

Chronicle Diabetes Walkthrough Guide



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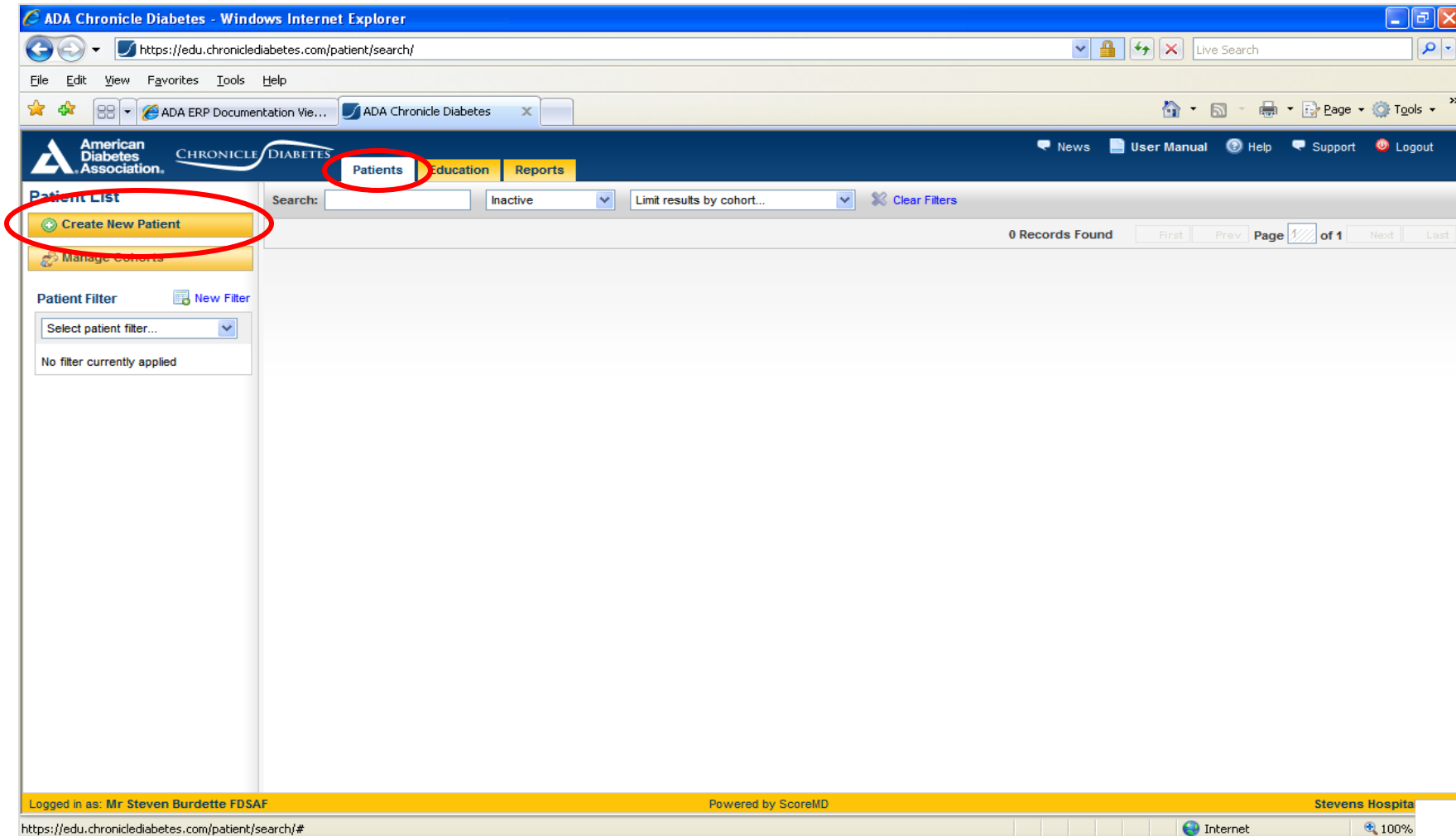
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Module 1: Creating and Managing Patient Records

- 1. Patient Records**
 - A. Creating, viewing and editing Patient Records
 - B. DSME Assessment & Health Status
 - C. Documenting Hospital Admission and Emergency Room Visits Pre-Education
 - D. Documenting Contact History / Notes/ Uploading Documents
 - E. Patient Snapshot Reports
- 2. Documenting Behavior Changes**
- 3. Documenting Clinical & Lab Values**
- 4. Documenting Medications**
- 5. Creating/Managing Patient Cohorts**

Creating a new patient Record *Page 1 of 3*

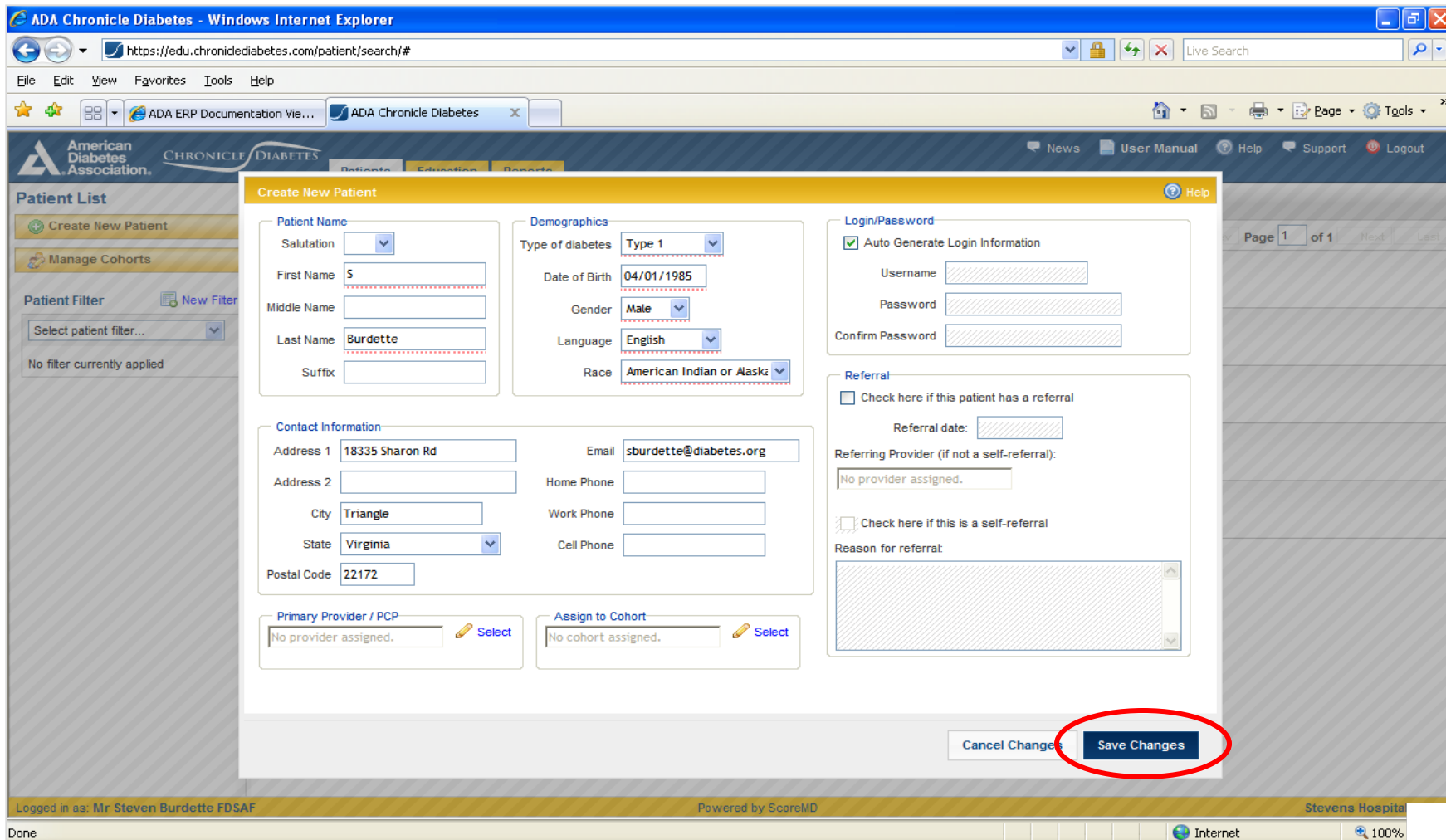
Click on the **Patients** tab at the top of the page, and then the **Create New Patient** button.



The screenshot shows a web browser window titled "ADA Chronicle Diabetes - Windows Internet Explorer" with the URL "https://edu.chronicdiabetes.com/patient/search/". The page features a navigation bar with tabs for "Patients", "Education", and "Reports". The "Patients" tab is highlighted and circled in red. Below the navigation bar, there is a "Patient List" section with a search bar and filters. A yellow button labeled "Create New Patient" is circled in red. The page also displays "0 Records Found" and a "Patient Filter" section. The footer includes the text "Logged in as: Mr Steven Burdette FDSAF", "Powered by ScoreMD", and "Stevens Hospital".

Creating a new patient Record *Page 2 of 3*

Fill in as much information as you have. Fields marked with a red dotted line under the field are required. Click **Save Changes**.



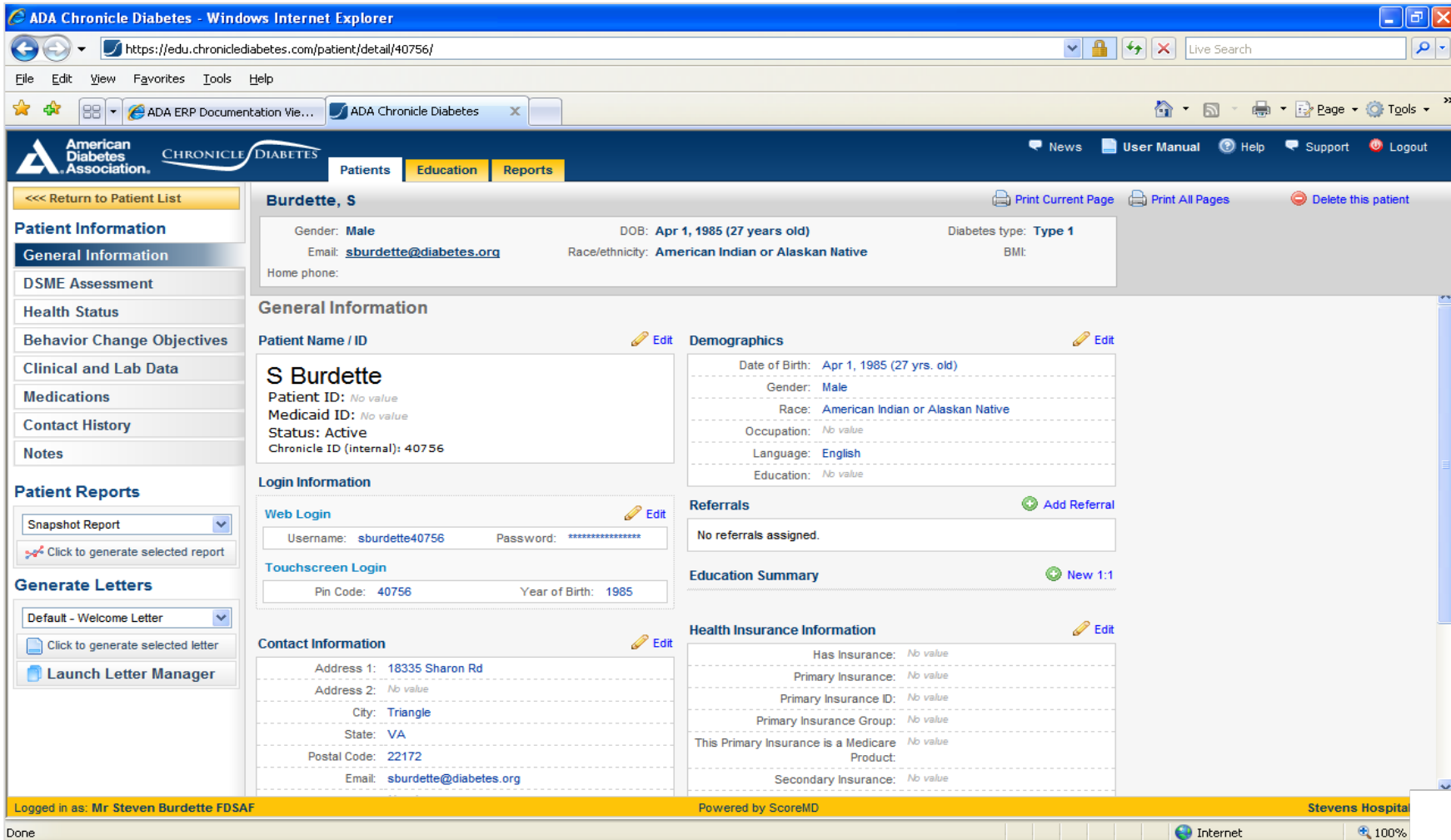
The screenshot shows the 'Create New Patient' form in a web browser. The form is titled 'Create New Patient' and contains several sections:

- Patient Name:** Salutation (dropdown), First Name (S), Middle Name, Last Name (Burdette), Suffix.
- Demographics:** Type of diabetes (Type 1), Date of Birth (04/01/1985), Gender (Male), Language (English), Race (American Indian or Alaski).
- Login/Password:** Auto Generate Login Information, Username, Password, Confirm Password.
- Contact Information:** Address 1 (18335 Sharon Rd), Address 2, City (Triangle), State (Virginia), Postal Code (22172), Email (sburdette@diabetes.org), Home Phone, Work Phone, Cell Phone.
- Primary Provider / PCP:** No provider assigned.
- Assign to Cohort:** No cohort assigned.
- Referral:** Check here if this patient has a referral. Referral date, Referring Provider (if not a self-referral): No provider assigned. Check here if this is a self-referral. Reason for referral.

At the bottom right, there are two buttons: 'Cancel Changes' and 'Save Changes'. The 'Save Changes' button is circled in red.

Creating a new patient Record *Page 3 of 3*

You will now be on the General Information page of the patient's record. You can view the various pages of the patient record by clicking the tabs on the left side of the page (e.g. DSME Assessment, Health Status, etc.)



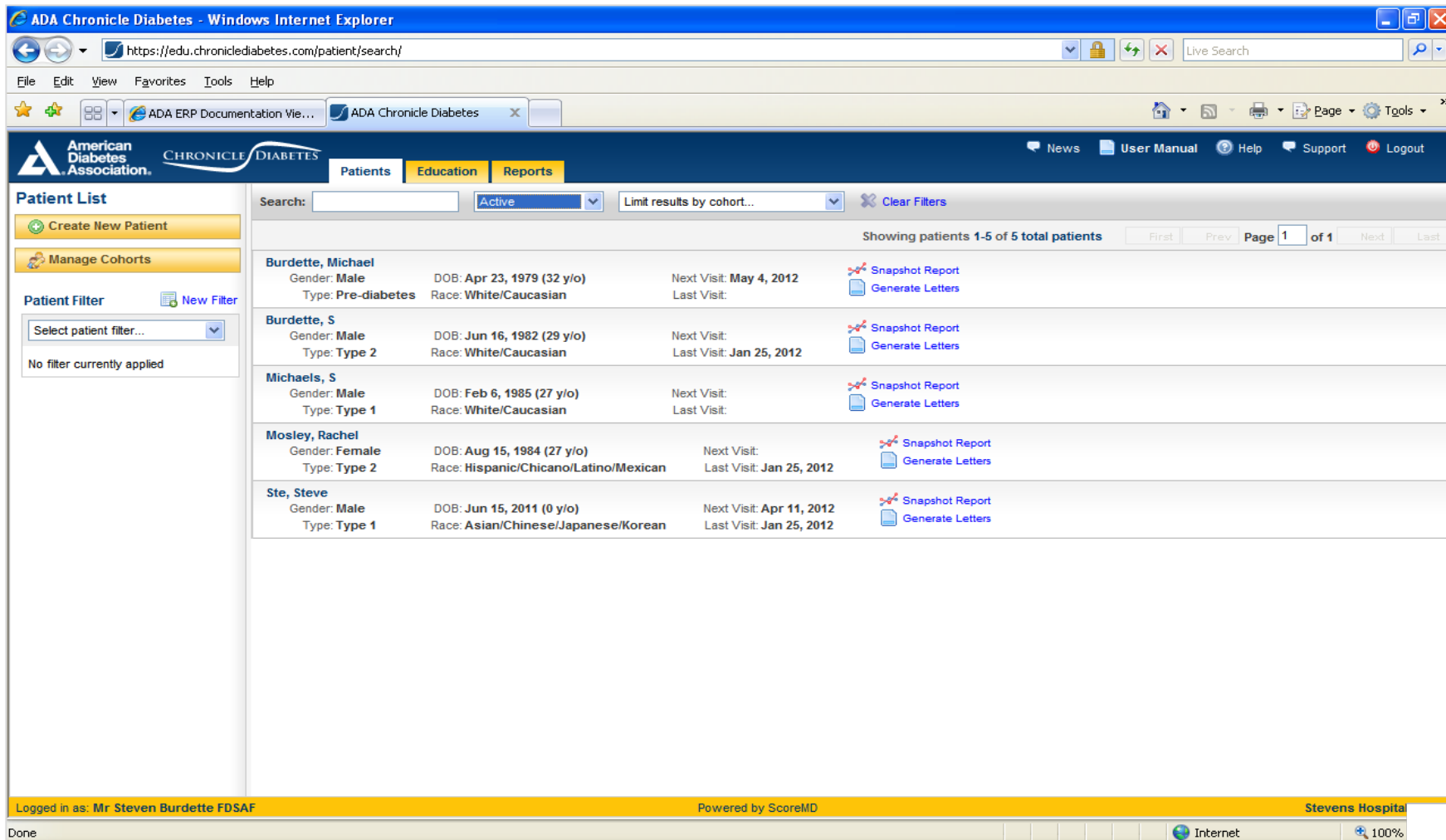
The screenshot shows a web browser window displaying the ADA Chronicle Diabetes patient record for Steven Burdette. The page is titled "ADA Chronicle Diabetes - Windows Internet Explorer" and the URL is "https://edu.chroniclediabetes.com/patient/detail/40756/". The browser's address bar shows the URL and a search box. The page header includes the American Diabetes Association logo and navigation links for News, User Manual, Help, Support, and Logout. The main content area is divided into several sections:

- Patient Information:** Displays patient details such as Gender (Male), DOB (Apr 1, 1985), Diabetes type (Type 1), Email (sburdette@diabetes.org), Race/ethnicity (American Indian or Alaskan Native), and BMI.
- General Information:** Shows Patient Name (S Burdette), Patient ID, Medicaid ID, Status (Active), and Chronicle ID (40756).
- Demographics:** Displays Date of Birth (Apr 1, 1985), Gender (Male), Race (American Indian or Alaskan Native), Occupation (No value), Language (English), and Education (No value).
- Login Information:** Includes Web Login (Username: sburdette40756, Password: [redacted]) and Touchscreen Login (Pin Code: 40756, Year of Birth: 1985).
- Contact Information:** Shows Address 1 (18335 Sharon Rd), Address 2 (No value), City (Triangle), State (VA), Postal Code (22172), and Email (sburdette@diabetes.org).
- Referrals:** Indicates "No referrals assigned."
- Education Summary:** Shows "New 1:1".
- Health Insurance Information:** Displays insurance details such as Has Insurance (No value), Primary Insurance (No value), Primary Insurance ID (No value), Primary Insurance Group (No value), and Secondary Insurance (No value).

The left sidebar contains navigation tabs for Patient Information, General Information, DSME Assessment, Health Status, Behavior Change Objectives, Clinical and Lab Data, Medications, Contact History, Notes, Patient Reports, and Generate Letters. The bottom of the page shows the user is logged in as "Mr Steven Burdette FDSAF" and the page is powered by ScoreMD. The footer includes "Stevens Hospital" and "Internet" with a 100% zoom level.

Viewing other patients *Page 1 of 2*

Click the Return to Patient List button in the upper left. **Note** that the patient that you just added is listed in the patients table. If you do not see the patient you can search for them by typing their last name in the search box and hitting return.



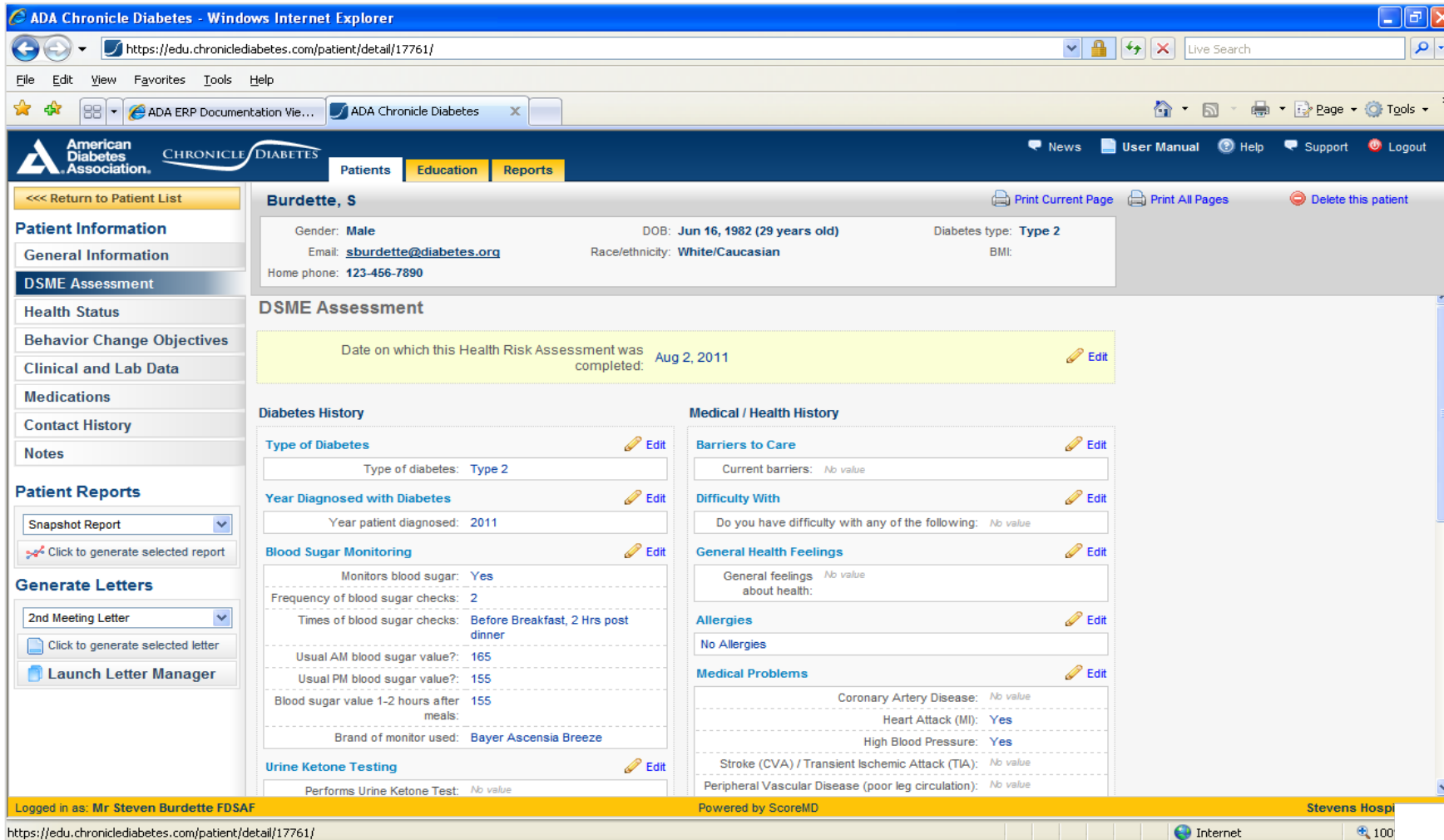
The screenshot shows a web browser window titled "ADA Chronicle Diabetes - Windows Internet Explorer" with the URL "https://edu.chronicdiabetes.com/patient/search/". The page displays the "Patient List" section of the ADA Chronicle Diabetes application. The interface includes a search bar, a filter dropdown set to "Active", and a "Limit results by cohort..." dropdown. The patient list shows 5 patients, with the first five displayed on this page. Each patient entry includes their name, gender, age, race, next and last visit dates, and links for "Snapshot Report" and "Generate Letters".

Showing patients 1-5 of 5 total patients					
Burdette, Michael	Gender: Male	DOB: Apr 23, 1979 (32 y/o)	Next Visit: May 4, 2012	Snapshot Report	
Type: Pre-diabetes	Race: White/Caucasian	Last Visit:	Generate Letters		
Burdette, S	Gender: Male	DOB: Jun 16, 1982 (29 y/o)	Next Visit:	Snapshot Report	
Type: Type 2	Race: White/Caucasian	Last Visit: Jan 25, 2012	Generate Letters		
Michaels, S	Gender: Male	DOB: Feb 6, 1985 (27 y/o)	Next Visit:	Snapshot Report	
Type: Type 1	Race: White/Caucasian	Last Visit:	Generate Letters		
Mosley, Rachel	Gender: Female	DOB: Aug 15, 1984 (27 y/o)	Next Visit:	Snapshot Report	
Type: Type 2	Race: Hispanic/Chicano/Latino/Mexican	Last Visit: Jan 25, 2012	Generate Letters		
Ste, Steve	Gender: Male	DOB: Jun 15, 2011 (0 y/o)	Next Visit: Apr 11, 2012	Snapshot Report	
Type: Type 1	Race: Asian/Chinese/Japanese/Korean	Last Visit: Jan 25, 2012	Generate Letters		

Logged in as: Mr Steven Burdette FDSAF Powered by ScoreMD Stevens Hospital

Viewing other patients *Page 2 of 2*

Click on a patient's listing to open the patient's record. You will be on the General Information page of the patient's record.



The screenshot shows a web browser window displaying the ADA Chronicle Diabetes patient record for Mr. Steven Burdette. The browser title is "ADA Chronicle Diabetes - Windows Internet Explorer" and the address bar shows "https://edu.chroniclediabetes.com/patient/detail/17761/". The page features a navigation menu with "Patients", "Education", and "Reports" tabs. The main content area is titled "Burdette, S" and includes a "Patient Information" section with details such as Gender: Male, DOB: Jun 16, 1982 (29 years old), Diabetes type: Type 2, Email: sburdette@diabetes.org, Race/ethnicity: White/Caucasian, and Home phone: 123-456-7890. Below this is a "DSME Assessment" section indicating the date of completion as Aug 2, 2011. The "Diabetes History" section includes fields for Type of Diabetes (Type 2), Year Diagnosed with Diabetes (2011), Blood Sugar Monitoring (Monitors blood sugar: Yes, Frequency of blood sugar checks: 2, Times of blood sugar checks: Before Breakfast, 2 Hrs post dinner, Usual AM blood sugar value?: 165, Usual PM blood sugar value?: 155, Blood sugar value 1-2 hours after meals: 155, Brand of monitor used: Bayer Ascensia Breeze), and Urine Ketone Testing (Performs Urine Ketone Test: No value). The "Medical / Health History" section includes Barriers to Care (Current barriers: No value), Difficulty With (Do you have difficulty with any of the following: No value), General Health Feelings (General feelings about health: No value), Allergies (No Allergies), and Medical Problems (Coronary Artery Disease: No value, Heart Attack (MI): Yes, High Blood Pressure: Yes, Stroke (CVA) / Transient Ischemic Attack (TIA): No value, Peripheral Vascular Disease (poor leg circulation): No value). The footer shows "Logged in as: Mr Steven Burdette FDSAF", "Powered by ScoreMD", and "Stevens Hosp".

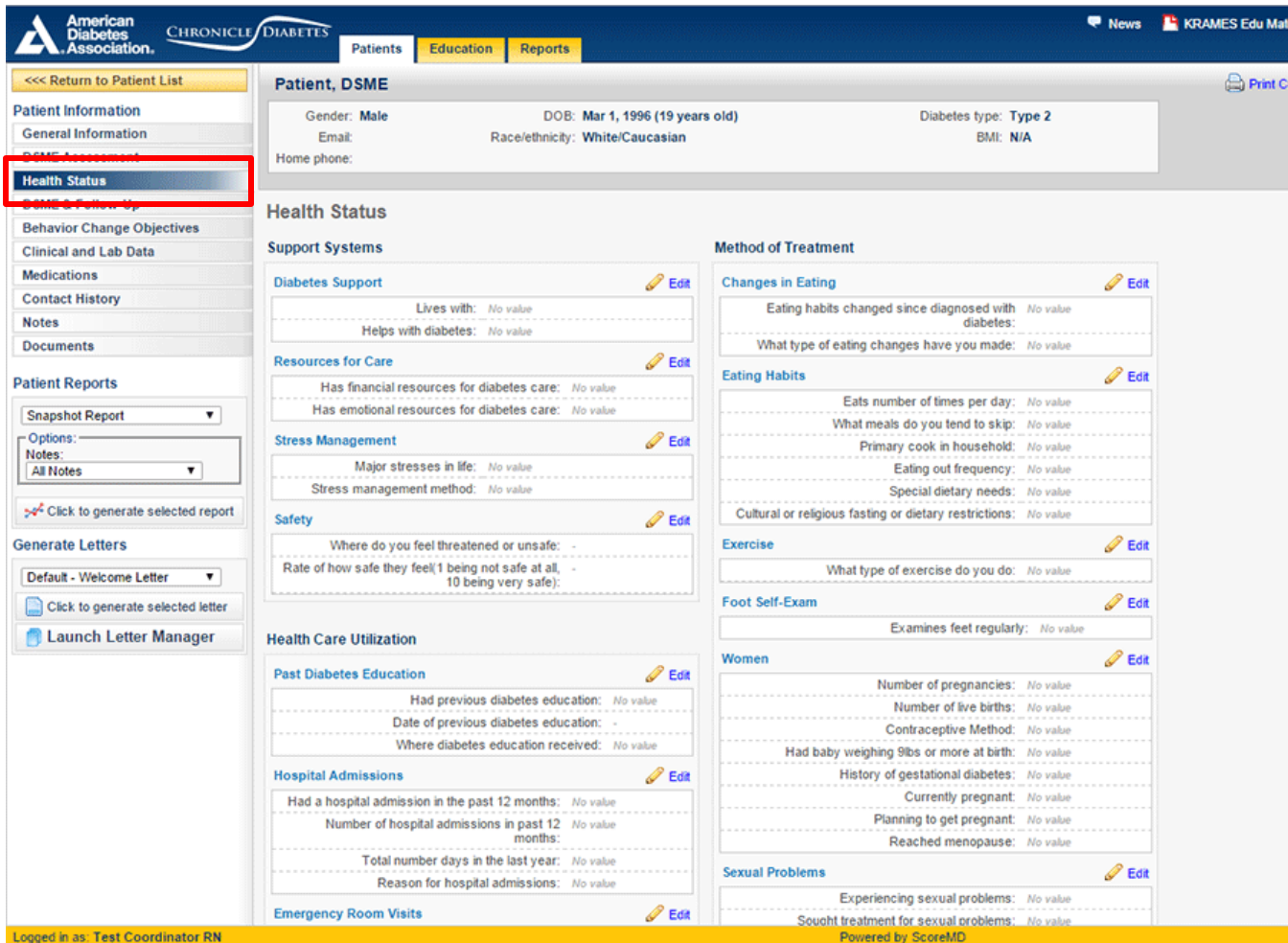
Online Patient Self-Assessment

When a patient record is created in Chronicle, the system automatically sets up a **username and password** for the patient to complete their assessment. The login credentials for the online patient self-assessment are included in the default **Welcome Letter** discussed in **Module 3**.

The screenshot displays the patient record for 'DSME, New' in the CHRONICLE DIABETES system. The patient's information includes Gender: Female, DOB: Jan 7, 2015 (0 years old), Diabetes type: Type 1, Race/ethnicity: American Indian or Alaskan Native, and BMI: N/A. The 'Web Login' section is highlighted with a blue box, showing the username 'newdsme212676' and a masked password. The 'Generate Letters' section in the left sidebar is highlighted with a red box, showing a dropdown menu set to 'Default - Welcome Letter', a 'Click to generate selected letter' button, and a 'Launch Letter Manager' button. A red arrow points from the text in the paragraph above to the 'Web Login' section, and another red arrow points from the 'Click to generate selected letter' button to the text in the paragraph above.

DSME Assessment & Health Status Page 1 of 2

The **Health Status section** can be completed electronically by the patient during their initial patient self-assessment (PSA) or by the educator on behalf of the patient. Any of the information on this page can be edited by clicking on the *Edit* pencil to the right of the section name.



American Diabetes Association | CHRONICLE DIABETES | Patients | Education | Reports | News | KRAMES Edu Mate

<<< Return to Patient List | Print Cu

Patient, DSME

Gender: Male | DOB: Mar 1, 1996 (19 years old) | Diabetes type: Type 2
 Email: | Race/ethnicity: White/Caucasian | BMI: N/A
 Home phone: |

Health Status (Highlighted)

Support Systems

Diabetes Support [Edit](#)

Lives with: No value
 Helps with diabetes: No value

Resources for Care [Edit](#)

Has financial resources for diabetes care: No value
 Has emotional resources for diabetes care: No value

Stress Management [Edit](#)

Major stresses in life: No value
 Stress management method: No value

Safety [Edit](#)

Where do you feel threatened or unsafe: -
 Rate of how safe they feel (1 being not safe at all, 10 being very safe): -

Method of Treatment

Changes in Eating [Edit](#)

Eating habits changed since diagnosed with diabetes: No value
 What type of eating changes have you made: No value

Eating Habits [Edit](#)

Eats number of times per day: No value
 What meals do you tend to skip: No value
 Primary cook in household: No value
 Eating out frequency: No value
 Special dietary needs: No value
 Cultural or religious fasting or dietary restrictions: No value

Exercise [Edit](#)

What type of exercise do you do: No value

Foot Self-Exam [Edit](#)

Examines feet regularly: No value

Women [Edit](#)

Number of pregnancies: No value
 Number of live births: No value
 Contraceptive Method: No value
 Had baby weighing 9lbs or more at birth: No value
 History of gestational diabetes: No value
 Currently pregnant: No value
 Planning to get pregnant: No value
 Reached menopause: No value

Health Care Utilization

Past Diabetes Education [Edit](#)

Had previous diabetes education: No value
 Date of previous diabetes education: -
 Where diabetes education received: No value

Hospital Admissions [Edit](#)

Had a hospital admission in the past 12 months: No value
 Number of hospital admissions in past 12 months: No value
 Total number days in the last year: No value
 Reason for hospital admissions: No value

Emergency Room Visits [Edit](#)

Sexual Problems [Edit](#)

Experiencing sexual problems: No value
 Sought treatment for sexual problems: No value

Logged in as: Test Coordinator RN | Powered by ScoreMD

DSME Assessment & Health Status *Page 2 of 2*
**Documenting Hospital Admission and Emergency Room Visits
Pre-Education**

Chronicle has always allowed you to document the number of hospital admissions and emergency room visits that a patient. This functionality has been updated and improved in a number of ways.

- On the **Health Status** tab of the **patient record**, under the Health Care Utilization section, the ability to document hospitalizations & ER visits was expanded to allow for documenting both diabetes-related as well as non-diabetes-related hospitalizations & ER visits.


These sections relate to hospitalizations & ER visits that occurred prior to the start of education.

Hospital Admissions (pre education, not due to diabetes)  Edit


Had a hospital admission <u>not</u> due to diabetes in the past 12 months (prior to starting the initial DSME education cycle)::	No
Number of hospital admissions <u>not</u> due to diabetes in past 12 months:	No value
Total number days <u>not</u> due to diabetes in the last year:	No value
Reason for hospital admissions <u>not</u> due to diabetes:	No value

Hospital Admissions (pre education, due to diabetes)  Edit

Had a hospital admission due to diabetes in the past 12 months (prior to starting the initial DSME education cycle)::	Yes
Number of hospital admissions due to diabetes in past 12 months:	2
Total number days due to diabetes in the last year:	5
Reason for hospital admissions due to diabetes:	Low Blood Sugar

Emergency Room Visits (pre education, not due to diabetes)  Edit

Had an emergency room visit in the past 12 months <u>not</u> due to diabetes (prior to starting the initial DSME education cycle)::	Yes
Number emergency room visits in past 12 months <u>not</u> due to diabetes:	2
Reason for Emergency Room Visits <u>not</u> due to diabetes:	Low Blood Sugar

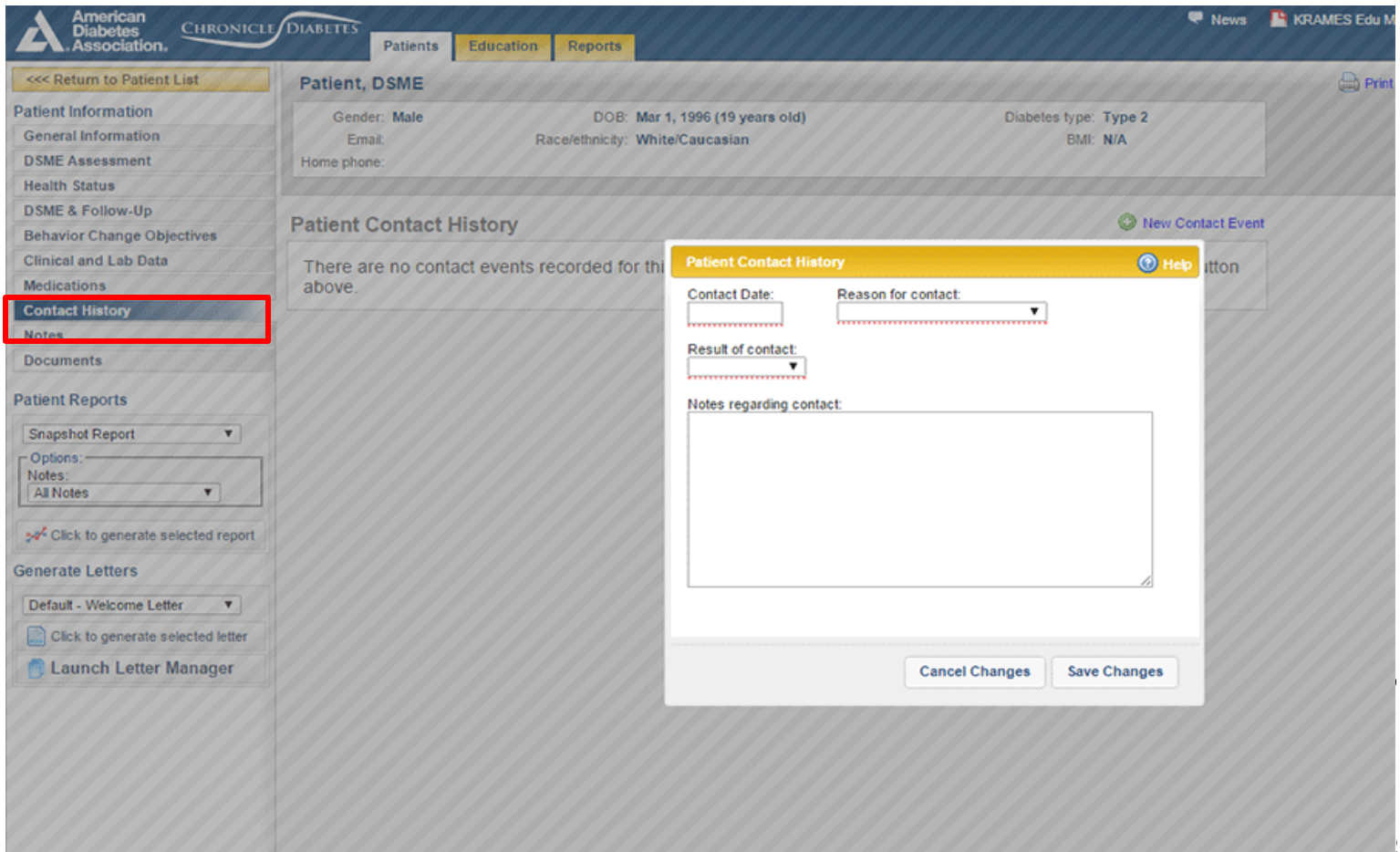
Emergency Room Visits (pre education, due to diabetes)  Edit

Had an emergency room visit in the past 12 months due to diabetes (prior to starting the initial DSME education cycle)::	Yes
Number emergency room visits in past 12 months due to diabetes:	3
Reason for Emergency Room Visits due to diabetes:	Low Blood Sugar

can

Contact History / Notes / Patient Documents Page 1 of 3

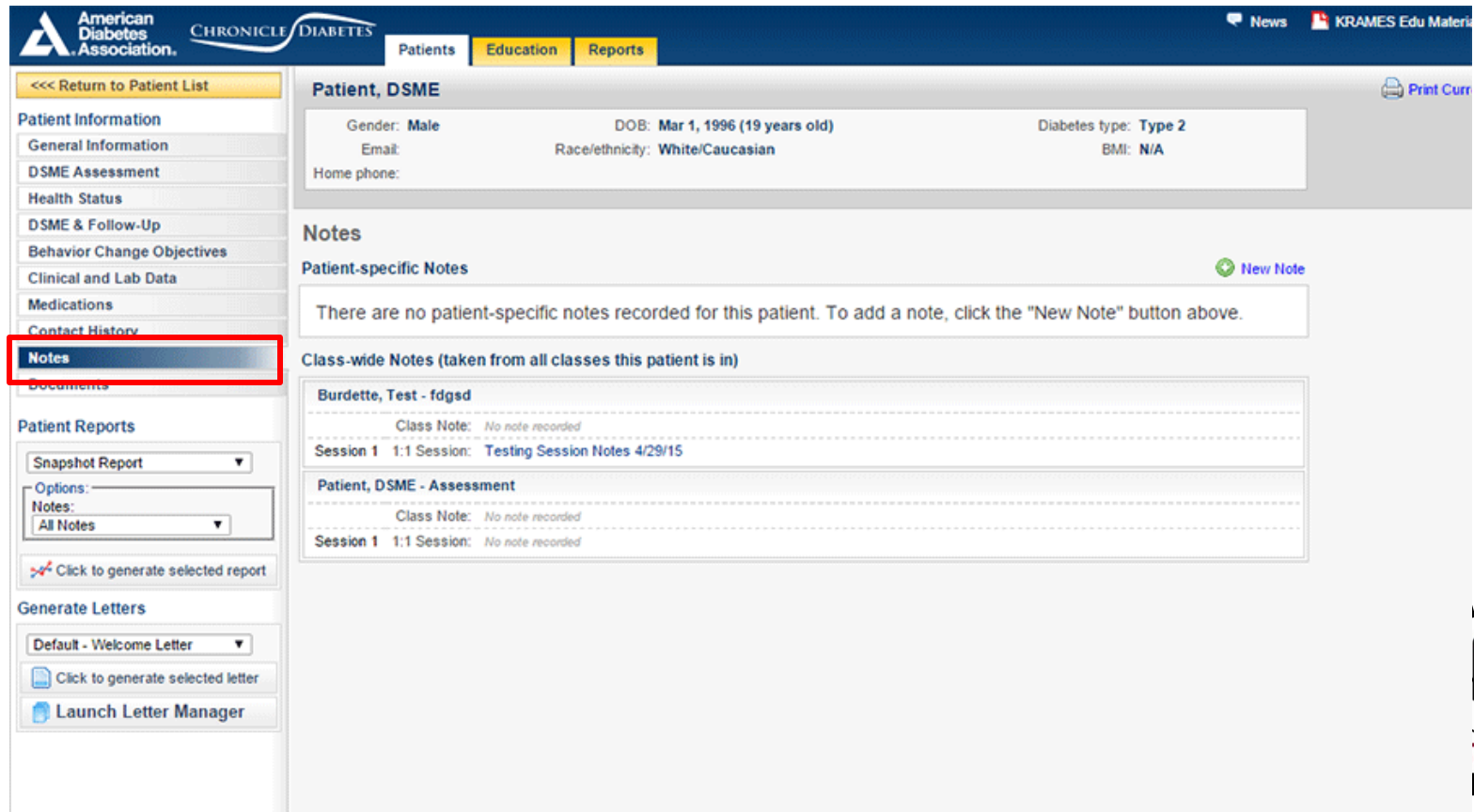
The **Contact History** section allows you to record and view contacts that have been made or attempted with the patient. Enter a date for the event, select the *Reason for Contact*, and the *Result of Contact*. If there is any other information that you'd like to record you can enter it in the *Notes* box.



The screenshot displays the American Diabetes Association patient management interface. The top navigation bar includes the logo, "CHRONICLE DIABETES", and tabs for "Patients", "Education", and "Reports". The main content area is titled "Patient, DSME" and shows patient details: Gender: Male, DOB: Mar 1, 1996 (19 years old), Diabetes type: Type 2, Race/ethnicity: White/Caucasian, and BMI: N/A. Below this is the "Patient Contact History" section, which currently displays "There are no contact events recorded for this patient above." A "New Contact Event" button is visible. A modal window titled "Patient Contact History" is open, containing the following fields: "Contact Date:" (text input), "Reason for contact:" (dropdown menu), "Result of contact:" (dropdown menu), and "Notes regarding contact:" (text area). The modal also includes "Cancel Changes" and "Save Changes" buttons. On the left sidebar, the "Contact History" menu item is highlighted with a red box. A "can" watermark is present in the bottom right corner.

Contact History / Notes / Patient Documents Page 2 of 3

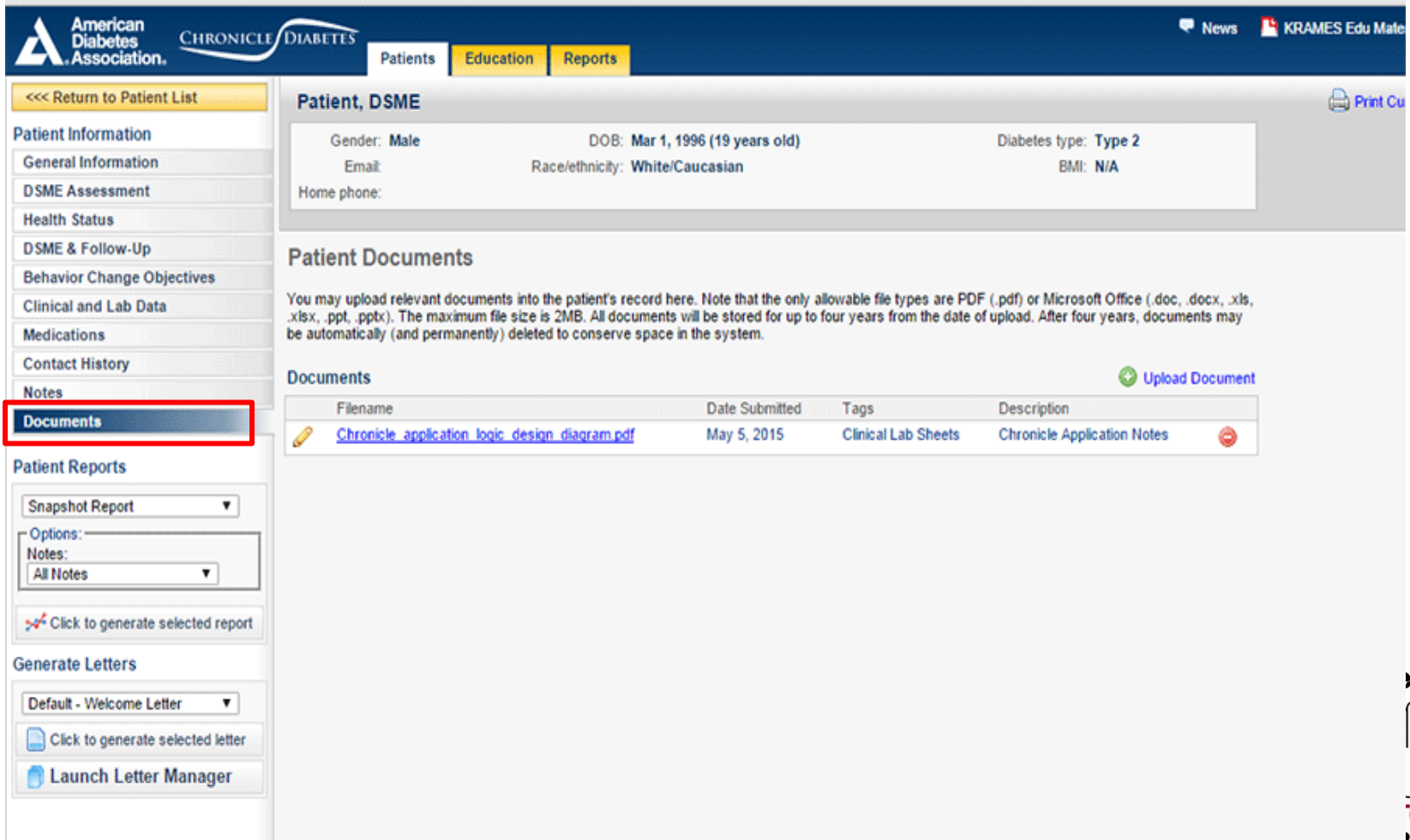
The **Notes** section allows you to record and view free-text notes about the patient. To add a new patient-specific note, click *Add New Note*, which will open the *Add / Edit Note* window. Below the patient-specific notes are both **class-wide notes** and **session-specific notes**. These are notes that are recorded for classes that the patient is in. Each class that the patient is in will be listed, and any class-wide and session notes will be displayed.



The screenshot displays the American Diabetes Association patient portal interface. The top navigation bar includes the logo, 'CHRONICLE DIABETES', and tabs for 'Patients', 'Education', and 'Reports'. The main content area is titled 'Patient, DSME' and shows patient information: Gender: Male, DOB: Mar 1, 1996 (19 years old), Diabetes type: Type 2, Email, Race/ethnicity: White/Caucasian, BMI: N/A, and Home phone. Below this is the 'Notes' section, which is highlighted with a red box in the left sidebar. The 'Notes' section contains a 'New Note' button and a message: 'There are no patient-specific notes recorded for this patient. To add a note, click the "New Note" button above.' Underneath, there are two sections for 'Class-wide Notes (taken from all classes this patient is in)'. The first is 'Burdette, Test - fdgsd' with a 'Class Note: No note recorded' and 'Session 1 1:1 Session: Testing Session Notes 4/29/15'. The second is 'Patient, DSME - Assessment' with a 'Class Note: No note recorded' and 'Session 1 1:1 Session: No note recorded'. The left sidebar includes a 'Return to Patient List' button, a 'Patient Information' menu with 'Notes' selected, and sections for 'Patient Reports' and 'Generate Letters'.

Contact History / Notes / Patient Documents Page 3 of 3

The **Patient Documents** section allows you to upload relevant documents into the patient's record. Note that the only allowable file types are PDF (.pdf) or Microsoft Office (.doc, .docx, .xls, .xlsx, .ppt, .pptx). The maximum file size is 2MB.



The screenshot displays the patient portal interface for a patient named DSME. The top navigation bar includes the American Diabetes Association logo, the 'CHRONICLE DIABETES' logo, and tabs for 'Patients', 'Education', and 'Reports'. The 'Patients' tab is active. The main content area is titled 'Patient, DSME' and includes a 'Print Cu' button. Below the patient name, there is a summary of patient information: Gender: Male, DOB: Mar 1, 1996 (19 years old), Diabetes type: Type 2, Email, Race/ethnicity: White/Caucasian, BMI: N/A, and Home phone. The 'Patient Documents' section is highlighted, showing a table of documents and an 'Upload Document' button. The table contains one document: 'Chronicle_application_logic_design_diagram.pdf' submitted on May 5, 2015, with the tag 'Clinical Lab Sheets' and description 'Chronicle Application Notes'. The left sidebar contains a navigation menu with 'Documents' highlighted in a red box. Other menu items include 'Patient Information', 'Patient Reports', and 'Generate Letters'.



Patient, DSME [Print Cu](#)

Gender: Male DOB: Mar 1, 1996 (19 years old) Diabetes type: Type 2
Email: Race/ethnicity: White/Caucasian BMI: N/A
Home phone:

Patient Documents

You may upload relevant documents into the patient's record here. Note that the only allowable file types are PDF (.pdf) or Microsoft Office (.doc, .docx, .xls, .xlsx, .ppt, .pptx). The maximum file size is 2MB. All documents will be stored for up to four years from the date of upload. After four years, documents may be automatically (and permanently) deleted to conserve space in the system.

[Upload Document](#)

Filename	Date Submitted	Tags	Description
 Chronicle_application_logic_design_diagram.pdf	May 5, 2015	Clinical Lab Sheets	Chronicle Application Notes 

Documents

Patient Reports

Snapshot Report ▼

Options:
Notes:
All Notes ▼

[Click to generate selected report](#)

Generate Letters

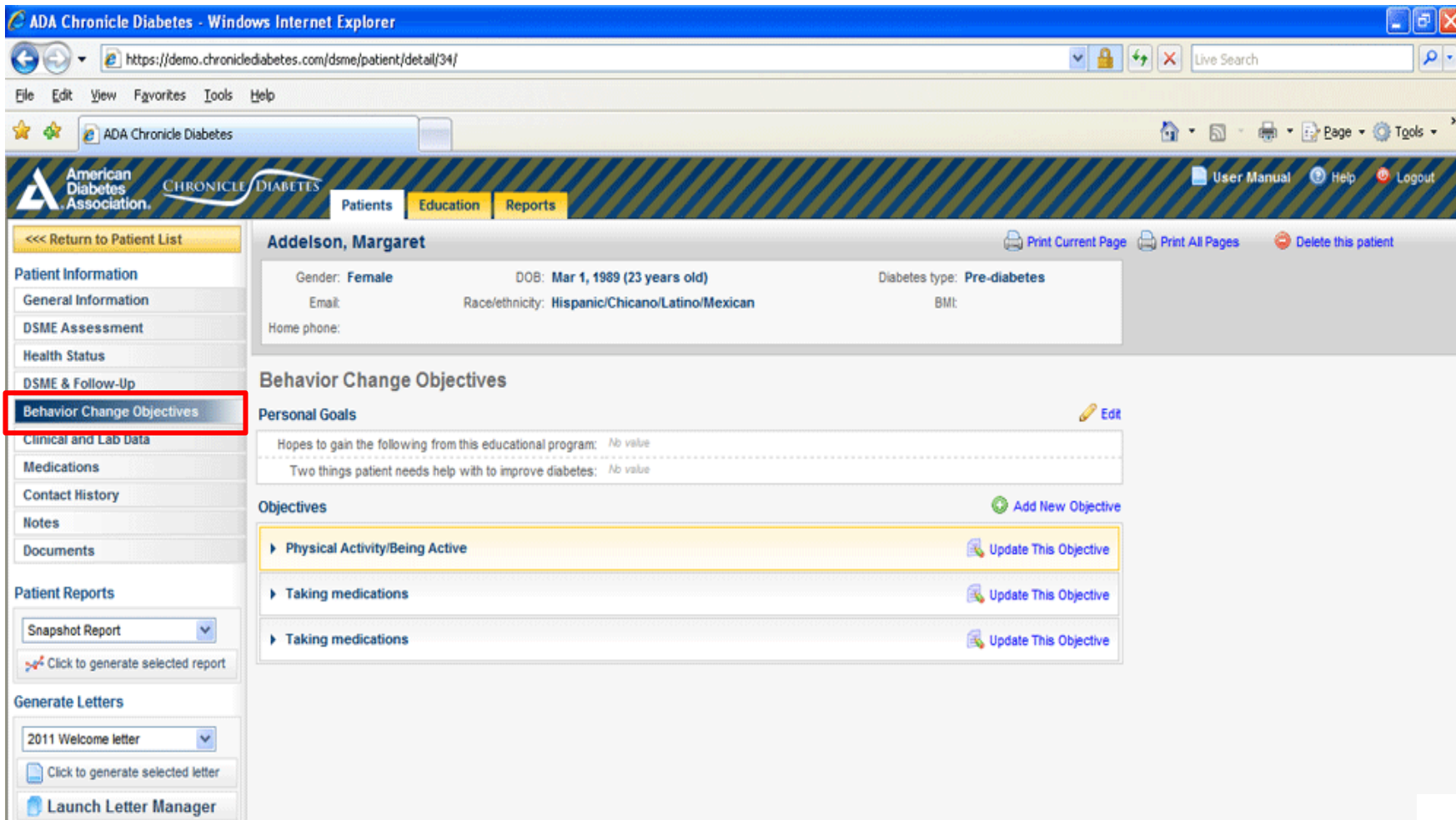
Default - Welcome Letter ▼

[Click to generate selected letter](#)

[Launch Letter Manager](#)

Behavioral Change Objectives *Page 1 of 2*

Clicking the **Behavior Change Objectives** tab from the left navigation pane displays a page that lists all of the patient's behavior change objectives, including a full history for each objective. At the top of the page are two *Personal Goals* which are questions asked of the patient during the PSA.



The screenshot shows a web browser window titled "ADA Chronicle Diabetes - Windows Internet Explorer" with the URL "https://demo.chronicdiabetes.com/dsme/patient/detail/34/". The page header includes the American Diabetes Association logo and navigation tabs for "Patients", "Education", and "Reports". The patient's name, "Addelson, Margaret", is displayed at the top right, along with options to "Print Current Page", "Print All Pages", and "Delete this patient".

The left navigation pane contains several sections: "Patient Information" (with sub-items: General Information, DSME Assessment, Health Status, DSME & Follow-Up, **Behavior Change Objectives**, Clinical and Lab Data, Medications, Contact History, Notes, Documents), "Patient Reports" (with a "Snapshot Report" dropdown and a "Click to generate selected report" button), and "Generate Letters" (with a "2011 Welcome letter" dropdown and a "Click to generate selected letter" button, plus a "Launch Letter Manager" button).

The main content area is titled "Behavior Change Objectives" and includes an "Edit" link. It features two "Personal Goals" sections, each with a "No value" status: "Hopes to gain the following from this educational program:" and "Two things patient needs help with to improve diabetes:". Below these are "Objectives" with an "Add New Objective" button. The listed objectives are:

- Physical Activity/Being Active (Update This Objective)
- Taking medications (Update This Objective)
- Taking medications (Update This Objective)

Behavioral Change Objectives *Page 2 of 2*

The *Objectives* section allows you to document how the patient's objectives (and their adherence to those objectives) change over time. To add a new baseline objective, click on **Add new objective**. When you next follow up with the patient you can **update the objective's status**, recording the patient's new achievement level. An existing baseline objective or objective update can be edited by clicking on the **edit pencil** to the left of the record.

Health Status

DSME & Follow-Up

Behavior Change Objectives

Clinical and Lab Data

Medications


Contact History

Notes

Documents


Patient Reports


Snapshot Report ▼

 Click to generate selected report


Generate Letters

2011 Welcome letter ▼

 Click to generate selected letter

 Launch Letter Manager


Behavior Change Objectives


Personal Goals  Edit


Hopes to gain the following from this educational program: No value


Two things patient needs help with to improve diabetes: No value


Objectives Add New Objective

▼ Physical Activity/Being Active  Update This Objective

Established/Updated	Objective	Achievement	Status	Barriers Addressed
<div style="display: flex; align-items: center;"> ▼  Jul 22, 2010 </div>	Be more physically fit Plan: take the stairs at work Outcome: less out of breath Followup Method: Notes:	100% (All of the time)	Discontinued	No
▶ Apr 27, 2009	Be more physically fit	75% (Most of the time)	Continued	Yes
▶ Mar 24, 2009	Be more physically fit	0% (None of the time)	Baseline	Yes

 Delete this Objective

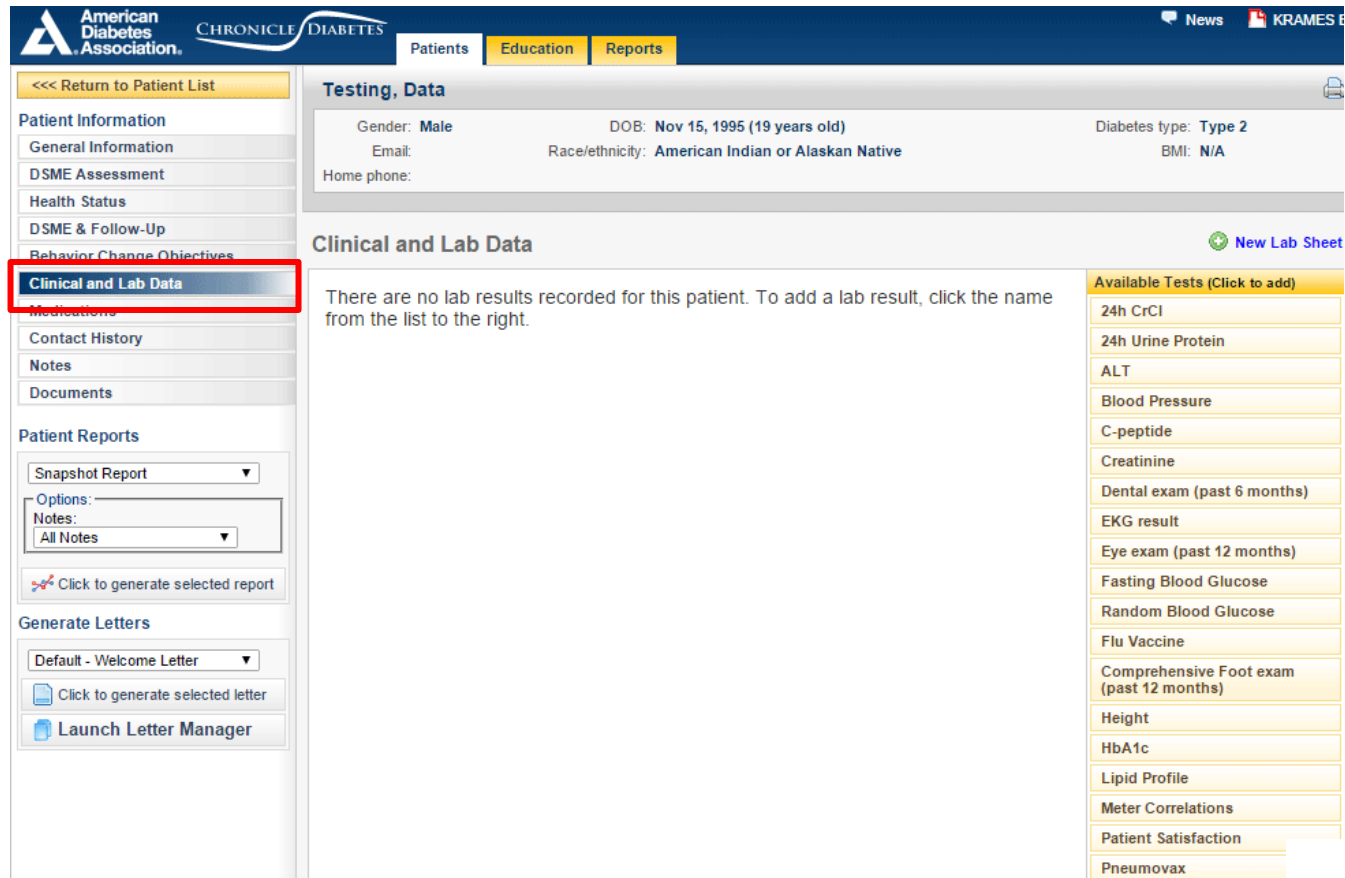
▶ Taking medications  Update This Objective

▶ Taking medications  Update This Objective

Clinical Data and Labs *Page 1 of 4*

Clicking the **Clinical and Lab Data** button from the left navigation pane displays a page that lists all of the most recent clinical data and lab information for the patient. For a new patient with no clinical data or labs documented, the main middle section of this page will be empty and the full list of *Available Tests* will be displayed on the right side of the page.

As test values are documented, those values will be displayed in the main middle section and the test will be removed from the *Available Tests* lists.



The screenshot shows the patient portal interface for the American Diabetes Association. The top navigation bar includes 'Patients', 'Education', and 'Reports'. The main content area is titled 'Testing, Data' and displays patient information: Gender: Male, DOB: Nov 15, 1995 (19 years old), Diabetes type: Type 2, Race/ethnicity: American Indian or Alaskan Native, and BMI: N/A. Below this is the 'Clinical and Lab Data' section, which is currently empty, displaying the message: 'There are no lab results recorded for this patient. To add a lab result, click the name from the list to the right.' On the right side, there is a list of 'Available Tests (Click to add)', including 24h CrCl, 24h Urine Protein, ALT, Blood Pressure, C-peptide, Creatinine, Dental exam (past 6 months), EKG result, Eye exam (past 12 months), Fasting Blood Glucose, Random Blood Glucose, Flu Vaccine, Comprehensive Foot exam (past 12 months), Height, HbA1c, Lipid Profile, Meter Correlations, Patient Satisfaction, and Pneumovax. The left navigation pane includes 'Patient Information', 'General Information', 'DSME Assessment', 'Health Status', 'DSME & Follow-Up', 'Behavior Change Objectives', 'Clinical and Lab Data' (highlighted with a red box), 'Medications', 'Contact History', 'Notes', 'Documents', 'Patient Reports', and 'Generate Letters'.

Clinical Data and Labs - Adding a new clinical data or lab test result *Page 2 of 4*

After you have gathered clinical data or lab results for a patient, you can enter both the most recent values as well as historical values into Chronicle. To enter a test result for a test that doesn't have any previous data, begin by clicking on the test's name in the *Available Tests* lists. Alternatively, if the test already has one or more previous results and you're going to be adding another test result, click the *Add Results* link to the right of the test's name. Doing either of these will bring up the *New Lab* window.

Enter the following information:

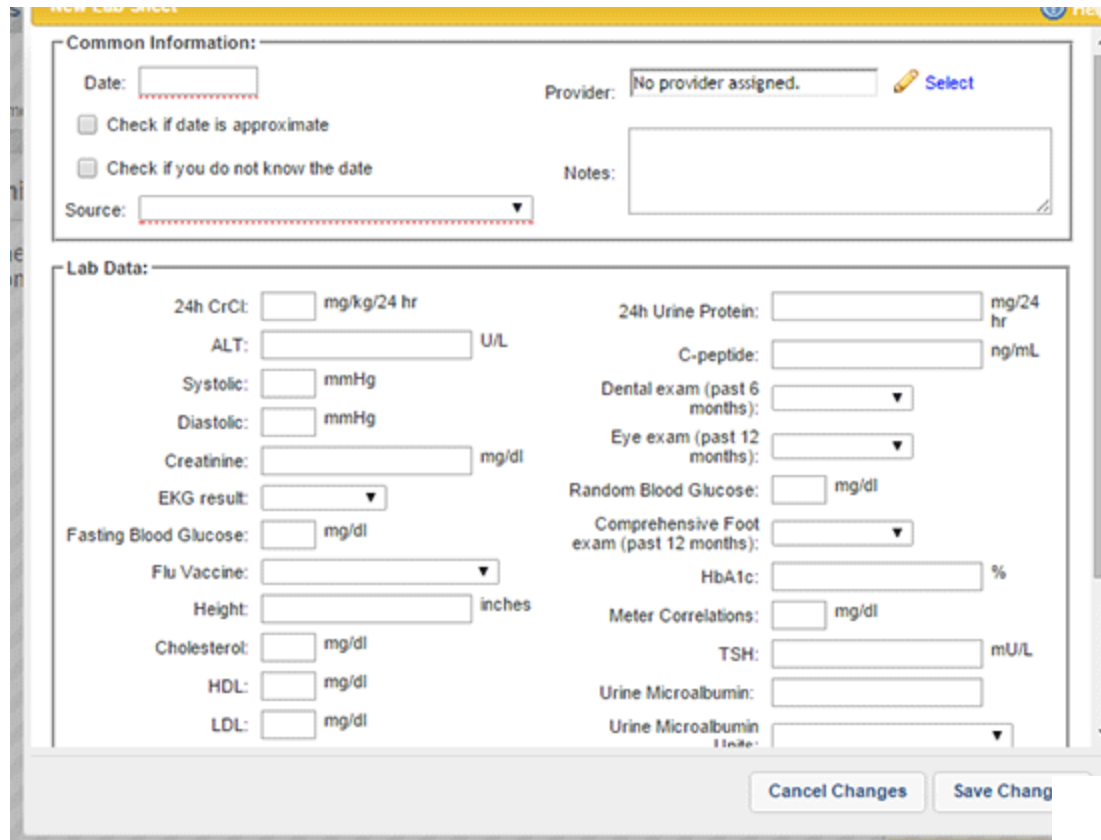
- Test result
- Date Performed
- Source of data
- Notes
- Provider

When you have entered all of the information, click the *Save Changes* button to save the test result. If the value you just entered is the most recent value for that test, then the new value will be displayed in the center table.

Clinical Data and Labs - Adding multiple clinical data or lab test results using a Lab Sheet *Page 3 of 4*

If you are going to be entering multiple clinical data or lab test result values that all share the same common information you can use a *Lab Sheet* to speed the entry. Click the *New Lab Sheet* link in the upper right above the *Available Tests* lists.

Note that all of the data entered on the *Lab Sheet* will share the same Common Information. Also, when the Lab Sheet is saved, the individual test results are all stored individually- they're not stored as a single lab sheet..



The screenshot displays the 'New Lab Sheet' form, which is divided into two main sections: 'Common Information' and 'Lab Data'.

Common Information:

- Date:
- Provider: [Select](#)
- Check if date is approximate
- Check if you do not know the date
- Source:
- Notes:

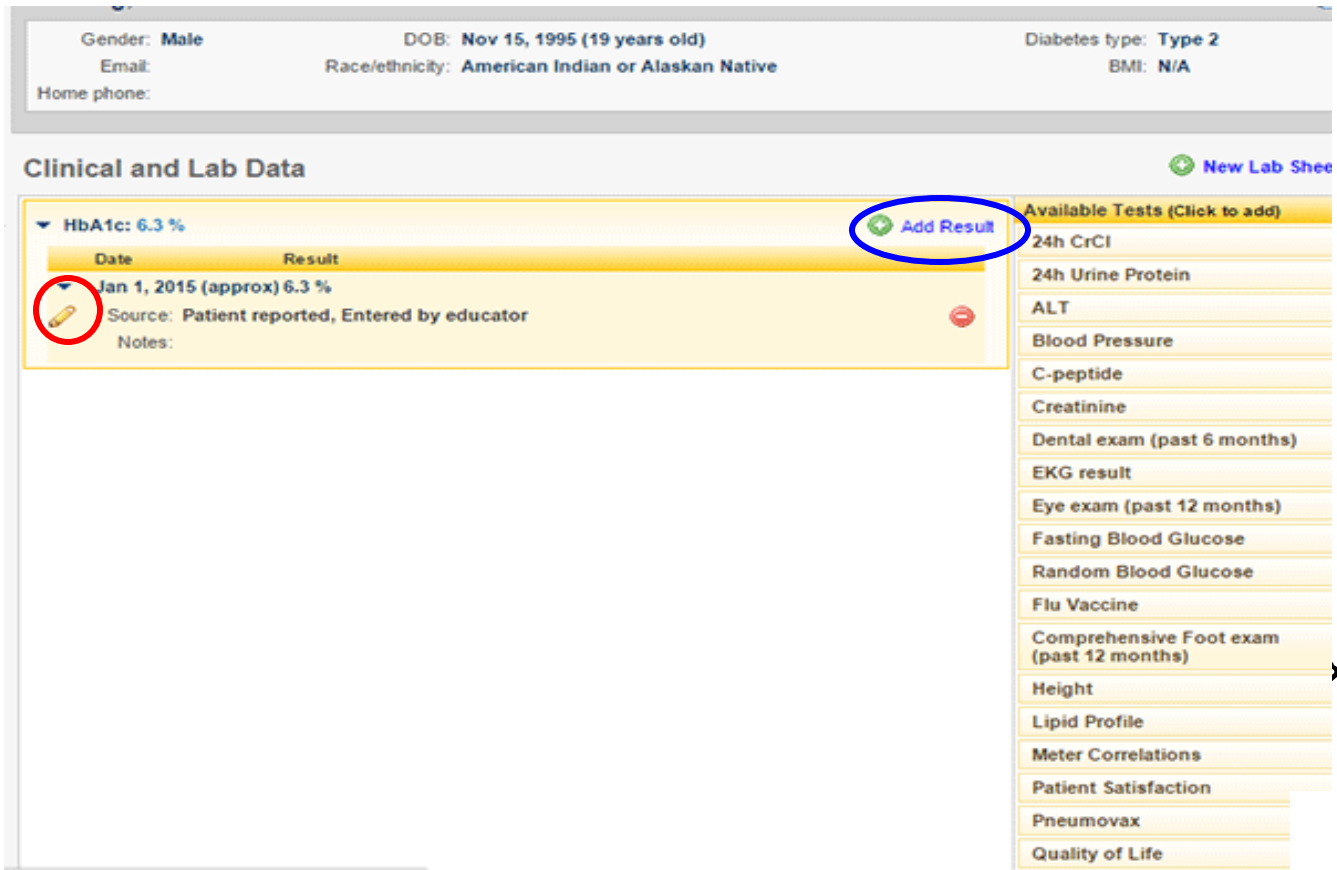
Lab Data:

24h CrCl: <input type="text"/> mg/kg/24 hr	24h Urine Protein: <input type="text"/> mg/24 hr
ALT: <input type="text"/> U/L	C-peptide: <input type="text"/> ng/mL
Systolic: <input type="text"/> mmHg	Dental exam (past 6 months): <input type="text"/>
Diastolic: <input type="text"/> mmHg	Eye exam (past 12 months): <input type="text"/>
Creatinine: <input type="text"/> mg/dl	Random Blood Glucose: <input type="text"/> mg/dl
EKG result: <input type="text"/>	Comprehensive Foot exam (past 12 months): <input type="text"/>
Fasting Blood Glucose: <input type="text"/> mg/dl	HbA1c: <input type="text"/> %
Flu Vaccine: <input type="text"/>	Meter Correlations: <input type="text"/> mg/dl
Height: <input type="text"/> inches	TSH: <input type="text"/> mU/L
Cholesterol: <input type="text"/> mg/dl	Urine Microalbumin: <input type="text"/>
HDL: <input type="text"/> mg/dl	Urine Microalbumin Test: <input type="text"/>
LDL: <input type="text"/> mg/dl	

At the bottom right of the form, there are two buttons: 'Cancel Changes' and 'Save Chang'.

Clinical Data and Labs - Editing or deleting an existing test result *Page 4 of 4*

To edit an existing test result, begin by clicking on the test in the main middle section, which will expand the test down to reveal the historical results. Click on the specific test result that you'd like to edit (which will expand that individual result) and then click the **Edit pencil icon**. This will open the *Edit Lab* window where you can make any necessary corrections and click the *Save Changes* button. To add a result to an existing lab value, click on the **Add Result** link next to the appropriate lab entry.



The screenshot displays a patient's clinical and lab data. At the top, patient information is shown: Gender: Male, Email: Home phone: (blank), DOB: Nov 15, 1995 (19 years old), Race/ethnicity: American Indian or Alaskan Native, Diabetes type: Type 2, and BMI: N/A. Below this is the "Clinical and Lab Data" section, which includes a "New Lab Sheet" button. The main data area is divided into two columns. The left column shows a table of HbA1c results. The right column lists "Available Tests (Click to add)" such as 24h CrCl, 24h Urine Protein, ALT, Blood Pressure, C-peptide, Creatinine, Dental exam (past 6 months), EKG result, Eye exam (past 12 months), Fasting Blood Glucose, Random Blood Glucose, Flu Vaccine, Comprehensive Foot exam (past 12 months), Height, Lipid Profile, Meter Correlations, Patient Satisfaction, Pneumovax, and Quality of Life.

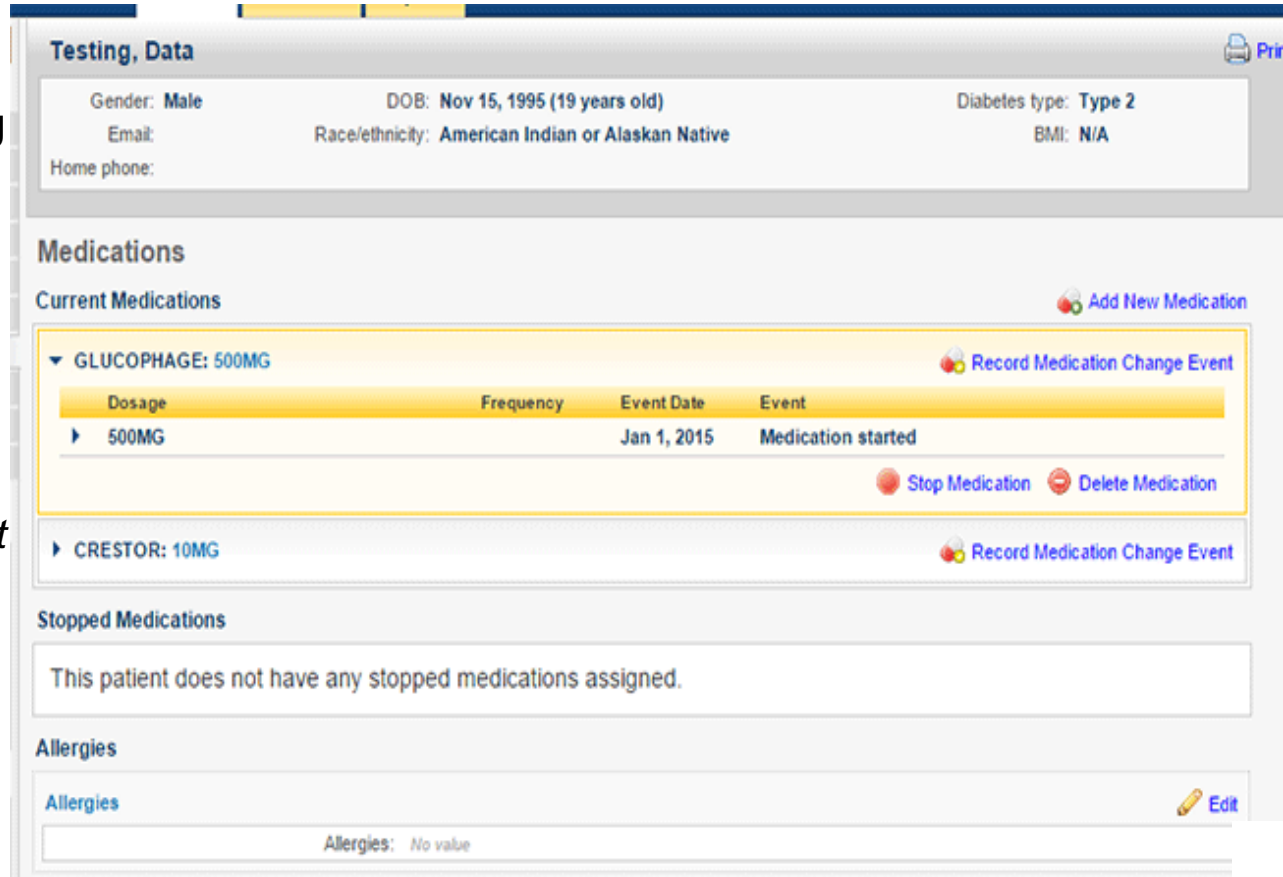
Clinical and Lab Data	
Gender: Male DOB: Nov 15, 1995 (19 years old) Diabetes type: Type 2	
Email: Race/ethnicity: American Indian or Alaskan Native BMI: N/A	
Home phone:	
Clinical and Lab Data + New Lab Sheet	
▼ HbA1c: 6.3 % + Add Result	
Date	Result
▼ Jan 1, 2015 (approx) 6.3 %	
Source: Patient reported, Entered by educator	
Notes:	
Available Tests (Click to add)	
24h CrCl	
24h Urine Protein	
ALT	
Blood Pressure	
C-peptide	
Creatinine	
Dental exam (past 6 months)	
EKG result	
Eye exam (past 12 months)	
Fasting Blood Glucose	
Random Blood Glucose	
Flu Vaccine	
Comprehensive Foot exam (past 12 months)	
Height	
Lipid Profile	
Meter Correlations	
Patient Satisfaction	
Pneumovax	
Quality of Life	


Documenting Medications *Page 1 of 5*

Clicking the *Medications* tab from the left navigation pane displays a page that lists all of the medications that the patient is taking or was taking in the past. Each listing in the center table lists a medication and the most recent information about that medication. For new patient the center section will be empty.

By clicking on a specific medication line, the listing will expand down to reveal a complete history of *Medication Change Events* for that medication.


Clicking on a specific *Medication Change Event* will cause it to expand down and reveal any notes for that event.




Testing, Data  Print



Gender: Male DOB: Nov 15, 1995 (19 years old) Diabetes type: Type 2
Email: Race/ethnicity: American Indian or Alaskan Native BMI: N/A
Home phone:


Medications

Current Medications  Add New Medication

▼ GLUCOPHAGE: 500MG  Record Medication Change Event

Dosage	Frequency	Event Date	Event
▶ 500MG		Jan 1, 2015	Medication started


 Stop Medication  Delete Medication

▶ CRESTOR: 10MG  Record Medication Change Event

Stopped Medications

This patient does not have any stopped medications assigned.

Allergies

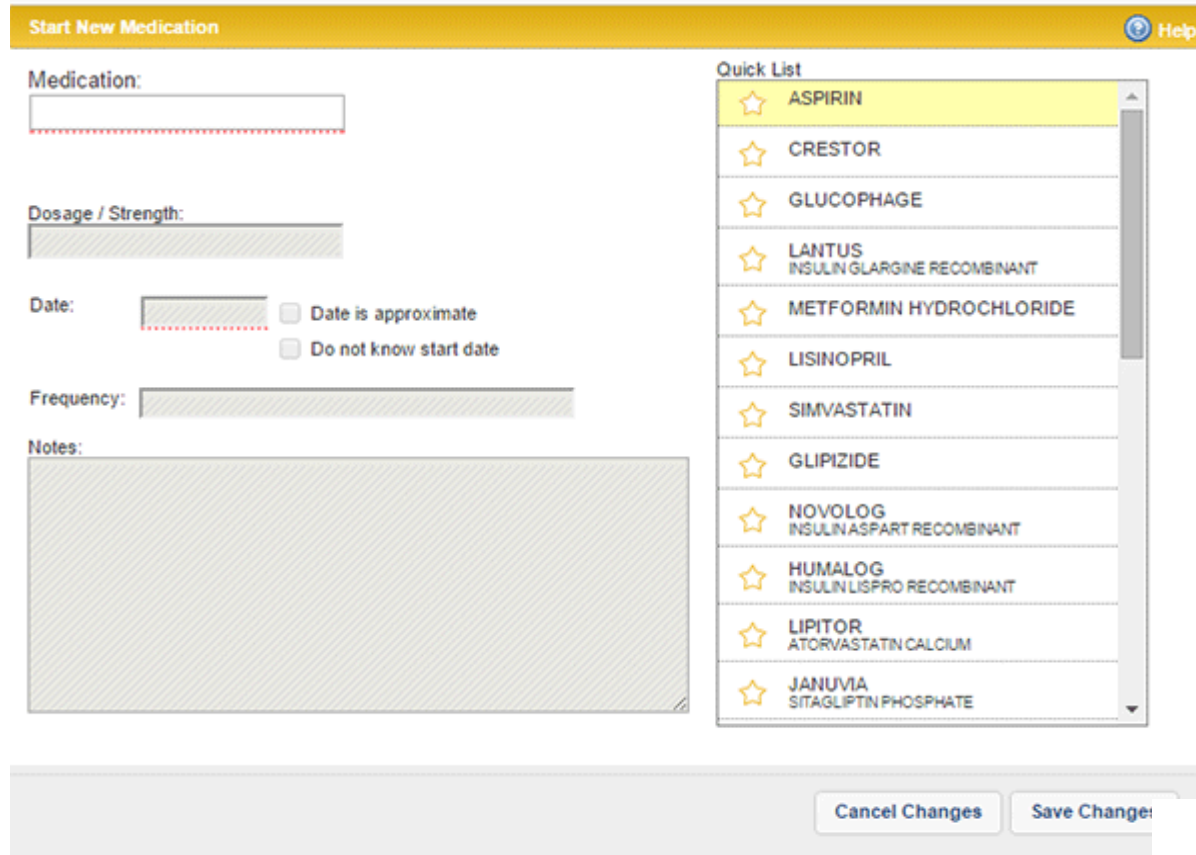
Allergies  Edit

Allergies: No value

Adding a medication *Page 2 of 5*

To enter a new medication, click the *Add New Medication* link (near the top right of the *Medications* page) to bring up the *Start New Medication* window. This box allows you to enter a new medication for this patient. The *Quick List* on the right contains medications that you've previously marked as a favorite (marked with solid stars) as well as other popular or recent medications (marked with empty stars). The boxes on the left allow you to select a medication that isn't already in your *Quick List*.

Tip: If the medication that you just entered is one that you believe you'll be using frequently, you can add it to the *Quick List* by clicking the link *Add medication to favorites* link next to the medication's name.



Start New Medication Help

Medication:

Dosage / Strength:

Date: Date is approximate
 Do not know start date

Frequency:

Notes:

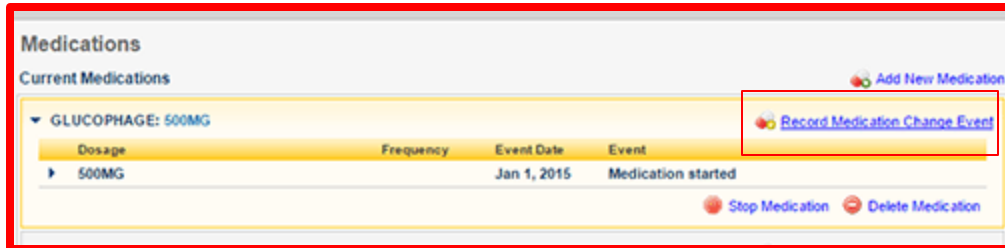
Quick List

- ☆ ASPIRIN
- ☆ CRESTOR
- ☆ GLUCOPHAGE
- ☆ LANTUS
INSULIN GLARGINE RECOMBINANT
- ☆ METFORMIN HYDROCHLORIDE
- ☆ LISINAPRIL
- ☆ SIMVASTATIN
- ☆ GLIPIZIDE
- ☆ NOVOLOG
INSULIN ASPART RECOMBINANT
- ☆ HUMALOG
INSULIN LISPRO RECOMBINANT
- ☆ LIPITOR
ATORVASTATIN CALCIUM
- ☆ JANUVIA
SITAGLIPTIN PHOSPHATE

Cancel Changes Save Changes

Recording a medication change event *Page 3 of 5*

If a patient's prescribed medication regimen changes (e.g. the dosage or frequency of a medication that they are on is modified), you can document this information by recording a medication change event.

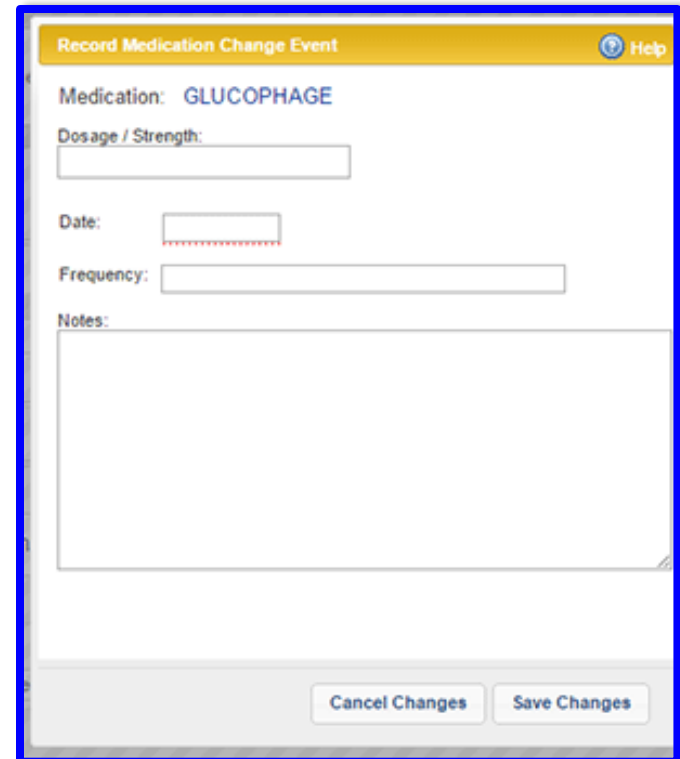


The screenshot shows a 'Medications' interface. Under 'Current Medications', there is a table with the following data:

Dosage	Frequency	Event Date	Event
500MG		Jan 1, 2015	Medication started

To the right of the table, there is a link labeled 'Record Medication Change Event'. Below the table are buttons for 'Stop Medication' and 'Delete Medication'. An 'Add New Medication' link is also visible at the top right.

Click the **Record Medication Change Event** link to the right of the medication's name, which will bring up the **Record Medication Change Event window**. Here you can enter the date that the medication change event took place. Then enter the new dosage and frequency for the medication, and any notes that you'd like associated with the change of this medication.



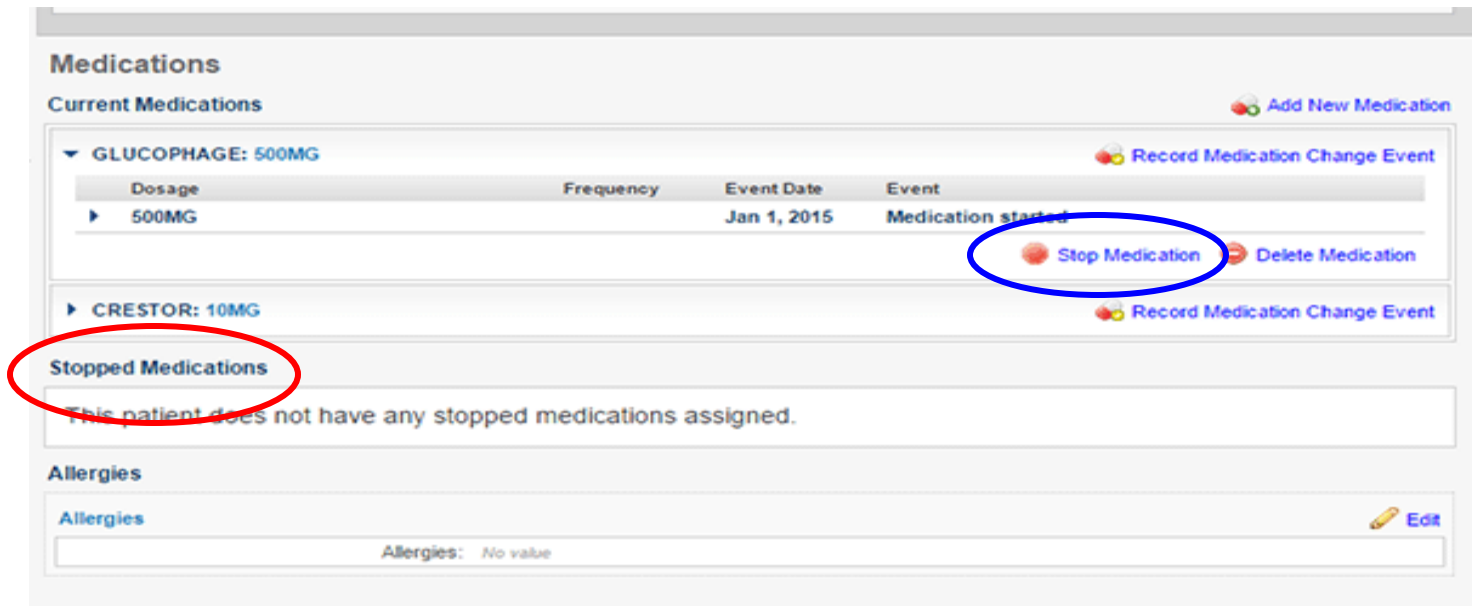
The screenshot shows the 'Record Medication Change Event' window. It contains the following fields:

- Medication: GLUCOPHAGE
- Dosage / Strength:
- Date:
- Frequency:
- Notes:

At the bottom, there are two buttons: 'Cancel Changes' and 'Save Changes'.

Recording a **Stop** medication event *Page 4 of 5*

If a patient is no longer taking a medication that they had previously been prescribed, you can document this information by recording a stop medication event. Begin by clicking on the medication's name in the main medication table. Then click the **Stop Medication** link to bring up the *Stop Medication* window. Enter the date on which the patient stopped taking the medication and any associated notes. When you have entered all of the information, click the *Save Changes* button to save the stop medication event. You'll see that the medication has been removed from the *Current Medication* table down into the **Stopped Medications table**.



The screenshot displays the 'Medications' section of a patient's record. It is divided into 'Current Medications' and 'Stopped Medications'.

Current Medications:

- GLUCOPHAGE: 500MG** (circled in blue): Includes a table with columns for Dosage, Frequency, Event Date, and Event. The event is 'Medication started' on 'Jan 1, 2015'. Below the table are 'Stop Medication' (circled in blue) and 'Delete Medication' buttons. A 'Record Medication Change Event' link is also present.
- CRESTOR: 10MG** (circled in red): Includes a 'Record Medication Change Event' link.

Stopped Medications: (circled in red) This patient does not have any stopped medications assigned.

Allergies: Allergies: No value (with an 'Edit' button).

Creating a new (custom) medication *Page 5 of 5*

If a patient is taking a medication that is not already in the database, you can manually add the medication to your site's medication database so that it will be available for future use.

Begin by trying to add the medication to a patient's record

- Click the **Add New Medication** button to bring up the Start New Medication window.
- Type in the Trade Name, and if the medication isn't already in the medication database you'll be presented with no matches but will have an option to click Add a new medication named [name]. Clicking this option will bring up a link that says Click to add "[name]" as a custom medication. Clicking that will add the medication you entered as a new medication in the database. From then on it will be available to all your site's educators in the medication's list in the future.

Patient Reports Page 1 of 3

The **Snapshot Report** and the **DSME Record report** give an overview of the data about a specific patient. Both reports are generated through the **Patient Reports** section of the patient record.

The screenshot displays the 'Patient, DSME' record page. The left sidebar contains a navigation menu with 'Patient Reports' highlighted in red. A dropdown menu is open under 'Patient Reports', showing 'Snapshot Report' selected, 'Snapshot Report', 'Diabetes Self-Management Education Record', and 'All Notes'. The main content area shows patient details: Gender: Male, DOB: Mar 1, 1996 (19 years old), Diabetes type: Type 2, Email, Race/ethnicity: White/Caucasian, BMI: N/A, Home phone. Below this is the 'General Information' section with fields for Patient Name / ID (DSME Patient), Patient ID, Medicaid ID, Status (Active), and Chronicle ID (202815). Other sections include Web Login (username: dsmpatient202815), Contact Information (Address 1, Address 2, City, State, Postal Code, Email, Work Phone, Home Phone, Cell Phone), Provider / Physician (Primary Physician (PCP): Dr William Rodgers), Patient Type, Demographics (Date of Birth, Gender, Race, Occupation, Preferred Language, Education), Sites (ERP Clinic), Referrals (Referral Date: Nov 6, 2014, Referring Provider: Dr William Rodgers), Health Insurance Information (Has Insurance: No value), and Cohorts.

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Patient Reports *Page 2 of 3*

The Snapshot Report This report gives an overview of the data about a specific patient. The left column contains lists of the patient's current medications, recent interventions, topics that were covered during the educational sessions, and the patient's goals (and their change rate). The right column of the report contains clinical data, with historical values listed in a table and a graph displaying the change over time.

4/11/2016

Patient, DSME DOB: 4/18/1946

DSME Patient (ID:211456)

Printed on: 4/11/2016 at 2:52 PM

Diabetes: Type 2	Gender: Female	DOB: 4/18/1946 (70)	Last edu. visit: May 3, 2015	Height: 75.00	Weight: 145.00	BMI: 18.1	Waist: 36.0	Referring Provider: Steven Burdette
------------------	----------------	---------------------	------------------------------	---------------	----------------	-----------	-------------	-------------------------------------

Current Medications

Glipizide 10MG
 Glucophage 500MG
 Lipitor EQ 10MG BASE
 allergies: None

Recent Interventions

Intervention	Result / Date
Dental Exam	Yes as of 4/06/2016
Eye Exam	Yes as of 4/04/2016
Foot Exam	Yes as of 4/01/2016
Urine Protein	34 as of 4/05/2016
Urine microalb	No Data
Flu Vaccine	Vac as of 4/04/2016
Pneumonia Vaccine	No Data
EKG	No Data

Educational Topics Addressed

Topic	Most recently covered
Disease Process	5/03/2015
Nutritional Management	5/03/2015
Being Active	5/03/2015
Taking medications	5/03/2015
Monitoring	5/03/2015
Acute complications	5/03/2015
Chronic complication	5/03/2015
Psychosocial Adjustment	5/03/2015
Promote health	5/03/2015

Behavior Change Objectives

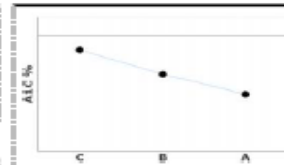
Objective	Current Level	Assessed
Self Foot Checks	100% (All)	4/04/2016
Quality of Life	25% (Very Little)	5/06/2015
Carb Counting	75% (Most)	5/01/2015

DSMS Plan

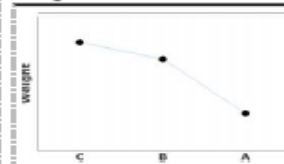
Diabetes Forecast-800-342-2383-
www.diabetesforecast.org

Weight Watchers-800-621-6000-
www.weightwatchers.com

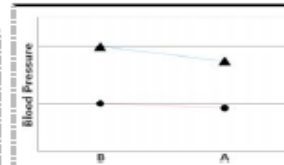
HbA1c



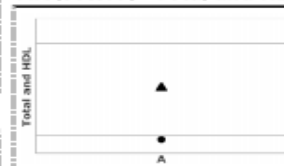
Weight



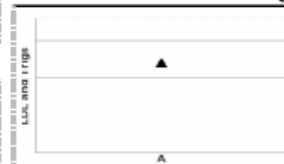
Blood Pressure



Cholesterol - Total and HDL



Cholesterol - LDL and Trigs



Patient Reports *Page 3 of 3*

The **DSME Record report** contains the information that was documented for the patient's educational session(s). This includes the pre assessment and post evaluation of the patient's ability in the nine ADA topic/learning objectives, class methods and materials, barriers and DSMS plan. All of the educational information included in this report will represent the most current information documented in Chronicle.

Diabetes Self-Management Education Record

Topics/Learning Objectives	Pre-Session Assessment	Comments	Instr. Date	Post-Session Evaluation	Comments
Diabetes disease process and Treatment options	1		04/01/2015	3	
Incorporating nutritional management into lifestyle	2		04/01/2015	4	
Incorporating physical activity into lifestyle	2		04/01/2015	3	
Using medications safely	1		04/01/2015	4	
Monitoring blood glucose, interpreting and using results	1		04/01/2015	4	
Prevention, detection and treatment of acute complications	1		04/01/2015	3	
Prevention, detection and treatment of chronic complications	1		04/01/2015	3	
Developing strategies to address psychosocial issues	2		04/01/2015	4	
Developing strategies to promote health/change behavior	2		04/01/2015	4	

Ratings: 1=Needs instruction 2=Needs review 3= Comprehends key points 4= Demonstrates competency NA=Not applicable

Education plan:

Instruction Method:

Lecture/Discussion, Demonstration (Source: Assessment (12/01/2014))

Education Materials/Equipment Provided:

Computer aided (Interactive) (Source: Assessment (12/01/2014))

Identified Barriers to learning/adherence to self management plan:

DSMS Plan:

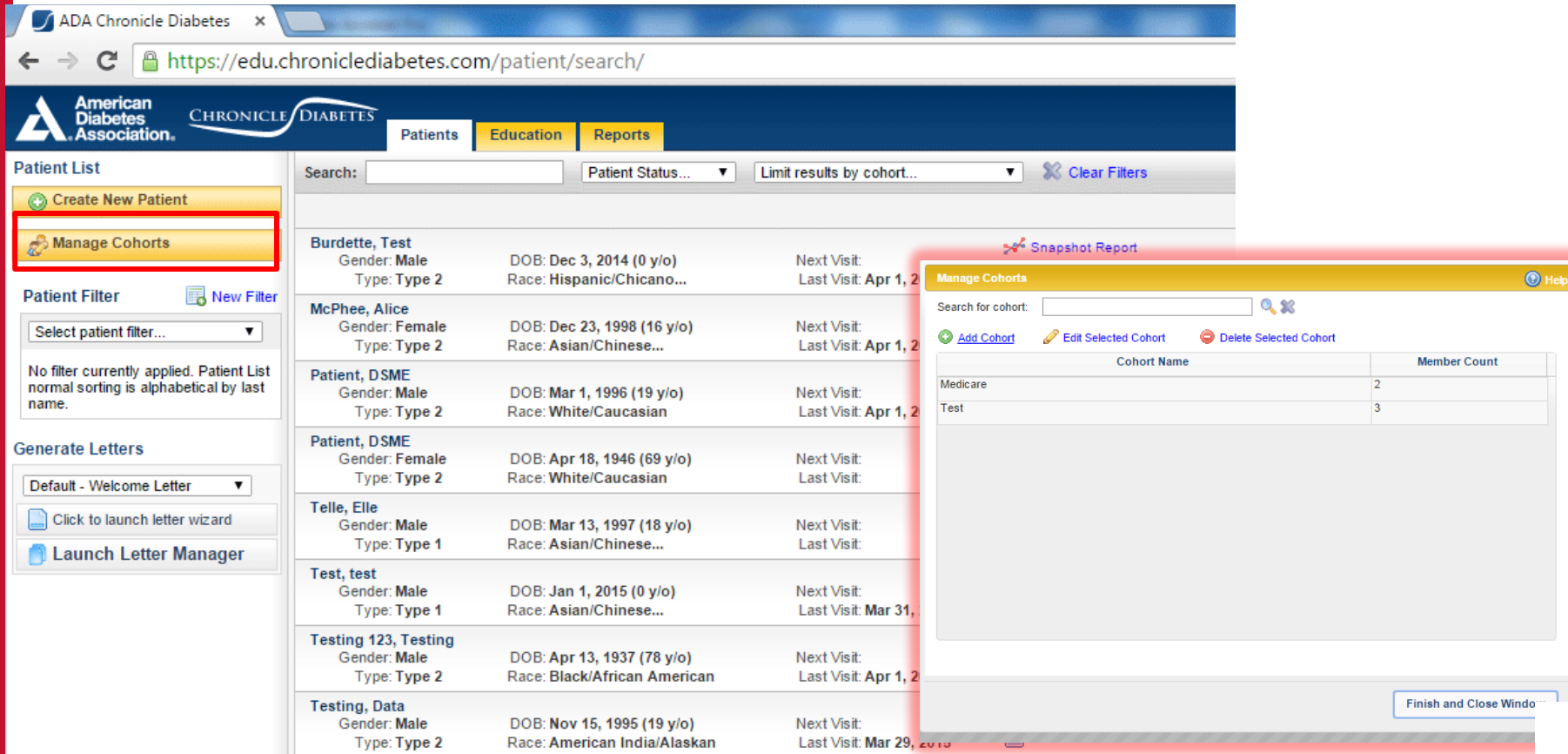
Diabetes Forecast- 800-342-2393- www.diabetesforecast.org Diabetes Self-Management- 855-367-4813- www.diabetesselfmanagement.com (Source: Assessment (12/1/14))

Creating/Managing Patient Cohorts *Page 1 of 2.*

Patient Cohorts are a way to categorize patients into groups of similar patient types such as Insulin Starts, GDMs, PEDs or Referring Provider.

Creating/Managing a Cohort

1. From the Patients List Page, Click the **Manage Cohorts** Button
2. Click the *Add Cohort* button and give it an identifiable name
3. Select patients from the list to be in the cohort



The screenshot shows the ADA Chronicle Diabetes website interface. The main page is titled "Patient List" and features a search bar, filters, and a list of patients. A "Manage Cohorts" button is highlighted in the left sidebar. A "Manage Cohorts" modal window is open, showing a search bar and a table with two cohorts: "Medicare" (2 members) and "Test" (3 members).

Search: **Patient Status...** **Limit results by cohort...** [Clear Filters](#)

Search for cohort:	Cohort Name	Member Count
<input type="checkbox"/>	Medicare	2
<input type="checkbox"/>	Test	3

Manage Cohorts [Help](#)

[Add Cohort](#) [Edit Selected Cohort](#) [Delete Selected Cohort](#)

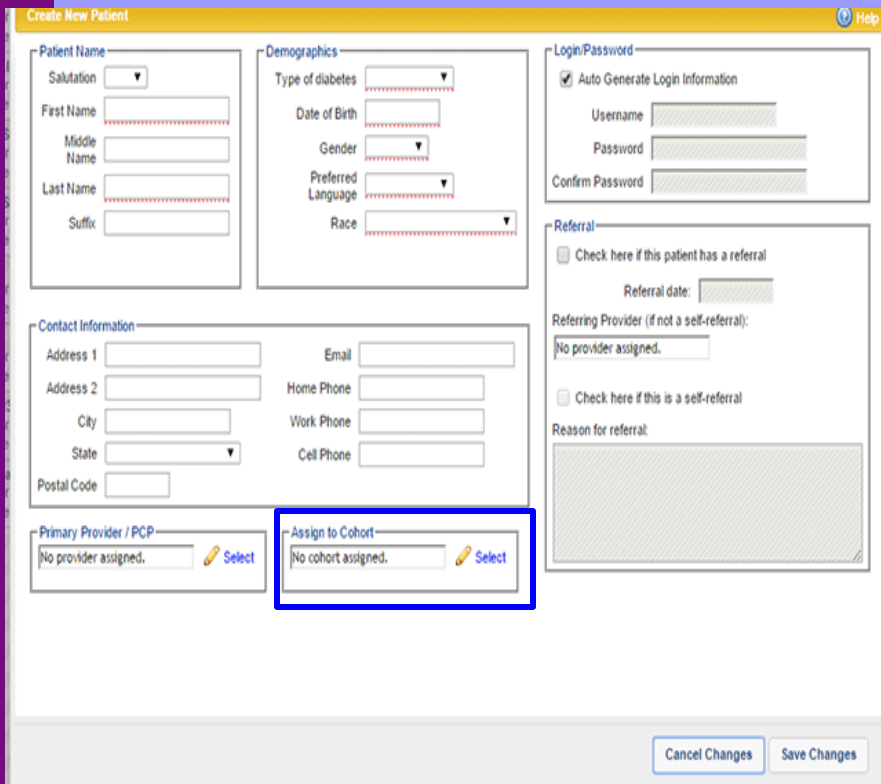
[Finish and Close Window](#)

Creating/Managing Patient Cohorts *Page 2 of 2*

Assigning a Patient to a Cohort - Cohorts can be assigned when initially creating a patient record or added within the **general information** section of an existing patient.

Assigning a **patient cohort** while creating a new patient record.

Assigning a **patient cohort** to an existing patient record.



Create New Patient

Patient Name
Salutation: [v]
First Name: []
Middle Name: []
Last Name: []
Suffix: []

Demographics
Type of diabetes: [v]
Date of Birth: []
Gender: [v]
Preferred Language: [v]
Race: [v]

Login/Password
 Auto Generate Login Information
Username: []
Password: []
Confirm Password: []

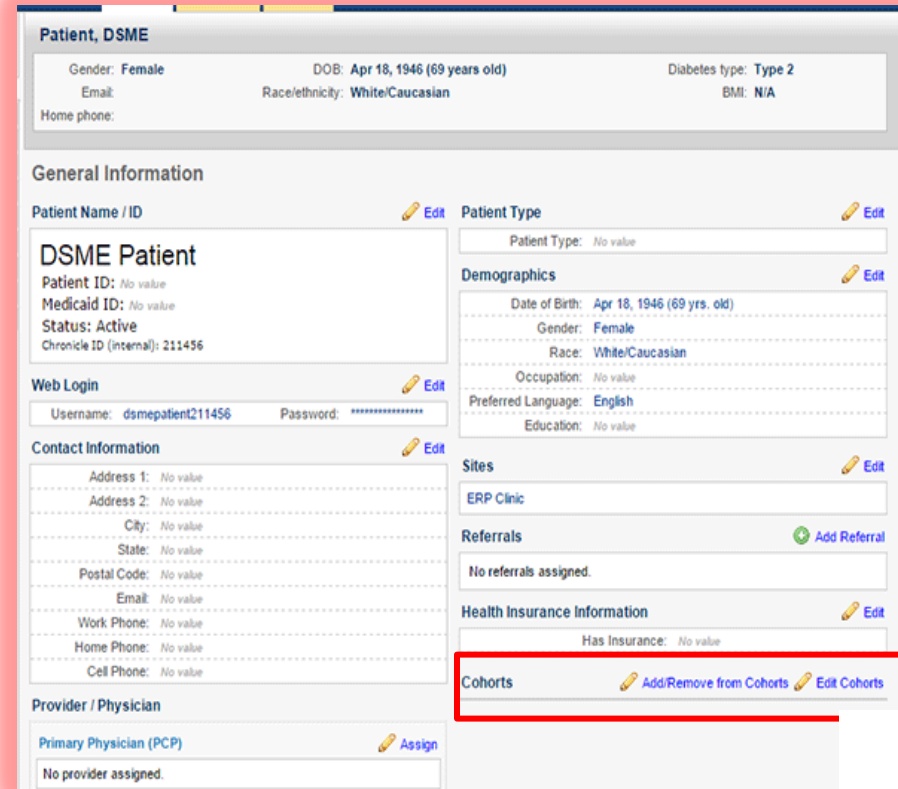
Referral
 Check here if this patient has a referral
Referral date: []
Referring Provider (if not a self-referral):
No provider assigned.
 Check here if this is a self-referral
Reason for referral: []

Contact Information
Address 1: [] Email: []
Address 2: [] Home Phone: []
City: [] Work Phone: []
State: [v] Cell Phone: []
Postal Code: []

Primary Provider / PCP
No provider assigned. [Select]

Assign to Cohort
No cohort assigned. [Select]

Cancel Changes Save Changes



Patient, DSME
Gender: Female DOB: Apr 18, 1946 (69 years old) Diabetes type: Type 2
Email: Race/ethnicity: White/Caucasian BMI: N/A
Home phone:

General Information

Patient Name / ID [Edit] **Patient Type** [Edit]
DSME Patient
Patient ID: No value
Medicaid ID: No value
Status: Active
Chronicle ID (internal): 211456

Web Login [Edit]
Username: dsmpatient211456 Password: *****

Contact Information [Edit]
Address 1: No value
Address 2: No value
City: No value
State: No value
Postal Code: No value
Email: No value
Work Phone: No value
Home Phone: No value
Cell Phone: No value

Demographics [Edit]
Date of Birth: Apr 18, 1946 (69 yrs. old)
Gender: Female
Race: White/Caucasian
Occupation: No value
Preferred Language: English
Education: No value

Sites [Edit]
ERP Clinic

Referrals [Add Referral]
No referrals assigned.

Health Insurance Information [Edit]
Has Insurance: No value

Cohorts [Add/Remove from Cohorts] [Edit Cohorts]

Provider / Physician [Assign]
Primary Physician (PCP)
No provider assigned.

Patient Cohort Tips

- Filter reports can be filtered by patient cohort
- Each Patient can be assigned to one or more cohorts
- You can Add, Edit or Delete a cohort through the Manage Cohorts button located near the upper left of the Patient List page.

Module 2: Managing Classes & Documenting Education

- **Setting up and Managing Classes**
 - Creating a 1:1 or Group Class
 - Creating/Managing class templates for a series of classes
- **Documenting Patient Education**
 - Topics Covered During Class session
 - Attendance Slide
 - Educator Hours Slide
 - Individual Pre Assessment and Post Education Evaluation
 - Individual DSMS Plan
 - Documenting Hospital Admission and Emergency Room Visits Post Education

Module 2: Creating/Managing Classes & Documenting Education

Creating a 1:1 or Group Class: Page 1 of 7

1. Click on the **Education tab** at the top of the page. You will see a list of existing classes, along with basic information about the class.

The screenshot shows a Windows Internet Explorer browser window displaying the ADA Chronicle Diabetes website. The browser's address bar shows the URL <https://edu.chronicdiabetes.com/edclass/search/>. The website's navigation menu includes 'Patients', 'Education', and 'Reports', with 'Education' highlighted and circled in red. The main content area displays a 'Class List' with a search bar and a table of classes. The table shows 8 total classes, with the first page displaying 1-8. The classes listed are:

Class Name	Format	Sessions	Attendees	Start/End	Action
fdasf	Combination of 1:1 and Group	Not Scheduled	None Assigned		Generate Letters
2	Classroom / Group	Not Scheduled	None Assigned		Generate Letters
May 2012	Combination of 1:1 and Group	3	1	May 4, 2012 - May 31, 2012	Generate Letters
Ste, Steve - SSS	1:1			Apr 11, 2012	Generate Letters
January 24 to February 28	Combination of 1:1 and Group	2	3	Jan 24, 2012 - Jan 25, 2012	Generate Letters
Ste, Steve - safsdaf	1:1			Jan 12, 2012	Generate Letters
Stevens 1st EDU Class	Combination of 1:1 and Group	1	1	Aug 2, 2011 - Aug 2, 2011	Generate Letters
Steven's Test	Classroom / Group	4	3	Jul 12, 2011 - Sep 8, 2011	Generate Letters

The footer of the page indicates the user is logged in as 'Mr Steven Burdette FDSAF', the site is powered by ScoreMD, and the user is at Stevens Hospital. The browser's status bar shows the URL <https://edu.chronicdiabetes.com/reports/> and the page is zoomed to 100%.

Creating a 1:1 or Group Class: Page 2 of 7

2. Click **Create New Class** on the left side of the page to bring up the window. Enter a name for the class. Examples could be "June 2012" or "June 2012 Friday AM". Choose a name that you will logically associate with this class. Enter the Class Type and Education Format and click Save Changes.

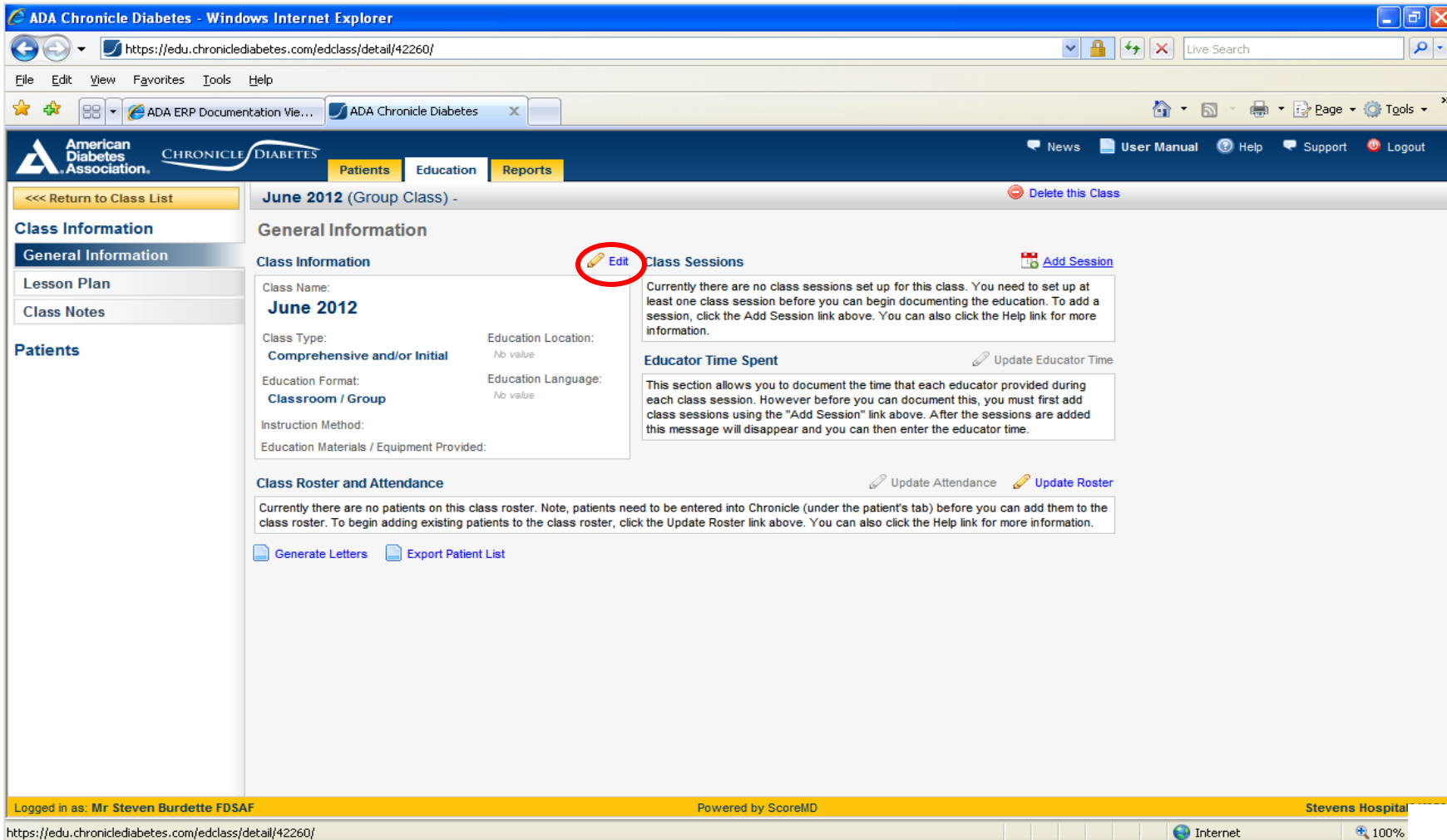
The screenshot displays the ADA Chronicle Diabetes website interface. The browser window title is "ADA Chronicle Diabetes - Windows Internet Explorer" and the address bar shows "https://edu.chroniclediabetes.com/edclass/search/". The website header includes the ADA logo, "CHRONICLE DIABETES", and navigation tabs for "Patients", "Education", and "Reports". A "Class List" section is visible, showing a table of classes with columns for class name, format, sessions, attendees, start/end dates, and a "Generate Letters" button. A red circle highlights the "Create New Group Class" link in the left sidebar. A modal dialog box titled "Create Group Class" is open, containing the following fields:

- Class Name: June 2012
- Class Type: Comprehensive and/or Initial
- Education Format: Classroom / Group

Buttons for "Cancel Changes" and "Save Changes" are located at the bottom of the dialog box. The footer of the page indicates the user is logged in as "Mr Steven Burdette FDSAF", the site is powered by "ScoreMD", and the user is at "Stevens Hospital".

Creating a 1:1 or Group Class: Page 3 of 7

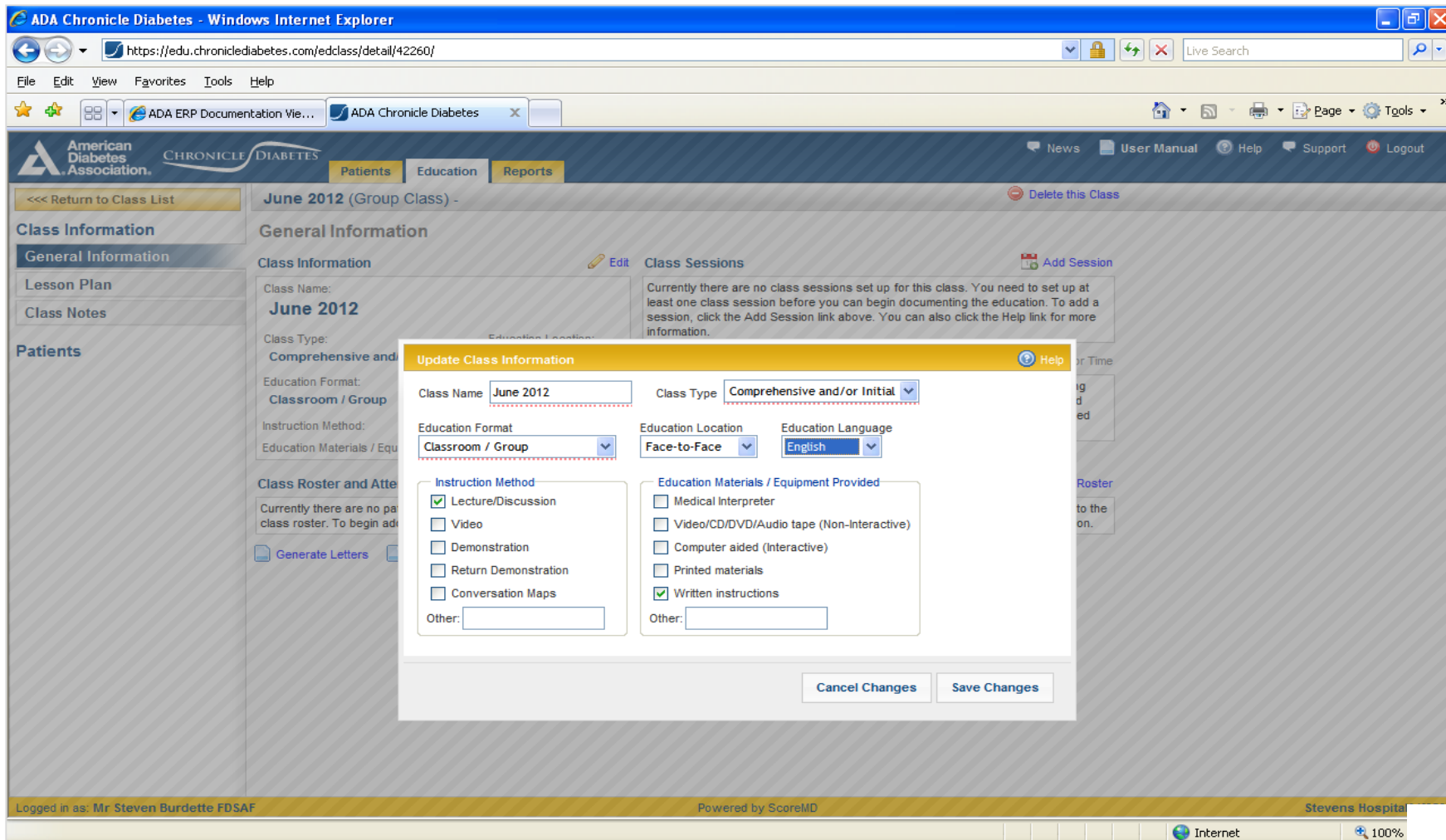
3. Once you have created a new class, you can begin by adding the general class information by clicking the **Edit** pencil link above the Class Information box.



The screenshot shows a web browser window titled "ADA Chronicle Diabetes - Windows Internet Explorer" with the URL "https://edu.chronicdiabetes.com/edclass/detail/42260/". The page displays the "Class Information" section for a "June 2012 (Group Class)". The "Edit" pencil icon is circled in red. The page includes a navigation menu with "Patients", "Education", and "Reports" tabs. The "Class Information" section contains fields for Class Name, Class Type, Education Location, Education Format, Education Language, Instruction Method, and Education Materials / Equipment Provided. The "Class Sessions" section includes an "Add Session" link and a message stating that no sessions are currently set up. The "Educator Time Spent" section includes an "Update Educator Time" link and a message explaining that time can only be documented after sessions are added. The "Class Roster and Attendance" section includes "Update Attendance" and "Update Roster" links and a message stating that no patients are currently on the roster. The page footer shows the user is logged in as "Mr Steven Burdette FDSAF" and the page is powered by "ScoreMD".

Creating a 1:1 or Group Class: Page 4 of 7

4. Enter the Location, Language, instruction methods and any materials you are using, and then click Save Changes.



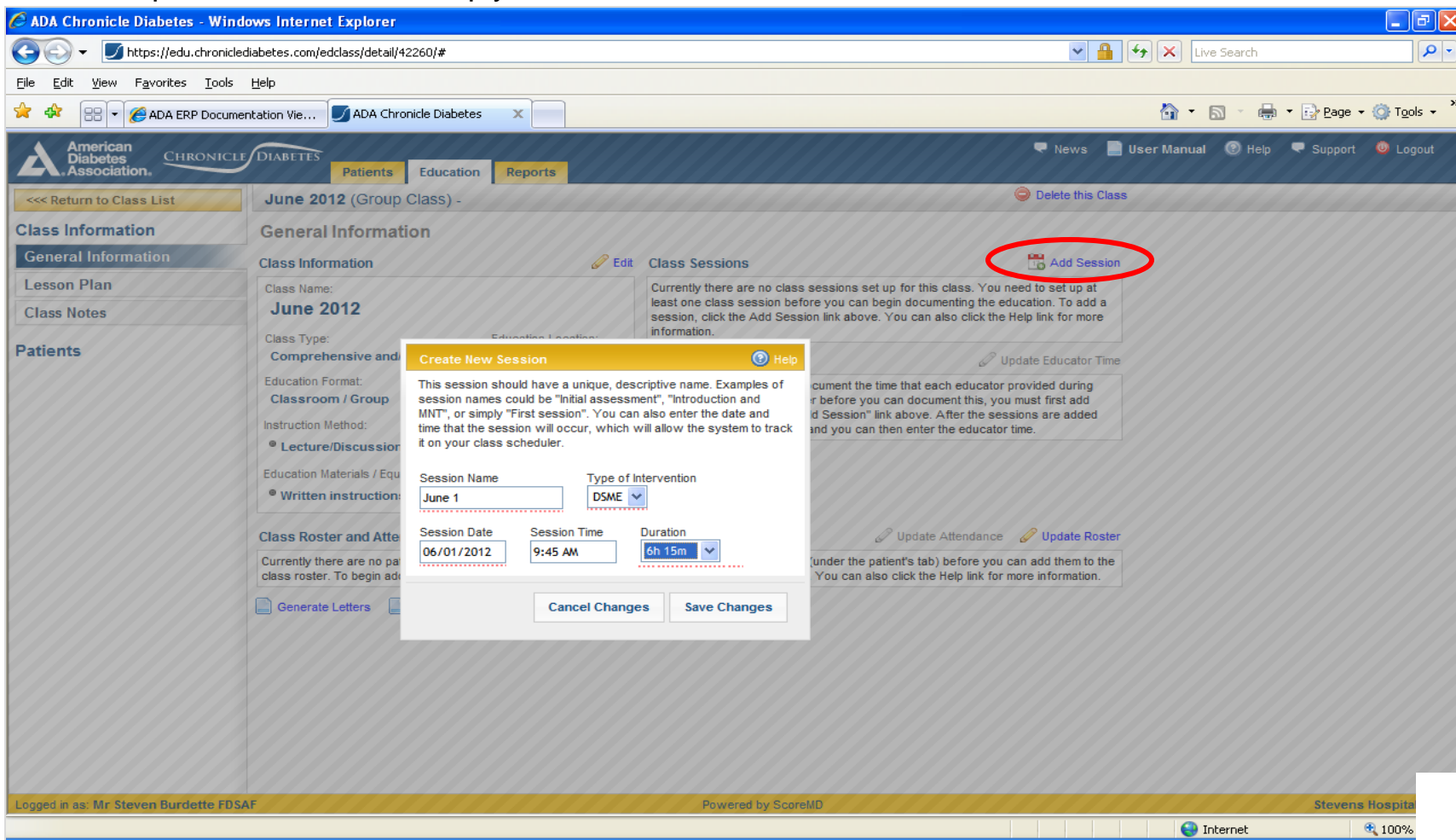
The screenshot shows a web browser window displaying the ADA Chronicle Diabetes application. The main page is titled "June 2012 (Group Class)" and includes a "Delete this Class" link. A "Class Information" sidebar is visible on the left. A modal dialog box titled "Update Class Information" is open, allowing for the following configuration:

- Class Name:** June 2012
- Class Type:** Comprehensive and/or Initial
- Education Format:** Classroom / Group
- Education Location:** Face-to-Face
- Education Language:** English
- Instruction Method:**
 - Lecture/Discussion
 - Video
 - Demonstration
 - Return Demonstration
 - Conversation Maps
 - Other:
- Education Materials / Equipment Provided:**
 - Medical Interpreter
 - Video/CD/DVD/Audio tape (Non-Interactive)
 - Computer aided (Interactive)
 - Printed materials
 - Written instructions
 - Other:

Buttons for "Cancel Changes" and "Save Changes" are located at the bottom of the dialog box. The background page shows the "Class Information" section with fields for Class Name, Class Type, Education Format, Education Location, Education Language, Instruction Method, and Education Materials / Equipment Provided. The "Class Sessions" section indicates that no sessions are currently set up for this class.

Creating a 1:1 or Group Class: Page 5 of 7

- Each class must have one or more sessions. A class that meets three times over the month of June will have three sessions. **Click the Add Sessions link** above the Class Schedule box to bring up the entry window. Enter a name for the session. Choose a name that you will logically associate with your class session. For example: "Welcome and Intro", "Pumps and Meters", or simply "Class 1".



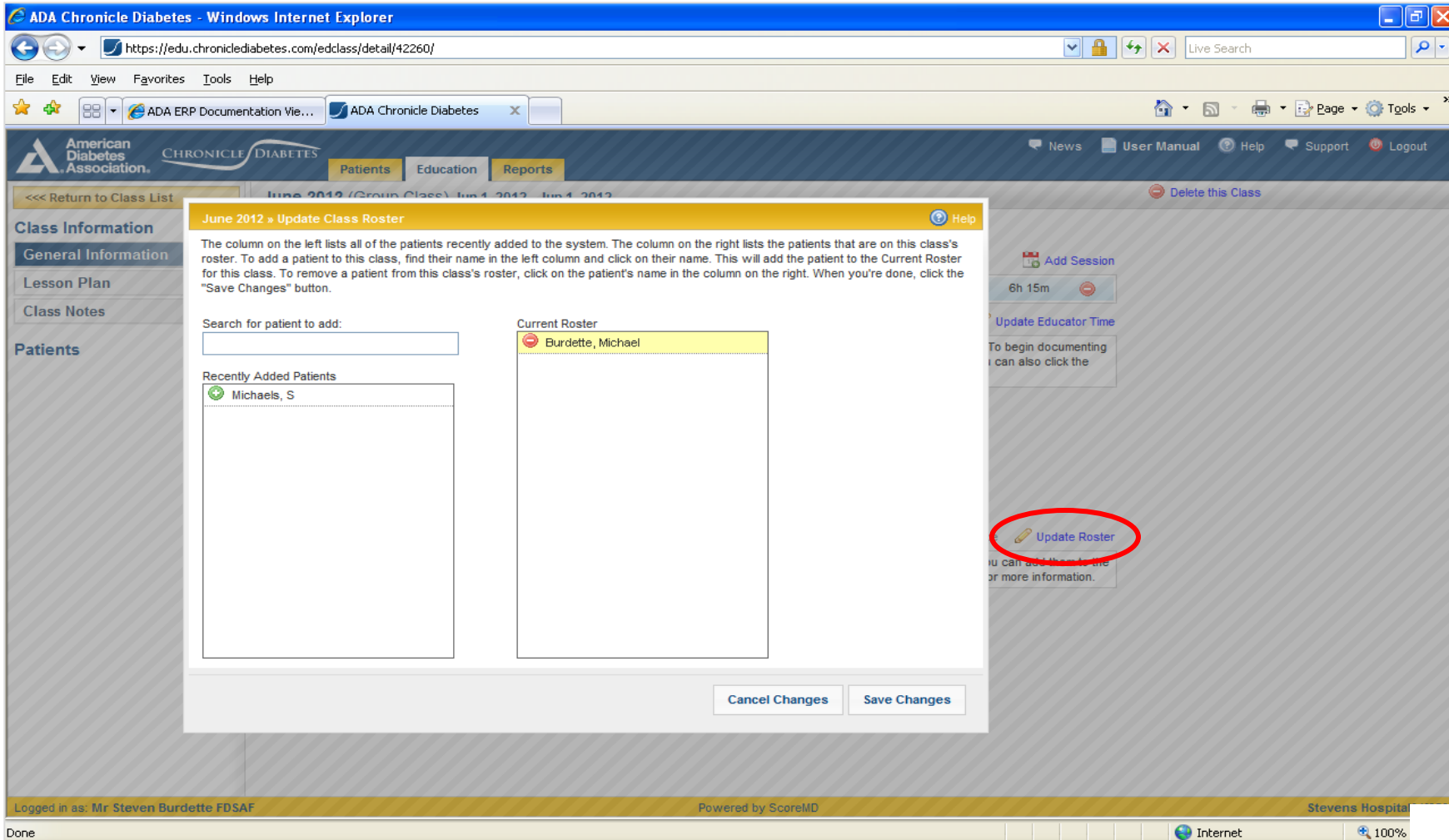
The screenshot shows a web browser window displaying the ADA Chronic Diabetes website. The page title is "June 2012 (Group Class)". The "Add Session" link is circled in red. A "Create New Session" dialog box is open, showing the following fields:

- Session Name: June 1
- Type of Intervention: DSME
- Session Date: 06/01/2012
- Session Time: 9:45 AM
- Duration: 6h 15m

The dialog box also includes "Cancel Changes" and "Save Changes" buttons. The background page shows the "Class Information" section with a message: "Currently there are no class sessions set up for this class. You need to set up at least one class session before you can begin documenting the education. To add a session, click the Add Session link above. You can also click the Help link for more information."

Creating a 1:1 or Group Class: Page 6 of 7

6. Above the Class Roster and Attendance box, click **Update Roster** to bring up the patient selector. In the left recently Added Patients list find each patient that will be in the class and click on the patient to move her to the Current Roster list. When you have selected all the patients in the class; click Save Changes.

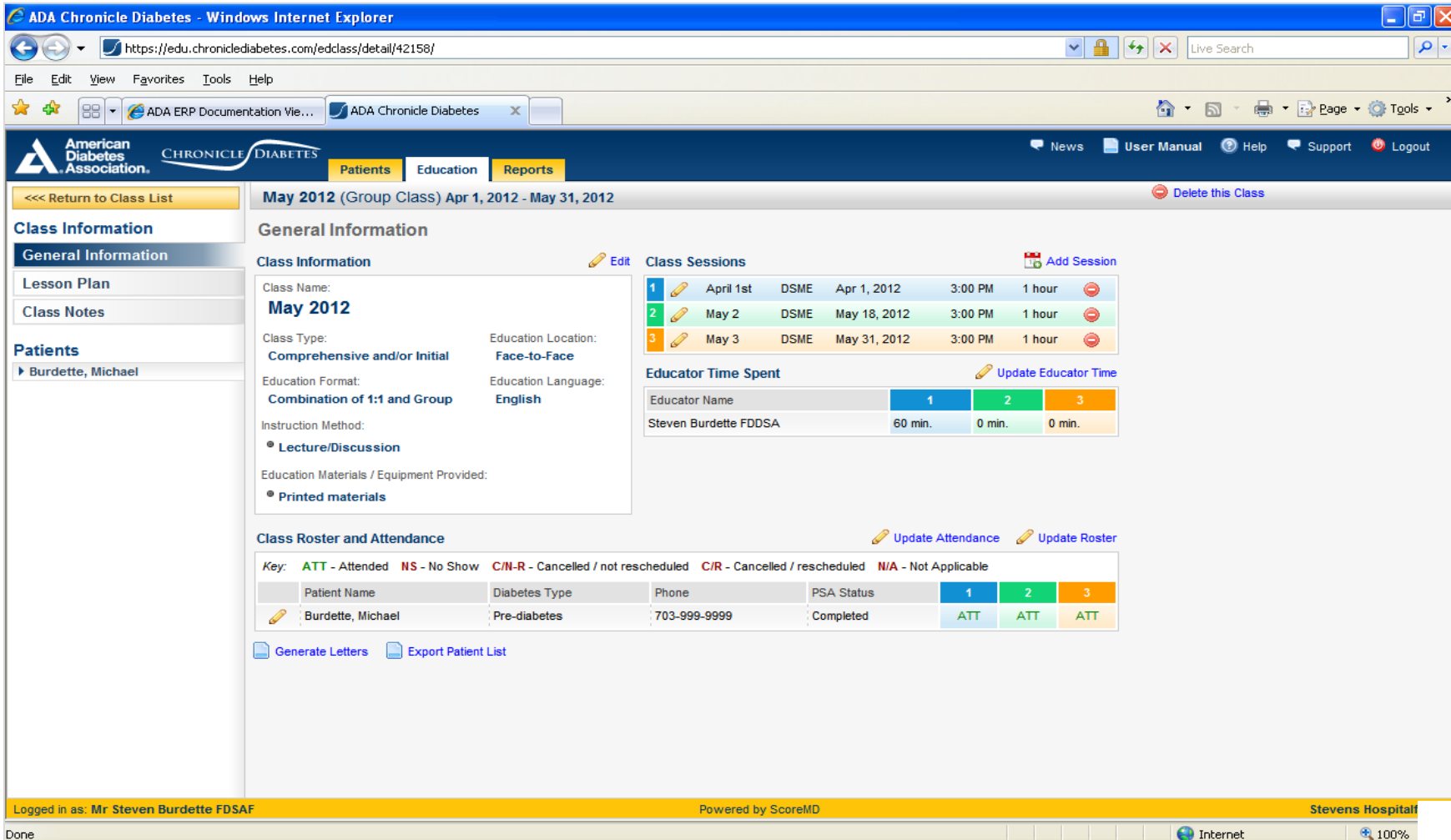


The screenshot shows a web browser window displaying the ADA Chronicle Diabetes application. The main page is titled "June 2012 (Group Class)" and includes a "Delete this Class" link. A modal dialog box titled "June 2012 » Update Class Roster" is open, providing instructions on how to manage the class roster. The dialog contains a search field, a "Recently Added Patients" list with "Michaels, S", and a "Current Roster" list with "Burdette, Michael". At the bottom of the dialog are "Cancel Changes" and "Save Changes" buttons. In the background, the "Update Roster" button is circled in red.

ADA Chronicle Diabetes - Windows Internet Explorer
https://edu.chroniclediabetes.com/edclass/detail/42260/
File Edit View Favorites Tools Help
ADA ERP Documentation Vie... ADA Chronicle Diabetes x
News User Manual Help Support Logout
Patients Education Reports
<<< Return to Class List June 2012 (Group Class) Jun 1 2012 Jun 1 2012 Delete this Class
Class Information
General Information
Lesson Plan
Class Notes
Patients
June 2012 » Update Class Roster Help
The column on the left lists all of the patients recently added to the system. The column on the right lists the patients that are on this class's roster. To add a patient to this class, find their name in the left column and click on their name. This will add the patient to the Current Roster for this class. To remove a patient from this class's roster, click on the patient's name in the column on the right. When you're done, click the "Save Changes" button.
Search for patient to add:
Recently Added Patients
+ Michaels, S
Current Roster
- Burdette, Michael
Add Session
6h 15m
Update Educator Time
To begin documenting
can also click the
Update Roster
You can add the...
for more information.
Cancel Changes Save Changes
Logged in as: Mr Steven Burdette FDSAF Powered by ScoreMD Stevens Hospital
Done Internet 100%

Creating a 1:1 or Group Class: Page 7 of 7

On the **General Information** page of the record, the Class Roster and Attendance table lists each patient's attendance. Each colored column represents a specific class session as listed in the Class Schedule section. **Note:** By default all patients are marked as being in attendance (ATT) at each session.



ADA Chronicle Diabetes - Windows Internet Explorer
 https://edu.chronicdiabetes.com/edclass/detail/42158/

File Edit View Favorites Tools Help

ADA ERP Documentation Vie... ADA Chronicle Diabetes

American Diabetes Association CHRONICLE DIABETES

News User Manual Help Support Logout

<<< Return to Class List **May 2012 (Group Class) Apr 1, 2012 - May 31, 2012** Delete this Class

Class Information

General Information

Lesson Plan

Class Notes

Patients

Burdette, Michael

General Information

Class Information Edit

Class Name: **May 2012**

Class Type: **Comprehensive and/or Initial** Education Location: **Face-to-Face**

Education Format: **Combination of 1:1 and Group** Education Language: **English**

Instruction Method:

- Lecture/Discussion

Education Materials / Equipment Provided:

- Printed materials

Class Sessions Add Session

	1	2	3
1	April 1st DSME Apr 1, 2012 3:00 PM 1 hour		
2	May 2 DSME May 18, 2012 3:00 PM 1 hour		
3	May 3 DSME May 31, 2012 3:00 PM 1 hour		

Educator Time Spent Update Educator Time

Educator Name	1	2	3
Steven Burdette FDDSA	60 min.	0 min.	0 min.

Class Roster and Attendance Update Attendance Update Roster

Key: **ATT** - Attended **NS** - No Show **C/N-R** - Cancelled / not rescheduled **C/R** - Cancelled / rescheduled **N/A** - Not Applicable

Patient Name	Diabetes Type	Phone	PSA Status	1	2	3
Burdette, Michael	Pre-diabetes	703-999-9999	Completed	ATT	ATT	ATT

Generate Letters Export Patient List

Logged in as: Mr Steven Burdette FDSAF Powered by ScoreMD Stevens Hospital

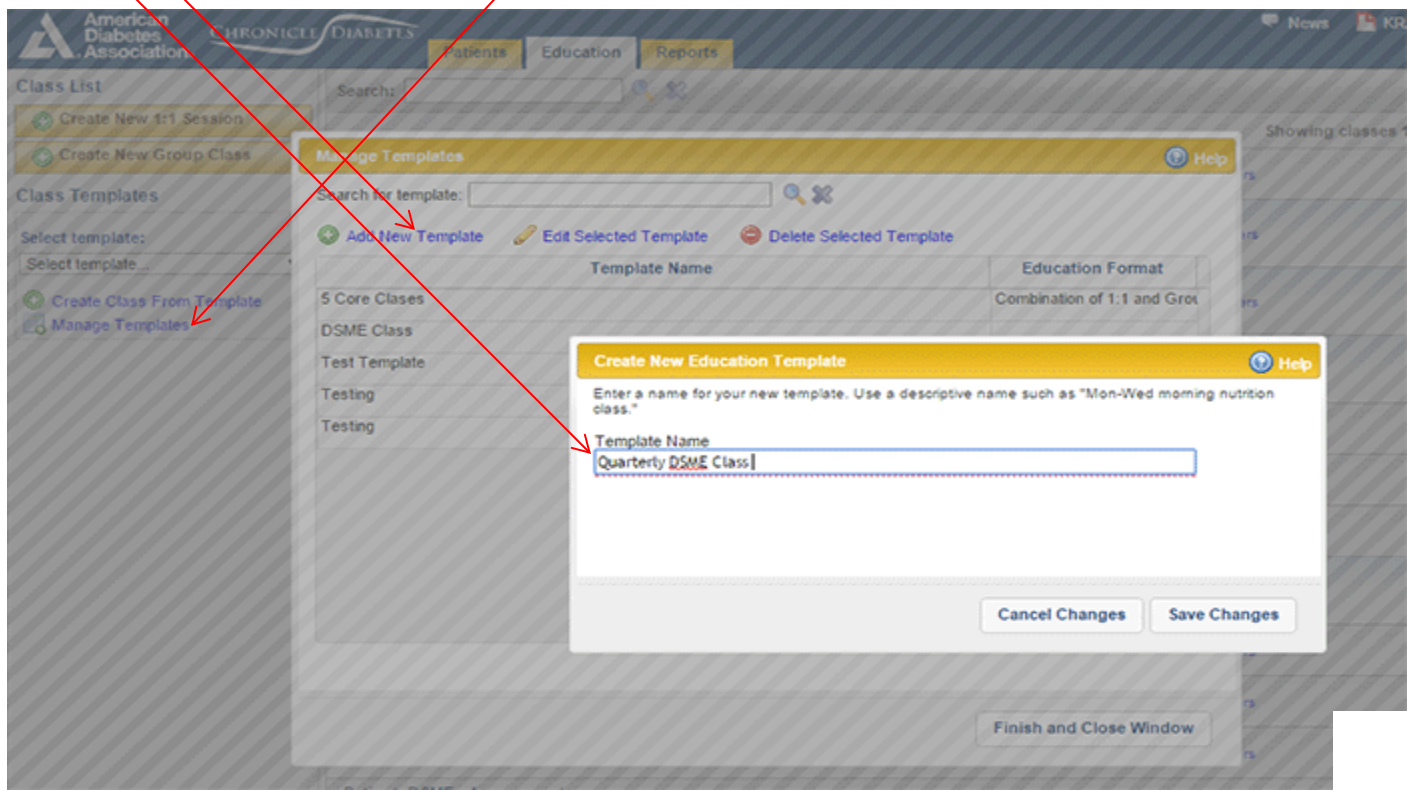
Done Internet 100%

Managing and Using Class Templates *Page 1 of 3*

Classes can be created “from scratch” or can be created from a class template that you can set up for a series of classes. In this section we will cover creating a class template and using that template to create a class.

To create a new class template:

- 1) From the Education Tab, Click the **Manage Templates** link
- 2) Click Add **New Template**
- 3) **Enter the name of the template** i.e. Quarterly DSME Class, click Save Changes



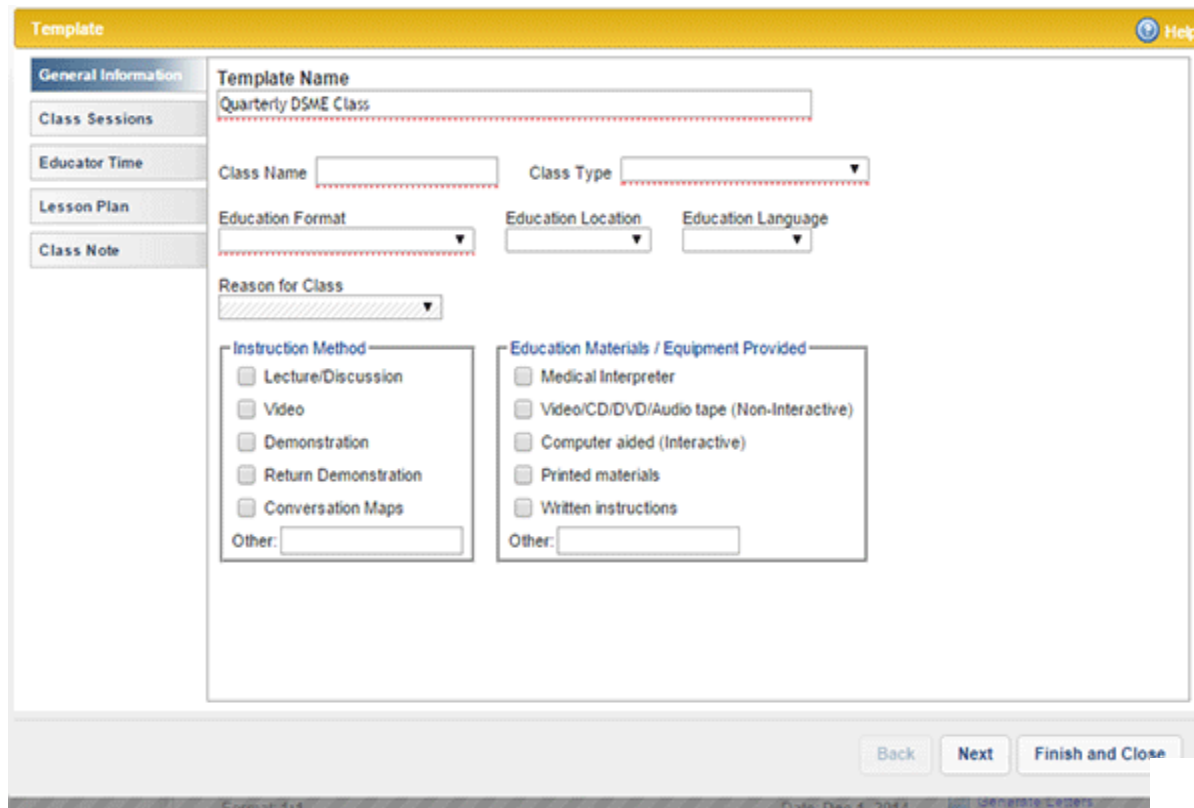
The screenshot displays the American Diabetes Association software interface. The 'Manage Templates' dialog box is open, showing a list of existing templates: '5 Core Classes', 'DSME Class', 'Test Template', 'Testing', and 'Testing'. The 'Add New Template' button is highlighted. A second dialog box, 'Create New Education Template', is also open, with the 'Template Name' field containing the text 'Quarterly DSME Class'. Red arrows point from the text in the list above to the 'Add New Template' button and the 'Template Name' field in the second dialog box.

Template Name	Education Format
5 Core Classes	Combination of 1:1 and Gro
DSME Class	
Test Template	
Testing	
Testing	

Managing and Using Class Templates *Page 2 of 3*

You will now be on the tab where you can define the *General Information* for the class. Fill as much information out on this tab as will be common to all classes created with this template. **Nothing is required** (other than the *Template Name*), but the more information you fill out, the more information will be pre-populated when you create the class.

For example, if all classes created with this template will share the same Class Type, Education Format, Location, and Language, (but will differ on the Education Materials provided), then fill out all of the common fields.



The screenshot shows a web-based form titled "Template" with a yellow header bar containing a "Help" icon. The form is divided into several sections:

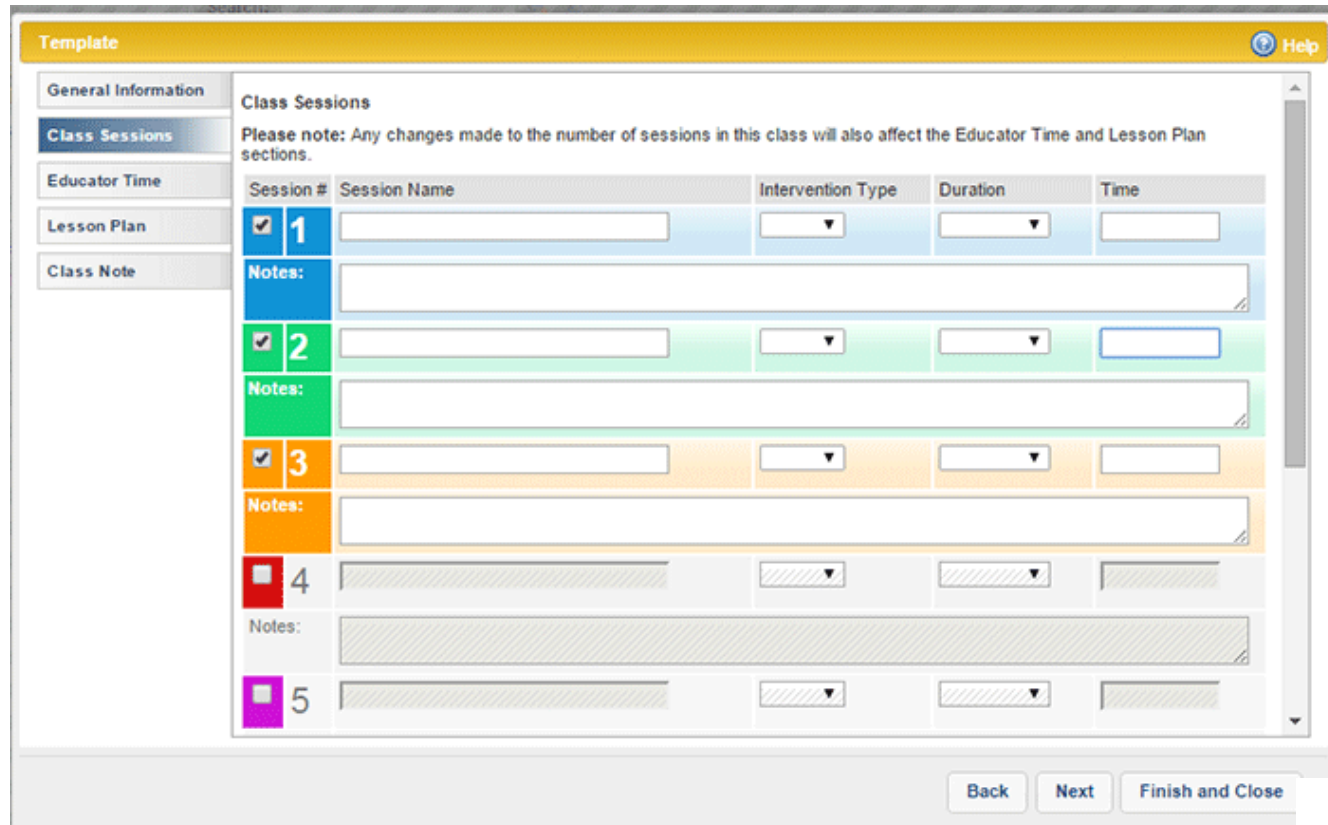
- General Information** (selected tab):
 - Template Name: Quarterly DSME Class
 - Class Name: [Empty field]
 - Class Type: [Dropdown menu]
 - Education Format: [Dropdown menu]
 - Education Location: [Dropdown menu]
 - Education Language: [Dropdown menu]
 - Reason for Class: [Dropdown menu]
 - Instruction Method:
 - Lecture/Discussion
 - Video
 - Demonstration
 - Return Demonstration
 - Conversation Maps
 - Other: [Text field]
 - Education Materials / Equipment Provided:
 - Medical Interpreter
 - Video/CD/DVD/Audio tape (Non-Interactive)
 - Computer aided (Interactive)
 - Printed materials
 - Written instructions
 - Other: [Text field]
- Class Sessions**
- Educator Time**
- Lesson Plan**
- Class Note**

At the bottom of the form, there are three buttons: "Back", "Next", and "Finish and Close".

Managing and Using Class Templates *Page 3 of 3*

The **Class Sessions** tab allows you to define the sessions that each class will have. For each session give it a name, intervention type, duration, time, and a note. All of these are optional in the template, and can be added later when you're creating the class. The **Educator Time** tab allows you to define how much time each educator will contribute to each of the sessions. The **Lesson Plan** tab allows you to define which educational topics will be covered during each of the sessions. The **Class Note** tab allows you to enter a note that will apply to all patients in the class.

When you are done entering all of the information for the class template, click **Finish and Close**



Template Help

General Information

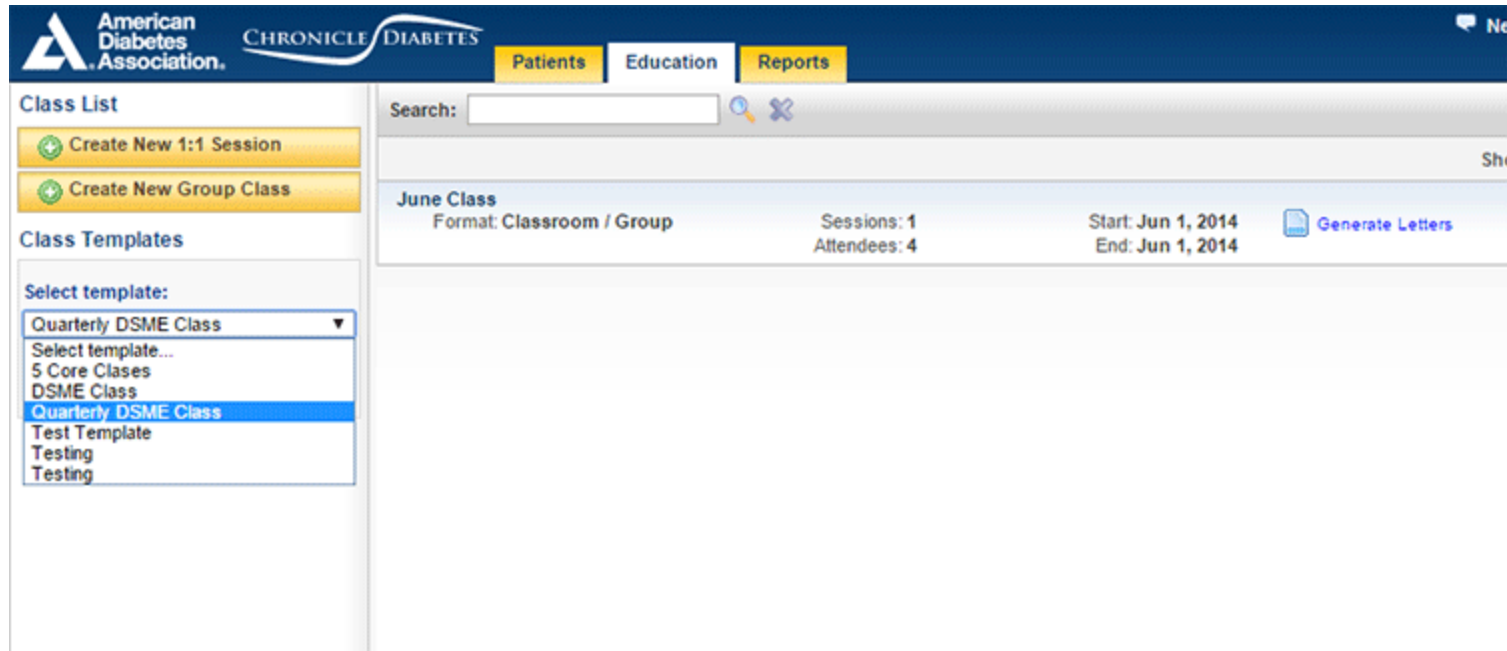
Class Sessions

Please note: Any changes made to the number of sessions in this class will also affect the Educator Time and Lesson Plan sections.

Session #	Session Name	Intervention Type	Duration	Time
<input checked="" type="checkbox"/> 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Notes: <input type="text"/>				
<input checked="" type="checkbox"/> 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Notes: <input type="text"/>				
<input checked="" type="checkbox"/> 3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Notes: <input type="text"/>				
<input type="checkbox"/> 4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Notes: <input type="text"/>				
<input type="checkbox"/> 5	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Creating a new Class from a Class Template *Page 1 of 2*

To create a new class from an existing class template, select the class template from the dropdown list in the **Class Templates** section of the left navigation pane, then click **Create Class From Template**.

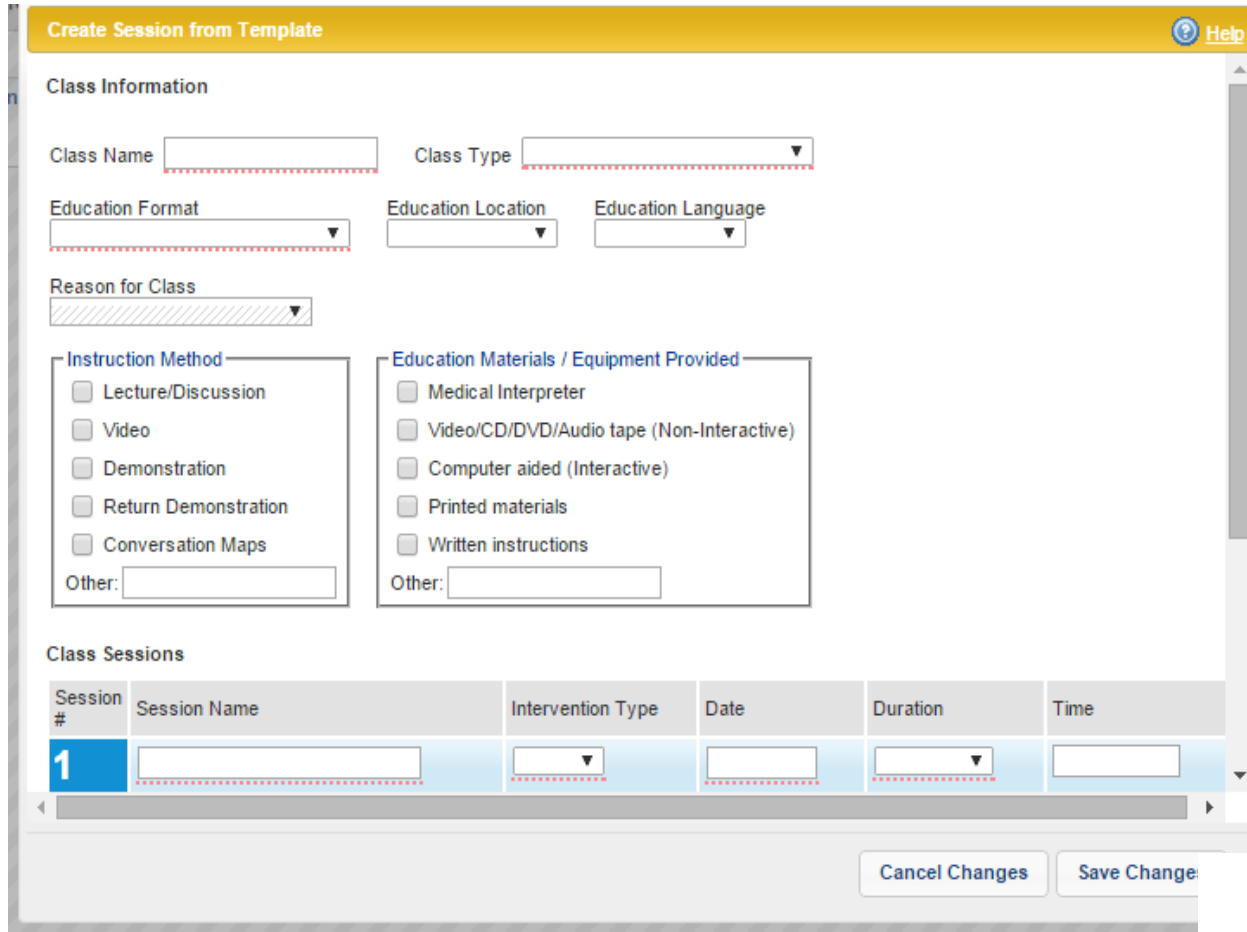


The screenshot displays the 'American Diabetes Association CHRONICLE DIABETES' software interface. The top navigation bar includes 'Patients', 'Education', and 'Reports' tabs. The left sidebar contains 'Class List' and 'Class Templates' sections. The 'Class Templates' section features a dropdown menu with the following options: 'Quarterly DSME Class' (selected), 'Select template...', '5 Core Classes', 'DSME Class', 'Test Template', 'Testing', and 'Testing'. The main content area shows a search bar and a table with one entry: 'June Class' (Format: Classroom / Group, Sessions: 1, Attendees: 4, Start: Jun 1, 2014, End: Jun 1, 2014). A 'Generate Letters' button is visible next to the entry.

Creating a new Class from a Class Template *Page 2 of 2*

This will open up the **Create Class from Template** window, with all of the information from the template already populated into the class. Here you can add any additional information, making sure that all required fields (with red underlines) are completed. Note that if your class template included one or more sessions, you will need to fill in the session date for each session.

When all the class information is correct, click *Save Changes*, which will create the class and automatically open the class to the *General Information* page. **Next you can follow the normal class creation process by updating the patient roster.**



Create Session from Template Help

Class Information

Class Name Class Type

Education Format Education Location Education Language

Reason for Class

Instruction Method

Lecture/Discussion

Video

Demonstration

Return Demonstration

Conversation Maps

Other:

Education Materials / Equipment Provided

Medical Interpreter

Video/CD/DVD/Audio tape (Non-Interactive)

Computer aided (Interactive)

Printed materials

Written instructions

Other:

Class Sessions

Session #	Session Name	Intervention Type	Date	Duration	Time
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Cancel Changes Save Changes

Class Template Tips

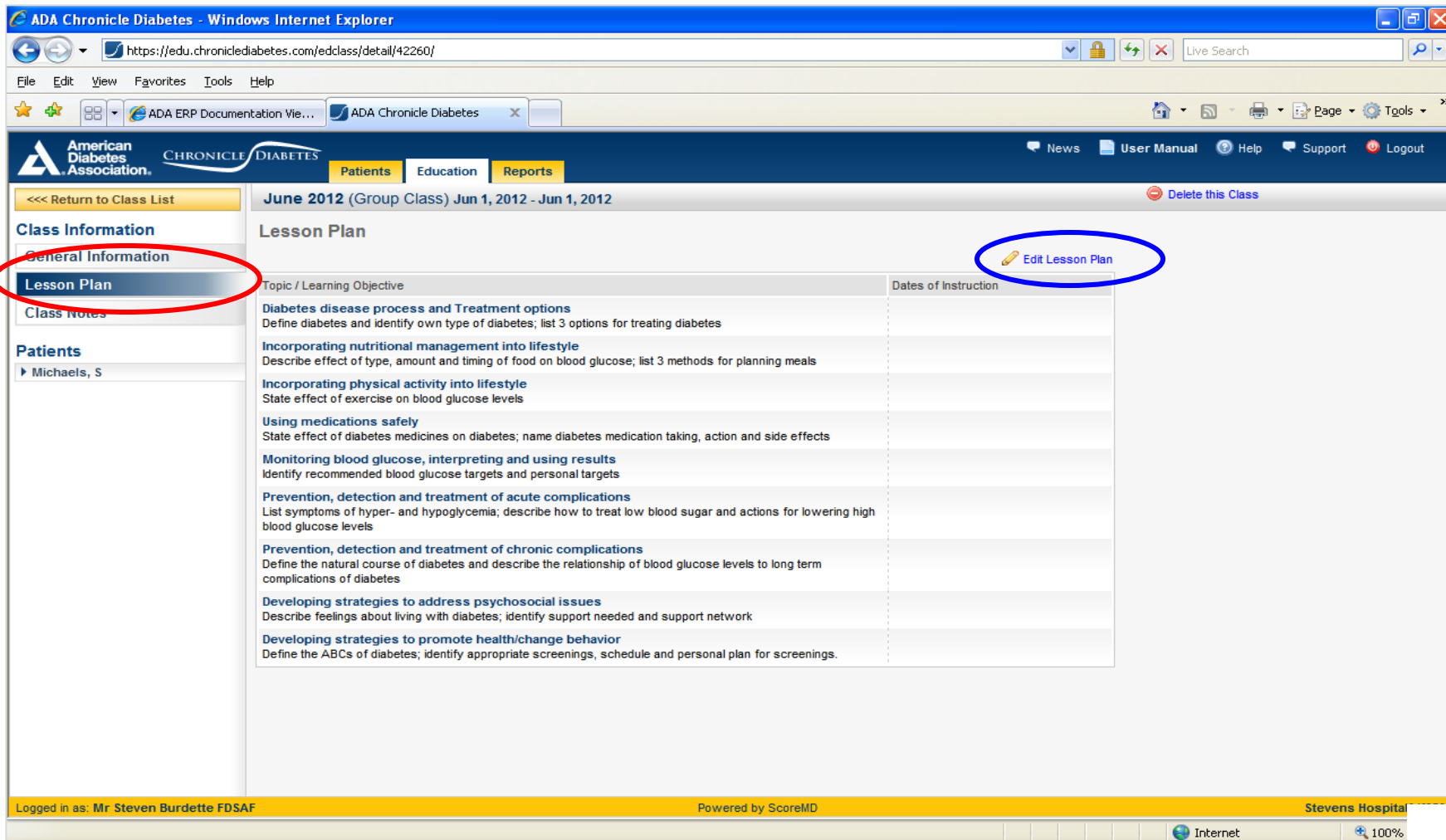
It may be helpful to print and fill out the Class Template Worksheet below prior to creating a class template within Chronicle. [Download PDF Version](#)

	Class 1	Class 2	Class 3	Class 4	Class 5	Class 6
	1:1 or Group	1:1 or Group	1:1 or Group	1:1 or Group	1:1 or Group	1:1 or Group
Class Time	Hours	Hours	Hours	Hours	Hours	Hours
Diabetes Disease Process						
Nutrition Management						
Physical Activity? Being Active						
Taking Medications						
SMBG						
Preventing Acute Complications						
Preventing Chronic Complications						
Psycho social adjustment/Healthy Coping						
Promoting Health Change Behavior						

Documenting Patient Education *Page 1 of 9*

Topics Covered During Class Session

1. Click the **Lesson Plan** tab on the left site of the page to view or setup the class's educational lesson plan. Click the **Edit Lesson Plan** link.



ADA Chronicle Diabetes - Windows Internet Explorer

https://edu.chronicdiabetes.com/edclass/detail/42260/

File Edit View Favorites Tools Help

ADA ERP Documentation Vie... ADA Chronicle Diabetes

American Diabetes Association. CHRONICLE DIABETES

News User Manual Help Support Logout

Patients Education Reports

<<< Return to Class List

June 2012 (Group Class) Jun 1, 2012 - Jun 1, 2012 Delete this Class

Class Information

General Information

Lesson Plan

Class Notes

Patients

Michaelis, S

Lesson Plan

Topic / Learning Objective	Dates of Instruction
Diabetes disease process and Treatment options Define diabetes and identify own type of diabetes; list 3 options for treating diabetes	
Incorporating nutritional management into lifestyle Describe effect of type, amount and timing of food on blood glucose; list 3 methods for planning meals	
Incorporating physical activity into lifestyle State effect of exercise on blood glucose levels	
Using medications safely State effect of diabetes medicines on diabetes; name diabetes medication taking, action and side effects	
Monitoring blood glucose, interpreting and using results Identify recommended blood glucose targets and personal targets	
Prevention, detection and treatment of acute complications List symptoms of hyper- and hypoglycemia; describe how to treat low blood sugar and actions for lowering high blood glucose levels	
Prevention, detection and treatment of chronic complications Define the natural course of diabetes and describe the relationship of blood glucose levels to long term complications of diabetes	
Developing strategies to address psychosocial issues Describe feelings about living with diabetes; identify support needed and support network	
Developing strategies to promote health/change behavior Define the ABCs of diabetes; identify appropriate screenings, schedule and personal plan for screenings.	

Logged in as: Mr Steven Burdette FDSAF

Powered by ScoreMD

Stevens Hospital

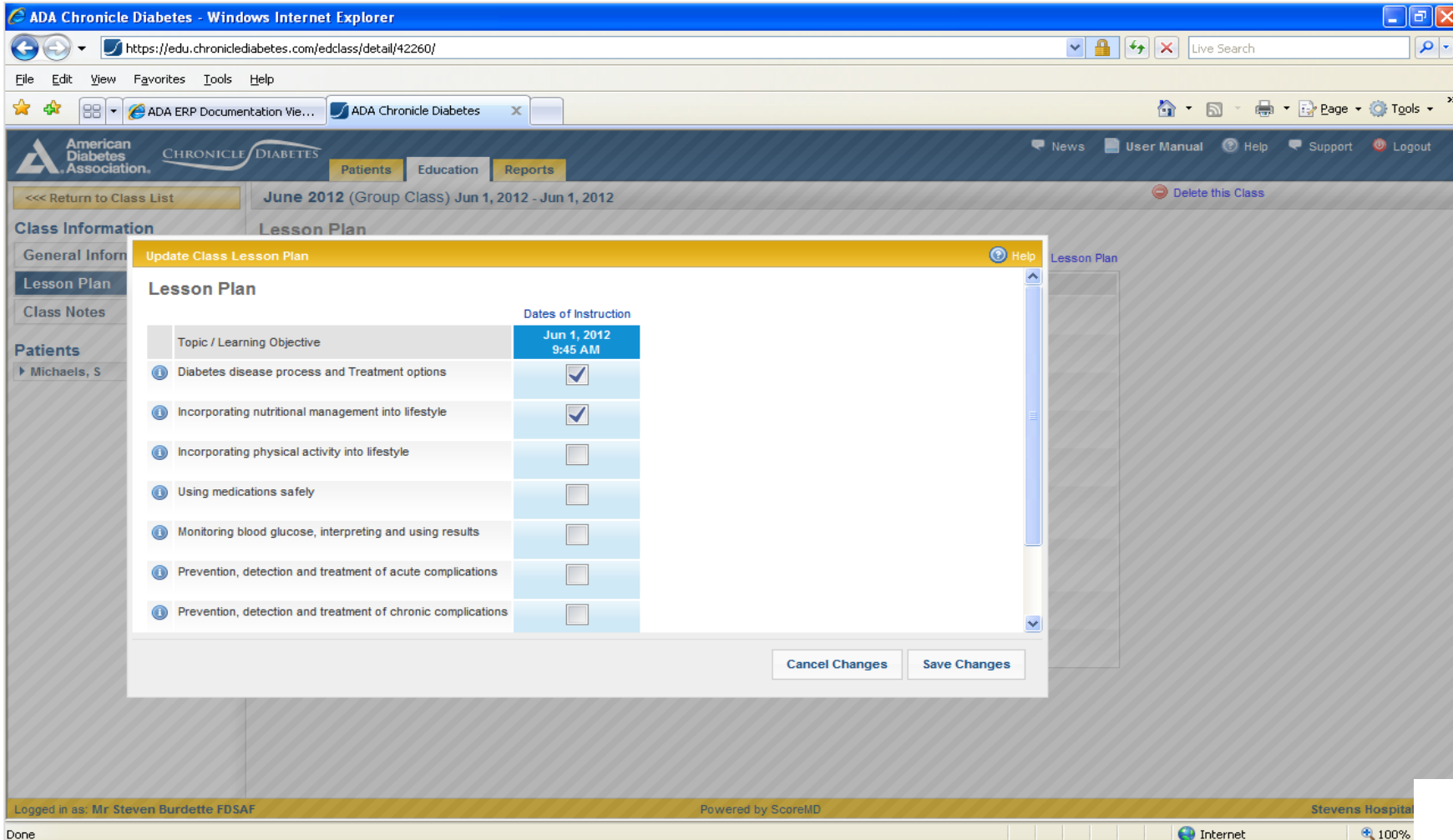
Internet 100%

Documenting Patient Education *Page 2 of 9*

Topics Covered During Class Session

For each educational topic that will be address during the class, click the check box to the left of the topic under the appropriate session column. You can check multiple boxes for a topic if it will be taught during multiple sessions. (Note, completing the Lesson Plan can be done after the education has occurred.)

Click Save Changes.



The screenshot shows a web browser window titled "ADA Chronic Diabetes - Windows Internet Explorer" with the URL <https://edu.chronicdiabetes.com/edclass/detail/42260/>. The page displays the "Update Class Lesson Plan" dialog box for a class titled "June 2012 (Group Class) Jun 1, 2012 - Jun 1, 2012".

The dialog box contains a table with the following structure:

Topic / Learning Objective	Dates of Instruction	
	Jun 1, 2012 9:45 AM	
<input checked="" type="checkbox"/> Diabetes disease process and Treatment options	<input checked="" type="checkbox"/>	
<input checked="" type="checkbox"/> Incorporating nutritional management into lifestyle	<input checked="" type="checkbox"/>	
<input type="checkbox"/> Incorporating physical activity into lifestyle	<input type="checkbox"/>	
<input type="checkbox"/> Using medications safely	<input type="checkbox"/>	
<input type="checkbox"/> Monitoring blood glucose, interpreting and using results	<input type="checkbox"/>	
<input type="checkbox"/> Prevention, detection and treatment of acute complications	<input type="checkbox"/>	
<input type="checkbox"/> Prevention, detection and treatment of chronic complications	<input type="checkbox"/>	

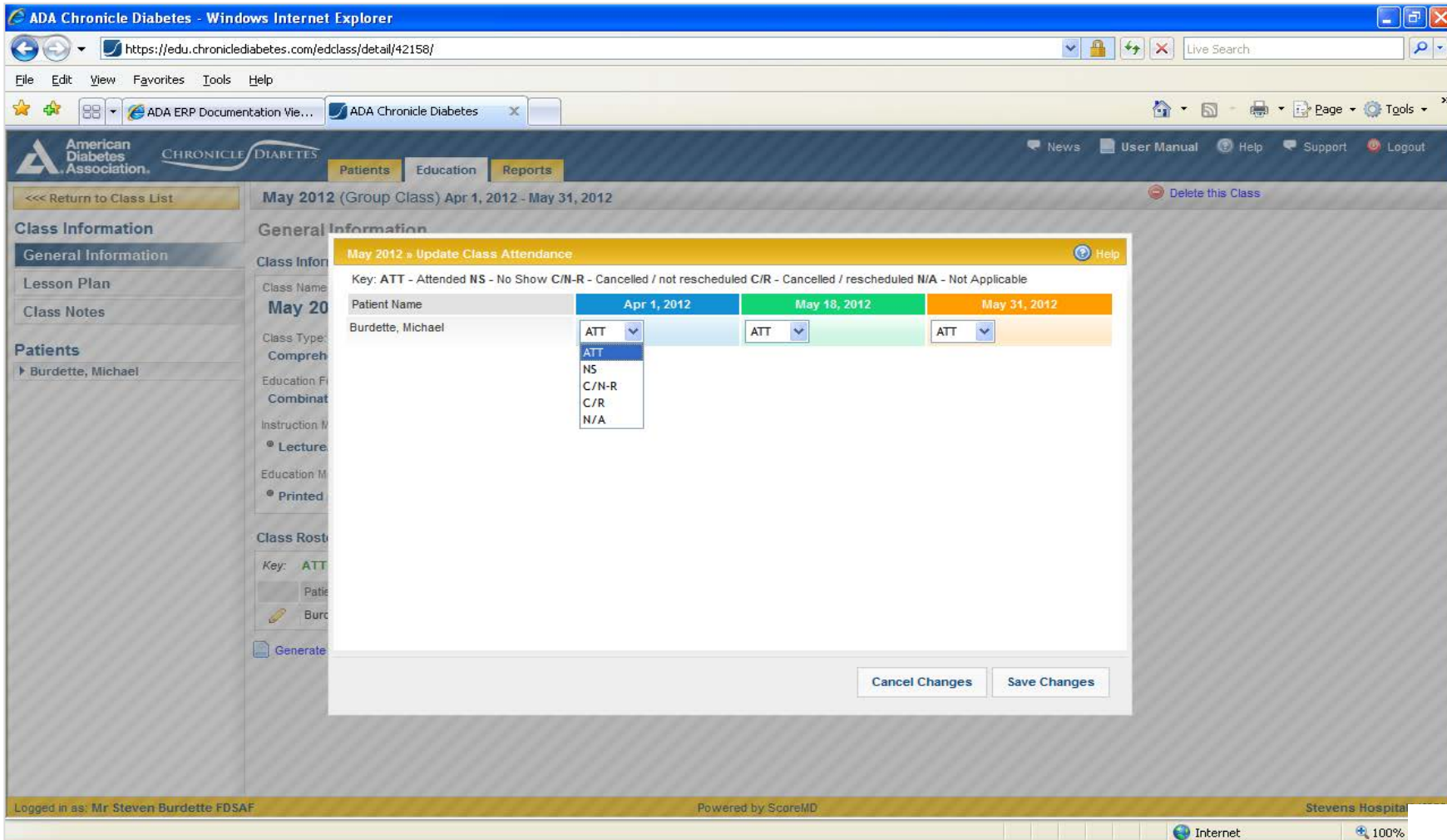
At the bottom of the dialog box, there are two buttons: "Cancel Changes" and "Save Changes".

The background page shows the "American Diabetes Association" logo, navigation tabs for "Patients", "Education", and "Reports", and a sidebar with "Class Information", "Lesson Plan", "Class Notes", and "Patients" (listing "Michaelis, S").

At the bottom of the browser window, it says "Logged in as: Mr Steven Burdette FDSAF", "Powered by ScoreMD", and "Stevens Hospital".

Documenting Patient Education *Page 3 of 9*

To update the **attendance**, within the *General Information* section of the class, click the Update Attendance link to bring up the Update Class Attendance window. To change a patient's attendance status as a session, click the dropdown list under the respective class session and change the appropriate value. Repeat this until all patients attendance is correct, then click Save Changes.



ADA Chronicle Diabetes - Windows Internet Explorer
 https://edu.chroniclediabetes.com/edclass/detail/42158/

File Edit View Favorites Tools Help

ADA ERP Documentation Vie... ADA Chronicle Diabetes

American Diabetes Association. CHRONICLE DIABETES

News User Manual Help Support Logout

Patients Education Reports

<<< Return to Class List

May 2012 (Group Class) Apr 1, 2012 - May 31, 2012 Delete this Class

Class Information

General Information

Lesson Plan

Class Notes

Patients

Burdette, Michael

May 2012 » Update Class Attendance Help

Key: ATT - Attended NS - No Show C/N-R - Cancelled / not rescheduled C/R - Cancelled / rescheduled N/A - Not Applicable

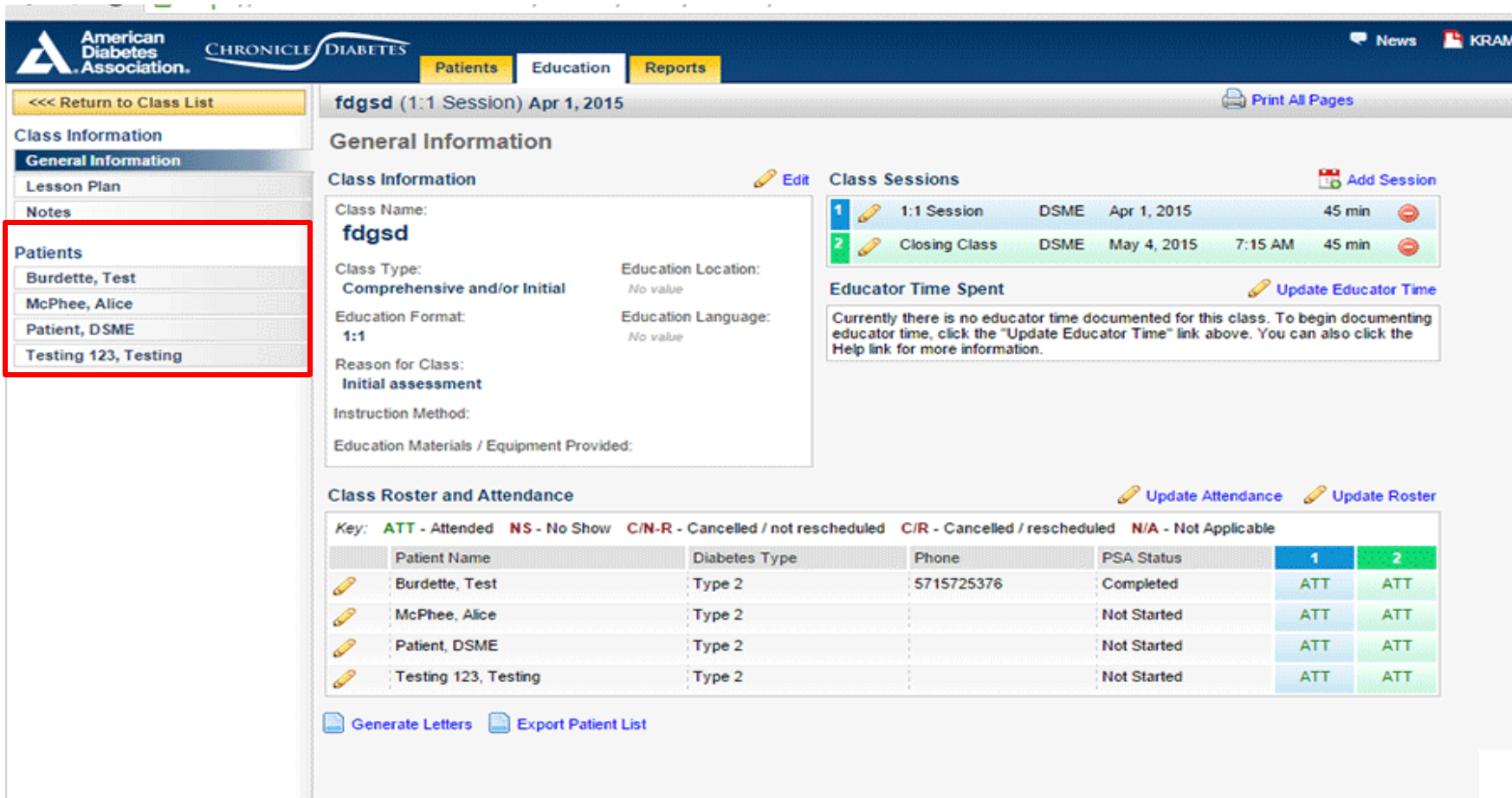
Patient Name	Apr 1, 2012	May 18, 2012	May 31, 2012
Burdette, Michael	ATT	ATT	ATT

Cancel Changes Save Changes

Logged in as: Mr Steven Burdette FDSAF Powered by ScoreMD Stevens Hospital Internet 100%

Documenting Patient Education *Page 4 of 9*

Individual Pre-Assessment and Post Education Evaluation are done on a patient-by-patient basis. If you are currently in the class record, click on the **patients name** in the left menu to update patient education record (example below). If you are in a patient record, the education record is located in the *DSME & Follow-up* section. **Please continue to the next page for pre assessment & post education evaluation documentation.**



American Diabetes Association | CHRONICLE DIABETES | Patients | Education | Reports | News | KRAM

<<< Return to Class List | fdgsd (1:1 Session) Apr 1, 2015 | Print All Pages

General Information

Class Information [Edit](#)

Class Name: **fdgsd**

Class Type: **Comprehensive and/or Initial** | Education Location: *No value*

Education Format: **1:1** | Education Language: *No value*

Reason for Class: **Initial assessment**

Instruction Method:

Education Materials / Equipment Provided:

Class Sessions [Add Session](#)

Session	Type	Location	Date	Time	Duration
1	1:1 Session	DSME	Apr 1, 2015		45 min
2	Closing Class	DSME	May 4, 2015	7:15 AM	45 min

Educator Time Spent [Update Educator Time](#)

Currently there is no educator time documented for this class. To begin documenting educator time, click the "Update Educator Time" link above. You can also click the Help link for more information.

Class Roster and Attendance

[Update Attendance](#) | [Update Roster](#)

Key: **ATT** - Attended | **NS** - No Show | **C/N-R** - Cancelled / not rescheduled | **C/R** - Cancelled / rescheduled | **N/A** - Not Applicable

Patient Name	Diabetes Type	Phone	PSA Status	1	2
Burdette, Test	Type 2	5715725376	Completed	ATT	ATT
McPhee, Alice	Type 2		Not Started	ATT	ATT
Patient, DSME	Type 2		Not Started	ATT	ATT
Testing 123, Testing	Type 2		Not Started	ATT	ATT

[Generate Letters](#) | [Export Patient List](#)

Documenting Patient Education *Page 5 of 9*

The **DSME & Follow Up Section** shows all of the educational information for this patient. You will never need to leave this page to document this patient's educational assessment. **Note** that creating new classes (and class sessions), defining the lesson plan, and managing the roster and attendance are still done under the main top yellow *Education* tab.

DSME & Follow-Up

Education Summary + New 1:1

2012 Mar Mon AM (Group Class) ✎ Edit			
Location: ABC DSME Center			
1	Mar 5, 2012	Intro	Attended
2	Mar 12, 2012	Main info	Attended
3	Mar 19, 2012	Conclusion	Attended

Addelson, Margaret - Initial assessment (1:1 Session) ✎ Edit			
Location: ABC DSME Center			
1	Mar 1, 2012	1:1 Session	Attended

Follow-Up Summary + New Follow-Up

F/U Date	Method	Clinician	
✎ Jun 13, 2012	Phone	Ellen Educator	⊖
✎ Aug 1, 2012	Phone	Ellen Educator	⊖

Patient Education Record

Key:	1 - Needs instruction	2 - Needs review	3 - Comprehends key points	4 - Demonstrates competency	N/A - Not applicable
Topic / Learning Objective	✎ Pre Assess.	✎ Post Eval.	✎ F/Up (6/13/12)	✎ F/Up (8/1/12)	
Disease Process	1	3	4	3	
Nutritional Management	2	4	3	4	
Physical Activity/Being Active	2	4	4	3	
Taking medications	1	4	4	2	
Monitoring	1	4	4	3	
Acute complications/Problem Solving	1	4	3	3	
Psychosocial Adjustment/healthy Coping	1	4	3	3	
Promote health/change behavior	1	4	4	2	

Education Plan + New Education Plan

Current Education Plan		
Documented during: 2012 Mar Mon AM (3/5/12 - 3/19/12)	✎ Edit Education Plan	⊖ Delete Education Plan
Attended 7 hr comprehensive DM class. Has appt for initial 1 hr time with RD and RN. Will continue to FU with 30 min appt - q 3 months.		
▶ Previous Education Plans		

DSMS Plan + New DSMS Plan

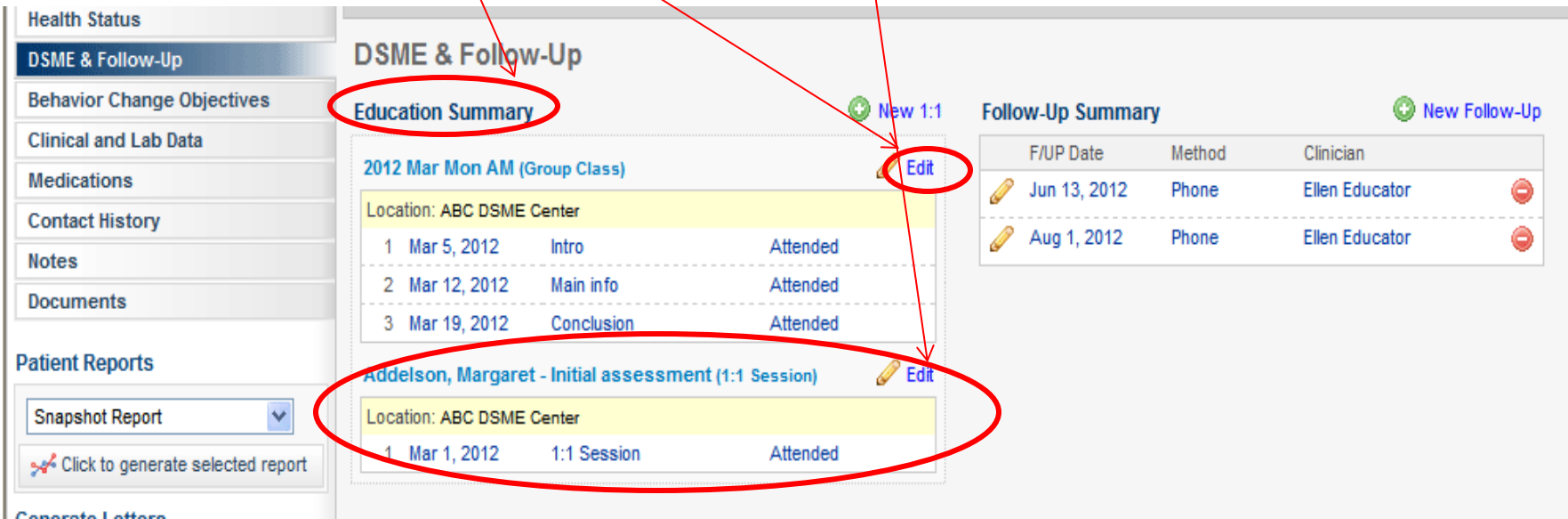
Current DSMS Plan		
Documented during: F/Up (8/1/12)	✎ Edit DSMS Plan	⊖ Delete DSMS Plan
Ongoing contact with PCP regarding insulin adjustments. Mayo clinic and ADA materials for the blind. Pt has already ordered materials.		
▶ Previous DSMS Plans		

Identified Barriers to learning/adherence to self management plan + New Entry

Current Entry		
Documented during: Initial assessment (3/1/12)	✎ Edit Entry	⊖ Delete Entry
Has no insurance. Lives in a rural community with no gym		

Documenting Patient Education Page 6 of 9

The **Education Summary** box lists all of the classes that this patient is on the *Roster* for. Clicking the **Edit** pencil next to a class will open that class's record (under the main top yellow *Education* tab) where you can make changes to the class's information (e.g. edit general information, add sessions, update roster and attendance, complete lesson plan, etc.). Note that every time you meet with a patient (e.g. for an **initial assessment**, a group class, or for additional education), that meeting is considered a class and should be added to the patient's record as a class (not a follow-up).



The screenshot displays a patient's record with the following sections:

- Health Status**
- DSME & Follow-Up** (selected)
- Behavior Change Objectives
- Clinical and Lab Data
- Medications
- Contact History
- Notes
- Documents
- Patient Reports

Education Summary (circled in red):

- 2012 Mar Mon AM (Group Class)** (with **Edit** pencil icon circled in red)
- Location: ABC DSME Center
- 1 Mar 5, 2012 Intro Attended
- 2 Mar 12, 2012 Main info Attended
- 3 Mar 19, 2012 Conclusion Attended

Addelson, Margaret - Initial assessment (1:1 Session) (circled in red):

- Location: ABC DSME Center
- 1 Mar 1, 2012 1:1 Session Attended

Follow-Up Summary (with **New Follow-Up** icon):

F/UP Date	Method	Clinician	
Jun 13, 2012	Phone	Ellen Educator	⊖
Aug 1, 2012	Phone	Ellen Educator	⊖

Documenting Patient Education *Page 7 of 9*

The top right **Follow-Up Summary** box lists all of the follow-ups that have occurred with this patient. A patient can have any number of follow-ups. At each follow-up you can document an educational reassessment and make updates to the education plan, barriers to learning, and the DSMS plan. Note that follow-ups are not used when you meet with a patient to provide education. Follow-ups are intended to allow you to document when you follow-up with a patient to reassess their progress (e.g. three to six months after education). You can add a new follow-up by clicking the *New Follow-up* link and filling out the reassessment information.

DSME & Follow-Up

Education Summary + New 1:1

2012 Mar Mon AM (Group Class) ✎ Edit

Location: ABC DSME Center

1	Mar 5, 2012	Intro	Attended
2	Mar 12, 2012	Main info	Attended
3	Mar 19, 2012	Conclusion	Attended

Addelson, Margaret - Initial assessment (1:1 Session) ✎ Edit

Location: ABC DSME Center

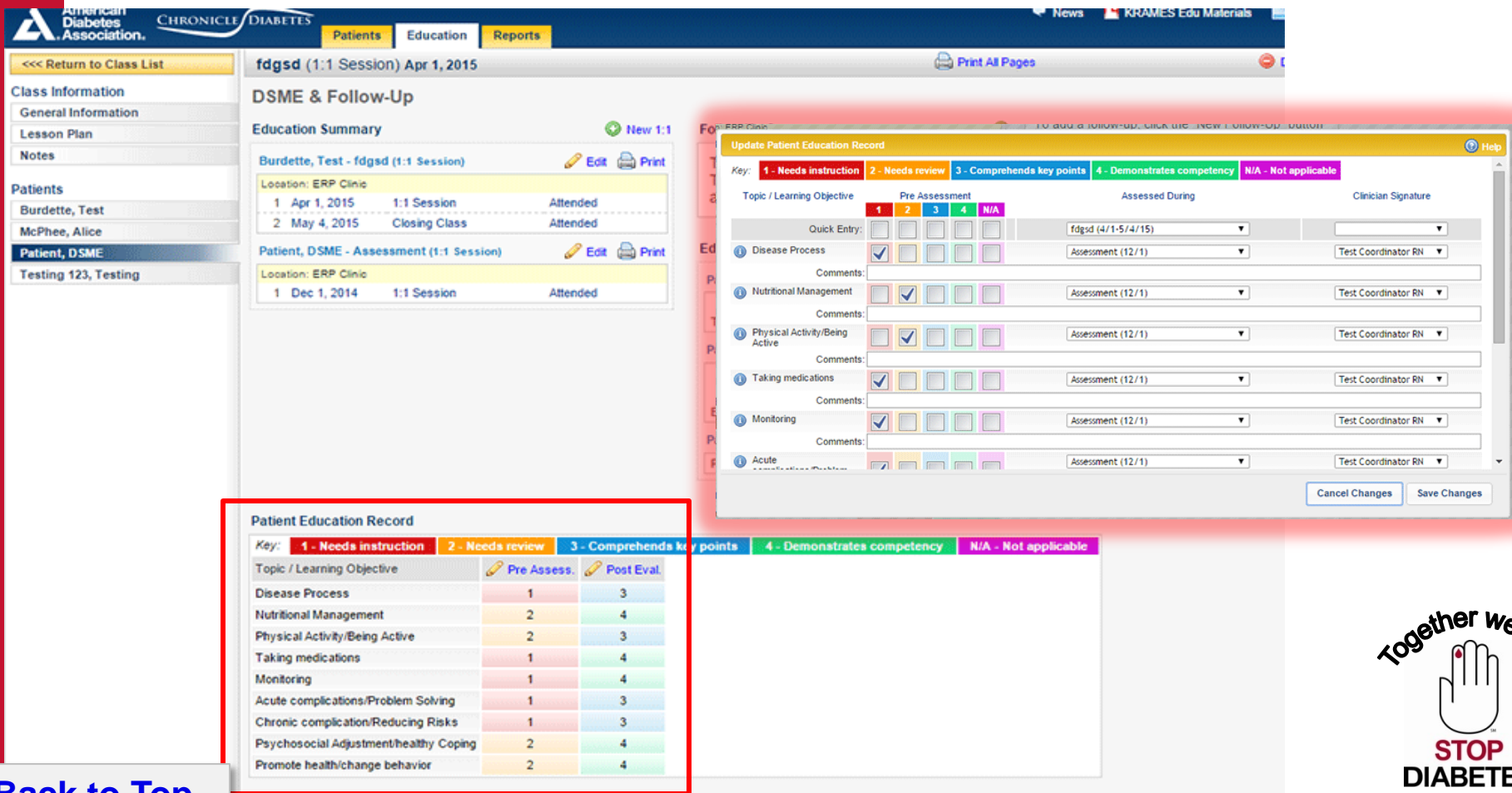
1	Mar 1, 2012	1:1 Session	Attended
---	-------------	-------------	----------

Follow-Up Summary + New Follow-Up

	F/U Date	Method	Clinician	
✎	Jun 13, 2012	Phone	Elen Educator	-
✎	Aug 1, 2012	Phone	Elen Educator	-

Documenting Patient Education Page 8 of 9

Within the **education record** you are presented with a window which displays each of the nine topics and has two colored tables for *Pre Assessment* and a *Post Evaluation* scoring. For each of the nine areas that were taught, you can check a box in the *Pre Assessment* and *Post Evaluation* columns to indicate this patient's level before and after education.



Update Patient Education Record

Key: 1 - Needs instruction 2 - Needs review 3 - Comprehends key points 4 - Demonstrates competency N/A - Not applicable

Topic / Learning Objective	Pre Assessment					Assessed During	Clinician Signature
	1	2	3	4	N/A		
Quick Entry:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	fdgsd (4/1-5/4/15)	
① Disease Process	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assessment (12/1)	Test Coordinator RN
Comments:							
① Nutritional Management	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assessment (12/1)	Test Coordinator RN
Comments:							
① Physical Activity/Being Active	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assessment (12/1)	Test Coordinator RN
Comments:							
① Taking medications	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assessment (12/1)	Test Coordinator RN
Comments:							
① Monitoring	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assessment (12/1)	Test Coordinator RN
Comments:							
① Acute complications/Problem Solving	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assessment (12/1)	Test Coordinator RN
Comments:							

Cancel Changes Save Changes

Patient Education Record

Key: 1 - Needs instruction 2 - Needs review 3 - Comprehends key points 4 - Demonstrates competency N/A - Not applicable

Topic / Learning Objective	Pre Assess.	Post Eval.
Disease Process	1	3
Nutritional Management	2	4
Physical Activity/Being Active	2	3
Taking medications	1	4
Monitoring	1	4
Acute complications/Problem Solving	1	3
Chronic complication/Reducing Risks	1	3
Psychosocial Adjustment/healthy Coping	2	4
Promote health/change behavior	2	4

Documenting Patient Education *Page 9 of 9*

The **Education Plan**, **DSMS Plan** and **Barriers to Learning** are located under the Patient Education Record. Click on the New or Edit option next to the appropriate section to enter or update the information.

<<< Return to Class List
fdgsd (1:1 Session) Apr 1, 2015
 Print All Pages

Class Information

General Information

Lesson Plan

Notes

Patients

Burdette, Test

McPhee, Alice

Patient, DSME

Testing 123, Testing

Date Completed: No value

Education Status Note: No value

Patient follow up success Edit

Patient Lost to Follow-Up: No

Patient Education Record

Key: 1 - Needs instruction 2 - Needs review 3 - Comprehends key points 4 - Demonstrates competency N/A - Not applicable

Topic / Learning Objective	Pre Assess	Post Eval
Disease Process	1	3
Nutritional Management	2	4
Physical Activity/Being Active	2	3
Taking medications	1	4
Monitoring	1	4
Acute complications/Problem Solving	1	3
Chronic complication/Reducing Risks	1	3
Psychosocial Adjustment/healthy Coping	2	4
Promote health/change behavior	2	4

Education Plan New Education Plan

There have not been any Education Plans documented for this patient. To add a new Education Plan, click the New Education Plan link above.

DSMS Plan New DSMS Plan

▼ Current DSMS Plan

Documented during: Assessment (12/1/14) Edit DSMS Plan Delete DSMS Plan

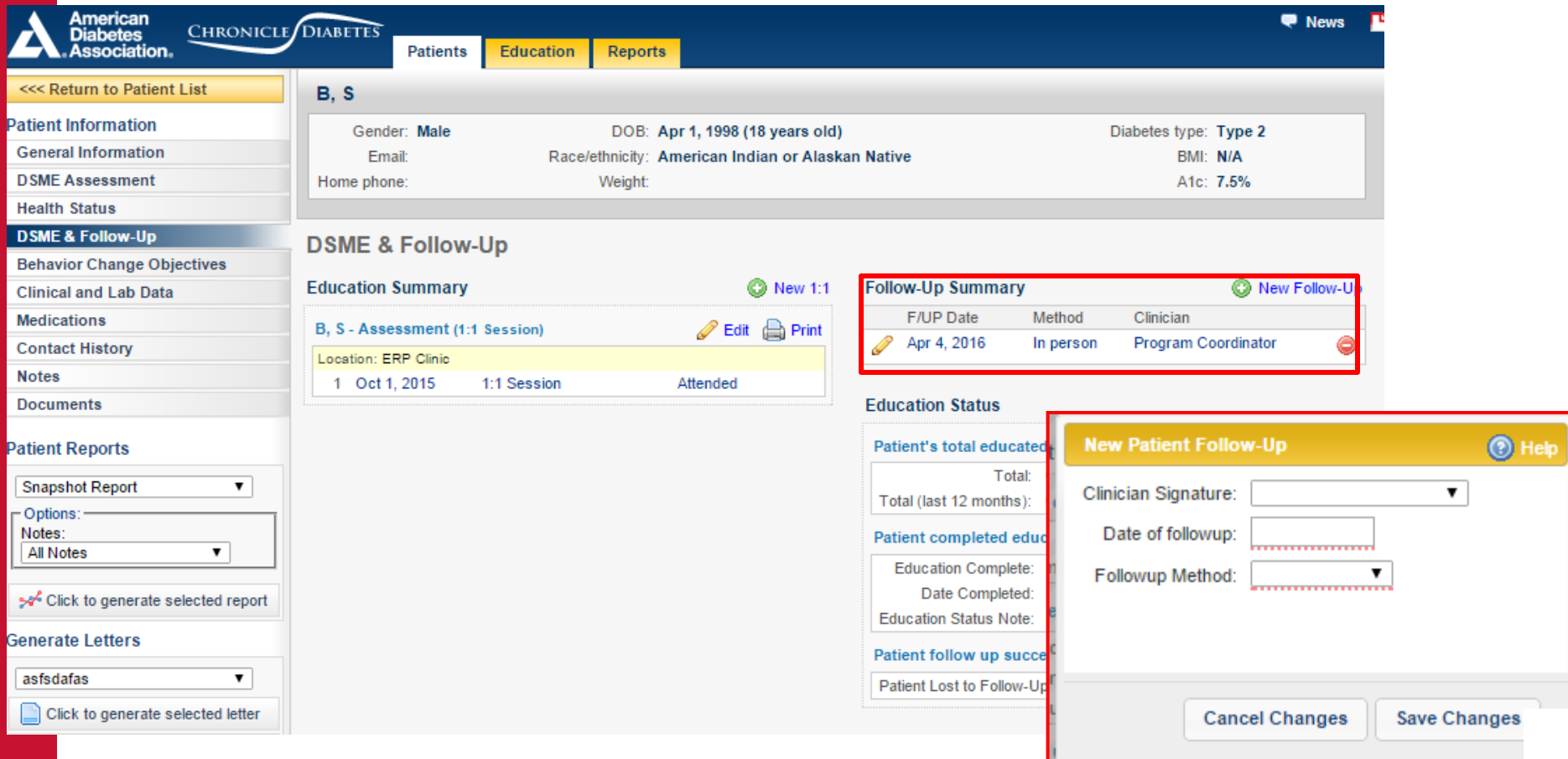
- Diabetes Forecast- 800-342-2383- www.diabetesforecast.org
- Diabetes Self-Management- 855-367-4813- www.diabetesseifmanagement.com

Identified Barriers to learning/adherence to self management plan New Entry

There have not been any identified Barriers to learning/adherence to self management plan documented for this patient. To add a new Entry, click the New Entry link above.

Documenting Hospital Admission and Emergency Room Visits Post Education

Chronicle provides you with the ability to document hospitalizations & ER visits that occurred **after** education was complete as part of the patient's follow-up assessment. **To document this information, open the patient's follow-up assessment and click on the Hospitalizations & ER Visits tab.**



The screenshot displays the Chronicle Diabetes software interface for a patient named B, S. The interface includes a navigation menu on the left with options like Patient Information, DSME Assessment, and DSME & Follow-Up. The main content area shows patient details (Gender: Male, DOB: Apr 1, 1998, Race/ethnicity: American Indian or Alaskan Native, Diabetes type: Type 2) and a DSME & Follow-Up section. This section contains an Education Summary table and a Follow-Up Summary table. The Follow-Up Summary table is highlighted with a red box and contains one entry: Apr 4, 2016, In person, Program Coordinator. Below this is an Education Status section. A 'New Patient Follow-Up' dialog box is open in the foreground, also highlighted with a red box, showing fields for Clinician Signature, Date of followup, and Followup Method, along with 'Cancel Changes' and 'Save Changes' buttons.

Follow-Up Summary

F/UP Date	Method	Clinician
Apr 4, 2016	In person	Program Coordinator

Education Status

Patient's total educated
Total:
Total (last 12 months):

Patient completed education
Education Complete:
Date Completed:
Education Status Note:

Patient follow up success
Patient Lost to Follow-Up

New Patient Follow-Up

Clinician Signature:

Date of followup:

Followup Method:

Cancel Changes Save Changes

Module 3: Creating/Editing letters with the Letter Manager

- Creating and Editing Letters with the Letter Manager
- Sending Login Details for Online Assessment
- Generating Letters to send to Class Participants

Module 3: Creating and Editing Letters with the Letter Manager Page 1 of 5

1. From any Letter Generation Wizard window, or from the **Launch Letter Manager** tab at the bottom left of a patient's record, you can use the Letter Manager to create and edit your letters in the system.

The screenshot shows the ADA Chronic Diabetes patient record interface. The browser title is "ADA Chronic Diabetes - Windows Internet Explorer" and the address bar shows "https://edu.chronicdiabetes.com/patient/detail/17761/". The page header includes the American Diabetes Association logo and navigation tabs for "Patients", "Education", and "Reports". The patient's name is "Burdette, S".

Patient Information

- Gender: Male
- DOB: Jun 16, 1982 (29 years old)
- Diabetes type: Type 2
- Email: sburdette@diabetes.org
- Race/ethnicity: White/Caucasian
- BMI:
- Home phone: 123-456-7890

DSME Assessment

Date on which this Health Risk Assessment was completed: Aug 2, 2011

Diabetes History

- Type of Diabetes**: Type of diabetes: Type 2
- Year Diagnosed with Diabetes**: Year patient diagnosed: 2011
- Blood Sugar Monitoring**:
 - Monitors blood sugar: Yes
 - Frequency of blood sugar checks: 2
 - Times of blood sugar checks: Before Breakfast, 2 Hrs post dinner
 - Usual AM blood sugar value?: 165
 - Usual PM blood sugar value?: 155
 - Blood sugar value 1-2 hours after meals: 155
 - Brand of monitor used: Bayer Ascensia Breeze
- Urine Ketone Testing**: Performs Urine Ketone Test: No value

Medical / Health History

- Barriers to Care**: Current barriers: No value
- Difficulty With**: Do you have difficulty with any of the following: No value
- General Health Feelings**: General feelings about health: No value
- Allergies**: No Allergies
- Medical Problems**:
 - Coronary Artery Disease: No value
 - Heart Attack (MI): Yes
 - High Blood Pressure: Yes
 - Stroke (CVA) / Transient Ischemic Attack (TIA): No value
 - Peripheral Vascular Disease (poor leg circulation): No value

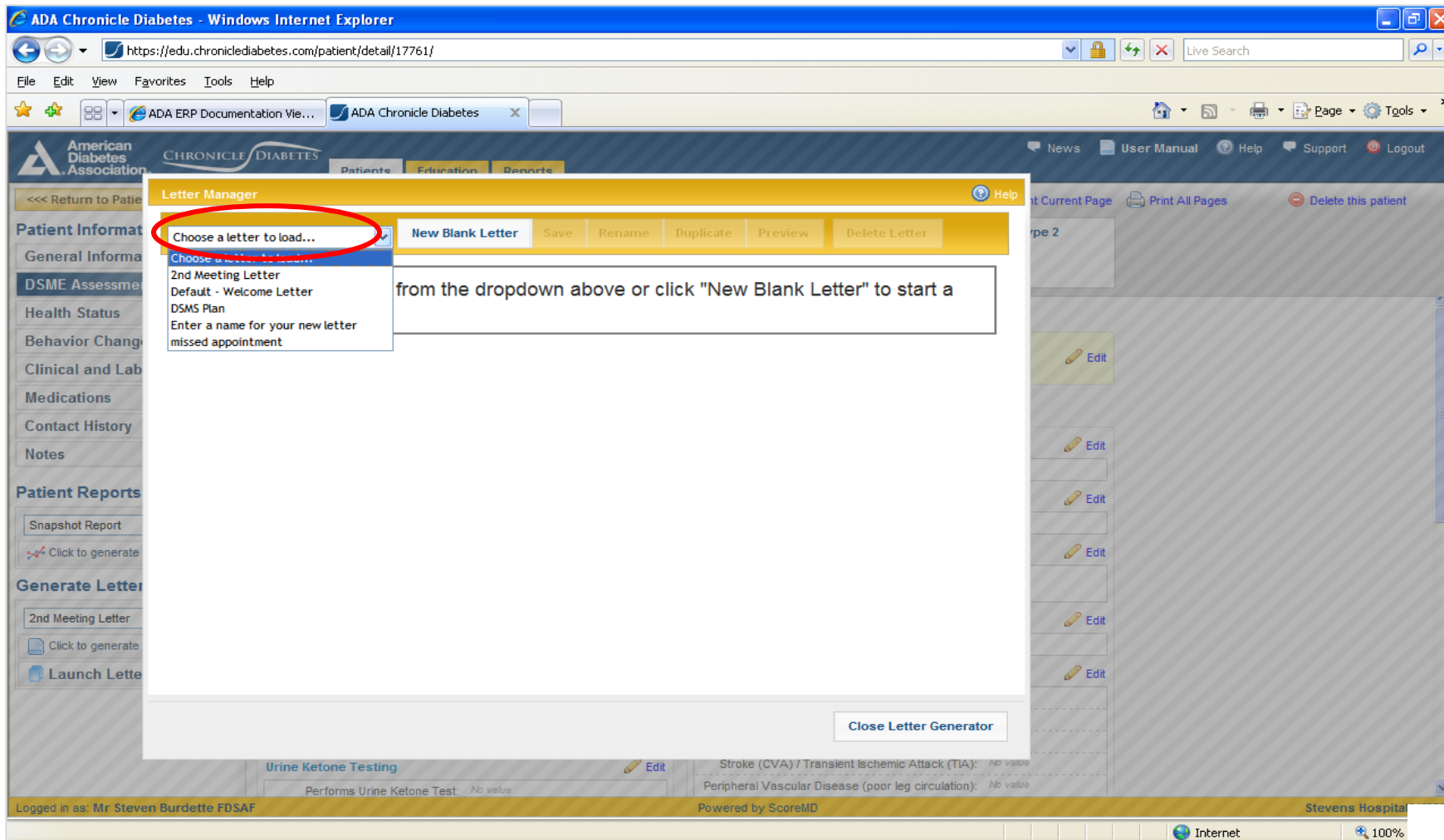
Generate Letters

- 2nd Meeting Letter
- Launch Letter Manager** (circled in red)

Logged in as: Mr Steven Burdette FDSAF | Powered by ScoreMD | Stevens Hospital

Creating and Editing Letters with the Letter Manager *Page 2 of 5*

2. To begin editing an existing letter, select the letter from the **Choose a letter to load** drop down list at the top of the wizard. That will load the letter template in the main text area. Alternatively, you can click New Blank Letter to start from scratch.



ADA Chronicle Diabetes - Windows Internet Explorer

https://edu.chronicdiabetes.com/patient/detail/17761/

File Edit View Favorites Tools Help

ADA ERP Documentation Vie... ADA Chronicle Diabetes

American Diabetes Association CHRONICLE DIABETES Patients Education Reports

<< Return to Patient Information

Patient Information

General Information

DSME Assessment

Health Status

Behavior Change

Clinical and Lab

Medications

Contact History

Notes

Patient Reports

Snapshot Report

Click to generate

Generate Letter

2nd Meeting Letter

Click to generate

Launch Letter

Letter Manager

Choose a letter to load...

Choose a letter to load...

2nd Meeting Letter

Default - Welcome Letter

DSMS Plan

Enter a name for your new letter missed appointment

New Blank Letter Save Rename Duplicate Preview Delete Letter

from the dropdown above or click "New Blank Letter" to start a

Close Letter Generator

Urine Ketone Testing Performs Urine Ketone Test: No value

Stroke (CVA) / Transient Ischemic Attack (TIA): No value

Peripheral Vascular Disease (poor leg circulation): No value

Logged in as: Mr Steven Burdette FDSAF Powered by ScoreMD Stevens Hospital

Internet 100%

Creating and Editing Letters with the Letter Manager Page 3 of 5

3. Edit the text of the letter using normal text editing steps (type, delete, etc.). To format text, select a section of text and use the **formatting bar** directly above the main letter area to change the style, justification and formatting.

The screenshot displays the ADA Chronicle Diabetes Letter Manager interface within a Windows Internet Explorer browser. The browser's address bar shows the URL <https://edu.chronicdiabetes.com/patient/detail/17761/>. The interface features a navigation menu on the left with options like 'Patient Information', 'DSME Assessment', and 'Generate Letter'. The main content area is titled 'Letter Manager' and includes a dropdown menu for 'Default - Welcome Letter', buttons for 'New Blank Letter', 'Save', 'Rename', 'Duplicate', 'Preview', and 'Delete Letter', and a 'Help' icon. A red circle highlights the 'formatting bar' containing icons for bold (B), italic (I), underline (U), bulleted list, numbered list, left-align, center-align, right-align, and justify. Below the formatting bar, the letter text is displayed with several placeholder tags highlighted in yellow, such as «Patient Name», «Site Name», «Upcoming Education Session Date», «Upcoming Education Session Time», «Patient Username», «Patient Password», «Site Address Block», and «Site Address Block». The interface also includes a 'Close Letter Generator' button at the bottom right and a status bar at the very bottom showing 'Logged in as: Mr Steven Burdette FDSAF' and 'Powered by ScoreMD'.

Creating and Editing Letters with the Letter Manager *Page 4 of 5*

4. To insert a data field (e.g. current date, patient's name, etc.) that will be replaced when the letter template is merged with patient data, start by positioning the cursor where you would like the tag to go. Next click on the **Insert Custom Tag** menu and then select the tag you would like from the menu. This will insert a yellow tag into the letter, which will be replaced with the corresponding data when the actual letter is generated.

The screenshot displays the ADA Chronicle Diabetes Letter Manager interface within a Windows Internet Explorer browser. The browser's address bar shows the URL <https://edu.chronicdiabetes.com/patient/detail/17761/>. The page title is "ADA Chronicle Diabetes - Windows Internet Explorer". The interface includes a navigation menu with options like "Patients", "Education", and "Reports". The main content area is titled "Letter Manager" and features a dropdown menu for "Default - Welcome Letter" and a "New Blank Letter" button, which is circled in red. Other buttons include "Save", "Rename", "Duplicate", "Preview", and "Delete Letter". The letter template text is as follows:

Dear «Patient Name»,

Thank you for scheduling your appointment at «Site Name». There are a lot of new and significant changes to the treatment of diabetes and we are here to guide you every step of the way.

Your first visit is scheduled for «Upcoming Education Session Date» at «Upcoming Education Session Time».

Prior to your visit, please log on to the following website to complete your initial patient self-assessment:
<https://patient.chronicdiabetes.com>
Username: «Patient Username»
Password: «Patient Password»

If you do not have access to a computer with internet access, please arrive for your appointment 30 minutes early to complete your self-assessment on a computer at our office. Your answers to these questions will help guide our educational session.

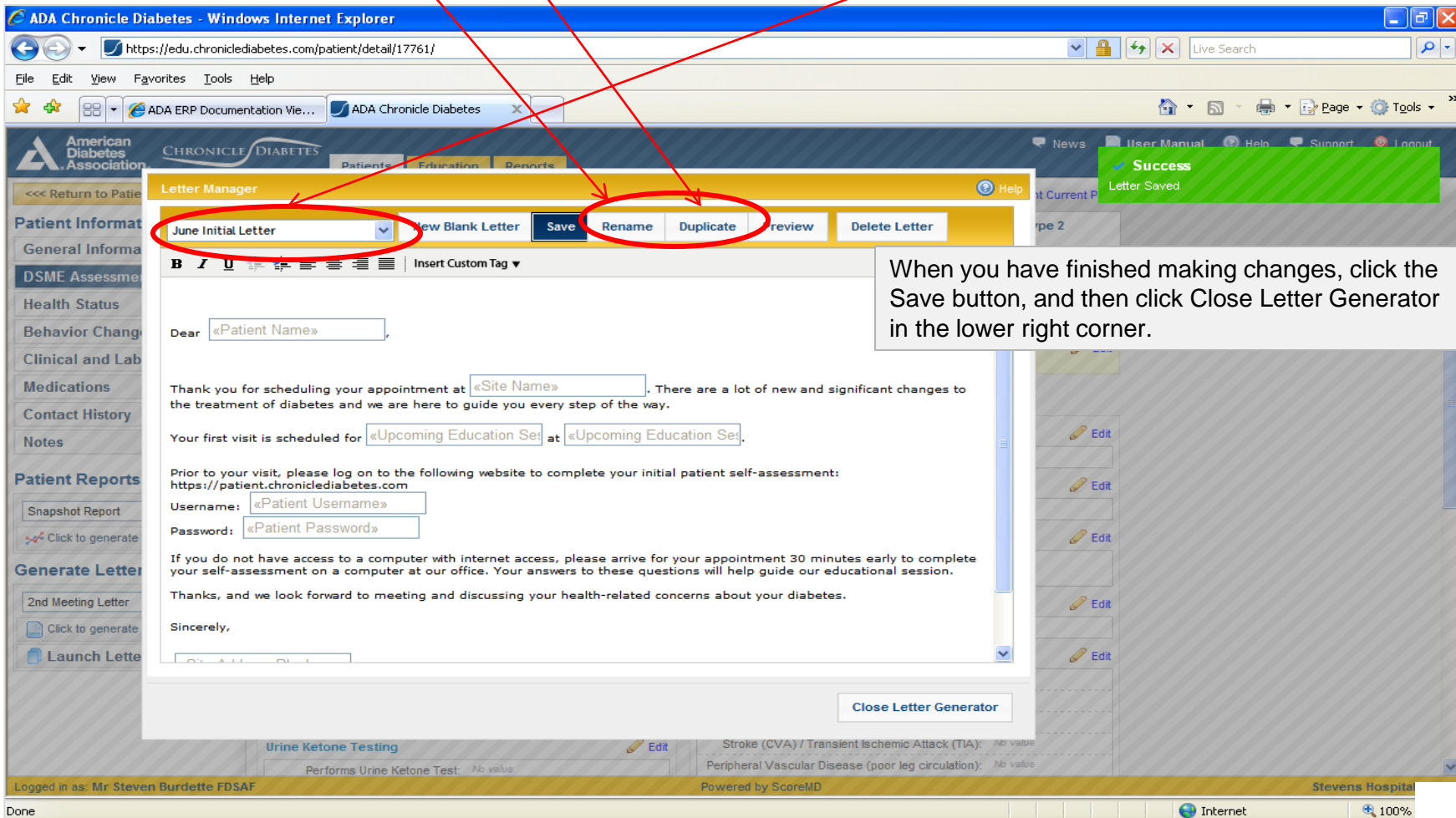
Thanks, and we look forward to meeting and discussing your health-related concerns about your diabetes.

Sincerely,
«Site Address Block»

The interface also includes a "Close Letter Generator" button at the bottom right. The footer of the page shows "Logged in as: Mr Steven Burdette FDSAF", "Powered by ScoreMD", and "Stevens Hospital".

Creating and Editing Letters with the Letter Manager *Page 5 of 5*

A letter can be renamed (e.g. change the name of the letter as it appears in the Select **Letter dropdown** menu) by clicking the **Rename** button. To create a new letter based on an existing letter, first select the existing letter and then click **Duplicate** and give the new letter a new name. Perform any edits to this new letter and save it when done. Clicking Preview will generate a downloadable version of the letter in the Microsoft Word format.



When you have finished making changes, click the Save button, and then click Close Letter Generator in the lower right corner.

Generating Individual Patient Letters Page 1 of 2

Once you are in the patient record:

- 1) Choose the letter you would like to send within the Generate Letters dropdown menu
- 2) Click the *Click to generate selected letter* button on the lower left menu.

The screenshot shows the American Diabetes Association patient record interface for a patient named Elle Telle. The interface includes a navigation menu on the left, a patient information summary at the top, and several sections for patient details. The 'Generate Letters' dropdown menu is highlighted with a red box, showing options for 'Default - Welcome Letter' and a 'Click to generate selected letter' button. The 'Launch Letter Manager' button is also visible below the dropdown.

Patient Information Summary:

- Gender: Male
- DOB: Mar 13, 1997 (18 years old)
- Diabetes type: Type 1
- Email: [Redacted]
- Race/ethnicity: Asian/Chinese/Japanese/Korean
- BMI: N/A
- Home phone: [Redacted]

General Information:

- Patient Name / ID: Elle Telle
- Patient ID: No value
- Medicaid ID: No value
- Status: Active
- Chronicle ID (internal): 203144

Web Login:

- Username: elletelle203144
- Password: [Redacted]

Contact Information:

- Address 1: No value
- Address 2: No value
- City: No value
- State: No value
- Postal Code: No value
- Email: No value
- Work Phone: No value
- Home Phone: No value
- Cell Phone: No value

Provider / Physician:

- Primary Physician (PCP): No provider assigned.
- Physician Responsible for Diabetes Management: [Redacted]

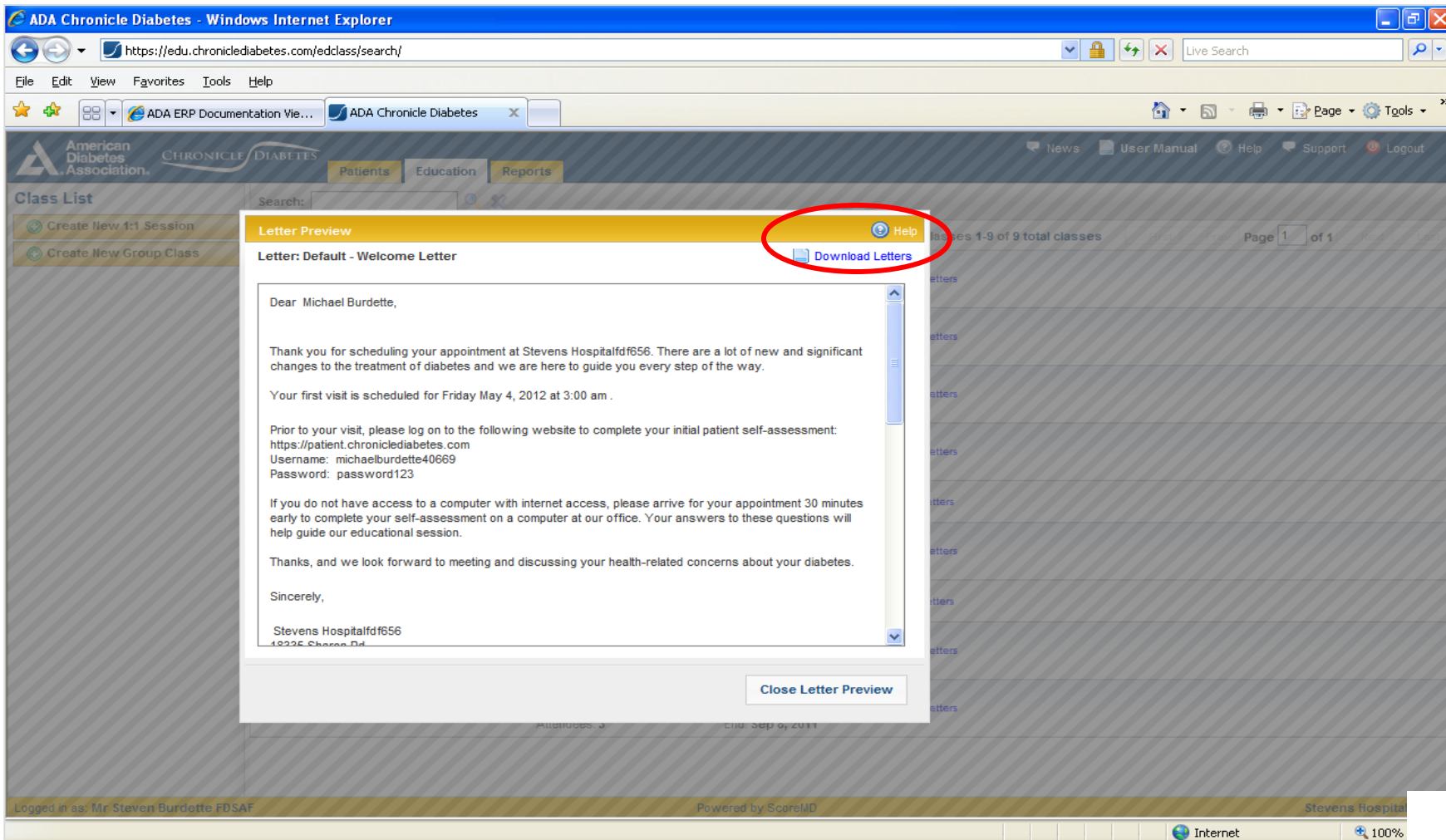
Generate Letters Dropdown Menu:

- Default - Welcome Letter
- Default - Welcome Letter
- Click to generate selected letter
- Launch Letter Manager



Generating Individual Patient Letters *Page 2 of 2*

You will see a preview of the letter(s) that will be created. If this looks correct, click **Download Letters**, which will prompt you to download the resulting Microsoft Word file to your computer. Once the letters file is on your computer you can open it in Microsoft Word, edit it as necessary, and print the letter to send to the patients.



The screenshot shows a web browser window titled "ADA Chronicle Diabetes - Windows Internet Explorer" with the URL "https://edu.chroniclediabetes.com/edclass/search/". The page displays a "Letter Preview" modal window for a "Letter: Default - Welcome Letter". The letter content is as follows:

Dear Michael Burdette,

Thank you for scheduling your appointment at Stevens Hospitaldf656. There are a lot of new and significant changes to the treatment of diabetes and we are here to guide you every step of the way.

Your first visit is scheduled for Friday May 4, 2012 at 3:00 am .

Prior to your visit, please log on to the following website to complete your initial patient self-assessment:
https://patient.chroniclediabetes.com
Username: michaelburdette40669
Password: password123

If you do not have access to a computer with internet access, please arrive for your appointment 30 minutes early to complete your self-assessment on a computer at our office. Your answers to these questions will help guide our educational session.

Thanks, and we look forward to meeting and discussing your health-related concerns about your diabetes.

Sincerely,

Stevens Hospitaldf656
48226 Stevens Rd

The "Download Letters" button is circled in red. Other visible elements include a "Help" button, a "Close Letter Preview" button, and a footer with the text "Logged in as: Mr Steven Burdette FDSAF", "Powered by ScoreMD", and "Stevens Hospital".

Generating Letters to send to Class Participants *Page 1 of 4*

After the class has been set up you can create a welcome letter that can be sent (via U.S. mail) to each of the patients to give them initial information and invite them to complete their online initial patient self-assessment (PSA). Return to the main class list by clicking the Return to Class Listing button in the upper left. In the listing row for the class you created, click the **Generate Letters** link on the right side and follow the next 3 steps.

The screenshot shows a web browser window displaying the ADA Chronicle Diabetes website. The page title is "ADA Chronicle Diabetes - Windows Internet Explorer" and the URL is "https://edu.chronicdiabetes.com/edclass/search/". The website header includes the American Diabetes Association logo and navigation tabs for "Patients", "Education", and "Reports". The main content area is titled "Class List" and contains a table of classes. The first row of the table is highlighted, and the "Generate Letters" link in the right column is circled in red. The table also includes a search bar, a "Showing classes 1-9 of 9 total classes" indicator, and pagination controls.

Class Name	Format	Sessions	Attendees	Start/End	Action
fdasf	Combination of 1:1 and Group	Not Scheduled	None Assigned		Generate Letters
2	Classroom / Group	Not Scheduled	None Assigned		Generate Letters
June 2012	Classroom / Group	1	1	Jun 1, 2012	Generate Letters
May 2012	Combination of 1:1 and Group	3	1	May 4, 2012	Generate Letters
Ste, Steve - SSS	1:1			Apr 11, 2012	Generate Letters
January 24 to February 28	Combination of 1:1 and Group	2	3	Jan 24, 2012	Generate Letters
Ste, Steve - safsdaf	1:1			Jan 12, 2012	Generate Letters
Stevens 1st EDU Class	Combination of 1:1 and Group	1	1	Aug 2, 2011	Generate Letters
Steven's Test	Classroom / Group	4	3	Jul 12, 2011	Generate Letters

Logged in as: Mr Steven Burdette FDSAF Powered by ScoreMD Stevens Hospital

Generating Letters to send to Class Participants *Page 2 of 4*

1. Select the letter you would like to create from the drop down list.

The screenshot displays the 'Letter Wizard' interface within a web browser. The browser's address bar shows the URL <https://edu.chronicdiabetes.com/edclass/search/>. The page header includes the American Diabetes Association logo and navigation links for 'Patients', 'Education', and 'Reports'. The main content area is titled 'Class List' and features a search bar and two buttons: 'Create New 1:1 Session' and 'Create New Group Class'. A 'Letter Wizard' dialog box is overlaid on the page, divided into two steps:

- Step 1: Select Letter**: A dropdown menu is open, showing the following options: '2nd Meeting Letter' (selected), 'Default - Welcome Letter', and 'DSMS Plan'. A 'Launch Letter Manager' button is visible to the right of the dropdown.
- Step 2: Select Patients**: This step contains two lists of patient names. The first list, 'Recently Added Patients', includes 'Burdette, Michael' and 'Michaels, S'. The second list, 'Patient(s) to receive letters', includes 'Michaels, S'. Below these lists are 'Preview Letter' and 'Close Letter Wizard' buttons.

The footer of the page shows the user is logged in as 'Mr Steven Burdette FDSAF', the system is powered by 'ScoreMD', and the user is at 'Stevens Hospitaldf656'. The browser's status bar at the bottom indicates 'Done' and 'Internet'.

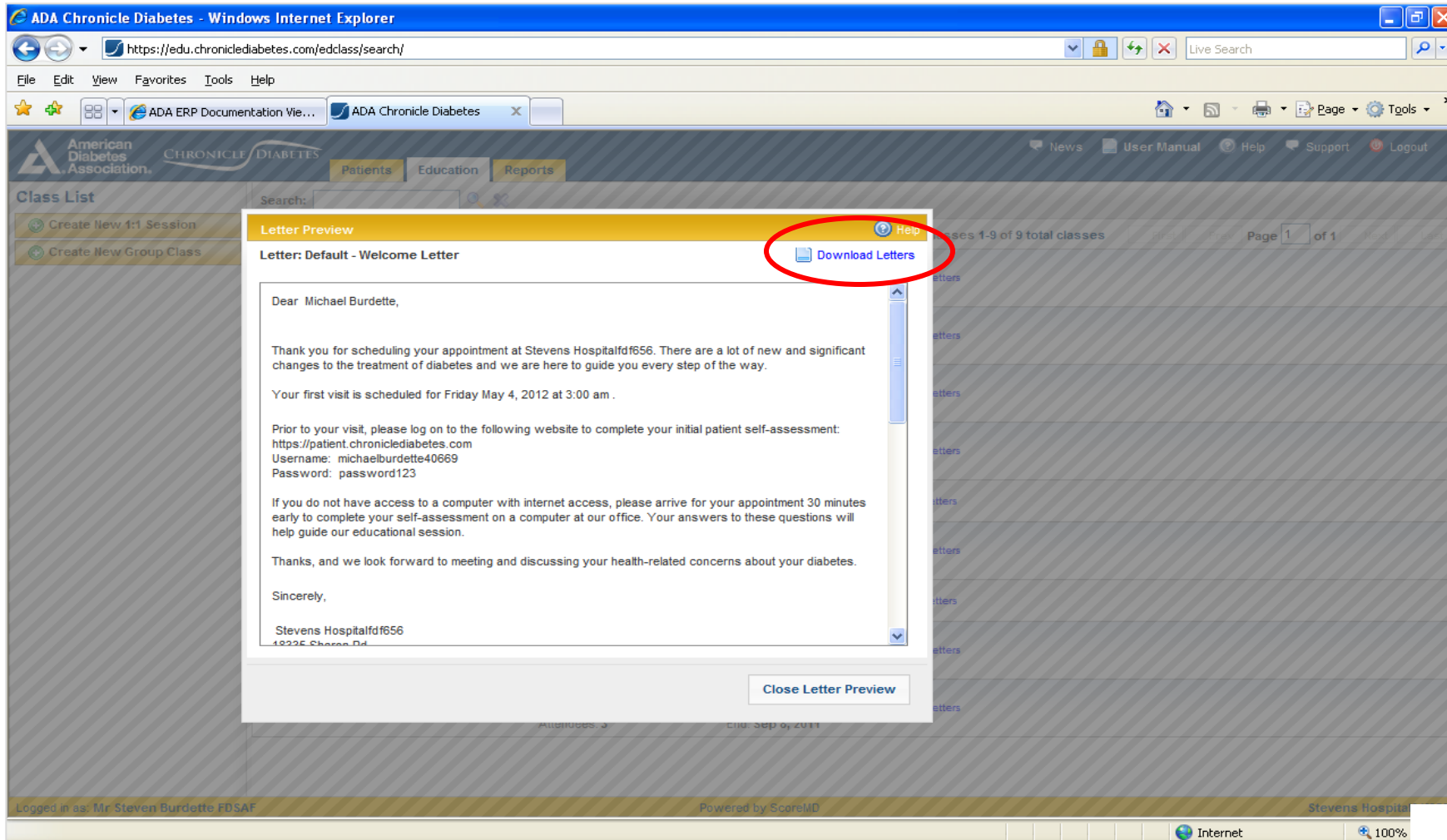
Generating Letters to send to Class Participants *Page 3 of 4*

2. Select the patients you would like to receive the letter. By default, all of the patients in the class are selected. If there are any other patients that you would like include, click on the patient's name in the left column to add them to the right column (the recipients list). To remove someone from the recipients list, just click on her name in the right column. When the recipients list is correct; click on **Preview Letter**.

The screenshot displays the ADA Chronicle Diabetes web application interface. A 'Letter Wizard' dialog box is open, showing the process of selecting a letter and recipients. The 'Preview Letter' button at the bottom of the dialog is highlighted with a red circle. The background shows a 'Class List' table with columns for 'Classes 1-9 of 9 total classes', 'First', 'Prev', 'Page 1 of 1', 'Next', and 'Last'. The page footer includes 'Logged in as: Mr Steven Burdette FDSAF', 'Powered by ScoreMD', and 'Stevens HospitalID#'. The browser title is 'ADA Chronicle Diabetes - Windows Internet Explorer' and the address bar shows 'https://edu.chroniclediabetes.com/edclass/search/'.

Generating Letters to send to Class Participants *Page 4 of 4*

3. You will see a preview of the letter(s) that will be created. If this looks correct, click **Download Letters**, which will prompt you to download the resulting Microsoft Word file to your computer. Once the letters file is on your computer you can open it in Microsoft Word, edit it as necessary, and print the letter to send to the patients.



The screenshot shows a web browser window titled "ADA Chronicle Diabetes - Windows Internet Explorer" with the URL "https://edu.chronicdiabetes.com/edclass/search/". The browser's address bar and menu bar are visible. The website's header includes the American Diabetes Association logo and navigation tabs for "Patients", "Education", and "Reports". A "Class List" section is visible on the left, with options to "Create New 1:1 Session" and "Create New Group Class". The main content area displays a "Letter Preview" window for a "Default - Welcome Letter". The letter text is as follows:

Dear Michael Burdette,

Thank you for scheduling your appointment at Stevens Hospitalfd656. There are a lot of new and significant changes to the treatment of diabetes and we are here to guide you every step of the way.

Your first visit is scheduled for Friday May 4, 2012 at 3:00 am .

Prior to your visit, please log on to the following website to complete your initial patient self-assessment:
https://patient.chronicdiabetes.com
Username: michaelburdette40669
Password: password123

If you do not have access to a computer with internet access, please arrive for your appointment 30 minutes early to complete your self-assessment on a computer at our office. Your answers to these questions will help guide our educational session.

Thanks, and we look forward to meeting and discussing your health-related concerns about your diabetes.

Sincerely,

Stevens Hospitalfd656
15225 Stevens Rd

The "Letter Preview" window has a yellow header with "Letter Preview" and "Help" icons. A blue "Download Letters" button with a document icon is circled in red. A "Close Letter Preview" button is located at the bottom of the window. The background shows a list of classes with "Page 1 of 1" and "1-9 of 9 total classes" visible.

Logged in as: Mr Steven Burdette FDSAF Powered by ScoreMD Stevens Hospitalfd656

Internet 100%

Letter Manager Tips

- The default welcome letter (already within Chronicle) provides you with the login details and web address for the online Patient Self-Assessment. (This can be sent via postal mail or copied and pasted into an email to send to the patient.)
- You have the ability to copy and past your own existing letters into the letter wizard and save them accordingly.
- Organization Logos are not able to be uploaded into the Letter Wizard. You may add a logo once the letter has been exported to a Word document.

Module 4 - Chronicle Reports

ERP Site Report

Provides cumulative data for your site in all of the areas necessary for ADA ERP recognition during a specific reporting period.

Patient Status Report

Provides the number of participants that have been documented as either: Referred Assessment Completed, Inactive, Entered, and Education Completed and/or have a follow-up documented during a specific reporting period.

Educator Hours Report

Provides the total amount of time (minutes) an educator has contributed to the DSME program whether through a group or 1:1 session during a specific reporting period.

Patient No Show Report

Provides the patient contact information (name, phone number and address) for patients that have been placed in No Show status within the attendance section of a group or 1:1 session during a specific reporting period.

ERP Delta Report

Provides an aggregate outcome of pre and post values for a number of clinical indicators (HgbA1c, blood pressure, etc.) and Behavior Goals during a specific reporting period.

ERP Filter Report

Provides the ability to define exactly what data you would like to be generated by the system within a specific reporting period. Reports can be filtered by participant information (ex. pt. demographics, insurance type), DSME information and Clinical Data. The filter report provides the ability to export patient Information, provider information, insurance information, Pre & Post Labs and Clinical Data and more.

Hospital Admission and Emergency Room Visit Report

Provides the change in the number of hospitalizations & ER visits that occurred prior to education versus post education. When you run this report, you can see the number of patients with a hospitalization & ER visit as well as the total count of hospitalizations & ER visits, and compare the numbers pre and post education to see the positive effect the education is having.



ERP Site Report

ERP Clinic

Alexandria, VA

Total number of participants during reporting period

- 13 Comprehensive and/or Initial
- 1 Post Program Instruction
- 3 Education not documented *

Average hours of DSME received by participants during reporting period

- 2.9 Comprehensive and/or Initial
- 1 Post Program Instruction

Age of participants receiving DSME during reporting period

- 6 More than 65 years of age
- 3 45-64 years of age
- 3 19-44 years of age
- 4 Less than 19 years of age

Diabetes type of participants receiving DSME during reporting period

- 0 Pre-diabetes 0-18 years of age
- 0 Pre-diabetes >= 19 years of age
- 2 Type 1 0-18 years of age
- 4 Type 1 >= 19 years of age
- 2 Type 2 0-18 years of age
- 7 Type 2 >= 19 years of age
- 1 GDM
- 0 Other / Don't know

Race/ethnicity of participants receiving DSME during reporting period

- YES American Indian or Alaskan Native
- YES Asian/Chinese/Japanese/Korean/Pacific Islander
- YES Black/African American
- YES Hispanic/Chicano/Cuban/Mexican/Puerto Rican/Latino
- YES White/Caucasian
- NO Middle Eastern

Special needs of participants receiving DSME during reporting period

- YES Physically disabled
- YES Visually impaired
- YES Hearing impaired
- NO Low literacy
- NO English as a second language

Site DSME method(s)

- YES 1:1
- YES Group

Behavioral Outcome(s)

Avg %	# Patients	Behavior Outcomes
78.1%	8	Nutritional Management
37.5%	2	Physical Activity/Being Active
100%	1	Taking medications
100%	4	Monitoring
0%	0	Acute complications/Problem Solving
100%	1	Chronic complication/Reducing Risks
100%	1	Psychosocial Adjustment/healthy Coping

Other Participant Outcomes

Actual %	Other Participant Outcomes
62.5%	10/16 A1c
18.8%	3/16 Eye Exam
18.8%	3/16 Foot Exam
6.3%	1/16 Lipids
18.8%	3/16 BP
43.8%	7/16 Weight Change

ERP Site Report Description

- **Total number of participants during reporting period** – This is the total number of patients that were included when calculating the report, based on the report period criteria explained above. The patient was included in the report number and outcomes because she/he had either a clinical data point or a behavior change objective, but did not have a class session, then he/she will be counted as Education not documented and the patient's Chronicle ID will be listed at the bottom of the page for your reference.
- **Average hours of DSME received by participants during reporting period** – These numbers are calculated based on the length (duration) of all attended class sessions (1:1 and group) divided by the total number of participants.
- **Age of participants receiving DSME during reporting period** – These numbers are based on individual patient demographics.
- **Diabetes type of participants receiving DSME during reporting period** – These numbers are based on individual patient demographics.
- **Race/ethnicity of participants receiving DSME during reporting period** – This information is based on individual patient demographics.
- **Special needs of participants receiving DSME during reporting period** – This information is based on individual patient demographics.
- **Site DSME method(s)** – This information is based on the types of classes documented.
- **Behavioral Outcome(s)** – These numbers are calculated for patients that have at least two assessed values (a baseline and at least one objective update) for a behavioral outcome. For example, if you have 200 total patients seen during the report period, and the report lists 50 under # Patients for Nutritional Management, that means that out of those 200 patients, 50 had Nutritional Management listed as a behavioral outcome and had a baseline evaluation and at least one update made to that objective. Then, the highest objective update value is reflected and the average assessment is calculated under the Avg % section.

Patient Status Report

Patient Entry Report									
Steven's Test Program 4									
10/14/2013 - 10/14/2014									
Site Name	Patient Status				Total	Education Status			
	Referred	Active w/Assmt	Active wo/Assmt	Inactive		Entered	Assment	Edu Complt	Follow-up
ERP Clinic	0	1	0	0	1	1	1	0	1

Patient Status Report Key

Referred - Patient has been placed in referred status within the general information section of the patient record. (*Patient Name / ID Section*)

Assment - Patient has date entered under DSME Assessment > Date on which this Health Risk Assessment was completed. (*DSME Assessment section of patient record*)

Note: Active w/Assmnt and Active w/o Assmnt provides the total number of patients with and without assessments.

Inactive - Patient has been placed in inactive status within the general information section of the patient record. (*Patient Name / ID Section*)

Entered - Patient encounter has been added to Chronicle during the specified data range. The encounter could be an assessment, class (1:1 or group) or behavioral goal or other outcome entered.

Edu Complt - Patient has Education Complete checked under DSME & Follow-Up section of the patient record. (*Education Status section*)

Follow-up - Patient has at least one Follow-up listed under Follow-Up Summary and does not have Lost to Follow-Up checked

This report can be exported to an Excel spreadsheet.



Educator Hours Report

Educator Hours Report : 10/14/2013 - 10/14/2014	
ERP Clinic	
Alexandria, VA	
Educator Name	Time
Test Coordinator RN CDE	75
Test Paraprofessional	60

The **Educator Hours report** provides the total amount of time (minutes) an educator has contributed to the DSME program whether through a group or 1:1 session. (*The Educator Hours can be added or updated through the DSME & Follow-Up section of the patient record or through the Education tab*). This report is able to be exported to an Excel spreadsheet.

Patient No Show Report

Patient No Shows: 10/14/2013 - 10/14/2014

ERP Clinic

Alexandria, VA

Patient Name	Class Name	Session Name	Session Date
John Doe	Nutrition Counts	1:1 Session	Oct 1, 2014

The **Patient No Show report** provides the patient contact information (name, phone number and address) for patients that have been placed in No Show status within the attendance section of a group or 1:1 session. This report is able to be exported to an Excel spreadsheet.

Delta Report Pg. 1 of 3

The report first determines which patients within the program are to be included in the report.. If the user specifies a data range, the report reflects patients that have at least 1 attended educational session (1:1 or group) during the date range. **If no date range is specified, the report selects all non-deleted patients within the program.**

This is a report that reflects how a data point has changed. For patients' data to be aggregated in this report, the patient must have at least 2 documented entries with at least one follow up entry during the data period. For labs, the patient needs to have at least 2 values documented, at least 30 days apart. For goals, there needs to be at least a baseline and 1 goal review. For goals, there is no minimum requirement for how far apart the baseline and review is.

For each data point, for the first value (the "Pre"), the report takes the earliest documented value. This does not have to be during the data range if specified.

For the second value (the "Post"), if a data range was specified, the data must have been collected during this time..

If a date range is specified, the report finds the earliest documented, attended educational session within the date range and requires that the Post value is later than that date.

If a date range is not specified, the report just takes the last documented value.

On the next two pages you will find examples and descriptions of the data exported from the Delta Report.



Delta Report Pg. 2 of 3

Behavior Change Objectives

For the low, high and average:

- **# High:** this is the highest single value found.
- **# Average:** this is an average of all the values found.
- **# Low:** This is the lowest single value found.

Example:

Patient 1: Baseline 0% Assessment 75%
 Patient 2: Baseline 0% Assessment 50%
 Patient 3: Baseline 25% Assessment 100%

Goals	n		Pre	Post	Avg
		High	25	100	75
Nutritional Management	3	Avg	8.33	75	66.67
		Low	0	50	50

Pre Avg: All Baseline Results / # of Patients $(0 + 0 + 25 / 3 = 8.33\%)$

Post Avg: All Assessment Results / # of Patients $(75 + 50 + 100 / 3 = 75\%)$

Avg Degree of Change: All Degrees of change / # of patients $(75 + 50 + 75 / 3 = 66.67\%)$

Total # of Patients: Total number of patients with two or more results for the specific goal

Delta Report Pg. 3 of 3

Clinical and Lab Data

For the low, high and average:

- **# High:** this is the highest single value found.
- **# Average:** this is an average of all the values found.
- **# Low:** This is the lowest single value found.

Example:

Patient 1: Initial HbA1c 8.0% f/u HbA1c 7.0%
 Patient 2: Initial HbA1c 9.0% f/u HbA1c 7.5%
 Patient 3: Initial HbA1c 8.0% f/u HbA1c 6.5%

Labs			Pre	Post	Change
	n				
		High	9	7.5	1.5
A1c	3	<u>Avg</u>	8.33	7	1.33
		Low	8	6.5	1.5

Pre Avg: Sum of all initial HbA1c results / # of Patients ($8.0 + 9.0 + 8.0 / 3 = 8.33\%$)

Post Avg: Sum of all f/up HbA1c results / # of Patients ($7.0 + 7.5 + 6.5 / 3 = 7\%$)

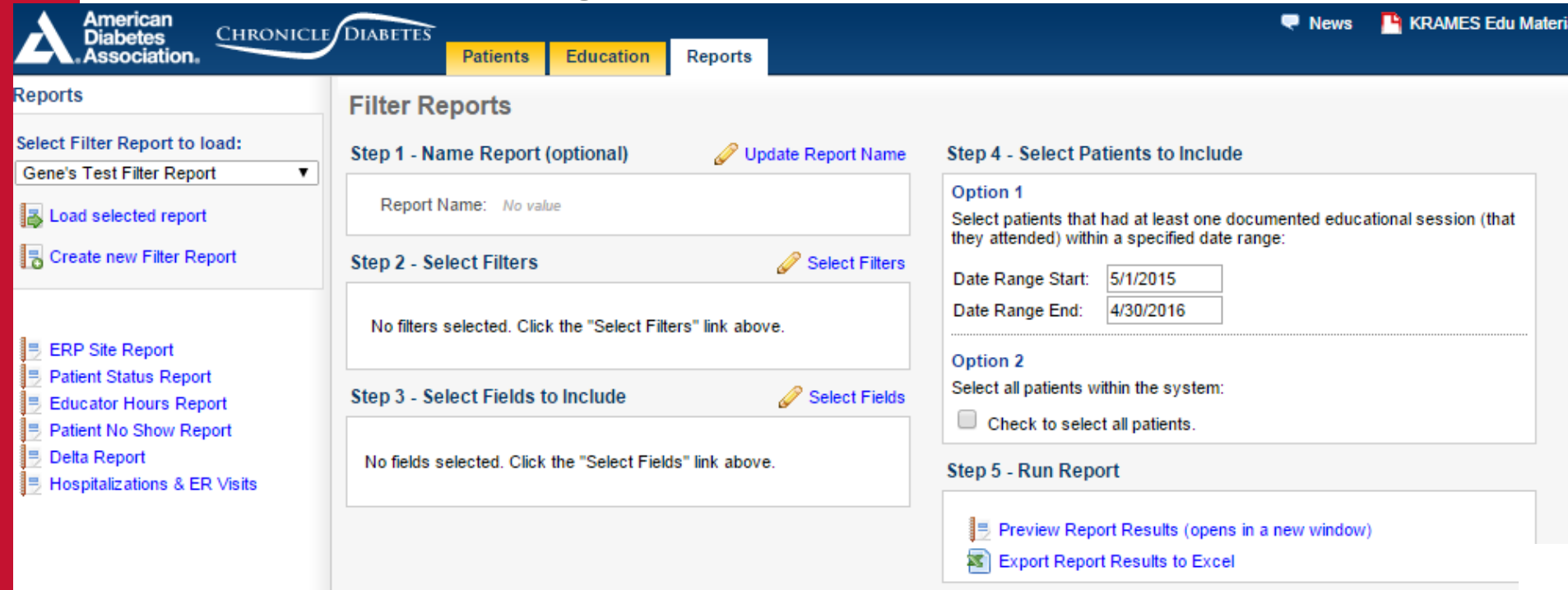
Avg Degree of Change: Sum of all HbA1c changes / # of patients ($1.0 + 1.5 + 1.5 / 3 = 1.33\%$)

Total # of Patients: Total number of patients with two or more results for the specific lab value.

ERP Filter Report *(Page 1 of 6)*

Filter Reports allow you to define exactly what data you would like to be generated by the system and how you would like to receive that data (on screen, exported, etc.). Each report will result in a table of data, like an Excel spreadsheet. You can save the reports that you created and to access them on the left is a dropdown that allows you to select an existing report to load. To load an existing report, select it from the dropdown and select the Click to load selected report link. You can also create a new report by selecting the Click to create new Filter Report link.

Creating a filter report has five steps



The screenshot shows the American Diabetes Association Chronicle Diabetes ERP interface. The top navigation bar includes the American Diabetes Association logo, the text "CHRONICLE DIABETES", and tabs for "Patients", "Education", and "Reports". The "Reports" tab is active. On the right side of the navigation bar, there are links for "News" and "KRAMES Edu Materi".

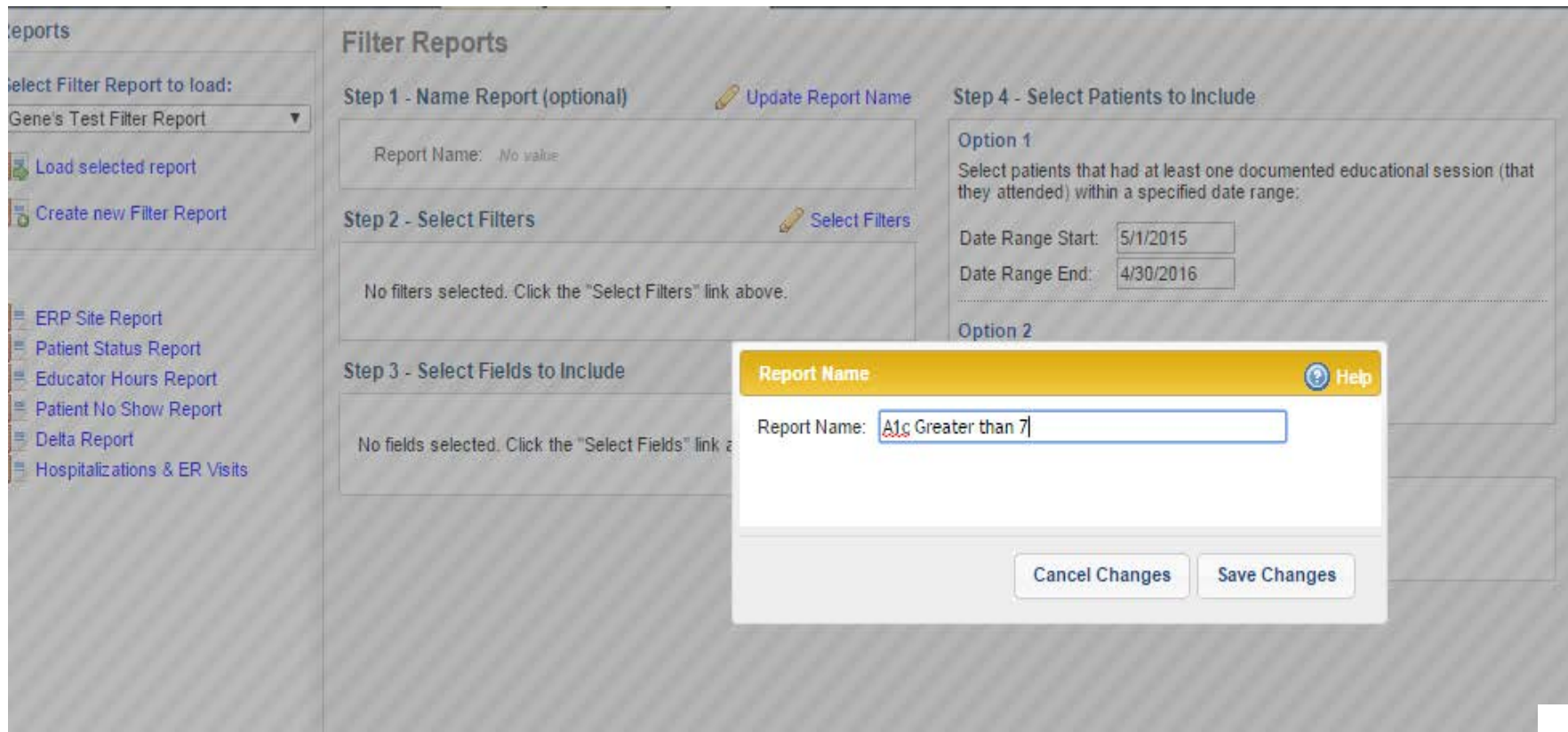
The main content area is titled "Filter Reports" and is divided into five steps:

- Step 1 - Name Report (optional)**: Includes a text input field for "Report Name" (currently "No value") and an "Update Report Name" link.
- Step 2 - Select Filters**: Includes a "Select Filters" link and a message: "No filters selected. Click the 'Select Filters' link above."
- Step 3 - Select Fields to Include**: Includes a "Select Fields" link and a message: "No fields selected. Click the 'Select Fields' link above."
- Step 4 - Select Patients to Include**: Includes two options:
 - Option 1**: "Select patients that had at least one documented educational session (that they attended) within a specified date range:" with input fields for "Date Range Start" (5/1/2015) and "Date Range End" (4/30/2016).
 - Option 2**: "Select all patients within the system:" with a checkbox labeled "Check to select all patients."
- Step 5 - Run Report**: Includes two links: "Preview Report Results (opens in a new window)" and "Export Report Results to Excel".

On the left side, there is a "Reports" sidebar with a dropdown menu "Select Filter Report to load:" currently showing "Gene's Test Filter Report". Below the dropdown are two links: "Load selected report" and "Create new Filter Report". At the bottom of the sidebar, there is a list of report types: ERP Site Report, Patient Status Report, Educator Hours Report, Patient No Show Report, Delta Report, and Hospitalizations & ER Visits.

Step 1 – Name the Filter Report (Page 2 of 6)

Give your report a name by clicking the Update Report Name link. Make the name short but descriptive. It must be unique (two reports cannot have the same name). The report name will be used to identify the report in the selection drop down box.



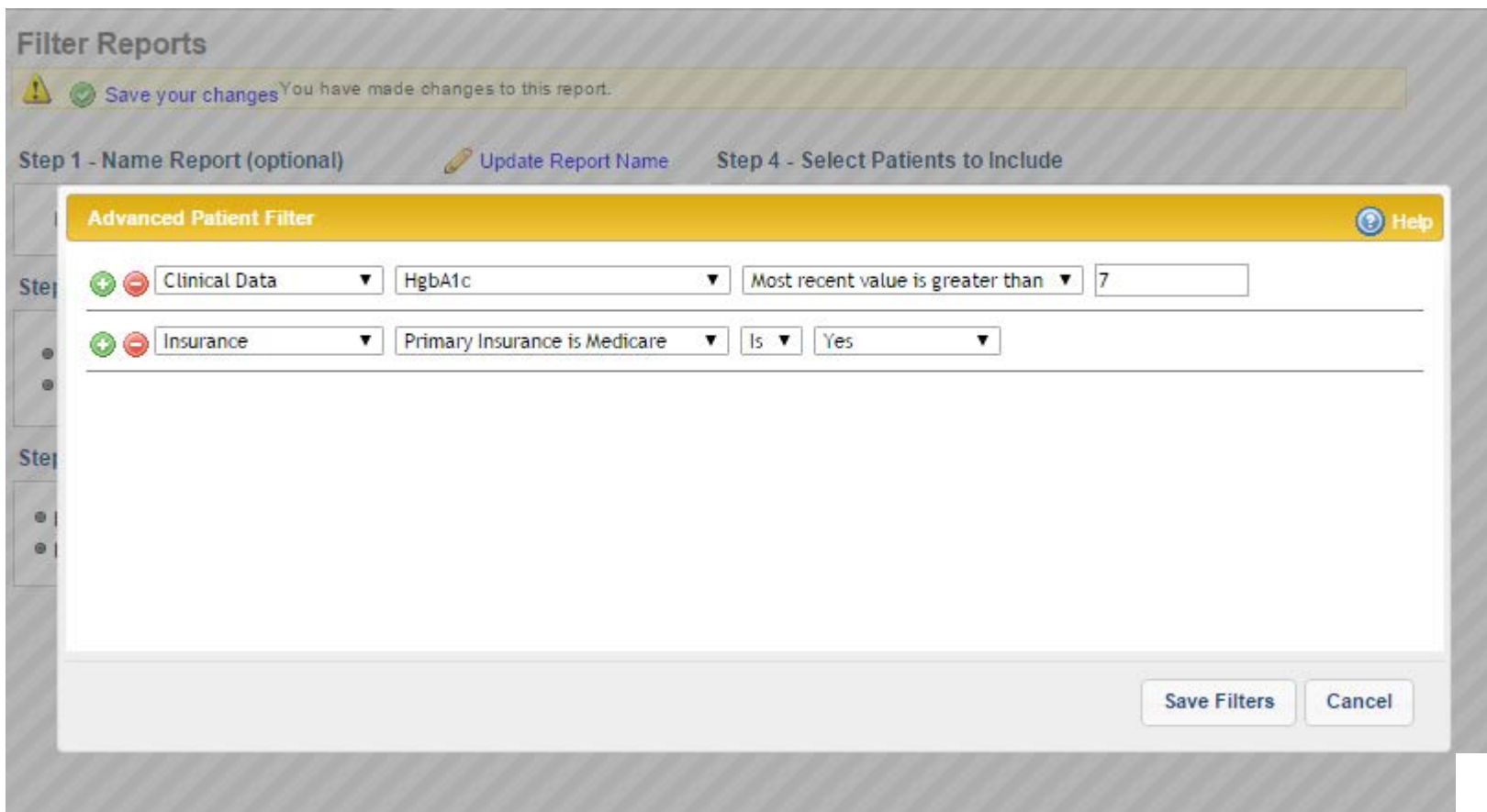
The screenshot displays the "Filter Reports" interface. On the left, a sidebar lists various reports, with "Gene's Test Filter Report" selected. The main area is divided into four steps:

- Step 1 - Name Report (optional)**: Includes an "Update Report Name" link and a text input field for the report name. The current name is "No value".
- Step 2 - Select Filters**: Includes a "Select Filters" link and a message: "No filters selected. Click the 'Select Filters' link above."
- Step 3 - Select Fields to Include**: Includes a "Select Fields" link and a message: "No fields selected. Click the 'Select Fields' link above."
- Step 4 - Select Patients to include**: Includes two options for patient selection and date range filters. Option 1 is selected, with "Date Range Start" set to 5/1/2015 and "Date Range End" set to 4/30/2016.

A modal dialog titled "Report Name" is open in the foreground, showing a text input field with the value "A1c Greater than 7". The dialog includes a "Help" icon, "Cancel Changes", and "Save Changes" buttons.

Step 2 – Select your Filter(s) *(Page 3 of 6)*

Select and configure the filters that you'd like to have used in the report. After clicking the Select Filters link, you can click the Help link in the Select Filters window for detailed information about setting up the report's filters. **For the example below, we would like to pull a report of all patients that have Medicare as their Primary Insurance and have a recent A1c value greater than 7.**



The screenshot shows the 'Filter Reports' interface. At the top, there is a yellow banner with a warning icon and the text 'Save your changes You have made changes to this report.' Below this, the interface is divided into four steps: 'Step 1 - Name Report (optional)', 'Update Report Name', 'Step 4 - Select Patients to Include', and 'Step 4 - Select Patients to Include'. The 'Advanced Patient Filter' dialog box is open, showing two filter rules. The first rule is for 'Clinical Data' with 'HgbA1c' selected, and the condition is 'Most recent value is greater than' with the value '7'. The second rule is for 'Insurance' with 'Primary Insurance is Medicare' selected, and the condition is 'Is' with the value 'Yes'. At the bottom right of the dialog box, there are two buttons: 'Save Filters' and 'Cancel'.

Filter Reports

Save your changes You have made changes to this report.

Step 1 - Name Report (optional) Update Report Name Step 4 - Select Patients to Include

Advanced Patient Filter Help

Step 1
Step 2
Step 3
Step 4

Clinical Data HgbA1c Most recent value is greater than 7

Insurance Primary Insurance is Medicare Is Yes

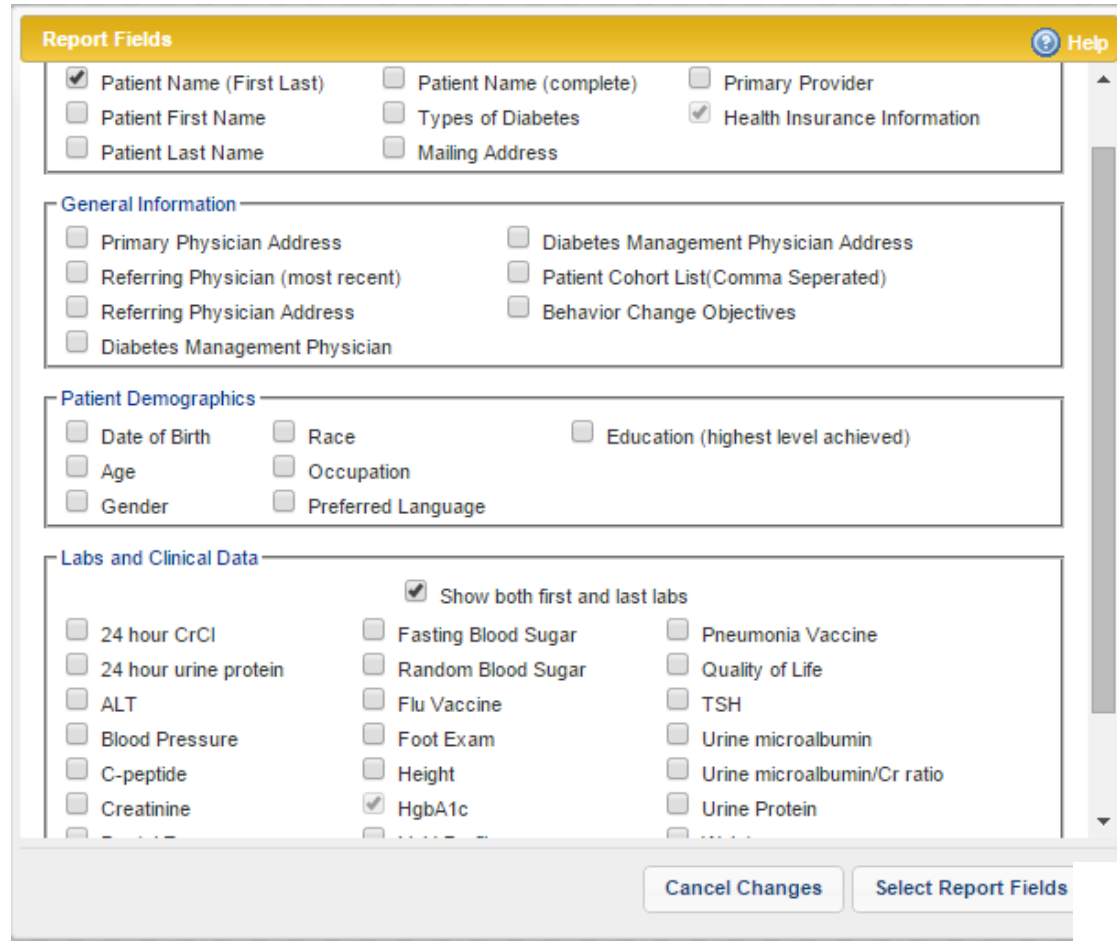
Save Filters Cancel

Step 3 – Select the Data You Would Like to Export *(Page 4 of 6)*

Step 3- Select what fields the data report should include. The report that is generated is like an Excel table, where each row is a patient record and each column is a field that you can select. After clicking the Select Fields link, you can click the Help link in the Select Fields window for detailed information about selecting the report's fields.

For this example we have selected the report to export the participants:

- First & Last Name
- Health Insurance Information
- Pre & Post A1c values



Report Fields Help

Patient Name (First Last)
 Patient Name (complete)
 Primary Provider
 Patient First Name
 Types of Diabetes
 Health Insurance Information
 Patient Last Name
 Mailing Address

General Information

Primary Physician Address
 Diabetes Management Physician Address
 Referring Physician (most recent)
 Patient Cohort List(Comma Separated)
 Referring Physician Address
 Behavior Change Objectives
 Diabetes Management Physician

Patient Demographics

Date of Birth
 Race
 Education (highest level achieved)
 Age
 Occupation
 Gender
 Preferred Language

Labs and Clinical Data

Show both first and last labs
 24 hour CrCl
 Fasting Blood Sugar
 Pneumonia Vaccine
 24 hour urine protein
 Random Blood Sugar
 Quality of Life
 ALT
 Flu Vaccine
 TSH
 Blood Pressure
 Foot Exam
 Urine microalbumin
 C-peptide
 Height
 Urine microalbumin/Cr ratio
 Creatinine
 HgbA1c
 Urine Protein

Step 4 – Select the Date Range (Page 5 of 6)

The report can be limited to only include patients that were seen during a specified date range (**Option 1**) or can include all patients (**Option 2**).

Note that if you are selecting a date range, the system will include every patient that has at least one educational session (1:1 or group) during that date range. The default range is within the last 12 months, but you can enter other ranges. Note that reports only include active (non-archived) patients.

Filter Reports

Step 1 - Name Report (optional) [Update Report Name](#)

Report Name: A1c Greater than 7

Step 4 - Select Patients to Include

Option 1
 Select patients that had at least one documented educational session (that they attended) within a specified date range:

Date Range Start:

Date Range End:

Option 2
 Select all patients with Check to select

Step 2 - Select Filters [Select Filters](#)

- HbA1c > 7
- This Primary Insurance is a Medicare Product = Yes

Step 5 - Run Report

[Preview Report](#)

[Export Report](#)

Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
						31

can

Step 5 – Export the Results (Page 6 of 6)

When all of the steps have been defined, select the Preview Report Results link. This will open a window showing the results of your report. Note that it may take a number of seconds for this window to open, depending on the complexity of the report. If you are pleased with the report, you can close the preview window and click the Export Report Results to Excel link. **Below you will find an example of the data exported for this example.**

A1c Greater than 7 - All Patients

Patient ID	Patient Name(Last, First)	Primary Insurance	Primary Insurance ID	Primary Insurance Group	This Primary Insurance is a Medicare Product	Secondary Insurance	Secondary Insurance ID	Secondary Insurance Group	This secondary Insurance is a Medicare Product	Other Insurance	Other Insurance ID	Other Insurance Group	This other Insurance is a Medicare Product	HbA1c	HgbA1c Test Date	HgbA1c (first value)	HgbA1c Date (first value)
287685	B, S	Medicare	00922115	Medicare	Yes									7.5	2016-04-07	8.0	2015-11-03

Helpful Tips

- **To pull a report for all patients within the system;** choose *General Information > Age > Is greater than > 0* (Step 2 Select Filters section).
- There is no limit to the number of filters you can apply to the report in (Step 2).



Hospitalization and Emergency Room Visit Report

The hospitalization & ER visit report allows you to see the change in the number of hospitalizations & ER visits that occurred prior to education versus post education. You can find the Hospitalizations & ER Visits report under the main Reports tab. This report can be limited to only include patients from a specific cohort or only from a specific provider by using the filters in the report configuration window. When you run this report, you can see the number of patients with a hospitalization & ER visit as well as the total count of hospitalizations & ER visits, and compare the numbers pre and post education to see the positive effect the education is having.

Hospital and ER Visits:

Patient Count	1yr Pre ed.			3 month follow-up			6 month follow-up		
	N	# had pre edu event	# had post edu event	% decrease	# had post edu event	% decrease	# had post edu event	% decrease	
Hospital Admissions not due to diabetes	2	0	0	-%	-	-%	-	-%	
Hospital Admissions due to diabetes	2	2	1	50%	-	-%	-	-%	
Emergency Room Visits not due to diabetes	1	1	0	-%	-	-%	-	-%	
Emergency Room Visits due to diabetes	2	2	1	50%	-	-%	-	-%	

Event Count	3 month follow-up			6 month follow-up			
	N	# events pre edu	# events post edu	% decrease	# events pre edu	# events post edu	% decrease
Hospital Admissions not due to diabetes	2	0	0	-%	0	-	-%
Hospital Admissions due to diabetes	2	2	1	50%	3	-	-%
Emergency Room Visits not due to diabetes	1	1	0	-%	1	-	-%
Emergency Room Visits due to diabetes	2	2	2	0%	5	-	-%

Report Guide

Pt must have had at least one education encounter or one behavioral outcomes or one other participant outcomes documented during reporting period.

If a patient has more than one follow up documented, but Hospitalizations / ER Visits are only documented for one of the follow ups, then the follow up with the Hospitalizations / ER Visits documented will be used for the calculation.

For a patient to be included in the report they must have a the hospitalization and ER visit question answered pre education and between 45 and 225 days post education.

If a patient has more than one follow up documented but Hospitalizations / ER Visits are documented for more than one of the follow ups, then the patient will be included in the calculation for each of the period sub-sections.

Follow up report inclusion guidelines:

Below guidelines are based on the date the data is entered in Chronicle.

3 month follow-up: 45 - 135 days after education completed date

6 month follow-up: 136 - 225 days after education completed date

Any follow up documented with a date that is before 45 days post-education or after 225 days post education will not be included in the calculations

Accessing Chronicle Diabetes (CD)

Program Coordinator(s):

- Staff member access to CD is assigned through the ERP Portal <https://erp.diabetes.org>
- The login credentials for each staff member will need to be sent manually to the appropriate staff member

Full setup instructions can be found at www.diabetes.org/erp under the Chronicle Diabetes tab.

Staff Members:

- The Program Coordinator will assign you access to CD and provide you with your login credentials
- Once you have been assigned login credentials, you can access CD through the link below:

Chronicle Login: <https://edu.chroniclediabetes.com>



**All of the Chronicle Resources below can
be found at www.diabetes.org/erp**

- Chronicle User Manual
- Chronicle Workbook
- Recorded Chronicle Webinar
- Chronicle Reports Guide
- Demo version of Chronicle
- Required Data for an Annual Status Report
- Required Data for an Application
- Chronicle Diabetes Assessment Form
- Chronicle Diabetes Assessment Form (Spanish)

For assistance with Chronicle Diabetes please contact ADA staff
at ERP@diabetes.org or 888-232-0822.