COPD Toolset: Care Plan and Dashboard
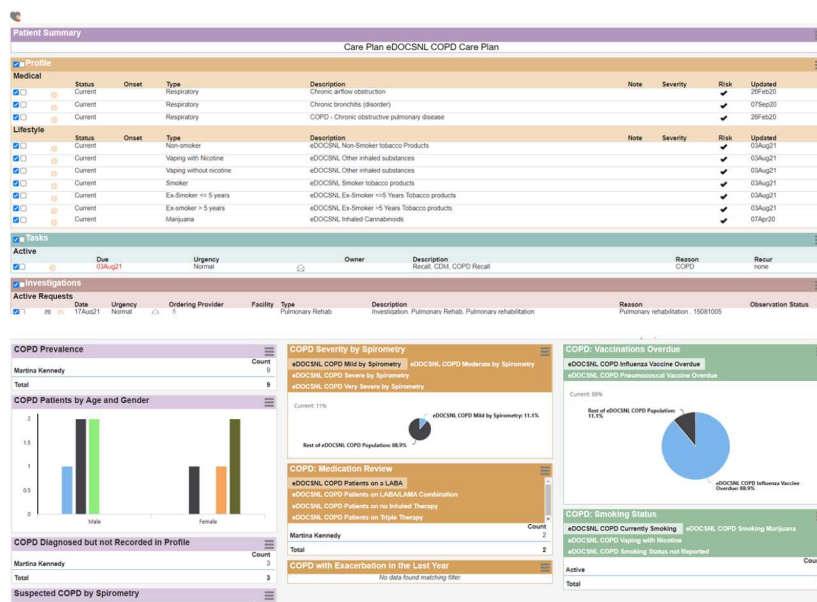
- Hello and thanks for reviewing this presentation for an exploration of the eDOCSNL Practice 360: COPD Smart Tools for Care.
- Practice 360 is an ongoing eDOCSNL initiative designed to increase clinical value and practice efficiencies in the Med Access EMR for users in Newfoundland and Labrador. The COPD tools you will see today are a few of many mature use tools that will be released by the program in the coming months.
- eDOCSNL has partnered with the Family Practice Renewal Program and provincial advisory groups on this development that aligns to the published COPD guidelines. This is a first of its kind initiative that Newfoundland and Labrador and our care providers are leading
- This presentation will introduce the components of the toolset and give you some idea as to why you might want to use them for the care and monitoring of the people with living with COPD in your practice.
- Please keep in mind that all screenshots seen in these slides are taken from a test system, so the content may not exactly reflect what you see in your own EMR.

The practice 360 COPD toolset is comprised of three main elements: a visit documentation template, a care plan and a practice management reporting dashboard.

The elements of this intuitive toolset are mutually reinforcing and facilitate the monitoring and delivery of guidelines-based care of your patients living with COPD using advanced features of the Med Access solution.

The eDOCSNL COPD Visit Template

The visit documentation template is the foundational component of the toolset. This robust template takes advantage of many of the advanced features of the EMR including embedded auto-populated forms, triggers as reminders of best practice, launchable web-based tools to assist in decision making and diagnosis and patient and provider educational resources.

The template was developed to reflect current clinical practice guidelines and the development effort was informed by feedback from provincial advisory committees and local specialty services.

You will note that some information entered in other areas in the patient's chart will display automatically in the template.

Similarly, information entered into the template can link to other features such as individualized patient goals, clinical decisions support triggers and the COPD reporting dashboard, which you will see in a moment.

The eDOCSNL COPD Care Plan

A care plan is a way to add multiple documentation items or perform multiple tasks simultaneously.

This is an efficiency measure that prevents providers from having to navigate to multiple places in a chart to perform tasks one by one.

It also enables you to set up recurrent tasks that support the Clinical Practice guidelines principles.

The care plan has been designed to make following guidelines easier: using a combination of the tools embedded in the visit template and the care plan, you can be confident that you have considered all the necessary elements of care and monitoring for your patients.
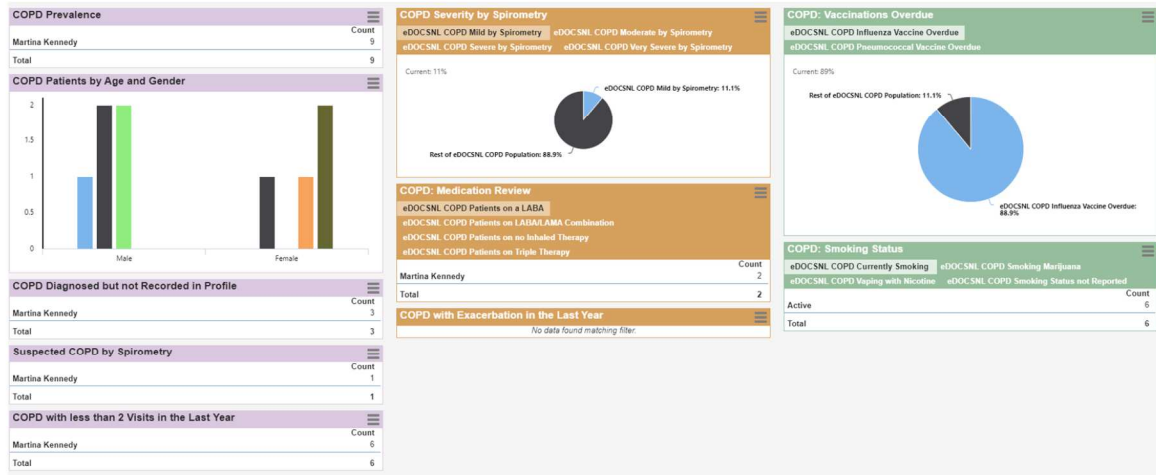
The third pillar of the Practice 360 COPD toolset is the reporting dashboard; this is where the focus switches from patient-level to population-level and where the information entered into the visit template becomes useful to you as it provides you with a clear view of COPD care in your practice.

The dashboard presents information to providers on the patient population living with COPD, highlights items of potential interest and provides a population-level overview of adherence to guidelines which supports best practice.

The dashboard is also a very useful tool that allows you to generate follow up tasks such as appointments or lab requests across the patient population that is identified as requiring some additional intervention.

The dashboard reinforces the practice of standardized documentation – the more you use the documentation template and other pieces, the more information you will see here.
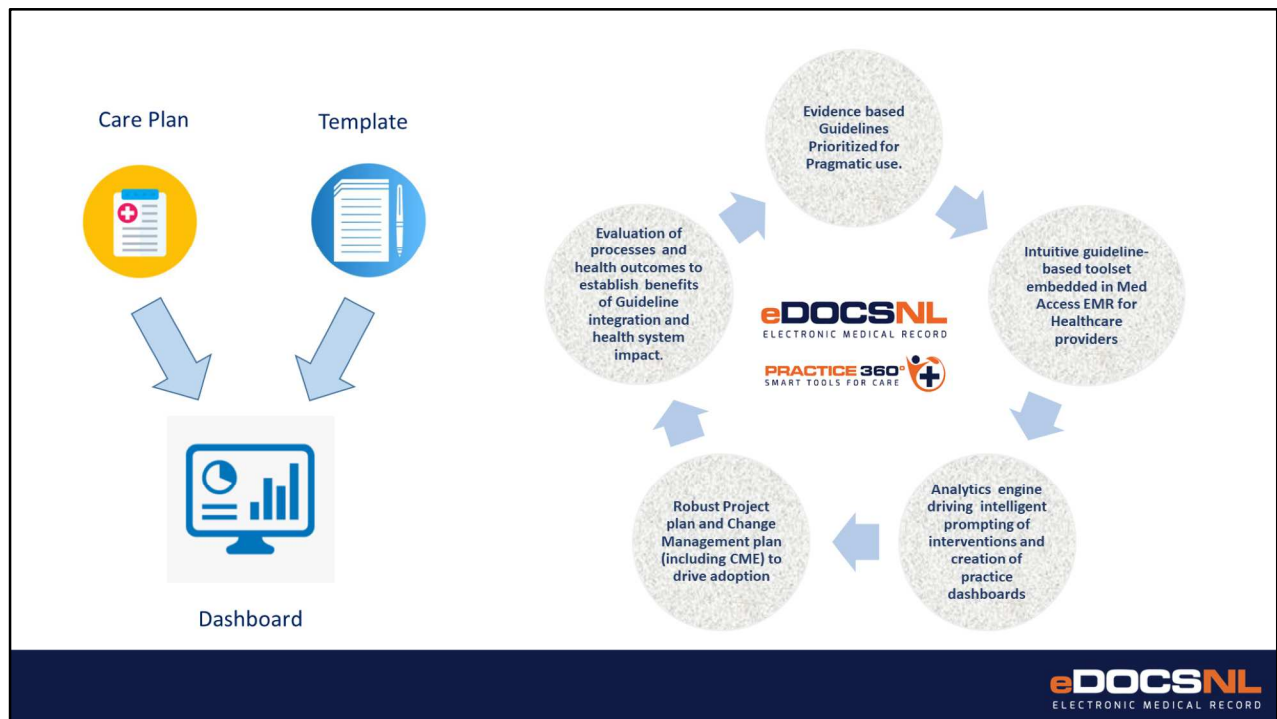
The components of the toolset are mutually reinforcing.

The documentation template provides all the information to make point of care decisions while automating normally manual tasks, standardizes data input so that the software can enable other features providing clinical value and supports the creation of a data set for providers that can inform population level management.

The care plan populates chart information, patient goals and tasks in an efficient way that makes ongoing guidelines-based care and monitoring seamless.

The data generated by standardized documentation supported by the patient level tools and visit template informs the COPD dashboard and gives providers a population-level view of COPD in their practice.

This aligns with the eDOCSNL Practice 360 approach of using the intelligent and standardized features of the EMR to support and evaluate guidelines based care, presenting providers with the information they need for best practice decision making. Data provided by the EMR through the Practice 360 tools will enable the evaluation and refinement of guidelines and supports health system changes that will benefit patients living with COPD in Newfoundland and Labrador.

Thank You

- Thank you for reviewing this introductory presentation on the Practice 360: COPD Toolset, a collaborative initiative of eDOCSNL and the Family Practice Renewal Program
- For more detail on each component of the toolset and for information on how to prepare your EMR instance to fully utilize the tools, please review the documents found at eDOCSNL.ca under the Practice 360 tab.