INCREASING NON-HOSPITAL REPORTING: THE NH EXPERIENCE

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BACKGROUND

Diagnosis and management of cancer is occurring more frequently in outpatient settings.

Inconsistent reporting by non-hospital (outpatient) entities prompted NHSCR to focus on capturing underreported cases.

CDC-NPCR requires states to increase physician reporting by 10% each year for physician specialties, as well as reporting from Surgery Centers, Nursing Homes and Hospice facilities.

PURPOSE

Increase overall cancer reporting in New Hampshire by non-hospital sources and meet NPCR's standard of 10% increase or more per year.

METHODS

Physicians

A letter detailing the importance of reporting cancer cases to the NH State Cancer Registry was sent to specialty practices in New Hampshire.

Practice contact information, reporting methods, pathology labs used, hospital affiliations and EHR utilization were collected. (Table 1)

Through discussions with each practice, we identified their preferred mode of reporting.

Subsequently, we ensured cancer reporting was implemented by tracking physician reporting.

On-site audits were performed, beginning with the largest practices serving the state.

Newsletters continue to be sent to maintain contact and visibility with practices and reporting entities.

New Hampshire State Cancer Registry

Physician Reporting Update **November/December 2014**

New Hampshire State Cancer Registry is continuing with efforts to optimize and increase reporting of new cancer cases, in accordance with NH law. As you are aware this information is crucial to accurately report cancer trends via the Centers for Disease Control and Prevention (CDC).

Earlier this year, we sent letters to and corresponded with Dermatology, Urology, Gastroenterology, Radiation Oncology specialty practices in NH, as well as some of the larger Reference Laboratories. [We will continue our efforts this quarter and throughout the coming year, with a focus on additional reporting entities including; Ambulatory Surgery Centers, Nursing Homes, and Hospice Centers.

There are several mechanisms for reporting to the NHSCR. Some offices have an arrangement with their hospital cancer registry to report on their behalf. In some instances, a Reference Laboratory handles the reporting. The recommended approach is to report cancer cases through a secure electronic method. If you wish to submit cases electronically, we will provide your practice access (login and password) to the WebPlus® website. Please contact us to learn more about this secure option. An alternative method is to fax (603-653-6699) our *Cancer Report Form* with an attached **Pathology Report.** Please visit our website for the most current *Cancer Report Form* (http://geiselmed.dartmouth.edu/nhscr/).

The newly deployed *WISDOM* (http://wisdom.dhhs.nh.gov/wisdom/) tool allows for statistical review of cancer data for NH. It also enables the user to customize cancer reports. Please feel free to contact Cathy Ayres with any questions or concerns at 603-653-6624 or send an email to catherine.m.ayres@dartmouth.edu

Happy Holidays!

NHSCR
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Hospice Facilities

Presented at a meeting of NH Hospice Administrators to ask for assistance in reporting cancer cases to the NHSCR.

One of the attendees agreed to send their facility's data to NHSCR.

It consisted of admissions in 2014 with a cancer diagnosis.

We compared their patient list against our registry to identify missing cancers.

RESULTS: PHYSICIAN REPORTING

Some physicians retrospectively submitted cases starting with year 2013.

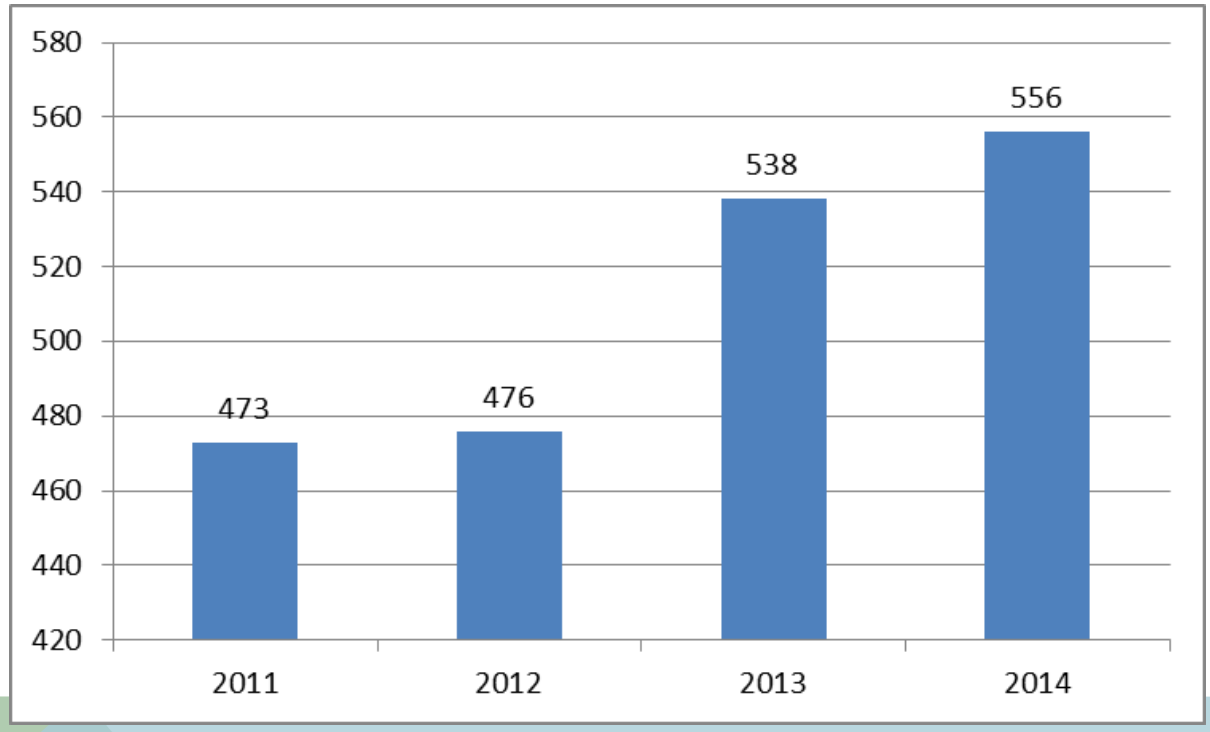
Cancer reporting directly from physician offices increased (see Figure 1)

- 13% from year 2012 (n=476) to year 2013 (n=538)
- 3.3% the next year (n=556)*
- Average 8.2% from year 2012 to year 2014 thus far

Reports from other facilities are expected, and we anticipate a growing trend in non hospital reporting in future years.

**Since diagnosis year 2014 is not complete yet, we anticipate those figures to increase.*

FIGURE 1. NUMBER OF PHYSICIAN CASES REPORTED DIRECTLY FROM PHYSICIAN OFFICE*



**Does not include physician-only cases reported by hospital registries or those identified by pathology review.*

TABLE 1. NUMBER OF TARGETED PHYSICIANS BY SPECIALTY.*

Physician Specialty	No.	%
Gastroenterology	82	25.0
Urology	71	21.6
Dermatology	63	19.2
Radiation Oncology	22	6.7
Hematology	16	4.9
Hematology/Oncology	30	9.1
Medical Oncology	32	9.8
Gynecology/Oncology	5	1.5
Radiation Therapy	1	0.3
Surgical Oncology	1	0.3
Total	328	100.0

**Physician licensing information from NH Board of Medical Examiners as of 12/31/2014 (https://www.nh.gov/medicine/)*

TABLE 2. PHYSICIAN REPORTING AFTER IMPLEMENTATION OF PHYSICIAN OUTREACH.

	Dermatology		Urology		Gastroenterology	
	No.	%	No.	%	No.	%
Previously reporting	51	81.0	51	67.1	78	95.1
New reporting*	10	15.9	0	0.0	1	1.2
No longer practicing	2	3.2	5	6.6	3	3.7
Not reporting as of 2014**	0	0.0	20	26.3	0	0.0
Total	63	100.0	76	100.0	82	100.0

**Does not include new physician-only cases reported by hospital registries or those identified by pathology review.*

***The 20 urologists are from two large urology practices. Contact has been made and we are awaiting reports.*

Began with Dermatology in 2014.

Currently pursuing Urology reporting. Changes in their administrative personnel/reference labs have affected reporting.

Gastroenterology reported primarily by hospitals or ambulatory surgical centers.

We found many physicians in the targeted specialties already have a reporting mechanism in place.

RESULTS: HOSPICE REPORTING TRIAL

We received a comprehensive list of eighty-three (83) patients from one hospice as a pilot test.

The majority of the facility admission dates were in late 2014.

Diagnoses included malignancies of the breast, pancreas, lung, liver, GI tract, brain, prostate, ovary, as well as several leukemias and lymphomas.

The age range of the "unreported" patients was between 55 to 95 years old. Of these, 3 were residents of ME.

73 cases were reported by other sources with 10 cases that were new to NHSCR. 2 patients were subsequently reported later in 2015. 8 new cases remain as reportable cancer cases. These may not have been reported to NHSCR had it not been for the Hospice Reporting Trial.

We will continue to work with Hospices through meetings and correspondence to encourage ongoing reporting to NHSCR.

FUTURE STEPS

Ongoing identification of new physicians via NH Board of Medical Examiners and possibly Hospital Medical Staff Services Departments.

Encourage other specialties to report.

Target ambulatory surgery centers.

Continue efforts with hospice reporting.

Implement reporting by nursing homes.

DISCUSSION

Overall, results have been positive; we have experienced infrequent pushback and noncompliance.

Everyone has been cooperative and willing to comply with cancer reporting, although detailed documentation of the legal requirements was occasionally needed to encourage reporting.

Perseverance, communication and education have been helpful in these cases.

We have continued with outreach including the dissemination of quarterly newsletters, educational talks to physician practice group meetings, and site visits for audit and educational purposes.

Note that the 2014 cases are not technically reportable until 6 months (180 days) after diagnosis, so these findings are preliminary. It is possible that “missed” cases will in fact be reported to us later through conventional channels but it should be noted that NH law requires a rapid report within 45 days of diagnosis.

ACKNOWLEDGMENTS

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