DCPNS Registry Reports (2023)

Primary Health Care and
Chronic Disease Management
Diabetes Care Program of Nova Scotia

1. Introduction

The DCPNS Registry (Diabetes Information Management System) has been developed, enhanced, and is maintained by DCPNS IMIT staff. All Nova Scotia Diabetes Centres (DCs) contribute data to the DCPNS Registry.

- Diabetes Centres use the Registry to generate daily/monthly statistics and to collect longitudinal data on their patient populations. *Note: fiscal year end reports are provided by the DCPNS to allow zone and provincial comparisons*.
- The DCPNS website (under Reports) hosts information derived from the Registry.
- Additionally, a series of reports can be generated locally by Registry users to increase usefulness of data within the DC. Broadly, these can be categorized into data quality reports, post-visit reports and letters, and quality improvement reports, and are described below.
- Technical support and assistance with the Registry are provided through the DCPNS.
- Users of the Registry must be approved by the DC Manager. Process for obtaining new user access:
  - A formal request is made to the DCPNS Manager or DCPNS IMIT staff.
  - A confidentiality agreement must be reviewed, signed, and returned by the new user to the DCPNS before access is granted.
  - Users must attend mandatory Registry training sessions offered by the DCPNS
  - Users are responsible for protecting patient information by ensuring restricted access to the Registry and treating all patient information as confidential.
  - The DCPNS must be notified when a staff person leaves the DC as future access to the Registry is prohibited.
- See DCPNS Registry Description for further information on the Registry (purpose, access, information collected).

2. Data Quality Reports

i. SUMMARY OF VISITS

Purpose:

- To allow comparison of data entered into the DCPNS Registry to the DC appointment schedule. This provides a means to ensure that no one has been missed or misclassified as well as to ensure visits from Meditech/Star/Meditech Magic have been confirmed prior to running the month-end report.

Points to remember:

- Ensure insulin starts (SI); pump start (PSI); continuous glucose monitoring (CGM) entries are not forgotten.
- If run regularly (daily, weekly, bi-weekly, etc.), missing information will be identified earlier; and time can be saved when the month-end report is generated.

ii. MONTHLY STATS

Purpose:

- To provide a summary of patient visits by diabetes type (type 1, type 2, GDM, etc.), area of contact (outpatient, inpatient, and telephone), and age grouping (adult and youth [< age 19]). This replaces the need for the manual collection of daily visit information.

Data requirements:

- DoB; visit date; and type of visit, DM, and treatment as well as confirmation of visits transferred from Meditech/Star/Meditech Magic.

Points to remember:

- An exception report will provide a list of entries requiring additional information, including visits transferred from Meditech that have not been confirmed.
- Monthly Stats report cannot be printed until all required fields have been completed.
- Monthly Stats report should be generated routinely, not only at the year-end, to ensure data completeness and the correction of an exceptions, if needed.
- Changes made to visits following the generation of the Monthly Stats report require the DC to generate a new report for that month.
- Allows reporting on multiple sites; combining satellites as one; combining satellites and/or main site(s).

iii. ACTIVE PATIENT LIST – Visit within specified 2-year period (*including ability to run patient labels*)

Purpose:

- To electronically generate a list of active patients seen by DC staff (i.e., the past 2-years) at the time of report generation, by location (municipality/community).
- This report assists with planning service delivery. For example, it can help to determine if there is a large enough active population in a specific community that would support a satellite/community.
- It also provides a grand total count and subtotals by municipality and community.

Points to remember:

- This report can be used to indicate those patients actively seen in the DC as a percentage (%) of total patients ever referred (total active + inactive cases = total patients ever referred).
- This report also indicates if an individual has been discharged or transitioned during the specified time period. Discharged and transitioned grand totals are also provided.

iv. INACTIVE PATIENT LIST – No visit within specified period of time (i.e., 2 years)

Purpose:

- To electronically generate a list of patients not seen by DC staff in the past 2-years. It also provides a grand total count. This report can be used to identify patients for future contact purposes.

3. Post-visit Reports and Letters

i. PROVIDER REPORT

Purpose:

- To provide a report to the physician/NP following the patient visit to the DC. This report retrieves data from the demographic, visit, and indicators sections of the Registry.
- It also allows for the recording of a brief narrative note to highlight patient progress and recommendations for action/reinforcement. This report can provide up to four of the most recent dates for laboratory testing.

Data Requirements:

- Mandatory: Physician name and patient name
- Required:
  - **Demographic:** HCN, sex, and DoB
  - **Visit:** Date, visit type, and treatment type
  - **IOC:** Weight, height, BP, DM meds, meal plan, foot assessment, lab data, comments

Points to Remember:

- If the physician names are not entered in the Registry correctly, the report cannot be printed.
- Comments for inclusion in the report should have been entered in the IOC section of the Registry (Comments Tab). Try to keep comments short (~ 10 lines, but there is unlimited space if needed).
- If data for the report is missing in the Registry, these areas on the report will be left blank.

ii. DISCHARGE LETTERS

Purpose:

- To provide standardized letters to the patient and family physician/NP about an individual's discharge from the DC.
  - The letter for the patient reinforces where to access reliable diabetes information (Diabetes Canada website), reminds them of the screenings/assessments should be conducted routinely, and when and how re-referral should be made back to the DC.
  - The letter to the family physician/NP indicates the individual's discharge date, reinforces annual diabetes screenings/assessment that should be done, and when and how re-referral should be made back to the DC.

Data Requirements:

- Mandatory Family physician/NP name and patient name mandatory
- Required **Visit:** Selection of "Discharged" in the Discharge/Transition tab

Points to Remember:

- If the discharge date is not entered, the letters cannot be generated/ printed.

iii. TRANSITION LETTERS – IN DEVELOPMENT

Purpose:

- Similar to the Discharge Letters. There will be a letter for the transitioning youth/young adult, and a letter for the family physician/NP.

iv. Lab Graphs

Purpose:

- To facilitate patient education/self-management education.
- These graphs can be produced for viewing on the computer screen and printed for specific individuals during the visit or any time thereafter.

***Data Requirements*:**

- Required: **IOC:** Lab data (e.g., A1C, lipids, eGFR, etc.) and visit measures (e.g., wt, BMI, BP, MVPA)

4. Quality Improvement Reports

i. PHYSICIAN/NURSE PRACTITIONER PATIENT LIST

Purpose:

- To provide a **confidential** report to the referring physician on the patients seen by the DC during a specified period of time (i.e., past 12 months). This includes date of last DC visit as well as last recorded BP, A1C, and lipid results (Total Cholesterol [TC], HDL, TC:HDL, LDL, and TG).
- This report should be generated annually (or as preferred by the provider) and provided in confidence to the referring physician/NP.
- A letter that explains the report purpose and intent and invites discussion/dialogue about patients, as needed, accompanies this report.

Data Requirements:

- Mandatory: Family physician/NP name and patient name
- Required: **Demographic:** Sex and DoB
  Visit: Visit date within specified period; DM type
  IOC: BP, A1C, and lipids

Points to Remember:

- If the physician/NP name is not entered in the Registry correctly, the report cannot be printed.
- The report should not be sent without a letter of explanation (see attached sample).

ii. ADVANCED CLINICAL INDICATOR REPORT (*including ability to run patient labels*)

Purpose:

- To provide the DC with a quick query tool to identify individuals (by specific visit type –Follow-up or New Referral) with specific indicator values (from 1 to 4 indicators at one time); e.g., A1C > 8.4%, BP > 140/90; eGFR < 30 mL/min, foot assessments completed, etc., during a specified period of time, on a specific patient population (the population can be selected by diabetes type [type 1, 2, pregnant, or prediabetes], age, and gender). This is a very useful quality assurance tool.

Data Requirements: Required **Demographic:** HCN, patient name, sex, and DoB
Visit: Physician name, visit type, and type of DM
IOC: Weight, height, BP, foot assessment, and lab data

Points to Remember:

- BMI calculations are dependent on other values, i.e., ht. and wt.; without these values the BMI cannot be reported.

New Referrals (NR)—Time to First Appointment

Purpose:

- To provide the DC with time to first appointment for all new referrals (newly diagnosed [ND], not-newly diagnosed [NND], and re-referrals [NND-R]). For the NDs, time from diagnosis to first visit is also provided. *Note: this information (time from diagnosis to referral) is not as meaningful for the NND and NND-R patients as for many the diagnosis date can be many years ago.*
- In addition to the time (provided in days), the most recent A1C associated with the NR (up to 120 days prior to the NR visit) visit is also provided. This can be used with the Triage Criteria to see if the criteria are being met.
- This is a very useful quality assurance tool to start local conversations. There may be many reasons why the time between referral and first visit is longer than expected, e.g., patient cancels/rebooks, the dates/times offered are not acceptable, staff vacation/leaves, etc.

Data Requirements:	Mandatory	**Visit:**	Type of visit (ND, NND, NND-R) Diagnosis date, referral date, and 1st visit date
		IOC:	A1C

Points to Remember:

- Local context is important to interpret/understand the reported numbers. Time from diagnosis to referral may also reflect patient preference, referring provider practice, etc. This could demonstrate/reinforce the need for communication/messaging around the timeliness of initial/foundational diabetes education, the services provided by the DC/usual wait times for specific patient types, etc.
- Allows reporting on many sites.

iii. Unattached Patient List

Purpose:

- To provide the DC with a list of patients during a specified period of time, and on their last visit within, who **did not have a family physician or NP recorded** (making them "unattached").
- Some unattached patients do have a referring provider and/or specialist physician recorded in the Registry; this information is also provided on the report (3 columns – 1. no MD/NP of any kind; 2. with **referring** MD/NP noted; 3. with **specialist** MD noted).

  Note: If there was an error in recording family, referring, or specialist physician, this can be corrected locally.
- This report also allows for labels to be generated for the select patient population. This would be useful if providing a specific service to your unattached patients (GMV, access to an NP for reordering of prescriptions, etc.).

Data Requirements:	Mandatory	Family physician/NP name
	Required	**Visit:** Type of visit (ND, NND, NND-R, FUV); DM type, etc.

Points to Remember:

- Recording Family physician/NP, as well as specialist physicians, in the appropriate areas (family, referring, and specialist) is very important to help ensure this report is as useful/accurate as possible.
- Allows reporting on many sites.

iv. Discharge / Transition Patient List

Purpose:

- To provide the DC with a list of patients who had one or more discharges/transitions in the specified time period. The most recent discharge/transition of each type is included for each patient; therefore, a patient may be listed more than once, but never more than once for each type.

Data Requirements:	Mandatory:	**Visit:** Discharge or Transition.
	Required:	**Visit:** DM type, etc. **IOC***:* A1C

Points to Remember:

- Allows reporting on many sites.

5. Other

i. Standard reports

- The DCPNS generates the following standard reports for each DC:
  a) **Fiscal year-end package** with provincial stats, Form A (FTEs and visit type by DC - % of provincial total), Form B (FTEs & visit type by DC - % of DC total), Summary of Visits, and Insulin and Insulin Pump Starts.
  b) **Follow-up Indicator Report**, provided on the **follow-up, adult population**, with:
    - A description of the population (age, sex, BMI),
    - The number of visits by diabetes treatment type, and
    - Specific indicator data (blood pressure, A1C, ratio TC:HDL-C, LDL-C, triglycerides, creatinine, eGFR , etc.
  - This report is provided by zone (individual DC within) and provides provincial comparators.

ii. Custom reports

- Other data can be requested from the DCPNS using the **DCPNS Data Request Intake Form**.

iii. Patient Labels

- As well as being able to print labels for any patient, most reports have label printing functionality.
- Users have found this to support solutions not solely as patient labels. For example, for cross-referencing purposes as a label will not be produced for a patient marked as deceased.