Table of Contents

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.

This guide provides a walk-through of the tool with examples, highlighting the most important functionalities. 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.

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 & 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 was 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 OSCAR Pro

Navigating to the modules within the tool

The components related to the provision of care for heart failure have been broken into 4 modules: Assessment, Management, Medication, and the Patient Care Plan.

- By no means does this require all modules to be completed during a visit but allows you to navigate to a module of your choosing that you would like to focus on for the encounter.

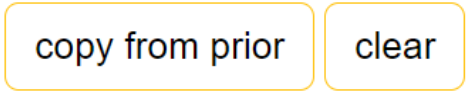
Summary Tabs

The summary tabs give clinicians flexibility to support patient encounter needs while also keeping the patient metrics or labs or history or even the resources panel open.

Tabs:

- Metrics
- Labs
- History
- Resources

Pull from previous



After the tool has been completed in a prior visit, clicking the **copy from prior** button will pull all data for each section in the form.

- The **clear** button enables the sections that were "copied from prior" to be cleared.

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

* *review*

Red *italic* text – Indicates warning/high-priority information pertaining to patients at high risk of harming themselves or others

Open

Purple text with an underline – Clicking on these will open the hyperlink in a new window

substitute decision maker

Button with a yellow border – Clicking on these will open the resource/tool in a new window

Generate note

Clicking on this button will pull the information that was entered in the tool to the text box beside the button

Copy to Encounter

Clicking on this button will copy the information that was pulled from the "Generate note" button to the progress note section

Summary Tabs

The summary tabs give clinicians the flexibility to show/hide the patient metrics or labs or history or the resources panel immediately next to the module content to enhance documentation during patient encounters.

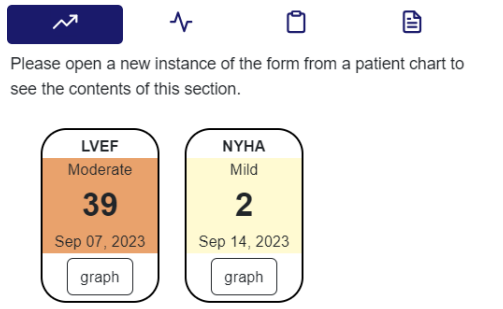
From the Summary tabs, the user can simultaneously:

- View/update metrics for LVEF and NYHA
- Review lab values, modify goals, and launch the lab requisition form.
- Review the resources that were shared with the patient (i.e., heart failure, diabetes, anxiety, and depression)

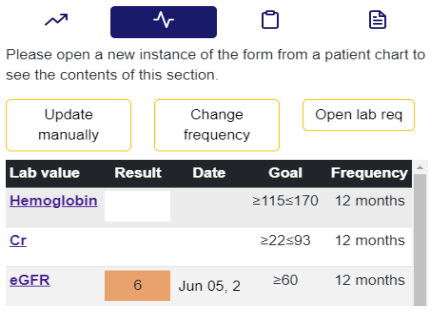
From the History Tab, the user can simultaneously:

- Complete the patient's full history of cardiac disease, risk factors, and lifestyle/SDOH.
- This section has form memory automatically enabled, allowing for easy documentation of pertinent information related to care that may be helpful to refer to over the course of treatment.

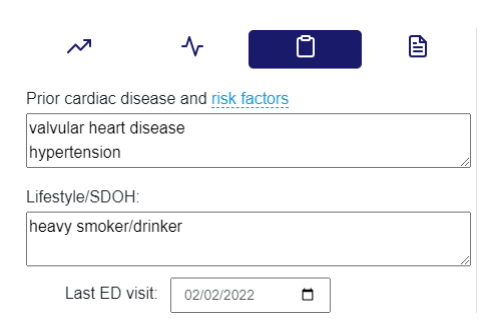
Metrics Tab:



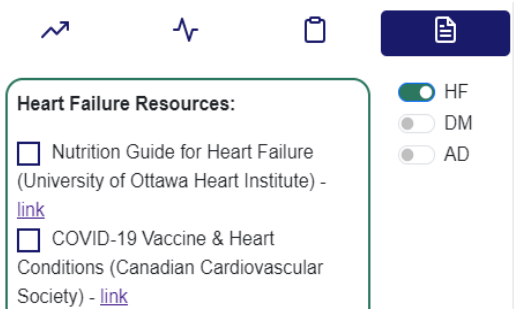
Lab Tab:



History Tab:



Resources Tab:

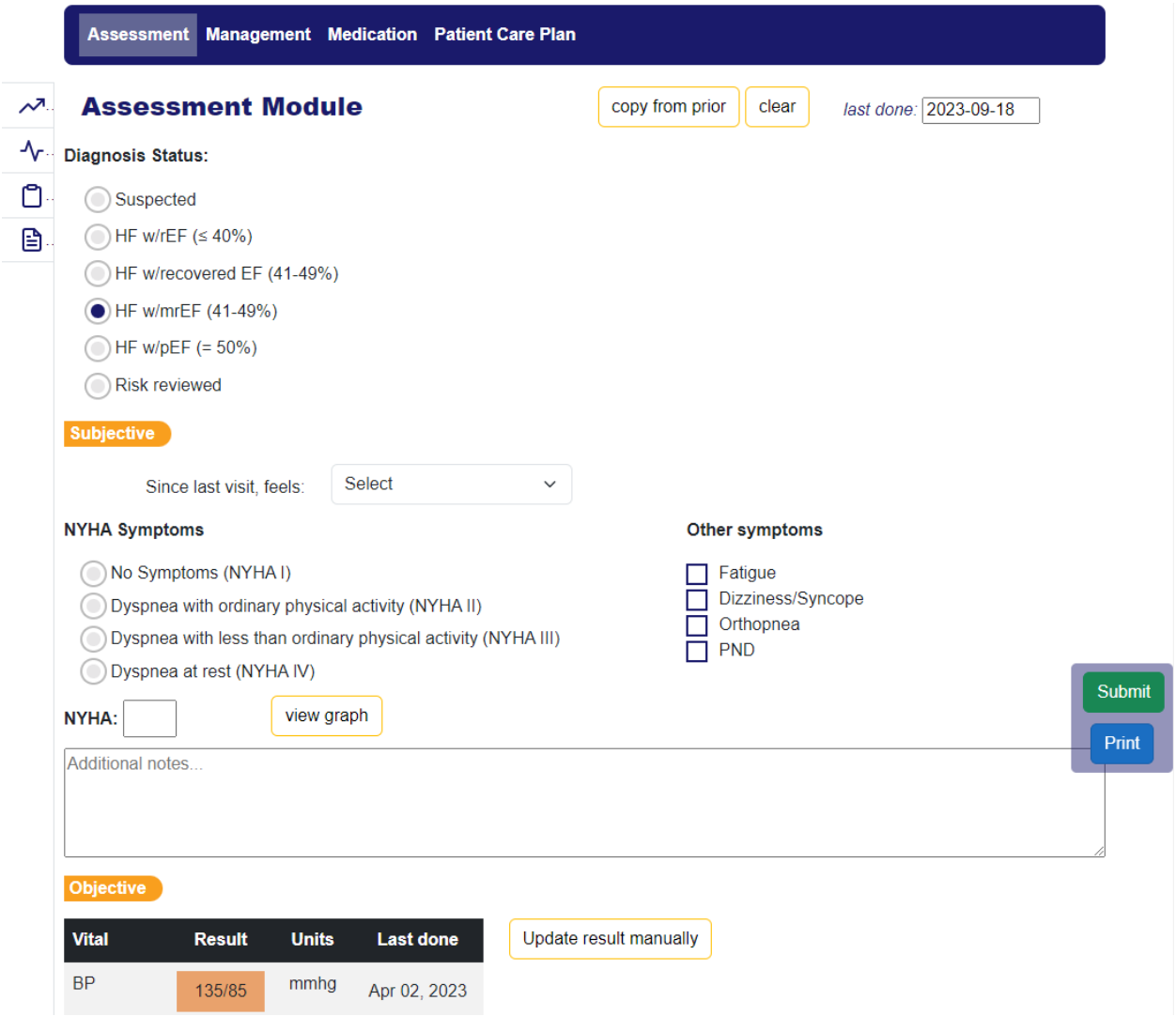


Launching Clinical Modules

Assessment Module

The first module of the tool is the assessment module. In this section, users can update how the patient feels since the last visit. These modules have form memory and will populate upon selecting the pull from the previous button.

The main elements of this module are the subjective and objective sections which allow for the monitoring of NYHA (New York Heart Association) and other symptoms. As well as reviewing vital results, including LVEF, along with tracking the progression of volume status, and edema, including pitting edema, cardiac assessments, and respiratory exams.

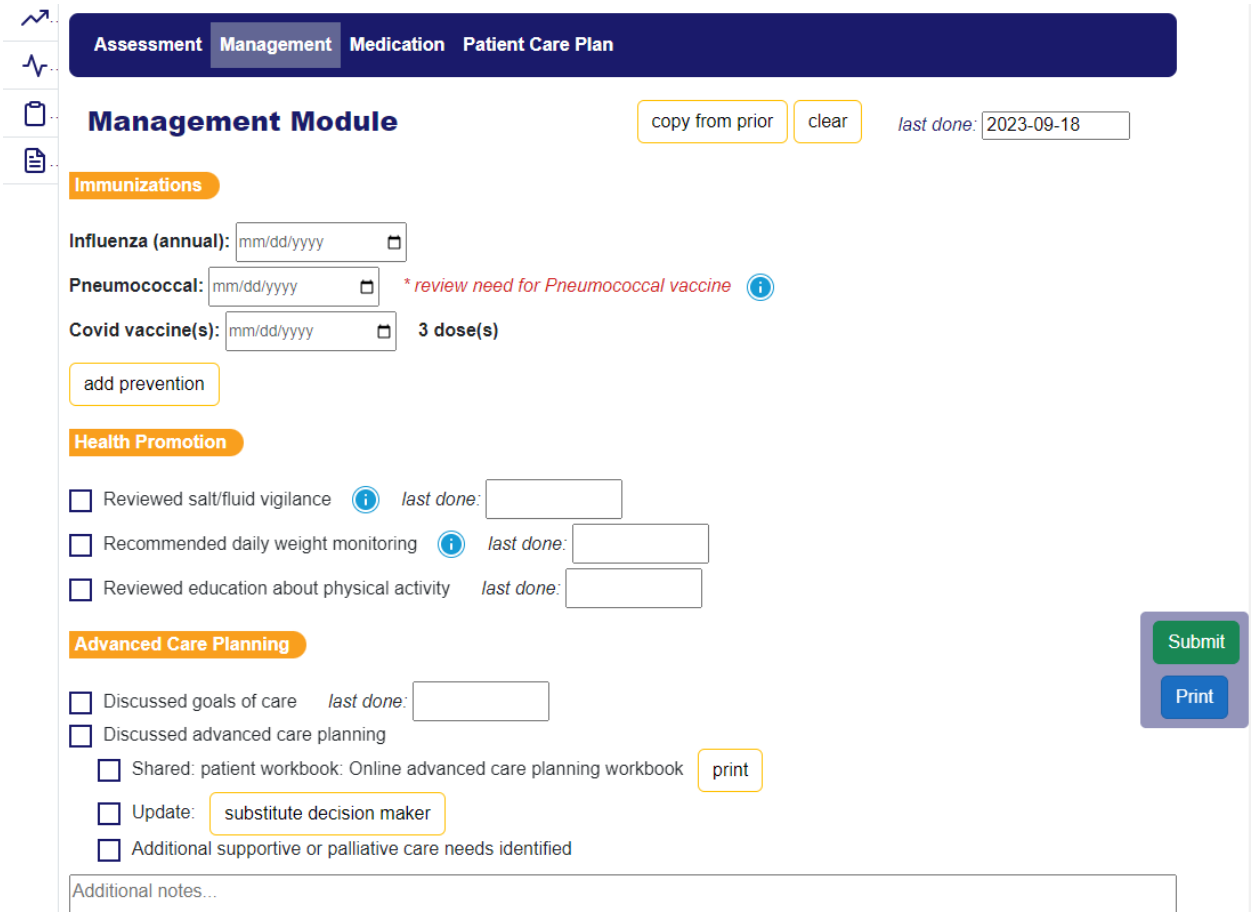


Management Module

The management section pulls in the patient's immunization records and enables clinicians to input any additional treatments the patient has obtained.

This module 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.

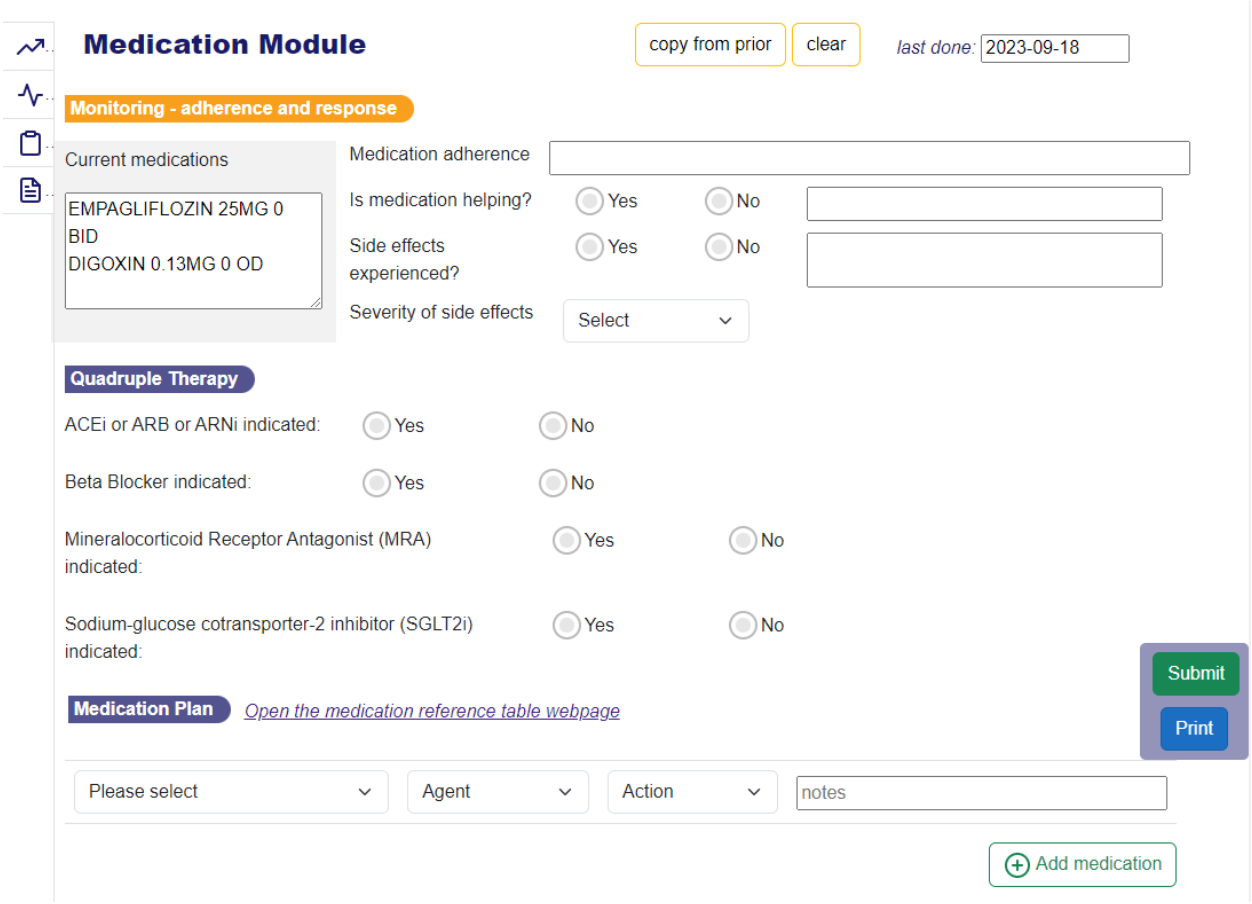


Medication Module

In the medication module, the current list of medications is pulled in as well as an area to document and monitor the patient's adherence and response to the medications prescribed. The section for Quadruple therapy includes areas to document whether ACEi, ARC, ARNi, Beta-blockers, or MRAs were indicated for the patient.

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.

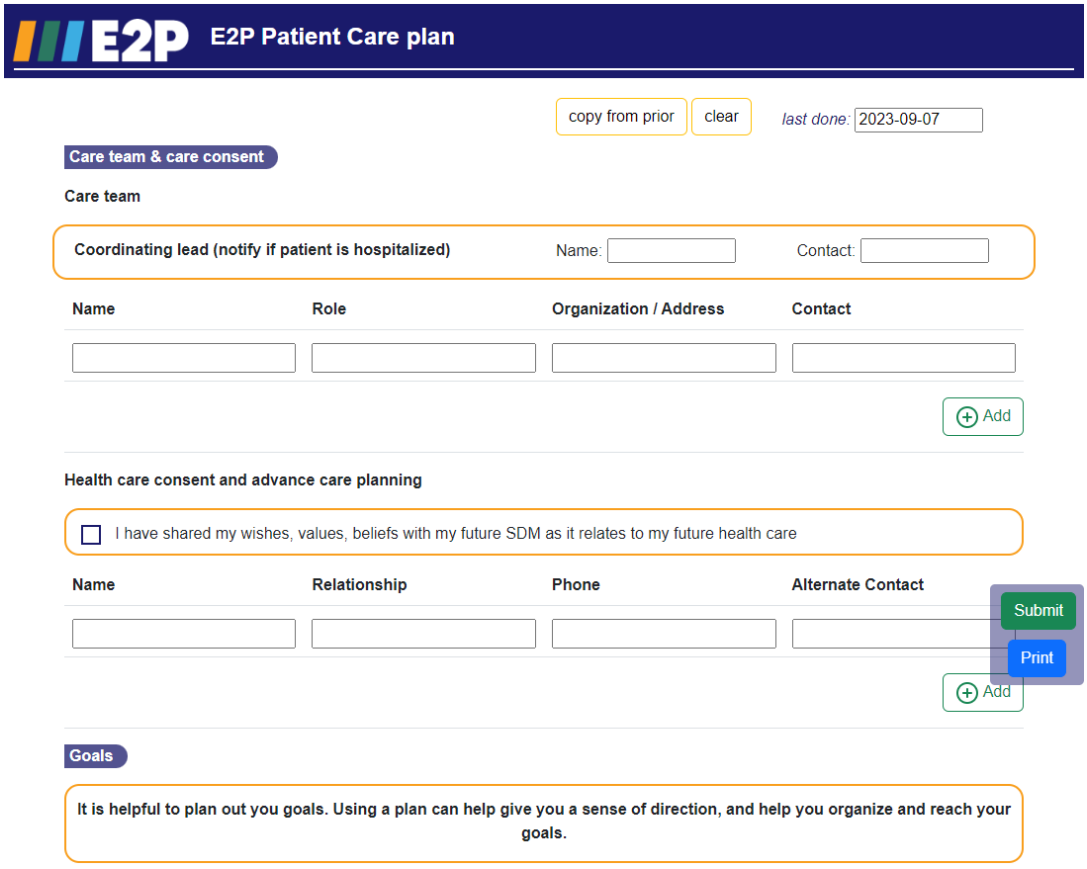


Patient Care Plan Module

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

The goal of this module is to construct a plan of care for the patient including documenting the care team, care consent, patient goals, lifestyle changes, therapy, allergies, medications, and any next steps or follow-up details.

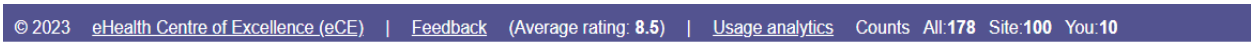
The patient resources section contains a collection of curated resources. This section pulls in the resources that might have been selected within the other modules and even any that have been shared in the anxiety disorders & depression tool as well as the diabetes tool to ensure all resources will be included in one place.

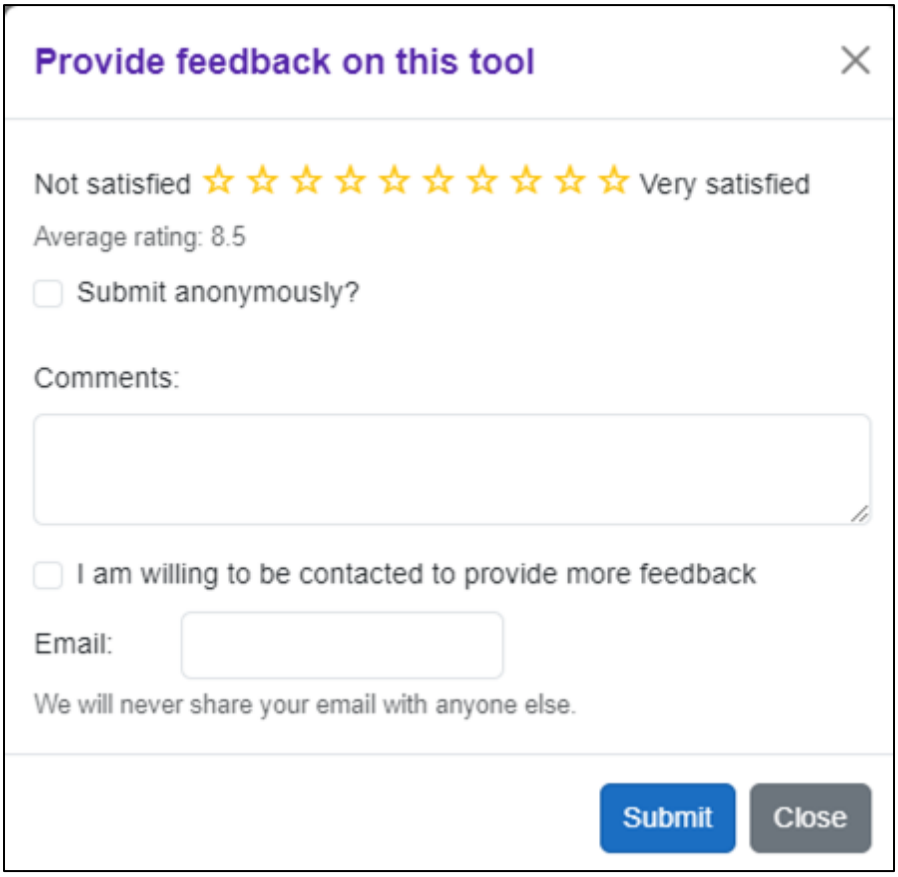


Feedback

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 every module. 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. However, 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. It applies to community settings, including primary care, specialist care, home care, hospital outpatient clinics, and long-term care.

1. Diagnosing Heart Failure (Clinical Assessment Module)
    a. 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
    a. To improve communication and self-management by curating a repository of resources related to self-management for HF, including patient discussion guides, education for self-management of HF, and physical activity/ exercise/ rehabilitation for individuals with HF.
    b. To embed a person-centred comprehensive care plan that is readily available to clinicians, patients, and caregivers (addressed in the Treatment Plan module, Patient Education & Supports module).
5. Quadruple Therapy for People with Heart Failure Who Have a Reduced Ejection Fraction (Medication Management Module)
    a. To assist clinicians in identifying individuals with HF 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)
    a. To alert clinicians that individuals presenting with gradual, progressive, worsening symptoms of HF 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)
    a. To assist clinicians with symptom management of HF by enabling the referral of newly diagnosed or worsening HF individuals to specialized multidisciplinary care and/or palliative care.