Hospital Registry Operations

- Presented by

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ProRegistry
SERVICES

Cancer Registry Procedure Manual

- Required by CoC
  - Necessary to document policies & procedures for the daily operations of the registry & may include policies for the cancer program.
  - Reviewed annually by Cancer Committee
  - Changes to existing P & P approved by Cancer Committee

Cancer Registry P & P Manual

- Manual should include:
  - Abstracting
  - Case accessions
  - Case eligibility
  - Casefinding/Case Ascertainment
  - Coding references
  - Confidentiality & Release of Information
  - Dates of implementation or changes in policies or registry operations

SOURCE: Cancer Program Standards, 2004 Revised Edition pg. 47

Cancer Registry P & P Manual

- Manual should include: *(continued)*
  - Follow-up
  - Job Descriptions
  - Maintaining & using the suspense system
  - Quality control of registry data
  - Reference data
  - Reporting requirements
  - Retention of documents
  - Staging systems

Cancer Registry P & P Manual

Manual should include: *(continued)*

- *Program Activity*
  - *Cancer Committee meetings*
  - *Cancer Conference activities*
  - *Cancer program objectives*
  - *Policy for AJCC and/or other applicable staging*
  - *Studies of quality and quality improvement system*

Registry P & P – Table of Contents

1. Cancer Program Management-Cancer Committee Meetings
2. Reference Date
3. Reportable List
4. Case Finding/Suspense
5. Abstracting/Accessioning/Data Definitions & Guidelines
6. Staging
7. Follow-up & Confidentiality Policy
8. Quality Control of Registry Data
9. State Reporting
10. Data usage – Request Log
11. Cancer Conferences – Clinical Management
12. Public Education Plan
13. Quality Management Plan – Cancer Committee
14. Reference Manual/Implementation Dates
15. Job Descriptions

Case Ascertainment/Case Finding

- Policy
  - Who regulates what cases you abstract?
    - ACoS-CoC
    - SEER
    - State Cancer Registry
    - NAACCR – North American Association of Central Cancer Registries
    - Hospital Cancer Committee

Case Ascertainment/Casefinding

- Policy
  - Purpose: Casefinding is a systematic method of identifying all eligible cases that are included in cancer registry database.
  - Scope - What is required?
    - Analytic
    - Non-Analytic

    - All malignant tumors
    - Benign tumors
    - Pre-malignant diseases
    - Reportable – by – agreement

    - Exclusions –
      - Patients seen only for 2nd opinion or second opinion to confirm diagnosis or treatment plan
      - Patients seen for transient care to avoid interruption of treatment started elsewhere.
      - Carcinoma in-situ of cervix (CIS) and intraepithelial neoplasia (CIN-III, PIN-III, VIN-III, VAIN-III and AIN-III)

    - Special rules – (Ambiguous Terminology)

Case Ascertainment/Case Finding

- Ambiguous terminology

Terms That Constitute a Diagnosis for Case Finding

- Apparent(ly)
- Appears (effective with cases diagnosed 1/1/1998 and later)
- Comparable with (effective with cases diagnosed 1/1/1998 and later)
- Compatible with (effective with cases diagnosed 1/1/1998 and later)
- Consistent with
- Favor(s)
- Malignant appearing
- Most Likely

Case Ascertainment/Case Finding

Ambiguous terminology

Terms That Constitute a Diagnosis for Case Finding

- **Most likely**
- **Presumed**
- **Probable**
- **Suspect(ed)**
- **Suspicious (for) *Suspicious Cytology must also have positive Bx or physician clinical impression to constitute a positive diagnosis for Case Finding.**
- **Typical (of)**
- **Neoplasm / Tumor** (beginning with 2004 diagnoses and only for C70.0 – C72.9, C75.1 – C75.3) non-malignant primary intracranial or central nervous system tumors only

Case Ascertainment/Case Finding

- Policy
  - Why do you need to identify cases?
    - Casefinding is a system for locating every patient-inpatient or outpatient, who is diagnosed and/or treated with a reportable diagnosis.
    - The registrar must determine what the hospital-specific guidelines are for coding certain diagnoses to ensure the accuracy of the codes used to identify cancer cases in the hospital.

  - Who does this apply to?
    - What departments contribute to process?
      - Medical Records – Disease Index/Dx codes
      - IT – Information Technology
      - Pathology – Copies of positive path reports
      - Cancer Center – List of daily appointments
      - Radiology – Review all mammography reports
      - Surgery – Copy of surgical schedule
      - Pharmacy – List of patients receiving chemo/other drugs
      - Endoscopy – List of colonoscopies, EGD's, etc.

Case Ascertainment/Case Finding

What happens if not done?

- Missed cases
- Inaccurate statistics
- State fines/penalties
- Non-accreditation

Case Ascertainment/Case Finding

Procedure

1. Registry reviews every pathology report for identification of positive pathology.

   - Pathology secretary provides a copy of all pathology reports. Reports are held in CR folder in pathology secretary's office.
   - Reports are picked up by registrar from pathology office at the end of each day.
   - Positive pathology reports will be entered into Suspense file.
   - Negative pathology reports will be shredded.
   - Questionable pathology will be held for 1 month then if no confirmation of reportable disease is identified the pathology will be shredded.

Case Ascertainment/Case Finding

Procedure (continued)

2. Registry reviews Disease Index report to identify new cases for abstracting.

    - Disease Index reports are generated every month on the 15th by the registry coordinator.

    - Diagnosis & procedure codes used for this report include:

      140.0 - 208.9; 225.0 - 225.9; 227.3 – 227.4; 230.0 – 234.9; 237._; ….. (may reference Case Finding list rather than list all codes)

    - Cases identified as possible new cases will be entered into Suspense file.

    - Review of Disease Index also identifies Follow-up of previously reported cases.

Case Ascertainment/Case Finding

Procedure (continued)

3. Registry obtains a copy of daily surgical schedule from OR secretary.

    - Surgical schedule is reviewed to identify additional reportable cases.

    - Verify reportability of case.

    - Verify if previously identified and included in Suspense.

    - Add to Suspense, if eligible and not previously added.

Case Ascertainment/Case Finding

Procedure (continued)

4. Cancer Center logs

- Cancer Registry coordinator obtains a copy of the daily Cancer Center appointments.
- Review of appointments is done to identify eligible cases for inclusion in registry.
- Cases identified for inclusion will be entered into Suspense file.
- Review of appointments also identifies Follow-up of previously reported cases.
- Cancer Center appointment log copies will be shredded once review is complete.

Case Ascertainment

- Suspense file
  - Cases identified through various methods of casefinding as reportable cases will be entered into Registry database as Suspense Case.
  - Patient name, address, DOB, SS#, Date of diagnosis, Primary site must be entered in Suspense record.
  - Copies of paper documents used for casefinding will be filed by month/year of diagnosis in green file cabinet until case is abstracted.
    - Once abstracted, paper documents will be filed by patient name in completed abstract file.
    - If identified as not reportable, re-file documents in Non-Reportable file in green file cabinet, 2nd drawer.

Title/Description: **Case Ascertainment**	Page 1 of 4
Departments Affected: Hospital / Provider-Wide (Health Information Management)	
Topic: Case-finding/Suspense	

Effective Date:	**Reviewed/Revised**: **Date:** 5/2005	**Approved by**: CANCER COMMITTEE	**Prepared by**:

PURPOSE
A. Describe the goals of a hospital-based case-finding and suspense system.
B. List the hospital departments that provide case-finding information.
C. Describe the preferred methods for identifying new cancer cases.
D. Describe methods for monitoring case-finding.

DEFINITIONS
Case ascertainment is the systematic process used to identify all cases eligible to be included in the cancer registry database. Reportable is defined as what must be included in the case-finding process according to the screening list of ICD-9 cases for case-finding. (See Attachment #1 Screening List of ICD-9 Codes for Case-finding.)

GOAL:
To identify "all" reportable cancer cases diagnosed, treated and/or evaluated at XXXX Hospital. The cancer registrar is responsible for identifying all cancer cases according to the requirements of XXXX Hospital, the American College of Surgeons and the Illinois State Cancer Registry. Localized squamous and basal cell carcinomas of the skin are reportable by agreement, meaning they are to be accessioned and abstracted, but not transmitted to the state. The cancer registrar is responsible for monitoring the completeness of case-finding through various quality control procedures.

The Reportable List is maintained in the cancer registry with copies available in the Department of Pathology.

IDENTIFYING SOURCE DOCUMENTS:
1. Pathology and Cytology documents
2. Disease Index of ICD-9 Cancer Coded Cases (Inpatient and Outpatient)
3. Inpatient and Outpatient Medical Records
4. Radiation Oncology treatment summaries
5. Hematology/Oncology Center documents

Departments Affected: Hospital / Provider-Wide (Health Information Management)

Topic: Case-finding/Suspense

CASEFINDING METHODS:

The following sources are to be used to identify potential new cancer cases.

Disease Index: The cancer registrar shall obtain a computerized list from the hospital Information Systems department that contains the disease index for the cancer registry. The Director or Assistant Director of the Health Information Department generates this list.

Inpatient and Outpatient Chart Review: Charts pulled from the disease index to review for inclusion in registry.

Pathology and Cytology Reports: The Department of Pathology sends to the cancer registry on a daily basis all pathology and cytology reports. The registry reviews all cases, filtering for cases that show a malignant disease and those that are possibly malignant.

Oncology Reports: The registry performs manual review of Radiation Oncology treatment summaries and Hematology/Oncology Center reports to determine those cases that may be diagnosed clinically. Radiology reports are filed separately in date order in the Health Information Management Department.

Departments Affected: Hospital / Provider-Wide (Health Information Management)

Topic: Case-finding/Suspense

SUSPENSE FILE:

Once a case has been identified from any one of the listed sources above, the registrar needs to determine if: this is a new **suspense case**, a case already abstracted or a case already entered as a suspense case. If this is a new case and is not in suspense the case needs to be entered into the ERS Suspense System (follow the ERS manual for entering a new case into the suspense system). If this case is already abstracted, the registrar needs to investigate whether patient is having a recurrence or a new primary diagnosed or if this is just a routine follow-up visit. Follow the policy on documenting the proper follow-up information.

The paper case-finding sources are keep manually until the case is abstracted at which time they are filed in the registry by accession year and patient name (alphabetical).

COMPLETENESS MONITORING:

Monitoring completeness of case-finding shall be done to ensure complete reporting of all reportable cases. The Illinois State Cancer Registry monitors case-finding on an annual basis reviewing 3-4 months of case-finding documents.

References:

American College of Surgeons, *Commission on Cancer*, *Cancer Program Standards,* 2004, Chapter 2.

"Cancer Registry Management Principles and Practice", second ed., NCRA, 2004.

International Classification of Diseases, Third Edition, ICD-O-3, World Health Organization

Date Revised: _____

Date Reviewed: _____

Date Initiated: _____

Staging

- Policy – Who, What
  - CoC, SEER, State Cancer Registry require Collaborative Staging for all analytic cases in the cancer registry database.
    - Collaborative Stage requires coding of discrete pieces of information once and the CS computer algorithm derives the values for AJCC Stage and Summary Stage 1977 & 2000.
  - AJCC Staging is required in medical record for commendation award for CoC Surveys.
    - AJCC staging by physicians includes T, N, M and stage group.

Staging

- Policy – (*Continued*)
  - AJCC Stage is required for all analytic cases.
    - Diagnosis and all or part of 1st course treatment at ABC Hosp.
    - Diagnosis elsewhere and all or part of 1st course treatment at ABC Hosp.
    - Diagnosis at ABC Hosp. and all of 1st course treatment elsewhere or decision not to treat made at other facility
      - Bx only cases – physician should stage cases at that point in time.
      - At Bx, Unknown Stage may be the correct stage.

Staging

- **Policy –** *(Continued)*
  - AJCC Stage is to be completed by managing physician.
    - Cancer Committee defines managing physician as:
      - Surgeon, medical oncologist or radiation oncologist
      - Fellows, residents, medical students, physician assistants, cancer registrars or other non-physician fellows do not meet CoC requirement.
    - T, N, M, stage Group and physician signature are required
    - Medical record is considered deficient until AJCC Staging is completed

Staging

- **Policy**
  - What happens if not done?
    - Failure to include Collaborative Staging in registry database may produce:
      - Incomplete data
      - Non-accreditation/penalties
    - Failure to have complete AJCC Staging in medical record could produce:
      - Incomplete data
      - Missed Commendation Score for Standard 4.3 (Effective with 2007 surveys)

Collaborative Staging

- Policy
  - Collaborative Staging (CS) data fields will be completed by registrar at time of abstracting.
    - CS is to be recorded for analytic cases diagnosis on or after January 1, 2004.
    - CS instructions and site-histology codes are found in *Collaborative Staging Manual and Coding Instructions (CS Manual) version 1.0*.
    - Collaborative Stage algorithm will produce "derived Clinical AJCC, Pathologic AJCC and SEER Summary Stage 1977 and Summary Stage 2000) in registry database.
  - Collaborative Stage will be included in Abstract Q/A reviews.

Collaborative Staging

- Procedure
  - Registrar will assign up to 15 different data codes according to CS coding instructions & rules.
    - Data is collected per instructions and site-histology codes which are found in "*Collaborative Staging Manual and Coding Instructions*" (*CS Manual*) *version 1.0*.
    - Data used to code CS is both clinical and pathological.
    - The medical record is primary source for finding data for CS.
    - Registry database software applies the CS algorithm to produce all derived stages. CS algorithm will derive c-AJCC, p-AJCC, Summary Stage 1977 and Summary Stage 2000.
    - Collaborative Staging will be included in Q/A review of abstracts.

AJCC Staging

- **Procedure**
  - **AJCC Staging**
    - Appropriate AJCC Staging form will be identified by the pathology department or medical record coders.
    - AJCC Staging form will be placed in the medical record by coders.
      - Staging forms will be flagged for physician completion
      - Completion of form includes T, N, M, Stage Group and signature of physician.
      - Charts are considered incomplete until staging form is completed by physician.

AJCC Staging

- **Procedure**
  - **AJCC Staging** *(continued)*
    - Medical records will be reviewed by cancer registrar for completeness of staging.
      - Incomplete forms will be returned to physicians
      - Staging issues will be addressed by the cancer committee
        - » Completeness
        - » Accuracy
    - Other issues to consider in policy
      - Timeliness of staging
      - Impact or process of electronic medical record

Title/Description: **TNM Staging**	Page 1 of 1		
Departments Affected: Hospital / Provider-Wide (Health Information Management)			
Topic: Procedure for staging			
Effective Date:	**Reviewed/Revised**: **Date:** 5/2005	**Approved by**: Cancer Committee	**Prepared by**:

PURPOSE

To define proper procedure for TNM Staging, which is a required component for all reportable and eligible cases in an approved cancer program.

POLICY

Every analytic case eligible for TNM staging, with a staging scheme in the AJCC TNM Staging, 6th edition Manual must have a staging form on the hospital or oncology chart. For cases diagnosed before 2005, the registry is responsible for placing a pre-printed site appropriate form on the hospital chart at time of abstracting. The demographics section must be filled out, and physician name (see staging assignment hierarchy below) with diagnosis date written above patient name section. The form is then attached to front of chart and returned to medical records department where a deficiency is to be added to the physician's work queue to be completed and then returned to registry for review. In the event a stage is questioned, the registrar will resubmit to the physician with additional documentation or information and review again. If there is still an issue, the Cancer Program Director or Cancer Committee Chair will review the case.

For cases diagnosed as of January 01, 2005, the coding department in Medical Records will be placing TNM forms on every chart with a new reportable diagnosis and assign to appropriate physician. Registry will then review completed stage and enter it into the electronic abstract following the above instructions as before.

STAGING RESPONSIBILITY HIERARCHY

1. Surgeon, if patient has cancer-directed surgery.
2. Oncologist, if patient has cancer-directed treatment.
3. Physician who performed biopsy or diagnosis if no treatment performed at this institution.
4. Managing physician, if a clinical diagnosis only made.
5. Cancer Committee designee if none of the above is able to stage the case.

Date Initiated: _____

Date Revised: _____   **Date Reviewed:** _____

Title/Description: **TNM Staging Procedure**	Page 1 of 2
Departments Affected: Hospital / Provider-Wide (Health Information Management)	
Topic: Procedure for staging	

Effective Date:	**Reviewed/Revised**: **Date:** 5/2005	**Approved by**: Cancer Committee	**Prepared by**:

Staging Procedure – XXXX Hospital for cases beginning January 1, 2007
In order to accommodate electronic medical record implementation at XXXX Hospital, staging forms will be sent to physicians for completion and then provided to Health Information Management for scanning into the electronic record.

Procedure
Approximately mid-month, run a suspense list following procedure below:
In ERS, select **Reporting,** then **Adhoc**
In Adhoc, select **Rpt_file**
From Label drop down, select **Reporter Staging Forms**
From Filename drop down, select **SUNA**
In **Selection Attr**, change Admit date to date of suspense month prior to current month, i.e. in February, select cases from January.
Select **Transfer to Excel**
Save excel sheet to C: and name of month - staging, i.e. January Staging.
In **C:** open the **January Staging** spreadsheet and adjust columns to accommodate text in the columns.
Highlight columns with text – Name, MR#, Admit Date and Site and using right mouse key, select **Copy.**
From **My Documents**, select and open **STAGE TRACKER**
In cell below last patient in TRACKER, place cursor and using right mouse key, select **Paste.**
Pull path reports from suspense file for the month you are working with prepare mailing.
Copy path report and prepare staging from for each case with patient name, MR#, Managing physician name and XXXX Hospital.

Departments Affected: Hospital / Provider-Wide (Health Information Management)	
Topic: Procedure for staging	

Effective Date:	**Reviewed/Revised**: **Date:** 5/2005	**Approved by**: Cancer Committee	**Prepared by**:

Procedure: (continued)

Place cover letter, staging form, copy of path report and business reply envelope in mailing envelope. Use 9 x 12 envelopes for multiple forms when needed. Update STAGE TRACKER with the following:

Physician staging form being sent to – *see Staging Responsibility Hierarchy.

Date sent.

In cases for which there is no AJCC staging schema or another reason staging is not required, enter **NA** in **Date Sent** column and reason in **Comments.**

When information completed for each patient, **Sort** cases so that entire list is in alphabetical order and **Save** STAGE TRACKER. (To sort, place cursor in first cell of spreadsheet with patient name and select **AZ↓** from toolbar.)

Enter date received as each staging form is returned and take completed staging form to Health Information Management.

Prior to sending next month's forms, make follow-up calls to check on form completion of cases sent out during previous month.

At end of the next month, i.e. end of March for January cases, compile list of outstanding forms with patient name, MR#, physician name and date sent and provide to HIM for so that they can contact physicians.

Date Initiated: _____

Date Revised: _____   **Date Reviewed:** _____

Staging

- New CoC requirements – "2008"
  - Standard 4.3 – Staging
    (Also impacts Standard 2.10)
    - 2008 surveys
      - AJCC Staging will not be reviewed by surveyor unless hospital seeks commendation award.
      - If 95% of cases are staged, commendation score will be given.
      - If less than 95% of cases are staged a compliance score will be given.
      - If hospital does not seek commendation, chart review will not be done and a compliance score will be given for Standard 4.3.

Staging

- New CoC requirements
  - Standard 4.3 – Staging *(continued)*
    - 2008 surveys
      - A process/policy to promote and document physician use of AJCC Stage in treatment planning. "**Clinical T,N,M, Stage Group**"
      - A process/policy for Cancer Committee to:
        - » Establish accuracy rate for Collaborative Stage in registry database.
        - » Annual evaluation/review of accuracy of the Collaborative Stage data items.
      - Change to cancer registry quality control plan (Standard 2.10) to include review of Collaborative Stage accuracy.

Staging

- New CoC requirements
  - Standard 4.3 – Staging *(continued)*
  - Final revisions not available yet.
    - Final plan to be available mid 2008
    - Applicable for all programs January 1, 2009
    - Focus on quality of physician staging & methods of effectively using AJCC Staging in treatment planning.
  - Free web conference – Monday, Jan. 14, 2008

Staging

- Ambiguous Terminology for Staging
  - Four Lists!
    - SEER Summary Stage
    - SEER EOD
    - Collaborative Staging
    - AJCC

Ambiguous Terminology Collaborative Staging

(Consider as involvement)

- *apparent(ly)*
- appears to
- comparable with
- *compatible with*
- *consistent with*
- contiguous/continuous with
- *encroaching upon*
- extension to, into, onto, out onto

- features of
- fixation to another structure
- fixed
- impending perforation of
- impinging upon
- impose/imposing on
- incipient invasion

Ambiguous Terminology Collaborative Staging

(Consider as involvement)

- induration
- infringe/infringing
- into
- intrude
- invasion to into, onto, out onto
- most likely
- onto

- overstep
- presumed
- probable
- protruding into (unless encapsulated)
- suspected
- suspicious
- to
- up to

Collaborative Staging
(*Consider as non-involvement)*

- abuts
- approaching
- approximates
- attached
- cannot be excluded/ruled out
- efface/effacing/effacement
- encased/encasing
- encompass(ed)
- entrapped
- equivocal

- extension to without invasion/
- involvement of
- kiss/kissing
- matted (except for lymph nodes)
- possible
- questionable
- reaching
- rule out
- suggests
- very close to
- worrisome

Ambiguous Terminology Collaborative Staging

- Determination of the cancer stage is both a subjective and objective assessment of how far the cancer has spread.

- If individual clinicians use these terms differently, the clinicians definitions and choice of therapy should be recognized.

- If a term used in a diagnostic statement is not listed, consult the clinician to determine the intent of the statement.

CS – Ambiguous Terms

- Examples:
  - Adenocarcinoma with extension *to* the prostatic capsule
    - Consider the prostatic capsule involved
  - Serous adenocarcinoma *fixed* to the pelvic wall
    - Consider the pelvic wall involved
  - Squamous cell carcinoma *approaching* the carina
    - Do not consider the carina involved

Registry Staffing

- Job Description – every position
  - Registry Supervisor/Coordinator
  - Abstractor
  - Follow-up coordinator
  - Meeting coordinator
- CTR – required by CoC
  - CTR must oversee abstracting
    - May use contract CTR's to monitor abstracting or do the abstracting

Registry Staffing

- Recent Time Study* - Mary Marshall, CTR – Kootenai Medical Center, Idaho
  - Who coordinates CoC Approval?
  - Who coordinates Cancer Conferences?
  - Who maintains Follow-Up?
  - Who does Cancer Registry report to?
  - Doe registry have a supervisor?
    - If not, do registrars coordinate & split work between staff?
  - What tasks do you perform that you feel should not be duties of cancer registry?

Registry Staffing

🔯 Recent Time Study*

- 🔶 Is there a difference between the role of cancer registrar and registry coordinator?

- 🔶 Is the estimate of 1 case per hour still appropriate for abstracting average?

- 🔶 Are you given adequate time for CE and maintaining and/or learning new information?

- 🔶 List 3 problem areas in the registry.

- 🔶 List 3 procedures you do that could be of benefit to other registries.

Registry Staffing
Time Study (task categories)

Abstracting

- Pull charts
- Pull path reports
- Pull new patient admits/consults
- Maintain casefinding & suspense lists
- Identify & maintain non-reportable cases
- Placement of Staging forms

Follow-Up

- Maintain Follow-up information through patient medical records
- Patient letters
- Patient phone calls
- Physician/and or facility phone calls/letters
- Lost to Follow-up

Registry Staffing
Time Study (task categories)

Cancer Conference

- Organize patient cases for conferences
- Schedules meetings and speakers
- Maintains conference records to meet CoC Standards
- Promotes Cancer Conferences

Cancer Committee

- Organize agenda
- Schedule meetings
- Maintain information to comply with CoC Standards
- Assist in annual report or newsletter
- Promotes Cancer Committee

Registry Staffing
Time Study (task categories)

CoC Standards

- Coordinates facility compliance with CoC Standards (Survey preparation
- Maintains Survey Application Record, NCDB Record, Audits
- Maintains Policy and Procedure Manual

Data Reporting

- Organizes & compiles registry data for release to research depts., physicians, and other health agencies.
- Provides data for all requests, studies, out-reach, research activities, state reporting, etc.

Registry Staffing
Time Study (task categories)

- **Registry Operations**
  - Creates registry documents
  - Attends meetings
  - Updates & maintains computer applications
  - Answers telephone
  - Completes misc. registry tasks

- **Education**
  - Continued education for CTR
  - Hospital education requirements
  - Staff training – new employee

Registry Staffing

Time Study – Conclusions

Distribution of time by task category

Abstracting = 45%

Follow-up = 13%

CoC Standards = 11%

Cancer Conference = 10%

Registry Operations = 6%

Reporting = 5%

Cancer Committee = 3%

Education = 3%

Registry Staffing

Time Study - Conclusions

- Cancer Registry Coordinator/Supervisor position
- Divide duties into categories
- Categorize positions based on duties and consideration for advancement
- Cancer Registry should have own identity

<400	400-800	800->	1100 ->
1 FTE	1+ FTE	2 FTE's	+1 FTE / 300

Registry Staffing

- Recruitment
  - NCRA job bank
  - Internship
  - Local community colleges – HIM programs
  - Promote from within – other hospital employees
- Good Personality Traits
  - Independent
  - Career vs. job
  - Ownership
  - Detail oriented
  - Leader not a follower
- Training
  - Start with simple tasks
  - Focus on 1 site at a time
  - New Abstractor Q/A 100% & provide feedback

Registry Staffing

- **On-line / Self study courses**
  - AHIMA/NCRA online course
    - http://campus.ahima.org/Campus/course_info/CRM/crm_intro.html
  - SEER's Training Web Site
    - http://training.seer.cancer.gov/index.html

- **Community College Programs**
  - Burlington County College, Pemberton, NJ
  - College Ahuntsic, Quebec, Canada
  - Davidson County Comm. College, Lexington, NC
  - Lehman College, Bronx, NY
  - Minnesota State Comm. & Tech. College, Moorhead, MN
  - Ogeechee Technical College, Statesboro, GA
  - San Jacinto College North, Houston, Tx
  - Santa Barbara City College, Santa Barbara, CA (on-line course)
  - Scott Community College, Bettendorf, IA
  - SUNY Downstate, Brooklyn, NY
  - Western Suffolk BOCES, Dix Hills, NY
  - http://www.ncra-usa.org/education/formal.htm

Job Description: Cancer Conference Coordinator

The cancer committee monitors cancer conference activity through the work of the cancer conference coordinator. The cancer conference coordinator is chosen on the basis of their specialty, knowledge, skills, and interest Both physician and non-physician members of the committee may serve as the cancer conference coordinator.

The coordinator's roles and responsibilities are defined by the cancer committee. These include, but are not limited to:

I.   **Contribute to the development of the annual cancer conference goals and objectives of the cancer committee**
  A.   Format of conference
  B.   Frequency of conference
  C.   Multidisciplinary specialty attendance requirements and the number of times (percentage) they are to attend.

II.   **Monitor the cancer conference activities**
  A.   Format and frequency are appropriate for category and facility needs.
  B.   Multidisciplinary attendance requirements
            1. Need for consultative services
            2. Need for education
  C.   Prospective presentation of annual analytic accessions
            1. Types of cases seen by facility
            2. Prospective case presentation

III. **Report cancer conference activities**
  A.   Communicate regularly with cancer committee chair
  B.   Recommend corrective action if activity falls below the annual goals or requirements
  C.   Follow-up on recommendations and corrective actions
  D.   Document reports in the cancer committee minutes

Job Description: Coordinator for the Quality of Cancer Registry Data

The methods used to monitor cancer registry data are set by the cancer committee and documented in the cancer registry quality control plan. The cancer committee monitors cancer registry data and activity through the work of the coordinator, for the quality of cancer registry data. This coordinator is chosen on the basis of their specialty, knowledge, skills, and interest Both physician and non-physician members of the committee may be serve as the quality improvement coordinator.

The cancer conference coordinator's roles and responsibilities are defined by the cancer committee. These include, but are not limited to:

I.   **Contribute to the development of the annual quality control plan**
    A.   Sets the review criteria
    B.   Sets the quality control time table
    C.   Identifies the quality control methods and individuals involved
    D.   Defines the scope of evaluation
    E.   Establishes the minimal quality benchmarks

II.   **Coordinate the implementation of the cancer registry quality control plan**
    A.   Reviews required activities
        1.   Casefinding
        2.   Abstract timeliness
        3.   Accuracy of abstracted data
        4.   Follow-up information
        5.   Completion and accuracy of AJCC staging by the managing physician
        6.   College of American Pathology Protocols
        7.   NCDB data submission, correction of data errors, and re-submission of corrected data
    B.   Maintains documentation of the quality control activity
        1.   Review criteria
        2.   Cases reviewed
        3.   Identified errors and resolutions

III   **Monitors the results of the quality control activities**
    A.   Participate in registrar education to improve the quality of data
    B.   Recommend physician education or intervention, as needed

IV   **Report cancer registry quality control activities**
    A.   Communicate regularly with cancer committee chair
    B.   Recommend corrective action if activity falls below the annual goals or requirements
    C.   Follow-up on recommendations and corrective actions
    D.   Document reports in the cancer committee minutes

Confidentiality

- Policy
  - Check hospital policy & HIPAA officer
    - Check for State & Federal regulations
  - Identify areas that apply
    - Patient records
    - Tumor Board
    - Cancer Committee Minutes
    - Registry paper files
    - Registry Database
    - Phone conversations – Patient & Physician offices
    - E-mail

Confidentiality

- Policy
  - Data release criteria
  - Informed consent and authorization
  - Patient rights

  - Retention of documents
    - Cancer Abstracts
      - Retained in perpetuity
    - Cancer Program & Registry activity
      - Facility policy or 5 years, whichever is longer

Confidentiality

- Procedure
  - Should include detailed steps
  - How do you protect patient records?
    - Storage in registry
    - Transporting
  - Include security of registry office/files
  - Include security of registry database
  - Include security of access to other computer files
    - Back-up files

Confidentiality

- Procedure
  - Include "Release of Information"
    - What agencies do you release to?
      - State Health Registry
      - NCDB
      - Other hospital registries
      - Any other special studies/research?
    - Do you require approval to release data?
      - Process for request of data
      - Process for approval to provide data

Confidentiality

- Procedure
  - Request Log – required by CoC
    - What is recorded?
      - Copy of data provided
      - Data requested
      - Date request was fulfilled
      - Intent of use of data
      - Request date
      - Requester's name/organization

    - Have someone review log annually.

Title/Description: **Registry and Confidentiality Policy/HIPAA Policy**	Page 1 of 2

Departments Affected: Hospital / Provider-Wide (Health Information Management)

Topic: Registry compliance with confidentiality guidelines

Effective Date:	Reviewed/Revised: **Date:** 5/2005	Approved by: Cancer Committee	Prepared by:

CONFIDENTIALITY:

Federal laws pertaining to cancer registry are designed to protect patient privacy. The National Cancer Registry Act of 1971 mandates the collection, analysis and dissemination of data for use in prevention, diagnosis and treatment of cancer. The National Program of Cancer Registries (NPCR) Public Law 102-515, The Cancer Registries Amendment Act of 1992, grants the Centers for Disease Control and Prevention authority to implement, monitor and assist population-based cancer registries in the collection and maintenance of cancer data. The Illinois State Cancer Registry mandates that all health care facilities report newly diagnosed cancer cases. Each of these laws has the intent of protecting patient privacy while also allowing data to be used for research and surveillance purposes. See also the included Hospital's HIPAA policy for further information.

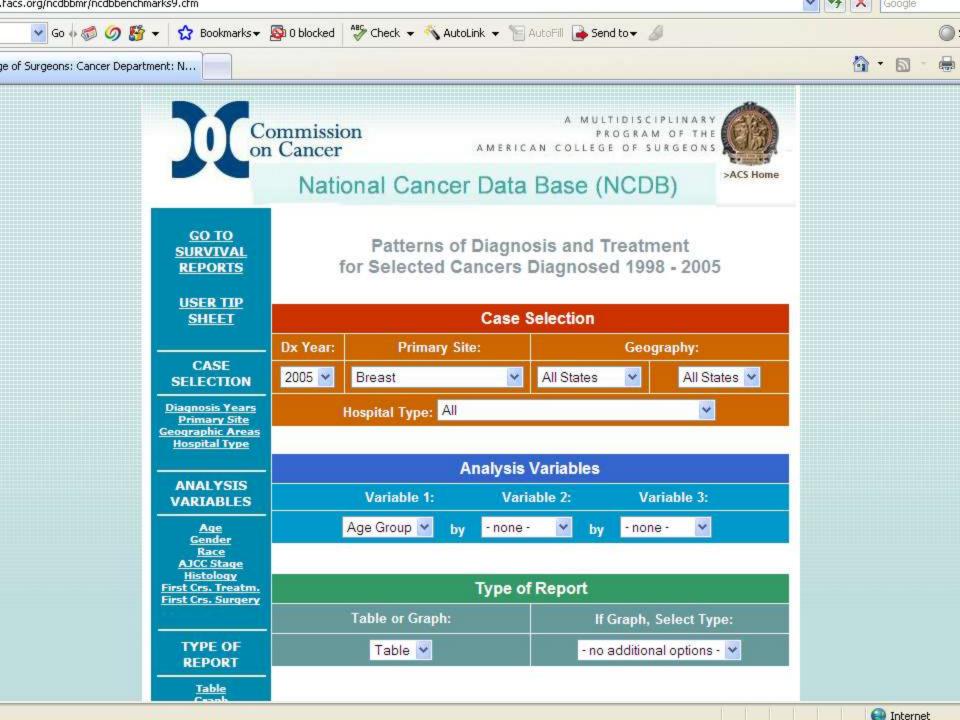| Title/Description: Registry and Confidentiality Policy/HIPAA Policy		Page 2 of 2
Departments Affected: Hospital / Provider-Wide (Health Information Management)		
Topic: Registry compliance with confidentiality guidelines		
Effective Date:	Reviewed/Revised: Date: 5/2005	Approved by: Cancer Committee	Prepared by:

XXXX Hospital is committed to maintaining the confidentially of cancer patient information. All data obtained by the Cancer Registry on malignant diseases shall be considered confidential and shall be used only for statistical, scientific and medical research and for reducing the morbidity or mortality of malignant diseases to the extent possible. This includes data collected from physician offices and other health care facilities. The cancer registry staff shall sign a confidentiality pledge statement annually indicating their commitment to patient confidentiality.

Data Analysis

NCDB – Public Use data

- Benchmark reports
  - http://web.facs.org/ncdbbmr/ncdbbenchmarks9.cfm

- Survival reports
  - http://web.facs.org/ncdbbmr/survival8.cfm

Go | Bookmarks | 0 blocked | Check | AutoLink | AutoFill | Send to

Commission on Cancer

A MULTIDISCIPLINARY
PROGRAM OF THE
AMERICAN COLLEGE OF SURGEONS

>ACS Home

National Cancer Data Base (NCDB)

GO TO SURVIVAL REPORTS

USER TIP SHEET

CASE SELECTION

Diagnosis Years
Primary Site
Geographic Areas
Hospital Type

ANALYSIS VARIABLES

Age
Gender
Race
AJCC Stage
Histology
First Crs. Treatm.
First Crs. Surgery

TYPE OF REPORT

Table
Graph

Patterns of Diagnosis and Treatment
for Selected Cancers Diagnosed 1998 - 2005

Case Selection

Dx Year:	Primary Site:	Geography:	
2005 ▾	Breast ▾	All States ▾	All States ▾
Hospital Type:	All ▾		

Analysis Variables

Variable 1:		Variable 2:		Variable 3:
Age Group ▾	by	- none - ▾	by	- none - ▾

Type of Report

Table or Graph:	If Graph, Select Type:
Table ▾	- no additional options - ▾

Internet

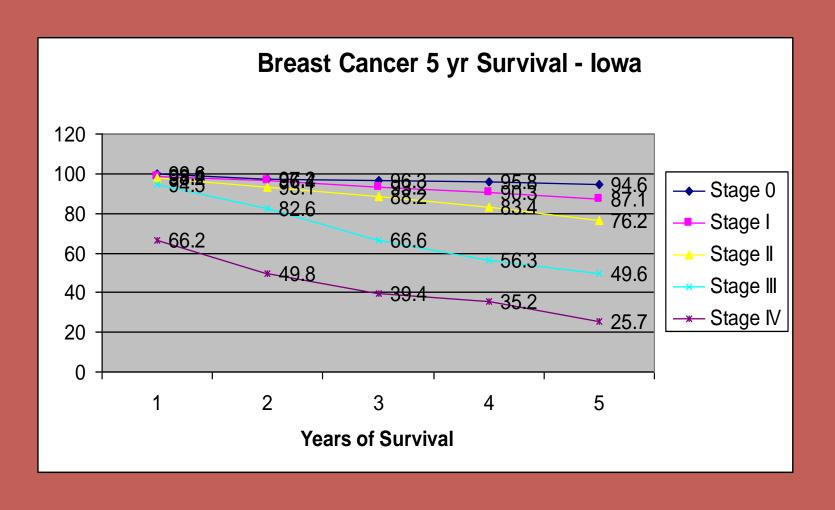| 2001 Breast cases - Iowa	SURGERY									
	None; no surgery of primary site	Partial mastectomy, NOS; less than total mastectomy, NOS	Subcutaneous mastectomy	Total (simple) mastectomy, NOS	Modified radical mastectomy	Radical mastectomy, NOS	Mastectomy, NOS	Surgery, NOS	Unknown if surgery performed	TOTAL
STAGE										
0	7	151	2	47	8	.	.	.	1	216
1	12	429	.	43	165	2	3	.	.	654
2	7	183	.	31	205	7	2	.	.	4
3	3	6	.	10	65	2	.	.	.	86
4	22	9	.	1	15	.	.	1	.	48
Unk	18	23	1	3	9	.	2	.	.	56
TOTAL	69	801	3	135	467	11	7	1	1	1495

2005 Breast Cases - Iowa	None; no surgery of primary site	Partial mastectomy, NOS; less than total mastectomy, NOS	Total (simple) mastectomy, NOS	Modified radical mastectomy	Radical mastectomy, NOS	Mastectomy, NOS	Surgery, NOS	TOTAL
Stage								
0	12	183	50	4	1	2	.	252
1	9	482	95	58	2	3	1	650
2	6	217	80	103	3	1	.	410
3	11	34	21	77	1	1	1	146
4	25	3	1	11	1	.	.	41
Unk	22	38	14	18	1	.	.	93
TOTAL	85	957	261	271	9	7	2	1592

NCDB Public Use data - Survival

Breast Cancer 5 yr Survival - Iowa

Stage 0: 99.6, 97.2, 96.3, 95.8, 94.6
Stage I: 94.5, 95.1, 88.2, 90.3, 87.1
Stage II: 93.4, 83.4, 76.2
Stage III: 82.6, 66.6, 56.3, 49.6
Stage IV: 66.2, 49.8, 39.4, 35.2, 25.7

X-axis: Years of Survival (1, 2, 3, 4, 5)
Y-axis: 0 to 120

Legend:
- Stage 0
- Stage I
- Stage II
- Stage III
- Stage IV

Data Analysis

- CP^{3}R – Stage III colon cancer, chemotherapy offered/given
  - Comparison of your facility with all other CoC Approved facilities.
- E-Quip – Electronic Quality Improvement Packet
  - Breast Cancer patients < 70 with Breast conservation surgery offered/given Radiation.
  - Stage I or Stage II/III w/node +, ER/PR- offered/given chemo
  - Stage I or Stage II/III w/node +, ER/PR + offered/given hormonal therapy
- CoC Special Studies – Standard 3.8
  - 2007 – Neoadjuvant Therapy on Staging of Breast & Rectal Cancer

Data Analysis

- Other Resources
  - SEER
    - Fast Stats
      - http://seer.cancer.gov/faststats/

    - Cancer Query Systems
      - http://seer.cancer.gov/canques/
      - SEER incidence statistics
      - US Mortality statistics
      - SEER Survival Statistics
      - Cancer Prevalence Database
      - Probability of Developing or Dying of Cancer
      - Delay-Adjusted SEER Incidence Rates

Tumor Board

- Policy
  - Cancer Conferences/Tumor Boards are integral to improving the care of cancer patients by contributing to the patient management process and outcomes, as well as providing education to physicians and ancillary staff in attendance.
  - Representatives from surgery, medical oncology, radiation oncology, diagnostic radiology and pathology are required to attend 85% of meetings.

Tumor Board

- Policy
  - 10% of annual cases will be presented
  - Cancer Committee will establish and monitor frequency, attendance and case mix annually.
  - Site-specific conferences are also offered.
    - Breast
    - Lung

Tumor Board

- Procedure
  - Who is responsible to schedule conference?
    - Room
    - Food
  - How are cases selected?
  - Who needs to be contacted with case information & when?
  - Who handles equipment, microphones, video projector, etc.?

Tumor Board

- Procedure
  - Is sign-in sheet used?
    - Who is responsible for it?
  - Are CME hours available?
    - Who handles CME issues related to conferences?
  - Are minutes/notes taken?
    - How are theses used?
    - Where are they kept?

Title/Description: **Clinical Management/Cancer Conference**	Page 1 of 2

Departments Affected: Cancer Registry (Health Information Management)

Topic: Cancer Conference Management

Effective Date:	Reviewed/Revised: **Date:** 5/2005	Approved by: Cancer Committee	Prepared by:

GOAL:

1.Multi-modality and interdisciplinary cancer case reviews are conducted on a regular basis to ensure patients' access to consultative services by all disciplines.

2.Interdisciplinary cancer conferences provide prospective patient case review and assures quality of care evaluation related to diagnosis, treatment, follow-up, rehabilitation, and supportive care. Prospective is defined as prior to treatment or at any time a clinical treatment plan is reviewed for further evaluation.

3.The cancer conferences contribute to the education of all health care providers.

4.Cancer Conferences are held on a weekly basis in accordance with the requirements of the American College of Surgeons for Approved Cancer Programs for a Teaching Hospital Cancer Program.

5.Category I credits are given for the conference. The CME credit sheets are printed out by the medical education staff and distributed at the meetings.

Departments Affected: Cancer Registry (Health Information Management)			
Topic: Cancer Conference Management			
Effective Date:	**Reviewed/Revised**: **Date:** 5/2005	**Approved by**: Cancer Committee	**Prepared by**:

CANCER REGISTRY'S ROLE:

Distribute cancer conference notices in various posting locations on campus. Seven days before the conference, the registrar makes calls to the office of the physician scheduled to present, to obtain the information about the case they are to present. The registrar will ask the Cancer Program Director to select and present cases for discussion as a last resort and only if none are submitted by scheduled physicians.

Coordinate cancer conference schedules/notices with patient information to Pathology, Radiology, Surgery, Internal Medicine (including patient's primary care physician, Radiation Oncology and Medical Oncology.

Maintain attendance records including names and specialties of the attendees, whether the case is prospective or retrospective.

References:

American College of Surgeons, *Commission on Cancer, Cancer Program Standards, 2004*

"Cancer Registry Management Principles and Practice", second edition, NCRA, 2004.

Date Initiated: _____ **Date Revised:** _____

Date Reviewed: _____

References

- Commission on Cancer, Cancer Program Standards, 2004, Revised Edition.
- FORDS, Facility Oncology Registry Data Standards, Revised for 2007
  - FORDS; Temporary Replacement pages 20-21, Revised 01/08 (12/03/07 PDF downloads)
- Journal of Registry Management, Fall 2007, "Staffing a Cancer Registry in a CoC Approvals Program", Mary Marshall, CTR & Nora McMurrey, BA

References

- National Cancer Database (NCDB)
  http://www.facs.org/cancer/ncdb/publicaccess.html
- National Cancer Registrar's Association (NCRA), Education/Formal Programs
  http://www.ncra-usa.org/education/formal.htm
- Commission on Cancer Best Practices:
  http://www.facs.org/cancer/coc/bestpractices.html
- National Cancer Institute, Surveillance Epidemiology and End Results (SEER), Finding Statistics
  http://seer.cancer.gov/faststats/

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