NHSCR
Registry Report

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Change to NHSCR Education Meetings

Historically, NHSCR sponsored two meetings each year, one in the spring and another in the fall. In line with current fiscal restrictions, beginning in 2009 we will be holding only one annual meeting. NHSCR continues to be committed to providing the educational resources needed for obtaining quality data from our registrars. We hope that with other educational opportunities available (CRANE, NCRA, NAACCR webinars), NH registrars will not be affected by the difficult choice we have made. We welcome additional suggestions. This year NHSCR's annual meeting is tentatively scheduled for Friday, September 25, 2009. More information will be available nearer to that date.

NAACCR Webinar Schedule

Special thanks to those hospitals who have kindly volunteered to host the NAACCR webinars. Without your help presenting these webinars would not be feasible. Please consider hosting at least one of the remaining webinars of the 2008-2009 Webinar Series:

- **Cancer Staging In-depth 3/5/2009** 3-hour in-depth look at the coding rules and theory for AJCC staging, pediatric staging and collaborative staging.
- **Collecting Cancer Data: Central Nervous System 4/2/2009** This 3-hour seminar covers benign, borderline, and malignant tumors of the central nervous system: anatomical review for abstracting and coding the cases; determining number of primary tumors; coding topography and histology; coding collaborative staging data items; coding treatment.
- **Collecting Cancer Data: Prostate 6/11/2009** 3-hour class on malignancies of the prostate: anatomical review for abstracting and coding the cases; determining number of primary tumors; coding topography and histology; coding collaborative staging data items; treatment coding.
- **Advanced Coding & Abstracting 7/9/2009** A 2007 Journal of Registry Management article, other QA studies, questions to the ACoS /CoC Inquiry and Response System (I & R) and to the SEER Inquiry System (SINQ): all have highlighted misinterpretation of rules and coding discrepancies for data items including race, address, physician, date of first contact, and date of diagnosis as well as text fields. This 3-hour class identifies and clarifies coding rules for many problematic data items.
- **Collecting Cancer Data: Breast 8/6/2009** 3-hour presentation on malignancies of the breast: anatomical review for abstracting and coding; determining number of primary tumors; coding topography and histology; coding collaborative staging data items; and coding treatment.

NHSCR Website Goes Live!

We have launched the new and improved NHSCR website which we hope will prove to be more informative and user-friendly. We invite you to visit us online at:
http://dms.dartmouth.edu/nhscr/

We welcome your suggestions about continued improvements.

A Very Big THANK YOU!

NHSCR staff would like to thank all of you for helping us meet our NAACCR, NPCR, and DHHS call-for-data deadlines. Registrars know the hours involved in preparing for a call-for-data, a site visit, or any of the other reporting functions which are part of cancer surveillance. Your willingness to accommodate our timelines and requests is very much acknowledged and appreciated.

Update: 2006 Medical Record Disease Index (MRDI) Audit

Thank you for your time & effort in completing the NHSCR 2006 Disease Index audit. The excellent results again show an average of only 4 missed cases per responding facility, most of which involved changes effective since 10/01/06. A few comments:

Because complete data are crucial for our progress reports and call-for-data submissions to NPCR, NAACCR, and DHHS, our periodic pathology reviews and MRDI audits are major resources for insuring complete cancer surveillance in the state. Actually, all hospital registrars should conduct an internal MRDI audit ***at least*** annually. This is easier if performed quarterly or even monthly, allowing timely discovery of missed cases and coding errors; maintaining an exclusion list also can be a tremendous timesaver in eliminating previously reviewed cases. While we hope eventually to perform pathology and disease indices audits electronically, for now we must manually match MRDI lists against the Registry database.

The 2006 Disease Index audit again focused on those sites which might be missed because of the absence of a surgical specimen: lung, hematopoietics and CNS. Interestingly, while the registrars have achieved a high level of reporting completeness, there seems to be confusion about hematopoietic diagnoses among coders. One example is secondary polycythemia, too often miscoded to *P. vera*. We've also noticed many **metastatic** lung or CNS cancers incorrectly coded as **primary** tumors. The Registry DI audit is a valuable QA exercise in general, and you may want to share your findings with your hospital's HIM director and/or financial officer. As always, we are grateful for your continued support.

The NH State Cancer Registry is a collaborative effort, so do contact us if you have any comments, questions, or suggestions.

Recoding and Reabstracting Audits

In addition to case finding audits, we also perform data quality activities. We will resume recoding and reabstracting audits for diagnosis years 2005-2008.

- With *recoding* audits, NHSCR staff reviews the first 100 analytic cases reported by a hospital for each diagnosis year under review. Coded variables are reviewed against text provided on transmitted abstracts.
- *Reabstracting* audits involve reviewing 20 cases per registrar, two from five (5) major sites (breast, prostate, lung, colon, and hematopoietic) and 10 from other sites. Coded variables are checked against the original source of data—the hospital medical record.

We will provide feedback on audit findings. These QA activities are primarily a learning tool for registrars to improve abstracting skills. At our end, we familiarize ourselves with your registry and hospital systems and come to understand your unique situations. It also helps us identify areas where training is needed. Thank you in advance for your cooperation as we request charts to be pulled for these audits.

New Urology Audit

An area of increasing concern for cancer surveillance involves patients who receive all of their care in an out-patient setting. Such instances, when neither submitted by hospital registries nor reviewed at local pathology labs, contribute to under-reporting of cancer in the state. This is especially true of melanoma and of some urological primaries.

We have recently contacted all urologists licensed by the State of New Hampshire to ascertain how their pathology is handled. We have already heard from several urologists who report that their specimens are processed at NH hospital path labs and the cases submitted to us by the hospital cancer registrar. We have notified those registrars and expect there will be others. We will visit practices whose pathology is processed and read at an independent lab and audit for unreported cases. These physicians will need to report cases directly to us. We will keep you informed as this project progresses.

PLEASE REMEMBER: BY NH STATUTE ALL NEW CANCERS, INCLUDING CLASS OF CASE 7 (PATH REPORT ONLY), MUST BE REPORTED.

Hints, Tips, and General Points....

During our regular data processing and editing, we find common errors on cancer cases. Here are a few:

- **Sequencing:** If a patient has multiple primaries, please text out the other primary. If you are working on the 1st primary knowing you also have to complete an abstract for a 2nd primary, please let us know what that 2nd primary is. And vice-versa.
- **Sequence 60s:** Benign meningiomas, as well as malignant ones, must have site coded to the meninges. Sequence 60 is only used for benign brain. It is not used for any other site reported to NHSCR.
- **Collaborative Stage:** CS should be used for cases diagnosed 1/01/04 forward. While AJCC staging by a physician is recommended for these cases, it is not required by the NHSCR; registrar staging is acceptable.
- **GenEdits:** For a Prostate primary: (pg 434 in CS) Note 4: According to AJCC, staging basis for transurethral resection of prostate (TURP) is clinical and is recorded as CS TS/Ext-Eval "1". Also, if a surgery has been done, again same page (pg 434 in CS) under CS TS/Ext-Eval, you no longer use a "3" to state a surgery was done. The "3" says: No surgical resection done, but evidence derived from autopsy, etc... On the following pg 435, use a 4, 5, or 6 to describe the surgery.
- **For Head and Neck primaries:** (CS pg 285-288) for the coding of site-specific factors (SSF): If there is no lymph node involvement, SSF 1, 3-6 are all 000, and SSF 2 is 888.

First Name and Gender Checks

Our contract with DHHS specifies that we perform a match between first name and gender on each case we receive, as a data edit for the SEX variable. While in the past most first names were generally reliable gender markers, lately we have noted an increase in names which are ambiguous or gender neutral. We are also seeing more names from other countries which may be unfamiliar to us. When you add this to the increase in androgynous names and invented names, matching first names and gender on each new case is becoming more of a challenge.

For the last 5 years we have used a table of names to check name and gender, but this table has become outdated. As an exercise, we created a program to review the gender assigned to each first name and assigned a gender based on frequency of the first name. (Side note: we found over 5,000 different first names in our database!) Cases diagnosed in years 1995-2008 were put through the algorithm, and those where first name was not assigned to the dominant gender were flagged for review. For example, we found 50 cases with the first name "Bruce" which were coded as male and 2 cases with that first name coded as female. The first name "Bruce" was determined to be male. The 2 cases coded as female, along with any cases for which a first name could not be assigned to a dominant gender, were put into a separate file for review.

Out of the 88,000 cases checked, we found 569 questionable cases to review. The first names that appeared most often on our list to check were: JEAN (9.5%), LESLIE (8.39%), TERRY (4.03%), DANA (2.52%), LEE (2.35%), DALE (2.35%).

We have resolved as many as possible with the information we have available. (Of these 569 cases, 86 were gender-specific sites such ovary or testis, for all of which the sex codes matched the appropriate gender even though the first name might not.) We will be sending you a list of your cases showing 1) those we were able to match; 2) those for which we changed the sex in our database (and which you will want to correct in yours); and 3) those for which we were unable to justify the assigned sex, which we will ask you to research and return. We are requesting that when you abstract a case with an ambiguous first name (or an ambiguous sex), please make a note to that effect in the comment section. It would be very helpful to us, and it would reduce the amount of follow-back requests to your hospital.

Non-registry Hospital Corner

With 2007 cases complete, Pat will be calling to schedule visits for abstracting the 2008-2009 cases. We have seen an appreciable change in the reporting of rapids since the introduction of the WebPlus system, and we thank all the non-registry sites for their increased and timely reporting.

Here are a few suggestions that would assist when submitting rapids:

- Before entering a new case, check to see if that case has already been sent to NHSCR. For example: the patient had a positive needle biopsy of the right breast and you send in a rapid. The patient returns to your facility a week or a month later for a lumpectomy of the same site with the same cancer. **You do not have to send in another rapid**. NHSCR staff will pick up all subsequent information for that patient when they abstract the case.
- Squamous cell carcinoma and basal cell carcinoma of the skin are **NOT** reportable. Only melanomas of the skin need to be reported.
- Please include any information on the patient's race or ethnicity (Spanish/Hispanic origin) when submitting the rapid report.
- Be sure to enter a code in the Diagnostic Confirmation box. Diagnostic confirmation codes are: 1=positive histology, 2=cytology, 4=positive microscopic confirmation, 5=positive lab test, 6=visual without microscopic confirmation, 7=radiography and other imaging techniques, 8=clinical and 9=unknown.

As the NHSCR staff travel around the state, we've noted changes at the various hospitals: some undergoing new construction or additions to their facilities, many now supporting an electronic record. Most hospitals using the electronic record have given NHSCR staff access to it, streamlining the abstracting process and saving time for everyone. We are most appreciative of that sharing and of the gracious assistance we always receive when visiting your departments.

NH Cancer Reporting: Completeness Reports

We hope that you are finding the quarterly completeness reports useful. These reports are based on NH Rules requiring cancer cases to be reported within six months from the date of diagnosis. NHSCR expected to be 50% complete for diagnosis year 2008 as of 12/31/08. Overall, the average completion rate was 29%. We urge reporters to try to meet the 75% completion rate expected for 3/31/09, the end of the 1st quarter of 2009, when we'll again assess completeness of reporting. Reminder: If your facility fails to meet these timelines 2 times in a row, and a plan of action is not agreed upon, we are required to notify DHHS and your hospital supervisor/administrator.

Reporting schedule for the quarters of 2009:

1st Quarter (Jan-Mar)	75% of 2008 cases
2nd Quarter (Apr-June)	100% of 2009 cases
3rd Quarter (July-Sept)	25% of 2009 cases
4th Quarter (Oct-Nov)	50% of 2009 cases

The New NAACCR Record: For Registry Hospitals

We were, to say the least, astounded at the announcement that the new NAACCR 12 record will be increased in length from 6,694 bytes to 22,794 bytes! This 340% increase in the base record size, necessary to accommodate new data items, changes to existing data items, and expansion of text fields, was completely unanticipated in the context of our long range IT planning. While your registry *database* may increase only 10 to 15% in size at first, much greater *storage space* will be needed for your backup extracts of rapid and definitive submissions.

The change will be effective 01/01/10. Your IT staff will need to know as soon as possible that this change is coming. As always, Bruce Riddle (603-653-1036, *bruce.l.riddle@dartmouth.edu*) is available to you and your IT people for more information and guidance.

NNECOS Study

NHSCR is collaborating in a tri-state project assessing access to cancer care in rural New England. Conducted by the Northern New England Clinical Oncology Society (NNECOS), the purpose of this project is to look at availability and utilization of appropriate multimodality care, such as radiation, chemotherapy and clinical trials, at community hospitals vs. tertiary hospitals in rural NH, Maine, and Vermont. The study involves breast and colon cases diagnosed in 2003 and 2004. NHSCR staff reviewed all eligible cases for accuracy and completeness, with cases having missing or conflicting information returned to the reporting hospitals for review. If you have received follow-back forms, please return them ASAP. Thank you to those who have already replied.

NHSCR Advisory Panel

Last year, we restructured the NHSCR Advisory Panel in an effort to make its membership more relevant. Shirley Foret CTR, Catholic Medical Center, Manchester and Barbara Snyder CTR, Portsmouth Regional Hospital now represent registry hospitals and Marilyn Thorson BS, CCS, Alice Peck Day, Lebanon, represents non-registry hospitals. The Advisory panel will meet for the first time during the NH Comprehensive Cancer Collaboration's 4th Annual Meeting in Concord on 4/06/09. Please contact one of the hospital reps if you would like something addressed on your behalf.

Educational Meetings

Spring is national meeting time for central and state registries. In April, Bruce and our state cancer epidemiologist, Dr. Sai Cherala, will attend the CDC National Program of Cancer Registries Directors' Meeting in Atlanta. At the end of May, Pat will travel to New Orleans for the annual NCRA meeting. And in June, Maria and Bruce will represent NH at the NAACCR Meeting in San Diego. Anyone going to NCRA, please let us know and we will try to connect for lunch or dinner.

Important Dates—Mark Your Calendar!

- Basic Training-Principles & Practice of Cancer Registration, Surveillance and Control
  March 2-6, 2009— Atlanta, GA
  July 20-24, 2009—Atlanta, GA
  http://www.sph.emory.edu/GCCS/training/

- 2009 CTR Exam
  Testing window: March 7-21, 2009
  Application Due: February 15, 2009
  http://www.ctrexam.org/

- NH Comprehensive Cancer Collaboration Annual Meeting
  April 6, 2009— Concord, NH
  http://www.nhcancerplan.org/index-nhccc.php?nhccc

- National Cancer Registrars Week — April 6-10, 2009

- Principles of Oncology for Cancer Registry Professionals
  April 20-24, 2009—Reno, NV
  http://www.afritz.org/pocr.htm

- Intermediate Training - Cancer Case Abstracting, Staging and Coding
  May 11-15, 2009—Atlanta, GA
  http://www.sph.emory.edu/GCCS/training/

- NPCR Program Director's Meeting
  May 12-16, 2009—Atlanta, Georgia

- Memorial Day Holiday— May 25, 2009

- NCRA Annual Educational Conference
  May 31-June 3, 2009— New Orleans, LA
  http://www.ncra-usa.org

- International Association of Cancer Registries Annual Meeting
  June 3-5, 2009—New Orleans, LA
  http://www.iacr.com.fr/

- NAACCR 2009 Annual Conference
  June 13-19, 2009— San Diego, CA
  http://www.naaccr.org/

- 2009 CTR Exam
  Testing Window: September 12-26, 2009
  Application Due: July 31, 2009
  http://www.ctrexam.org/

- CTR Exam Preparation Workshop
  August 13-15, 2009—Reno, NV
  http://www.afritz.org/CTRws.htm

- NHSCR Educational Meeting—September 25, 2009

- CRANE Annual Meeting
  November 2-3, 2009—Bedford, MA
  http://craneonline.org/

- Principles of Oncology for Cancer Registry Professionals
  November 16-20, 2009—Reno, NV
  http://www.afritz.org/pocr.htm

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NHSCR on the Web

Please visit at: **http://dms.dartmouth.edu/nhscr/**
We continuously aim to improve the NHSCR website. Suggestions are welcome!

The state website for New Hampshire cancer data is:
http://www.dhhs.nh.gov/DHHS/HSDM/cancer-data.htm

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WE NEED RAPIDS AND DEFINITIVES EACH AND EVERY MONTH!

Data transmissions should be made at least once a month. The simplest way to transmit is via the website. There's no zipping and it's secure. If you need help, please contact Bruce Riddle at 603-653-1036. He's always happy to help with sending your cases in!

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