Programme de pratique factuelle sur le diabète de type 2

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Practice Assessment Form # 1 - Instructions

- Please complete **10 (ten)** Practice Assessment Forms (e-PAF) on patients that meet the eligibility criteria. The data that you enter can only be viewed by you and individual practice assessment form results will never be shared.
- Each e-PAF consists of **seven (7) pages** and should take between **10 – 20 minutes** to complete
- Once you have completed the entire page, click the **"Next"** button to proceed to the next page of the e-PAF. Clicking the **"Next"** button will automatically save the entries of the previous page (if entirely completed)
- To return to the previous page of the e-PAF, click the **"Back"** button. Please note that if you click the **"Back"** button before completing the page in its entirety you will lose the progress for the current page.
- **Once you have completed the e-PAF and click "Next" on Page 7, you can either:**
  - Click the **"Review"** button to return to Page 1 of the e-PAF to review your entries and/or make changes to your responses
  - Click the **"Submit"** button once you are satisfied with your responses and consider the e-PAF as final. Once the e-PAF is submitted, you will not be able to make changes to your responses but will be able to return and view you're the e-PAF in read-only format.
- The CHRC will remunerate you **$50.00** for each completed e-PAF.
- Download the **"Internal Patient Log"** to keep track of the pertinent information.

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Practice Assessment Form # 1 – Instructions

Adding a new e-PAF and Practice Assessment #1 Home Page

Click on this icon to create a new, blank e-PAF

ID	Practice Assessment Form	Feedback Form	Status	Scheduled Appointment Date	Measure Assessment Form	Feedback Form	Status
1			Completed	01/12/2015			Incomplete
2			Completed	31/12/2015			Incomplete
3			Completed	16/01/2016			Incomplete
4			Completed	31/12/2015			Incomplete
5			Completed	25/12/2015			Incomplete
6			Completed	24/12/2015			Incomplete
7			Completed	01/12/2015			Incomplete
8			Incomplete	01/12/2015			Incomplete

You can add up to 10 (ten) e-PAFs. A sequential numeric ID will be assigned to the e-PAF. To access the e-PAF click on the "Red File Folder" icon.

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Practice Assessment Form # 1 – Instructions

PAGE 1 - ELIGIBILITY

Pre-assigned sequential numeric ID. Displayed on every e-PAF page

1: Eligibility ID: 9

Internal Reference Number:

Next Scheduled Appointment:

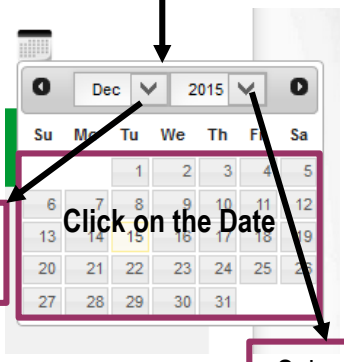
Enter an alpha, numeric or alpha-numeric Internal Reference ID that will assist you in identifying this patient. **PLEASE DO NOT ENTER THE PATIENT'S NAME OR ANY INFORMATION THAT COULD IDENTIFY THE PATIENT**

Click on the calendar icon to enter the next scheduled appointment date for this patient.

Eligibility Criteria: ALL of the criteria must be present

1. Male and female patients older than 18 years of age
2. Diagnosis of type 2 diabetes mellitus (CDA definition)
3. At least ONE prior diabetes related visit
4. Patient treated with at least ONE antihyperglycemic agent
5. Next diabetes related visit to occur within the next 3 – 6 weeks

Mouse over to view the definition



☐ **This patient satisfies all of the Eligibility Criteria**

Check the box to confirm that this patient meets all the eligibility criteria

Non-eligibility criteria: None of the criteria present

1. Clinically significant concomitant kidney (e.g., creatinine clearance < 30 ml / min) or liver (e.g., active hepatitis) disease
2. Contraindications or intolerance to combination therapy
3. Clinically significant concomitant illness or co-morbid condition

☐ **This patient does NOT meet any of the Non-Eligibility**

Check the box to confirm that this patient does NOT meet any of the Non-eligibility criteria

NEXT

Click **"NEXT"** to advance to page 2. The information entered will be saved but can still be modified

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Practice Assessment Form # 1 – Instructions

PAGE 2 – DEMOGRAPHICS AND GENERAL INFORMATION

2: Demographics and General Information ID: 9

Patient's Age: _____ years

Enter as a numeric value. No decimal places. **Accepted Range: 18-100** years

Gender: ● Male ● Female

Select ONE

Duration of Diabetes: Select one from the drop down menu

Ethnicity Select one from the drop down menu

Medication Coverage Select one from the drop down menu

Employment Status Select one from the drop down menu

Select a response for each from the drop down menu

Is this patient co-managed by any of the following?

Check ALL that APPLY or Select None of the Above	✓
Cardiologist	■
Diabetes Educator / Dietitian	■
Endocrinologist	■
General Internist	■
Nephrologist	■
Ophthalmologist	■
None of the Above	■

Check ALL that Apply **OR** Select "None of the Above"

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Practice Assessment Form # 1 – Instructions

PAGE 2 – DEMOGRAPHICS AND GENERAL INFORMATION

On average how many different types of medications (prescription and/or over the counter) does this patient take each day?

Select one from the drop down menu

On average how many different types of antihyperglycemic agents does this patient take each day specifically for diabetes?
(Fixed dose combination agents are considered 2 antihyperglycemic agents)

Select one from the drop down menu

In your opinion, on average how adherent is this patient with his/her current medications?

Select one from the drop down menu

Select a response for each from the drop down menu

How did you estimate medication adherence for this patient?

Check ALL that APPLY or Select "I did not evaluate adherence in this patient"	✓
I asked the patient / caregiver	☐
I obtained pharmacy renewal records	☐
I did a medication count	☐
I estimated / guessed	☐
I did not evaluate adherence in this patient	☐

Check ALL that Apply **OR**
Select "I did not evaluate adherence in this patient"

Have language barriers affected your ability to care for this patient?

- ○ No
- ○ Somewhat
- ○ Yes

Select ONE

BACK

Click **"BACK"** to return to page 1. To save your entries, complete the page in its entirety and click **"NEXT"** Please note that if you click the **"BACK"** button prior to following the above steps, you will lose the progress on the current page.

NEXT

Click **"NEXT"** to advance to page 3. The information entered will be saved but can still be modified

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Practice Assessment Form # 1 – Instructions

PAGE 3 – HISTORY, CO-MORBIDITIES AND PHYSICAL ASSESMENT

3: History, Co-Morbidities and Physical Assessment ID: 9

Smoking History: Select one from the drop down menu

Alcohol Intake: Select one from the drop down menu

Select a response for each from the drop down menu

If "Current Smoker" is selected from the drop down menu under "Smoking History", this question will be displayed

Was a cessation plan discussed in the past 12 months?

- Yes
- No
- Not Known

Select ONE

CO-MORBID CONDITIONS:

Check ALL applicable co-morbid conditions **OR** if none of the co-morbidities are present Select "None of the Above"

Check ALL that APPLY or Select None of the Above	✓
MICROVASCULAR	
Chronic Kidney Disease	
eGFR 45-59	☐
eGFR 30-44	☐
eGFR < 30	☐
Microalbuminuria	☐
Macroalbuminuria	☐
Retinopathy	☐
Neuropathy	☐
MACROVASCULAR	
Coronary Artery Disease	☐
Cerebrovascular Disease	☐
Abdominal Aortic Aneurysm	☐
Peripheral Arterial Disease	☐
LIVER DISEASE:	
Non-alcoholic fatty liver disease	☐
Non-alcoholic steatohepatitis	☐
Cirrhosis	☐
Other	☐

If applicable, select only ONE of the THREE

...CONTINUED

OTHER CO-MORBID	
Premature Family History of CV disease (1° relative - 55 yo/male, 65 yo/female)	☐
Modified Framingham Risk Score >20%	☐
Overweight / Obesity	☐
High-risk Hypertension	☐
Dyslipidemia	☐
Atrial Fibrillation	☐
Congestive Heart Failure	☐
Depression	☐
Cognitive Impairment	☐
Erectile Dysfunction	☐
Polycystic Ovary Syndrome	☐
Infertility	☐
Sleep Apnea	☐
Thyroid Disease	☐
Malignancy	☐
None of the Above	☐

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Practice Assessment Form # 1 – Instructions

PAGE 3 – HISTORY, CO-MORBIDITIES AND PHYSICAL ASSESMENT

PHYSICAL ASSESSMENT:

Heart Rate:		BPM		Not Available
Height:		cm	in	
Weight:		kg	lbs	
Waist Circumference:		cm	in	Not Available

Click **"BACK"** to return to page 2. To save your entries, complete the page in its entirety and click **"NEXT"** Please note that if you click the **"BACK"** button prior to following the above steps, you will lose the progress on the current page.

Click **"NEXT"** to advance to page 4. The information entered will be saved but can still be modified

Heart Rate:
Enter as a numeric value. No decimal places.
Accepted Range: 18-100 beats per minute (BPM)
Check the "**Not Available**" box if the Heart Rate measure is not available

Height:
Enter as a numeric value **AND** check **"cm"** for centimetres **OR "in"** for inches
Accepted Range: 100-230 cm **OR 39-90** in

Weight:
Enter as a numeric value **AND** check **"kg"** for kilograms **OR "lbs"** for pounds
Accepted Range: 30-300 kg **OR 66-660** lbs

Waist Circumference:
Enter as a numeric value. **AND** check **"cm"** for centimetres **OR "in"** for inches
Accepted Range: 60 – 150 cm **OR 22 - 55** in
Check the "**Not Available**" box if the Waist Circumference measure is not available

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Practice Assessment Form # 1 – Instructions

PAGE 4 – BLOOD PRESSURE PROFILE AND MANAGEMENT

4: Blood Pressure Profile and Management ID: 9

What is your Systolic Blood Pressure target for this patient: Select one from the drop down

What is your Diastolic Blood Pressure target for this patient: Select one from the drop down

Select **your** target for this patient's SBP & DBP from the drop down menus

	Systolic		Diastolic	
Blood Pressure at last visit:		mmHg		mmHg

Enter the most current SBP and DBP as numeric values. No decimal places.

Accepted Ranges:

- **SBP: 60-250** mmHg
- **DBP: 30-150** mmHg

Blood Pressure Therapy:

Check ALL that APPLY or Select "None of the Above"	✓
α-blocker	☐
ACE Inhibitor	☐
ARB	☐
Beta Blocker	☐
Calcium Channel Blocker	☐
Diuretic	☐
Combination Therapy	
ACE Inhibitor + Diuretic	☐
ARB + Diuretic	☐
Beta Blocker + Diuretic	☐
Calcium Channel Blocker + ARB	☐
None of the Above	☐

Check ALL applicable current (last recorded) Blood Pressure Therapies **OR** Select "None of the Above" if the patient is not currently treated with any Blood Pressure Therapy

BACK

Click **"BACK"** to return to page 3. To save your entries, complete the page in its entirety and click **"NEXT"** Please note that if you click the **"BACK"** button prior to following the above steps, you will lose the progress on the current page.

NEXT

Click **"NEXT"** to advance to page 5. The information entered will be saved but can still be modified

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Practice Assessment Form # 1 – Instructions

PAGE 5 – LIPID PROFILE AND MANAGEMENT

5: Lipid Profile and Management ID: 9

What is your LDL-C target for this patient: Select one from the drop down menu

Select **your** target for this patient's LDL-C from the drop down menu

Has this patient had his/her lipid levels checked within the past 12 months?

○ Yes ○ No

Select ONE

Record values exactly as they appear in the lab report. Include decimal places where applicable

Total Cholesterol:		mmol/L
LDL-C:		mmol/L
HDL-C:		mmol/L
Non HDL-C:		mmol/L
Triglycerides:		mmol/L

Enter the most current labs as numeric values. Record values exactly as they appear in the lab report and include decimal places where applicable

Accepted Ranges:

- **Total Cholesterol: 1.0 – 10.0** mmol/L
- **LDL-C: 1.0 – 10.0** mmol/L
- **HDL-C: 0.1 – 5.0** mmol/L
- **Non HDL-C: automatically calculated as following: Total Cholesterol minus HDL-C = Non HDL-C**
- **Triglycerides: 0.1 – 10.0** mmol/L

Lipid Modifying Therapy:

Check ALL that APPLY or Select "None of the Above"	✓
Statin	☐
Bile Acid Sequestrant	☐
Ezetimibe	☐
Fibrate	☐
Niacin	☐
PCSK9 Inhibitor	☐
None of the Above	☐

Check ALL applicable current (last recorded) Lipid Modifying Therapies **OR** Select "None of the Above" if the patient is not currently treated with any Lipid Modifying Therapy

BACK

Click **"BACK"** to return to page 4. To save your entries, complete the page in its entirety and click **"NEXT"** Please note that if you click the **"BACK"** button prior to following the above steps, you will lose the progress on the current page.

NEXT

Click **"NEXT"** to advance to page 6. The information entered will be saved but can still be modified

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Practice Assessment Form # 1 – Instructions

PAGE 6 – GLYCEMIC PROFILE AND MANAGEMENT

6: Glycemic Profile and Management ID: 9

What is your A1C target for this patient: Select one from the drop down menu

Select **your** target for this patient's A1C from the drop down menu

Has this patient had his/her A1C checked within the past 6 months?

● Yes ● No

Select ONE

Record values exactly as they appear in the lab report. Include decimal places where applicable

A1C: ____ %

FPG: ____ mmol/L ■ **Not Available**

Enter the most current labs as numeric values. Record values exactly as they appear in the lab report and include decimal places where applicable

Accepted Ranges:

- **A1C: 5.0 – 12.0** %
- **FPG: 3.0 – 12.0** mmol/L **OR** Check the **"Not Available"** box if the FPG value is not available

Please select ALL applicable reason(s) for selecting an A1C target of >7.0% for this patient?

Check ALL that APPLY or Select "None of the Above"	✓
Limited life expectancy	■
High level of functional dependancy	■
Extensive coronary artery disease / at high risk of ischemic events	■
Multiple co-morbidities	■
History of recurrent severe hypoglycemia	■
Hypoglycemia unawareness	■
Longstanding diabetes: Difficult to achieve A1C ≤ 7.0%, despite effective doses of multiple antihyperglycemic agents, including intensified basal-bolus insulin therapy	■
Target is based on my clinical judgement	■
None of the Above	■

If an A1C target of <7.0% is selected from the drop down menu under "What is your A1C target for this patient", this box will be displayed.

- Check ALL that apply or Select "None of the Above"

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Practice Assessment Form # 1 – Instructions

PAGE 6 – GLYCEMIC PROFILE AND MANAGEMENT

Was this patient referred to or counselled by a certified diabetes educator / recognized diabetes program for disease state management education?

Select one from the drop down menu

Has this patient followed a diet plan in the last 12 months?

Select one from the drop down menu

Physical Activity:

Select one from the drop down menu

Was this patient given a written exercise plan with measurable goals in the last 12 months?

Select one from the drop down menu

Was a comprehensive foot exam performed within the past 12 months?

Select one from the drop down menu

Has this patient been referred for an eye exam within the past 12 months?

Select one from the drop down menu

Have you recommended Self Monitoring of Blood Glucose (SMBG) to this patient?

Select one from the drop down menu

Select a response for each from the drop down menu

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Practice Assessment Form # 1 – Instructions

PAGE 6 – GLYCEMIC PROFILE AND MANAGEMENT

Was a comprehensive foot exam performed within the past 12 months?

Yes

Foot Exam Finding:

Select one from the drop down menu

Has this patient been referred for an eye exam within the past 12 months?

Yes

Eye Exam Finding:

Select one from the drop down menu

Have you recommended Self Monitoring of Blood Glucose (SMBG) to this patient?

Yes

Did you review the SMBG results with the patient at the last diabetes related visit?

Select one from the drop down menu

If the response is "Yes" to any of these questions, additional questions will be displayed below.

Select a response from the drop down menu

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Practice Assessment Form # 1 – Instructions

PAGE 6 – GLYCEMIC PROFILE AND MANAGEMENT

Antihyperglycemic Therapy:

Check ALL that APPLY (At least ONE must be Selected)	
α-Glucosidase Inhibitor	☐
DPP-4 Inhibitor	☐
GLP-1 Receptor Agonist	☐
Insulin	☐
Meglitinide	☐
Metformin	☐
Metformin + DPP4 Inhibitor Fixed Dose Combination	☐
SGLT2 Inhibitor	☐
Sulfonylurea	☐
Thiazolidinedione	☐

Check ALL applicable current (last recorded) Antihyperglycemic Therapies.

The patient must be treated with AT LEAST ONE antihyperglycemic agent as per the eligibility criteria.

Insulin Regimen:

Select one from the drop down n

Did you provide this patient with "Sick Day Instructions":

Select one from the drop down menu

If "Insulin" is selected in the "Antihyperglycemic Therapy" box, these two questions will be displayed below.

Select a response for each question from the drop down menu

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Practice Assessment Form # 1 – Instructions

PAGE 6 – GLYCEMIC PROFILE AND MANAGEMENT

Have any of the following hypoglycemia related events occurred in the past 12 months:

Check ALL that APPLY or Select "No Discussion or Evidence of Hypoglycemia"	✓
Patient reported hypoglycemia episodes	☐
Evidence of hypoglycemia in patient's blood glucose log	☐
Patient required paramedic or emergency room visit	☐
No discussion or evidence of hypoglycemia	☐

Check ALL that Apply **OR** Select "No discussion or evidence of hypoglycemia"

Click **"BACK"** to return to page 5. To save your entries, complete the page in its entirety and click **"NEXT"** Please note that if you click the **"BACK"** button prior to following the above steps, you will lose the progress on the current page.

Click **"NEXT"** to advance to page 7. The information entered will be saved but can still be modified

Hypoglycemia: What action(s) did you take?

Check ALL that APPLY or Select "No Action Taken"	✓
Adjusted current therapy	☐
Discussed role of exercise on hypoglycemia	☐
Discussed nutrition therapy to manage and/or prevent hypoglycemia	☐
Provided written hypoglycemia management plan	☐
No action taken	☐

If any response(s) other than "No discussion or evidence of hypoglycemia" is selected, this box will be displayed.

Check ALL that Apply or Select "No action taken"

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Practice Assessment Form # 1 – Instructions

PAGE 7 – Additional Lab Values and Medications

7: Additional Lab Values and Medications ID: 9

Record values exactly as they appear in the lab report. Include decimal places where applicable

Creatinine:		µmol/L	Not Available
e-GFR:		mL/min	Not Available
ACR:		mg/mmol	Not Available

Enter the most current additional labs as numeric values. Record values exactly as they appear in the lab report and include decimal places where applicable

Accepted Ranges:

- **Creatinine: 5 – 150** µmol/L **OR** Check the **"Not Available"** box if the Creatinine value is not available
- **e-GFR: 29 – 150** mL/min **OR** Check the **"Not Available"** box if the e-GFR value is not available
- **ACR: 1-50** mg/mmol **OR** Check the **"Not Available"** box if the ACR value is not available

Other Medications:

Check ALL that APPLY or Select "None of the Above"	✓
Antidepressant	
ASA	
Other Antiplatelet Agent	
Erectile Dysfunction Treatment	
NSAID / Cox Inhibitor	
PPI / H_2 Blocker	
Smoking Cessation Agent	
Vitamins / Supplements	
Warfarin	
New Oral Anticoagulant	
None of the Above	

Check ALL applicable current (last recorded) Other Medications **OR** Select "None of the Above" if the patient is not currently treated with any of the listed medications.

Click **"BACK"** to return to page 6. To save your entries, complete the page in its entirety and click **"NEXT"** Please note that if you click the **"BACK"** button prior to following the above steps, you will lose the progress on the current page.

Click **"NEXT"** to advance. This is the LAST page of the e-PAF. Once you click **"NEXT",** you will be able to either **"REVIEW"** or **"SUBMIT"** the e-PAF

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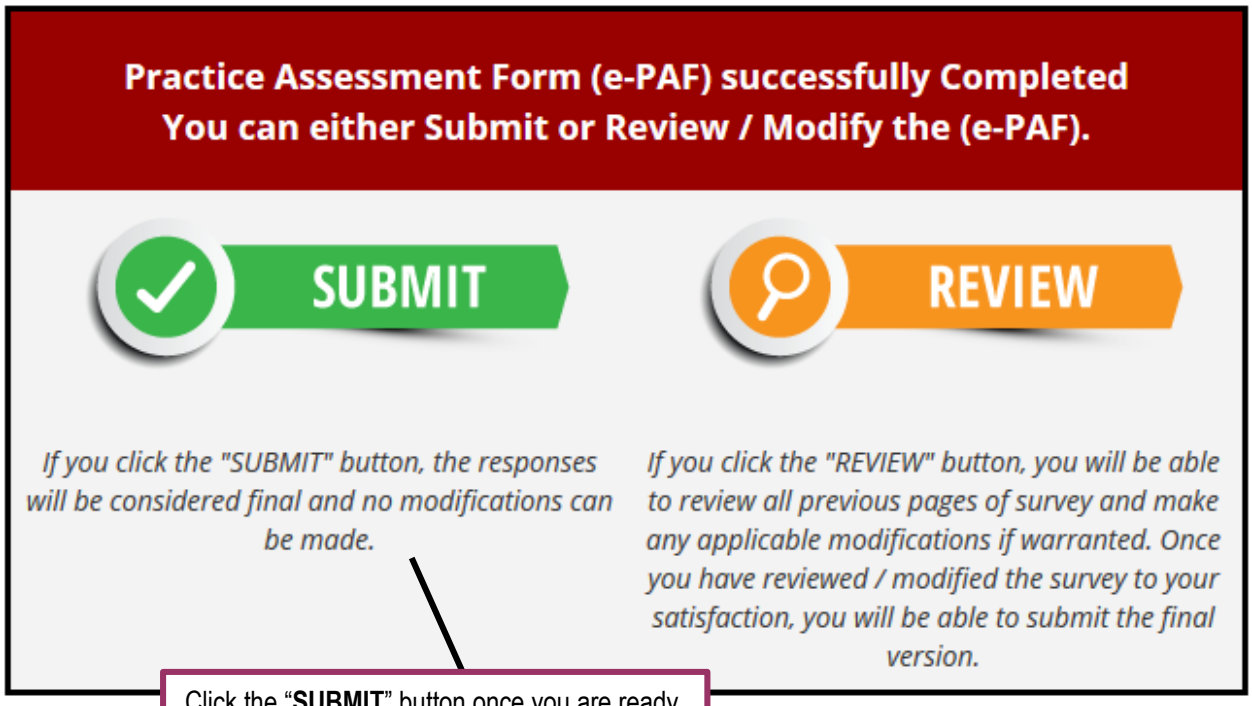
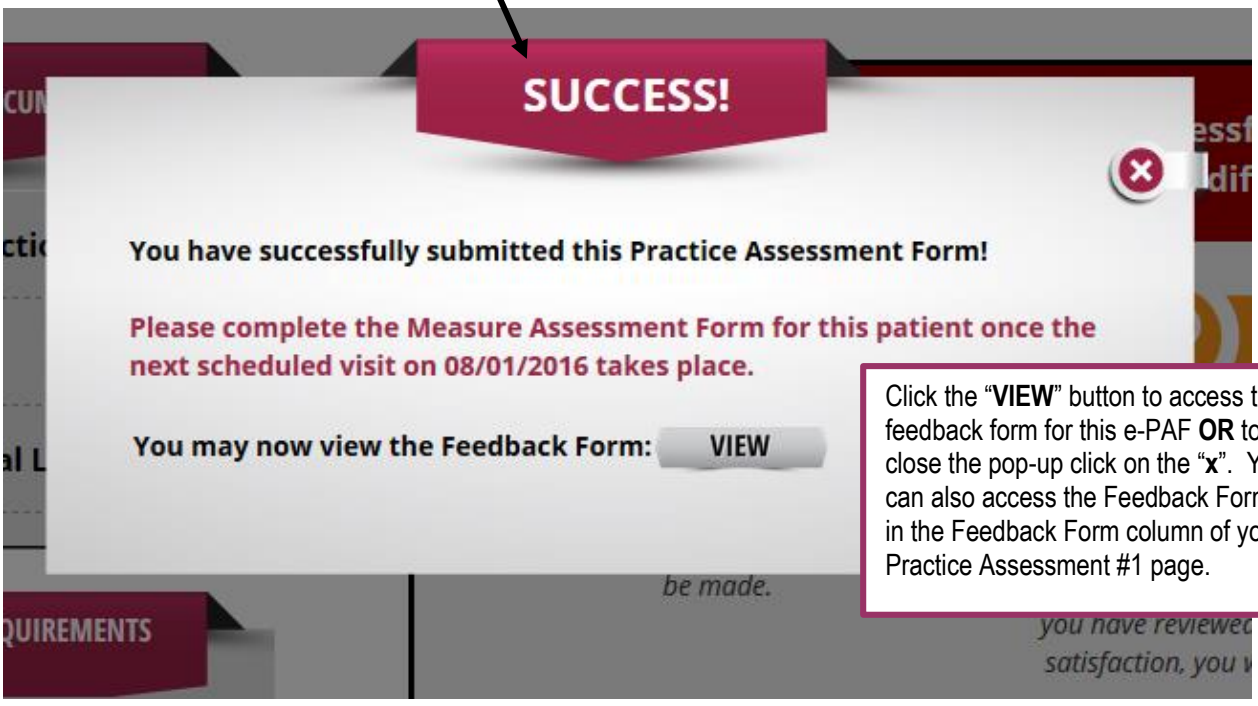
Practice Assessment Form # 1 – Instructions

REVIEWING AND SUBMITTING the e-PAF



Click the "**SUBMIT**" button once you are ready to submit the e-PAF.



Click the "**VIEW**" button to access the feedback form for this e-PAF **OR** to close the pop-up click on the "**x**". You can also access the Feedback Form in the Feedback Form column of your Practice Assessment #1 page.

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Practice Assessment #1 – Home Page

ID	Practice Assessment Form	Feedback Form	Status	Scheduled Appointment Date	Measure Assessment Form	Feedback Form	Status
1			Completed	01/12/2015			Incomplete
2			Completed	31/12/2015			Incomplete
3			Completed	16/01/2016			Incomplete
4			Completed	31/12/2015			Incomplete
5			Completed	25/12/2015			Incomplete
6			Completed	24/12/2015			Incomplete
7			Completed	01/12/2015			Incomplete
8			Incomplete	01/12/2015			Incomplete
9			Completed	08/01/2016			Incomplete

The file folder icon changed from red to green. You can click on the **"Green File Folder"** icon to view the submitted e-PAF.

The feedback form icon icon changed from grey to green. You can click on the **"Green Feedback"** icon to view the Feedback Form.

Next scheduled appointment date

The file folder icon changed from grey to red. You can access and complete the measure assessment form once the next scheduled appointment date takes place