Practice 360 Diabetes Tools: How can my EMR support Diabetes Clinical Practice Guidelines?

Survey Reminder: https://survey.alchemer-ca.com/s3/50149604/Diabetes360CME

Land Acknowledgement

We acknowledge that the lands on which we gather and conduct our business are located in the traditional territories of diverse Indigenous groups, and acknowledge with respect the diverse histories and cultures of the Beothuk, Mi'kmaq, Innu and Inuit of the province of Newfoundland and Labrador.

We strive for respectful relationships with all the peoples of this province as we search for collective healing and true reconciliation and honor this beautiful land together.

Faculty/Presenter Disclosure

- Presenters: Dr. Fred Melindy
- Relationships with financial sponsors: None
- Speakers Bureau/Honoraria: None
- Presenter is employed by eDOCSNL/NLCHI
- Grants/Research Support - None

Practice 360° Clinical Advisors

- Dr. Peter Senior MBBS, PhD, FRCP, FRCPC(E) - Edmonton AB – National Clinical Practice Guidelines Committee
- Dr. Harpreet Bajaj MD, MPH, FACE, -Brampton ON – National Diabetes Guidelines Committee
- Dr. Zaina Albalawi MD, FRCPC – Calgary, AB– Co-Author National Diabetes Guidelines

DIABETES CANADA

Practice 360° Physician Education Team

- Dr. Roxanne Cooper
- Dr. Celine Dawson
- Dr. Tony Gabriel

Agenda

- Etiquette
- Practice 360° Project Overview
- Why this is important to me and my practice?
- ABCDESSS of Diabetes – Clinical Practice Guidelines
- Demo of Practice 360 Diabetes Visit template and other tools – practical application of the tools
- Reflection and Q&A
- Next Steps

https://survey.alchemer-ca.com/s3/50149604/Diabetes360CME

Poll everywhere question

Respond at **PollEv.com/fredmelindy788**

Text **FREDMELINDY788** to **37607** once to join, then text your message

What's your next holiday destination?

Purpose

- The purpose of today's training session is to provide education on how to use the National Diabetes Guideline Integrated Visit Template and Toolset within your Med Access EMR.

Learning Objectives

- At the conclusion of this activity, participants will be able to:
  - explain the ABCDES of the Diabetes Clinical Practice Guidelines and how the MedAccess EMR prompts and supports the delivery of the ABCDESSS of guideline-based care.
  - effectively navigate through the Diabetes Chronic Disease Management Visit Template and associated Dashboards to support delivery of best practice diabetes care and support practice management goals.
  - provide Diabetes chronic disease management through the Med Access EMR toolset in a planned, proactive manner.

Why eDOCSNL CDM??

Why Implement a Diabetes CDM EMR Toolset?

Project objectives:

1. To improve patient safety & quality of outcomes.
2. To facilitate (and ideally improve) clinical integration and adoption of Diabetes Guidelines.
3. To simplify the utilization of best practices through seamless integration at point of care.
4. To lay a cornerstone for a provincial Diabetes observational database and analytics capability.
5. To support continuous improvement.
6. To advance the mature use of the EMR to demonstrate clinical value of eDOCNSL.
7. To demonstrate efficiency measures of eDOCSNL.

Overload

- “Too many patients, not enough me”
- “Too much information, not enough time”
- “Too many expectations, not enough capacity”
- New medical articles are appearing at a rate of at least one every 26 seconds* or over 1.2 million per year.
    - If a physician were to read every medical journal published, they would need to read 5000 articles per day.*
- Joule (A CMA Company) CPG Infobase contains approximately 1,200 evidence-based Canadian clinical practice guidelines (CPGs) endorsed by authoritative medical or health organizations in Canada.

Source: Proliferations of Scientific Medical Journals: A Burden or A Blessing ,Stephen Garba, Adamu Ahmed, Ahmed Mai, Geoffery Makama, and Vincent OdigieOman Med J. 2010 Oct;2010


Evidence based Guidelines Prioritized for Pragmatic use.
Intuitive guideline-based toolset embedded in Med Access EMR for Healthcare providers
Analytics engine driving intelligent prompting of interventions and creation of practice dashboards
Robust Project plan and Change Management plan (including CME) to drive adoption
Evaluation of processes and health outcomes to establish benefits of Guideline integration and health system impact.
eDOCSNL
ELECTRONIC MEDICAL RECORD
PRACTICE 360°
SMART TOOLS FOR CARE

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

Focus on the ABCDES

Faculty/Presenter Disclosure

- Faculty: Dr. Zaina Albalawi
- Relationships with financial sponsors:
  - Speaker honorarium, Consultancy, CME delivery
    - S&L Solutions Event Management Inc., Palliser Primary Care Network, Diabetes Update. Behringer Ingelheim, AstraZeneca, Diabetes Canada, Canadian Collaborative Research Network, Canadian Medical & Surgical Knowledge Translation Research Group, Novo Nordisk.
- Grants/Research Support: University of Alberta Hospital Foundation, Alberta Health Services, CIHR
  - Grant for Clinical Trial in postoperative outcomes, intervention: ERAS protocol, Evaluation of footcare outcomes in AB
- Co-author 2018 Diabetes Canada Clinical Practice Guidelines

Diabetes Canada Clinical Practice Guidelines

the ABCDESSS Framework (2020)

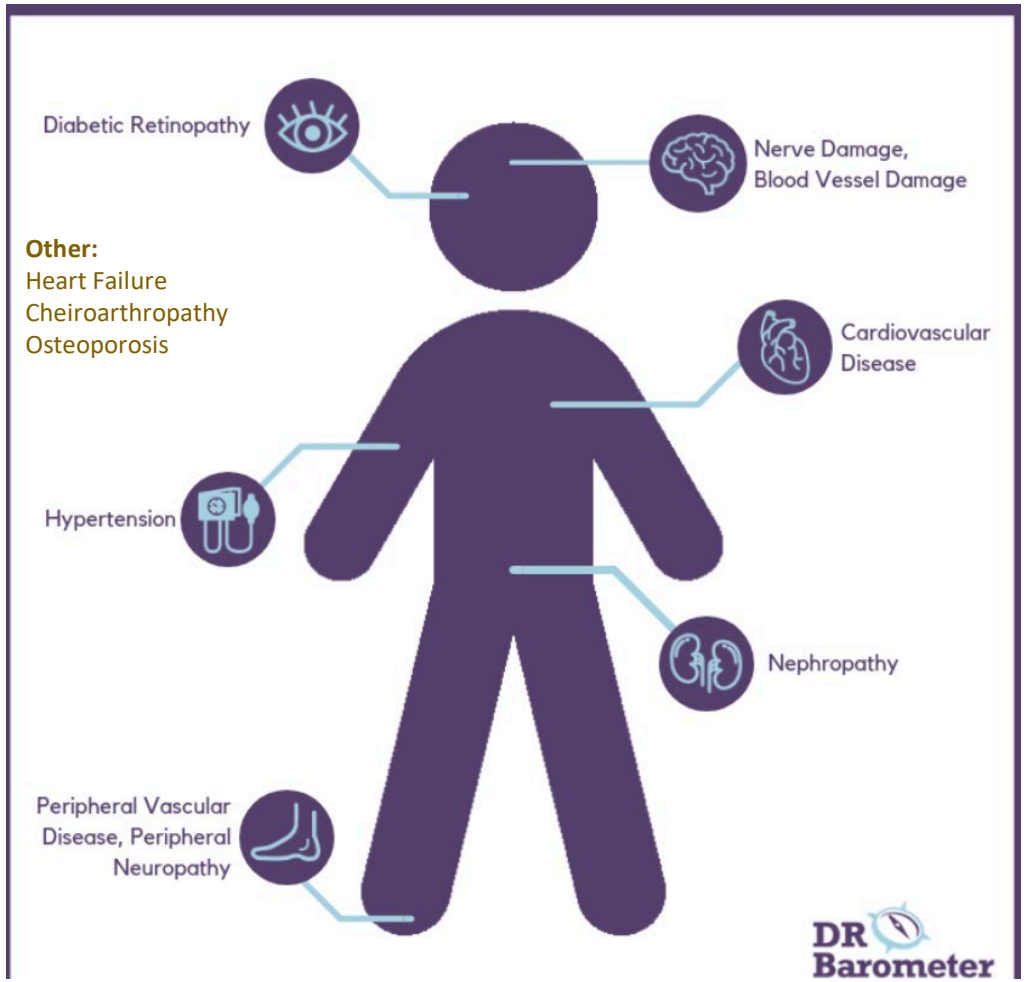
Practice 360° – Diabetes Toolset Training Program

Objectives

1. Discuss key principles in the approach to diabetes care in clinic

2. Overview of the ABCDES^3 Framework (2020)

Key Principles In The Approach To Diabetes Care



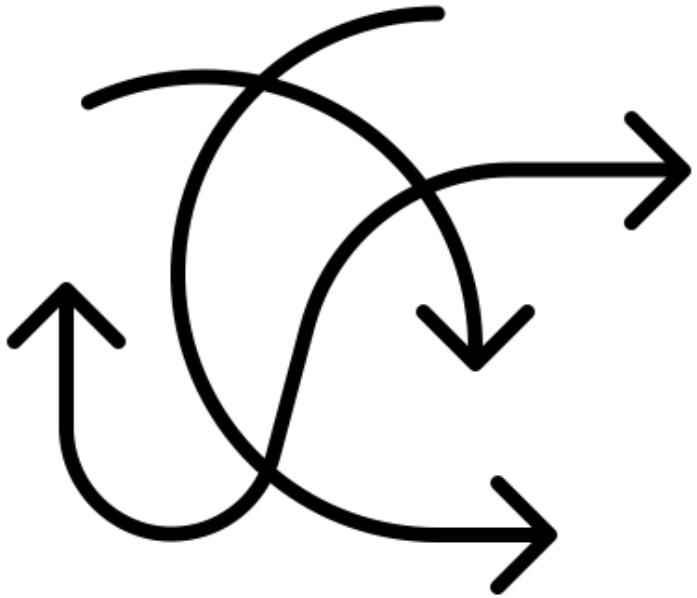
Background

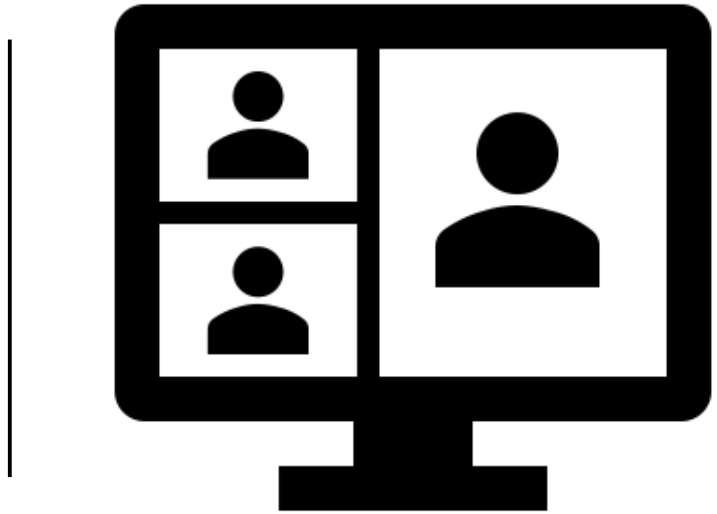
- Distinguishing between type 1 and type 2 diabetes → distinct pathophysiology
- Diabetes is associated with microvascular, macrovascular, and other complications

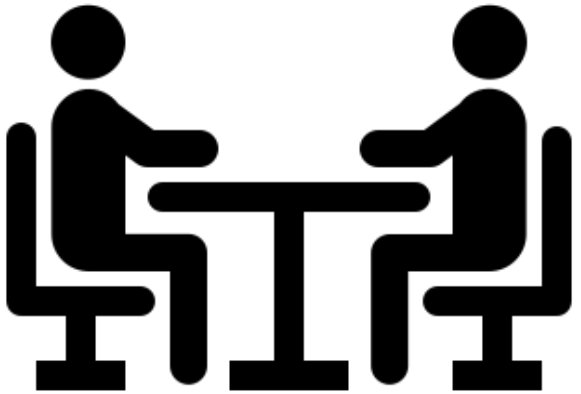
Goals

- Reduce complications
- Keep people safe
- Support self-management

Image courtesy of DRBarometer







Navigating Diabetes Care

Where to start?

eDOCSNL
ELECTRONIC MEDICAL RECORD

PRACTICE 360°
SMART TOOLS FOR CARE

The ABCDES^3 Framework For Diabetes Care

ABCDES of diabetes care

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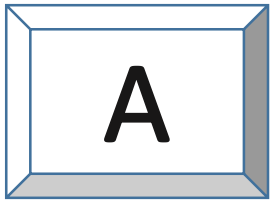
DIABETES CANADA



	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

A1C%	Targets
≤6.5	Adults with type 2 diabetes to reduce the risk of CKD and retinopathy if at low risk of hypoglycemia*
≤7.0	**MOST ADULTS WITH TYPE 1 OR TYPE 2 DIABETES**
7.1 ↓ 8.5	Functionally dependent*: **7.1-8.0%** Recurrent severe hypoglycemia and/or hypoglycemia unawareness: **7.1-8.5%** Limited life expectancy: **7.1-8.5%** Frail elderly and/or with dementia†: **7.1-8.5%**
	Avoid higher A1C to minimize risk of symptomatic hyperglycemia and acute and chronic complications

End of life: A1C measurement not recommended. Avoid symptomatic hyperglycemia and any hypoglycemia.
* based on class of antihyperglycemic medication(s) utilized and the person's characteristics
† see Diabetes in Older People chapter

Practical Points

- HbA1c every 3-6 months
- **Consider** factors that may may affect HbA1c accuracy (e.g. hemoglobinopathies, iron deficiency, hemolytic anemia, severe hepatic and renal disease)
- If CGM is used or Flash glucose monitor: consider using Time-In-Range (TIR)

Poll everywhere question

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Iron deficiency anemia and kidney disease (renal failure) are associated with falsely low HbA1c levels

True

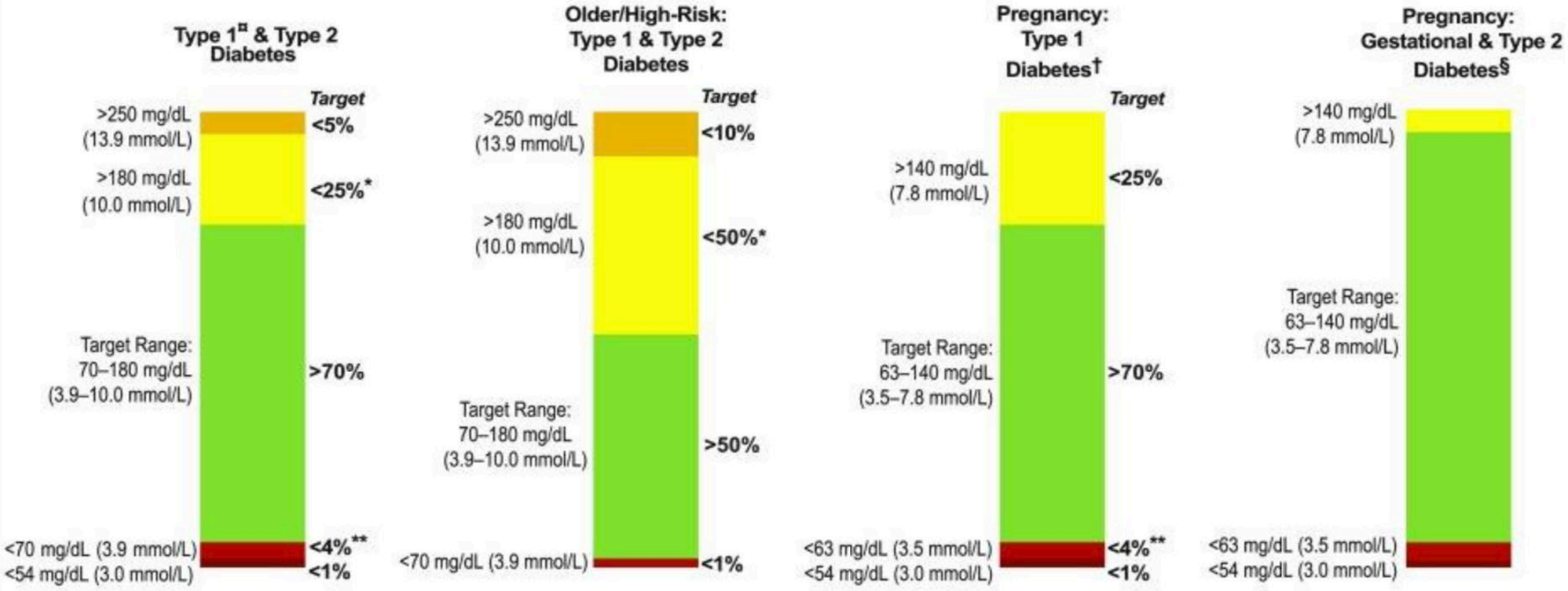
False

Nonglycemic Factors That May Interfere with HbA1c Measurement

Falsely lower A1C	**Lower or elevate A1C**
Acute blood loss	Hemoglobinopathies or hemoglobin variants
Chronic liver disease	Malnutrition
Hemolytic anemias	**Falsely elevate A1C**
Patients receiving antiretroviral treatment for human immunodeficiency virus	Aplastic anemias
Pregnancy	Hyperbilirubinemia
Vitamins E and C	Hypertriglyceridemia
	Iron deficiency anemias
	Renal failure
	Splenectomy

Am Fam Physician. 2016 Jan 15;93(2):103-109

Time-In-Range (TIR): An Alternat to HbA1c



¤ For age <25 yr., if the A1C goal is 7.5%, then set TIR target to approximately 60%. (See *Clinical Applications of Time in Ranges* section in the text for additional information regarding target goal setting in pediatric management.)

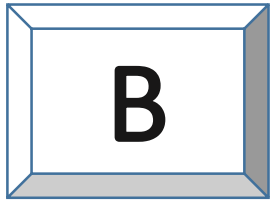
† Percentages of time in ranges are based on limited evidence. More research is needed.

§ Percentages of time in ranges have not been included because there is very limited evidence in this area. More research is needed. Please see *Pregnancy* section in text for more considerations on targets for these groups.

* Includes percentage of values >250 mg/dL (13.9 mmol/L).

** Includes percentage of values <54 mg/dL (3.0 mmol/L).

Battelino, Tadej et al. "Clinical Targets for Continuous Glucose Monitoring Data Interpretation: Recommendations From the International Consensus on Time in Range." *Diabetes care* vol. 42,8 (2019): 1593-1603. doi:10.2337/dci19-0028



B	**BP** targets	BP <130/80 mmHg If on treatment, assess for risk of falls

Practical Points

- At least annual assessment, and more often if BP is high

- **1st line:** ACEI or ARB if following factors present:
  - CV disease
  - Kidney disease
  - CV risk factors (+HTN)

Essential Resource: Hypertension Canada

Poll everywhere question

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In individuals with diabetes and HTN, what is the recommended 2nd line pharmacotherapy if ACEi/ARB is inadequate?

ACEi/ARB + HCTZ
ACEi/ARB + Indapamide
ACEi/ARB + CCB
ACEi/ARB + SGLT-2-in

C	**Cholesterol** targets	LDL-C <2.0 mmol/L (or >50 % reduction from baseline)

Practical Points

- Annual assessment
- Risk calculation not required in most cases
- >40 years old
- >30 years old +>15 years of Diabetes
- Or presence of micro or macrovascular complications

D

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

Practical Points

- No role for ASA in 1ry prevention
- Consider costs and coverage, renal function, comorbidity, side effect profile, and potential for pregnancy

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

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




Poll everywhere question

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When should screening for microvascular and macrovascular complications be initiated in individuals with type 1 diabetes?

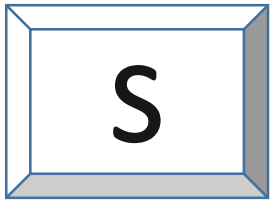
At diagnosis

3 years post diagnosis

5 years post diagnosis

S

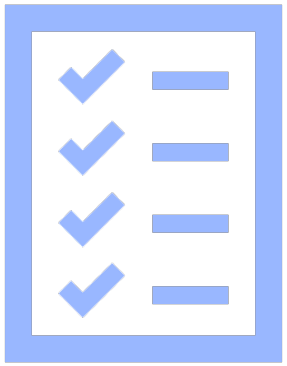
S	**Smoking** cessation	If smoker: Ask permission to give advice, arrange therapy and provide support



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

Individualized goal setting

Potential Self-management Goals	Examples
Eat healthier	See a dietitian to help develop a healthy eating plan.
Be more active	Increase physical activity with the goal of getting to 150 minutes aerobic activity/week and resistance exercise 2-3 times/week. Choose physical activity that meets preferences/needs.
Lose weight	Use strategies (e.g., reduce calories or portions) to lose 5-10% of initial weight.
Take medication regularly	Taking medication will help to improve symptoms and take control of your life. Consider using a pillbox or setting a timer.
Avoid hypoglycemia	Recognize the signs of hypoglycemia and take action to prevent it.
Check blood glucose	Establish a routine and act accordingly.
Check feet	Do a daily self-check and follow-up with a health-care provider if anything is abnormal.
Manage stress	Screen for distress (depressive and anxious symptoms) by interview or a standardized questionnaire (e.g. PHQ-9 www.phqscreeners.com).



Specific **M**easurable **A**chievable **R**ealistic **T**imely

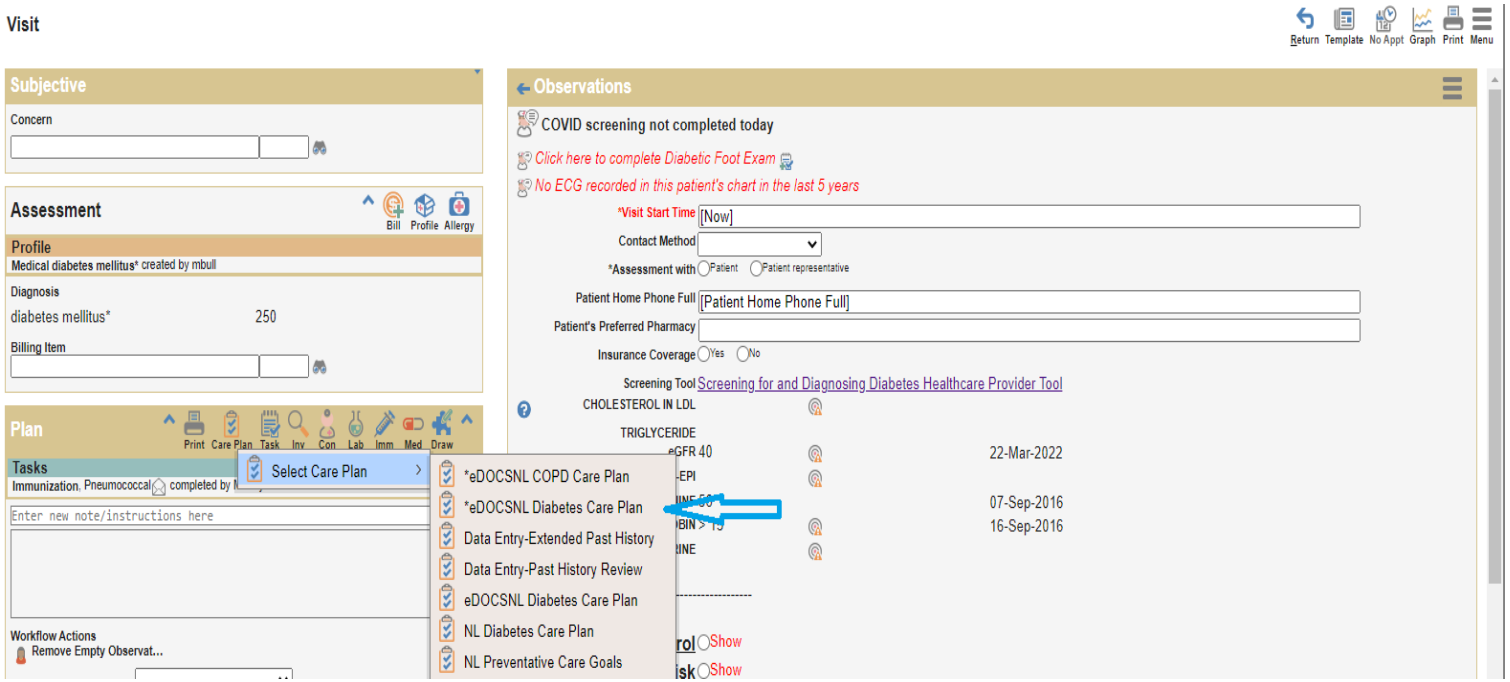
In Summary

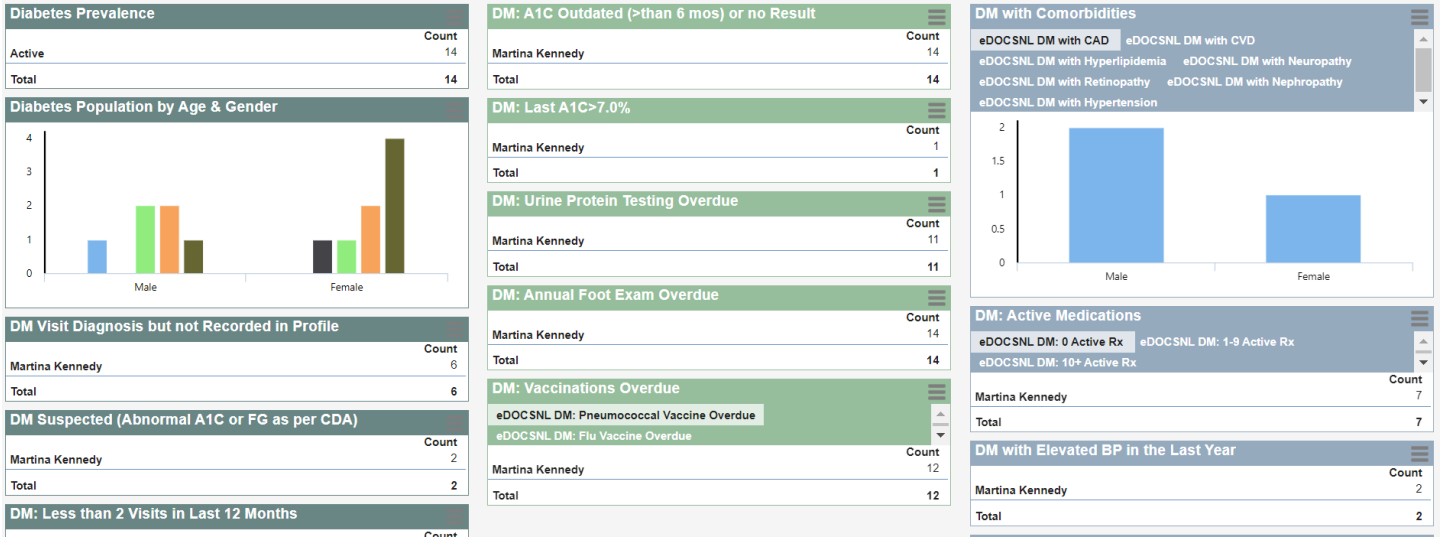
- Diabetes (type 1 and type 2) are conditions with distinct pathophysiology
- Shared principles in diabetes care include:
  - Reducing complications
  - Keeping people safe
  - Supporting self-management
- The Diabetes Canada 2020 ABCDESSS approach provides a framework for structuring diabetes care
- The ABCDESSS framework is integrated into the diabetes flow sheet using eDOCSNL

Q & A

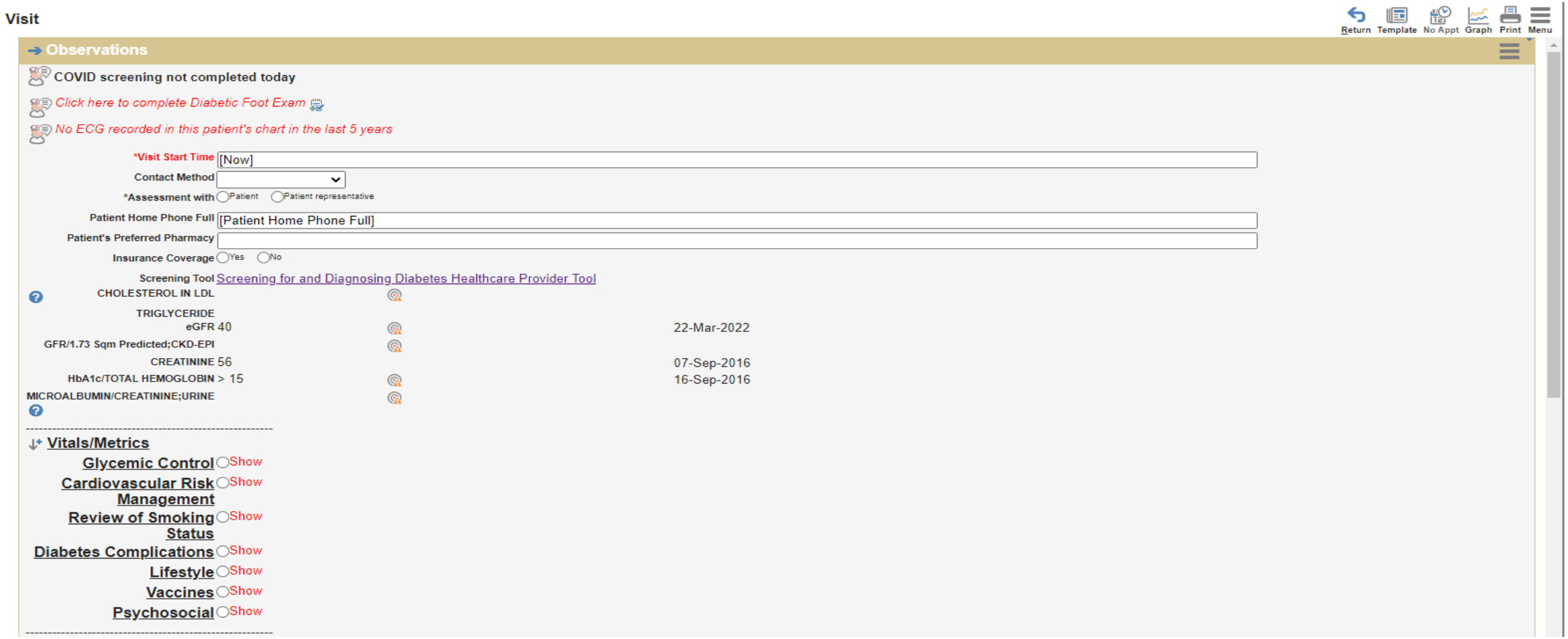
Diabetes Toolset: Introduction

- 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

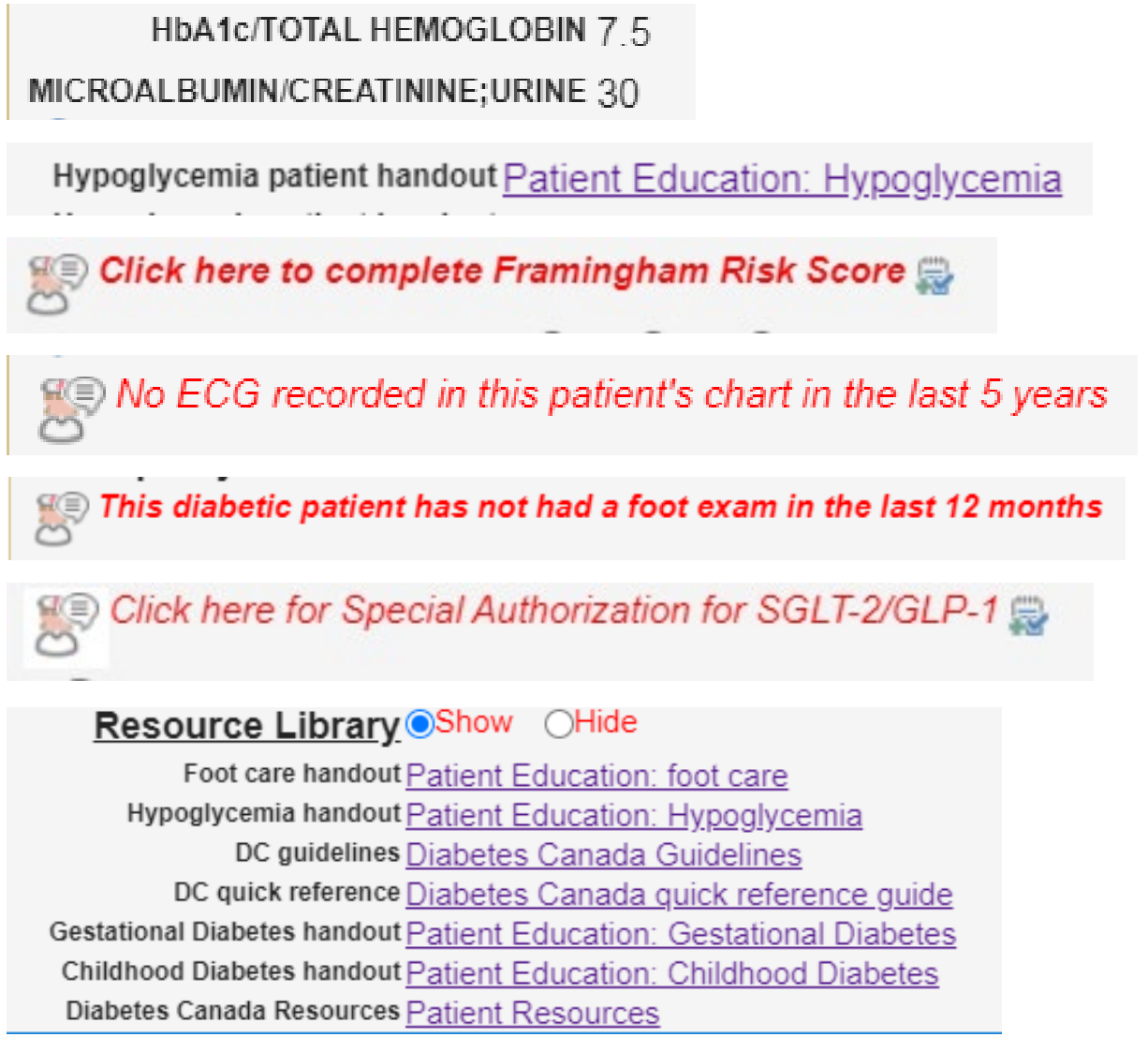




The eDOCSNL Diabetes Visit Template



- The diabetes visit template has a number of embedded advanced features:
  - Automatically populated metrics from other eHealth systems
  - Embedded clinical decision support triggers
  - Directly executable forms and tasks
  - Information from Diabetes Canada guidelines
  - Launchable calculators and web-links
  - Educational resources for patients and providers



The eDOCSNL Diabetes Care Plan

Patient Summary

Care Plan eDOCSNL Diabetes Care Plan

Profile

Medical

Status	Onset	Type	Description	Note	Severity	Risk	Updated
Current			Cerebrovascular Disease			✔	11Dec19
Current			Chronic Kidney Disease			✔	09Oct19
Current			COPD - Chronic obstructive pulmonary disease			✔	09Oct19
Current			Coronary Vascular Disease			✔	09Oct19
Current			Diabetes mellitus type 1			✔	12Dec19
Current			Diabetes Mellitus Type 2			✔	24Sep19
Current			Diabetic Nephropathy			✔	12Dec19
Current			Diabetic Retinopathy			✔	09Oct19
Current			Essential Hypertension			✔	12Dec19
Current			Gestational diabetes			✔	09Oct19
Current			Hyperlipidemia			✔	09Oct19
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

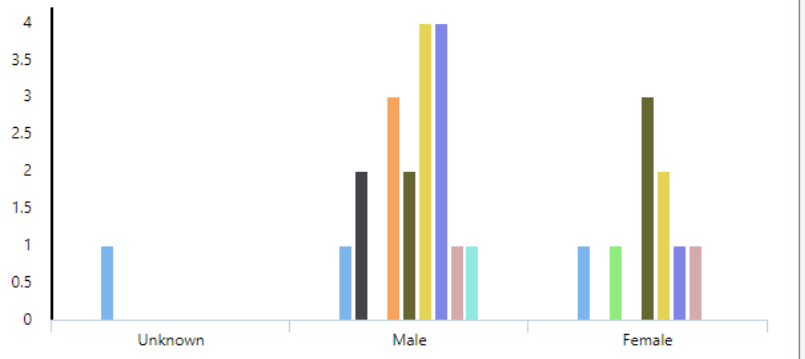
Date	Test Group Name	Description	Observations
08Sep20 07:59 PM	eDOCSNL NAFLD Screening bloodwork	Lab, NAFLD Screening (ALT), nnual Screening Bloodwork for NAFLD, eDOCSNL NAFLD Screening bloodwork	
30Oct19 10:40 AM	eDOCSNL q3 Monthly HbA1c	Lab, Diabetes Labs 3 Months, q3 Monthly HbA1c, eDOCSNL q3 Monthly HbA1c	
02Oct19 11:22 AM	eDOCSNL Diabetic Annual Labs	Lab, Diabetes Lab Annual, Annual Diabetic Labs, eDOCSNL Diabetic Annual Labs	

The eDOCSNL Diabetes Reporting Dashboard

Diabetes Prevalence

	Count
Active	28
Total	28

Diabetes Population by Age & Gender



DM Visit Diagnosis but not Recorded in Profile

	Count
Kim Dadd	1
Total	1

DM Suspected (Abnormal A1C or FG as per CDA)

	Count
Kim Dadd	1
Total	1

DM Less than 2 Visits in Last 12 Months

	Count
Kim Dadd	27
Total	27

DM A1C Outdated (>than 6 mos) or no Result

	Count
Kim Dadd	28
Total	28

DM Last A1C > 7.0%

	Count
Kim Dadd	1
Total	1

DM Chronic Kidney Disease

eDOCSNL DM Urine Protein Testing Overdue | eDOCSNL DM GFR Testing Overdue

	Count
Kim Dadd	27
Total	27

DM Annual Foot Exam Overdue

	Count
Kim Dadd	27
Total	27

DM Vaccinations Overdue

eDOCSNL DM Pneumococcal Vaccine Overdue | eDOCSNL DM Flu Vaccine Overdue

	Count
Kim Dadd	28
Total	28

DM with Comorbidites

eDOCSNL DM with CAD | eDOCSNL DM with CVD | eDOCSNL DM with Hyperlipidemia | eDOCSNL DM with Neuropathy | eDOCSNL DM with Retinopathy | eDOCSNL DM with Nephropathy | eDOCSNL DM with Hypertension

	Count
Kim Dadd	3
Total	3

DM Active Medications

eDOCSNL DM 0 Active Rx | eDOCSNL DM 1-9 Active Rx | eDOCSNL DM 10+ Active Rx

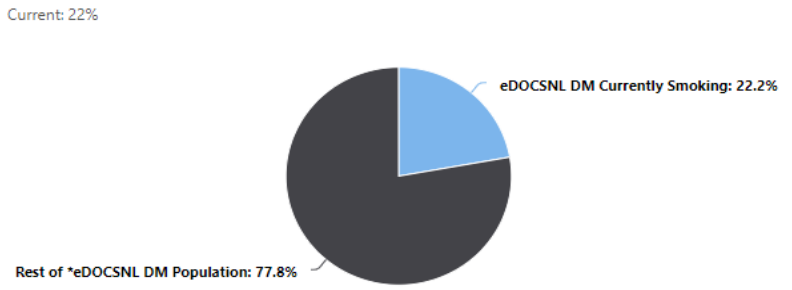
	Count
Kim Dadd	24
Total	24

DM with Elevated BP in the Last Year

	Count
Kim Dadd	2
Total	2

DM Smoking Status

eDOCSNL DM Currently Smoking | eDOCSNL DM Smoking Status Not Recorded in Profile



eDOCSNL
ELECTRONIC MEDICAL RECORD

Why use the Practice 360 Diabetes Tools?

DIABETES CANADA
CLINICAL PRACTICE GUIDELINES

Designed to support guidelines-based care

Efficiency measures throughout the toolset make following guidelines easy

Population level data informs best-practice care; put your data to work for your patients!

One stop shop for documentation and tasking collects and summarizes clinical information succinctly

Reminders, alerts and individualized patient goals provides at-a-glance patient summary to support clinical decision making

Case Study

- 54-year-old male, longstanding Type 2 Diabetes
- Hx of hyperglycemia and challenges with adherence to healthy behaviour interventions.
- Rx: Metformin 1000mg BID, Gliclazide MR 120mg daily, perindopril 8mg daily (non-adherent)
- Hx of high BP (last reading 146/94), high BMI (last measurement 32.4), has had high LDL in the past, last A1C 9%, family hx of CVD
- Reports occasional chest pain, no pattern, not present today
- This is his first office visit in over a year

Managing the case using Practice 360

- First – look at the labs, vitals and triggers: I have a patient with poorly controlled diabetes with high BP, high BMI and high LDL
- Proceed to the CV risk section
  - Highlights from the guidelines – this patient is high risk, indicate in the question – this feeds into further functionality
  - Highlight Framingham. Framingham risk score pulls in (if previously exists).
  - The patient has not had a recent EKG (trigger)
  - Check the meds in the sidebar - Is a statin indicated? Go back to the verbiage from guidelines. Is an ACEi/ARB indicated?
  - Does the patient need an antiplatelet agent?
  - Should they be considered for an SGLT-2/GLP?
  - Is he a smoker? Indicate the smoking section
  - Do they need dietary and exercise advice? This is in the “lifestyle” section
  - Print Patient resources from the Resource library section
  - Run the careplan – first time you are using these tools
    - Add some profile items (family Hx of CVD, DM type 2)
    - Order BW and EKG
    - Refer to a diabetes collaborative
    - Setup the goals

Poll everywhere question

When poll is active, respond at **PollEv.com/fredmelindy788**

Text **FREDMELINDY788** to **37607** once to join

How do the practice 360 diabetes tools support the monitoring and evaluation of diabetes patients at risk for CVD?

Clinical decision support triggers highlight elements of care and monitoring

Individualized goals allow tracking of relevant labs/metrics

Highlights from guidelines help identify patients at risk for CVD

Embedded tools and resources assist with evaluation and monitoring

All of the above

Poll everywhere question

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What is the difference between triggers and goals in Med Access?

- Triggers appear in the sidebar whereas goals appear at the top of the chart
- Goals can be individualized whereas triggers apply as configured across the entire patient population
- Only goals can contain clinically relevant information
- Goals disappear when the patient meets the criteria for the goals to appear whereas triggers are always visible
- All of the above

Break

Case Study

- 72-year-old female
- Longstanding Type 2 Diabetes
- Sugars within target on Metformin 1000mg BID, Sitagliptin 100mg daily, Gliclazide MR 60mg daily (last A1c 6.5%)
- Last BP 125/76, BMI 26.8
- Kidney parameters: Cr 110, eGFR 47, ACR/microalbumin 18 (persistent)
- Sees optometrist regularly – last visit was told there are some “changes associated with diabetes”
- Presents with “weakness”
- During the encounter she reports numbness and swelling in the feet worsening over last 3 months

Managing the case using Practice 360

- The diabetes visit template can be pulled into any visit template you may be using – users often report that they are seeing a patient for something else and diabetes related issues come up secondary to the presenting complaint
- First – look at the labs, triggers and goals: I have a patient with decently controlled long standing diabetes with impaired kidney function and has not seen ophthalmologist in the last year or had foot exam completed
- Today I look at glycemic control section and complications
  - I notice the patient has reported hypoglycemic episodes through the trigger
  - I check the complications section – notice the relevant labs displayed again
  - Check the profile in the sidebar for complications
  - Do an online creatinine clearance calculation
  - Consider further med changes
  - Note patient overdue for foot exam
  - Click to create the foot exam, note the educational video available
  - Document the neuropathy, indicate the foot exam completed
  - Provide the educational resource on foot care to patient or caregiver
  - Run the careplan – refer to the collaborative, contribute to the profile, set her up for recurrent appointments, send to see ophthalmologist
  - Demonstrate customizability of goals – targets and intervals can be changed, goals pinned to top or deferred or cancelled for a variety of reasons
- In general how am I doing with my diabetic population - the dashboard
  - Highlight the diabetic population details
  - Overdue HgBA1c, overdue foot exams, overdue and out of target metrics
  - Chart review patients with DM and CVD
  - Bulk tasking feature is part of dashboard functionality e.g. bath generate reqs for outdated HbA1c using the “services” feature on the report output screen

Poll everywhere question

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Which of the following is the best way to set yourself up for success with following DC guidelines using the Practice 360 tools?

Use the template whenever you want to do a comprehensive review of diabetes but use another template when a patient with diabetes has another complaint

Use the diabetes visit template for every encounter with patients with diabetes in your practice and use the care plan for all your diabetics

Only use goals on patients you are following for acute problems, disable them when the issue is resolved

Ignore the triggers, they are just "noise"

Enter all the information on the template every time you use it, don't omit a single field

Poll everywhere question

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Text **FREDMELINDY788** to **37607** once to join

How do dashboards assist with managing patients with diabetes?

- You can identify your patient population with diabetes
- You can easily see and access patients who have overdue or out of range elements of care and monitoring
- The dashboard can allow you to apply tasks in bulk across the entire population of patients identified in a report
- There are widgets on the dashboard that can assist in identifying patients who have diabetes with comorbidities
- All of the above

Diabetes Toolset: Supporting the Guidelines

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

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

Visit Template

HbA1c/TOTAL HEMOGLOBIN 7.5

Hypoglycemic episodes reported (●) Yes ( ) No

Hypoglycemic episode details

Has patient experienced severe hypoglycemia? ( ) Yes ( ) No

Hypoglycemic episodes per week

Hypoglycemia patient handout Patient Education: Hypoglycemia

Dashboard

DM: A1C Outdated (>than 6 mos) or no Result

DM: Last A1C>7.0%

This patient has multiple A1c readings over 7.0, consider med adjustment

Hypoglycemic episodes reported by this diabetic patient, consider adjusting medications

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

Care Plan

Labs

Active Requests

	Date	Test Group Name	Description
☑	18Jun21 02:15 PM	*eDOCSNL q3 Monthly HbA1c	Lab, Diabetes Labs 3 Months, q3 Monthly HbA1c, *eDOCSNL q3 Monthly HbA1c
☑	18Jun21 02:15 PM	*eDOCSNL Diabetic Annual Labs	Lab, Diabetes Lab Annual, Annual Diabetic Labs, *eDOCSNL Diabetic Annual Labs

Goals

Active Goals

Goal Name	Last Date	Last Value	Next Due
HbA…	03Sep2020	7.5	Overdue

B	**BP** targets	BP <130/80 mmHg If on treatment, assess for risk of falls

Visit Template

Blood Pressure

BP ____/____ mm Hg

Dashboard

DM with Elevated BP in the Last Year

Care Plan

Goals

Active Goals

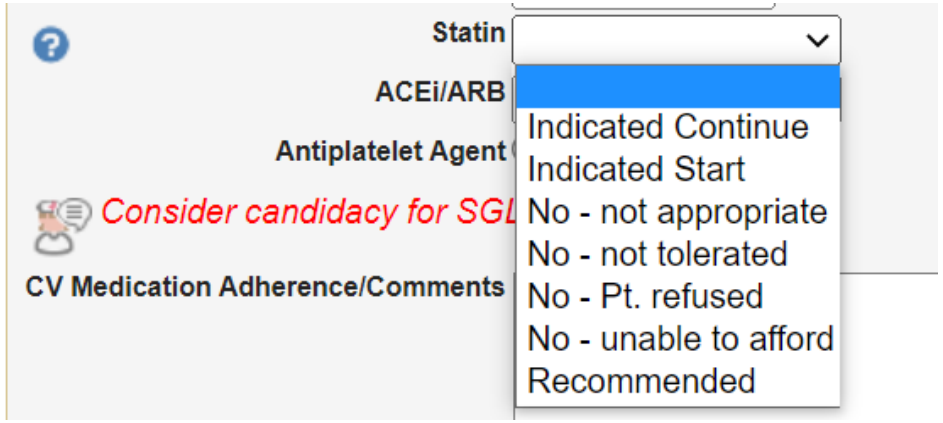
Ophthalmol…		Overdue
HbA1c/TOTA…	8.5	Overdue
BP diastolic	70	30Mar2022
BP systolic	180	04Jun2022

C	**Cholesterol** targets	LDL-C <2.0 mmol/L (or >50 % reduction from baseline)

Visit Template

CHOLESTEROL IN LDL 2.5

Click here to complete Framingham Risk Score



Statin therapy should be used to reduce CV risk in adults with type 1 or type 2 diabetes with any of the following features:

1. Clinical CVD
2. Age>40 Years
3. Age<40 years and 1 of the following:
   - Diabetes duration>15 years and age>30 years
   - Microvascular complications

C	**Cholesterol** targets	LDL-C <2.0 mmol/L (or >50 % reduction from baseline)

Dashboard

Care Plan

DM with Comorbidities

eDOCSNL DM with CAD eDOCSNL DM with CVD

eDOCSNL DM with Hyperlipidemia

Goals

Active Goals

Goal Name	Last Date	Last Value	Next Due
LDL Chol…	13Jun2018	1.8	Overdue

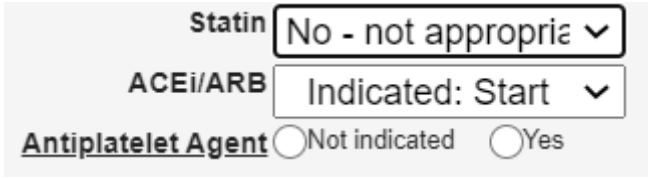
Labs

Active Requests

	Date	Test Group Name	Description
☑	18Jun21 02:15 PM	*eDOCSNL q3 Monthly HbA1c	Lab, Diabetes Labs 3 Months, q3 Monthly HbA1c, *eDOCSNL q3 Monthly HbA1c
☑	18Jun21 02:15 PM	*eDOCSNL Diabetic Annual Labs	Lab, Diabetes Lab Annual, Annual Diabetic Labs, *eDOCSNL Diabetic Annual Labs

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

Visit Template



Patients are considered **at risk for CVD** if any of the following apply:

1. Age>40 years
2. Duration of Diabetes >15 years and agre >30 years
3. End organ damage (microvascular, CV)
4. One or more CVD risk factor(s) (current smoking, hypertension, family history of premature CVD in first degree relative [men<55 years, women <65 years], CKD, obesity [BMI>30 kg/m2], erectile dysfunction)
5. Age>40 years and planning to undertake very rigorous or prolonged exercise, such as competitive running, long distance running, or high-intensity interval training.

Click here for Special Authorization for SGLT-2/GLP-1

Click here for Special Authorization for Oral Glycemic Agents in Patients with Type 2 Diabetes and High CVD risk

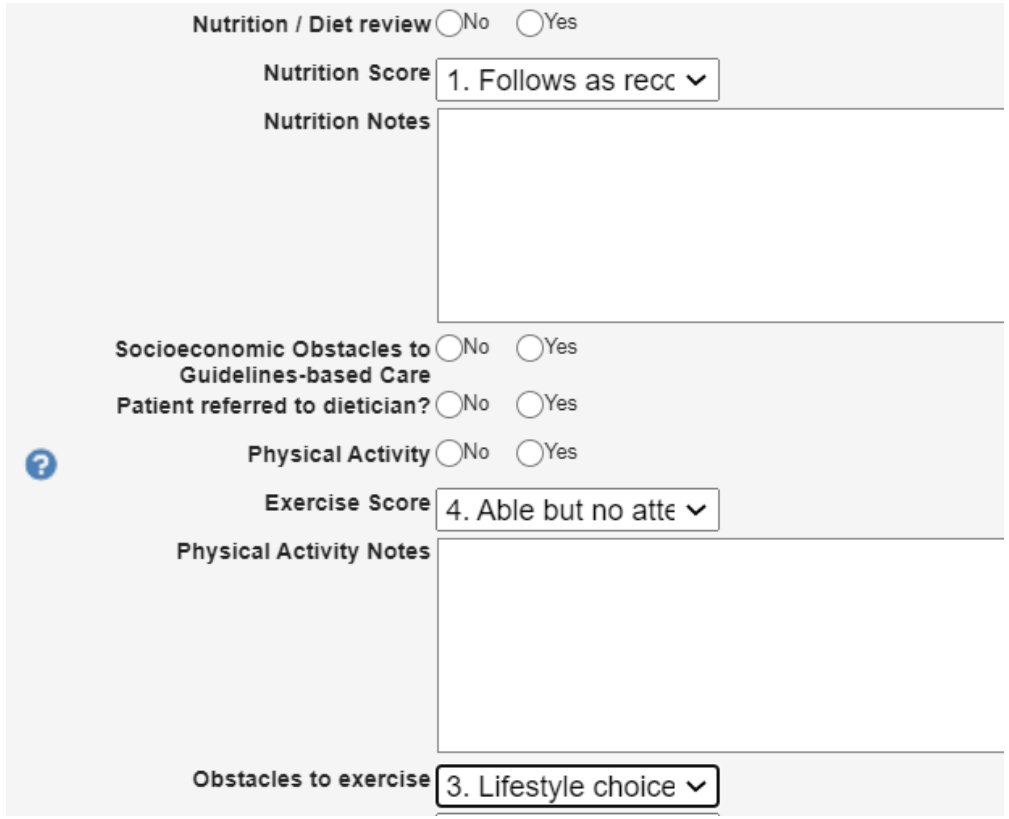
Dashboard

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)

Visit Template

Resource Library Show

Foot care handout	Patient Education: foot care
Hypoglycemia handout	Patient Education: Hypoglycemia
DC guidelines	Diabetes Canada Guidelines
DC quick reference	Diabetes Canada quick reference guide
Gestational Diabetes handout	Patient Education: Gestational Diabetes
Childhood Diabetes handout	Patient Education: Childhood Diabetes
Diabetes Canada Resources	Patient Resources



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

Visit Template

No ECG recorded in this patient's chart in the last 5 years

eGFR CREATININE	
HbA1c/TOTAL HEMOGLOBIN	7.9
MICROALBUMIN/CREATININE;URINE	30

Diabetic Nephropathy	◯No	◯Yes
Diabetic Retinopathy	◯No	◯Yes
Diabetic Neuropathy	◯No	◯Yes

This diabetic patient has not had a foot exam in the last 12 months

Click here to complete Diabetic Foot Exam

Diabetic Foot Exam Video *Diabetic Foot Exam Video*

Dashboard

DM Chronic Kidney Disease

eDOCSNL DM Urine Protein Testing Overdue

eDOCSNL DM eGFR Testing Overdue

DM: Annual Foot Exam Overdue

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

Care Plan

Labs

Active Requests

	Date	Test Group Name	Description
☑	18Jun21 02:15 PM	*eDOCSNL q3 Monthly HbA1c	Lab, Diabetes Labs 3 Months, q3 Monthly HbA1c, *eDOCSNL q3 Monthly HbA1c
☑	18Jun21 02:15 PM	*eDOCSNL Diabetic Annual Labs	Lab, Diabetes Lab Annual, Annual Diabetic Labs, *eDOCSNL Diabetic Annual Labs

☑ ☐	18Jun21	Normal		Ophthalmologist	Consult, Ophthalmologist, Diabetes Ophthalmology Referral

Goals

Active Goals

Goal Name	Last Date	Last Value	Next Due
Ophthalmologist	03Mar2020		Overdue
Diabetic Foot Exam Completed	12Jun2020	Yes	12Jun2021
MICROALBUMIN/CREATININE;...	12Jun2020	30	12Jun2021

S	**Smoking** cessation	If smoker: Ask permission to give advice, arrange therapy and provide support

Visit Template

Review of Smoking Status ◉Show

Smoking status

Quit Date dd-MMM-yyyy

Pack Year Calculator Pack Year Calculator

Pack Years

Smoking Cessation Advice

Cessation Aid Discussed ◯Yes ◯No

Quit Now Quit Now

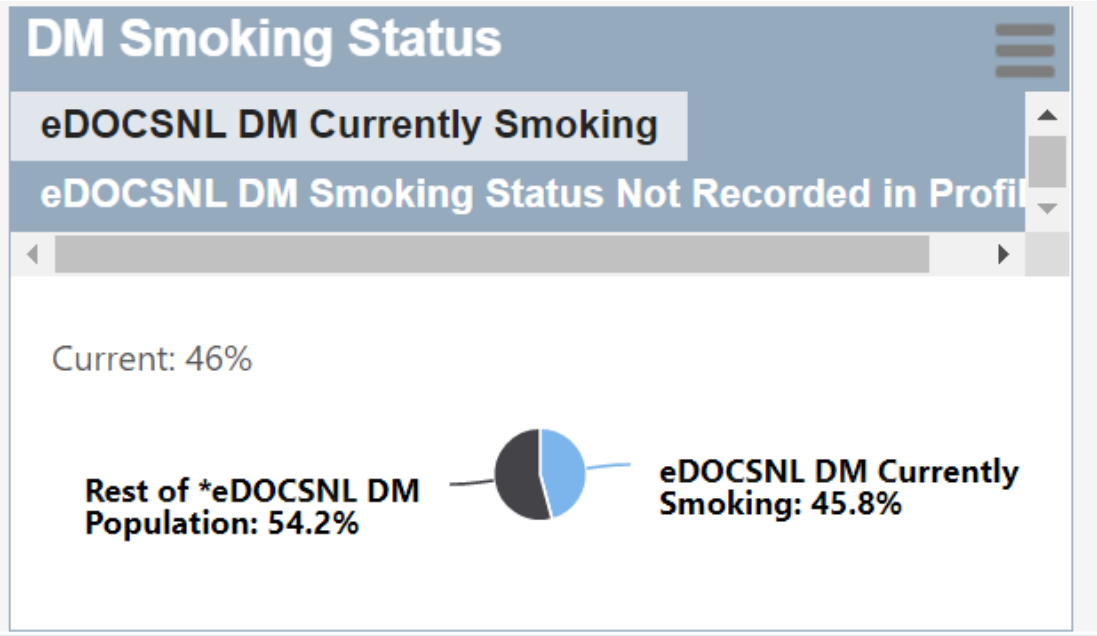
Quit Now info provided ☐

Smoking Cessation Reference: Effects of Stopping Smoking on FEV1

Create Consult to Smokers Helpline

Smoker's Helpline Weblink Smoker's Helpline Website

Dashboard



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

Visit Template

Screened for Depression, anxiety, other Stressors ◯No ◯Yes

Click here to complete PHQ-9

PHQ-9 Question 1 Score

Click here to complete GAD-7

GAD-7 Question 1

Referred to mental health and addictions services? ◯No ◯Yes

Foot care handout Patient Education: foot care

Hypoglycemia handout Patient Education: Hypoglycemia

DC guidelines Diabetes Canada Guidelines

DC quick reference Diabetes Canada quick reference guide

Gestational Diabetes handout Patient Education: Gestational Diabetes

Childhood Diabetes handout Patient Education: Childhood Diabetes

Diabetes Canada Resources Patient Resources

Managing yourself when you are sick discussed ◯No ◯Yes ◯Not Applicable

Patient Handout Patient self management handout

Women – Contraception/Preconception Planning Discussed ◯No ◯Yes ◯Not Applicable

Driving Guidelines Reviewed ◯No ◯Yes ◯Not Applicable

Patient goals / self-management

Resources given to patient ◯No ◯Yes

Lifestyle ◉Show ◯Hide

Socioeconomic Obstacles to Guidelines-based Care ◯No ◯Yes

Nutrition / Diet review ◯No ◯Yes

Patient referred to dietician? ◯No ◯Yes

Physical Activity Review ◯No ◯Yes

Smoking Status

Smoking Cessation Advice ◯No ◯Yes

Create Consult to Smokers Helpline

Alcohol Use ◯No ◯Yes

Drug use

eDOCSNL ELECTRONIC MEDICAL RECORD

Why use the Practice 360 Diabetes Tools?

DIABETES CANADA
CLINICAL PRACTICE GUIDELINES

Designed to support guidelines-based care

Efficiency measures throughout the toolset make following guidelines easy

Population level data informs best-practice care; put your data to work for your patients!

One stop shop for documentation and tasking collects and summarizes clinical information succinctly

Reminders, alerts and individualized patient goals provides at-a-glance patient summary to support clinical decision making

Q & A

Next Steps

- Self learning/review modules online – materials posted
- eDOCSNL Staff visits
- Mainpro follow-up evaluation
- Coordinate care with RHA Diabetes Collaboratives
- The Med Dialog tool

Thank You


eDOCSNL
ELECTRONIC MEDICAL RECORD


PRACTICE 360°
SMART TOOLS FOR CARE


Newfoundland & Labrador
Centre for
Health Information


Newfoundland
Labrador