

Updated: April 2025*

This guide is the most recent version of the tool: **Version 4.2**, that includes resources for heart failure, diabetes, anxiety disorders, depression, and COPD.

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!

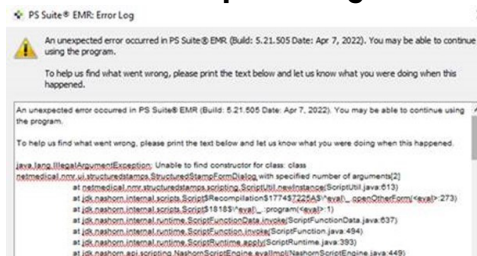
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Notices

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.

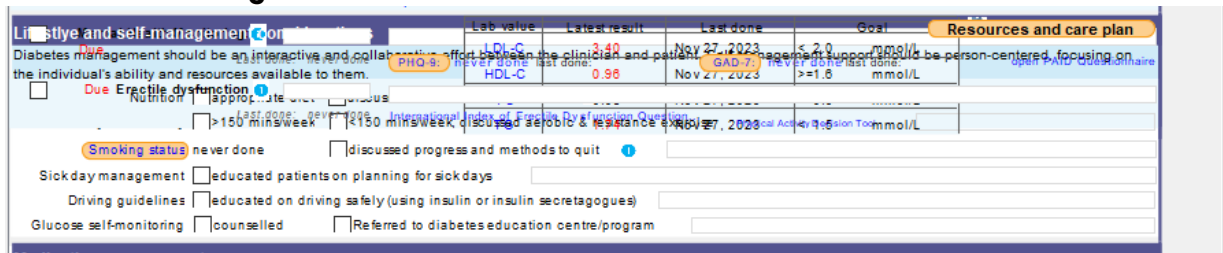
Solution: Since the "E2P - HF - Main Form Toolkit" does not include any data or documentation, it is recommended that all instances of this custom form be deleted from the patient chart.

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@amplifycare.com 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.

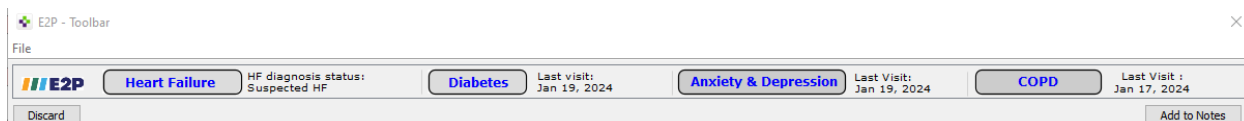
Getting Started with the E2P Toolbar

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	@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	<ul style="list-style-type: none"> Confirmed Unconfirmed Suspected 	Records the COPD Diagnosis Status. It also gives the tool the ability to track the progression of the diagnosis.
	@AECOPD	Numeric	Records number of acute COPD exacerbations.
	@DyspneaScale		Records the mMRC Dyspnea Scale Score.
	@CAT		Records the COPD Assessment Tool Score.
	@FEV1		Records the FEV1 (Spirometry Result).
	@FEV1FVC		Records the Absolute FEV1/FVC ratio (Spirometry).
Criteria Form	@targetWt	Numeric	Records the target weight or dry weight set for the patient.

***We have retired the custom vitals for @Hfdiagnosis: Preserved, Recovered, or Riskreviewed**

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).



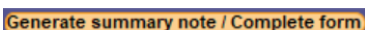
Blue text – hyperlink. Clicking on this will open a new window either directing to the web browser, will open a graph window, or will open a pop-up image related to clinical content.



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 ***



Blue 'i' icon – 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.

Resources & Care Plan

V 1.1

Patient name: Cat Test

Created/Updated: Sep 3, 2024

Show printout view

Resources

Care Plan

insert from previous:

clear form

View:

All

Heart Failure

Diabetes

Anxiety/Depression

COPD

Instructions

Select which sections you would like to include in the care plan, customize, and print/email as required

Care team

Goals

Allergies

Therapy and lifestyle changes

Medications

Heart Failure Action Plan

Follow-up and next steps

Palliative care plan

Health care consent and Advance care planning

Resources

COPD Action Plan

Care Plan

Care team

Name	Role	Organization / Address	Contact Information

Goals

Allergies

No known allergies Sep 6, 2022

Therapy and lifestyle changes

Patient Care Plan - Page 2

Patient name: Cat Test

Medications

My medications list	Additional Notes
furosemide (N/A) - 80 mg 2 times daily starting Oct 26, 2022	
digoxin (N/A) - 500 mcg 1 time daily starting Oct 26, 2022	
hydralazine (N/A) - 10 mg 4 times daily starting Oct 26, 2022	
dexamethasone (N/A) - 1 mg 3 times daily starting Oct 26, 2022	
salmeterol (50 mcg/dose) - 2 inhalations every 4 hours, PRN for 30 days starting Jan	

Heart Failure Tool Version 3.0

Purpose of the Tool


The objective was to create an EMR-integrated tool that supports clinicians in the diagnosing and management of heart failure.

The tool is designed to support a variety of workflows, from team-based environments to solo practitioners, with a high level of flexibility and the ability to customize to meet individual user preferences. It also incorporates clinical guidelines and ensures compliance, enabling users to bill for the appropriate codes.

Getting Started

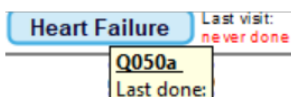
The tool is designed to be completed progressively over time. Some sections may not have been addressed or discussed during the initial visit, but the goal is to enable users to update these sections at subsequent visits, enhancing the tool's comprehensiveness.

Heart Failure Toolbar

A blue rectangular button with rounded corners containing the text "Heart Failure" in white.

Clicking on this button will prompt the visit tool to appear in a pop-up window.

**To have the tool appear in the progress note section, [see the installation guide for instructions](#).*



Hovering over the button will show the last billing date.

Last visit:
Feb 5, 2024

The last visit date will be red if the form has never been used in the patient's chart.

If the text "last visit" or "never done" is clicked, a pop-up will appear to inform the user that the form does not exist for the patient and ask if one should be created.

Once a form has been added, the most recent date will be pulled in.

Heart Failure Management Tool

The main sections of this tool include the Diagnosis section, the Visit Documentation (SOAP) section, and the Management Hub (tabbed area).

Diagnosis section

The screenshot shows the top section of the E2P Heart Failure Management Tool. The 'Diagnosis status' is set to 'Suspect'. Below this, there are radio buttons for 'Suspect', 'HF w/rEF (< 40%)', 'HF w/mrEF (41-49%)', and 'HF w/pEF (≥ 50%)'. The 'Suspect' option is selected. To the right, there is a 'filter imaging' link. Below the diagnosis status, there are tabs for 'Visit', 'Diagnostics', 'Rx Reconciliation', 'Billing flowsheet', and 'Form settings'. The 'Visit' tab is active, showing 'Insert from previous: Jan 9, 2025', 'clear all', and 'SOAP stamp' buttons. There is also an 'Immunizations' section with a table showing dates and actions for Influenza virus, Pneumococcal, RSV, and COVID.

The default option for the diagnosis status is set to “Suspect” to allow the user to confirm the diagnosis via ejection fraction. The options provided include suspect, reduced ejection fraction, mid-range ejection fraction, and preserved ejection fraction.

The form also includes the numeric ranges beside each option to support decision-making as well as a button that will prompt the EMR to filter the imaging results in the patient's chart.

This screenshot shows the same interface as the previous one, but with the 'Diagnosis status' changed to 'HF w/ Reduced Ejection Fraction'. A pop-up window titled 'E2P - HF Dx coding tool' is open. It prompts the user to 'Select the diagnosis label and code(s) you want to add to the problem list'. The window contains a table with four columns: SNOMED, ICD-9, ENCODE, and Description only (no code). Each column has checkboxes for 'Heart Failure', 'HF mrEF', 'HF rEF', and 'HF pEF'. Below the table are buttons for 'Discard', 'Finish Later', and 'Finish'. The background interface shows the 'Visit' tab with various patient data fields like BP, HR, O2, Wt, kg, and a 'Medication reference tool' link.

Once a diagnosis status option has been selected, a pop-up window will open prompting the user to select the diagnosis label and code(s) to add to the patient's problem list. The code options include SNOMED, ICD-9, ENCODE, or just adding the description only. Hover over the text to reveal the label and code.

Users can finish later which would “yellow bar” it in the EMR, indicating that the task can be completed later.

Visit documentation (SOAP) section

The screenshot displays the E2P Heart Failure Management Tool v 3.0 interface. The top navigation bar includes tabs for Visit, Diagnostic, Rx Reconciliation, Billing FlowSheet, and Form Settings. The main content area is divided into two columns. The left column, titled 'Visit documentation (SOAP)', contains a text area for notes with buttons for 'insert from previous', 'clear all', and 'SOAP stamp'. Below the text area are fields for 'Today's vitals' (BP, HR, O2, Wt) and 'NYHA' classification. The right column contains a 'Management' section with checkboxes for 'PI is being co-managed w/ th cardiologist's specialist' and 'PI on oxygen therapy'. Below this is a 'Medication' section with a table listing medications (ACEI / ARB / ARNI, Beta Blocker, MRA, SGLT2i) and their status (Rx*, Rx, Rx*). The bottom section includes 'Referrals' (Cardiologist, Heart function clinic, Smoking cessation) and 'Advanced Care Planning' (Discussed goals of care, Discussed code status, SOM form).

At the top of this section are the text area set-up buttons, which include “insert from previous”, “clear all”, and “SOAP stamp”.

- The “Insert from Previous” button displays the date the form was last completed. All previously documented information from the last visit will be automatically populated into the form by clicking on it.
- The “SOAP stamp” button will insert the SOAP note stamp into the text area. The default SOAP stamp has been developed by Evidence2Practice (E2P). *Customization can be made to change it to a different stamp of the user’s preference.*

Today's vitals will only display the readings recorded for the current day. Users can also record vitals, target weight, and NYHA classification here as well as view graphs by clicking on the blue text.

The stamp that E2P developed for this tool is designed to streamline and standardize documentation, making it faster, more accurate, and more aligned with clinical, billing, and regulatory requirements. The stamp includes options for users to select and remove items as needed. Regardless, additional notes can be added in any section.

Once the form is fully completed, clicking the “Generate Note” button will compile the visit documentation and management hub information, creating a summary in the progress notes section.

Management Hub section

The Management Hub has five tabs: the Visit Panel, Diagnostics Panel, Prescription Reconciliation Panel, Billing Flowsheet Panel, and Form Settings Panel.

Visit Panel

Within the immunization portion, the tool will pull in the most recent dates for the immunizations. Users have the option to document:

- New immunizations by clicking on the immunization name.
- Declined immunizations: Clicking the decline button adds a red date for documentation, not integrated with the treatment panel. The button switches to "Undo" to reverse the action.

Within the management section, the user can document whether the patient is co-managed with a cardiologist or specialist and if they are receiving oxygen therapy.

The medication portion provides a link to the E2P "Medication Reference tool" that was developed to support medication decision-making. This section allows for reviewing and documenting the quadruple therapy plan for patients with reduced ejection fraction. The tool pulls in the patient's prescribed medications and allows users to prescribe directly by clicking the blue "Rx" text.

Clicking the blue "Referrals" text opens a customizable menu of referral forms and resources. Please see the installation guide for instructions.

The advanced care planning portion allows the user to document items of discussion. The buttons for the substitute decision-maker form and patient resources and care plan are also housed in this section.

Diagnostics Panel

Heart Failure Management Tool v 2.0

Diagnosis status: **HF w/ Reduced Ejection Fraction**

Change/update diagnosis: ☐ Suspect ☒ HF w/ rEF (< 40%) ☐ HF w/ mEF (41-49%) ☐ HF w/ pEF (≥ 50%) [filter imaging](#)

Visit | **Diagnostics** | Rx Reconciliation | Billing Flowsheet | Form settings

Diagnostics - Labs and Imaging

Lab value	Latest result	Last done	Freq	Goal
Hb	18.1	Oct 21, 2022	12	135 - 175 g/L Due
eGFR	73	Oct 21, 2022	12	> 60 mL/min/1.73m ² Due
Na	125	Oct 21, 2022	12	135 - 145 mmol/L Due
K	2.1	Oct 21, 2022	12	3.5 - 5.1 mmol/L Due
TSH	1.2	Oct 21, 2022	12	0.4 - 4.8 Due
LDL	44	Jul 25, 2024	12	< 3.4 mmol/L
A1C	0.67	Oct 21, 2022	6	<= 7 % Due
Ferritin	never done		12	20 - 200 Due
Iron saturation	never done		12	0.13 - 0.50 Due
Albumin	never done		12	35 - 50 g/L Due
NT-pro BNP	154	Oct 21, 2022	12	< 501 ng/L Due
BNP	never done		12	< 100 ng/L Due

Chest x-ray Last done:
Electrocardiography Last done: Jul 31, 2024
Echocardiogram Last done:

[Generate lab req](#) [Open imaging referral](#)

The Diagnostics section is the primary area for evaluating laboratory results and reviewing the latest imaging reports. In this section, lab values can be compared to target values. Users can view the recommended testing frequency, and the form will flag overdue labs and abnormal values in red. The gear icon can tailor the target and frequency values to the user's preference.

The lab requisition form and imaging referral form are also housed in this section.

- The lab requisition form offers options for initial investigations and ongoing management. When selected, these options automatically populate the form with the relevant lab groupings.
 - Labs can be added or removed based on the user's preferences and the patient's needs.
- The imaging referral form must be configured before the tool's initial use. *Please see the installation guide for instructions.*

Ontario Ministry of Health and Long-Term Care
Laboratory Requisition
Requisitioning Clinician / Practitioner

Name _____
Address _____

Clinician/Practitioner Number _____ CPSO / Registration No. _____

Laboratory Use Only

Initial Investigations **Ongoing management**

Heart Failure ☐ Heart Failure ☐

Diabetes ☐ Diabetes - Quarterly ☐

Diabetes - Annual ☐

Clear

Clinician/Practitioner's Contact Number for Urgent Results () Ext. () Service Date yyyy mm dd

Health Number () Version () Sex ☒ M ☐ F Date of Birth yyyy mm dd

Province () Other Provincial Registration Number () Patient's Telephone Contact Number ()

Check (✓) one:
☐ OHIP/Insured ☐ Third Party / Uninsured ☐ WSIB

Rx Reconciliation Panel

The screenshot displays the 'Rx Reconciliation' tab within the 'Heart Failure Management Tool'. It features a table with three main columns: 'Direction', 'Name', and 'Instructions'. The 'Direction' column includes interactive buttons: 'start/change' (highlighted in blue), 'discontinue', and 'FLAG'. The 'Name' column lists various heart failure medications. The 'Instructions' column provides specific dosing and timing for each drug. Below the table, there are four action buttons: 'prescribe', 'send message', 'send letter', and 'review previous'.

This section displays each medication the patient is taking, along with the corresponding instructions.

- To review the previous flagged comments, click on "review previous".
- To review the medications to discontinue, click on the blue "i" icon.

Various functions can be done in this section such as starting/changing medication(s), discontinuing medication(s), and flagging medication(s) for review.

To start/change:	To discontinue:	To flag:
<ol style="list-style-type: none"> 1. Locate the medication. 2. Click the empty box in the "Direction" column. After 1 click, it will change to "start/change." 3. Repeat for other medications as needed. 4. Click the "prescribe" button on the bottom left 5. Complete the prescription writer as normal. 	<ol style="list-style-type: none"> 1. Locate the medication. 2. Click the empty box in the "Direction" column. After 2 clicks, it will change to "discontinue." 3. Repeat for other medications as needed. 4. Proceed to the EMR to discontinue the medication as normal. 	<ol style="list-style-type: none"> 1. Locate the medication. 2. Click the empty box in the "Direction" column. After 3 clicks, it will change to "FLAG." 3. Add instructions or comments to include in the body of the message or letter. 4. Repeat for other medications as needed. 5. Click the "Send Message" button at the bottom left. 6. Enter the initials of the user you wish to flag.

Billing Flowsheet

The Billing Flowsheet panel is designed to enhance transparency around the billing process associated with the E2P Heart Failure tool. In this section, users can review the specific areas of the tool that support billing for the Q050A code.

Form Setting Panel

The Form Settings panel displays all the customized settings for the form. Any changes must be made in the form editor, and all updates will apply site wide. *Please see the installation guide for instructions.*

At the bottom of the tool are links to the usage analytics, feedback, user guide, and references for your review.

Diabetes Tool Version 1.1

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Purpose of the Tool

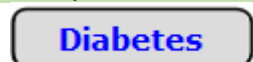
The objective was to create an EMR-integrated tool that supports clinicians in the screening and management of diabetes. The E2P diabetes tool for TELUS PSS supports a more comprehensive picture of the clinical assessment, pharmacologic & nonpharmacologic treatment goals, shared decision-making, self-management, 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.

Last visit:
Sep 18, 2023
Last visit:
Jan 18, 2023

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

Diabetes

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

Last screened:
Oct 11, 2023

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

Last screened:
Sep 18, 2017

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.

Diabetes Screening and Diagnosis V 1.1
 insert from previous: Sep 3, 2024
clear form

Diagnosis status: Very high risk
Screen freq (months): 6 update

Update:
☐ Diabetes Type 2
 ☐ Prediabetes
 ☐ Very high risk
 ☐ High risk
 ☐ Low risk/normal

Use the [Canadian diabetes risk assessment questionnaire \(CANRISK\)](#) to determine risk level and recommended screening frequency

Last done: Sep 3, 2024 Last score: 39 update risk score: 1

Risk factors: Match on one or more risk factors View risk factors summary

To interpret A1C/FPG results for undiagnosed/asymptomatic individuals, follow the Diabetes Canada [screening and diagnosis algorithm](#)

Labs Generate lab req

Lab value	Latest result	Last done	Diagnostic cutoff	Frequency (mos)
A1C	0.057	May 18, 2022	< 1	36
FPG	12	Aug 8, 2024	< 5.6 mmol/L	36
2h PG OTT	18	Aug 8, 2024	< 7.8 mmol/L 1	N/A
RPG	35	Aug 8, 2024	< 11.1 mmol/L 1	N/A

Additional notes

[Usage analytics](#) | [Feedback](#)

Evidence2Practice Ontario's tools for primary care are developed and delivered by the eHealth Centre of Excellence and the Centre for Effective Practice.

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.

DM Risk Factors - Cat Test
Last done: Sep 22, 2023

At risk criteria - Match summary: 7.0

Problem and past health list contains: 4.0

- ☒ Hypertension
- ☐ Overweight
- ☐ Abdominal obesity
- ☐ History of GDM
- ☐ History of pancreatitis
- ☒ Delivery of macrosomic infant
- ☐ Polycystic ovarian syndrome
- ☐ Hyperuricemia/gout
- ☐ Non-alcoholic steatohepatitis
- ☒ Mental health diagnosis
- ☐ HIV infection
- ☐ Obstructive sleep apnea
- ☒ Cystic fibrosis
- ☐ CV (coronary, cerebrovascular, peripheral)
- ☐ Microvascular (retinopathy, neuropathy, nephropathy)

Presence of vascular factors: 0.0

- ☐ HDL-C <1.3 mmol/L (females)
- ☐ TG >= 1.7 mmol/L

Family history: 0.0

- ☐ First degree relative type 2 DM (requires manual validation)

Risk factor contains: 1.0

- ☒ Smoking

Current meds contain: 2.0

- ☐ Atypical antipsychotics
- ☐ Highly active antiretroviral therapy
- ☒ Statins
- ☒ Glucocorticoids (requires manual validation)
- ☐ Anti-rejection drugs (requires manual validation)

Members of high-risk population 0.0

- ☐ African, Arab, Asian, Hispanic, Indigenous or South Asian descent, low socioeconomic status (requires manual validation)

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.

Visit

Dashboard

Resources

View: Full visit Assessment Complications Monitoring Lifestyle / Self-Management Med management Referrals & Follow-up

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.

Patient Dashboard					Generate lab req
For Review					Filter Labs Visit flow sheet
Lab value	Latest result	Last done	Goal	Considerations:	
A1C	0.67	Oct 21, 2022	<= 0.07 %	Due	A1C values are ≥ 1.5% above target, initiating metformin in combination with a second antihyperglycemic agent should be considered to increase the likelihood of reaching target
ACR	never done	never done	< 2.0 mg/mr	Due	
eGFR	73	Oct 21, 2022	> 60.0 mL/n		
LDL-C	never done	never done	< 2.0 mmol/l	Due	

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.

Assessment Subjective/Objective	
<p>Reason for Visit: <input type="text"/></p> <p>Since last visit, patient feels: <input type="text"/></p> <p>Symptoms since last visit: <input type="checkbox"/> hypoglycemia</p> <p>Additional Sx & Notes: <input type="text"/></p>	<p>Today's vitals</p> <p>BP: <input type="text"/> mmHg Target: 130/80 mmHg</p> <p>HR: <input type="text"/> bpm</p> <p>WT: <input type="text"/> kg</p> <p>WC: <input type="text"/> cm</p> <p>BMI: <input type="text"/></p>

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.

The screenshot shows the 'Specific complication monitoring / co-morbidities' module. It features a table with columns for 'Dx Confirmed', 'Screened/Reviewed', and 'Quick Notes'. The table lists various conditions with checkboxes for confirmation and input fields for screening/review dates and notes. A gear icon in the top right corner allows for customization of screening ranges and lab values. The conditions listed include Peripheral neuropathy, Retinopathy, Due Gum disease, Chronic kidney disease, Cardiovascular disease, Due Dyslipidemia, Mental Health Monitoring, and Due Erectile dysfunction. Each row has a 'Last done' date and a 'Quick Notes' section with specific prompts and links.

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.

The screenshot shows the 'Lifestyle and self-management considerations' module. It includes a header with 'Resources and care plan' and a sub-header 'Diabetes management should be an interactive and collaborative effort between the clinician and patient. Self-management support should be person-centered, focusing on the individual's ability and resources available to them.' The form contains several sections with checkboxes and input fields for various lifestyle factors: Nutrition, Physical activity, Smoking status, Sick day management, Driving guidelines, and Glucose self-monitoring. Each section has a corresponding 'Physical Activity Decision Tool' link.

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.

Medication management

When starting or adjusting medications, consider reviewing the [Medication reference tool](#)

Monitoring - adherence and response optional notes

Medication adherence

Is the medication helping? ☐ Yes ☒ No

Side effects experienced? ☒ Yes ☐ No

Severity of side effects

Cardiovascular protection

Statins ☒ Prescribed

ACE /ARB ☐ Not prescribed

SGLT2i or GLP1-RA ☒ Prescribed

Nonsteroidal MRA ☐

Immunizations

Immunization	Last done:
Influenza (annual)	<input type="text"/>
Pneumococcal (Pneu-P-23)	<input type="text"/>
Shingrix (Shingles)	<input type="text"/>

Medication change summary

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

Anxiety & Depression

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

Last visit:
Sep 18, 2023

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

Change/Update Diagnos is:

Screening Tool

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

Anxiety & Depression

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

Last screened:
Oct 11, 2023

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.

Depression and Anxiety Disorders - Screening V 1.0.0
 Full Visit Tool

When speaking to patients use understandable language and avoid stigmatizing labels, maintaining a focus on your patient's strengths

Refresh

Screening tools

Disorder type	Screening tool	Latest score	Last done	Diagnosis	
				Suspected	Confirmed
Depression	PHQ-9	never done		<input type="checkbox"/>	<input type="checkbox"/>
Anxiety / General Anxiety Disorder	GAD-7	never done		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Social Anxiety Disorder	Spin scale	never done		<input type="checkbox"/>	<input type="checkbox"/>
Panic Disorder	Panic disorder severity	never done		<input type="checkbox"/>	<input type="checkbox"/>
Specific phobia or agoraphobia	Severity measure for specific phobi	never done		<input type="checkbox"/>	<input type="checkbox"/>

Labs

Lab name	Latest result	Last done
Hb	18.1	Oct 21, 2022
HbA1C	0.67	Oct 21, 2022
TSH	1.2	Oct 21, 2022
Ferritin	ever dor	
B-12	ever dor	

Additional notes

insert from previous: clear

Generate Lab Req
Filter Labs
Launch Ocean
Full Visit Tool

Usage analytics | Feedback

eHealth Tool developed by the eHealth Centre of Excellence, in support of Evidence2Practice Ontario

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 screenshot shows the top navigation bar of the E2P Tool. It has two main tabs: 'Visit' and 'Dashboard'. The 'Visit' tab is currently selected. Below the tabs, there is a 'View:' dropdown menu set to 'Full visit'. To the right of the 'View:' menu is a 'Select visit type' dropdown and a 'Resources and Care Plan' button. Below the 'View:' menu, there are several buttons: 'Full visit', 'Comprehensive Assessment', 'Management Plan', 'Medications', 'Referrals & Follow-up', and 'Visit tool menu'. The 'Dashboard' tab is also visible, with buttons for 'All', 'Labs/Metrics', and 'History', and a 'Dashboard menu' 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.

The screenshot shows the 'Patient Dashboard' interface. At the top, there is a navigation bar with 'View: All', 'Labs/Metrics', and 'History' tabs. The 'All' tab is selected. Below the navigation bar, the main content area is titled 'Dashboard: Patient Metrics and Labs'. This area contains two tables: 'Metrics' and 'Labs'. The 'Metrics' table has columns for 'Lab name', 'Latest result', and 'Last done'. The 'Labs' table has columns for 'Lab name', 'Latest result', and 'Last done'. Below the tables, there are links for 'Open Gad-7 Custom form', 'Open PHQ-9 Custom form', and 'Launch Ocean'. To the right of the 'Labs' table, there are links for 'Generate Lab Req' and 'Filter Labs'. At the bottom, there is a section titled 'Dashboard: Patient History (note tooltip)' with a text area for 'History of stress or trauma (note tooltip)' and links for 'Filter screening history' and 'Filter visit history'.

Lab name	Latest result	Last done
GAD-7		
PHQ-9		

Lab name	Latest result	Last done
Hb	18.1	Oct 21, 2022
HbA1C	0.67	Oct 21, 2022
TSH	1.2	Oct 21, 2022
Ferritin	ever dor	
B-12	ever dor	

Open Gad-7 Custom form
Open PHQ-9 Custom form
Launch Ocean

Generate Lab Req
Filter Labs

Dashboard: Patient History (note tooltip)
Information added to this section will be saved for future review and revision
History of stress or trauma (note tooltip)
Filter screening history
Filter visit 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.

Visit insert from previous: clear form

Comprehensive Assessment

Subjective

Reason for visit details:

Since last visit, patient feels: Improved

Recent stressful or traumatic life events Consider asking about work, school, divorce/breakups, bereavement, trauma, abuse, etc...
For patients with a severe history of abuse or trauma, consider refer to mental health services or an eConsult

Suicide risk assessment: select one ☐ safety plan discussed safety plan form 1
[Weblink: Columbia-Suicide Severity Rating Scale \(C-SSRS\)](#)

Subjective notes insert stamp **SDOH Lifestyle Personal and psychosocial support**
Consider asking about housing, employment, food, income, etc. and supporting patient to address and manage social determinants
Consider asking about diet, physical activity, sleep, total screen time
Consider asking about family, friends, and community

Objective

Mental status examination insert stamp
When assessing consider:

yes stamp
Affect/Behaviour - calm, restless, nervous
Dress/groom - tidy, disheveled

Today's vitals
BP: mmHg
WT: kg

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.

Management Plan insert stamp

Guidelines

Psychotherapy
Decide together whether psychotherapy should be used as monotherapy or as an adjunctive therapy. [Learn more](#)

Patient referred to:

Free psychotherapy options:

☐ Ontario Structured Psychotherapy [open link](#)

☐ GP/FP psychotherapy [open link](#)

At cost options:

☐ Psychologist [Find a therapist using Ontario Psychological Association](#)

☐ Psychotherapist or social worker [Find a therapist using Psychology Today](#)

Lifestyle considerations
Lifestyle considerations should be optimized for all patients. Select which items to include in the patient plan

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.

Medication

Engage the patient in shared decision-making about their medications. See general guidelines: ⓘ

Considerations if pregnant or post-partum ⓘ

Talking points for starting and taking medications ⓘ

Current med plan

first line therapy or monotherapy:

adjunctive therapy:

Medication Plan

Monitoring, adherence and response

Consider using scales when monitoring a patient's response to medication when combined with meaningful conversation .

Is patient taking medication(s) as directed? : ☐yes ☐No

Is the medication(s) helping? : ☐yes ☐No

negative side effects? : ☐yes ☐No

Referrals and Follow-up

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

Referrals and follow-up

Follow up with patient to ensure they have timely access to the agreed upon medications

Recommended to schedule f/u: Every 2 weeks for 6 weeks or until adherence and response are achieved

Every 4 weeks until remission

Next follow-up appointment booked for: 4 w weeks

Referrals and follow-up notes

«Referred out for management»

Care plan and resources

Open health map

Generate summary note / Complete form

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.

<input type="checkbox"/> 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	
<input type="checkbox"/> 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

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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 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

COPD

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

Last visit:
Sep 18, 2023

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.

Last visit:
Jan 18, 2023

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

COPD

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

Last screened:
Oct 11, 2023

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.

Last screened:
Sep 18, 2017

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.

At risk criteria - Match summary: 0 Check for identified symptoms Last done: Jan 17, 2024

Respiratory Symptoms: 0

- ☐ Persistent shortness of breath that worsens with activity and/or exercise
- ☐ Chronic cough
- ☐ Regular sputum production
- ☐ Recurrent respiratory infections
- ☐ Chronic wheezing
- ☐ Chest tightness
- ☐ Activity and/or exercise limitation owing to breathlessness

Risk factor contains: 0

- ☐ Current or past tobacco smoking
- ☐ Exposure to second-hand smoke
- ☐ Exposure to occupational lung irritants, such as dust, vapours, fumes, gases, and other chemicals
- ☐ Childhood factors, such as low birthweight, recurrent respiratory infections, and other lung development issues
- ☐ Exposure to significant air pollution
- ☐ Family history of COPD (alpha-1 antitrypsin deficiency)
- ☐ Genetic predisposition
- ☐ History of asthma
- ☐ Use of biomass fuels for indoor heating or cooking without proper ventilation

People are clinically suspected of having COPD if they have at least 1 respiratory symptom and 1 risk factor for COPD

People clinically suspected of having COPD should be referred for spirometry to confirm diagnosis

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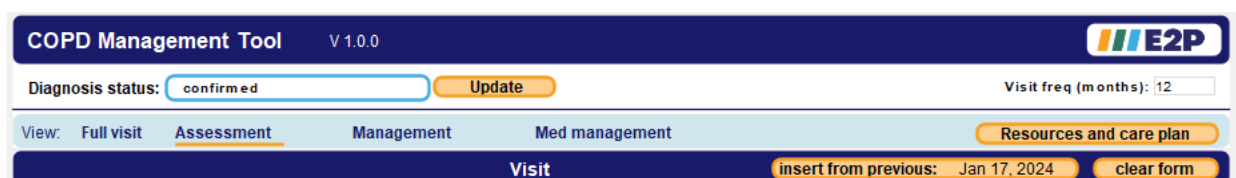
Taking Action

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.

COPD Management Tool V 1.0.0

Diagnosis status: Visit freq (months):

View:

Assessment Subjective/Objective

Reason for Visit:

Date of hospital visit:

Since last visit, patient feels:

Actions

of AECOPD in last year:

Consider comorbidities (e.g., asthma, metabolic diseases, mental illness, osteoporosis) when assessing and planning care with patients.

Additional Notes

Today's vitals

BP: mmHg

HR: bpm

WT: kg

RR: bpm

O2: %

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.

Exacerbation Last time form was done:

☐ Add exacerbation Severity:

☐ Add exacerbation Severity:

☐ Add exacerbation Severity:

Evidence2Practice Ontario's tools for primary care are developed and delivered by the eHealth Centre of Excellence and the Centre for Effective Practice.

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.

COPD Management Tool V 1.1 References

Diagnosis status: Update Visit freq (months):

View: Full visit Assessment **Management** Med management Resources and care plan

Visit insert from previous: Jan 17, 2024 clear form

Management Perform Treatment

Immunizations

Influenza (annual)	never done	* review need for influenza vaccine	RSV	never done	* Consider the RSV vaccine for patients with COPD
Pneumococcal	never done	* review need for pneumococcal vaccine	Shingles	never done	* review need for Shingles vaccine
Covid vaccines(s)	never done	0 dose(s)	Tdap	never done	* review need for Tdap vaccine

Oxygen Therapy

Patient on oxygen therapy ☐ Regular Oxygen L/min Increase oxygen (L/min) to

Lifestyle considerations

Smoking cessation Smoking status ☐ discussed progress and methods to quit [Smoking Treatment for Ontario Patients](#)

Self-monitoring and management

☐ Counsellor

Physical activity

☐ Referred to pulmonary rehab program

☐ Counsellor on daily activity routine

☐ Referred out for management

Referrals and follow-up The visit form needs to be added to the chart first for the care plan to reflect latest updates Resources and care plan

«Referred out for management» Open health map

Generate summary note / Complete form

Usage analytics | Feedback

Evidence2Practice Ontario's tools for primary care are developed and delivered by the eHealth Centre of Excellence and the Centre for Effective Practice.

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.

The screenshot shows the 'Medication Plan' interface. At the top, it says 'last updated:'. Below this, there are two main sections: 'SHORT-ACTING' and 'LONG-ACTING'. The 'LONG-ACTING' section has a 'show recommended long acting' button and a 'show all' button. Below these, there are input fields for 'CAT 25', 'mMRC Dyspnea 5', 'FEV1 17', and 'AECOPD Risk Low risk'. A note states: 'Only step down in therapy if it did not improve symptoms, health status declined, or the risk of adverse events outweighs the benefit.' Below this is the 'COPD Action Plan' section, which includes a checkbox for 'Regular sputum colour white' and a checkbox for 'Exacerbating factors'. There is also a section for 'If more short of breath than usual' with input fields for 'Increase puffs of 2' to '4' puffs per day, to a max of: 2 times per day. At the bottom, there is a 'create prescription for COPD flare-ups' button.

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.

The screenshot shows the 'Referrals and follow-up' section. It has a header with 'Referrals and follow-up' and a note: 'The visit form needs to be added to the chart first for the care plan to reflect latest updates'. There is a 'Resources and care plan' button. Below this, there is a text area for '«Referred out for management»'. At the bottom, there is a 'Generate summary note / Complete form' button. The footer includes logos for 'eHealth', 'CEP', and 'Evidence2Practice Ontario's tools for primary care are developed and delivered by the eHealth Centre of Excellence and the Centre for Effective Practice.'

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

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.

