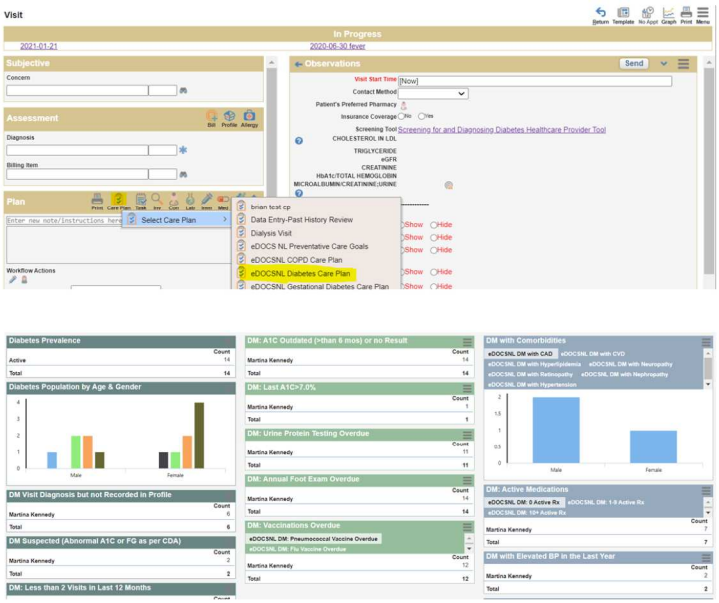
- Hello and welcome to the learning series for eDOCSNL Practice 360: Diabetes Smart Tools for Care.
- Practice 360 is an ongoing eDOCSNL initiative designed to increase clinical value and practice efficiencies in the Med Access EMR for users in Newfoundland and Labrador. The diabetes tools you will see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

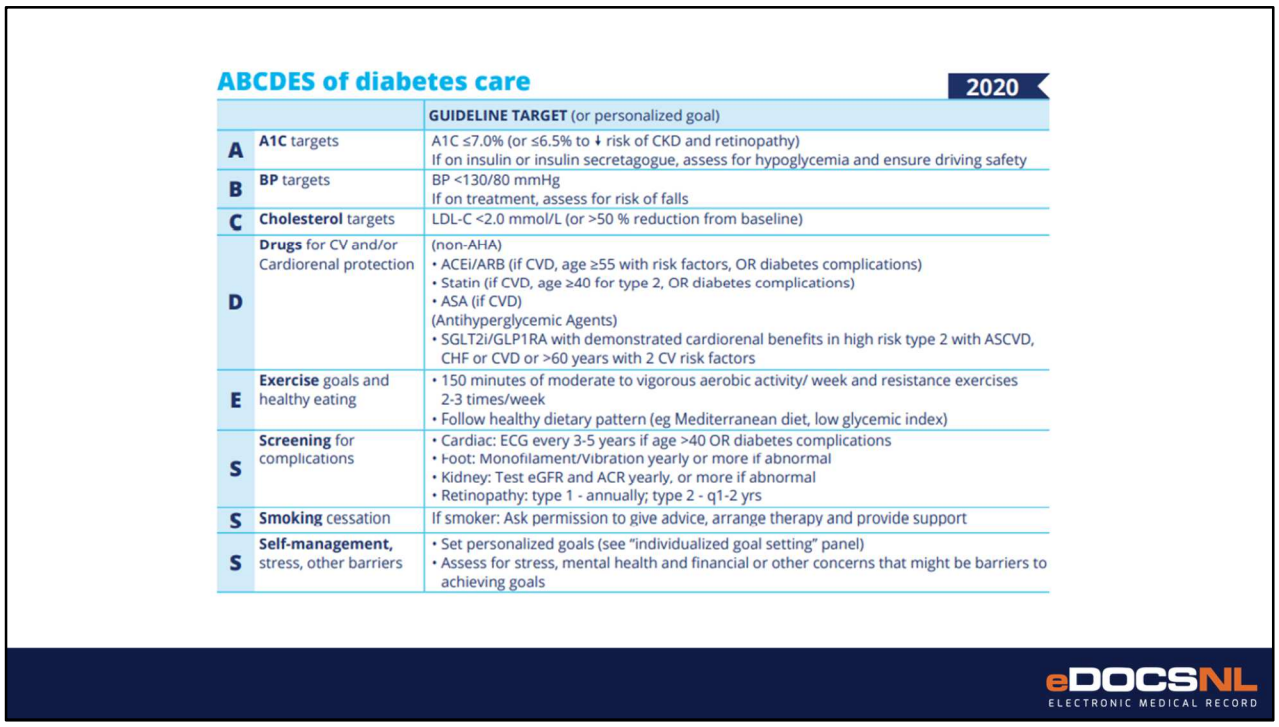


eDOCSNL ELECTRONIC MEDICAL RECORD

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 videos 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.

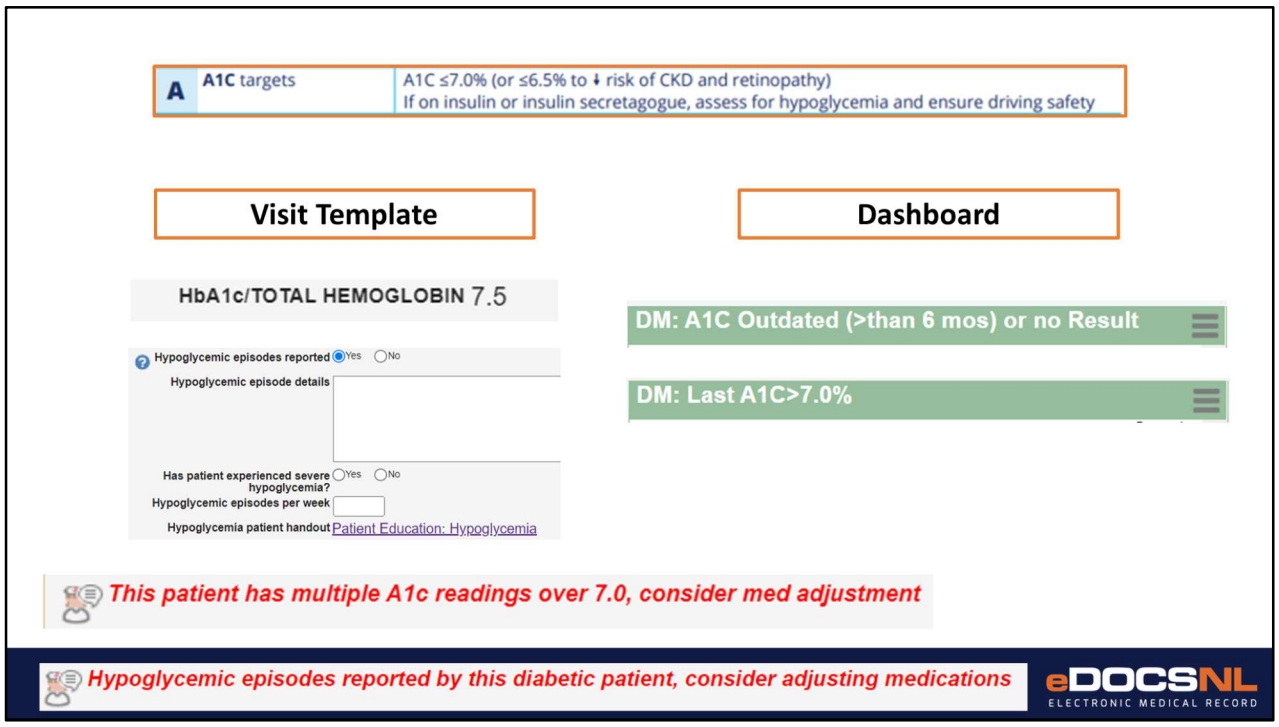


ABCDES of diabetes care

2020

		GUIDELINE TARGET (or personalized goal)
A	**A1C** targets	A1C ≤7.0% (or ≤6.5% to ↓ risk of CKD and retinopathy) If on insulin or insulin secretagogue, assess for hypoglycemia and ensure driving safety
B	**BP** targets	BP <130/80 mmHg If on treatment, assess for risk of falls
C	**Cholesterol** targets	LDL-C <2.0 mmol/L (or >50 % reduction from baseline)
D	**Drugs** for CV and/or Cardiorenal protection	(non-AHA) • ACEi/ARB (if CVD, age ≥55 with risk factors, OR diabetes complications) • Statin (if CVD, age ≥40 for type 2, OR diabetes complications) • ASA (if CVD) (Antihyperglycemic Agents) • SGLT2i/GLP1RA with demonstrated cardiorenal benefits in high risk type 2 with ASCVD, CHF or CVD or >60 years with 2 CV risk factors
E	**Exercise** goals and healthy eating	• 150 minutes of moderate to vigorous aerobic activity/ week and resistance exercises 2-3 times/week • Follow healthy dietary pattern (eg Mediterranean diet, low glycemic index)
S	**Screening** for complications	• Cardiac: ECG every 3-5 years if age >40 OR diabetes complications • Foot: Monofilament/Vibration yearly or more if abnormal • Kidney: Test eGFR and ACR yearly, or more if abnormal • Retinopathy: type 1 - annually; type 2 - q1-2 yrs
S	**Smoking** cessation	If smoker: Ask permission to give advice, arrange therapy and provide support
S	**Self-management,** stress, other barriers	• Set personalized goals (see "individualized goal setting" panel) • Assess for stress, mental health and financial or other concerns that might be barriers to achieving goals

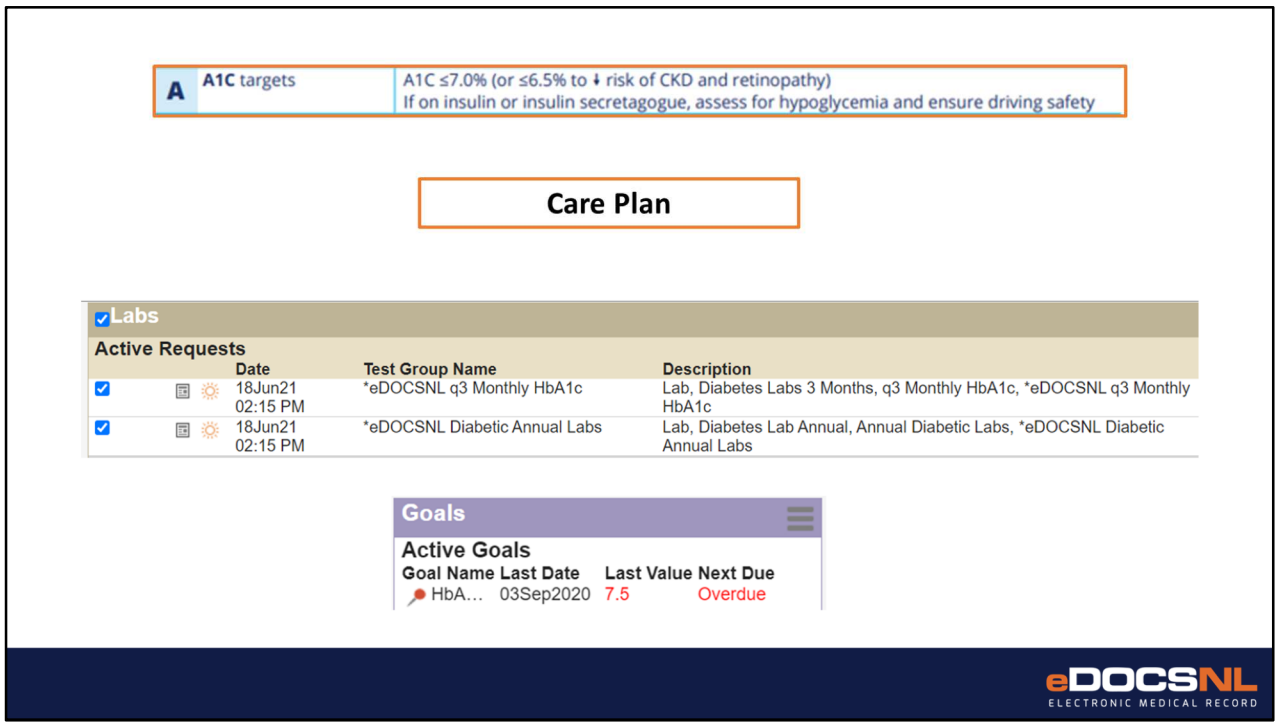
The Practice 360 Diabetes tools support the ABCDES of Diabetes Canada's clinical practice guidelines by providing documentation, clinical decision support and education for all the critical elements of the guidelines identified by diabetes Canada.



A1c targets are reinforced at the patient level by the visit template which increases visibility into the current and historical A1c values for the current patient and alerts providers when the patient has poor A1c control.

The care plan and associated goals allow the provider a similar quick-glance visibility of A1c status and alerts when values are outside of normal range or overdue for measurement according to beat practice guidelines.

The reporting dashboard provides a population level overview of patients whose A1c falls outside normal values or outside the acceptable measurement interval as determined by the Diabetes Canada guidelines.



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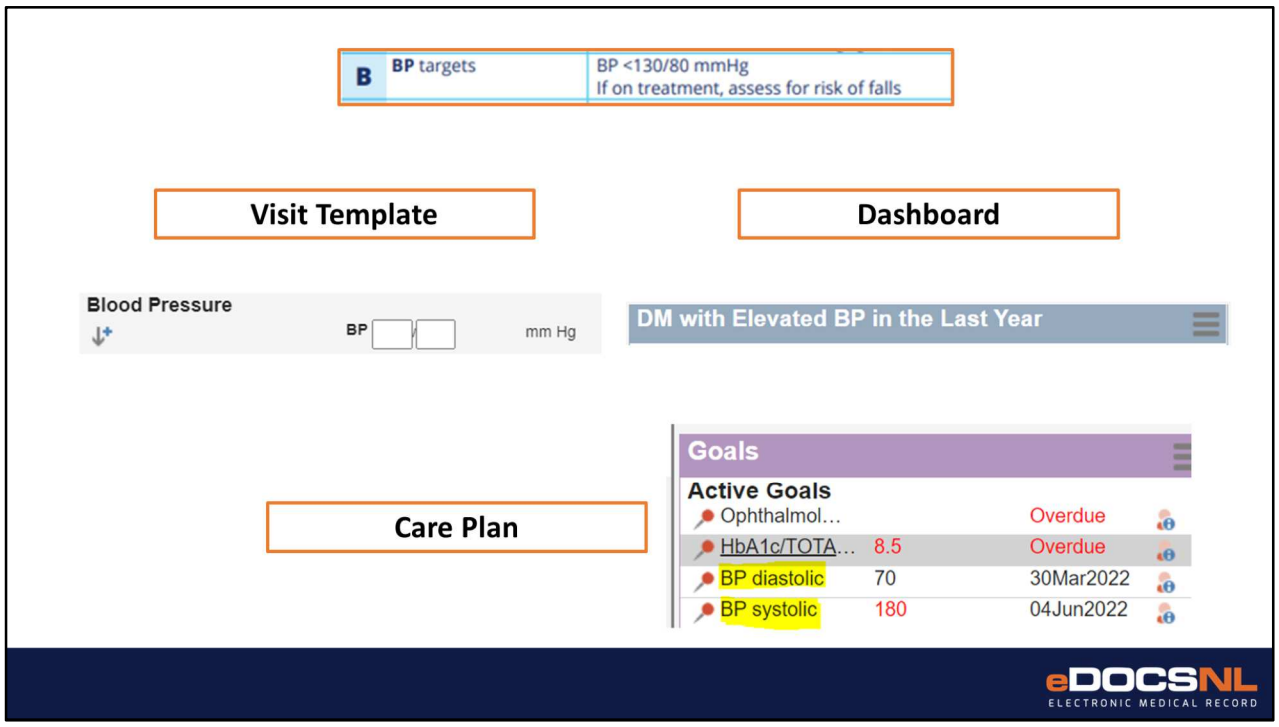
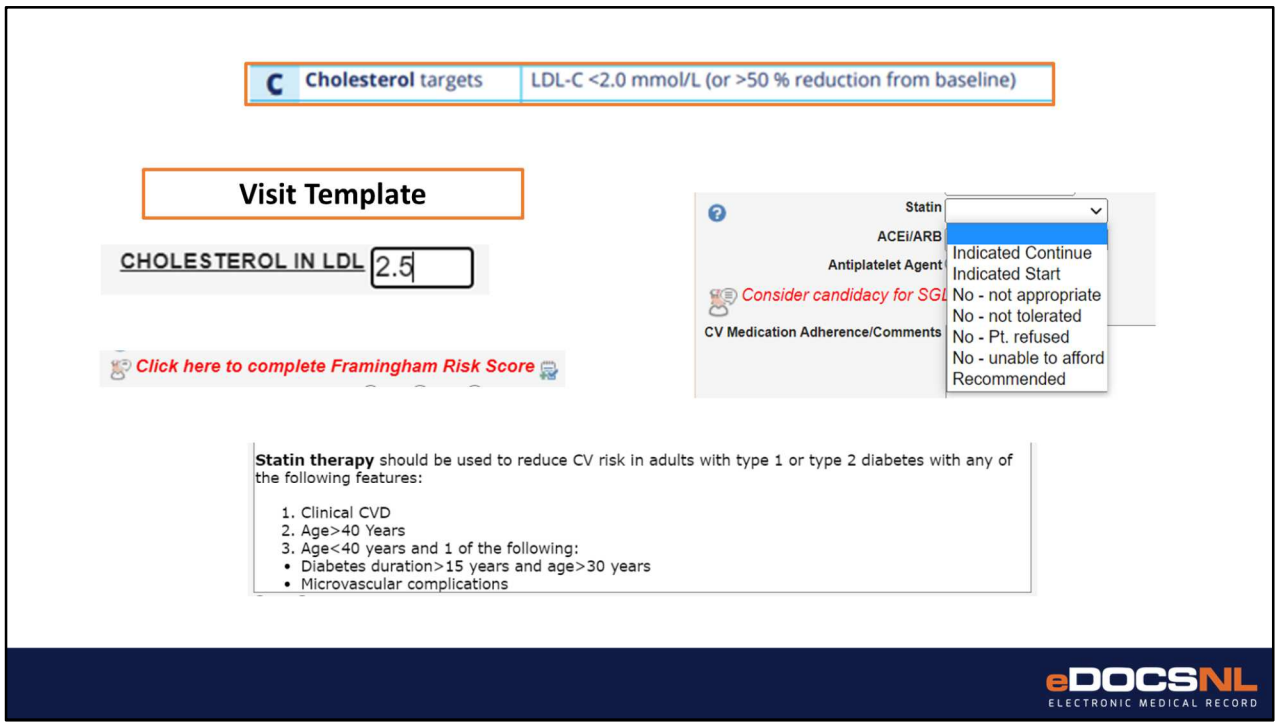


The visit template allows for multiple blood pressure readings in a single visit if required, as well as allowing visibility into the historical BP values for the current patient.

The reporting dashboard provides a population level overview of diabetic patients with elevated blood pressure measurements in the last year.



LDL targets are reinforced at the patient level by the visit template which increases visibility into the current and historical LDL values for the current .
The care plan and associated goals allow the provider a similar quick-glance visibility of LDL status and alerts when values are outside of normal range or overdue for measurement according to beat practice guidelines.
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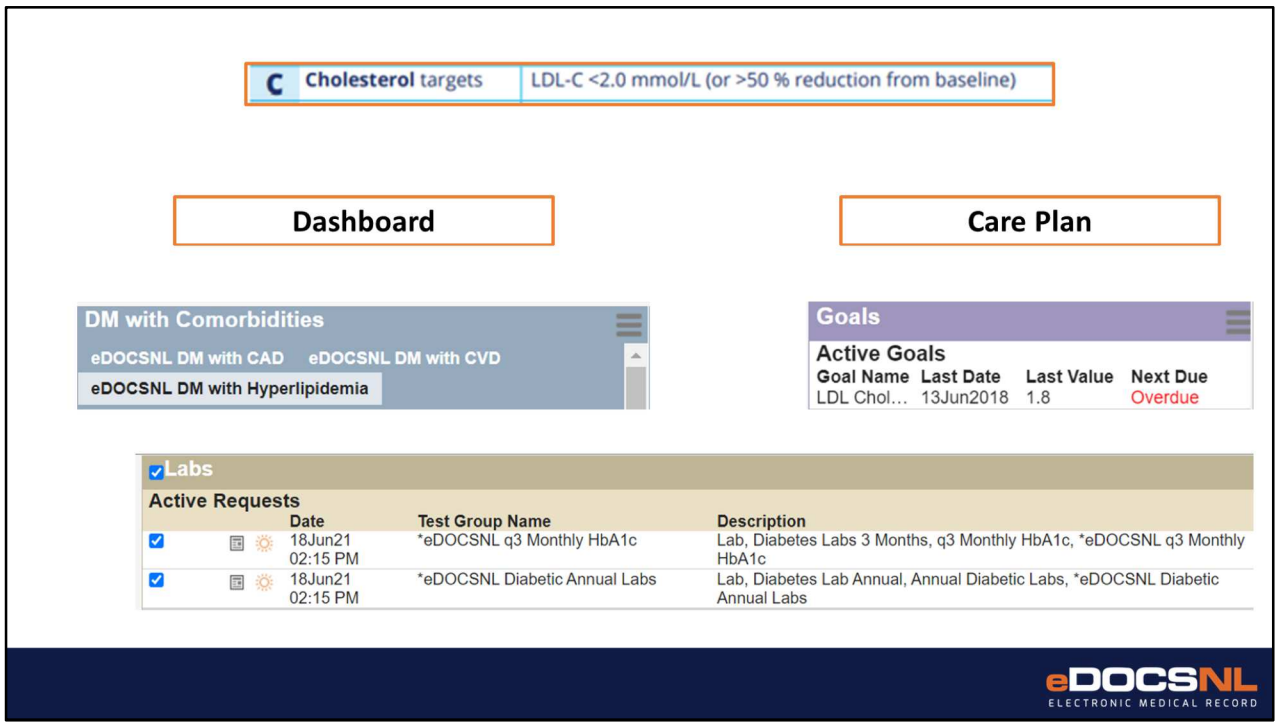

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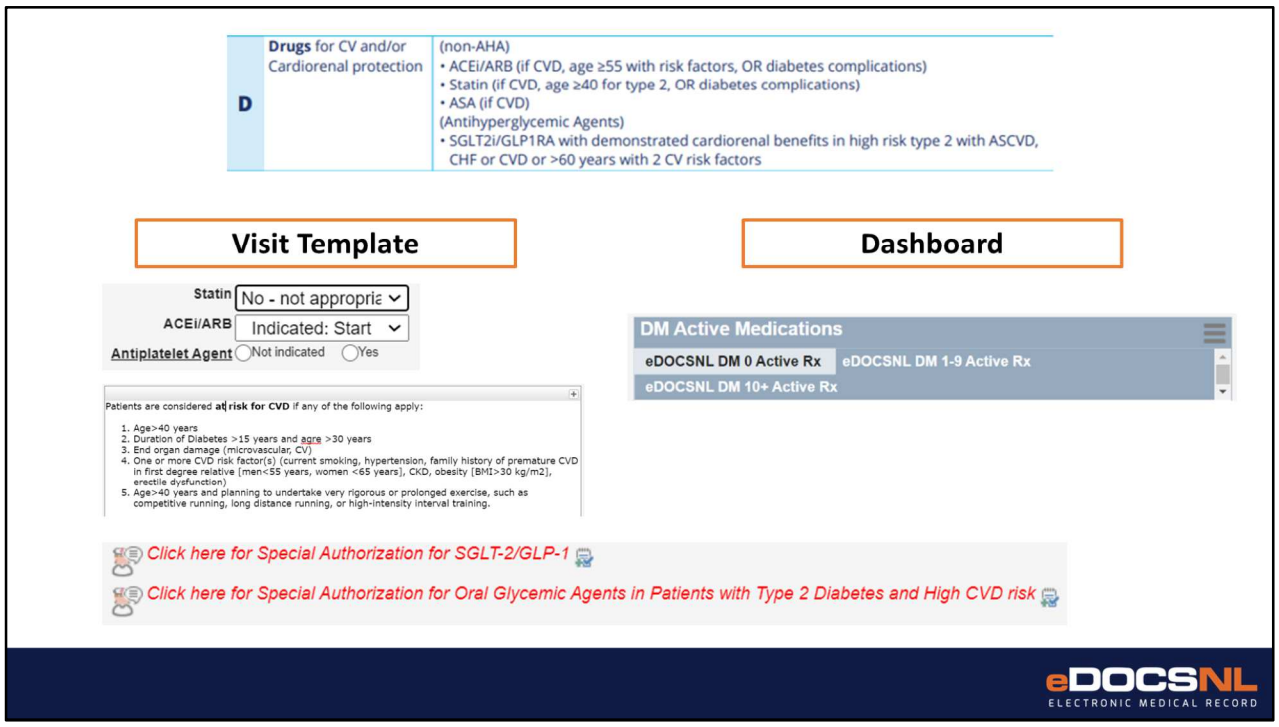
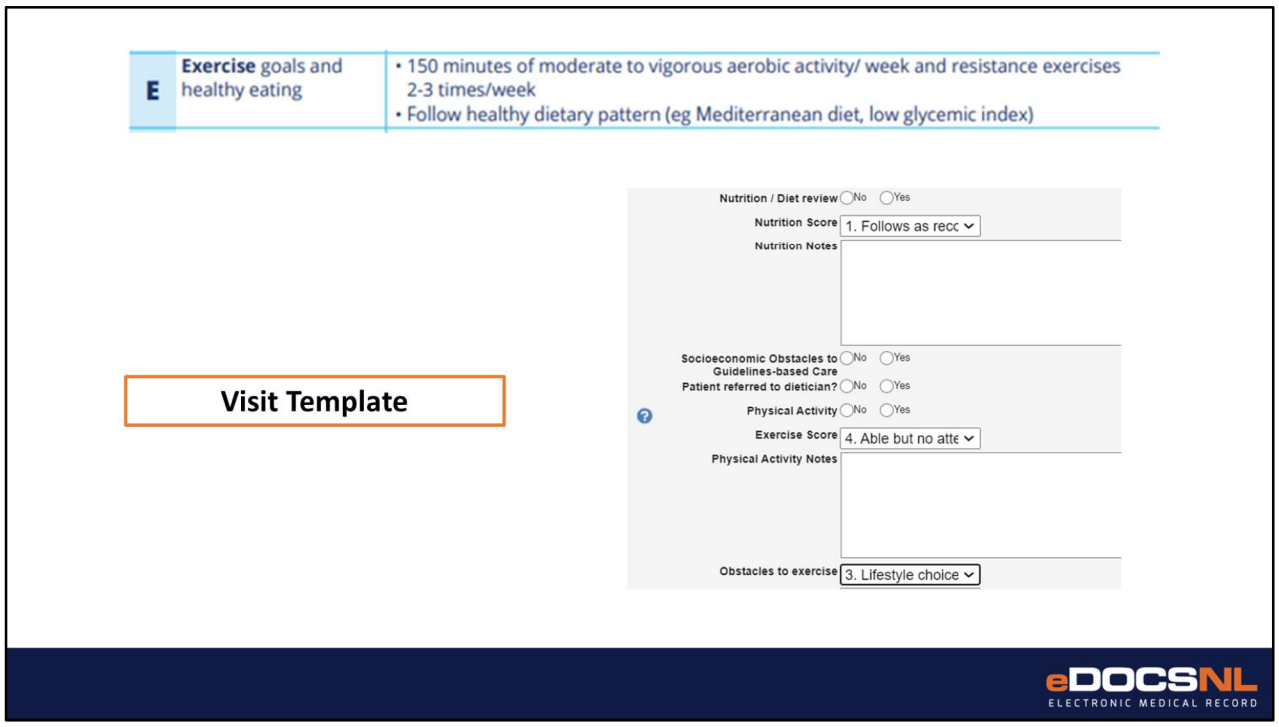


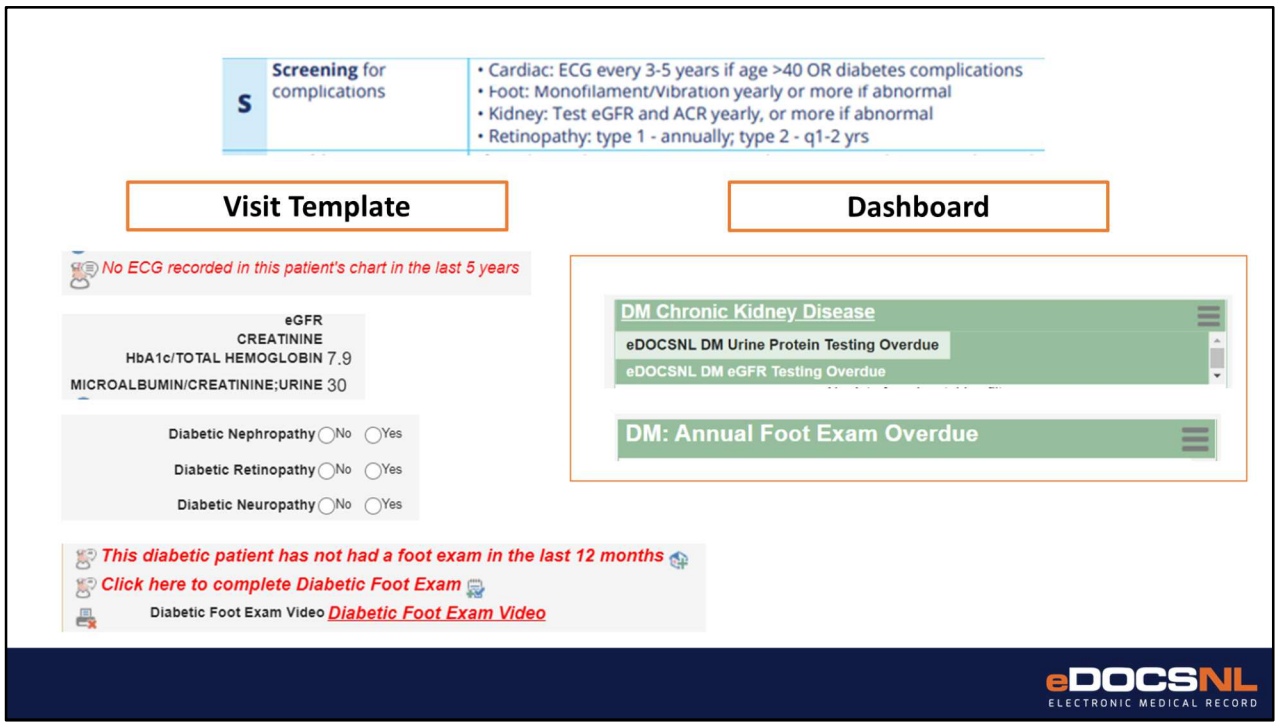
The eDOCSNL Diabetes visit template highlights CV risk and reminds providers to consider the best practice guidelines for medical management of diabetes.
The template also provides easy access to the necessary special authorization form for drug coverage for glycemic agents indicated for high CV risk patients.
The reporting dashboard provides a population level overview of medical management for the provider's diabetic population.



The diabetes visit template encourages physicians to review exercise and nutrition with patients.

There is an extensive reference library attached to the template as well with many educational resources for patients, including materials on the topic of lifestyle choices and management of diabetes.

The care plan encourages referral to Diabetes management programs which educate patients and promote a healthy lifestyle supportive of best practice management of diabetes.



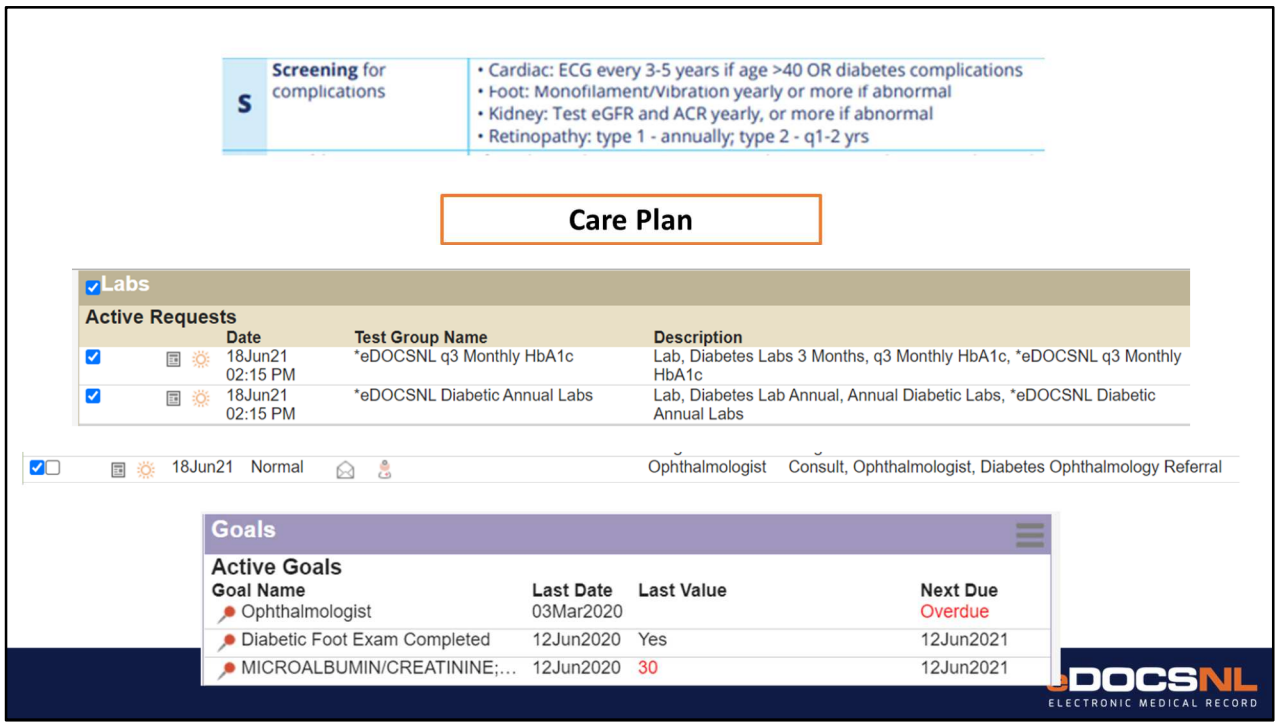
Screening for complications is one of the strengths of the eDOCSNL Practice 360 diabetes tools.

There are several clinical decision support triggers built into the template specific to screening for diabetic complications, including CV risk and diabetic neuropathy.

As a compliment to these alerts, the tools and educational resources to manage the patient are built directly into the template as well as the opportunity to directly add diagnoses to the patients medical profile, which can enable further software functionality and is data that is necessary to populate the reporting dashboard.

The goals activated through the eDOCSNL Diabetes care plan also support the at-a-glance assessment of progress with monitoring patients for complications and visual reminders of overdue notices for these screening elements.

Finally, the diabetes reporting dashboard provides a population-level view of information relevant to the complications of diabetes in your diabetic patient population.



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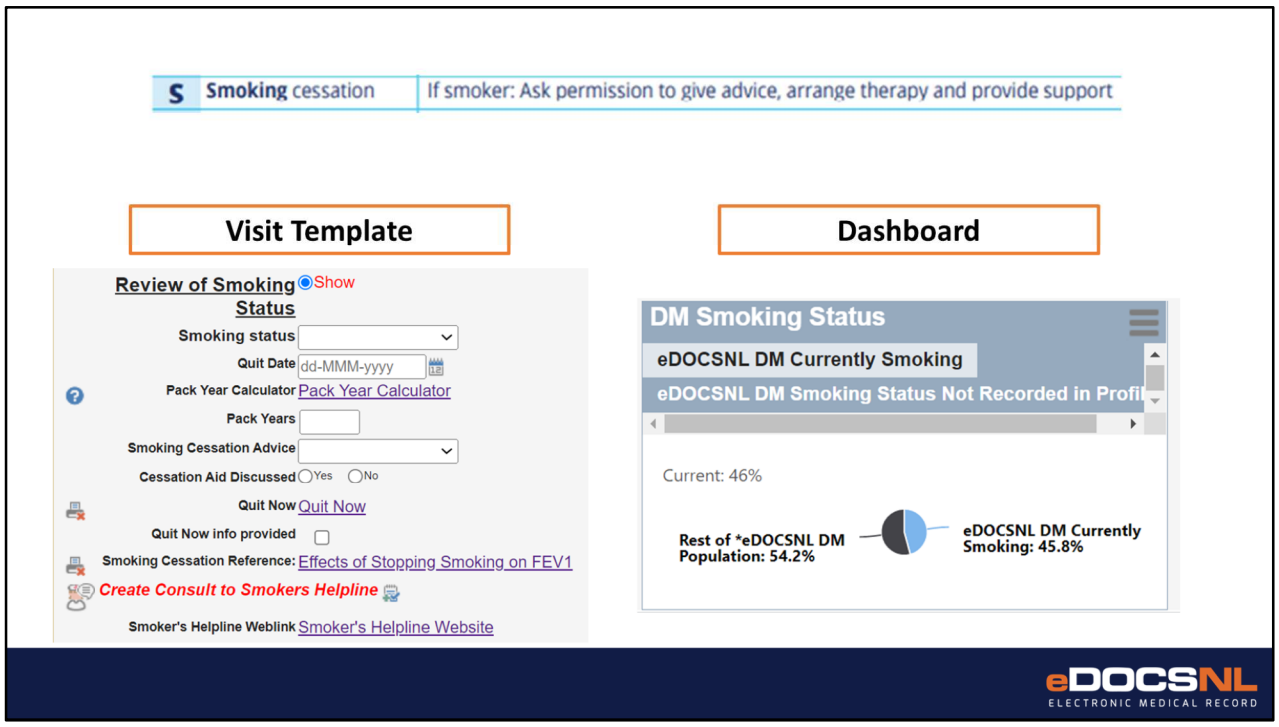
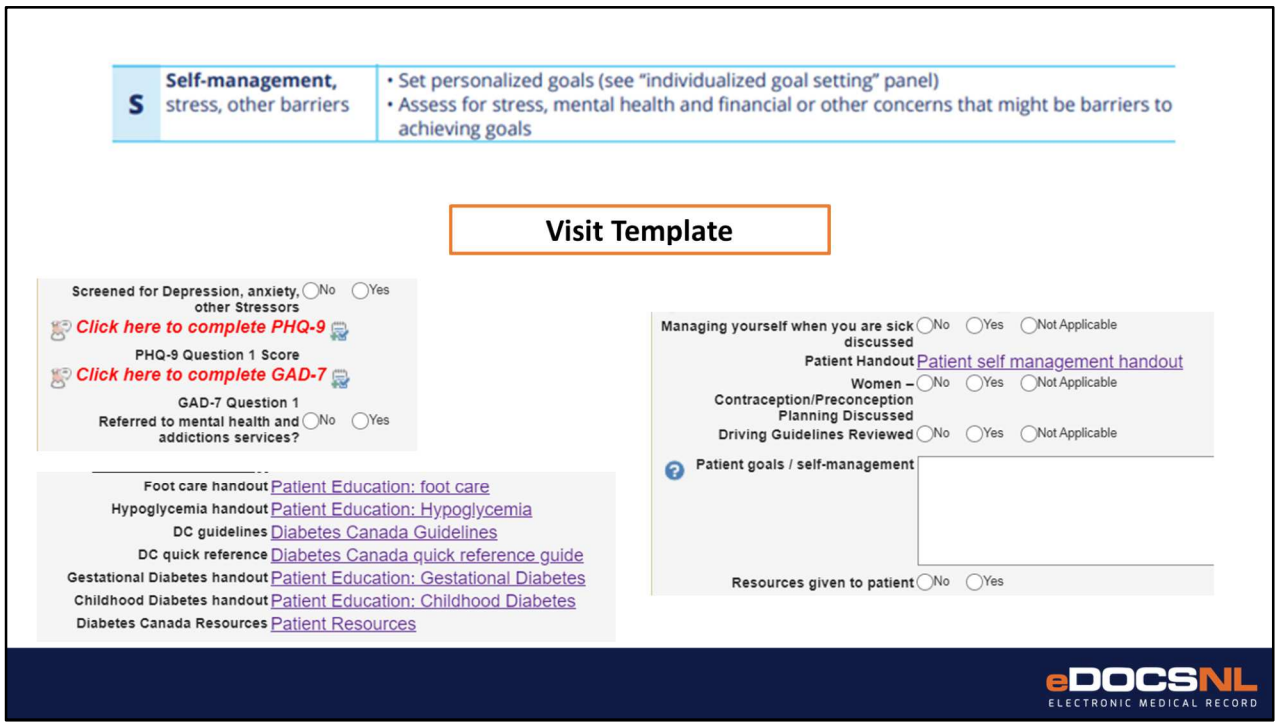
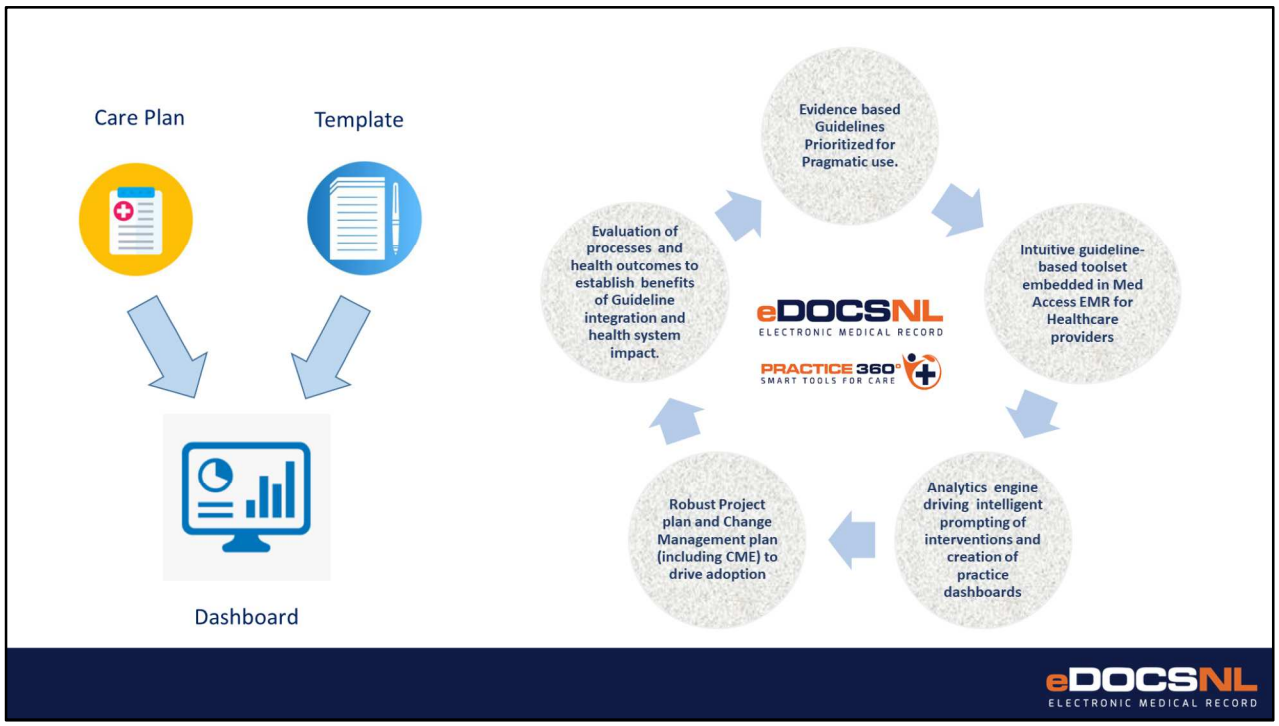


Providers are prompted to discuss smoking status and provide smoking cessation advice, with embedded tools to support the patient with existing services.
The diabetes reporting dashboard alerts providers to the proportion of and identity of their diabetic patients who smoke and also highlights diabetic patients for whom the provider has not reviewed smoking status. You can't manage what you aren't aware of!



Using the eDOCSNL tools, patients are empowered for self-management. Providers are prompted to review mental health status, with associated scoring tools, and discuss self management with the patient.
The extensive resource library attached to the visit template supports patient education and self-management.



The components of the toolset are mutually reinforcing and address the ABCDES of guidelines-driven diabetes care.
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 review the remainder of the presentation series which can be found on the eDOCSNL website at eDOCSNL.ca under the Practice 360 tab.