Radiation Oncologist Exercise Booklet

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# 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.

## 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 orders

* Order medications, procedures, or labs.
	+ 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  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 in the clinic. For all other medications, 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 the Class that indicates where the test or procedure will be performed.
* Reorder or discontinue medications.
	+ Go to Plan > Meds & Orders.
* Click  and select the Med History check box to see discontinued or expired meds if needed.
	+ Expand the medication you need and click  to reorder it or  to discontinue it.
* When you're finished, sign the orders and refresh your note. The orders should appear under the Assessment/Plan heading.

## 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?
* 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?
* 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?

# 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.

## 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.

## 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?>
* 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?

# Quick office visit

## Review visit info and complete standard documentation

<If you're not using Express Lanes, remove this section (and the associated review questions) and replace it with the Document another routine visit exercise that uses SmartSets.>

* Review allergies, meds, and problems.
	+ Mark these items as reviewed.
	+ Review vitals and other rooming information in the sidebar. If you have one, your last progress note for this patient is also available from the sidebar.
* Efficiently place orders and document the visit.
	+ Select the appropriate items from the Express Lane. Search for any orders you need that aren't listed.
	+ Complete your note using one of the templates available in the Express Lane or write a different note from the Notes tab in the sidebar.
	+ Sign the Express Lane.
* Wrap up and sign the visit.
	+ Print the After Visit Summary.
	+ Sign the visit.

## If you have time: Document another routine visit

<Remove this topic if your specialty will not use SmartSets to document routine visits.>

<If there isn't an Express Lane for a routine visit, you can also use a SmartSet.> SmartSets are similar templates that help you quickly select diagnoses, write orders, choose a level of service, and more.

* Open the visit.
	+ Do this from your schedule.
	+ If you already signed the visit, you'll need to create an addendum.
* Efficiently place orders and document the visit.
	+ Go to Plan > SmartSets.
	+ <Typically, an appropriate SmartSet is suggested for you.> If necessary, enter an appropriate search term and select a SmartSet. Then click  Open SmartSets.
	+ Open each section of the SmartSet and select the appropriate items, similar to the Express Lane you just used.
	+ Sign the SmartSet.
* Wrap up and sign the visit.
	+ Complete any other necessary documentation using your standard tools.
	+ Sign the visit (or the addendum, if you had to create one).

## 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.

## Review questions

<If you're not using Express Lanes, remove this section.>

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

* Do you need to manually open the Express Lane when you need it?
* What should you do if you need to place orders that aren't listed in the Express Lane?
* What should you do if you need to make other changes or find information that's not in the Express Lane?
* Can you start your note in the room before you sign orders?

# Reporting

## Run reports

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

* <Add your organization's relevant reports>

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.
* 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.
* 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 - 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.>
* 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

## Answers - Quick office visit

<If you're not using Express Lanes, remove this section.>

* Do you need to manually open the Express Lane when you need it?
	+ No. It automatically appears for certain routine visits.
	+ You can open an Express Lane on the fly if needed – just search for the Express Lane you need using Chart Search.
* What should you do if you need to place orders that aren't listed in the Express Lane?
	+ Search for them in the Search field at the top of that section.
	+ The content in each Express Lane is configurable. If you commonly need something, such as an order or note template, that's not available from the Express Lane, contact your project team.
* What should you do if you need to make other changes or find information that's not in the Express Lane?
	+ All your other tools and activities, like Chart Search, Wrap-Up, and Communications, are still available. Use the activity tabs on the left side of your screen as usual.
* Can you start your note in the room before you sign orders?
	+ Yes. Just scroll to the Progress Notes section of the Express Lane and click Add Now at any point.
	+ Also, you don't need to complete the note to sign the Express Lane. The note will be saved when you sign the Express Lane (and any orders you've selected from the Express Lane), but can be edited in the Notes sidebar before you sign the visit.