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

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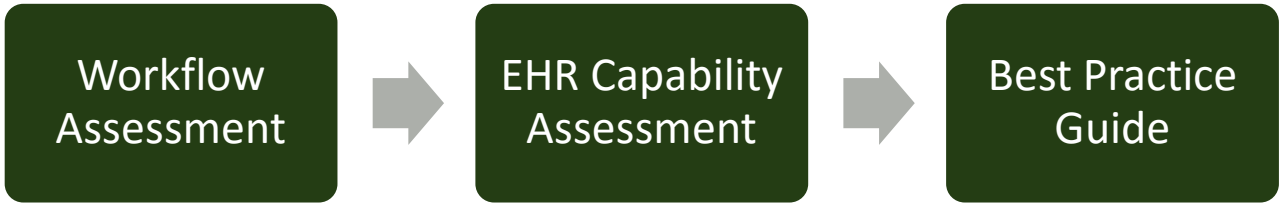
EHR Best Practice Workflow & Documentation Guide



- 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

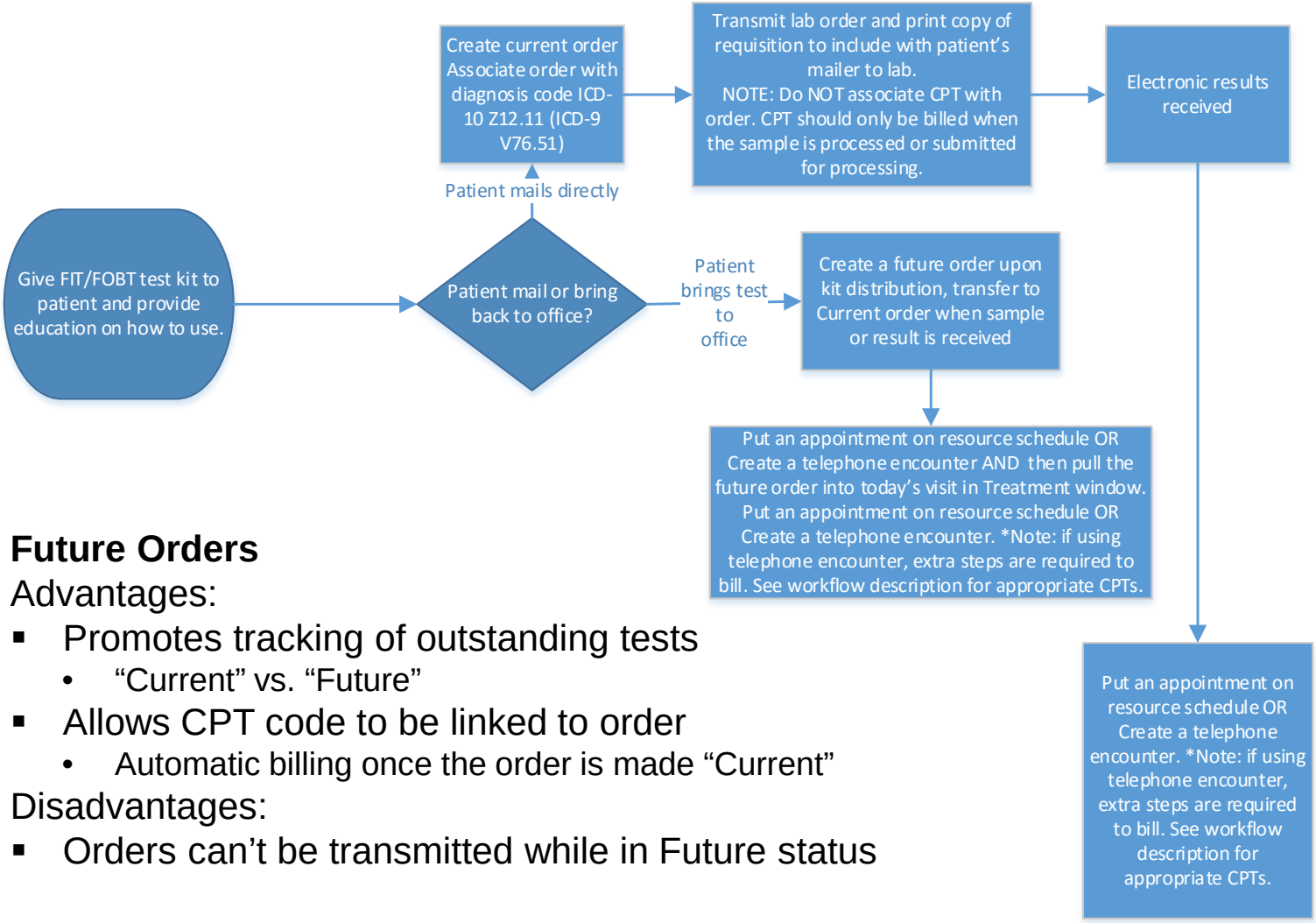
Billing in eCW (may vary in other EMRs)

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

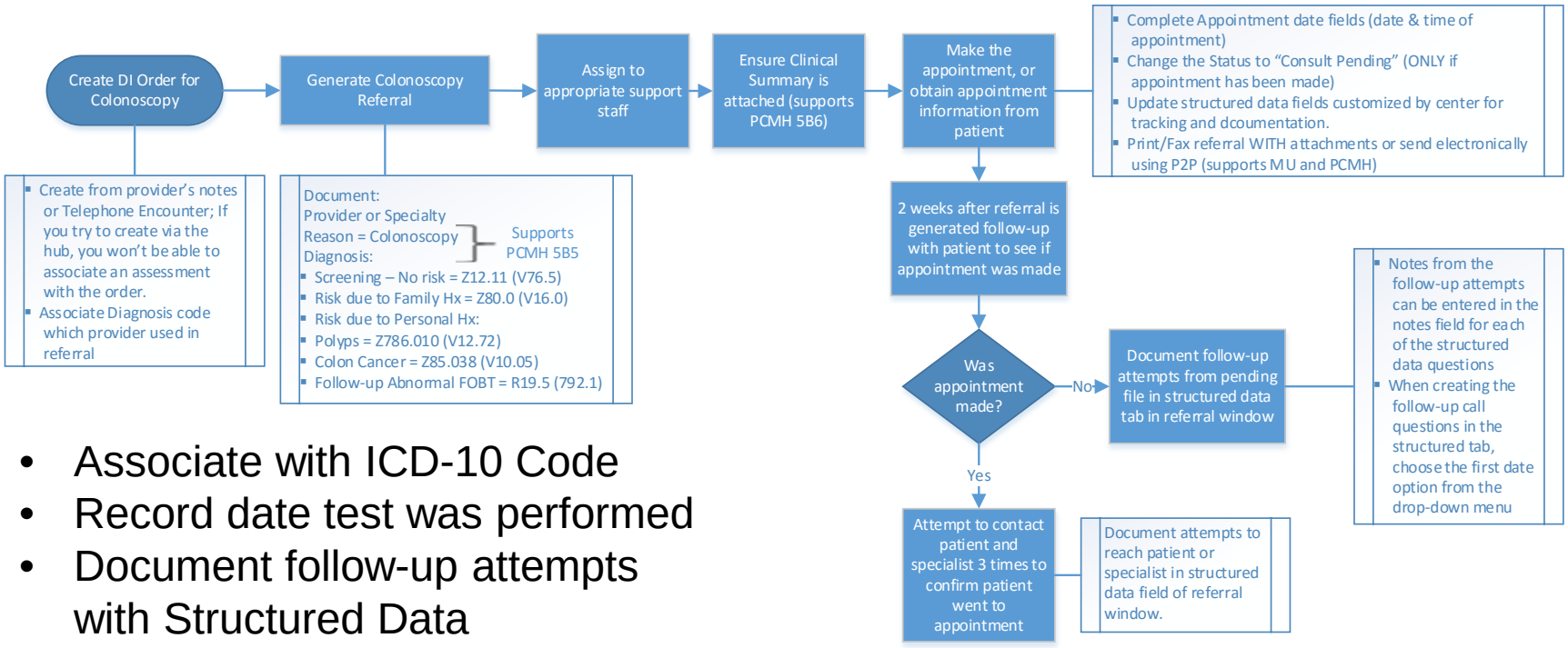
Colonoscopy Workflow - Goals

- 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

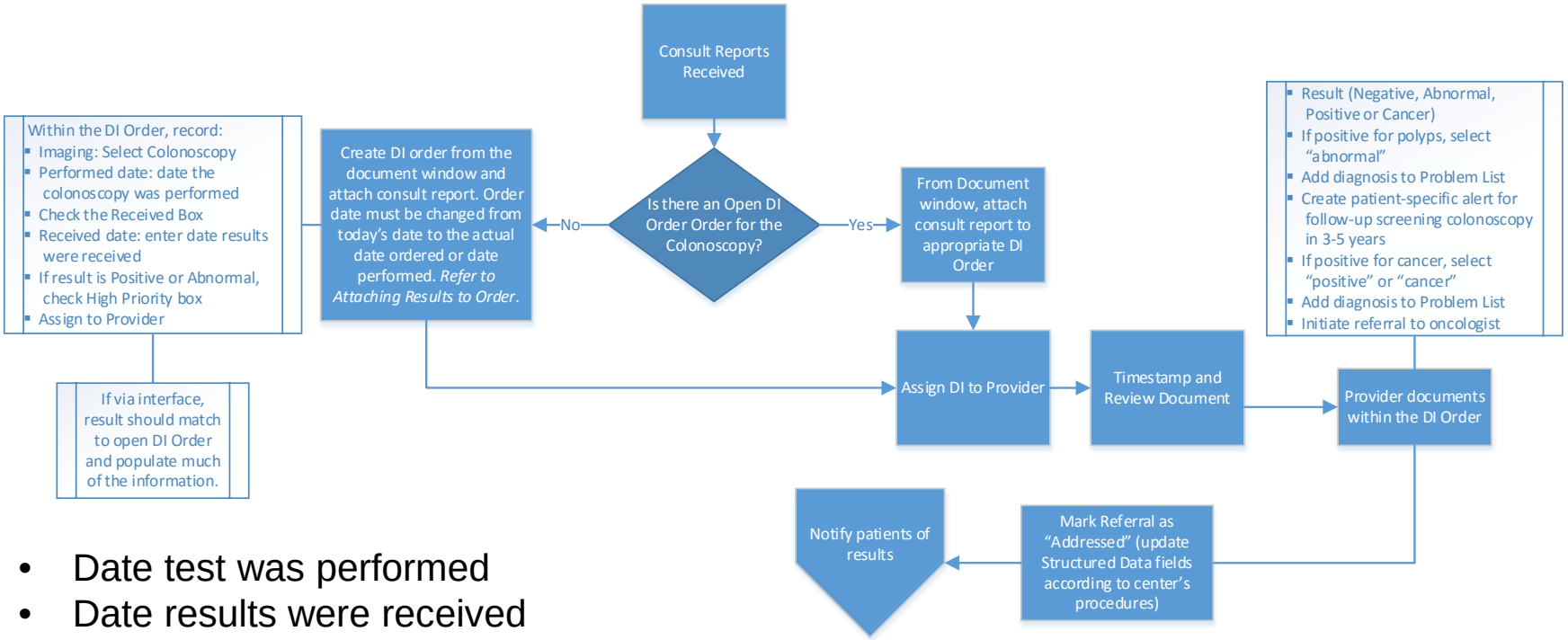
- **Reason for colonoscopy referrals**
  - ⇨ Educate that for the centers' purpose, ICD-10 Code is a *reason* code, not a *billing diagnosis code* (GI is responsible for billing)
  - ⇨ Workflow recommends associating referral with ICD code.
- **Date test was performed**
  - ⇨ Order date commonly used 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

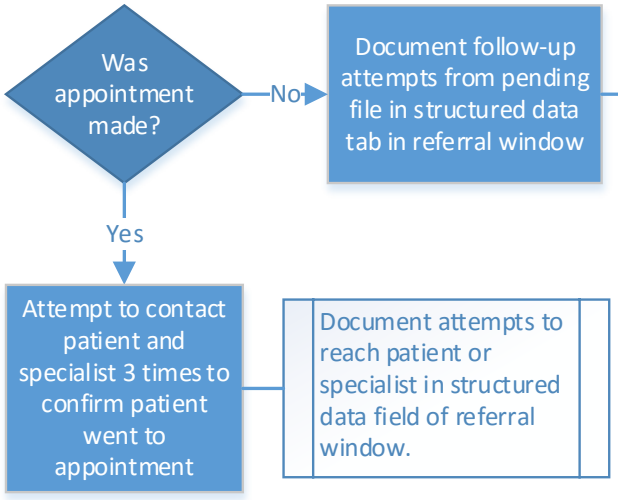


- Date test was performed
- Date results were received
- Positive or Abnormal – High Priority
- Positive for polyps – Abnormal
- Create patient specific alert for more frequent screening
- Positive for cancer – Positive or Cancer
- Add diagnosis to Problem List
- Referral to oncologist

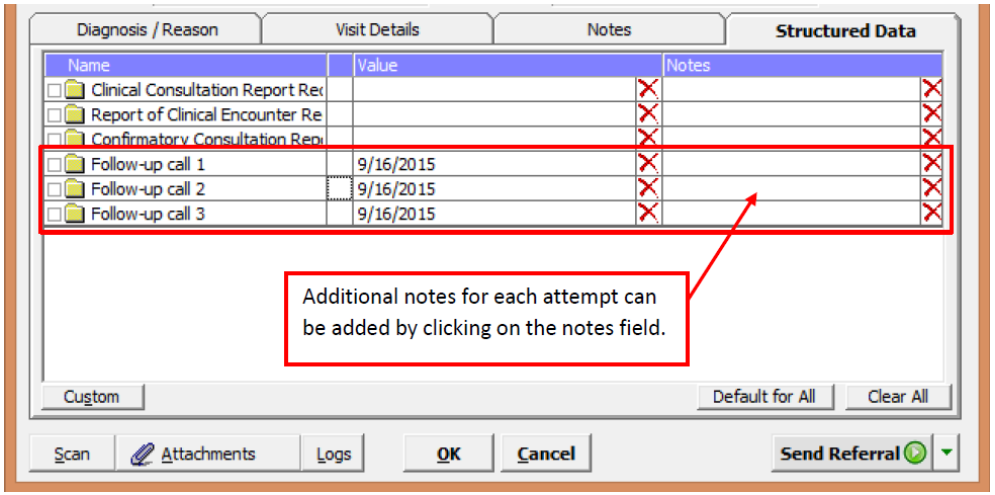
Tracking, Follow-up & Closing the Loop Challenges

- **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



- Notes from the follow-up attempts can be entered in the notes field for each of the structured data questions
- When creating the follow-up call questions in the structured tab, choose the first date option from the drop-down menu



Family History – Cancer Goals

Key elements for minimum adequate cancer family history:

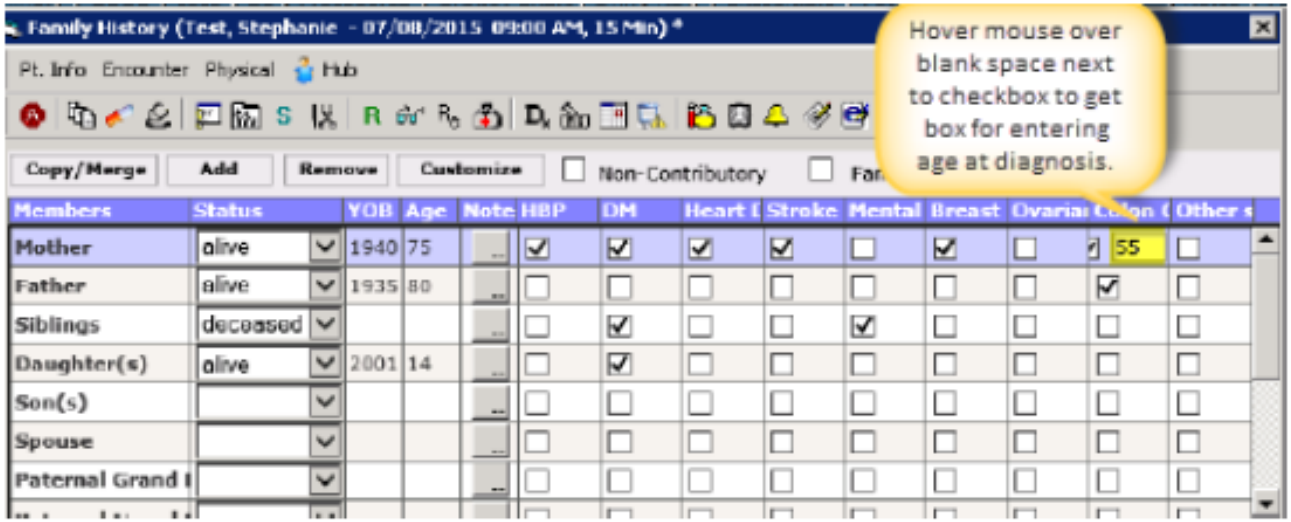
- First-degree relatives: siblings, parents, children
- Second-degree relatives: grandparents, aunts, uncles, grandchildren, nieces, nephews, half siblings
- Both maternal and paternal sides
- For each cancer case in the family establish:
  - Age at cancer diagnosis
  - Type of primary cancer

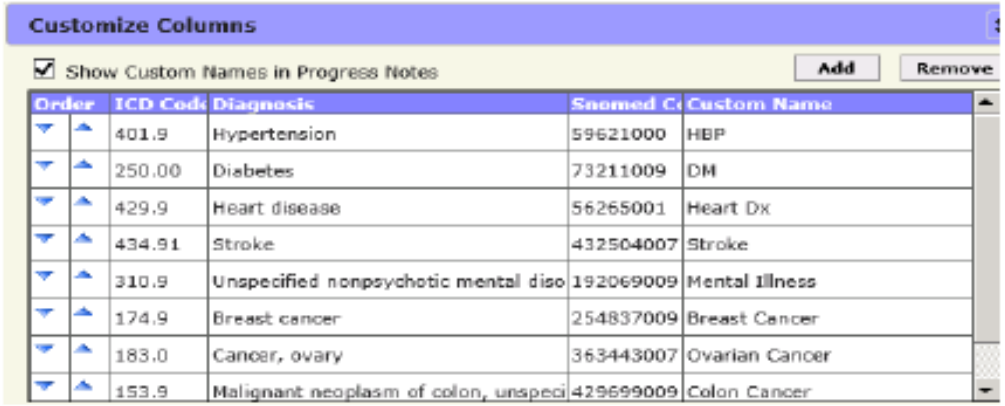
The Journal of Clinical Oncology, 3/10/2014, Volume 32, Number 9

Family History Challenges

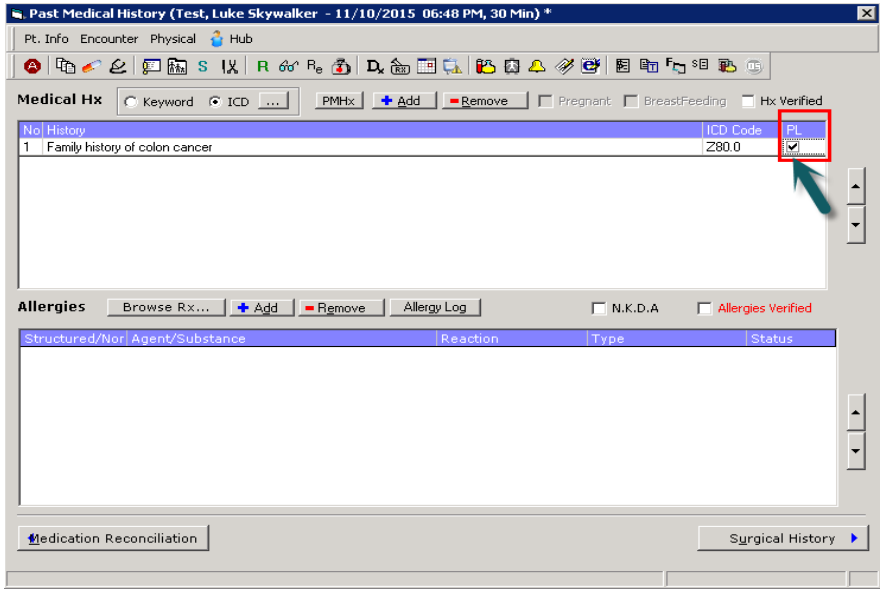
- Limited views of **structured data capture**
  - ⇨ Identified vendor enhancement requests.
- **Age at diagnosis** exists, but is not intuitive
  - ⇨ Identified vendor enhancement requests.
- Doesn't allow for **ICD-10 code entry**
  - ⇨ Workflow recommends documenting family history of colon cancer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

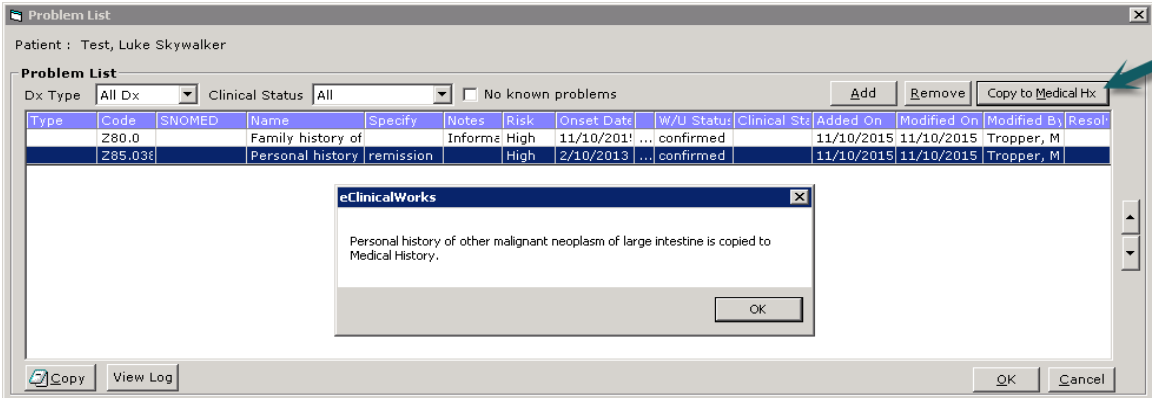
Documenting Family History





Documenting Family History in Medical History and Problem List





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

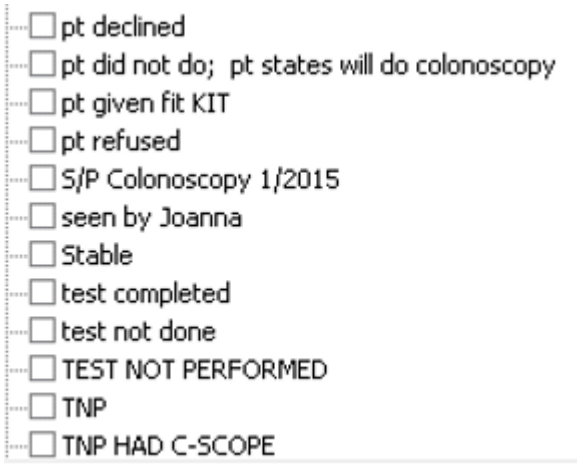
Snapshot of actual FOBT/FIT results from the EHR database

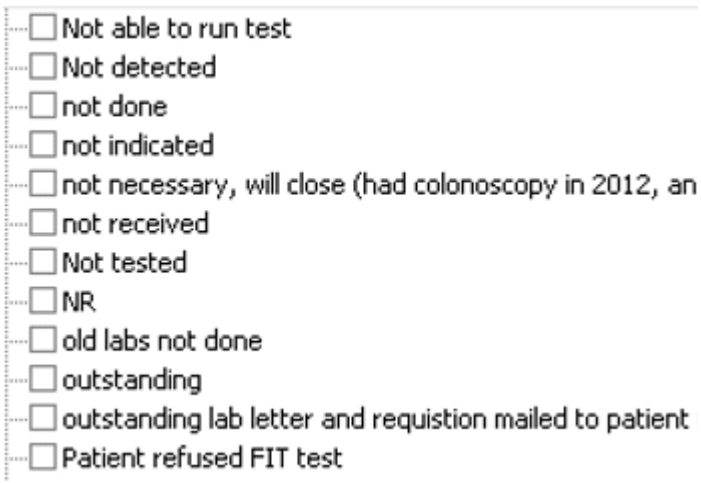
- #1 Pos,#2#3-Negatives
- +
- +FIT
- +FOBT
- +fobt, referral to GI
- +FOBT/referral processed
- +ve
- 1 Normal
- 1 normal,2,3 positive
- 1 out of 3 positive
- 1&2 Negative # 3 Positive
- 1/3 positive
- 1-positive 2- negative
- 2 Abnormal
- 2 negative, 1 positive
- 2 positive results
- 3 Negative
- 3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





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

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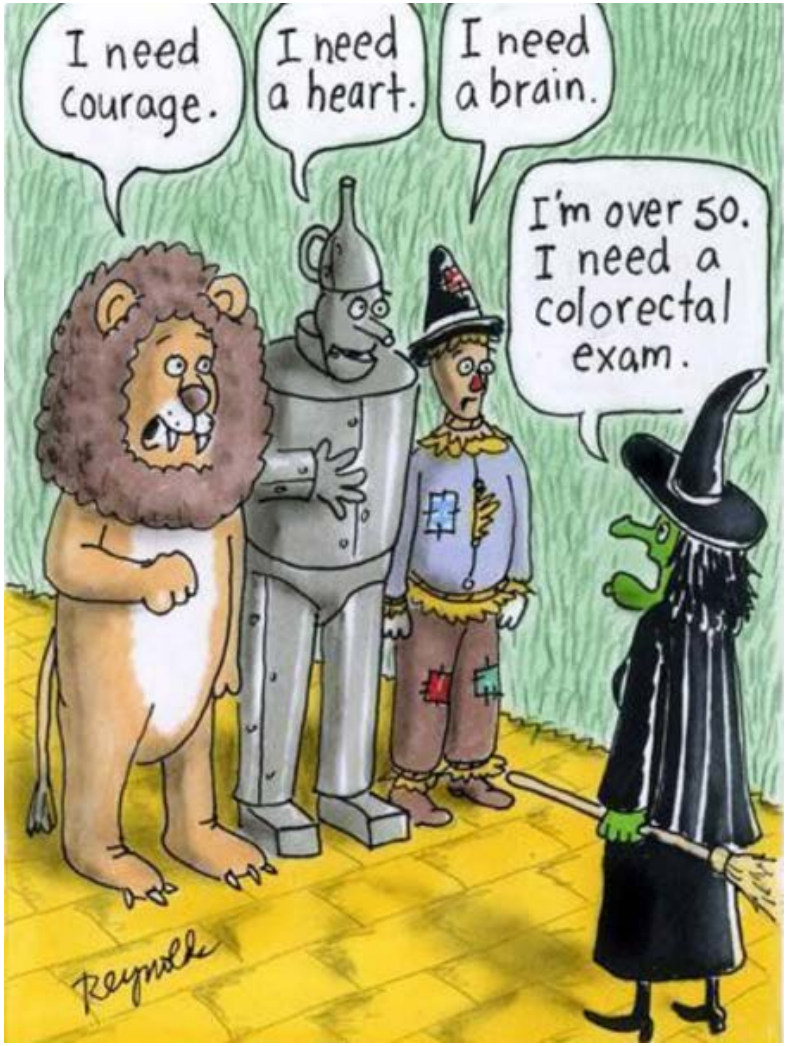
Health Center Network of New York – David Skory, MD, Carla Henke, MD, Rina Ramirez, MD, Michael McNett, MD, Sandy Cafarchio, Stephanie Rose, Desiree Railine

Questions?



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

Acknowledgements

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

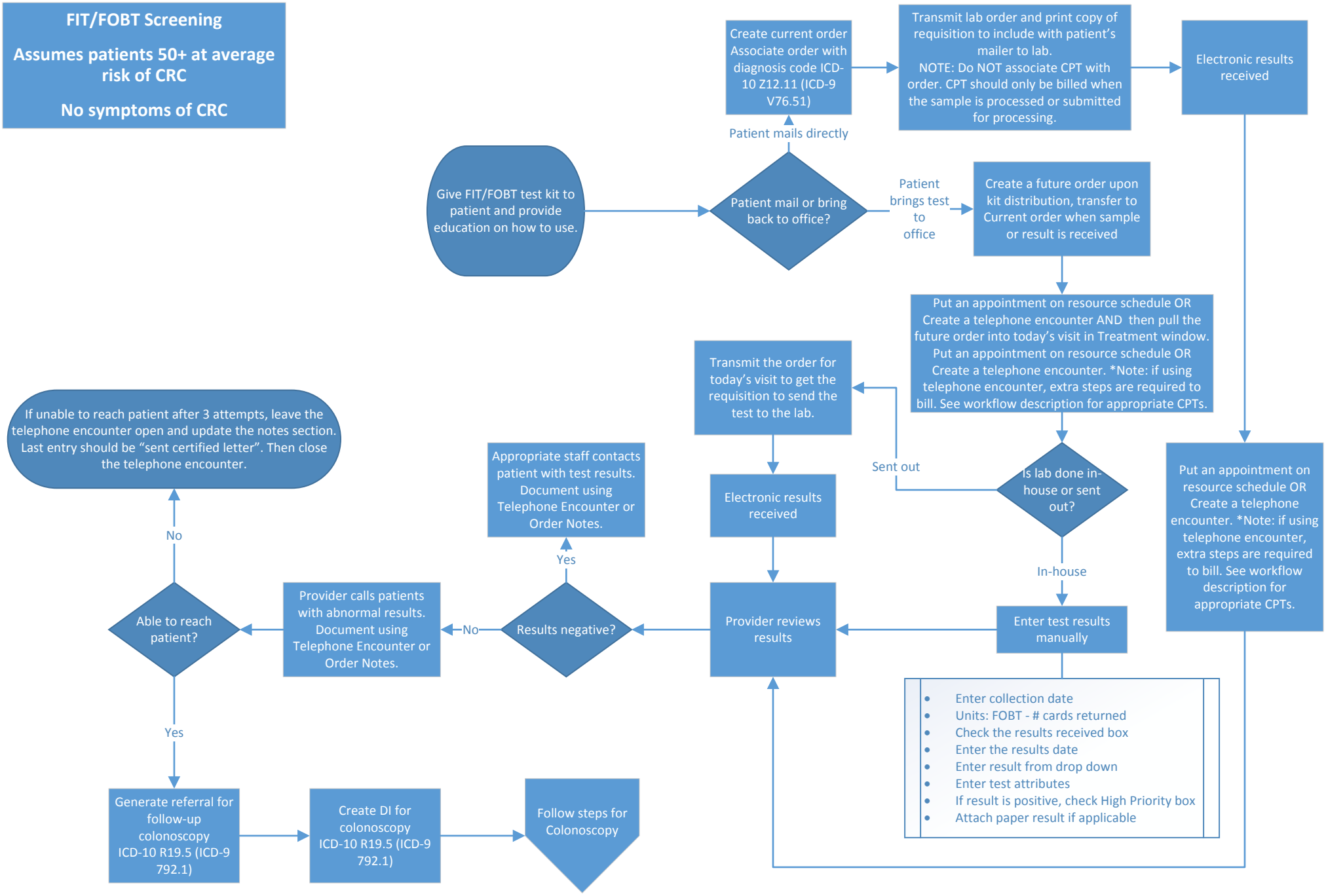
National Association of Community Health Centers (NACHC)

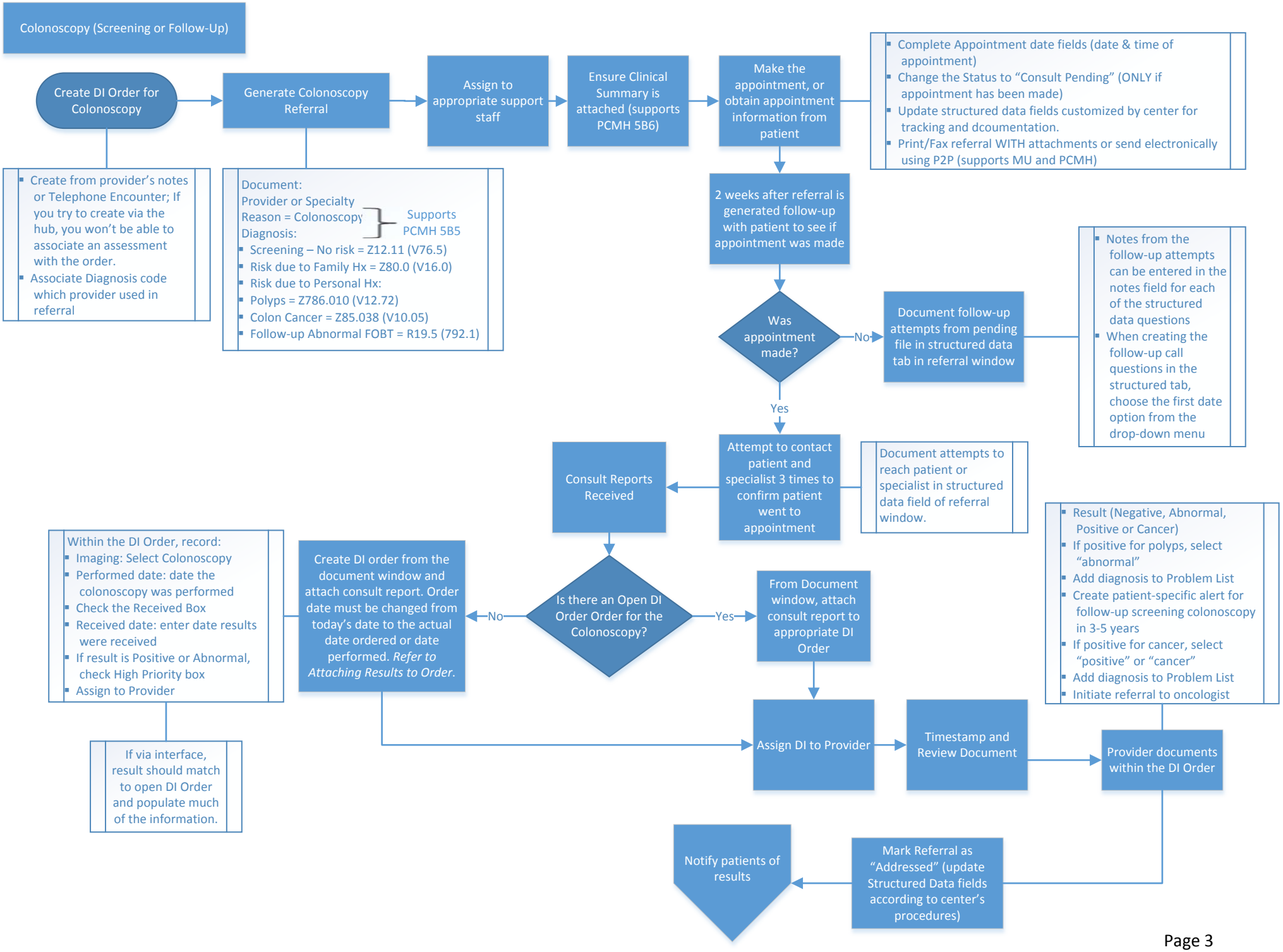
National Association of Chronic Disease Directors

American Cancer Society

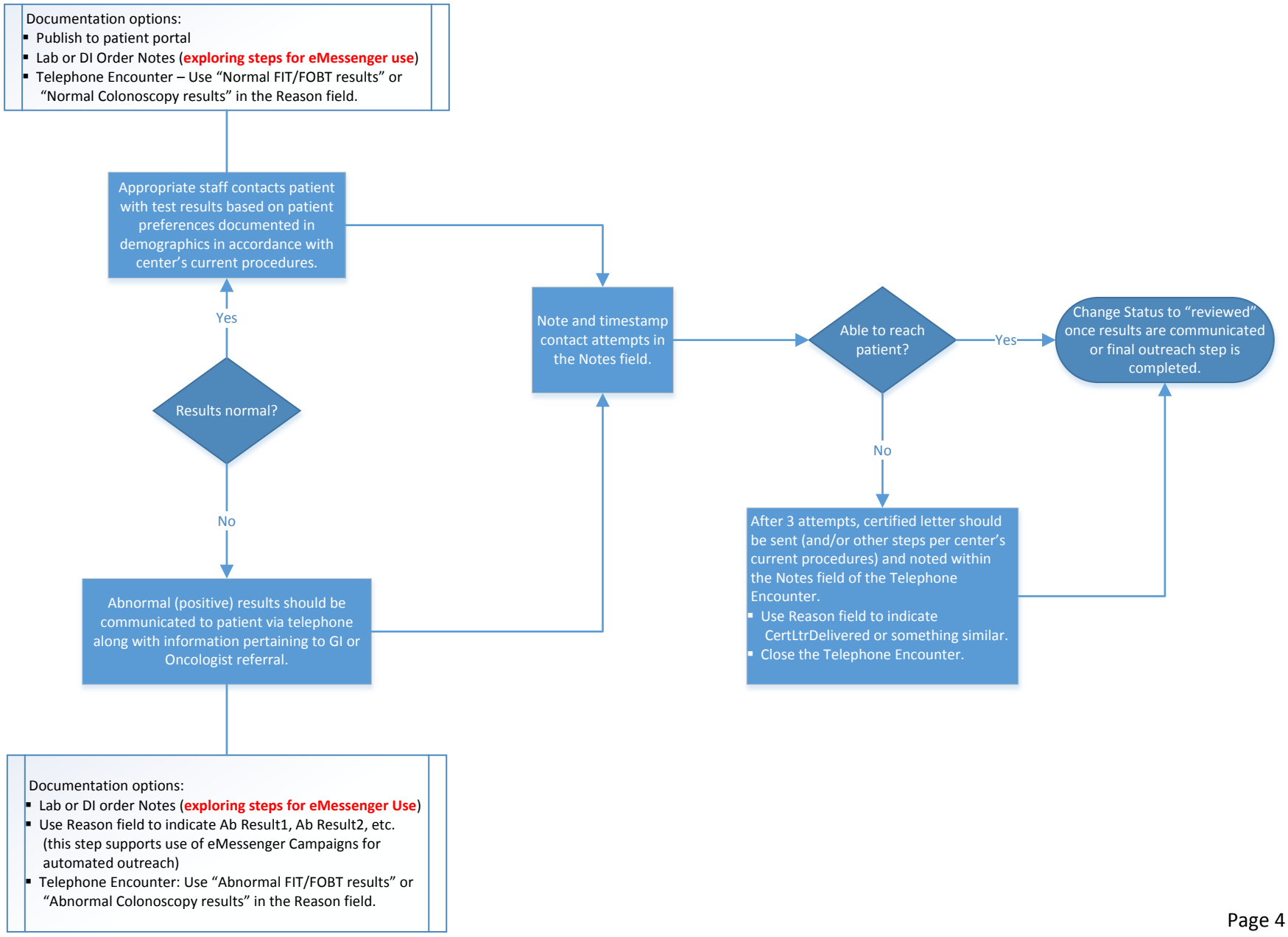
National Colorectal Cancer Roundtable

Health Center Network of New York member health centers

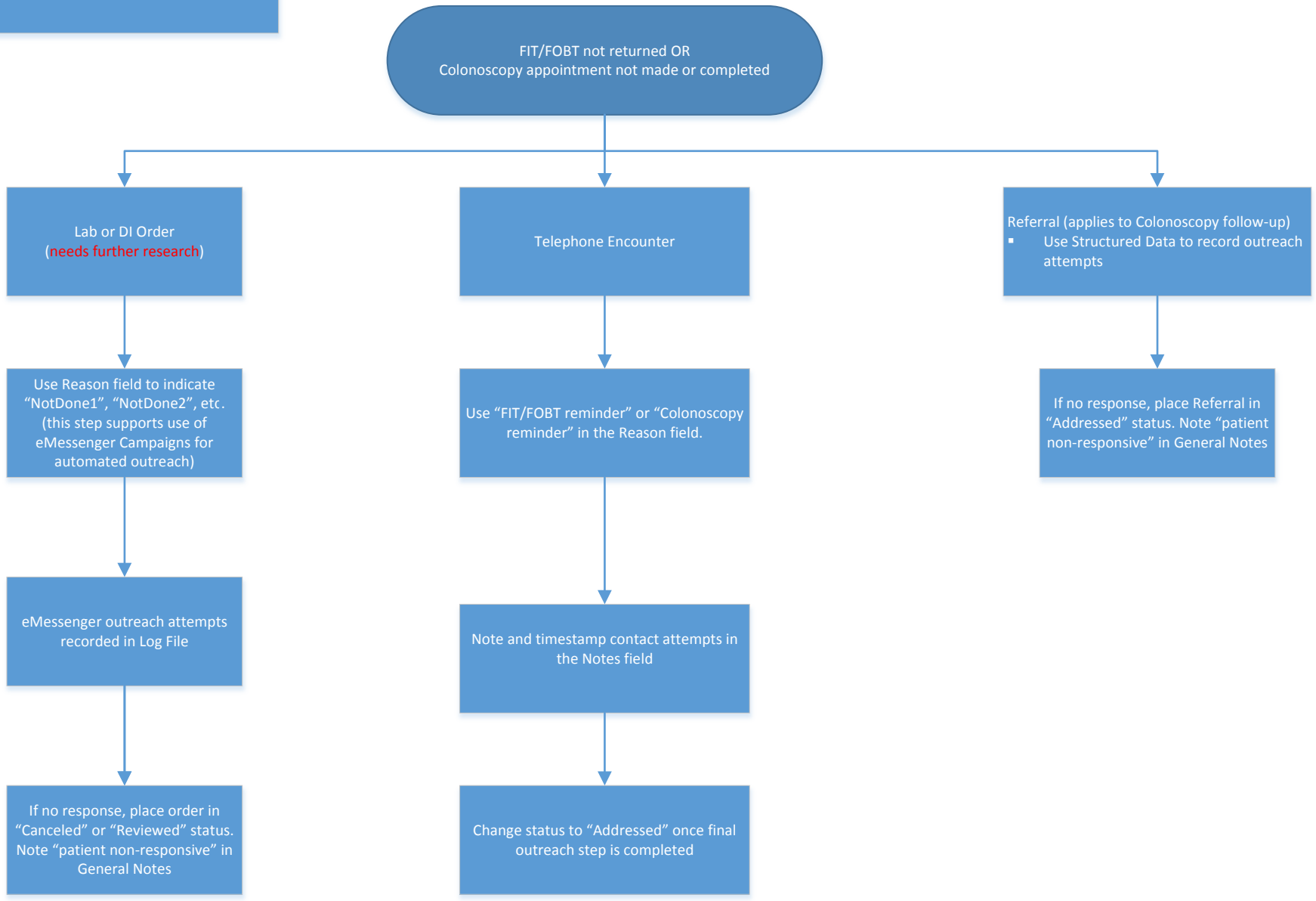

FIT/FOBT Screening
Assumes patients 50+ at average risk of CRC
No symptoms of CRC
Create current order Associate order with diagnosis code ICD-10 Z12.11 (ICD-9 V76.51)
Transmit lab order and print copy of requisition to include with patient's mailer to lab. NOTE: Do NOT associate CPT with order. CPT should only be billed when the sample is processed or submitted for processing.
Electronic results received
Patient mails directly
Give FIT/FOBT test kit to patient and provide education on how to use.
Patient mail or bring back to office?
Patient brings test to office
Create a future order upon kit distribution, transfer to Current order when sample or result is received
Put an appointment on resource schedule OR Create a telephone encounter AND then pull the future order into today's visit in Treatment window. Put an appointment on resource schedule OR Create a telephone encounter. *Note: if using telephone encounter, extra steps are required to bill. See workflow description for appropriate CPTs.
Transmit the order for today's visit to get the requisition to send the test to the lab.
Sent out
Is lab done in-house or sent out?
Put an appointment on resource schedule OR Create a telephone encounter. *Note: if using telephone encounter, extra steps are required to bill. See workflow description for appropriate CPTs.
If unable to reach patient after 3 attempts, leave the telephone encounter open and update the notes section. Last entry should be "sent certified letter". Then close the telephone encounter.
Appropriate staff contacts patient with test results. Document using Telephone Encounter or Order Notes.
Electronic results received
In-house
No
Yes
Able to reach patient?
Provider calls patients with abnormal results. Document using Telephone Encounter or Order Notes.
No
Results negative?
Provider reviews results
Enter test results manually
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
Yes
Generate referral for follow-up colonoscopy ICD-10 R19.5 (ICD-9 792.1)
Create DI for colonoscopy ICD-10 R19.5 (ICD-9 792.1)
Follow steps for Colonoscopy


Colonoscopy (Screening or Follow-Up)
Create DI Order for Colonoscopy
Generate Colonoscopy Referral
Assign to appropriate support staff
Ensure Clinical Summary is attached (supports PCMH 5B6)
Make the appointment, or obtain appointment information from patient
Complete Appointment date fields (date & 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 dcoumentation.
Print/Fax referral WITH attachments or send electronically using P2P (supports MU and PCMH)
Create from provider's notes or Telephone Encounter; If you try to create via the hub, you won't be able to associate an assessment with the order.
Associate Diagnosis code which provider used in referral
Document:
Provider or Specialty
Reason = Colonoscopy
Diagnosis:
Supports PCMH 5B5
Screening – No risk = Z12.11 (V76.5)
Risk due to Family Hx = Z80.0 (V16.0)
Risk due to Personal Hx:
Polyps = Z786.010 (V12.72)
Colon Cancer = Z85.038 (V10.05)
Follow-up Abnormal FOBT = R19.5 (792.1)
2 weeks after referral is generated follow-up with patient to see if appointment was made
Was appointment made?
No
Document follow-up attempts from pending file in structured data tab in referral window
Notes from the follow-up attempts can be entered in the notes field for each of the structured data questions
When creating the follow-up call questions in the structured tab, choose the first date option from the drop-down menu
Yes
Attempt to contact patient and specialist 3 times to confirm patient went to appointment
Document attempts to reach patient or specialist in structured data field of referral window.
Consult Reports Received
Result (Negative, Abnormal, Positive or Cancer)
If positive for polyps, select "abnormal"
Add diagnosis to Problem List
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
Initiate referral to oncologist
Within the DI Order, record:
Imaging: Select Colonoscopy
Performed date: date 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
Create DI order from the document window and attach consult report. Order date must be changed from today's date to the actual date ordered or date performed. Refer to Attaching Results to Order.
No
Is there an Open DI Order Order for the Colonoscopy?
Yes
From Document window, attach consult report to appropriate DI Order
If via interface, result should match to open DI Order and populate much of the information.
Assign DI to Provider
Timestamp and Review Document
Provider documents within the DI Order
Notify patients of results
Mark Referral as "Addressed" (update Structured Data fields according to center's procedures)

Notifying patients of FIT/FOBT or Colonoscopy results



Documenting follow-up Outreach for Incomplete Tests



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):

<u>Generate Colonoscopy Referral and DI Order</u> (**Exhibit 5 & Exhibit 6**)

- Document the following:
  - Provider or Specialty
  - Reason = Colonoscopy
  - Diagnosis

  } Supports PCMH 5B5

    - 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.

<u>Documenting Results / Closing the Loop</u>

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

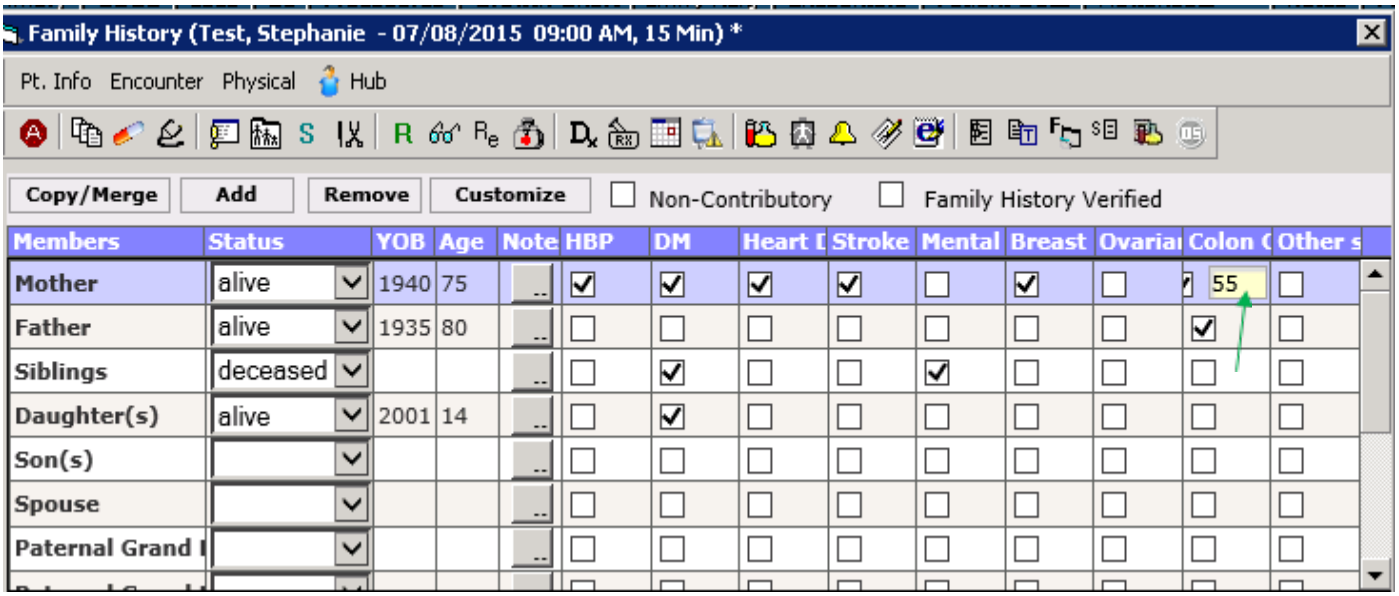
Details related to age of diagnosis of colon cancer for first and second degree relatives should be entered into Family History.

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

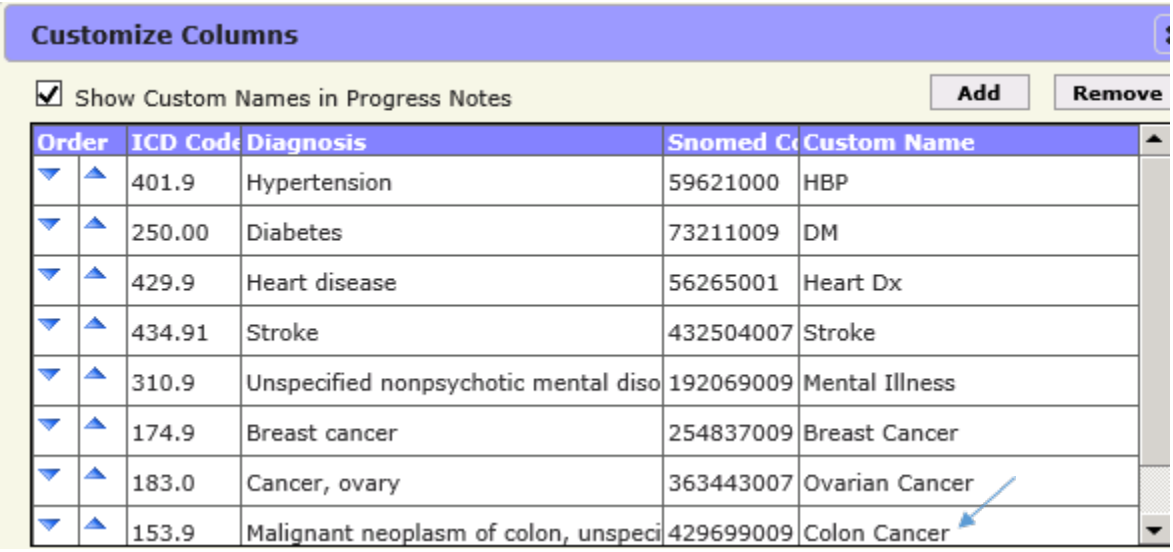
Enter patient's family history of colon cancer, indicating first and second degree relatives and age of diagnosis for the condition.

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.



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

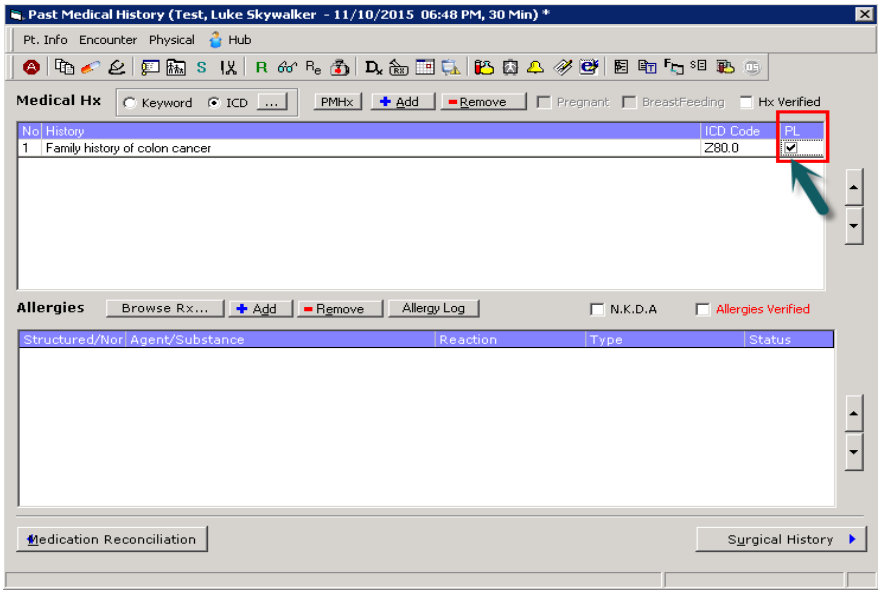


Documenting in Medical History

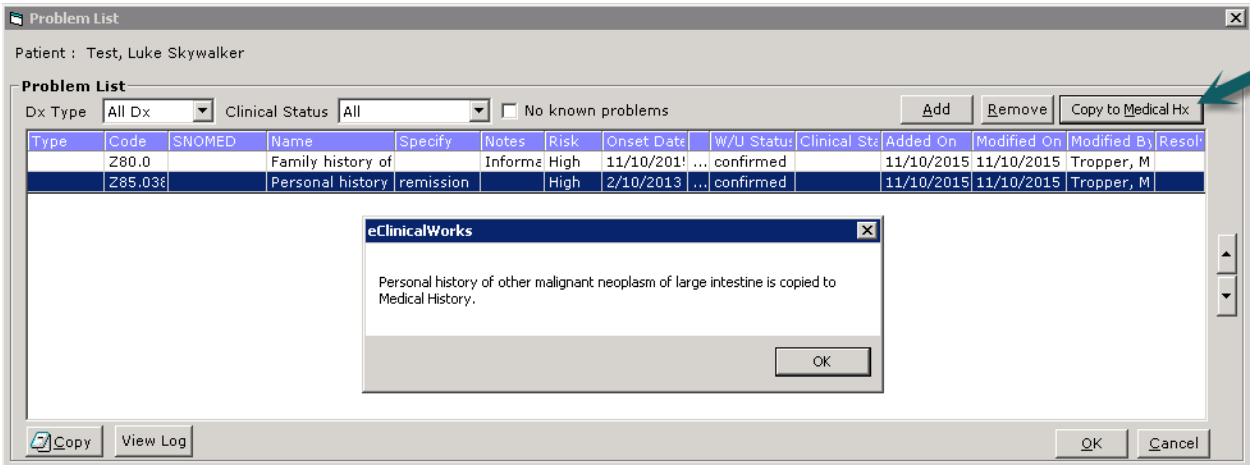
Add appropriate code(s) for family history and/or high risk of colon cancer to the Medical History by changing the radio button to ICD and using the ICD Browse button (ellipsis) and searching for one of the ICD10 codes below. NOTE: History added through the Keyword Browse/Search or free texted using 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

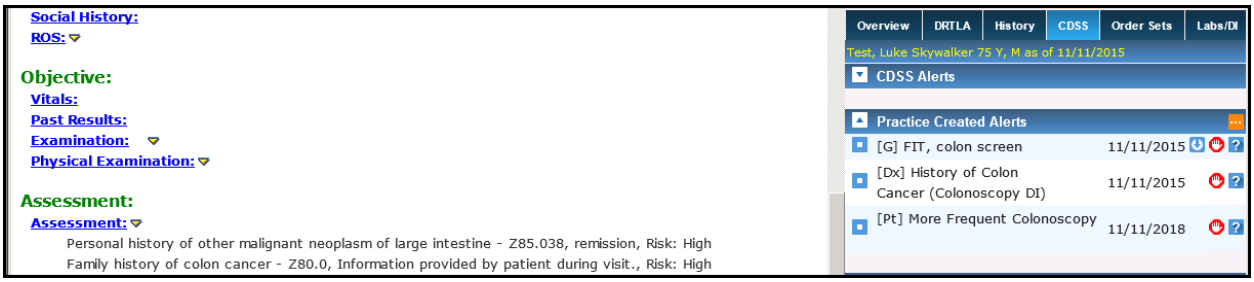
Click on “PL” to add the Medical History entries to the Problem List.



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

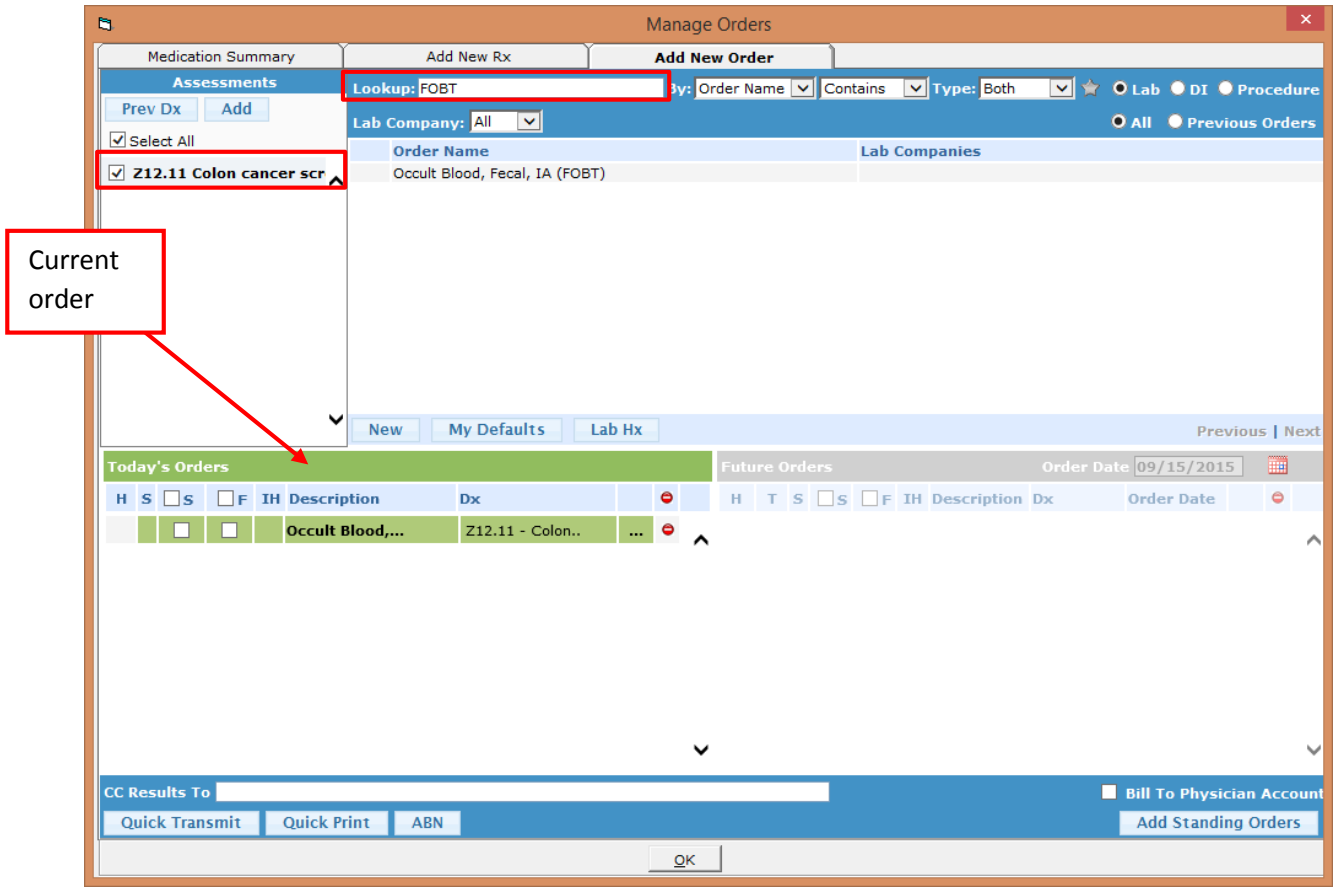
The Journal of Clinical Oncology, 3/10/2014, Volume 32, Number 9 article on Collection and Use of Cancer Family History for Oncology Providers recommends collecting the following key elements for a minimum adequate cancer family history:

- 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

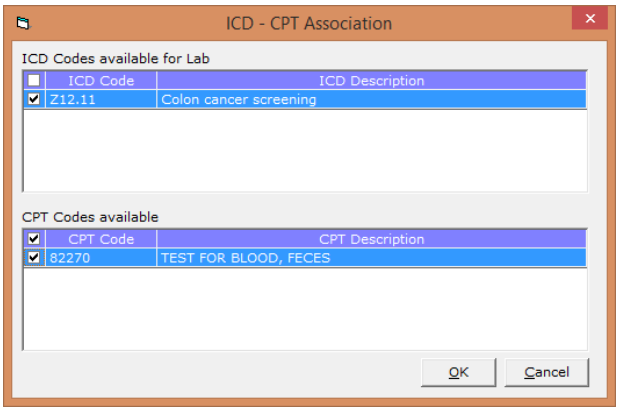
Requests for eCW:

- 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



*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:

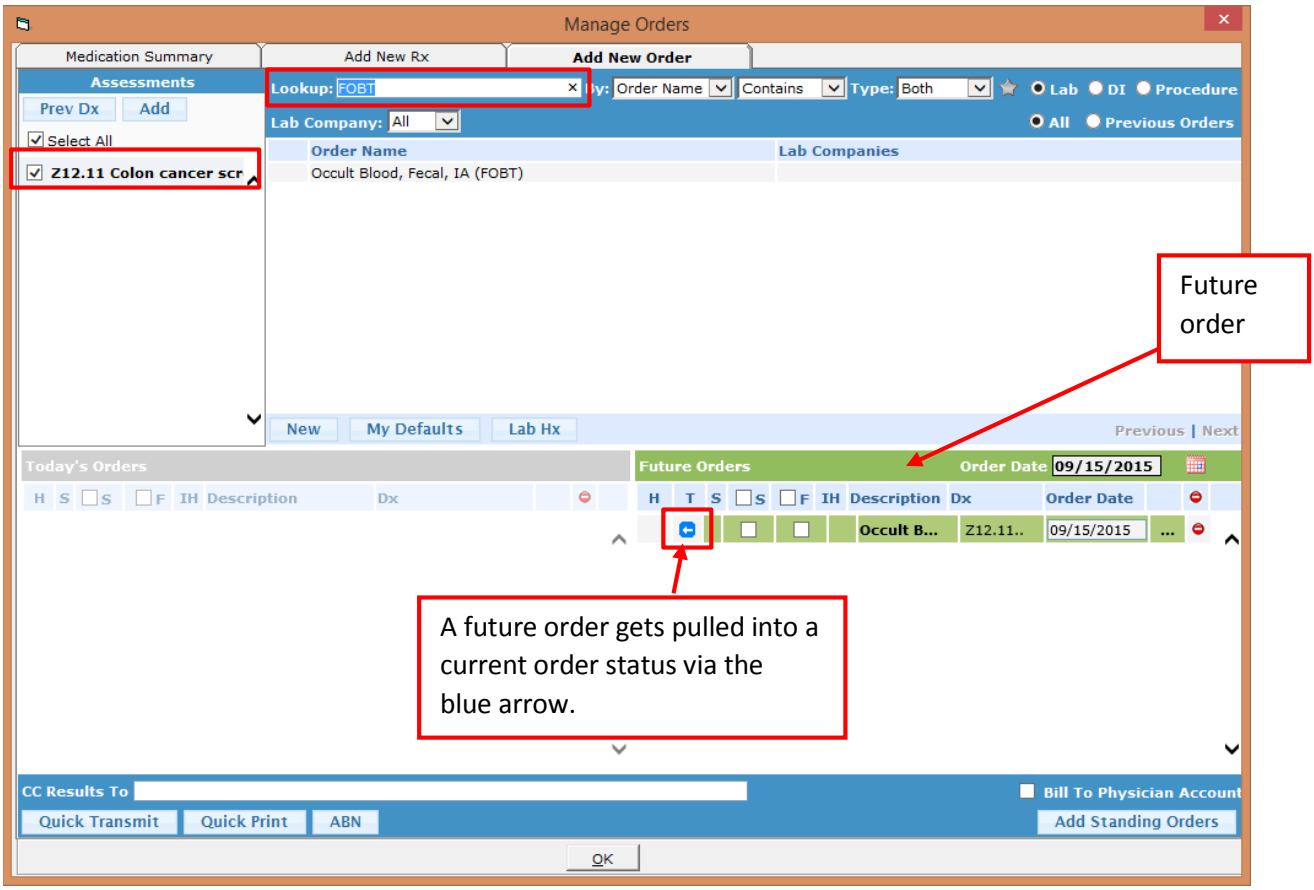
Next Appointment:

Billing Information:

Visit Code:

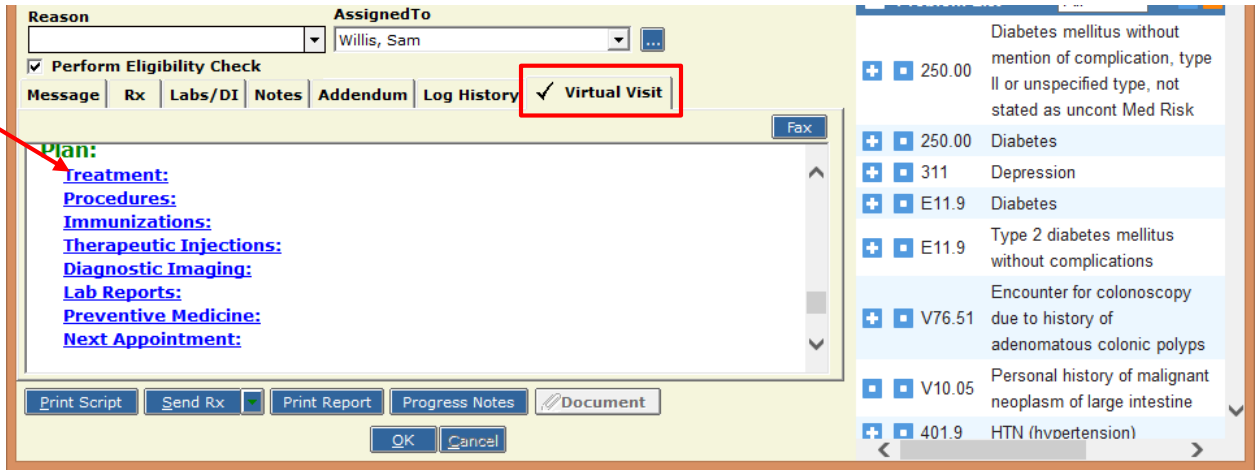
Procedure Codes:

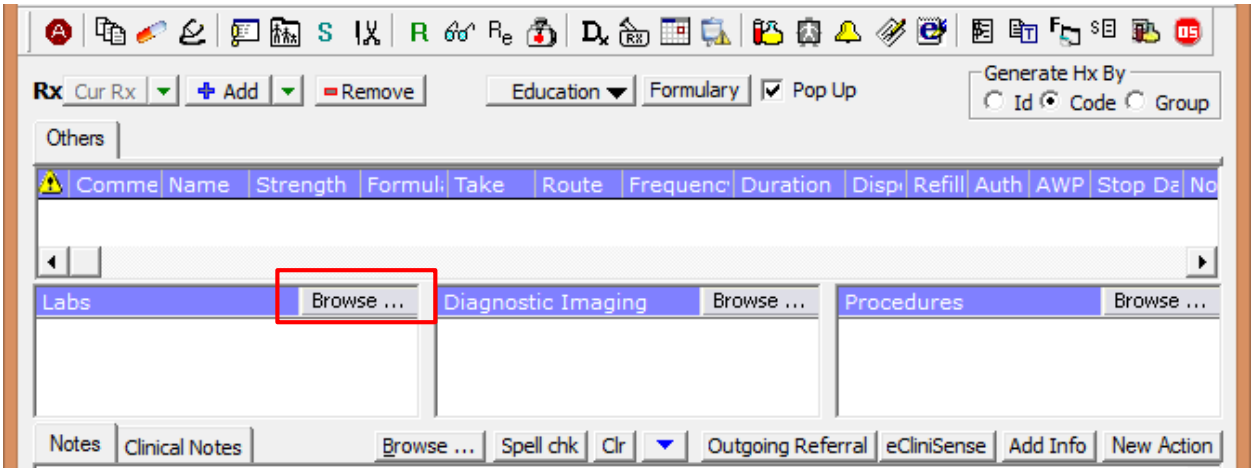
- 82272 OCCULT BLOOD, FECES, SINGLE.

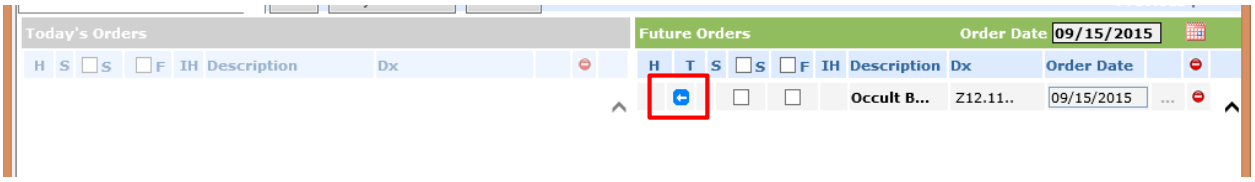


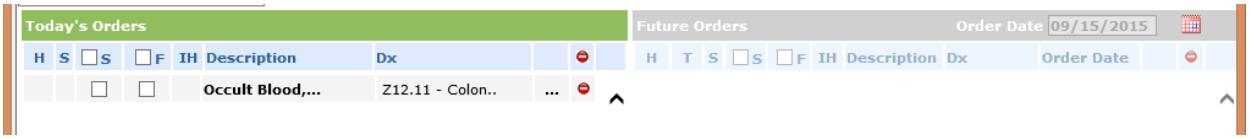
*If CPT code is attached to the lab in configuration, the code will not appear in the Procedure Codes section of the PN and produce a claim until the lab is a current order status. ***(NOTE: billing guidelines prohibit billing until samples are collected.)***

Exhibit 2 - Accessing a Future Order from a Telephone Enounter









*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 when the future order is pulled into a current order status. ***(NOTE: billing guidelines prohibit billing until samples are collected.)***

Exhibit 3 - Entering lab results

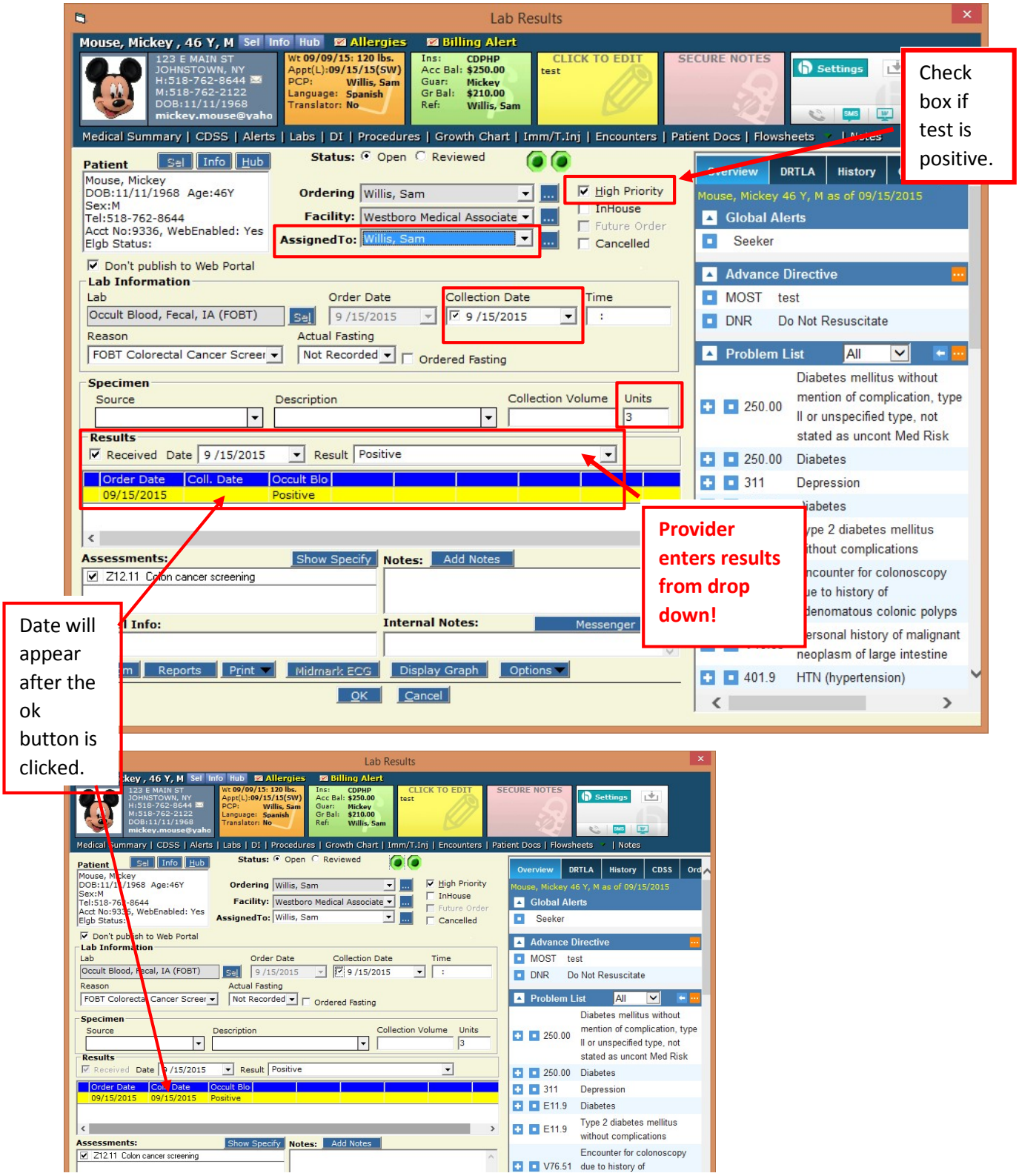
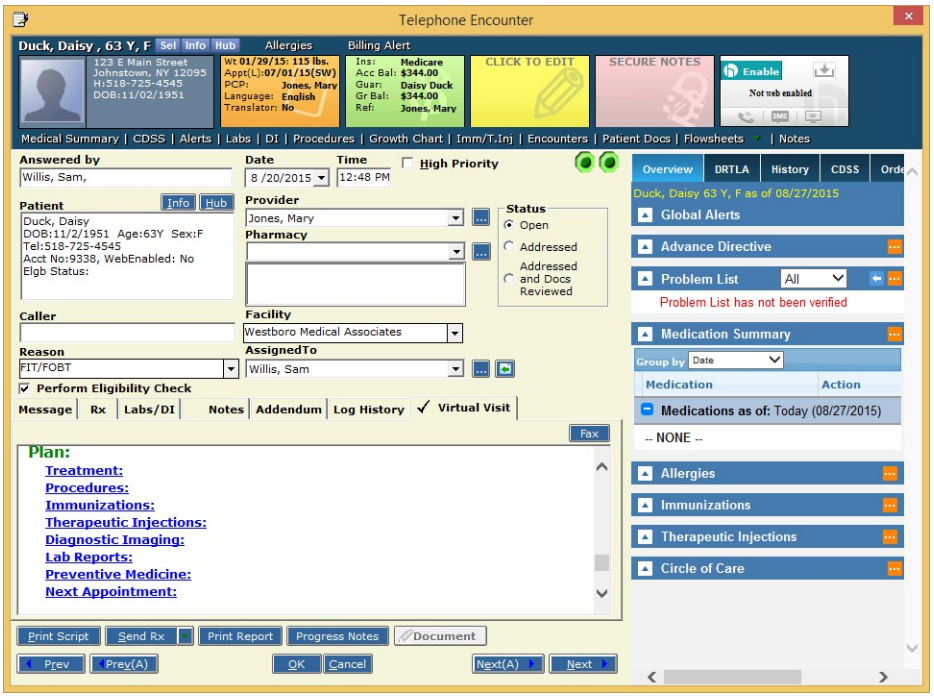


Exhibit 4 - Creating a claim from a Telephone or Web Encounter

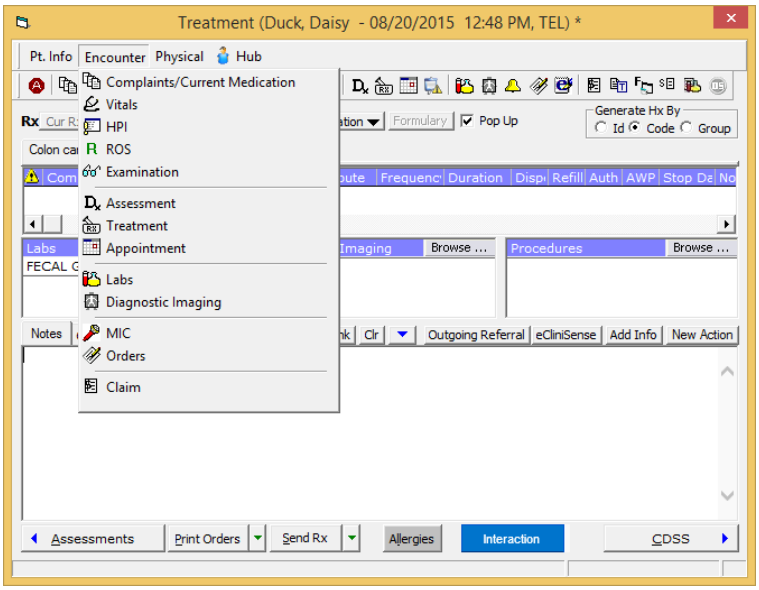
There are two ways in which you can create a claim from a telephone or web encounter.

Option 1

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

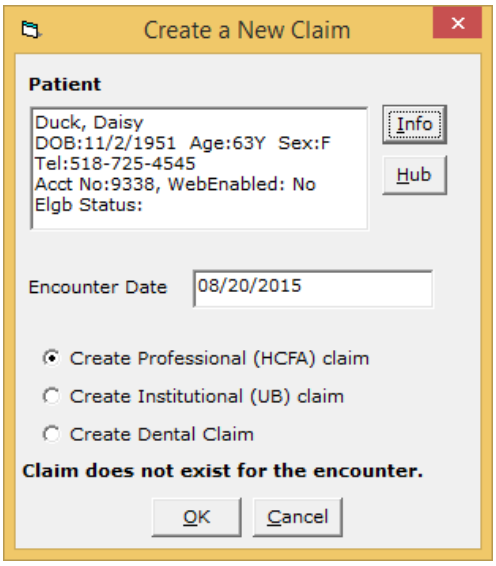


When done documenting your note, click on the Encounter option at the top of the screen. Click on the claim option.

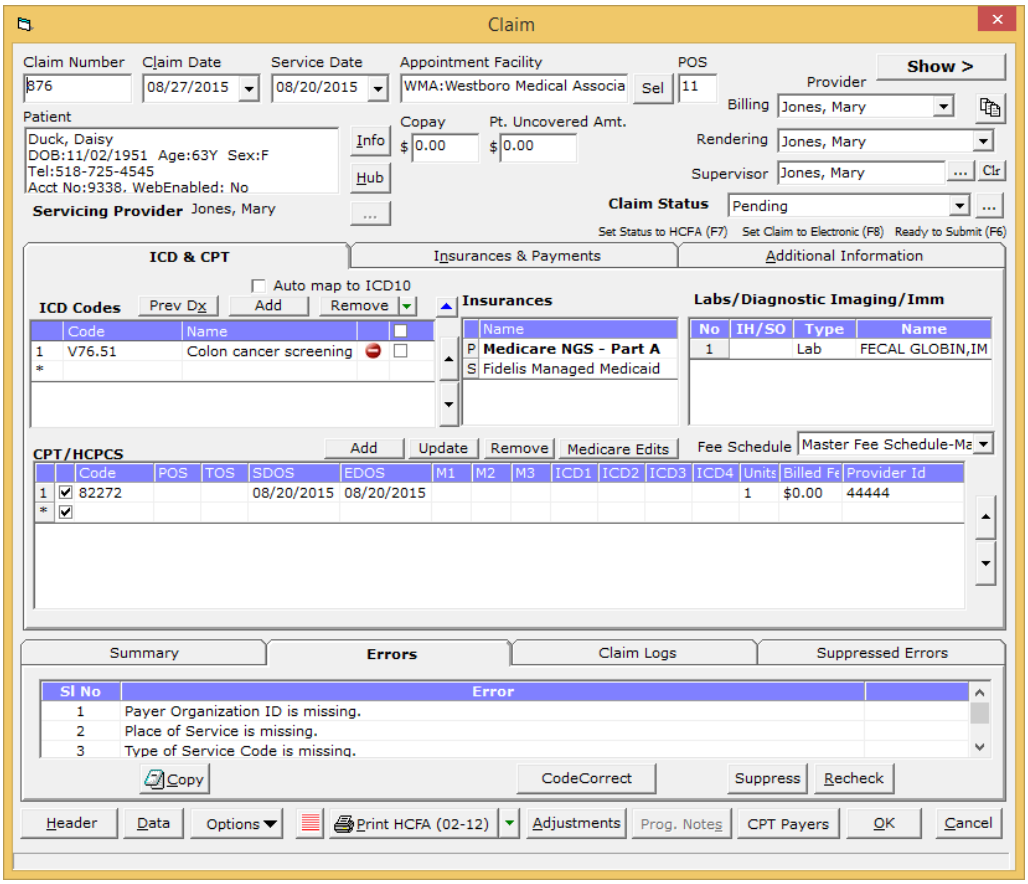


The Create New Claim window appears.

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

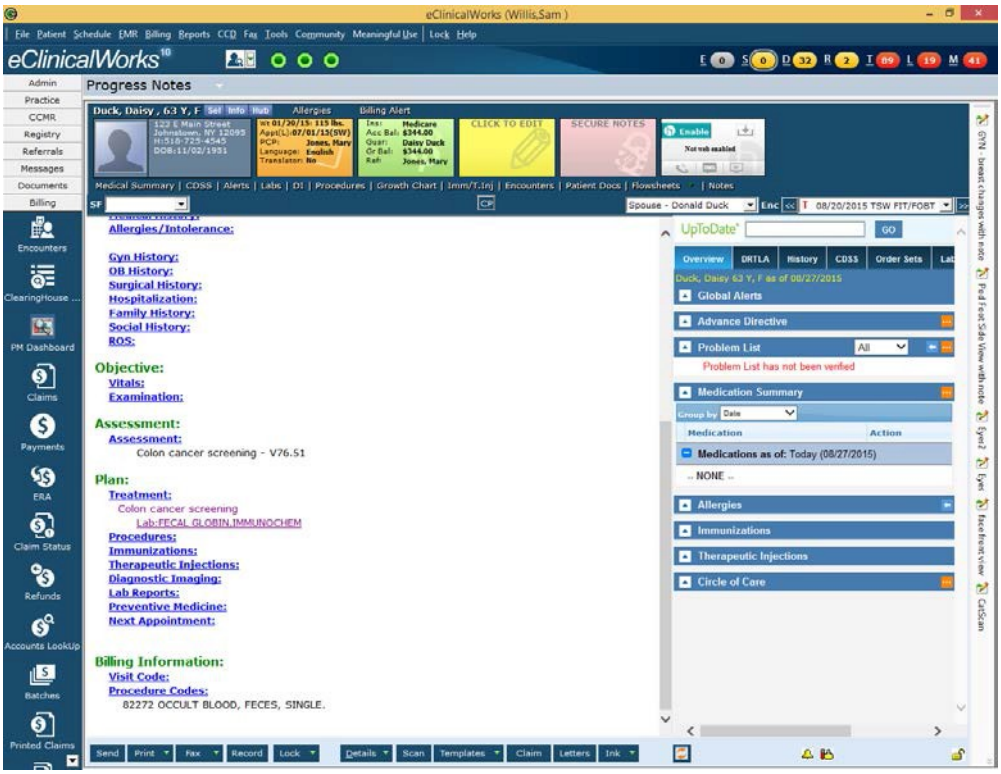


The claim will open.



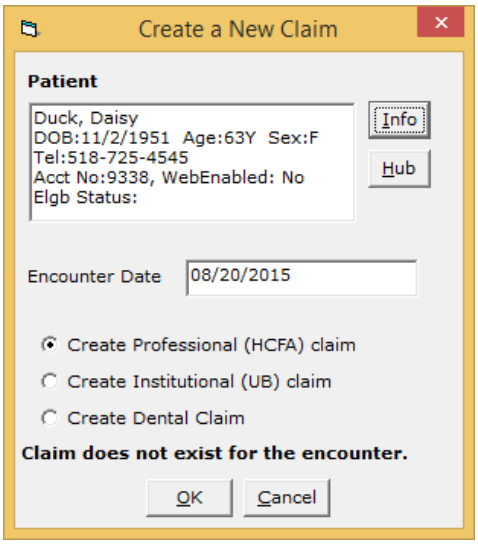
Option 2

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.



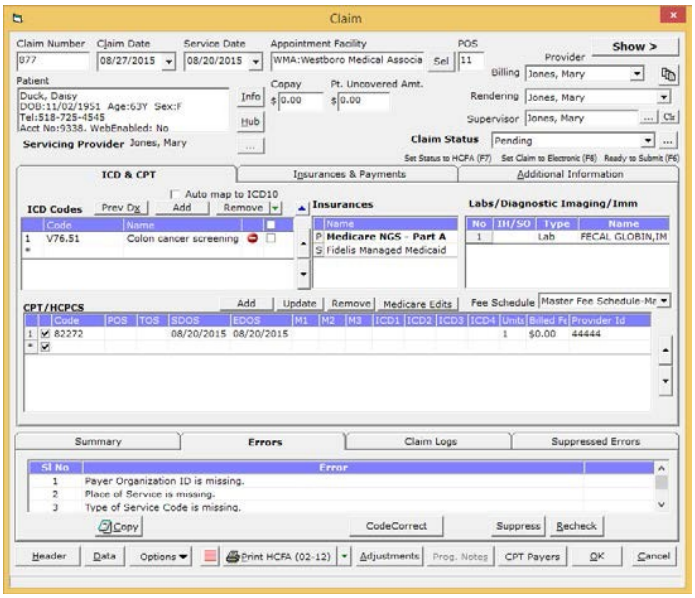
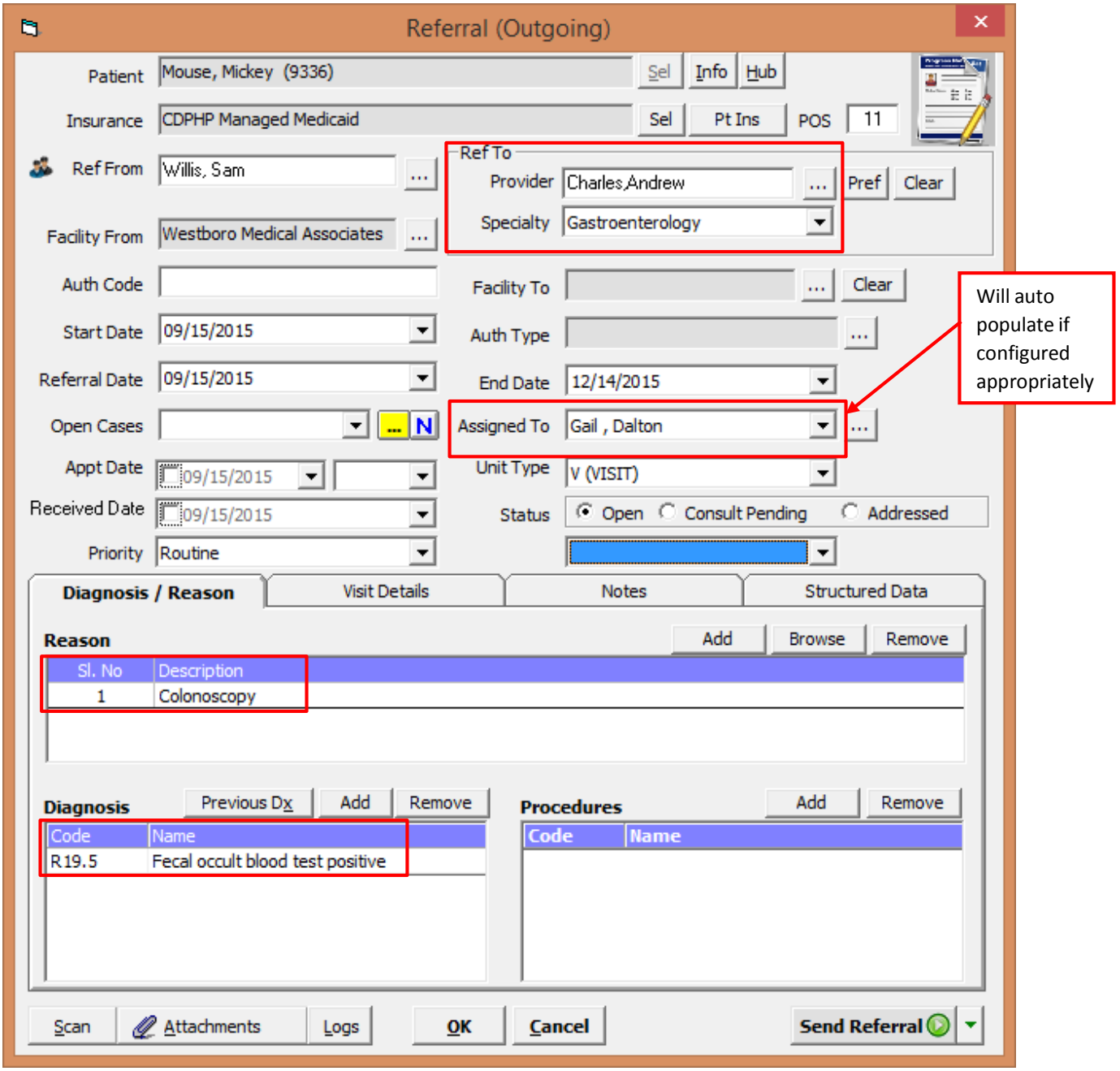


Exhibit 5 - Generating a Colonosocpy Referral

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



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

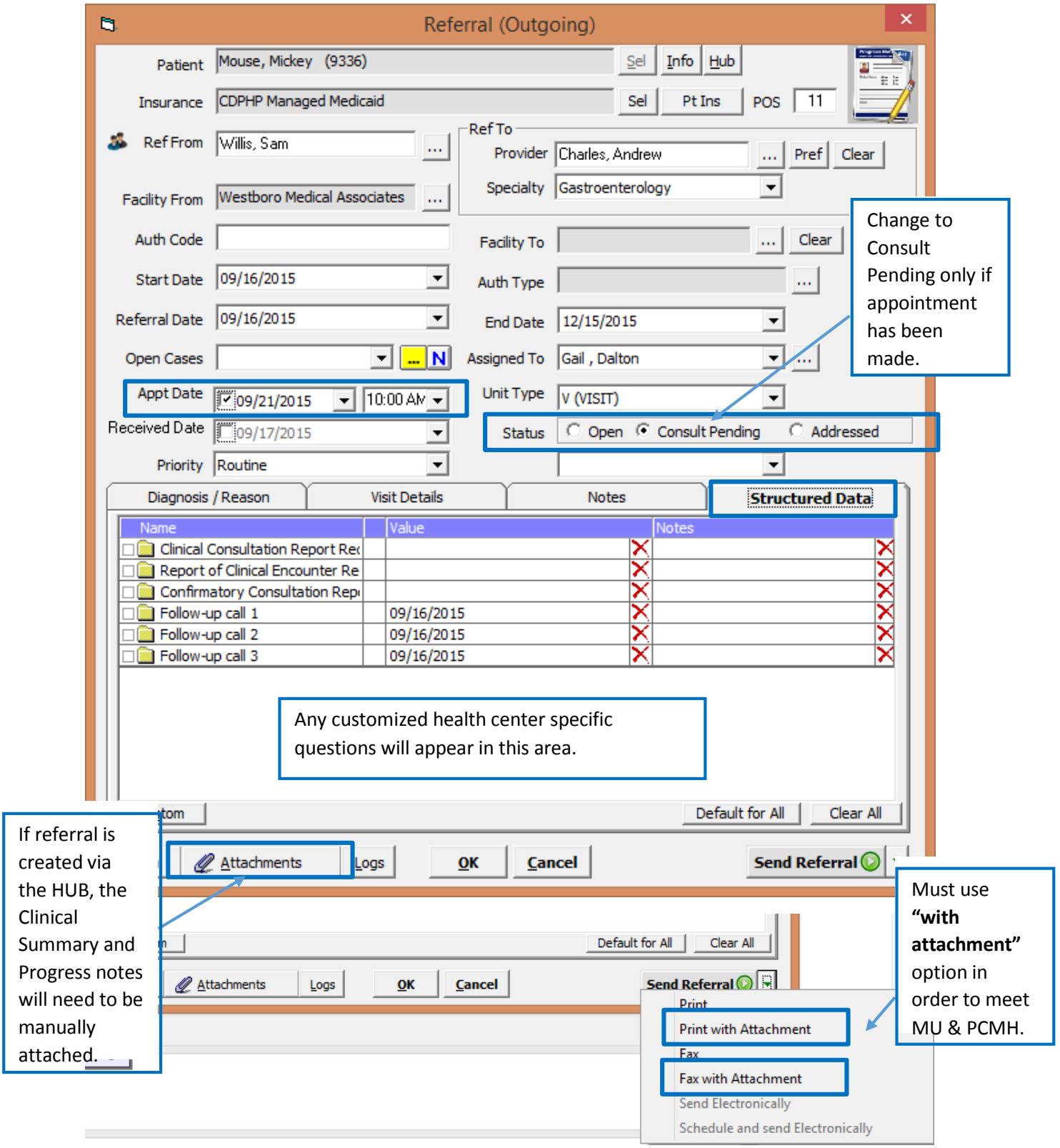
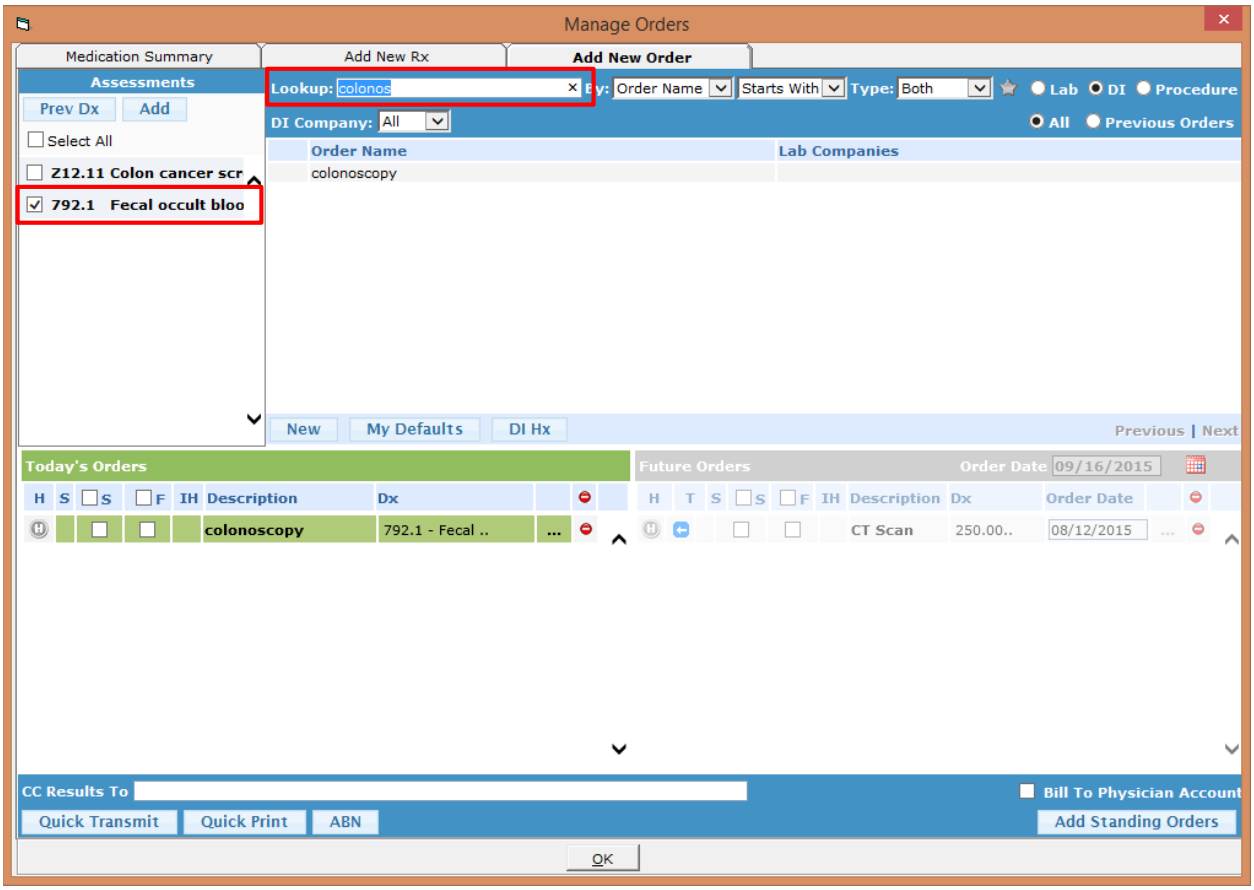


Exhibit 6 - Creating a DI order

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



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

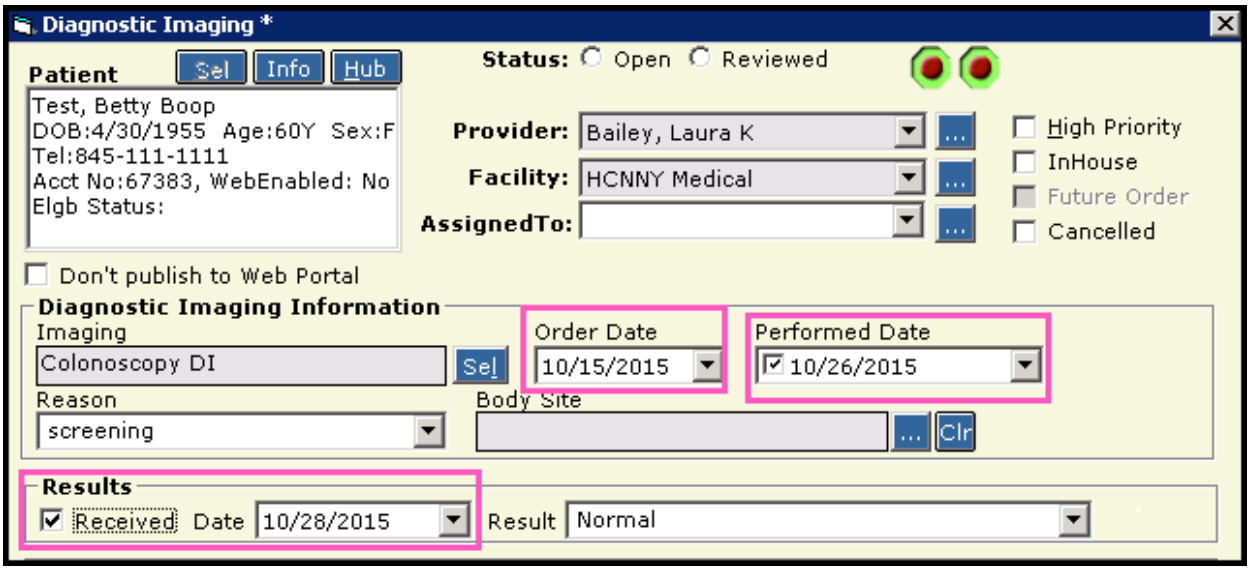
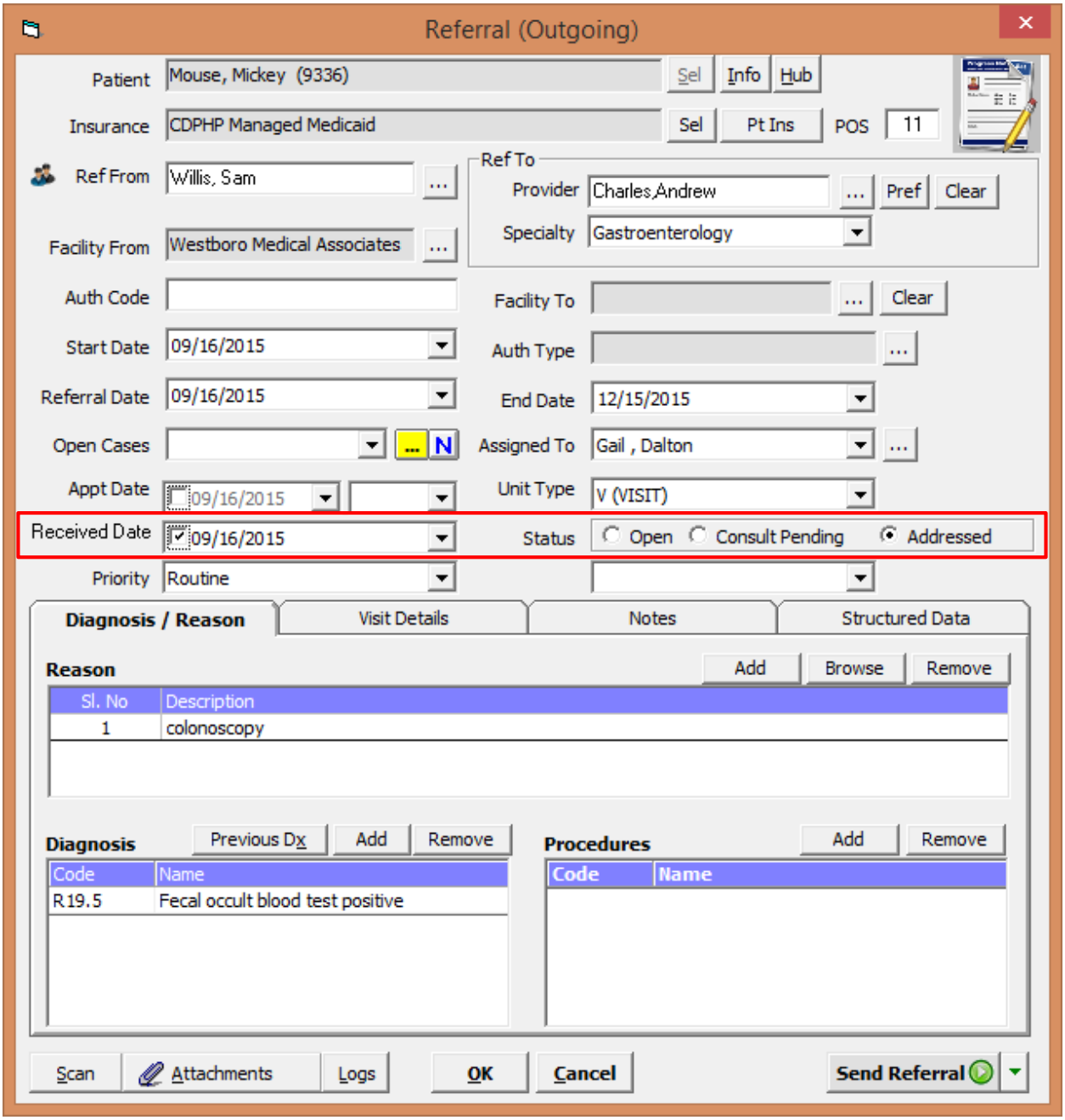


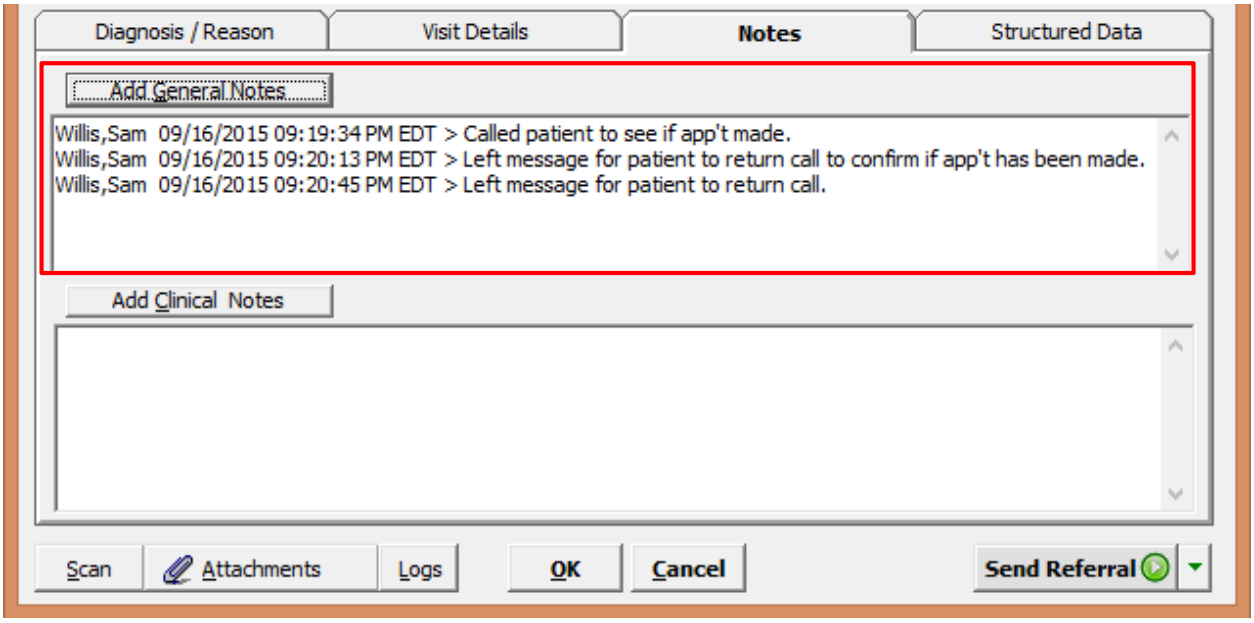
Exhibit 7 - Closing the Loop

Referral - Option 1



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

Referral - Option 2



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

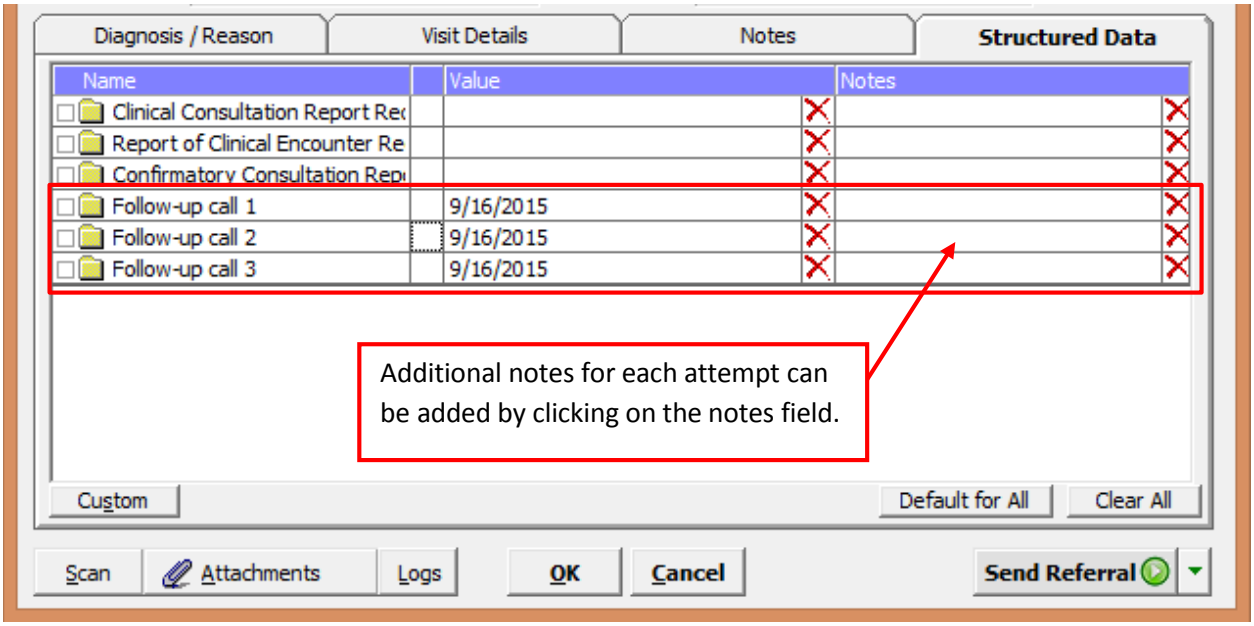
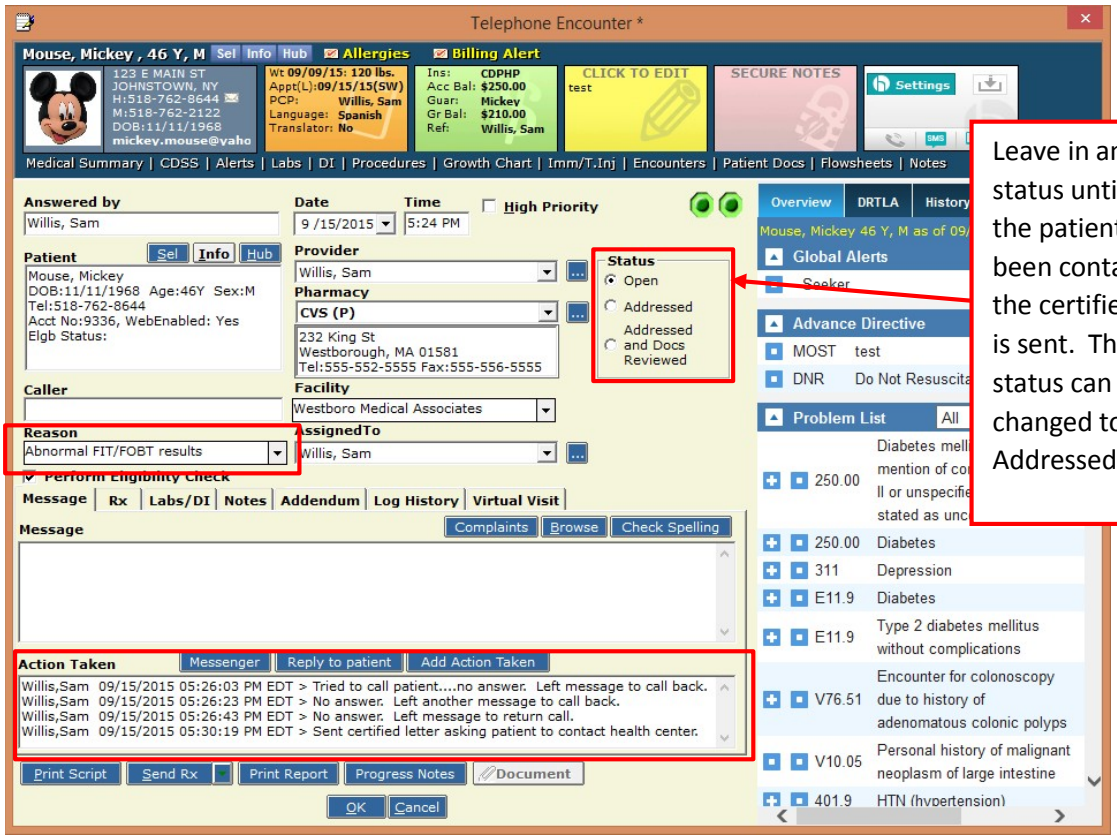
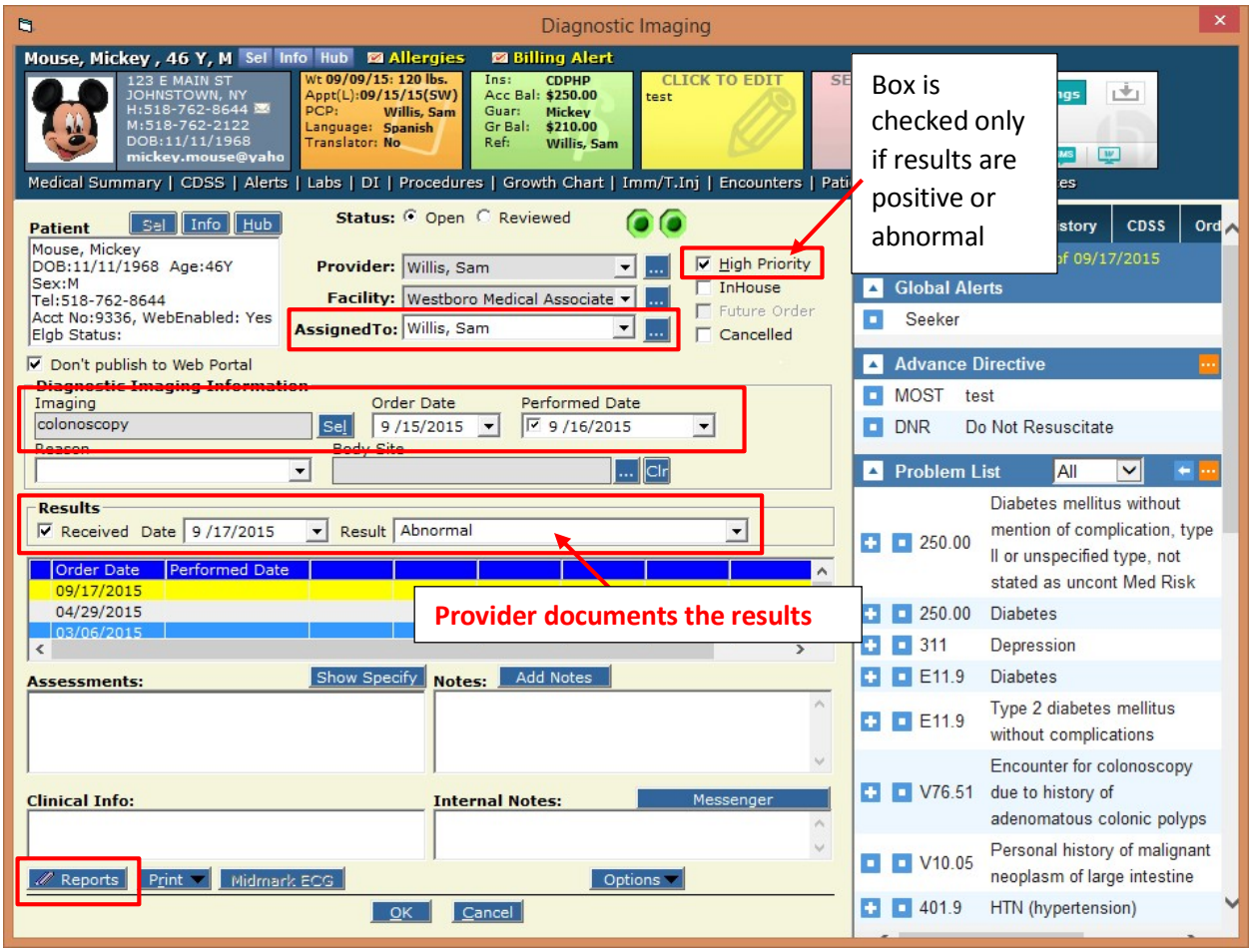


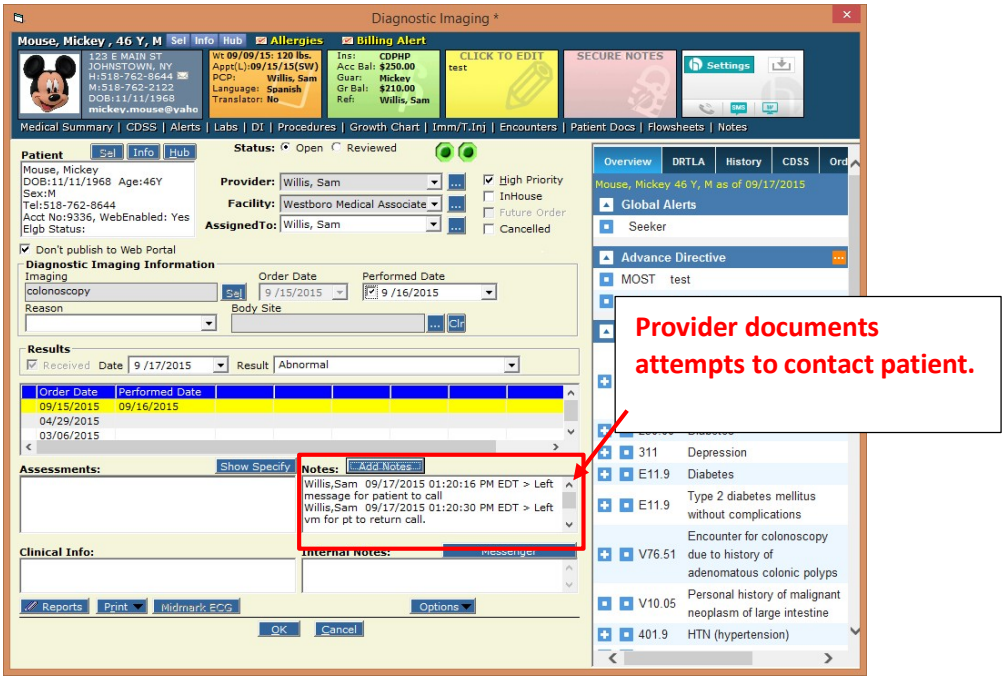
Exhibit 8 - Using Telephone Encounter to track Patient Communication of Results



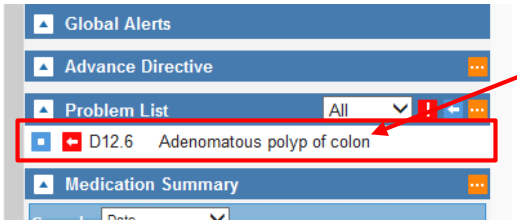
Leave in an Open status until either the patient has been contacted; or the certified letter is sent. Then the status can be changed to Addressed.

Exhibit 9 - ***Documenting Colonoscopy Results and Tracking Patient Communication***

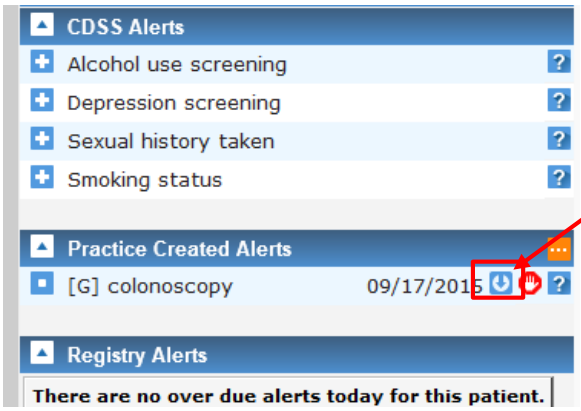




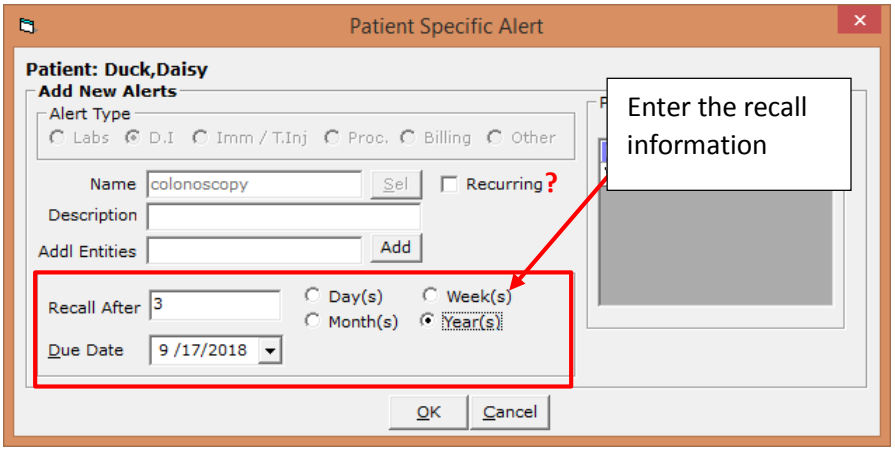
Additional steps if colonoscopy result is abnormal



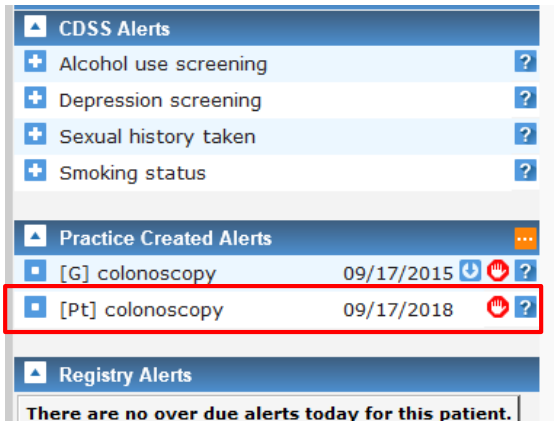
Add diagnosis to problem list.



Click blue downward arrow to create pt specific alert

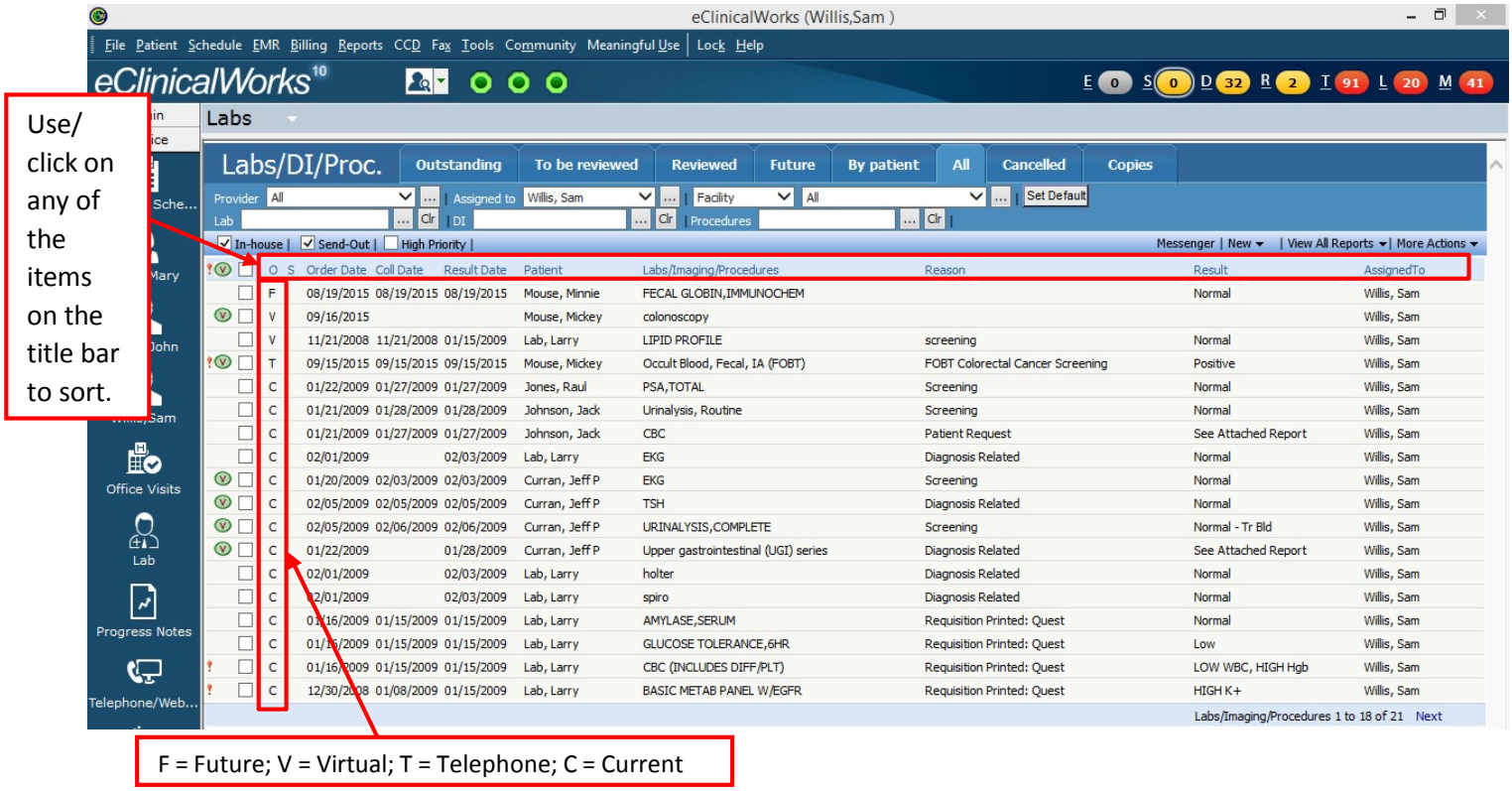


Enter the recall information



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

Exhibit 10 - Following up on Outstanding Orders



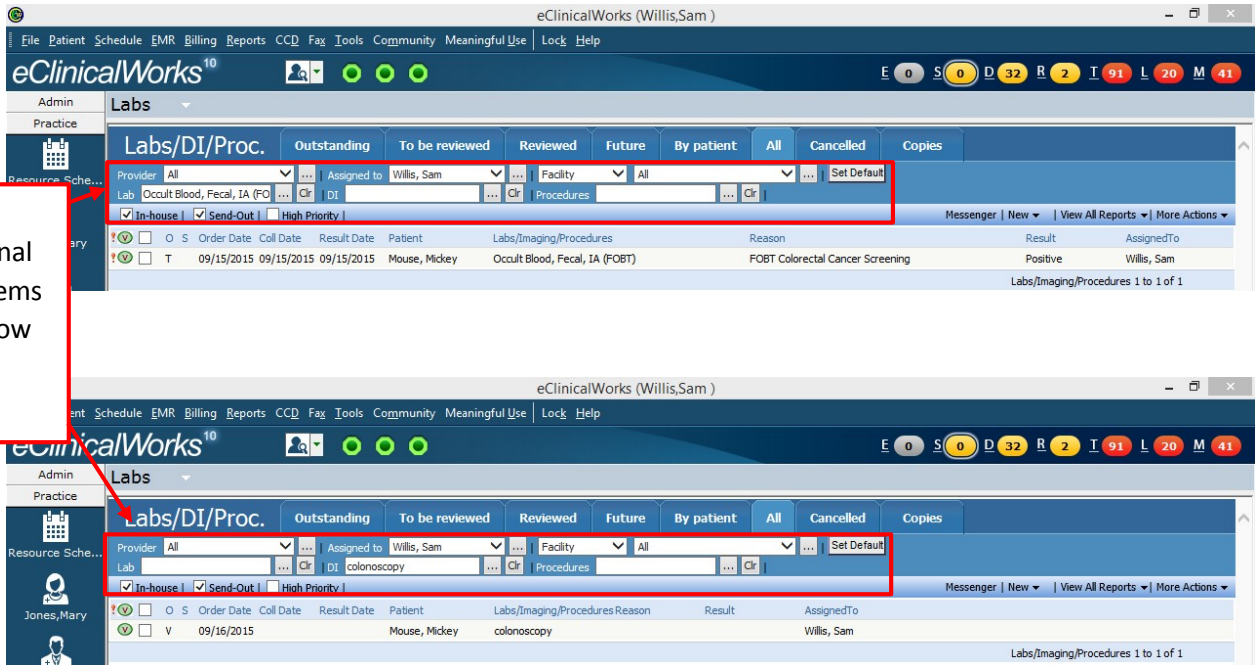
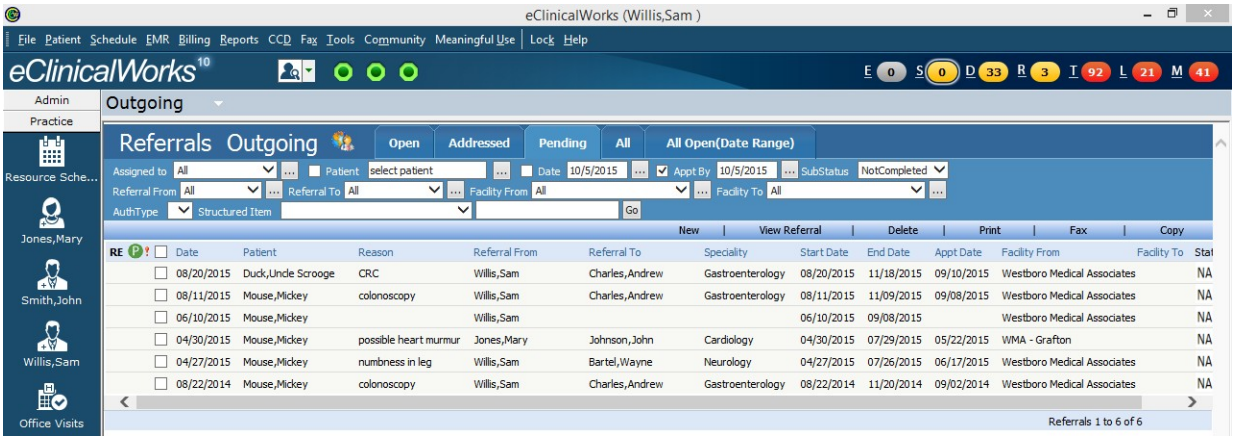


Exhibit 11 - Referral Appointment reminders and consult report follow-up

R Jellybean

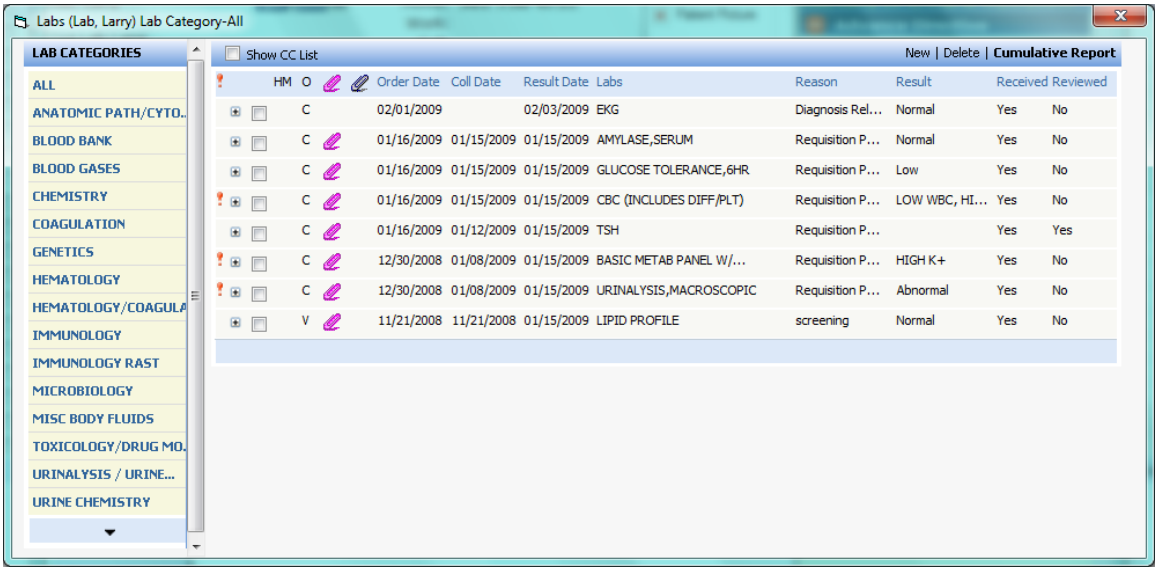


Attaching Results to Order – Paperclip Workflow

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



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.

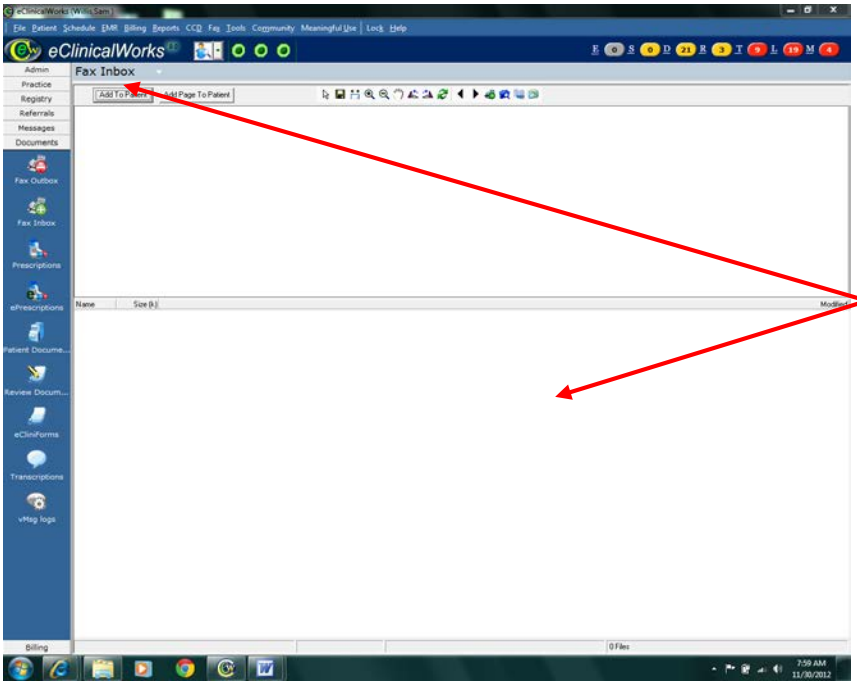
Workflow for Attaching Results to Tests

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!

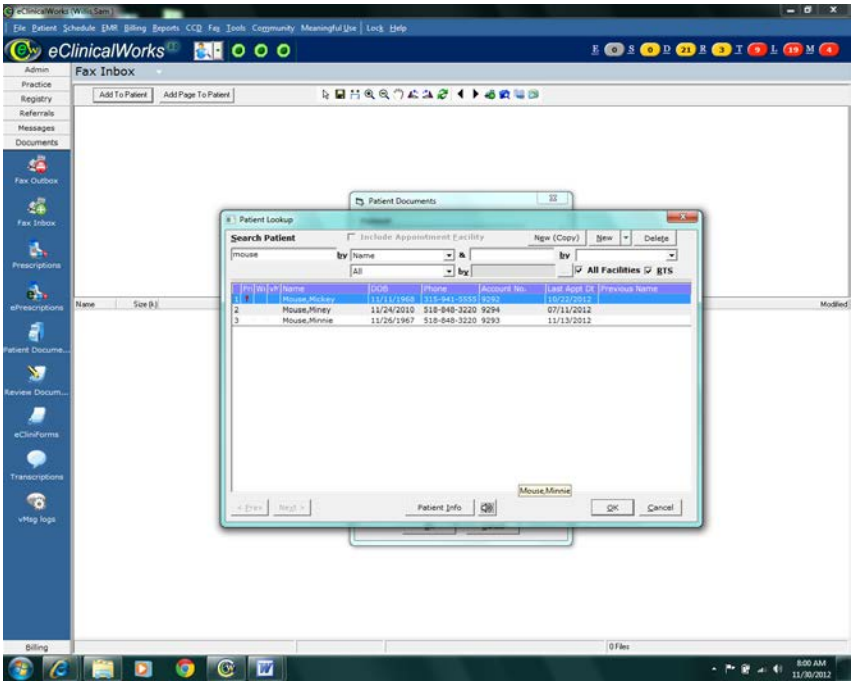
Attaching a paper result from the fax inbox:

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

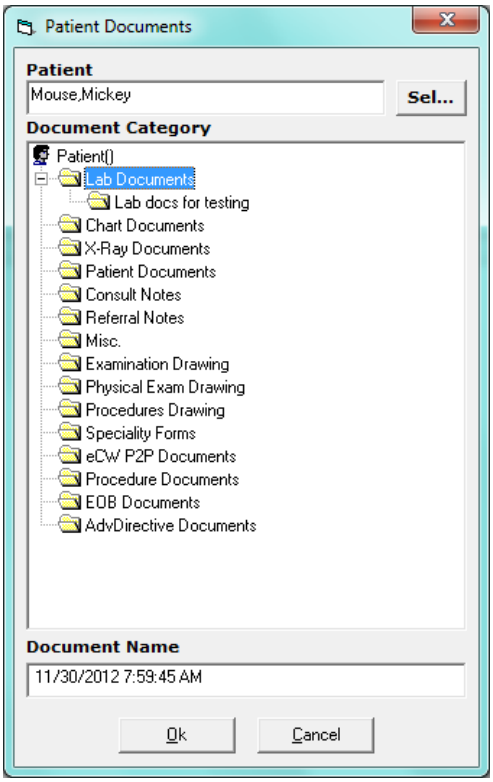


The list of documents will show in the lower half of the screen. Click on the desired document to choose it. Then click on the Add to Patient button; or right click and add to patient.

- Select the patient and click OK.

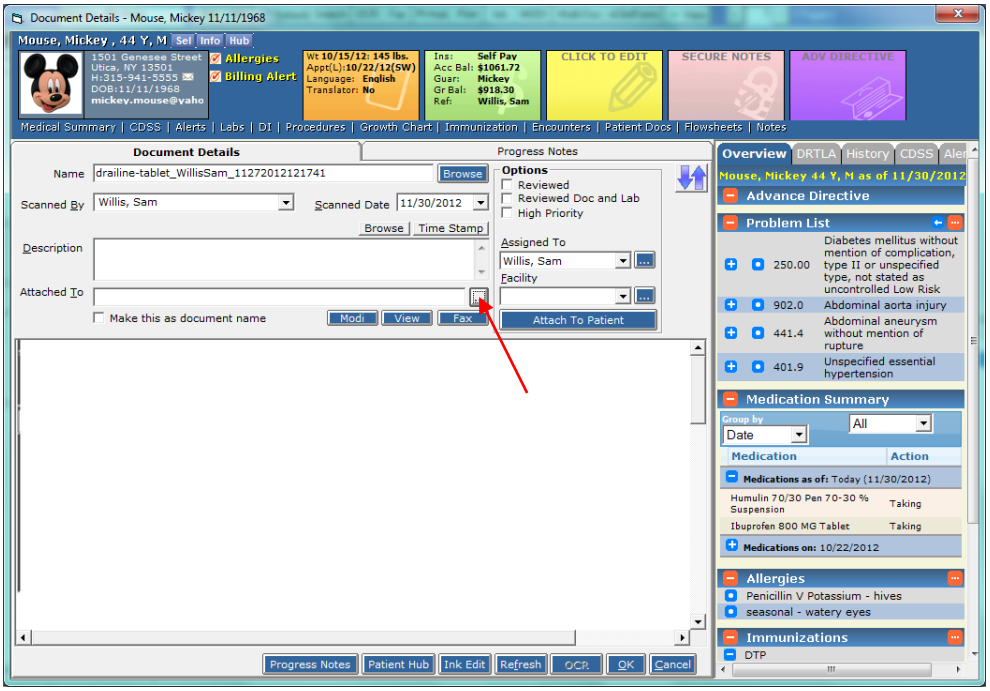


- Highlight the folder that you want to add the document to (Lab or X-ray).
- Click OK.

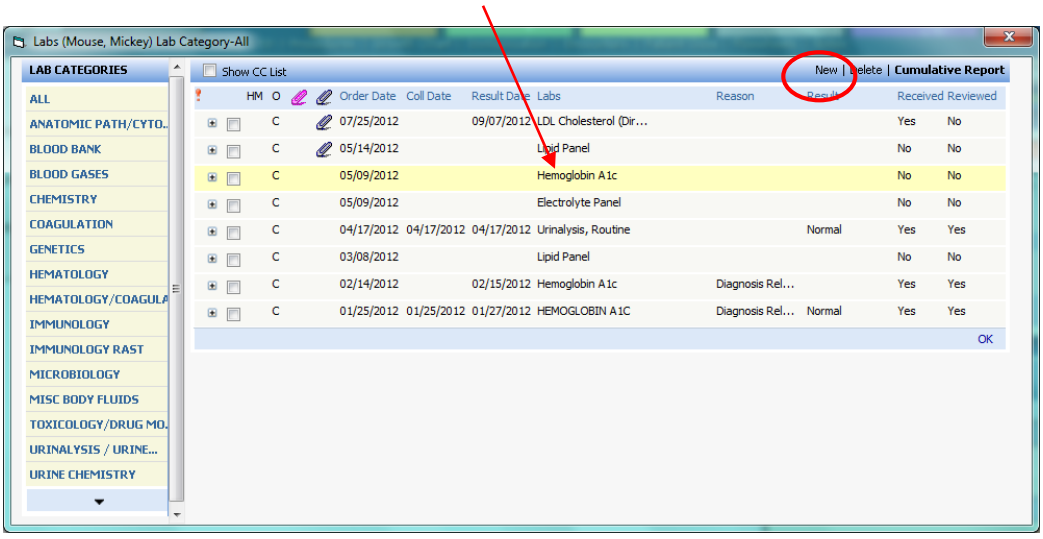


The Document Details window opens up.

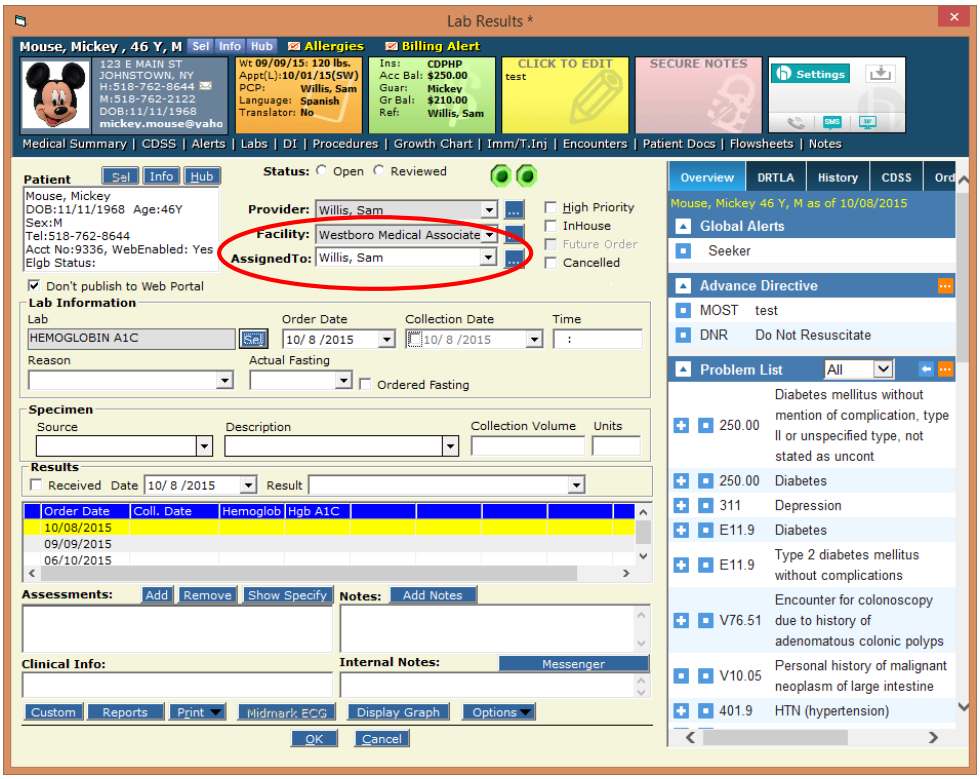
- Click the ellipsis button next to the Attach to field.



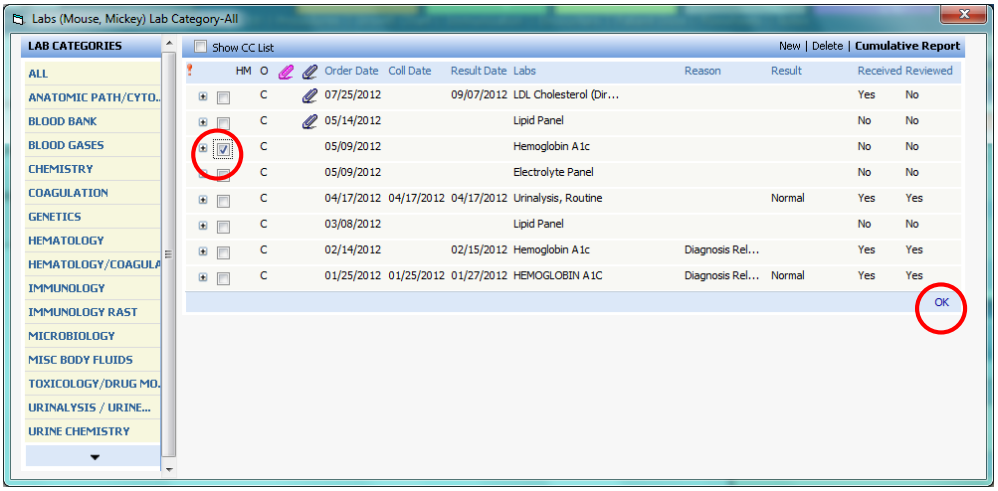
- To open the lab results window, click directly on the lab.
- If the desired lab is not on the list, click the "New" link to open the Lab Results window.



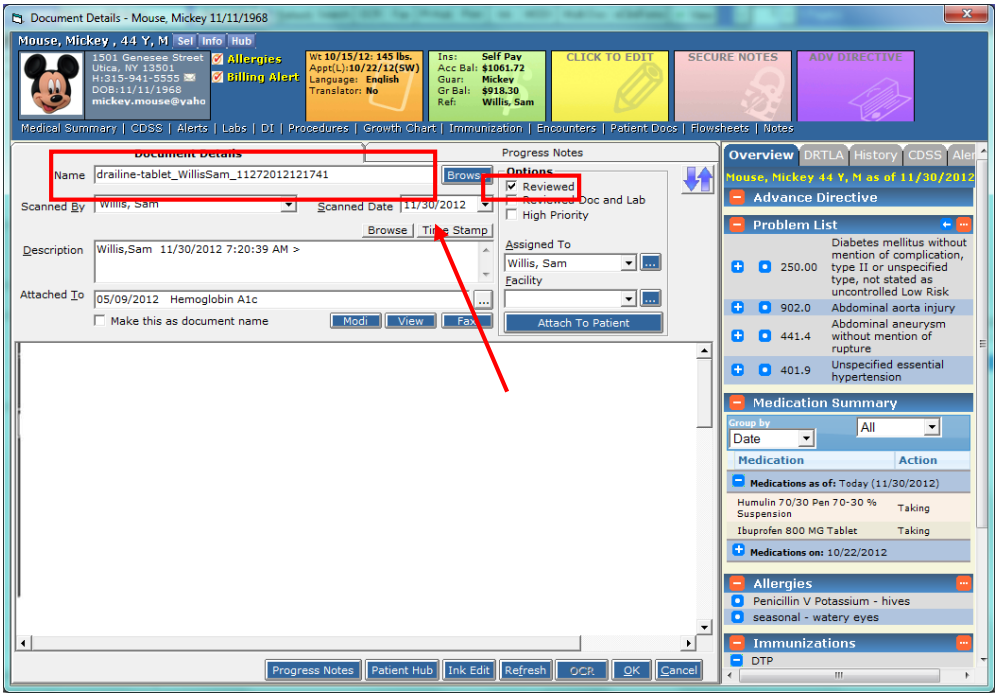
- For a new lab, enter the appropriate information according to your health center's workflow. ***(Note: when creating an order in this manner, you will not have access to add the Assessments.)***
- Assign the lab to the proper provider.
- Click OK.



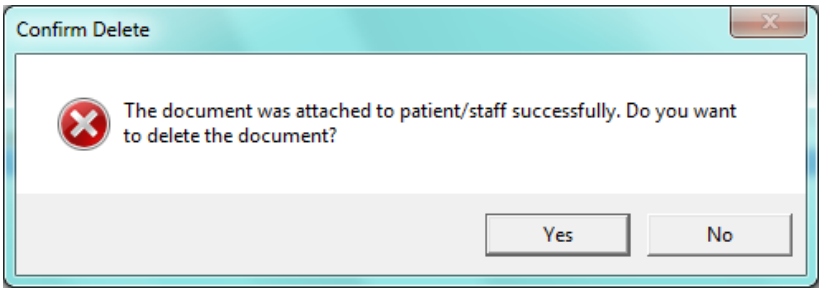
- Check the box next to the desired lab
- Click OK



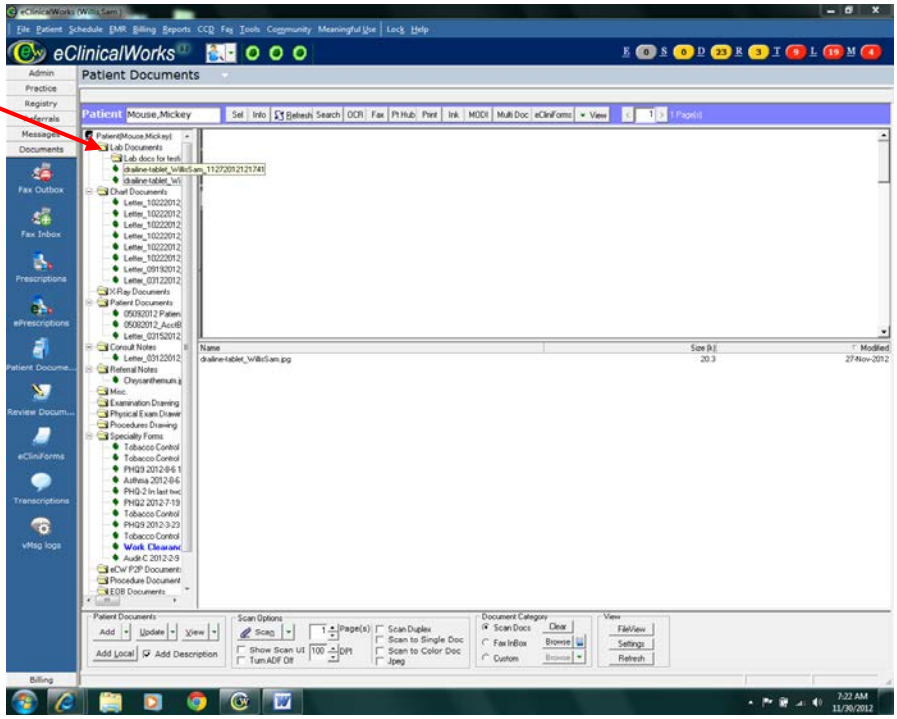
- The lab name now appears in the Attached to field.
- Time Stamp the document
- Change the name of the document according to your health center's naming convention.
- Fill out any other fields according to your health center's workflow.
- Check the Reviewed box
- Click OK.



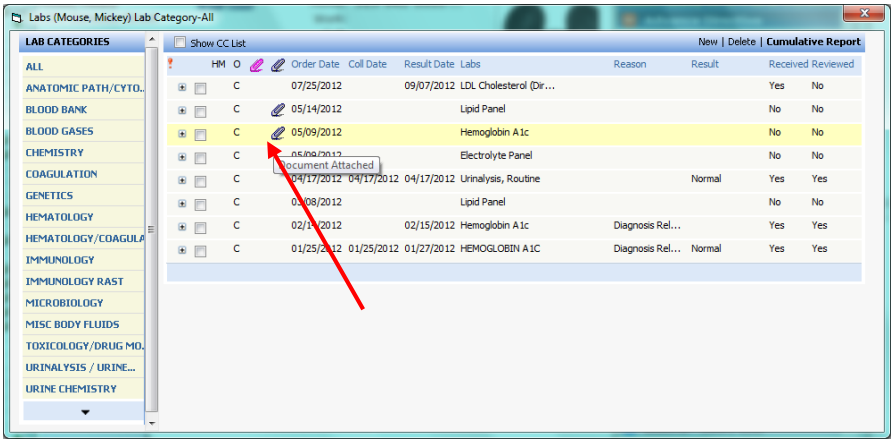
- Click Yes to delete the document from the list of scanned documents. Note: this does not delete the document from the folder that it was placed in.



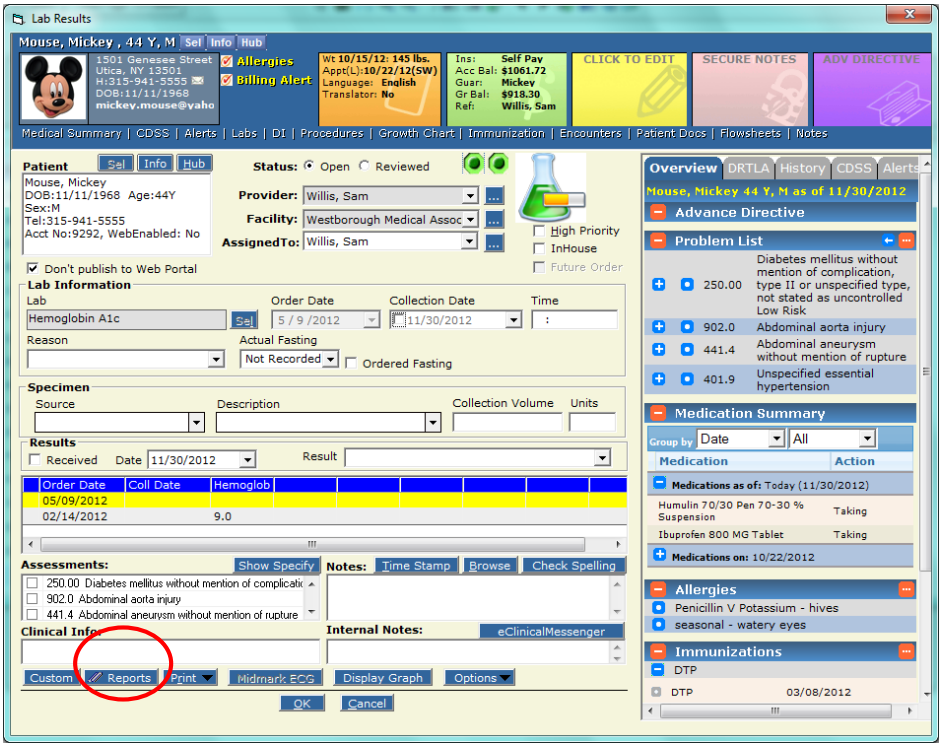
- The document now shows as reviewed in the proper folder.



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

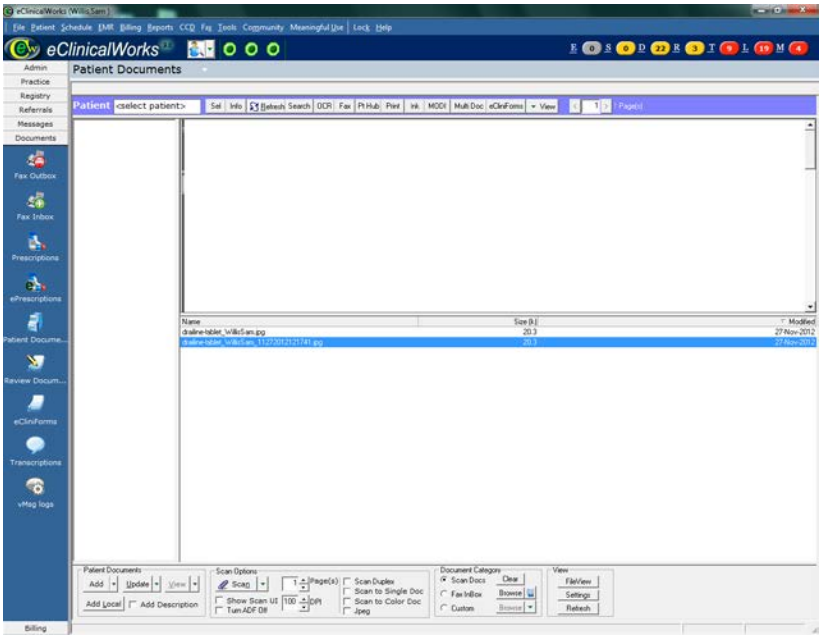


- A paperclip also appears on the reports button in the lab results window.

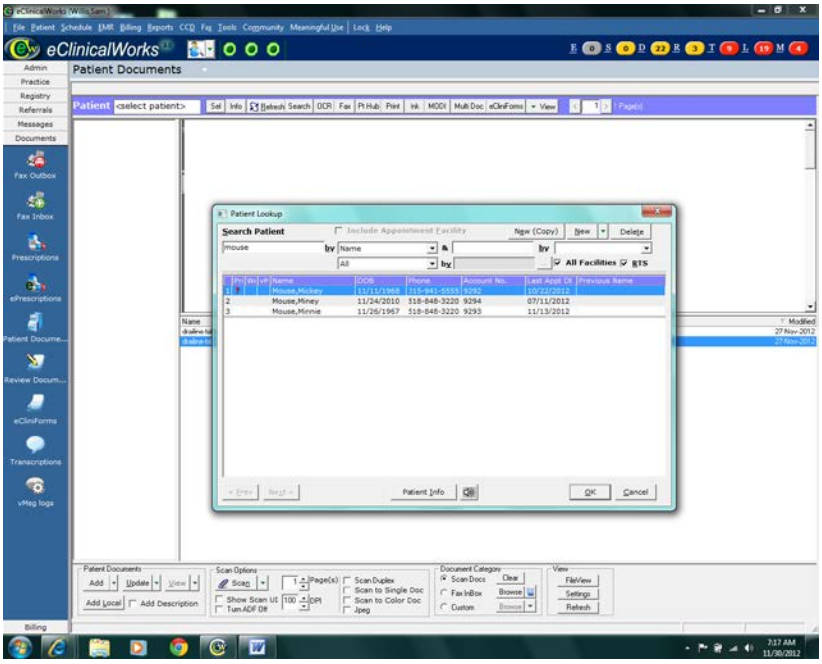


Attaching a paper result from a scanned document:

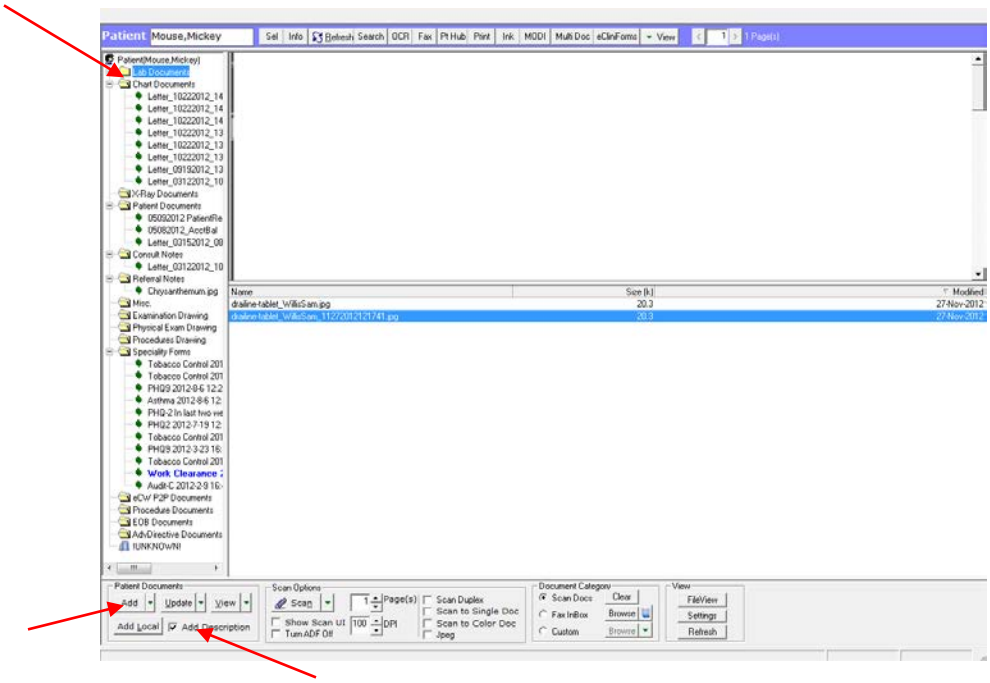
- Highlight the document.
- Click the SEL button to select the patient.



- Select the patient and click OK.

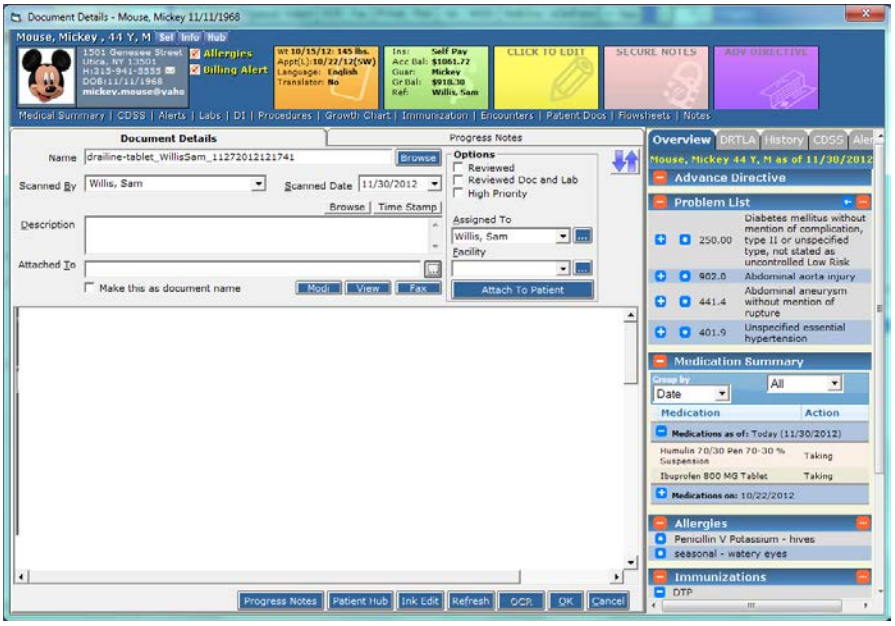


- Highlight the folder that you want to add the document to (Lab or X-ray).
- Check the Add Description box
- Click Add



The Document Details window opens up.

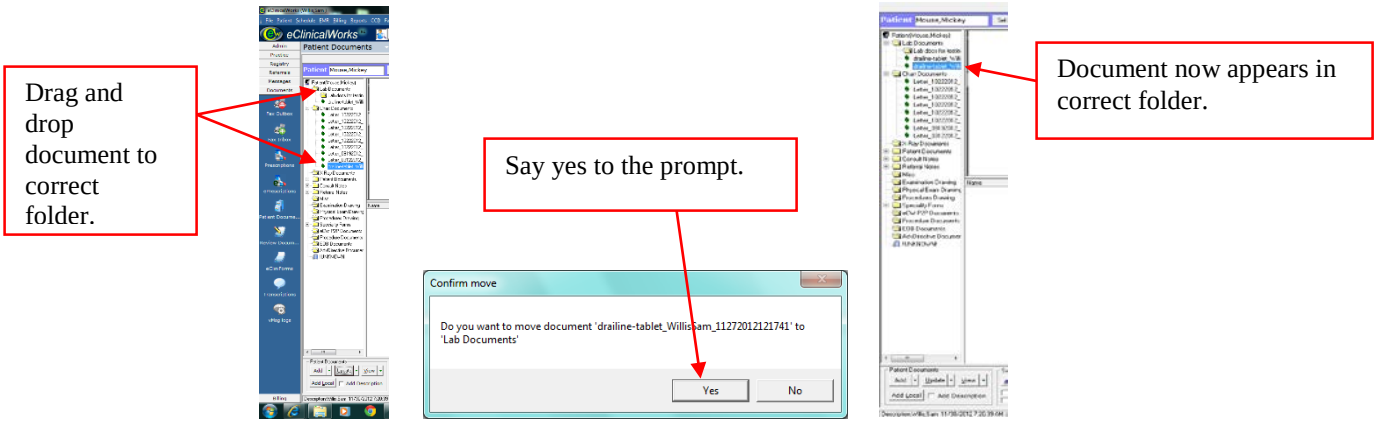
- Refer to page 4 and follow the remaining steps



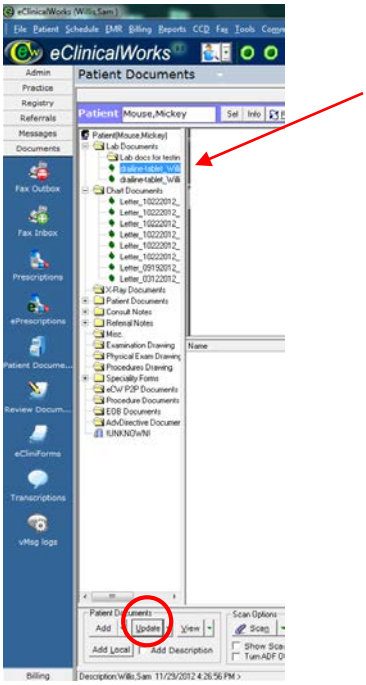
Attaching results previously filed in the Patient Chart:

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.

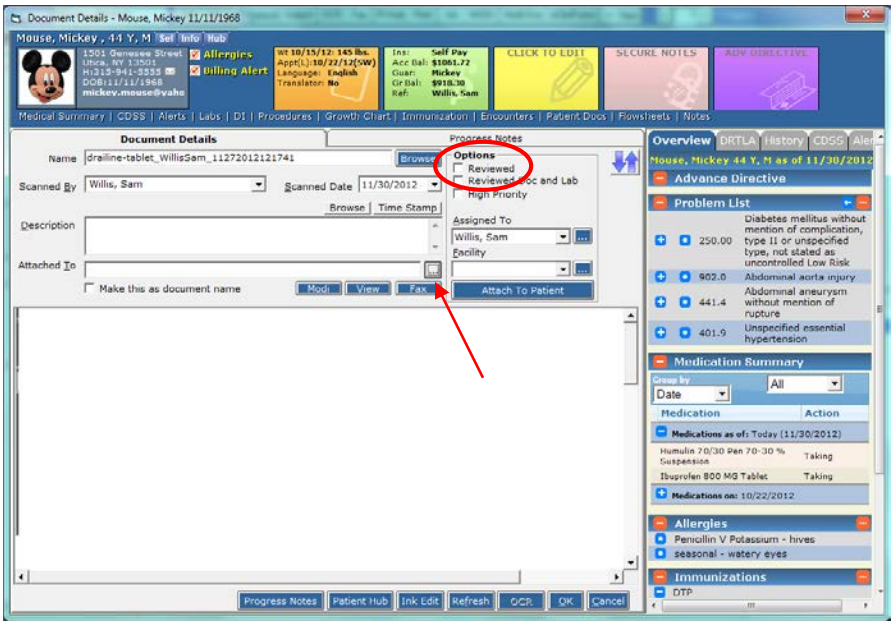


- Highlight the document
- Click the Update button

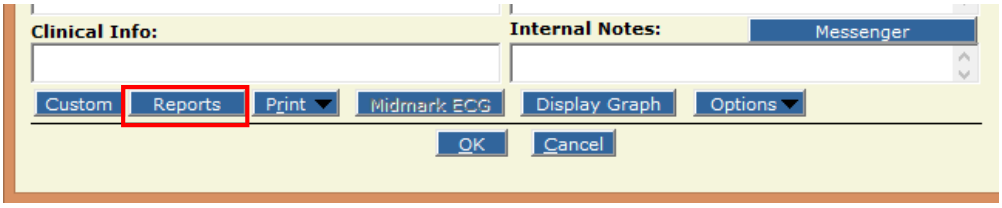


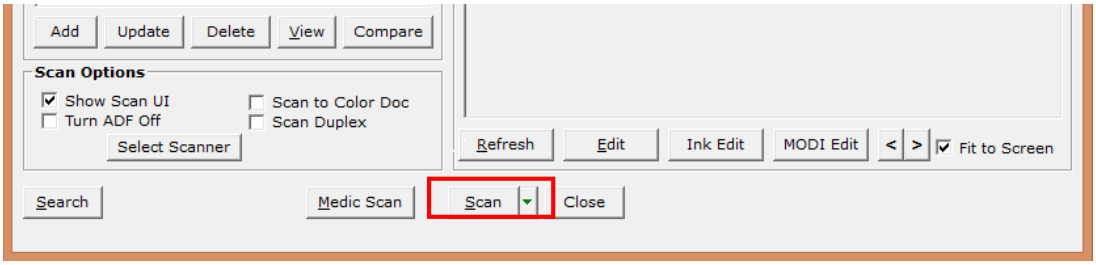
The Document Details window opens up.

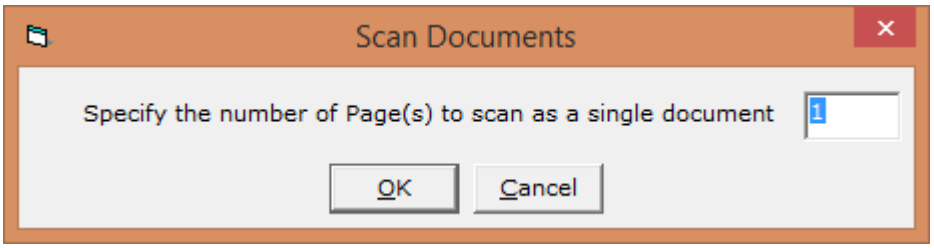
- If the document has been reviewed, you have to uncheck the Reviewed box. This will make the ellipsis button next to the Attach to field available.
- Refer to page 32 and follow the remaining steps

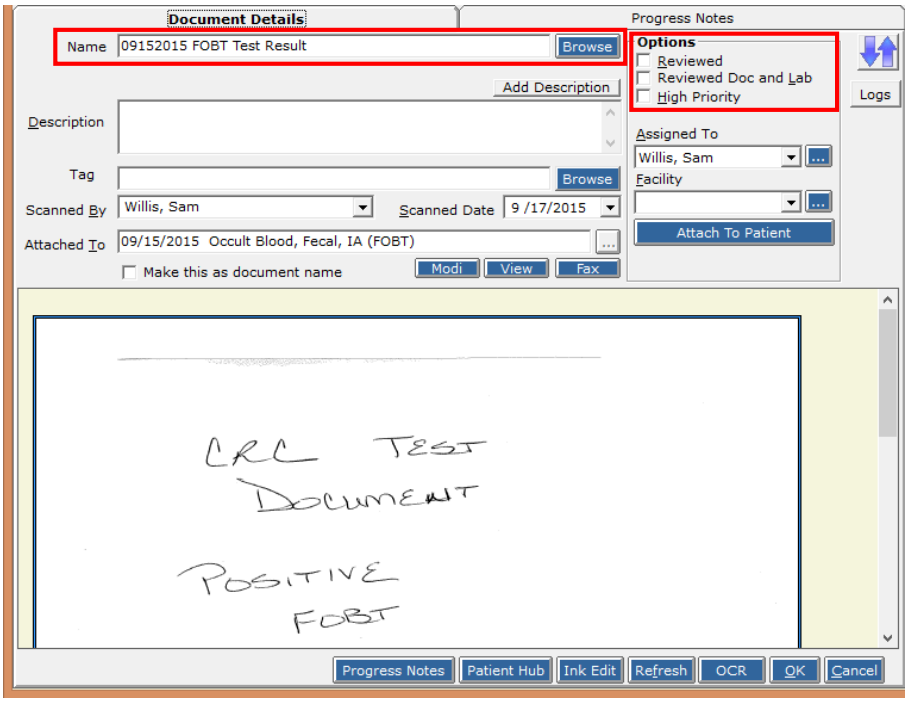


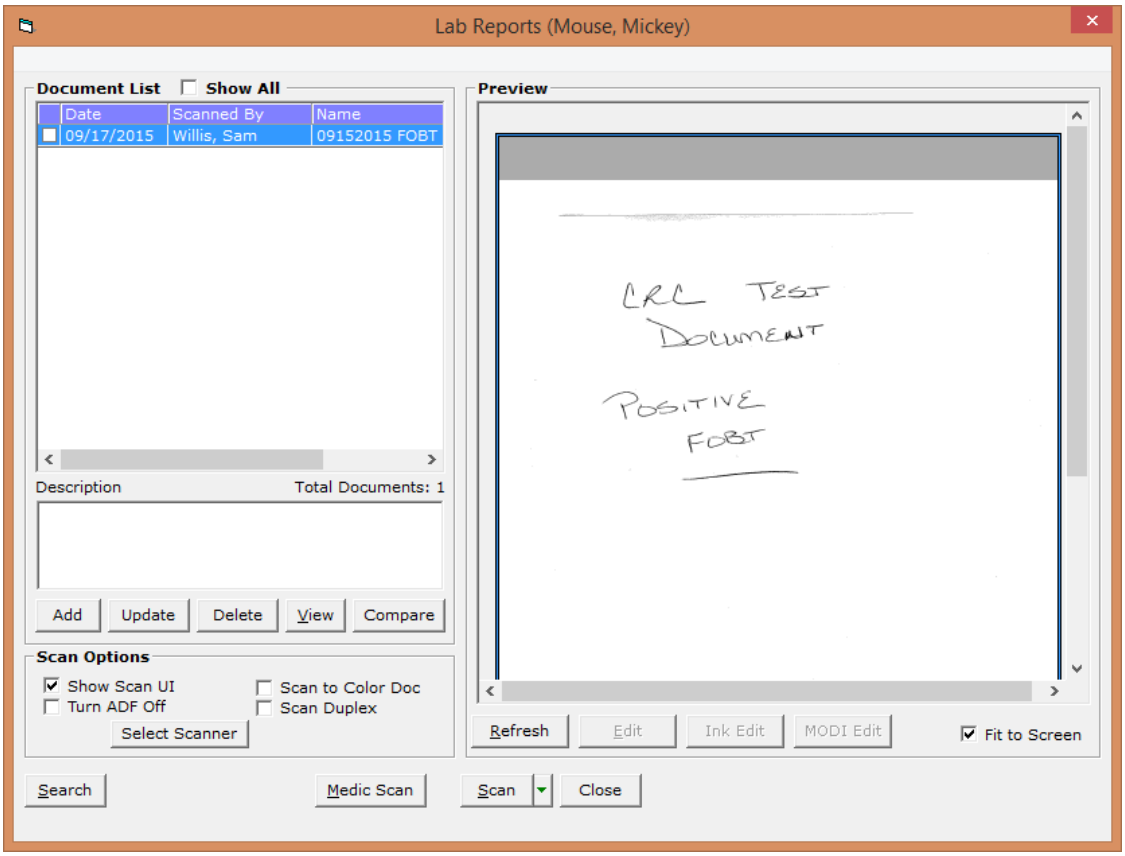
Alternate Workflow - Attaching report (that is not already scanned into the Lab Folder in Patient Docs) to an order

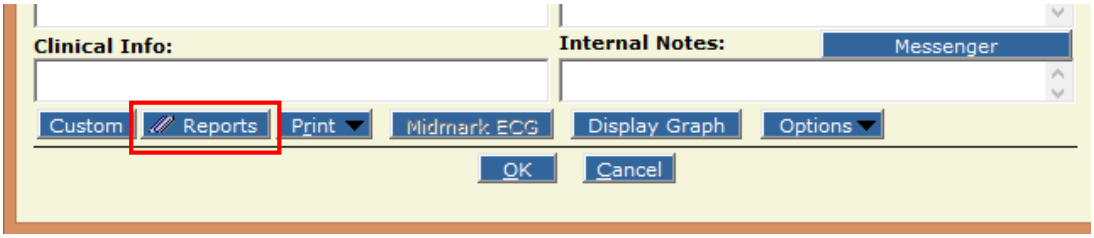


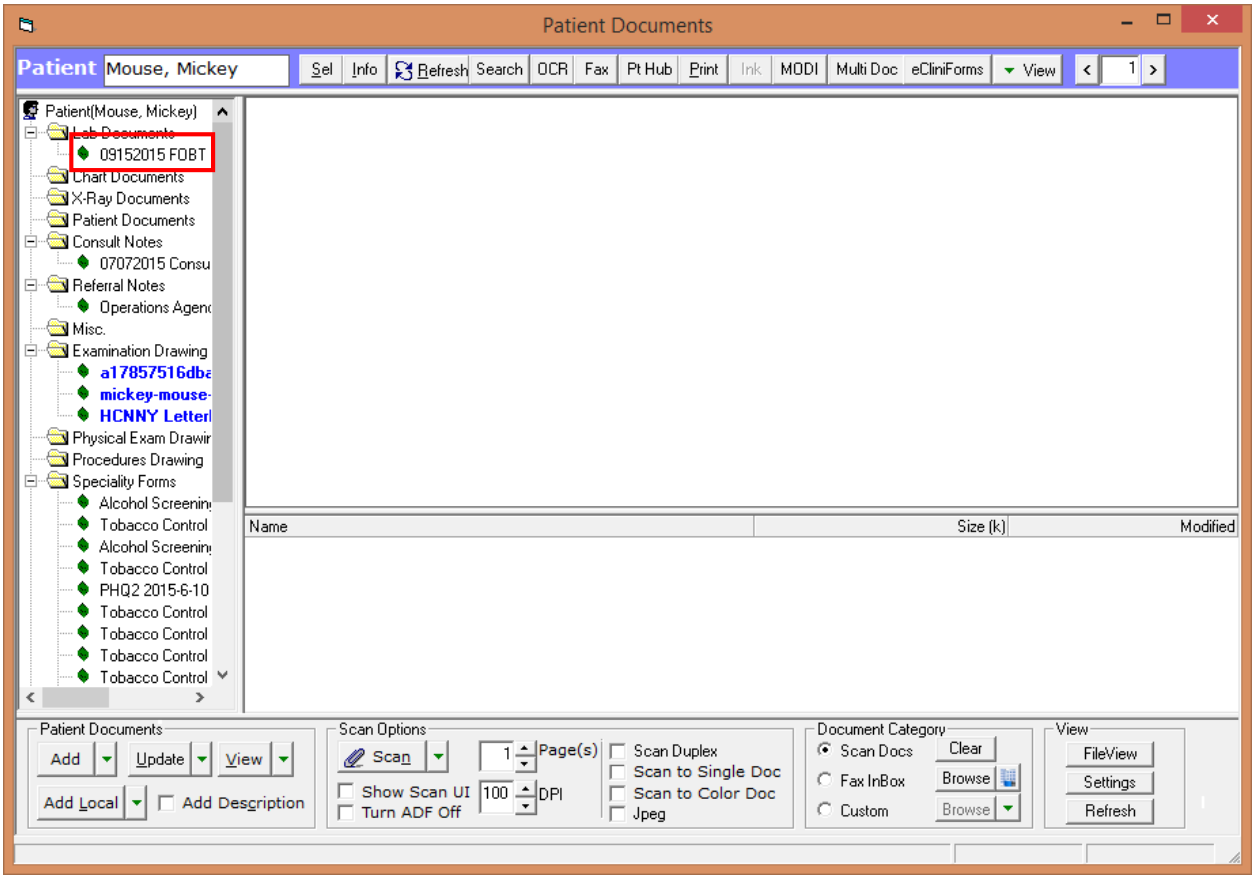







Lab Reports (Mouse, Mickey)
Document List
Show All
Date
Scanned By
Name
09/17/2015
Willis, Sam
09152015 FOBT
Description
Total Documents: 1
Add
Update
Delete
View
Compare
Scan Options
Show Scan UI
Turn ADF Off
Scan to Color Doc
Scan Duplex
Select Scanner
Preview
LRL TEST
DOCUMENT
POSITIVE
FOBT
Refresh
Edit
Ink Edit
MODI Edit
Fit to Screen
Search
Medic Scan
Scan
Close


Clinical Info:
Internal Notes:
Messenger
Custom
Reports
Print
Midmark ECG
Display Graph
Options
OK
Cancel


Patient Documents
Patient
Mouse, Mickey
Sel
Info
Refresh
Search
OCR
Fax
Pt Hub
Print
Ink
MODI
Multi Doc
eCliniForms
View
Patient(Mouse, Mickey)
09152015 FOBT
Chart Documents
X-Ray Documents
Patient Documents
Consult Notes
Referral Notes
Misc.
Examination Drawing
Physical Exam Drawir
Procedures Drawing
Speciality Forms
Tobacco Control
PHQ2 2015-6-10
Name
Size (k)
Modified
Patient Documents
Add
Update
View
Add Local
Add Description
Scan Options
Scan
Page(s)
Show Scan UI
Turn ADF Off
DPI
Scan Duplex
Scan to Single Doc
Scan to Color Doc
Jpeg
Document Category
Scan Docs
Fax InBox
Custom
Clear
Browse
View
FileView
Settings
Refresh