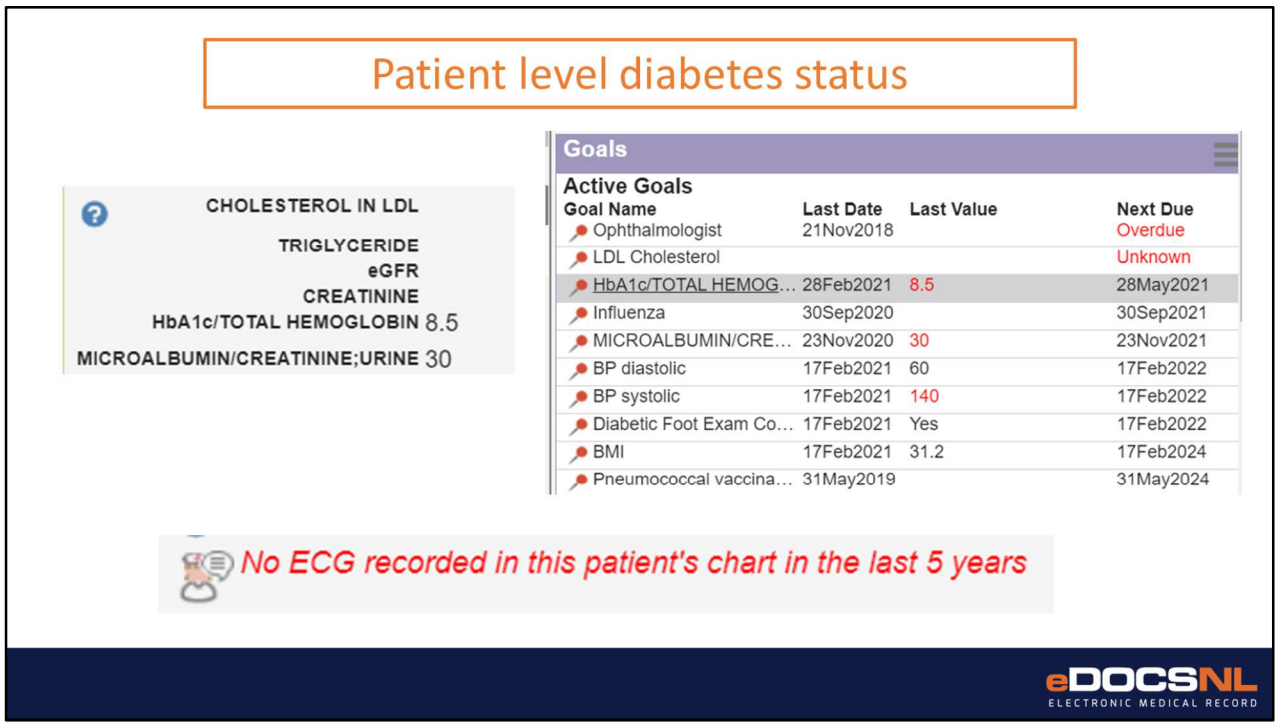
- Hello and welcome to the learning series for eDOCSNL Practice 360: Diabetes Smart Tools for Care.
- Practice 360 is an ongoing eDOCSNL initiative designed to increase clinical value and practice efficiencies in the Med Access EMR for users in Newfoundland and Labrador. The diabetes tools you will see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



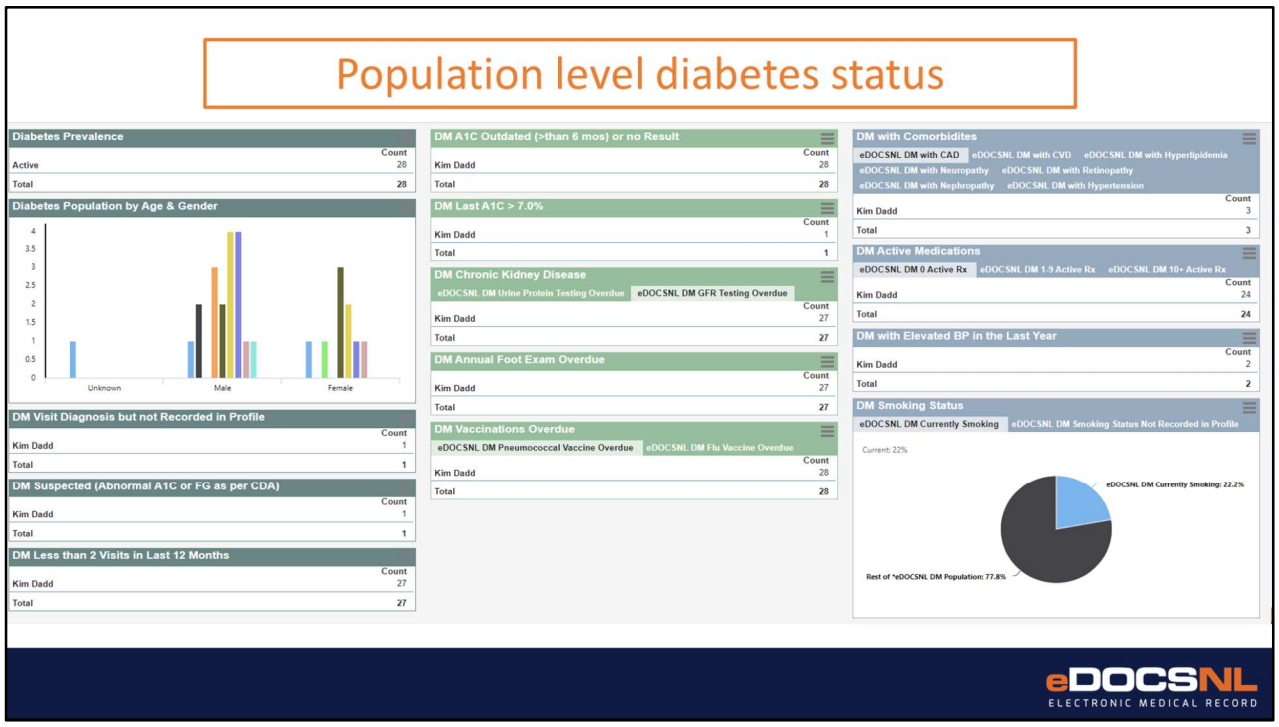
The practice 360 Diabetes toolset is designed to provide an up to the minute and quick glance assessment of the status of your diabetic patients from both patient-level and population-level perspective.

On opening the diabetes visit template you are greeted immediately with diabetes relevant labs, which pull in automatically when there are values in the patient's chart. The absence of a value provides a quick visual indication that a test result of this nature has never come into the patient's EMR chart. This could be due to the patient being relatively new to the EMR or reflect that the test has never been ordered for this patient from this EMR.

As you continue documenting in the template, these values are repeated when relevant to the section being documented and clinical decision support triggers provide additional information about the status of the patient's care and monitoring.

In the sidebar to the right of the visit template, the goals section draw attention to the established elements of care and monitoring for the current patient.

These goals provide immediate insight into actions that are overdue or have never been performed, while also highlighting test results or other metrics that are out of acceptable range. Information is also provided on when the maneuvers were last performed and when they are due again, according to clinical best practice guidelines.



On the reporting dashboard, the focus switches from patient-level to population-level.

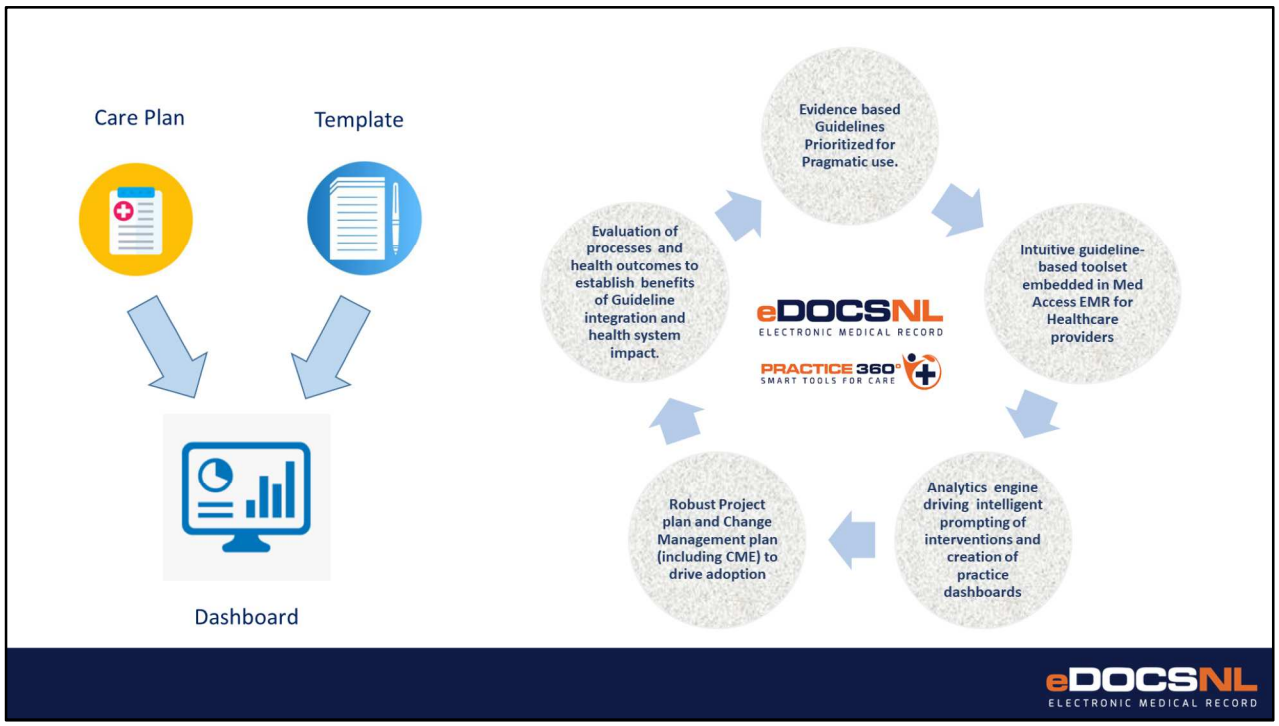
The dashboard presents information to providers on the diabetic patient population, highlights items of potential interest and provides a population-level overview of adherence to guidelines which supports best practice.

The middle column of the dashboard highlights elements of care and monitoring that may be regularly missed or falling out of range in the diabetic patient population as a whole while at the same time drawing attention to segments of the patient population that the provider may have been previously unaware of.

For instance, knowing that a large proportion of the diabetic patient population are smokers may trigger a concerted effort to educate patients on smoking cessation.

Insight into the fact that a large portion of your diabetic patients are not getting foot exams done regularly may result in a change in practice.

Similarly, realizing that a large portion of the diabetic patient population hasn't been seen regularly may prompt a focused recall effort.



The components of the toolset are mutually reinforcing and support proactive guidelines based care and monitoring by providing immediate insight into patient health status.

The documentation template provides all the information to make point of care decisions while providing efficient clinical decision support features.

The data generated by standardized documentation supported by the 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.

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 to view the remainder of the presentation series which can be found on the eDOCSNL website at eDOCSNL.ca under the Practice 360 tab.