Updated: April 2025*

This guide is the most recent version of the tool: **Version 2.0**

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 – Heart Failure Management Tool - 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 goal is to assist primary care clinicians in effectively tracking the progression and management of heart failure patients over time. Given the complex nature of heart failure, continuous monitoring is critical to ensure timely interventions and optimal care. This tool is designed to enable close monitoring of a patient's stability, providing real-time insights to support informed clinical decisions and ensure safe, high-quality care.

Developed with primary care clinicians in mind, this tool helps standardize documentation practices, reducing variability and improving consistency across patient records. By incorporating clinical best practices and evidence-based guidelines, it aims to streamline workflows, enhance communication, and empower healthcare providers with the necessary resources to deliver the best care for heart failure patients.

Getting Started

While we recognize that the forms can appear overwhelming at first glance, please rest assured that we have designed our tools with the intention that they are to be used over time; forms do not need to be completed in one visit. Users can pull the information that was documented in the previous patient visit and continue to add to it, making your documentation more comprehensive as time goes on.

A. Navigating to the modules within the tool:

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

B. Import values:

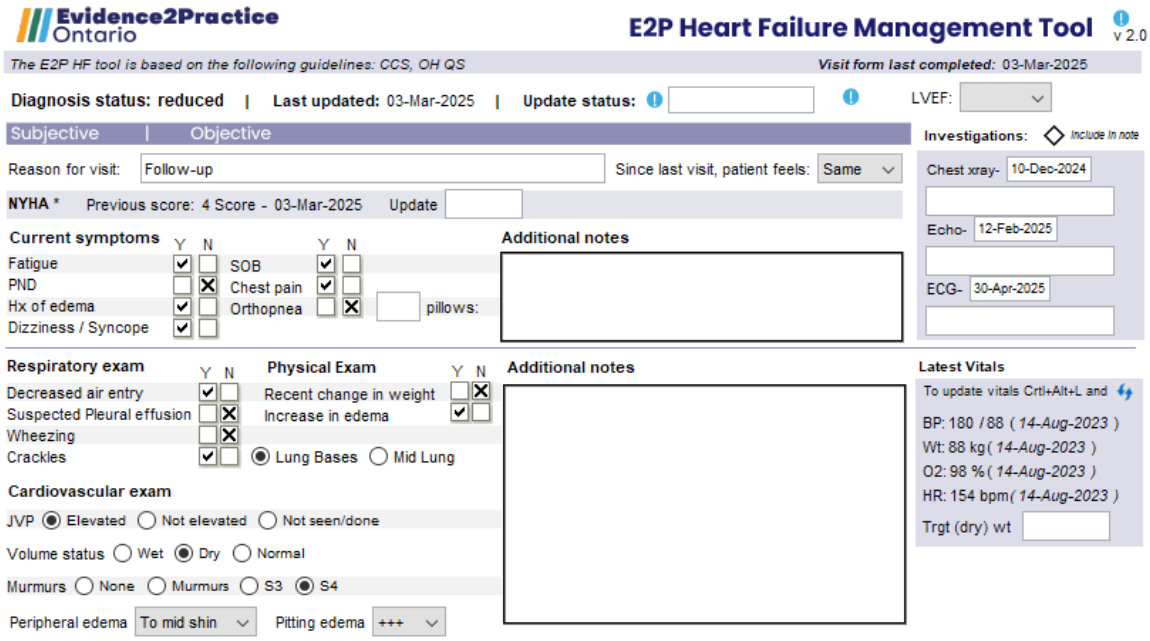
Clicking the **Import Values** button will pull the previous values/information from any previously completed E2P COPD form into the current form.

- This allows users to review previously documented information and add or update details for the current visit.

Icon Library

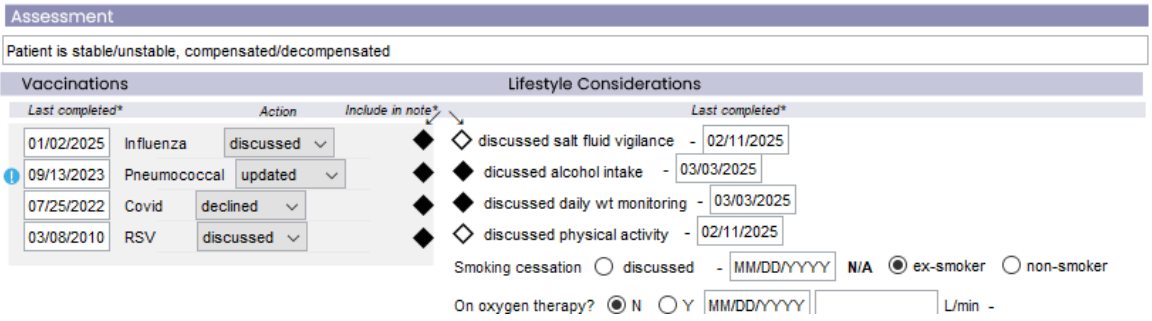
!	**Blue tooltip icon – Pop-up text** Click your mouse over this icon to view the content.
*	**Asterisk symbol – Hover over text** Hold your mouse over this area to view the content.
Give feedback	**Blue text with underline – Hyperlink** Click your mouse on this text to open the website in a new window.
Include in note	Throughout the tool, users will see the "*include in note**" checkbox this will be for specific sections that will allow users to decide if they would like to include a section into the note. • This means the user can include if something was ordered or discussed during the current visit in the visit note, saving precious documentation time, while also still recording the date that something was ordered/discussed which can be viewed at a future visit.

Heart Failure Management Tool



At the top of the tool, you'll find the Diagnosis Status section, where users can view the most recent update date and update the patient's HF status. The available options for entering the status are "Preserved," "Mid-Range," or "Reduced."

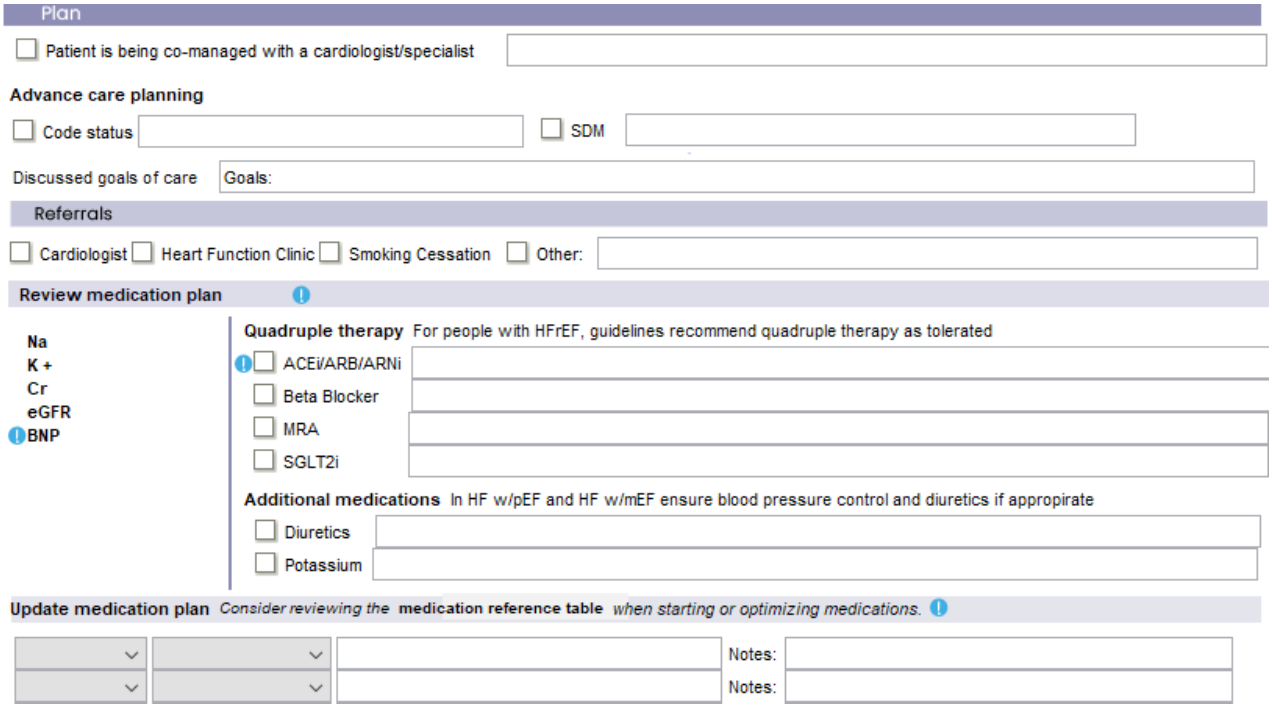
The Subjective and Objective sections serve to provide a comprehensive overview of the patient's current condition, combining both reported symptoms and clinical findings to guide further diagnosis and treatment decisions. Users can document the reason for the visit, assess the NYHA score, and record the patient's current symptoms. Additionally, users can perform respiratory, physical, and cardiovascular exams, record the dates of any investigations, and review the patient's most recent vital signs.



In the Assessment section, users can document whether the patient is stable or unstable, and compensated or decompensated. This section also includes areas for documenting vaccinations and lifestyle considerations. Users can record whether immunizations—such as

influenza, pneumococcal, COVID, or RSV—were discussed, updated, or declined by the patient. Additionally, lifestyle factors like salt and fluid management, physical activity, smoking cessation, and oxygen therapy can be noted if discussed with the patient.

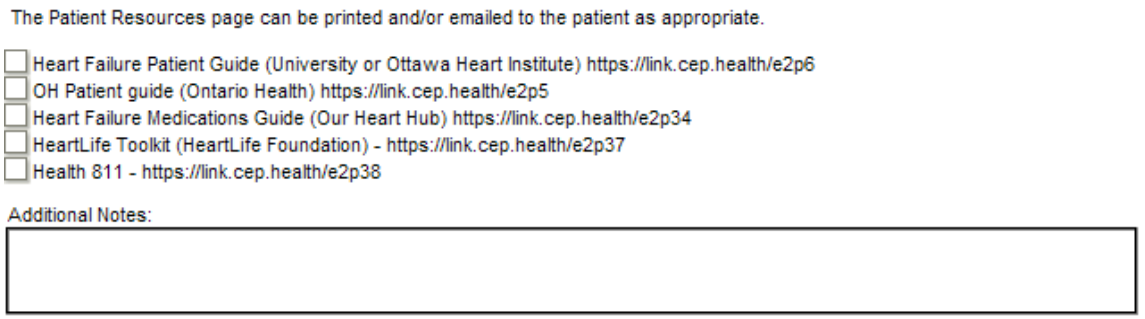
To ensure these topics are included in the summary note generated at the end of the visit, users can select the diamond checkbox next to any relevant items they wish to highlight.



In the Plan section, users can document whether the patient is being co-managed with a cardiologist or specialist, and record advanced care planning details, including code status, substitute decision-makers, and goals of care. Users can also indicate if the patient is being referred externally.

A key component of this section is the “Review Medication Plan” area, where users can review the patient's lab results, including sodium, potassium, creatinine, eGFR, and BNP levels. This section also allows users to document whether the patient is on quadruple therapy or additional medications such as diuretics or potassium supplements.

The final part of the Plan section is the "Update Medication Plan" area, which enables users to record changes or updates to the patient's medication regimen, provide rationale for adjustments, and encourage a collaborative approach to managing the chronic condition. This section includes a medication reference table, offering guidance on best practice medications, information on starting doses, target doses, optimizing therapy, coverage details, and more.

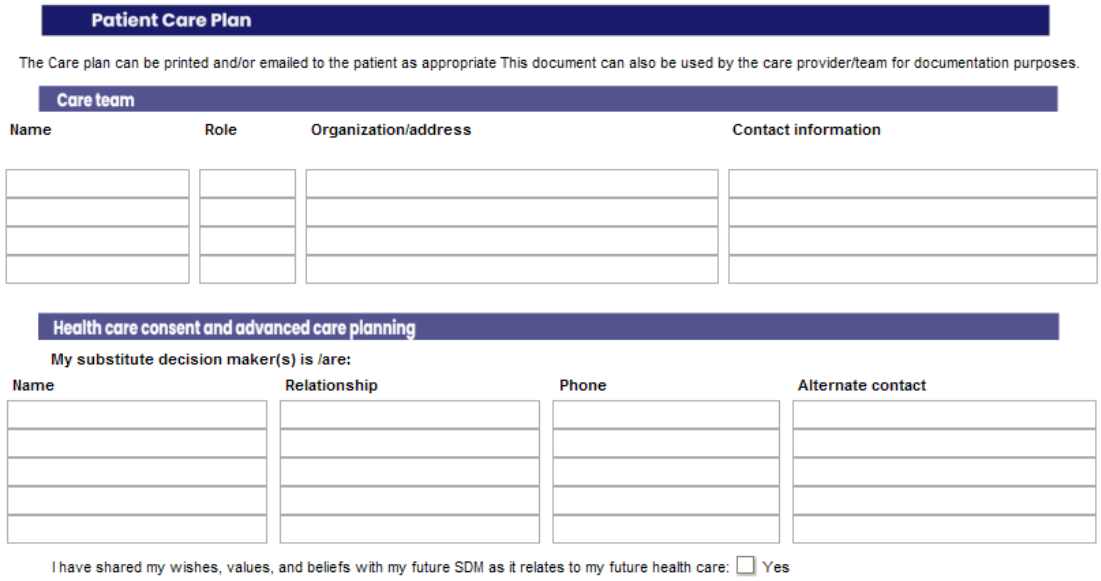

The Patient Resources page can be printed and/or emailed to the patient as appropriate.

- ☐ Heart Failure Patient Guide (University or Ottawa Heart Institute) https://link.cep.health/e2p6
- ☐ OH Patient guide (Ontario Health) https://link.cep.health/e2p5
- ☐ Heart Failure Medications Guide (Our Heart Hub) https://link.cep.health/e2p34
- ☐ HeartLife Toolkit (HeartLife Foundation) - https://link.cep.health/e2p37
- ☐ Health 811 - https://link.cep.health/e2p38

Additional Notes:

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

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.


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:

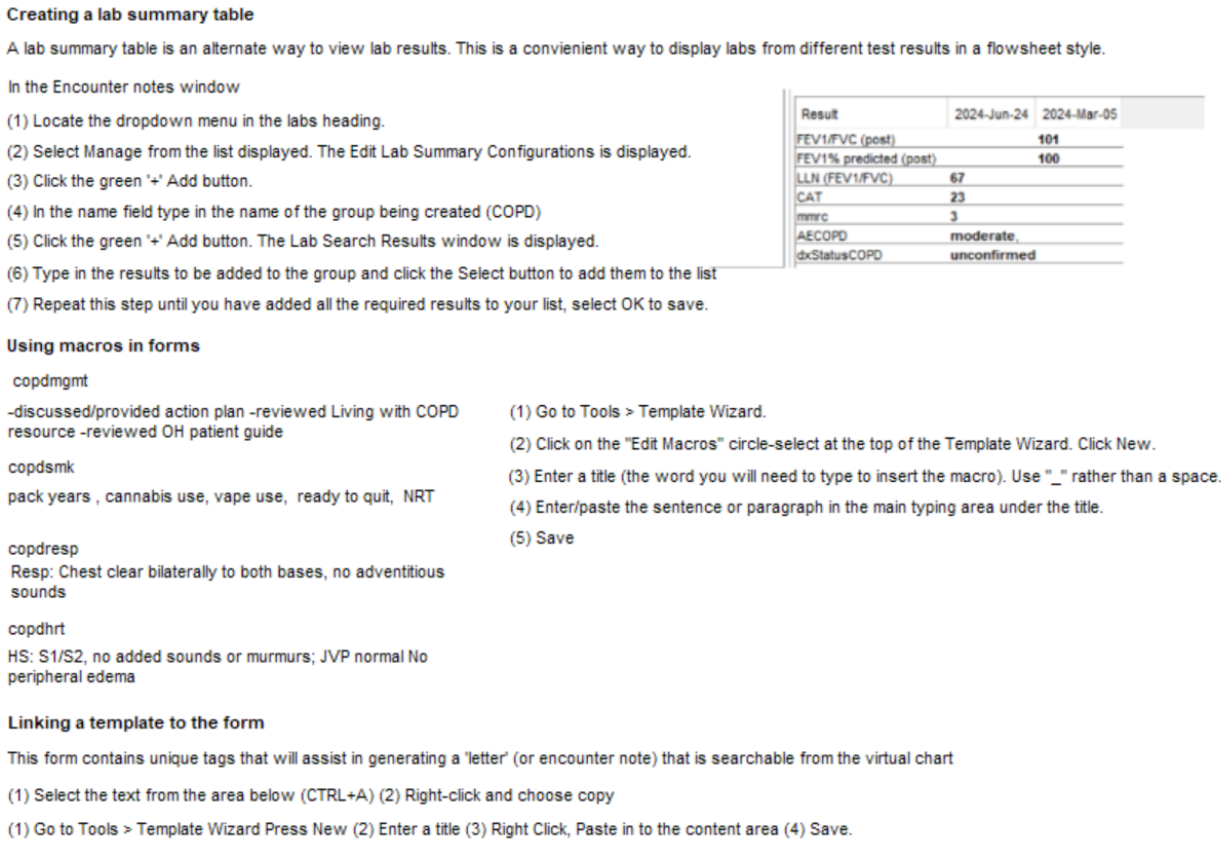
Name	Relationship	Phone	Alternate contact

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

The care plan is a patient-facing resource that can be used during the visit 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.

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.

This section of the tool contains the Heart Failure Action Plan as well as the Palliative Approach to Care section.



Creating a lab summary table

A lab summary table is an alternate way to view lab results. This is a convienient way to display labs from different test results in a flowsheet style.

In the Encounter notes window

(1) Locate the dropdown menu in the labs heading.

(2) Select Manage from the list displayed. The Edit Lab Summary Configurations is displayed.

(3) Click the green '+' Add button.

(4) In the name field type in the name of the group being created (COPD)

(5) Click the green '+' Add button. The Lab Search Results window is displayed.

(6) Type in the results to be added to the group and click the Select button to add them to the list

(7) Repeat this step until you have added all the required results to your list, select OK to save.

Result	2024-Jun-24	2024-Mar-05
FEV1/FVC (post)		101
FEV1% predicted (post)		100
LLN (FEV1/FVC)	67	
CAT	23	
mmrc	3	
AECOPD	moderate,	
dxStatusCOPD	unconfirmed	

Using macros in forms

copdmgmt

-discussed/provided action plan -reviewed Living with COPD resource -reviewed OH patient guide

copdsmk

pack years , cannabis use, vape use, ready to quit, NRT

copdresp

Resp: Chest clear bilaterally to both bases, no adventitious sounds

copdhrt

HS: S1/S2, no added sounds or murmurs; JVP normal No peripheral edema

(1) Go to Tools > Template Wizard.

(2) Click on the "Edit Macros" circle-select at the top of the Template Wizard. Click New.

(3) Enter a title (the word you will need to type to insert the macro). Use "_" rather than a space.

(4) Enter/paste the sentence or paragraph in the main typing area under the title.

(5) Save

Linking a template to the form

This form contains unique tags that will assist in generating a 'letter' (or encounter note) that is searchable from the virtual chart

(1) Select the text from the area below (CTRL+A) (2) Right-click and choose copy

(1) Go to Tools > Template Wizard Press New (2) Enter a title (3) Right Click, Paste in to the content area (4) Save.

The Tips and Tricks page is intended to provide users with ready-to-use instructions that will help improve the functionality of this form and the EMR. Much of this information may already be known to the user but reassures us that users have the best tools at their fingertips for optimal experience.

This page includes steps on how to in a lab summary table which will enable users to review labs in the most ideal manner, as well as provides condition-related macros that can make documentation within the tool more efficient and consistent, as well as the templates designed specifically for the generate letter features.

For support with any of these additions, please reach out to EMRtools@amplifycare.com to book a training session.

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.

Overview of 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.