

As part of the Evidence2Practice Ontario (E2P) program, [Amplify Care](#) (formerly 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@amplifycare.com and we will be happy to help!

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Evidence2Practice – COPD Management 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. They were 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 COPD Management tool uses a modular approach to assist primary care clinicians with capturing critical information during an encounter. The tool is divided into sections: Patient Dashboard, Assessment, Medication, Management, and Patient Care Plan and Resources.

Purpose of the Tool

This tool aims to streamline the assessment, monitoring, and treatment of COPD, enabling healthcare providers to deliver personalized and effective care.

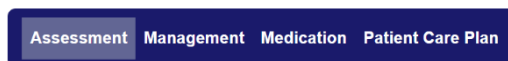
By utilizing this COPD Tool, primary care clinicians can improve the quality of care, enhance patient outcomes, and foster a collaborative approach to managing this chronic condition. We encourage you to explore the features and utilize them in your practice to support your patients with COPD.

Key Features

- **Patient Assessment:** Comprehensive template for the documentation of encounters with the patient.
- **Tracking and Monitoring:** Tools for tracking patient progress over time, including spirometry results, medication adherence, and exacerbation frequency.
- **Data Integration:** Seamless integration with existing EMR functionalities, allowing for easy access to patient records, lab results, and other relevant health information.
- **Care Plans:** Customizable care plans tailored to each patient's needs, including medication management, lifestyle interventions, and self-management resources.

Using the E2P COPD Management Tool in OSCAR Pro

Navigating to the modules within the tool



(Found on the top of each module)

The components related to the care provision for COPD have been broken into sections.

Patient Dashboard

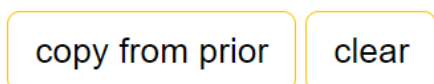


(Found on the left corner of each module)

Tabs:

- Metrics
- Labs
- History
- Resources

Pull from previous



(At the top of each module)

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 will clear all the sections.

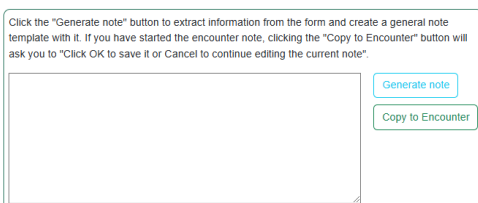
Navigation Buttons



(At the bottom of each module)

There are navigation buttons to allow users to move through the tool without having to scroll up to the top navigation menu.

Generate Note



(At the bottom of each module)

The **Generate note button** will extract information from the form and create a general note template with it.

Copy to Encounter and paste it into the patient's note section.

Getting Started with the COPD Management Tool

Dashboard

The dashboard gives clinicians the flexibility to show/hide the patient metrics, labs, history, or the resources panel alongside the main tool content to enhance documentation during patient encounters.

Recently implemented is the ability to combine showing measurements from other E2P tools (i.e., Heart Failure, Anxiety Disorders & Depression, and Diabetes). Users can toggle through the different measurements from one tool to the other. Our intention was to support the care of patients who may have multiple co-morbidities and allow the users to be able to view and address both in a single visit using just one tool.

Metrics Tab:
<div><div></div><div></div><div></div><div></div></div> <div><div>Update result manually</div></div> <div><div><div><div>CAT</div><div>open new form</div><div>Medium</div><div>11</div><div>Oct 01, 2024</div><div>graph</div></div><div><div>MMRC</div><div>open new form</div><div>High</div><div>5</div><div>Oct 01, 2024</div><div>graph</div></div></div><div><div><div>FEV1%</div><div>Update</div><div>Very severe</div><div>19</div><div>Oct 01, 2024</div><div>graph</div></div><div><div>AECOPD</div><div>open new form</div><div>High Risk</div><div>3</div><div>N/A</div><div>graph</div></div></div><div><div><div>FEV1/FVC</div><div>Update</div><div>0.9</div><div>Oct 16, 2024</div><div>graph</div></div><div><div>LLN</div><div>Update</div><div>3</div><div>Oct 16, 2024</div><div>graph</div></div></div></div> <div><div><div><div><input checked="" type="checkbox"/> COPD</div><div><input type="checkbox"/> HF</div><div><input type="checkbox"/> AD</div><div><input type="checkbox"/> DM</div></div></div></div>

<p>Users can open and complete the COPD accessory forms CAT, MMRC, and AECOPD forms from this section. As well as review spirometry results.</p> <ul style="list-style-type: none">- After a questionnaire is submitted the visit form will update dynamically pulling in the most recent score.- We have also implemented the generate note functionality into these accessory forms.- CAT and mMRC scores can also be updated manually.

Lab Tab:															
<div><div></div><div></div><div></div><div></div></div> <div><div>Update manually</div><div>Change frequency</div><div>Open lab req</div></div> <div><div><div><input checked="" type="checkbox"/> COPD</div><div><input type="checkbox"/> HF</div><div><input type="checkbox"/> AD</div><div><input type="checkbox"/> DM</div></div></div> <div>Please select the labs you would like to include in the lab requisition form.</div> <table><tr><th>Lab value</th><th>Result</th><th>Last done</th><th>Goal</th><th>Req.</th></tr><tr><td>eGFR</td><td></td><td></td><td>50-100 µmol/L</td><td><input checked="" type="checkbox"/></td></tr><tr><td>Hb</td><td>1.5</td><td>Apr 06, 2023</td><td>120-160 g/L</td><td><input type="checkbox"/></td></tr></table>	Lab value	Result	Last done	Goal	Req.	eGFR			50-100 µmol/L	<input checked="" type="checkbox"/>	Hb	1.5	Apr 06, 2023	120-160 g/L	<input type="checkbox"/>
Lab value	Result	Last done	Goal	Req.											
eGFR			50-100 µmol/L	<input checked="" type="checkbox"/>											
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<p>Users can update values manually, change the targets and frequency to tailor the goals to the patient, and launch the lab requisition form.</p> <ul style="list-style-type: none">- Recently implemented is the ability to review labs from the other E2P Tools as well as the functionality to be able to add lab investigations that need to be ordered into the lab requisition form.

History Tab:

The screenshot shows the 'History Tab' interface. At the top, there are icons for a line graph, a heart rate monitor, a clipboard, and a document. Below these is a yellow button labeled 'Update Patient Profile'. The 'Diagnosis Status' section has a blue information icon and the text 'never done', followed by a blue '+ Medical History' button. Below this are three radio buttons: 'Confirmed', 'Unconfirmed', and 'Suspect'. A green '+ Disease Reg' button is also present. The 'Smoking status' section has the text 'never done' and a blue '+ Medical History' button. Below this are three radio buttons: 'Current smoker', 'Ex-smoker', and 'Non-smoker', and a checkbox for 'Second-hand exposure'. The 'Risk Factors' section has a large text area. The 'Other co-morbid conditions' section has four text areas: 'Heart failure: never done', 'Diabetes: never done', 'Anxiety: never done', and 'Depression: never done'. Below this is another large text area. The 'Medication history and response' section has a large text area. The 'Non pharmacologic history and response' section has a large text area. The 'Family History' section has a large text area.

Users have the option to select Confirmed, Unconfirmed, or Suspect. The definitions for those status's will be explained in the blue information icon.

Clicking on **+ medical history** will insert a note into the medical history section to better integrate with the EMR. Users also have the option to add to the **+disease registry**, which the tool will automatically load the COPD code to support efficiency. Smoking status can be updated here.

Record relevant risk factors related to any of the patient's chronic condition(s).

Other co-morbid conditions:

The tool will pull in the dates the other E2P Tools were completed for Heart Failure, Anxiety Disorders & Depression, or Diabetes.

Text area to document overall medication history, response, non-pharmacologic history and response, and family history.

Once this section has been completed, users can click **Update Patient Profile**.

The patient profile tab will be automatically opened, updated and submitted.

Resources Tab:



☒ HF ☐ COPD ☐ MH ☐ DM

Selected resources will be displayed with links on the patient care plan.

Heart Failure Resources:

- ☐ Heart Failure Patient Guide - [link](#)
- ☐ OH Patient guide - [link](#)
- ☐ Heart Failure Medications Guide - [link](#)
- ☐ HeartLife Toolkit (HeartLife Foundation) - [link](#)
- ☐ Health 811 - [link](#)
- ☐ Heart Failure Action Plan - [link](#)

Quickly review the resources that were shared with the patient for all E2P tool-supported conditions from visits in the past.

Checked resources will also appear on the patient care plan with URLs.

E2P Patient Profile

Designed to be a consolidated overview of the patient including the diagnosis status for all E2P tool-supported conditions. Users can record smoking status, risk factors, other co-morbid conditions, medication history and response, non-pharmacologic history and response, and family history.

This section enables users to update and tailor lab value targets and frequencies for each E2P tool-supported condition.

E2P E2P Patient Profile

History Lab values Pending

History

copy from prior clear last done: 2024-10-29

Diagnosis status

Anxiety: ☐ generalized ☐ social ☐ phobia ☐ panic disorder
Depression: ☐ confirmed
Diabetes: ☐ diabetes type 2 ☐ prediabetes ☐ very high risk ☐ high risk ☐ low risk/no risk
Heart failure: ☐ suspect ☐ HF w/rEF ☐ HF w/recovered EF ☐ HF w/mrEF ☐ HF w/pEF
COPD: ☐ confirmed by spirometry ☐ unconfirmed by spirometry ☐ suspect

Smoking status

☐ Current smoker ☐ Ex-smoker ☐ Non-smoker ☐ Second-hand exposure
☐ tobacco /day pack years
☐ vaping/e-cigarettes
☐ marijuana
☐ other inhaled substances

Risk Factors

Submit Print

Launching Clinical Modules

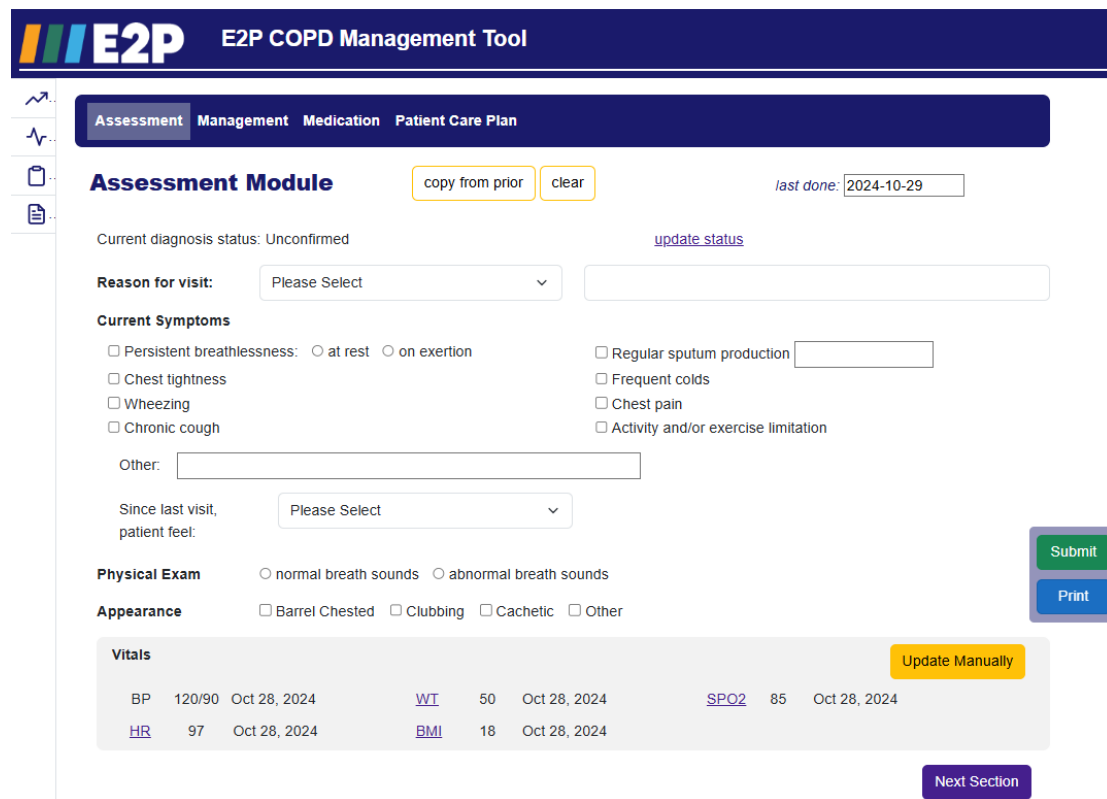
The components related to the provision of COPD care have been broken into 4 modules, allowing for flexibility. Users are not expected to complete every module at every visit but rather, users can complete the modules that were discussed/required updating during the patient encounter.

Assessment Module

This section is designed to facilitate comprehensive documentation and evaluation of each patient's condition, ensuring that all relevant information is captured for effective diagnosis and treatment planning.

The beginning of this section displays the current diagnosis status. Clicking on the update status button will require users to update the COPD diagnosis status in the history section within the dashboard.

Key elements of this section include the reason for the visit, current symptoms, physical exam, appearance, and the ability to record and review the patient's current vital signs. These metrics are essential for evaluating the patient's stability and identifying any immediate concerns.



E2P COPD Management Tool

Assessment Management Medication Patient Care Plan

Assessment Module copy from prior clear last done: 2024-10-29

Current diagnosis status: Unconfirmed [update status](#)

Reason for visit: Please Select

Current Symptoms

☐ Persistent breathlessness: ☐ at rest ☐ on exertion ☐ Regular sputum production

☐ Chest tightness ☐ Frequent colds

☐ Wheezing ☐ Chest pain

☐ Chronic cough ☐ Activity and/or exercise limitation

Other:

Since last visit, patient feel: Please Select

Physical Exam ☐ normal breath sounds ☐ abnormal breath sounds

Appearance ☐ Barrel Chested ☐ Clubbing ☐ Cachetic ☐ Other

Vitals Update Manually

BP	120/90	Oct 28, 2024	WT	50	Oct 28, 2024	SPO2	85	Oct 28, 2024
HR	97	Oct 28, 2024	BMI	18	Oct 28, 2024			

[Next Section](#)

Management Module

The focus of this section is to optimize ongoing care and management of COPD. The areas that are addressed include smoking status, the ability to record if inhaler technique education was provided, notes of any discussions regarding physical activity, self-management strategies, and educational topics covered during the visit. Encouraging patients to engage in regular physical activity and providing them with tools to manage their condition can significantly enhance their ability to cope with COPD. The last key component of this section is the referrals area where users can document any referrals made to specialists, such as Respiriologist, smoking cessation, COPD education, Spirometry, and PFT.

The section also includes functionality for sending Ticklers (internal messages within the EMR), as well as the ability to open the consultations window for seamless communication and collaboration among healthcare clinicians.

Assessment
Management
Medication
Patient Care Plan

Management Module

copy from prior
clear
last done: 2024-10-29

Smoking status: current smoker

update smoking status
show smoking cessation info

Smoking Cessation Initial Visit ⓘ

☐ advised

Patient ready to quit? ☐ Yes ☐ No

☐ discussed programs and methods to quit (e.g., behavioural support, smoking cessation programs, nicotine replacement therapy)

☐ Patient on oxygen therapy
☐ Discussed /reviewed vaccinations

update preventions

☐ Educated on inhaler technique
☐ Discussed physical activity
☐ Referred to pulmonary rehabilitation program
☐ Discussed self-management and education

Submit

Print

Referrals

☐ Respirologist
☐ Smoking cessation
☐ COPD education
☐ Spirometry
☐ PFT

Send Tickler

Open Consultations

Previous Section

Next Section

Medication Module

The emphasis of this section is the two key components related to medication management: the first addresses the patient's adherence and response to treatment, while the second outlines the comprehensive medication plan tailored to the patient's current health status and needs. Here users can view the recommended medication plan for the patient using an algorithm pulling in the information gathered in the tool i.e. CAT/MMRC scores, spirometry results, and acute exacerbations. Updating the plan creates a history of changes made to support achieving optimal treatment and documenting specific response and symptoms.

Users also will have access to the medication reference table to help make informed decisions on the best practice medication options.

Assessment
Management
Medication
Patient Care Plan

Medication Module

copy from prior
clear
last done: 2024-10-29

Monitoring - adherence and response

Medication adherence:

Is medication helping? ☐ Yes ☐ No

Side effects experienced? ☐ Yes ☐ No

Severity of side effects

Patient CTS severity is severe

[Medication reference table](#)

Only step down in therapy if it did not improve symptoms, health status declined, or the risk of adverse events outweighs the benefit.

Update Plan


Action
Please select
Agent
notes

SABA	Ipratropium	New medication	PRN	Oct 29, 2024	<input type="button" value="X"/>
LAMA/LABA	Aclidinium/Formoterol	New medication		Oct 29, 2024	<input type="button" value="X"/>

Previous Section

Patient Care Plan Module

The care plan module is a shared tool for all the E2P Tools and is meant to be a patient-facing resource. The Patient Care Plan is a comprehensive resource that outlines the patient's care team, consent, goals, allergies, lifestyle changes, medication plan, and follow-up/next steps. It also provides access to education resources for patients and caregivers, empowering them to better understand their chronic condition(s), and manage their condition(s) effectively.


E2P Patient Care plan

last done:

Patient name:
Date of birth:

Care team & care consent

Care team

Coordinating lead (notify if patient is hospitalized)
Name:
Contact:

Name	Role	Organization / Address	Contact
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

The COPD Action Plan can be found here as well, primary care clinicians can complete this document and share it with the patient via email or hard copy.

COPD Action Plan

My Symptoms	I Feel Well	I Feel Worse	I Feel Much Worse
I have sputum.	My usual sputum colour is: <input type="text"/>	Changes in my sputum, for at least 2 days. <input type="radio"/> Yes <input type="radio"/> No	My symptoms are not better after taking my flare-up medicine for 48 hours.
I feel short of breath.	When I do this: <input type="text"/>	More short of breath than usual for at least 2 days. <input type="radio"/> Yes <input type="radio"/> No	I am very short of breath, nervous, confused and/or drowsy, and/or I have chest pain.
My Actions	Stay Well I use my daily puffers as directed.	Take Action If I checked 'Yes' to one or both of the above, I use my prescriptions for COPD flare-ups.	Call For Help I will call my support contact and/or see my doctor and/or got to the nearest emergency department.
	If I am on oxygen, I use <input type="text"/> L/m.	I use my daily puffers as usual. If I am more short of breath than usual, I will take <input type="text"/> puffs of <input type="text"/> up to a maximum of <input type="text"/> times per day.	I will dial 911.

Notes:

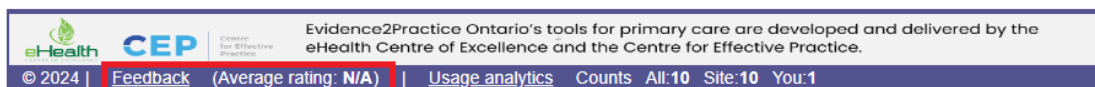
I use my breathing and relaxation methods as taught to me. I pace myself to save energy.
If I am on oxygen, I will increase it from L/m to L/m

Important information: I will tell my doctor, respiratory educator, or case manager **within 2 days** if I had to use any of my flare-up prescriptions. I will also make follow-up appointments to review my COPD Action Plan twice a year.

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:



Usage Analytics

Please visit our website to review our [overview of usage analytics](#).

E2P brings together multi-disciplinary, cross-sector expertise under the joint leadership of [the Centre for Effective Practice](#), [Amplify Care](#), 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