

EMR Chronic Disease Management (CDM)

Requirements

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1 INTRODUCTION

1.1 Overview

This specification is part of a suite of provincial specifications that define functional and non-functional requirements for jurisdictionally certified EMR Offerings. Each specification focuses on a particular component, functionality or interoperability and will be updated over time as new requirements and/or enhancements are introduced.

This specification is intended to inform EMR vendors of the minimum requirements for incorporating Chronic Disease Management (CDM) functionality into their EMR Offerings for the following six chronic diseases:

- Diabetes
- Asthma
- Heart Failure
- Chronic Obstructive Pulmonary Disease (COPD)
- Hypertension
- Smoking Cessation

It is not the intent of this specification to define best practices in patient care, but rather to establish a minimum set of requirements based on clinical guidelines published by organizations representing a particular chronic disease (e.g., Canadian Diabetes Association in the case of diabetes).

This specification defines:

- Requirements to support the implementation and management of chronic disease flowsheets
- Requirements to support out-of-box views and ad-hoc reporting
- The minimum out-of-box care elements to be tracked for each chronic disease
- Care elements that include:
 - Definition of the care element
 - Default treatment target
 - Default treatment requirements
 - Default unit of measure

1.2 Version History

Historical Specification versions can be found in the EMR Specification Library: [Historical EMR Specifications](#)

VERSION	REVISION DATE	REVISION NOTES
1.2	2026-09-22	a) Introduced a new requirement, CDM01.06, to incorporate Smoking Cessation; subsequent requirement numbering has been updated accordingly. b) Added 3.7 section in Care Elements for Smoking Cessation c) Added the table of sources referred in the “Related Documents and References” section d) Added Influenza and pneumonia vaccine related data elements to Heart Failure-Clinical Documentation. e) Added two data elements HF-Advance care planning and Date-HF Advance care planning to Heart Failure. f) Added two data elements COPD-Advance care planning and Date-COPD Advance care planning to COPD.

1.3 Related Documents and References

This specification includes concepts from various Ontario Ministry of Health (MOH) incentive programs, such as Diabetes Management Incentive and the Heart Failure Management Incentive. The most current information related to these programs is provided by the Ontario Ministry of Health Family Practice Compensation Models.

The following table lists all documents related to or referenced in this specification.

DOCUMENT NAME/INCENTIVE PROGRAM/COMPENSATION MODELS	VERSION	PUBLICATION DATE
Schedule of Benefits: OHIP Schedule of Benefits and fees ontario.ca	N/A	April 1, 2025
BC CDM Physician Toolkit: diabetescare associated document 2021.pdf	N/A	N/A
CPG Guidelines: Diabetes Canada Clinical Practice Guidelines Screening: Diabetes Canada Clinical Practice Guidelines	N/A	N/A
Lung Health Foundation - Provider Toolkit: https://hcp.lunghealth.ca/clinical-tools/	N/A	N/A
Asthma Care Map: ACM 2018 Final Care Map- Sept29-20	N/A	September 15, 2020
Canadian Thoracic Society: https://cts-sct.ca/guideline-library/knowledge-tools-resources/asthma/	N/A	N/A
Ontario Health Quality Standards: https://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/View-all-Quality-Standards/Chronic-Obstructive-Pulmonary-Disease	N/A	June 24, 2026
Diabetes CareFlow Sheet diabetescare associated document 2021.pdf	N/A	N/A
Hypertension Canada: https://hypertension.ca/guidelines/	N/A	N/A
BC Guidelines - Hypertension Diagnosis & Management: https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/hypertension	N/A	June 21, 2024
Ontario Health Hypertension Quality Standard: Clinical and Quality Standards Ontario Health	N/A	June 24, 2024

DOCUMENT NAME/INCENTIVE PROGRAM/ COMPENSATION MODELS	VERSION	PUBLICATION DATE
CAMH / CAN-ADAPTT Clinical Summary: https://intrepidlab.ca/en/canadaptt	N/A	N/A
Canadian Task Force - Tobacco Smoking in Adults: https://canadiantaskforce.ca/tobacco-smoking-in-adults-clinician-summary/	N/A	March 31, 2026
Ontario Health - Smoking Cessation Quality Standard: https://www.ontariohealth.ca/clinical/quality-standards.html	N/A	N/A
Health Canada / PHAC - Smoke-Free Connect Hub: https://www.canada.ca/en/health-canada/services/smoking-tobacco/quit-smoking.html	N/A	N/A
STOP Program: https://www.nicotinedependenceclinic.com/en/stop	N/A	N/A
CAMH tools (Decisional Balance Sheet, Fagerstrom Test, Smoking Diary): Smoking Cessation: Tools & Resources CAMH	N/A	N/A
Historical EMR Specifications https://www.ontariomd.ca/emr-certification/library/historical-archived	Various	Various

2 FUNCTIONAL REQUIREMENTS

This specification defines requirements to be implemented into the EMR Offerings to support the management of the chronic diseases that are in scope for this specification.

For the purposes of this section, the following terms and abbreviations are defined and shall be applied to all tables in this section:

Support:

M = Mandatory. EMR Offerings certified for this specification **MUST** support this requirement

O = Optional. EMR vendors **MAY** choose to support this requirement in their certified EMR Offering

Status:

N = New requirement for this EMR Specification

P = Previous requirement from the EMR-CDM Specification

U = Updated requirement from the previous EMR-CDM Specification

R = Retired from the previous EMR-CDM Specification

OMD #:

A unique identifier that identifies each requirement within OntarioMD's EMR Specifications Library

CONFORMANCE LANGUAGE

The following definitions of the conformance verbs are used in this document:

- **SHALL/MUST:** Required/Mandatory
- **SHOULD:** Best Practice/Recommendation
- **MAY:** Acceptable/Permitted

The tables that follow contain column headings named: 1) “Requirements,” which generally contains a high-level requirement statement; and 2) “Guidelines”, which contains additional instructions or detail about the high-level requirement. The text in both columns is considered requirement statements.

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
CDM01.01	The EMR Offering MUST provide the ability to capture dated entries for Diabetes care elements, as described in section 3.2 Diabetes – Care Elements.	At a minimum, each care element MUST be defined by the following attributes: a) Name of the care element b) Date of recording/collecting the care element value c) Value of the care element	M	P
CDM01.02	The EMR Offering MUST provide the ability to capture dated entries for Asthma care elements, as described in section 3.3 Asthma- Care Elements.	At a minimum, each care element MUST be defined by the following attributes: a) Name of the care element b) Date of recording/collecting the care element value c) Value of the care element	M	P
CDM01.03	The EMR Offering MUST provide the ability to capture dated entries for Heart Failure care elements, as described in section 3.4 Heart Failure - Care Elements.	At a minimum, each care element MUST be defined by the following attributes: a) Name of the care element b) Date of recording/collecting the care element value c) Value of the care element	M	P
CDM01.04	The EMR Offering MUST provide the ability to capture dated entries for COPD care elements, as described in section 3.5 COPD – Care Elements.	At a minimum, each care element MUST be defined by the following attributes: a) Name of the care element b) Date of recording/collecting the care element value c) Value of the care element	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
CDM01.05	The EMR Offering MUST provide the ability to capture dated entries for Hypertension care elements, as described in section 3.6 Hypertension - Care Elements.	At a minimum, each care element MUST be defined by the following attributes: a) Name of the care element b) Date of recording/collecting the care element value c) Value of the care element	M	P
CDM01.06	The EMR Offering MUST provide the ability to capture dated entries for Smoking Cessation, as described in section 3.7 Smoking Cessation- Care Elements	At a minimum, each care element MUST be defined by the following attributes: a) Name of the care element b) Date of recording/collecting the care element value c) Value of the care element	M	N
CDM01.07	The EMR Offering MUST provide the initial out-of-the-box chronic disease flowsheets including the initial set up for the treatment target and treatment intervals as described in section 3 CARE ELEMENTS.	The initial out-of-box flowsheet MUST include: a) The name of the care element b) The date associated with the care element c) The value associated with the care element The flowsheets MUST: a) Allow tracking of the dated care elements over time b) Allow the selection of a date range for which dated care elements to be displayed c) Must be printable	M	P
CDM01.08	The EMR Offering MUST allow the construction of custom-defined chronic disease flowsheets at the clinic level.	All characteristics of the “initial out-of-box chronic disease flowsheets” apply to the “custom CDM flowsheets”. At a minimum, the EMR user MUST be able to add and/or remove: a) Care elements (refer to section 3- CDM Care Elements)	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
		b) Lab Results (e.g., urine tests, O2 saturation) downloaded or manually entered in the EMR c) Medications (name and dosage) The custom-defined flowsheet MUST be available for further re-use.		
CDM01.09	The EMR Offering MUST allow the construction of custom-defined chronic disease flowsheets at the physician level.	All characteristics of the “initial out-of-box chronic disease flowsheets” apply to the “custom CDM flowsheets”. At a minimum, the EMR user MUST be able to add and/or remove: Care elements (refer to section 3 - CDM Care Elements) Lab Results (e.g., urine tests, O2 saturation) downloaded or manually entered in the EMR Medications (name and dosage) The physician's setup takes precedence over the clinic's setup. The custom-defined flowsheet MUST be available for further re-use.	M	P
CDM01.10	The EMR Offering MUST allow the construction of custom-defined chronic disease flowsheets at the patient level.	All characteristics of the “initial out-of-box chronic disease flowsheets” apply to the “custom CDM flowsheets”. At a minimum, the EMR user MUST be able to add and/or remove: a) Care elements (refer to section 3 - CDM Care Elements) b) Lab Results (e.g., urine tests, O2 saturation) downloaded or manually entered in the EMR c) Medications (name and dosage) The patient's setup takes precedence over the physician's setup. The custom-defined flowsheet MUST be available for further re-use.	M	P
CDM01.11	The EMR Offering MUST provide a mechanism to modify the treatment	At a minimum, the treatment target MUST be customizable based on patient gender.	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
	targets and treatment intervals for each care element in the initial out-of-box chronic disease flowsheets.	In order for this requirement to be met this MUST be user-administered and does not require an EMR vendor to attend the process.		
CDM01.12	The EMR Offering MUST provide a functionality that enables EMR users to set up and modify treatment targets and treatment intervals for chronic disease care elements at the clinic level.	MUST apply to care elements in “custom-defined” chronic disease flowsheets. At the minimum, the treatment target MUST be customizable based on patient gender. In order for this requirement to be met, this MUST be user-administered and does not require an EMR vendor to attend the process.	M	P
CDM01.13	The EMR Offering MUST provide a functionality that enables EMR users to set up and modify the treatment targets and treatment intervals for chronic disease care elements at the clinician level.	MUST apply to care elements in “custom-defined” chronic disease flowsheets. At the minimum, the treatment target MUST be customizable based on patient gender. In order for this requirement to be met this MUST be user-administered and does not require an EMR vendor to attend the process. Custom settings at the clinician level take precedence over the clinic’s setup.	M	P
CDM01.14	The EMR Offering MUST provide a functionality that enables EMR users to set up and modify the treatment targets and treatment intervals for chronic disease care elements at the patient level.	MUST apply to care elements in “custom-defined” chronic disease flowsheets. At the minimum, the treatment target MUST be customizable based on patient gender. In order for this requirement to be met this MUST be user-administered and does not require an EMR vendor to attend the process. Custom settings on a patient-level take precedence over the clinician’s setup.	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
CDM01.15	The EMR Offering MUST provide visual alert(s) to the EMR users when a patient's recorded chronic disease care elements exceed or fall outside the treatment target or treatment interval.	MUST apply to care elements in the "initial out-of-box" and "custom-defined" chronic disease flowsheets. The alert(s) are based on the treatment targets and treatment intervals as set up for each of the care elements in the corresponding flowsheet. The visual alert(s) are integrated into the flowsheet and apply to all care elements over time. Requiring the EMR user to execute additional steps is not an acceptable solution. Following implementations are not an accepted solution: a) Pop-up alerts b) Creating a task	M	P
CDM01.16	The EMR Offering MUST provide the ability to associate co-morbid conditions from the patient's problem list with diagnoses of all chronic diseases.	Co-morbid conditions list MUST be viewable any time within the "initial out-of-box" and "custom-defined" chronic disease flowsheet view. Adding the co-morbid condition as a care element is not an acceptable solution.	O	P
CDM01.17	The EMR Offering MUST ensure that the data entered from any of the chronic disease flowsheets gets automatically populated to the "progress note" for the current encounter.	Requiring the EMR user to re-enter data will not meet the requirement.	M	P
CDM01.18	The EMR Offering MUST ensure that chronic disease care element information entered from EMR data fields automatically creates the	At a minimum applies to care elements recorded: a) In the SOAP / Progress Notes b) Lab results	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
	appropriate dated entry/entries in each chronic disease flowsheets where these care elements are tracked.	c) Vital signs (generic care elements) d) Medication (name and dosage) For information regarding the date associated with a specific care element refer to section 3 – CDM Care Elements.		
CDM01.19	The EMR Offering MUST provide the functionality to view all care elements and their dated entries for a selected chronic disease that are outside of: a) Treatment target b) Treatment interval	At a minimum, MUST support: a) Out of range treatment target view – display only those care elements and the values that are outside of treatment target b) Out of range treatment interval - displaying only those care elements and the values that are outside of treatment interval The functionality MUST be available from within the selected flowsheet. Requiring the user to navigate outside the flowsheet in order to access the functionality is not an acceptable solution.	M	P
CDM01.20	The EMR Offering MUST provide the functionality to view all care elements and their dated values for a selected chronic disease by a selected number of previous dated entries.	At a minimum, MUST support: a) Latest result view – display only the latest entry for all care elements in a selected flowsheet b) Last two results view - display only the last two results recorded for each of the care the elements in the selected flowsheet c) Last three results view - display only the last three results recorded for each of the care elements in the selected flowsheet The functionality MUST be available from within the selected flowsheet. Requiring the EMR user to navigate outside the flowsheet in order to access the functionality is not an acceptable solution. The EMR user MUST be able to print the “view”.	M	P
CDM01.21	The EMR Offering MUST provide the functionality to view and select care	At a minimum MUST support: a) Latest result view – display only the latest entry for selected care elements in the selected flowsheet	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
	elements and their dated entries for a selected chronic disease: a) By a selected number of previous dated entries b) Over a selected timespan	b) Last two results view - display only the last two results recorded for selected care elements in the selected flowsheet c) Last three results view - display only the last three results recorded for selected care elements in the selected flowsheet d) Timespan view - display the dated entries recorded for the selected care elements in the selected flowsheet for the selected timespan Timespan functionality MUST be available from within the selected flowsheet. Requiring the EMR user to navigate outside the flowsheet in order to access the functionality is not an acceptable solution. The EMR user MUST be able to print the “view”.		
CDM01.22	The EMR Offering MUST support the generation of ad hoc reports for chronic disease care elements and dated entries: a) Across the entire patient population contained within the EMR b) Across one or more cohorts	At a minimum, the EMR user MUST be able to: a) Select the date range for dated entries b) Select the reported fields (care elements) c) Allow for filtering based on Boolean logic At the minimum, the report MUST display: a) The name of the patient b) The name of the care element c) The value of the dated entry In order for this requirement to be met: a) Must be user-administered and does not require an EMR vendor to attend the process b) Able to search the entire EMR patient population without vendor intervention	M	P

OMD #	REQUIREMENT	GUIDELINES	M/O	STATUS
CDM01.23	The EMR Offering MUST provide chronic disease management flowsheets for Diabetes and Heart Failure as per the effective MOH incentive guidelines.	At a minimum, the Diabetes flowsheets MUST include: a) Lipids, cholesterol, HgbA1C, blood pressure, weight, and body mass index (BMI), and medication dosage b) Discussion and offer of preventive measures including vascular protection, influenza and pneumococcal vaccination c) Documentation of health promotion counselling and patient self-management support d) ACR (albumin to creatinine ratio) e) Discussion and offer of referral for a dilated eye examination f) Documentation regarding foot examination and neurological examination At a minimum, the Heart Failure flowsheets MUST include: a) Comprehensive physical examination b) Laboratory monitoring of Na+, K+, serum creatinine and eGFR c) Patient education for modifiable risk factor reduction and self-management d) Pharmacologic management for appropriate use of first-line, symptom relief and preventive medications Refer to MOH incentive guidelines.	M	P
CDM01.24s	The EMR Offering MUST provide a feature to manage the display of care elements in the chronic disease flowsheets.	At a minimum, the system MUST allow: a) Grouping of selected care elements under a custom created "category" b) Order the care elements within the "category"	O	P

3 CARE ELEMENTS

The tables below define the care elements to be captured by certified EMR Offerings related to each of the chronic diseases that are in scope for this specification. This is not a comprehensive list of all care elements to be tracked for a chronic disease, but an initial set up for EMR users to get started in tracking against a particular chronic disease. These tables are also not meant to define the display of the care elements within the EMR. Vendors are expected to leverage their existing user interfaces or workflows to best accommodate the capture of dated entries.

Where initial set up treatment target or initial set up treatment interval is indicated as N/A, this means there is no initial set up target or interval. However, EMR users are expected to have the ability to create their own targets or intervals, if desired. EMR Vendors are expected to leverage their existing user interface and system workflow in order to best provide this functionality to EMR users.

Every care element in this specification is mandatory.

For the purposes of this section, the following terms and abbreviations are defined and shall be applied to all tables in this section:

DE#	A unique identifier that identifies each discrete data element within the Ontario EMR Requirements Repository
CDM#	A unique identifier that identifies each care elements within this specification
Initial Set up - Treatment Target:	The default set up for the Treatment Target
Initial Set up - Treatment Interval:	The default set up for the Treatment Interval
Status:	N = New care element for this EMR Specification P = Previous care element from EMR-CDM Specification U = Updated care element from a previous EMR-CDM Specification R = Retired care element from previous EMR-CDM Specification
YEAR:	The year the care element became part of the Ontario EMR Requirements Repository
UM:	Unit of Measure
COPD:	Chronic Obstructive Pulmonary Disease
HT:	Hypertension

HF:	Heart Failure
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3.1 Terminology

Care Element means a discrete piece of information related to chronic disease. Care Elements are characterized by one or more of the following attributes:

- Care Element Name
- Care Element Value
 - numeric value (e.g., HbA1c=4%; BMI=16 kg/m²)
 - non-numeric value (e.g., Smoking Status [Yes/No]);
 - the care elements with non-numeric value are flagged by “[]” and
 - assumes that the patient has been asked and provided an answer regarding the status of a care element
 - no value (e.g., Diabetes Education, ECG); the care elements with no values can be translated to “YES” in the flowsheets to indicate that the service was provided
- Care Element Date:
 - the date the specimen has been collected for lab test results (e.g., HbA1c=4%)
 - the date the test has been performed for non-lab tests (e.g., ECG)
 - the Start Date for a medication
 - the date the immunization has been provided
 - the date a service has been performed by the physician that does not require the physician inquiring the patient (e.g., Diabetes Education)
 - the date a service has been performed by the physician that does require an answer to be provided by the patient (e.g., Smoking Status)
 - the date a service has been performed by the physician that does require the physician to execute certain procedures/measurements (e.g., BMI)
- Treatment Target
- Treatment Interval

Chronic disease care elements are not currently standardized, and vendors may implement as consistent with their product. A comparison of dated entries from different sources (e.g., from different labs) may require some logic that must be managed by the vendor.

Treatment Target refers to the recommended treatment goal associated with the care element based on evidence-based guidelines for chronic disease care elements. Differences in treatment targets may exist due to factors such as:

- type of chronic disease: BP (< 130/80 mmHg) in Diabetes versus BP (< 140/90 mmHg) in Hypertension
- gender: ACR test (male < 2.0 mg/mmol versus female < 2.8 mg/mmol)
- age

A treatment target can be defined by:

- a numeric value
 - HbA1c $\leq$ 7.0%; values that are greater than 7% are considered outside the treatment target
 - # Of Hypoglycemic Episodes = 0 (zero); values greater than 0 are considered outside the treatment target
 - BMI 18.5 - 24.9 kg/m²; values that are less than 18.5 or greater than 24.9 are considered outside the treatment target
- a non-numeric value
 - Self-Monitoring BG = YES; values that are “NO” are considered outside the treatment target

Treatment Interval refers to the recommended time interval for testing, monitoring, or recording a care element based on evidence-based guidelines for chronic disease care elements.

Differences in treatment intervals may exist due to factors such as different best practices for chronic diseases. For example, patients with diabetes have a blood pressure treatment interval of three months whereas patients with hypertension have an undefined blood pressure treatment interval.

CDM Flowsheet is a tri-dimensional representation (Care Element Name, Care Element Date, Care Element Value) of the selected care elements for a particular chronic disease.

3.2 Diabetes – Care Elements

Referenced Sources: MOH - Diabetes Management Incentive, CPG Guidelines, BC CDM Physician Toolkit.

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
LAB VALUES						
N/A	1	HBA1c	Records the value of the HBA1c test. UM: % Alternate Name: Glycosylated Hemoglobin	<= 7.0%	3 months	P
N/A	2	Date - HBA1c	The date the specimen was collected.			P
N/A	3	FPG	Records the value of the FPG test. UM: mmol/L Alternate Name: Fasting Plasma Glucose	4 - 7 mmol/L	3 months	P
N/A	4	Date - FPG	The date the specimen was collected.			P
N/A	5	2 hr PC BG	Records the value of the 2 hr PC BG test. UM: mmol/L	5 - 10 mmol/L	3 months	P
N/A	6	Date - 2 hr PC BG	The date the specimen was collected			P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
N/A	7	LDL-C	Records the value of the LDL-C test. UM: mmol/L	<= 2.0 mmol/L	Annual	P
N/A	8	Date - LDL-C	The date the specimen was collected.			P
N/A	9	HDL-C	Records the value of the HDL-C test. UM: mmol/L	N/A	Annual	P
N/A	10	Date - HDL-C	The date the specimen was collected.			P
N/A	11	TC: HDL-C Ratio	Records the value of the TC: HDL-C Ratio test. UM: mmol/L	< 4.0	Annual	P
N/A	12	Date - TC: HDL-C Ratio	The date the specimen was collected.			P
N/A	13	Triglycerides	Records the value of the Triglycerides test. UM: mmol/L	< 2.0 mmol/L	Annual	P
N/A	14	Date - Triglycerides	The date the specimen was collected.			P
N/A	15	ACR	Records the value of the ACR test. UM: mg/mmol	M: < 2.0 mg/mmol F: < 2.8 mg/mmol	Annual	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
			Alternate Name: Albumin to Creatinine Ratio			
N/A	16	Date - ACR	The date the specimen was collected.			P
N/A	17	eGFR	Records the value of the eGFR test. UM: ml/min/1.73m ²	N/A	Annual	P
N/A	18	Date - eGFR	The date the specimen was collected.			P
N/A	19	Urinary Microalbumin Screen	Records the value of the Urinary Microalbumin test. UM: mg/L	N/A	N/A	P
N/A	20	Date - Urinary Microalbumin Screen	The date the specimen was collected.			P
CLINICAL DOCUMENTATION						
N/A	21	Influenza Vaccine	Records whether the Influenza Vaccine was administered.	N/A	Annual	P
N/A	22	Date - Influenza Vaccine	Date the Influenza Vaccine was administered.			P
N/A	23	Pneumococcal Vaccine	Records whether the Pneumococcal Vaccine was administered.	N/A	N/A	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
N/A	24	Date - Pneumococcal Vaccine	Date the Influenza Vaccine was administered.			P
GENERIC CARE ELEMENTS						
DE16.001	25	Blood Pressure	The blood pressure as measured by the physician. Blood pressure is out of target if either systolic or diastolic BP is out of target. UM: mmHg	< 130/80 mmHg	3 months	P
DE16.002	26	Date - Blood Pressure	Date the blood pressure was measured by the physician.			P
DE16.005	27	Height	The height as measured by the physician. UM: cm	N/A	N/A	P
DE16.006	28	Date - Height	Date height was measured by the physician.			P
DE16.007	29	Weight	The weight as measured by the physician. UM: kg	N/A	N/A	P
DE16.008	30	Date - Weight	Date weight was measured by the physician.			P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
DE16.009	31	BMI	The Body Mass Index automatically calculated by the EMR system, based on the Height and Weight recorded by the physician. UM: kg/m ²	18.5 - 24.9 kg/m ²	3 months	P
DE16.010	32	Date - BMI	Date the BMI was recorded by the physician.			P
DE16.011	33	Waist Circumference	The waist circumference as measured by the physician.	M: <102 cm F: < 88 cm	3 months	P
DE16.012	34	Date - Waist Circumference	Date the waist circumference was measured by the physician.			P
DE16.013	35	Smoking Status (Yes/No)	Records whether the patient is currently smoking or not. Default values are not accepted. Smoking Status recorded in the Risk Factor must flow in all the flowsheet where the data element is used, based on the recorded date.	N/A	N/A	P
DE16.014	36	Date - Smoking Status	Date the "smoking status" was reported by the patient.			P
DE16.015	37	Smoking Packs/Day	The number of packs per day smoked as reported by the patient.	N/A	N/A	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
			It is assumed that 1 pack=20 cigarettes.			
DE16.016	38	Date - Smoking Packs/Day	Date the patient reported the number of packs/day is smoking.			P
DE16.019	39	Erectile Function (Normal/Abnormal)	Records whether the "Erectile Function" is normal or abnormal. Default values are not accepted.	N/A	Annual	P
DE16.020	40	Date - Erectile Function	Date the patient reported that the "Erectile Function" is normal or abnormal.			P
NON-GENERIC CARE ELEMENTS						
DE16.057	41	Self-Monitoring BG (Yes/No)	Records whether the patient was self- monitoring his/her blood glucose level or not. Default values are not accepted.	yes	3 months	P
DE16.058	42	Date - Self Monitoring BG	Date the "Self-Monitoring BG" was reported by the patient.			P
DE16.059	43	# Of Hypoglycaemic Episodes (since last assessed)	The number of hypoglycaemic episodes since last assessed as reported by the patient.	0	3 months	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
DE16.060	44	Date - # Of Hypoglycaemic Episodes	Date the patient reported the number of hypoglycaemic episodes.			P
DE16.061	45	Dilated Eye Exam	Records whether the patient was completed the "Dilated Eye Exam" test. Default values are not accepted. Alternative name: Retinal Exam	N/A	Annual	P
DE16.062	46	Date - Dilated Eye Exam	Date the "Dilated Eye Exam" was performed.			P
DE16.063	47	Foot Examination (Normal/Abnormal)	Records whether the result of the "Foot Examination" performed by the physician is normal or abnormal. Default values are not accepted.	N/A	Annual	P
DE16.064	48	Foot Examination [Indicate Findings]	Records the findings of the "Foot Examination".	N/A	Annual	P
DE16.065	49	Date - Foot Examination	Date the "Foot examination" was performed by the physician.			P
DE16.066	50	Neurological Examination (Normal/Abnormal): 10-g monofilament 128 Hz tuning fork D1	Records whether the result of the "Neurological Examination" performed by the physician is normal or abnormal. Default values are not accepted.	N/A	Annual	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
DE16.067	51	Neurological Examination - <i>[Indicate Findings]</i>	Records the findings of the "Neurological Examination."	N/A	Annual	P
DE16.068	52	Date - Neurological Examination	Date the "Neurological Examination" was performed by the physician.			P
DE16.069	53	Fasting Glucose Monitor / Lab Result Comparison (<i>Calibrated Yes/No</i>).	Records whether patient reported that the "Fasting Glucose Monitor / Lab Result" is calibrated or not (Yes - is calibrated, NO - is not calibrated). Default values are not accepted.	N/A	Annual	P
DE16.070	54	Date - Fasting Glucose Monitor / Lab Result Comparison	Date the patient reported that the "Fasting Glucose Monitor / Lab Result" is calibrated or not.			P
DE16.071	55	ASA Use	Records whether the physician has recommended ASA use (ASA 81mg daily use).	N/A	N/A	P
DE16.072	56	Date - ASA Use	Date the "ASA Use" was recommended by the physician.			P
DE16.073	57	ECG	Records whether the ECG test was performed. Alternate Name: Electrocardiogram	N/A	Biennial	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
DE16.074	58	Date - ECG	Date the ECG test was performed.			P
DE16.075	59	Diabetes - Motivational Counselling Completed - Smoking Cessation - Nutrition - Exercise - Other	Records whether the “Diabetes- Motivational Counselling” was completed by the physician. Each item must be independently identifiable.	N/A	3 months	P
DE16.076	60	Date - Diabetes Motivational Counselling	Date the “Diabetes Motivational Counselling” was completed by the physician.			P
DE16.077	61	Diabetes – Education - Diabetes - Nutrition (lipids) - Nutrition (diabetes)	Records whether the “Diabetes- Education” was completed by the physician. Default values are not accepted.	N/A	Annual	P
DE16.078	62	Date - Diabetes Education	Date the “Diabetes Education” was completed by the physician.			P
DE16.079	63	Diabetes - Collaborative Self-Management Goals <i>[Indicate Goal]</i>	Records patient goals as recorded by the physician.	N/A	3 months	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
DE16.080	64	Date - Diabetes Collaborative Self-Management Goals	Date the “Diabetes - Collaborative Self-Management Goals” was recorded by the physician.			P
DE16.081	65	Diabetes - Self Management Challenges <i>[Indicate Challenge]</i>	Records patient challenges as recorded by the physician.	N/A	3 months	P
DE16.082	66	Date - Diabetes Self-Management Challenges	Date the “Diabetes - Self-Management Challenges” was recorded by the physician.			P
DE16.083	67	Psychosocial Screening	Records whether the “psychosocial screening” was performed by the physician.	N/A	N/A	P
DE16.084	68	Date - Psychosocial Screening	Date the “Psychosocial Screening” was performed by the physician.			P

3.3 Asthma- Care Elements

Referenced Sources included: Lung Association Asthma Care Map for Primary Care.

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
CLINICAL DOCUMENTATION						
GENERIC CARE ELEMENTS						
DE16.021	1	FEV1 (before puff) - (personal best of three)	Forced Expiratory Volume -the volume of air that was exhaled by the patient at the end of the first second of forced expiration.	N/A	N/A	P
DE16.022	2	Date - FEV1 (before puff)	Date the “FEV1 (before puff)” was measured.			P
DE16.023	3	FVC (before puff)	Forced Vital Capacity - the volume of air that was forcibly and maximally exhaled out by the patient until no more can be expired.	N/A	N/A	P
DE16.024	4	Date - FVC (before puff)	Date the “FVC (before puff)” was measured.			P
DE16.025	5	FEV1% (before puff)	The ratio of FEV1 to FVC calculated for the patient. Alternate Name: FEV1 / FVC ratio	N/A	N/A	P
DE16.026	6	Date - FEV1% (before puff)	Date the “FEV1% (before puff)” was measured.			P
DE16.027	7	FEV1 predicted	The FEV1 calculated in the population with similar characteristics (e.g., height, age, sex, race, weight, etc.)	N/A	N/A	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
DE16.028	8	Date - FEV1 predicted	Date the “FEV1” predicted was measured.			P
DE16.029	9	FVC predicted	Forced Vital Capacity predicted - calculated in the population with similar characteristics (height, age, sex, and sometimes race and weight).	N/A	N/A	P
DE16.030	10	Date - FVC predicted (before puff)	Date the “FVC” predicted was measured.			P
DE16.031	11	FEV1% predicted	The ratio of FEV1 predicted to FVC predicted, calculated in the population with similar characteristics (height, age, sex, and sometimes race and weight). Alternate Name: FEV1 / FVC predicted ratio	N/A	N/A	P
DE16.032	12	Date - FEV1% predicted	Date the “FEV1% predicted” was measured.			P
DE16.033	13	FEV1% of predicted (before puff)	FEV1% (before puff) of the patient divided by the average FEV1% predicted in the population with similar characteristics (e.g., height, age, sex, race, weight, etc.) Alternate Name: FEV1 ratio (before puff)	N/A	N/A	P
DE16.034	14	Date - FEV1% of predicted (before puff)	Date the “FEV1% of predicted (before puff)” was measured.			P
DE16.035	15	FVC ratio (before puff)	FVC actual (before puff) / FVC predicted.	N/A	N/A	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
DE16.036	16	Date - FVC ratio (before puff)	Date the “FVC ratio (before puff)” was measured.			P
DE16.037	17	FEV1 / FVC ratio (before puff)	FEV1 / FVC (before puff) actual divided by FEV1 / FVC predicted	N/A	N/A	P
DE16.038	18	Date - FEV1/FVC ratio (before puff)	Date the “FEV1/FVC ratio (before puff)” was measured.			P
DE16.041	19	FEV1 (after puff) - (personal best of three)	Forced Expiratory Volume - the volume of air that was exhaled by the patient at the end of the first second of forced expiration.	N/A	N/A	P
DE16.042	20	Date - FEV1 (after puff)	Date the “FEV1 (after puff)” was measured.			P
DE16.043	21	FVC (after puff)	Forced Vital Capacity - the volume of air that was forcibly and maximally exhaled out by the patient until no more can be expired.	N/A	N/A	P
DE16.044	22	Date - FVC (after puff)	Date the “FVC (after puff)” was measured.			P
DE16.045	23	FEV1% (after puff)	The ratio of FEV1 to FVC calculated for the patient. Alternate Name: FEV1 / FVC ratio	N/A	N/A	P
DE16.046	24	Date - FEV1% (after puff)	Date the “FEV1% (after puff)” was measured.			P
DE16.047	25	FEV1% of predicted (after puff)	FEV1% (after puff) of the patient divided by the average FEV1% predicted in the	N/A	N/A	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
			population with similar characteristics (e.g., height, age, sex, race, weight, etc.) Alternate Name: FEV1 ratio (after puff)			
DE16.048	26	Date - FEV1% of predicted (after puff)	Date the “FEV1% of predicted (after puff)” was measured.			P
DE16.049	27	FVC ratio (after puff)	FVC actual (after puff) / FVC predicted	N/A	N/A	P
DE16.050	28	Date - FVC ratio (after puff)	Date the “FVC ratio (after puff)” was measured.			P
DE16.051	29	FEV1 / FVC ratio (after puff)	FEV1 / FVC (after puff) actual divided by FEV1 / FVC predicted.	N/A	N/A	P
DE16.052	30	Date - FEV1/FVC ratio (after puff)	Date the “FEV1/FVC ratio (after puff)” was measured.			P
NON-GENERIC CARE ELEMENTS						
DE16.085	31	Spirometry Test	Records whether the “Spirometry Test” was performed by the physician. Default values are not accepted.	N/A	N/A	P
DE16.086	32	Date - Spirometry Test	Date the “Spirometry Test” was performed by the physician.			P
DE16.087	33	Asthma - Symptoms [frequency/week]:	The number of each individual “Asthma Symptoms” per week as reported by the patient.	DY: < 4 days/wk CO: < 4 days/wk	N/A	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
		- Dyspnoea - Cough - Wheeze - Chest tightness - Nighttime symptoms	Each item must be independently identifiable and have its own “treatment target” and “treatment interval”. Displaying each item as a care element within the flowsheet is not an acceptable solution.	WH: < 4 days/wk CT: < 4 days/wk NTS: (0)		
DE16.088	34	Date -Asthma Symptoms	Date the “Asthma-Symptoms” have been recorded.			P
DE16.089	35	Asthma - # Of Exacerbations Requiring Clinical Evaluation (since the last assessment)	The number of exacerbations since the last assessment requiring clinical evaluations reported by the patient.	0	N/A	P
DE16.090	36	Date - Asthma # Of Exacerbations Requiring Clinical Evaluation	Date the “Asthma - # Of Exacerbations Requiring Clinical Evaluation” and was recorded by the physician.			P
DE16.091	37	Asthma - School/Work Absence (since the last assessment)	Records whether the patient missed school/work since the last assessment.	N/A	N/A	P
DE16.092	38	Asthma - # Of School/Work Absence (since the last assessment)	Records the number of times the patient reported as missing school/work due to asthma since the last assessment.	0	N/A	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
DE16.093	39	Date - Asthma # Of School/Work Absence	Date the “Asthma # Of School/Work Absence” was recorded by the physician.			P
DE16.094	40	Asthma - Limits Physical Activity (<i>Yes/No</i>)	Records whether asthma limits patient physical activity or not. Defaulted values are not accepted.	NO	N/A	P
DE16.095	41	Date - Asthma Limits Physical Activity	Date “Asthma Limits Physical Activity” was recorded by the physician.			P
DE16.096	42	Asthma - Reliever Use [<i>frequency/week</i>]	Records the number of times the asthma reliever was used per week as reported by the patient.	< 4 doses/week or < 2 times/week	N/A	P
DE16.097	43	Date - Asthma Reliever Use	Date the “Asthma Reliever Use” was recorded by the physician			P
DE16.098	44	Asthma - Action Plan (<i>Provided / Revised / Reviewed</i>)	Records whether the educational document was provided to the patient, revised or reviewed. Default values are not accepted.	N/A	N/A	P
DE16.099	45	Date - Asthma Action Plan	Date the “Asthma Action Plan” was provided, revised or reviewed.			P
DE16.100	46	Asthma - Medication Review	Records whether medication adherence for the Asthma purpose was discussed with the patient.	N/A	N/A	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
			Default values are not accepted.			
DE16.101	47	Date - Asthma Medication Review	Date the “Asthma Medication Review” was performed by the physician.	N/A	N/A	P
DE16.102	48	Asthma - Smoking Cessation Discussed	Records whether smoking cessation was discussed with the patient. Default values are not accepted.	YES	N/A	P
DE16.103	49	Date - Asthma Smoking Cessation Discussed	Date the “Asthma Smoking Cessation” was discussed with the patient.			P
DE16.104	50	Asthma - Optimal Device Technique Review	Records whether the optimal device technique was reviewed by the physician.	N/A	N/A	P
DE16.105	51	Date - Asthma Optimal Device Technique Review	Date the “Asthma Optimal Device Technique Review” was recorded by the physician.			P
DE16.106	52	Asthma - Education Referral	Records to whether the patient was referred to an asthma educator (e.g., respiratory therapist, nurse). Default values are not accepted.	N/A	N/A	P
DE16.107	53	Date - Asthma Education Referral	Date the patient was referred to an asthma educator.			P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
DE16.108	54	Asthma/COPD- Specialist Referral	Records whether the patient was referred to a “respirologist” or “allergist”. Default values are not accepted.	N/A	N/A	P
DE16.109	55	Date -Asthma/COPD-Specialist Referral	Date the patient was referred to the “respirologist”.			P
DE16.110	56	Asthma - Environmental Control	Records whether “Asthma - Environmental Control” was reviewed by the physician	N/A	N/A	P
DE16.111	57	Date - Asthma Environmental Control	Date the “Asthma - Environmental Control” was recorded by the physician.			P
DE16.112	58	Asthma - Coping Strategies	Records whether “Asthma - Coping Strategies” have been reviewed by the physician	N/A	N/A	P
DE16.113	59	Date - Asthma Coping Strategies	Date the “Asthma Coping Strategies” was recorded by the physician.			P
DE16.114	60	Asthma - Trigger Avoidance	Records whether “Asthma - Trigger Avoidance” was reviewed by the physician	N/A	N/A	P
DE16.115	61	Date - Asthma Trigger Avoidance	Date the “Asthma Trigger Avoidance” was recorded by the physician.			P
DE16.116	62	Asthma - Definition Review	Records whether the “Asthma Definition” was reviewed by the physician. Default values are not accepted.	N/A	N/A	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
DE16.117	63	Date - Asthma Definition Review	Date the "Asthma - # Of Definition Review" was recorded by the physician.			P

3.4 Heart Failure - Care Elements

Referenced Sources: MOH - Heart Failure Incentive

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
LAB VALUES						
N/A	1	eGFR	Records the value of the eGFR test. UM: ml/min/1.73m ²	Caution if < 60 mL/min	N/A	P
N/A	2	Date - eGFR	The date the specimen was collected.			P
N/A	3	Na+	Records the value of the Na+ test. UM: mmol/L Alternate Name: Serum Sodium	N/A	N/A	P
N/A	4	Date - Na+	The date the specimen was collected.			P
N/A	5	K+	Records the value of the K+ test. UM: mmol/L Alternate Name: Serum Potassium	N/A	N/A	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
N/A	6	Date - K+	The date the specimen was collected.			P
N/A	7	Serum Creatinine	Records the value of the Serum Creatine test. UM: umol/L	M: < 110 umol/L F: < 90 umol/L	N/A	P
N/A	8	Date - Serum Creatinine	The date the specimen was collected.			P
CLINICAL DOCUMENTATION						
N/A	9	Influenza Vaccine	Records whether the Influenza Vaccine was administered.	N/A	Annual	N
N/A	10	Date - Influenza Vaccine	Date the Influenza Vaccine was administered.			N
N/A	11	Pneumococcal Vaccine	Records whether the Pneumococcal Vaccine was administered.	N/A	N/A	N
N/A	12	Date - Pneumococcal Vaccine	Date the Influenza Vaccine was administered.			N
GENERIC CARE ELEMENTS						
DE16.001	13	Blood Pressure	The blood pressure as measured by the physician. Blood pressure is out of target if either systolic or diastolic BP is out of target. UM: mmHg	N/A	N/A	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
DE16.002	14	Date - Blood Pressure	Date the blood pressure was measured by the physician.			P
DE16.003	15	Heart Rate	The heart rate as measured by the physician. UM: bpm (beats per minute)	N/A	N/A	P
DE16.004	16	Date - Heart Rate	Date the heart rate was measured by the physician.			P
NON-GENERIC CARE ELEMENTS						
DE16.071	17	ASA Use	Records whether the physician has recommended ASA use (ASA 81mg daily use).	N/A	N/A	P
DE16.072	18	Date - ASA Use	Date the "ASA Use" was recommended by the physician.			P
DE16.118	19	NYHA Functional Capacity Classification: - Class I – no symptoms - Class II – symptoms with ordinary activity - Class III – symptoms with less than ordinary activity	The NYHA classification for the patient as recorded by the physician. Each item must be independently identifiable.	N/A	N/A	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
		Class IV – symptoms at rest				
DE16.119	20	Date - NYHA Functional Capacity	Date the “NYHA Functional Capacity” was measured/classified.			P
DE16.120	21	Pitting Edema (<i>Yes/No</i>)	Records whether the patient has pitting edema or not. Default values are not accepted.	N/A	N/A	p
DE16.121	22	Pitting Edema [<i>Indicate Location</i>]	Records pitting edema location.	N/A	N/A	P
DE16.122	23	Date - Pitting Edema	Date the patient was identified as having “pitting edema”.			P
DE16.123	24	Lung Crackles (<i>Yes/No</i>)	Records whether the patient has lung crackles or not. Default values are not accepted.	N/A	N/A	P
DE16.124	25	Lung Crackles [<i>Indicate Location</i>]	Records the location of the lung crackles.	N/A	N/A	P
DE16.125	26	Date - Lung Crackles	Date the patient was identified as having “lung crackles”.			P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
DE16.126	27	Wheezing (Yes/No)	Records whether the patient is wheezing or not. Default values are not accepted.	N/A	N/A	P
DE16.127	28	Wheezing [Indicate Location]	Records the location of wheezing.	N/A	N/A	P
DE16.128	29	Date - Wheezing	Date the patient was identified as "wheezing".			P
DE16.129	30	JVP Elevation (Yes/No)	Records whether the patient has jugular venous pressure elevated or not (yes - elevated, no- not elevated). Default values are not accepted.	N/A	N/A	P
DE16.130	31	Date - JVP Elevation	Date the "JVP" was measured.			P
DE16.131	32	HF - Symptoms (frequency/week): • Fatigue • Dizziness • Syncope • Dyspnea on Exertion • Dyspnea at Rest • Orthopnea • Paroxysmal Nocturnal Dyspnea	Records symptoms of the "Heart Failure" as reported by the patient. Each symptom must be independently identifiable.	N/A	N/A	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
DE16.132	33	Date - Heart Failure Symptoms	Date the “Heart Failure Symptoms” was recorded by the physician.			P
DE16.133	34	HF - # ER Visits (since last assessment)	Records the number of ER (Emergency Room) visits since the last assessment as reported by the patient.	0	N/A	P
DE16.134	35	Date - HF # ER Visits	Date the “HF # ER Visits” was recorded by the physician.			P
DE16.135	36	HF - Medication Review	Records whether medication adherence for Heart Failure purpose was discussed with the patient. Default values are not accepted.	N/A	N/A	P
DE16.136	38	HF - Signs of Pharmacological Intolerance <i>[Indicate Intolerance]</i>	Records medications intolerance as reported by the patient. Refers to intolerance for all medications prescribed for “Heart Failure” chronic disease management.	N/A	N/A	P
DE16.137	39	Date - HF Medication Review	Date the patient's medication adherence for HF was reviewed and the signs of pharmaceutical intolerance have been recorded.			P
DE16.138	40	HF - Target Modifiable Risk Factors: Hypertension	Records whether “Heart Failure - Target Modifiable Risk Factors” was reviewed by the physician.	N/A	N/A	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
		- Smoking - Diabetes - Overweight/Obesity - Hyperlipidemia	Each item must be independently identifiable. Default values are not accepted.			
DE16.139	41	Date - Heart Failure Target Modifiable Risk Factors	Date the “Heart Failure Target Modifiable Risk Factors” was recorded by the physician.			P
DE16.140	42	HF - Collaborative Self-Management Goals <i>[Indicate Goal]</i>	Records patient goals as recorded by the physician.	N/A	N/A	P
DE16.141	43	Date - HF Collaborative Self-Management Goals	Date the “Collaborative Self-Management Goals” was recorded by the physician.			P
DE16.142	44	HF - Self Management Challenge <i>[Indicate Challenge]</i>	Records patient challenges as recorded by the physician.	N/A	N/A	P
DE16.143	45	Date - HF Self-Management Challenge	Date the “HF Self-Management Challenge” was recorded by the physician.			P
DE16.144	46	HF Education - Medication Review - Salt/Fluid Balance - Daily Weight Monitoring - Exercise	Record whether “HF Education” was reviewed by the physician. Each item must be independently identifiable. Default values are not accepted.	N/A	N/A	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
DE16.145	47	Date - HF Education	Date the “HF Education” was recorded by the physician.			P
N/A	48	HF – Advance Care Planning	Record discussions with the patient and/or substitute decision-maker regarding: • Advance care planning, values, wishes, and goals of care • Palliative care needs and future healthcare preferences • Heart Failure progression and future care decisions Free-text box.	N/A	N/A	N
N/A	49	Date - HF Advance Care Planning	Date the “HF - Advance Care Planning” discussion was documented by the physician.			N

3.5 COPD – Care Elements

Referenced Sources: Ontario Health Quality Standards, BC CDM Toolkit

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
CLINICAL DOCUMENTATION						
N/A	1	Influenza Vaccine	Records whether the Influenza Vaccine was administered.	N/A	Annual	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
N/A	2	Date - Influenza Vaccine	Date the Influenza Vaccine was administered.			P
N/A	3	Pneumococcal Vaccine	Records whether the Pneumococcal Vaccine was administered.	N/A	N/A	P
N/A	4	Date - Pneumococcal Vaccine	Date the Influenza Vaccine was administered.			P
GENERIC CARE ELEMENTS						
DE16.009	5	BMI	The Body Mass Index automatically calculated by the EMR system, based on the Height and Weight recorded by the physician. UM: kg/m ²	=< 27 kg/m ²	N/A	P
DE16.010	6	Date - BMI	Date the BMI was recorded by the physician.			P
DE16.021	7	FEV1 (before puff) - (personal best of three)	Forced Expiratory Volume - the volume of air that was exhaled by the patient at the end of the first second of forced expiration.	N/A	N/A	P
DE16.022	8	Date - FEV1 (before puff)	Date the "FEV1 (before puff)" was measured.			P
DE16.023	9	FVC (before puff)	Forced Vital Capacity - the volume of air that was forcibly and maximally exhaled out by the patient until no more can be expired.	N/A	N/A	P
DE16.024	10	Date - FVC (before puff)	Date the "FVC (before puff)" was measured.			P
DE16.025	11	FEV1% (before puff)	The ratio of FEV1 to FVC calculated for the patient. Alternate Name: FEV1 / FVC ratio	N/A	N/A	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
DE16.026	12	Date - FEV1% (before puff)	Date the “FEV1% (before puff)” was measured.			P
DE16.027	13	FEV1 predicted	The FEV1 calculated in the population with similar characteristics (e.g., height, age, sex, race, weight, etc.)	N/A	N/A	P
DE16.028	14	Date - FEV1 predicted	Date the “FEV1” predicted was measured.			P
DE16.029	15	FVC predicted	Forced Vital Capacity predicted - calculated in the population with similar characteristics (height, age, sex, and sometimes race and weight).	N/A	N/A	P
DE16.030	16	Date - FVC predicted (before puff)	Date the “FVC” predicted was measured.			P
DE16.031	17	FEV1% predicted	The ratio of FEV1 predicted to FVC predicted, calculated in the population with similar characteristics (height, age, sex, and sometimes race and weight). Alternate Name: FEV1 / FVC predicted ratio	N/A	N/A	P
DE16.032	18	Date - FEV1% predicted	Date the “FEV1% predicted” was measured.			P
DE16.033	19	FEV1% of predicted (before puff)	FEV1% (before puff) of the patient divided by the average FEV1% predicted in the population with similar characteristics (e.g., height, age, sex, race, weight, etc.) Alternate Name: FEV1 ratio (before puff)	N/A	N/A	P
DE16.034	20	Date - FEV1% of predicted (before puff)	Date the “FEV1% of predicted (before puff)” was measured.			P
DE16.035	21	FVC ratio (before puff)	FVC actual (before puff) / FVC predicted	N/A	N/A	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
DE16.036	22	Date - FVC ratio (before puff)	Date the "FVC ratio (before puff)" was measured.			P
DE16.037	23	FEV1 / FVC ratio (before puff)	FEV1 / FVC (before puff) actual divided by FEV1 / FVC predicted	N/A	N/A	P
DE16.038	24	Date - FEV1/FVC ratio (before puff)	Date the "FEV1/FVC ratio (before puff)" was measured.			P
DE16.039	25	PEF personal (before puff) - (best of three)	Peak Expiratory Flow (or PEFR) - the maximal flow (or speed) achieved during the maximally forced expiration initiated at full inspiration.	N/A	N/A	P
DE16.040	26	Date - PEF personal (before puff)	Date the "PEF personal (before puff)" was measured.			P
DE16.041	27	FEV1 (after puff) - (personal best of three)	Forced Expiratory Volume -the volume of air that was exhaled by the patient at the end of the first second of forced expiration.	N/A	N/A	P
DE16.042	28	Date - FEV1 (after puff)	Date the "FEV1 (after puff)" was measured.			P
DE16.043	29	FVC (after puff)	Forced Vital Capacity - the volume of air that was forcibly and maximally exhaled out by the patient until no more can be expired.	N/A	N/A	P
DE16.044	30	Date - FVC (after puff)	Date the "FVC (after puff)" was measured.			P
DE16.045	31	FEV1% (after puff)	The ratio of FEV1 to FVC calculated for the patient. Alternate Name: FEV1 / FVC ratio	N/A	N/A	P
DE16.046	32	Date - FEV1% (after puff)	Date the "FEV1% (after puff)" was measured.			P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
DE16.047	33	FEV1% of predicted (after puff)	FEV1% (after puff) of the patient divided by the average FEV1% predicted in the population with similar characteristics (e.g., height, age, sex, race, weight, etc.) Alternate Name: FEV1 ratio (after puff)	N/A	N/A	P
DE16.048	34	Date - FEV1% of predicted (after puff)	Date the "FEV1% of predicted (after puff)" was measured.			P
DE16.049	35	FVC ratio (after puff)	FVC actual (after puff) / FVC predicted	N/A	N/A	P
DE16.050	36	Date - FVC ratio (after puff)	Date the "FVC ratio (after puff)" was measured.			P
DE16.051	37	FEV1 / FVC ratio (after puff)	FEV1 / FVC (after puff) actual divided by FEV1 / FVC predicted.	N/A	N/A	P
DE16.052	38	Date - FEV1/FVC ratio (after puff)	Date the "FEV1/FVC ratio (after puff)" was measured.			P
DE16.053	39	PEF personal (after puff) - (best of three)	Peak Expiratory Flow (or PEFr) - the maximal flow (or speed) achieved during the maximally forced expiration initiated at full inspiration.	N/A	N/A	P
DE16.054	40	Date - PEF personal (after puff)	Date the "PEF personal (after puff)" was measured.			P
DE16.055	41	O ₂ Saturation	Records the "O ₂ Saturation" as measured by the physician or received from the laboratory. UM: %	N/A	N/A	P
DE16.056	42	Date - O ₂ Saturation	Date the O ₂ Saturation was measured.			P
NON-GENERIC CARE ELEMENTS						

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
DE16.085	43	Spirometry Test	Records whether the “Spirometry Test” was performed by the physician. Default values are not accepted.	N/A	N/A	P
DE16.086	44	Date - Spirometry Test	Date the “Spirometry Test” was performed by the physician.			P
DE16.108	45	Asthma/COPD - Specialist Referral	Records whether the patient was referred to a “respirologist” or “allergist”. Default values are not accepted.	N/A	N/A	P
DE16.109	46	Date -Asthma/COPD-Specialist Referral	Date the patient was referred to the “respirologist”.			P
DE16.146	47	COPD Classification: - Mild: FEV1 >= 80% predicted; - Moderate:50% <= FEV1 < 80% predicted; - Severe:30% <= FEV1 < 50% predicted; - Very Severe: FEV1 < 30% predicted	The COPD classification based on the spirometry results (FEV1) before the puff was administered to the patient. Each item must be independently identifiable. Default values are not accepted.	N/A	N/A	P
DE16.147	48	Date - COPD Classification	Date the “COPD Classification” was recorded.			P
DE16.148	49	COPD - Date of Last Exacerbation	Records the date of the last COPD exacerbation as reported by the patient.	N/A	N/A	P
DE16.149	50	Date - COPD Last Exacerbation	Date the “COPD - Date of Last Exacerbation” was recorded by the physician.			P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
DE16.150	51	COPD - # of Exacerbations (since last assessment)	The number of exacerbations due to COPD since the last visit, as reported by the patient.	N/A	N/A	P
DE16.151	52	Date - # of Exacerbations	Date the "COPD - # of Exacerbations" was recorded by the physician.			P
DE16.152	53	COPD - Need for Supplemental O ₂ Review	Records whether the need for supplemental O ₂ was reviewed by the physician. Default values are not accepted.	N/A	Annual	P
DE16.153	54	Date - COPD Need for Supplemental O ₂ Review.	Date the "COPD Need for Supplemental O ₂ Review" was recorded by the physician.			P
DE16.154	55	COPD - Need for Nocturnal Ventilation Support - Review	Records whether the need for nocturnal ventilated support was reviewed by the physician. Default values are not accepted.	N/A	Annual	P
DE16.155	56	Date - COPD Need for Nocturnal Ventilated Support Review	Date the "COPD Need for Nocturnal Ventilated Support Review" was recorded by the physician.			P
DE16.156	57	ABG Test - Recommended (<i>Yes/Not Applicable</i>)	Records whether the "ABG Test" was recommended or is not applicable. Each item must be independently identifiable. Default values are not accepted. Alternate Name: Arterial Blood Gas	N/A	N/A	P
DE16.157	58	Date - ABG Test Recommended	Date the "ABG Test" was recommended or recorded as "not applicable"			P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
DE16.158	59	COPD - Medication Review	Records whether medication adherence for COPD purpose was discussed with the patient. Default values are not accepted.	N/A	6 months	P
DE16.159	60	Date - COPD Medication Review	Date the patient's medication adherence for COPD was reviewed by the physician.			P
DE16.160	61	Review pathophysiology, prognosis, treatment with the patient	Records whether the pathophysiology, prognosis, treatment was reviewed by the physician. Default values are not accepted.	N/A	6 months	P
DE16.161	62	Date - COPD Review pathophysiology	Date the "Review pathophysiology" was recorded by the physician.			P
DE16.162	63	COPD - Smoking Cessation Discussed	Records whether smoking cessation was discussed with the patient. Default values are not accepted.	N/A	N/A	P
DE16.163	64	Date - COPD Smoking Cessation Discussed	Date the "COPD Smoking Cessation" was discussed with the patient.			P
DE16.164	65	Smoking Cessation Program - Referral	Records whether the patient was referred to a "Smoking Cessation Program". Default values are not accepted.	N/A	N/A	P
DE16.165	66	Date - Smoking Cessation Program Referral	Date the patient was referred to a "smoking cessation program".			P
DE16.166	67	COPD - Pulmonary Rehabilitation Referral	Records whether the patient was referred to a "pulmonary rehabilitation program". Default values are not accepted.	N/A	N/A	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
DE16.167	68	Date - COPD Pulmonary Rehabilitation Referral	Date the patient was referred to the “respiratory therapist”.			P
DE16.168	69	COPD - Exacerbation Plan (<i>Provided / Revised / Reviewed</i>)	Records whether the exacerbation plan document was <i>provided</i> to the patient, <i>revised</i> or <i>reviewed</i> . Default values are not accepted.	N/A	6 months	P
DE16.169	70	Date - COPD Exacerbation Plan	Date the “COPD Exacerbation Plan” was provided, revised or reviewed.			P
DE16.170	71	COPD - Collaborative Self-Management Goals [<i>Indicate Goal</i>]	Records patient goals as recorded by the physician.	N/A	6 months	P
DE16.171	72	Date - COPD Collaborative Self-Management Goals	Date the “COPD Collaborative Self-Management Goals” was recorded by the physician.			P
DE16.172	73	COPD - Provide patient education materials	Records whether education materials for COPD have been provided to the patient. Default values are not accepted.	N/A	N/A	P
DE16.173	74	Date - COPD Provide patient education materials	Date the “COPD Provide patient education materials” was recorded by the physician.			P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
N/A	75	COPD – Advance Care Planning	Record discussions with the patient and/or substitute decision-maker regarding: • Advance care planning, values, wishes, and goals of care • Palliative care needs and future healthcare preferences • Heart Failure progression and future care decisions Free-text box.	N/A	N/A	N
N/A	76	Date – COPD Advance Care Planning	Date the “HF - Advance Care Planning” discussion was documented by the physician.			N

3.6 Hypertension - Care Elements

Referenced Sources: GAC Guidelines, BC CDM Toolkit, JNC 7, CHEP 2007

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
LAB VALUES						
N/A	1	FPG	Records the value of the FPG test. UM: mmol/L Alternate Name: Fasting Plasma Glucose	<= 6.0 mmol/L	N/A	P
N/A	2	Date - FPG	The date the specimen was collected.			P
N/A	3	LDL-C	Records the value of the LDL-C test. UM: mmol/L	< 3.5 mmol/L	N/A	P
N/A	4	Date - LDL-C	The date the specimen was collected.			P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
N/A	5	TC: HDL-C Ratio	Records the value of the TC: HDL-C Ratio test. UM: mmol/L	< 5.0	N/A	P
N/A	6	Date - TC: HDL-C Ratio	The date the specimen was collected.			P
N/A	7	Triglycerides	Records the value of the Triglycerides test. UM: mmol/L	N/A	N/A	P
N/A	8	Date - Triglycerides	The date the specimen was collected.			P
N/A	9	eGFR	Records the value of the eGFR test. UM: ml/min/1.73m ²	N/A	Annual	P
N/A	10	Date - eGFR	The date the specimen was collected.			P
N/A	11	Urinary Microalbumin Screen	Records the value of the Urinary Microalbumin test. UM: mg/L	Male < 2.0 Female < 2.8	Biennial	P
N/A	12	Date - Urinary Microalbumin Screen	The date the specimen was collected.			P
CLINICAL DOCUMENTATION						
GENERIC CARE ELEMENTS						
DE16.001	13	Blood Pressure	The blood pressure as measured by the physician. Blood pressure is out of target if either systolic or diastolic BP is out of target. UM: mmHg	=< 140/90 mmHg	N/A	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
DE16.002	14	Date - Blood Pressure	Date the blood pressure was measured by the physician.			P
DE16.005	15	Height	The height as measured by the physician. UM: cm	N/A	N/A	P
DE16.006	16	Date - Height	Date height was measured by the physician.			P
DE16.007	17	Weight	The weight as measured by the physician. UM: kg	N/A	N/A	P
DE16.008	18	Date - Weight	Date weight was measured by the physician.			P
DE16.009	19	BMI	The Body Mass Index automatically calculated by the EMR system, based on the Height and Weight recorded by the physician. UM: kg/m ²	18.5 - 24.9 kg/m ²	N/A	P
DE16.010	20	Date - BMI	Date the BMI was recorded by the physician.			P
DE16.011	21	Waist Circumference	The waist circumference as measured by the physician.	M: < 100 cm F: < 90 cm	N/A	P
DE16.012	22	Date - Waist Circumference	Date the waist circumference was measured by the physician.			P
DE16.013	23	Smoking Status (Yes/No)	Records whether the patient is currently smoking or not. Default values are not accepted. Smoking Status recorded in the Risk Factor must flow in all the flowsheet where the	N/A	N/A	P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
			data element is used, based on the recorded date.			
DE16.014	24	Date - Smoking Status	Date the “smoking status” was reported by the patient.			P
DE16.015	25	Smoking Packs/Day	The number of packs per day smoked as reported by the patient. It is assumed that 1 pack=20 cigarettes.	N/A	N/A	P
DE16.016	26	Date - Smoking Packs/Day	Date the patient reported the number of packs/day is smoking.			P
DE16.017	27	Alcohol Use (# drinks/week)	The number of drinks equivalents per week as reported by the patient.	M > 14 drinks/wk F > 8 drinks/wk	N/A	P
DE16.018	28	Date - Alcohol Use	Date the patient reported the number of drinks/week.			P
NON-GENERIC CARE ELEMENTS						
DE16.174	29	10 Year CAD Risk (Framingham)	The value of the “10 Year CAD Risk (Framingham)” as recorded by the physician. UM: %	N/A	N/A	P
DE16.175	30	Date - 0 Year CAD Risk (Framingham)	Date the “10 Year CAD Risk (Framingham)” was calculated/measured.			P
DE16.176	31	HT - Medication Review	Records whether medication adherence for Hypertension purpose was discussed with the patient. Default values are not accepted.	N/A	N/A	P
DE16.177	32	Date - HT Medication Review	Date the patient's medication adherence for HT was reviewed by the physician.			P

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
DE16.178	33	Hypertension - Exercise Reviewed	Records whether “Hypertension Exercise” was reviewed by the physician. Default values are not accepted.	N/A	N/A	P
DE16.179	34	Date - Hypertension Exercise Reviewed	Date the “Hypertension Exercise Review” was completed by the physician.			P
DE16.180	35	HT- Collaborative Self-Management Goals <i>[Indicate Goal]</i>	Records patient goals as recorded by the physician.	N/A	N/A	P
DE16.181	36	Date - HT Collaborative Self-Management Goals	Date the “HT Collaborative Self-Management Goals” was recorded by the physician.			P
DE16.182	37	HT – Self-Management Challenge <i>[Indicate Challenge]</i>	Records patient challenges as recorded by the physician.	N/A	N/A	P
DE16.183	38	Date - HT Self-Management Challenge	Date the “HT Self-Management Challenge” was recorded by the physician.			P
DE16.184	38	HY - Salt Intake Reviewed	Records whether the salt intake was reviewed by the physician.	N/A	N/A	P
DE16.185	40	Date - Salt Intake Reviewed	Date the “Salt Intake Reviewed” was recorded by the physician.			P

3.7 Smoking Cessation – Care Elements

Referenced sources:

Centre for Addiction and Mental Health

Canadian Action Network for the Advancement, Dissemination and Adoption of Practice-informed Tobacco Treatment

Ontario Health

Public Health Ontario

Government of Ontario

Public Health Agency of Canada

Canadian Task Force on Preventive Health Care

DE#	CDM#	CARE ELEMENT	DEFINITION	INITIAL SETUP TREATMENT TARGET	INITIAL SETUP TREATMENT INTERVAL	STATUS
CLINICAL DOCUMENTATION						
GENERIC CARE ELEMENTS						
DE16.013	1	Smoking status (Yes/No)	Records whether the patient is currently smoking or not. Current smoking status of the patient (e.g., current smoker, former smoker, never a smoker). Default values are not accepted. Smoking status recorded in the risk factor must flow in all the flowsheet where the data element is used, based on the recorded date.	N/A	1 MONTH	N

DE16.014	2	Date – smoking status	Date the smoking status was recorded.			N
N/A	3	Smoking product type	Type of tobacco or nicotine products currently used (e.g., cigarettes, cigars, vape).	N/A	N/A	N
N/A	4	Date – Smoking product type	Date the tobacco product type was recorded.			N
DE16.015	5	Smoking frequency	Average number of cigarettes or smoking/vaping episodes per day as reported by the patient.	>0	N/A	N
DE16.016	6	Date – smoking frequency	Date the smoking frequency was recorded.			N
N/A	7	First smoke/vape for the day	How many minutes after waking up do you first smoke/vape? ____ (number of minutes)	>0	N/A	N
N/A	8	Date– First smoke/vape for the day	Date the First smoke/vape for the day was recorded.			N
NON-GENERIC CARE ELEMENTS						
SMOKING BEHAVIOUR MONITORING						
N/A	9	Smoking diary completed	Records whether a Smoking Diary was completed by the patient since the last assessment. Conditional Yes/No with required free-text follow-up, patient statement.	N/A	N/A	N
N/A	10	Date – smoking diary	Date the “smoking diary” was completed or reviewed.			N

N/A	11	Smoking – daily cigarette pattern	Summary of smoking frequency pattern (e.g., clustered, evenly spaced). Free-text, patient reported.	N/A	N/A	N
N/A	12	Date – smoking daily pattern	Date the “smoking – daily cigarette pattern” was recorded.			N
N/A	13	Smoking – common triggers identified	Records whether common smoking triggers (e.g., stress, boredom, social situations) were identified. Default values are not accepted. Free-text, patient-reported.	N/A	N/A	N
N/A	14	Date – smoking triggers identified	Date the “Smoking – Common Triggers” were identified.			N
N/A	15	Smoking – craving severity	Average craving severity (scale 0–10).	≤ 3	N/A	N
N/A	16	Date – smoking craving severity	Date the “smoking – craving severity” was recorded.			N
N/A	17	Smoking – high-risk times of day	Times of day associated with strongest desire to smoke. Free-text box.	N/A	N/A	N
N/A	18	Date – smoking high-risk times	Date the “Smoking – High-Risk Times of Day” were recorded.			N
N/A	19	Smoking – Caffeine consumption reduction	Records whether the patient was reminded to reduce caffeine consumption by 50% on the quit date. Default values are not accepted. Free-text, provider-documented.	N/A	N/A	N

N/A	20	Date – Caffeine consumption reduction advised	Date the “Caffeine consumption reduction” was advised.			N
N/A	21	Smoking – Common relapse risks review	Records whether common risks for relapse (e.g., stress, alcohol use, exposure to other smokers) were reviewed. Default values are not accepted. Free-text, provider-documented.	N/A	N/A	N
N/A	22	Date – Common relapse risks reviewed	Date the “Common relapse risks” were reviewed.			N
N/A	23	Smoking – Strategies for managing cravings and withdrawal	Records whether strategies for managing nicotine cravings and withdrawal symptoms were recommended (e.g., behavioral strategies, distraction, or other coping techniques). Default values are not accepted. Free-text, provider-documented	N/A	N/A	N
N/A	24	Date – Strategies for managing cravings and withdrawal recommended	Date the “Strategies for managing cravings and withdrawal” were recommended.			N
N/A	25	Smoking – Short-term mood changes	Records whether the possibility of short-term changes in mood following smoking cessation was discussed with the patient. Default values are not accepted. Free-text, provider-documented.	N/A	N/A	N
N/A	26	Date – Short-term mood changes discussed	Date the “Short-term mood changes” were discussed.			N

N/A	27	Smoking – Nicotine Addiction Treatment booklet	Records whether the Nicotine Addiction Treatment booklet was provided to the patient as part of smoking cessation support. Default values are not accepted. Free-text, provider-documented.	N/A	N/A	N
N/A	28	Date – Nicotine Addiction Treatment booklet provided	Date the “Nicotine Addiction Treatment booklet” was provided.			N
N/A	29	Smoking – follow-up enrollment	Records whether the patient was enrolled in follow-up for smoking cessation support, when appropriate. Default values are not accepted. Free-text, provider-documented.	N/A	N/A	N
N/A	30	Date – follow-up enrolment recorded	Records whether the patient was enrolled in follow-up for smoking cessation support, when appropriate. Default values are not accepted. Free-text, provider-documented.			N
PROS AND CONS OF CONTINUING SMOKING						
N/A	31	Pros of continuing smoking	Patient-identified perceived benefits of continuing to smoke at the current level (e.g., stress relief, social reasons). Free-text, patient-reported.	N/A	N/A	N
N/A	32	Cons of continuing smoking	Patient-identified perceived negative effects of continuing to smoke (e.g., health concerns, cost, family impact). Free-text, patient-reported.	N/A	N/A	N
N/A	33	Date – continuing smoking pros/cons	Date the pros and cons of continuing smoking were documented.			N
PROS & CONS OF REDUCING OR STOPPING SMOKING						

N/A	34	Pros of reducing or stopping smoking	Patient-identified perceived benefits of reducing or stopping smoking (e.g., improved health, finances, energy). Free-text, patient-reported.	N/A	N/A	N
N/A	35	Cons of reducing or stopping smoking	Patient-identified perceived concerns or barriers related to reducing or stopping smoking (e.g., withdrawal, stress, weight gain). Free-text, patient-reported.	N/A	N/A	N
N/A	36	Date – reducing or stopping smoking pros/cons	Date the pros and cons of reducing or stopping smoking were documented.			N
MOTIVATION & READINESS (CAMH DECISIONAL BALANCE)						
N/A	37	Smoking cessation – decisional balance completed	Records whether a decisional balance exercise (pros/cons of continuing vs reducing or stopping smoking) was completed with the patient. Default values are not accepted. Conditional Yes/No with required free-text follow-up.	N/A	N/A	N
N/A	38	Date – smoking cessation decisional balance	Date the decisional balance exercise was completed.			N
CLINICAL ACTION AND FOLLOW-UP						

N/A	39	Smoking cessation – readiness to change	Records whether the patient’s readiness is assessed to quit or reduce smoking. Default values are not accepted. Conditional Yes/No response with a required follow-up selection. Yes – has quit within the last 6 months; Quit Date: MM/DD/YY Planning to quit/reduce today; or is planning to quit/reduce in the next month. No – is planning to quit/reduce in the next 6 months; or is not ready to quit/reduce in the next 6 months** **Patients selecting “No” option are not appropriate for follow-up support.	N/A	N/A	N
N/A	40	Date – smoking cessation readiness	Date the “readiness to change” was recorded.			N
E16.162	41	Smoking cessation – counseling provided	Records whether smoking cessation counseling was provided. Default values are not accepted. Conditional Yes/No with required free-text follow-up.	N/A	N/A	N
DE16.163	42	Date – smoking cessation counseling	Date the “smoking cessation counseling” was provided.			N
DE16.164	43	Smoking cessation – referral	Records whether the patient was referred to smoking cessation support services. Default values are not accepted. Conditional Yes/No with required free-text follow-up.	N/A	N/A	N
DE16.165	44	Date – smoking cessation referral	Date the “smoking cessation referral” was made.			N