NHSCR

Registry Report

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Welcome!

NHSCR is pleased to welcome two new employees to our team. Lisa Oakes and Pamela Whitney joined our staff in May and are currently training in all aspects of cancer registry operations. Please join us in welcoming them on board!

Completeness Reports

While the deadline for submission of all 2010 cases was June 30, 2011, NHSCR has deferred the completeness reports for the 2nd quarter of 2011 due to software conversions at both the hospital and central registry level. The next reports will go out in October to track reporting through September 2011, the end of the 3rd quarter for this year. Note that cases diagnosed through March 2011 are due at that time. NHSCR will also send a separate completeness report for year 2010 to close out that year.

Death Clearance Follow-back

It's that time of year, and again we must do the inevitable. We have identified all New Hampshire cancer deaths in 2009 that have not been reported by any source. We are first following-back to physicians the unmatched cancer deaths that did not occur at a hospital. We will then send out the hospital follow-back forms in mid-September. NHSCR cannot have more than 3% total caseload be DCO (death clearance only). Please help us identify those reportable cases that may have been missed. If a patient died at your facility with evidence of cancer or was undergoing cancer treatment at time of death, it is a reportable cancer even if the patient was not originally diagnosed or treated at your hospital.

NAACCR Webinar Series

There is one more webinar remaining in the current 2009-2010 NAACCR series:

09/01/11 Coding Pitfalls @ Wentworth-Douglas Hospital, Dover, NH

NHSCR is happy to announce that we have again purchased a subscription for the upcoming NAACCR 2011-2012 Webinar Series:

10/6/11 Collecting Cancer Data: Larynx including Mucosal Melanoma of Larynx
11/3/11 Collecting Cancer Data: Ovary
12/1/11 Collecting Cancer Data: Thyroid and Adrenal Gland
1/5/12 Collecting Cancer Data: Pancreas
2/2/12 Collecting Cancer Data: Hematopoietic
3/1/12 Abstracting and Coding Boot Camp: Cancer Case Scenarios
4/5/12 Collecting Cancer Data: Lower Digestive System
5/3/12 Collecting Cancer Data: Lung
6/7/12 Using and Interpreting Data Quality Indicators
7/12/12 ICD-10-CM and Cancer Surveillance
8/2/12 Collecting Cancer Data: Melanoma of Skin
9/6/12 Coding Pitfalls

If you would like to sponsor or attend one of these webinars, please contact NHSCR. All are welcome to attend. A special thanks to those hospitals who have kindly volunteered to host these sessions. Without your help, we would not be able to make these available to all registrars. Please consider hosting at least one webinar during the upcoming 2011-2012 series.

NPCR Audit Results for 2007 Data

Every year, NPCR audits central registries all around the country for data quality. As a result of discussions with our central registry colleagues, we are aware of issues with coding of treatment and tumor grade and applying the Multiple Primary/Histology rules. Here are a few take home tips:

Treatment Codes 00 (none) vs. 99 (unknown)

- Code 00 indicates that 1) there is no information in the medical record regarding that treatment and it is known that this treatment is not performed for this type and/or stage of disease, or 2) there is no reason to suspect the patient would have received treatment (e.g. patient receives multiple options and doesn't choose this one).
- Code 99 should reflect when there is no documentation as to whether treatment was recommended or performed. In other words, treatment would have been expected to have been administered.
- If it is known that treatment (i.e. chemotherapy) is usually administered for this type and stage of cancer but it was not administered to the patient, record the reason it was not given (codes 82-88). **These codes take precedence over codes 00 and 99**.

Surgery of Primary Site Record the most invasive procedure. Codes 00-79 are hierarchical and the last listed code takes precedence over the codes listed above. Example: skin cancer excisional biopsy = code 27. If laser ablation is done in combination with excisional biopsy = code 24. Code 24 is listed after code 27 and therefore takes precedence even though it is numerically lower than code 27.

Tumor Grade Grade is recorded for the primary tumor only, not the metastatic site. Do not use the WHO grade. Refer to ICD-O-3 for instructions on pages 30-31 and 67. Note that there are specific rules for two-grade and three-grade systems, and also site-specific rules for the breast (c50.0-c50.9), kidney (c64.9), and prostate (c61.9).

- Two-tier and three-tier grade: 1/3=2, 2/3=3, 3/3=4, 2/4=2
- Terminology: Low grade=2, high grade=4 *except* for non-invasive bladder tumors. Assign code 9 because the WHO grades are applied to urothelial tumor ranging from dysplasia to non-invasive urothelial carcinoma.
- Priority order for breast is Bloom Richardson Score, Bloom Richardson Grade, Nuclear Grade, Terminology, and then Histology Grade.
- Priority order for kidney: Fuhrman grade, nuclear grade, terminology, and then histology
- Metastatic site=9

Multiple Primary/Histology Rules

- Rule H1 and H4 are the first rules in each section. They specify how to code when there is no path/cytology or those reports are not available. These rules provide specifics on the priority of documents to use. They also allow the coding of specific information that a physician may be referring to.
- Colon: Rule H4 states to use specific histology codes when the adenocarcinoma is in a polyp. The final diagnosis in the pathology report must indicate that the tumor originates in a polyp. The final diagnosis may be adenocarcinoma with information regarding the residual polyp recorded in other sections of the report. There may also be a reference to a residual or pre-existing polyp. The final diagnosis may indicate that the adenocarcinoma originated in a polyp. Or perhaps you have information that the patient underwent a polypectomy. Please take into consideration all this type of information to apply rule H4.
- Colon: Rule H5 directs the registrar to use specific codes for mucinous/colloid or signet ring cell carcinoma when the final diagnosis is just mucinous/colloid adenocarcinoma or signet ring cell carcinoma or when it is an adenocarcinoma and the microscopic description documents that 50% or more of the tumor is mucinous/colloid or signet ring cell carcinoma.
- Colon: Rule H6 provides guidance regarding code a tumor to adenocarcinoma, NOS (8140) when less than 50% of the tumor is of a specific type or the percentage of mucinous/colloid or signet ring cell is unknown.

NPCR Audit Results for 2007 Data, cont.

- Breast: Rule H6 is not being applied. This rule relates to in-situ tumors and provides rules for applying the combination code 8523. It is important to refer to Table 3. If the histology is a combination of intraductal carcinoma and two or more specific intraductal carcinomas (listed on Table 1) OR two or more specific intraductal carcinomas, use combination code 8523.
- Breast: Rule H12 allows a more specific code than an NOS code, and in this instance, for breast primaries – described as Duct carcinoma, with a specific subtype. For cases diagnosed as duct carcinoma, predominately cribriform & solid growth pattern – using rule H12 – would only yield the code 8201 – cribriform carcinoma. This is a major shift from what we often coded before the MP/H rules.
- Kidney: Rule H5 has the same rules regarding coding a specific type when the diagnosis is an NOS condition and a more specific histology. Rule H5 refers the abstractor to Table 1 to identify specific renal cell types.
- Kidney: Rule H7 is the last rule in each section of the MPH rules for "single tumors". It is used if rules regarding combination codes don't fit the case, code the histology with the numerically higher ICD-O-3 code.
- Other Sites (Thyroid): Rules H14 and H15 are specific to the thyroid. H14 directs us to code papillary carcinoma to 8260 (papillary adenocarcinoma) rather than to 8050 (papillary carcinoma). And, for a case of follicular and papillary carcinoma, since it's of the thyroid, rule H15 says to code it as papillary carcinoma, follicular variant 8340.
- Other Sites (Endometrial): Rule H11 is used to code histology when only one histologic type is identified. We often see the histology Endometrial Adenocarcinoma coded to 8380, which is for ENDOMETRIOD adenocarcinoma. However, in this case, endometrial refers to the site in which the adenocarcinoma arose and if we apply rule H11, should be coded to 8140, adenocarcinoma, NOS.

Recoding & Reabstracting Audits

NHSCR has completed the QC or visual editing of year 2009 data and will have year 2010 done by the end of August. For facilities not achieving the 98% accuracy rate, we will continue to visually edit 100% of cases for the year under review. Individual hospital reports will be sent via WebPlus so that registrars may reconcile the cases that were found to have coding errors. We plan to visit each hospital this fall and chat with you about the results of our 2009 and 2010 audits. As year 2011 cases are received, we will immediately review the data quality, paying special attention to the new CER data items. The upcoming site visits will provide an opportunity for NHSCR staff to perform reabstracting audits and discuss areas for improvement with year 2011 cases and to receive input from the registrars. We look forward to seeing you all.

Rapid Reporting

The Metriq screen for entering rapids does not include Dx Date. Once you enter the info and save the rapid report, you must go back into the case and fill in the date of diagnosis. Metriq will include the fix for this in its next update.

Casefinding Audits

We recently sent lists of any missing cases found during the 2010 pathology review along with guidelines for completing the 2010 disease indices audits to all New Hampshire facilities via WebPlus, with an email alert sent the same day. Please be sure to check your WebPlus account if you have not already done so. Many registries have been performing periodic, in-house pathology and disease index audits, which have reduced missed case numbers substantially.

We urge everyone to use WebPlus for this and similar functions. It is completely secure and more flexible than cumbersome paper transactions. For instance, the pathology missing case list we sent you is an Excel spreadsheet. You can sort this for your convenience; make your notations directly on the sheet, and zip it right back via WebPlus.

We had set the completion target for 09/01/11. If, because of staff reductions, this date may not be realistic, please let us know. For any questions or concerns about the audits contact Christina at christina.e.robinson@dartmouth.edu or 603-653-6623.

CER Update

As hospitals begin abstracting year 2011 cases, here are a few updates on the Comparative Effectiveness Research project:

- NHSCR is continuously updating the NHSCR Data Collection Manual with revisions as they become available. The manual includes important information about NHSCR reporting requirements, definitions, and instructions for coding. It also includes the CER Data Dictionary, list of town and county codes, NH Rules and Regulations, and the most current SEER Casefinding List. We will send out blast emails when a revised version is posted.
- We have been notified by Metriq that reporting hospitals will have to make two separate transmissions in order for NHSCR to receive the new CER data items: one will have reports that come with the CER data items and another without the items. We are working closely with Metriq to make this as simple as possible. Please let us know if you have any questions.
- A draft letter for hospital supervisors and administrators has been submitted to NPCR for approval. As soon as it is approved we will get it out to you to share with your cancer committee, supervisor, or administration.
- A number of training PowerPoint training presentations have been approved. We are in the process of updating our website to accommodate these training materials.
- Newly reported 2011 cases will be reviewed as they are reported. We will check that all CER-required data items are complete and of good quality. If data is missing or questionable, expect a phone call or site visit to obtain better information. The process is new and we do expect glitches! Site visits will be done in conjunction with the recoding and reabstracting audits starting this fall.

More Abstracting Tips...

We continue to put data through edits, and while errors are few and far between, they are of concern as they tend to occur consistently.

- Please be careful recording demographics. We are finding that punctuation is being used where there should be none, including dashes, # signs, and periods (example: "7 Hanover St" rather than "#7 Hanover St."). To ensure that residence is accurately geocoded, we ask that ONLY the house number and street be on the 1st address line. PO Box, unit, and apartment numbers, along with building, trailer park, institution names, etc. should be noted on the "supplemental" address line. If you have only a PO Box, put UNKNOWN on the street address line and put the PO Box on the 2nd or supplemental line. Also, try to avoid recording UNKNOWN on the town, state, and zip-code fields. An address is required even if the case is a class 43 (Pathological Only). We need *at least* a town for geocoding. As we come across these, we will send these cases back to you with other edits to ensure that an address wasn't missed.
- And then there is Collaborative Staging (CS). When information is available, please do not use code 999 in the CS Site-Specific Factors (SSF).
- Another problem item is with primary site of prostate. When coding the CS SSF 8, Note 2 states "If there are two numbers, assume that they refer to two patterns (the first number being the primary and the second number being the secondary) and *sum* them to obtain the score". Do not put the number 2 as the sum. Actually add them. For example: Gleason scores 2 and 5 = 7. You would put 007 in the CS SSF 8 area.

And finally, a big hint - TEXT, TEXT, TEXT!!! Text documentation is an essential component of a complete abstract and is heavily utilized for information not transmitted within coded values. High-quality text helps us consolidate information from multiple reporting sources at the central registry. Again, the rule of thumb is that one should be able to fully code a case using the text provided in an abstract. Give it a try! Can you code an abstract based on what you document?

2011 Update Planned for CSv02.03

The Collaborative Stage (CS) team plans to update CS version 02.03.03 this fall to address issues and add clarification to select schemas as identified by the registry community. Priority will be given to ~24 issues out of 157 reported that affect staging. All program components will be available to vendors early October. There will be a two-month development/feedback period, and the final release is scheduled for early December. These new changes will be effective 1/1/2012. In the meantime, please continue using CSv02.03 to code all cases diagnosed on or after January 1, 2011. Once it is implemented in a registry, use this to code all newly abstracted cases diagnosed from 2004 forward. The Collaborative Stage (CS) Team has developed a document that lists questions and answers and provides coding guidance for the known issues with CSv02.03 that will be resolved in the next release of CS. Please take some time to review this document. It can be found on the CS website: http://cancerstaging.org/cstage/csv2/faqs.html

On a lighter note, a "hyperlinked" CS Manual is now available online. This manual links Parts 1 and 2 (coding instructions and schemas), identifying relationships and providing links between sections to support registrar ease of access to information. You can download the Hyperlinked CS Coding Instructions Program from here: http://www.cancerstaging.org/cstage/manuals/coding0203.html

NHSCR is happy to answer any questions related to CS. Another resource to refer to is CAnswer Forum. This blog keeps track of questions and answers already submitted. We understand from the CS team that a number of similar questions have been submitted, so it could be that someone else already asked your question.

Important Dates—Mark Your Calendar!

- 9/5 Labor Day Holiday—NHSCR office closed
- 9/15 Cancer Registrars of Maine—Fall Meeting
  Central Maine Med Ctr—Lewiston, ME
- 9/23 CRANE Education Conference—Lung Cancer
  Gifford Med Ctr—Randolph, VT
- 10/6 **Webinar:** Collecting Cancer Data: Larynx including Mucosal Melanoma of Larynx
- 10/12-14 RMCDS Annual Meeting—Charlestown, SC
- 10/24-25 CRANE Annual Meeting
  Springfield, MA
- 10/30 Quarterly Completeness Reports
- 11/3 **Webinar:** Collecting Cancer Data: Ovary
- 11/6 Daylight Saving Time Ends (Sunday)
- 11/24-25 Thanksgiving Holiday—NHSCR office closed
- 12/1 NAACCR/NPCR Call-for-data 2009 DX Year
- 12/23-31 Winter Holiday and Break—NHSCR office closed
- 1/1-1/2/12 New Year's Day Holiday—NHSCR office closed
- 1/5/12 **Webinar:** Collecting Cancer Data: Pancreas

Your Data at Work

NHSCR Director, Judy Rees, presented "Cancer in the Oldest Old" at this year's NAACCR Annual Meeting in June. This comparative study, using New Hampshire and Norway data, examined trends in cancer among the very elderly and found a lot of missing data – in both countries. This makes studying cancer in the very old a big challenge! We will pursue the analyses further and keep you posted with our findings at a later date.

Non-Registry Corner

Now that we are fully staffed, NHSCR will resume case abstracting this fall. We will be contacting each of the non-registry facilities to schedule site visits throughout September and October. Thanks to all for continuing to report the rapids. **Note: As rapids are entered in the new upgraded version of WebPlus, it is important to note that any date fields will require you to input dates in YYYY/MM/DD format.**

NAACCR and NPCR Data Quality

Once again, with the help of cancer reporters in New Hampshire, NHSCR received NAACCR gold certification for its 2008 data. This certification allows our data to be included in NAACCR Cancer in North America (CINA) monograph and data set. NHSCR data also met the CDC NPCR Standards for the Advanced National Data Quality and Completeness program, National Data Quality and Completeness program, and the United States Cancer Statistics (USCS) Publication Standard. Meeting these standards allows our state's data to be included in this year's USCS report. Thanks to all our cancer reporters for the hard work and dedication to collecting high quality and timely data!

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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 603-653-6620. He's always happy to help with sending your cases in!

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