OSCAR EMR Cancer Screening Guidelines

Version 2.3

November 2018

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Better care, together

Crown Point Family Health Centre

Cancer Care Ontario
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OntarioMD
Empowered Practices. Enhanced Care.

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OSCAR EMR Cancer Screening Guidelines

1. INTRODUCTION – GETTING READY

To increase the chances of successful treatment, it is important to be able to detect cancer in the early stages. While education and screening for patients are effective strategies for early detection [1] of cancer in patients, providers need to ensure that they have accurate and timely access to screening records and results. Evidence shows that information technology can enable proactive primary care [2].

The cancer screening recommendations in this document are based on the Provincial Cancer Screening Guidelines published by the Ministry of Health and Long-term Care, and support cancer screening in Primary Care practices in Ontario. This model uses OSCAR EMR to highlight one optimal methodology for documentation and reporting for cancer prevention of breast, cervical and colorectal cancers.

This document was written collaboratively by Cancer Care Ontario's Regional primary care lead for HNHB LHIN, Crown Point Family Health Centre – Lower Level, the Hamilton Family Health Team and OntarioMD.

1.1 Before You Begin

1. Ensure your version of OSCAR is using the most recent build with the latest available patches - available from your OSCAR Service Provider (OSP).
    - This workflow uses screen captures from the OSCAR V15
    - **Stop Signs** should be enabled to provide additional decision support

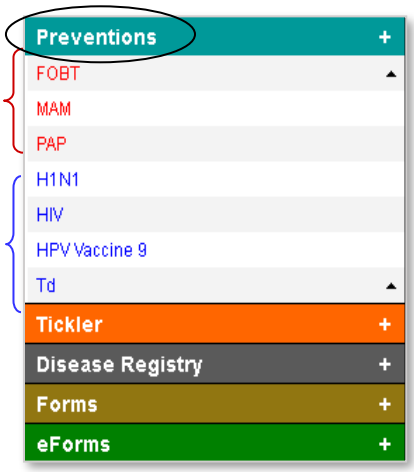
2. Ensure your OSP has enabled access to the **Demographic Report Tool** and **Ontario Prevention Report** modules.

[1] World Health Organization, http://www.who.int/cancer/detection/en/ – Early Detection of Cancer
[2] Cusack CM, Knudson AD, Kronstadt JL, Singer RF, Brown AL. Practice-Based Population Health: Information Technology to Support Transformation to Proactive Primary Care (Prepared for the AHRQ National Resource Center for Health Information Technology under Contract No. 290-04-0016.) AHRQ Publication No. 10-0092-EF. Rockville, MD: Agency for Healthcare Research and Quality. July 2010.

2. DATA STANDARDIZATION

2.1 Using the Preventions Module

- A summary of the patient's preventions procedures is located in the top left corner of the patient's eChart. For the purpose of this document we will focus solely on the cancer screening items.
- Preventions are patient specific and will automatically appear within the eChart when conditions matching the recommendation(s) are met. **Ex.** age, gender or timeframe.
- Preventions for patients overdue for screening or for whom no information has been documented will be indicated in **Red**
- Up-to-date or optimal preventions will be indicated in **Blue**
- These preventions can be adjusted in the Preventions module based on patient requirements or screening needs (ex. high-risk).



- To access the Preventions module click on the **Preventions** heading at the top of the screen. The function of this module is to assist the clinicians in monitoring and tracking common procedures and recommendations.

- Once the Preventions module has been accessed a prevention management window will appear.

Any clinical recommendations yet to be completed will be flagged in red.

Note:

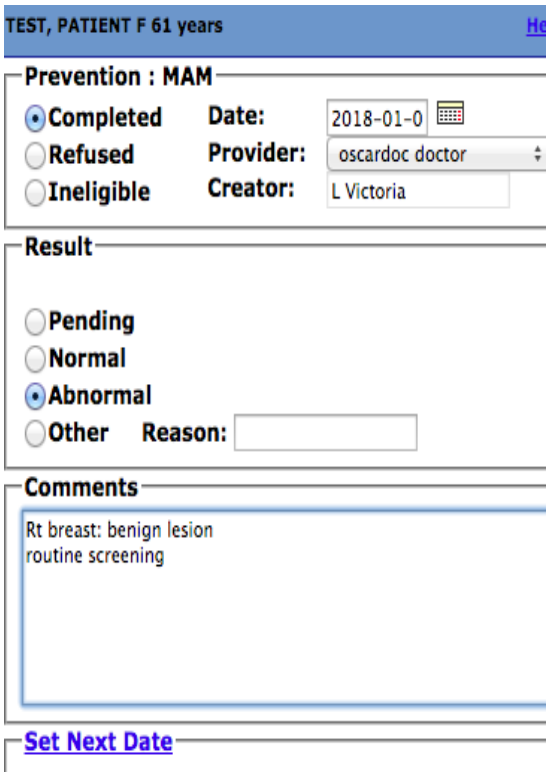
Stop Signs on the appointment screen also serve as prevention warnings to alert of any overdue screening

- To up-date or manage a cancer screening item simply click on the text/link on the corresponding button.
- In this example we will select **MAM** for mammogram.

- Upon clicking on MAM a new window will appear. This window will allow you to document the relevant details for screening, and is divided into 4 sections:

Section1: Prevention

Click the completion option, select the date of completion and select the provider. The name in the Creator field will be defaulted to the person currently logged in.



Section 2: Results

Select the relevant tab: normal, abnormal or other. Use the Reason box to provide details pertaining to the result that you have selected.

Section 3: Comments

Document any additional information that is relevant to the patient and their cancer screening procedure and/or history. This should include any high-risk criteria and/or exclusions.

Examples:. *Rt breast: benign lesion; BRACA, Chest radiation, >25%, OBSP high risk program; prophylactic double mastectomy, breast cancer*

Section 4: Set Next Date

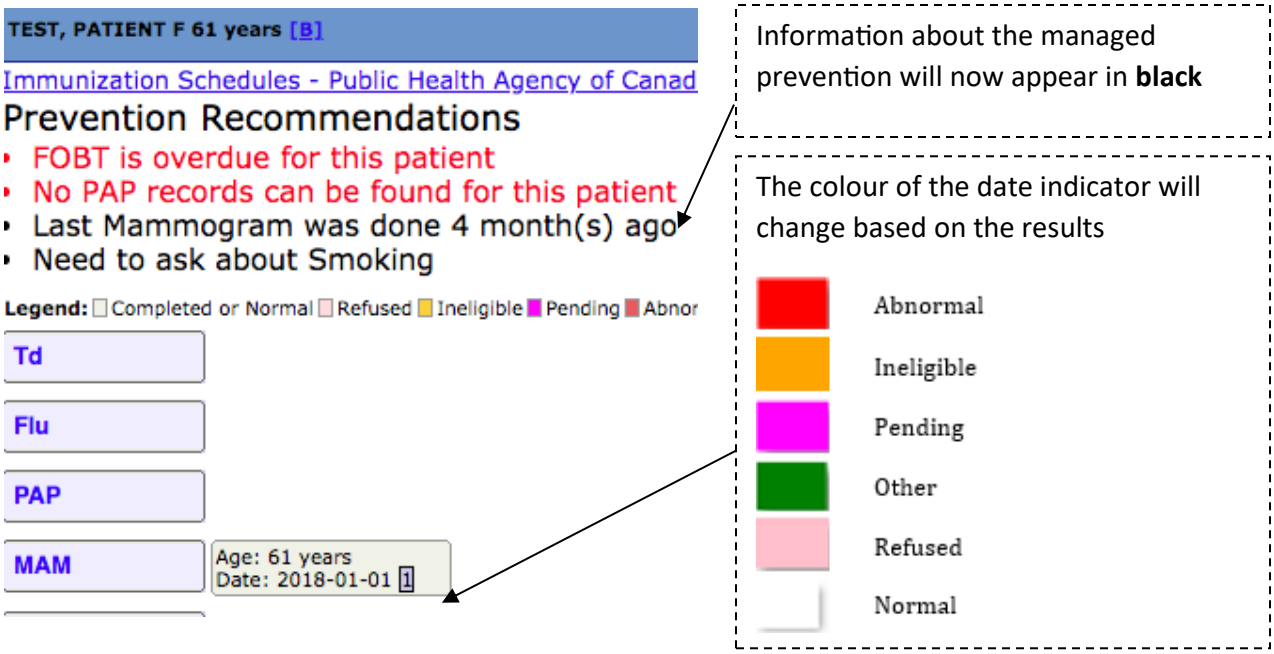
OSCAR is designed to automatically identify the next due date based on the Provincial Cancer Screening Guidelines:

- MAM & FOBT every 2 years
- PAP every 3 years
- Colonoscopy every 10 years

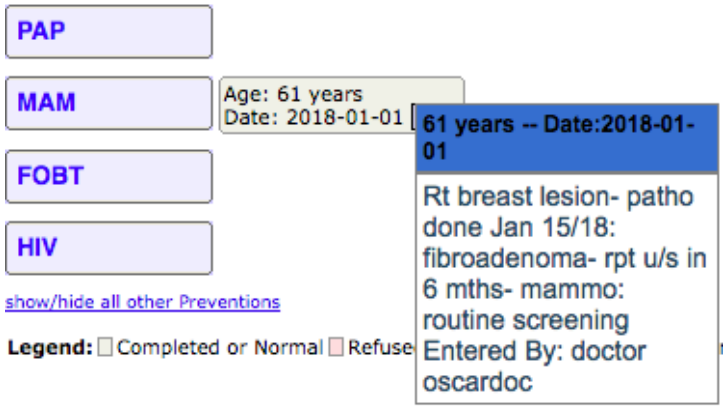
Notes:

- When implementing cancer screening results in the Preventions module it is important to document relevant details in **Comments**. This will increase tracking efficiency and patient care by compiling the data in one centralized location within the EMR and also avoid having to search records to make decisions for the next screening interval.
- If the patient requires repeat screening that does not fall within these general guidelines, it is vital you manually set the next date due to override the system.
- If the next due date does not coincide with the general guideline it can only be tracked via queries and is not recognized in the Ontario Prevention Report.
- Use the Tickler module to set a reminder for future cancer screening dates for patients who do not fall within the general cancer screening guidelines (e.g. where there are abnormal results, high-risk criteria or history of cancer).

- Once the cancer screening item has been documented a date indicator will appear beside the corresponding tab and the status will change from overdue to up-to-date in the Ontario Prevention Report.



- The Prevention Recommendations list will automatically up-date and will no longer indicate the cancer screening item is overdue. Information about the managed prevention will now appear in **black** on the list of the Prevention Recommendations
- When hovering the mouse indicator over the date tab a pop-up will appear and display what has been entered in the comments.



- If this module is completed consistently and with adequate details the need to find multiple documents will not be necessary - an overview of all cancer screening for a patient will be in a centralized location in the EMR.
- Please see the corresponding Data Entry sections for further information on documentation for each cancer screening.

2.2 Data Entry - Breast Cancer Screening

2.2.1 Mammogram Records

All mammogram records and results should be documented in the Preventions module as previously outlined.

2.2.2 Breast MRI Records

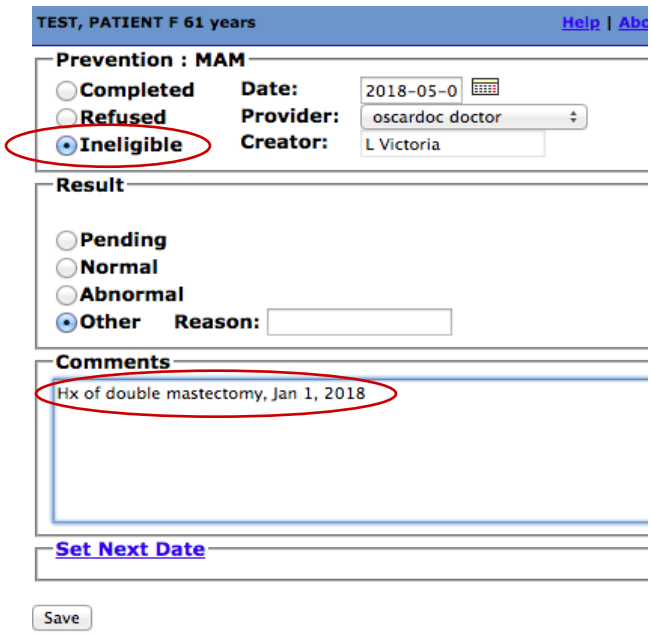
All breast MRI records and results should be documented in the Preventions module as previously outlined and using the corresponding **MRI Breast** tab.

Note: If your Preventions module does not have an option for **MRI Breast**, it is recommended that you ask your OSCAR Service Provider (OSP) to add the tab in your module. Otherwise you may use the MAM tab and document accordingly.

2.2.3 History of Double Mastectomy

Use the following guidelines to document records of double mastectomy in OSCAR.

1. Document the surgical procedure in the Medical History section of the patient's eChart
2. In the Preventions module
    a. Select the MAM tab and flag the patient as Ineligible
    b. Document the reason for exclusion in the comments section

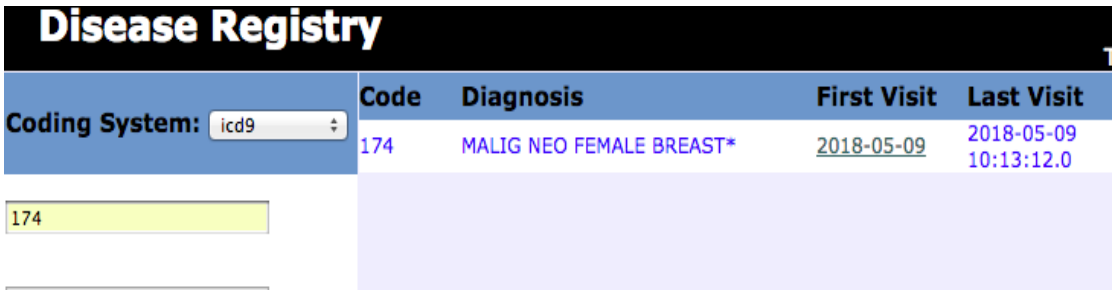


3. Use the Tickler module to set a reminder of when the next cancer screening is due (e.g chest wall exam)

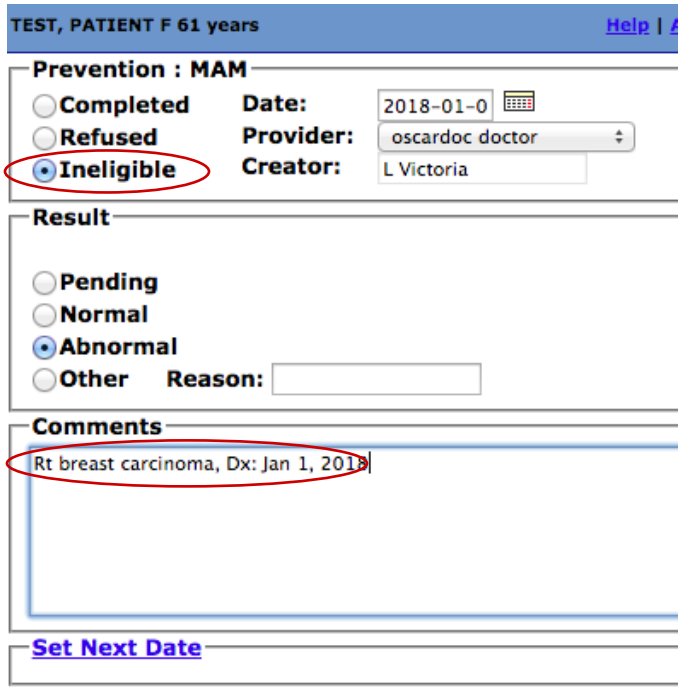
2.2.4 History of Breast Cancer

Use the following guidelines to document records of breast cancer in OSCAR.

1. Add the diagnosis code 174 to the **Disease Registry** from the eChart - Disease Registry >> Add 174



2. Document the medical diagnosis in the **Medical History** section of the patient's eChart
3. In the Preventions module
    a. Select the MAM tab and flag the patient as Ineligible
    b. Document the reason for exclusion in the comments section



4. Use the Tickler module to set a reminder of when the next cancer screening is due (e.g chest wall exam or unilateral mammogram)
5. To ensure consistency and proper organization of the data, continue to document future mammogram results in the Preventions module

2.2.5 High-Risk Criteria for Breast Cancer Screening

High-risk criteria include:

- Carrier or First-Degree Relative of a Deleterious Gene Mutation Carrier
- Determined to be at >25% Lifetime Risk of Breast Cancer
- Received chest radiation before the age 30
- Part of the OBSP high risk program

1. Document the high-risk criteria in the **Medical History** section of the patient's eChart

2. In the Preventions module
    a. Select the MAM tab to document the mammogram records and results
    b. Document the high-risk criteria in the comments section
    c. If part of the OBSP high-risk program, yearly mammogram and breast MRI are recommended
        i. **Set Next Date** must be manually completed with every mammogram and breast MRI entry

3. Use the Tickler module to set a reminder of when the next cancer screening is due

Notes:

For patients who are at high-risk for breast cancer, it is recommended that they get both Breast MRI and Mammogram annually. Both sets of screening records and results should be documented in the Preventions module.

2.2.6 Abnormal Findings & Exclusions

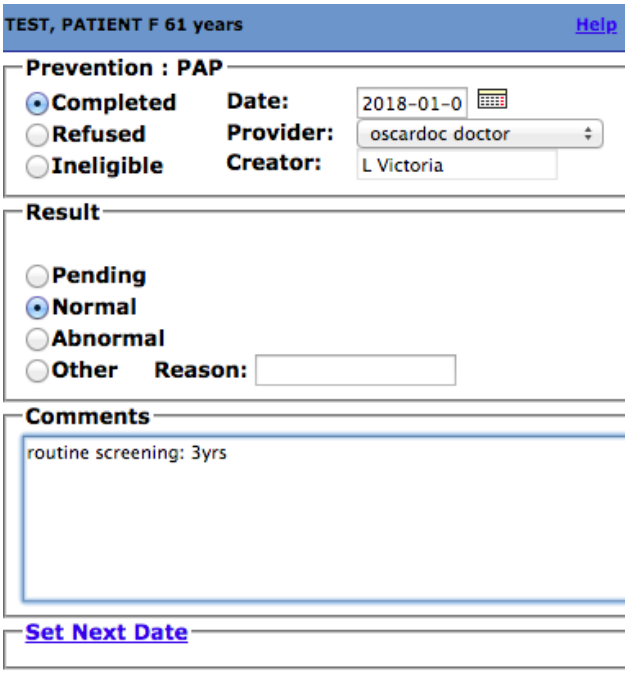
Document any findings that change your clinical decision for the due date of the next screening or requires immediate action in the **Comments** section of the Preventions module.

Document any exclusions like prophylactic double mastectomy and breast cancer in the **Comments** section of the Preventions module.

2.3 Data Entry - Cervical Cancer Screening

2.3.1 PAP Test Records

All pap test records and results should be documented in the Preventions module as previously outlined, but using the PAP tab.



2.3.2 HPV Test/Status Records

1. If positive status, document medical diagnosis in the Medical History section of the patient's eChart.
2. All HPV records and results should be documented in the Preventions module as previously outlined and using the corresponding **HPV Swab** tab.

   Note: If your Preventions module does not have an option for **HPV Swab**, it is recommended that you ask your OSCAR Service Provider (OSP) to add the tab in your module. Otherwise you may use the PAP tab and document accordingly.

3. Use the Tickler module to set a reminder of when the next cancer screening is due.

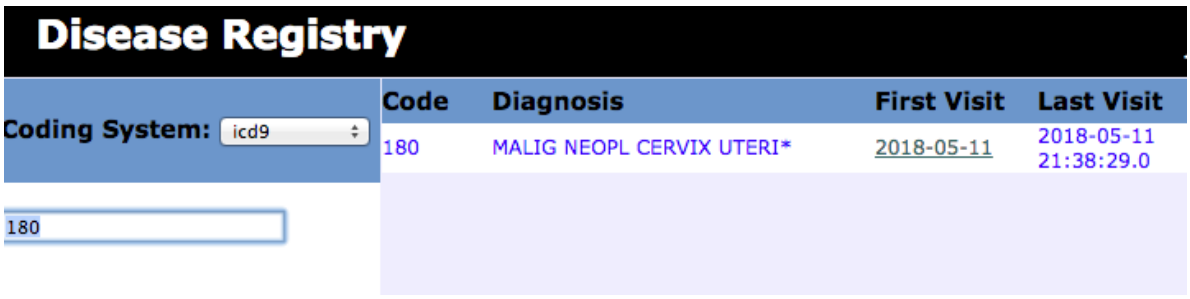
2.3.3 Colposcopy Records

1. All colposcopy records and results should be documented in the Preventions module as previously outlined, but using the PAP tab
    a. Document the relevant details in the comments section
    b. **Set Next Date** must be manually completed
2. Document the medical diagnosis in the Medical History section of the patient's eChart

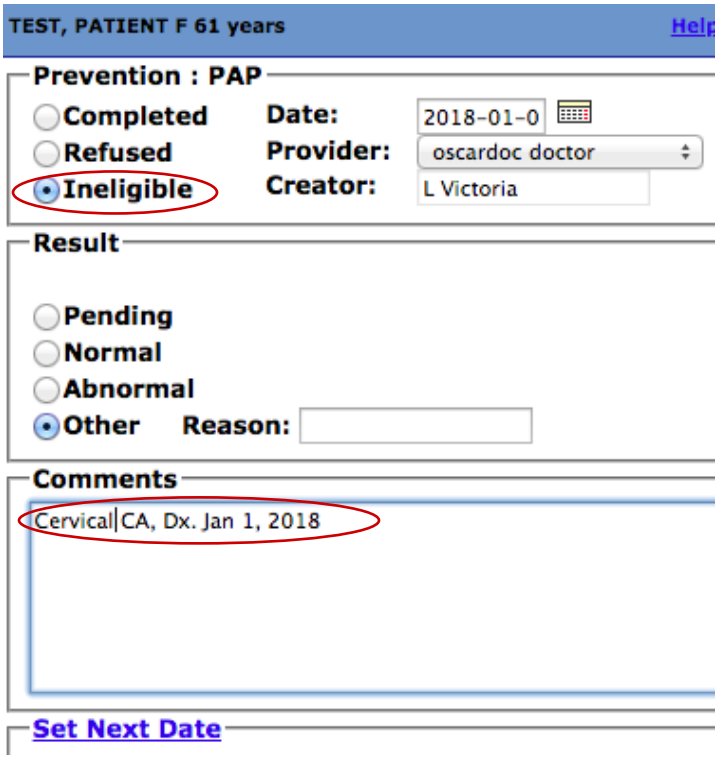
2.3.4 History of Cervical Cancer

Use the following guidelines to document records of cervical cancer in OSCAR.

1. Add the diagnosis code 180 to the **Disease Registry** from the eChart - Disease Registry >> Add 180



2. Document the medical diagnosis in the **Medical History** section of the patient's eChart
3. In the Preventions module
    a. Select the PAP tab and flag the patient as Ineligible
    b. Document the reason for exclusion in the comments section



4. Use the Tickler module to set a reminder of when the next cancer screening is due

Note: You can use the same exclusion guidelines for patients with a history of a total hysterectomy or no record of sexual activity

2.3.5 High-Risk Criteria for Cervical Cancer Screening

High-risk criteria include:

- History of dysplasia
- Immunodeficiency
- Cervical Cancer
- HPV positive

1. In the Preventions module
    a. Select the PAP tab to document the PAP records and results
    b. Document the high-risk criteria in the comments section
    c. Use Ontario Cervical Screening Cytology Guideline to determine the next date for cancer screening as this will be customized for each patient
        i. **Set Next Date** must be manually completed with every PAP data entry

2. Document the high-risk criteria in the **Medical History** section of the patient's eChart

3. Use the Tickler module to set a reminder of when the next cancer screening is due

2.3.6 Abnormal Findings & Exclusions

Document any findings that change your clinical decision for the due date of the next screening or requires immediate action in the **Comments** section of the Preventions module.

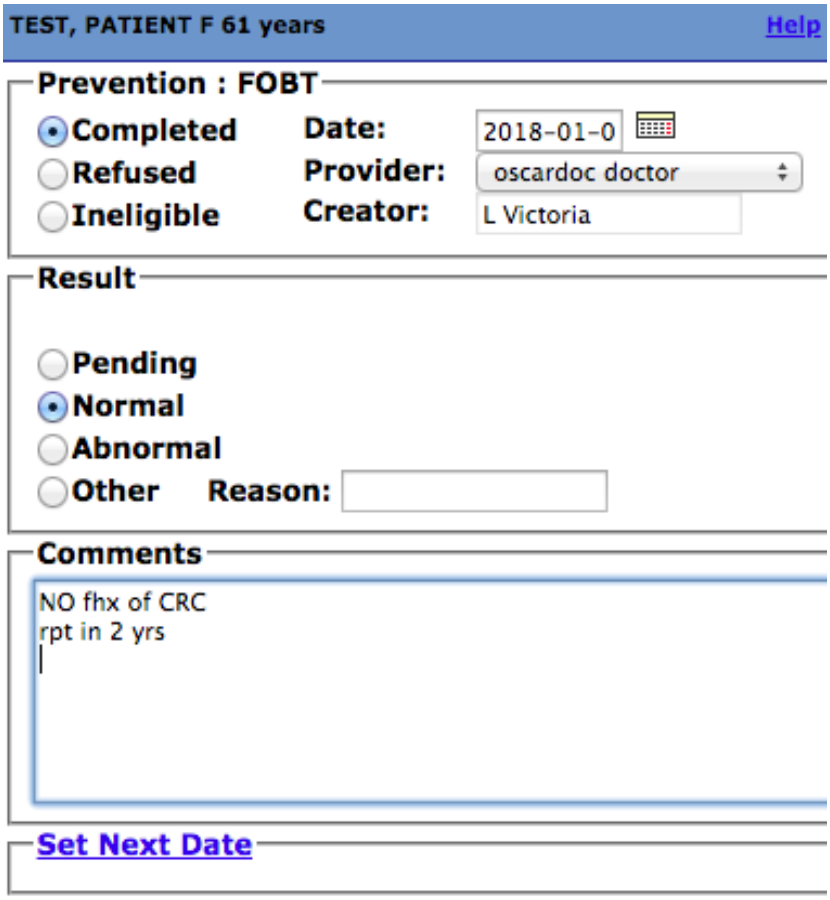
Document any exclusions like total hysterectomy or no sexually activity in the **Comments** section of the Preventions module.

2.4 Data Entry - Colorectal Cancer Screening

2.4.1 FOBT Records

All FOBT records and results should be documented in the Preventions module as previously outlined, but using the FOBT tab

Note: Once a colonoscopy is documented as complete in the Preventions module the FOBT automatically becomes ineligible. The reminder for FOBT will disappear.

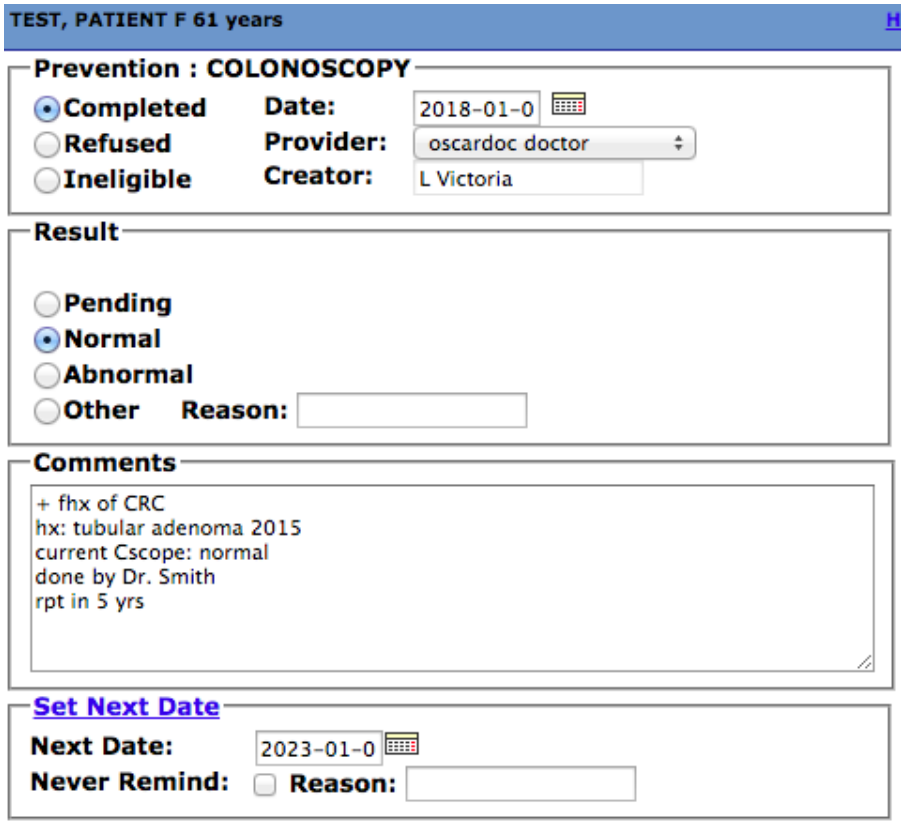


2.4.2 Colonoscopy Records

1. All colonoscopy records and results should be documented in the Preventions module as previously outlined and using the corresponding COLONOSCOPY tab.
    a. Document the relevant details in the comments section
    b. **Set Next Date** must be manually completed if the patient requires a repeat colonoscopy earlier that 10 years

2. Document the medical diagnosis in the Medical History section of the patient's eChart

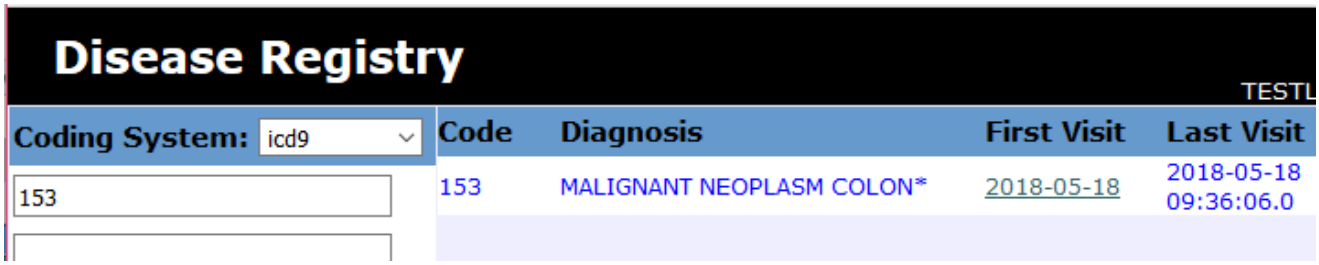
3. Use the Tickler module to set a reminder of when the next cancer screening is due – either FOBT or COLONOSCOPY



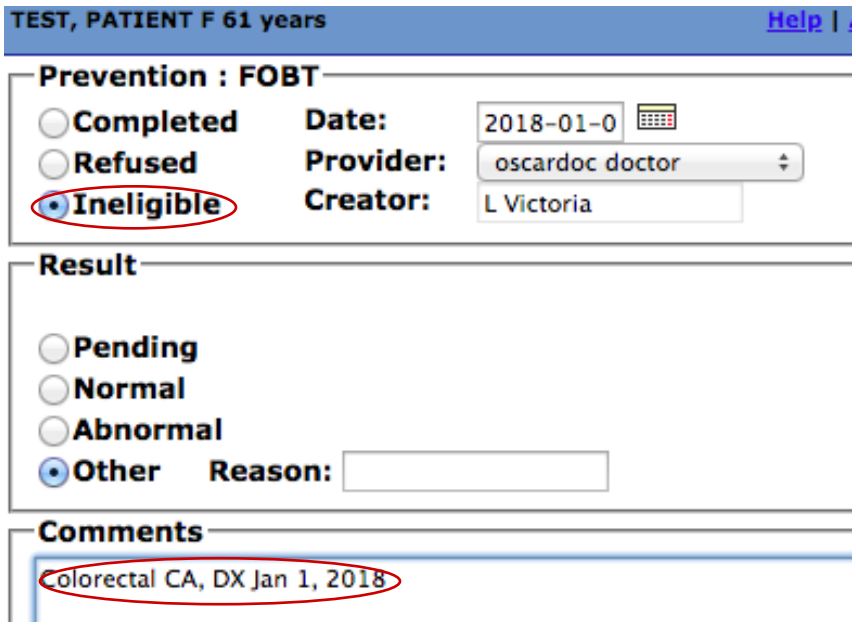
2.4.3 History of Colorectal Cancer

Use the following guidelines to document records of colorectal cancer in OSCAR.

1. Add the diagnosis code 153 to the **Disease Registry** from the eChart - Disease Registry >> Add 153



2. Document the medical diagnosis in the **Medical History** section of the patient's eChart
3. In the Preventions module
    a. Select the FOBT tab and flag the patient as Ineligible
    b. Document the reason for exclusion in the comments section



4. Use the Tickler module to set a reminder of when the next cancer screening is due

Note: You can use the same exclusion guidelines for patients with a history of a total colectomy, 1st degree relative with a history of colon cancer, inflammatory bowel disease or familial polyposis

2.4.4 High Risk Criteria for Colorectal Cancer Screening

High-risk criteria include:

- First-degree relative with history of Colorectal Cancer
- Inflammatory Bowel Disease
- Familial Polyposis
- Current or previous abnormal results (e.g. tubular adenoma, dysplastic polyp)

1. In the Preventions module
    a. Select the COLONOSCOPY tab to document the colonoscopy records and results

    Note: If your Preventions module does not have an option for COLONOSCOPY, use the FOBT tab and document accordingly

    b. Document the high-risk criteria in the comments section
    c. Use the ColonCancerCheck Screening Recommendations to determine the next date for cancer screening as this will be customized for each patient
        ii. **Set Next Date** must be manually completed with every colonoscopy data entry

    d. Document the high-risk criteria in the **Medical History** section of the patient's eChart

    e. Use the Tickler module to set a reminder of when the next cancer screening is due

2.4.5 Abnormal Findings & Exclusions

Document any findings that change your clinical decision for the due date of the next screening or requires immediate action in the **Comments** section of the Preventions module.

Document any exclusions like colorectal cancer, family history of colorectal cancer, colonoscopy or colectomy in the **Comments** section of the Preventions module.

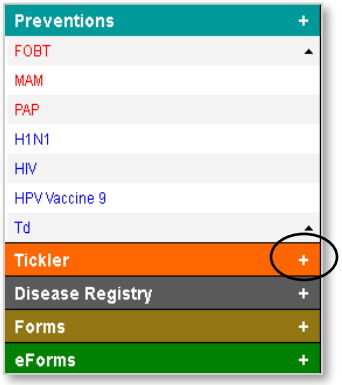
2.5 Notifications for Cancer Screening

2.5.1 Setting Tickler Reminders

A **Tickler** can be used as a reminder to alert staff to follow-up on procedures or other items for patients.

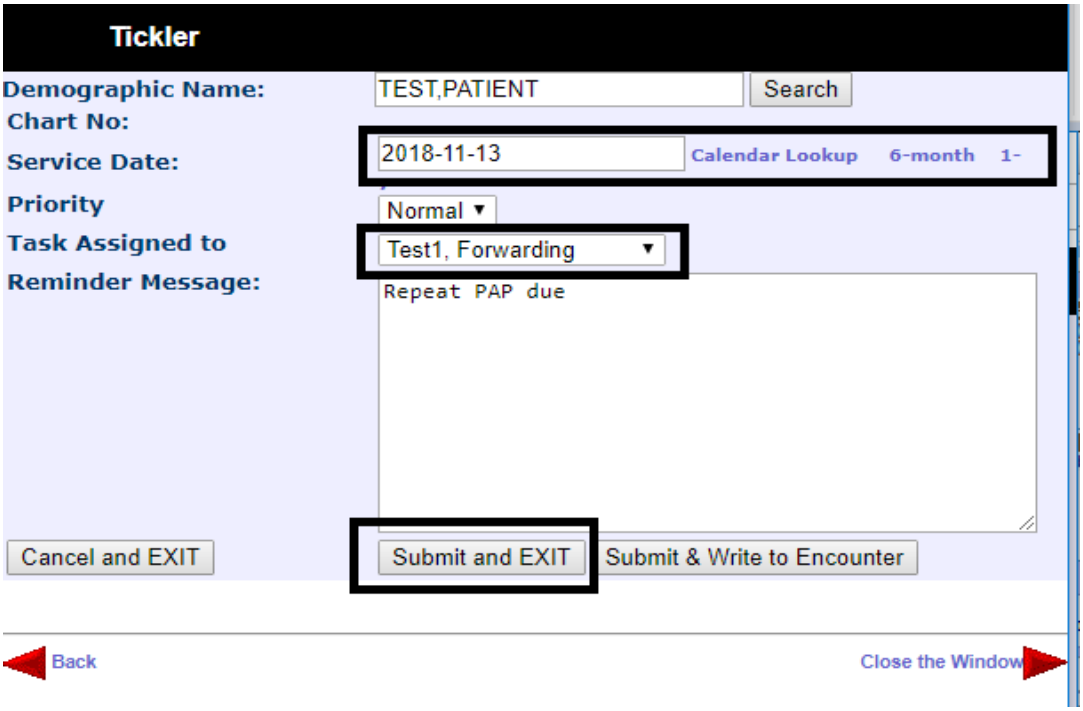
For patients at high-risk or those requiring individualized cancer screening follow-up, a Tickler is a good way to ensure that follow-up is performed when required.

To set a Tickler click on the "+" sign to the right of the **Tickler** heading in the patient's eChart

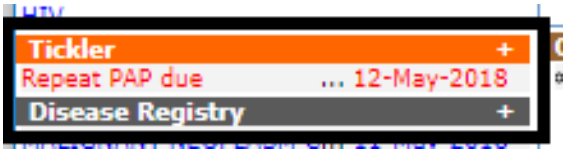


In the Tickler popup window:

- set the date you want the reminder to appear
- select the person who will be responsible for organizing the completion of the task
- enter a reminder message – a note corresponding to the task due
- select **Submit and EXIT** to close the Tickler window

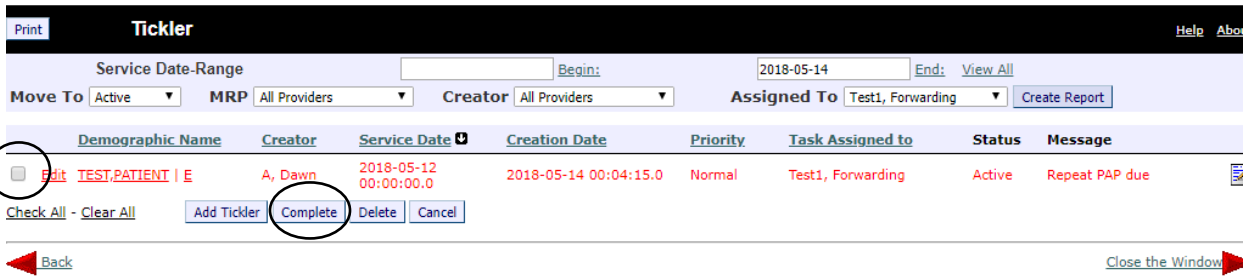


The Tickler will appear blue in the patient's eChart until the item becomes due.



Once the due date for the reminder has arrived, the tickler will appear red in the eChart and will also appear in the Ticker inbox of the person it was assigned to.

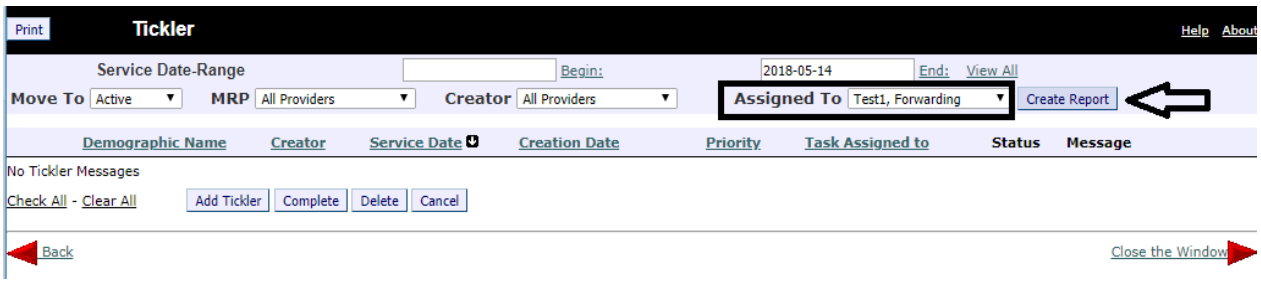
Ticklers assigned to someone can be found by selecting the Tickler option from the main menu in the appointment screen in OSCAR



When the requested task has been completed, put a check mark in the box beside the completed task and click on the **Complete** button.

To delete a task put a check mark in the box beside the task to be deleted and click on the **Delete** button.

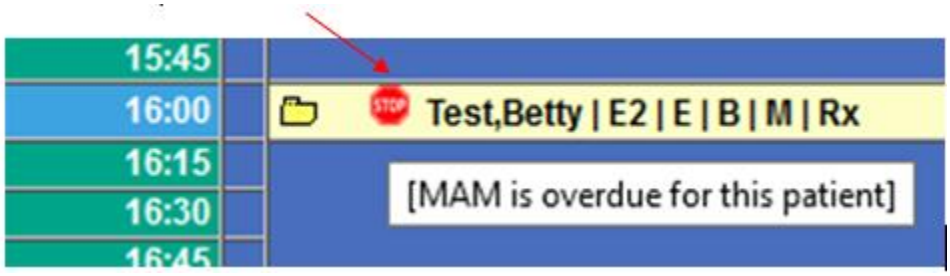
Note: If the Tickler list does not default to the current user, select the user from the **Assigned To** dropdown list and click **Create Report**.



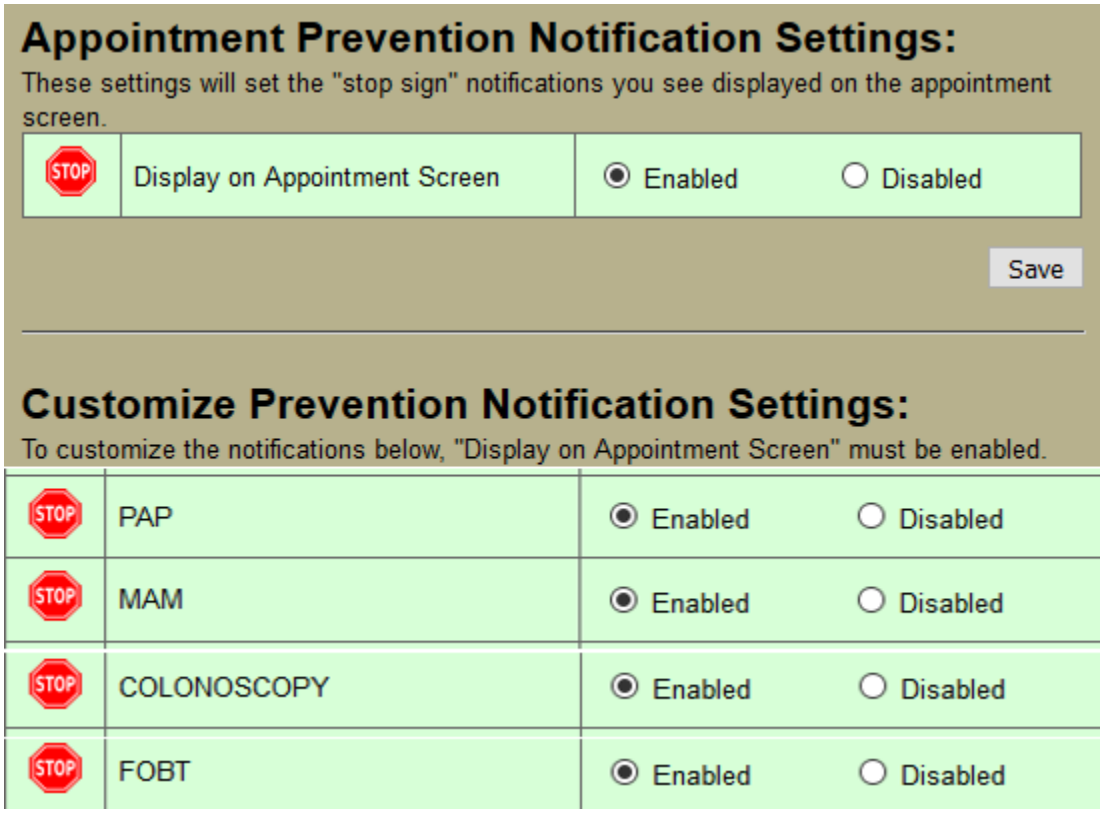
2.5.2 Using Stop Signs

A **Stop Sign** appears on the appointment screen when a patient is overdue for screening. This prevention warning provides additional decision support in OSCAR to help you manage cancer screening.

When hovering the mouse indicator over a **Stop Sign** a pop-up will appear and display what screening is overdue for the patient.



Stop Sign functionality is enabled in the Administration section of OSCAR.



Speak to your OSCAR Service Provider (OSP) before enabling **Stop Signs**.

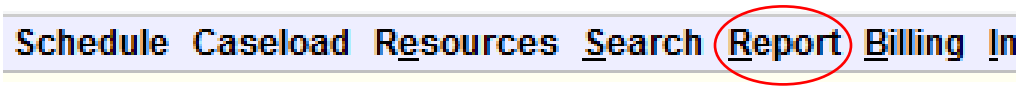
3. REPORTING

3.1 Demographic Report Tool

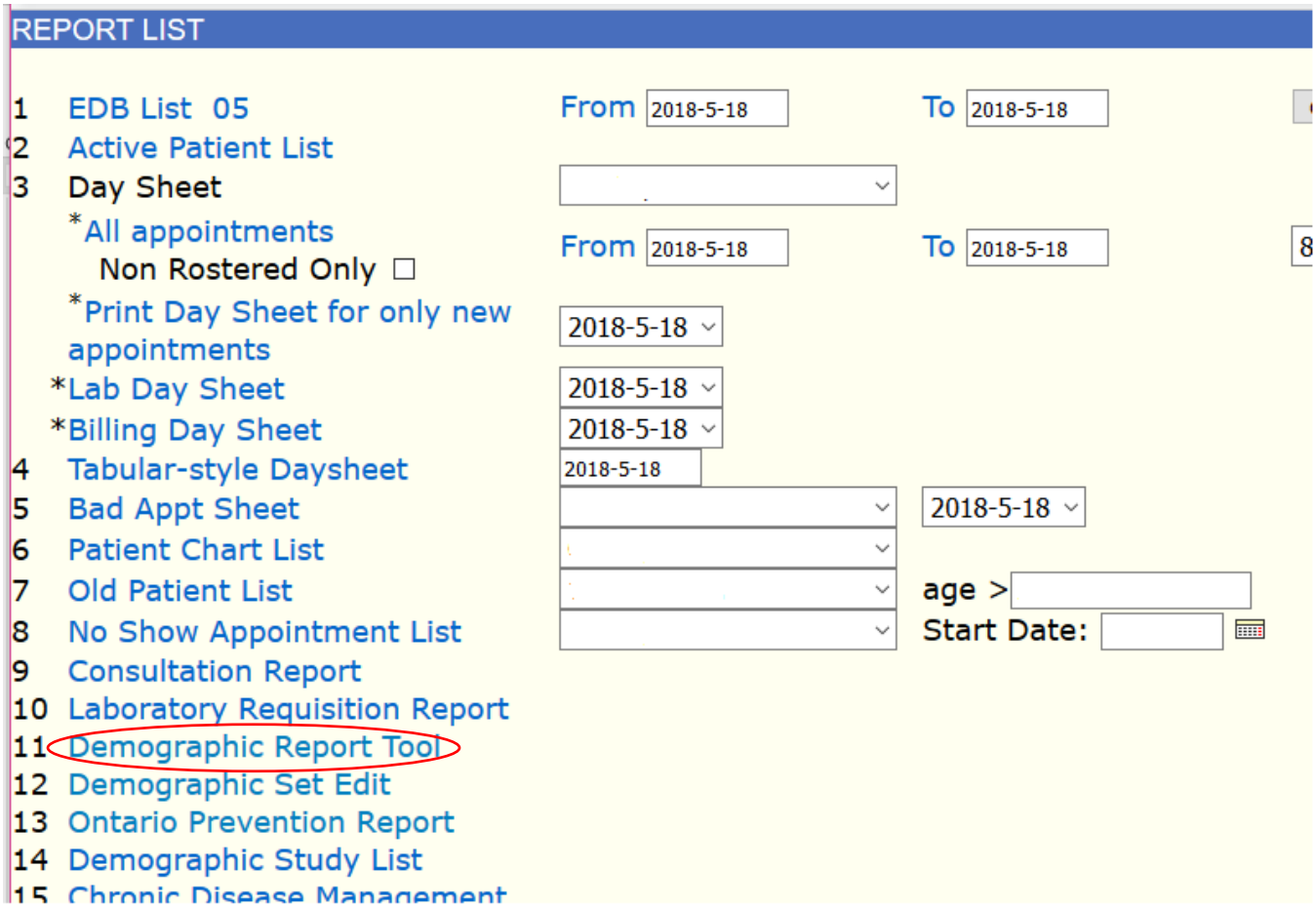
The **Demographic Report Tool** is used to create **patient sets** by selecting specific patient criteria from the OSCAR database. Patient sets are templated used in the **Ontario Prevention Report** – a reporting tool used to track your prevention progress and calculate your percentage for the Prevention Bonus.

3.1.1 Creating Report Templates

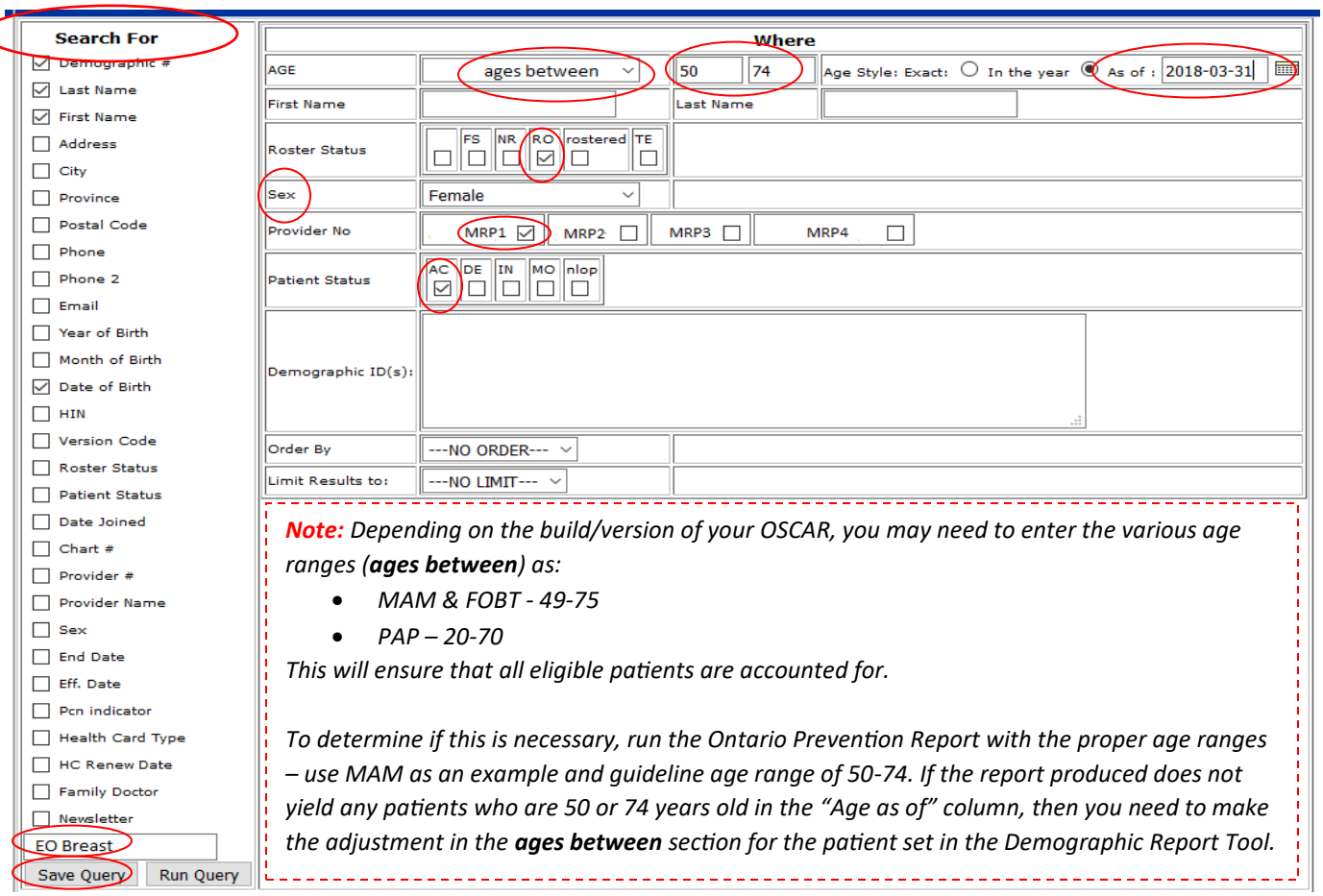
- From the main menu in the appointment screen in OSCAR, select **Report**



- From the Report List, select **Demographic Report Tool**



In the window, select the following items that will be used as the criteria for creating a **patient set** to be used with the Ontario Prevention Report.



- The Ontario Prevention Report has a pre-defined default format for patient demographic information, however in order to save a patient set, at least one item in the **Search For** column must be selected (e.g. Demographic #).
- In the **Where** section, select:
  - **ages between** from the dropdown and enter the age range for the particular cancer screening (as per cancer screening guidelines)
    - MAM & FOBT = 50 -74
    - PAP = 21 - 69
  - **As of** and enter the end of the reporting period (e.g. 2018-03-31)
  - **RO** to identify Rostered patients
  - **MRP** to identify the physician for whom the report will be created (*the name of the MRPs in your clinic will appear here*)
  - **AC** to identify Active patients
- Enter a name for the patient set and click on the **Save Query** button
- Follow the procedures above to create a separate patient set for each prevention type and for each physician

3.2 Ontario Prevention Report

3.2.1 Overview

The **Ontario Prevention Report** is a reporting tool used to track your prevention progress and calculate your percentage for the Prevention Bonus.

Note:

1. This report is based on the Provincial Cancer Screening Guidelines and should NOT be used to track which patients are overdue for preventions.

2. The **Due** status in this report is based on the following guidelines:
   - Cervical Cancer Screening (PAP) – 36 months
   - Breast Cancer Screening (MAM) – 24 months
   - Colorectal Cancer Screening (FOBT) – 24 months

3. The **Due** status in the report does not capture manual input using the **Set Next Date** in the Preventions module.

   For example, if a patient had a PAP in March and needed a repeat in 6 months, the **Ontario Prevention Report** will still report that patient as **Up to date** until 36 months after the most recent PAP date.

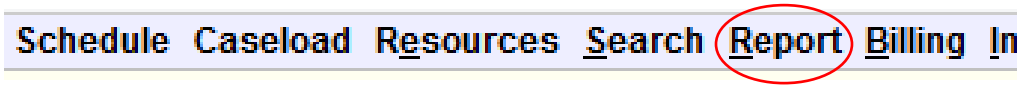
4. To use the **Ontario Prevention Report**, patients sets must first be created for each prevention type and for each physician using the Demographic Report Tool.

5. Bonus calculations are based on services provided to rostered patients - ensure that your rostered patient list is up-to-date.

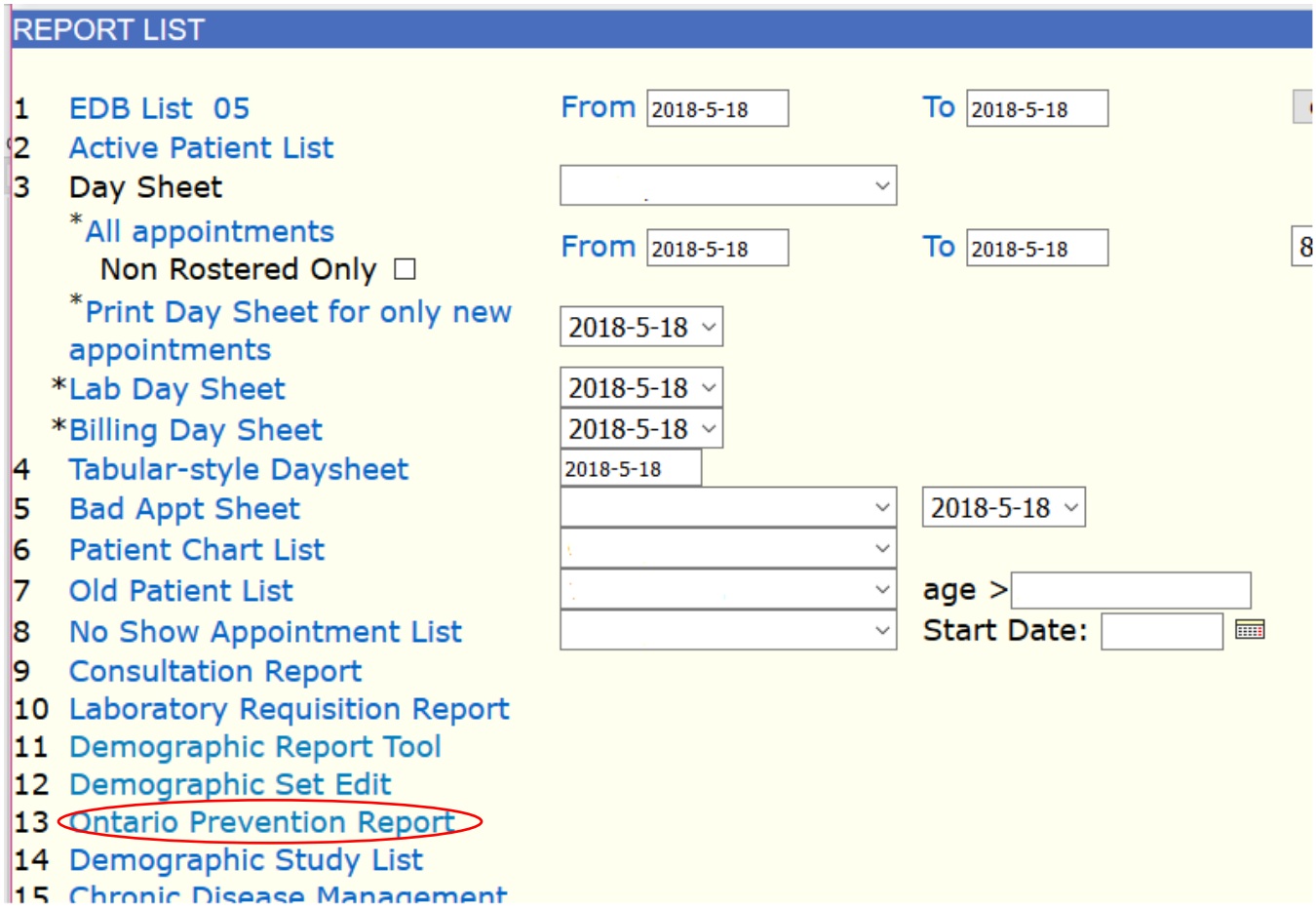
6. To maintain accuracy with your patient lists, ensure that patients are made ineligible or excluded in the Preventions module as necessary. In Ontario, you may use the Cancer Care Ontario (CCO) Screening Activity Report (SAR) to assist you with keeping your EMR up-to-date.

3.2.2 Using the Ontario Prevention Report

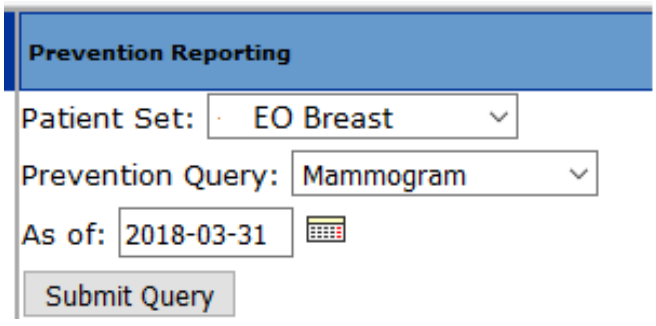
- From the main menu in the appointment screen in OSCAR, select **Report**



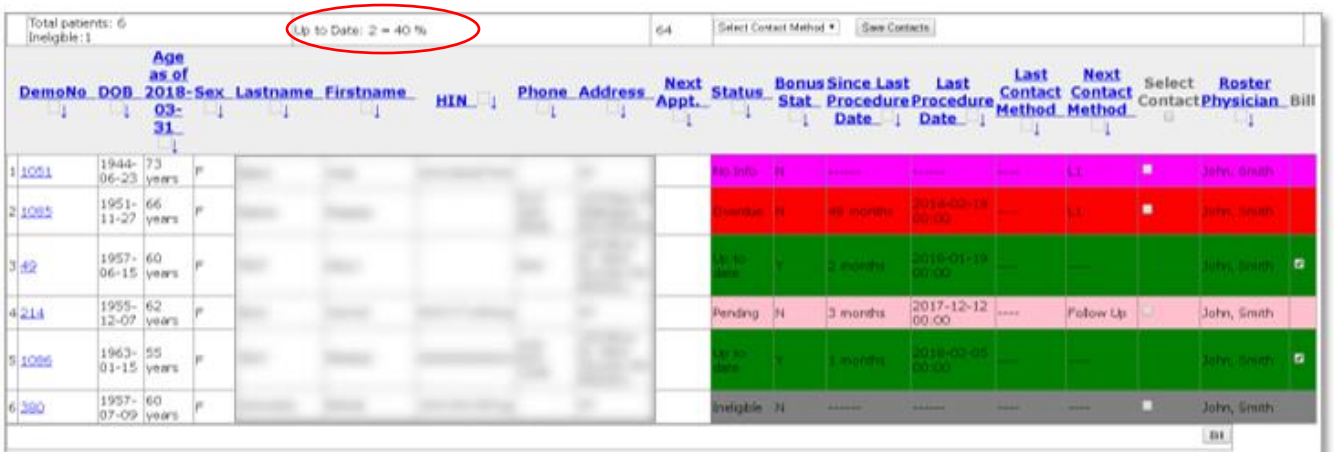
- From the Report List, select **Ontario Prevention Report**



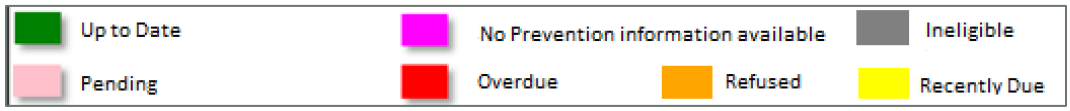
- From the **Patient Set** dropdown, select the name of the patient set you created previously in the Demographic Report Tool
- Select the appropriate prevention from the **Prevention Query** dropdown
- Enter the **As of** date (for Bonus calculations, this will be March 31st of the current year
- Click on the **Submit** button to generate the report



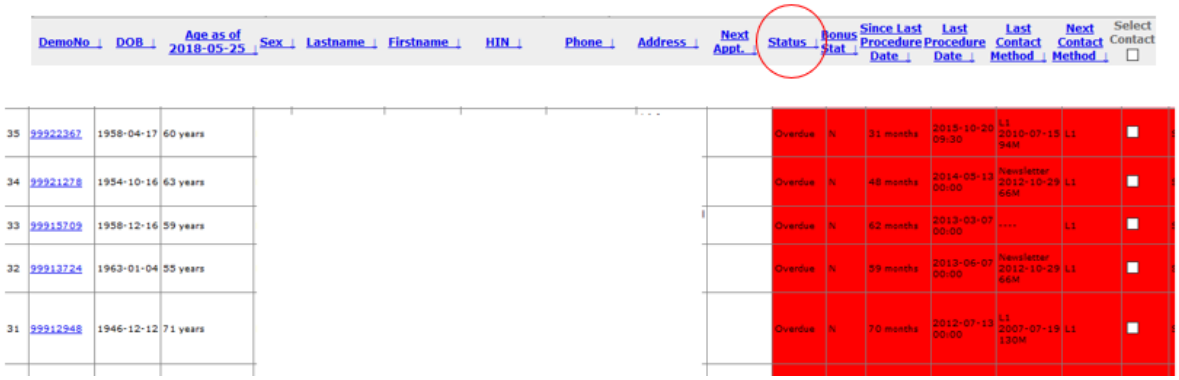
- The **Up to Date** prevention percentage (used for Bonus calculations) will appear in the top row of the report



- The list of patients and their prevention status appears with each one colour-coded as follows:



- You may sort the **Ontario Preventions Report** by **status** to obtain a list of patients who require follow-up – patients overdue for screening.



Notes:

1. Patients with a PAP status of **Pending** in the Preventions module will appear in the **Ontario Preventions Report** as **Up To Date**
2. Patients with a FOBT or MAM status of **Pending** in the Preventions module will appear in the **Ontario Preventions Report** as **Pending**
3. The colour-coding is based on the date at which the report is ran, however, the **Up to Date** percentage is based on the **As of** date defined before running the report
    - For example, a patient may appear red because they became DUE in April, but they are counted in the **Up To Date** percentage calculations because they were up to date as of March 31st

4. SUMMARY

When implementing cancer screening results in the Preventions module it is important to document relevant details in **Comments**. This will increase tracking efficiency and patient care by compiling the data in one centralized location within the EMR and also avoid having to search records to make decisions for the next screening interval.

Recommended documentation:

1. **Abnormal findings** - Anything that changes your clinical decision for the due date of the next screening or requires immediate action.
2. **High Risk Patients**
    a. PAP - dysplasia/colposcopy, HIV positive, HPV positive, cervical cancer
    b. COLONOSCOPY - positive family history of colorectal cancer, current or previous abnormal results (e.g. tubular adenoma, dysplastic polyp)
    c. MAM – BRACA, chest radiation, >25% lifetime risk, OBSP high risk program
3. **Exclusions**
    a. PAP – total hysterectomy, not sexually active
    b. FOBT - Positive family history, requires colonoscopy, colectomy, colon cancer
    c. MAM – prophylactic double mastectomy, breast cancer

Once a screening intervention has been recorded into the Preventions module, OSCAR is designed to automatically identify the next due date based on the Provincial Cancer Screening Guidelines:

- MAM & FOBT every 2 years
- PAP every 3 years
- Colonoscopy every 10 years

If the patient requires repeat screening and does not fall within these general guidelines, it is vital you manually set the next date due to override the automated system.

Use the Tickler system to set a reminder for future cancer screening due dates for patients that do not fall within the general guidelines (e.g. abnormal results, high risk, or history of cancer). When that defined date arrives, the relevant test can be ordered and patient notified.

Use the **Registry** for breast, colorectal or cervical cancer patients and exclude them from screening. You can still use the Preventions module to track the surveillance and use Ticklers as reminders.

Ask your OSCAR Service Provider (OSP) to add **HPV Test** and **Breast MRI** tabs to your Preventions module if you do not already have them. Discuss enabling Stop Signs with your OSP.

Use the Ontario Preventions Report to assist you with your bonus calculations. Ensure that you have your roster list up to date and your patients properly excluded if needed.

In Ontario, you may use the Cancer Care Ontario (CCO) Screening Activity Report (SAR) to assist you with keeping your EMR up-to-date.