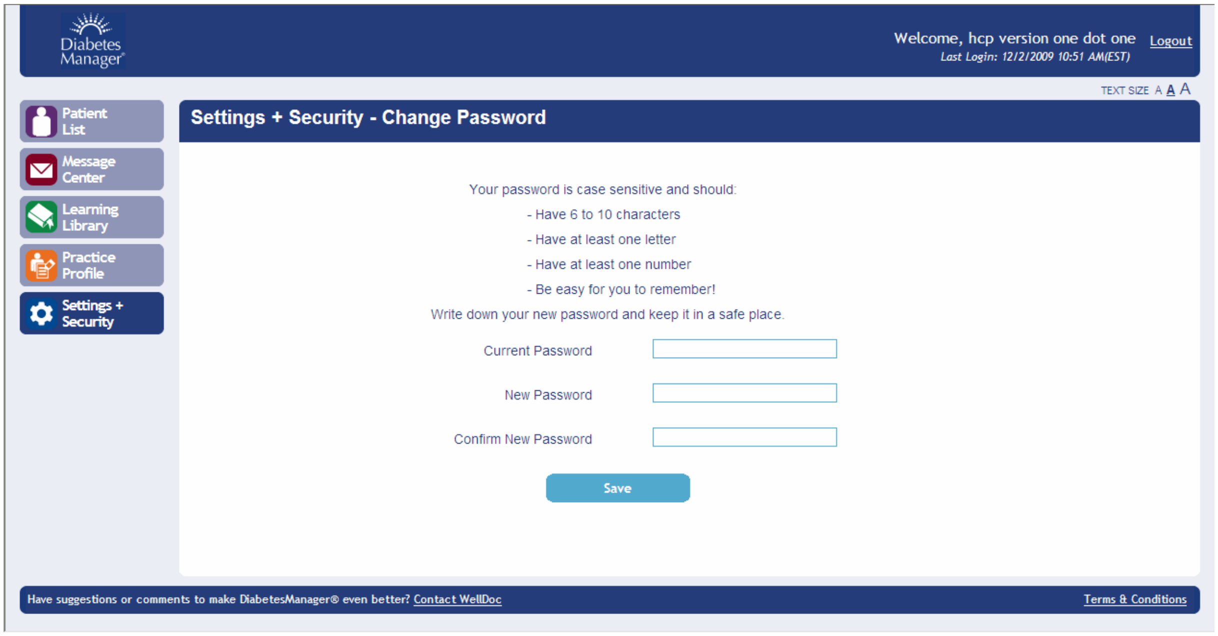
1. Click **Settings + Security** on the left navigation bar.

   The Settings and Security page appears.



2. Click **Change Password**.

The Change Password screen appears.



3. Enter your current password, the new password, and the new password again.
4. Click **Save**.

Chapter 4: Using the Message Center

The Message Center provides secure communication between you and the DiabetesManager system and between you and your patients. It works in a similar fashion to many other e-mail clients in that it has an inbox, outbox, and sent, drafts, and saved items folders. The DiabetesManager may send you messages about your patient that need your attention or patients may send you messages. Some messages are based on defined thresholds set in the system for your patient. The message system has the following features:

Feature	Description
Inbox	Message are received from the DiabetesManager system or from the patient. Messages can be general communication or items that need your attention.
Compose	Ability to compose messages for communication with your patients.
Sent Items	Record of messages that were composed.
Outbox	Messages that are currently being sent.
Drafts	Messages that were composed but not sent. Messages were saved to this folder.
Saved	Messages that have been specially marked to save.

Note: You can control whether your patient can initiate communication with you (see “Patient Communication” on page 3-2).

In This Chapter

- Composing Messages
- Reading Messages
- Deleting Messages
- Searching for Messages

Composing Messages

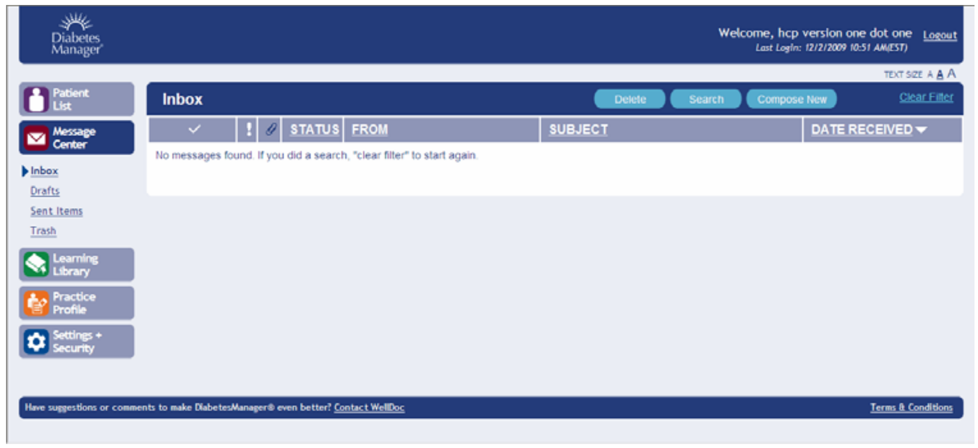
Use the message system in between appointments to communicate non-urgent information to your patient.

You can compose messages that are sent directly to your patients.

To compose new messages:

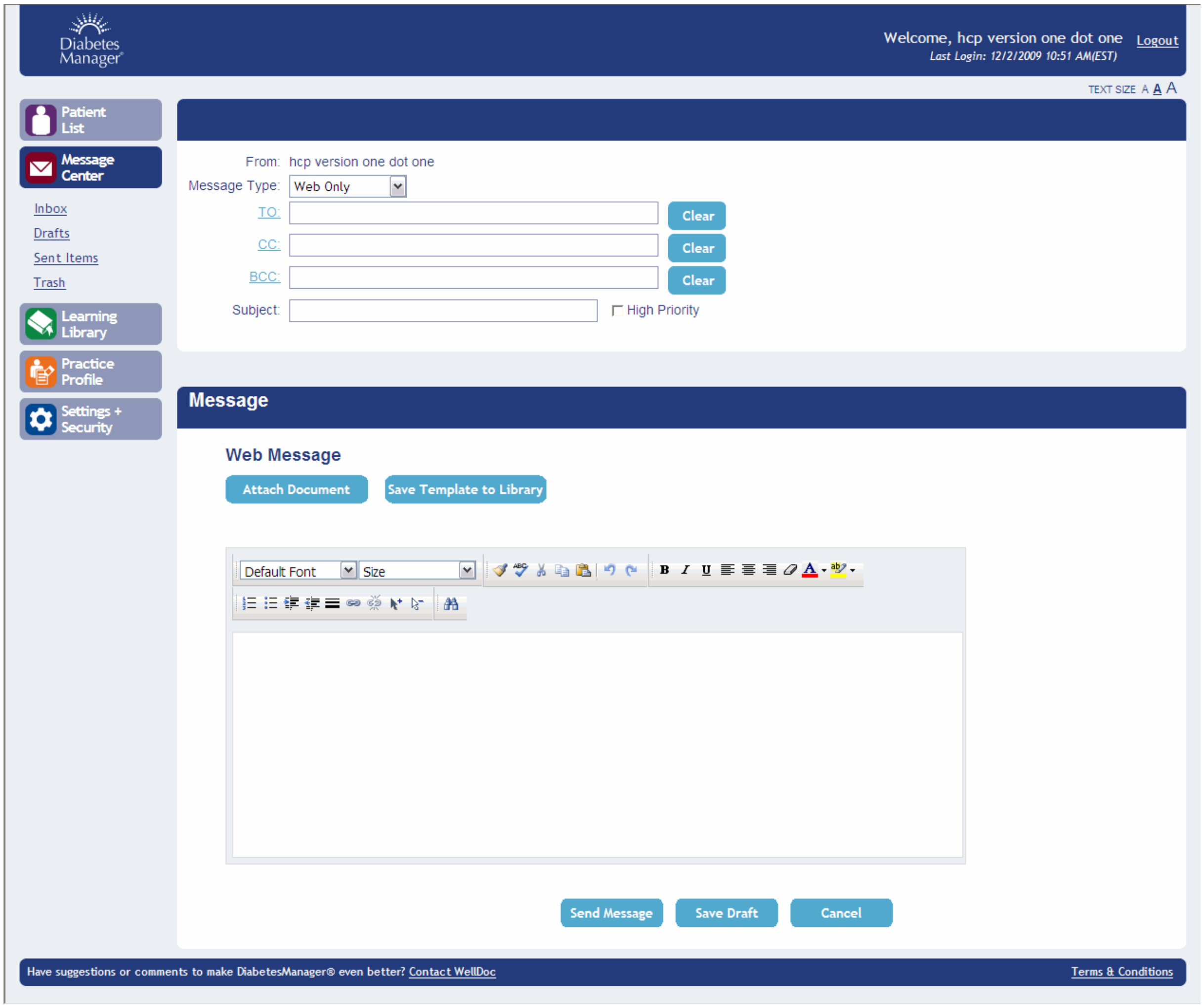
1. Click **Message Center** on the left navigation bar.

   The messages in your inbox are displayed.



2. Click **Compose New**.

The New Message window appears.



3. Select the message type from the pulldown.

   You can send messages to the Patient Web-based application or the Patient Mobile application.

4. Click the **To** link to select recipients from your patient list.

   You can also click the **CC** link to send carbon copies of the message to other providers and case managers. Remember that only your patients or other healthcare providers in the system can receive e-mail from this system. Use your regular e-mail clients for communication with other people.

   If you want to delete all the names out of the To or CC lines, click **Clear** and then re-enter the desired names.

5. Enter a subject for the e-mail.

6. If the message is high priority, click the **High Priority** check box.

7. In the message area, enter your message.

   You can hover over the icons in the message toolbar and click the icon to use their formatting functionality.

8. If you wish to attach a document, click **Attach** and then **Browse** to locate the desired document. Click the document and then click **Open**. Click **Done** to return to the message window.

   If you wish to save a draft of the message before it is sent, click **Save Draft**. The draft is then stored in the Drafts folder.

9. **Save Template to Library**, if desired.
10. Click **Send Message**.

    You can view the templates when you send a message to a patient when in the Patient's Summary table.

Reading Messages

Your inbox is displayed when you enter the Message Center or when you click **Inbox** on the left navigation bar. To read a message, click on the message's subject. You can forward an open message to another healthcare provider, delete the message, or compose a new message.

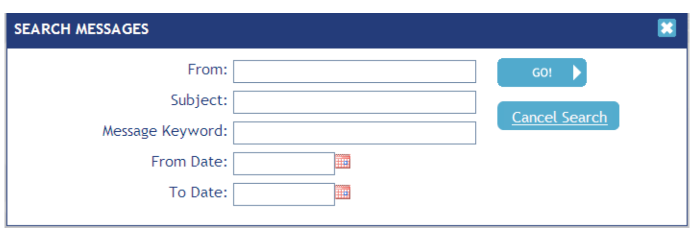
To return to your inbox, click **Inbox** on the left navigation bar.

Deleting Messages

From any of your mail folders, you can delete messages by clicking the checkbox in the message summary line and then clicking **Delete**.

Searching for Messages

You can search for messages in each of your message folders. Click the desired folder and then the **Search** button above the message list. Enter the desired search criteria and Click **Go**.



To return to the current inbox, select **Clear Filter**. This removes the searched messages from the display area and replaces them with the most current messages in your inbox.

Chapter 5: Using Your Patient List

The Patient List screen is displayed every time you log into the application. It provides a list of all of your (and your practice's) patients that are registered with DiabetesManager. Each patient is listed in the Patient Summary Table. In the Patient Summary Table, the patients row summarizes patient cell phone use, medication validation, risk (as set by you), messages from the patient from the Message Center, progress notes and follow up dates (set by you), and the patient's other HCPs (if applicable).

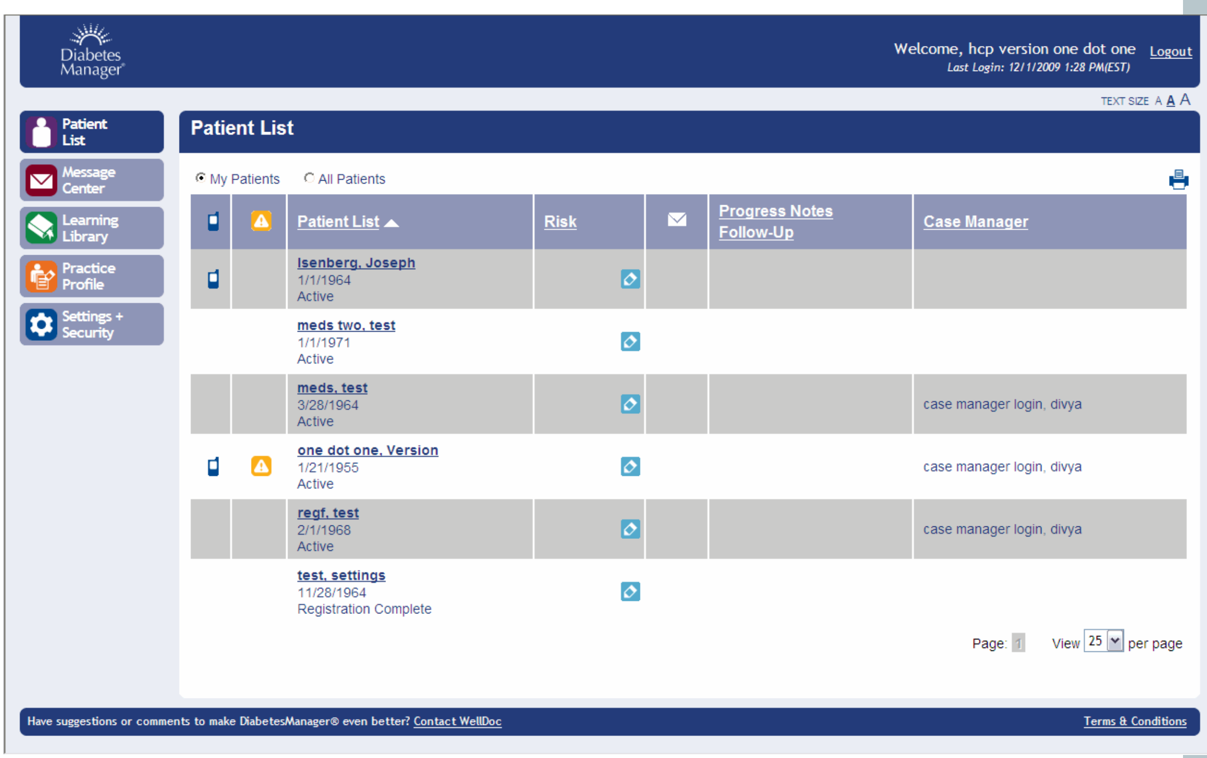
You can return to the Patient Summary Table at anytime by clicking the Patient List menu on the left navigation bar.

In This Chapter

- View
- Patient Medication Changes
- Messages
- Progress Notes
- Patient Settings

View

You can view a list of patients assigned to you (My Patients) or to your practice (All Patients) by clicking the desired radio button. The Patient Summary Table displays the list of patients according to your selection.



To view or change all other populated items contained in the summary row, click the item.

Note: Only the items that apply to the specific patient are shown in the patient's row. Some cells in the table may be empty. For example, if there are no progress notes, the progress notes cell will be empty.

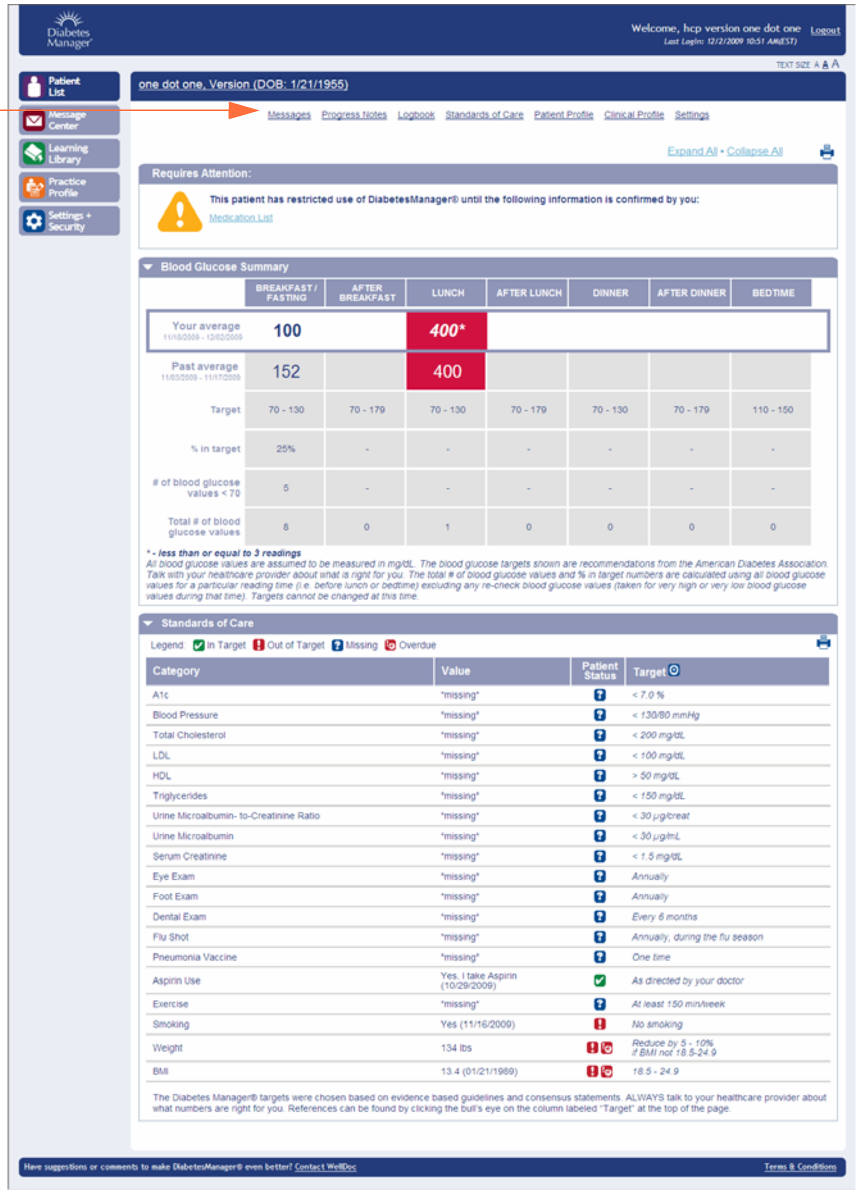
Setting Patient Risk

You can edit the patients risk status by clicking the edit icon. Select from the pulldown to indicate whether you consider the patient to be low risk, medium risk or high risk.

Drilling Down to Patient Details

To drill down into the patients details, click the name of the patient in the Patient Summary Table. You are placed in the Patient Summary page.

Top Navigation Bar



Once you are in a Patient's Summary Page, navigation is performed through the Top navigation bar. All items selected from this bar pertain only to the selected patient. Items contained in the Top navigation are the same items available to the patient in the Patient Web-based application. Although the names of these items may be tailored for the HCP view, the content is the same.

In addition to the Top navigation bar, the Patient Summary Page has section that indicates when validation is needed for the patient (only enabled for pHCPs, the patients logbook Blood glucose summary, and the patients Standards of Care summary (referred to as the Control Center in the Patient version)

Patient Medication Changes

Patients can make changes to their medication regimen in their application. When they make these changes, the change is shown in the Patient List and enabled for pHCPs to verify. When pHCP approval is needed an icon appears next to the patient's name in the list. npHCPs can see that the medication needs validation, but cannot perform this task. The option is grayed out.

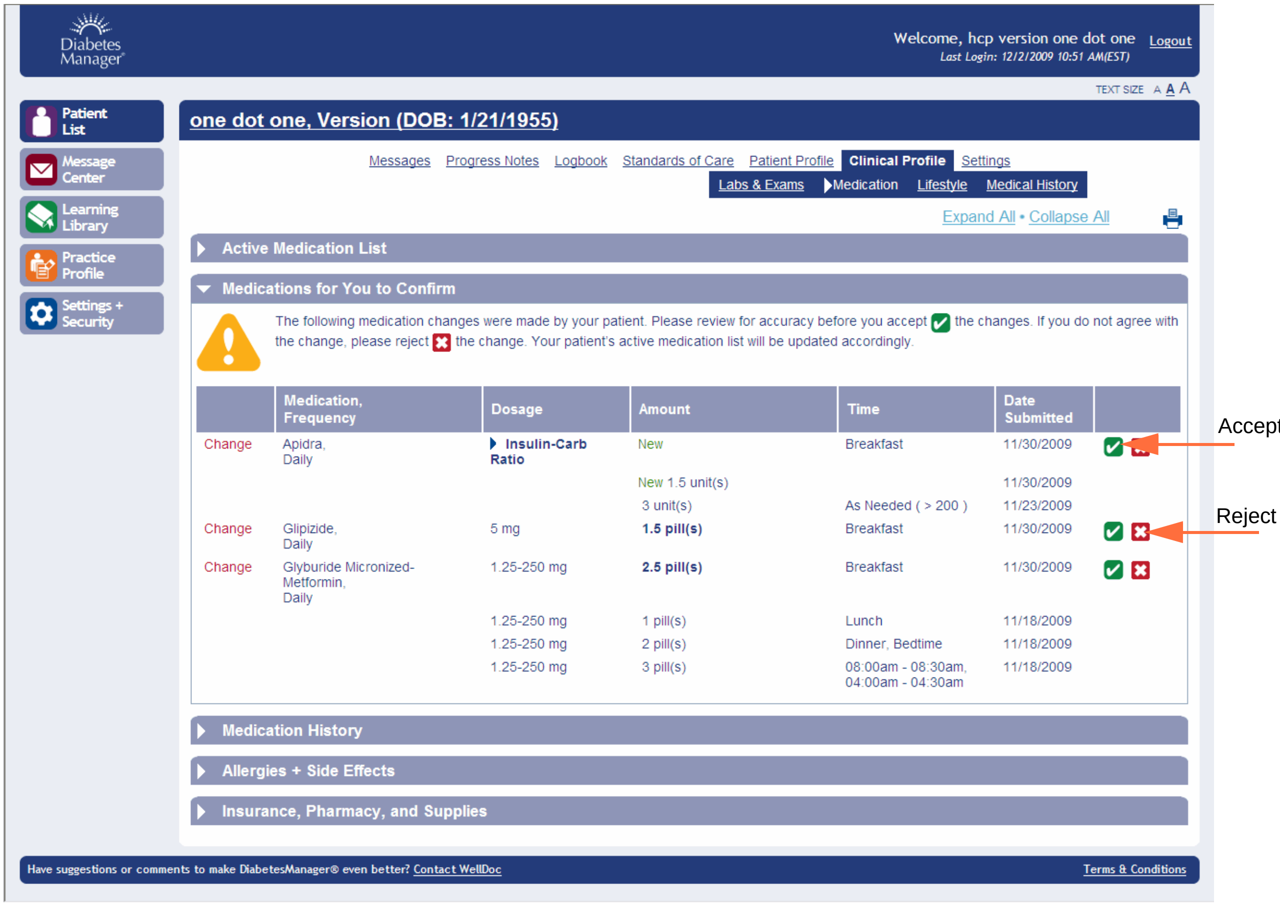
pHCP validation, allows the medication to be displayed with full dosage information to the patient in their logbook entry screen. Without pHCP validation, the patient can only see the name of the medication in their logbook entry screen.

To validate medication

1. In the patient list, click the icon in the Patient's summary row.

   You may also click the patient name to see the Patient Summary window. The validation window appears.
2. Click the item type in the Requires attention pane that you wish to validate.

The validation window appears for the item selected.



3. Click the Accept icon to validate the change or the Reject icon to reject the change.

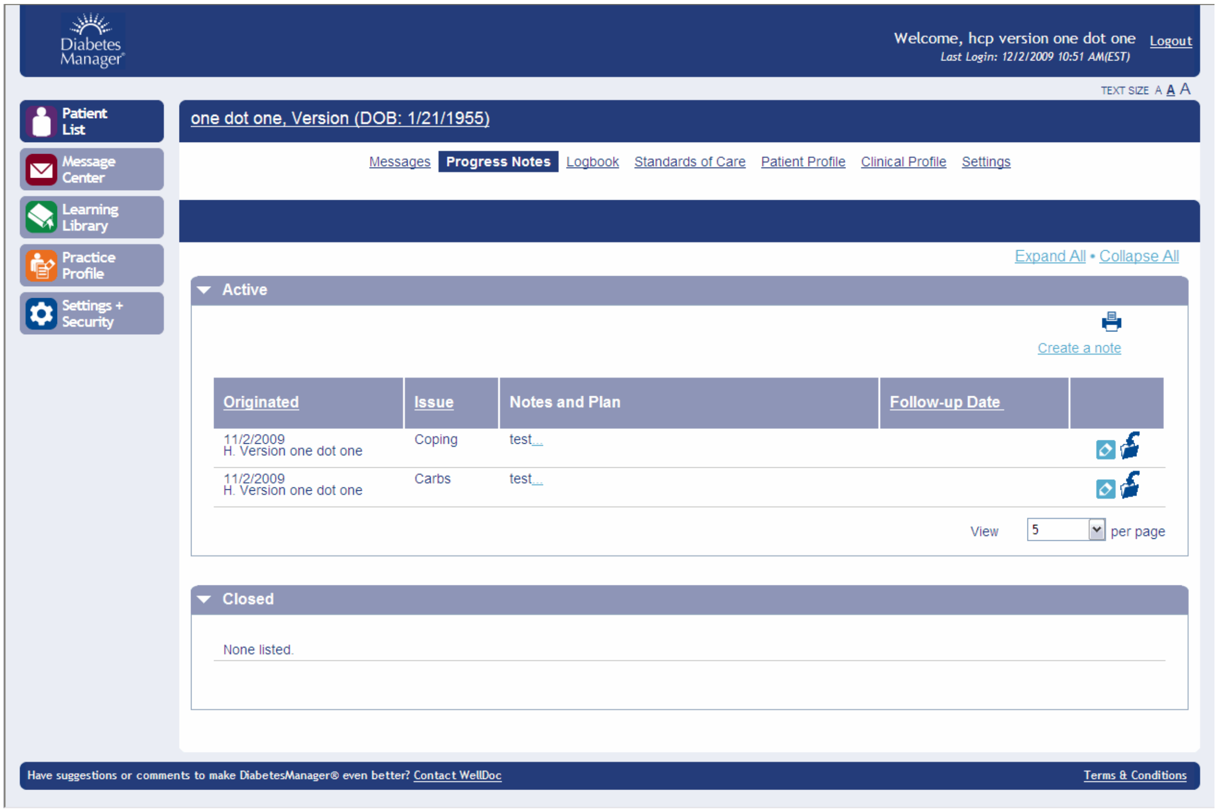
Your patient is notified of your changes.

Messages

Clicking the messages in the summary table of the message option in the top navigation bar, takes to you to the Message Center specifically for this patient. See “Using the Message Center” on page 4-1 for more information.

Progress Notes

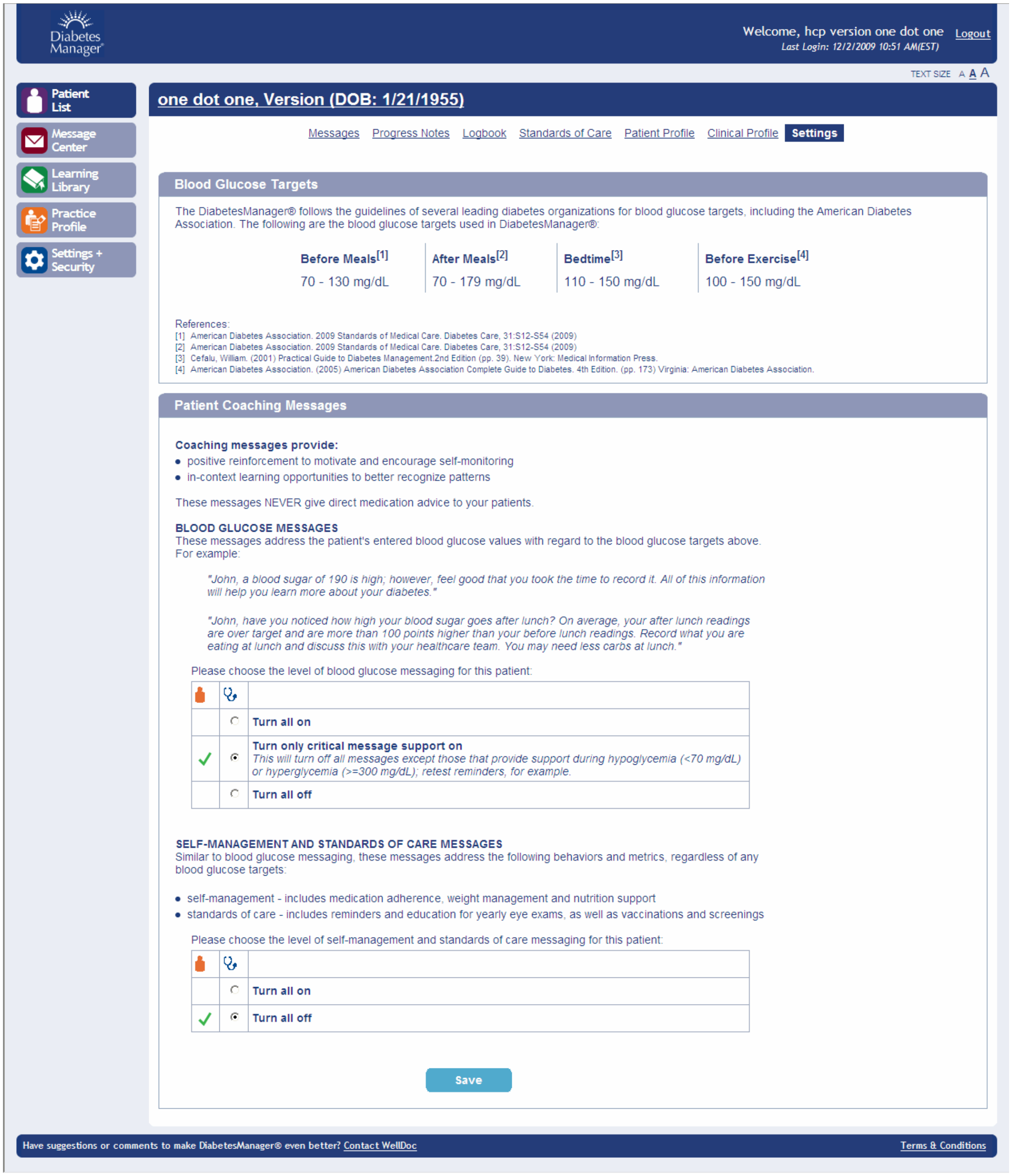
You can create notes about your patient that include general progress and follow up dates. Current notes are listed in the Patient Summary table. Clicking on them takes you to the note details and the ability to edit them or close them when they are no longer pertinent. You can create new notes for a patient using the Progress Notes option in the top navigation bar and clicking **Create Note**.



Patient Settings

The Patient Settings page, accessible from the Top Navigation bar, shows the patients blood glucose targets. These targets are then used to evaluate in target and out of target readings.

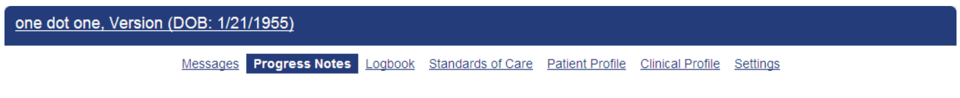
It also allows pHCPs to set the level of Real-time BG coaching feedback patients get when they enter blood glucose values into their logbook and whether patients receives self-management education or standards of care messages in their Message Center inbox.



Chapter 6: Reviewing Your Patient's Information

In This Chapter

The Top navigation bar allows you to review all of the information your patient into their Web-based application and allows you enter or modify that information.



Logbook

The DiabetesManager Logbook provides a single location where information about daily diabetes-related activity is stored. Information such as blood glucose readings, carbohydrate intake counts, medication taken, and exercise can be entered into the logbook by you or your patient. This information can be entered as it happens or at a later date. The logbook is viewable and modifiable.

Entering New Information

You can enter information about a patient's current activity, such as blood sugar readings, eating, and exercising. A time stamp is added to the data when you enter it.

1. Select **Logbook** from the top navigation menu.

Reviewing Your Patient’s Information

The Logbook Calendar View is displayed.

2. Select **Enter New Info**.

The Enter New Info Screen appears.

3. Select the desired menu item and submenu item (if required).

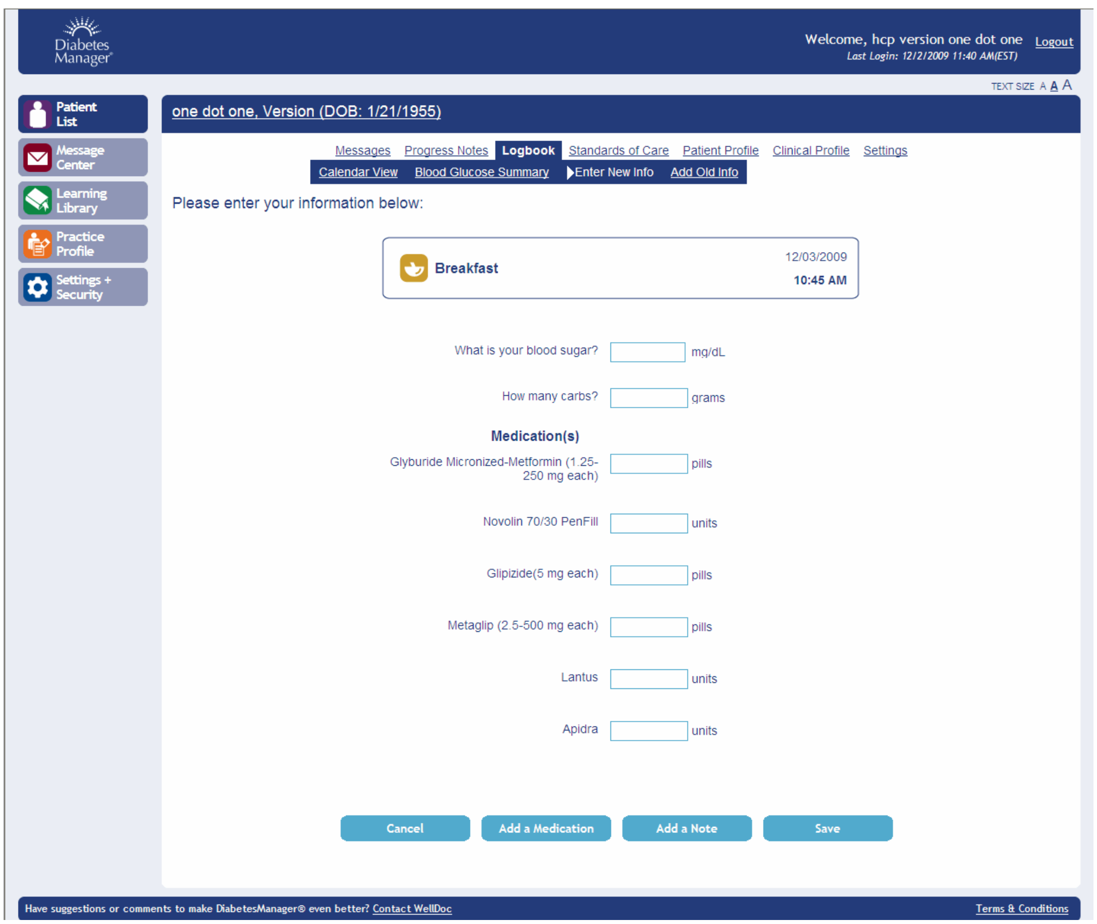
The following menus are available:

Menu item	Description
Meal Info	Enter information before they ate a meal.
Bedtime	Enter information before they go to bed.
Just Take Meds	Only enter the medications they are taking.
Just Check Sugar	Only enter blood sugar readings.
After Meal	Enter information related to 1-2 hours after the start of a meal.
Exercise Info	Enter information before exercise.
After Exercise Info	Enter information related to the exercise just done.
Make A Note	Add a note to entries about eating, medications, feelings, schedule, activity, and anything is important to note.

Reviewing Your Patient's Information

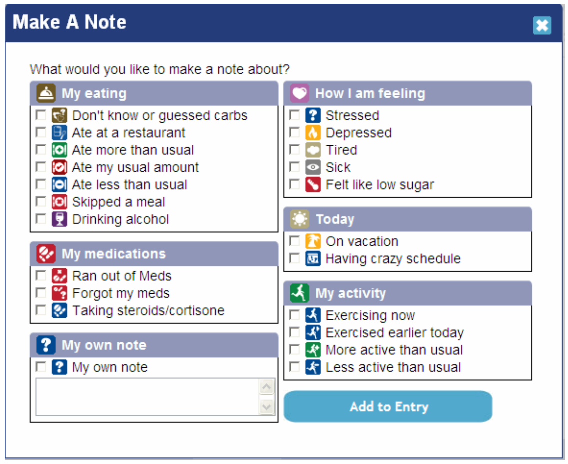
An example of a submenu is the Meal info submenu.

4. Continue navigating through the screens until you reach the desired data entry screen.



5. Enter all the data you wish to record.

   If you wish to add notes, click **Add Notes**. The following screen appears, click the desired notes or add your own. Click **Add to Entry**.



   If you wish to add a medication, click **Add Medication**, Add the medication from the lists of medications you are currently taking. Click **Save**.

   To add a new medication to the list see "Medications" on page 6-8.

6. After all data has been entered, select **Save**.

Adding Old Information in the Logbook

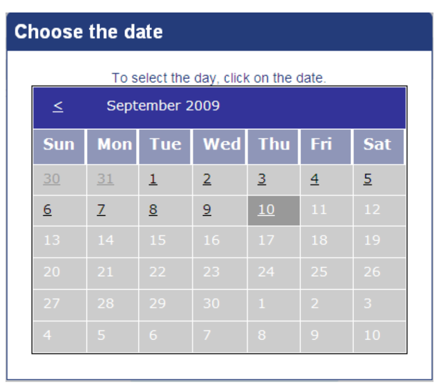
You can enter information that happened earlier, such as blood sugar readings you took. You can enter information from anytime after you completed registration of the product.

1. Select **Logbook** from the top navigation menu.

   The Logbook Calendar View is displayed.

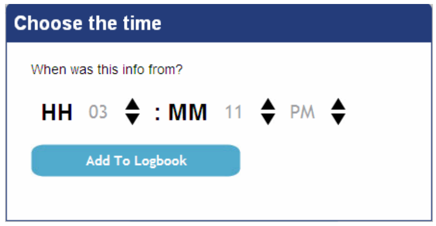
2. Select **Add old info**.

   A calendar is displayed.



3. Select the date the activity occurred.

A time entry window appears.



4. Select the time the activity occurred.

   Use the up and down arrows. Include hours, minutes, and am or pm.

5. Click **Add to logbook**.

   The Enter Old Info Window appears. See "Entering New Information" on page 6-1 for details on menu selections and entering data.

6. Select the desired menu item and submenu item (if required).
7. Enter the data such as blood sugar number or carbohydrate count.
8. Select **Save**.

Viewing/Editing Information in the Logbook

The last two weeks worth of entries are displayed in the logbook by default. You can search for specific logbook entries by date range or other criteria. High or low sugar readings are shown in red. You can turn the color coding off by checking the **turn color off** box.

1. Select **Logbook** from the top navigation menu.

   The Logbook Calendar View is displayed.

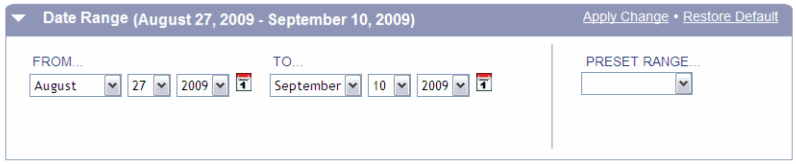
2. Select **Calendar View**.

Searching for Logbook Entries

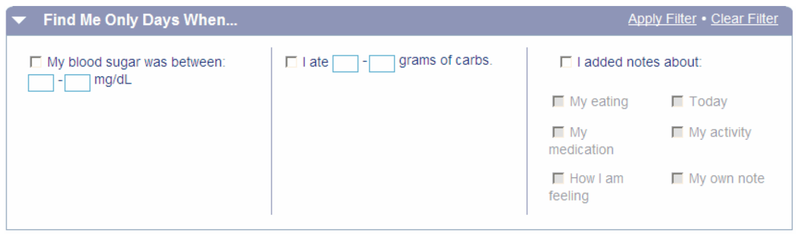
1. Search for the desired logbook entry using a **Date Range** or **Find Me Only On Days When...**.

Reviewing Your Patient's Information

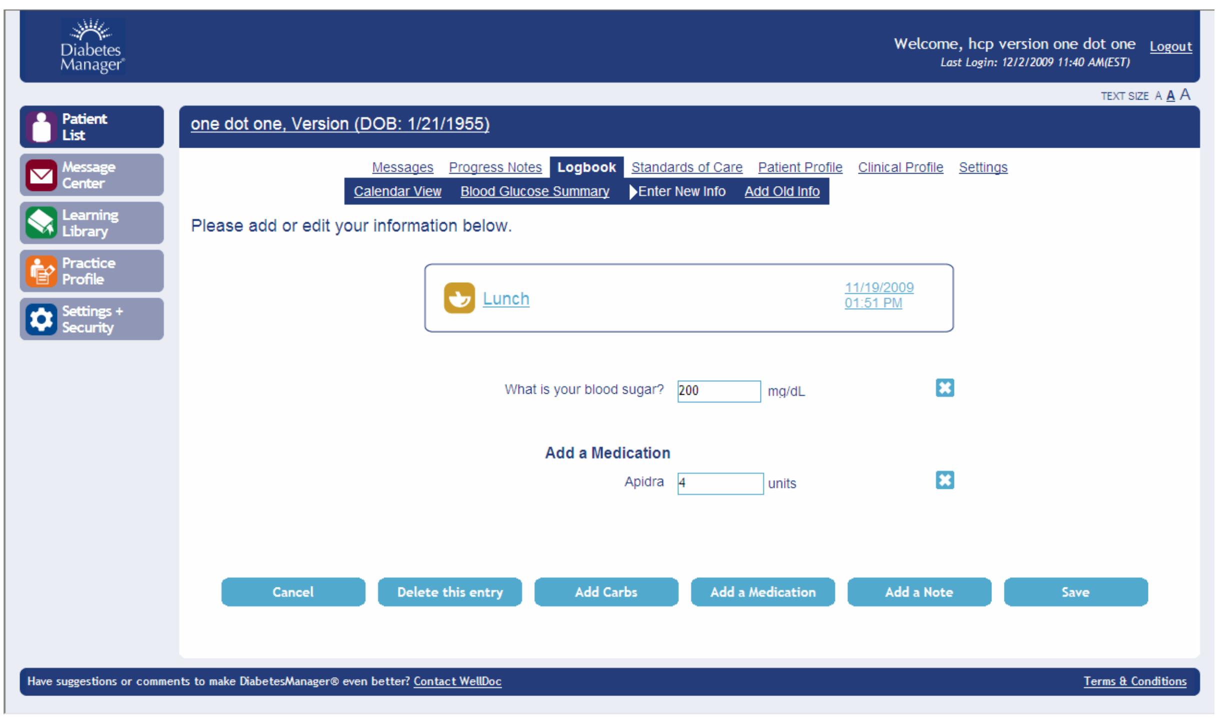
Select the Date Range pane and the select the From and To dates from the pulldowns or a Present Range. Click **Apply Change** to change the logbook view below.



Select the Find me Only on Days When... pane and then check the boxes in each section that indicate the blood sugar or carbohydrate reading or notes for which you wish to search. Click **Apply Filter** to change the logbook view below.



2. To modify entries, click the entry in the logbook.
3. Edit the data shown using normal data entry methods on the web.



4. Select **Save** after you have modified information.

   You can also Add More Info, such as notes, or additional medication, to this entry or Delete it, by clicking those buttons.

Sugar Summary

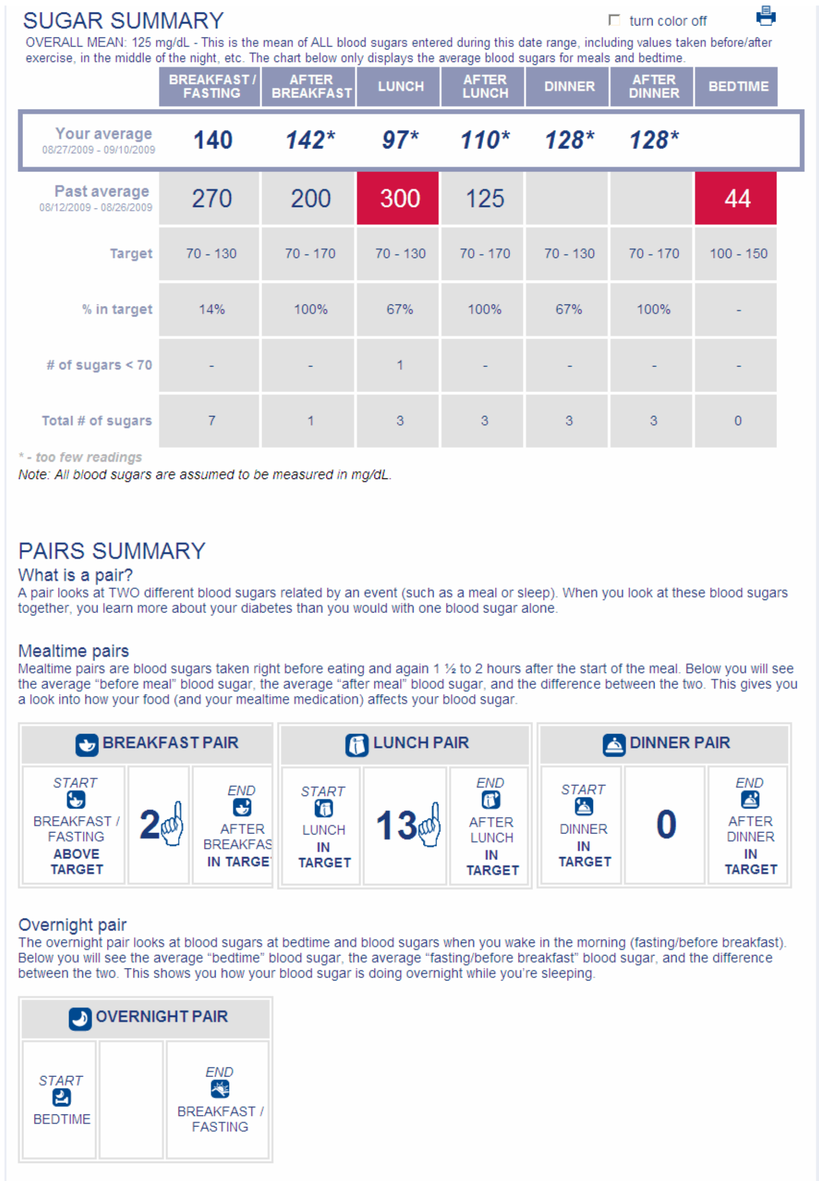
You can view a summary based on blood sugar readings that evaluates the data you have entered and provides you with averages and pair information.

1. Select **Logbook** from the top navigation menu.

   The Logbook Calendar View is displayed.

2. Select **Sugar Summary**.

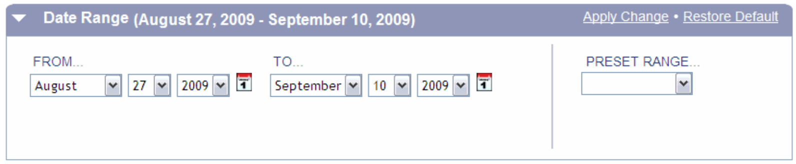
   The Sugar Summary screen is displayed.



	BREAKFAST / FASTING	AFTER BREAKFAST	LUNCH	AFTER LUNCH	DINNER	AFTER DINNER	BEDTIME
Your average 08/27/2009 - 09/10/2009	140	142*	97*	110*	128*	128*	
Past average 08/12/2009 - 08/26/2009	270	200	300	125			44
Target	70 - 130	70 - 170	70 - 130	70 - 170	70 - 130	70 - 170	100 - 150
% in target	14%	100%	67%	100%	67%	100%	-
# of sugars < 70	-	-	1	-	-	-	-
Total # of sugars	7	1	3	3	3	3	0

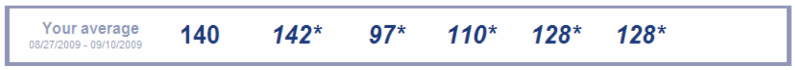
Reviewing Your Patient’s Information

3. If desired, select a date range from the Date Range pane From and To pulldowns or a Present Range.



4. Click **Apply Change** to change the sugar summary view below.

Averages are calculated and displayed in the table. If only some information is available, an asterisk is placed next to the value listed indicating that this may not be a true average.



If not enough entries have been added, data may not be displayed at all. High and low sugar reading are shown in red. You can turn the color coding off by checking the **turn color off** box.

Understanding Pairs

A pair looks at two different blood sugars related by an event (such as a meal or sleep). Mealtime pairs are blood sugars taken right before eating and again 1 ½ to 2 hours after the start of the meal. Mealtime pairs show the average “before meal” blood sugar, the average “after meal” blood sugar, and the difference between the two. This gives you a look into how food (and mealtime medication) affects your patient’s blood sugar.

The overnight pair looks at blood sugars at bedtime and blood sugars in the morning (fasting/before breakfast). Overnight pairs show the average “bedtime” blood sugar, the average “fasting/before breakfast” blood sugar, and the difference between the two. This shows you how blood sugar is changing overnight.

Standards of Care

This page provides an overview of the following patient information:

- Lab values
- Exam dates
- Lifestyle behaviors
- Weight and BMI
- Recommended labs, exams, and shots
- Target values: in target, out of target, missing, or overdue
- Status

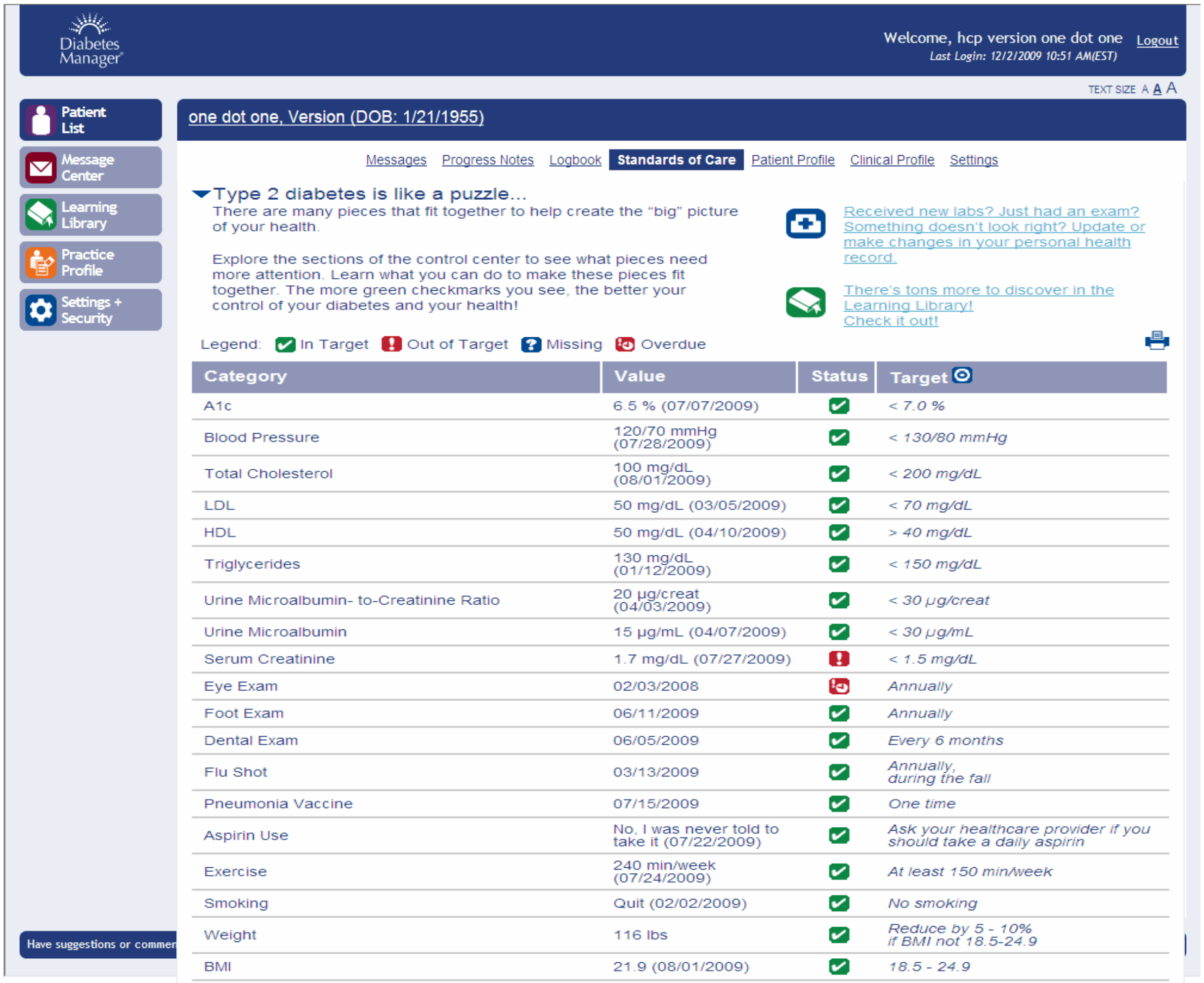
If changes are needed to the information displayed in the Standards of Care, access the personal health record to make those changes. See “Clinical Profile” on page 6-11 for more information.

Note: The patients view of this page is called the Control Center.

To access your patient's standards of care:

1. Click **Standards of Care** on the top navigation bar.

   The Control Center screen is displayed.



Category	Value	Status	Target
A1c	6.5 % (07/07/2009)	In Target	< 7.0 %
Blood Pressure	120/70 mmHg (07/28/2009)	In Target	< 130/80 mmHg
Total Cholesterol	100 mg/dL (08/01/2009)	In Target	< 200 mg/dL
LDL	50 mg/dL (03/05/2009)	In Target	< 70 mg/dL
HDL	50 mg/dL (04/10/2009)	In Target	> 40 mg/dL
Triglycerides	130 mg/dL (01/12/2009)	In Target	< 150 mg/dL
Urine Microalbumin- to-Creatinine Ratio	20 µg/creat (04/03/2009)	In Target	< 30 µg/creat
Urine Microalbumin	15 µg/mL (04/07/2009)	In Target	< 30 µg/mL
Serum Creatinine	1.7 mg/dL (07/27/2009)	Out of Target	< 1.5 mg/dL
Eye Exam	02/03/2008	Overdue	Annually
Foot Exam	06/11/2009	In Target	Annually
Dental Exam	06/05/2009	In Target	Every 6 months
Flu Shot	03/13/2009	In Target	Annually, during the fall
Pneumonia Vaccine	07/15/2009	In Target	One time
Aspirin Use	No, I was never told to take it (07/22/2009)	In Target	Ask your healthcare provider if you should take a daily aspirin
Exercise	240 min/week (07/24/2009)	In Target	At least 150 min/week
Smoking	Quit (02/02/2009)	In Target	No smoking
Weight	116 lbs	In Target	Reduce by 5 - 10% if BMI not 18.5-24.9
BMI	21.9 (08/01/2009)	In Target	18.5 - 24.9

2. View the desired information.

Clinical Profile

You can view or change information that has been saved in the patient's personal health record. A subset of this information is displayed in the Standards of Care, but all of this information can only be modified in the Clinical Profile. This Clinical Profile contains:

- Medical history
- Medication list
- Medication history
- Medication schedules

- Medication allergies
- Exams and shots
- Lab reports
- Weight and BMI
- Lifestyle habits
- Pharmacy, diabetes supplies, and insurance information

This information was entered during registration and is modifiable in this application.

Note: The patient view of this page is call Personal Health History (PHR).

Labs & Exams

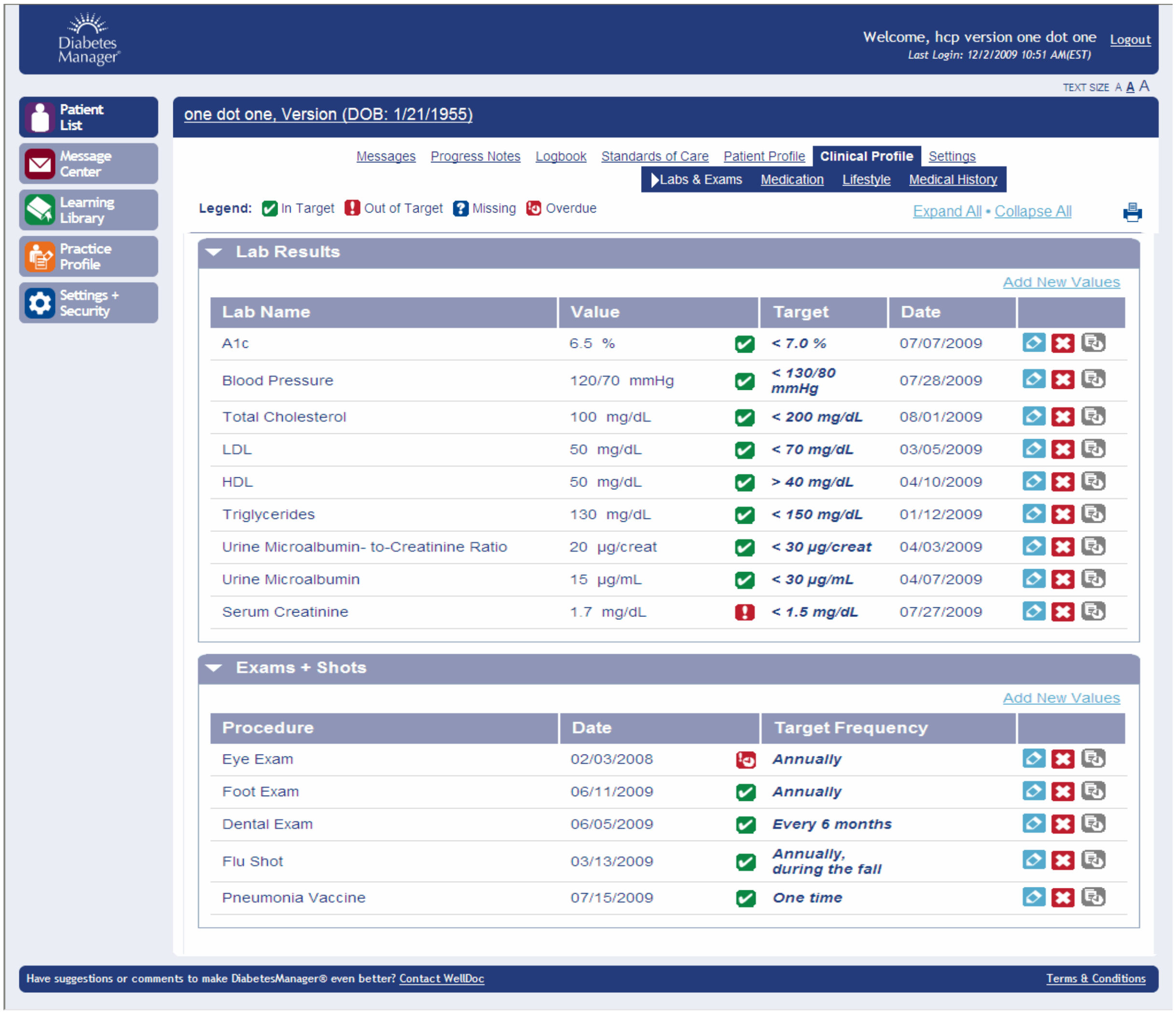
You can view or modify lab reports as well as exam history and schedule.

To modify lab and exam information:

1. Click **Clinical Profile** on the top navigation bar.

   The Procedures screen (labs and reports default screen) appears with labs and reports selected.
2. Click **Labs & Reports**.

The labs and reports screen is displayed.



3. Use the edit, delete, and history icons to edit the existing line item, delete it, or review its history.

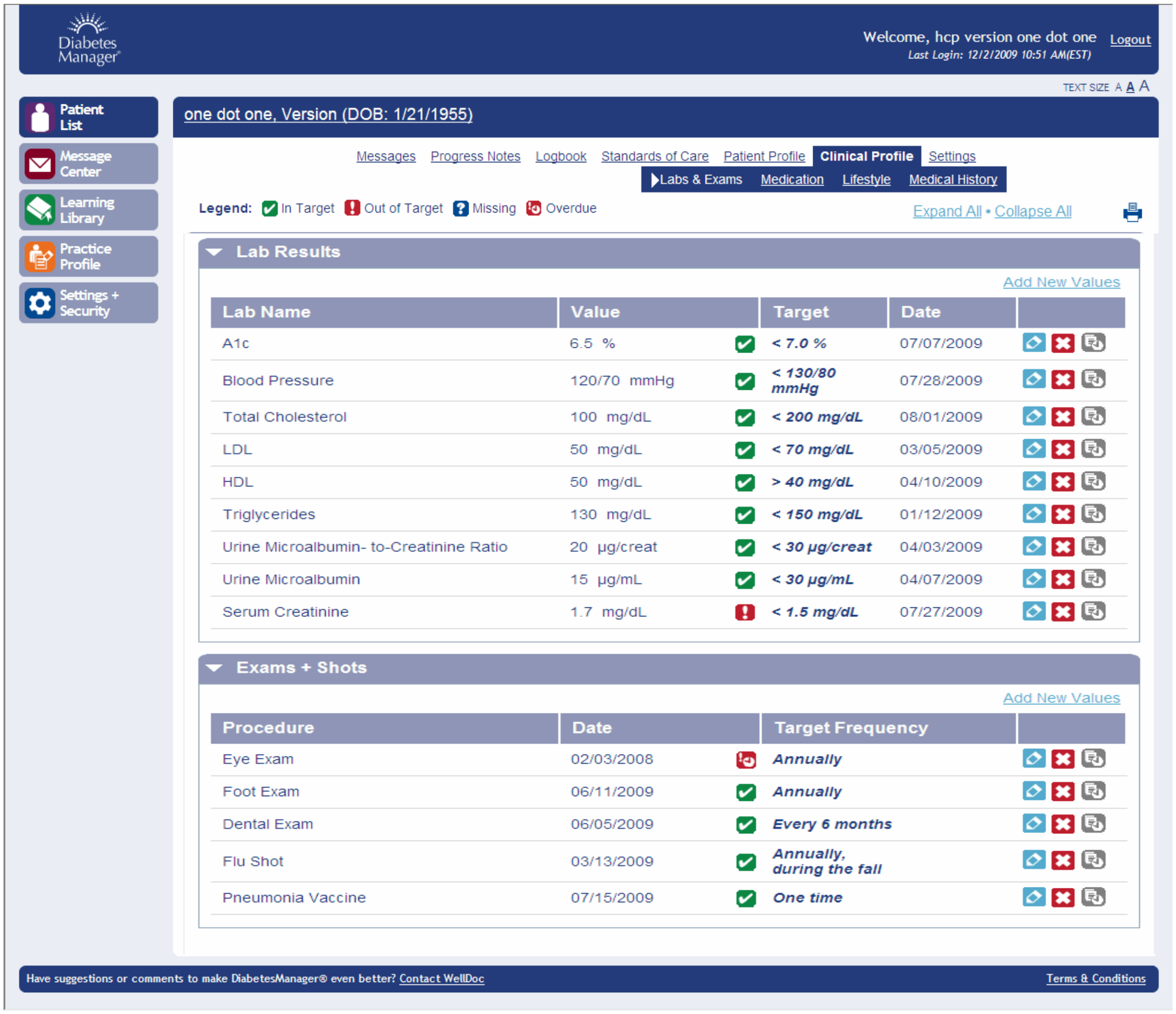
To add lab and exam information:

1. Click **Clinical Profile** on the top navigation bar.

   The Procedures screen (labs and reports default screen) appears with labs and reports selected.

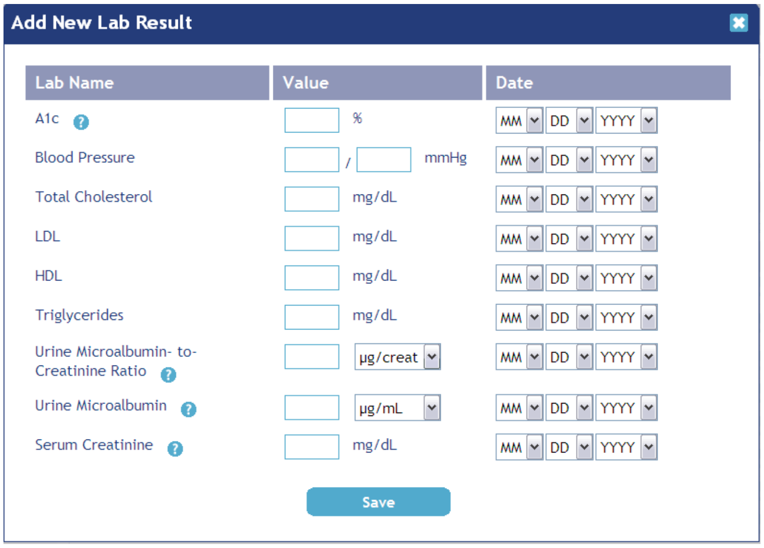
Reviewing Your Patient's Information

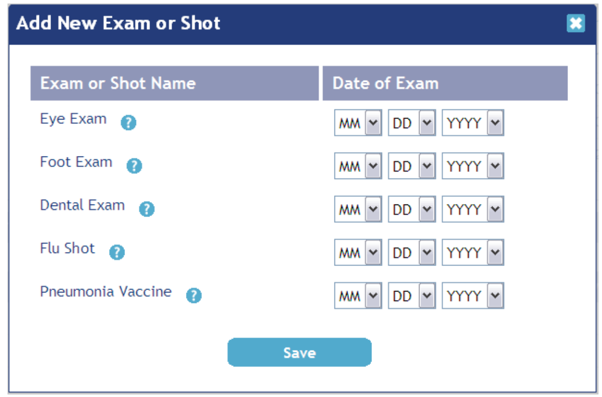
The labs and reports screen is displayed.



2. Click **Add New Values** for Labs Results or Exams & Shots.

The Add New values screen appears.





3. Enter the desired information.
4. Click **Save**.

Medical History

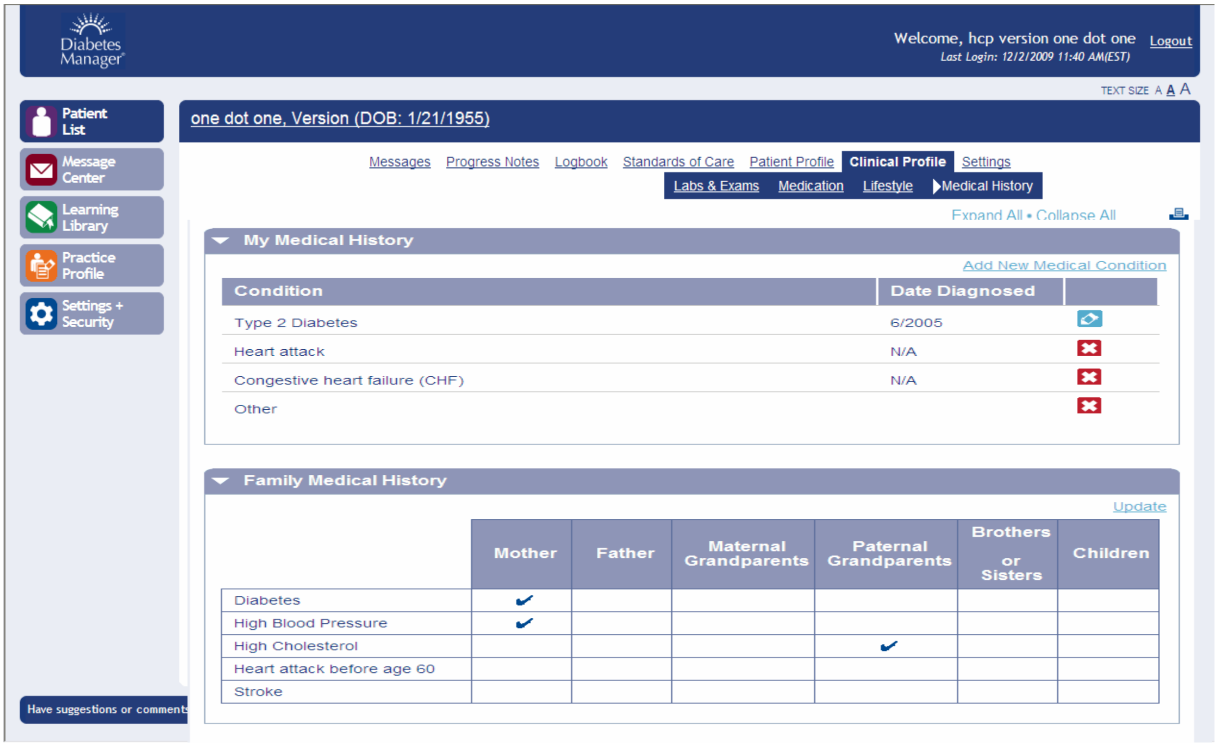
You can view or modify your patient’s medical history.

To modify your existing medical history:

1. Click **Clinical Profile** on the top navigation bar.

   The Procedures screen (labs and reports default screen) appears with labs and reports selected.

2. Click **Medical History**.



3. Use the edit and delete icons to edit the existing line item or delete it.

To add new medical history entries:

1. Click **Clinical Profile** on the top navigation bar.

   The Procedures screen (labs and reports default screen) appears with labs and reports selected.
2. Click **Medical History.**
3. Click **Add New Medical Condition**.
4. Enter the desired information.
5. Click **Save**.

Lifestyle

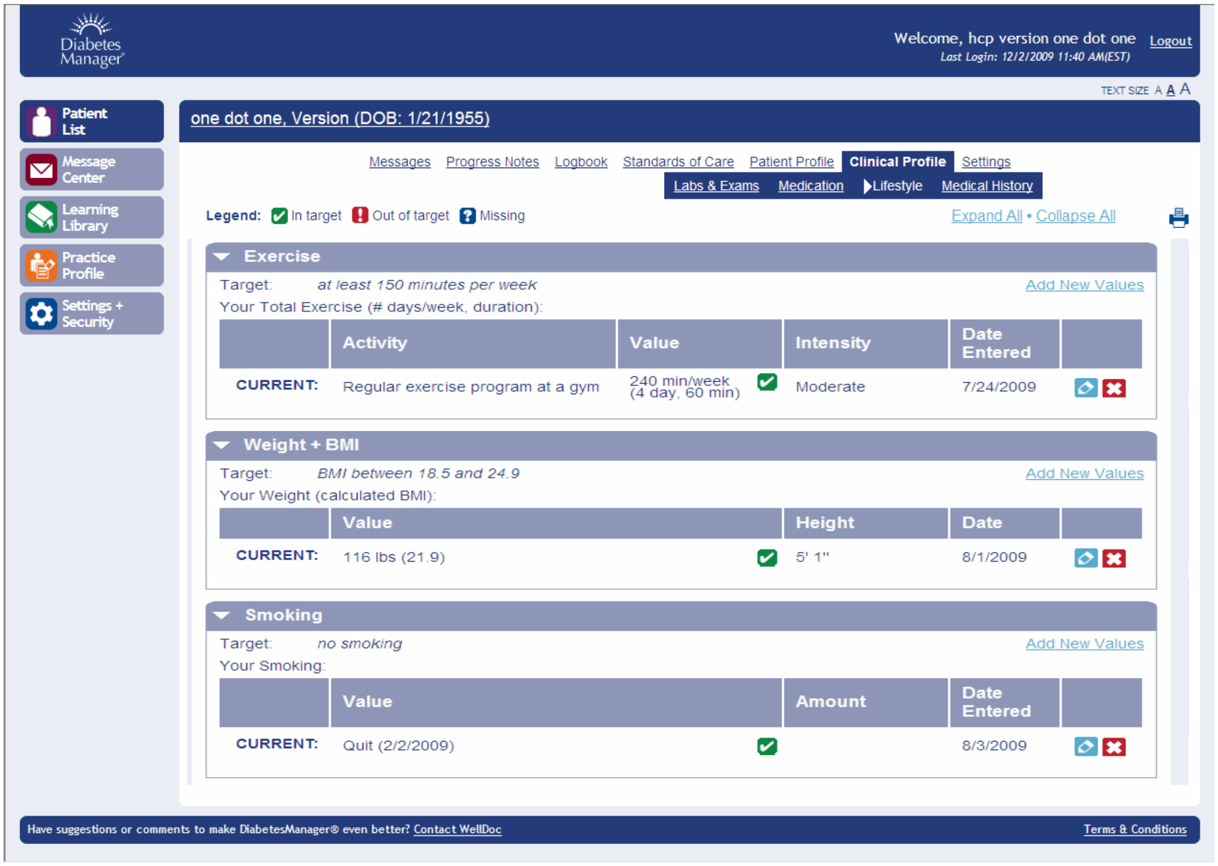
You can view or modify your patient's lifestyle records.

To modify existing medical history:

1. Click **Clinical Profile** on the top navigation bar.

   The Procedures screen (labs and reports default screen) appears with labs and reports selected.

2. Click **Lifestyle**.



3. Use the edit and delete icons to edit the existing line item or delete it.

To add new medical history entries:

1. Click **Clinical Profile** on the top navigation bar.

   The Procedures screen (labs and reports default screen) appears with labs and reports selected.
2. Click **Lifestyle.**
3. Click **Add New Value**.
4. Enter the desired information.
5. Click **Save**.

Patient Profile

This feature supplies contact information for your patient’s healthcare team and personal support network. It is viewable and modifiable.

Profile

The profile contains your patient’s contact information.

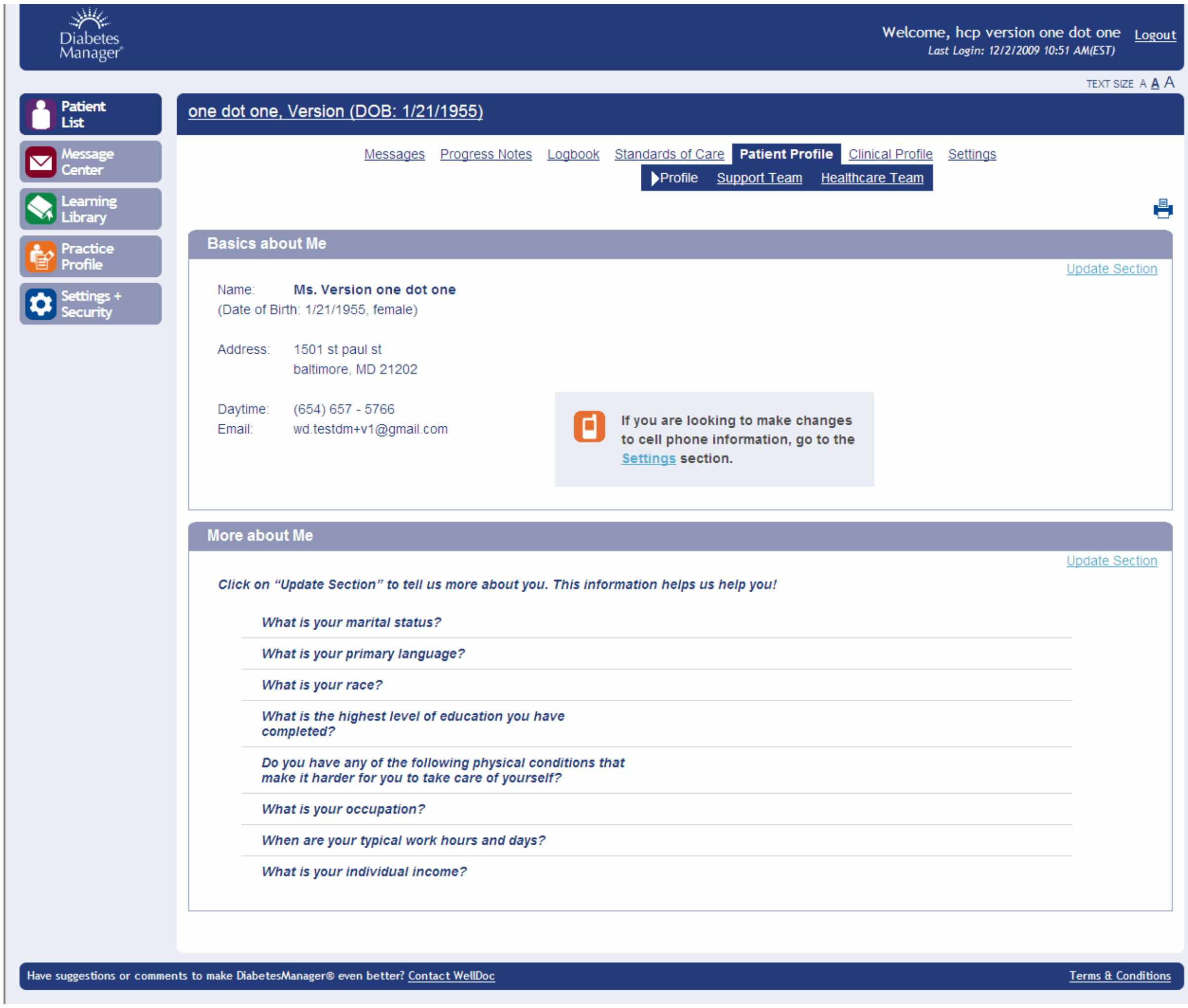
Reviewing Your Patient's Information

To modify your existing personal profile:

1. Click **Patient Profile** on the left navigation bar.

   The Patient Profile screen appears with Profile selected.

2. Click **Profile**.



3. Review the existing settings.

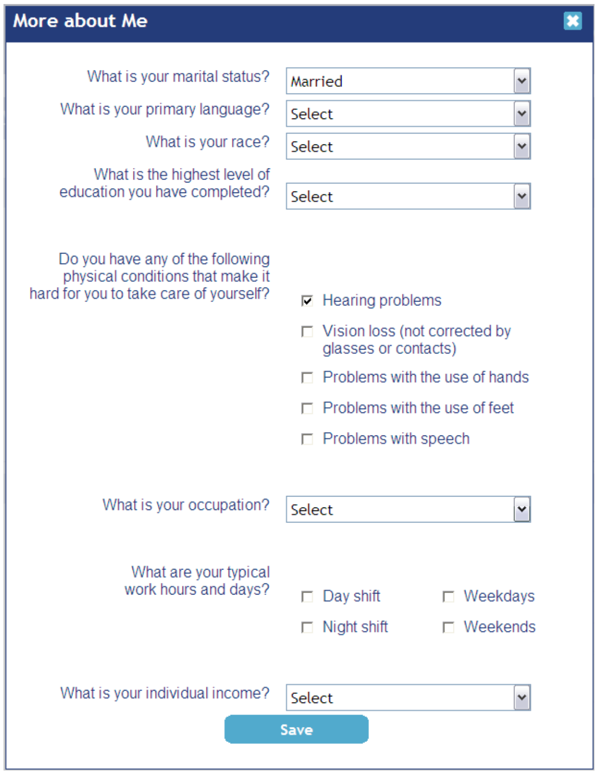
To change profile entries:

1. Click **Patient profile** on the left navigation bar.

   The Patient Profile screen appears with Profile selected.

2. Click **Profile**.
3. Click **Update Section** in the Basics about Me or More about Me panes.

The More about Me screen is shown.



4. Enter the desired information.
5. Click **Save**.

Healthcare Team

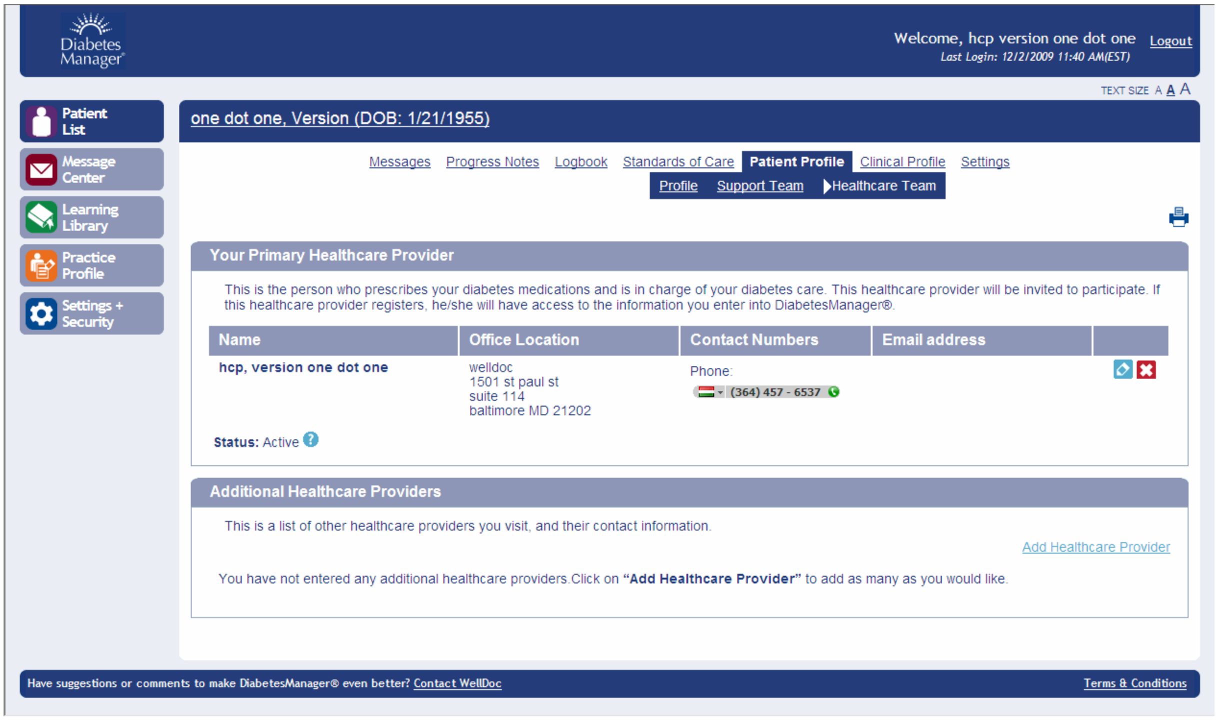
The healthcare team profile contains contact information for the healthcare team.

To modify the healthcare team profile:

1. Click **Patient profile** on the left navigation bar.
   The Patient Profile screen appears with Profile selected.

Reviewing Your Patient's Information

2. Click **Healthcare Team**.



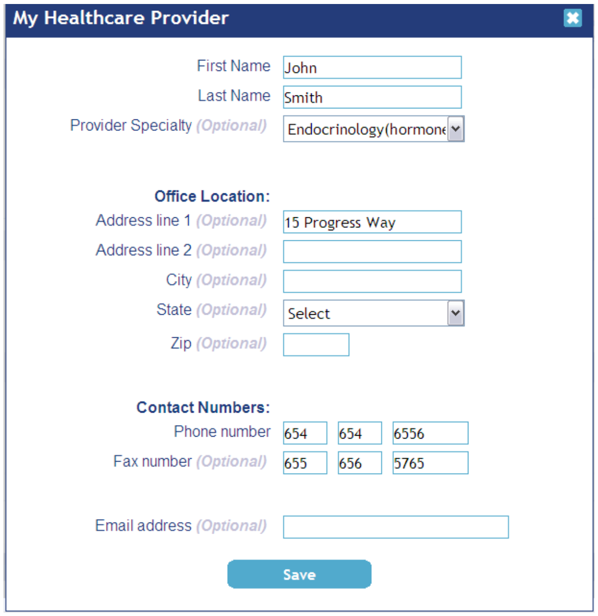
3. Review the existing settings.
4. Use the edit and delete icons to edit the existing provider or delete them.

To add a healthcare provider:

1. Click **Patient profile** on the left navigation bar.

   The Patient Profile screen appears with Profile selected.
2. Click **Healthcare Team**.

3. Click **Add Healthcare Provider.**



4. Enter the desired information.
5. Click **Save**.

Support Team

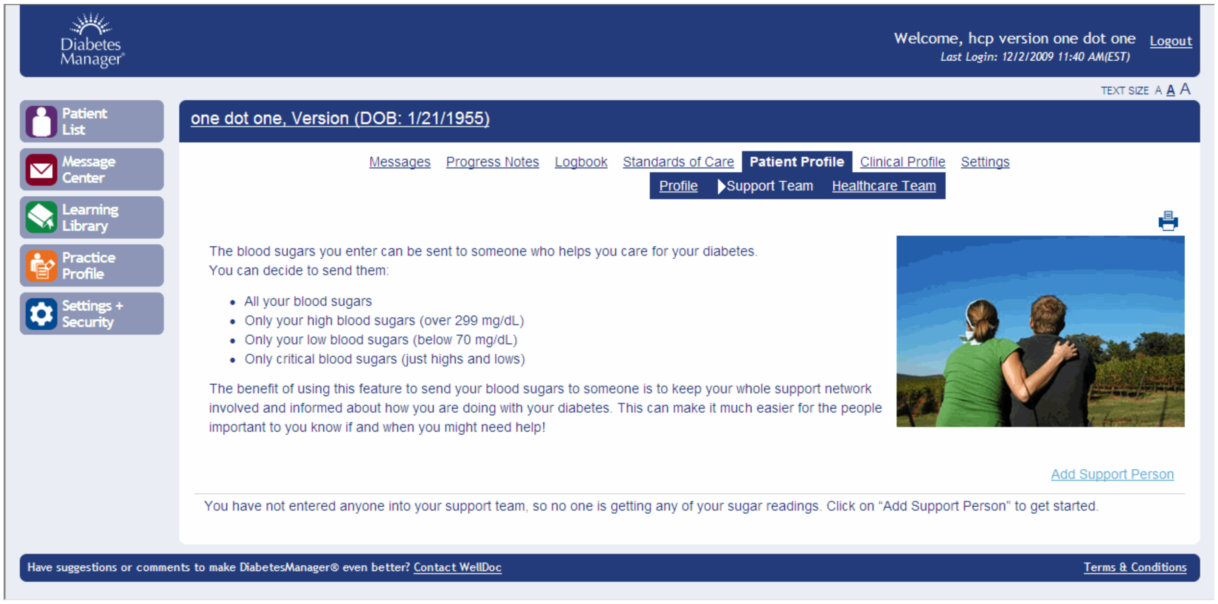
The support team profile contains contact information for the patient's support team. Their support team members can receive messages about certain blood glucose readings.

To modify the support team profile:

1. Click **Patient profile** on the left navigation bar.

   The Patient Profile screen appears with Profile selected.

2. Click **Support Team**.



3. Review the existing settings.
4. Use the edit and delete icons to edit the existing provider or delete them.

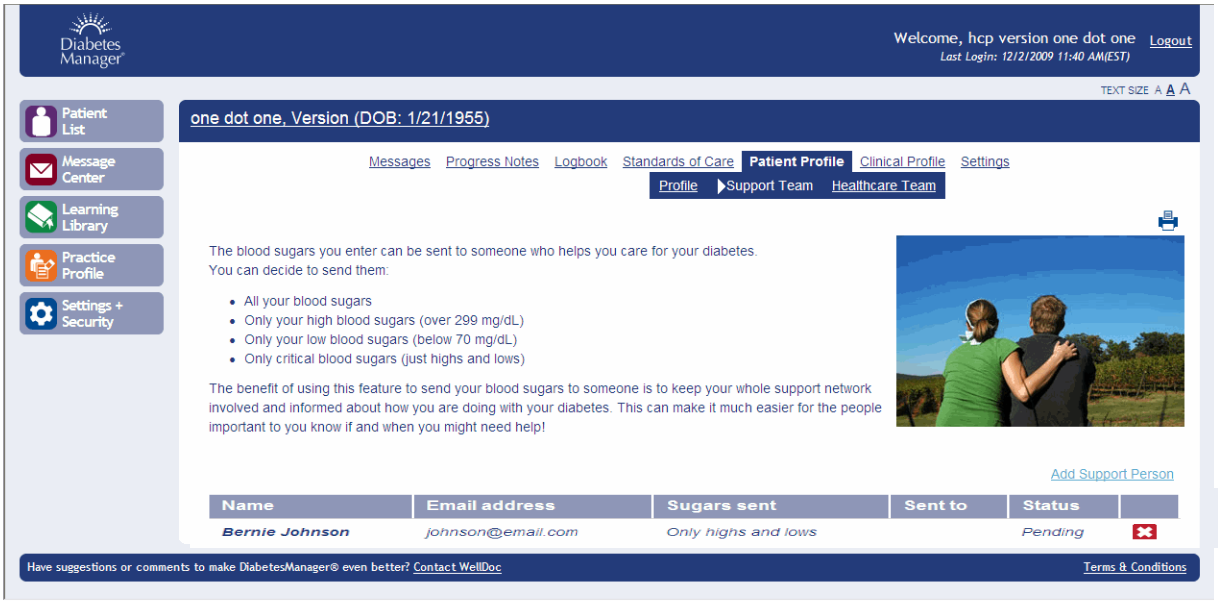
To add a support team member:

1. Click **Patient profile** on the left navigation bar.

   The Patient Profile screen appears with Profile selected.
2. Click **Support Team**.
3. Click **Add Support Person.**

4. Enter the desired information.
5. Click **Save**.

The support person is added with a pending status. An e-mail is sent to the support person asking them to confirm that it is ok to send them your patient's information. Once they confirm your request, the status is changed to active and they will receive the information you specified.



Chapter 7: Recording Patient Homecare Activity

The homecare environment requires additional methods of documenting healthcare provider and patient personal interaction. DiabetesManager accommodates this need through a variety of forms you can use during and after your visits.

Encounter Form

The Encounter form allows you to record the events that occurred and data you collected during a specific contact with a patient.

Encounter Form Wizard Interaction Type

The Encounter form wizard helps you record your interaction with patients. The type of interaction selected on the first page of the four page wizard determines which fields are available to you.

To record patient interaction:

1. Click **Patient List** on the left navigation bar.

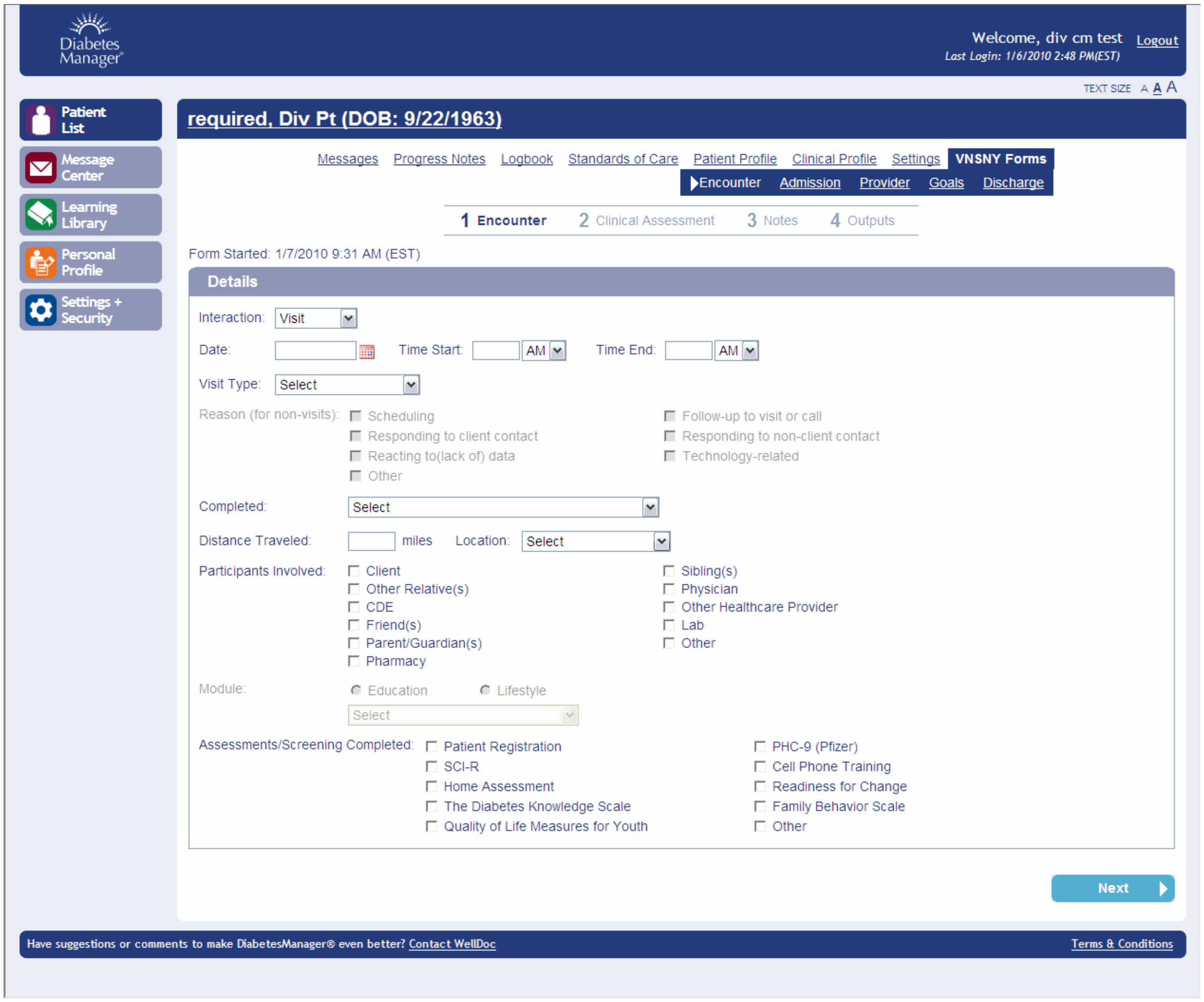
   The Patient Summary table is displayed.
2. Select the desired patient in the Patient Summary table.
3. Select **VNSNY Forms** from the top navigation menu.
4. Select **Encounter** from the top navigation submenu.

   This is default selection.

If there are existing forms, they are listed in the Encounter Summary table.

5. Click **Add New Encounter**.

The encounter form wizard appears.



6. Select the Interaction type.
7. You can choose from a variety of interaction types. The options not available for a specific type are greyed out. The interaction types are:

Interaction	Description
Visit	An in person encounter at the patients home or at a facility.
Call	A telephone conversation via mobile phone or land line.
email	Communication through computer via email.
Text/SMS	Communication through a mobile phone via standard text/SMS messaging.
Other	Any other type of communication between you and the patient. Enter a description of the encounter in the text box provided for this selection.

8. Go to the sections below for the interaction you selected.

Record visits:

1. Enter the date of the encounter using the calendar provided and include the start time of the encounter.
2. Select the Visit Type: scheduled, pre-arranged, or urgent.
3. Select the indicator for visit completion from the Completed pulldown.

   You can choose from Yes (visit completed), cancelled en route (up to 1 hour before), attempted (client not at home), attempted (client refused visit not rescheduled), or attempted (client refused visit rescheduled). This is a required field.
4. Enter the number of miles traveled to see the patient and select the location where you saw the patient.

   This is a required field.
5. Check the boxes next to all of the participants that were present at the encounter.

   This is a required field. If a text entry box appears, enter the name of the participant. Click **Add**, to add additional names of participants of this type.
6. Click the module radio button: Education or Lifestyle.
7. Select the descriptor for the module.
8. Check the boxes next to the type of Assessments/Screening that happened during the encounter.
9. Click **Next**.

   Go to “Clinical Assessment” on page 7-5.

Record calls:

1. Enter the date of the encounter using the calendar provided and include the start time of the encounter.
2. Select the indicator for visit completion from the Completed pulldown.

   You can choose from Yes (visit completed), cancelled en route (up to 1 hour before), attempted (client not at home), attempted (client refused visit not rescheduled), or attempted (client refused visit rescheduled). This is a required field.
3. Check the boxes next to all of the participants that were present at the encounter.

   This is a required field. If a text entry box appears, enter the name of the participant. Click Add, to add additional names of participants of this type.
4. Click **Next**.

   Go to “Clinical Assessment” on page 7-5.

Record emails, text, or other interactions:

1. Enter the date of the encounter using the calendar provided.
2. Check the boxes next to all of reasons for the encounter.

   This is a required field.
3. Check the boxes next to all of the participants that were present at the encounter.

   This is a required field. If a text entry box appears, enter the name of the participant. Click Add, to add additional names of participants of this type.
4. Click **Next**.

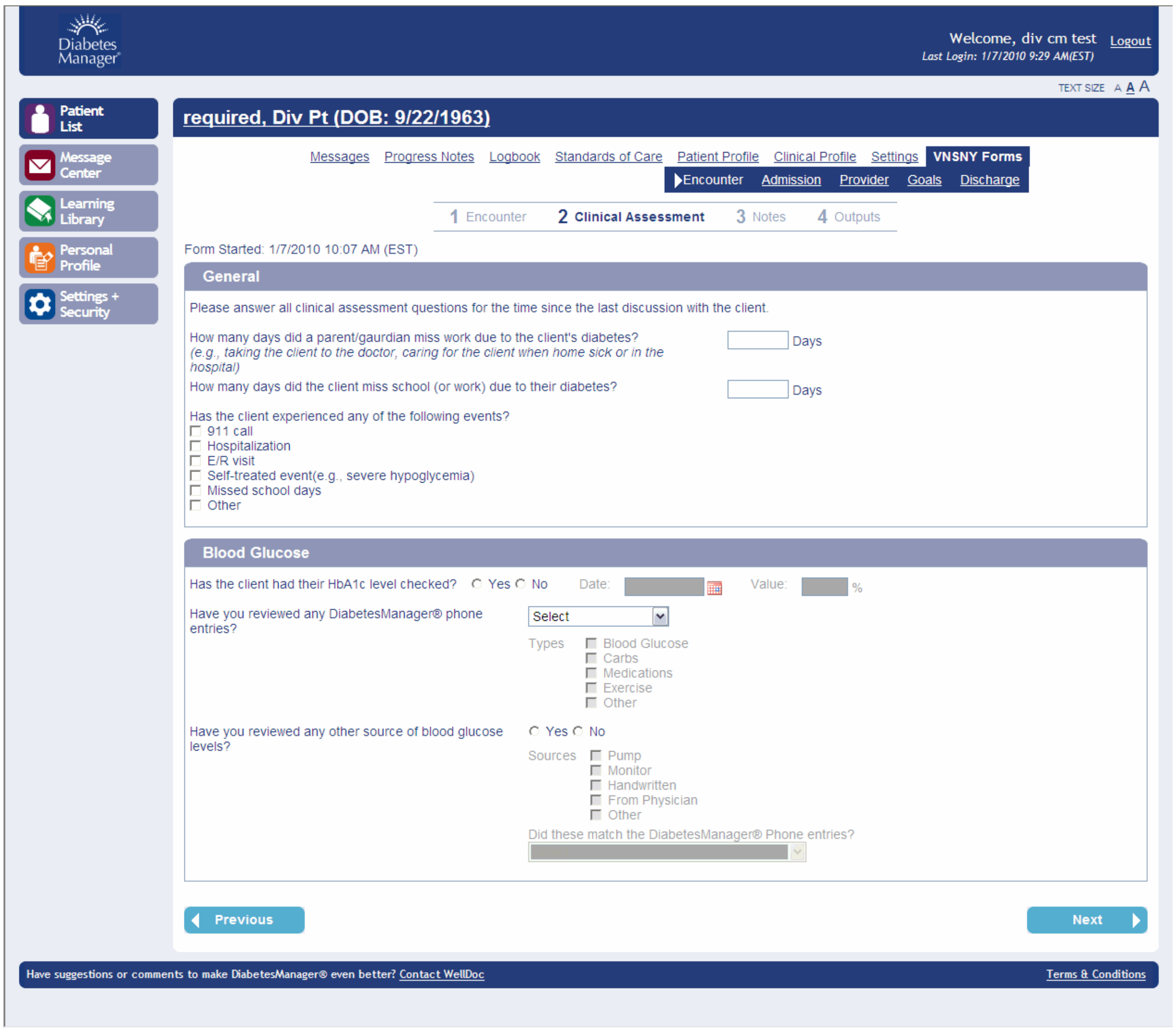
Go to "Clinical Assessment" on page 7-5.

Clinical Assessment

The second page of the Encounter Form wizard, allows you to record clinical data gathered during the interaction as well as the patient's use of DiabetesManager.

To record clinical data:

1. Enter how many days the parent/guardian missed work due to the client's diabetes since your last encounter.



This is a required field.

2. Enter how many days the client missed school (or work) due to their diabetes since your last encounter.

   This is a required field.

3. Check all of the boxes that indicate events that happened since your last encounter.

4. Select **Yes** if the client had their HbA1c level checked since your last encounter and enter the date of the test and the value. Select No if they have not had it checked.
5. If you have checked the client's entries on DiabetesManager, select **Yes** and check the types of data the patient entered. If you have not reviewed the entries, select the **No** entry from the pulldown that best describes why. For Other enter a reason.
6. If you have reviewed other sources of blood glucose records, select **Yes** and check the source types of data. Select the type of matching criteria for these reading compared to those recorded in DiabetesManager. If you have not reviewed the entries, select **No**.
7. Click **Next**.

   Go to "Notes" on page 7-7.

Notes

To record notes about the encounter:

1. Enter notes about the encounter.

Each pane is a topic for which you can record notes. The objective of each section is listed. Sample notes are provided in grey in the text box. Once you click in the box, the sample text disappears and you can enter in your own text.

2. Click **Next**.

Outputs

To record outputs and client receptions for the encounter:

1. Select the radio button number that rates the client reaction to the encounter

1 is a low rating and 5 is the highest positive rating.

2. Enter the percent of planned content that was covered during the encounter.
3. Enter the percentage of time spent on each item listed.

The total value must equal 100.

4. Check all the boxes for the type of referrals you suggested.
5. Enter the names of the educational material you distributed.
6. Enter the names of the forms you completed during the encounter.
7. Click **Save**.

Editing an Existing Encounter

To record patient interaction:

1. Click **Patient List** on the left navigation bar.

   The Patient Summary table is displayed.
2. Select the desired patient in the Patient Summary table.
3. Select **VNSNY Forms** from the top navigation menu.
4. Select **Encounter** from the top navigation submenu.

   This is default selection.

   If there are existing forms, they are listed in the Encounter Summary table.

5. In the Actions column in the row for the desired encounter, click **Edit**.
6. Modify the data as desired.

   The screens in the wizard flow in the same manner as creating a new encounter. See “Encounter Form Wizard Interaction Type” on page 7-1 through “Outputs” on page 7-8 for descriptions of the wizard.

Admission

The Admission form records information about the patients admission into the VNSNY program.

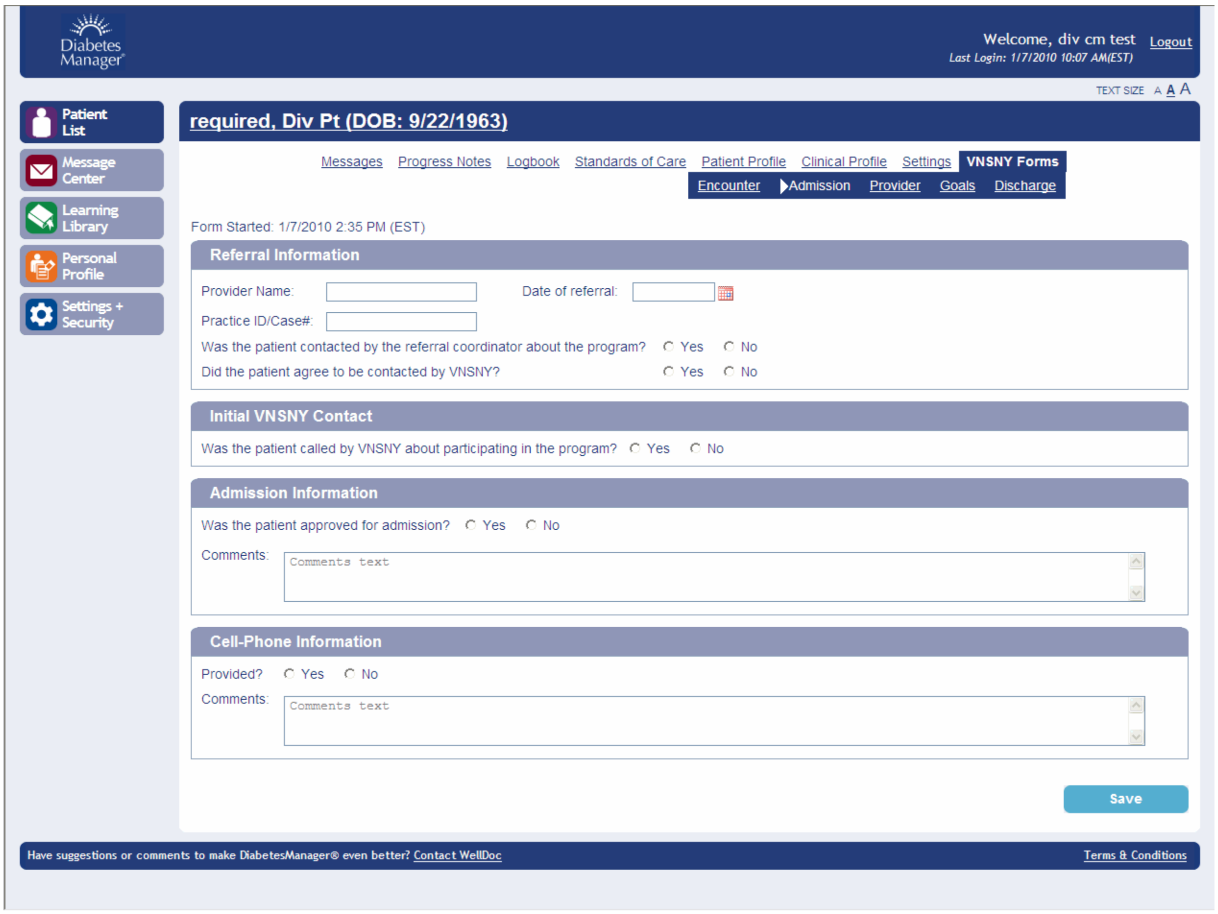
Admission

To record patient admissions:

1. Click **Patient List** on the left navigation bar.

   The Patient Summary table is displayed.
2. Select the desired patient in the Patient Summary table.
3. Select **VNSNY Forms** from the top navigation menu.
4. Select **Admissions** from the top navigation submenu.

   The Admission form appears



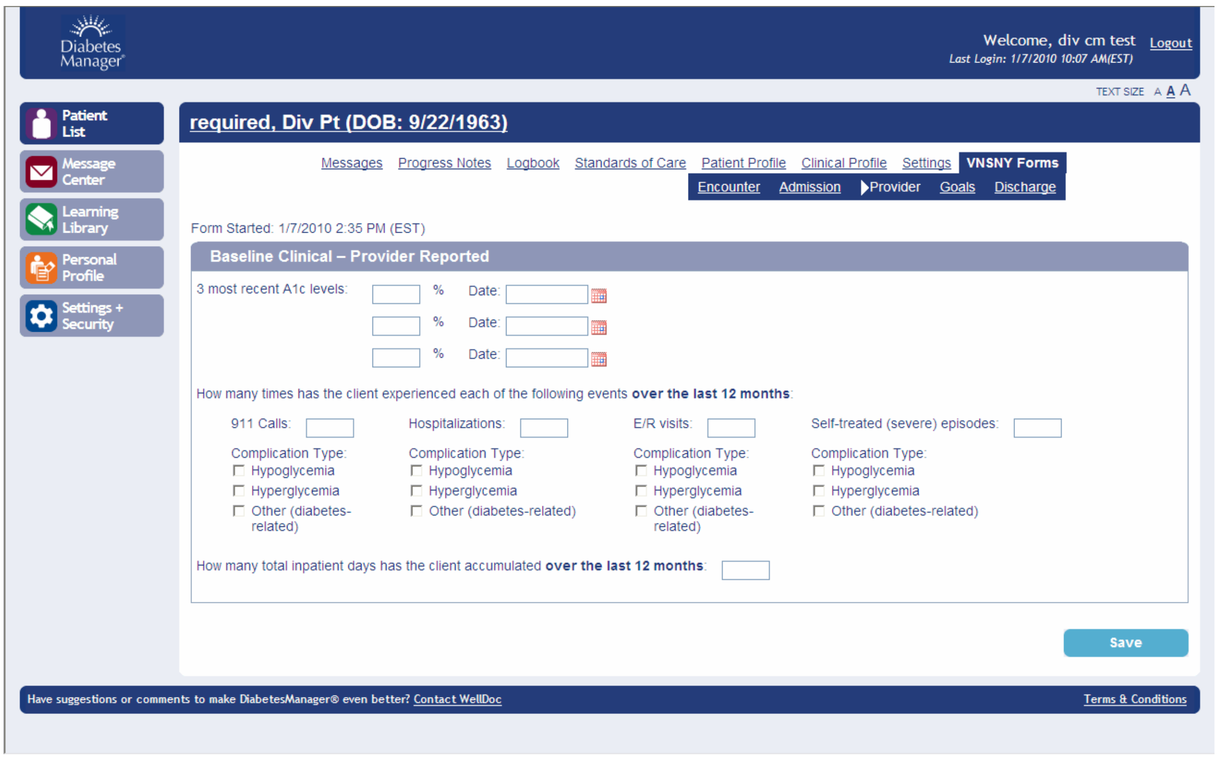
5. Enter information about how the patient was referred to the program in the Referral pane.
6. If the patient was called by VNSNY about participating in the program, click **Yes**, if not, click **No**.
7. If the patient was approved for admission, click **Yes**, if not, click **No**. Enter comments, if needed.
8. If the patient cell phone was provided, click **Yes**, if not, click **No**. Enter comments, if needed.
9. Click **Save**.

Provider

The provider form provide baseline clinical information as recorded by the provider.

To record provider information:

1. Click **Patient List** on the left navigation bar.
   The Patient Summary table is displayed.
2. Select the desired patient in the Patient Summary table.
3. Select **VNSNY Forms** from the top navigation menu.
4. Select **Provider** from the top navigation submenu.
   The Provider form appears.



5. Enter the 3 most recent A1c level (percent) and the date taken.
6. Enter how times the patient experienced 911 calls, Hospitalizations, ER visits, self treated episodes over the past 12 months. For each type, check the complication types that apply for that event.
7. Enter how many total inpatient days the patient has accumulated over the past 12 months.
8. Click **Save**.

Goals

The goals form allows you to enter a goals for you and the patient to work towards.

To record patient goals:

1. Click **Patient List** on the left navigation bar.

   The Patient Summary table is displayed.
2. Select the desired patient in the Patient Summary table.
3. Select **VNSNY Forms** from the top navigation menu.
4. Select **Goals** from the top navigation submenu

   The Goals form appears.

Existing goals are listed in the Current goals pane.

5. Select a Goal type from the pulldown.
6. Enter the specific goal.
7. Enter notes regarding the goal.
8. Click **Add to Goals**.

Discharge

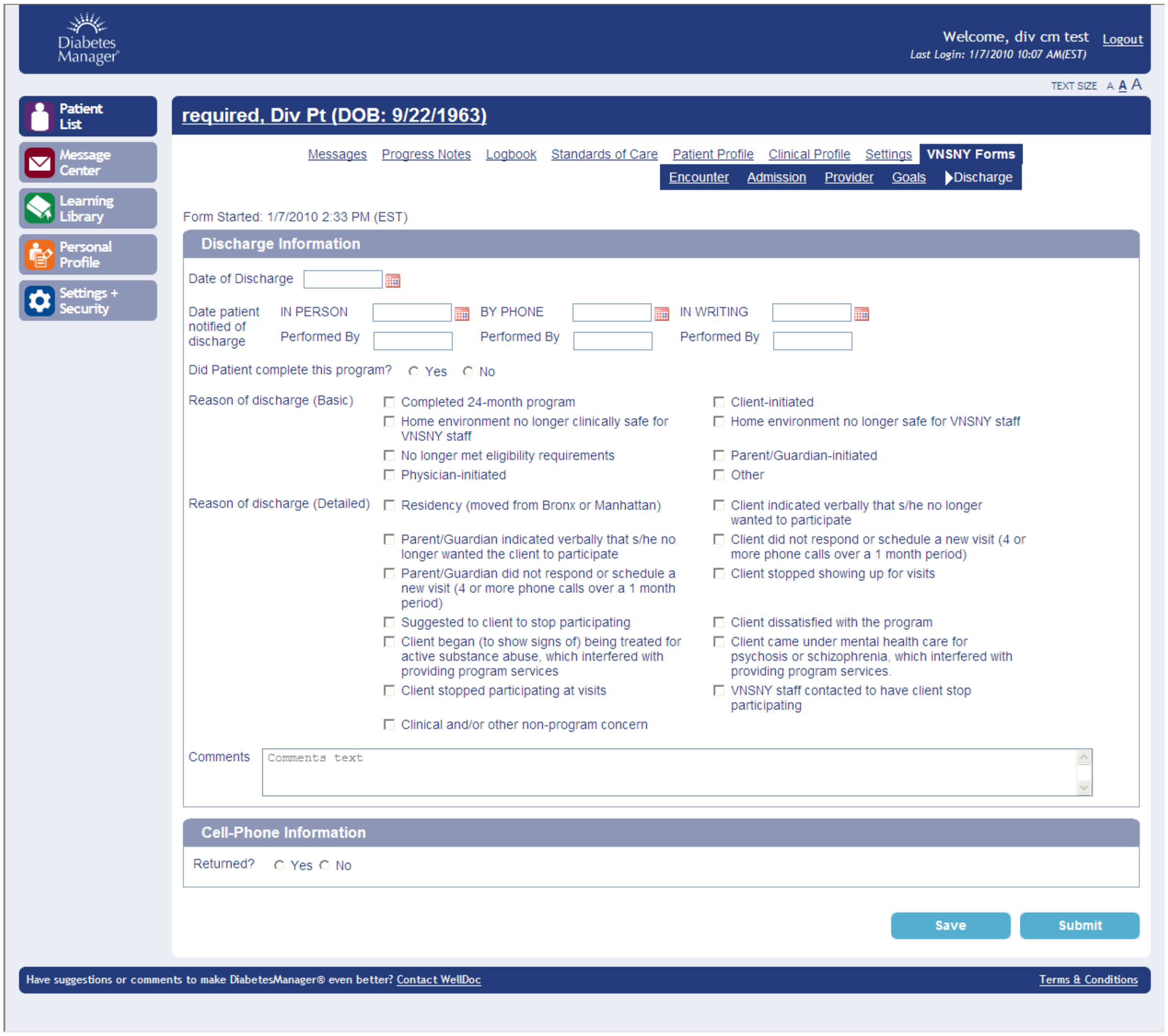
The Discharge for allows you to record details about when a patient leaves program.

To record patient discharge information:

1. Click **Patient List** on the left navigation bar.

   The Patient Summary table is displayed.
2. Select the desired patient in the Patient Summary table.
3. Select **VNSNY Forms** from the top navigation menu.
4. Select **Discharge** from the top navigation submenu.

The Discharge form appears.



5. Using the calendar provided, select the date of discharge.
6. Using the calendars provided, select the date the patient was notified of discharge for each type of notification, if applicable. For each type, enter the name of the person performing the notification.
7. If the Patient completed the program, click **Yes**. If not, click **No**.
8. Check all of the boxes that apply to the basic and detailed reason for discharge.
9. Enter comments, if desired.
10. If the cell phone was returned, click **Yes**. If not, click **No**
11. Click **Submit**.
12. Click **Save**.

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