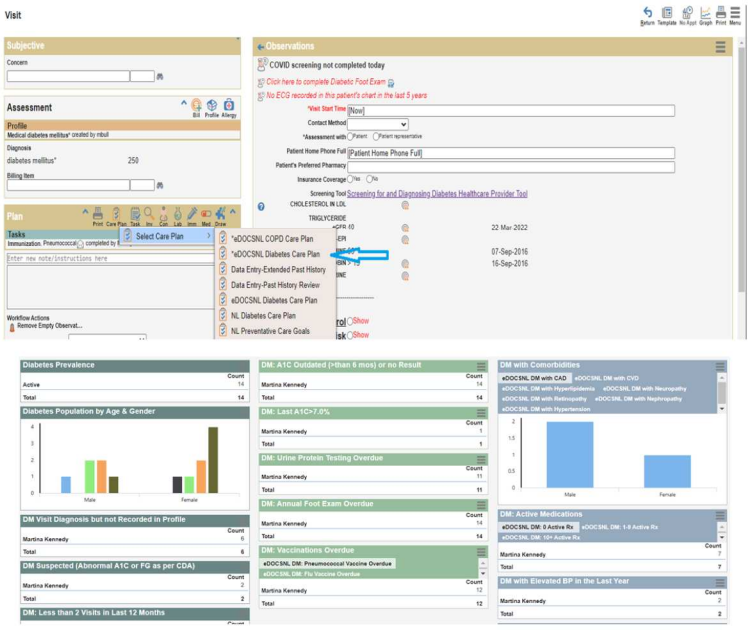
- Hello and welcome to the learning series for eDOCSNL Practice 360: Diabetes Smart Tools for Care.
- Practice 360 is an ongoing eDOCSNL initiative designed to increase clinical value and practice efficiencies in the Med Access EMR for users in Newfoundland and Labrador. The diabetes tools you will see today are the first of many chronic disease management tools that will be developed by the program in the coming months.
- eDOCSNL has partnered with Diabetes Canada and provincial advisory groups on the development that aligns to the National Diabetes Clinical Practice Guidelines. This is a first of its kind initiative that Newfoundland and Labrador and our care providers are leading
- In this presentation we 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 diabetes or pre-diabetes in your practice.
- Please keep in mind that all screenshots seen in this presentation are taken from a test system, so the content may not exactly reflect what you see in your own EMR but be assured the final product will be supported with all the necessary information to ensure you have absolute clarity and knowledge on how to use the toolset effectively in your practice.

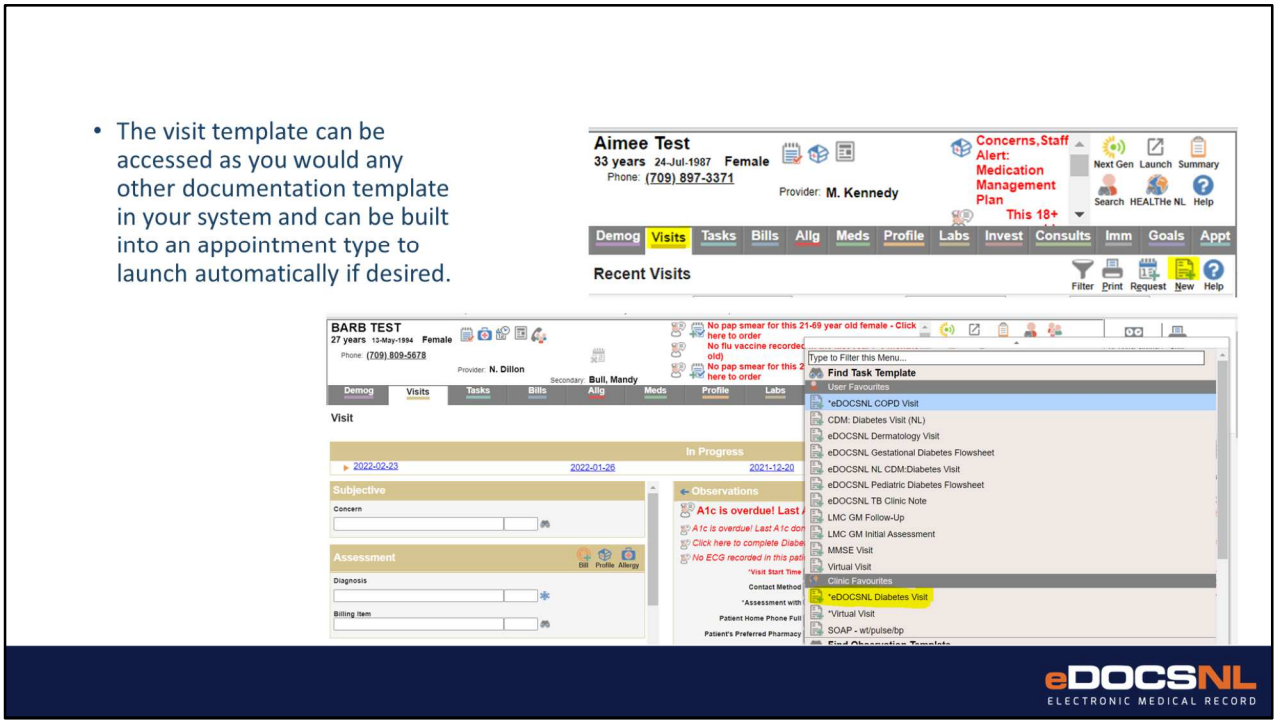
- The Practice 360 Diabetes toolset is a package of guidelines-based tools comprised of:
  - A visit documentation template
  - A care plan
  - A practice management reporting dashboard
- The three items are mutually reinforcing and enable easy guidelines-based care and monitoring



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

We will explore each of these in brief in the following slides and in more detail in other presentations in this series.

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



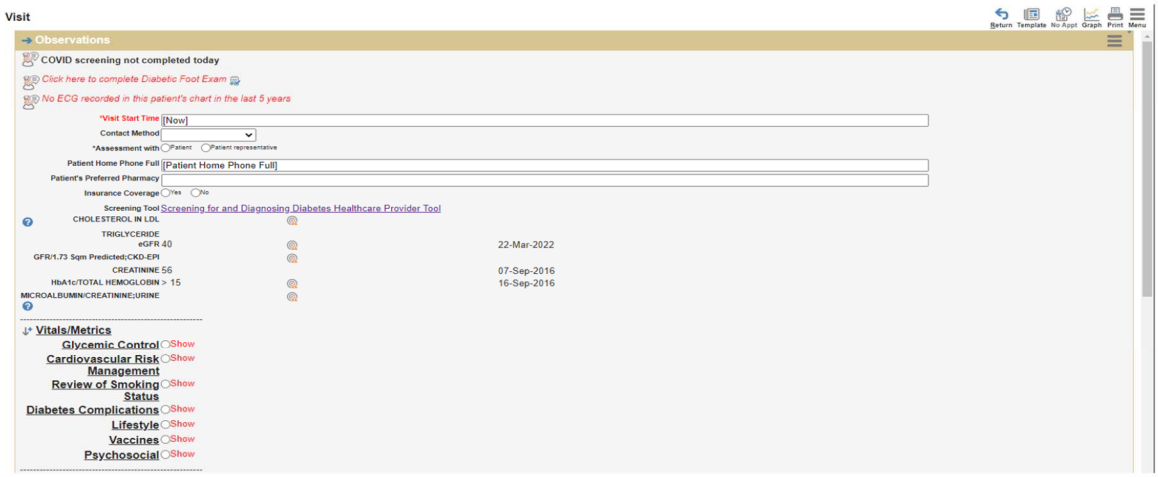
The visit template can be accessed in the same way as any other documentation template you would use for visits in your EMR.

Please see the presentation entitled “Practice 360: Diabetes Tools – Preparing your EMR” for more information on favoriting the template and/or attaching it to an appointment type to automatically appear when the visit is launched. A link to this video can be found on the slide which will be posted to edocsnl.ca

In the absence of any appointment type setup the template can be accessed by clicking with the right button of your mouse the “New” Icon when you are in the “Visit” tab in the patient’s chart and selecting the “eDOCSNL Diabetes Visit” template you see highlighted here.

The template will only appear in this list when it has been favorited, please see the “Preparing your EMR” presentation for instructions on how to do this.

The eDOCSNL Diabetes 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.

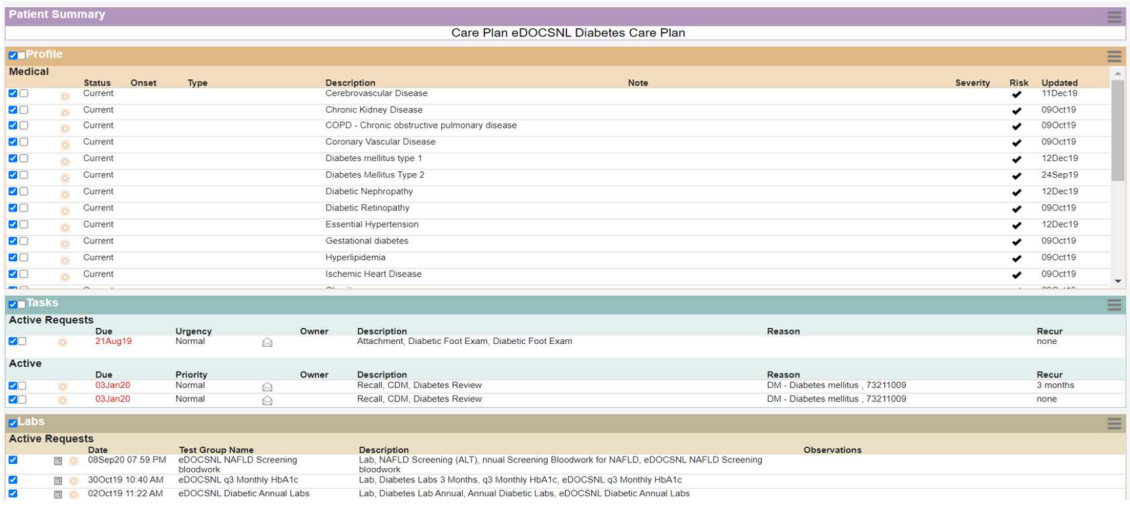
The template was developed to reflect current clinical practice guidelines and the development effort was informed by feedback from Diabetes Canada, provincial advisory committees and our pilot group.

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

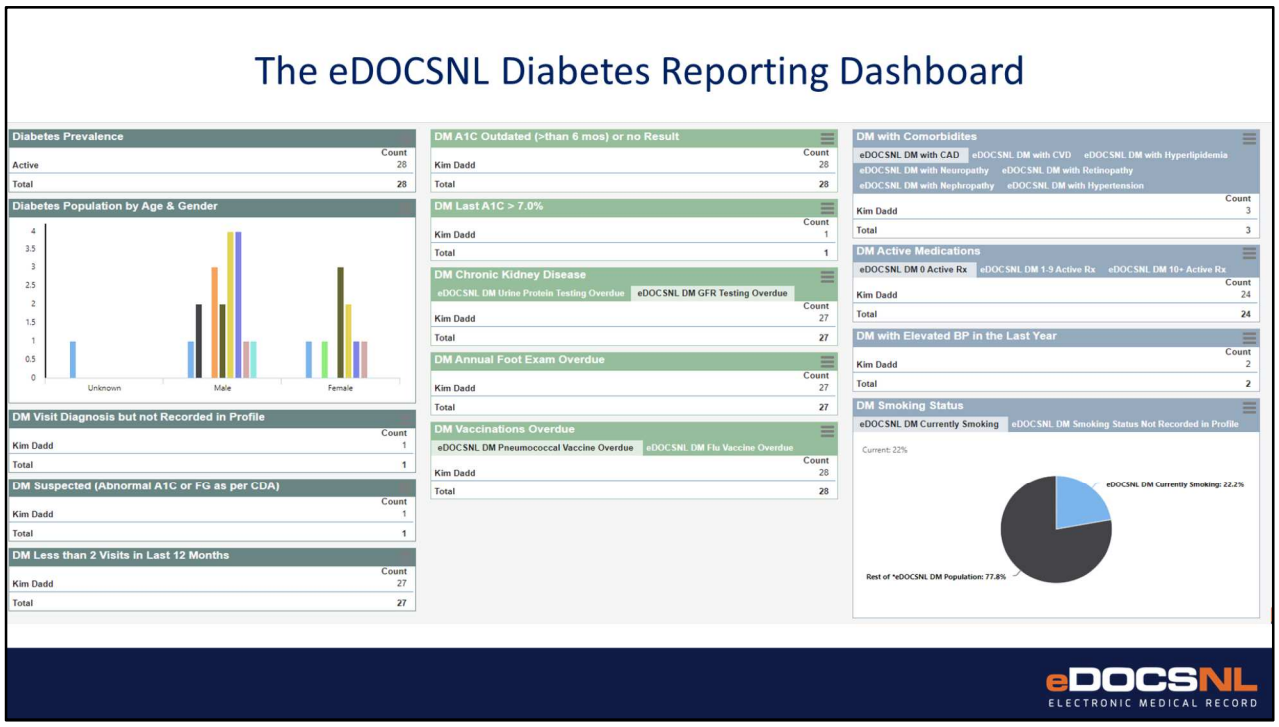
Similarly, information entered into the template can link to other features such as individualized patient goals, clinical decisions support triggers and the Diabetes reporting dashboard, which you will see in a moment.

Continue viewing the other presentations in this series for more information on the features of the visit template.

The eDOCSNL Diabetes Care Plan



The next piece of the suite of tools is the Diabetes 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 Diabetes Canada Clinical Practice guidelines principles.
One of the other strengths of the care plan is the ability to set up individualized patient goals, in this case these would be relevant to diabetes care and monitoring. When these goals are visible in your side bar, they give you visibility into the patient's health status and remind you of items of care and monitoring that are overdue or out of acceptable range, making them simple to action.
For more information on the care plan and goals, please continue to view the other Practice 360 presentations.

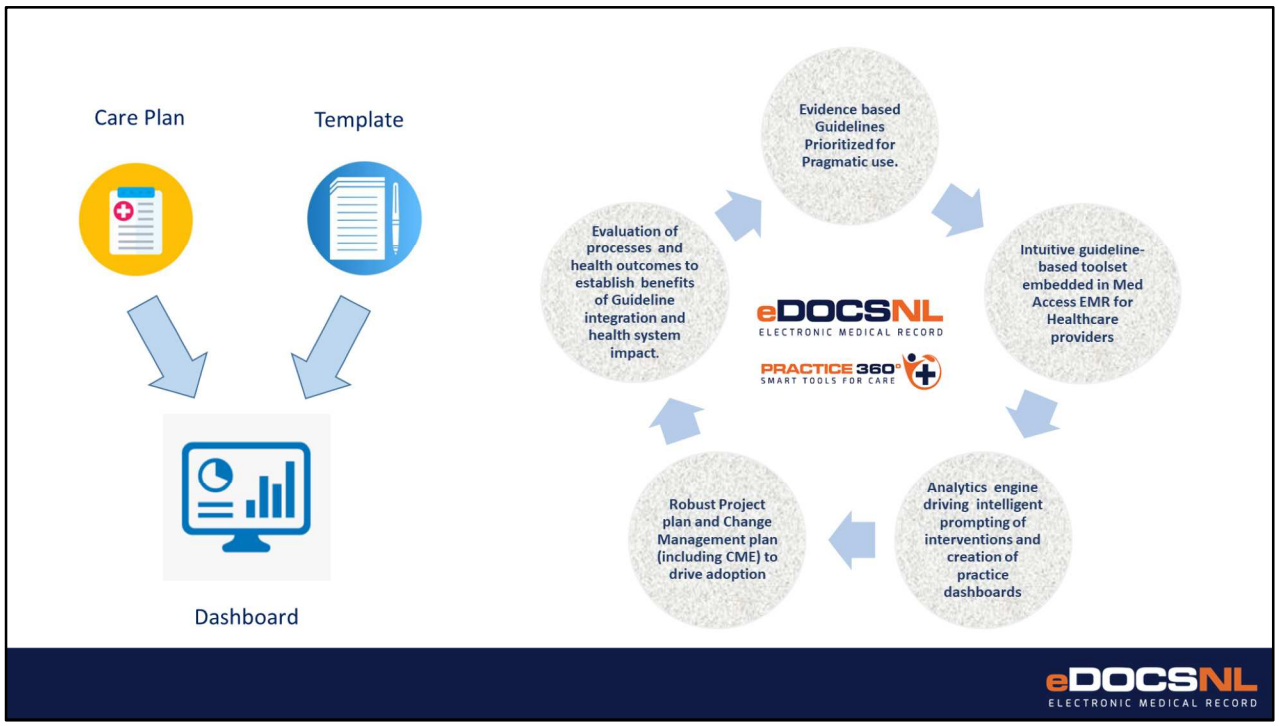


The third piece is the reporting dashboard, this is where the focus switches from patient-level to population-level and where the information entered into the visit template becomes useful to you as it provides you with a clear view of Diabetes care in your practice.

The dashboard presents information to providers on the diabetic patient population, 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 and data entry – 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 diabetes dashboard and gives providers a population-level view of diabetes 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 the diabetic patients of Newfoundland and Labrador.

Thank You

- Thank you for viewing this introductory presentation on the Practice 360: Diabetes Toolset, a collaborative initiative of eDOCSNL and Diabetes Canada
- 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 continue viewing the remainder of the presentation series which can be found on the eDOCSNL website at eDOCSNL.ca under the Practice 360 tab.