

eDOCSNL

ELECTRONIC MEDICAL RECORD

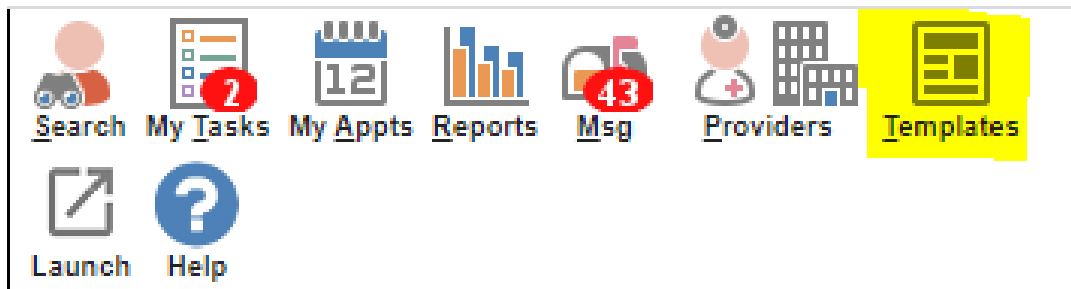
Using the Practice 360 Unified Chronic Disease Short Form

Since the launch of the original Diabetes template in 2018 eDOCSNL has consulted extensively with busy physicians and received a lot of feedback on the use of the Practice 360 tools. The common themes from this feedback indicate that, in some practice settings, the long form templates for chronic disease management do not fit with existing workflow but do contain numerous features of value, including Triggers, embedded templates, resources and automatically populated labs. As a result, we have decided to deploy a truncated version of the templates that captures the features felt to be of value while at the same time preserving existing workflow and documentation by supplementing the existing documentation template, rather than replacing it. This truncated version of the visit template still supports the fundamentals of the clinical practice guidelines for chronic disease management and collects CDS-focused short forms for Diabetes, Heart Failure and COPD together in one convenient location. The original long form templates are still available for use if preferred or if the practice setting/nature of the visit requires.

Accessing the template

Favoriting the template will be necessary to easily access the template from within the existing documentation template. This can be done as follows:

1. Navigate to the “Template” menu from the main dashboard view.
2. Click the “Obs” tab on the far right side.
3. Type “Unified” in the Template name field and hit enter. The NL Unified Chronic Disease Short Form template will display in the resulting list.
4. Select the heart icon appropriate to the need on the right side, the template may be favorited on a per user basis (the leftmost heart icon) or for an entire clinical group (the rightmost heart icon).



Template Management

Demog Visits Tasks Bills Meds Profile Labs Invest Consults Imm Goals Appt CDS Filter Workflow Dashboards Obs

Observation Templates

Category	Template Name	Observation Name	Discipline	Territory	Domain	Tag	Details	Status	Order Type
All	unified		All Subscribed	All Subsc...	All	All	None	Active	All
Visit	*eDOCSNL NL Unified Chronic Disease...	*eDOCSNL NL Unified Chronic Disease Short F...					system	2025-02-07	

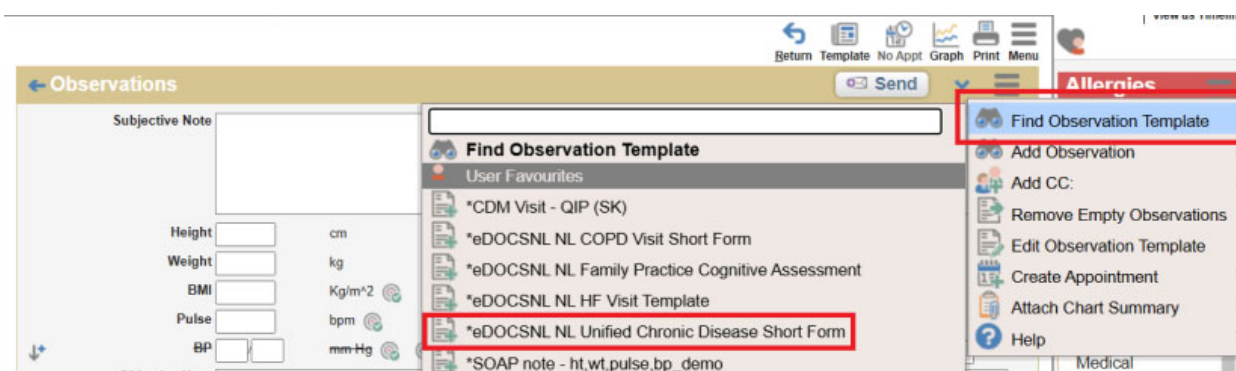
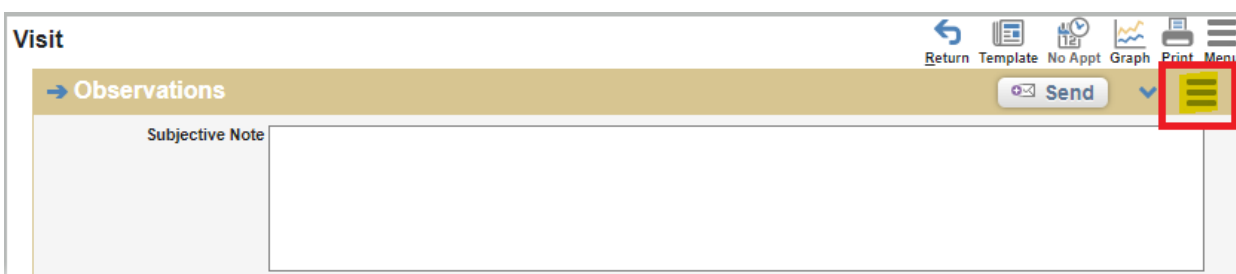
Launching the template

The Unified Chronic Disease Short Form visit template will be accessed in a slightly different way. Users can launch the template from WITHIN the existing visit documentation template. This reflects one of the pieces of feedback that we received: that providers prefer to use their own documentation template and that often the provider is unaware the patient is visiting for a given condition until they are already in the visit.

From the existing documentation template:

1. click the “menu” icon in the upper right corner,
2. hover over “Find Observation Template” and
3. select the *eDOCSNL NL Unified Chronic Disease Short Form.

The template will only appear in this list when it has been favorited, as described above.



In the example shown above, the user is already using a SOAP note and is pulling the CDS template into this documentation as **supplemental documentation**. If this is done according to these instructions, this template **enhances** the SOAP note and does not **replace** it.

As you can see from the example shown below, the Unified Chronic Disease Short Form is pulled into the bottom of the existing SOAP note and adds the key functionality that users have requested while allowing them to use their existing documentation and workflow.

Objective Note

Assessment Note

Plan

CHRONIC DISEASE DIAGNOSIS AND MANAGEMENT

Is your patient dyspneic? Yes

Does my patient have Diabetes? [Diabetes Canada Screening Tool](#)

Show relevant Diabetes screening labs? Yes

Chronic Disease COPD Diabetes Heart Failure

The first part of the template that appears is focused on screening or identification of chronic disease and has decision support features for COPD, Heart Failure and Diabetes. Indicating the patient is dyspneic will open a decision pathway as to the likelihood of Heart Failure or COPD, while there is a screening tool embedded for Diabetes and the relevant labs can be viewed to see whether it is likely your patient has Diabetes.

CHRONIC DISEASE DIAGNOSIS AND MANAGEMENT

Is your patient dyspneic? Yes

Does my patient have Diabetes? [Diabetes Canada Screening Tool](#)

Show relevant Diabetes screening labs? Yes

HbA1c/TOTAL HEMOGLOBIN 9

GLUCOSE FASTING
GLUCOSE 2h POST CHALLENGE

05-Feb-2025

Indicating the patient is dyspneic will open a related decision support section which draws attention to relevant investigations, consults and bloodwork to assist in making a diagnosis. An adaptation of CCS HF screening and diagnosis guidelines for local use is embedded as well.

Differential Dx of Dyspnea Acute dyspnea is most likely caused by acute myocardial ischemia, **heart failure**, cardiac tamponade, bronchospasm, pulmonary embolism, pneumothorax, pulmonary infections in the form of bronchitis or pneumonia, upper airway obstructions caused by aspiration or anaphylaxis, or **acute exacerbations of asthma or COPD**.

Chronic dyspnea is usually due to one of a small number of causes: bronchial asthma, **COPD**, **congestive heart failure**, interstitial lung disease, pneumonia, and mental disorders (e.g., anxiety disorders, panic disorders, somatization disorders).

Heart Failure is underdiagnosed in Newfoundland and Labrador, NLHS Cardiovascular Services would encourage you to **THINK HEART FAILURE** when approaching the differential diagnosis of dyspnea and **order a BNP**.

👤 Patient has BNP on file, check value below 📄

NATRIURETIC PEPTIDE B 100	mmol/L	05-Feb-2025
NT-PRO B NATRIURETIC PEPTIDE 100	mmol/L	05-Feb-2025

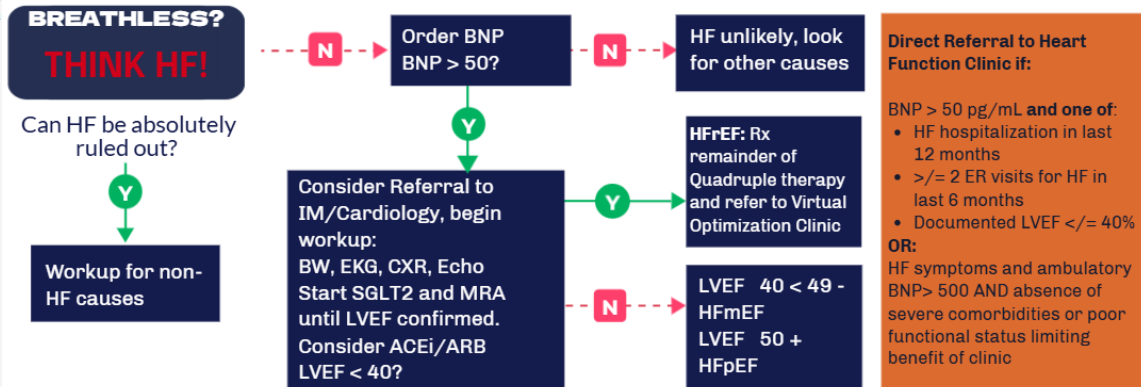
- 👤 No echocardiogram on file
- 👤 No MUGA Scan on file
- 👤 No Pulmonary Function Test Report on file
- 👤 No Chest X-Ray on file
- 👤 No Cardiology consult on file
- 👤 No Respiriology consult on file
- 👤 No Internist consult on file

HF Risk Factors Does your patient have any of the following?

- History of Ischemic Heart Disease
- History of Valvular Heart Disease
- Smoking history
- History of heavy alcohol or substance use
- Family history of Cardiomyopathy
- History of Diabetes History of chemo or radiation therapy
- History of hyperlipidemia
- History of Hypertension

If you answered "Yes" to any of the above or you have previously diagnosed your patient with any chronic pulmonary condition, you should THINK HF and rule it out. Please click the "Show" button below to view a HF identification and management algorithm for NL.

THINK HF Expand Collapse
Algorithm
THINK HF
Infographic



Once the diagnosis is confirmed, you can use the short form for clinical decision support for CD management by indicating which condition you are managing during this visit (multiple conditions can be selected).

Chronic Disease COPD
 Diabetes
 Heart Failure

Template Features

There are many clinical decision support features built into the template without making it difficult to use, providing the information and tools that are valuable to manage the patient without replacing standard workflow.

Auto-populated labs/metrics: There are data fields that may get auto-populated by the software, these may include lab values or the results from calculators that are native to Med Access (that is to say, not launched externally).

These fields do not need to be actioned. They will display the most recent value for the relevant metric but if you hover over the field title, historic values will be displayed. If there is no value in this field but you are aware of a value that exists but is not documented in the EMR, you can right click the field title and select “make editable” and then enter a value manually. This might be useful in the case of a lab value that was ordered by another provider and hence does not appear in the EMR but is still known. In this case a user can manually enter the value.

From the Diabetes Section:

CHOLESTEROL IN LDL 2.5
TRIGLYCERIDE
eGFR 70
GFR/1.73 Sqm Predicted;CKD-EPI
CREATININE
HbA1c/TOTAL HEMOGLOBIN 9
MICROALBUMIN/CREATININE;URINE 90

From the Heart Failure Section:

Sodium
Potassium
GFR/1.73 Sqm
Predicted;CKD-EPI
Creatinine
Hemoglobin 120
HbA1c 9
TSH
Cholesterol
LDL 2
Magnesium
NATRIURETIC 100
PEPTIDE B
NT-PRO B 100
NATRIURETIC
PEPTIDE
LV Ejection Fraction

Clinical Decision Support (CDS) Triggers and embedded tasks: Clinical decision support triggers bring together potentially disparate pieces of information from the chart to produce an alert that may help to guide clinical decision making. When the criteria for the trigger are met, the message will appear. When the criteria are not met either the message will not appear or a message may appear indicating that the match criteria are not met, when that is clinically relevant.

Completing embedded tasks involves simply single left clicking the document icon you see highlighted here to open the task. Complete the task like any other in Med Access and when the task is closed the user will be brought back to the visit template.

From the Diabetes Section:



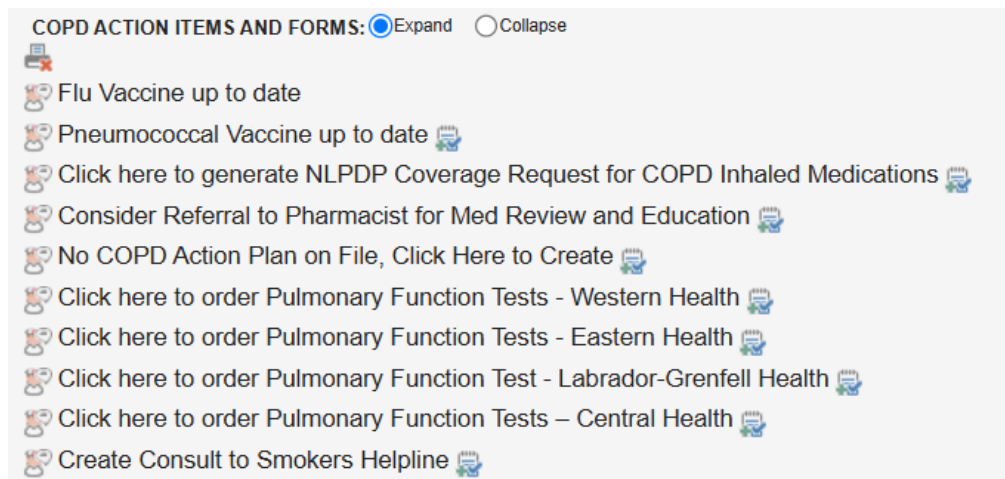
Action Items Expand Collapse

- A1c is overdue! Last A1c done > 3 months ago*
- No ECG recorded in this patient's chart in the last 5 years*
- Hypoglycemic episodes reported by this patient, consider adjusting medications*
- Patient at risk for CVD, consider candidacy for SGLT-2 or GLP-1*

Launch Tasks

- 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
- Click here for Special Authorization for Blood Glucose Test Strips

From the COPD Section:



COPD ACTION ITEMS AND FORMS: Expand Collapse

- Flu Vaccine up to date
- Pneumococcal Vaccine up to date
- Click here to generate NLPDP Coverage Request for COPD Inhaled Medications
- Consider Referral to Pharmacist for Med Review and Education
- No COPD Action Plan on File, Click Here to Create
- Click here to order Pulmonary Function Tests - Western Health
- Click here to order Pulmonary Function Tests - Eastern Health
- Click here to order Pulmonary Function Test - Labrador-Grenfell Health
- Click here to order Pulmonary Function Tests – Central Health
- Create Consult to Smokers Helpline

From the Heart Failure Section:

HF ACTION ITEMS AND FORMS: Expand Collapse

- CONSIDER PRESCRIBING MRA
- CONSIDER PRESCRIBING ACEi/ARB/ARNI
- CONSIDER PRESCRIBING BETABLOCKER
- CONSIDER PRESCRIBING SGLT2i

Check Allergies

[Click here to complete GAD-7](#)

GAD-7 Question 1 0

[Click here to complete PHQ-9](#)

PHQ-9 Question 1 Score 0

Excerpts from the guidelines: So that users will be able to easily access the key components of the guidelines for decision making, we have embedded in various places excerpts from chronic disease guidelines. Click “Expand” to view the text and “Collapse” when finished viewing, if desired.

ABCDESSS of Diabetes Care Expand Collapse

ABCDESSS of Diabetes Care

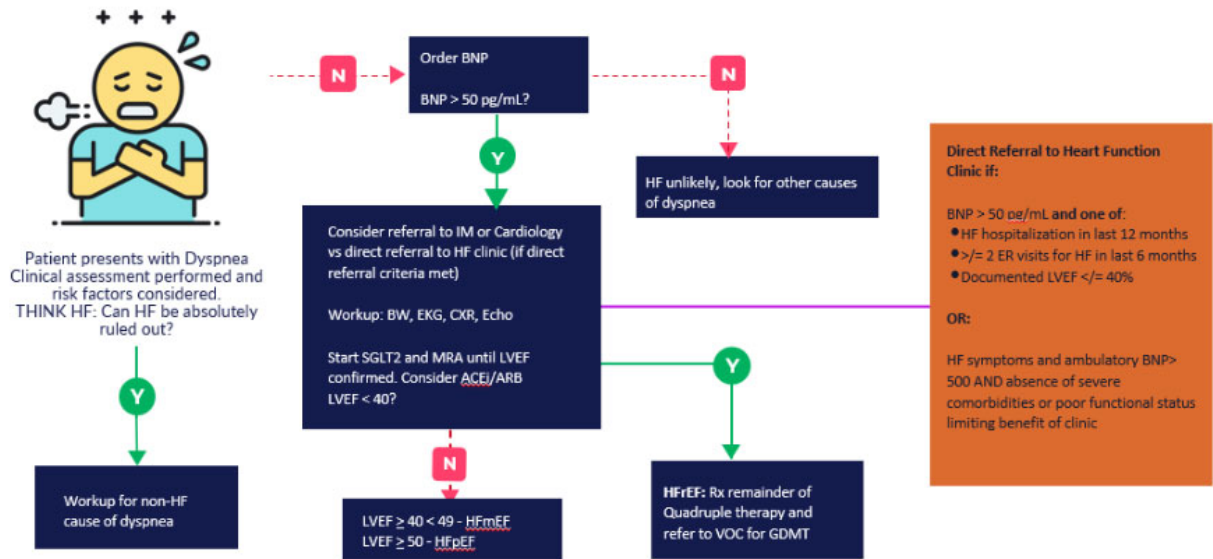
		GUIDELINE TARGET (or personalized goal)
A	A1C targets	A1C ≤7% If on insulin or insulin secretagogue, assess for hypoglycemia and ensure driving safety
B	BP targets	BP <130/80 mmHg If on treatment, assess for risk of falls
C	Cholesterol targets	LDL-C <2.0 mmol/L
D	Drugs for CVD risk reduction	ACEi/ARB (if CVD, age ≥55 with risk factors, OR diabetes complications) Statin (if CVD, age ≥40 for Type 2, OR diabetes complications) ASA (if CVD) SGLT2i/GLP1ra with demonstrated CV benefit (if have type 2 DM with CVD and A1C not at target)

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

1. Age>40 years
2. Duration of Diabetes >15 years and age >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<65 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.

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:
4. Diabetes duration>15 years and age>30 years
5. Microvascular complications



Patient and clinician resources: Each section of the template has its own resources area, containing all the patient and clinician resources necessary to educate both patients and providers in the care and self-management of the appropriate condition.




















From the Diabetes section:

DIABETES RESOURCES: Expand Collapse

- Foot care handout [Patient Education: foot care](#)
- Hypoglycemia handout [Patient Education: Hypoglycemia](#)
- Gestational Diabetes handout [Patient Education: Gestational Diabetes](#)
- Childhood Diabetes handout [Patient Education: Childhood Diabetes](#)
- Managing your Diabetes when you are sick hangout [Managing your diabetes when you are sick](#)
- Diabetes Canada Resources [Patient Resources](#)
- DC guidelines [Diabetes Canada Guidelines](#)
- DC quick reference [Diabetes Canada quick reference guide](#)
- Foot Exam Instructional Video [Foot Exam Video](#)










From the COPD section:

COPD RESOURCES: Expand Collapse

-  BC Health Services [COPD Guidelines & Protocols](#) 
-  Canadian Thoracic Society [COPD Tools, Resources, Guidelines and Standards](#) 
-  Patient handout: [COPD Inhaler Technique - RxFiles](#) 
-  Patient Resource: [Inhaler Technique Lung Association Video](#) 
-  Patient Resource: [Using an MDI with Spacer Device](#) 
-  Advanced Care Plan [Advanced Care Plan](#) 
-  COPD Management Reference: [COPD Management - RxFiles](#) 
-  BC Health Services [COPD Guide for Patients](#) 
-  Smoking Cessation Reference: [Effects of Stopping Smoking on FEV1](#) 
-  Smoker's Helpline Weblink [Smoker's Helpline Website](#) 

From the Heart Failure section:



HF RESOURCES: Expand Collapse

-  Pocket Guide [Canadian Cardiovascular Society - Pocket Guide](#) 
-  heartfailurematters.org [Heart Failure Information for Patients and Caregivers](#) 
-  CCS KT Tools for HF Management [CCS KT Tools](#) 
-  Heart Hub: HF Medications Guide [Heart Hub: Medications Guide](#) 
-  NL Diagnosis Classification Pathway Expand Collapse

Care Plans: Care plans are a critical pillar of the toolset. The template supports documentation and clinical decision support while the care plans enable guideline-based and recurrent actions.

We would suggest executing the care plans on every patient you manage with the template, which sets up the clinician and patient on a path that virtually ensures guidelines-consistent care. The care plans can be launched from within the short form or from the icon on the left side of the visit template if desired or if using some other visit template at the time when a care plan is required.

 [Click here to add diabetes care plan, including patient goals >](#) 

 [Click here to add Heart Failure care plan >](#) 

 [Click here to add COPD care plan >](#) 

Documentation that supports decision making: The only pieces of documentation in the CDS template support other Clinical Decision Support functionality. The intention was to have **no arbitrary documentation** in this template.

For example, in the Diabetes section, when “Yes” is selected for “Hypoglycemic episodes reported”, a trigger will appear in subsequent visits that identifies this and suggests med review. When “Yes” is selected for “Risk for CVD?”, a trigger will appear in subsequent visits indicating that an SGLT2i should be considered. When “Yes” is selected for “Diabetic Foot Exam Completed”, this will satisfy the goal for foot exam that can be added to the patient chart from the Diabetes Care Plan.

Similarly, selecting the Heart Failure Type in the HF template, will modify alerts that appear for medical management of Heart Failure based on HF type and the medications currently documented in patient’s EMR record.

ABCDESSS of Diabetes Care Expand Collapse

? Hypoglycemic episodes reported Yes No

? Risk for CVD? Yes No

CVD Risk Guidelines Expand Collapse

? Diabetic Foot Exam Completed Yes No

Heart Failure Type: HFrEF HFmEF HFpEF

Thanks for viewing this Practice 360 educational document on the Unified Chronic Disease Short Forms. This template is a product of the collaboration between eDOCSNL and national guidelines organizations.

For more detail on each component of the Practice 360 tools, please see the Practice 360 section on the eDOCSNL website which can be viewed [here](#) or under the Practice 360 tab in the “Advancing to Mature Use” section.