

iKnowMed Generation 2 –Patient History > Supportive Care Interventions
Definitions

iKM Field	Definition
Date of Service	Date of encounter with/for patient
Date of Referral	Date referral received
Date Pathology Received	Date pathology report received in oncology office
Date of C1D1 or Surgery	Date of first treatment. This can be date of surgery, date chemo/immunotherapy starts, date hormonal therapy starts, etc. Does not have to be date patient starts in said practice.
<u>People Present</u>	Can be with whomever clinician is communicating with/about/for patient
Patient	
Caregiver	
Family Member	
Provider/Clinician	
Community Partner/Case Manager	
<u>Clinical Barriers to Care</u>	
Healthcare System Knowledge Deficit	Lack of knowledge regarding health system routines and general flow. (e.g., whether a referral is needed by patient's insurance, which physician or care team to see first, understanding of their insurance coverage.)
Health Literacy	Lack of knowledge or understanding of personal health care to make informed decisions about one's health and health care, including importance of screenings, annual physicals, smoking cessation, hygiene, personal health care, etc.
Complex Coordination of Care	Multiple and/or complex tasks needed to coordinate care for patient including presentation at tumor board, multidisciplinary treatment plans, specific and strict timing of treatments and surgery, etc.
Concurrent Chemo/Immunotherapy/Radiation	Requiring specific coordination of care and clear and precise communication with the patient and multidisciplinary care team.
Treatment or Providers at Multiple Facilities/Incompatible EMRs	Treatment that requires coordination and communication among multiple facilities
Unknown Diagnosis/Lack of Pathology	Lack of clear diagnosis at time of visit
Fertility Concerns	Any person of child bearing age that would potentially receive treatment that will effect fertility.
Multiple/Conflicting Appointments or Workups Incomplete	Patient requires multiple appointments, possibly at various different locations (e.g., patients with head and neck cancer require several appointments with different specialties prior to starting treatment)

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<u>Communication Method</u>	
In-person	Meeting in person
Virtual-telehealth	Meeting via telehealth
Telephone	Meeting conducted via telephone; audio-only
Electronic Correspondence	Sending communication via email (with patient permission); via Ontada Health, Navigating Care, CareVive, etc.
<u>Visit Type</u>	
Advance Care Planning	When the individual was seen specifically for Advance Care Planning (ACP), or the visit was primarily ACP-related
Follow-Up	When the individual has been seen before by this clinician; following up on prior visit; check-in
New Consult	First time individual has been seen by this clinician
Palliative Care	When the individual is seen by this clinician in the context of a palliative care visit; may be in collaboration with another palliative care clinician
Support Group	When individual is primarily inquiring about support groups; information is provided about support groups; referrals made; individual attended a support group
Transition/Coordination of Care	When patient's care is discussed; may include discussions with or about caregivers and family members; communicating with care team at clinic or others in the community who are involved in patient's care--either in-person, telephonic, or electronic
<u>No Needs Identified/Addressed</u>	
	Referral received, individual contacted but no needs identified/addressed
<u>Referral Source</u>	
Advanced Practice Provider (APP)	Referral from clinic APP
APEX Report	APEX report used to identify patient for outreach
Caregiver Self-Referral	Caregiver referred themselves
Clinic Social Worker	Referral from clinic social worker
Clinic Staff	Referral from clinic staff
Distress/Depression Screen	Patient identified for outreach based on responses to Distress and/or Depression Screening tool
Established Patient	Patient has worked with this clinician before; not a new referral
Hospital Navigator/Case Manager/Social Worker	Referral from hospital-based navigator/case manager/social worker
Infusion Nurse	Referral from clinic infusion nurse
Malnutrition Screening Tool	Patient identified for outreach based on responses to Malnutrition Screening Tool (MST)

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Outside Agency	Referral from staff/clinician of an outside agency/organization
Palliative Care	Referral from a palliative care clinician/team; can be internal or external referral
Patient Self-Referral	Patient referred themselves
Physician	Referral from clinic physician
Radiation Physician/APP/Nurse/Staff	Referral from radiation physician/APP/nurse/staff; can be internal or external referral
Triage/Clinical/Nurse	Referral from clinic triage/clinical nurse
Other	Specify other referral source
<u>Task Work</u>	
Chart Prep/Review	Time spent reviewing patient's chart; researching patient information; preparing for call/visit
Documentation	Time spent documenting in EMR or other platforms regarding interventions/call/visit with or for patient
<u>Total Time Spent</u>	
Capture total time spent preparing for and time spent on interventions with and for patient; including documentation **NOT to be used for billing purposes	
Hours	
Minutes	
<u>Next Follow-Up Date</u>	
Choose date for future follow-up with patient (if desired)	