WHERE TO DOCUMENT

Choose a documentation method that allows for easy retrieval, assessment and updating, as family history changes over time.

There are different approaches to documenting family history information, including in narrative or list form, a structured table, and visual representations such as a pedigree. Recording information in a pedigree can help you see patterns of disease more easily, but pedigrees are not typically supported in most EHRs. If you prefer to have the option of viewing family history information in a pedigree or genogram format, consider evaluating different family history tools as well as the capability of your EHR system.

Family history data can be entered into the EHR in numerous ways, and methods may be different even among providers in the same office. Standardizing how and where family history data is recorded in the EHR will increase the usability of this information. It is generally considered best practice to record family history data in preset structured fields rather than as free text, when structured data collection is an option.

PARTICIPANTS
Implementation lead, staff involved in family history processes, IT vendor or EHR superuser

WHAT YOU'LL NEED
Family history collection tool, clinic workflow, EHR

BARRIERS
Time, varying preferences among providers, EHR functionality

LEARN MORE
Collecting Sufficient Family History

Documenting Family History Information

STEPS

1. Work with your EHR and/or family history tool vendor to learn about available reports and what kinds of fields can be included in reports, that will help your practice monitor family history activities. The outcome of this discussion may impact decisions you make about where and how to document family history data.
2. Determine where practice staff will enter family history data in the EHR: the family history section, problem list, visit summary, and/or progress report. There may be different rules for the comprehensive information collected and information deemed relevant for the patient's risk assessment.
3. For practices that use a paper questionnaire or stand-alone electronic family history tool, establish a process for how these forms or reports get scanned or uploaded in the EHR for reference over time.

TIPS FOR DOCUMENTING FAMILY HISTORY IN THE ELECTRONIC HEALTH RECORD

These tips can help streamline documentation to result in family history data that can be utilized for risk assessment over time.

Record family history data in structured fields rather than as free text to enable the use of clinical decision support and accurate reporting, when possible. This usually means recording the family history in the family history section, rather than in the narrative progress note.

Add family history through ICD10 diagnoses to the patient's medical history or problem list. This will support the use of alerts and clinical decision support.

Work with your EHR vendor to determine whether red flags or alerts can be generated based on known risk factors.

Explore ways to adapt existing EHR functionality and workflows with your vendor, in order to maximize the benefits of collecting family history.

Note:
The Electronic Health Record has the potential to be a powerful tool for family history collection, documentation, and risk assessment as well as to facilitate the use of family history information in medical decision making through clinical decision support systems. While significant advances are being made by some vendors and researchers, many EHRs currently lack the functionality necessary to support the clinician in recording the necessary family history data in structured fields to perform accurate risk assessment or to use the collected family history information for medical decision making. For this reason, some clinicians look to external vendors for a family history tool solution that can collect family history in structured and usable way, and also perform varying degrees of automated risk assessment. Such external tools may or may not be designed to interface with the EHR and even when they are, the level of integration is often limited to importing a PDF report into the EHR as a static document.

Efforts are ongoing to improve standards and EHRs capabilities in this area. In 2012, the Stage 2 Meaningful Use rules addressed collecting a structured family history for the first time. NCCRT and other national organizations are currently working towards a set of best practice recommendations for both the process and content of cancer family history collection that should be included in high quality EHRs.

METHOD IN ACTION

Using an electronic patient questionnaire to collect cancer family history.

University Women's Care is an obstetric and women's health practice affiliated with an academic teaching hospital in an urban setting. Staff include attending physicians, nurse practitioners, and nurses. OBGYN residents and medical and nursing students participate in rotations. After an initial pilot project with the medical genetics department, the practice adopted a family history collection approach that is based on an electronic collection and risk assessment tool.

New patients are asked to arrive 15 minutes early to their appointment to check in and fill out paperwork. This includes completing a short electronic questionnaire on a tablet computer in the waiting room. The questionnaire collects information about the family history of cancer. When the patient is done, the questionnaire data is automatically run through the tool database to perform cancer risk assessment and a report is generated and imported into the EHR.

During the clinical encounter, the provider reviews the risk assessment results and clarifies family history information with the patient as needed. Using the risk assessment results, the provider and patient discuss red flags in the family history and next steps, which can include a recommendation for cancer screening and/or a referral for genetic counseling and further evaluation. The provider documents the encounter and any referrals in the EHR.

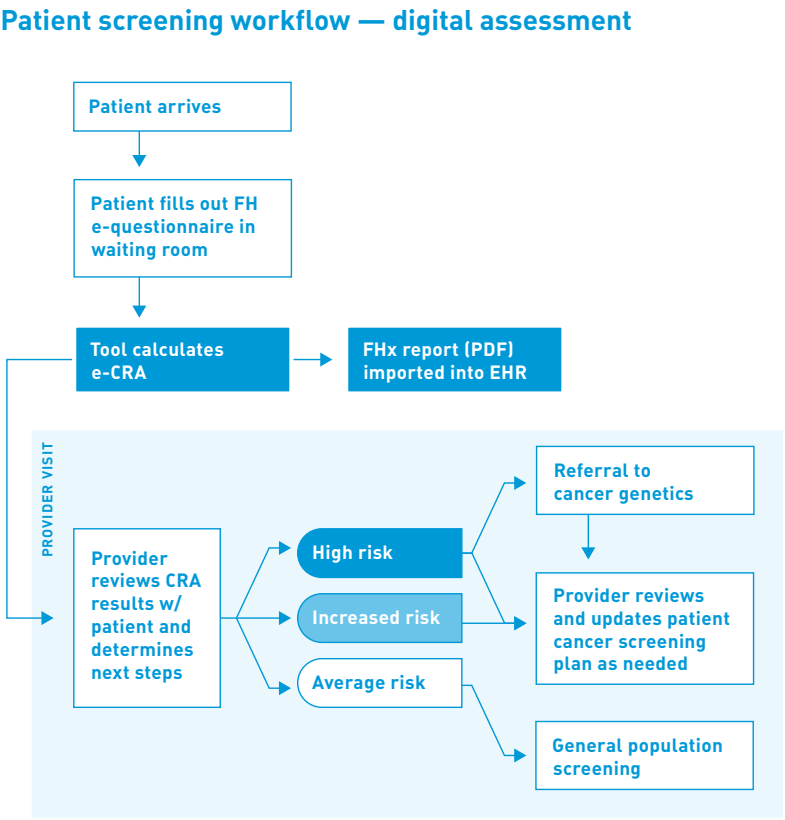

Figure 3. Workflow with patient-entered family history collection in the waiting room and provider risk assessment using an electronic tool. CRA = cancer risk assessment. FH = family history. EHR = Electronic Health Record.

This example was adapted from published reports[13,14,15] and commercial tools, such as CRA Health, Family Healthware, MyLegacy, and Progeny. See the Family History Features Worksheet for additional family history tools.