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EHR Best Practices Guide: What we know and what we don't know

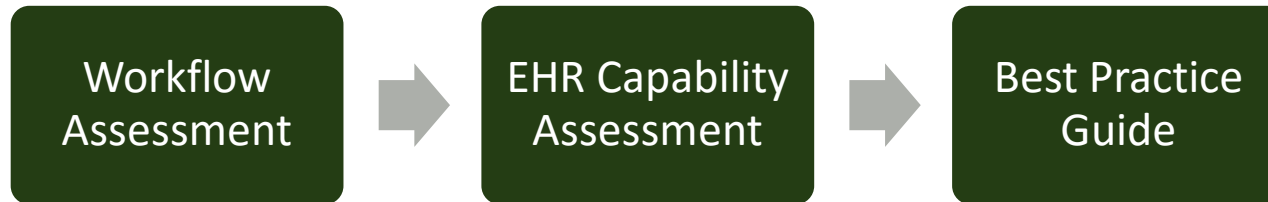
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Clinical Quality Improvement Coordinator

February 18, 2016



EHR Best Practice Workflow & Documentation Guide



- Key Features:

- Process flows for FIT/FOBT and Colonoscopy Screening and follow-up
- Documenting follow-up outreach for incomplete tests
- Notifying patients of test results
- Documenting family history



FIT/FOBT Workflow – Goals

- Track and measure:
 - ⇒ Cards distributed and returned
 - ⇒ Tests done for average risk CRC Screening
 - ⇒ Follow-up/communication with patients to return cards
 - ⇒ Follow-up/communication with patients on test results
- Associate Lab Order with ICD-10 code
- Ensure appropriate billing for test (if billing)
- Document Test Results
- Generate Referral for follow-up colonoscopy if test result is positive



FIT/FOBT Workflow - Challenges

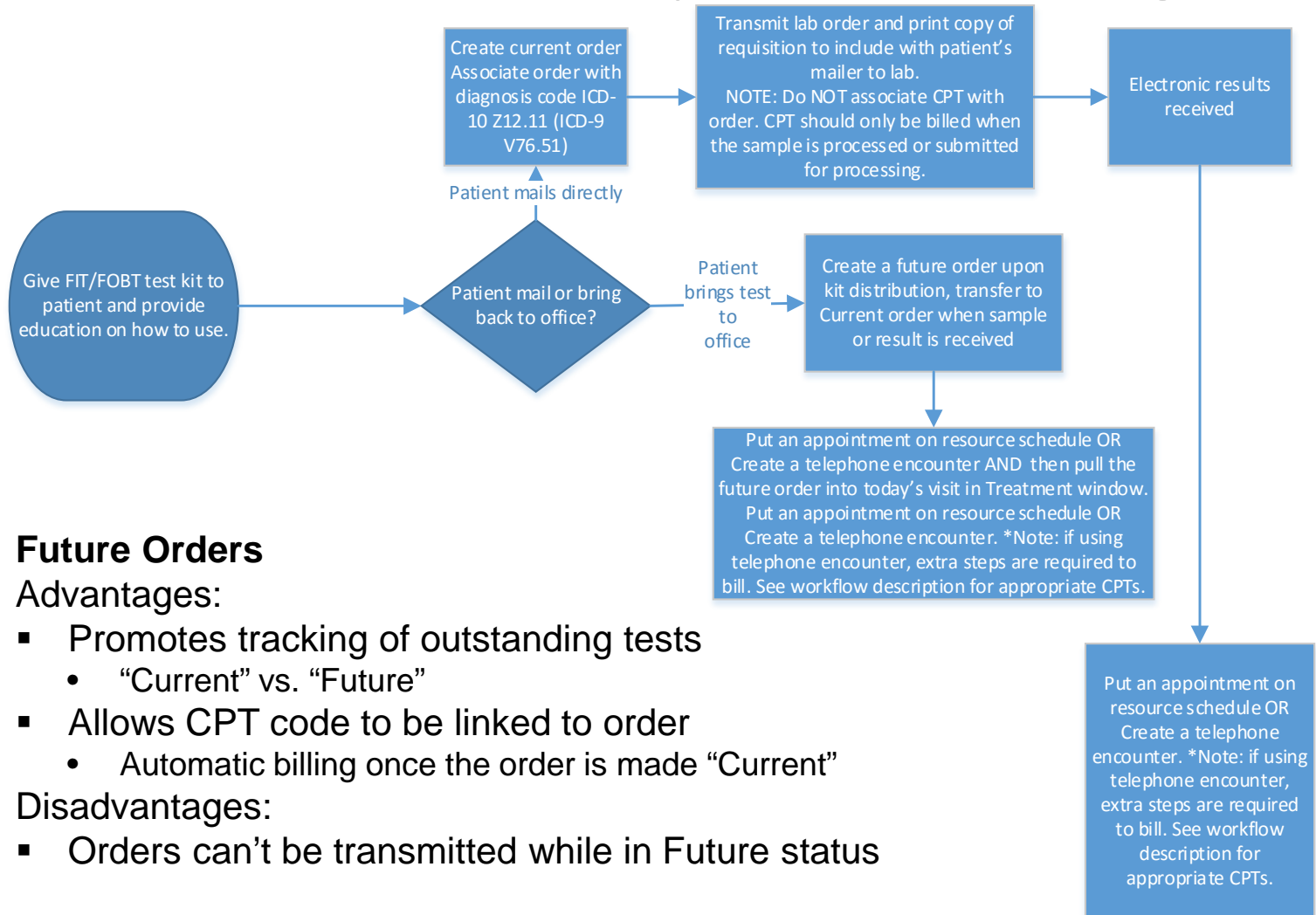
Billing in eCW (may vary in other EMRs)

Procedure codes (CPTs) can be tied to orders, users prompted upon order to include CPT.

- ⇒ No such prompt exists when entering results or indicating receipt of samples (necessary for FOBT/FIT). Some centers billing “accidentally” upon order due to CPT linkage, others not billing at all due to complexity.
- ⇒ Recommended Workflow offers options for current and future orders that address this issue.



FIT/FOBT Workflow – Options for Billing



Future Orders

Advantages:

- Promotes tracking of outstanding tests
 - “Current” vs. “Future”
- Allows CPT code to be linked to order
 - Automatic billing once the order is made “Current”

Disadvantages:

- Orders can't be transmitted while in Future status



Colonoscopy Workflow - Goals

- Track and measure:
 - ⇒ Tests done for average risk CRC Screening
 - ⇒ Tests done as follow-up to positive FOBT
 - ⇒ Tests done for high-risk patients
 - ⇒ Follow-up/communication with patients to make appointment with specialist
 - ⇒ Follow-up/communication with patients on test results
- Document Test Results
- Document Follow-up



Colonoscopy Workflow - Challenges

- **Reason for colonoscopy referrals**

- ⇒ Educate that for the centers' purpose, ICD-10 Code is a *reason* code, not a *billing diagnosis code* (GI is responsible for billing)
- ⇒ Workflow recommends associating referral with ICD code.

- **Date test was performed**

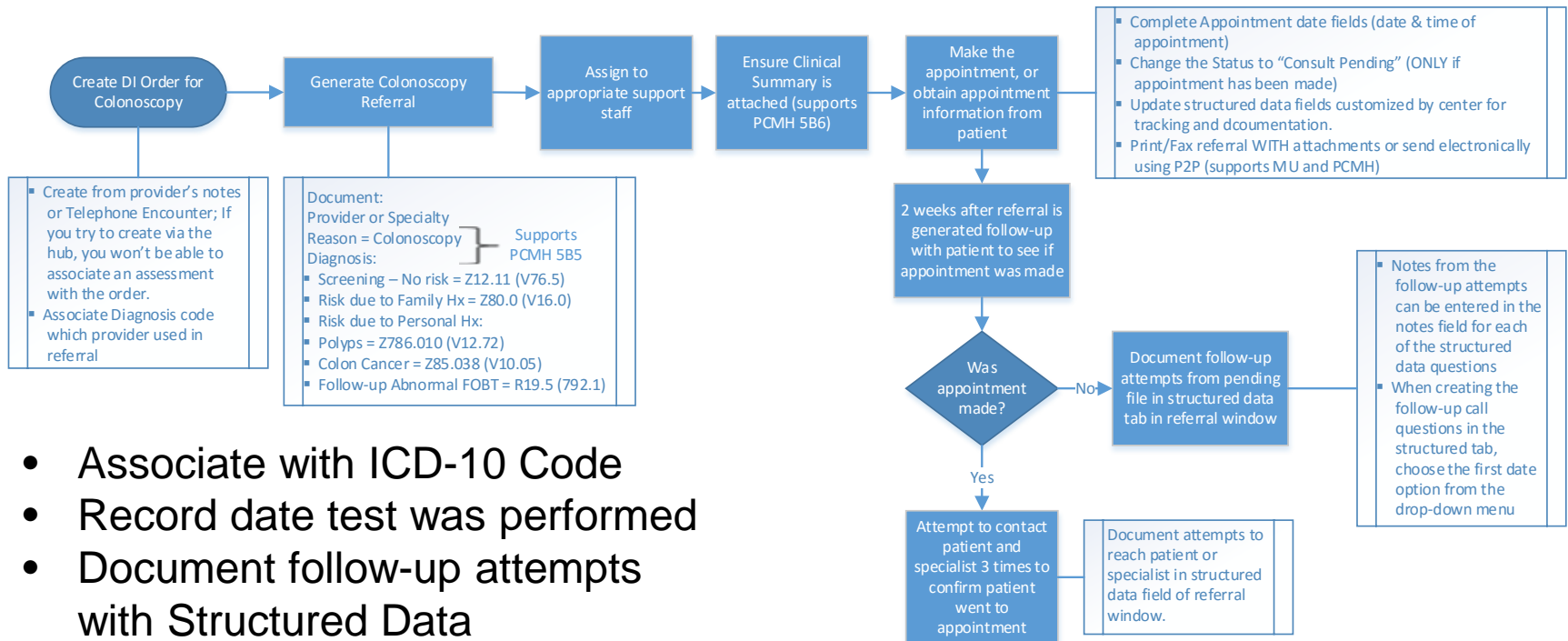
- ⇒ Order date commonly used as the date the test was performed, which often is the date the patient was referred.
- ⇒ Workflow recommends including date test was performed in the DI Order.

- **Colonoscopy results - inconsistent capture**

- ⇒ Patient usually gets results from specialist after colonoscopy.
- ⇒ Need to determine lines of responsibility for patients co-managed by specialist.



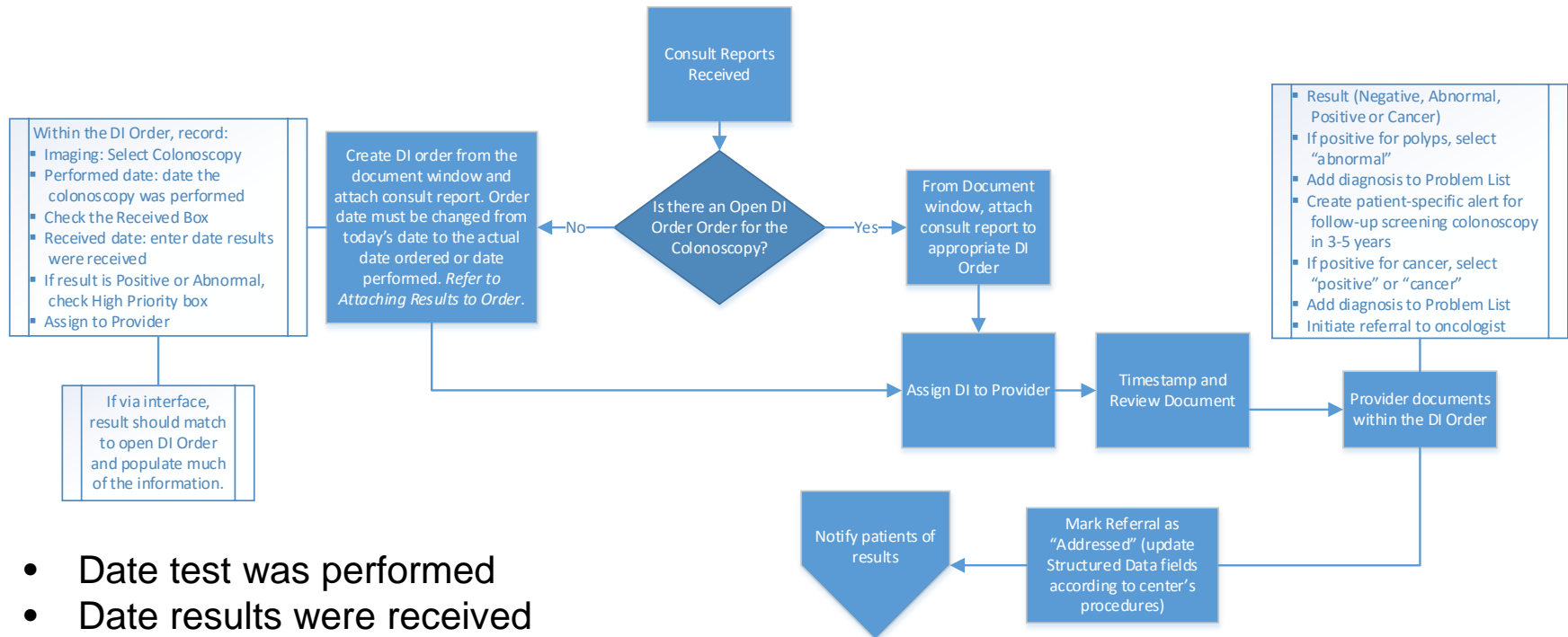
Colonoscopy Workflow –DI Order & Colonoscopy Referral



- Associate with ICD-10 Code
- Record date test was performed
- Document follow-up attempts with Structured Data



Colonoscopy Workflow – Documenting Results



- Date test was performed
- Date results were received
- Positive or Abnormal – High Priority
- Positive for polyps – Abnormal
- Create patient specific alert for more frequent screening
- Positive for cancer – Positive or Cancer
- Add diagnosis to Problem List
- Referral to oncologist



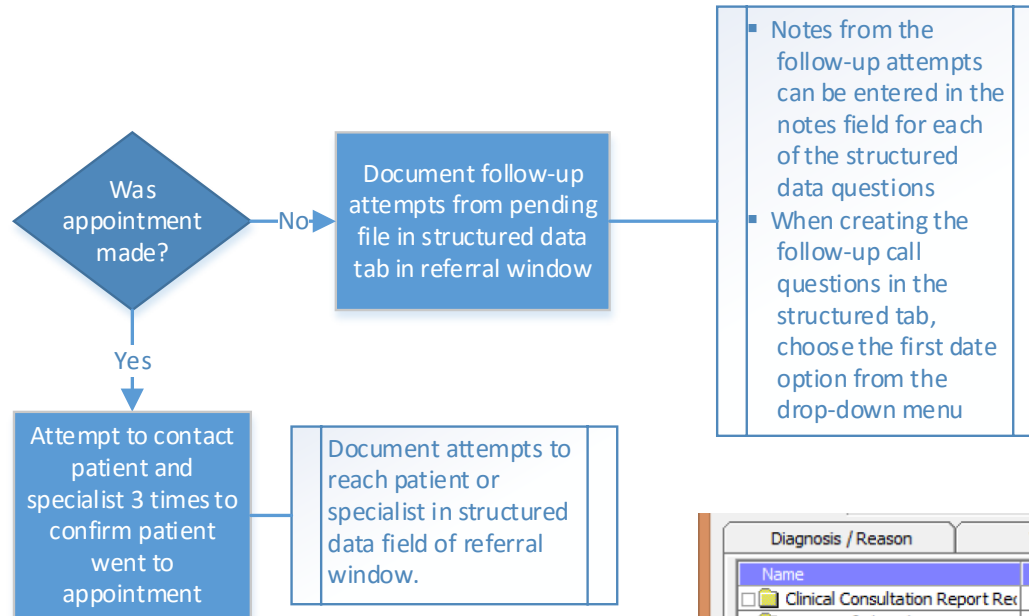
Tracking, Follow-up & Closing the Loop Challenges

■ Automated messaging

- ⇒ Task lists for referrals and orders are available. Letters, **automated messaging** (SMS, phone, portal) can be used.
- ⇒ No clear best practice; challenging to design efficient workflow utilizing the right fields to support automated messaging.
- ⇒ Workflow recommends using Structured Data in Referral to document follow-up.



Closing the Loop – Structured Data



Name	Value	Notes	
<input type="checkbox"/> Clinical Consultation Report Re			<input checked="" type="checkbox"/>
<input type="checkbox"/> Report of Clinical Encounter Re			<input checked="" type="checkbox"/>
<input type="checkbox"/> Confirmatory Consultation Rep			<input checked="" type="checkbox"/>
<input type="checkbox"/> Follow-up call 1	9/16/2015		<input checked="" type="checkbox"/>
<input type="checkbox"/> Follow-up call 2	9/16/2015		<input checked="" type="checkbox"/>
<input type="checkbox"/> Follow-up call 3	9/16/2015		<input checked="" type="checkbox"/>

Additional notes for each attempt can be added by clicking on the notes field.



Family History – Cancer Goals

Key elements for minimum adequate cancer family history:

- First-degree relatives: siblings, parents, children
- Second-degree relatives: grandparents, aunts, uncles, grandchildren, nieces, nephews, half siblings
- Both maternal and paternal sides
- For each cancer case in the family establish:
 - Age at cancer diagnosis
 - Type of primary cancer

The Journal of Clinical Oncology, 3/10/2014, Volume 32, Number 9



Family History Challenges

- Limited views of **structured data capture**
 - ⇒ Identified vendor enhancement requests.
- **Age at diagnosis** exists, but is not intuitive
 - ⇒ Identified vendor enhancement requests.
- Doesn't allow for **ICD-10 code entry**
 - ⇒ Workflow recommends documenting family history of colon cancer and other risk factors for CRC in Medical History and Problem List using the ICD-10 code.



Documenting Family History

Family History (Test, Stephanie - 07/08/2015 09:00 AM, 15 Min) *

Pt. Info Encounter Physical Hub

Copy/Merge Add Remove Customize Non-Contributory Far

Hover mouse over blank space next to checkbox to get box for entering age at diagnosis.

Members	Status	YOB	Age	Note	HBP	DM	Heart I	Stroke	Mental	Breast	Ovarian	Colon	(Other s
Mother	alive	1940	75	...	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	55	<input type="checkbox"/>
Father	alive	1935	80	..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Siblings	deceased			...	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daughter(s)	alive	2001	14	...	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Son(s)				..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spouse				..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paternal Grand				..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Customize Columns

Show Custom Names in Progress Notes Add Remove

Order	ICD Code	Diagnosis	Snomed C	Custom Name
▼ ▲	401.9	Hypertension	59621000	HBP
▼ ▲	250.00	Diabetes	73211009	DM
▼ ▲	429.9	Heart disease	56265001	Heart Dx
▼ ▲	434.91	Stroke	432504007	Stroke
▼ ▲	310.9	Unspecified nonpsychotic mental diso	192069009	Mental Illness
▼ ▲	174.9	Breast cancer	254837009	Breast Cancer
▼ ▲	183.0	Cancer, ovary	363443007	Ovarian Cancer
▼ ▲	153.9	Malignant neoplasm of colon, unspeci	429699009	Colon Cancer



Documenting Family History in Medical History and Problem List

Past Medical History (Test, Luke Skywalker - 11/10/2015 06:48 PM, 30 Min) *

Pt. Info Encounter Physical Hub

Medical Hx Pregnant BreastFeeding Hx Verified

No	History	ICD Code	PL
1	Family history of colon cancer	Z80.0	<input checked="" type="checkbox"/>

Allergies N.K.D.A Allergies Verified

Structured/Nor	Agent/Substance	Reaction	Type	Status
----------------	-----------------	----------	------	--------

Problem List

Patient : Test, Luke Skywalker

Problem List

Dx Type: All Dx Clinical Status: All No known problems

Type	Code	SNOMED	Name	Specify	Notes	Risk	Onset Date	W/U Status	Clinical Str	Added On	Modified On	Modified By	Resol
	Z80.0		Family history of		Informa	High	11/10/2015	confirmed		11/10/2015	11/10/2015	Tropper, M	
	Z85.03		Personal history	remission		High	2/10/2013	confirmed		11/10/2015	11/10/2015	Tropper, M	

eClinicalWorks

Personal history of other malignant neoplasm of large intestine is copied to Medical History.



CRC Screening - Exploratory Measures

Screening Colonoscopy **Referrals**

Screening Colonoscopy **Referral to Completion Time**

Adenomas detected during colonoscopy

Positive FIT/FOBT

Number of **Referrals** for follow up colonoscopies **after positive FIT/FOBT**



Non-Structured Lab Results

Snapshot of actual FOBT/FIT results from the EHR database

- #1 Pos,#2#3-Negatives
- +
- +FIT
- +FOBT
- +fobt, referral to GI
- +FOBT/referral processed
- +ve
- 1 Normal
- 1 normal,2,3 positive
- 1 out of 3 positive
- 1&2 Negative # 3 Positive
- 1/3 positive
- 1-positive 2- negative
- 2 Abnormal
- 2 negative, 1 positive
- 2 positive results
- 3 Negative
- 3 x negative
- 3x Negative

- Positive # 3;Negative # 1,2
- Positive #1,Negatives #2#3
- Positive #1,Negatives #2,#3
- Positive #2, Negative #1,#3
- Positive #2,#3;Negative #1
- Positive #2,Negatives #1,#3
- Positive #3,Neg. #1,2
- Positive #3,Negative #1,2
- Positive #3,Negatives #1,2
- positive FIT
- positive FOB
- positive on coumadin
- Positive Stable
- Positive x 3
- Positive x 3 days
- Positive x1, neg. x 2
- Positive x3
- Positive#1;Negative#2 and # 3
- Positive#2;Negative #1 and # 3
- Positive#3;Negative#1 and # 2



Other Challenges and Lessons Learned

- Growing desire to work within the EHR rather than from external registries to improve efficiency
- Years of creative workflows and poor data capture to overcome, primarily with Results documentation

- pt declined
- pt did not do; pt states will do colonoscopy
- pt given fit KIT
- pt refused
- S/P Colonoscopy 1/2015
- seen by Joanna
- Stable
- test completed
- test not done
- TEST NOT PERFORMED
- TNP
- TNP HAD C-SCOPE

- Not able to run test
- Not detected
- not done
- not indicated
- not necessary, will close (had colonoscopy in 2012, an
- not received
- Not tested
- NR
- old labs not done
- outstanding
- outstanding lab letter and requisition mailed to patient
- Patient refused FIT test

Query of patients seen in August 2015 with an FOBT/FIT result on file showed only 162 of the 5,356 results (3%) were “junk results”. HUGE improvement from 3 years ago!



eCW Enhancement Requests

- **Family History**
 - Add column to capture ICD-10 code in a structured manner
 - Indicate that the box to the right of the checkbox is for age of diagnosis
- **Practice Alert**
 - Improve logic to allow for more granular logic such as Colonoscopy in 10 years OR FOBT/FIT in 1 year..., OR screening in XX years if they have a diagnosis of xxx
- **CDSS**
 - Improve logic. You can check for a particular diagnosis OR you can do an alert for a DI OR an alert for the FOBT Lab. Currently, there's no combination logic. Provide options for users to build/modify.
 - At a minimum, order the colonoscopy and FOBT alerts sequential in the CDSS display
- **Results Fields**
 - Ability to lock-down Results fields based on test by test configuration
- **Order Screens**
 - provide access to Dx field regardless of where launched
- **Lab Order - FIT/FOBT Results**
 - Option for CPT code association upon result entry



Next Steps

Immediate

Disseminate EHR Best Practice Guide

Submit enhancement requests to vendor

Leverage automated features of EHR for outreach and follow-up

Future

Further define & develop exploratory measures

Develop outcome measures

Assess workflow implementation

Further explore quality of family history in EHRs



Acknowledgements

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Questions?



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EHR Best Practice Workflow and Documentation Guide to Support Colorectal Cancer Screening Improvement in eClinicalWorks

Section	Pages
Process Flowcharts.....	2-5
Best Practices and Workflows.....	6-10
Documenting Family History.....	11-14
Supporting Exhibits.....	15-31
Detailed Instructions for Attaching Results to Order.....	32-46

Acknowledgements

Thank you to the funding and partnering organizations whose support and contributions were instrumental in the development of this Guide:

National Association of Community Health Centers (NACHC)

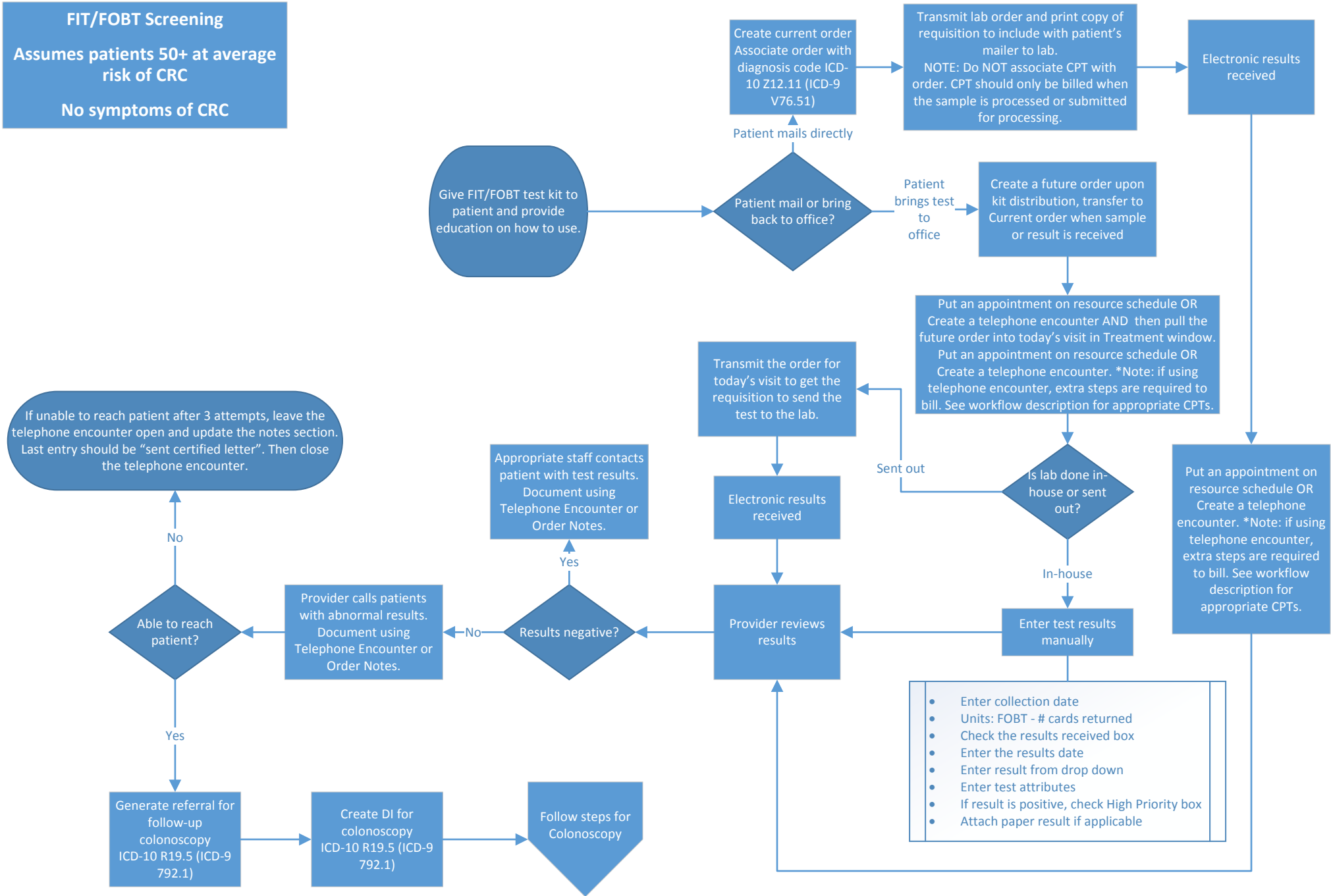
National Association of Chronic Disease Directors

American Cancer Society

National Colorectal Cancer Roundtable

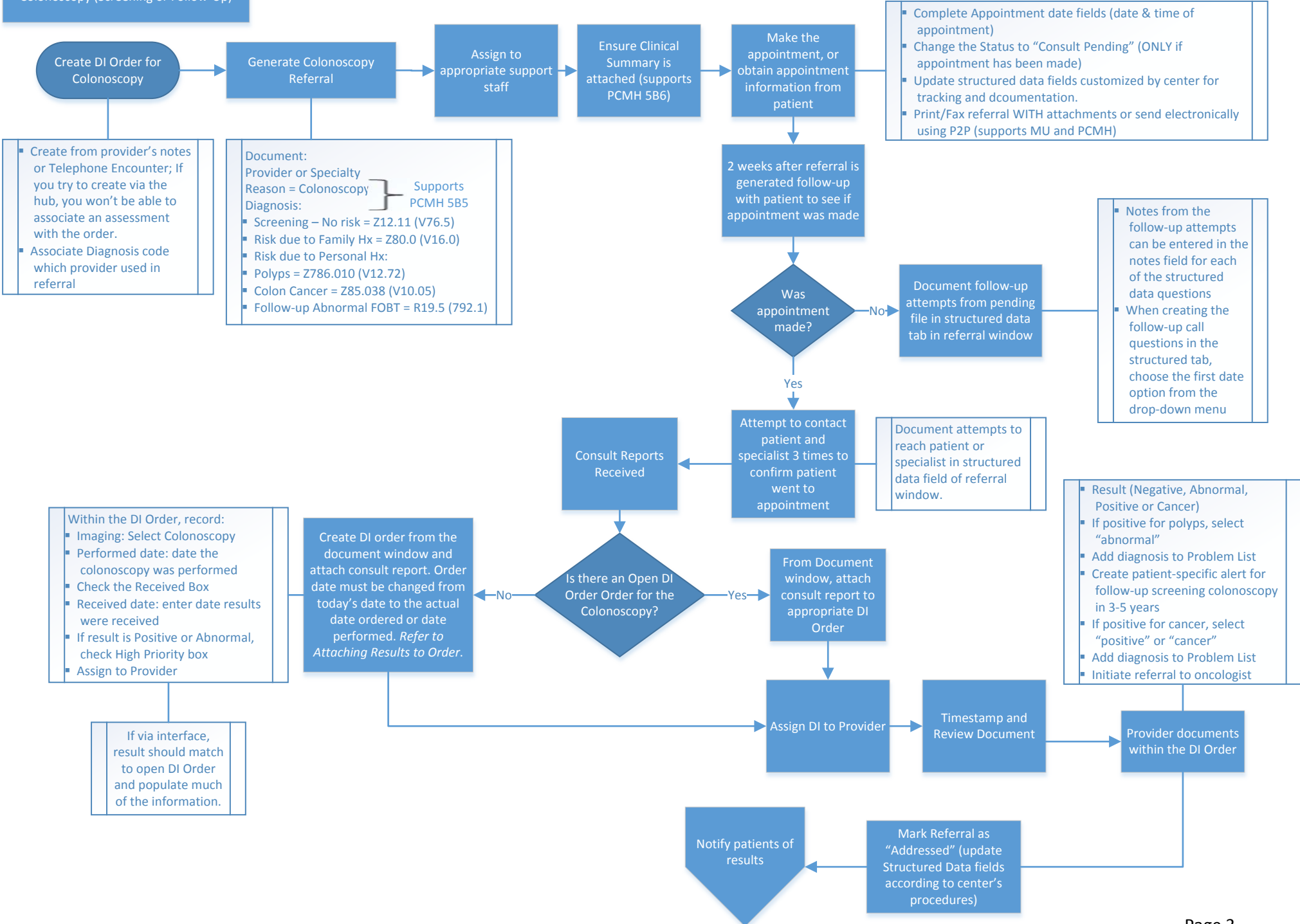
Health Center Network of New York member health centers

FIT/FOBT Screening
Assumes patients 50+ at average risk of CRC
No symptoms of CRC



- Enter collection date
- Units: FOBT - # cards returned
- Check the results received box
- Enter the results date
- Enter result from drop down
- Enter test attributes
- If result is positive, check High Priority box
- Attach paper result if applicable

Colonoscopy (Screening or Follow-Up)



Notifying patients of FIT/FOBT or Colonoscopy results

Documentation options:

- Publish to patient portal
- Lab or DI Order Notes (**exploring steps for eMessenger use**)
- Telephone Encounter – Use “Normal FIT/FOBT results” or “Normal Colonoscopy results” in the Reason field.

Appropriate staff contacts patient with test results based on patient preferences documented in demographics in accordance with center’s current procedures.

Results normal?

Abnormal (positive) results should be communicated to patient via telephone along with information pertaining to GI or Oncologist referral.

Documentation options:

- Lab or DI order Notes (**exploring steps for eMessenger Use**)
- Use Reason field to indicate Ab Result1, Ab Result2, etc. (this step supports use of eMessenger Campaigns for automated outreach)
- Telephone Encounter: Use “Abnormal FIT/FOBT results” or “Abnormal Colonoscopy results” in the Reason field.

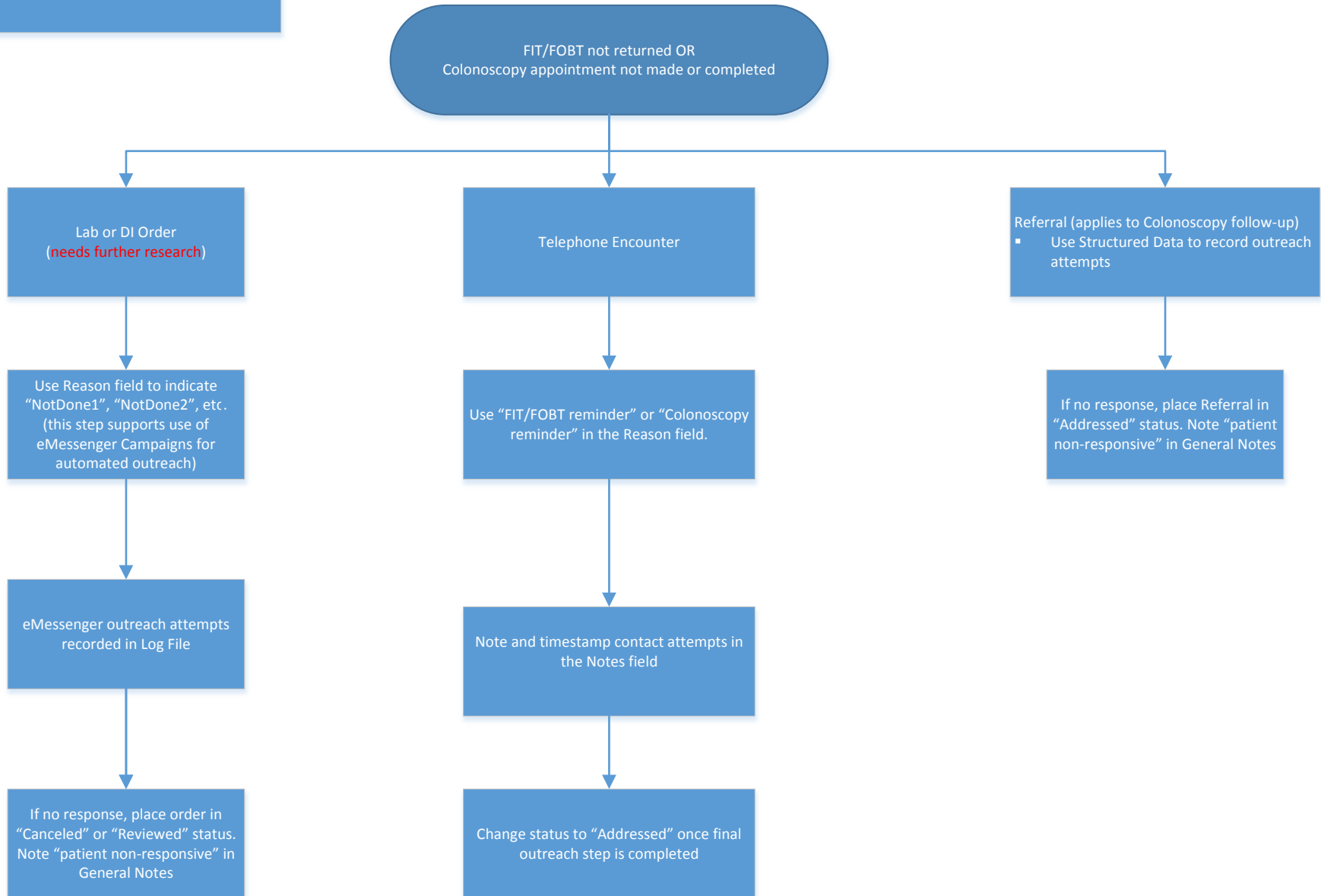
Note and timestamp contact attempts in the Notes field.

Able to reach patient?

Change Status to “reviewed” once results are communicated or final outreach step is completed.

After 3 attempts, certified letter should be sent (and/or other steps per center’s current procedures) and noted within the Notes field of the Telephone Encounter.

- Use Reason field to indicate CertLtrDelivered or something similar.
- Close the Telephone Encounter.



Colorectal Cancer Screening HCNNY Best Practices and Workflows

Standard Naming Conventions to Support Data Query Design

- **FIT/FOBT:** The lab test name must contain the text “FIT” or “FOBT” in order to be captured in the BridgeIT report. Attributes should be created with appropriate lab order and LOINC Codes
- **Colonoscopy:** The imaging test name must contain the text “colonoscopy”.
- **Sigmoidoscopy:** The imaging test name must contain the text “sigmoid”.

The bulleted workflow that follows provides step by step recommendations for the major steps of closed-loop colorectal cancer screening management in eClinicalWorks. Supplemental screenshots with instructions are included as Exhibits.

Placing the order for Colon Cancer Screening

FIT/FOBT Screening:

The manner in which tests are configured and placed should be aligned with practice procedures. Presented below are two options: Option 1 most effectively supports the practice of billing for screening once samples or results are received. Option 2 effectively supports immediate transmission of orders and requires manual intervention for any desired billing. Please take note of the advantages and disadvantages highlighted for both options.

Place lab order for FIT/FOBT with an associated diagnosis of ICD-10 Z12.11 (V76.51): Special Screening for Malignant Neoplasm of Colon. **(Exhibit 1)**

Workflow Options

Option 1: Place “Future Order” upon kit distribution, transfer to “Current Order” when sample or result is received **(Exhibit 2)**

Advantages:

- Promotes tracking of outstanding tests due to distinction between “Current” and “Future”
- Allows CPT code to be linked to order which supports automatic billing once the order is made “Current”
 - 82274 = FIT test - screening
 - 82270 = FOBT test – screening
 - 82272 = FOBT - diagnostic

! If ordering test due to symptoms reported, technically 82272 should be used with a Dx code representing the symptom. Determine if patient is due for annual screening and if so, use screening code to minimize patient payment responsibility.

Disadvantages:

- Orders can’t be transmitted while in Future status (important step if offering patients the option to mail cards directly to external lab company). *See Place Current Order below.*

- Sample received, Paper or In-house Result received
 - Through a Resource progress note or Telephone Encounter progress note, pull Future lab to Current
 - Enter the Collection Date
 - Units: For FOBT, enter the number of cards returned
 - If/when result is available:
 - Check the Results Received box
 - Enter the Results Date
 - Enter test attributes
 - If result is positive, check High Priority box (**Exhibit 3**)
 - Attach paper result if applicable. *See supporting document attached.* (**Attaching Results to Order**)
 - Assign to provider
 - Provider enters result from drop down (Negative or Positive)
 - If Positive, generate Colonoscopy Referral
- ! If using Telephone Encounter, additional steps are necessary to trigger billing (see supporting detail) (**Exhibit 4**)

Option 2: Place “Current Order” upon kit distribution with an associated diagnosis of ICD-10 Z12.11 (V76.51): Special Screening for Malignant Neoplasm of Colon (**Exhibit 1**)

! DO NOT enter a CPT code for FOBT at this time (ensure there’s no CPT linked in configuration). Billing guidelines prohibit billing until the sample has been collected.

Advantage:

- Order can be transmitted to the lab in anticipation of patient submitting their sample directly.

Disadvantage:

- No automated billing option; a reliable workflow must be designed to ensure that CPT code is entered into a billable note once sample or result is received.

- Sample received, Paper or In-house Result received
 - Follow steps outlined in same step above

Colonoscopy (Screening or Follow-up):

Generate Colonoscopy Referral and DI Order (Exhibit 5 & Exhibit 6)

- Document the following:
 - Provider or Specialty
 - Reason = Colonoscopy
 - Diagnosis
 - If for screening
 - No risk = Z12.11 (V76.5) *Screening for malignant neoplasm of colon*
 - Risk due to Family Hx = Z80.0 (V16.0) *Family history of malignant neoplasm of digestive organs*
 - Risk due to Personal Hx
 - Polyps = Z86.010 (V12.72) *Personal history of colonic polyps*

- Colon Cancer = Z85.038 (V10.05) *Personal history of other malignant neoplasm of large intestine*
 - If for follow-up
 - Abnormal FOBT = R19.5 (792.1) *Occult blood in feces*
- Assign to appropriate support staff

Support staff then will:

Ensure Clinical Summary is attached (supports MU and PCMH 5B6)

NOTE: The Clinical Summary and Progress Note can be set to automatically attach from the Practice Default settings when the referral is created from the Progress Note. If referral is created from the HUB, you must manually attach the Clinical Summary.

 - Make the appointment, or obtain appointment information from patient (**Exhibit 7**)
 - Complete Appt Date fields (date and time of appointment)
 - Change the Status to Consult Pending (*ONLY* if appointment has been made)
 - Update Structured Data fields customized by center for tracking and documentation
 - Recommend: *See supporting document attached. (Exhibit 7)*
 - Print/Fax the Referral WITH attachments or send electronically using P2P (supports MU and PCMH)
 - Create DI Order for Colonoscopy (**Exhibit 6**)
 - Associate the Diagnosis Code which provider used in Referral (from options listed above)
 - *NOTE: the DI order needs to be created from Progress Note or Telephone Encounter in order to attach an assessment to the order. If you try to create the DI via the Hub or DI window, you won't be able to attach an assessment.*

NOTE: Centers may choose to do this in reverse, whereby provider creates DI and assigns to support staff who then create the referral.

- The recommended workflow is to record the date the test was performed in the “Performed Date” field. Recent review of the data indicates very low usage of this field. It’s likely that “Order Date” is currently being used for measurement purposes as the date the test was performed.

Documenting Results / Closing the Loop

Consult Reports Received

- From the Document window, attach consult report to appropriate Colonoscopy DI order (if via interface, result should match to open DI Order and populate much of the information below; no separate Document will exist)
 - If no open DI Order is found, create one through using the “new” button in the order selection screen and then attach consult report. *See **Attaching Results to Order** for additional detail. NOTE: when creating the order this way, you won't be able to access the assessment to include the reason for colonoscopy.*
 - Order Date must be changed from today’s date to the actual date ordered or date performed
- Within the DI order, record (**Exhibit 9**):
 - Imaging: Select “colonoscopy”
 - Performed date: date that the colonoscopy was performed

- Check the Received box
- Received date: enter date results were received
- If result is Positive or Abnormal, check High Priority box
- Assign to provider
- Timestamp and Review document
- Mark Referral as Addressed (update Structured Data fields according to center's procedures) (**Exhibit 7**)

NOTE: This workflow ensures the provider receives only the order with result information attached (instead of receiving the order, the document, and the referral).

Provider then documents within the DI Order (**Exhibit 9**)

- Result (Negative, Abnormal, Positive or Cancer)
 - If positive for polyps, select "abnormal"
 - Add diagnosis to Problem List
 - K63.5 (211.3) = Polyp of Colon
 - D12.6 (211.4) = Adenomatous polyps
 - Create patient-specific alert for follow-up screening colonoscopy in 3-5 years
 - If positive for cancer, select "positive" or "cancer"
 - Add diagnosis to Problem List
 - C18.9 (153.x) Malignant neoplasm of colon, unspecified
 - Initiate Referral to oncologist

Notifying patients of FOBT or Colonoscopy results:

- Negative results should be communicated based on patient preferences documented in demographics in accordance with center's current procedures.

Documentation Options (Exhibit 9, 10 & 11)

- Publish to patient portal
- Lab or DI Order Notes (**exploring steps for eMessenger use**)
- Telephone Encounter
 - Use "*Negative FIT/FOBT results*" or "*Negative Colonoscopy results*" in the Reason field.
 - Note and timestamp contact attempts in the Notes field.
 - If unable to reach after three attempts, certified letter should be sent (and/or other steps per center's current procedures) and noted within Telephone Encounter.
 - Use Reason field to indicate CertLtrDelivered or something similar.
 - Close the telephone encounter
 - Change status of Order to "Reviewed" once results are communicated or final outreach step is completed.
- Abnormal (Positive) results should be communicated to patient via telephone along with information pertaining to colonoscopy referral.

Documentation Options

- Lab Order (**needs further research**)
 - Note and timestamp contact attempts in the Notes field.
 - Use Reason field to indicate Ab Result1, Ab Result2, etc. (this step supports use of eMessenger Campaigns for automated outreach)
 - If unable to reach after three attempts, certified letter should be sent (and/or other steps per center's current procedures) and noted in the Notes field. Use Reason field to indicate CertLtrDelivered or something similar.
- Telephone Encounter (**Exhibit 8**)
 - Use “*Abnormal FIT/FOBT results*” or “*Abnormal Colonoscopy results*” in the Reason field.
 - Note and timestamp contact attempts in the Action Taken field.
 - If unable to reach after three attempts, certified letter should be sent (and/or other steps per center's current procedures) and noted within Telephone Encounter.

Documenting Follow-up Outreach for Incomplete Tests

- FOBT/FIT not returned OR
 - Colonoscopy appointment not made or completed
-
- Lab or DI Order (**needs further research**)
 - Note and timestamp contact attempts in the Notes field.
 - eMessenger outreach attempts recorded in log file
 - If no response, place order in Cancelled or Reviewed status. Note “patient non-responsive” in General Notes.
 - Telephone Encounter
 - Use “*FIT/FOBT reminder*” or “*Colonoscopy reminder*” in the Reason field.
 - Note and timestamp contact attempts in the Action Taken field.
 - Change status to addressed once final outreach step is completed.
 - Referral (applies to Colonoscopy follow-up)
 - Use structured data to record outreach attempts
 - If no response, place referral in Addressed status. Note “patient non-responsive” in General Notes.

Recommendations to Document Family History & High Risk of Colon Cancer

Details related to age of diagnosis of colon cancer for first and second degree relatives should be entered into Family History.

Additionally, family history of colon cancer and other risk factors should be documented in Medical History and on the Problem List using the ICD-10 code.

Documenting in Family History: Colon Cancer Detail

Enter patient's family history of colon cancer, indicating first and second degree relatives and age of diagnosis for the condition.

Enter the age at diagnosis for the condition next to the checkmark in eCW. It is a number only field to the right of the checkmark. The example below shows the age that the test patient's mother was diagnosed. Her current age is calculated from the YOB field. Additional notes are in the Notes box.

Members	Status	YOB	Age	Note	HBP	DM	Heart	Stroke	Mental	Breast	Ovarian	Colon	Other
Mother	alive	1940	75	...	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> 55	<input type="checkbox"/>
Father	alive	1935	80	...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Siblings	deceased			...	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daughter(s)	alive	2001	14	...	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Son(s)				...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spouse				...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paternal Grand				...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The columns with the checkmarks are customizable by clicking the Customize button. eCW currently delivers V10 with a starter set but you can change it as long as you include the SNOMED code. Add a column for colorectal and connect it to SNOMED 429699009. The screenshot from our test system (below) has Colon Cancer as a column. Although you can add as many columns as needed, you'll only be able to reasonably view 8 or 9 columns on your screen (as shown in the screenshot above) with checkmarks and age of diagnosis for each of the conditions captured.

Configure by Customize button

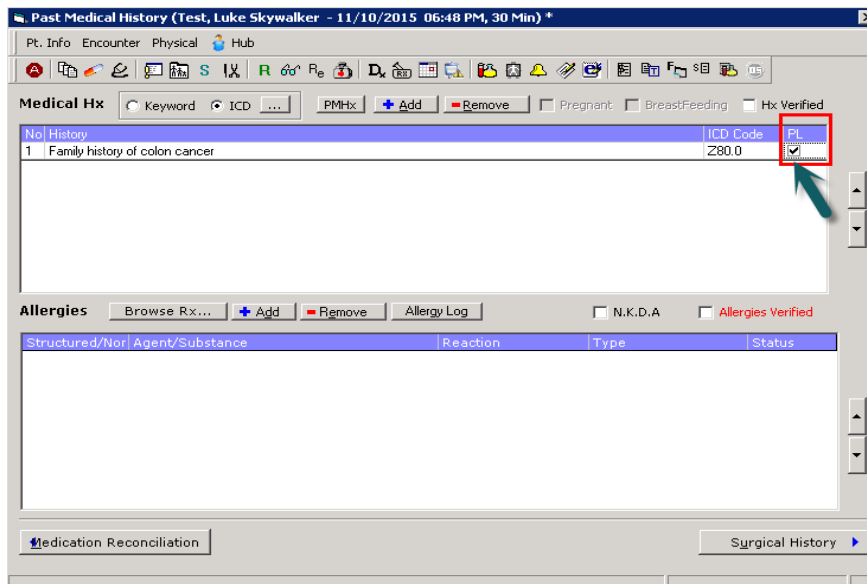
Customize Columns				
<input checked="" type="checkbox"/> Show Custom Names in Progress Notes				
Order	ICD Code	Diagnosis	Snomed Code	Custom Name
▼ ▲	401.9	Hypertension	59621000	HBP
▼ ▲	250.00	Diabetes	73211009	DM
▼ ▲	429.9	Heart disease	56265001	Heart Dx
▼ ▲	434.91	Stroke	432504007	Stroke
▼ ▲	310.9	Unspecified nonpsychotic mental diso	192069009	Mental Illness
▼ ▲	174.9	Breast cancer	254837009	Breast Cancer
▼ ▲	183.0	Cancer, ovary	363443007	Ovarian Cancer
▼ ▲	153.9	Malignant neoplasm of colon, unspeci	429699009	Colon Cancer

Documenting in Medical History

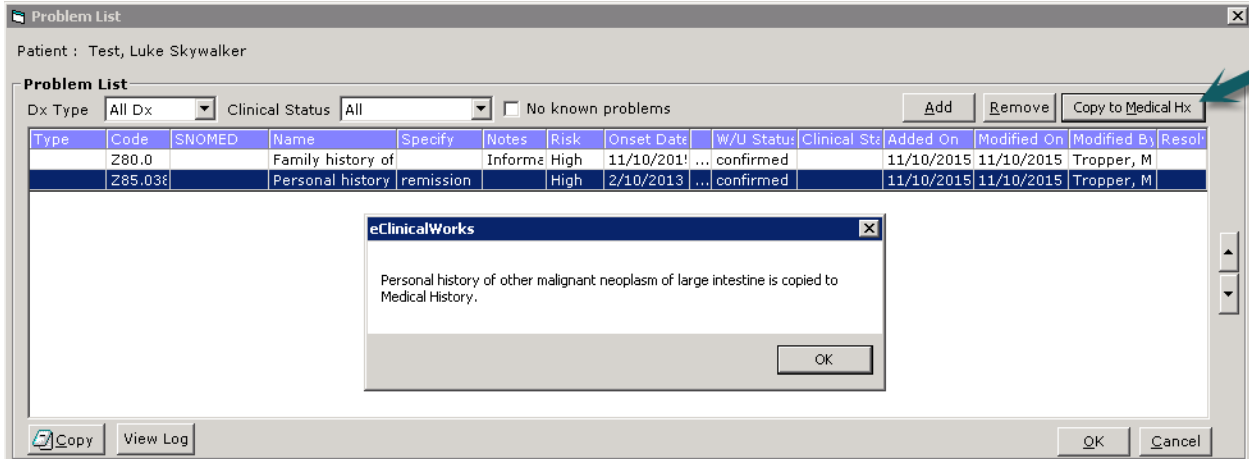
Add appropriate code(s) for family history and/or high risk of colon cancer to the Medical History by changing the radio button to ICD and using the ICD Browse button (ellipsis) and searching for one of the ICD10 codes below. NOTE: History added through the Keyword Browse/Search or free texted using the Add button cannot be added to the Problem List using the checkbox.

- Z80.0 Family History of Colon Cancer
- Z83.71 Family History of Colonic Polyps
- Z86.010 Personal History of Colonic Polyps
- Z85.038 Personal history of other malignant neoplasm of large intestine
- K51.90 Ulcerative Colitis, unspecified, without complications
- Q85.8 Other Phakomatoses, Peutz-Jeghers Syndrome

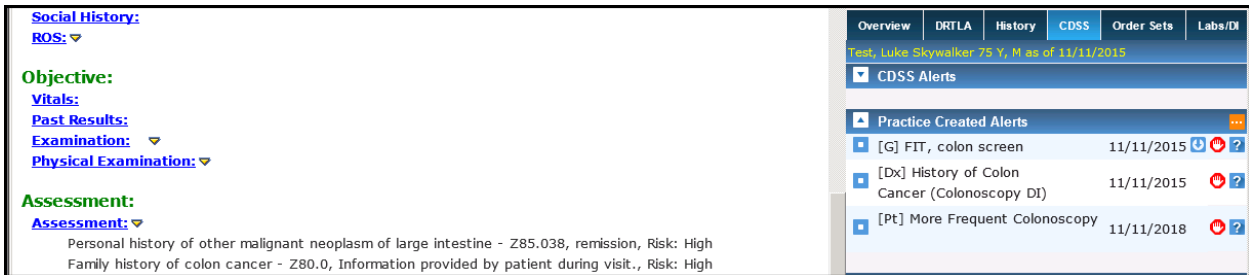
Click on “PL” to add the Medical History entries to the Problem List.



Alternatively, you can add the appropriate codes to the Problem List and copy them to Medical History.



Create Dx Specific Practice Alert to require more frequent colonoscopy tests if any of the above codes appear in the patient’s assessments (see below). Or create a Patient Specific alert for more frequent colonoscopies (see Exhibit 9).



Improving Family History Documentation

The Journal of Clinical Oncology, 3/10/2014, Volume 32, Number 9 article on Collection and Use of Cancer Family History for Oncology Providers recommends collecting the following key elements for a minimum adequate cancer family history:

- First-degree relatives: siblings, parents, children
- Second-degree relatives: grandparents, aunts, uncles, grandchildren, nieces, nephews, half siblings
- Both maternal and paternal sides
- Ethnicity
- For each cancer case in the family establish:
 - Age at cancer diagnosis
 - Type of primary cancer
- Results of any cancer predisposition testing in any relative

Requests for eCW:

- Add a column to Family Hx to capture the ICD10 code in a structured manner similar to Medical Hx
- Add a button to Family History that would allow the “Family History of ICD10” code from above to pull into the problem list.
- Indicate in a clearer way that the box to the right of the checkbox is for age of diagnosis.
- Improve **Practice Alert** logic to allow for more granular logic such as Colonoscopy in 10 years OR FOBT/FIT in 1 year...., OR screening in XX years if they have a diagnosis of xxx.
- Improve logic for CDSS. You can check for a particular diagnosis OR you can do an alert for a DI OR an alert for the FOBT Lab. Currently, there’s no combination logic. Provide options for users to build/modify.
 - At a minimum, order the colonoscopy and FOBT alerts sequential in the CDSS display

Exhibit 1 - Placing an Order

Current order

*If CPT code is attached to the lab in configuration, the code will appear in the Procedure Codes section of the PN and produce a claim. **(NOTE: billing guidelines prohibit billing until samples are collected.)**

Plan:

Treatment:

[Colon cancer screening](#)
[Lab:Occult Blood, Fecal, IA \(FOBT\)](#)

Procedures:

Immunizations:
Therapeutic Injections:
Diagnostic Imaging:
Lab Reports:
Preventive Medicine: ▾

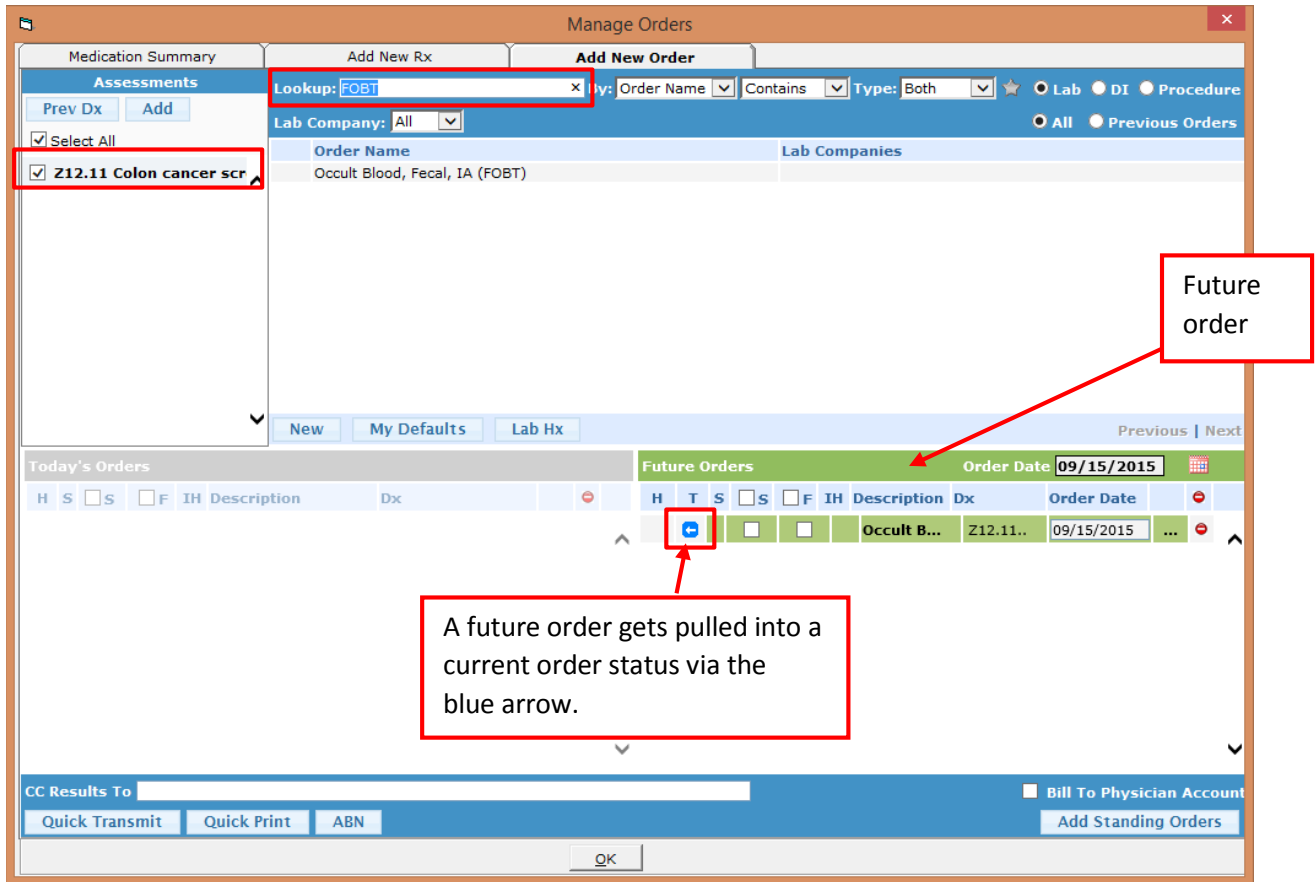
Next Appointment:

Billing Information:

Visit Code:

Procedure Codes:

- 82272 OCCULT BLOOD, FECES, SINGLE.



*If CPT code is attached to the lab in configuration, the code will not appear in the Procedure Codes section of the PN and produce a claim until the lab is a current order status. ***(NOTE: billing guidelines prohibit billing until samples are collected.)***

Exhibit 3 - Entering lab results

Check box if test is positive.

Provider enters results from drop down!

Date will appear after the ok button is clicked.

Order Date	Coll. Date	Occult Blo
09/15/2015	09/15/2015	Positive

Exhibit 4 - Creating a claim from a Telephone or Web Encounter

There are two ways in which you can create a claim from a telephone or web encounter.

Option 1

Access the Virtual Visit Tab to document as you normally would.

The screenshot shows a 'Telephone Encounter' window for patient 'Duck, Daisy, 63 Y, F'. The patient's address is 123 E Main Street, Johnstown, NY 12095. The provider is 'Jones, Mary'. The encounter date is 8/20/2015 at 12:48 PM. The status is 'Open'. The reason for the encounter is 'FIT/FOBT'. The plan includes links for Treatment, Procedures, Immunizations, Therapeutic Injections, Diagnostic Imaging, Lab Reports, Preventive Medicine, and Next Appointment. The 'Virtual Visit' checkbox is checked. The right sidebar contains various tabs like Overview, DRTLA, History, CDSS, and a list of medication and allergy sections.

When done documenting your note, click on the Encounter option at the top of the screen. Click on the claim option.

The screenshot shows a 'Treatment' window for patient 'Duck, Daisy' on 08/20/2015 at 12:48 PM. The left sidebar shows a menu with options like Pt. Info, Encounter, Physical, Hub, Complaints/Current Medication, Vitals, HPI, ROS, Examination, Assessment, Treatment, Appointment, Labs, Diagnostic Imaging, Notes, MIC, Orders, and Claim. The 'Claim' option is highlighted. The main area shows a table with columns for Date, Frequency, Duration, Disp, Refill, Auth, AWP, Stop, and Dose. The 'Interaction' tab is selected at the bottom.

The Create New Claim window appears.

Choose the type of claim that you want to create. Click OK.

Create a New Claim

Patient
 Duck, Daisy
 DOB: 11/2/1951 Age: 63Y Sex: F
 Tel: 518-725-4545
 Acct No: 9338, WebEnabled: No
 Elgb Status:

Encounter Date: 08/20/2015

Create Professional (HCFA) claim
 Create Institutional (UB) claim
 Create Dental Claim

Claim does not exist for the encounter.

OK Cancel

The claim will open.

Claim

Claim Number: 876 Claim Date: 08/27/2015 Service Date: 08/20/2015 Appointment Facility: WMA: Westboro Medical Associa POS: 11

Patient: Duck, Daisy DOB: 11/02/1951 Age: 63Y Sex: F Acct No: 9338. WebEnabled: No

Copay: \$0.00 Pt. Uncovered Amt.: \$0.00

Rendering: Jones, Mary Supervisor: Jones, Mary

Claim Status: Pending

ICD & CPT

Code	Name
1 V76.51	Colon cancer screening

Insurances

Name
P Medicare NGS - Part A
S Fidelis Managed Medicaid

Labs/Diagnostic Imaging/Imm

No	IH/SO	Type	Name
1		Lab	FECAL GLOBIN,IM

CPT/HCPCS

Code	POS	TOS	SDOS	EDOS	M1	M2	M3	ICD1	ICD2	ICD3	ICD4	Units	Billed Fc	Provider Id
1 82272			08/20/2015	08/20/2015								1	\$0.00	44444

Errors

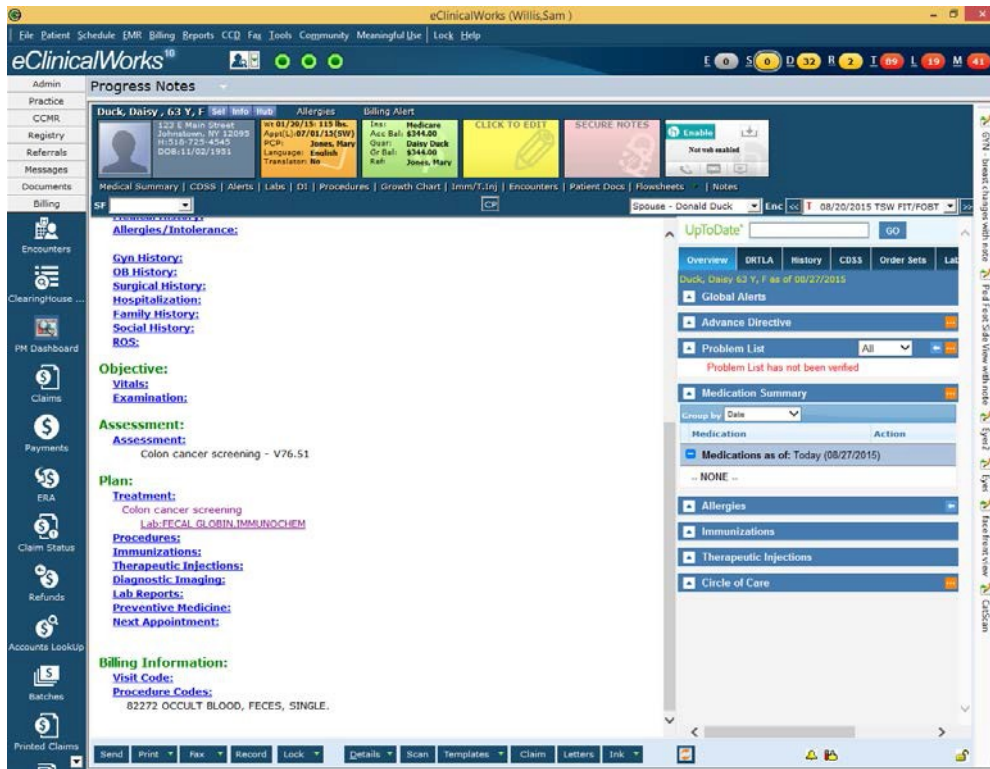
Sl No	Error
1	Payer Organization ID is missing.
2	Place of Service is missing.
3	Type of Service Code is missing.

Copy CodeCorrect Suppress Recheck

Header Data Options Print HCFA (02-12) Adjustments Prog. Notes CPT Payers OK Cancel

Option 2

From within the PN drop down, choose the desired telephone or web encounter note.



Click the Claim button on the bottom of the PN. The Create Claim window appears.

Choose the type of claim to create. Click OK. The claim will open.

Create a New Claim

Patient

Duck, Daisy
 DOB:11/2/1951 Age:63Y Sex:F
 Tel:518-725-4545
 Acct No:9338, WebEnabled: No
 Elgb Status:

Encounter Date: 08/20/2015

Create Professional (HCFA) claim
 Create Institutional (UB) claim
 Create Dental Claim

Claim does not exist for the encounter.

Claim

Claim Number: 977 | Claim Date: 08/27/2015 | Service Date: 08/20/2015 | Appointment Facility: WMA:Westboro Medical Associa | POS: 11 | Provider: Jones, Mary

Patient: Duck, Daisy | DOB: 11/02/1951 | Age: 63Y | Sex: F | Tel: 518-725-4545 | Acct No: 9338, WebEnabled: No | Servicing Provider: Jones, Mary

Capay: \$0.00 | Pt. Uncovered Amt: \$0.00 | Billing: Jones, Mary | Rendering: Jones, Mary | Supervisor: Jones, Mary | Claim Status: Pending

ICD Codes	Prev Oig	Add	Remove	Insurances	Labs/Diagnostic Imaging/Imm
1	V76.51	Colon cancer screening		P Medicare NCS - Part A S Fidelis Managed Medicaid	1 FECAL GLOBIN,IM

CPT/HCPCS	Code	POS	TOS	SDCS	ICD9	IC10	IC11	IC12	IC13	IC14	Units	Blnd	Pr	Provider Id
1	82272				08/20/2015	08/20/2015					1	\$0.00	44444	

Summary | Errors | Claim Logs | Suppressed Errors

Sl No	Error
1	Payer Organization ID is missing.
2	Place of Service is missing.
3	Type of Service Code is missing.

Header | Data | Options | Print HCFA (02-12) | Adjustments | Prop. Notes | CPT Payers | OK | Cancel

Exhibit 5 - Generating a Colonoscopy Referral

Fields to be filled out by provider if generated from progress note

The screenshot shows a 'Referral (Outgoing)' form with the following fields and values:

- Patient: Mouse, Mickey (9336)
- Insurance: CDPHP Managed Medicaid
- Ref From: Willis, Sam
- Facility From: Westboro Medical Associates
- Ref To: Provider Charles Andrew, Specialty Gastroenterology
- Assigned To: Gail, Dalton
- Start Date: 09/15/2015
- Referral Date: 09/15/2015
- End Date: 12/14/2015
- Appt Date: 09/15/2015
- Received Date: 09/15/2015
- Priority: Routine
- Status: Open
- Unit Type: V (VISIT)

Red boxes highlight the 'Ref To' section, the 'Assigned To' dropdown, the 'Reason' table, and the 'Diagnosis' table. A callout box points to the 'Assigned To' field with the text: 'Will auto populate if configured appropriately'.

Reason	
Sl. No	Description
1	Colonoscopy

Diagnosis	
Code	Name
R19.5	Fecal occult blood test positive

Procedures	
Code	Name

Provider fills out order, then the support staff generates referral from the hub and completes all fields highlighted in previous screenshot and the one below

Referral (Outgoing)

Patient: Mouse, Mickey (9336) [Sel] [Info] [Hub]

Insurance: CDPHP Managed Medicaid [Sel] [Pt Ins] POS: 11

Ref From: Willis, Sam [...]

Ref To: Provider: Charles, Andrew [... Pref Clear] Specialty: Gastroenterology

Facility From: Westboro Medical Associates [...]

Facility To: [... Clear]

Auth Code: [] Auth Type: [...]

Start Date: 09/16/2015 End Date: 12/15/2015

Referral Date: 09/16/2015

Open Cases: [] [N]

Assigned To: Gail, Dalton [...]

Appt Date: 09/21/2015 10:00 AM

Unit Type: V (VISIT)

Received Date: 09/17/2015

Status: Open Consult Pending Addressed

Priority: Routine

Diagnosis / Reason		Visit Details	Notes	Structured Data
Name	Value			
<input type="checkbox"/> Clinical Consultation Report Rec			X	X
<input type="checkbox"/> Report of Clinical Encounter Re			X	X
<input type="checkbox"/> Confirmatory Consultation Repi			X	X
<input type="checkbox"/> Follow-up call 1	09/16/2015		X	X
<input type="checkbox"/> Follow-up call 2	09/16/2015		X	X
<input type="checkbox"/> Follow-up call 3	09/16/2015		X	X

Any customized health center specific questions will appear in this area.

Attachments [Logs] [OK] [Cancel] [Send Referral]

Attachments [Logs] [OK] [Cancel] [Send Referral]

Print
 Print with Attachment
 Fax
 Fax with Attachment
 Send Electronically
 Schedule and send Electronically

Change to Consult Pending only if appointment has been made.

Any customized health center specific questions will appear in this area.

If referral is created via the HUB, the Clinical Summary and Progress notes will need to be manually attached.

Must use "with attachment" option in order to meet MU & PCMH.

Exhibit 6 - Creating a DI order

Access the Manage Orders window from within the progress note or from a Telephone Encounter (TE → Virtual Visit Tab → Treatment link):

Medication Summary Add New Rx Add New Order

Assessments

Prev Dx Add

Select All

212.11 Colon cancer scr

792.1 Fecal occult bloo

Lookup: colonos

By: Order Name Starts With Type: Both Lab DI Procedure

DI Company: All

Order Name Lab Companies

colonoscopy

New My Defaults DI Hx Previous | Next

Today's Orders Future Orders Order Date: 09/16/2015

H	S	S	F	IH	Description	Dx		H	T	S	S	F	IH	Description	Dx	Order Date	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	colonoscopy	792.1 - Fecal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CT Scan	250.00..	08/12/2015	...

CC Results To

Quick Transmit Quick Print ABN Bill To Physician Account Add Standing Orders

OK

The recommended workflow is to record the date the test was performed in the "Performed Date".

Diagnostic Imaging *

Patient Sel Info Hub

Test, Betty Boop
DOB:4/30/1955 Age:60Y Sex:F
Tel:845-111-1111
Acct No:67383, WebEnabled: No
Elgb Status:

Status: Open Reviewed

Provider: Bailey, Laura K

Facility: HCNNY Medical

Assigned To:

High Priority
 InHouse
 Future Order
 Cancelled

Don't publish to Web Portal

Diagnostic Imaging Information

Imaging: Colonoscopy DI Sel

Reason: screening

Body Site: ... Clr

Order Date: 10/15/2015

Performed Date: 10/26/2015

Results

Received Date: 10/28/2015 Result: Normal

Exhibit 7 - Closing the Loop

Referral - Option 1

Patient: Mouse, Mickey (9336) Sel Info Hub

Insurance: CDPHP Managed Medicaid Sel Pt Ins POS 11

Ref From: Willis, Sam ...

Ref To: Provider: Charles Andrew ... Pref Clear

Specialty: Gastroenterology

Facility From: Westboro Medical Associates ...

Facility To: ... Clear

Auth Code: ...

Auth Type: ...

Start Date: 09/16/2015

End Date: 12/15/2015

Referral Date: 09/16/2015

Assigned To: Gail, Dalton ...

Open Cases: ... N

Appt Date: 09/16/2015

Unit Type: V (VISIT)

Received Date: 09/16/2015 Status: Open Consult Pending Addressed

Priority: Routine

Diagnosis / Reason Visit Details Notes Structured Data

Reason Add Browse Remove

Sl. No	Description
1	colonoscopy

Diagnosis Previous Dx Add Remove

Code	Name
R19.5	Fecal occult blood test positive

Procedures Add Remove

Code	Name
------	------

Scan Attachments Logs OK Cancel Send Referral

MU Best practice: checking the consult Received date. This will automatically change the status to Addressed.

Referral - Option 2

Diagnosis / Reason Visit Details **Notes** Structured Data

Add General Notes

Willis, Sam 09/16/2015 09:19:34 PM EDT > Called patient to see if app't made.
Willis, Sam 09/16/2015 09:20:13 PM EDT > Left message for patient to return call to confirm if app't has been made.
Willis, Sam 09/16/2015 09:20:45 PM EDT > Left message for patient to return call.

Add Clinical Notes

Scan Attachments Logs OK Cancel Send Referral

Document attempts to contact the patient in general notes (above); or create Follow-up call questions in the Structured Data tab (below).

Diagnosis / Reason Visit Details Notes **Structured Data**

Name	Value	Notes	
<input type="checkbox"/> Clinical Consultation Report Rec		X	X
<input type="checkbox"/> Report of Clinical Encounter Re		X	X
<input type="checkbox"/> Confirmatory Consultation Rep		X	X
<input type="checkbox"/> Follow-up call 1	9/16/2015	X	X
<input type="checkbox"/> Follow-up call 2	9/16/2015	X	X
<input type="checkbox"/> Follow-up call 3	9/16/2015	X	X

Additional notes for each attempt can be added by clicking on the notes field.

Custom Default for All Clear All

Scan Attachments Logs OK Cancel Send Referral

Exhibit 8 - Using Telephone Encounter to track Patient Communication of Results

The screenshot displays the 'Telephone Encounter' interface for a patient named Mickey Mouse. The patient's information includes address (123 E MAIN ST, JOHNSTOWN, NY), phone numbers, and email (mickev.mouse@vaho). The encounter is dated 9/15/2015 at 5:24 PM, with a high priority status. The provider is Willis, Sam, and the facility is Westboro Medical Associates. The reason for the encounter is 'Abnormal FIT/FOBT results'. The 'Status' dropdown menu is currently set to 'Open', with other options being 'Addressed', 'Addressed and Docs Reviewed', and 'Reviewed'. The 'Action Taken' log shows several messages sent to the patient, including one asking to contact the health center. A callout box on the right side of the screen contains the following text:

Leave in an Open status until either the patient has been contacted; or the certified letter is sent. Then the status can be changed to Addressed.

Exhibit 9 - Documenting Colonoscopy Results and Tracking Patient Communication

Diagnostic Imaging

Mouse, Mickey, 46 Y, M

123 E MAIN ST
JOHNSTOWN, NY
H:518-762-8644
M:518-762-2122
DOB:11/11/1968
mickey.mouse@vaho

Wt:09/09/15: 120 lbs.
App(L):09/15/15(SW)
PCP: Willis, Sam
Language: Spanish
Translator: No

Ins: CDPHP
Acc Bal: \$250.00
Guar: Mickey
Gr Bal: \$210.00
Ref: Willis, Sam

CLICK TO EDIT test

Box is checked only if results are positive or abnormal

Medical Summary | CDSS | Alerts | Labs | DI | Procedures | Growth Chart | Imm/T.Inj | Encounters | Patient

Patient: Mouse, Mickey
DOB:11/11/1968 Age:46Y
Sex:M
Tel:518-762-8644
Acct No:9336, WebEnabled: Yes
Elgb Status:

Status: Open Reviewed

Provider: Willis, Sam High Priority
Facility: Westboro Medical Associate
Assigned To: Willis, Sam

Diagnostic Imaging Information

Imaging: colonoscopy
Order Date: 9/15/2015
Performed Date: 9/16/2015

Results

Received Date: 9/17/2015
Result: Abnormal

Order Date	Performed Date
09/17/2015	09/16/2015
04/29/2015	
03/06/2015	

Provider documents the results

Assessments: Show Specify Notes: Add Notes

Clinical Info: Internal Notes: Messenger

Reports Print Midmark: ECG Options

Global Alerts

- Seeker
- Advance Directive
 - MOST test
 - DNR Do Not Resuscitate
- Problem List
 - Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled Med Risk
 - 250.00 Diabetes
 - 311 Depression
 - E11.9 Diabetes
 - E11.9 Type 2 diabetes mellitus without complications
 - V76.51 Encounter for colonoscopy due to history of adenomatous colonic polyps
 - V10.05 Personal history of malignant neoplasm of large intestine
 - 401.9 HTN (hypertension)

Diagnostic Imaging

Mouse, Mickey, 46 Y, M

123 E MAIN ST
JOHNSTOWN, NY
H:518-762-8644
M:518-762-2122
DOB:11/11/1968
mickey.mouse@vaho

Wt:09/09/15: 120 lbs.
App(L):09/15/15(SW)
PCP: Willis, Sam
Language: Spanish
Translator: No

Ins: CDPHP
Acc Bal: \$250.00
Guar: Mickey
Gr Bal: \$210.00
Ref: Willis, Sam

CLICK TO EDIT test

SECURE NOTES Settings

Medical Summary | CDSS | Alerts | Labs | DI | Procedures | Growth Chart | Imm/T.Inj | Encounters | Patient Docs | Flow sheets | Notes

Patient: Mouse, Mickey
DOB:11/11/1968 Age:46Y
Sex:M
Tel:518-762-8644
Acct No:9336, WebEnabled: Yes
Elgb Status:

Status: Open Reviewed

Provider: Willis, Sam High Priority
Facility: Westboro Medical Associate
Assigned To: Willis, Sam

Diagnostic Imaging Information

Imaging: colonoscopy
Order Date: 9/15/2015
Performed Date: 9/16/2015

Results

Received Date: 9/17/2015
Result: Abnormal

Order Date	Performed Date
09/17/2015	09/16/2015
04/29/2015	
03/06/2015	

Notes: Add Notes

Willis, Sam 09/17/2015 01:20:16 PM EDT > Left message for patient to call
Willis, Sam 09/17/2015 01:20:30 PM EDT > Left vm for pt to return call.

Provider documents attempts to contact patient.

Global Alerts

- Seeker
- Advance Directive
 - MOST test
- Problem List
 - 311 Depression
 - E11.9 Diabetes
 - E11.9 Type 2 diabetes mellitus without complications
 - V76.51 Encounter for colonoscopy due to history of adenomatous colonic polyps
 - V10.05 Personal history of malignant neoplasm of large intestine
 - 401.9 HTN (hypertension)

Additional steps if colonoscopy result is abnormal

Global Alerts

Advance Directive

Problem List All

D12.6 Adenomatous polyp of colon

Medication Summary

Add diagnosis to problem list.

CDSS Alerts

- Alcohol use screening
- Depression screening
- Sexual history taken
- Smoking status

Practice Created Alerts

- [G] colonoscopy 09/17/2015

Registry Alerts

There are no over due alerts today for this patient.

Click blue downward arrow to create pt specific alert

Patient Specific Alert

Patient: Duck, Daisy

Add New Alerts

Alert Type: Labs, D.I, Imm / T.Inj, Proc., Billing, Other

Name: colonoscopy Sel Recurring?

Description:

Addl Entities: Add

Recall After: 3 Day(s) Week(s) Month(s) Year(s)

Due Date: 9 /17/2018

OK Cancel

Enter the recall information

CDSS Alerts

- Alcohol use screening
- Depression screening
- Sexual history taken
- Smoking status

Practice Created Alerts

- [G] colonoscopy 09/17/2015
- [PT] colonoscopy 09/17/2018

Registry Alerts

There are no over due alerts today for this patient.

NOTE: Depending on surveillance schedule by patient, you may choose to suppress the standard colonoscopy alert.

Exhibit 10 - Following up on Outstanding Orders

Use/ click on any of the items on the title bar to sort.

	O	S	Order Date	Coll Date	Result Date	Patient	Labs/Imaging/Procedures	Reason	Result	AssignedTo
<input type="checkbox"/>	F		08/19/2015	08/19/2015	08/19/2015	Mouse, Minnie	FECAL GLOBIN, IMMUNOCHEM		Normal	Willis, Sam
<input type="checkbox"/>	V		09/16/2015			Mouse, Mickey	colonoscopy			Willis, Sam
<input type="checkbox"/>	V		11/21/2008	11/21/2008	01/15/2009	Lab, Larry	LIPID PROFILE	screening	Normal	Willis, Sam
<input type="checkbox"/>	T		09/15/2015	09/15/2015	09/15/2015	Mouse, Mickey	Occult Blood, Fecal, IA (FOBT)	FOBT Colorectal Cancer Screening	Positive	Willis, Sam
<input type="checkbox"/>	C		01/22/2009	01/27/2009	01/27/2009	Jones, Raul	PSA, TOTAL	Screening	Normal	Willis, Sam
<input type="checkbox"/>	C		01/21/2009	01/28/2009	01/28/2009	Johnson, Jack	Urinalysis, Routine	Screening	Normal	Willis, Sam
<input type="checkbox"/>	C		01/21/2009	01/27/2009	01/27/2009	Johnson, Jack	CBC	Patient Request	See Attached Report	Willis, Sam
<input type="checkbox"/>	C		02/01/2009	02/03/2009	02/03/2009	Lab, Larry	EKG	Diagnosis Related	Normal	Willis, Sam
<input type="checkbox"/>	C		01/20/2009	02/03/2009	02/03/2009	Curran, Jeff P	EKG	Screening	Normal	Willis, Sam
<input type="checkbox"/>	C		02/05/2009	02/05/2009	02/05/2009	Curran, Jeff P	TSH	Diagnosis Related	Normal	Willis, Sam
<input type="checkbox"/>	C		02/05/2009	02/06/2009	02/06/2009	Curran, Jeff P	URINALYSIS, COMPLETE	Screening	Normal - Tr Bld	Willis, Sam
<input type="checkbox"/>	C		01/22/2009	01/28/2009	01/28/2009	Curran, Jeff P	Upper gastrointestinal (UGI) series	Diagnosis Related	See Attached Report	Willis, Sam
<input type="checkbox"/>	C		02/01/2009	02/03/2009	02/03/2009	Lab, Larry	holter	Diagnosis Related	Normal	Willis, Sam
<input type="checkbox"/>	C		02/01/2009	02/03/2009	02/03/2009	Lab, Larry	spiro	Diagnosis Related	Normal	Willis, Sam
<input type="checkbox"/>	C		01/16/2009	01/15/2009	01/15/2009	Lab, Larry	AMYLASE, SERUM	Requisition Printed: Quest	Normal	Willis, Sam
<input type="checkbox"/>	C		01/16/2009	01/15/2009	01/15/2009	Lab, Larry	GLUCOSE TOLERANCE, 6HR	Requisition Printed: Quest	Low	Willis, Sam
<input type="checkbox"/>	C		01/16/2009	01/15/2009	01/15/2009	Lab, Larry	CBC (INCLUDES DIFF/PLT)	Requisition Printed: Quest	LOW WBC, HIGH Hgb	Willis, Sam
<input type="checkbox"/>	C		12/30/2008	01/08/2009	01/15/2009	Lab, Larry	BASIC METAB PANEL W/EGFR	Requisition Printed: Quest	HIGH K+	Willis, Sam

F = Future; V = Virtual; T = Telephone; C = Current

Use additional filter items to narrow your search.

The screenshots demonstrate the following filter steps:

- Screenshot 1:** Shows the full list of 21 lab orders. The filter bar is set to 'All' for Provider, Facility, and Lab. The 'In-house' checkbox is checked.
- Screenshot 2:** The 'Lab' filter is set to 'Occult Blood, Fecal, IA (FOBT)'. The list is now filtered to 1 item.
- Screenshot 3:** The 'Lab' filter is set to 'colonoscopy'. The list remains filtered to 1 item.

Exhibit 11 - Referral Appointment reminders and consult report follow-up

R Jellybean

The screenshot shows the eClinicalWorks interface for 'Willis,Sam'. The main window is titled 'Referrals Outgoing' and displays a list of referrals. The interface includes a top navigation bar with menu items like 'File', 'Patient', 'Schedule', 'EMR', 'Billing', 'Reports', 'CCD', 'Fax', 'Tools', 'Community', 'Meaningful Use', 'Lock', and 'Help'. Below the navigation bar, there are status indicators for 'E', 'D', 'R', 'I', 'L', 'M' with corresponding counts. The left sidebar shows a navigation menu with options like 'Admin', 'Practice', 'Resource Sche...', 'Jones,Mary', 'Smith,John', 'Willis,Sam', and 'Office Visits'. The main content area has filters for 'Assigned to', 'Referral From', 'Referral To', and 'Facility From', along with a 'Date' and 'Appt By' filter. The table below lists the following referrals:

RE	Date	Patient	Reason	Referral From	Referral To	Speciality	Start Date	End Date	Appt Date	Facility From	Facility To	Staf
<input type="checkbox"/>	08/20/2015	Duck,Unde Sroooge	CRC	Willis,Sam	Charles,Andrew	Gastroenterology	08/20/2015	11/18/2015	09/10/2015	Westboro Medical Associates		NA
<input type="checkbox"/>	08/11/2015	Mouse,Mickey	colonoscopy	Willis,Sam	Charles,Andrew	Gastroenterology	08/11/2015	11/09/2015	09/08/2015	Westboro Medical Associates		NA
<input type="checkbox"/>	06/10/2015	Mouse,Mickey		Willis,Sam			06/10/2015	09/08/2015		Westboro Medical Associates		NA
<input type="checkbox"/>	04/30/2015	Mouse,Mickey	possible heart murmur	Jones,Mary	Johnson,John	Cardiology	04/30/2015	07/29/2015	05/22/2015	WMA - Grafton		NA
<input type="checkbox"/>	04/27/2015	Mouse,Mickey	numbness in leg	Willis,Sam	Bartel,Wayne	Neurology	04/27/2015	07/26/2015	06/17/2015	Westboro Medical Associates		NA
<input type="checkbox"/>	08/22/2014	Mouse,Mickey	colonoscopy	Willis,Sam	Charles,Andrew	Gastroenterology	08/22/2014	11/20/2014	09/02/2014	Westboro Medical Associates		NA

At the bottom right of the table area, it says 'Referrals 1 to 6 of 6'.

Attaching Results to Order – Paperclip Workflow

BridgeIT uses the “paperclip logic” for the cancer screening reports. This means that a paperclip (pink or gray) has to appear on the lab in eCW in order to be able to report on it. The paperclip signifies that results are attached.

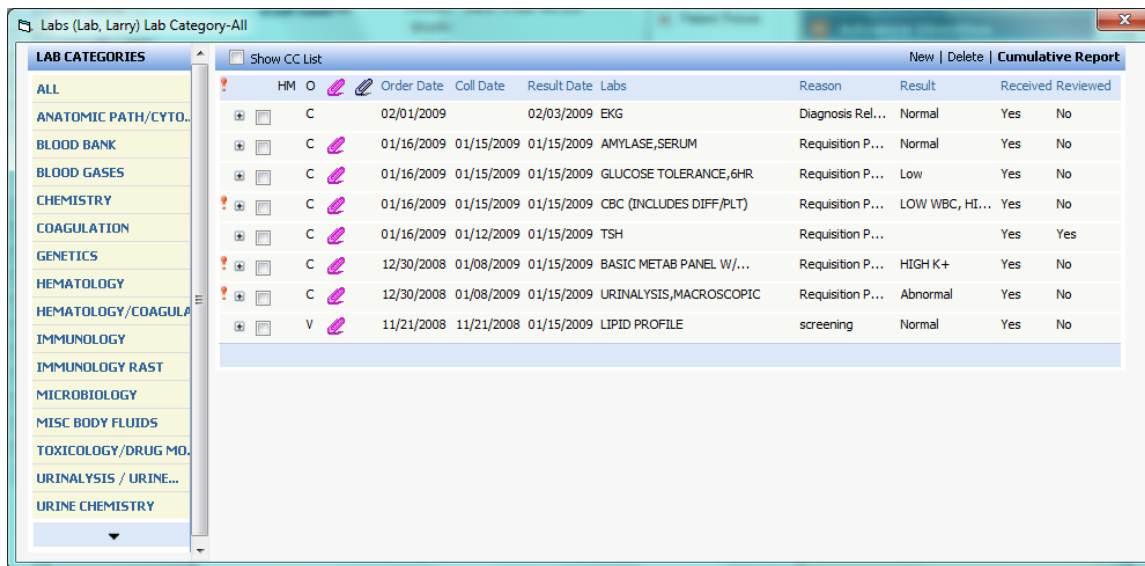
eCW uses the patient’s last name, first name, and date of birth to match an electronic result to a current order. If these three items match and there is a current order in the system, the result will be attached to the order and a pink paper clip will appear on the lab. If these three items match but there is no order in the system, a virtual order is created by the system and the result is attached to that order. A pink paper clip appears on that lab, along with a V to indicate that it was created via a virtual order.

Pink paper clip = an electronic result

Gray paper clip = paper result

C = current order

V = virtual order



LAB CATEGORIES	HM	O	Order Date	Coll Date	Result Date	Labs	Reason	Result	Received	Reviewed
ALL		C	02/01/2009		02/03/2009	EKG	Diagnosis Rel...	Normal	Yes	No
ANATOMIC PATH/CYTO...		C	01/16/2009	01/15/2009	01/15/2009	AMYLASE,SERUM	Requisition P...	Normal	Yes	No
BLOOD BANK		C	01/16/2009	01/15/2009	01/15/2009	GLUCOSE TOLERANCE,6HR	Requisition P...	Low	Yes	No
BLOOD GASES		C	01/16/2009	01/15/2009	01/15/2009	CBC (INCLUDES DIFF/PLT)	Requisition P...	LOW WBC, HI...	Yes	No
CHEMISTRY		C	01/16/2009	01/15/2009	01/15/2009	TSH	Requisition P...		Yes	Yes
COAGULATION		C	12/30/2008	01/08/2009	01/15/2009	BASIC METAB PANEL WJ...	Requisition P...	HIGH K+	Yes	No
GENETICS		C	12/30/2008	01/08/2009	01/15/2009	URINALYSIS,MACROSCOPIC	Requisition P...	Abnormal	Yes	No
HEMATOLOGY		V	11/21/2008	11/21/2008	01/15/2009	LIPID PROFILE	screening	Normal	Yes	No

Note: *If a matching test order does not exist when the report is received, the test must be created using the appropriate test date to which the result is then attached. When results are received electronically and no matching test is found for that patient, a new test is automatically created.*

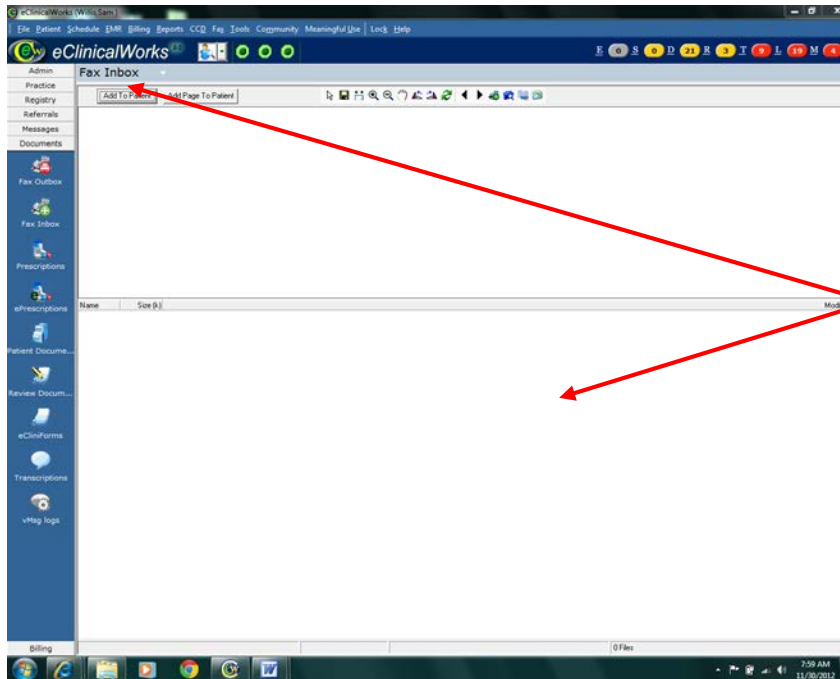
Workflow for Attaching Results to Tests

In this best practice workflow for attaching results to tests, the staff member who is attaching the result to the test should mark the document “Reviewed”. This step avoids the providers receiving both Documents (D jellybean) and Tests (L jellybean) to view. Only the test, with the document embedded, will be forwarded to the provider for review. Below are instructions both for attaching a paper result from the fax inbox and attaching a paper result from a scanned document.

Note: For efficiency in attaching, results can only be stored in the Lab Documents and X-ray Documents folders. No subfolders should be used!

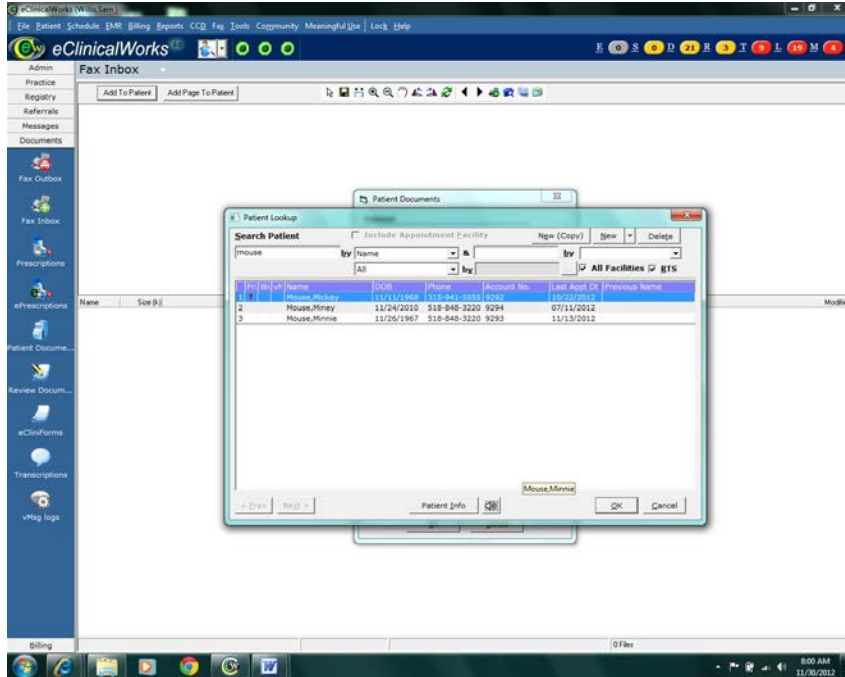
Attaching a paper result from the fax inbox:

- Highlight the document.
- Click the Add to Patient button OR right click and add to patient.

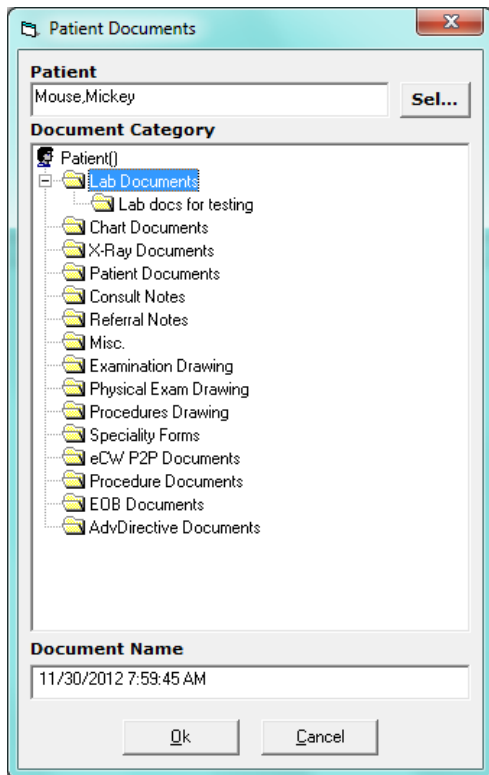


The list of documents will show in the lower half of the screen. Click on the desired document to choose it. Then click on the Add to Patient button; or right click and add to patient.

- Select the patient and click OK.

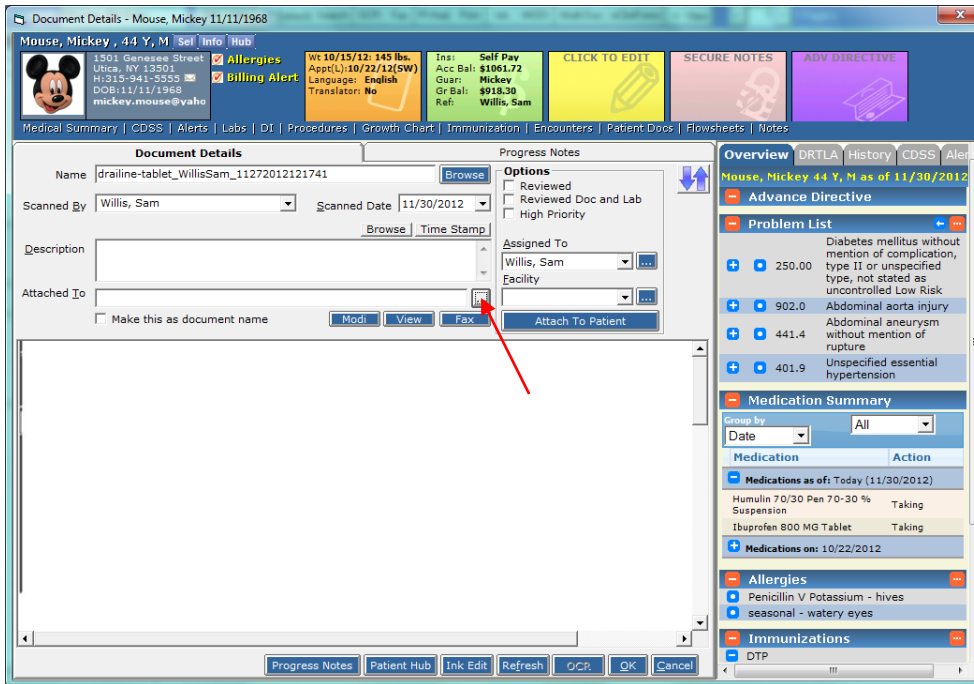


- Highlight the folder that you want to add the document to (Lab or X-ray).
- Click OK.

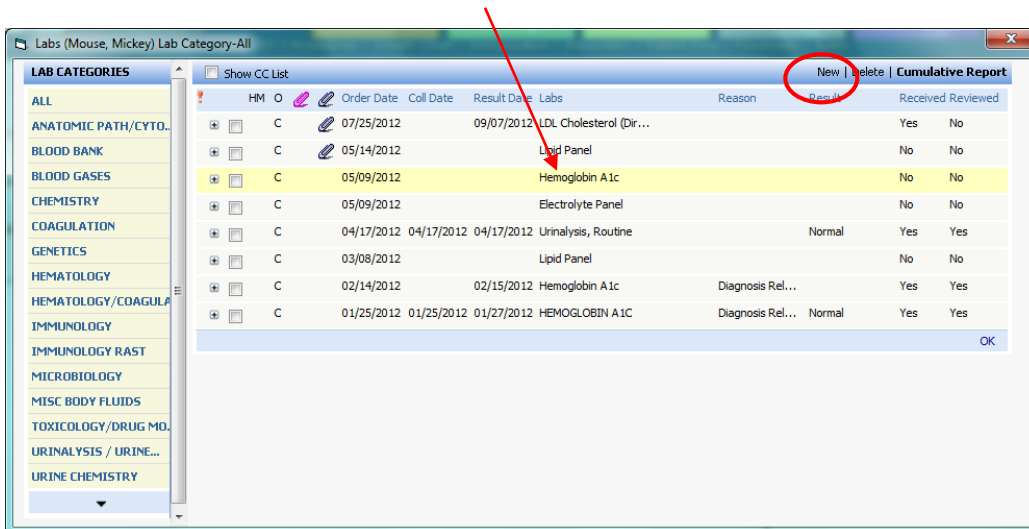


The Document Details window opens up.

- Click the ellipsis button next to the Attach to field.



- To open the lab results window, click directly on the lab.
- If the desired lab is not on the list, click the “New” link to open the Lab Results window.



- For a new lab, enter the appropriate information according to your health center's workflow. (*Note: when creating an order in this manner, you will not have access to add the Assessments.*)
- Assign the lab to the proper provider.
- Click OK.

The screenshot shows the 'Lab Results' window for Mickey Mouse. The 'AssignedTo' dropdown menu is highlighted with a red circle and contains the name 'Willis, Sam'. Other fields include Patient info, Lab Information (HEMOGLOBIN A1C), and a table of results.

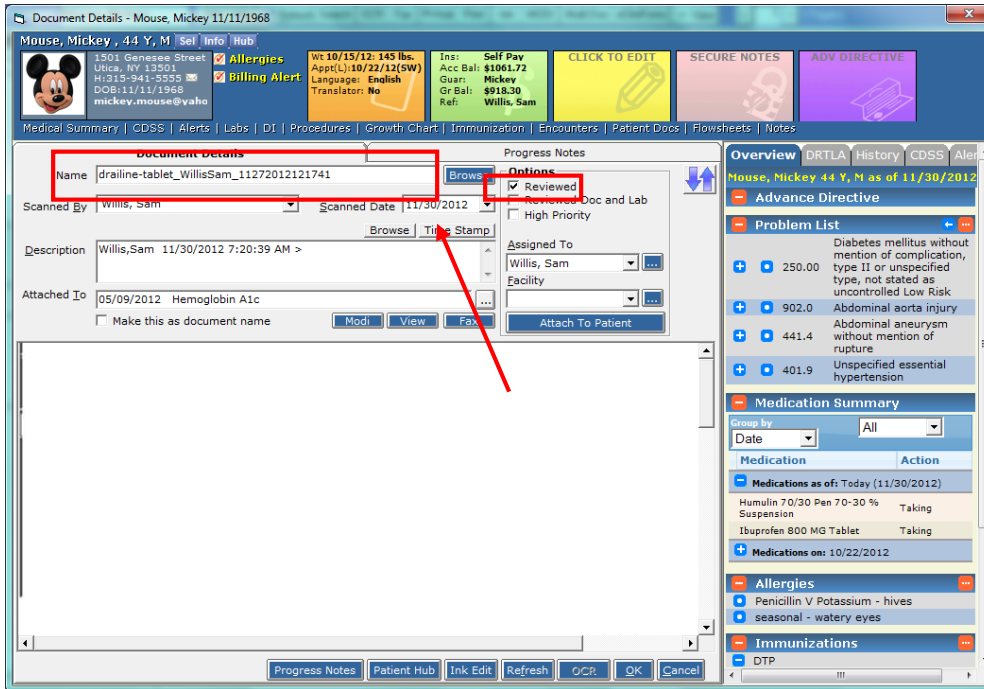
Order Date	Coll. Date	Hemoglob	Hgb A1C
10/08/2015			
09/09/2015			
06/10/2015			

- Check the box next to the desired lab
- Click OK

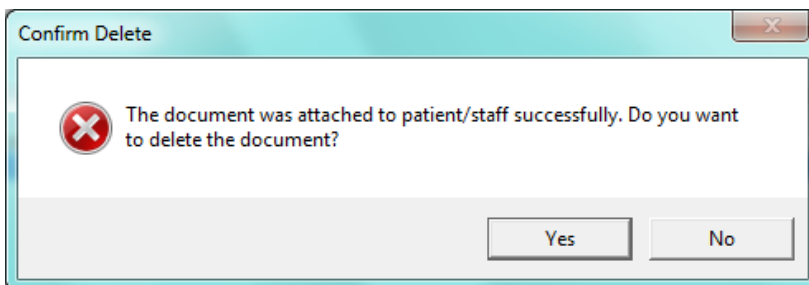
The screenshot shows the 'Labs (Mouse, Mickey) Lab Category-All' window. A table lists various lab categories and their results. The 'HEMOGLOBIN A1C' row is highlighted with a red circle, and the 'OK' button at the bottom right is also circled in red.

LAB CATEGORIES	HM	O	Order Date	Coll Date	Result Date	Labs	Reason	Result	Received	Reviewed
ALL										
ANATOMIC PATH./CYTO...			07/25/2012		09/07/2012	LDL Cholesterol (Dir...			Yes	No
BLOOD BANK			05/14/2012			Lipid Panel			No	No
BLOOD GASES			05/09/2012			Hemoglobin A1c			No	No
CHEMISTRY			05/09/2012			Electrolyte Panel			No	No
COAGULATION			04/17/2012	04/17/2012	04/17/2012	Urinalysis, Routine		Normal	Yes	Yes
GENETICS			03/08/2012			Lipid Panel			No	No
HEMATOLOGY			02/14/2012		02/15/2012	Hemoglobin A1c	Diagnosis Rel...		Yes	Yes
HEMATOLOGY/COAGULA...			01/25/2012	01/25/2012	01/27/2012	HEMOGLOBIN A1C	Diagnosis Rel...	Normal	Yes	Yes
IMMUNOLOGY										
IMMUNOLOGY RAST										
MICROBIOLOGY										
MISC BODY FLUIDS										
TOXICOLOGY/DRUG MO...										
URINALYSIS / URINE...										
URINE CHEMISTRY										

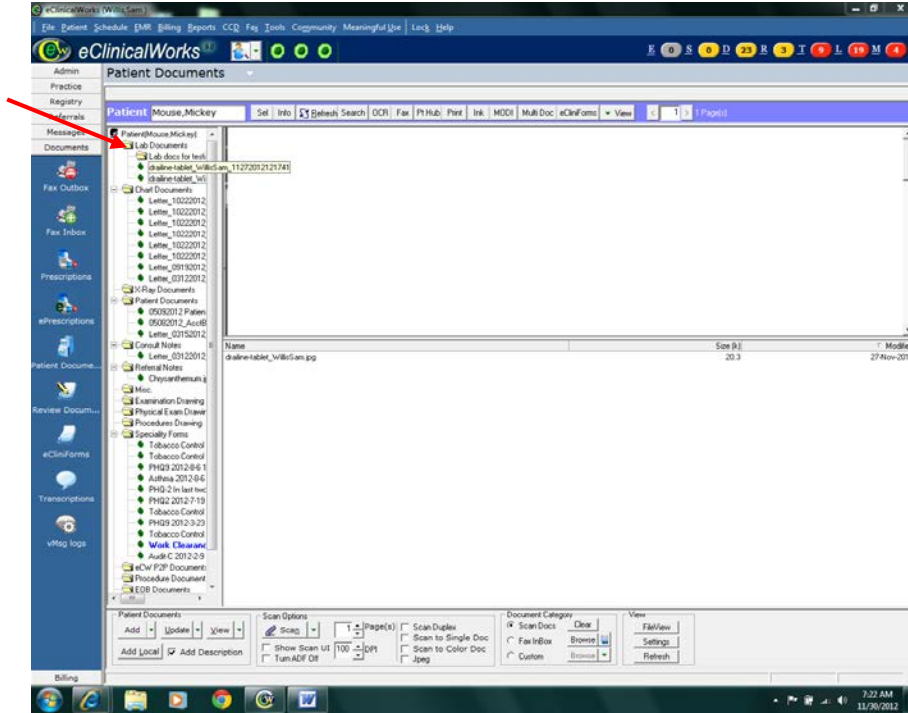
- The lab name now appears in the Attached to field.
- Time Stamp the document
- Change the name of the document according to your health center's naming convention.
- Fill out any other fields according to your health center's workflow.
- Check the Reviewed box
- Click OK.



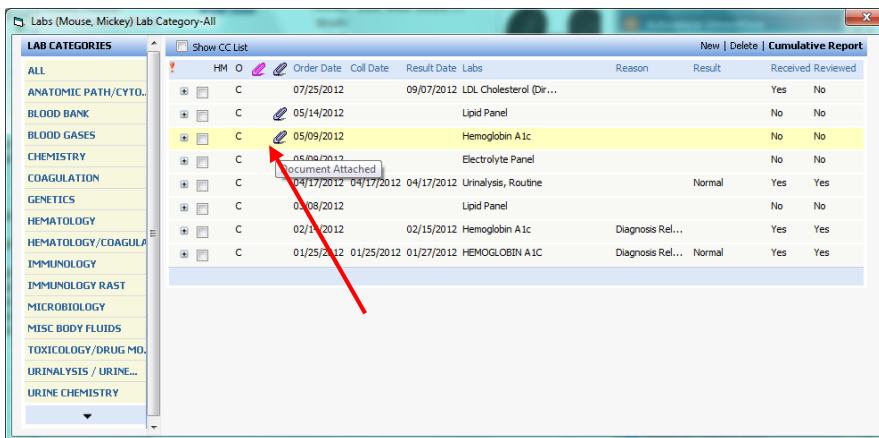
- Click Yes to delete the document from the list of scanned documents. Note: this does not delete the document from the folder that it was placed in.



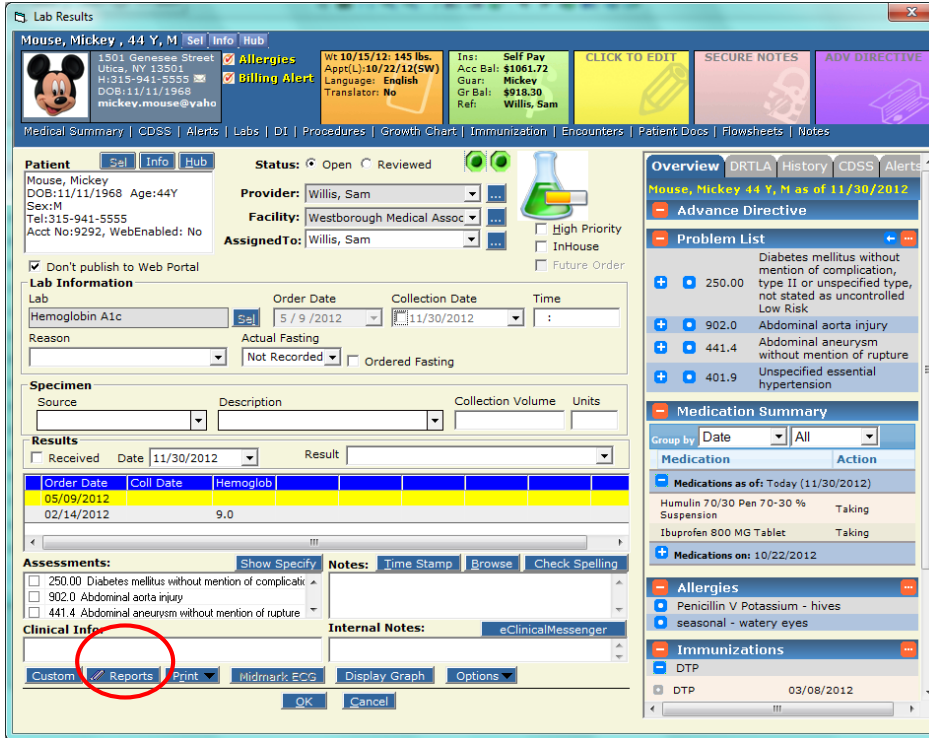
- The document now shows as reviewed in the proper folder.



- A gray paper clip now appears next to the lab in the labs window to indicate that the result is attached.

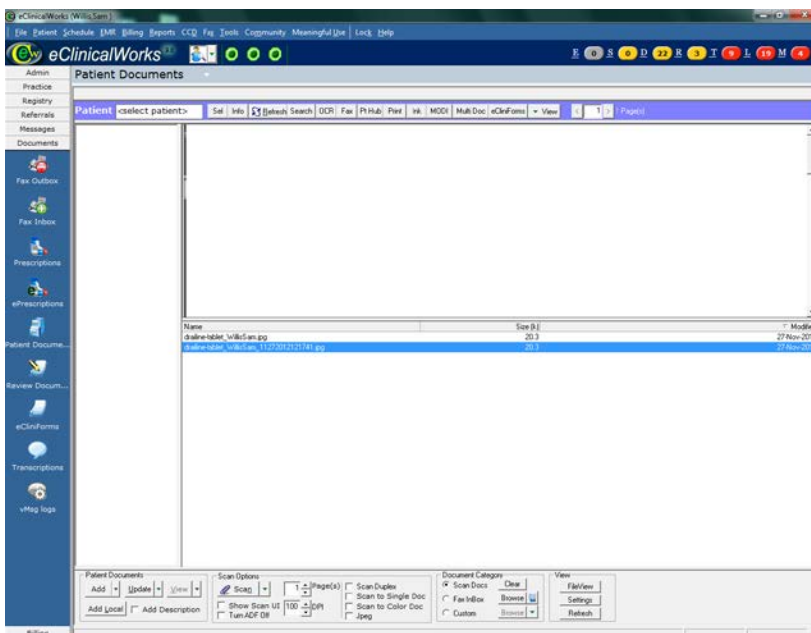


- A paperclip also appears on the reports button in the lab results window.

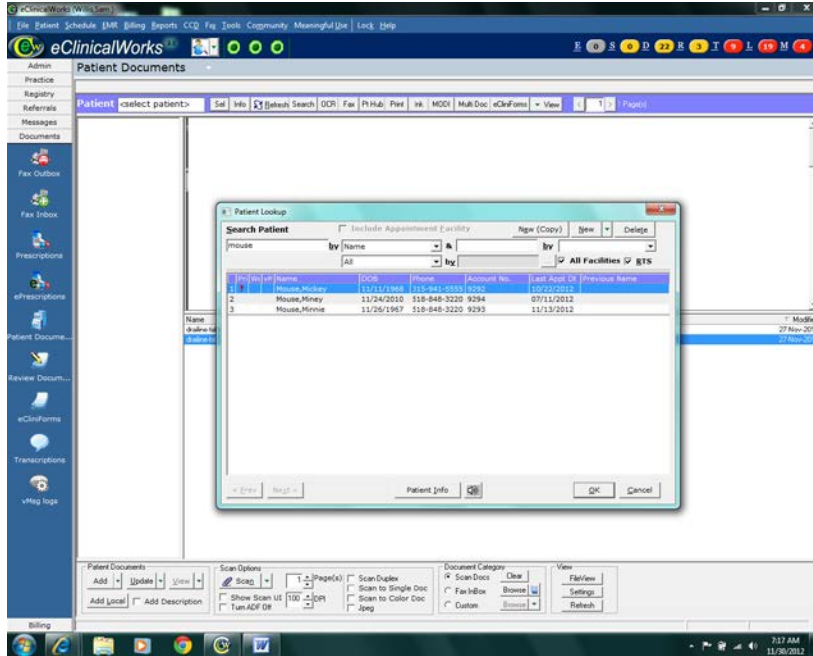


Attaching a paper result from a scanned document:

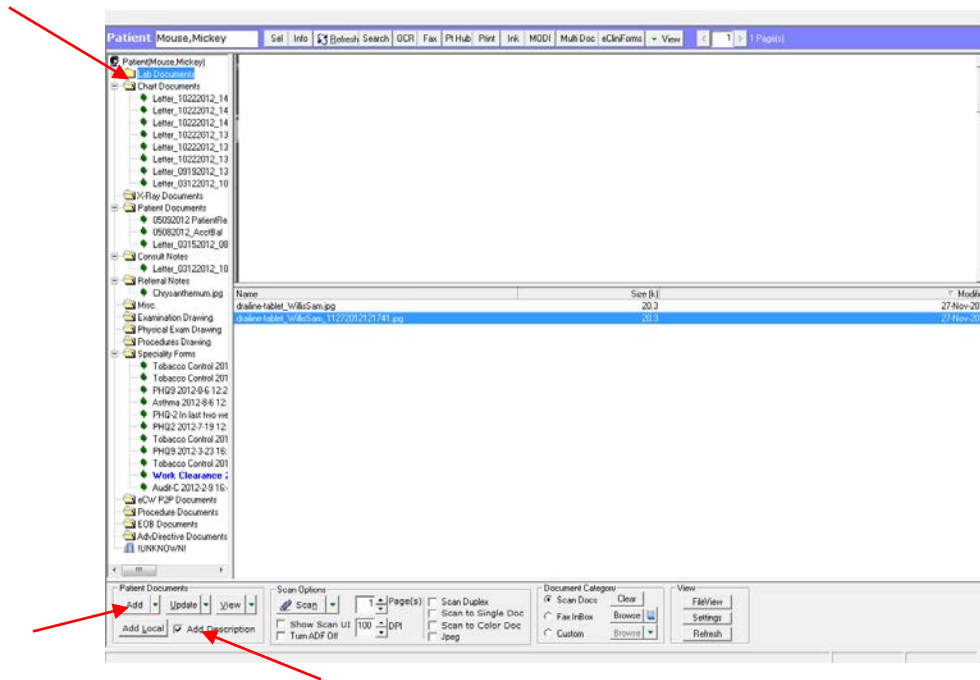
- Highlight the document.
- Click the SEL button to select the patient.



- Select the patient and click OK.

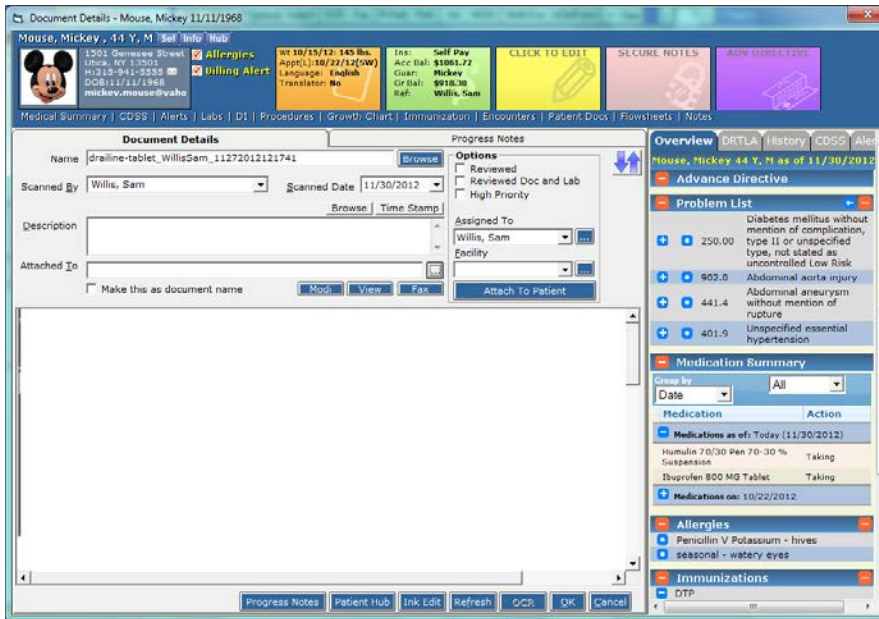


- Highlight the folder that you want to add the document to (Lab or X-ray).
- Check the Add Description box
- Click Add



The Document Details window opens up.

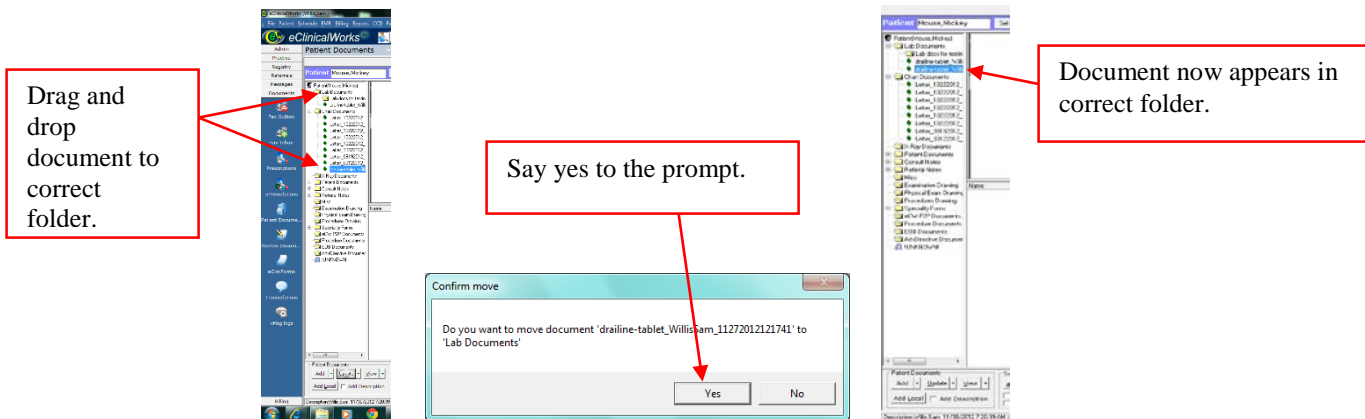
- Refer to page 4 and follow the remaining steps



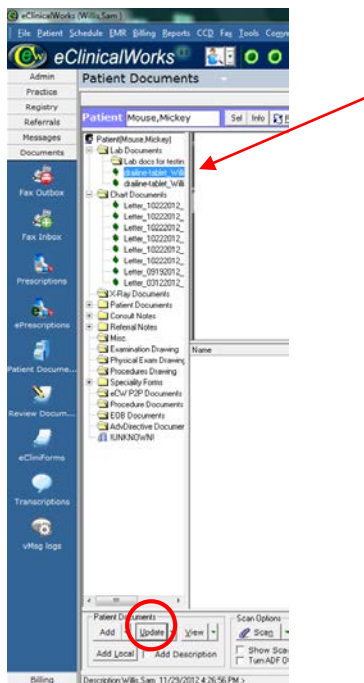
Attaching results previously filed in the Patient Chart:

Lab document(s) must be housed in the Lab Documents folder; and DI documents must be housed in X-ray documents folder. If the document is not in the appropriate (Lab/X-ray) folder, it must be moved to the correct folder before trying to attach it to the lab/x-ray via the drag and drop method.

- Highlight the document.
- Left click the mouse on the document name and drag to the correct folder while holding the left click button down. Release the button when it's moved to the correct folder.
- The document now appears in the correct folder.

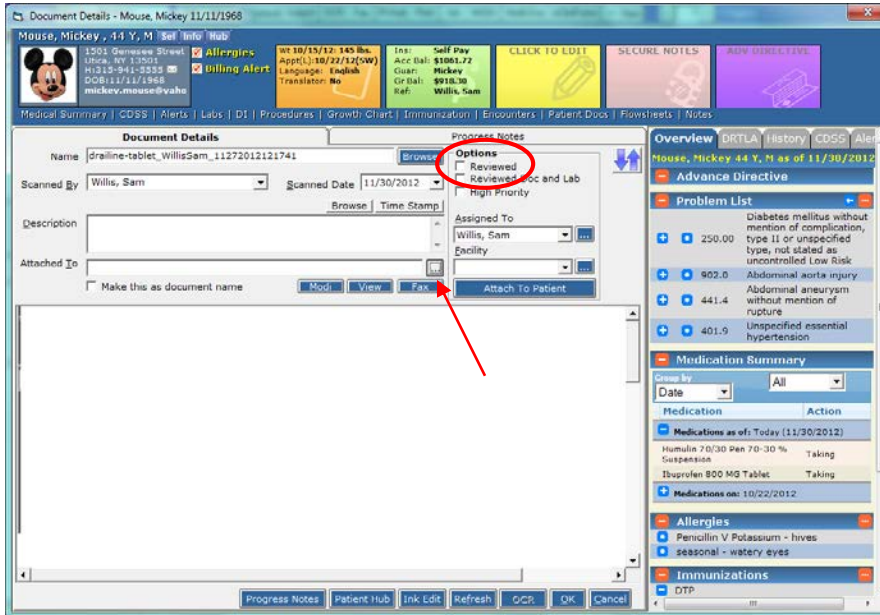


- Highlight the document
- Click the Update button



The Document Details window opens up.

- If the document has been reviewed, you have to uncheck the Reviewed box. This will make the ellipsis button next to the Attach to field available.
- Refer to page 32 and follow the remaining steps



Alternate Workflow - Attaching report (that is not already scanned into the Lab Folder in Patient Docs) to an order

