NHSCR
Registry Report

VOLUME 15, ISSUE 1
FEBRUARY 2015

NHSCR Staff Change

It is with mixed emotions that we bid farewell to Janet Goodhue as she retires. We are sorry to lose an important and long tenured member of the NHSCR team but so glad that she will be traveling and enjoying the next chapter of her life.

Janet holds a very special place at the NH State Cancer Registry, as she first became involved in 1986, when she and Shirley Foret started the New Hampshire State Cancer Registry. She worked to insure that the NHSCR met all state and national guidelines needed for accreditation and then subsequently worked in various other capacities. Most recently, she was responsible for entering the non-hospital physician cases, case-finding and myriad of other registry duties. She will be sorely missed.

Join us in bidding her safe-travels and happy trails.

NHSCR staff bid farewell to Janet
Standing: Maria, Bruce, and Claire
Sitting: Janet and Shirley
Kneeling: Pauline and Cathy

Patient Centered Outcomes (PCO) Project

The PCO project continues with collection of follow-up data on 2011 breast and colorectal cancers. Many thanks go out to all registrars for their help with facilitating site visits, record access and data collection in the past several months. Records have been reviewed, and required subsequent treatment information and disease status have been added to the NHSCR abstracts. Data collection and coding has been completed at 12 registry hospitals and 7 non-registry hospitals. Remaining site visits and data coding will continue into the spring.

Non-Hospital Update

We are continuing with our efforts to optimize and encourage cancer reporting by our non-hospital partners. Most recently, we have reached out to Hospice Administrators at their December meeting and Physician Practice Managers at their MGMA January meeting to further our efforts.

We have started to audit the larger Dermatology practices to insure that they are capturing reportable cases and appropriately reporting to NHSCR. In addition to physician practices, we have communicated with Ambulatory Surgery Centers, Radiation Oncology Centers, Pathology Laboratories, and Reference Laboratories to insure they are aware of their reporting responsibilities.

Please let Cathy Ayres know if you have any concerns or questions:
catherine.m.ayres@dartmouth.edu or (603)653-6624.

IMPORTANT 2015 CHANGES!

A number of major changes are coming effective with diagnosis year 2015. Here is a summary of what is coming:

FORDS Revised for 2015

The FORDS has been revised for 2015. NHSCR will be providing NH-specific requirements on our website by April 2015. Please be sure to read the Preface and review Appendix C for an overview of the 2015 changes.

NAACCR Data Standards and Data Dictionary

NAACCR v15 effective with cases diagnosed on or after January 1, 2015 is available at: http://www.naaccr.org/StandardsandRegistryOperations/VolumeII.aspx

While we will try to summarize the major changes for v15, please be sure to carefully read the 2015 Implementation Guidelines and Recommendations: http://www.naaccr.org/LinkClick.aspx?fileticket=63qAFwBuj2g%3d&tabid=161&mid=523

Changes presented here that are specific to NHSCR and NPCR will be incorporated into FORDS 2015.

It is important that all cases diagnosed 2014 and earlier be completed before converting registry data to v15. Please let NHSCR know when you plan to convert and when you have actually converted. This will help us keep track of which data transmissions are ready to be imported into our registry.

New Items Relating to Survival, Not Required by CoC

Hospital registry software will soon be calculating new survival data items [item numbers 1782-1788] using your data. These were introduced in order to standardize the way survival statistics are calculated across cancer registries. Five of the items are derived values, and they depend on data you already collect as well as the two new items, Surv-Date Active Followup [1782] and Surv-Date Presumed Alive [1785]. Surv-Date Active Followup [1782] is defined as the earlier of the Date of Last Contact [1750] and the study cutoff date. The study cut-off date is a pre-determined date based on the year of data submission. Surv-Date Presumed Alive [1785] is the last date for which complete death ascertainment is available from the registry at the time a file is transmitted. We do not anticipate any training being needed for this new set of items.

Two Items Have Expanded Coding Options

New Sex [220] Codes: Two new sex codes, 5 Transsexual, natal male and 6 Transsexual, natal female. If an individual was formerly reported with sex code 4, Transsexual NOS and a subsequent tumor is reported in 2015, it might be important to have agreement. However, it is also possible for a person to have been accurately reported as a male or female for an early cancer and to be diagnosed as a transsexual for a subsequent tumor.

New RX Date Other Flag [1251] Code: The new code 15 indicates that an alternative treatment was expected to be given, but it was not known to have been started when the abstract was prepared. There is no conversion needed for existing records. Effective with Standards Volume II, Version 15, the new code will be available for incoming records and for records abstracted at the central cancer registry. Because this code and its meaning are analogous to the situation for the other treatment modalities, no specific training will be needed for the reporting facilities.

2015 Changes, continued

ICD-O-3 Updates

Please review new changes effective January 2015 as noted in the Guidelines for ICD-O-3 Update Implementation, page 7. Available at: http://www.naaccr.org/LinkClick.aspx?fileticket=u7d3sB71t5w%3D&tabid=126&mid=466

- Carcinoid tumor (8240/3) of appendix (C18.1) is now reportable.
- Reportability guidelines for GIST tumors have been partially addressed in a sentence added to FORDS 2013 and the SEER 2013 Coding Manual, which indicate that GIST tumors and thymomas are reportable when there is evidence of multiple foci, lymph node involvement, or metastasis.
- Effective for 2015 diagnoses, two histology codes became obsolete, 8157/1 Enteroglucagonoma, NOS and 8157/3 Enteroglucagonoma, malignant. The root of these codes has been replaced by histology code 8152/1 for enteroglucagonoma, NOS, and 8152/3 for enteroglucagonoma, malignant. Enteroglucagonoma is now a related term for glucagonoma. The conversion program will make all of these conversions on the database, effective for tumors diagnosed prior to 2015.

New Histologies Not Yet Implemented

Several new histologies are in current use by pathologists that cannot be handled by CS v02.05. Therefore, those codes are not allowed in registry data for cases diagnosed in 2015 or earlier from U.S. and Canada hospitals. A crosswalk has been made available to replace the new, non-implemented codes with appropriate traditional histology codes. Please see enclosed Appendix A taken from the Implementation Guidelines.

ICD-10-CM and ICD-10-PCS Implementation—10/1/2015?

In their newsletter, the Florida Cancer Registry reports this update which we thought would be useful to reproduce for you here with their permission:

"The Health Information Management Profession and Medical Records Discharge Data is expected to change format on October 1, 2015 to ICD-10-CM and ICD-10-PCS to record the diagnosis hospital patient encounters (in-patient care) and hospital ambulatory care procedures. This means that YOU must inform YOUR Information Technology and/or Health Information Management Department of the changes that you will need for running reports for case identification of cancer cases using the new diagnosis and procedure coding version (ICD-10). The ICD-9-CM list will only be valid until 11:59pm on 9/30/2015. ICD-10-CM goes into effect at midnight on 10/1/2015 across the country.

*Please use the ICD-9-CM diagnosis list for patient encounters 1/1/2015-9/30/2015.

*Please use the ICD-10-CM diagnosis list for patient encounters 10/1/2015-forward."

Summary of Completeness

As of December 31, 2014, we were 38% complete for registry hospitals' analytic case reporting. We should have been at 50%! We appreciate all your efforts to meet reporting deadlines and realize that individual circumstances can occasionally cause delays. Please let us know if you are encountering problems with meeting reporting requirements.

We hope that the next quarterly reports will show significant progress in data collection efforts. The next completeness reports will be going out in April. These reports will cover the reporting period for Jan-Mar 2015. Note that 75% of year 2014 will be due at that time. Please see enclosed submission schedule.

Required Staging Systems Effective 2015

All cases diagnosed in 2015 MUST be staged using all 3 staging systems: Collaborative Staging, AJCC staging as well as directly-coded SEER Summary Stage 2000.

This requirement applies to all facilities and providers. Cases reported from small providers or pathology-only reports are NOT exempt from the NPCR staging requirements. Clinical and pathological T, N, and M and stage group may be reported/collected from different sources.

Both clinical and pathological AJCC stage information are required in all cases where they apply (see coding rules). Each piece of the AJCC stage is important: this includes the clinical and pathological T, N, M; clinical and pathological stage groups; and any biomarkers or prognostic factors that are required for staging or specifically required by NPCR. Even if complete AJCC staging information is not available, any piece of staging information that is available should be collected and reported. Registrars will need to directly assign TNM and stage group even if they are not in the record when the underlying information is available to do so. Each stage component is important and should be collected and reported to NHSCR. For example, if the T and N are available but no information is available on M, the T and N should be reported. National standard setters recognize that this will be a new skill set for some registrars and are working across the cancer surveillance partners to develop and implement training tools to assure that registrars can obtain the necessary skills.

There will also be additional focus on the dates of cancer treatment since these dates are very important in distinguishing between clinical and pathological stage. These dates will identify information gathered AFTER neoadjuvant therapy that cannot be used for clinical or pathological stage. Together with the dates of treatment, the staging variables will receive particular attention in trainings or in discussions about requirements for cases diagnosed in 2016, when CS will no longer be required.

In addition, some Site-Specific Factors (SSF) will still be necessary for coding directly-assigned AJCC stage and are therefore essential for quality assurance and analysis. Currently, CDC-NPCR requirements focus primarily on those items required for stage and on a few common and prognostically important SSFs. (Note: NHSCR requires all SSFs to be coded.) The complete list of SSFs will be provided with 2016 Required Status Table. CDC and other partners will continue to use the data structure and variable definitions for SSFs used in Collaborative Stage until there has been a thorough review of the SSFs to determine which are truly collectable within cancer registries; and the best NAACCR data structure for collection of the SSFs has been established. Of course, new prognostic factors and biomarkers may be added to data collection requirements with the implementation of the AJCC 8th edition.

FYI

On PBS, March 30, 31st and April 1st at 9:00 PM, Ken Burns will present 'Cancer: the Emperor of All Maladies,' a film by Barak Goodman.

See http://cancerfilms.org for more information.

A 2011 book with same name won the Pulitzer Prize.

Coding Reminders

- Height, Weight, Smoking, Occupation/Industry, Complications & Comorbidities are required!
- In Situ neoplasms of the Cervix are not reportable. This includes adenocarcinoma, CINIII, etc.
- PIN is not reportable.
- Phyllodes tumor of the breast is only reportable if stated to be malignant.
- Caution when entering address: Only exact street address should be entered in Street Address. The PO Box, Apt, Space, Unit, etc should be entered in the supplemental line.
- Address again: If a person lives outside of NH when diagnosed, then moves here for whatever reason (e.g. be closer to family), do not put the current NH address in *Address at DX* field; please provide the state where patient resided at time of diagnosis.
- Remember to transmit at least once every month. If you have no cases to report, email Maria or Claire to let us know.
- Text, Text, Text….we've started to notice "skimpy text" while doing the management reports. NPCR is EXTREMELY keen that we collect enough text to enable the case to be fully abstracted.
- Basal Cell and Squamous Cell Carcinoma of the Skin are not reportable. Only reportable tumors to the NHSCR are counted when assigning sequence numbers. If your hospital chooses to accession non-reportable cancers, please note that NHSCR will not keep your sequence number. *(See FORDS Revised for 2013, p6).*
- Prostate cancer can only be a single primary in a man's lifetime. Any subsequent occurrences are considered recurrences. (*See Rule M3 under Other Sites of the MP/H Rules*)
- Brushings, washings, cell aspiration, and hematologic findings are not considered surgical procedures and should not be coded in the Surgical Diagnostic and Staging Procedure, or as a biopsy (code 01, 02). The cytology information should be noted in the text and coded in the diagnostic confirmation if that was the only type of positive confirmation of the cancer. *(See FORDS Revised for 2013, p137)*
- For leukemia only, diagnostic confirmation should be coded 1 (histologic) when diagnosis is based only on complete blood count, white blood count, or peripheral blood smear. *(See FORDS Revised for 2013, p128)*
- When in doubt, please call or email us. We will help.

NAACCR Webinar Series

Here is the remaining schedule of the NAACCR Webinars. Please consider hosting one of the upcoming sessions. If you would like to access a previous webinar or would like to host a session, contact Maria and we can give you access. Please take advantage of this great educational opportunity!

- 3/5/15 Abstracting and Coding Boot Camp: Cancer Case Scenarios (Wentworth-Douglass, Dover, NH)
- 4/2/15 Collecting Cancer Data: Stomach and Esophagus – HOST NEEDED!
- 5/7/15 Collecting Cancer Data: Larynx and Thyroid– HOST NEEDED!
- 6/4/15 Collecting Cancer Data: Pancreas– HOST NEEDED!
- 7/9/15 Survivorship Care Plans– HOST NEEDED!
- 8/6/15 Collecting Cancer Data: Central Nervous System– HOST NEEDED!
- 9/3/15 Coding Pitfalls (Wentworth-Douglas in Dover, NH)

New Online Help Files

A new version of Registry Plus Online Help (RPOH) has been released by CDC's Division of Cancer Prevention and Control. RPOH is part of the Registry Plus software suite for cancer registries. This new version is available at http://www.cdc.gov/cancer/npcr/tools/registryplus/rpoh_tech_info.htm

RPOH is an integrated, user-friendly help system for cancer registrars and others who work with cancer data. Developed in support of CDC's National Program of Cancer Registries (NPCR), RPOH facilitates the abstraction of cancer cases by centralizing standard abstracting and coding manuals required by cancer registry standard setters into one accessible, easy-to-use resource. The manuals within RPOH are cross-referenced, indexed, and context-linked, making the information readily available to the user, so RPOH can eliminate the need to refer to printed manuals.

The following manuals are included in this release:

- NAACCR Data Standards and Data Dictionary for record layout version 14
- Online help for the NAACCR Edits Metafile V14A
- FORDS (Facility Oncology Registry Data Standards) 2013
- Collaborative Stage Data Collection System [CS]: User Documentation and Coding Instructions, Version 02.05 (including both Parts I and II)
- SEER Program Coding and Staging Manual 2014
- ICD-O-3, Introductory Material and Morphology Numerical Lists
- Multiple Primary and Histology Coding Rules (updated through 8/24/12)

MP/H Rules

Revision of the Multiple Primary and Histology Coding Rules are tentatively scheduled for 2016. We will keep you updated as we learn more. The MP/H Rules can be found on the SEER website: http://www.seer.cancer.gov/tools/mphrules/

SEER Hematopoietic & Lymphoid Database

The Hematopoietic Stand-alone database has now been updated and posted on the SEER website.
New features have now been installed.

New Capabilities in the Stand-alone Version (Released February 4, 2015):
SEER added the ability to update the data in the stand-alone version of the Heme database in a more automated fashion. Here's how it works: each time the user's computer has an internet connection, it will automatically check to see if there is new Hematopoietic data, and download it when there is new data. For those who use the stand-alone version, you will now get newly published data automatically when you connect to the internet. https://seer.cancer.gov/tools/heme/download

SEER *Rx – Interactive Antineoplastic Drugs Database

The latest version of the SEER*Rx drug database was released in September 2014. SEER*Rx is available in two formats: a web-based tool and as stand-alone software.

SEER*Rx now has a new and improved search engine that does faster and more intelligent full text searching of all fields, with a sortable results table and a new relevance column so you can tell how relevant each search result is to your entered search string. Additionally, each drug and regimen is now displayed in its own page so that you can bookmark specific entries. For specific Summary of Changes related to the September 30, 2014 release please click on (details) located at: http://seer.cancer.gov/tools/seerrx/

Updating Our Directory of NH Cancer Reporters

We will be updating our directory of NH cancer reporters in the next month. We hope to make this directory available to our NH registrars only. Please be sure to check the information for accuracy, and let us know if you do not want this information shared with other NH registrars.

Recoding Audits

This winter/spring we are completing recoding audits for year 2012. These audits entail the review of text to determine the accuracy of coding. We are in the process of summarizing the findings for individual hospitals, which will help us focus our training needs. We hope to have information for you this spring.

2013 Death Clearance

We are starting the 2013 death clearance process. We have identified 2013 cancer deaths that are not in our registry. Follow-back forms to physicians will be sent within the next couple of weeks. Follow-back to hospitals will be sent with the April quarterly "mailing" .

Casefinding Audits

We are finalizing 2013 path reviews and 2014 is currently underway. Thanks to all hospital registries and path labs for accommodating site visits or sending us your path reports for review. Outstanding follow-back lists should be returned ASAP. We need to close-out previous years before starting a new year's audit.

We will soon be starting the 2014 Medical Disease Index request. Hopefully everyone has a process in place to simplify the process. More information coming soon.

Claire's Corner—Hoping for Spring!

NHSCR 2015 Calendar

3/5	Webinar: Abstracting and Coding Boot Camp WDH, Dover, NH
4/1	NH CCC Annual Meeting Grappone Center, Concord, NH
4/2	Webinar: Stomach and Esophagus Host Needed!
4/6-10	National Cancer Registrars Week
4/30	Provisional 2013, 90% complete Quarterly Completeness Reports – 75% of year 2014
5/7	Webinar: Larynx and Thyroid Host Needed!
5/20-23	NCRA 2015 Annual Meeting San Antonio, TX
5/25	Memorial Day Holiday
6/4	Webinar: Pancreas Host Needed!
6/13-18	NAACCR 2015 Annual Meeting Charlotte, NC
6/30	End of Fiscal Year
7/3	Independence Day Holiday
7/9	Webinar: Survivorship Care Plans Host Needed!
7/30	Quarterly Completeness Reports—100% of year 2014
8/6	Webinar: Central Nervous System Host Needed!
9/7	Labor Day Holiday
9/3	Webinar: Coding Pitfalls WDH, Dover, NH
9/18	NHSCR Annual Meeting *(tentative)* *Date and place to be determined*
10/x	CRANE Annual Meeting *Date and place to be determined*
10/31	Quarterly Completeness Reports—25% of year 2015
11/26-27	Thanksgiving Holiday
12/1	NAACCR Call-for-Data
12/24-25	Christmas Holiday
12/26-31	Winter Break (NHSCR closed)

603-653-6630

Courier Address:
46 Centerra Parkway, Suite 102
Lebanon, NH 03766

Mailing Address:
P.O. Box 186
Hanover, NH 03755

NHSCR Staff

Judy Rees, BM, BCh, PhD
Director
603-653-3683
Email: judith.rees@dartmouth.edu

Maria Celaya, MPH, CTR
Assistant Director, Field Operations
603-653-6621
Email: maria.o.celaya@dartmouth.edu

Bruce L. Riddle
Registry Manager, Computer Operations & Data Analysis
603-653-6620
Email: bruce.riddle@dartmouth.edu

Claire E. Davis, BA, CTR
Senior Registrar
603-653-6622
Email: claire.e.davis@dartmouth.edu

Pauline McGinn, BA, RHIT, CTR
Senior Registrar
603-653-6626
Email: pauline.m.mcginn@dartmouth.edu

Cathy Ayres, BSMT (ASCP)
Cancer Registrar
603-653-6624
Email: catherine.m.ayres@dartmouth.edu

State Cancer Epidemiologist

GM. Monawar Hosain, MD, PhD
603-271-7821
Email: gm.hosain@dhhs.state.nh.us

NHSCR on the Web

Please visit at: **http://geiselmed.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

NHSCR
P.O. Box 186
Hanover, NH 03755

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!

This project was supported in part by the Centers for Disease Control and Prevention's National Program of Cancer Registries, cooperative agreement U58/DP0003930 awarded to the New Hampshire Department of Health and Human Services, Division of Public Health Services, Bureau of Public Health Statistics and Informatics, Office of Health Statistics and Data Management. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or New Hampshire Department of Health and Human Services.

10 Appendix A:

New ICD-O-3 Histology Code Crosswalk for 2015:
The following table is an excerpt from the NAACCR Guidelines for ICD-O-3 Update Implementation (December 2013). The complete document can be found on the NAACCR web site: Guidelines for ICD-O-3 Update Implementation

ICD-O-3 Change	New ICD-O-3 Histology Code (do NOT use these codes in 2015)	Description	Comment	Use this Histology Code in 2015
New term and code	8158/1	Endocrine tumor, functioning, NOS	Not reportable	
New related term	8158/1	ACTH-producing tumor	Not reportable	
New term and code	8163/3	Pancreatobiliary-type carcinoma (C24.1)	DO NOT use new code	8255/3
New synonym	8163/3	Adenocarcinoma, pancreatobiliary-type (C24.1)	DO NOT use new code	8255/3
New term	8213/3	Serrated adenocarcinoma		8213/3*
New code and term	8265/3	Micropapillary carcinoma, NOS (C18._, C19.9, C20.9)	DO NOT use new code	8507/3*
New code and term	8480/1	Low grade appendiceal mucinous neoplasm (C18.1)	Not reportable	
New term and code	8552/3	Mixed acinar ductal carcinoma	DO NOT use new code	8523/3
New term and code	8975/1	Calcifying nested epithelial stromal tumor (C22.0)	Not reportable	
New term and code	9395/3	Papillary tumor of the pineal region	DO NOT use new code	9361/3*

ICD-O-3 Change	New ICD-O-3 Histology Code (do NOT use these codes in 2015)	Description	Comment	Use this Histology Code in 2015
New term and code	9425/3	Pilomyxoid astrocytoma	DO NOT use new code	9421/3
New term and code	9431/1	Angiocentric glioma	DO NOT use new code	9380/1*
New term and code	9432/1	Pituicytoma	DO NOT use new code	9380/1*
New term and code	9509/1	Papillary glioneuronal tumor	DO NOT use new code	9505/1
New related term	9509/1	Rosette-forming glioneuronal tumor	DO NOT use new code	9505/1
New term and code	9741/1	Indolent systemic mastocytosis	Not reportable	

***** ICD-O-3 rule F applies (code the behavior stated by the pathologist). If necessary, over-ride any advisory messages.

NHSCR DATA SUBMISSION SCHEDULE
FOR CASE SUBMISSIONS IN 2015

2014 QUARTER	1st			2nd			3rd			4th		
DUE DATE[3]	JAN 2015	FEB 2015	MAR 2015	APR 2015	MAY 2015	JUNE 2015	JULY 2015	AUG 2015	SEPT 2015	OCT 2015	NOV 2015	DEC 2015
DEFINITIVE CASES[1] (Date of Dx)	JULY 2014	AUG 2014	SEPT 2014	OCT 2014	NOV 2014	DEC 2014	JAN 2015	FEB 2015	MAR 2015	APR 2015	MAY 2015	JUNE 2015
RAPID CASES[2] (Date of Dx)	NOV - DEC 2014	DEC 2012 - JAN 2015	JAN - FEB 2015	FEB - MAR 2015	MAR - APR 2015	APR - MAY 2015	MAY - JUNE 2015	JUNE - JULY 2015	JULY - AUG 2015	AUG - SEPT 2015	SEPT - OCT 2015	OCT - NOV 2015
Percent Expected	75% of 2014			100% of 2014			25% of 2015			50% of 2015		
T&C Review[4] (reports sent to hosp)	APRIL 2015			JULY 2015			OCTOBER 2015			JANUARY 2016		

[1]Definitive cases are due 180 days from the date of initial diagnosis.
(e.g. cases diagnosed in June are due in December; 50% of cases diagnosed in 2015 are due by end of December.)

[2]Rapid cases are due 45 days from the date of initial diagnosis.
(e.g. cases diagnosed July 1st are due by Sept 15.)

[3]Due date: The month in which cases are due.
Total number of cases submitted during these months are included in the completeness review.

[4]C&T Review: The month in which NHSCR will review completeness and timeliness of case reporting and provide reporting facilities with reports.
Completeness monitors ALL case submissions up to the quarter being reviewed.
Timeliness monitors the time lag between diagnosis date and date case received at NHSCR.