Medical Oncologist-Hematologist (Outpatient) Exercise Booklet

[Introduction 3](#_Toc500233804)

[Educational opportunities 3](#_Toc500233805)

[Initial consult visit 4](#_Toc500233806)

[Review the chart 4](#_Toc500233807)

[Add and stage a cancer diagnosis 4](#_Toc500233808)

[Assign a chemotherapy regimen 5](#_Toc500233809)

[Assign maintenance therapy 5](#_Toc500233810)

[Write a note 5](#_Toc500233811)

[Place blood orders and non-recurring orders 6](#_Toc500233812)

[FYI: Advance Beneficiary Notices (ABNs) 7](#_Toc500233813)

[Wrap up the visit 8](#_Toc500233814)

[Review questions 9](#_Toc500233815)

[Treatment plan modification 11](#_Toc500233816)

[Adjust the treatment schedule 11](#_Toc500233817)

[Modify and add orders to the treatment plan 11](#_Toc500233818)

[Adjust AUC dosing 11](#_Toc500233819)

[Defer, hold, or cancel treatment 11](#_Toc500233820)

[Review questions 11](#_Toc500233821)

[Survivorship follow-up visit 13](#_Toc500233822)

[Review historical information 13](#_Toc500233823)

[Create survivorship documentation 13](#_Toc500233824)

[Review questions 13](#_Toc500233825)

[Reporting 14](#_Toc500233826)

[Run reports 14](#_Toc500233827)

[Answer key 15](#_Toc500233828)

[Answers - Initial consult visit 15](#_Toc500233829)

[Answers - Treatment plan modification 17](#_Toc500233830)

[Answers - Survivorship follow-up visit 17](#_Toc500233831)

# Introduction

## Educational opportunities

Classroom training is one piece of your Epic education. Other opportunities to learn more before go-live include:

* Pre-class e-learning and exercises
* Study halls and independent practice after class
	+ Use this exercise booklet as guidance
* Assessment
	+ You must pass to receive your login credentials for go-live
* Personalization labs
	+ Set up your personal preferences for note templates, Order Sets, and more
* Learning Home dashboard
	+ Includes quick start guides, efficiency tips, and updates about system changes
	+ The Learning Home is available in Hyperspace on the  tab.

# Initial consult visit

## Review the chart

* Review relevant visit information:
	+ Go to the Sidebar > This Visit > Visit Summary to review allergies, medications, problems, and rooming information. Mark the info as reviewed.
	+ Optional: Go to Rooming to update allergies and history. Go to Plan to update medications and problems.
* If you're looking for specific information, search the chart.
	+ Enter a search term in the field in the upper-right corner of the screen.
* Browse historical information and notes.
	+ Go to Chart Review to browse the complete chart.
	+ Explore various tabs, such as Encounters and Labs.
* Tip: On the Encounters tab, select a row to see a summary of the encounter. Hover your mouse over links in the Orders Placed and Medication Changes sections to see more information.
* Tip: On the Labs tab, check the MyChart and Pt. Viewed columns to see if test results have been released to the patient's MyChart account and whether the patient has seen them.
	+ If you need to narrow down the information in Chart Review, use the filters at the top of each tab.
	+ Tip: Customize Chart Review by clicking  in the upper-right corner of a tab. Drag and drop tabs to reorder them, change tab colors to make them stand out, and click the star for whichever tab you want to see first.

## Add and stage a cancer diagnosis

* Add the cancer diagnosis to the problem list.
	+ Go to Plan > Problem List and add a cancer problem.
	+ Tip: To customize your view of the problem list:
* Click  at the top right of the section. Then, choose a different view or customize your columns.
* Prioritize the patient's problems. Expand a problem, click the Unprioritized link, and select a priority for your view of the problem list.
	+ Click the piece of paper with the blue arrow to quickly add a problem to the visit diagnoses list.
	+ Mark the list as reviewed.
* Add any additional visit diagnoses.
	+ Go to Plan > Visit Diagnoses. Use a speed button or search in the Add field to document diagnoses that aren't on the problem list.
* Tip: Click the wrench to customize your speed buttons.
* Stage the cancer.
	+ Under the cancer problem, select Enter Staging Information.
	+ Complete and sign the staging form.
	+ Send the stage to the patient's PCP.
* Document the event on the Oncology History.
	+ Under the cancer problem, select Create Oncology History.

## Assign a chemotherapy regimen

* Go to Treatment > Treatment Plan > Create a New Plan.
* Search for protocols by drug, body site, and/or disease.
	+ Preview the protocol before selecting it.
* Fill out the plan properties, including dosing, and assign it to your patient.
* Active the treatment plan.
	+ Sign and release prescriptions.
	+ Complete the Prescriptions Cycle.
	+ Sign Cycle 1.
* Send the treatment plan to the patient's PCP.

## Assign maintenance therapy

* Discontinue the completed treatment plan.
* Assign a recurring therapy plan.
	+ Go to Treatment > Therapy Plan and associate the plan with a new problem.
	+ Fill out the Order Schedule and other order details for each medication.

## Write a note

* Go to Notes.
	+ To create a note using point-and-click forms, click the arrow next to Create Note and select ONC Cancer Initial Visit.
* Complete the HPI, ROS, and Physical Exam forms, then use the SmartList in the template to pull in your diagnoses and orders.
* Complete any other SmartLists and wildcards (\*\*\*), and add to the note as needed.
	+ To create a note using SmartTools, click Create Note.
* Enter "onc" in the Insert SmartText field to see internal medicine note templates or pull in a SmartPhrase by typing a period followed by the phrase's name.
* Tips:
	+ Keep your note open on the right as you do other things, like place orders and update the problem list.
	+ Use macros to apply common findings to the ROS or Physical Exam form, and then update the note with any differences for your patient.
	+ Use the more detailed Physical Exam forms as needed. Many include drawing tools you can use to annotate an image that will be included in your note.
	+ <Look for opportunities to copy a note, or a portion of a note, and update it as needed for the current visit. This can be particularly helpful for follow-up visits.>
	+ Click the wrench to save your frequently used templates as speed buttons.

|  |  |  |
| --- | --- | --- |
|  | SmartText/SmartPhrase | NoteWriter |
| What is it? | A text template with options to customize the text for each patient. | A point-and-click form that turns your selections into note text. |
| Where is it commonly used in notes? | * Very brief notes (like short H&Ps or simple progress notes)
* HPIs with a unique story
* Notes with elements that aren't options in NoteWriter
 | * Progress notes (including HPI, ROS, and Physical Exam)
* Procedure notes
 |
| How can I customize it? | Save your own version as a new SmartPhrase by clicking the green plus sign. SmartPhrases function like SmartTexts, but:* Can be created by anyone.
* Are pulled in by typing, ".phrasename"
 | Create a macro to apply your normal documentation in one click. Then, change only what's different for the current patient. |

## Place blood orders and non-recurring orders

* Order an outpatient blood transfusion.
	+ Go to Plan > SmartSets and select a blood administration SmartSet.
	+ Select desired labs and orders and fill out order details.
	+ When finished, sign the SmartSet.
* Place non-recurring orders outside of the treatment plan. Go to Plan > Meds & Orders.
	+ Click the link at the bottom of the section to update the pharmacy if needed.
	+ Search for an order or click New Order to browse your preference list.
* If you place an order frequently, click the star to add it to your preference list.
* When browsing your preference list from the New Order button, select the Only Favorites check box to see only the items you've added to your personal list.
* For medications:
	+ Select an order with the syringe icon if the medication will be administered within the clinic. For prescriptions, choose an order with the house icon.
	+ Select the Class that indicates how the order should be processed. Select Normal to e-prescribe the medication.
* For procedures or labs:
	+ Select a Status of:
* Normal if the test or procedure will occur once, now.
* Future if the test or procedure will occur only once, in the future.
* Standing if the test or procedure will occur more than once.
	+ Select a Class that indicates where the test or procedure will be performed.
* Reorder or discontinue medications
* Select the Med History check box to see discontinued or expired meds if needed.
* Expand the medication you need and click Reorder or Discontinue.
* When you're finished, refresh your note. The orders should appear under the Assessment/Plan heading.

## FYI: Advance Beneficiary Notices (ABNs)

<Remove this section if your specialty will not use Advanced Beneficiary Notices (ABNs).>

After go-live, you might encounter Advance Beneficiary Notices when placing orders for Medicare patients.

The following is for your information only and will not appear in the training environment.

* If the Order Validation window appears because an ABN was triggered, like in the image below, follow up on the warning right from this window:
	+ Click Review Diagnoses to see a list of diagnoses that are covered for the order you're trying to place. Select a new diagnosis if an appropriate one is listed.
	+ Click Waiver Form if no appropriate diagnoses are covered. The form includes the estimated cost of the order.
* After discussing the notice with the patient, update the notice status to indicate whether the form has been signed, refused, printed, voided, or is pending.
* Print the form if needed. Otherwise, your support staff or clinic manager can get the patient's signature.



## Wrap up the visit

* Write patient instructions.
	+ Go to Wrap-Up > Patient Instructions. Search for templates in the Insert SmartText field or click References to pull in an article. These instructions are included in the patient's After Visit Summary (AVS).
* Write a letter.
	+ Go to Wrap-Up > Communication Management. Create a new communication or send a Quick Communication.
	+ Select one or more recipients. Then create a specific type of letter, such as Work Excuse. If you don't see the template you need, click Other.
* Document your level of service.
	+ Go to Wrap-Up > LOS and select the appropriate code.
	+ Search for a code or click the wand if you don't see what you need.
	+ Tip: Click  to add buttons for codes you use frequently.
* Write follow-up instructions.
	+ Go to Wrap-Up > Follow-Up. These instructions are included in the AVS.
	+ Tip: To send the chart to another clinician or send yourself a reminder message, click Expand for more options.
* File charges.
	+ Professional charges for procedures are filed through your procedure documentation.
	+ To file other charges, go to Wrap-Up > Charge Capture.
* Close the encounter.
	+ Go to Sign Visit, address any outstanding documentation, and click Sign Visit to send it to billing.

## Review questions

The following questions cover topics from e-learning, classroom training, and exercises.

* When you open a visit, where's the first place you should go to review support staff documentation?
* If you're looking for something specific in the chart, which tool should you use?
* If Chart Review includes a lot of data, how can you quickly find what you need?
* How can you quickly review patient information before an appointment?
* What's the fastest way to document your diagnoses for a visit?
* What shortcuts can you use instead of searching for diagnoses in the Visit Diagnoses section?
* What if you can't find the appropriate staging form?
* Who can document on the oncology history?
* Where can I go to adjust dosing calculations?
* What is the difference between signing an order and releasing an order?
* How is the Treatment Plan activity different from the Treatment Plan Manager?
* What's the difference between Interval in the Order Schedule and Frequency in the Order Details?
* How do you indicate that the therapy treatment should stop three months from now?
* How can you add information to the text that's generated by NoteWriter?
* How do you document positive or negative findings without having to click the plus/minus icons in NoteWriter?
* What are some tools for quickly writing a routine note or a follow-up note?
* Will a macro overwrite anything you've already documented?
* How can you keep your note in view and update it as you're working in other areas of the chart?
* Do you still need to call the blood bank after placing blood orders?
* Is the blood ordering process the same in the hospital?
* If you want a lab order to be performed four times, once every three months, what order status should you select?
* How can you browse the preference list for quick, point-and-click ordering for the most common things?
* If you're ordering an injection to be administered in the clinic, which icon should you look for when placing the order?
* If you're giving a patient a Zofran tablet in the clinic, which icon should you look for when placing the order?
* If you need to print a prescription for a patient to take to the pharmacy instead of e-prescribing it, how can you do that?
* What types of charges must be filed manually?
* When you're finished documenting in the visit, should you close the workspace or sign the visit?

# Treatment plan modification

## Adjust the treatment schedule

* Create an Orders Only encounter:
	+ Open the patient's chart using Patient Lookup and select Place Amb Orders.
* Adjust the treatment schedule
	+ Change the Planned for date and propagate changes to the rest of the regimen if needed.

## Modify and add orders to the treatment plan

* Open the Treatment Plan Manager and modify a dose.
	+ Doses can be modified by percentage of the original dose or by entering a new weight, dose, or AUC value.
* Add a new order to an existing day.
	+ Assign orders to the appropriate category.
	+ Copy the order to other days as needed.
	+ Re-sign the order.
* Delete an existing order.

## Adjust AUC dosing

* In the Treatment Plan Manager, open the carboplatin order to edit the order details.
* Enter a different target AUC than the one calculated.
* Change the creatinine clearance formula.
* Enter a manual GFR or Serum Creatinine result.
* Sign and accept orders.

## Defer, hold, or cancel treatment

* Practice deferring, holding, and canceling treatment in the Treatment Plan Manager.
	+ Deferring and canceling can be done on the day or cycle level of the treatment plan.

## Review questions

The following questions cover topics from e-learning, classroom training, and exercises.

* When would you add an order directly into the treatment plan versus ordering it from the Meds & Orders section?
* How do you edit the details of the order (such as class)?
* What's the difference between changing the date of treatment and deferring the day?

# Survivorship follow-up visit

## Review historical information

* Get an overview of all types of oncology treatment your patient is currently receiving.
	+ Go to Treatment > Plan Summary for a comprehensive list of all chemotherapy, supportive care, and recurring regimens.
* Get an in-depth review of the patient's oncology treatment over time, including chemotherapy treatment and labs.
	+ Go to Synopsis and explore the different views available.
	+ Graph a few values and pin criteria to the Patient Spotlight.

## Create survivorship documentation

* Document the patient's remission in the patient's Oncology History.
	+ Go to Problem List > Create Oncology History to enter important treatment events.
* Create an Oncology Treatment Summary.
	+ Go to Problem List > Oncology Treatment Summary under the cancer diagnosis and fill out the form.
	+ Print the summary or send it to another provider.

## Review questions

The following questions cover topics from e-learning, classroom training, and exercises.

* Will other clinicians see the vitals you pinned to the Spotlight?
* Do you need to finish documenting the Treatment while you're with the patient?
* What information is included in the Treatment Summary?
* <When do you discontinue a treatment plan?>

# Reporting

## Run reports

After go-live, you'll be able to run several internal medicine reports from your dashboard, including the following:

* Unsigned Treatment Plan Orders
* Unstaged Patients on my Treatment Plans
* Treatment Plan Orders Awaiting Dual Sign

For more information and step-by-step instructions, refer to the Reporting guide on your Learning Home.

# Answer key

## Answers - Initial consult visit

* When you open a visit, where's the first place you should go to review support staff documentation?
	+ The sidebar.
	+ You can also mark items as reviewed from here.
	+ If you need to update something, go to the Rooming or Plan tab.
* If you're looking for something specific in the chart, which tool should you use?
	+ Chart Search.
* If Chart Review includes a lot of data, how can you quickly find what you need?
	+ Use filters.
* How can you quickly review patient information before an appointment?
	+ Single-click the appointment on your schedule to see the Snapshot Report.
* What's the fastest way to document your diagnoses for a visit?
	+ Add diagnoses as you review the problem list and then enter additional acute diagnoses in the Visit Diagnoses section.
* What shortcuts can you use instead of searching for diagnoses in the Visit Diagnoses section?
	+ Click the Common diagnoses speed buttons, use the Previous list, use the Problems list, and customize the Common buttons using the wrench.
* What if you can't find the appropriate staging form?
	+ The Cancer Staging activity includes all available AJCC V6, AJCC V7, and GOG forms - simply select the desired form.
	+ To request a new form, contact the Epic build team.
* Who can document on the oncology history?
	+ Any clinician with access to the problem list. This way, anyone involved with treating the patient's cancer can document in one centralized location.
* Where can I go to adjust dosing calculations?
	+ The Treatment Plan Properties, found in the Treatment Plan Manager
* What is the difference between signing an order and releasing an order?
	+ Sign: Provider signature
	+ Release: Order is sent to the pharmacy/medication is being administered.
* How is the Treatment Plan activity different from the Treatment Plan Manager?
	+ The Treatment Plan is view-only, the Treatment Plan Manager allows you to edit the plan.
	+ Button options reflect this
* What's the difference between Interval in the Order Schedule and Frequency in the Order Details?
	+ Order Schedule Interval: How often the treatment is given, refers to the treatment day
	+ Order Details Frequency: How many times the medication is given during that treatment day
* How do you indicate that the therapy treatment should stop three months from now?
	+ Change the Duration from Until discontinued to Until m+3
* How can you add information to the text that's generated by NoteWriter?
	+ Hover over a button and begin typing.
	+ Click the piece of paper to add comments for a whole section.
	+ Place your cursor before or after highlighted text in your note and begin typing.
* How do you document positive or negative findings without having to click the plus/minus icons in NoteWriter?
	+ Move your mouse down a column of buttons and left-click any you want to mark positive and right-click any you want to mark negative.
* What are some tools for quickly writing a routine note or a follow-up note?
	+ Apply a macro, and then chart by exception.
	+ Copy a whole note or just a part of the note, like a previous exam or ROS.
* Will a macro overwrite anything you've already documented?
	+ No.
* How can you keep your note in view and update it as you're working in other areas of the chart?
	+ Keep it open in the sidebar.
* Do you still need to call the blood bank after placing blood orders?
	+ <No. The blood bank can see the orders, but many clinicians still call the blood bank as a regular part of their workflow to confirm that the orders are accessible and verify the schedule of the transfusion.>
* Is the blood ordering process the same in the hospital?
	+ <For inpatient blood transfusions, you will use an Order Set instead of a Smart Set.>
* If you want a lab order to be performed four times, once every three months, what order status should you select?
	+ Standing
* How can you browse the preference list for quick, point-and-click ordering for the most common things?
	+ Click New Order.
* If you're ordering an injection to be administered in the clinic, which icon should you look for when placing the order?
	+ The syringe, which indicates it's a clinic-administered med.
* If you're giving a patient a Zofran tablet in the clinic, which icon should you look for when placing the order?
	+ The syringe. Even though you're not injecting this medication, it's still being administered in the clinic.
* If you need to print a prescription for a patient to take to the pharmacy instead of e-prescribing it, how can you do that?
	+ Select a Class of Print.
* What types of charges must be filed manually?
	+ <Update to match your organization's policies.>
* When you're finished documenting in the visit, should you close the workspace or sign the visit?
	+ Sign the visit – the visit isn't sent to billing until it's signed.

## Answers - Treatment plan modification

* When would you add an order directly into the treatment plan versus ordering it from the Meds & Orders section?
	+ Adding an order to the treatment plan syncs it to the treatment plan schedule, so any future date changes will automatically move the order date.
* How do you edit the details of the order (such as class)?
	+ Click the blue summary sentence below the order name to open the Order Composer.
* What's the difference between changing the date of treatment and deferring the day?
	+ Change the date if the reason is non-clinical. <Explain your organization's policies on changing treatment dates.>
	+ Defer the day if the reason is clinical.

## Answers - Survivorship follow-up visit

* Will other clinicians see the vitals you pinned to the Spotlight?
	+ No, pins are patient-specific and user-specific.
* Do you need to finish documenting the Treatment while you're with the patient?
	+ <Check your organization's policies.>
* What information is included in the Treatment Summary?
	+ <All chemotherapy and radiation therapy received by the patient; their treatment team; their schedule of follow-up visits; and more.>
* <When do you discontinue a treatment plan?>
	+ <Check your organization's policies.>