Radiation Oncologist Lesson Plan

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# Trainer information

In addition to your main talking points, this lesson plan includes underlined steps to demo in the system.

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| When you see a box with a dotted outline like this, these boxes contain specialty-specific information. |

Course introduction

* Welcome.
* Today's class will focus on your main workflows.
* You learned the basic concepts and tools in your previous training - now we'll put those all together to make sure you can get through:
  + Initial consult visits
  + Survivorship follow-up visits
  + Routine office
* I'll demonstrate while you follow along with me in the system.
  + We have a lot to cover and I want to make good use of your time, so we'll move quickly.
  + If at any point you get lost, stop following on your computer and just watch me.
* To get your login credentials for go-live, you need to pass an assessment.
  + The assessment will be completed after this class
* However, I don't expect you to be an Epic expert when you leave here today.
  + You all should have an exercise booklet.
  + We won't use these today in class, but you should use this for independent practice after class.

# Initial consult visit

* Let's start by looking at how to document an initial consult visit with a patient.
* I'll show you how to:
  + Quickly find information in the chart.
  + Add and stage a cancer diagnosis.
  + Place orders efficiently.
  + Wrap up the visit.

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| Scenario   * Patient: **Rosalind**, 33-year-old female   + Find the patient on your schedule – 8:00 AM appointment. * Reason for visit: Lump or mass in breast |

## Get up to speed on the patient

### Introduction

* The patient has been referred to oncology by her PCP after an abnormal Breast Exam.
* The nurse has just finished rooming the patient. I'd like to get up to speed before I enter the room.

### Review relevant visit information

* First, I'll quickly review some highlights from the patient's chart right from my Schedule, which I can do first thing in the morning, or between patients.
* Go to the Schedule and check the preview box so you can see the report on the right of the Schedule.
  + Point out key info on the report, including where your last note would appear and Oncology History.
  + Wrench the Springboard Report
* Double-click to open the appointment.
* The system automatically takes you to the Plan activity. This where you can begin by add a cancer problem to your patient’s problem list.l
* As you can see the activities are very similar to what you saw in your ambulatory class.
* Point out Chart Review, Rooming to review vitals then Plan Activity *is the primary activity that the provider works from.*
* Similar info appears in the sidebar on This Visit Tab if I haven't already reviewed it from my schedule.
  + Both of these places also offer a quick way to record that you reviewed certain info.
  + I've discussed allergies and meds with the patient now, so I'll mark those as reviewed.
  + Click Mark as Reviewed for Allergies and Medications in the sidebar.

## Add and stage a cancer diagnosis

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| Demo examples   * EXPAND PROBLEM: Lump or mass in breast * CHANGE DX TO: Ductal carcinoma of left breast - * ADD DX: Ductal carcinoma of left breast * STAGING DETAILS: cT1, cN1, cM0, G3, ER-, PR+, HER2+ * CANCER STAGE: Stage IIA |

### Introduction

* After reviewing the patient's chart and biopsy results, I determine the patient has cancer and needs immediate intervention.
* I'll begin by documenting the clinical stage.

### Review and update the problem list

* Go to Plan > Problem List.
* To see more info about a problem, expand it
  + Any notes that I or other clinicians have entered would appear here.
  + Ask: If this problem has evolved into something more specific, how should you update the problem list to reflect that and preserve your documentation?
* Change the diagnosis for that problem - don't delete the problem and add a new one.
* Saves your overview note and creates a historical record of the problem
  + Click Change Dx  and enter something more specific (ex. CHANGE DX TO DCIS).
  + I'll add it as a visit diagnosis right from here to save time and clicks.
* Click the Green Plus  to add the problem to the visit diagnosis list.
  + Point out the green check mark that appears.

INDEPENDENT PRACTICE:

* Take 1 minute to explore the problem list.
* We're finished with our review and updates, so let's mark the list as reviewed

### Stage the patient's cancer

* Staging information is attached to the cancer problem on the patient's problem list.
* Click Enter Staging Information.
* Point out the Classification and Form menus in the sidebar.
  + Digital form is the same as the paper AJCC form
  + Can select a pathologic stage or add a new form
* Can document recurring cancer this way.
* On the main part of the screen, can see any relevant reports
  + Can view the biopsy report while I document the stage
* Document the patient's cancer stage (ex. STAGING DETAILS)
* Click Enter Staging Information
  + *Mark as Not Needed is to ensure that the patient is not flagged in a report as missing documentation.*
  + *Point to down arrow for Classification: both Clinical and pathological staging can be done here.*
  + *The correct edition of the Breast cancer appears automatically based on the cancer type and diagnosis date.*
  + *If you need to you can change the body site and edition here. The form includes all fields on the AJCC staging form.* Click the drop-down arrow for Form
  + *There are also Lab/Path Report, Imaging and other relevant Staging forms on this screen that I can reference while filling out the staging form –* Point to top left.
  + *I will fill out the clinical stage now. To calculate a stage you need to select the T, N, M values for the patient. Let’s start with the T value. For more information about T values, I can review this list.* Scroll down to see all T, N, M choices.
  + T, N, and M values are used to automatically calculate the stage. (ex. CANCER STAGE)
* STAGING DETAILS: cT1, cN1, cM0, G3, ER-, PR+, HER2+
  + Click the down arrow for Primary Tumor (T) and choose cT1
  + Click down arrow for Regional Lymph Nodes (N) and select cN1
    1. Choose Method of assessment: Core biopsy
  + Click Distant Metastasis (M) to select cM0
    1. Select G3, ER-, PR+, HER2+
    2. Point out the link to AJCC's website
  + *Can also add prognostic indicators and specifications about the tumor*
  + Scroll up to Calculated stage group to see the CANCER STAGE: **Stage IIA**
  + Sign & Accept the stage when finished.
* Point out the calculated stage listed under the cancer problem.
* Can return to the staging activity at any time to edit the existing stage or add a new form.

### Create an oncology history

* From the patient’s problem list select create oncology history.
* Add in an event of cancer staged.
* Add in an event of radiation therapy.
* Point out that the stage automatically pulls into the patient's oncology history.

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| Oncology History   * Treatment and therapy plans are also automatically added to oncology history. * Radiation oncology episodes and CT SIM also pull automatically into the oncology history. * Anything that they had at another Aspirus location will come in here. * It is constantly updated as the patient goes through their treatment |

* Enter additional information like dates or notes and accept.

## Write a note

### Introduction

* I'm ready to write my progress note now.
* You don't have to write your note while the patient is still here but incorporating it into the visit can help save you time.
* Go to the Notes tab in the sidebar.
  + It's helpful to write your note in the sidebar so you can have it open while you review and enter other data in the chart.
  + Enter dotphrase “.dict”
  + Save note
  + Or you can use a note template. Open the Rad Onc consult template. Click into the Insert and search. Show how to favorite and click the monopoly cards icon .
* Discuss SmartTools – Left to Pick and Right to Stick
* NoteWriter ROS – Oncology only
* Recap basic NoteWriter concepts from prior training:
  + Use point-and-click forms Click buttons and select check boxes on the left to generate note text on the right.
  + Add comments about an entire section by clicking the piece of paper.
  + Add comments about a symptom by hovering over the button and typing.
  + Add free text by typing in the note anywhere outside of the highlighted text.
* Sign Note and close sidebar for notes.

## Place orders

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| Demo examples   * PRESCRIBE: something to treat the patient's insomnia * MED SEARCH: "amb" * MED TO SELECT: Ambien * REORDER: Albuterol or Ambien (demo only) * LAB SEARCH: "CT" to pull in the simulation CT, CBC * PREFERENCE LIST BROWSER: Simulation CT, CBC * MODIFY LAB: CBC - change status to Standing * MODIFY MED: Ambien * CHANGE MED DETAILS: 0 refills |

### Introduction

* Now that I've got most of my note written, I'm going to place some new orders, as well as renew anything else that Rosalind might need.
* Go to Plan > Meds & Orders.
* I've decided radiotherapy is appropriate for this patient, so I want to order a CT simulation.
  + Point out comments and Sched Instructions in the order composer and future 
* I'll queue up all my orders, then update any of the details as needed.

### Search for a medication

* I want to prescribe (ex. **Ambien 5 mg tab**).
* Choose the appropriate medication and dosage.

### Renew a prescription

* We also need to renew an existing prescription.
* All the current meds are listed here for easy access.
* Click Reorder arrow next to an appropriate medication (ex. **Ambien** it’s a patient reported med but can demo).

### Search for a lab

* Next, let's place the lab orders.
* Search for and select a lab order (ex CMP).

### Modify order details for a lab

* Open the Order Composer for a lab test you ordered (ex. MODIFY LAB).
* Ask: Let's say I wanted the patient to get this lab done several times. What would I need to update?
  + Status - change to Standing. 
  + Order status indicates when the order will be performed.
* Normal=One order, being performed and resulted in this visit, typically only for point of care tests
* Future=One order, in the future, any time after this visit, including later today
* Standing=Multiple orders, in the future, but the first order could be released and performed today
  + Enter an appropriate interval and count for the order.
* Order class indicates where the order will be performed.
* Right-click to close the Order Composer.

### Modify order details for a medication

* Open the Order Composer for a medication you ordered (ex. MODIFY MED).
* Change some details in the Order Composer, but do not close it (ex. CHANGE MED DETAILS).
* Point out the Use Free Text button in the Order Composer.
  + Useful when writing a prescription that can't be captured discretely, like a taper or ointment.
* Scroll down to the Medication class field in the Order Composer.
  + Indicates how the prescription will be processed
  + Normal means the med will be e-prescribed if possible.
  + If the med can't be e-prescribed, the prescription will print.
* Right-click to close the Order Composer and accept your changes.

INDEPENDENT PRACTICE:

* Stop and place some more orders.
* Try a medication, a lab, and anything else you commonly order.
* In 3 minutes, we'll come back and sign the orders.

### Sign the orders and complete your note

* Sign the orders, and associate any diagnoses as needed.

## Wrap up the visit

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| Demo examples   * LOS: New2 |

### Introduction

* With my orders placed, I just need to write some follow-up instructions, charge for the visit, and close the encounter so it can be sent to billing.
* Go to the Wrap-Up tab.

### Document your LOS

* I need to enter my level of service for billing.
* Select an LOS (ex. LOS).
* Remember from your pre-class e-learning that you can click the wand to calculate an LOS if you're not sure what's appropriate.
  + Back pocket: If you don't see the button you need, you don't have to enter it manually every time. You'll have a chance to add commonly used levels of service as speed buttons during personalization labs.

### Write follow-up instructions

* I'll enter a few quick notes about when I'd like to see the patient back. I have to put any scheduling instruction in the order composer.
  + Go to the Follow-up section and indicate when the patient should return by clicking the ORDER button for the corresponding Follow-up and Accept.
  + Open the order composer and complete the Required fields and Yellow Yield Signs and any additional scheduling information.
  + Sign and Associate the Clinic Appointment Request Order
    1. Scroll down and point out the Outpatient Procedures Ordered This Visit and expand for details.
  + Appears on AVS, in MyChart, and at the front desk, so patient can schedule appointments at check-out if necessary
  + Patients can also schedule appointments directly from MyChart.

### File charges

* I don't need to file any additional charges for this visit, but if I did, I'd use the Charge Capture section.
* Go to Charge Capture.
  + Point out the charge for the LOS you added: Description and CPT code.
  + For additional charges, you can browse by category or search in the Search for a new charge field. Point out RAD ONC Levels

### Close the visit

* I'm ready to close the visit and send it to billing, which we do in the Sign Visit activity.
* Go to the Sign Visit activity.
  + If you don't see the Sign Visit activity tab, go to the Sign Visit tab in the sidebar.
  + If there's missing documentation:
* Click a red banner to jump to the area of the chart that needs attention.
* When all documentation is complete, return to the Sign Visit tab.
* Ask: Thinking back to your clinic training, what happens if you forget to sign the visit?
  + You'll get a My Open Charts message in your In Basket, reminding you to close the visit.
* Ask: What if you need to change something after you've closed an encounter?
  + Create an addendum by opening the encounter again from your schedule or from Chart Review.

# Survivorship follow-up visit

* In this visit, we'll cover how to document a visit with a patient that has successfully completed a course of chemotherapy treatment.
* I'll show you how to:
  + Quickly review information about the patient's cancer and past treatment.
  + Complete survivorship documentation.
  + Assign maintenance therapy.

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| Scenario   * Patient: **Ramona**, 50-year-old female   + Find the patient on your schedule - 11 AM appointment. * Reason for visit: Breast cancer in remission |

## Review historical information

### Introduction

* The patient has successfully completed a regimen of chemotherapy and is now in remission.
* Before completing survivorship, documentation or assigning maintenance therapy, I'll review her current condition and recent history.

### Review oncology treatment information

* Use Synopsis for an in-depth review of the patient's chemotherapy administrations and condition over time.
* Go to Synopsis and point out the possible views.
  + Rad Oncology view
* Call out different types of information available on the Oncology View (some examples):
  + Chemotherapy
  + Oncology-pertinent (but not all) lab results
  + Biopsy/surgical procedures
  + Radiation Treatment
* Graph results directly from this view.
  + Expand a folder and select some data. (ex. Vitals > Weight)
* Pin important information to the Patient Spotlight.
  + Hover over an item and click the pushpin icon that appears. (ex. Weight)
  + Pinned items are patient- and user-specific.
  + Use to track a vital you're concerned about.
* Jump directly to the Treatment Plan Manager by clicking a chemotherapy drug.
  + Click a chemotherapy drug to demonstrate

## Create survivorship documentation

### Create survivorship documentation

* Go to Plan > Problem List and click Create Oncology History under the patient's cancer problem.
  + Add an event of Remission and enter a date of "t" for today.
  + .RAD demo a smartphase
  + Accept and save the history.
  + Click close.

### Create an oncology treatment summary

* Still under the patient's cancer problem on the problem list, click Create Oncology Treatment Summary.
  + A template is pre-loaded based on the cancer type, but you can change it if needed.
  + If it does not load click Insert Section and select Treatment Summary Introduction
  + Enter an End of Treatment Date.
* Point out the options to distribute the treatment summary:
  + Summary to give a copy to the patient or Delete Summary
  + Demo Send Summary to provide a copy to another provider
    1. PCP and free text cover page and Send
  + Mark Complete
    1. If you take the time to fill out all wild cards in the template, you can click Complete
    2. Or Save and close the summary.