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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](mailto:EMRtools@amplifycare.com) and we will be happy to help!

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## Evidence2Practice – Oscar Tool Bundle v 4.0 – User Guide

### Introduction

EMR tools from the Evidence2Practice Ontario (E2P) program are based on the Ontario Health Quality Standards. They have been developed to make it easier for clinicians to access and apply best practice information and quality standards at the point of care.

### 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

## Form Navigation

### E2P Dashboard

Each E2P Visit Form leverages a universal dashboard display. The dashboard includes information regarding metrics, diagnostics, history and resources. The dashboard can be accessed by clicking on the menu icon buttons on the right-hand side of the form. While expanded, the sections can be navigated by clicking the menu icon buttons. The dashboard can be minimized using the left arrow button.

#### Menu Icon Buttons



### E2P Management Tool

EMR tools from the Evidence2Practice Ontario (E2P) program are comprised of modules: Clinical Assessment, Medication, Management, and Patient Care Plan. Modules can be accessed via the menu tabs, or via the navigation buttons located at the bottom of each section.

#### Menu tabs

**Assessment** Management Medication Patient Care Plan

#### Navigation buttons

Previous Section

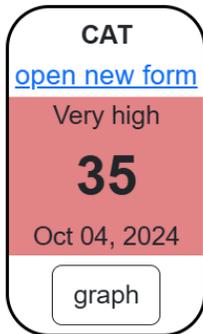
Next Section

## Getting started with the dashboard

### Metrics

This area of the dashboard contains metric display cards displaying the most recent assessment scores and last done dates. Use the condition toggles to cycle through specific measurements.

#### Create new measurements



There are two ways to create new measurements.

- 1) Use the 'open new form' link from each metric display card to access the Consolidated Screening Form for detailed questionnaires. Submit the Consolidated Screening Form to write measurements to the database. Metric cards will be updated in the current visit form.
- 2) Use the 'Update result manually' button to unput value and date. Metric cards will be updated in the current form but will not be written to the database until the visit form has been submitted.

#### Tracked measurements

<b>COPD</b>	<b>CAT, mMRC, FEV1%*, AECOPD*, FEV1/FVC*, LLN*</b>
<b>Mental Health</b>	PHQ9, GAD7
<b>Diabetes</b>	PHQ9, GAD7, PAID, WHO5
<b>Heart Failure</b>	LVEF, NYHA

\*Is not linked to Consolidated Screening Form

### Diagnostics

This section includes a results table that displays the latest results, last done date, and goal(target) values for lab results and investigations. Use the toggles to include lab values and investigations associated with specific forms.

#### Create new manual lab results

Lab values should be automatically linked to results coming into the EMR. Manual values can also be created using the 'update manually' button.

Update manually

Change frequency

Open lab req

MH

DM

HF

COPD

Please select the labs you would like to include in the lab requisition form.

select all currently displayed

Lab value	Result	Last done	Goal	Req.
<a href="#">2hPG</a>			<7.8 mmol/L	<input type="checkbox"/>
<a href="#">ACR</a>			<3.0	<input type="checkbox"/>
<a href="#">CHOL</a>			<5.20 mmol/L	<input type="checkbox"/>
<a href="#">eGFR</a>	74	Jul 25, 2022	20-30 µmol/L	<input type="checkbox"/>
<a href="#">FBS</a>	5.9	Jul 25, 2022	3.6-6.0 mmol/L	<input type="checkbox"/>
<a href="#">Hb</a>			20-30 g/L	<input type="checkbox"/>
<a href="#">HbA1C</a>	6.1	Jul 25, 2022	<30 %	<input type="checkbox"/>
<a href="#">HDL</a>	2.6	Jul 25, 2022	<1.3 mmol/L	<input type="checkbox"/>
<a href="#">LDL</a>	2.1	Jul 25, 2022	<30 mmol/L	<input type="checkbox"/>

### Change desired lab frequency or goal (target)

Individual targets and frequencies can be adjusted using the change frequency button. This will launch the **E2P Patient Profile Form**. Navigate to the lab values tab and update as required. When a lab result is outside of the identified range or frequency, a visual (orange) flag appears in the results table.

### Create lab requisition

Select the checkboxes from the results table to create a lab requisition. 'Select all currently displayed' checkbox to select all results at once. Use the 'open lab req' button to create desired requisition.

### Graph results

Use the lab value label to open a graph to trend results in a pop-up window.

### History

Linked to the E2P Patient Profile, the history section provides a holistic view of related patient information. It will pull the most recent values from, as well as write to the E2P Patient Profile so that the information is up to date regardless of which visit tool is being used.

Update E2P patient profile

**Diagnosis Status:** i never done + Medical History

Confirmed     Unconfirmed     Suspect

+ Disease Reg

**Smoking status:** never done + Medical History

### Update diagnosis status

Use the appropriate selections to capture the state of diagnosis. The **+Medical history** button will update the Oscar record patient profile. The **+Disease reg** button will launch the disease registry window to support coding specific conditions.

When submitting the form, there will be a check to ensure that the E2P patient profile has been updated. Alternatively, using the 'Update E2P patient profile' button will open, modify and close the E2P Patient Profile Form.

## Resources

The condition toggles can be used to view a curated list of patient resources for each condition. Click on the link label to open the resource during the patient encounter.

COPD  HF  MH  DM

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

**Heart failure resources:**

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

Selecting resource checkboxes will include the hyperlink on the Patient care plan when launching the care plan from the current form.

## Heart Failure Visit Form

### Assessment Module

The assessment module supports clinicians in easily identifying and documenting subjective symptoms and objective findings. Clinicians can collapse the comprehensive assessment inputs using the 'hide checkboxes button- opting for freeform text area notes instead.

### Vitals

Vitals that have been previously captured as measurements will display, alongside the last done date. New measurements can be added using the 'update manually' button. The visit form will refresh, but the measurements will not be added to the database until the visit form has been submitted. Clicking on the vital name label will graph historical measurement values.

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

Patients with reduced ejection fraction should be offered quadruple therapy as part of their pharmacologic plan. The medication module supports clinicians in identifying and reviewing the current plan at a glance. Updating the medication plan table creates a historical reference of adjustments – with the goal of achieving target doses as tolerated.

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 ⓘ

Action	Class	Agent	notes

Submit Print

+ Add medication

## Diabetes Visit Form

### Clinical Assessment Module

Assessment Management **Medication** Patient Care Plan

Assessment section – gathering information re: symptoms, side effects etc.

**Assessment Module**

copy from prior clear

last done: 2023-06-28

Use the [Canadian Diabetes Risk Assessment Questionnaire \(CANRISK\)](#) to determine risk level and [recommended screening frequency](#).  
To interpret A1C/FPG results for undiagnosed/asymptomatic individuals, follow the [Diabetes Canada Screening and Diagnosis algorithm](#).

Diagnosis status:  last done:

**Subjective**

Since last visit, feels:

**Symptoms**

- Unusual thirst  Frequent urination  Extreme fatigue or lack of energy  Frequent or recurring infections  Trouble getting or maintaining an erection  Discussed/Reviewed mental health
- Blurred vision  Weight change (gain or loss)  Cuts and bruises that are slow to heal  Episodes of hypoglycemia (since last visit):
- Tingling or numbness in the hands or feet

**Objective**

- Reviewed lab investigations *see above*  Reviewed additional risk factors *see medical history above*

**Physical exam**

Update result manually

Change goals

Vital	Result	Last done	Goal	Units
BP	120/80	May 10, 2023	≤130/80	mmhg
HR			N/A	bpm
Weight	265	May 10, 2023	N/A	kg
WC			≤102	cm

**Vaccinations**

Influenza last done:

Pneumococcal last done:

COVID-19 last done:

# of doses:

**Screening and monitoring diabetes specific complications**

Selecting the “+” button will indicate that results are abnormal or condition present and requires follow-up.

Selecting the “-” button will indicate that results are normal or screened but not present/no immediate action required.

**Management Module**

The management module supports clinicians in identifying lifestyle changes that can be taken into consideration as well as creating individual goals with the patient. To support the patient in engaging self-management strategies, related patient resources can be identified here and automatically included as part of the care plan.

Checkboxes are used to indicate if referrals have been made as well as textboxes to include any additional information. These details will also generate a note in the patient care plan to act as a reminder of the next steps. A button to open the consultations tab has been included to complete the referral if necessary.

**Assessment Management Medication Patient Care Plan**

Identification of patient goals and lifestyle considerations

**Management Module**

copy from prior clear

last done: 2023-06-28

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.

Prediabetes?

Patient Goals

Add goal

Barriers to self-management Consider SDoH when interacting with patient

**Lifestyle Considerations**

Patient plan includes:

- Nutrition**
  - appropriate diet
  - discussed individualized nutrition
- Physical activity**
  - 150 mins/week
  - discussed individualized plan
- Weight management**
  - discussed weight management
- Smoking cessation**
  - discussed progress and methods to quit
- Sick day management**
  - educated patients on planning for sick days
- Driving guidelines**
  - educated patients using insulin or insulin secretagogues on driving safety
- Stress management**
  - counselled

**Patient Resources**

\*selected when checked

- Mediterranean style diet - [link](#)
- DASH (Dietary Approaches to Stop Hypertension) - [link](#)
- Diabetes Canada- Healthy Eating - [link](#)
- Maintaining Aerobic Exercise - [link](#)
- Diabetes Canada- Physical activity interactive decision tool - [link](#)
- Managing your smoking cessation progress - [link](#)
- Sick Day Management - [link](#)  Driving Safe with Diabetes - [link](#)
- Diabetes Canada- Steps to Stress Management - [link](#)

Additional notes

Referrals and next steps

**Referrals**

Open consultations

- Referred to diabetes education center for ongoing management support
- Referred to endocrinologist
- Discussed and shared resources related to mental health

Medication Module

The purpose of this module is to aid in documentation and creation of a medication plan with regularly monitoring patient adherence and response to the prescribed medications.

Medication plan also populates the patient care plan with the most recent updates to their medication plan using the dynamic table available in this module.

**Assessment Management Medication Patient Care Plan**

**Medication Module**

copy from prior clear

last done: 2023-06-28

**Prediabetes**

In individuals with prediabetes, pharmacologic therapy with metformin (dosage 850mg twice daily) may be used to reduce the risk of type 2 diabetes.

Care plan should include assessment of diabetogenic medications (e.g., glucocorticoids and atypical antipsychotics [olanzapine, clozapine]). If a person is taking diabetogenic medications, weigh the risks and benefits of selecting alternative medications.

**Monitoring - adherence and response**

<p>Current medications</p> <p>SALBUTAMOL SULPHATE 200MCG Q 4H METFORMIN HCL 1000MG / ALOGLIPTIN BENZOATE 12.5MG Q24H</p>	<p>Medication adherence</p> <p>Is medication helping?</p> <p>Side effects experienced?</p> <p>Severity of side effects</p>	<p>Yes No</p> <p>Yes No</p> <p>Mild</p>
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Using this medication plan section creates an ongoing list that providers can use to ensure that they are optimizing pharmacologic treatment for their patients. It makes changes made to specific medications easily viewable, by capturing the specific action done (whether that was maintaining, increasing, or decreasing a specific medication) as well as notes around that decision. Also built into this section are information tooltips and guidance for both insulin and non-insulin therapy.

Dropdown medication lists can be used to select the specific medication along with documenting any adjustments (i.e., starting a new med, discontinuing, increasing dose, decreasing dose, maintaining)

**Medication Plan** [View medication reference table](#)

Non-insulin therapy  [Insulin initiation checklist](#)

Insulin therapy  [Switching insulin](#)

Diabetes and Cardiovascular Protection

Statins indicated  Yes  No

ACE/ARB indicated  Yes  No

SGLT2 or GLP-1 RA indicated  Yes  No

Dipeptidyl peptidase-4 inhibitors (DPP4)  Not prescribed  Prescribed  Not prescribed

20% Dose reduction method  Unit-to-unit method

[Add medication](#)

Insulin secretagogues-meglitinides	Repaglinide (Gluconorm®)	Increased dose	Jun 28, 2023	<input type="button" value="⊘"/>
Basal insulin	NPH (Humulin®N)	Maintain	Jun 28, 2023	<input type="button" value="⊘"/>
Prandial (bolus) insulin	Aspart (Kirsty™)	Discontinue	Jun 28, 2023	<input type="button" value="⊘"/>
Dipeptidyl peptidase-4 inhibitors (DPP4)	T/Alogliptin (Nesina®)	Decreased dose	Jun 28, 2023	<input type="button" value="⊘"/>

Note: This module is strictly for planning and documentation purposes and prescribing medications will still need to follow the usual workflow in OSCAR by opening the built-in medications window.

## Anxiety Disorders and Depression Visit Form

### Assessment Module

In the assessment module, users can document what the patient is here to discuss, whether the visit with the patient is due to a chronic or recent episodic event, as well as the estimated symptom onset date.

The main elements of this module are the mental status examination, recent stressful or traumatic life events, suicide risk assessment, personal and psychosocial stressors & supports,

lifestyle, social determinants of health, comorbid mental health conditions, and physical examination.

This module has form memory, which enables any text entered within the textboxes or checkboxes, and options selected from a previous visit will populate upon selecting the pull from the previous button. This allows users to add to existing notes or update the notes with any changes that occurred, therefore supporting a more comprehensive picture of the patient to be captured.

## Management Module

The management section offers the opportunity for clinicians to document that information has been provided to the patient about psychotherapy, lifestyle considerations, natural health products, and management of anxiety disorders and/or depression with the overall goal of improving patient engagement and enhancing their ability to make decisions about their care.

All checkboxes and text areas that are embedded with form-memory that will populate the next time the form is opened by clicking Copy from prior as well as populate the patient care plan with the management options that were selected.

**Assessment** **Management** Medication Patient Care Plan

**Management Module** copy from prior clear last done: 2024-06-11

Open consultations

Psychotherapy and medication contribute to improved outcomes. Management of depression should include psychotherapy and/or medication, with a combination of the two for severe or persistent symptoms. Management of anxiety disorders should include psychotherapy and/or medication and follow a stepped approach to ensure the least intensive and most effective management strategy is started first.

Engage the patient in shared decision-making about their management options and plan, taking into consideration:

- Results from the comprehensive assessment
- Symptom severity
- Previous response to management strategies
- Lifestyle considerations
- Needs and preferences
- Cost and health insurance coverage

Patient referred out for management

**Psychotherapy**

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

Patient referred to **free psychotherapy options** ([show details](#))

Ontario Structured Psychotherapy ([go to website](#))

GP/FP psychotherapy ([go to website](#))

**At cost options**

Psychologist

Psychotherapist or social worker

**Lifestyle considerations**

Lifestyle considerations should be optimized for all patients.

Patient plan includes:

**Evidence-based lifestyle considerations**

[Physical activity](#): First line monotherapy for mild to moderate depression, and second line adjunctive therapy for moderate to severe depression.

[Light therapy](#): First line monotherapy for seasonal depression, and second line adjunctive or monotherapy therapy for moderate to severe depression.

**Lifestyle considerations**

[Sleep hygiene](#)

[Nutrition](#)

Submit Print

## Medication 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 using the dynamic table available in this module.

The four elements of this plan are monitoring adherence, and response, as well as adjusting medications, all while emphasizing the focus on considering patient and medication factors

when initiating treatment throughout the tool. We've included Dropdown medication lists that can be used to select the name-specific medication you wish to prescribe. Additionally, dropdowns and text boxes for the quantity and direction make it easy for documentation purposes.

\*This module is strictly for planning and documentation purposes and prescribing medications will still need to follow the usual workflow in Oscar by opening the built-in medications window.

The screenshot displays the 'Medication Module' interface. At the top, there are navigation tabs: 'Assessment', 'Management', 'Medication', and 'Patient Care Plan'. Below the tabs, the 'Medication Module' title is shown along with 'copy from prior' and 'clear' buttons, and a 'last done: 2024-06-11' field. A sub-header reads 'Engage the patient in shared decision-making about their medications, taking into consideration: [patient factors & medication factors](#)'. A central box titled 'Set realistic expectations when initiating treatment' contains a quote: "People who stick to their treatment plan are the ones who see the most improvement over time. So, we are going to work together to make sure that happens." and another quote: "Side effects are normal and should wear off by 4-6 weeks. If you feel worried about this, we can chat about it some more." Below this is the 'Monitoring, adherence and response' section, which includes a 'Current Medications:' list, a 'Taking medication(s) as directed:' dropdown, and several radio button questions: 'Is the medication helping?' (Yes/No), 'Side effects' (Yes/No), 'Severity of side effects:' (Minimal dropdown), 'Indicators of suicide risk' (Yes/No), and a checkbox for 'Discussed [safety plan](#)'. An 'Additional notes:' text area is on the right. At the bottom of this section, it says 'Follow up with patient to ensure they have timely access to the agreed upon medications' and 'Follow-up appointment booked for: please select'. A 'Submit' button is visible. The 'Medication plan' section has buttons for 'Initial onset, effect and duration' and 'Medication after remission'. It shows a dropdown for 'Fluoxetine', a '2 mg' quantity, and an 'Increased dose' dropdown, with a 'notes' field. An 'Add medication' button is below. A table entry shows 'Fluoxetine 2 mg Increased dose Jun 11, 2024' with a red close button. The 'Adjusting medication' section at the bottom has buttons for 'Tapering medications', 'Switching medications', and 'Switching monotherapy vs. adding adjunctive medication'.

## COPD Visit Form

### Assessment Module

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

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

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

The screenshot shows the 'Assessment Module' interface for COPD management. It includes a navigation bar with 'Assessment', 'Management', 'Medication', and 'Patient Care Plan'. The 'Assessment Module' section contains a 'copy from prior' and 'clear' button, and a 'last done' field showing '2024-10-29'. The current diagnosis status is 'Unconfirmed' with an 'update status' link. The 'Reason for visit' section has a dropdown menu and a text input field. The 'Current Symptoms' section includes checkboxes for 'Persistent breathlessness' (at rest or on exertion), 'Chest tightness', 'Wheezing', 'Chronic cough', 'Regular sputum production', 'Frequent colds', 'Chest pain', and 'Activity and/or exercise limitation'. There is also an 'Other' text input field. The 'Physical Exam' section has checkboxes for 'normal breath sounds' and 'abnormal breath sounds'. The 'Appearance' section has checkboxes for 'Barrel Chested', 'Clubbing', 'Cachetic', and 'Other'. The 'Vitals' section displays a table of vital signs with an 'Update Manually' button. A 'Next Section' button is located at the bottom right.

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

## Management Module

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

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

Assessment Management Medication Patient Care Plan

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

Smoking status: current smoker update smoking status show smoking cessation info

Smoking Cessation Initial Visit ⓘ

advised

Patient ready to quit?  Yes  No

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

Patient on oxygen therapy

Discussed /reviewed vaccinations update preventions

Educated on inhaler technique

Discussed physical activity

Referred to pulmonary rehabilitation program

Discussed self-management and education

**Referrals**

Respirologist  Smoking cessation  COPD education  Spirometry  PFT Send Tickler Open Consultations

Previous Section Next Section Submit Print

## Medication Module

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

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

Assessment Management **Medication** Patient Care Plan

**Medication Module**

copy from prior clear

last done: 2024-10-29

Monitoring - adherence and response

Medication adherence:

Is medication helping?  Yes  No

Side effects experienced?  Yes  No

Severity of side effects

Patient CTS severity is severe

[Medication reference table](#)

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

Update Plan

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

## Patient Care Plan Module

The care plan is a universal 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.

