

## Using a customized electronic medical record toolkit for taking care of neuro-oncology patients.

Rick Steves\*

Department of Neurosurgery, Harvard University, Boston, MA, USA

### Abstract

**Brain tumors are commonly associated with significant symptoms that affect quality of life. The management of brain tumors is complicated due to the pathology of the tumors, associated symptoms, and prognosis. Brain tumors can be monitored with neuroimaging or treated with some combination of surgery, radiation, and chemotherapy, depending on the type of tumor.**

**Keywords:** Brain treatment, Neuro-oncology, Brain tumors.

### Introduction

Brain treatment is surveyed by the clinical status of the patient and neuroimaging. Most neuroimaging is through attractive reverberation imaging or processed tomography in patients who have contraindications to attractive reverberation imaging. Clinical administration of mind growths and their circumstances further develops endurance and nature of life. Seizures are perhaps the most generally overseen condition and can essentially affect nature of life. Seizure results can be estimated by reaction to antiepileptic drugs (AEDs) notwithstanding mediations like a medical procedure, radiation, and chemotherapy [1]. Other clinical issues that can be evaluated incorporate state of mind problems, exhaustion, profound vein apoplexy/pneumonic embolism, and cerebral edema. The range of likely side effects and inconveniences makes clinical administration complex. As such, normalizing care to resolve normal issues and following patients to screen results is of interest.

We looked to create a neuro-oncology "tool compartment" to normalize care for neuro-oncology patients. The tool stash characterizes the significant evaluation and clinical data that our neuro-oncology practice focused on as best practices. Besides, the tool compartment depends on discrete information section and accordingly gives an amazing chance to efficiently following results over the long run and leading quality improvement projects. The objective is to work on the nature of care for patients through efficient following of clinical results and utilization of information for quality improvement practice-based research [2].

The substance of the still up in the air through continuous doctor gatherings that happened like clockwork for quite some time. These gatherings included nervous system science, the office seat, neuro-oncologists, and clinical care staff (like clinical facilitators and attendants). The objective was to arrive at agreement on fundamental components that adjust to our training's meaning of best practices in treating patients

with cerebrum cancer. Concerning significant evaluations, we investigated the appropriate clinical writing and National Comprehensive Cancer Network rules for growths. We settled on standard data connected with analytic history, therapies like radiation and chemotherapy, current steady drugs, etc, as displayed in the Figure (screen captures) [3]. Every one of these fields incorporates drop-down menus that grow when an agreed reaction is placed. We additionally determined point by point pathologic data, including atomic subtypes for gliomas and metastatic cancers.

A few score test measures were chosen to address handicap, as well as related side effect seriousness. Since melancholy is normal among patients with mind cancer and more elevated levels of wretchedness are related with less fortunate results, we surveyed sorrow and tension involving the Center for Epidemiologic Studies Depression (CES-D) scale and General Anxiety Disorder 7-thing (GAD-7) scale. Moreover, the CES-D and GAD-7 were chosen for normalization with the other nervous system science tool compartments. We picked the MD Anderson Symptom Inventory-Brain Tumor (MDASI-BT) on the grounds that a normalized cerebrum cancer evaluation has been approved and distributed in the literature [1]. Also, we incorporated a normalized appraisal of execution status, the Karnofsky Performance Status. This was picked over other estimation devices since it is the normalized scale utilized broadly in neuro-oncology. The Short Test of Mental Status was chosen since it is a normalized nervous system science test that isn't protected, making it uninhibitedly accessible for use.

We fostered a robotized scoring framework for radiographic reaction in patients with glioma in view of the Response Assessment in Neuro-Oncology rules. Patient results were placed as discrete fields as per Response Assessment in Neuro-Oncology models and clinical standards. We surveyed the adequacy of AEDs as indicated by quiet reports of seizures. Furthermore, we evaluated the poisonousness of therapies (radiation and chemotherapy) and steady drugs.

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\*Correspondence to: Rick Steves, Department of Neurosurgery, Harvard University, Boston, MA, USA, E-mail: rick.steves@gmail.com

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In the wake of settling on the substance, we directed gatherings with developers from NorthShore's EMR (Epic Systems) Optimization group like clockwork. These gatherings furthermore included clinical care staff, as well as an analyst and business knowledge experts who were engaged with information extraction and synopsis. These gatherings happened for quite a long time [4]. They constructed the SCDS tool compartment that included guides (a sidebar file of cycles to look over), electronic structures (which been able to auto-score and auto-decipher), and outline stream sheets. We included free text fields to take into account extra data. We planned work processes (the request and task of undertakings to a consideration group that incorporates a medical caretaker and a neuro-oncologist) and planned things to the advancement takes note of (the request and design where the substance would compose).

During this time, we dealt with the tool compartment in an improvement configuration to guarantee convenience and consistency in definitions. Clients were urged to deal with the tool stash to distinguish likely obstructions and carry them to the functioning gathering for goal. The tool stash was intended to help the 2 fundamental arrangement types utilized at North Shore, starting visits and follow-up visits (which happen yearly or as span visits, with the exception of threatening cerebrum growths (every 6 months). The standard arrangement length for an underlying visit is an hour and for a subsequent visit is 30 minutes [5]. Thusly, the tool stash was organized to adjust to these times, with an abbreviated variant of the tool stash utilized at follow-up visits.

After the SCDS tool compartment execution, we kept on gathering like clockwork with developers worked in separating, changing, and stacking information from the EMR's information archive to information stores in NorthShore's Enterprise Data Warehouse (EDW). The EDW software engineers made enlistment reports for following patients and created information quality reports demonstrating which required information were absent from office visits. These information quality reports are circulated to the consideration

group month to month. Information not cleaned in somewhere around 90 days were filed as forever absent and were not recorded on ensuing reports.

The consideration group gained where they were blunder inclined from the information quality reports, and they remediated their utilization of the tool stash. At the point when efficient blunders happened for some suppliers, the groups had the chance to work on their utilization of the tool compartments or to demand improvements or an adjustment of information necessities. The month to month reports delivered a couple or no information checks per supplier after the task was laid out [2]. The week by week gatherings went on for a considerable length of time. The EDW group keeps on supporting the tool stash use and updates/changes are made case by case when adjustments (changes/increases/cancellations) are considered fitting by the clinical group in light of patient experiences. Furthermore, continuous help is accommodated recently onboarded clinical staff to give a learning climate to tool compartment use and give criticism on section.

## References

1. Owonikoko TK, Arbiser J, Zelnak A, et al. Current approaches to the treatment of metastatic brain tumours. *Nat Rev Clin Oncol*. 2014;11(4): 203-22.
2. Villanueva-Meyer JE, Mabray MC, Cha S. Current clinical brain tumor imaging. *Neurosurg*. 2017;81 (3):397-415.
3. Avila EK, Chamberlain M, Schiff D, et al. Seizure control as a new metric in assessing efficacy of tumor treatment in low-grade glioma trials. *Neuro Oncol*. 2017;19(1):12-21.
4. Zamanipour Najafabadi AH, Peeters MCH, Dirven L, et al. Impaired health-related quality of life in meningioma patients-a systematic review. *Neuro Oncol*. 2017;19(7): 897-907.
5. Politsky JM. Brain tumor-related epilepsy: A current review of the etiologic basis and diagnostic and treatment approaches. *Curr Neurol Neurosci Rep*. 2017;17(9):70.