Family history interpretation and risk assessment may be performed by the primary care provider, but can also be aided by other team members and specialists.

After the family history is collected, determine who in the practice will be involved in interpretation of the data and performing risk assessment. This decision, too, may be made in coordination with selecting a family history tool. An electronic risk assessment tool can perform initial assessment of the family history based on algorithms, but a clinician should also review the results before changing patient management.

**PARTICIPANTS**
Implementation lead, staff involved in family history processes

**WHAT YOU’LL NEED**
Risk assessment tool

**BARRIERS**
Competing priorities, knowledge, infrastructure

**LEARN MORE**
Assessing Risk and Identifying Red Flags
Categorizing Cancer Risk
Provider Education Resources

**APPROACHES**

1. **Provider interpretation**
The primary care provider will always have an important role in reviewing and interpreting collected family history and performing risk assessment. These activities may fall solely on the provider, or may be shared with one (or more) of the methods described below.

2. **Two-tiered: Allied health provider and provider**
As previously described, some practices may utilize another team member to perform family history collection, which can also include initial or preliminary risk assessment. This information is shared with the provider through the EHR or another channel, and the provider reviews the initial interpretation to make a final risk assessment and recommendation to the patient.

3. **Genetic expert review**
Some practices have established relationships with local genetic clinics or commercial genetic services to assist in risk assessment. A genetic specialist reviews charts at regular intervals to identify candidates for further genetic evaluation, and communicates the recommendations back to the practice for review and follow-up.
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.

Patient screening workflow — digital assessment

Patient arrives

Patient fills out FH e-questionnaire in waiting room

Tool calculates e-CRA

FHx report (PDF) imported into EHR

Provider reviews CRA results w/ patient and determines next steps

High risk

Referral to cancer genetics

Increased risk

Provider reviews and updates patient cancer screening plan as needed

Average risk

General population screening
Figure 4. Workflow with 2-tiered risk assessment utilizing nurse appointment and secondary provider review. In this scenario a paper family history and risk collection tools are used. CRA = cancer risk assessment. FH = family history. EHR = Electronic Health Record.

Patient screening workflow — paper assessment

- Patient self-identifies interest in CRA
- Patient scheduled for Nurse Wellness Visit
- Nurse reviews FHx questionnaire w/ Pt
- Nurse sends EHR task to Provider to review CRA results
- Nurse performs CRA using paper CRA tool
- Nurse communicates results and next steps to Pt
- Nurse transcribes FH data into EHR
- Provider reviews CRA results and determines next steps
- Referral to cancer genetics
- Provider reviews and updates patient cancer screening plan as needed
- General population screening