Updated: September 2025*

This guide is the most recent version of the tool: **Version 4.3**, 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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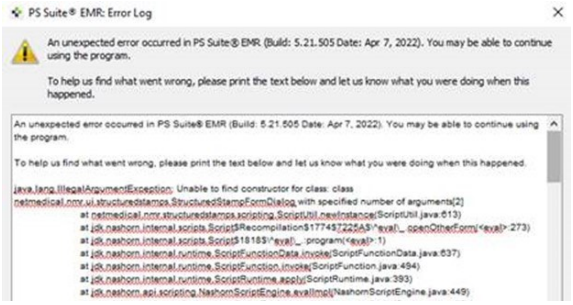
Notices

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.

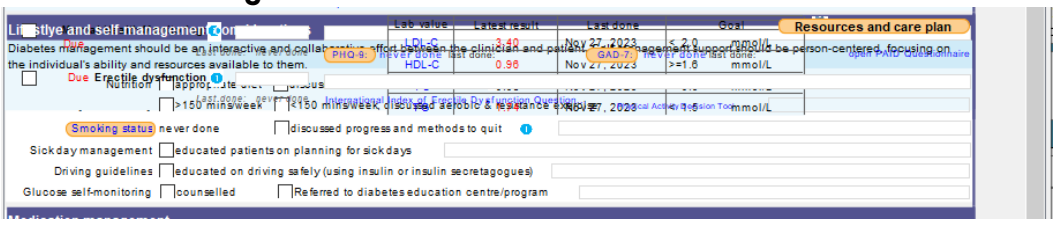
Solution: Since the "E2P - HF - Main Form Toolkit" does not include any data or documentation, it is recommended that all instances of this custom form be deleted from the patient chart.

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.

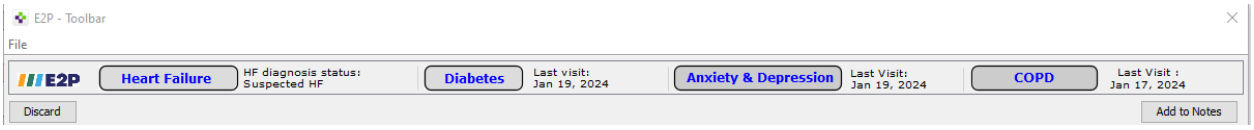
Getting Started with the E2P Toolbar

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

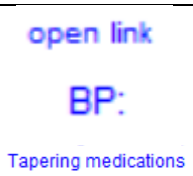
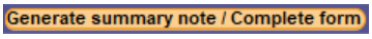
The tool was designed to include decision-support throughout the tool and has implemented tooltips, hover-overs, and pop-up windows to also help inform quality standard information.

Tool	Custom Vital Name	Value	Purpose
Heart Failure	@LVEF	Text	Records the left ventricular ejection fraction.
	@NYHA	Numeric	Records the New York Heart Association score dyspnea.
Diabetes	@CANRISK	Numeric	Records the CANRISK score.
COPD	@COPDDX	• 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).
	@LLN		Lower Limit of Normal
	@ spirometrydate	Date	
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.

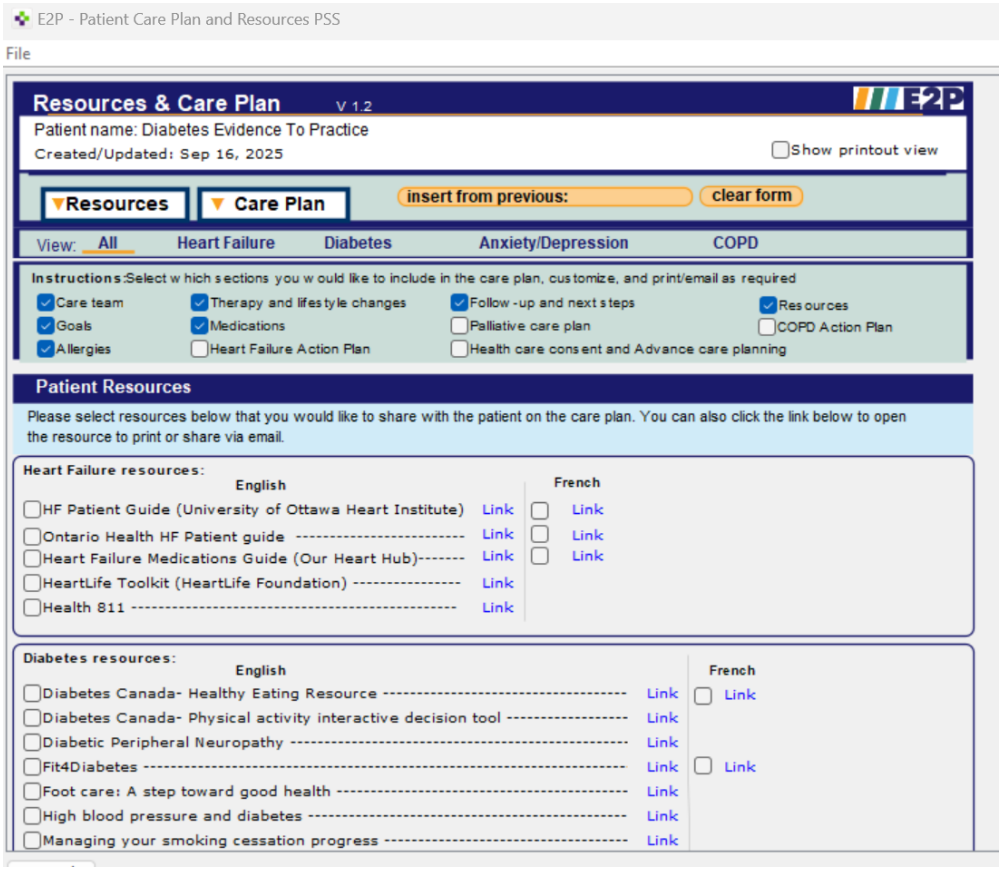
	Blue 'i' icons – Indicate hover-over text. Hold your mouse over this area to view the content.
	Yellow button – clicking on these will open a new window of the respective function (ex. view graph will open a window of a graph/ prescribe will open the prescription window).
	Red text – indicates warning/high-priority 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 1.2

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.

Patient resources are available in both English and French (when available.) Use the checkboxes under either the English or French column to include the desired resource on the printed version of the care plan.



Heart Failure Tool Version 3.1

Purpose of the Tool

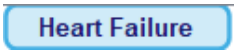
The objective was to create an EMR-integrated tool that supports clinicians in the diagnosing and management of heart failure.

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.

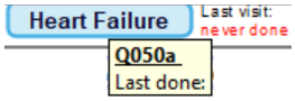
Getting Started

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



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.

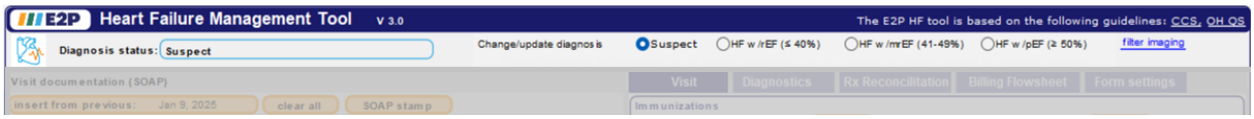
The last visit date will be red if the form has never been used in the patient's chart.
If the text "last visit" or "never done" is clicked, a pop-up will appear to inform the user that the form does not exist for the patient and ask if one should be created.

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

Heart Failure Management Tool

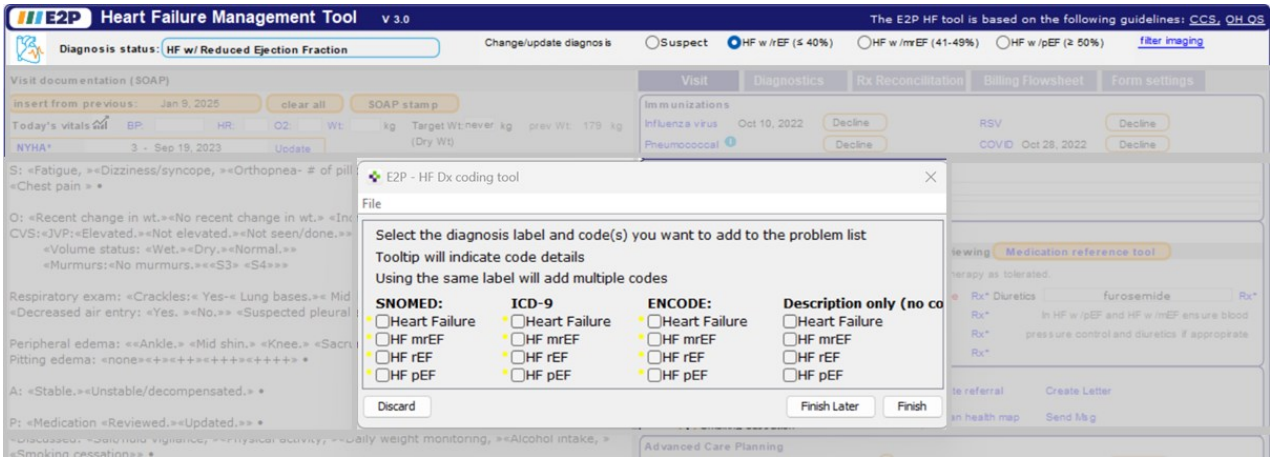
The main sections of this tool include the Diagnosis section, the Visit Documentation (SOAP) section, and the Management Hub (tabbed area).

Diagnosis section



The 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.

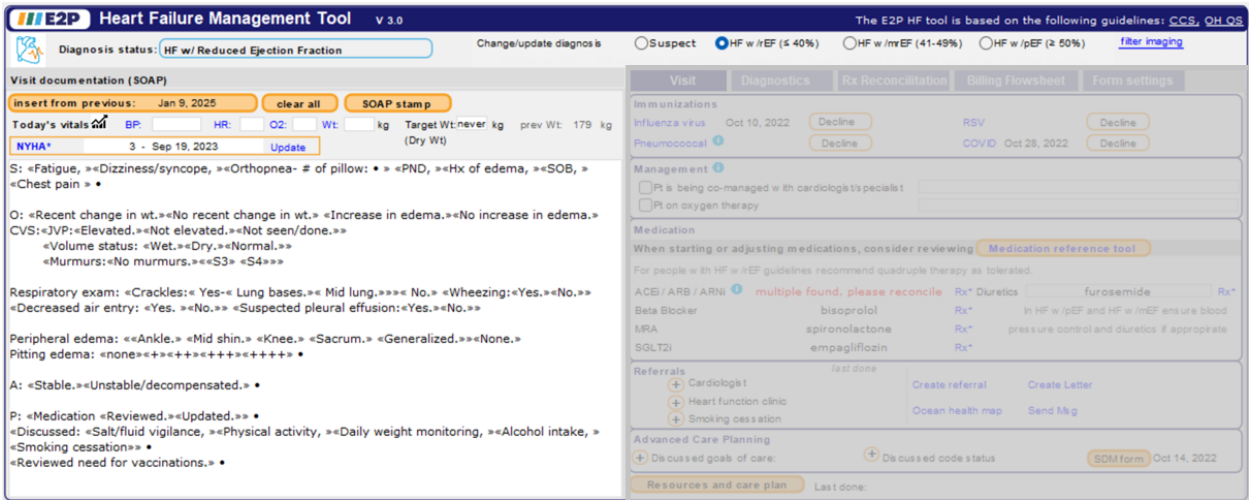
The form also includes the numeric ranges beside each option to support decision-making as well as a button that will prompt the EMR to filter the imaging results in the patient's chart.



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



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.

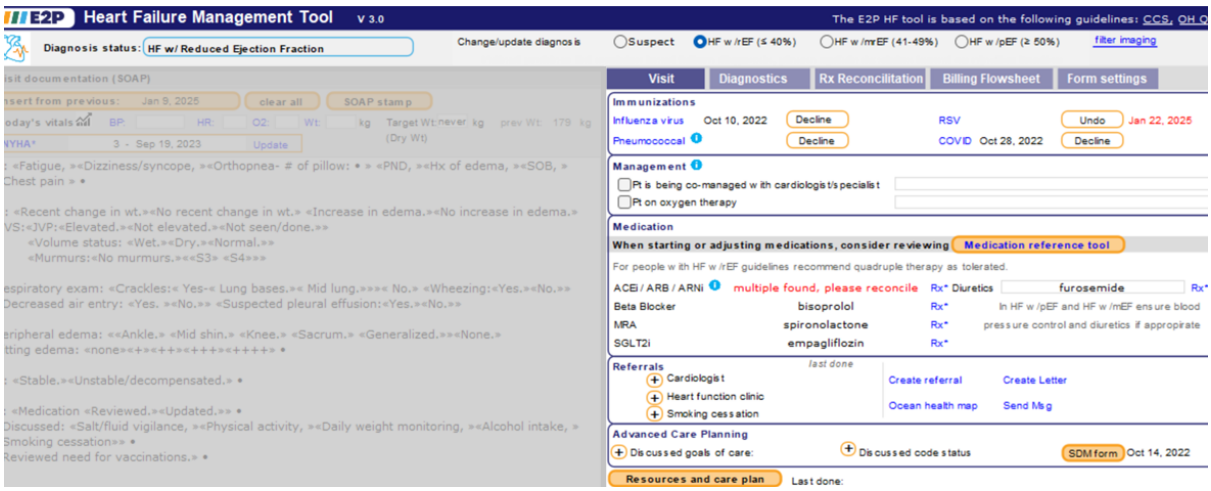
The stamp that E2P developed for this tool is designed to streamline and standardize documentation, making it faster, more accurate, and more aligned with clinical, billing, and regulatory requirements. The stamp includes options for users to select and remove items as needed. Regardless, additional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

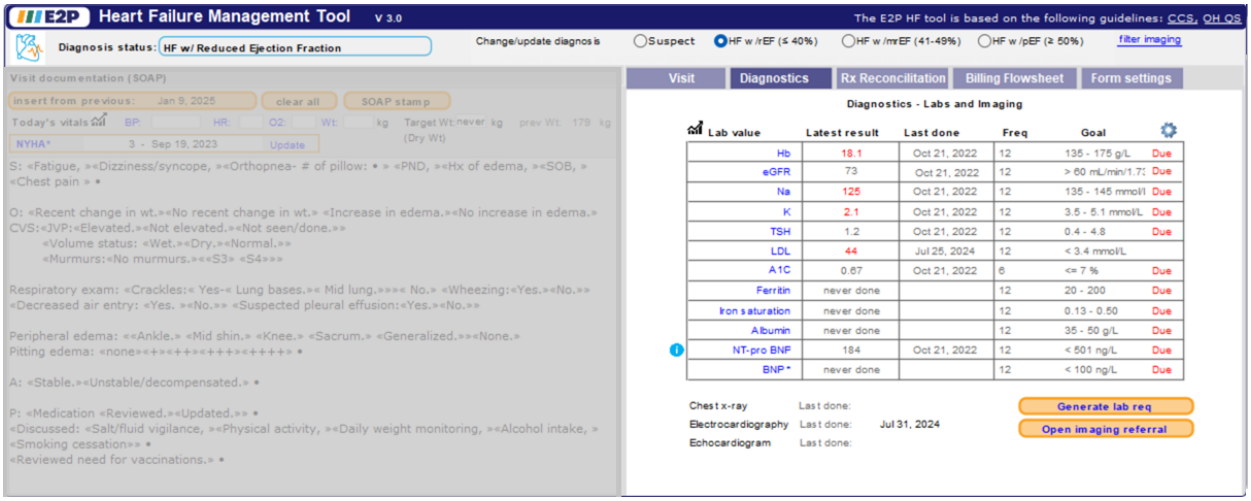
Within the management section, the user can document whether the patient is co-managed with a cardiologist or specialist and if they are receiving oxygen therapy.

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.

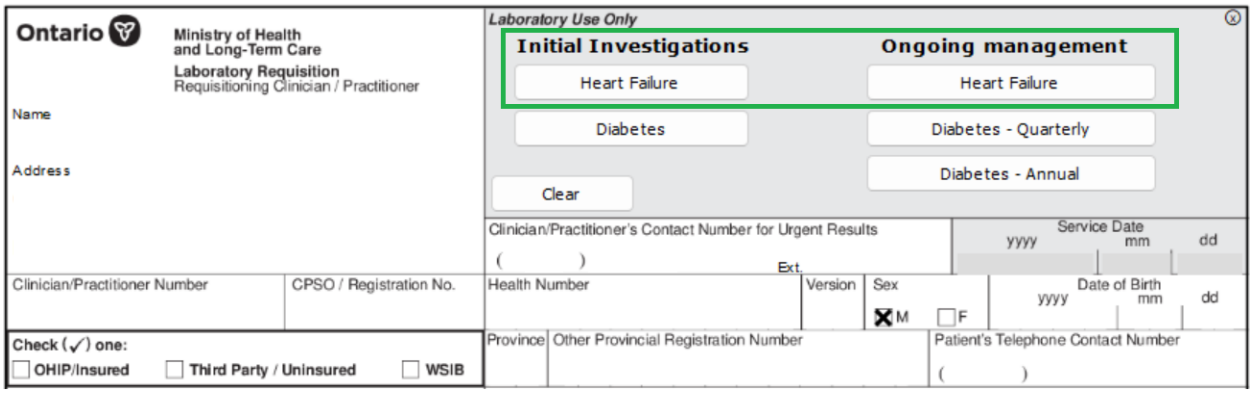
Diagnostics Panel



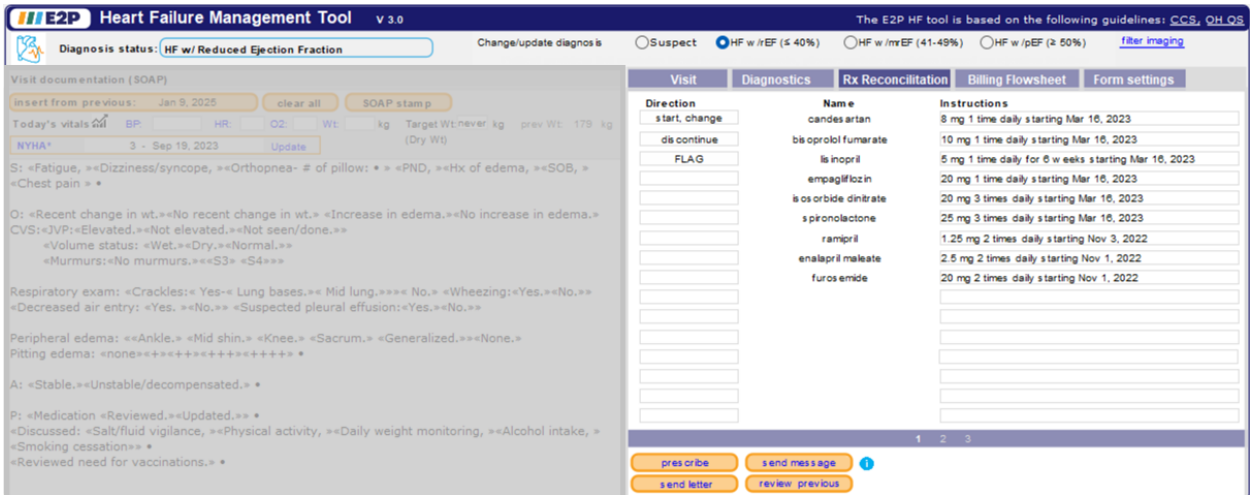
The Diagnostics section is the primary area for evaluating laboratory results and reviewing the latest imaging reports. In this section, lab values can be compared to target values. Users can view the recommended testing frequency, and the form will flag overdue labs and abnormal values in red. The gear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



Rx Reconciliation Panel



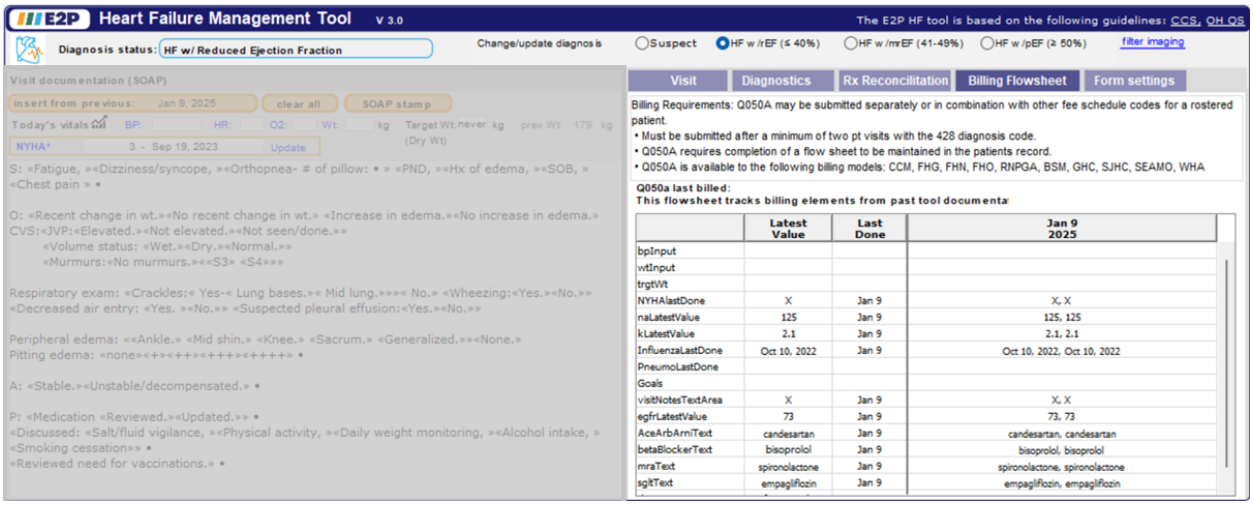
This section displays each medication the patient is taking, along with the corresponding instructions.

- 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.

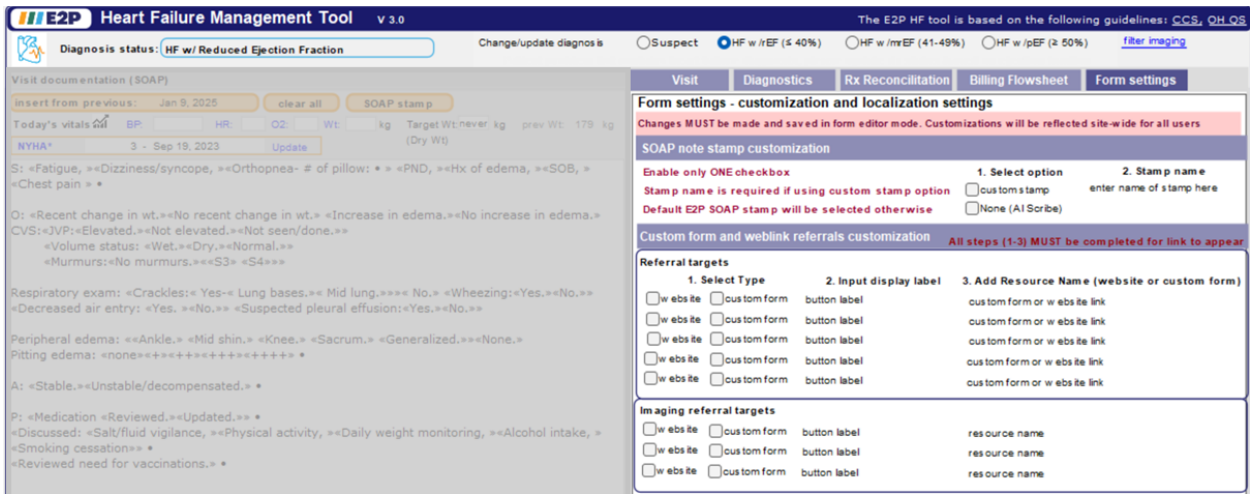
To start/change:	To discontinue:	To flag:
1. Locate the medication. 2. Click the empty box in the "Direction" column. After **1 click**, it will change to "start/change." 3. Repeat for other medications as needed. 4. Click the “prescribe” button on the bottom left 5. Complete the prescription writer as normal.	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.	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.

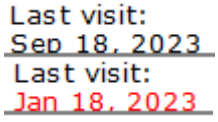
Features include:

- 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

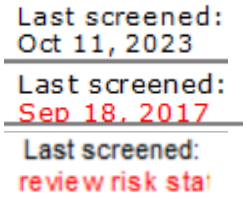
Clicking on this button will give the clinician access to the full tool.



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

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

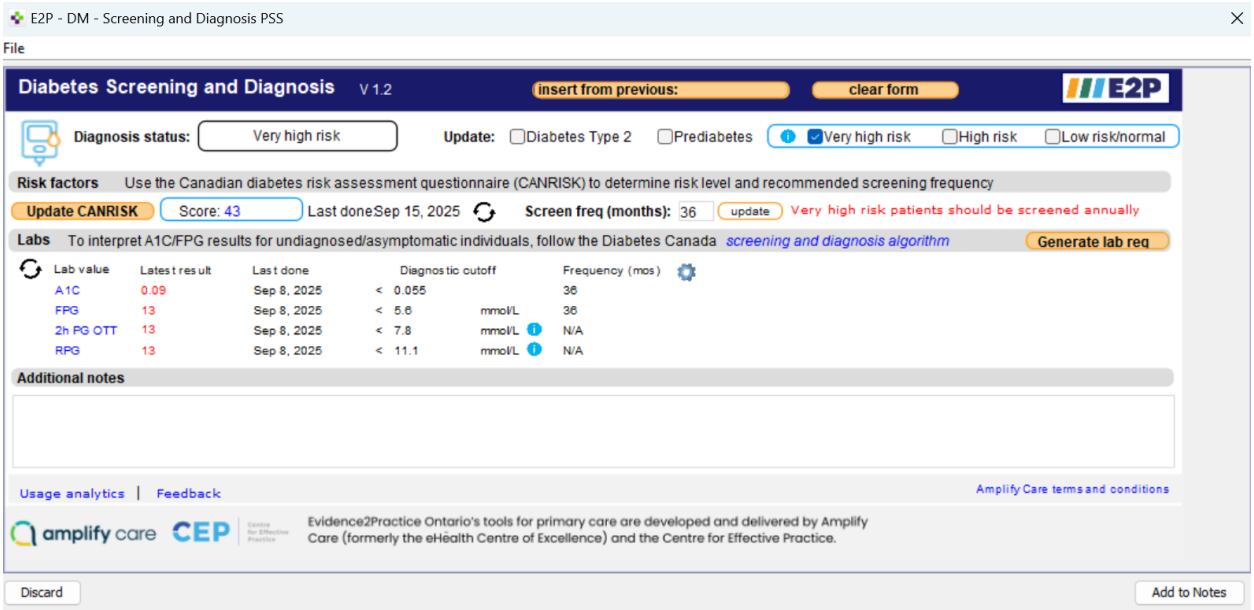


Screening has a frequency set for 36 months to revisit. It will turn red after 36 months.

The patient will have a flag to review risk if a screening form has never been completed – but certain criteria of the CANRISK have been met and is elevating potential risk.

Diabetes Screening and Diagnosis Window

The diagnosis status will use criteria from the CANRISK assessment to determine risk status. Click the button 'Update CANRISK' to complete the risk assessment and generate a score. The CANRISK score is used to determine frequency for screening. Very high-risk patients should be screened annually. Update the screening frequency with the indicated text box to ensure patient is flagged when overdue for visit. Reference the screening and diagnosis algorithm for diagnostic cut-off criteria. Click the 'Generate lab req' button to launch the Lab Requisition custom form.

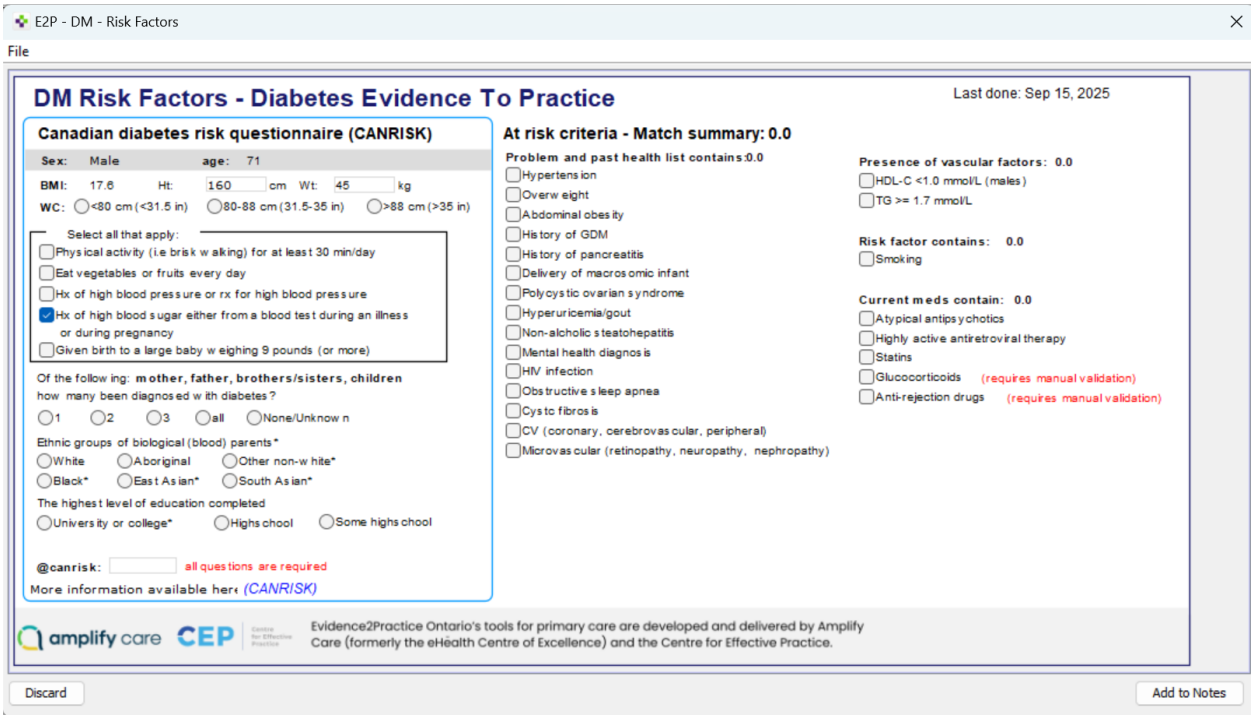


Diagnosis status

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 launch the coding EA.

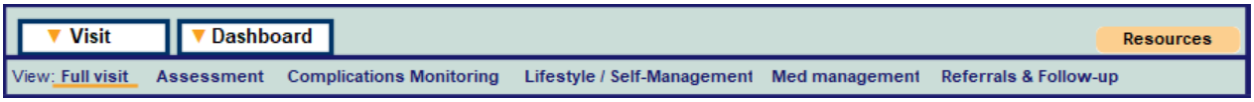


Launching Clinical Modules

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.

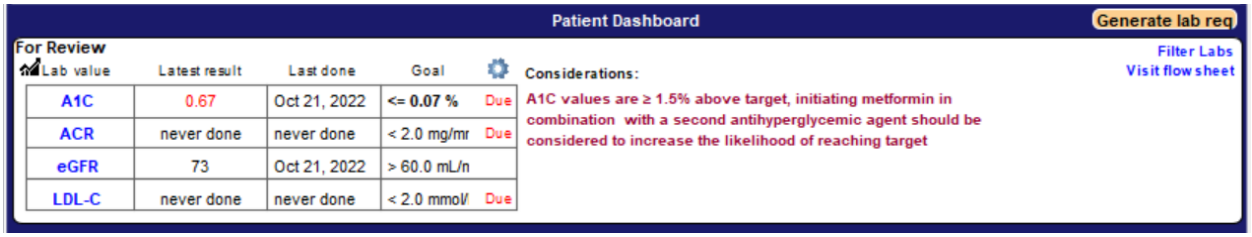


Patient Dashboard

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.

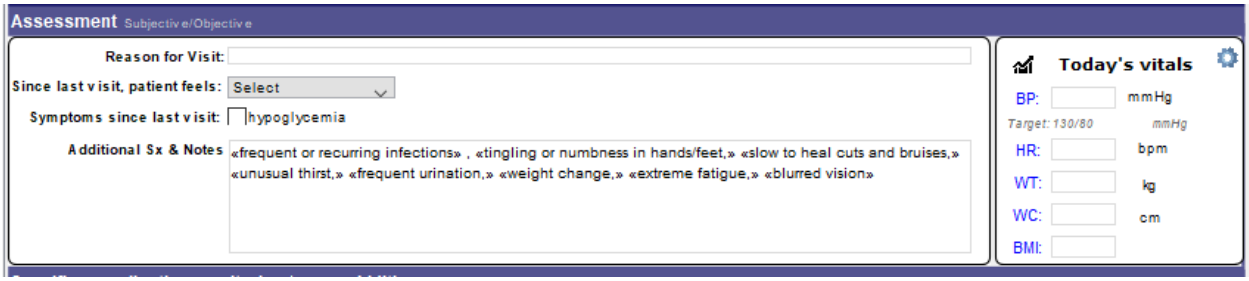


Assessment Module

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.

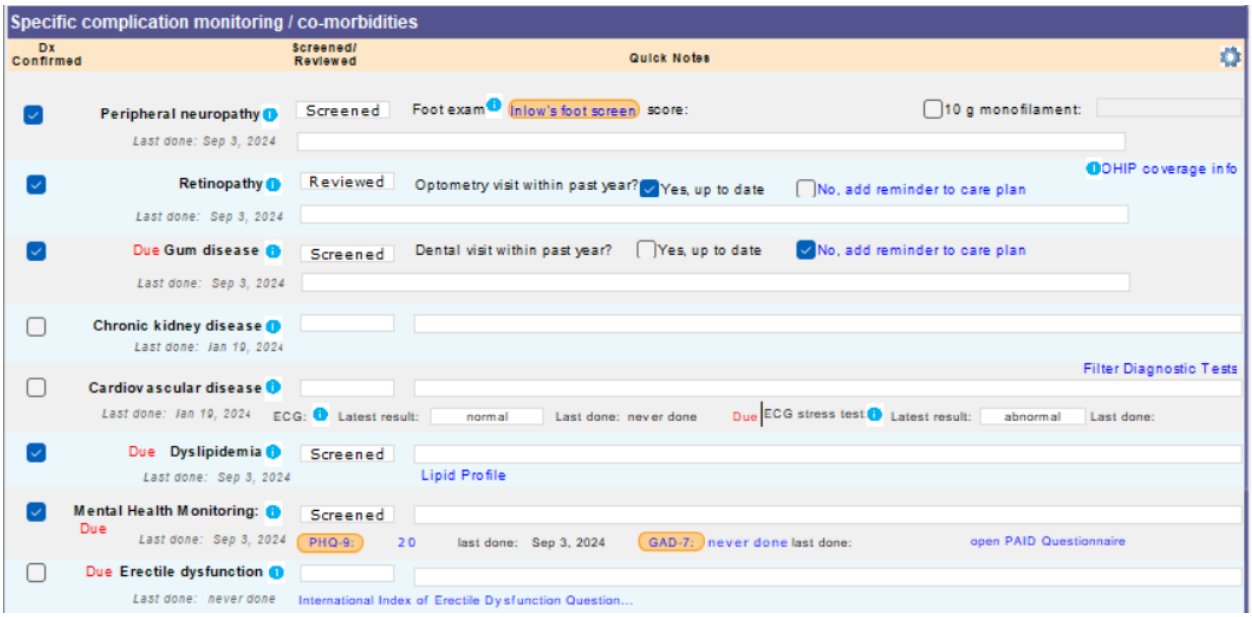
Today's vitals are embedded directly into this module which will pull in the patient's most up-to-date vitals for blood pressure, heart rate, weight, waist circumference, and BMI.



Specific Complications Monitoring/ Co-morbidities Module

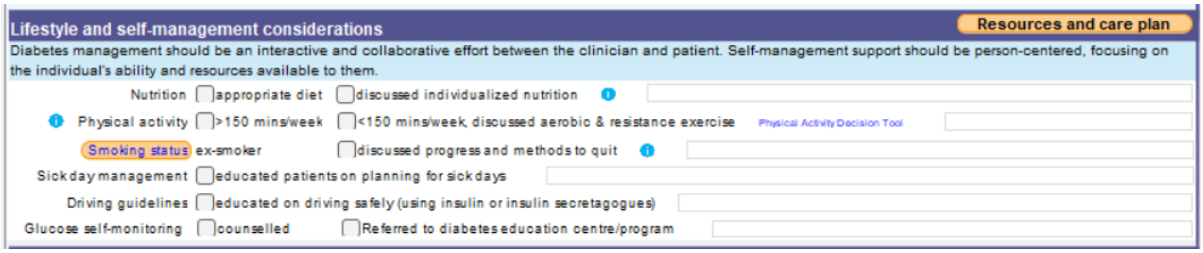
In this section, clinicians can monitor the specific complications and co-morbidities associated with diabetes. With the ability to identify which conditions the patient has been diagnosed with, users can input the date last screened/reviewed, filter diagnostic tests, as well as document relevant information 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.



Lifestyle and Self-Management Module

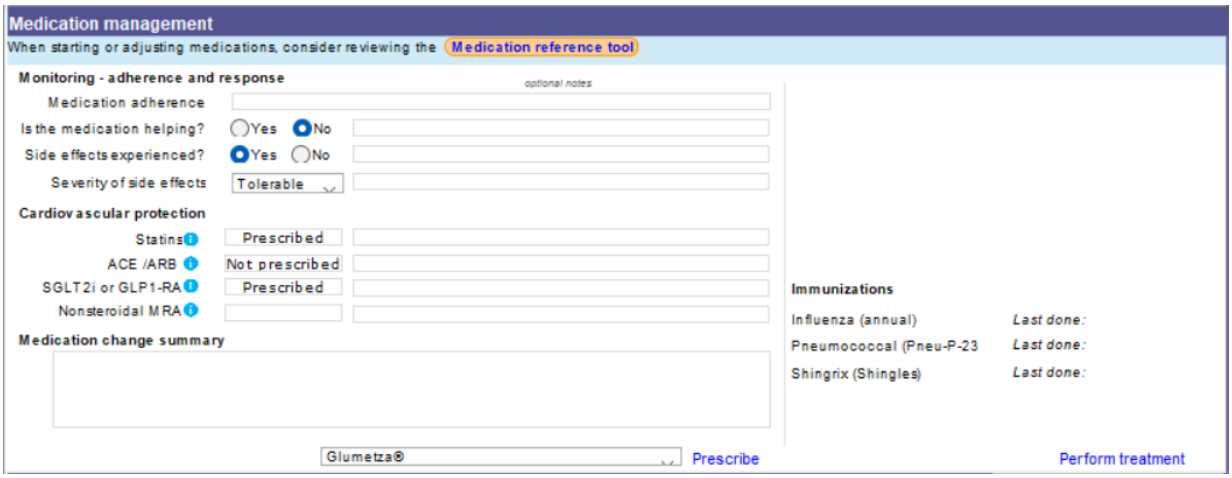
The management module supports clinicians in identifying lifestyle changes that can be taken into consideration as well as launches the smoking status toolbar.



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.



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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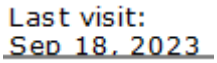
Purpose of the Tool

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.

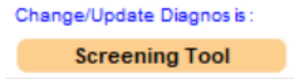
Anxiety Disorders and Depression Toolbar

The patient has an anxiety disorder or depression diagnosis in their Problem list

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



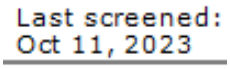
Last Visit: will appear if the patient has a confirmed MH diagnosis and will pull in the last visit date.



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 suspect anxiety disorder or depression diagnosis, but no confirmed diagnosis

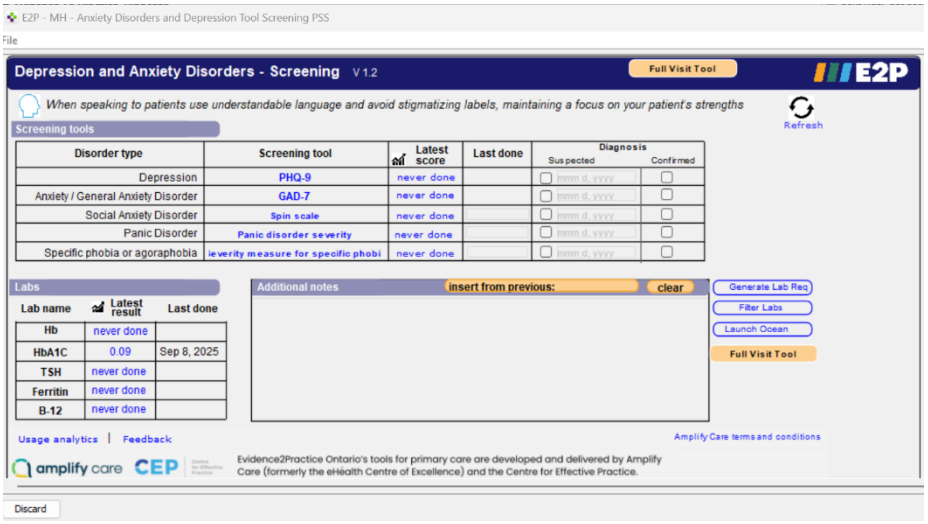
Clicking on this button will trigger the screener tool to appear.



Last Screened: will pull in the last date the screening tool was completed.

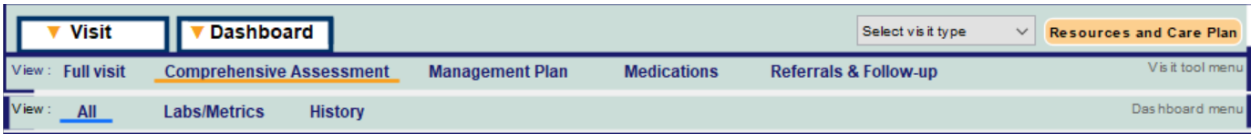
Anxiety Disorders and Depression Screening Tool

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.



Launching Clinical Modules

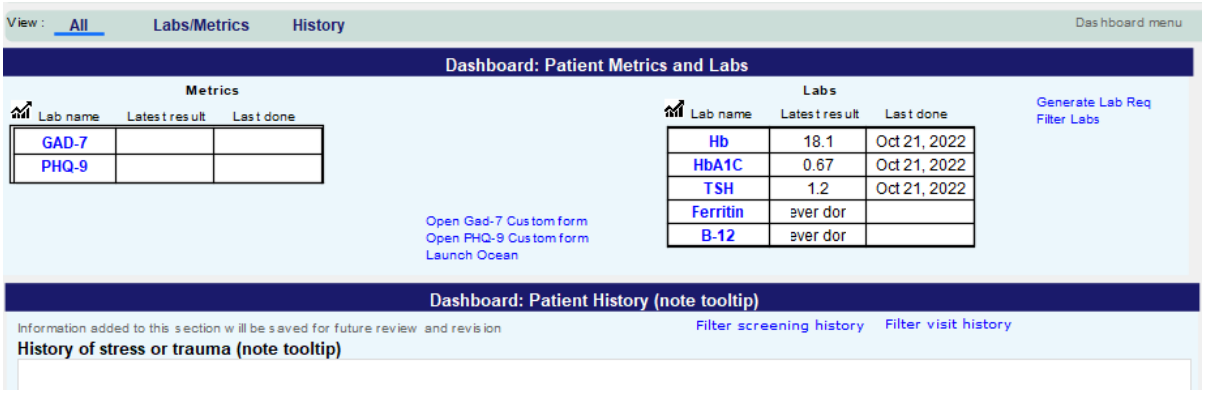
The components related to the provision of mental health care have been broken into 4 modules, allowing for flexibility. These modules have form memory and will populate upon selecting the pull from the previous button.



The 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'.

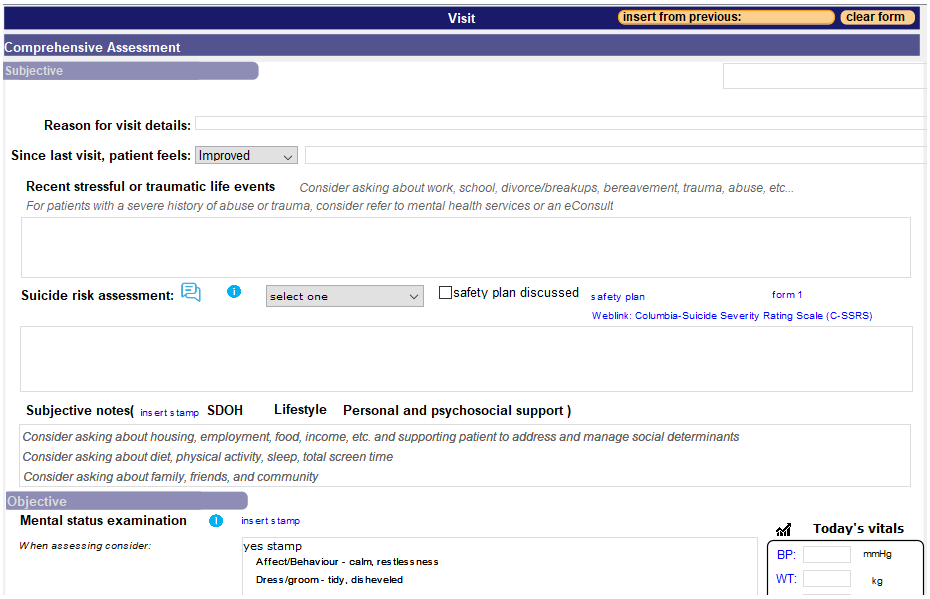
Patient Dashboard

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.



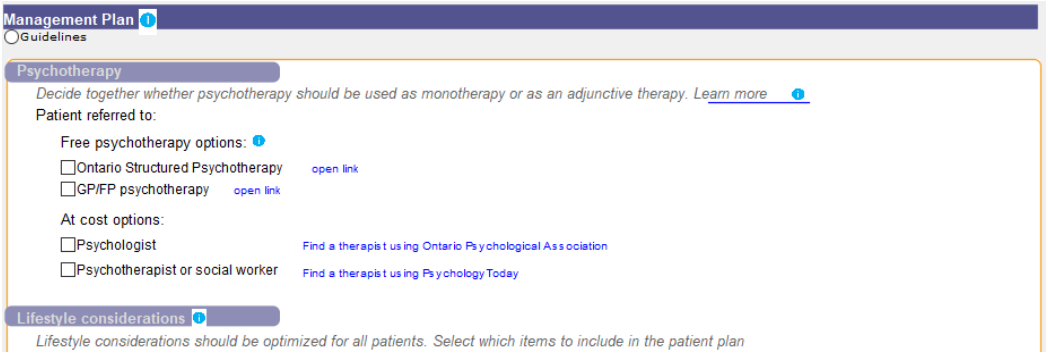
Comprehensive Assessment Module

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.



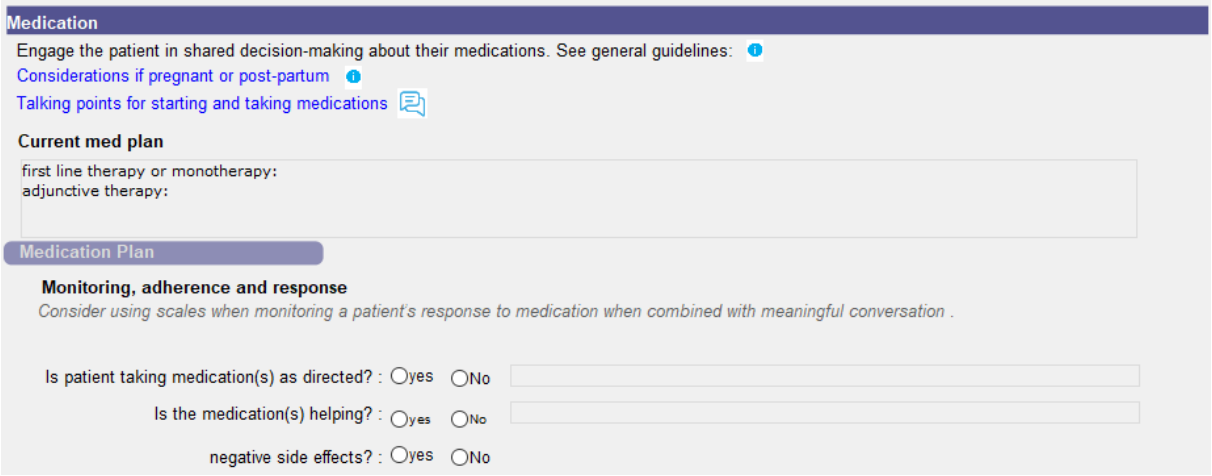
Management Plan Module

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.



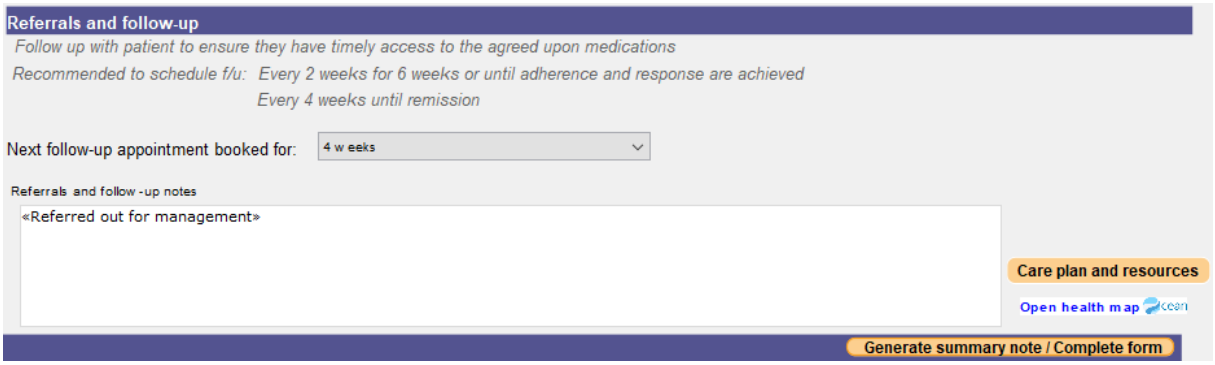
Medications Module

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.

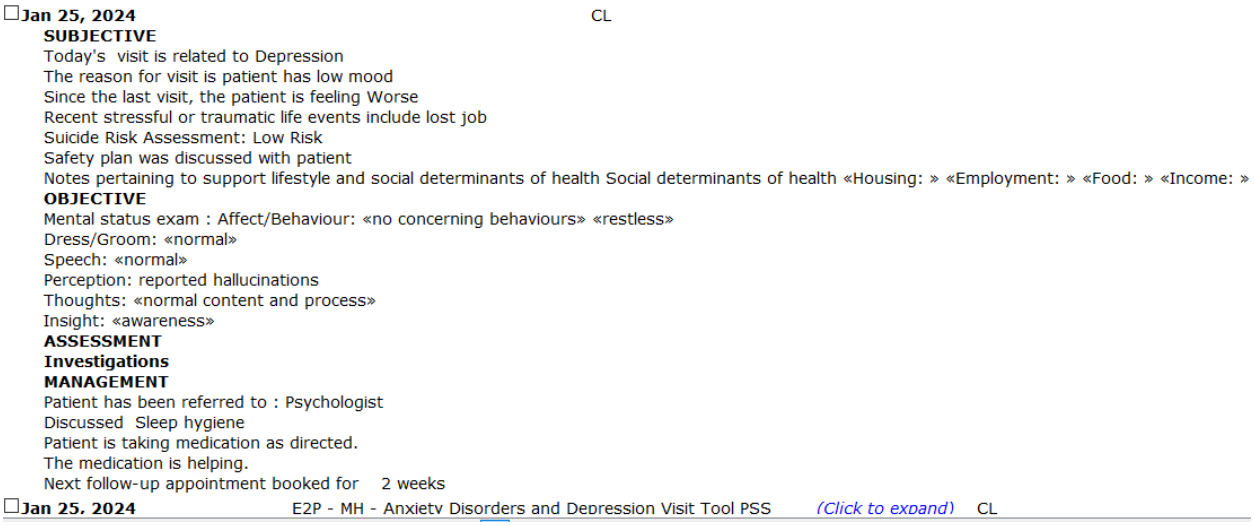


Referrals and Follow-up

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



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.



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.

green

Shown in : 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.

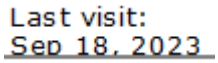
It is important to note that a diagnosis status is different than a diagnosis. The diagnosis status reflects that spirometry has been considered to confirm a diagnosis. The "update diagnosis" form allows users to input spirometry results in a way that the tool can use and be used for quality improvement initiatives (i.e., searches.)

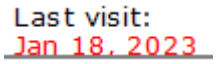
Shown in red: If the diagnosis status is never done or screened, it will display the "last screened" date and direct the clinician to the "screening and diagnosis" window.

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

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

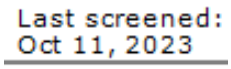


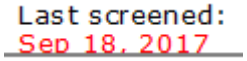


The frequency for visits is 12 months by default but can be edited based on the patient's individual needs and/or the user's discretion.
The text will turn red if the patient is overdue for a visit.

The patient does not have a COPD diagnosis on their Problem list

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

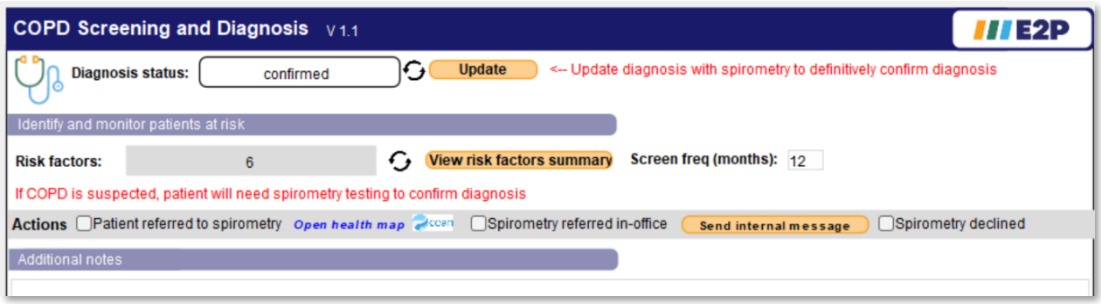




The frequency for screening is 12 months by default but can be edited based on the patient's individual needs and/or the user's discretion.
The text will turn red after 12 months to remind the user to book their patient in for a visit.

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.

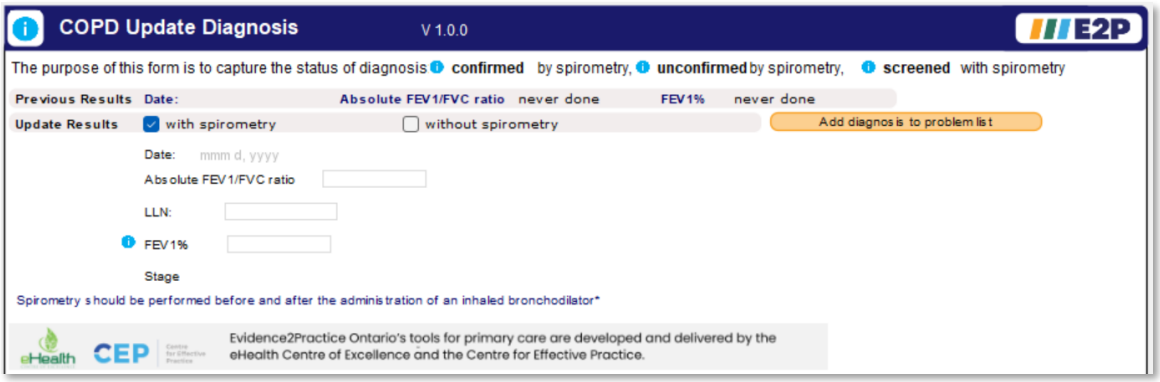


Screening and diagnosis form has three main functions:

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.

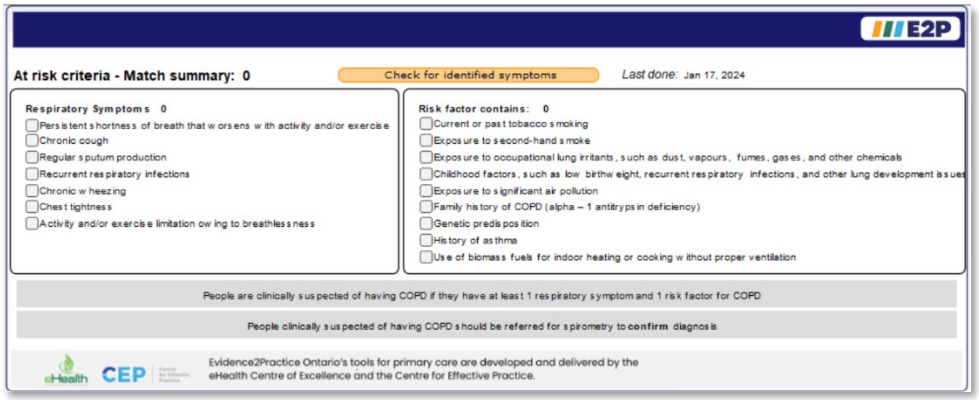


Reviewing risk factors

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.



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.

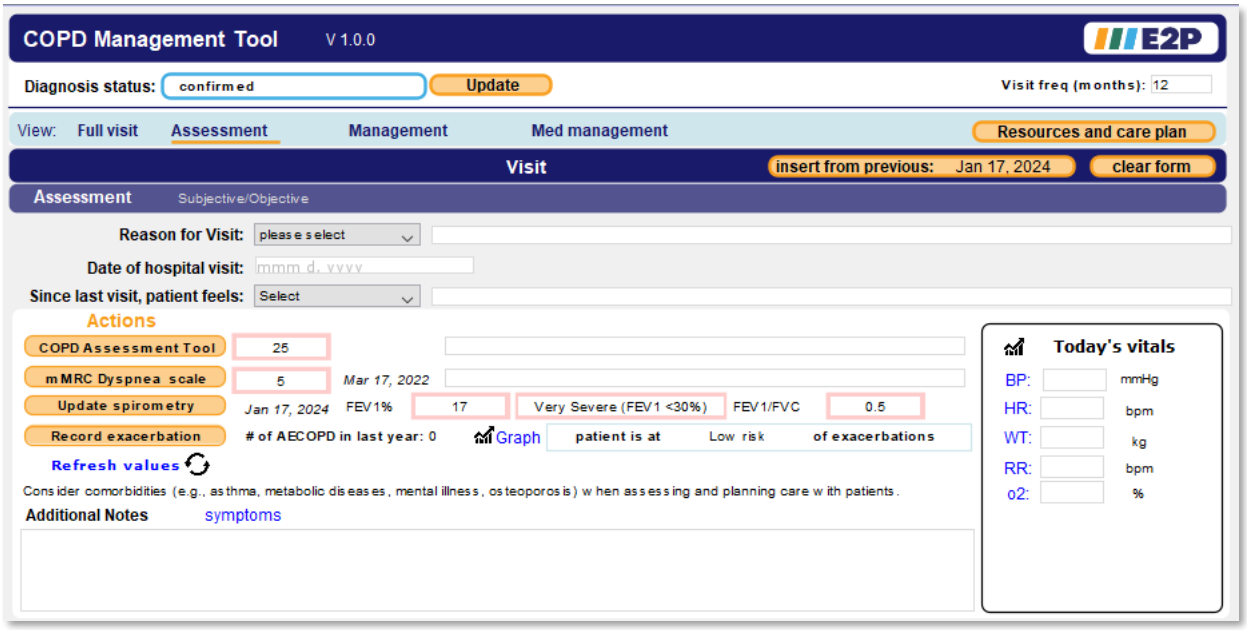
Assessment Module

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

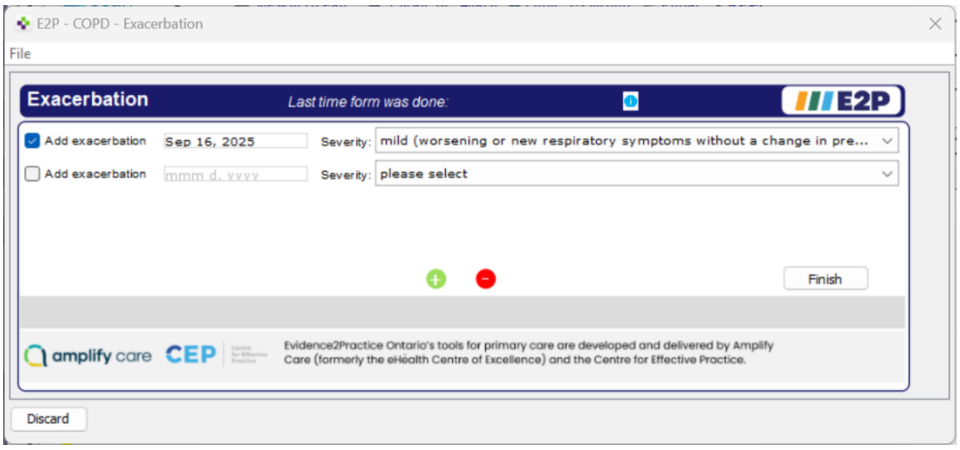
Additionally, the tool supports capturing a history of acute exacerbations (timing, frequency, severity) and uses an algorithm in the background to measure the risk of future exacerbations. These elements combined with the spirometry results help to build a bigger picture to support the user in recommending a pharmacologic pathway for the patient.



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.

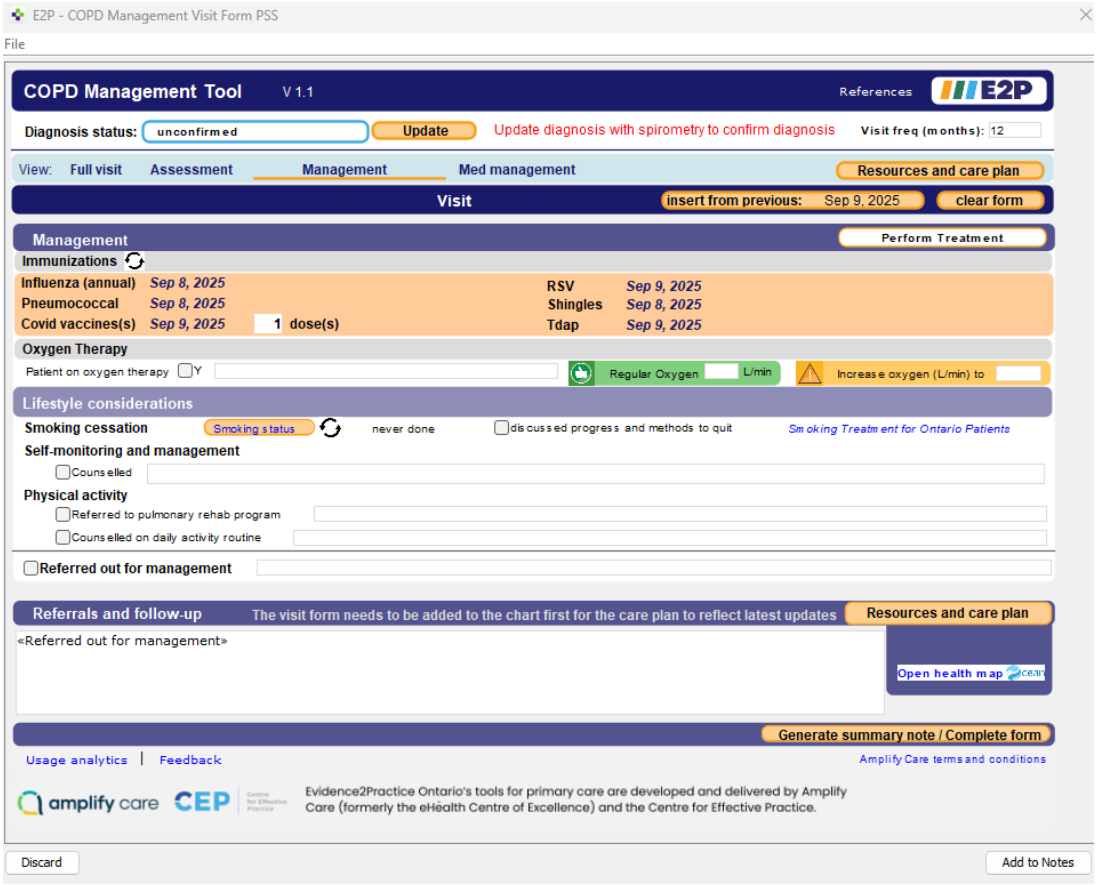


Management Module

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.

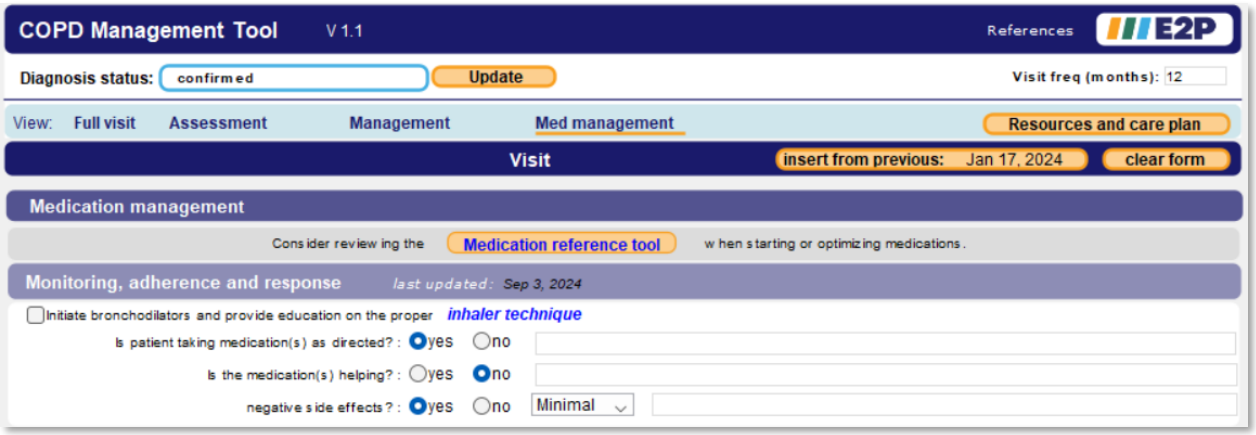
These sections also get included in the generate note feature that triggers once the visit has been completed and will quickly capture all your documentation into a concisely summarized visit note and copy it to the patient's chart.



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

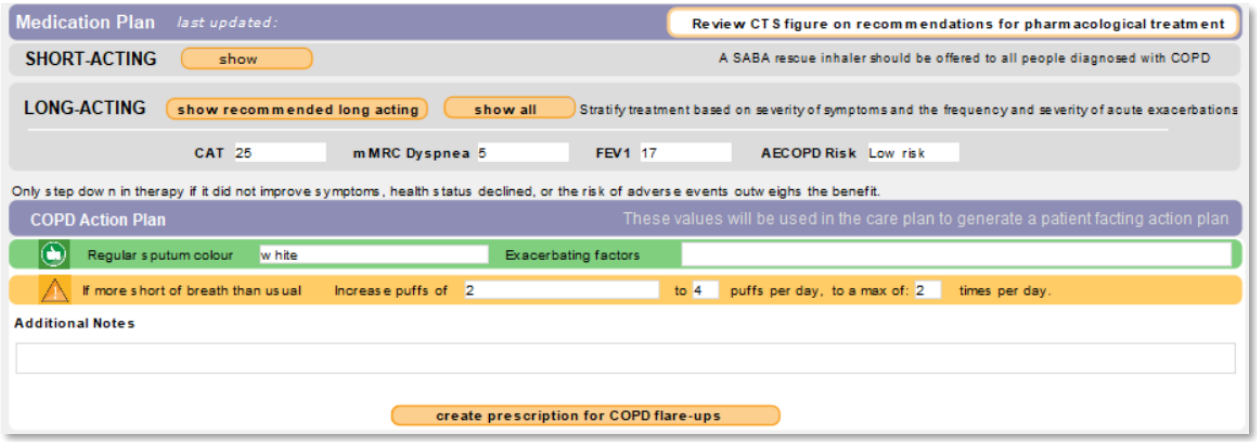
Users have the option to allow the tool to categorize the patient's COPD burden of disease using an algorithm adapted from the CTS guidelines factoring in the patient's more pressing factor, the tool will generate a recommended path for pharmacologic treatment. Once the scores have all been populated, 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.

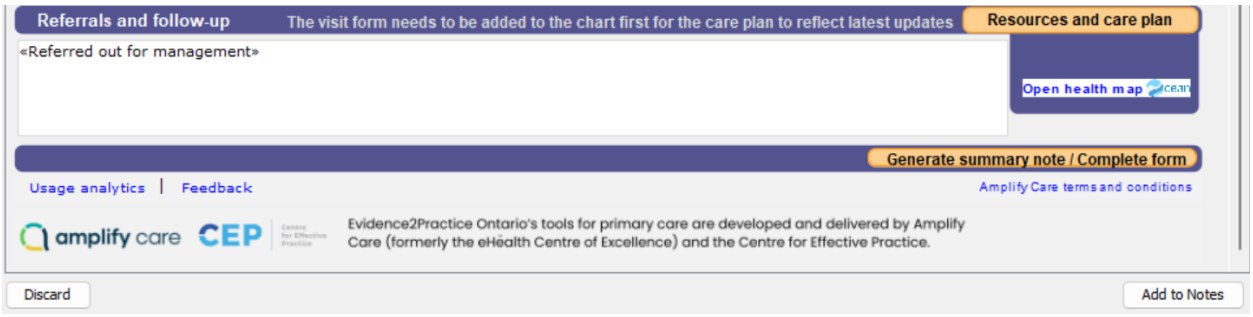
Using the checkboxes alongside the treatment path (i.e. LAMA or LABA) will update the date the medication plan was last updated.

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.



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.



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.