Updated: September 2024*

This guide is the most recent version of the tool: **Version 4.1**, that includes resources for heart failure, diabetes, anxiety disorders, depression, and COPD.

To review the release notes and breakdown of the changes by tool, please visit this link here.

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!

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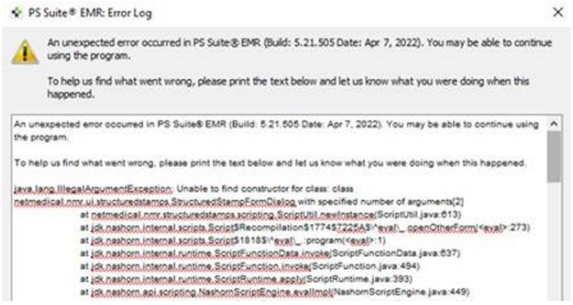
Notices

Please be advised of the following common events and issues that occur during the tool installation process

1. The tool not opening from the toolbar producing an error log.



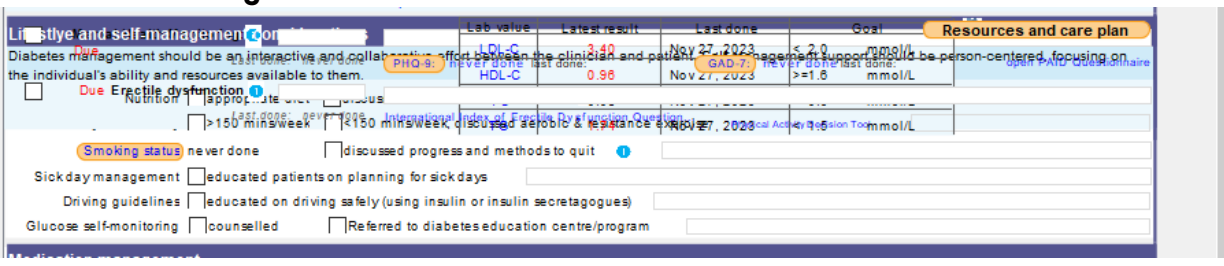
Problem: Some users have found that inserting the "E2P - HF - Main Form Toolkit" custom form directly into the patient chart (instead of viewing the form in its intended pop-up) has resulted in errors when attempting to launch the screening or visit custom forms.

Solution: Since the "E2P - HF - Main Form Toolkit" does not include any data or documentation, it is recommended that all instances of this custom form be deleted from the patient chart.
To do this,

1. Search for "E2P - HF - Main Form Toolkit" in the notes section of the patient's chart.
2. Navigate to the line, right-click, and select "Delete".
3. Repeat for all remaining inserts.

For assistance, please reach out to EMRtools@ehealthce.ca and we will be happy to help!

2. Form rendering issue.



Problem: All sites will experience the form overlapping issue on the first opening of the tools after installation/update.

Solution: Unfortunately, this is a known PS Suite error. Once each section of the tool has been opened once: Assessment, Medications, Management, the issue will be resolved.

*Please note that this will only happen once, you will not encounter this for each patient.

Evidence2Practice Ontario (E2P) Tool Bundle User Guide

Introduction

Evidence2Practice Ontario (E2P) tools are designed to support clinicians in the diagnosis and management of chronic diseases. Early diagnosis of chronic conditions allows primary care clinicians to engage in evidence-based treatment strategies to improve patient outcomes.

The development of the E2P TELUS Practice Suite Solution (PSS) toolbar is available for use across all patients. Condition-specific modules (scalable to multiple conditions) based on the core clinical functions of the quality standards have been developed to support clinicians in the assessment, diagnosis, treatment, and/or management of patients.

This guide provides a walk-through of the tools with examples, highlighting the most important functionalities. This guide includes an overview of the available tools in our suite.

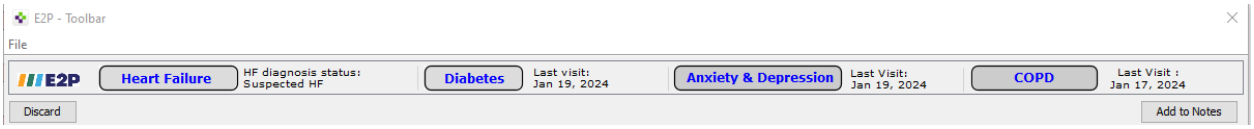
Getting Started with the E2P Toolbar

The E2P toolbar is designed to look for both a diagnosis in the problem list or the presence of specific text using a validated set of criteria (free-text terms, ICD-9, SNOMED-CT codes) to determine a confirmed diagnosis status.

Launching the Tools from the Toolbar

The tools can be accessed through the E2P toolbar by clicking on the “heart failure”, “diabetes”, “anxiety & depression”, or “COPD” buttons.

Once a condition has been selected the toolbar can indicate two different pathways depending on whether the patient has been diagnosed with the respective condition.



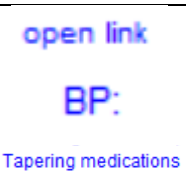
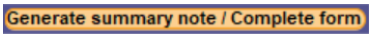
E2P Custom Vitals

The tool was designed to include decision-support throughout the tool and has implemented tooltips, hover-overs, and pop-up windows to also help inform quality standard information.

Tool	Custom Vital Name	Value	Purpose
Heart Failure	@Hfdiagnosis	• Suspect • Reduced, • Midrange • Preserved • Recovered • Riskreviewed	Gives the tool the ability to track the diagnosis progression.
	@LVEF	Numeric	Records the left ventricular ejection fraction.
	@NYHA		Records the New York Heart Association score dyspnea.
Diabetes	@CANRISK	Numeric	Records the CANRISK score.
COPD	@COPDDX	• Confirmed • Unconfirmed • Suspected	Records the COPD Diagnosis Status. Also gives the tool the ability to track the diagnosis progression.
	@AECOPD	Numeric	Records number of acute COPD exacerbations.
	@DyspneaScale		Records the nMRC Dyspnea Scale Score.
	@CAT		Records the COPD Assessment Tool Score.
	@FEV1		Records the FEV1 (Spirometry Result).
	@FEV1FVC		Records the Absolute FEV1/FVC ration (Spirometry).

E2P Tools Icons Meanings

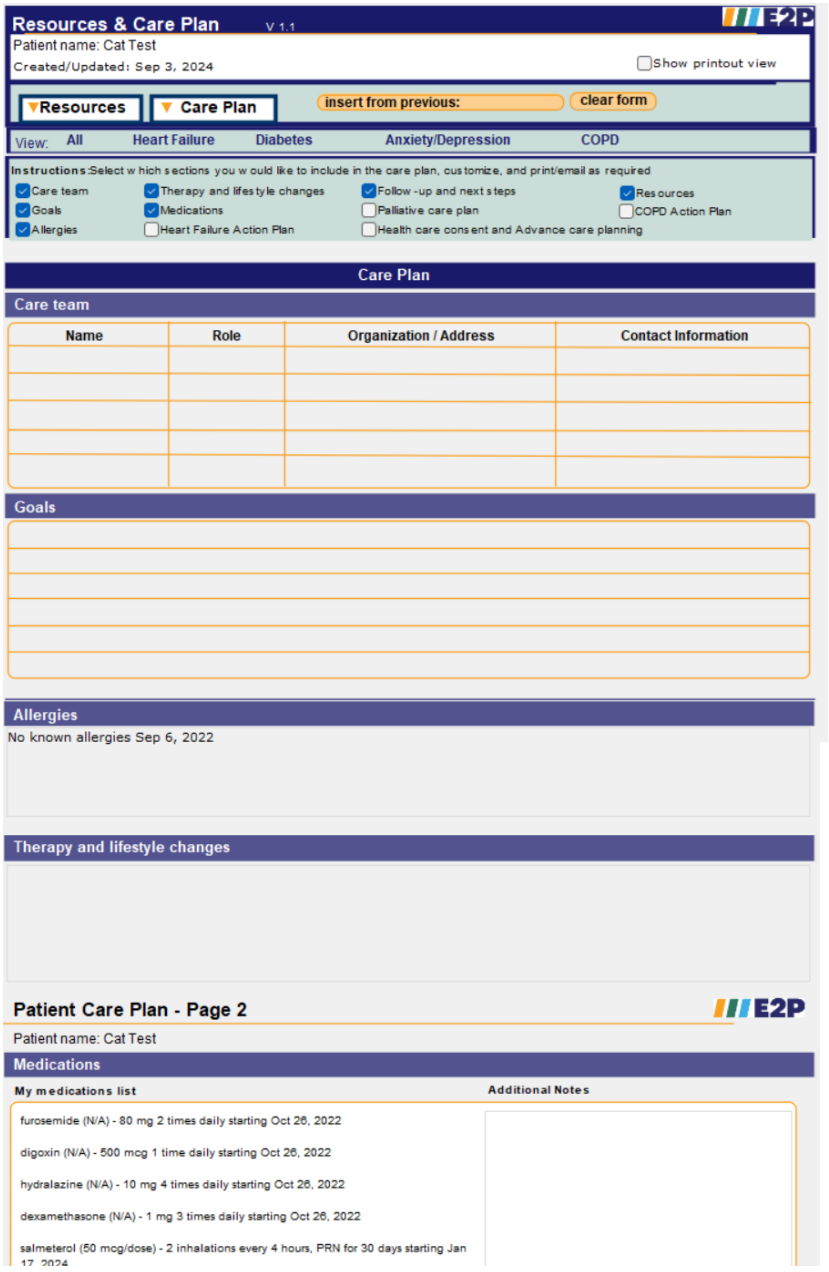
The tool was designed to include decision-support throughout the tool and has implemented tooltips, hover-overs, and pop-up windows to also help inform quality standard information.

	Blue 'i' icons – Indicate hover-over text. Hold your mouse over this area to view the content.
	Yellow button – clicking on these will open a new window of the respective function (ex. view graph will open a window of a graph/ prescribe will open the prescription window).
	Red text – indicates warning/high-priority information to consider regarding patient care.
	Blue text – Clicking on this button will redirect you to the patient notes section and filter to the respective area (for example: HRM reports, lab results).
	Blue text – hyperlink. Clicking on this will open a new window either directing to the web browser, will open a graph window, or will open a pop-up image related to clinical content.
	Blue chat icons – indicate talking tips. Click on this icon to view talking points that could be used to help conversations with patients.
	The refresh button pulls in the most up-to-date mental health diagnosis status.
	Clicking on this button will generate a summary note from the information that was entered in the form as well as collapse and add the completed form into the patient's chart.
* Specific to heart failure tool * 	'i' icon with a blue outlined circle – indicates hidden text. Clicking on this button will show the hidden text then clicking on it again will hide it.

Resources & Care Plan Module Version 1.1

The resources & care plan module contains a collection of curated resources for heart failure, diabetes, anxiety disorders & depression, and COPD to ensure all resources will be included in one place.

The goal of this module is to construct a care plan 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.



Heart Failure Tool Version 2.0

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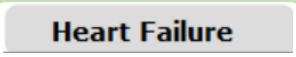
Purpose of the Tool

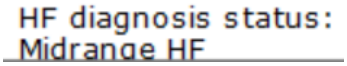
Our objective was to help primary care physicians track the progression and plans of heart failure patients. This tool allows for close monitoring of the patient's stability to help ensure safe practice. The tool was built to help standardize documentation, support primary care providers, and support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

Heart Failure Toolbar

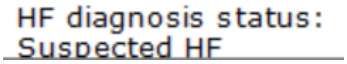
The patient has a heart failure diagnosis in their Problem list, or the clinician suspects the patient has heart failure.



Clicking on this button will give the clinician access to the full tool.

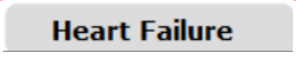


The heart failure diagnosis status will pull in the selected heart failure diagnosis.

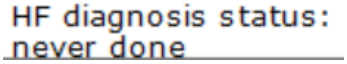


This diagnosis status will also grant the clinician access to the full tool.

The patient does not have a heart failure diagnosis in their Problem list



Clicking on this button will trigger the risk factors window to appear, directing the clinician to review if the patient possesses any of the heart failure-related risk factors.



The heart failure diagnosis status has not been done.

HF diagnosis status: Risk Reviewed

The clinician has reviewed the risk factors and does not suspect heart failure.

For either of the above statuses ("never done" and "risks reviewed"), the clinician will not have access to the full tool for this patient.

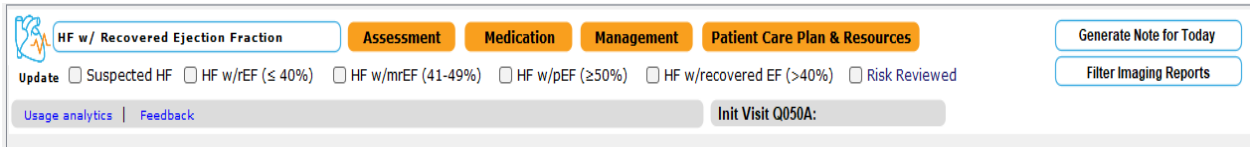
Heart Failure Risk Factor Tool

The heart failure Risk Factors window will appear if the patient does not have a suspected/confirmed heart failure diagnosis and will search for terms within the problem and past health list. A "green check mark" will appear beside the term if the respective risk factor was found or a "red X" if it was not found.

From here, the clinician can decide if they suspect heart failure or if they do not suspect it by clicking "Risk Factors Reviewed".

From the toolkit, a user has the option to:

- Update a heart failure diagnosis
- Launch into a clinical module
- Generate a progress note from the current day's visit modules
- Filter imaging results



Launching Clinical Modules

The components related to the provision of heart failure care have been broken into 4 modules, allowing for flexibility. Once a user opens a module from the toolkit, from

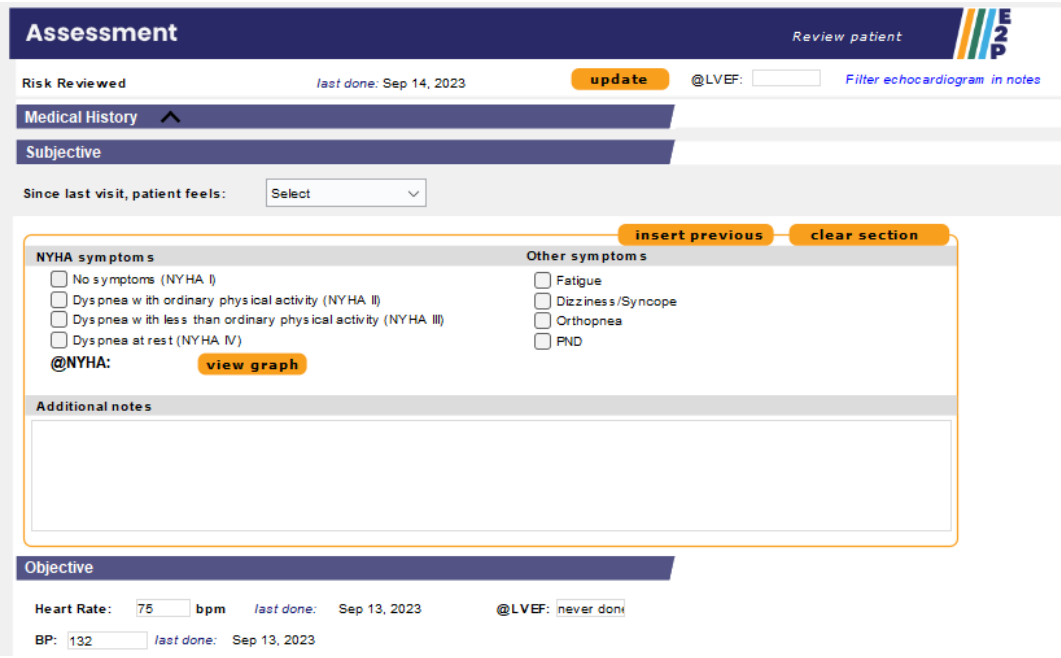
within the module, they have the option to finish and insert a progress note thereby closing the module or they can finish and open a new module, and continue the discussion during the visit, adding more information into the tool.

Assessment Module

The first time the assessment is launched, the medical history section will be expanded by default. The boxes labeled Symptoms, Prior cardiac disease, and risk factors and Medications are read-only areas for review.

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.

We have updated the lab requisition form to be pre-selected with the tests that are typically requested for patients with or suspected of heart failure. We also made changes to the respiratory examination section to include pulmonary crepitation, pleural crepitations, decreased air entry, etc.



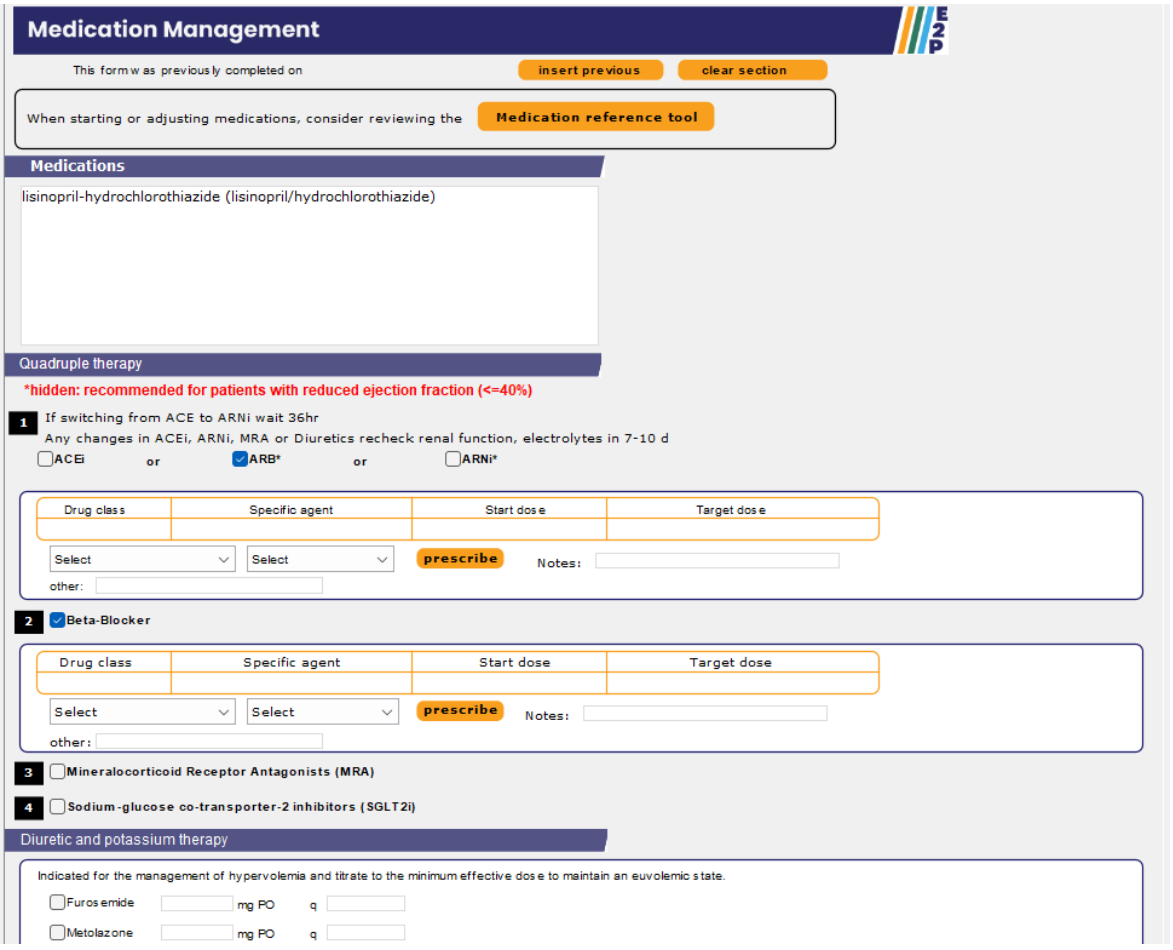
Medication Module

The purpose of the medication module is to create and document medication management plans using the medication reference tool, which was created to provide more information concerning coverage, harm, and monitoring, when to consider dose reduction, etc.

A key feature is the patient's medication list which pulls in the current list of medications for easy reference.

The quadruple therapy section will automatically expand for the patients that meet the criteria. Upon selection of the drug class checkbox, relevant sections will become visible.

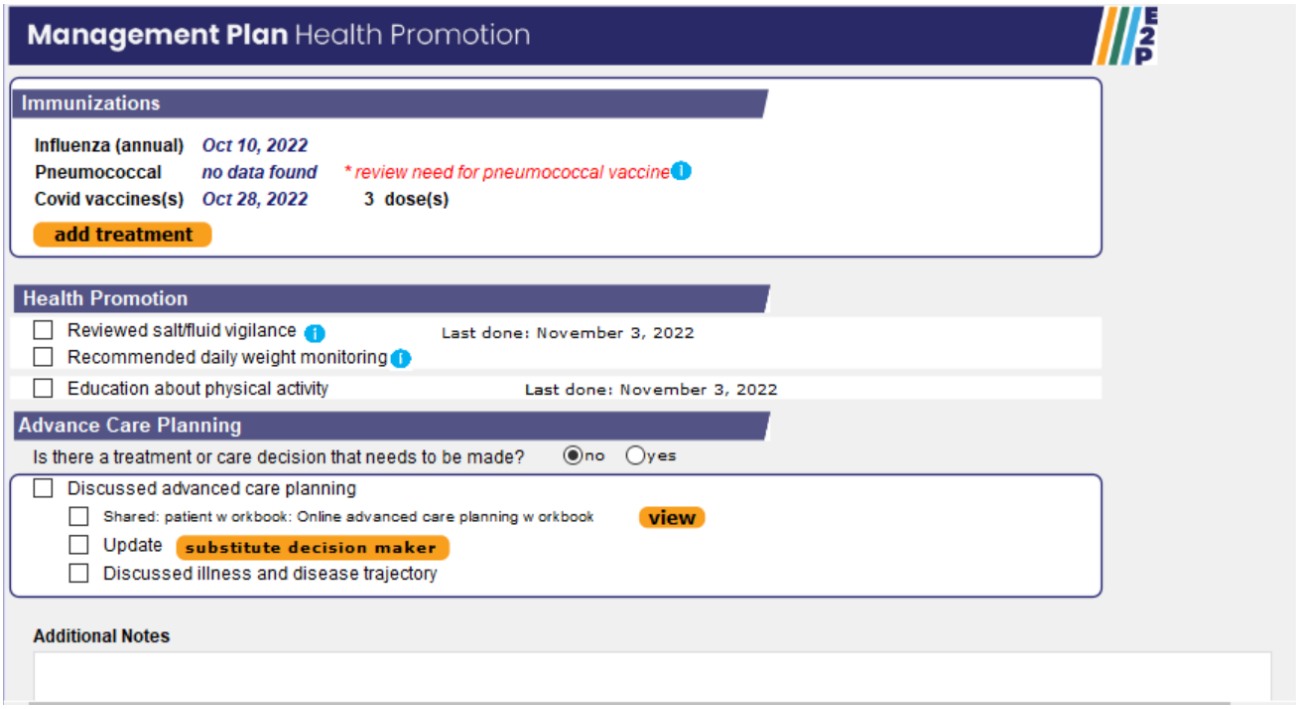
The prescribe button will automatically pass the medication name* to the PSS prescription writer. **Other prescription-related elements will still be required*



Management Module

The management section offers the opportunity for clinicians to document that information has been provided to the patient about 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. Additionally, this section links to the substitute decision-maker custom form.



Patient Care Plan and Resources Module

This module has been transformed into a consolidated care plan that includes a collection of curated resources for heart failure, diabetes, and prediabetes, anxiety disorders & depression, as well as COPD. This module is the same for all E2P tools in TELUS PSS; for more information, click here.

Diabetes Tool Version 1.1

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Purpose of the Tool

The objective was to create an EMR-integrated tool that supports clinicians in the screening and management of diabetes. The E2P diabetes tool for TELUS PSS supports a more comprehensive picture of the clinical assessment, pharmacologic & nonpharmacologic treatment goals, shared decision-making, self-management, and ongoing monitoring by the clinician, thereby ensuring that a comprehensive plan for the patient is created where appropriate.

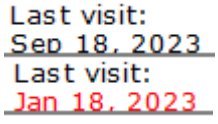
Features include:

- 8 out of 9 quality statements for people with Diabetes Type 2 or Prediabetes within the tool
- Review the last K030 and Q040

DM Toolbar

The patient has a DM2 or prediabetes diagnosis in their Problem list

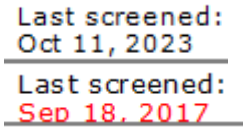
Clicking on this button will give the clinician access to the full tool.



Red text will appear if someone is overdue for a visit. Prediabetes is 6 months and DM2 is 3 months for frequency, but this is also adjustable in the assessment module.

The patient does not have a DM or Prediabetes diagnosis in their Problem list

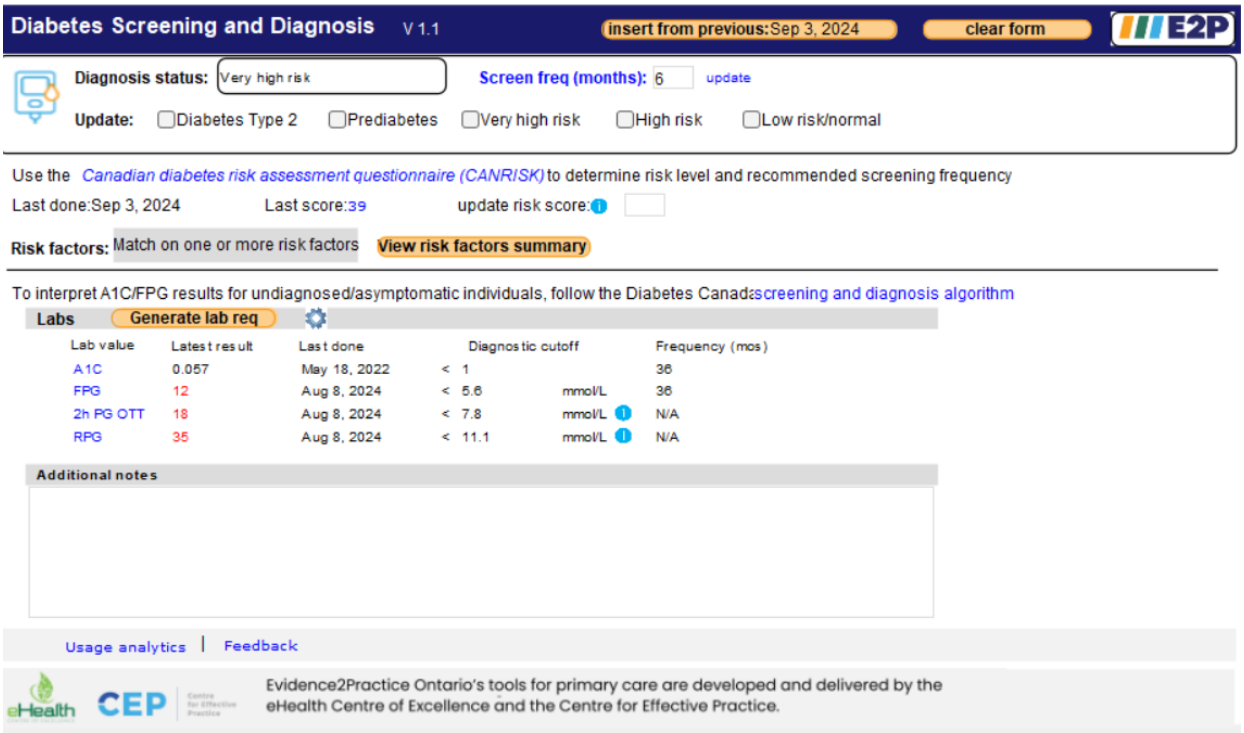
Clicking on this button will trigger the screener window to appear.



Screening has a frequency set for 36 months to revisit. It will turn red after 36 months.

Diabetes Screening and Diagnosis Window

The diabetes screening and diagnosis window is where users can update the diagnosis status, navigate to the Canadian diabetes risk assessment questionnaire, review relevant labs, and view the risk factors. The screening frequency field can be customized for each patient based on the Diabetes Canada screening and diagnosis algorithm.

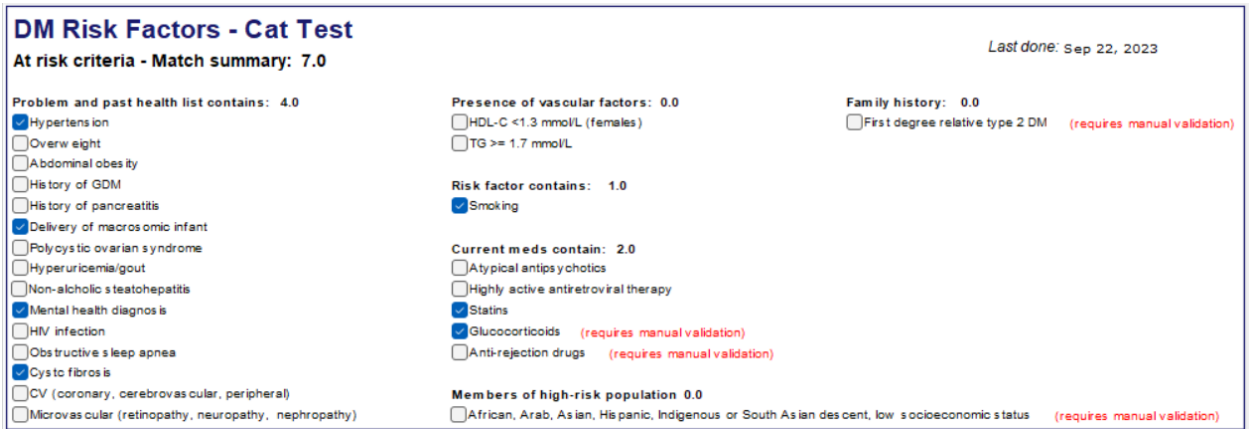


Diagnosis status

The diagnosis status can be updated to reflect one of the following:

- Diabetes type 2
- Prediabetes
- Very-high risk
- High risk
- Low risk/normal

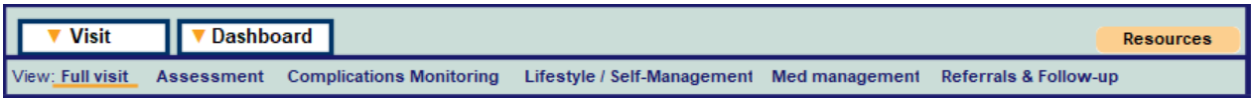
Selecting diabetes type 2 and prediabetes diagnoses will add a coded diagnosis to the CPP Prob List in the patient's chart.



Launching Clinical Modules

The components related to the provision of diabetic care have been broken into 5 modules, allowing for flexibility.

Starting from Assessment, Complication Monitoring, Lifestyle/Self–management, Management, Medication Management, and Referrals & Follow-up, these modules make up the visit portion of the tool and can be shown on their own by clicking on the individual buttons or can be viewed all together by clicking Full Visit, which is the default layout. These modules have form memory and will populate upon selecting the pull from the previous button.

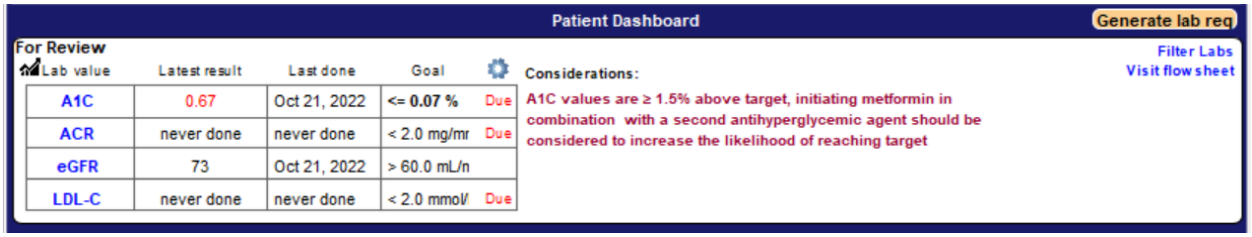


Patient Dashboard

The patient dashboard is separate from the visit portion of the tool and can be hidden and shown by clicking the dashboard button at the top. This section provides a summary of the patient's most current lab results at a glance and includes the link to generate a lab requisition form, filter labs, and visit flowsheet.

The lab req form has been developed with the intention to be used for both heart failure and diabetes, it includes the relevant lab test for initial investigations and ongoing management of the conditions.

The default ranges included in the tool are based on the guidelines provided for the general population.

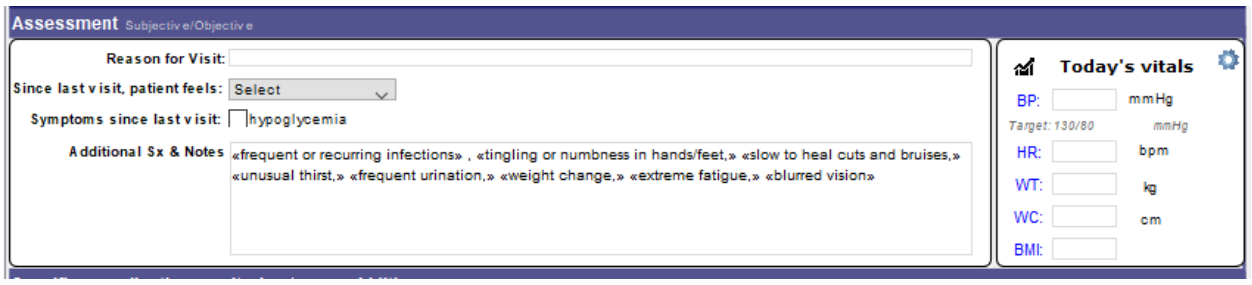


Assessment Module

In the assessment module, clinicians can update how the patient feels since the last visit and document if the patient has experienced hypoglycemia as well as how many episodes since the last visit.

A key feature is the placeholder text that is designed to help prompt the clinician to document any information regarding additional symptoms and notes.

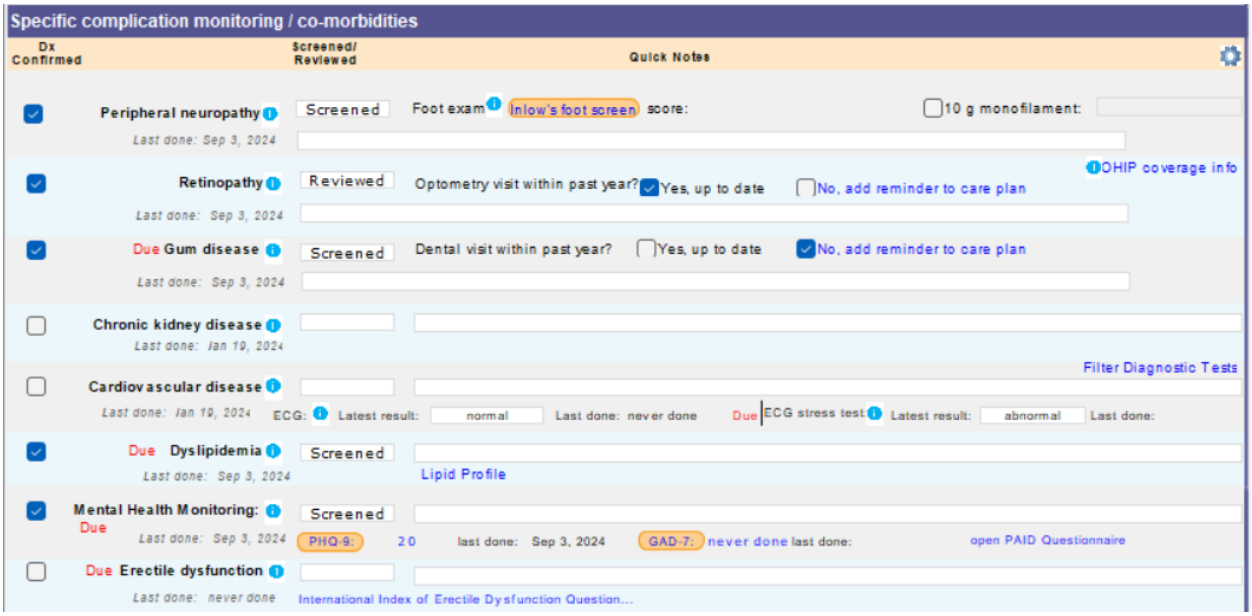
Today's vitals are embedded directly into this module which will pull in the patient's most up-to-date vitals for blood pressure, heart rate, weight, waist circumference, and BMI.



Specific Complications Monitoring/ Co-morbidities Module

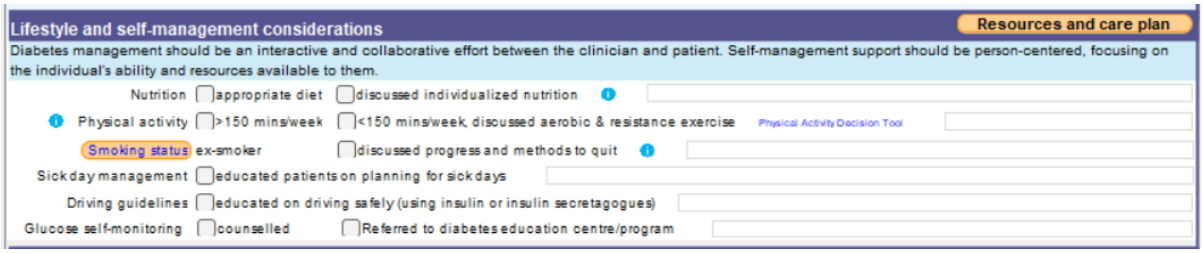
In this section, clinicians can monitor the specific complications and co-morbidities associated with diabetes. With the ability to identify which conditions the patient has been diagnosed with, users can input the date last screened/reviewed, filter diagnostic tests, as well as document relevant information in the quick note sections.

A key feature in this section is the gear icon that enables clinicians the ability to modify the default screening and lab value ranges and tailor them to the individual patient's needs.



Lifestyle and Self-Management Module

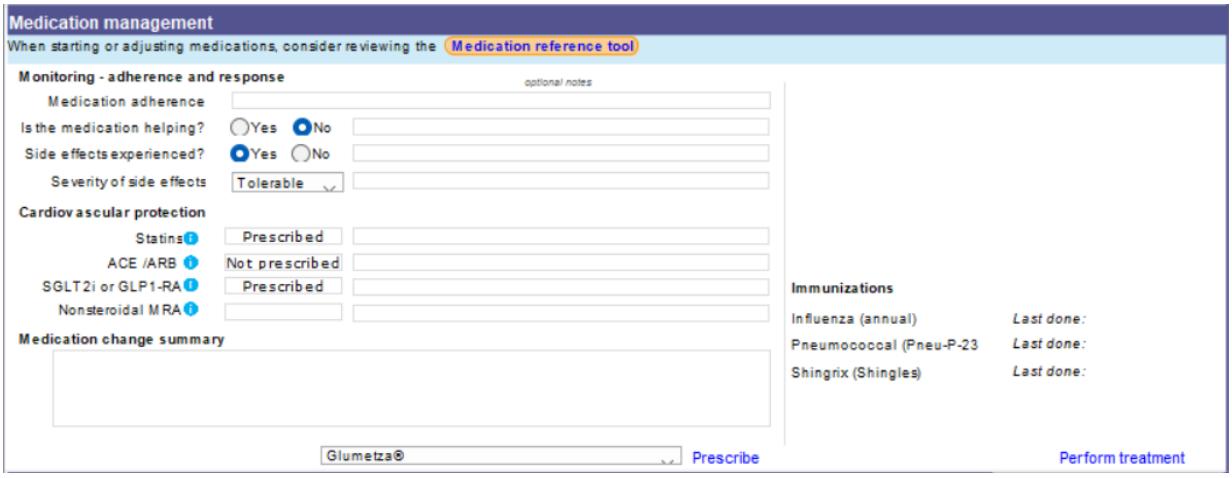
The management module supports clinicians in identifying lifestyle changes that can be taken into consideration as well as launches the smoking status toolbar.



Medication Module

The purpose of the medication module is to document medication adherence and response. The main feature is the Medication reference tool, which was created to provide more information concerning coverage, harms, when to consider dose reduction, etc. The dropdown medication list can be used to select the specific medication as well as prescribing it directly from the tool. Within the cardiovascular protection section, clinicians can document and track which drug class group they have prescribed for the patient.

This module also pulls in the patient's immunization records and enables clinicians to input any additional treatments the patient has obtained.



Resources and Care Plan Module

This module has been transformed into a consolidated care plan that includes a collection of curated resources for heart failure, diabetes, and prediabetes, anxiety disorders & depression, as well as COPD. This module is the same within both the heart failure and the diabetes tool; for more information, click here.

Anxiety Disorders and Depression Tool Version 1.1

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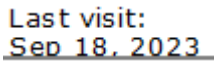
Purpose of the Tool

Our objective was to create an EMR-integrated tool that supports clinicians in the screening and management of mental health. The E2P anxiety disorders and depression tool for TELUS PS Suite EMR supports a comprehensive picture of the patient's mental health condition, treatment goals, and potential risk for suicide – thereby ensuring that a safety plan for the patient is created where appropriate.

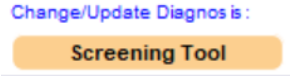
Anxiety Disorders and Depression Toolbar

The patient has an anxiety disorder or depression diagnosis in their Problem list

Clicking on this button will give the clinician access to the full tool.



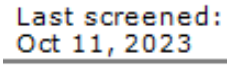
Last Visit: will appear if the patient has a confirmed MH diagnosis and will pull in the last visit date.



Within the visit tool, if there are any suspected disorders but not yet confirmed, clicking this button will trigger the screener tool to appear and allow users to confirm the diagnosis.

The patient has a suspected or does not have a DM or Prediabetes diagnosis in their Problem list

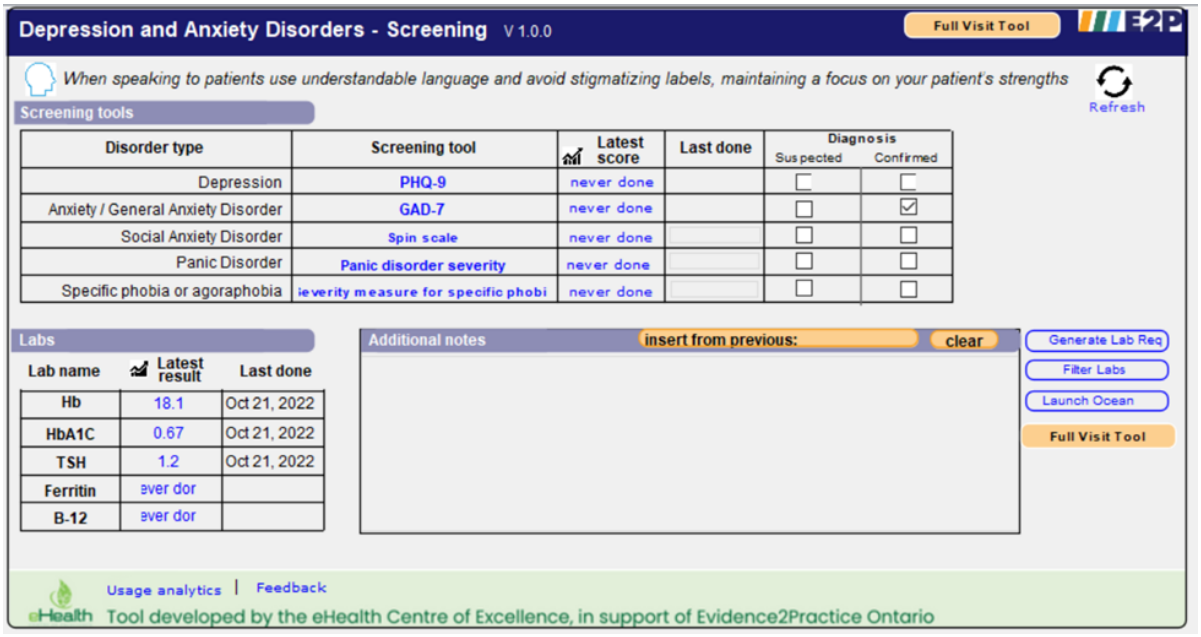
Clicking on this button will trigger the screener tool to appear.



Last Screened: will pull in the last date the screening tool was completed.

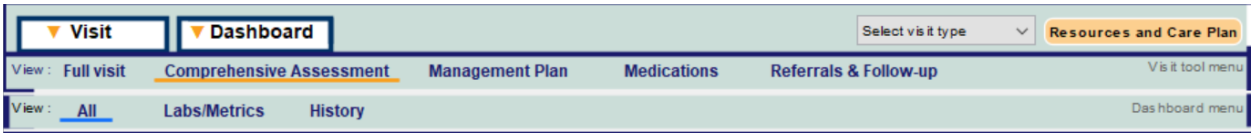
Anxiety Disorders and Depression Screening Tool

The purpose of the anxiety disorders and depression screening tool is to house all related screening tools and lab tests in one central location to support making a diagnosis. The appropriate screening tools are linked directly beside the respective disorder and once the assessment is completed, the score will populate into the latest score section. Both lab results and screener scores can be viewed in a graph.



Launching Clinical Modules

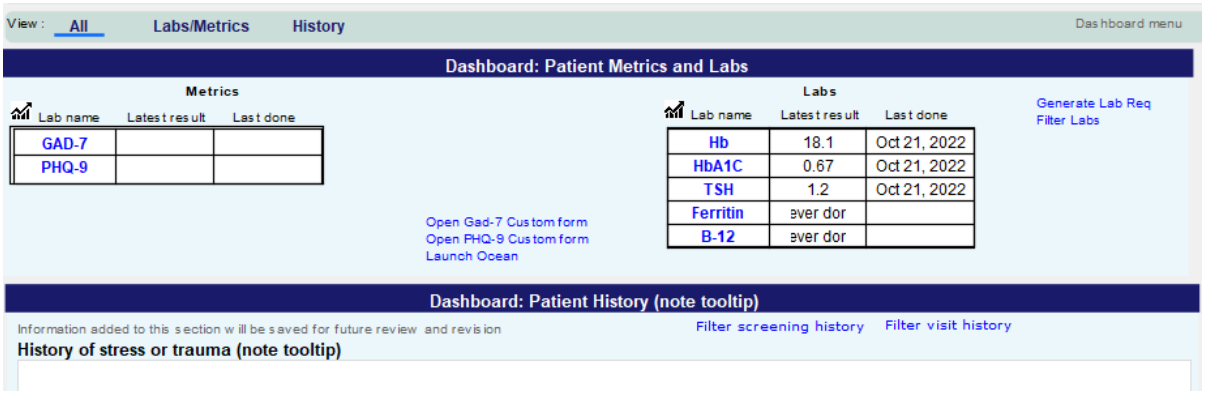
The components related to the provision of mental health care have been broken into 4 modules, allowing for flexibility. These modules have form memory and will populate upon selecting the pull from the previous button.



The visit tool menu starts at Full Visit, Comprehensive Assessment, Management Plan, Medication, and Referrals & Follow-up; these modules make up the visit portion of the tool and can be shown on their own by clicking on the individual buttons or can be viewed all together by clicking Full Visit, which is the default layout. These sections can be shown on their own or all together by clicking 'All'.

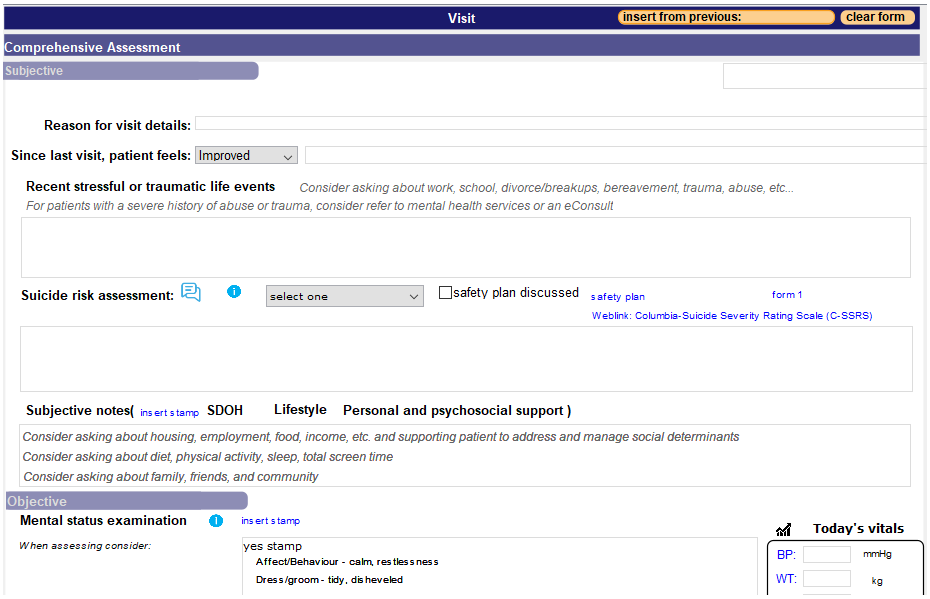
Patient Dashboard

The patient metrics and labs section will provide a summary of the patient's most recent lab results at a glance and include the link to generate a lab requisition form. The purpose of the patient history section is to provide an area intended for the documentation of the patient's history.



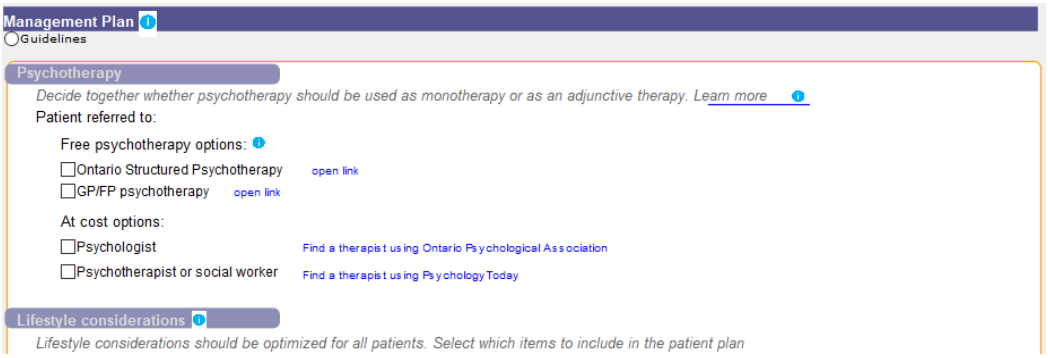
Comprehensive Assessment Module

In this module, clinicians can document the reason for the visit, what this visit is related to, how the patient feels since the last visit, and any recent stressful or traumatic life event(s). A key feature embedded is the insert stamp functionality that stamps in information from pre-designed templates and is intended to save documentation time and support the documentation of care in a standard format.



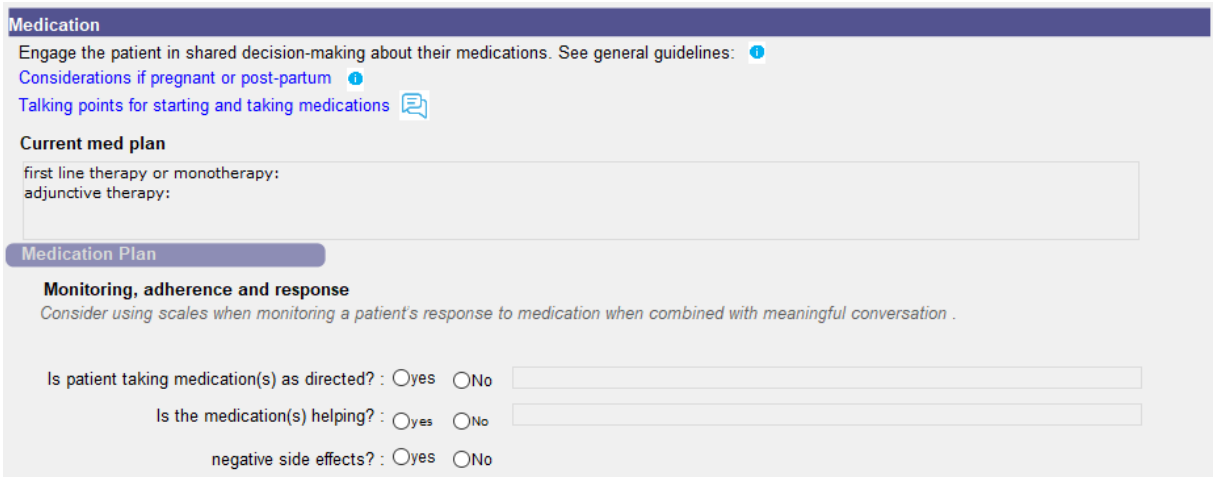
Management Plan Module

The management plan module consists of sections for psychotherapy and lifestyle considerations. The intention for this module is to work with the patient to decide whether psychotherapy should be used as a monotherapy or as an adjunctive therapy as well as discussing which lifestyle considerations should be optimized. Included are a number of decision-support aids, and direct links to free and at-cost psychotherapy options.



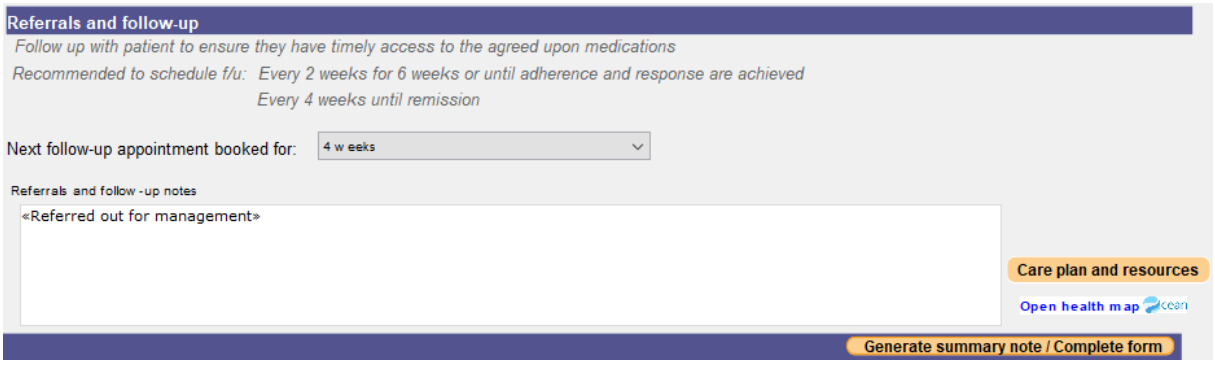
Medications Module

The purpose of the medication module is to create and document medication management plans based on the latest best practice guidelines for anxiety disorders and major depression, which in turn also populate the patient care plan with the most recent updates to their medication plan. Included are many guidelines and decision support pop-ups that provide information regarding patient and medication factors to consider when initiating treatment throughout the module.

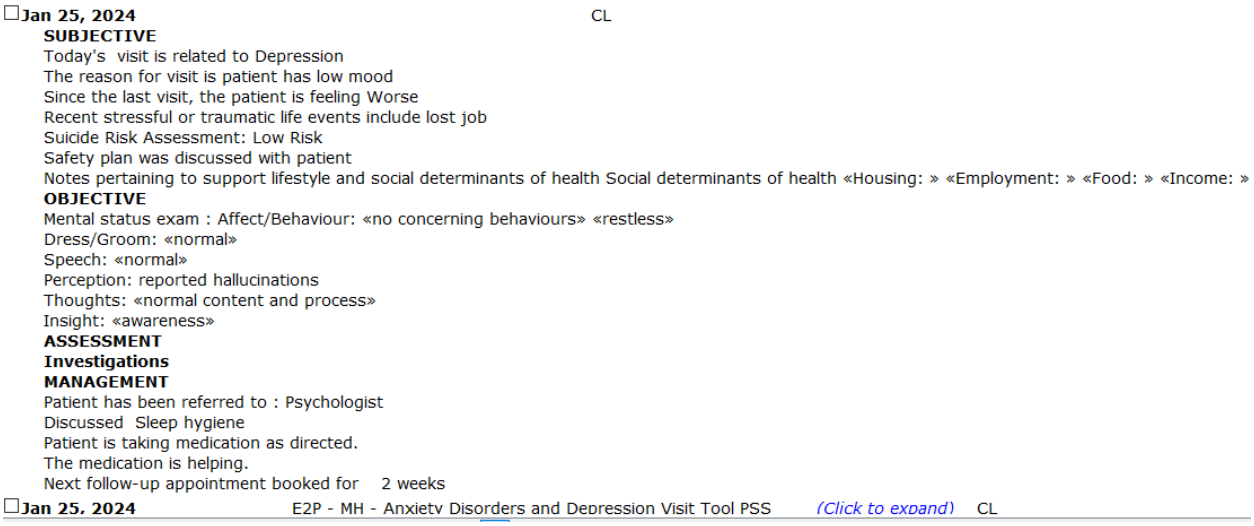


Referrals and Follow-up

This module provides guidance on follow-up appointment schedules and includes a link to the Care Plan and Resources Module.



Once the visit has been completed, the generate note feature will quickly capture all your documentation into a concisely summarized visit note and copy it to the patient's chart. It will also save a copy of the completed visit form below the note, which is in a collapsed state automatically to save space but can be expanded for review if desired.



☐**Jan 25, 2024** CL

SUBJECTIVE
Today's visit is related to Depression
The reason for visit is patient has low mood
Since the last visit, the patient is feeling Worse
Recent stressful or traumatic life events include lost job
Suicide Risk Assessment: Low Risk
Safety plan was discussed with patient
Notes pertaining to support lifestyle and social determinants of health Social determinants of health «Housing: » «Employment: » «Food: » «Income: »
OBJECTIVE
Mental status exam : Affect/Behaviour: «no concerning behaviours» «restless»
Dress/Groom: «normal»
Speech: «normal»
Perception: reported hallucinations
Thoughts: «normal content and process»
Insight: «awareness»
ASSESSMENT
Investigations
MANAGEMENT
Patient has been referred to : Psychologist
Discussed Sleep hygiene
Patient is taking medication as directed.
The medication is helping.
Next follow-up appointment booked for 2 weeks

☐**Jan 25, 2024** E2P - MH - Anxiety Disorders and Depression Visit Tool PSS *(Click to expand)* CL

Resources and Care Plan Module

This module has been transformed into a consolidated care plan that includes a collection of curated resources for heart failure, diabetes, and prediabetes, anxiety disorders & depression, as well as COPD. This module is the same within all E2P tools for TELUS PSS; for more information, click here.

COPD Tool Version 1.1

Table of Contents

Purpose of the Tool

Our objective was to create an EMR-integrated tool that supports clinicians in the screening and management of chronic obstructive pulmonary disease (COPD). The E2P COPD tool for TELUS PS Suite EMR supports a comprehensive picture of the patient's condition and treatment goals.

COPD Toolbar

There are two proposed workflows that will be launched from the COPD toolbar. The first is the *screening and diagnosis workflow*. All patients will initiate this workflow when the COPD button is triggered. The second is the *COPD management workflow*. A patient will fall into this workflow once their COPD diagnosis status has been updated to either; 1) confirmed by spirometry 2) unconfirmed by spirometry or 3) suspect.

Shown in green: If a diagnosis status is confirmed, unconfirmed, or suspect, it will display the "last visit" date to let clinicians know when the patient was last seen or when the form was completed.

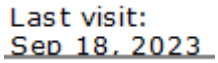
It is important to note that a diagnosis status is different than a diagnosis. The diagnosis status reflects that spirometry has been considered to confirm a diagnosis. The "update diagnosis" form allows users to input spirometry results in a way that the tool can use and be used for quality improvement initiatives (i.e., searches.)

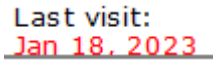
Shown in red: If the diagnosis status is never done or screened, it will display the "last screened" date and direct the clinician to the "screening and diagnosis" window.

Each of these workflows has an individualized frequency target. The frequency for visits is 12 months by default but can be edited based on the patient's individual needs and/or the user's discretion. The text will turn red if the patient is overdue for a visit.

The patient has a COPD diagnosis on their Problem list

Clicking on this button will give the clinician access to the visit tool.

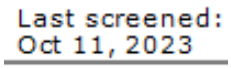


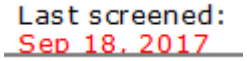


The frequency for visits is 12 months by default but can be edited based on the patient's individual needs and/or the user's discretion.
The text will turn red if the patient is overdue for a visit.

The patient does not have a COPD diagnosis on their Problem list

Clicking on this button will trigger the screener window to appear.

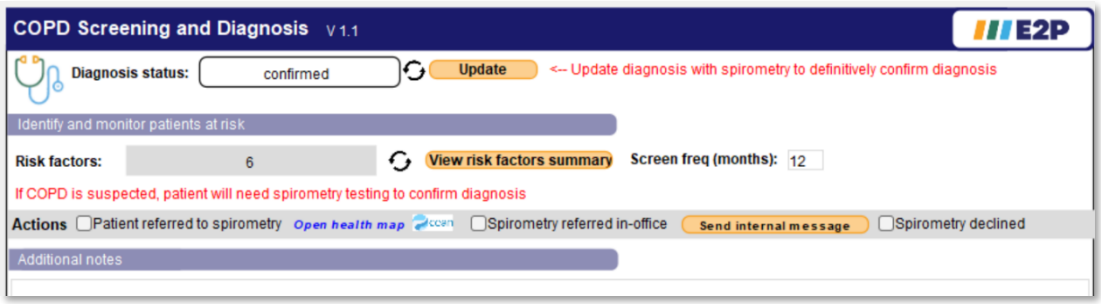




The frequency for screening is 12 months by default but can be edited based on the patient's individual needs and/or the user's discretion.
The text will turn red after 12 months to remind the user to book their patient in for a visit.

COPD Screening Tool

When a patient does not have COPD as a diagnosed condition in their problem list or chart, clicking on the "COPD" button will open the screening and diagnosis form window.

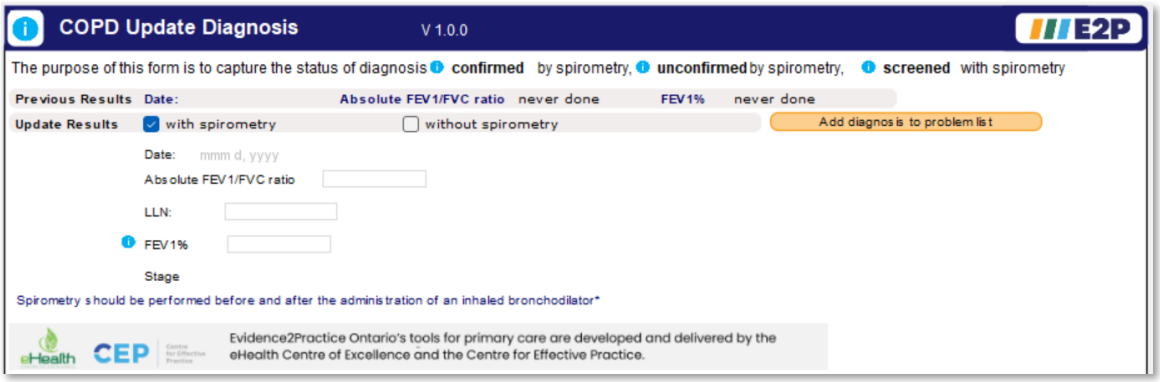


Screening and diagnosis form has three main functions:

1) Launch the "update diagnosis" form to input spirometry results or to indicate if COPD management is going to continue without confirming by spirometry.
2) Review and document risk factors that identify clinically suspected COPD patients who may require spirometry testing.
3) Taking action by obtaining a spirometry test either through a referral or an in-office resource.

Update Diagnosis Status

Users can open the update diagnosis button, which will open the update diagnosis form. Here, users can update the spirometry results, entering the date it was performed, the absolute FEV1/FVC ratio, and/or the FEV1%, and LLN. Based on the values entered, the tool will automatically stage the severity of airflow limitation; mild, moderate, or severe. If results are consistent with a diagnosis (FEV1%<.7) the user can add the diagnosis to the patient's problem list by clicking on the respective button and selecting the coding system used in the user's clinic. The diagnosis status "custom vital @COPDdx:" will be updated to **confirmed**. If results are not consistent with a COPD diagnosis (FEV1%>.7) The diagnosis status "custom vital @COPDdx:" will update to **screened** upon adding to notes.

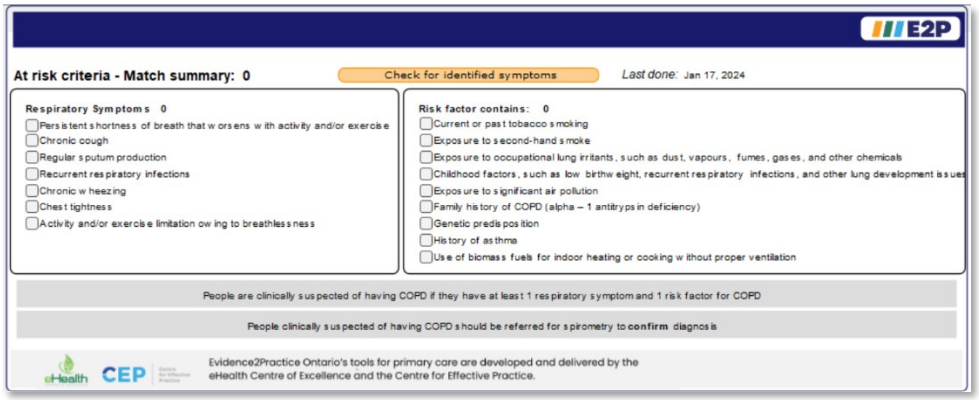


Reviewing risk factors

From this form, users have the option to review the risk factors associated with clinically suspected COPD patients. There are two categories: respiratory symptoms and other risk factors. People are clinically suspected of having COPD if they have at least one respiratory symptom and one risk factor of COPD. For patients who have at least one in either category the screening form will recommend that if COPD is suspected, the patient will need spirometry testing to confirm the diagnosis.

The 'check for identified symptoms' button will update the checkboxes with any previously identified factors. (The form will check the EMR risk factors area for smoking status.) The total number of matches will be displayed on the screening and diagnosis form.

The use of this form allows the clinicians to be able to see the date the last screening was completed as well as document the respiratory and risk factor symptoms the patient exhibits.



Taking Action

If spirometry is recommended as a course of action based on the patient's identified risk factors, the user can indicate that a referral has been sent, or that spirometry has been/will be done in-office. To support referrals a link is provided to the ocean health link map. To support in-office referrals, a quick message button function has been embedded into the form. This will send a message to the user identified by initials to book a spirometry. Both of these checkboxes will update the diagnosis status to **suspect**. If spirometry is not an option, users can continue to the COPD pathway using the unconfirmed checkbox. Users will be asked to identify a reason for declining to confirm with spirometry.

Launching Clinical Modules

The components related to the provision of mental health care have been broken into 4 modules, allowing for flexibility. These modules have form memory and will populate upon selecting the "insert from the previous" button.

The visit tool menu starts with Full Visit, Assessment, Lifestyle/Self-Management, Med Management, and Resources & Care Plan, these modules make up the visit portion of the tool and can be shown on their own by clicking on the individual buttons or can be viewed all together by clicking Full Visit, which is the default layout.

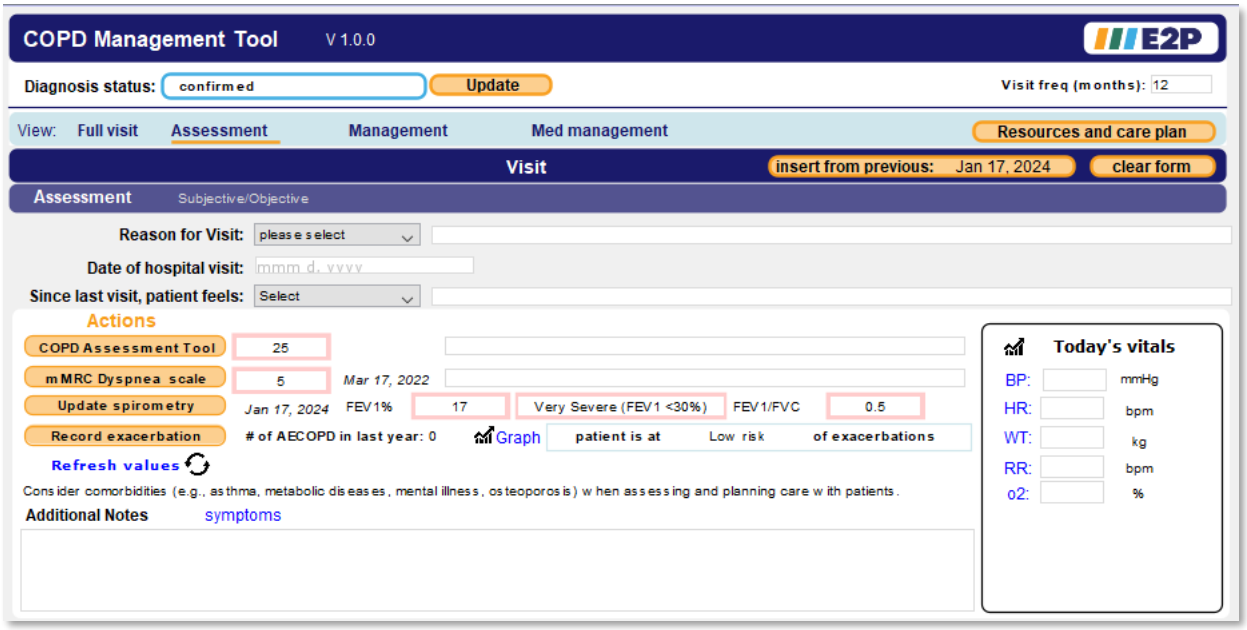
Assessment Module

Clinicians can document the reason for the visit, how the patient feels since the last visit, today's vitals, and COPD symptoms. A key feature embedded is the insert stamp functionality that stamps in information from pre-designed templates for COPD symptoms and is intended to save documentation time in an easy-to-use and accessible format. Using the text boxes in the vitals section will universally update those measurements in the patient's chart. Clicking the measurement label will launch a graph for historical values.

The degree of COPD-related disability depends on symptom severity. The E2P uses embedded tools to assist in measuring the degree of disability.

1) COPD Assessment Test
2) MRC Dyspnea Scale

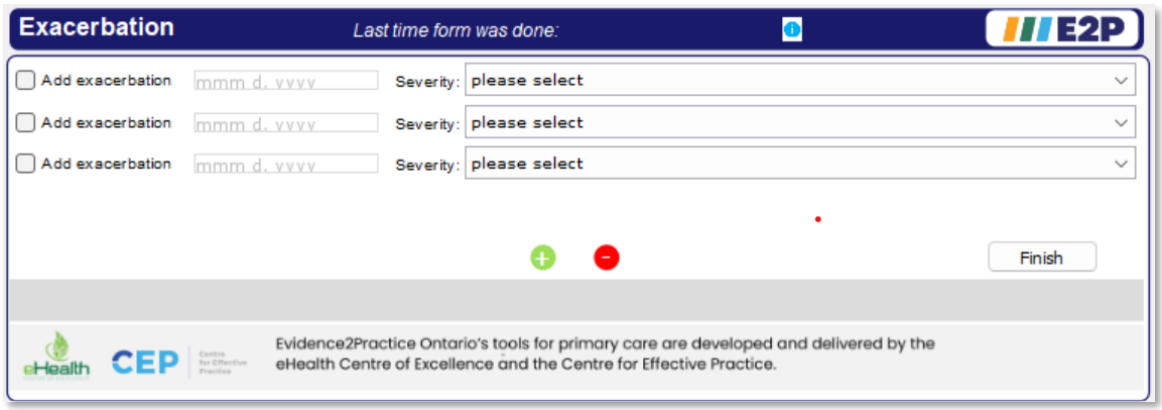
Additionally, the tool supports capturing a history of acute exacerbations (timing, frequency, severity) and uses an algorithm in the background to measure the risk of future exacerbations. These elements combined with the spirometry results help to build a bigger picture to support the user in recommending a pharmacologic pathway for the patient.



Using the record exacerbation form

Clicking on the checkbox will automatically insert today's date. Right-click on the date field to change the date. The algorithm counts the number of exacerbations in the past year based on today's date, so while capturing information as accurately as possible is best – if specifics are unknown, it is still best to insert a date. The severity dropdown is also used to stratify those at risk and also offers opportunities to educate patients on what is considered an exacerbation.

The form will also show the last done date to assist in gathering the most relevant information (e.g. "Since X date, have you had any times where you've had to manage an exacerbation). When accessory forms are used, the refresh button must be used to update the most recent vitals.

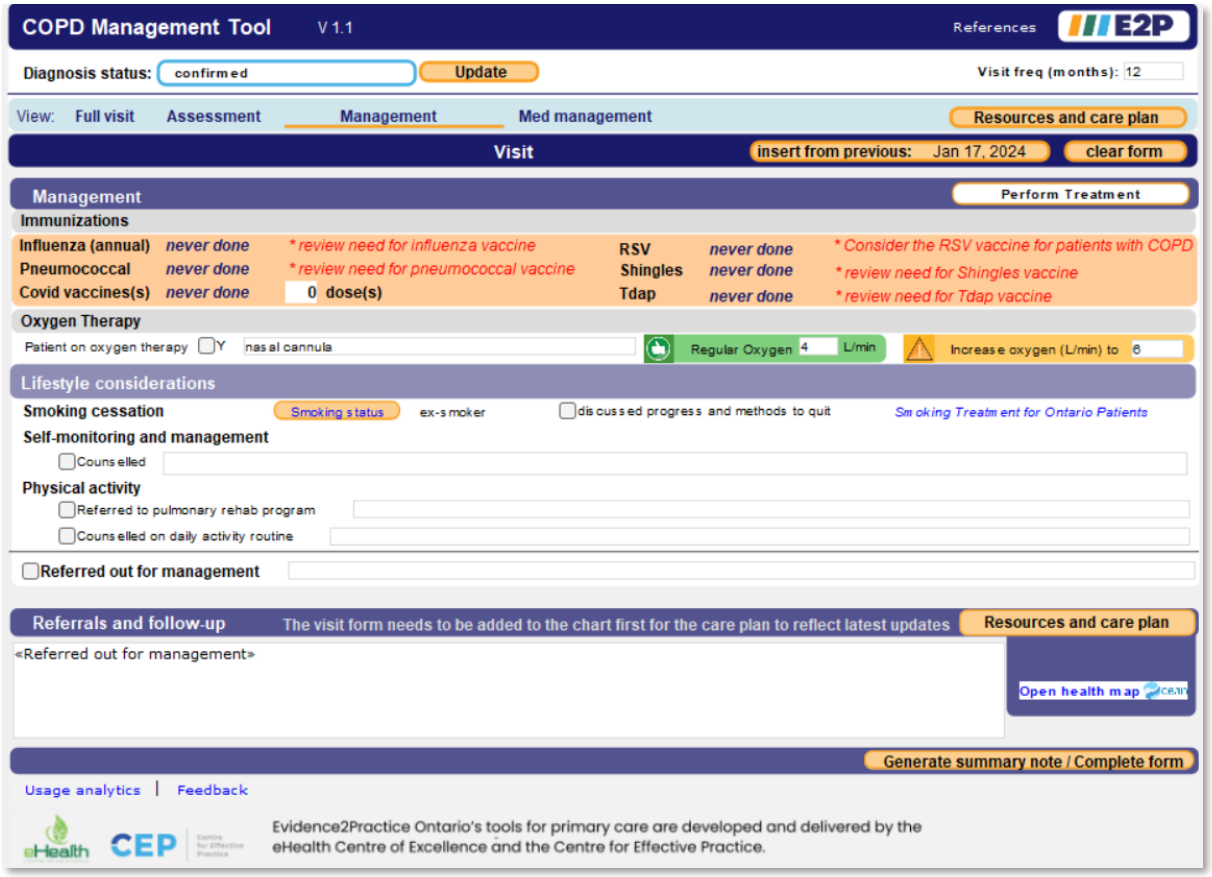


Management Module

The management module offers the opportunity to capture elements that were discussed during the visit. Users will also be able to review the patient's **immunization** record at a glance, this includes the influenza vaccine, pneumococcal, COVID, RSV, Shingles, and Tdap. Users can also indicate patients who are on **oxygen therapy** as well as initiate elements in the COPD action plan (part of the Care Plan).

This section also includes opportunities to document **lifestyle considerations**: the smoking status form (where users can update their smoking status as well as links to a resource for methods to quit), self-monitoring and management discussions, and physical therapy recommendations.

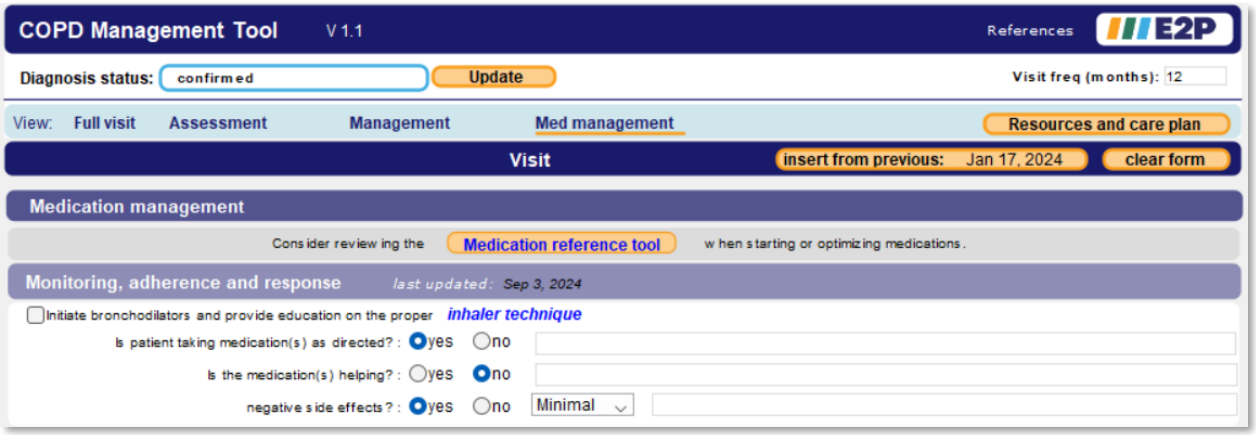
These sections also get included in the generate note feature that triggers once the visit has been completed and will quickly capture all your documentation into a concisely summarized visit note and copy it to the patient's chart.



Medications Module

The purpose of this section is to document **monitoring, adherence and response** to existing medications as well as **update the medication plan**. A link to the Canadian Thoracic Society (CTS) Guidelines for COPD is included at the top of this section to support users in categorizing the burden of the condition on the patient. This section will also pull in the patient's CAT score, dyspnea score, FEV ratio, and AECOPD score for the user to consider when initiating treatment.

A key feature in this section is the **medication reference tool**, which was created to provide more information concerning coverage, harm, monitoring, and when to consider dose reduction, etc. New to the reference tool is the opportunity to **COPY** the med name to bring back into PSS.



Medication Plan

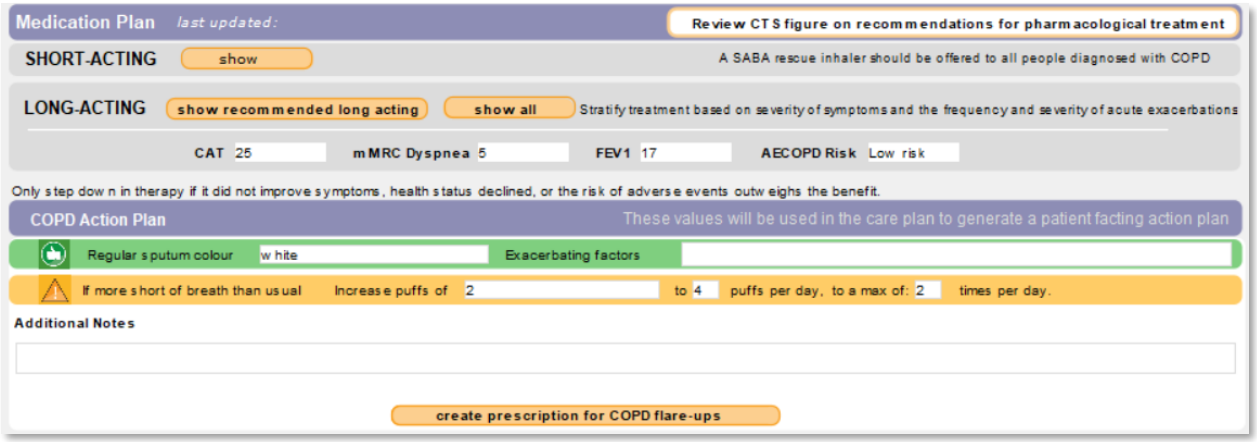
Users have the option to allow the tool to categorize the patient's COPD burden of disease using an algorithm adapted from the CTS guidelines factoring in the patient's more pressing factor, the tool will generate a recommended path for pharmacologic treatment. Once the scores have all been populated, users can click on the "show recommended" button and trigger the tool to show the treatment options for the patients.

Alternatively, the user could also click the "show all" button and review all the pharmacologic treatment options. Once a decision has been made, this section also can launch the prescription writer directly from the tool.

Use the input text boxes to **PASTE** values from the medication reference tool and the PRESCRIBE button to launch the prescription writer.

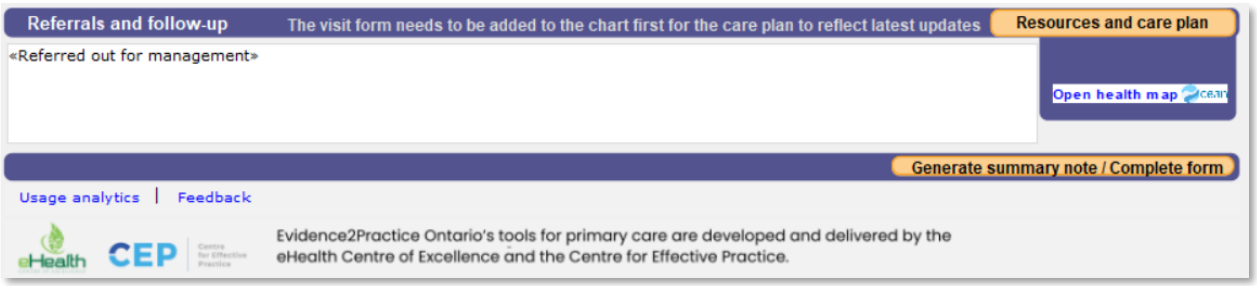
Using the checkboxes alongside the treatment path (i.e. LAMA or LABA) will update the date the medication plan was last updated.

The COPD Action Plan and Prescription for flare-ups can be initiated from the visit form. A more detailed patient-facing version is included in the care plan.



Referrals and Follow-up

This section allows for documentation regarding whether the patient was referred out for management including a link to the Care Plan and Resources Module.



Patient Care Plan and Resources Module

This module has been transformed into a consolidated care plan that includes a collection of curated resources for heart failure, diabetes, and prediabetes, anxiety disorders & depression, as well as COPD. This module is the same within each tool in the bundle, for more information, click here.

New with this launch, in addition to COPD resources, is the COPD Action Plan and Prescription for Flare-Ups.

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 way to support 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.