

OREGON CANCER REGISTRARS' ASSOCIATION



PRESIDENTS MESSAGE

Sunny greetings everyone,

Yeah summer is finally here! Hope everyone is enjoying all the good things that come with it.

Survey reminder for Installation of officers/Christmas Luncheon: Please complete and return to Shelley Lindsey ASAP. Thank you for your input.

In future newsletter's each EC officer will submit a brief overview of activities done to manage our association so members will know what's happening with OCRA.

Great NCRA conference!! I really appreciate the opportunity OCRA provided for me to attend this event. The conference CD was purchased for our library so everyone will have the opportunity to review and earn CE's. Get your name on the list by contacting Julie McKim, our new librarian. Congrats to Linda Derksen on winning TWO baskets at the conference!

Go green was the theme – electronic everything when possible. The topics focused on the ever expanding collection (does this surprise us!?) of data with the key elements being treatment according to clinical stage and prognostic indicators to determine best outcome for each patient.

New tools: The Cyber Cancer Registry now live under "SEER Training Modules" and it's FREE! Terrific training tool and can also be used for skills assessment in the interview process. NCRA Guidebook on Informatics available now as PDF for desk top. NCI, SEER has new web base program to replace the fold out chart in our "Abstracting & Coding Guide for Hematopoietic Diseases" book. For 2010 cases, release date TBA.

Some new high points of the Hematopoietic Abstracting & Coding changes include: Some new primaries due to a low incidence of reported cases.

New multiple primary rules to capture disease transformations because tx data is being lost, affecting quality of care and survival statistics. New rules to clear up collection on those vague areas that make us all crazy, such as "preleukemia or early multiple myeloma".

ACoS changes: Automatic email two weeks prior to survey with cases chosen for chart review. CP3R reports will align with National Quality Forum.

State Association ideas: Share workshops with other states for bigger/better events, cost sharing and greater networking.

Purchase electronic equipment for workshops – pays for itself over time vs. paying at every conference. FCRA (FL Cancer Registrars Assoc) has an Educational Charity Contribution Fund that is a tax-write off for the contributor, providing funds for the organization.

Leah Kiesow graciously submitted her NCRA summary to our newsletter. Thank you Leah.

Have a great summer and see you all this Fall at our workshop.

Connie Winkler, CTR
OCRA Pres. 2009

Summer '09 Edition

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2009 Nominating Committee Update:

Submitted by Shelley Lindsey, Past President, Nominating Committee Liaison

Your OCRA Nominating Committee is actively seeking nominees for the 2010 term. Currently, nominations are being accepted for the President-Elect (which would assume the office of President in 2011), Secretary 2010, Treasurer 2010, and Nominating Committee 2010 (4 positions).

Additional positions not requiring a vote are the 2010 Education Chair position and all committee positions (please see the current committee roster on the OCRA website).

Please remember, we cannot thrive as an organization without participation by our membership. If you are interested in running for an office, sitting on a committee, or being the Education Chair, we need you. You can review all job descriptions and duties on the website or call any current Executive Committee member for more information. If you are new to OCRA, please check the OCRA By-laws (also available on the website) for information concerning the minimum requirements to hold an office. Nominations are being accepted until August 21st, 2009.

For more information, contact your Nominating Committee Chairman:

Vicki Shindler, CTR, (503) 571-5078, or email Vicki.J.Shindler@kp.org

Installation of Officers Survey Update:

First off, a big thank you to all who responded to the recent survey regarding the Installation of Officers ceremony and DMA recipient presentation. We received 32/61 surveys which clinches a greater than 50% response rate. 31/32 respondents voted YES to having the Installation & DMA held during the OCRA Fall Conference. Unfortunately, only 6 felt a Christmas Luncheon should still be held. The Christmas Luncheon topic will be up for short discussion during the OCRA Business Meeting in October. In the meantime, you have until August 1st to return your survey if you would like to be included in this OCRA decision.

Distinguished Member Award:

Nominations are currently being accepted for the 2009 Distinguished Member Award. Please send email or written essay to Laura Wallace, OCRA Secretary, no later than September 7th. The DMA will be presented during the OCRA Fall Conference in October.

Ten Commandments for Cancer Registrars

- 1. Thou shalt endeavor to do it right the first time, for thou knowest there will be no time to do it over.***
- 2. Thou shalt not neglect the care and feeding of thy cancer committee, for they are thy shield and thy sword,***
- 3. Thou shalt put away thy ego, for thou knowest those who have plenty to go around.***
- 4. Thou shalt honor thy colleague, for mutual support is the first law of survival.***
- 5. Thou shalt not covet thy neighbor's computer, for thou knowest not when a hard drive will crash.***
- 6. Thou shalt not curse thy workload, for it is likely to increase.***
- 7. Thou shalt put it in writing and keep a copy, for that is thy job and bureaucracy is everywhere.***
- 8. Thou shalt enhance thy knowledge and thy skills, for only change is certain.***
- 9. Thou shalt not become a martyr, for perfection is a scarce commodity.***
- 10. Thou shalt maintain a sense of humor, for laughter is more useful than hysteria.***

Karen Phillips, CTR

Submitted by: Paulette E. Bethune, CTR



Relay for Life



Relay For Life is quickly approaching and I would like to share some information. The event will be held on July 24-25, 2009 from noon to noon at Lane Community College in Eugene.

Since I was unable to get volunteers to come down to join us in the Eugene Relay, Trent, Brittni, and I joined the Candlelighters team, which is for children who have had cancer. Our theme this year for our team, is Racing for a Cure. Each child will be a race car (like Nascar) and their track will be around the tents. Each child's picture will be on the hood and their race car number will be the number of years they have been a survivor.

I have never attended a relay so large; currently there are 185 teams and over 1,600 participants.

Included are the website for you to browse and if you are interested in doing an on-line donation, you can. The site: http://main.acsevents.org/site/TR?pg=team&fr_id=17771&team_id=430695 This should take you to our site, Candlelighters, Team 1, next you can select one of our names and do an on-line donation. If you want to do a donation but not on-line, just let me know.

Thank you for your support,

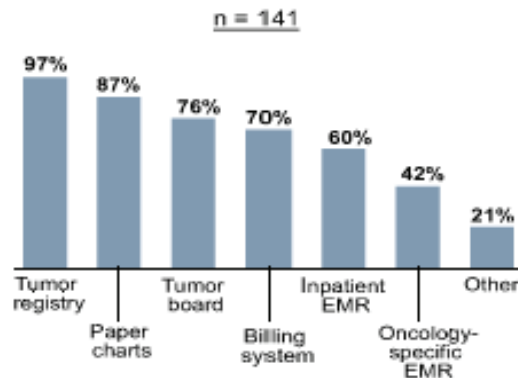
Martha Curl

Tumor registry key source for oncology quality info - 07/13/2009

The tumor registry can be a valuable tool for optimizing the collection of oncology quality data, although administrators must ensure that it is primed for quality reporting and assessment. Both timely data entry and the accuracy of registry information are top-of-mind concerns for oncology administrators. This is not surprising given that the Oncology Roundtable 2008 Quality Survey reveals that cancer programs utilize the tumor registry more than any other source when measuring quality performance. For more information, please see the Oncology Roundtable study, [The New Quality Mandate](#)

<http://www.advisory.com/members/default.asp?contentid=78325&program=8&collectionid=173>.

Rising to the top of the list
Percentage of hospitals utilizing data sources to measure quality performance



Source: Oncology Roundtable 2008 Membership Survey; Oncology Roundtable interviews and analysis

ANNOUNCEMENTS

Mark your calendars!

Fall Workshop – October 14th, 15th, 16th, 2009
Crown Plaza – Lake Oswego
Hosted by OHSU

Are you ready for this years fall conference? It is just around the corner. The Education Committee has been hard at work finding speakers for a variety of topics from colon cancer to palliative care to cancer survival statistics to the new Stereotactic Body Radiation Therapy that is now being done at OHSU.



New Positions Open at OHSU: OHSU Cancer Registry still has open positions for full time (40 hrs/week) and half time (20 hours/week) work. The job responsibilities would primarily involve abstracting and may also include other registry-related tasks as needed. Qualified candidates shall be a CTR or CTR-eligible. Abstracting experience is required and two years working in a cancer registry is preferred. OHSU offers extremely competitive wages and has an excellent benefit package. Remote opportunities are available for the right individuals. If you have any questions or want additional information about this position, please contact Teresa Mason at 503-494-6367 or email masont@ohsu.edu. Please feel free to apply online at <http://www.ohsu.edu/hr/>. The category is Hospital/Clinic Support and the title is tumor registrar. The job posting number for the half time job is **IRC27680**. The job posting number for the full time job is **IRC27682**

I & R Responses

Question: Patient had a Radical Anterograde Modular Pancreatosplenectomy(RAMPS). How is this coded in the site specific surgery classification as no duodenectomy or gastrectomy was done? Would it be coded to 30 Partial pancreatectomy, NOS,?

In Reply: Please code to 30, Partial Pancreatectomy in the Surgical Procedure/Primary Site, and code Splenectomy to 2, Surgical Procedure/Other regional sites. **FORDS page(s) App B, 262 was used as the resolution source. Transaction id: 45008**

Question: Lymphoma IPI scores. If the physician doesn't fill out the IPI portion on a staging form or dictate in the medical record the IPI score, can the registrar fill out the score if all the information is in the medical record?

In Reply: No, according to the notes for this field in CS Manual p11-547, the registrar is supposed to record the score as stated in the record. The registrar is not to calculate the score themselves. **Collaborative Staging Manual & Coding Instruct page(s) p11-547 was used as the resolution source. Transaction id: 45089**

Question: When a patient undergoes a cystoprostatectomy for bladder cancer and the prostate is negative, do you code the "nonprimary site surgery" of the prostate? Do you only code the "nonprimary site surgeries" when it is involved by the cancer?

In Reply:No you do not code nonprimary site surgery of the prostate. For bladder primaries, code 60-radical cystectomy, includes the prostate, seminal vesicles and distal ureters. **FORDS page(s) p-280 was used as the resolution source. Transaction id: 45372**



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Oregon Cancer Registrars' Association www.ocra-oregon.org

Helpful Resources

Cancer Registrar Training:

[Training for the Multiple Primary and Histology Coding Rules](#) - Recordings of the online MP/H Rules Training sessions.

[SEER's Training Web Site](#) - Web-based training modules for cancer registration and surveillance.

[SEER Self Instructional Manuals for Tumor Registrars](#) - A collection of instructional manuals in PDF format.

<http://seer.cancer.gov/seer inquiry/index.php>

Resources Beyond SEER:

[Commission on Cancer \(ACoS CoC\) Education Program](#)

[National Cancer Registrars Association \(NCRA\) Educational Resources](#)

[National Program of Cancer Registries \(NPCR\) Training](#)

[North American Association of Central Cancer Registries \(NAACCR\)](#)

[Education & Training](#)

[Principles of Oncology for Cancer Registry Professionals](#)

Websites:

[American Cancer Association \(www.cancer.org\)](http://www.cancer.org)

[American College of Surgeons \(www.facs.org\)](http://www.facs.org)

[Cancer Registrar Group \(Yahoo\) \(groups.yahoo.com/group/cancerregistrargroup/\)](http://groups.yahoo.com/group/cancerregistrargroup/)

[cancer.gov \(NCI\) \(www.cancer.gov\)](http://www.cancer.gov)

[CancerLinks \(www.cancerlinks.com\)](http://www.cancerlinks.com)

[OSCAR \(www.healthoregon.org/oscar/\)](http://www.healthoregon.org/oscar/)

Message from the Editor

Dear Fellow Registrars,

Thank you to everyone that submitted articles for this edition of the OCRA Newsletter. Please email any articles, I & R responses, job postings, treatment information, or suggestions for the newsletter to: wallacel@ohsu.edu

A few dates to add to your calendars:

- 2009 CTR EXAM • Exam Dates—Testing Window: September 12-26, 2009; Application Due by: July 31, 2009
- **OCTOBER 14-16, 2009: OCRA FALL CONFERENCE Fall Workshop – Crown Plaza – Lake Oswego Hosted by OHSU**
- APRIL 20-23, 2010: 36th Annual NCRA Conference

Laura Wallace, RHIT, CTR
Editor



2009 NCRA 35th Annual Conference
Transforming and Rebuilding
Working Together Towards Global Change
Overview: It's Not All About the What, but Rather the Why?

In summary, as cancer prevention, detection, and treatments evolve, the desire for personalized and individualized cancer care has brought about the need for improved and expanded data collection. The goal is to tailor medical treatment to the individual characteristics of each patient: the right treatment for the right disease for the right reason in the right patient (Carolyn C. Compton, MD, PhD, Chair, AJCC Executive Committee).

Highlights

The Future of Staging: AJCC 7th Edition

Release of 7th edition-Summer 2009

Implement January 1, 2010 for 2010 cases

Key Points

1. Need for inclusion of non-anatomic and biologic information
2. Optimal patient management requires more information for the prognostic evaluation equation
3. Full impact of new clinical practices not yet known with relation to the TNM stage
4. Prognostic indicators will alter the stage of some sites.
5. Anatomy has not yet been linked to biology of tumors in AJCC for outcome predictions
6. Predictive schemas require data on specific "kind" of disease present
7. TNM challenges-refers to "how much" disease is present, lacks biologic data and impact of response, creates 'bins' of like patients
8. Histopathologies have been updated and clarified, where applicable
9. Cancer Genome Atlas Project: collect normal specimens, cancer tissues, and compare for measurable data.
10. Ca HUB: The cancer human biobank, national biobank for translational research: ensure adequate and continuous supply of human biospecimens.

Collaborative Staging V.2: Transformation of TNM to CS

- Release?-Status in Progress
- Implementation for 2010 cases
- Hopeful release to vendors September 2009
- Electronic, user-friendly version that can be installed on desktop.

Key Points

1. Why a new version? Collaboration needed for 7th edition of AJCC
2. Prognostic indicators and increasing need for collection
3. Add sites not in V.1
4. Support pre and post staging classifications
5. Expand site specific factors
6. Field test survey-behind schedule (Spring 2009), reliability study after release of V.2-status is "in progress"
7. Pre and Post staging team-data capture issues (Jan 2011)
8. V.2 to accommodate such things as neuroendocrine, GIST, and eye tumors
9. Mapping: add codes to accommodate different mapping for histology and site. i.e.: Colon will have 3 schemas: colon, GIST, and NET.
10. V2 provides histology inclusion lists for the histologies that DO derive an AJCC Stage and provides them as ranges.
11. What you will see: place holders for up to 25 SSF's, additional column for AJCC 7th edition.

Synoptic Pathology

- Incorporate new TNM anatomic staging/prognostic systems
- AJCC and CSV2 to correlate with synoptic reporting
- Increased importance of collection of prognostic indicators hold promise for improved patient outcomes

Key Points

1. Address challenges in colorectal site specific factors
 2. Increased linkage of prognostic indicators to treatment and outcomes
 3. T4a and T4b categories have changed in AJCC
 4. KRAS testing-becoming the standard of care in T3 and T4 CRC's, large institutions testing all stages, T1 and T2 not tested unless there is a recurrence, in some institutions.
 5. Pathology committee to watch for changes in CAP requirements.
 6. 18q loss of heterozygosity-not widely performed outside of research, ? resistance to 5-FU in Stage II patients.
 7. GI neuroendocrine-new staging/prognostic system-TS, Depth of Invasion, LN mets, distant mets, Grade...GIST, Pancreatic neuroendocrine, hepatobiliary.
- ***Tumors arising at EGJ-if tumor arises in stomach within 5 cm of EGJ crosses the EGJ, it is classified as esophageal cancer.

BACK TO THE FUTURE: CLINICAL STAGING

- 50 yr anniversary of AJCC
- Only point in time to compare all cancer patients

Key Points

1. Clinical stage helps define treatment path for patients
2. Avoid the use of X when assigning clinical stage: registrars can imply that nodes and mets are "0" if record or patient lacks information about work up that would otherwise be done if patient was sus-

pected of having systemic disease. Do not need a direct statement from physician.

3. Mx has been removed from staging forms, CAP working to eliminate Mx
4. Clinical M may be used in pathologic stage group
5. New stage groups for CIS and pM1 in AJCC
6. Changes in AJCC strongly tied to subsequent changes in pathology reporting

Standard 4.3

- Main focus is to monitor the use of staging in treatment planning
- Focus is NOT on the mechanics of staging collection, but rather, adherence to NCCN guidelines
- Cancer Committee plans evaluation, identifies issues, and addresses concerns

Key Points

1. A portion of the 5 major sites should be examined >10%-CC decides
2. Format for monitoring is up to us, CoC is not going to micromanage our format
3. Identify information gaps between correct clinical staging practices and treatment guidelines...no percentages required.
5. Surveyor to discuss what has been implemented, what issues were found, and how the issues are being addressed.

*NO CHART REVIEW

*NO COMMENDATION

Tune up Time for FORDS: 2010

- Coordination needed with 7th edition of AJCC and medical advances, new registry data uses, computer tech., and problems with existing codes.
- Why now? Major changes only once every 3 years.
- Prepare to use updated version starting with 2010 cases.

Key Points

1. Rule change for in utero dx and treatment-no longer use date of birth as dx date, but date in utero ca was made. Use date of actual treatment for in utero cancer
2. Pre-surgical embolization-not recorded for any standard registry item, for example, when agent is alcohol
3. Code as chemotherapy when agent is a chemotherapeutic
4. Radioembolization-code as brachy (beads or coils)
5. Again, FORDS update incorporates changes of AJCC and CS V.2.

CoC's Rapid Quality Reporting System

- **RQRS**-enable programs to submit data concurrently
- CP3R data not much use when it's "3 years old"
- Alpha test May 2009, Beta Test June 2009, invitation for voluntary participation to all CoC approved programs 2010.

Key Points

1. Similar submission technique as NCDB, but minimal data required
2. Approximately 40 of the required FORDS data items needed to submit.
3. Hospitals provided with up to date concordance rates and notification of treatment expectations
4. Minimum requirements include patient demographics and surgical pathology.
5. Helps to facilitate CoC/ACOS/NCCN Quality Measures for breast and colorectal cancers
6. Pending therapy prospective alerts
7. Data available within 24 hours of submission, updates made nightly.
8. 7 sites have been tested in Georgia

Cyber Registry

- From paper to electronic records
- \$19.2 billion intended for support of widespread deployment and utilization of HIT and availability of HER for all citizens by 2014.

Key Point

Change is coming!

Hospital Workload Management Study

- Gathered detailed information on frequency and duration of time spent on major job activities in cancer registry
- 53% response rate from CoC programs (8% from NW)

Key Points

1. On average, 80% of abstracted data is from electronic sources
2. Mean weekly hours spent on abstracting=46, case finding=15, Follow-up, 20.
3. For programs with 1000+ cases, the mean abstracted amount varied from 319 cases to 541 per registrar.

Poor participation in study did not lead to pertinent findings, in my opinion. Caseload ranged anywhere from 101-24,000 cases?

Defensive Abstracting

- Review

SS Prognostic Indicators for use in NCCN Guidelines

- Review of 7th edition staging, standard 4.3, pathology, and outcome predictions from collection of biologic and molecular data on tumors.