

Patient Record Eligibility Criteria

1. A record from a repeat visitor to the Diabetes Care and Research Program ambulatory clinic assessed with the help of the diabetes CDMS between Jan 1st 2011 and April 1st 2011.
2. Record should have second most recent entry created between June 1st 2009 and June 1st 2010 in a usual care (non-CDMS) visit.

1. Sequentially identify 10 eligible patient records per provider beginning with those that contain most recent entries.

IN EACH RECORD:

3. Abstract data from entries generated in a past usual care encounter.

2. Abstract data from entries generated in a CDMS-assisted encounter.

June 1st 2009 and June 1st 2010

Jan 1st 2011 and April 1st 2011

Usual
Care

Transcript of
dictation
and attached
lab results

4. COMPARE

CDMS chart

CDMS

Transcript of
dictation and
attached lab
results

if missing ACEi/ARB or statin and no corresponding value for BP, LDL-C, or UACR present, then check Meditech and office chart for LDL-C or UACR

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Comparison 1: CDMS chart + CDMS-assisted transcript of dictation VS usual care transcript of dictation.

Comparison 2: CDMS-associated transcript of dictation VS usual care transcript of dictation.

Outcome: Number of the following diabetes metrics recorded: weight, blood pressure, use of ACE inhibitor (if appropriate), use of statin (if appropriate), HbA1c, serum creatinine, LDL cholesterol, urine albumin to creatinine ratio, eye examination within the past year, foot examination within the past year, severe hypoglycemic episodes, non-severe hypoglycemic episodes per month, CV event since last visit, perfusion of feet, light touch sensation in feet, and integrity of skin on feet.