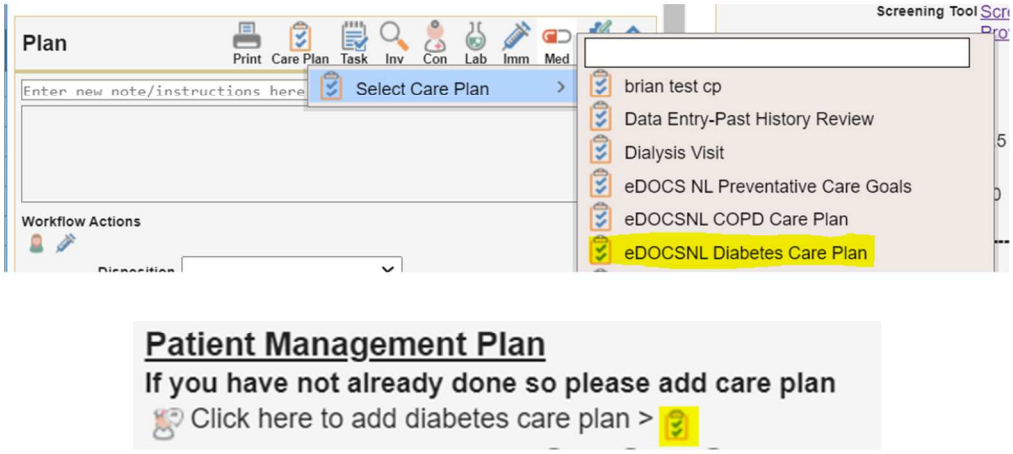
- Hello and welcome to the learning series for eDOCSNL Practice 360: Diabetes Smart Tools for Care.
- Practice 360 is an ongoing eDOCSNL initiative designed to increase clinical value and practice efficiencies in the Med Access EMR for users in Newfoundland and Labrador. The diabetes tools you will see 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



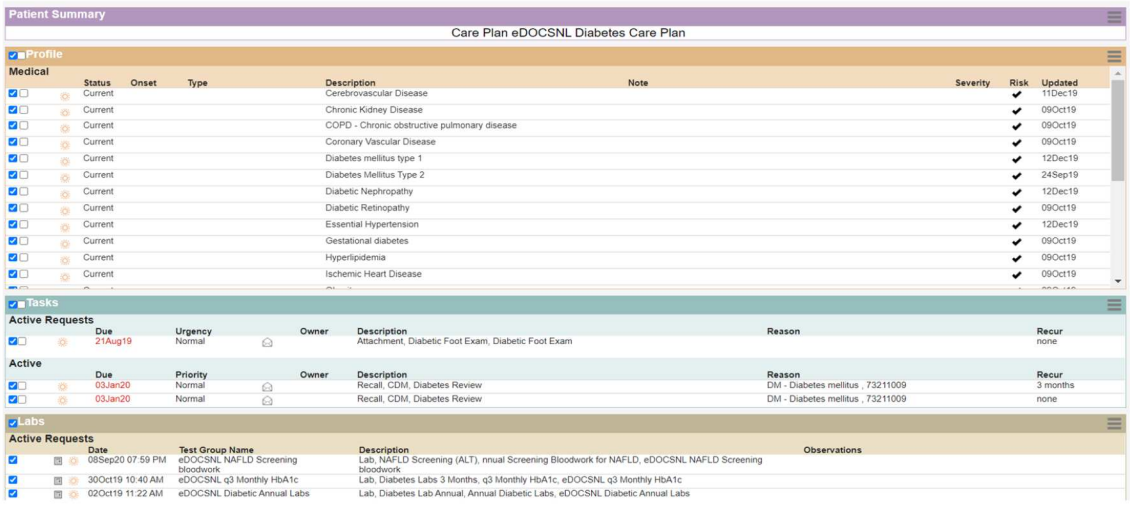
eDOCSNL ELECTRONIC MEDICAL RECORD

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



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.

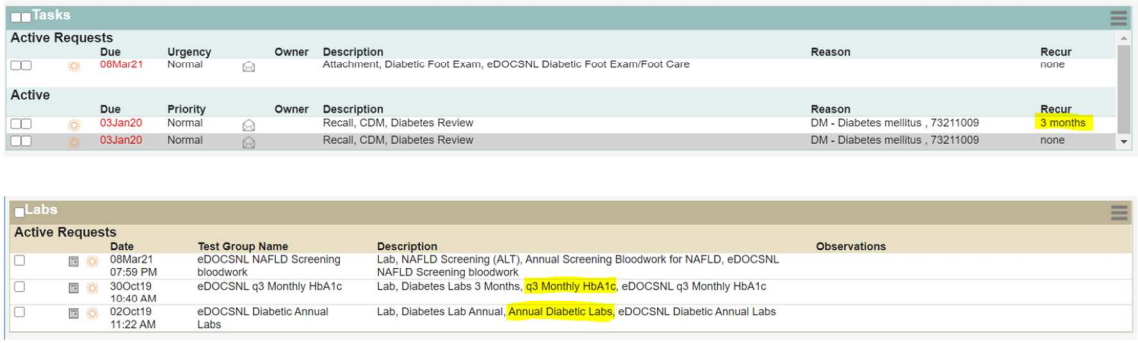
This can be done by clicking the right box on the “Chart Summary” line at top left and then unchecking the same box.

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

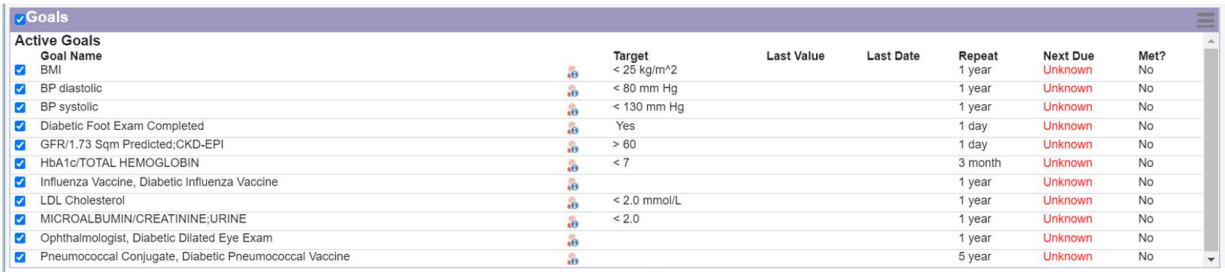
The first section you will see in the care plan is the “Profile” area. Any item you check here will be applied to the patients profile when you apply the care plan.
There are may possible diagnoses here, we have tried to limit them to the items that might be applicable to diabetics.
When items are added 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



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



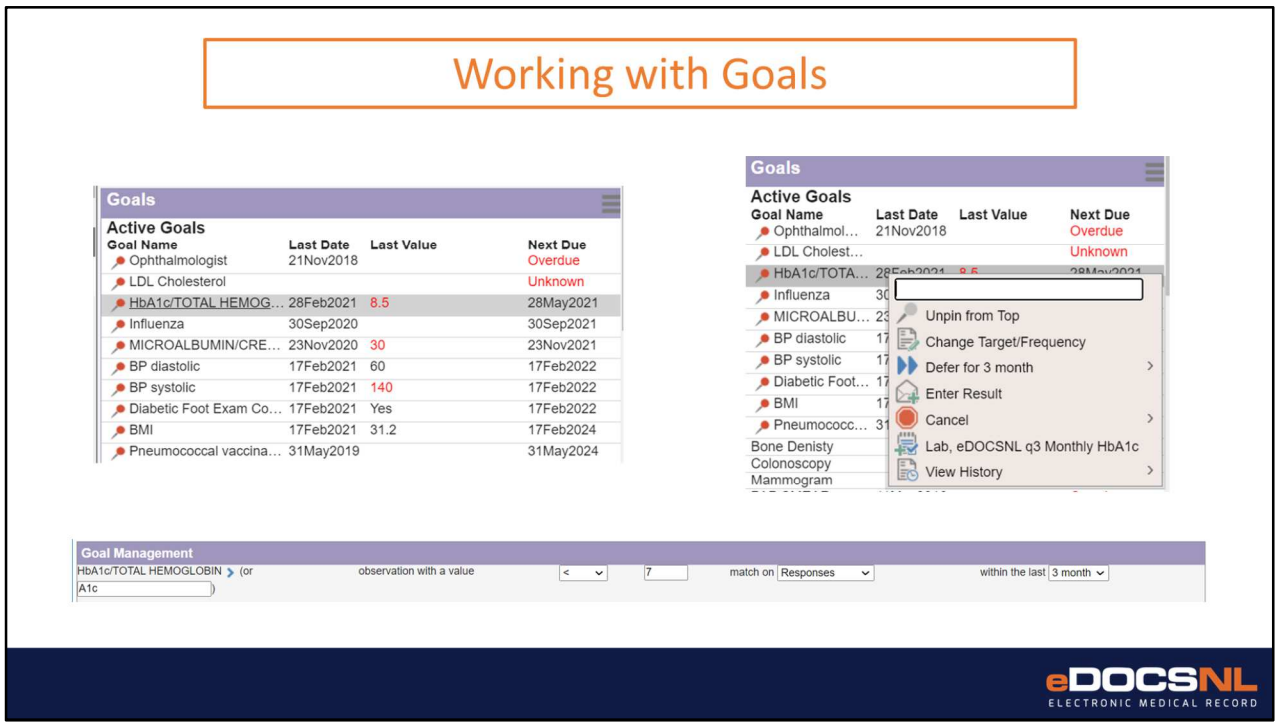
Patient goals can be set up from the diabetes care plan.
These goals are individualized to the particular elements of care and/or monitoring that you want to follow for this patient and have been configured to represent the critical elements of the Diabetes Canada guidelines.
You do not have to select 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.

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.

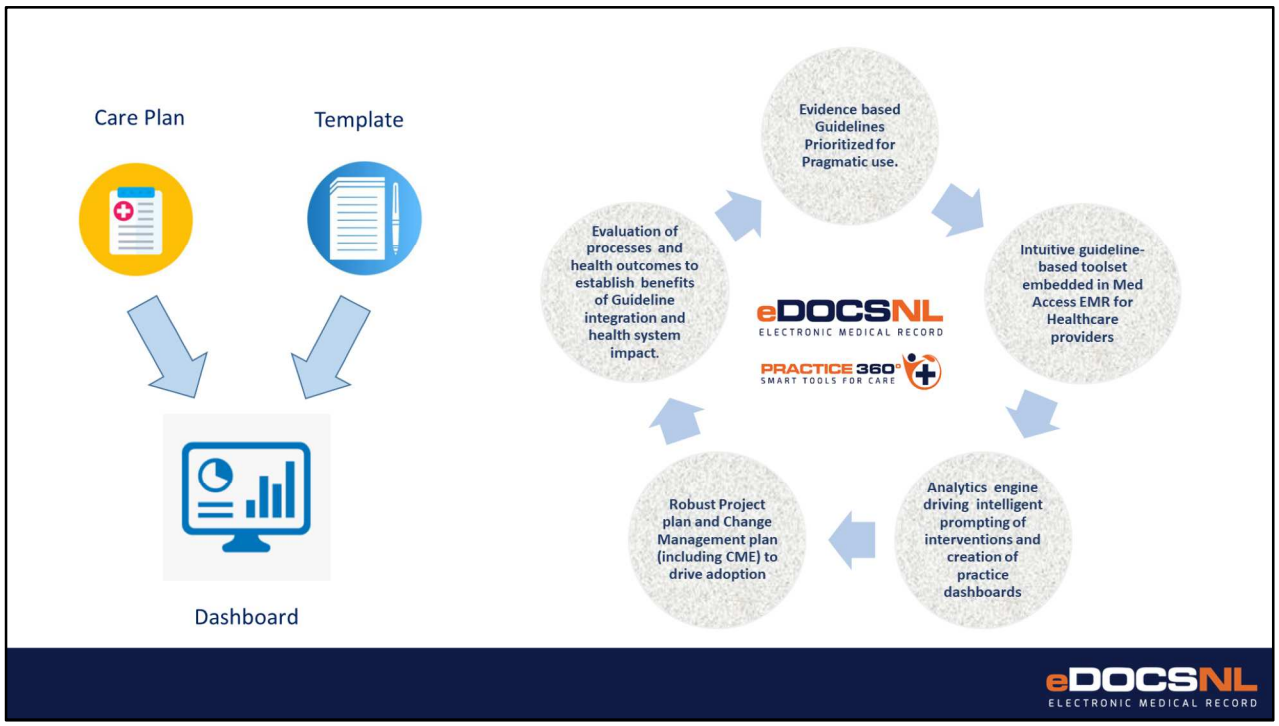


The goals are set up by default to reflect current recommendations in from the Diabetes Canada guidelines but can be modified if indicated for a given patient. Right clicking on the goal will produce a menu of options. From here, you can defer a goal to essentially skip a cycle, cancel a goal that you 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

- 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.