

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!

Table of Contents

Introduction	2
Background/Summary	2
Purpose of the Tool.....	2
Getting Started.....	2
Using the E2P Heart Failure Management Tool in OSCAR Pro	4
Getting Started with the COPD Management Tool	5
Launching Clinical Modules.....	8
Assessment Module.....	8
Management Module.....	9
Medication Module.....	10
Patient Care Plan Module.....	11
Feedback	12
Overview of Usage Analytics	12

Evidence2Practice – Heart Failure Tool v. 2.0.0 – 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.

Getting Started

The tool is intended 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.

Oscar Pro Feature Comparison

The suite of E2P tools has been developed for users who have deployed the Oscar Pro version of the EMR. While the eforms can be launched and used by alternative Oscar environments, there may be some functions unavailable.

Feature	Oscar Pro	Oscar Classic
Writing and reading multiple measurements to database	•	•
Viewing recent lab results with individualized targets and frequencies	•	•
Launching Disease registry with prepopulated search	•	
Opening and updating 'E2P Patient Profile' from within the eform	•	*
Launching Preventions window from within the eform	•	
Sending Ticklers from within the eform	•	
Launching Consultations window from within the eform	•	
Form memory workflow	•	•
Generate note and add copy to Encounter	•	*

• Included

*Alternate workflow available

Using the E2P Heart Failure 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 Heart Failure have been broken into sections.

Patient Dashboard

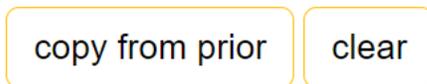


(Found on the left corner of each module)

Tabs:

- Metrics
- Diagnostics
- 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.

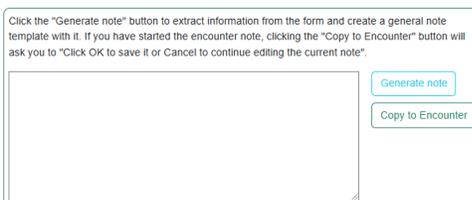
Navigation Buttons



(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 Heart Failure Management Tool

Dashboard

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

The ability to combine showing measurements from other E2P tools (i.e., Heart Failure, Anxiety Disorders & Depression, and Diabetes) is the newest feature. Users can now toggle through the different measurements from one tool to the other. We intended 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.

Summary Tabs

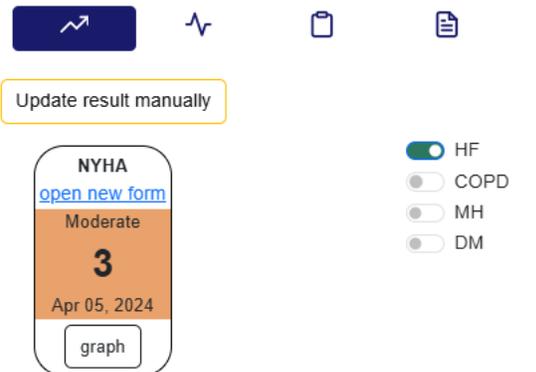
The summary tabs give clinicians the flexibility to show/hide the patient metrics, labs, history, or the resources panel immediately next to the module content to enhance documentation during patient encounters.

From the Summary tabs, the user can simultaneously:

- View/update metrics for NYHA
- Review diagnostic values, modify goals, and launch the lab requisition form.
- Review the resources that were shared with the patient (i.e., heart failure, COPD, 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 throughout treatment.

<p>Metrics Tab:</p> 	<p>Users can open and complete the NYHA form as well as review metrics for COPD, MH, and DM. We've incorporated color indicators that appear within optimal ranges, serving as visual flags to support diagnostic decision-making.</p> <p>Green – No concerns/mild Orange – moderate Red – severe</p>
---	---

Diagnostics Tab:

Lab value	Result	Last done	Goal	Req.
Alb			35-52 g/L	<input type="checkbox"/>
BNP			<100 ng/L	<input type="checkbox"/>
Cr			0.6-1.1 mg/dL	<input type="checkbox"/>
eGFR	6	Jun 05, 2023	50-100 µmol/L	<input type="checkbox"/>
Ferritin			15-272 ug/L	<input type="checkbox"/>
Hb			120-160 g/L	<input type="checkbox"/>
HbA1C	8	Jul 16, 2024	<6.5 %	<input type="checkbox"/>
K			3.5-5.2 mmol/L	<input type="checkbox"/>
LDL	6	Jun 05, 2023	<2.0 mmol/L	<input type="checkbox"/>
Na	21	Mar 28, 2023	135-145 mmol/L	<input type="checkbox"/>

Users can:

- Update/Insert diagnostic values manually
- Change the targets and frequency to tailor the goals to the patient
- Launch the lab requisition form

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:

Users have the option to select Suspect, HF w: reduced ejection, preserved ejection, and mid-range ejection.

The definitions for those statuses 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 respective code to support efficiency.

Smoking status can be updated here.

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.

<p>Resources Tab:</p>  <div style="border: 1px solid #ccc; padding: 5px; margin-top: 10px;"> <p>COPD Resources:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Ontario Health Patient Guide (link) <input type="checkbox"/> Living with COPD (link) <input type="checkbox"/> COPD Action Plan (link) <input type="checkbox"/> Smoking Treatment for Ontario Patients (STOP) Program (link) <input type="checkbox"/> Treating breathing issues: COPD (link) </div> <div style="margin-top: 10px;"> <p><input checked="" type="checkbox"/> COPD</p> <p><input type="checkbox"/> DM</p> <p><input type="checkbox"/> HF</p> <p><input type="checkbox"/> AD</p> </div>	<p>Quickly review the resources that were shared with the patient for all E2P tool-supported conditions from visits in the past.</p> <p>Checked resources will also appear on the patient care plan with direct web links.</p>
---	--

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 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

Assessment Module

The main elements of this section are the vitals, subjective, and objective sections which allow for the monitoring and updating of vitals and other symptoms. As well as recording the progression of volume status, murmurs, and edema, including pitting edema, and prompt to review diagnostics such as Na, K, Cr, and eGFR.

Assessment
Management
Medication
Patient care plan

Current Diagnosis Status: **Suspect** [update status](#) [Copy from prior](#) [Clear](#)

Vitals [Update manually](#)

BP	120/60	Jul 17, 2023	BMI	34	Jul 17, 2023	O2	HR	212	Jul 17, 2023
WT	212	Jul 17, 2023	TRGT(DRY)WT						

Subjective [Hide Checkboxes](#)

Symptoms has symptom does not have symptom not assessed

Fatigue Dizziness/Syncope Orthopnea # of pillows PND History of edema Shortness of breath Chest pain

Objective [Hide Checkboxes](#)

Recent change in weight Increase in edema

JVP Elevated Not elevated Not seen/done

Volume status Wet Dry Normal

Murmurs No Yes S3 S4

Crackles No Yes Lung bases Mid lung

Wheezing No Yes

Decreased air entry No Yes

Suspected pleural effusion No Yes

Peripheral edema No Ankle Mid shin Knee Sacrum Generalized

Pitting edema No 0+ ++ +++ ++++

[Review](#) Na, K, Cr, eGFR

Submit

Print

Management Module

The management section allows users to update the patient’s immunization records and document the smoking status and treatment plan.

This module offers the opportunity for clinicians to document that information has been provided to the patient on 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 is designed to easily document what was discussed. Followed by the Assessment and Plan section.

Assessment
Management
Medication
Patient care plan

Current Diagnosis Status: **Suspect** update status Copy from prior Clear

Discussed / reviewed immunizations update preventions

Discussed: Salt/fluid vigilance Physical activity Daily weight monitoring Alcohol intake

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 is being co-managed with cardiologist/specialist

Patient is on oxygen therapy

Advance Care Planning

Discussed: SDM Code status Goals of care

Assessment

Stable Unstable Compensated Decompensated

Plan

Referrals [Ocean Healthmap](#)

Cardiologist Heart function clinic Smoking cessation Open consultations Send tickler

Follow up in:

Medication Reviewed Updated

Submit

Print

Medication Module

The purpose of the medication section within this module is to document any active medications the patient is currently on and update the medication plan. This section houses the link to the medication reference table that can be used as a support when starting or adjusting medications.

Assessment Management Medication Patient care plan

Current Diagnosis Status: **Suspect** [update status](#) Clear

- When starting or adjusting medications, consider reviewing the [Medication reference table](#)
- For people with HFrEF, guidelines recommend quadruple therapy as tolerated.
- *In HF w/pEF and HF w/mEF ensure blood pressure control and diuretics if appropriate*

Active Medications

ACEi / ARB / ARNi ⓘ
 Beta blocker
 Mineralocorticoid receptor antagonists (MRA)
 Sodium-glucose co-transporter-2 inhibitors (SGLT2i)
 Diuretics
 Potassium

Update plan [Consider discontinuing ⓘ](#) Submit Print

Action Class Agent notes

+ Add medication

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.

E2P
E2P Patient Care plan

Patient name:
 Date of birth:
 last done:

Care team (Include active family/caregivers, clinicians, community supports)

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

✎ Edit
+ Add

Health care consent and advance care planning

Substitute Decision Maker

Name	Relationship	Phone
<input type="text"/>	<input type="text"/>	<input type="text"/>

Update

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

Name	Relationship	Phone	Alternate Contact
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

✎ Edit
+ Add

Goals

It is helpful to plan out you goals. Using a plan can help give you a sense of direction, and help you organize and reach your goals.

Patient Goals

✎ Edit
+ Add

Lifestyle changes & Therapy

Submit
Print

Feedback

This tool 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:

© 2024 | [Feedback](#) (Average rating: 8.1) | [Usage analytics](#) Counts All: 251 Site: 156 You: 7

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.