



# OSCAR EMR Cancer Screening Guidelines

Version 2.3

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**Cancer Care Ontario  
Primary Care Lead  
(HNHB LHIN)**



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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 <sup>[1]</sup> 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 <sup>[2]</sup>.

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.

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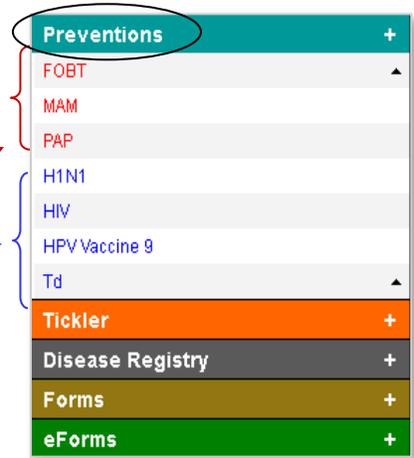
[1] World Health Organization, <http://www.who.int/cancer/detection/en/> – Early Detection of Cancer

[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.



TEST, PATIENT F 61 years [B]

[Immunization Schedules - Public Health Agency of Canada](#)

#### Prevention Recommendations

- No Mammogram records can be found for this patient
- FOBT is overdue for this patient
- No PAP records can be found for this patient
- Need to ask about Smoking

**Legend:**  Completed or Normal  Refused  Ineligible  Pending  Abnormal  Other

Td

Flu

PAP

**MAM**

FOBT

HIV

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.

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- 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:

### **Section 1: 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).

TEST, PATIENT F 61 years

**Prevention : MAM**

Completed    **Date:** 2018-01-0

Refused    **Provider:** ocardoc doctor

Ineligible    **Creator:** L Victoria

**Result**

Pending

Normal

Abnormal

Other    **Reason:**

**Comments**

Rt breast: benign lesion  
routine screening

[Set Next Date](#)

- 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](#).

**TEST, PATIENT F 61 years [B]**  
[Immunization Schedules - Public Health Agency of Canada](#)  
**Prevention Recommendations**

- FOBT is overdue for this patient
- No PAP records can be found for this patient
- Last Mammogram was done 4 month(s) ago
- Need to ask about Smoking

**Legend:**  Completed or Normal  Refused  Ineligible  Pending  Abnor

Td  
Flu  
PAP  
MAM

Age: 61 years  
Date: 2018-01-01

Information about the managed prevention will now appear in **black**

The colour of the date indicator will change based on the results

- Abnormal
- Ineligible
- Pending
- Other
- Refused
- Normal

- 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.

PAP  
MAM  
FOBT  
HIV

Age: 61 years  
Date: 2018-01-01

[show/hide all other Preventions](#)

**Legend:**  Completed or Normal  Refuse

61 years -- Date:2018-01-01  
 Rt breast lesion- patho done Jan 15/18: fibroadenoma- rpt u/s in 6 mths- mammo: routine screening  
 Entered By: doctor oscar doc

- 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

TEST, PATIENT F 61 years [Help](#) | [Abc](#)

**Prevention : MAM**

Completed    **Date:** 2018-05-0

Refused    **Provider:** ocardoc doctor

Ineligible    **Creator:** L Victoria

---

**Result**

Pending

Normal

Abnormal

Other    **Reason:**

---

**Comments**

Hx of double mastectomy, Jan 1, 2018

---

[Set Next Date](#)

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

Disease Registry				
Coding System:	Code	Diagnosis	First Visit	Last Visit
icd9	174	MALIG NEO FEMALE BREAST*	2018-05-09	2018-05-09 10:13:12.0

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

TEST, PATIENT F 61 years [Help](#) | [A](#)

**Prevention : MAM**

Completed    **Date:** 2018-01-0

Refused    **Provider:** oscar doc doctor

**Ineligible**    **Creator:** L Victoria

---

**Result**

Pending  
 Normal  
 **Abnormal**  
 Other    **Reason:**

---

**Comments**

Rt breast carcinoma, Dx: Jan 1, 2018

---

[Set Next Date](#)

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.

The screenshot shows a web-based form for entering a PAP test record. At the top, it says 'TEST, PATIENT F 61 years' with a 'Help' link. The 'Prevention : PAP' section has three radio buttons: 'Completed' (selected), 'Refused', and 'Ineligible'. To the right, there are fields for 'Date' (2018-01-0), 'Provider' (oscardoc doctor), and 'Creator' (L Victoria). The 'Result' section has four radio buttons: 'Pending', 'Normal' (selected), 'Abnormal', and 'Other'. A 'Reason' field is next to the 'Other' option. The 'Comments' section is a text area containing 'routine screening: 3yrs'. At the bottom, there is a 'Set Next Date' link.

### 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

TEST, PATIENT F 61 years [Help](#)

---

**Prevention : PAP**

**Completed**      **Date:**

**Refused**      **Provider:**

**Ineligible**      **Creator:**

---

**Result**

**Pending**

**Normal**

**Abnormal**

**Other**      **Reason:**

---

**Comments**

followed by colposcopy  
results: LSIL  
LEEP completed  
rpt in 6 mths

---

**[Set Next Date](#)**

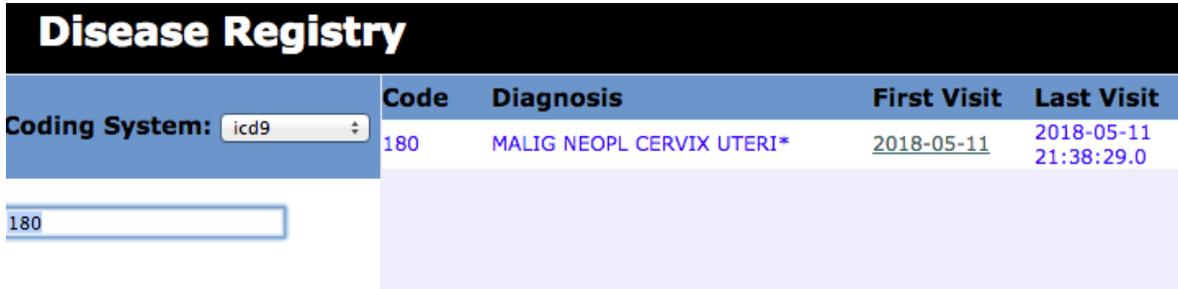
**Next Date:**

**Never Remind:**  **Reason:**

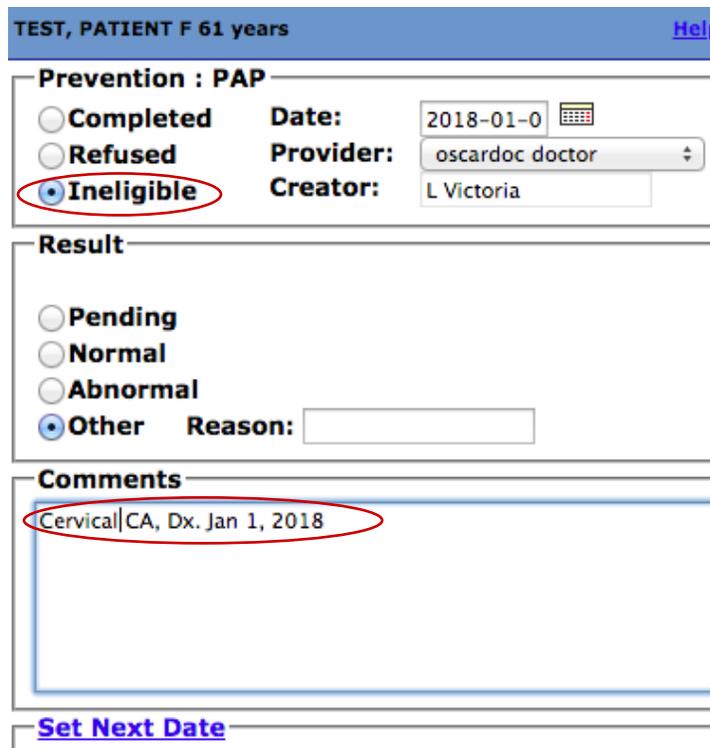
### 2.3.4 History of Cervical Cancer

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.

TEST, PATIENT F 61 years
[Help](#)

---

**Prevention : FOBT**

<input checked="" type="radio"/> <b>Completed</b>	<b>Date:</b>	2018-01-0 <input type="text" value="2018-01-0"/>
<input type="radio"/> <b>Refused</b>	<b>Provider:</b>	oscardoc doctor <input type="text" value="oscardoc doctor"/>
<input type="radio"/> <b>Ineligible</b>	<b>Creator:</b>	L Victoria <input type="text" value="L Victoria"/>

---

**Result**

Pending  
 **Normal**  
 Abnormal  
 Other Reason:

---

**Comments**

NO fhx of CRC  
 rpt in 2 yrs  
 |

---

[Set Next Date](#)

## 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 than 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

**TEST, PATIENT F 61 years**

**Prevention : COLONOSCOPY**

**Completed**      **Date:** 2018-01-0 

**Refused**      **Provider:** oscar doc doctor 

**Ineligible**      **Creator:** L Victoria

**Result**

**Pending**

**Normal**

**Abnormal**

**Other**      **Reason:**

**Comments**

+ fhx of CRC  
hx: tubular adenoma 2015  
current Cscope: normal  
done by Dr. Smith  
rpt in 5 yrs

**Set Next Date**

**Next Date:** 2023-01-0 

**Never Remind:**  **Reason:**

### 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

Disease Registry				
Coding System:	Code	Diagnosis	First Visit	Last Visit
icd9	153	MALIGNANT NEOPLASM COLON*	2018-05-18	2018-05-18 09:36:06.0

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

TEST, PATIENT F 61 years [Help](#)

**Prevention : FOBT**

Completed    **Date:** 2018-01-0

Refused    **Provider:** ocardoc doctor

**Ineligible**    **Creator:** L Victoria

---

**Result**

Pending

Normal

Abnormal

**Other**    **Reason:**

---

**Comments**

Colorectal CA, DX Jan 1, 2018

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, 1<sup>st</sup> 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.

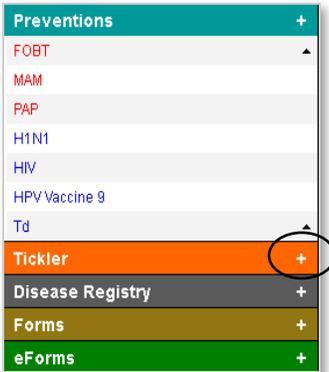
## 2.5 Notifications for Cancer Screening

### 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' window contains the following fields and controls:

- Demographic Name:** TEST,PATIENT [Search]
- Chart No:** [Empty field]
- Service Date:** 2018-11-13 [Calendar Lookup] 6-month 1-
- Priority:** Normal ▾
- Task Assigned to:** Test1, Forwarding ▾
- Reminder Message:** Repeat PAP due
- Buttons:** Cancel and EXIT, Submit and EXIT (highlighted with a box), Submit & Write to Encounter
- Navigation:** Back (left arrow), Close the Window (right arrow)

## OSCAR EMR Cancer Screening Guidelines

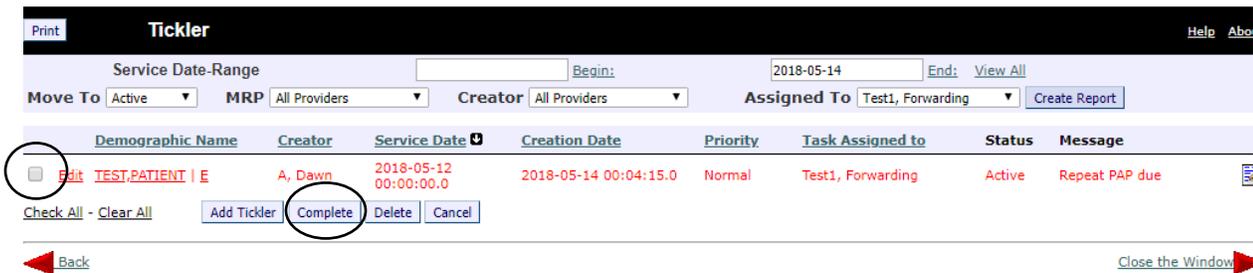
The Tickler will appear **blue** in the patient's eChart until the item becomes due.



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.



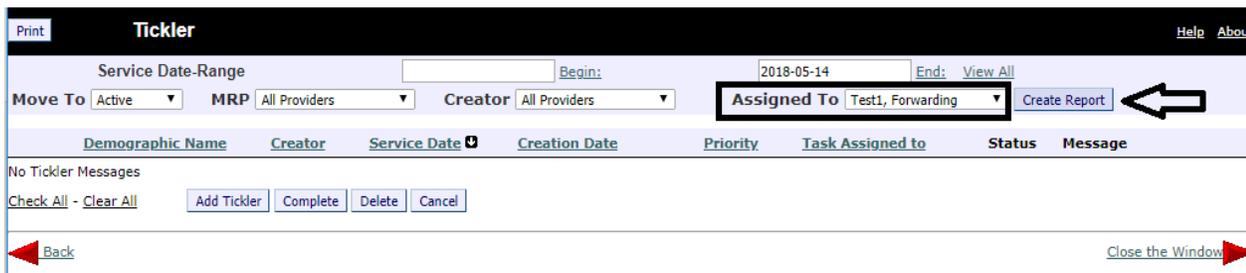
Ticklers assigned to someone can be found by selecting the Tickler option from the main menu in the appointment screen in OSCAR



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.

### Appointment Prevention Notification Settings:

These settings will set the "stop sign" notifications you see displayed on the appointment screen.

	Display on Appointment Screen	<input checked="" type="radio"/> Enabled <input type="radio"/> Disabled
---	-------------------------------	---

---

### Customize Prevention Notification Settings:

To customize the notifications below, "Display on Appointment Screen" must be enabled.

	PAP	<input checked="" type="radio"/> Enabled <input type="radio"/> Disabled
	MAM	<input checked="" type="radio"/> Enabled <input type="radio"/> Disabled
	COLONOSCOPY	<input checked="" type="radio"/> Enabled <input type="radio"/> Disabled
	FOBT	<input checked="" type="radio"/> Enabled <input type="radio"/> Disabled

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**

A screenshot of the 'REPORT LIST' interface. The title 'REPORT LIST' is in a blue header bar. Below it is a list of 15 report options, each with a number and a description. To the right of each option are various input fields like date pickers and dropdown menus. The 11th option, 'Demographic Report Tool', is circled in red. Other options include 'EDB List 05', 'Active Patient List', 'Day Sheet', 'Tabular-style Daysheet', 'Bad Appt Sheet', 'Patient Chart List', 'Old Patient List', 'No Show Appointment List', 'Consultation Report', 'Laboratory Requisition Report', 'Demographic Set Edit', 'Ontario Prevention Report', 'Demographic Study List', and 'Chronic Disease Management'. The interface also shows some date filters and a search field for 'age >' and 'Start Date:'.

Report ID	Report Name	From	To	Other Fields
1	EDB List 05	2018-5-18	2018-5-18	
2	Active Patient List			
3	Day Sheet			
	* All appointments			
	Non Rostered Only <input type="checkbox"/>	2018-5-18	2018-5-18	
	* Print Day Sheet for only new appointments	2018-5-18		
	* Lab Day Sheet	2018-5-18		
	* Billing Day Sheet	2018-5-18		
4	Tabular-style Daysheet	2018-5-18		
5	Bad Appt Sheet		2018-5-18	
6	Patient Chart List			
7	Old Patient List			age > [ ]
8	No Show Appointment List			Start Date: [ ]
9	Consultation Report			
10	Laboratory Requisition Report			
11	Demographic Report Tool			
12	Demographic Set Edit			
13	Ontario Prevention Report			
14	Demographic Study List			
15	Chronic Disease Management			

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.

**Note:** Depending on the build/version of your OSCAR, you may need to enter the various age ranges (**ages between**) as:

- MAM & FOBT - 49-75
- PAP – 20-70

This will ensure that all eligible patients are accounted for.

To determine if this is necessary, run the Ontario Prevention Report with the proper age ranges – use MAM as an example and guideline age range of 50-74. If the report produced does not yield any patients who are 50 or 74 years old in the “Age as of” column, then you need to make the adjustment in the **ages between** section for the patient set in the Demographic Report Tool.

- 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**

Schedule Caseload Resources Search **Report** Billing In

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

**REPORT LIST**

1	EDB List 05	From	2018-5-18	To	2018-5-18	
2	Active Patient List					
3	Day Sheet					
	* All appointments	From	2018-5-18	To	2018-5-18	8
	Non Rostered Only <input type="checkbox"/>					
	* Print Day Sheet for only new appointments		2018-5-18			
	* Lab Day Sheet		2018-5-18			
	* Billing Day Sheet		2018-5-18			
4	Tabular-style Daysheet		2018-5-18			
5	Bad Appt Sheet				2018-5-18	
6	Patient Chart List					
7	Old Patient List				age >	
8	No Show Appointment List				Start Date:	
9	Consultation Report					
10	Laboratory Requisition Report					
11	Demographic Report Tool					
12	Demographic Set Edit					
13	<b>Ontario Prevention Report</b>					
14	Demographic Study List					
15	Chronic Disease Management					

- 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 31<sup>st</sup> of the current year)
- Click on the **Submit** button to generate the report

**Prevention Reporting**

Patient Set: EO Breast

Prevention Query: Mammogram

As of: 2018-03-31

Submit Query

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

DemoNo	DOB	Age as of 2018-03-31	Sex	Lastname	Firstname	HIN	Phone	Address	Next Appt.	Status	Bonus Stat	Since Last Date	Last Procedure Date	Last Contact Method	Next Contact Method	Select Contact	Roster Physician	Bill
1001	1944-06-23	73 years	F							No Info	N				L1		John, Smith	
1005	1951-11-27	66 years	F							Overdue	N	48 months	2014-02-19 00:00		L1		John, Smith	
42	1957-06-15	60 years	F							Up to Date	N	2 months	2018-01-29 00:00				John, Smith	
214	1955-12-07	62 years	F							Pending	N	3 months	2017-12-12 00:00		Follow Up		John, Smith	
1006	1963-01-15	55 years	F							Up to Date	N	1 months	2018-02-05 00:00				John, Smith	
280	1957-07-09	60 years	F							Ineligible	N						John, Smith	

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

<span style="background-color: green; border: 1px solid black; display: inline-block; width: 15px; height: 15px;"></span> Up to Date	<span style="background-color: magenta; border: 1px solid black; display: inline-block; width: 15px; height: 15px;"></span> No Prevention information available	<span style="background-color: grey; border: 1px solid black; display: inline-block; width: 15px; height: 15px;"></span> Ineligible
<span style="background-color: pink; border: 1px solid black; display: inline-block; width: 15px; height: 15px;"></span> Pending	<span style="background-color: red; border: 1px solid black; display: inline-block; width: 15px; height: 15px;"></span> Overdue	<span style="background-color: orange; border: 1px solid black; display: inline-block; width: 15px; height: 15px;"></span> Refused
	<span style="background-color: yellow; border: 1px solid black; display: inline-block; width: 15px; height: 15px;"></span> Recently Due	

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

DemoNo	DOB	Age as of 2018-05-25	Sex	Lastname	Firstname	HIN	Phone	Address	Next Appt.	Status	Bonus Stat	Since Last Date	Last Procedure Date	Last Contact Method	Next Contact Method	Select Contact
22222367	1958-04-17	60 years								Overdue	N	31 months	2015-10-20 09:30	L1 2010-07-15 94M	L1	
22221278	1954-10-16	63 years								Overdue	N	48 months	2014-05-13 00:00	Newsletter 2012-10-29 66M	L1	
22215709	1950-12-16	59 years								Overdue	N	62 months	2013-03-07 00:00		L1	
22213724	1963-01-04	55 years								Overdue	N	39 months	2013-06-07 00:00	Newsletter 2012-10-29 66M	L1	
22212948	1946-12-12	71 years								Overdue	N	70 months	2012-07-13 00:00	L1 2007-07-19 130M	L1	

**Notes:**

- Patients with a PAP status of **Pending** in the [Preventions](#) module will appear in the **Ontario Preventions Report** as **Up To Date**
- Patients with a FOBT or MAM status of **Pending** in the [Preventions](#) module will appear in the **Ontario Preventions Report** as **Pending**
- 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 31<sup>st</sup>

## 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.