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Evidence2Practice – Heart Failure Tool v. 1.0.0 - User Guide

Introduction

EMR tools from the Evidence2Practice Ontario (E2P) program are comprised of condition-specific modules (scalable to multiple conditions) based on the core clinical functions of quality standards developed to make it easier for clinicians to access and apply best practice information and quality standards at the point of care.

The E2P heart failure tool engages a modular approach format to assist primary care providers with capturing critical information during an encounter. The tool is divided into a few modules: Clinical Assessment, Medication, Management, and Patient Care Plan and Resources. This guide provides a walk-through of the tool's modules with examples, highlighting the most important functionalities.

Background/Summary

Heart failure diagnosis is based on a clinical assessment combined with appropriate testing that either supports or rules out its presence. There is no single test that confirms the presence of heart failure. Formulating a diagnosis as soon as possible facilitates rapid symptom management and may help avoid hospitalization.

The E2P heart failure tool is designed to support clinicians in the diagnosis and management of heart failure. Early diagnosis of heart failure allows primary care clinicians to engage in evidence-based treatment strategies to improve patient outcomes.

Purpose of the Tool

Our objective is to help primary care physicians track the progression and plans of heart failure patients. This tool allows for close monitoring of the patient's stability to help ensure safe practice and was built to help standardize documentation, support primary care clinicians, and support clinical best practices.

Using the E2P Heart Failure Tool in Accuro QHR

Navigating to the modules within the tool:

To go to the different modules, use the left and right page arrows.

Page 1 – Assessment Module

Page 2 – Management and Medication Module

Page 3 – Patient Resources

Page 4 – Patient Care Plan

Page 5 – Patient Care Plan

Pull from previous:

Features:

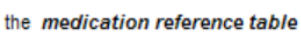
- 8 of 10 quality statements for people with heart failure embedded within the tool
- Update the suspected heart failure condition
- Review lab tests and values
- Provide tool feedback

Getting Started with the Heart Failure Tool

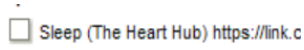
The tool was designed to include decision-support throughout the tool and has implemented tooltips to also help inform quality standard information.

Blue 'i' icons – Indicate tool-tip text. Click on this icon to view the tooltip content.

Light Blue text – Indicates warning/high-priority information to consider.



Bolded Italic text – Clicking on these will open the resource in a new window.



Checkboxes with website links – Clicking on the link will open a tooltip with the hyperlink that will open in a new window.

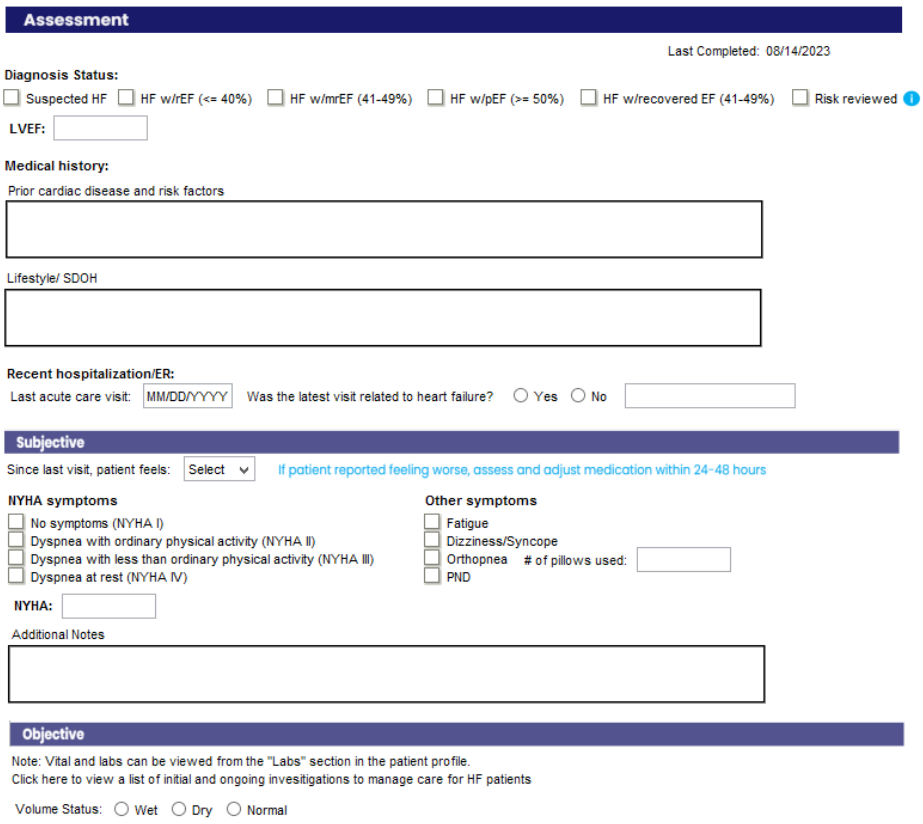
Launching Clinical Modules

The components related to the provision of heart failure care have been broken into 4 modules, allowing for flexibility. Users are not expected to complete every module at every visit but rather, users can complete the modules that were discussed/required updating during the patient encounter.

Assessment Module

The first page of the tool is the assessment module. In this section, users can update the suspected heart failure condition as well as enter the LVEF (level of ejection fraction). Under the Medical history area, the boxes labelled Lifestyle/SDOH and comorbidities are areas for documentation. These areas have form memory and will populate upon selecting the pull from the previous button.

The main elements of this module are the subjective, objective, and recent hospitalizations sections, which allow for the monitoring of NYHA (New York Heart Association) and other symptoms, hospitalizations, and ER visits, along with tracking the progression of pitting edema, cardiac assessment, respiratory exam, and imaging reports.



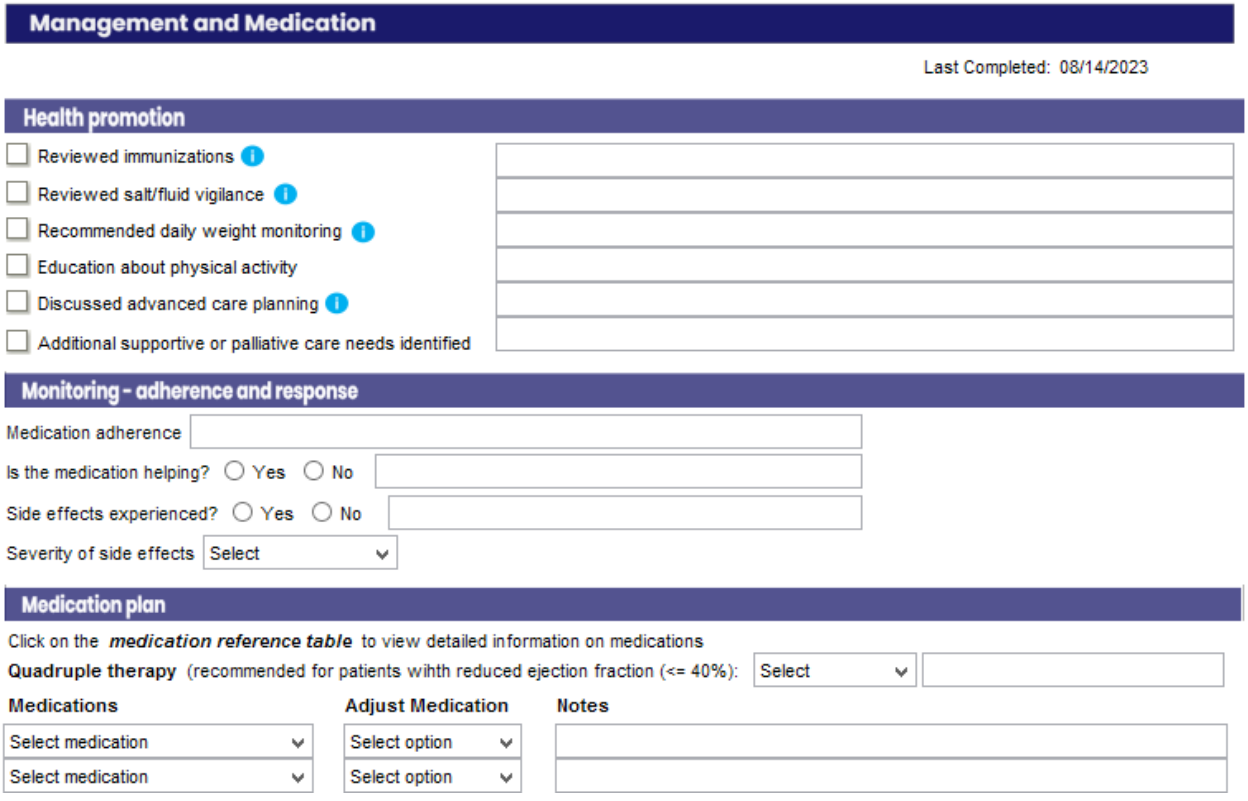
Management and Medication Module

The management section offers the opportunity for clinicians to document that information has been provided to the patient pertaining to diet, exercise and symptom management with the overall goal of improving patient confidence and enhancing their ability to make decisions about their care.

The advance care planning section helps to guide conversations with patients on their goals of care and to understand their illnesses. This section also links to the substitute decision-maker custom form.

Additionally, the purpose of the medication section within this module is to create and document medication management plans based on the latest best practice guidelines using the medication reference table.

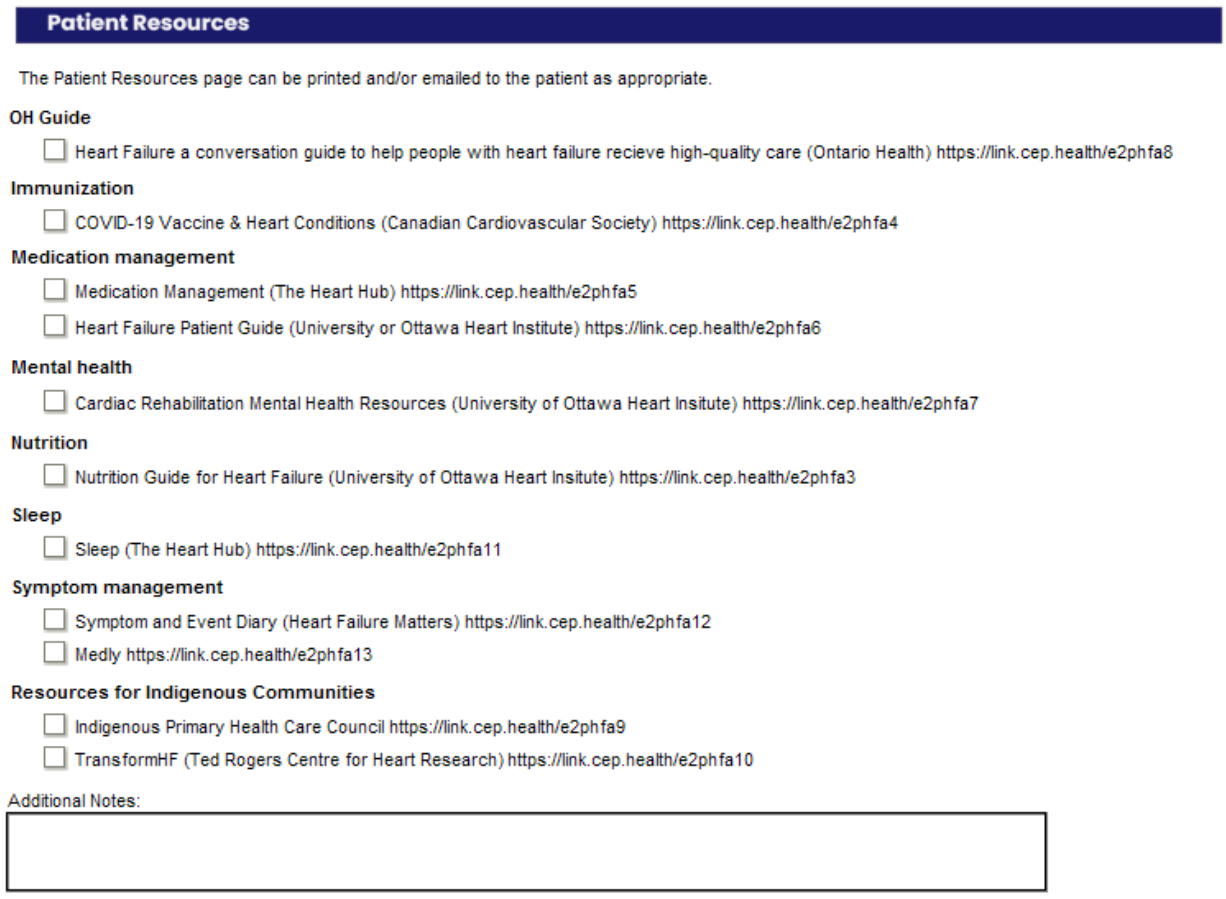
Patients who have been identified as having a reduced ejection fraction are recommended to follow a quadruple therapy pharmacologic treatment plan. Suspect HF patients or those who have been identified as having a preserved ejection fraction will be directed to other medications that may be appropriate for care.



Patient Resources Module

The patient resources section contains a collection of curated resources. The goal of this module is to provide resources for self-management supports.

Clicking on the text will open the pop-up with the link to the resource. Opening the resource will trigger the internet browser to open, redirecting to the link chosen, and allowing the user to print the resource directly. Selecting the checkbox will communicate to the patient which resources were discussed as well as track the date the resource was suggested.

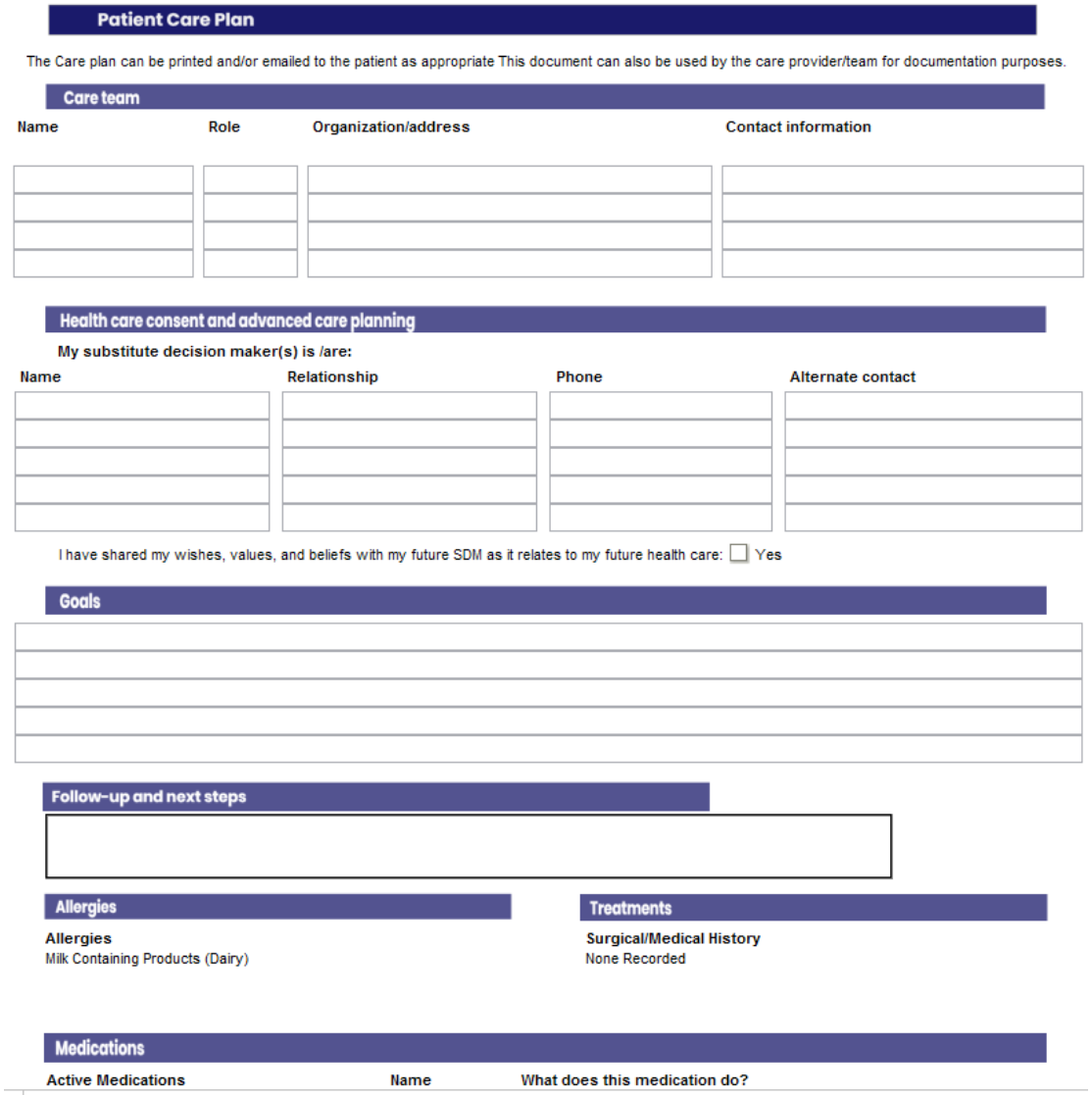


Patient Care Plan Module

The care plan is a patient-facing resource that can be used during the encounter or as a separate activity.

Some elements of the care plan need to be entered manually; this includes the patient's health care consent, goals, next appointment date, and next steps. Other elements can be populated by the patient's medical record, including the clinic contact, allergies, and treatment information.

A key feature of this module is the medications section, which pulls in the patient's current list of medications and provides an explanation of what the medication(s) does.



Patient Care Plan

The Care plan can be printed and/or emailed to the patient as appropriate This document can also be used by the care provider/team for documentation purposes.

Care team

Name	Role	Organization/address	Contact information

Health care consent and advanced care planning

My substitute decision maker(s) is /are:

Name	Relationship	Phone	Alternate contact

I have shared my wishes, values, and beliefs with my future SDM as it relates to my future health care: ☐ Yes

Goals

Follow-up and next steps

Allergies

Allergies
Milk Containing Products (Dairy)

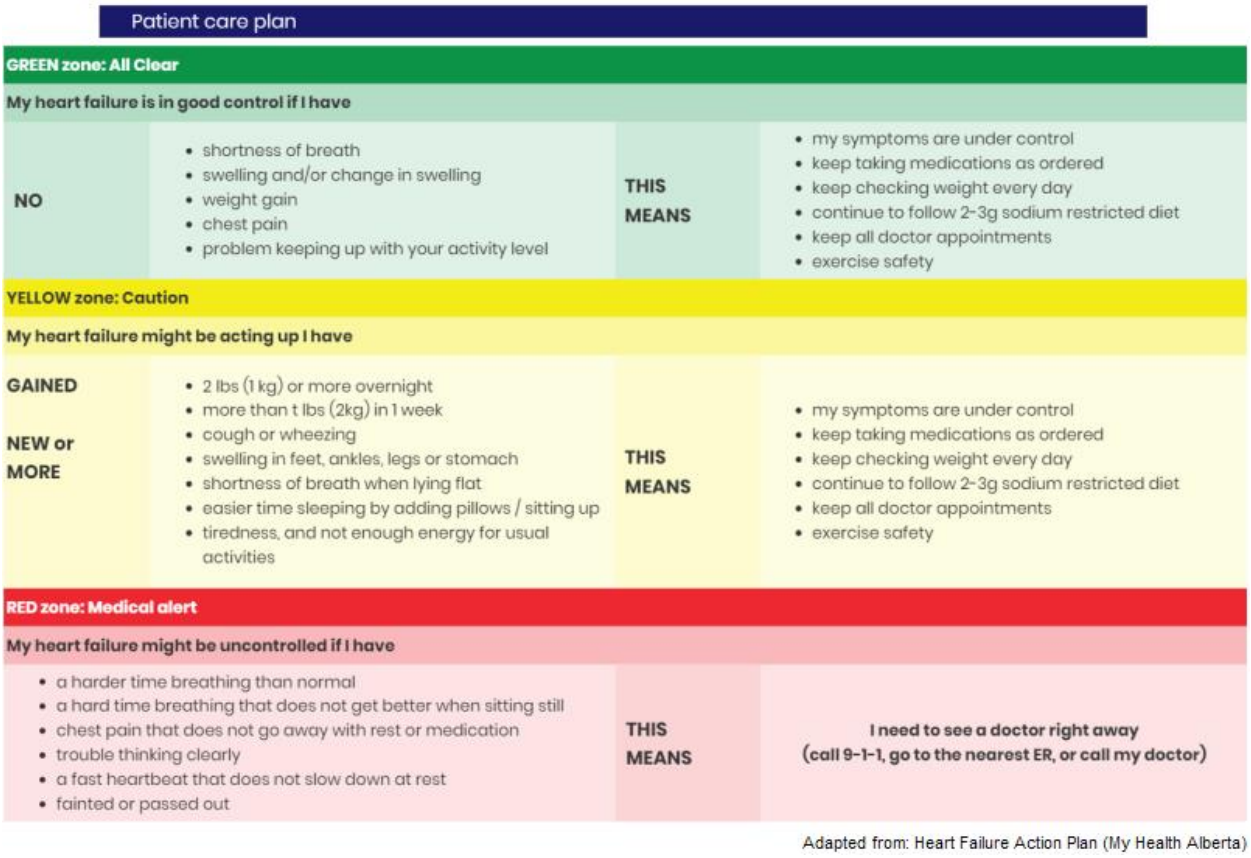
Treatments

Surgical/Medical History
None Recorded

Medications

Active Medications | Name | What does this medication do?

This section of the tool contains the Heart Failure Action Plan which is an important resource for patients to use and manage their symptoms.

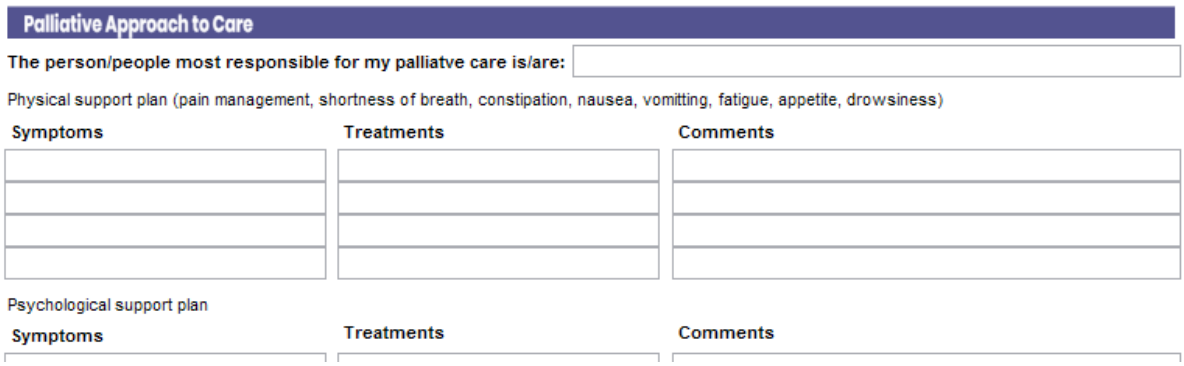


Patient care plan

GREEN zone: All Clear			
My heart failure is in good control if I have			
NO	• shortness of breath • swelling and/or change in swelling • weight gain • chest pain • problem keeping up with your activity level	**THIS MEANS**	• my symptoms are under control • keep taking medications as ordered • keep checking weight every day • continue to follow 2-3g sodium restricted diet • keep all doctor appointments • exercise safety
YELLOW zone: Caution			
My heart failure might be acting up I have			
GAINED **NEW or MORE**	• 2 lbs (1 kg) or more overnight • more than t lbs (2kg) in 1 week • cough or wheezing • swelling in feet, ankles, legs or stomach • shortness of breath when lying flat • easier time sleeping by adding pillows / sitting up • tiredness, and not enough energy for usual activities	**THIS MEANS**	• my symptoms are under control • keep taking medications as ordered • keep checking weight every day • continue to follow 2-3g sodium restricted diet • keep all doctor appointments • exercise safety
RED zone: Medical alert			
My heart failure might be uncontrolled if I have			
• a harder time breathing than normal • a hard time breathing that does not get better when sitting still • chest pain that does not go away with rest or medication • trouble thinking clearly • a fast heartbeat that does not slow down at rest • fainted or passed out		**THIS MEANS**	**I need to see a doctor right away (call 9-1-1, go to the nearest ER, or call my doctor)**

Adapted from: Heart Failure Action Plan (My Health Alberta)

The last piece of this module is the Palliative Approach to Care section, which offers patients the opportunity to complete when they are near end-of-life or if they wish to have a plan in place for that stage in their life.



Palliative Approach to Care

The person/people most responsible for my palliatve care is/are:

Physical support plan (pain management, shortness of breath, constipation, nausea, vomitting, fatigue, appetite, drowsiness)

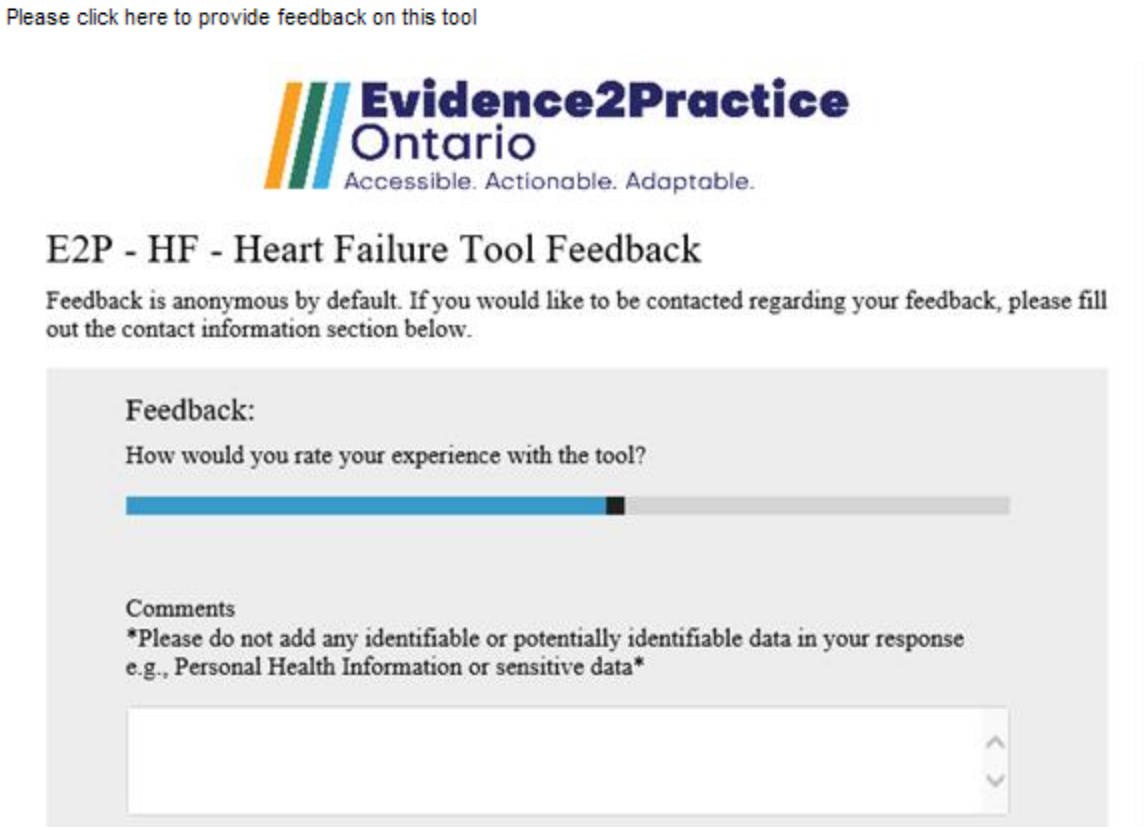
Symptoms	Treatments	Comments

Psychological support plan

Symptoms	Treatments	Comments

Feedback

Included in the tool is a link to provide feedback which allows users to submit their thoughts and communicate any issues they've encountered or any areas they wish to see added to the tool. This section allows you to submit feedback anonymously or allows you to add your email address and name if you wish to be contacted.
The links can be found at the bottom of pages: 1, 4, and 5. It will look like this:



Overview of Usage Analytics

The eHealth Centre of Excellence tracks usage to understand the extent to which our tools are being used. We are committed to protecting the data we are collecting and sharing. With our EMR usage analytics program, we collect general information about your usage (e.g., clinic name, name of tool used, date of usage, clinician type, anonymized clinician ID, and anonymized patient ID). **There is absolutely no Personal Health Information (PHI) collected by usage analytics**, and no assessment of clinical knowledge or expertise is made. Information collected by usage analytics may be shared with external organizations, such as funding

bodies and evaluators, to support program evaluation, sustainability, and future funding opportunities.

Participation in usage analytics is optional and you may withdraw your participation at any time.

Your participation ensures that E2P tools are meeting the needs of frontline clinicians. You would be supporting the meaningful adoption of clinical guidelines, as well as the development of future tools and updates.

It's an easy method of supporting quality improvement - you don't have to do anything!

For more information, please contact privacy@ehealthce.ca or see our privacy statement. If you would like to learn more about our EMR usage analytics program and the benefits of participating, please visit our website.

Contact

As part of the Evidence2Practice Ontario (E2P) program, the eHealth Centre of Excellence is providing change management at no cost to support clinicians with the implementation and optimal use of E2P tools. If you have any questions, please reach out to EMRtools@ehealthce.ca and we will be happy to help!

E2P brings together multi-disciplinary, cross-sector expertise under the joint leadership of the Centre for Effective Practice, eHealth Centre of Excellence, and North York General Hospital. Funding and strategic guidance for E2P is provided by Ontario Health in support of Ontario's Digital First for Health Strategy.

Appendix

Quality Standards for Heart Failure

Quality standards address care for adults who have heart failure, including the assessment and diagnosis of people with suspected heart failure. They apply to community settings, including primary care, specialist care, home care, hospital outpatient clinics, and long-term care.

1. Diagnosing Heart Failure (Clinical Assessment Module)
    - To improve and standardize the initial assessment and diagnosis of HF along the spectrum from preserved to reduced ejection fraction.
2. Individualized, Person-Centered, Comprehensive Care Plan
3. Empowering and Supporting People with Heart Failure to Develop Self-Management Skills
4. Physical Activity and Exercise
    - To improve communication and self-management by curating a repository of resources related to self-management for heart failure, including patient discussion guides, education for self-management of heart failure, and physical activity/exercise/ rehabilitation for individuals with heart failure.
    - To embed a person-centred comprehensive care plan that is readily available to clinicians, patients, and caregivers.
5. Quadruple Therapy for People with Heart Failure Who Have a Reduced Ejection Fraction (Medication Management Module)
    - To assist clinicians in identifying individuals with heart failure who should be started and titrated on quadruple therapy and provide patients and/or caregivers resources on medication instructions.
6. Worsening Symptoms of Heart Failure (Clinical Assessment Module)
    - To alert clinicians that individuals presenting with gradual, progressive, worsening symptoms of heart failure need to have medication adjusted within 24-48 hours.
7. Specialized Multidisciplinary Care (Clinical Assessment Module)
8. Palliative Care and Heart Failure (Supplemental provider education/support)
    - To assist clinicians with symptom management of heart failure by enabling the referral of newly diagnosed or worsening heart failure individuals to specialized multidisciplinary care and/or palliative care.