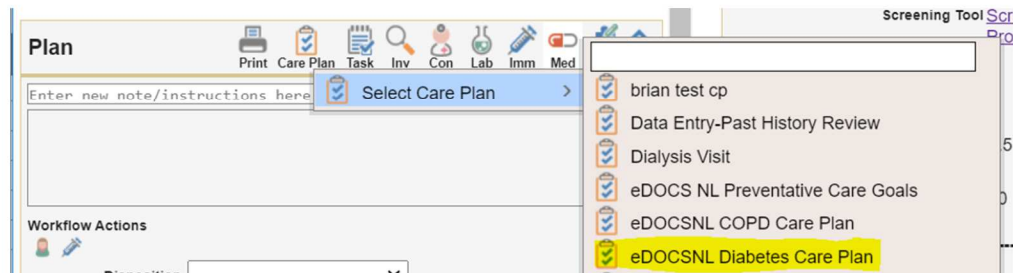




Diabetes Toolset: The Diabetes Care Plan

- 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 this 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 video 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 video 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.

Accessing The eDOCSNL Diabetes Care Plan



Patient Management Plan

If you have not already done so please add care plan

 Click here to add diabetes care plan > 

You can access the diabetes care plan in one of two ways, either:

Hover over the “Care plan” icon in the visit and select the eDOCSNL Diabetes Care plan from the dropdown that appears, or

In the patient management section of the visit template click the clipboard icon next to the “add diabetes care plan” message

The eDOCSNL Diabetes Care Plan

Patient Summary

Care Plan eDOCSNL Diabetes Care Plan

Profile

Medical

Status	Onset	Type	Description	Note	Severity	Risk	Updated
<input checked="" type="checkbox"/>	Current		Cardiovascular Disease				11Dec19
<input checked="" type="checkbox"/>	Current		Chronic Kidney Disease				09Oct19
<input checked="" type="checkbox"/>	Current		COPD - Chronic obstructive pulmonary disease				09Oct19
<input checked="" type="checkbox"/>	Current		Coronary Vascular Disease				09Oct19
<input checked="" type="checkbox"/>	Current		Diabetes mellitus type 1				12Dec19
<input checked="" type="checkbox"/>	Current		Diabetes Mellitus Type 2				24Sep19
<input checked="" type="checkbox"/>	Current		Diabetic Nephropathy				12Dec19
<input checked="" type="checkbox"/>	Current		Diabetic Retinopathy				09Oct19
<input checked="" type="checkbox"/>	Current		Essential Hypertension				12Dec19
<input checked="" type="checkbox"/>	Current		Gestational diabetes				09Oct19
<input checked="" type="checkbox"/>	Current		Hyperlipidemia				09Oct19
<input checked="" type="checkbox"/>	Current		Ischemic Heart Disease				09Oct19

Tasks

Active Requests

Due	Urgency	Owner	Description	Reason	Recur
21Aug19	Normal		Attachment, Diabetic Foot Exam, Diabetic Foot Exam		none

Active

Due	Priority	Owner	Description	Reason	Recur
03Jan20	Normal		Recall, CDM, Diabetes Review	DM - Diabetes mellitus , 73211009	3 months
03Jan20	Normal		Recall, CDM, Diabetes Review	DM - Diabetes mellitus , 73211009	none

Labs

Active Requests

Date	Test Group Name	Description	Observations
09Sep20 07:59 PM	eDOCSNL NAFLD Screening bloodwork	Lab, NAFLD Screening (ALT), nrual Screening Bloodwork for NAFLD, eDOCSNL NAFLD Screening bloodwork	
30Oct19 10:40 AM	eDOCSNL q3 Monthly HbA1c	Lab, Diabetes Labs 3 Months, q3 Monthly HbA1c, eDOCSNL q3 Monthly HbA1c	
02Oct19 11:22 AM	eDOCSNL Diabetic Annual Labs	Lab, Diabetes Lab Annual, Annual Diabetic Labs, eDOCSNL Diabetic Annual Labs	

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.

When the care plan first appears, all items are checked in blue on the left hand column as seen here.

These checkmarks indicated items that have been selected to apply to the current patient record.

Many of the items may not be applicable to apply to a given patient record so you will want to uncheck the items in bulk so that you can select only the items you want to apply.

This can be done by clicking the right box on the "Chart Summary" line at top left and then unchecking the same box.

The left box here would be clicked to "add details", this is more applicable to the chart summary function and does not really apply here so do not check this box.

Feature: Profile Items

Chart Summary

Patient Summary

Care Plan eDOCSNL Diabetes Care Plan

Profile

Medical	Status	Onset	Type	Description	Note	Severity	Risk	Updated
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Current		Cerebrovascular Disease			✓	11Dec19
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Current		Chronic Kidney Disease			✓	09Oct19
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Current		COPD - Chronic obstructive pulmonary disease			✓	09Oct19
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Current		Coronary Vascular Disease			✓	09Oct19
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Current		Diabetes mellitus type 1			✓	12Dec19
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Current		Diabetes Mellitus Type 2			✓	24Sep19
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Current		Diabetic Nephropathy			✓	12Dec19
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Current		Diabetic Retinopathy			✓	09Oct19
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Current		Essential Hypertension			✓	12Dec19
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Current		Gestational diabetes			✓	09Oct19

The first section you will see in the care plan is the “Profile” area. Any item you check here will be applied to the patients profile when you apply the care plan.

There are many possible diagnoses here, we have tried to limit them to the items that might be applicable to diabetics.

When items are added to the patient profile they will contribute information to the diabetes dashboard and will enable other clinical decision support features.

Note that if you add something here that the patient already has in their profile, due to the functionality of the software a duplicate entry will be created.

Feature: Recurrent Tasks

Tasks						
Active Requests						
<input type="checkbox"/>	Due	Urgency	Owner	Description	Reason	Recur
<input type="checkbox"/>	08Mar21	Normal		Attachment, Diabetic Foot Exam, eDOCSNL Diabetic Foot Exam/Foot Care		none
Active						
<input type="checkbox"/>	Due	Priority	Owner	Description	Reason	Recur
<input type="checkbox"/>	03Jan20	Normal		Recall, CDM, Diabetes Review	DM - Diabetes mellitus , 73211009	3 months
<input type="checkbox"/>	03Jan20	Normal		Recall, CDM, Diabetes Review	DM - Diabetes mellitus , 73211009	none

Labs				
Active Requests				
<input type="checkbox"/>	Date	Test Group Name	Description	Observations
<input type="checkbox"/>	08Mar21 07:59 PM	eDOCSNL NAFLD Screening bloodwork	Lab, NAFLD Screening (ALT), Annual Screening Bloodwork for NAFLD, eDOCSNL NAFLD Screening bloodwork	
<input type="checkbox"/>	30Oct19 10:40 AM	eDOCSNL q3 Monthly HbA1c	Lab, Diabetes Labs 3 Months, q3 Monthly HbA1c, eDOCSNL q3 Monthly HbA1c	
<input type="checkbox"/>	02Oct19 11:22 AM	eDOCSNL Diabetic Annual Labs	Lab, Diabetes Lab Annual, Annual Diabetic Labs, eDOCSNL Diabetic Annual Labs	












You can add actions to be completed in the form of tasks to the patient visit from the care plan.

This is an efficiency measure so you don't have to order tasks one by one.

Diabetes care and monitoring is a continuous exercise so some of these tasks are recurrent. When you set up recurrent tasks from the care plan they will automatically appear in your inbox in the designated interval.

This will serve as a reminder to you that, as in the examples you see here, the patient needs to be seen again or has tests that need to be ordered on the interval specified by Diabetes Canada guidelines

Feature: Goals

Goals							
Active Goals							
Goal Name		Target	Last Value	Last Date	Repeat	Next Due	Met?
<input checked="" type="checkbox"/> BMI		< 25 kg/m ²			1 year	Unknown	No
<input checked="" type="checkbox"/> BP diastolic		< 80 mm Hg			1 year	Unknown	No
<input checked="" type="checkbox"/> BP systolic		< 130 mm Hg			1 year	Unknown	No
<input checked="" type="checkbox"/> Diabetic Foot Exam Completed		Yes			1 day	Unknown	No
<input checked="" type="checkbox"/> GFR/1.73 Sqm Predicted;CKD-EPI		> 60			1 day	Unknown	No
<input checked="" type="checkbox"/> HbA1c/TOTAL HEMOGLOBIN		< 7			3 month	Unknown	No
<input checked="" type="checkbox"/> Influenza Vaccine, Diabetic Influenza Vaccine					1 year	Unknown	No
<input checked="" type="checkbox"/> LDL Cholesterol		< 2.0 mmol/L			1 year	Unknown	No
<input checked="" type="checkbox"/> MICROALBUMIN/CREATININE;URINE		< 2.0			1 year	Unknown	No
<input checked="" type="checkbox"/> Ophthalmologist, Diabetic Dilated Eye Exam					1 year	Unknown	No
<input checked="" type="checkbox"/> Pneumococcal Conjugate, Diabetic Pneumococcal Vaccine					5 year	Unknown	No

Patient goals can be set up from the diabetes care plan.

These goals are individualized to the particular elements of care and/or monitoring that you want to follow for this patient and have been configured to represent the critical elements of the Diabetes Canada guidelines.

You do not have to select all the goals for any individual patient, though they are built to align with guidelines.

Select which goals you will apply to the individual patient by clicking the check box to the left of the individual item.

Applying the Care Plan



Plan

Print Care Plan Task Inv Con Lab Imm Med Draw

Tasks

- Recall.** CDM, Diabetes Review assigned to Fred Melindy
- Lab.** Diabetes Labs 3 Months, q3 Monthly HbA1c, eDOCSNL q3 Monthly HbA1c assigned to Fred Melindy
- Consult.** Diabetes Program, eDOCSNL Central Health Diabetes Program Referral assigned to Fred Melindy
- Consult.** Ophthalmologist, eDOCSNL Diabetic Dilated Eye Exam assigned to Fred Melindy
- Immunization.** Pneumococcal Conjugate, Diabetic Pneumococcal Vaccine assigned to Fred Melindy

Goals			
Active Goals			
Goal Name	Last Date	Last Value	Next Due
🔍 Ophthalm...	21Nov2018		Overdue
🔍 LDL Chole...			Unknown
🔍 HbA1c/TOT...	28Feb2021	8.5	28May2021
🔍 Influenza	30Sep2020		30Sep2021
🔍 MICROAL...	23Nov2020	30	23Nov2021
🔍 BP diastolic	17Feb2021	60	17Feb2022
🔍 BP systolic	17Feb2021	140	17Feb2022
🔍 Diabetic Fo...	17Feb2021	Yes	17Feb2022
🔍 BMI	17Feb2021	31.2	17Feb2024
🔍 Pneumoco...	31May2019		31May2024

When you are finished selecting the elements of the care plan you wish to apply to the current patient, click the “Apply Care Plan” icon at the bottom of the care plan, you will then be returned to the patient visit view.

You will see in the “Plan” section, a summary of all the tasks that were ordered as a result of applying the care plan. You can action them individually from here.

Please note that these items are not completed or applied until they are actioned from this area.

Goals that were set up can be viewed from the sidebar view to the right of the patient visit template.

Working with Goals

The image displays two screenshots of the eDOCSNL Goals interface. The left screenshot shows a table of active goals, and the right screenshot shows a context menu for the HbA1c goal.

Goal Name	Last Date	Last Value	Next Due
Ophthalmologist	21Nov2018		Overdue
LDL Cholesterol			Unknown
HbA1c/TOTAL HEMOGLOBIN	28Feb2021	8.5	28May2021
Influenza	30Sep2020		30Sep2021
MICROALBUMIN/CREATININE	23Nov2020	30	23Nov2021
BP diastolic	17Feb2021	60	17Feb2022
BP systolic	17Feb2021	140	17Feb2022
Diabetic Foot Exam Complete	17Feb2021	Yes	17Feb2022
BMI	17Feb2021	31.2	17Feb2024
Pneumococcal vaccination	31May2019		31May2024

The right screenshot shows a context menu for the HbA1c goal with the following options:

- Unpin from Top
- Change Target/Frequency
- Defer for 3 month
- Enter Result
- Cancel
- Lab, eDOCSNL q3 Monthly HbA1c
- View History

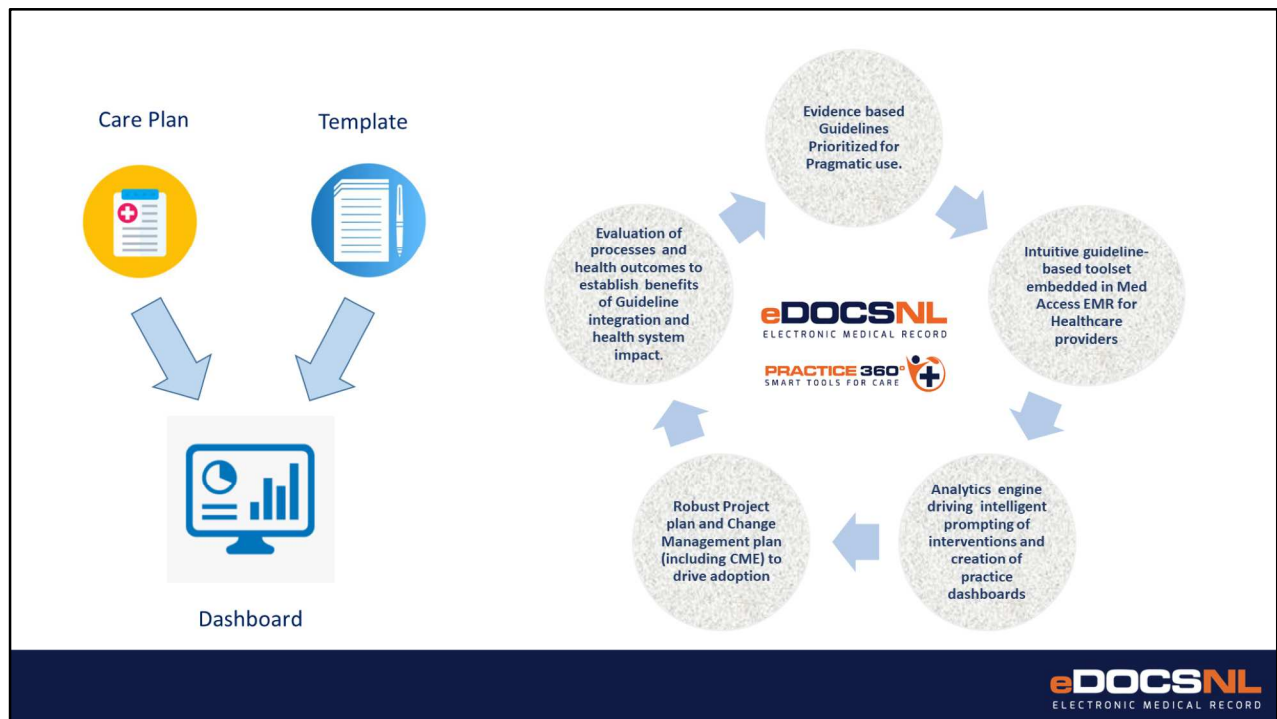
The bottom screenshot shows the Goal Management search bar with the following text:

Goal Management
HbA1c/TOTAL HEMOGLOBIN (or observation with a value) < 7 match on Responses within the last 3 month

The goals are set up by default to reflect current recommendations in from the Diabetes Canada guidelines but can be modified if indicated for a given patient. Right clicking on the goal will produce a menu of options. From here, you can defer a goal to essentially skip a cycle, cancel a goal that you no longer wish to follow, manually enter a result for the value in question (if applicable), and complete the associated task to address the goal. In this example, we have selected the Hemoglobin A1C goal and the ability to order the 3 monthly A1C is attached to the goal and can be ordered directly from the goal itself. Not all goals lend themselves well to this functionality so this is only applicable to some.

From the goals widget you can also select to change the target and/or frequency of a particular goal for an individual patient if indicated.

For example, if you decide that checking A1C every 6 months is sufficient for an individual patient you simple select "Change Target/Frequency" from this menu and change the interval or value on the resulting goal set up window and save. The new goal will now indicate overdue or out of acceptable range only for the parameters that you set, with the caution that this patient is now being cared for individually rather than strictly according to guidelines.



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

eDOCSNL
ELECTRONIC MEDICAL RECORD

PRACTICE 360°
SMART TOOLS FOR CARE



Newfoundland
Labrador

- Thank you for viewing this 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.