WHO WILL COLLECT

Work with your team to determine who will collect the family history: the patient him- or herself, allied health professional, the primary provider, or some combination of the three.

Consider how to best execute the initial family history collection for patients in your practice. Selecting tools to assist you should be closely tied to determining who will actually be involved in collecting the family history. Could your average patient complete a questionnaire to document his or her family history for you? Do you have Medical Assistants or Nurses on staff who can be trained to interview the patient to collect the necessary information? The answers to these questions can help determine a time efficient solution for your practice.

PARTICIPANTS
Implementation lead, staff involved in family history processes

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

BARRIERS
Competing priorities, patient and provider knowledge, time, institutional role restrictions

APPROACHES

1 *Patient collection*

To save time in the face-to-face clinical encounter, many practices prefer for patients to collect family history information prior to their appointment, either through a mailed questionnaire (or emailed electronic questionnaire), or in the waiting room. Collecting this information prior to the visit allows patients to research their family histories more completely.

2 *Allied health professional collection*

Some practices have developed innovative models for family history collection, with or without a triaging component, in which a nurse or medical assistant interviews the patient to collect standard family history information. This may include the allied health professional administering a screening tool to the collected information to triage whether the patient should be seen by a provider for further risk assessment and management. In these models, the health professional conducting the family history interview receives training on what information to collect and how to document it.

3 *Provider collection*

Family history collection as part of the visit intake by the primary care provider is the most common method used in practice. This process can be streamlined by using a tool or template in the clinic note and educating the provider on the essential elements to collect and red flags to recognize for individuals with increased cancer risk.

METHOD IN ACTION

Utilizing nurse wellness visits for cancer family history risk assessment.

Family Care USA is a large family medicine residency program in a rural setting. Staff include attending physicians, physician assistants, family medicine residents, and nurses. The practice recognized a need to improve the identification of at-risk individuals for hereditary cancer syndromes, including hereditary breast and ovarian cancer syndrome and Lynch syndrome. A new telegenetics satellite office recently opened in the community, reducing access barriers for patients to be seen in cancer genetic clinic.

Family Care developed a cancer risk assessment model that utilized an existing clinic infrastructure for nurse wellness visits. The RN received specialized training on collecting and assessing family health history information for cancer. To systematize the risk assessment criteria, the practice, in collaboration with the genetic clinic, developed a Red Flags Checklist for the nurse and a Genetic Referral Checklist for the provider.

There are two points of entry into the Cancer Family History Nurse Wellness visit: (1) the provider recognizes a potential concern and refers the patient for more thorough family history collection and risk assessment or (2) the patient initiates the appointment request after receiving education through materials in the waiting room.

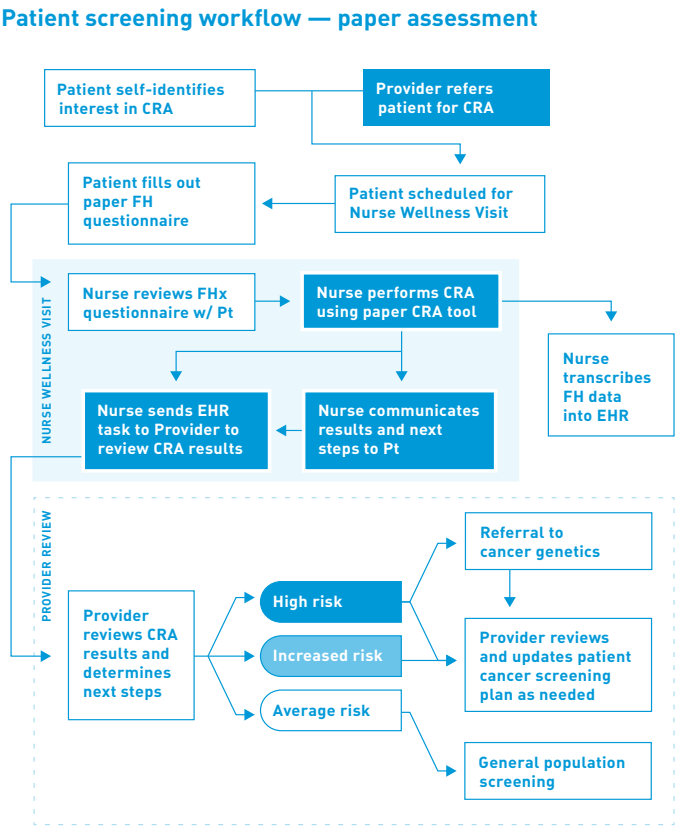

Figure 4. Workflow with 2-tiered risk assessment utilizing nurse appointment and secondary provider review of family history and paper family history collection and risk assessment tools. CRA = cancer risk assessment. FH = family history. EHR = Electronic Health Record.

In the Wellness Visit, patients complete a paper family history questionnaire that elicits structured family history information. The nurse reviews the family history, asking for additional information as needed, and completes a Red Flags Checklist to determine if the patient should be considered for changes in screening and/or a referral to genetic clinic.

The nurse submits a task in the EHR for the provider to review the patient's family history and nurse recommendation. The provider can use a Genetics Referral Checklist to determine if the patient should be referred to cancer genetic clinic. The patient is scheduled for a follow-up appointment after the Nurse Wellness Visit and genetic appointment to review any recommendations for changes in management.

This example was based on Maine Dartmouth Family Medicine Residency's model for cancer risk assessment in family practice. For more information, contact Dr. Greg Feero at W.Gregory.Feero@MaineGeneral.org.