Oklahoma Central Cancer Registry
December 2017

OCCR NEWSFLASH

SUBMISSION UPDATE

By Christy Dabbs, AA, CTR

It's that time of year again for the Oklahoma Central Registry (OCCR). The OCCR completed the data submission to the National Program of Central Registries (NPCR) and the North American Association of Central Cancer Registries (NAACCR) which included patients diagnosed between 1997 and 2015. In January we will submit 12-month data for evaluation which includes all 2016 cancer cases. Our goal is to meet or exceed the requirements from NAACCR for Gold Certification for our 2015 data. Those requirements include:

- Case ascertainment achieved 95% or higher completeness.
- Death certificate is the only source for identification of fewer than 3% of reported cancer cases.
- Fewer than 0.1% duplicate case reports.
- All data variables used to create incidence statistics by cancer type, sex, race, age, and county are 100% error-free.
- Less than 2% of the case reports are missing demographic information on age, sex, and county.
- Less than 3% of the cases are missing meaningful information on race.
- The data is submitted to NAACCR for evaluation within 23 months of the close of the diagnosis year under review.

(Registries)[1]

The OCCR works hard all year long preparing the data for submission each November and January. The same cancer case can be reported by hospitals, physician offices, treatment centers and pathology labs, depending on where the patient was diagnosed and treated. We remove duplicates from our database . A duplicate is a patient in the database more than once with the same primary and diagnosis date but with different central tumor registry numbers. The next step in the OCCR process is to review cases that are marked as a possible new primary. These cases are similar to a reported cancer that we have in the database but the primary site or sequence reported in the new incoming case might be different, for example, a patient with a primary C50.4 is reported from one source but another source reports it as C50.9. These cases are reviewed and a determination is made whether it is the same primary or a new primary. Lastly we consolidate reported cancer cases. If there are multiple reporting sources submitted it will be consolidated into one final abstract. This process takes all of the pieces of the puzzle, so to speak, and puts them together to create a complete picture of the patient's cancer and treatment.

During these processes we often identify items in the abstract that may need quality review when the cases are being abstracted at the reporting source level.

(Story continued on page 2)

INSIDE THIS ISSUE

Social Security Number

Social Security Numbers seem to be getting harder to come by in the medical record these days. If you do have access to the patients social security number we ask that you double and triple check the accuracy. You can do this by cross checking it with a scanned copy of the Social Security card or the Medicare card if they have one. You can also compare reported numbers from different admissions. Make sure you have not mistyped or transposed any numbers. We realize that accuracy of this number is sometimes out of your control, maybe the patient gave the wrong number at the registration desk or maybe the person registering the patient entered it incorrectly. The OCCR corrected quite a few social security numbers this past year on diagnosis year 2015 reported cases. This number is important because it helps the OCCR determine duplicates and when linking data to the National Death Index (NDI) and Social Security Death Index (SSDI) prior to submission to obtain vital status. Inaccurate numbers can cause quite a lot of manual review.

Text Documentation

I cannot stress enough how important accurate text documentation is for a central registry. Since we do not have access to your medical record we rely solely on what you enter into the abstract when we perform the processes mentioned above. What you document in your text should back up everything you are coding in the abstract including dates and names of facilities. If you code in the primary site field C50.4 (breast, upper outer quadrant) but your text only states breast, your text documentation does not accurately reflect what you have coded. A general rule of thumb to follow for text documentation is that anyone should be able to re-abstract the case using only your text documentation.

Accession Number and Sequence Number

Assigning a correct accession number is another area that we noticed to be incorrect in some cases. A patient should only be assigned one accession in their lifetime in your registry. You should name search your database prior to abstracting a case to verify if the patient has already been assigned an accession number in your registry. Instructions on assigning accession number can be found in the Facility Oncology Registry Data Standards (FORDS) manual and the RMCDS and Web Plus manuals provided by the OCCR. Please also document a patient's history of previous cancer(s) in the PE text. This really helps when we are reviewing the possible new cancer cases and assigning/verifying sequence numbers.

SECTION TWO: CODING INSTRUCTIONS / Patient Identification	37
ACCESSION NUMBER	Item Length: 9 NAACCR Item #550 Revised 01/04, 01/10

Description

Provides a unique identifier for the patient consisting of the year in which the patient was first seen at the reporting facility and the consecutive order in which the patient was abstracted.

Rationale

This data item protects the identity of the patient and allows cases to be identified on a local, state, and national level.

Instructions for Coding

- When a patient is deleted from the database, do not reuse the accession number for another patient.
- The first four numbers specify the year and the last five numbers are the numeric order in which the patient was entered into the registry database.
- Numeric gaps are allowed in accession numbers.
- A patient's accession number is never reassigned.
- If a patient is first accessioned into the registry, then the registry later changes its reference date and the patient is subsequently accessioned into the registry with a new primary, use the original accession number associated with the patient and code the data item *Sequence Number* (NAACCR Item #560) appropriately.
  (Surgeons)[2]

The Oklahoma Central Cancer Registry appreciates all of your hard work in providing us with accurate and timely reported data. Your hard work does not go unnoticed as we all continue to do our part in the fight against cancer.

[1]"Certification." *North American Association of Central Cancer Registries*, North American Association of Central Cancer Registries, 2016, www.naaccr.org.

[2]"Section Two: Coding Instructions/Patient Identification." *Facility Oncology Registry Data Standards*, Revised for 2016 ed., American College of Surgeons, 2016, pp. 37–37.

AMERICAN JOINT COMMITTEE ON CANCER STAGING MANUAL 8TH EDITION

By Susan Nagelhout, CTR

Effective with cancer cases diagnosed January 1, 2018, cancer reporters will commence using the 8th Edition of the AJCC Cancer Staging Manual. The OCCR has purchased one staging manual for each facility/medical practice that is required to document AJCC stage in the cancer abstract. I will begin distributing the 8th edition manuals shortly after the first of the year.

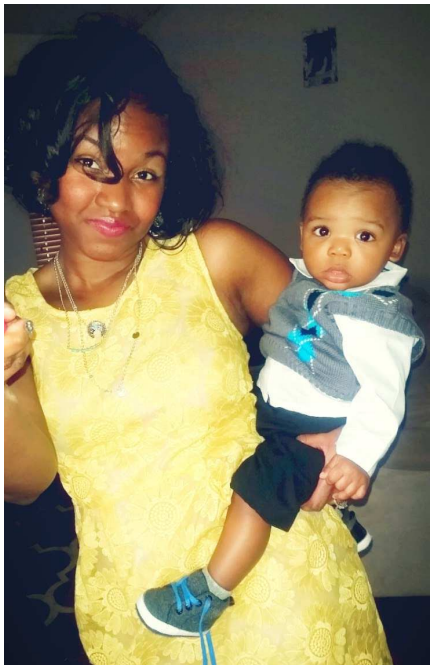
There are several free educational opportunities that you can take advantage of to assist you in learning about the new 8th Edition staging schemas. The OCCR provides the NAACCR monthly webinar. Most of the webinars are site-specific and include information on cancer staging. These live webinars are offered at a central location in both Oklahoma City and Tulsa. If you are unable to attend the live webinar, you can request a link to the recorded session.

AJCC will also be offering staging webinars throughout 2018. Additional information regarding the webinars is available at the AJCC website: https://cancerstaging.org/CSE/Registrar/Pages/8thEditionWebinars.aspx.

Current software versions are unable to accommodate use of the 8th edition staging at this time. Stay tuned for information about software upgrades, which are scheduled to take place in April 2018.

OKLAHOMA'S NEWEST CERTIFIED TUMOR REGISTRAR

By Christina Panicker, MBA, CTR



Congratulations to Chandell Norman, the most recent Certified Tumor Registrar (CTR) in Oklahoma!

What led Chandell into the field of cancer registry is her Bachelor degree in Public Health. One of the requirements in completing her degree was fulfilled by being an intern at Integris Southwest Medical Center. She has been with Integris for nine years and was selected as a Health Unit Coordinator in 2010. In 2015, she transitioned from an intern to being hired as a non-certified cancer registrar.

For those preparing for the CTR exams, some of the recommendations provided by Chandell include: going through the CTR preparation courses offered through NAACCR, creating flash cards through Quizlets, and visiting the SEER Educate site. These resources provided her with additional understanding of the material.

Chandell received her associate degree in Allied Health from Oklahoma City Community College and her bachelor degree in Public Health from the University of Central Oklahoma. Currently, she is working on her Masters of Public Health degree from Capella University. She lives in Edmond and in her free time spends time with her friends and family. "I love playing with my 1-year old son and teaching him new things. He is the best."

A TRIBUTE TO APRIL FRITZ: HER INFLUENCE AND INSPIRATION

By Jessica Freeman

April Fritz, RHIT, CTR, a known, respected and admired pioneer within the cancer surveillance community, passed away September 12, 2017. She was an amazing woman and I have been given the honor to express the great influence she had on my life and on many others.

Shortly after I started working for the OCCR, I was able to go to one of April's trainings in Reno, Nevada. It was a small group of 20, and I am sure I was the least experienced in the cancer registry field. The first thing I noticed about April was her humor and easygoing personality. Her husband, Bob, was there and his support for April's work was always apparent – sometimes participating as the object of her jokes, sometimes making runs to their house for forgotten items, and always making sure we had plenty of peanut M&Ms. I was occasionally overwhelmed by all the knowledge April had in that beautiful brain of hers but was completely amazed by her ***genuine desire to teach others***. After a full day reviewing the CoC Standards of Care, I remember asking April if facilities got financial incentives for becoming accredited. April paused for a brief moment and then replied "No" to which I asked, "Well if they don't get anything out of it, why do they do it?" She used that moment to teach me a valuable lesson—financial profit is not what motivates those in the cancer surveillance field. The contribution that April made to the field of cancer registry and surveillance such as, involvement in the development of national and international cancer standards and education, will never be forgotten. April had such a gift, and was able to teach the basics of anatomy, physiology and coding rules in a unique, fun way. I left the conference with an understanding that this field of work was challenging, but also satisfying and exciting. April's enthusiasm, humor and passion greatly inspired me and as soon as I returned from the training, I began exploring how I could become a Certified Tumor Registrar (CTR).

The next time I saw April was in 2014, shortly after her diagnosis of pancreatic cancer. The OCCR attended a regional conference in Missouri and even though we could tell she was fatigued, she was determined to be there – to share and teach. I was able to talk to her briefly and get a picture taken with her. It has taken me a while, but after years of hard work, I am in the final stretch and will be graduating this month with an Associate Degree in Cancer Information Management and plan to take the CTR exam in Spring 2018. My intention was to write April after I got my CTR certification and tell her that she inspired me to continue down this cancer registry path. April's passion for teaching motivates me and others to learn more and work hard towards improving cancer surveillance and most importantly, improving cancer outcomes. I can only hope that as a consultant for the OCCR that I can help encourage and foster learning like April did with me.

It is evident that April touched many lives, as seen by the tributes made to her. The articles below provide insights into her personal and professional life.

The Connection – Remembering April Fritz

Journal of Registry Management – A Tribute to April Fritz

The NAACCR Narrative – In Remembrance April Fritz

Several of April's original articles were published in the Fall 2017 issue of NCRA's Journal of Registry Management and can be found here: http://www.ncra-usa.org/About/Publications/Journal-of-Registry-Management.

AMERICAN JOINT COMMITTEE ON CANCER 8TH EDITION CANCER STAGING WEBINARS FOR REGISTRARS

By Susan Nagelhout, CTR

AJCC will offer free 8th Edition staging webinars for registrars beginning February 15, 2018.

- Minor Rule Changes – Thursday, February 15, 2018, 1 pm – 2 pm CST
- Major Rule Changes – Tuesday, March 20, 2018, 1 pm – 2 pm CST
- CAnswer™ Forum & Staging Questions – Tuesday, April 17, 2018, 1 pm – 2 pm CDT
- Head and Neck Staging – Wednesday, July 25, 2018, 1 pm – 2 pm CDT
- Breast Staging – Thursday – September 6, 2018, 1 pm – 2 pm CDT

Additional information and registration links are coming soon. Check the AJCC website to register, https://cancerstaging.org/CSE/Registrar/Pages/8thEditionWebinars.aspx.

ADVISORY COMMITTEE MEMBER SPOTLIGHT

By Kaela Howell, RHIA

Since 2013, OCCR has held a quarterly Advisory Committee meeting to receive support and guidance from the top medical and public health professionals in the state. These members are an important and appreciated resource for the central registry, offering their valuable time to assist in improving the usability of data, developing effective partnerships and increasing awareness of registry activities within the different communities across the state. This quarter, OCCR would like to spotlight one of our Advisory Committee members, Denise Baker.

Denise was born and raised in Oklahoma until 1976 when she, her husband and four-year-old son moved to Pennsylvania to care for elderly family members. During her time there, Denise held a few different positions. Initially she worked in an electrical supply warehouse for 11 years as an accounts receivable bookkeeper. Towards the end of her employment there she diligently sought employment at Penn State Milton S. Hershey Medical Center. Finally, after two years of applying for multiple positions, Denise was able to get her foot in the door as a part time front desk person. By the end of her two weeks of full time training, she was offered the position full time and never looked back. She went on to work multiple positions from front desk, new patient scheduler and nurse navigator support, cancer center supervisor for six front desk staff, certified professional coder out-patient and inpatient but all at Hershey Medical Center totaling 11 years.

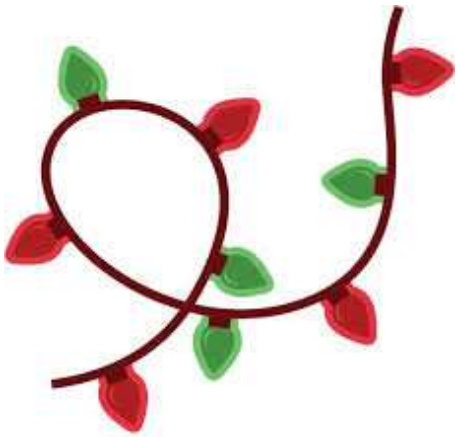
Denise's husband volunteered at the Campbelltown Volunteer Fire Company as a driver and fire police while they lived in Pennsylvania. This meant that she didn't see him much so she chose to get involved. She took classes every Saturday for 12 weeks which allowed her to take on the rewarding challenge of being an EMT (Emergency Medical Technician) and volunteer firefighter. She served in this position for 8 years, which she truly loved. During those years she had some amazing experiences, including delivering a baby, which she describes an outstanding rush of adrenaline!

By May of 2006, Denise and her husband no longer had family in Pennsylvania and they chose to move back to Oklahoma City. Before the big move, Denise started looking online for jobs at hospitals and stumbled upon a cancer registrar position at INTEGRIS Baptist Medical Center. She had never heard of such a position and had no idea what it entailed but she applied and got the job. One requirement of her job was to become a certified tumor registrar (CTR). At the age of 53, Denise enrolled in night classes two nights a week to take the required classes for the exam. With the support of her family, Denise passed the exam and received her CTR in 2009.

Denise has been a member of the Oklahoma Cancer Registrars Association and the NCRA since 2009. She has held several different positions with OCRA which includes Vice President for 2018. Denise has been with INTEGRIS Health for 11 years and is currently at INTEGRIS Southwest Medical Center as a CTR Specialist and Quality Control Coordinator. She has been a member of the OCCR Advisory Committee since 2015 and she states that she believes it is a worthwhile and needed committee.

FIRST QUARTER NAACCR WEBINARS

By Leslie Dill



The OCCR has purchased the NAACCR Cancer Registry and Surveillance Webinar Series and will be providing these monthly webinars at no cost in two convenient locations, Oklahoma City and Tulsa. Seating is limited, so contact Susan Nagelhout at SusanN@health.ok.gov if you are interested in attending. Webinar location details and handouts will be provided upon registration.

1/11/2018	Collecting Cancer Data: GIST and Soft Tissue Sarcomas
2/01/2018	Collecting Cancer Data: Stomach and Esophagus
3/01/2018	Abstracting and Coding Boot Camp: Cancer Case Scenarios

CODING LYMPH-VASCULAR INVASION

By Susan Nagelhout, CTR

Instructions for coding lymph-vascular invasion (LVI):

LVI Code	Description
0	Pathology report indicates no LVI; when the tumor is purely in-situ
1	Pathology report or physician statement indicates presence of LVI
8	Histology is 9590/3 or higher (hematopoietic and lymphoid neoplasms)
9	No microscopic examination of primary site; no information on pathology report about LVI; pathologist indicates specimen is insufficient to determine LVI; unknown primary site

For cases treated with neoadjuvant therapy, refer to the table below to code LVI:

LVI on pathology report PRIOR to neoadjuvant therapy	LVI on pathology report AFTER neoadjuvant therapy	Code LVI to
0 – Not present/Not identified	0 – Not present/Not identified	*0 – Not present/Not identified*
0 – Not present/Not identified	1 – Present/Identified	*1 – Present/Identified*
0 – Not present/Not identified	9 – Unknown/Indeterminate	*9 – Unknown/Indeterminate*
1 – Present/Identified	0 – Not present/Not identified	*1 – Present/Identified*
1 – Present/Identified	1 – Present/Identified	*1 – Present/Identified*
1 – Present/Identified	9 – Unknown/Indeterminate	*1 – Present/Identified*
9 – Unknown/Indeterminate	0 – Not present/Not identified	*9 – Unknown/Indeterminate*
9 – Unknown/Indeterminate	1 – Present/Identified	*1 – Present/Identified*
9 – Unknown/Indeterminate	9 – Unknown/Indeterminate	*9 – Unknown/Indeterminate*

ROCKY MOUNTAIN CANCER DATA SYSTEM (RMCDS) CORNER

By Christy Dabbs, AA, CTR

RMCDS for 2018: Updates and Enhancements

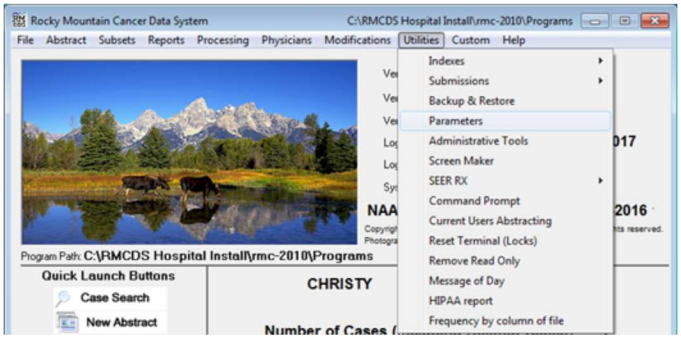
RMCDS has contracted with AJCC to provide the lookups for each AJCC staging field. This will be a nice improvement to assigning AJCC stage in the abstract. You will have choices to select from for clinical and pathologic T, N, M and stage group.

A tentative conversion date has been slated for April 2018. The 2018 RMCDS conversion being released in April is dependent on several updates being made by standard setters and the updates being completed by their assigned deadline.

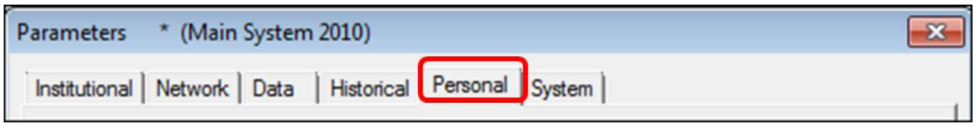
Quick Error Check

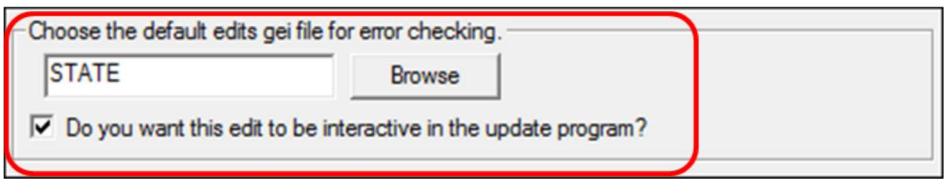
Did you know there is a faster way to run the error check on an abstract in RMCDS with just one click? With a simple setup process that takes only a few minutes you will be able to simplify your work life by using the quick error check. Each user will need to set this up if they wish to use it.

Setting up the quick error check:

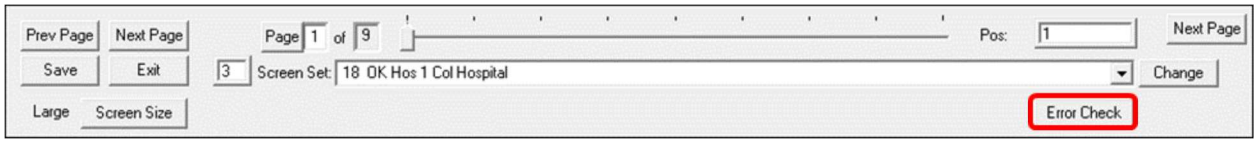


1. Open RMCDS
2. On the menu at the top navigate to Utilities >Parameters>Personal Tab
3. At the bottom of the parameters box you will choose the default edits gei for error checking
4. Click browse and navigate to rmc-2010 folder then the Genedits folder
5. You will select **STATE16.gei** file for Central: Incoming Abs State16.gei or **naaccr16.gei** for Standard 2017 edits error check (5/27/2017 V16E) to include CoC error checks.
6. Lastly you will select whether you would like to always run interactive edits. If the box is not checked you will get the print out.
7. Click Apply





The quick error check button is located in the abstract at the bottom right.



OKLAHOMA'S CANCER INCIDENCE AND DEATH RATE COMPARED TO NATIONWIDE STATISTICS

By Judy Hanna, HT (ASCP), CTR

The OCCR submits an annual data submission file of newly diagnosed cancer cases to the Centers for Disease Control and Prevention (CDC) and the NPCR. The 2014 data was submitted this past year nationwide by central cancer registries representing US states. The CDC makes the US cancer data available for the public and health professionals to be able to describe the cancer burden within their state and how it compares to the US. Below is a comparison of cancer incidence rates within the US, highlighting areas for improvement of cancer education, prevention and early diagnosis. Additional information on the cancer burden can be found on the CDC website located at https://www.cdc.gov/cancer/npcr/index.htm. Watch for next year's comparison of the most recent 2015 data submission.

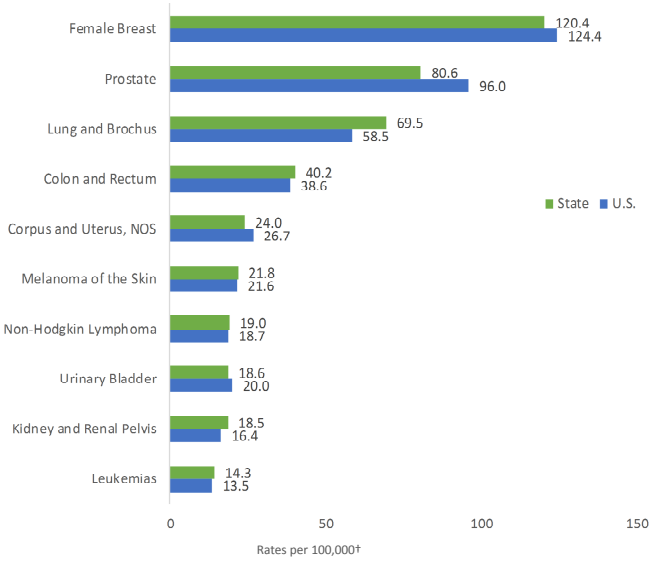
In 2014 1,596,486 new cancer cases were diagnosed in the United States* which includes 19,377 in Oklahoma.

2014 State vs. National Comparisons

Age-Adjusted Invasive Cancer incidence Rates for the 10 Primary Sites with the Highest Rates within the State- and Sex-Specific Categories (Table 6.37.1MF) *†

★ Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population (19 age groups - Census P25-1130).

State vs. National Rates: 2014, Male and Female, Oklahoma



State vs. National Rates: 2014, Male and Female, Oklahoma *†

Rates per 100,000‡

	Site	State	U.S.
1	Female Breast	120.4 (115.8-125.2)	123.9 (123.4-124.4)
2	Prostate	80.6 (76.8-84.6)	95.5 (95.1-96.0)
3	Lung and Bronchus	69.5 (67.1-72.1)	58.3 (58.0-58.5)
4	Colon and Rectum	40.2 (38.3-42.1)	38.4 (38.2-38.6)
5	Corpus and Uterus, NOS	24.0 (22.0-26.1)	26.5 (26.2-26.7)
6	Melanomas of the Skin	21.8 (20.4-23.3)	21.4 (21.3-21.6)
7	Non-Hodgkin Lymphoma	19.0 (17.7-20.4)	18.5 (18.4-18.7)
8	Urinary Bladder	18.6 (17.4-20.0)	19.8 (19.7-20.0)
9	Kidney and Renal Pelvis	18.5 (17.2-19.9)	16.2 (16.1-16.4)
10	Leukemias	14.3 (13.2-15.6)	13.3 (13.2-13.5)

(Table 6.37.1MF) Age-Adjusted Invasive Cancer incidence Rates for the 10 Primary Sites with the Highest Rates within State- and Sex-Specific Categories

* Data are from selected statewide and metropolitan area cancer registries that meet the data quality criteria for all invasive cancer sites combined. Rates cover approximately 100% of the U.S. population.

† Excludes basal and squamous cell carcinomas of the skin except when these occur on the skin of the genital organs, and *in situ* cancers except urinary bladder.

‡ Rates are age-adjusted to the 2000 U.S. standard population (19 age groups - Census P25-1130). Rates are suppressed and not ranked if the population of the specific category (area, sex) is less than 50,000 or case counts are fewer than 16.

Confidence interval (CI): Range of values for a rate that will include the true value of the rate a given percentage of the time. Example: 95% CI includes the true value of the 95% of the time.

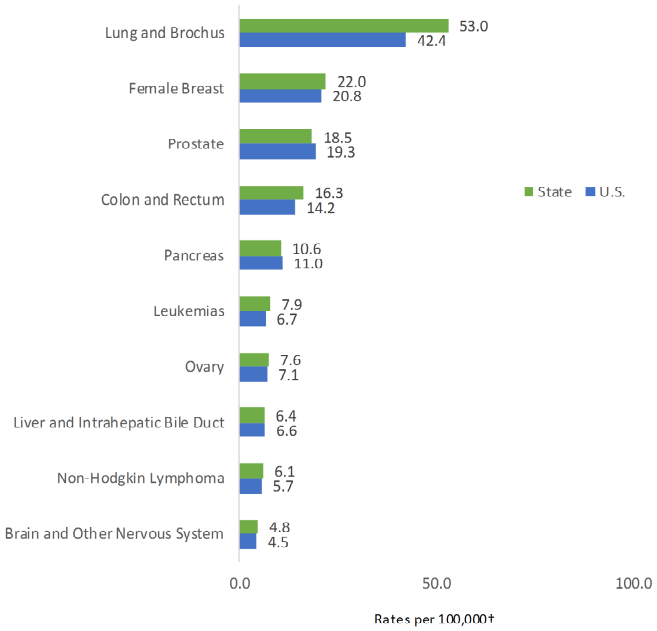
OKLAHOMA'S CANCER INCIDENCE AND DEATH RATE COMPARED TO NATIONWIDE STATISTICS, CONTINUED FROM PAGE 8

2014 State vs. National Comparisons

Age-Adjusted Cancer Death Rates for the 10 Primary Sites with the Highest Rates within the State- and Sex-Specific Categories (Table 6.37.2MF) *

★ Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population (19 age groups - Census P25-1130).

State vs. National Rates: 2014, Male and Female, Oklahoma



State vs. National Rates: 2014, Male and Female, Oklahoma *†

Rates per 100,000‡

	Site	State	U.S.
1	Lung and Bronchus	53.0 (50.9-55.3)	42.2 (42.0-42.4)
2	Female Breast	22.0 (20.1-24.0)	20.5 (20.3-20.8)
3	Prostate	18.5 (16.5-20.6)	19.1 (18.9-19.3)
4	Colon and Rectum	16.3 (15.1-17.5)	14.1 (14.0-14.2)
5	Pancreas	10.6 (9.7-11.7)	10.9 (10.8-11.0)
6	Leukemias	7.9 (7.0-8.7)	6.6 (6.5-6.7)
7	Ovary	7.6 (6.5-8.8)	7.0 (6.9-7.1)
8	Liver and Intrahepatic Bile Duct	6.4 (5.7-7.2)	6.5 (6.4-6.6)
9	Non-Hodgkin Lymphoma	6.1 (5.3-6.9)	5.7 (5.6-5.7)
10	Brain and Other Nervous System	4.8 (4.1-5.5)	4.4 (4.4-4.5)

(Table 6.37.2MF) Age-Adjusted Cancer Death Rates for the 10 Primary Sites with the Highest Rates within State- and Sex-Specific Categories

Footnotes

* Data are from the National Vital Statistics System (NVSS).

‡ Rates are age-adjusted to the 2000 U.S. standard population (19 age groups - Census P25-1130). Rates are suppressed and not ranked if the population of the specific category (area, sex) is less than 50,000 or case counts are fewer than 16.

Confidence interval (CI): Range of values for a rate that will include the true value of the rate a given percentage of the time. Example: 95% CI includes the true value of the 95% of the time.

OKLAHOMA CENTRAL CANCER REGISTRY

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Center for Health Statistics
1000 NE 10th Street
Oklahoma City, OK 73117

Phone: 405-271-6225
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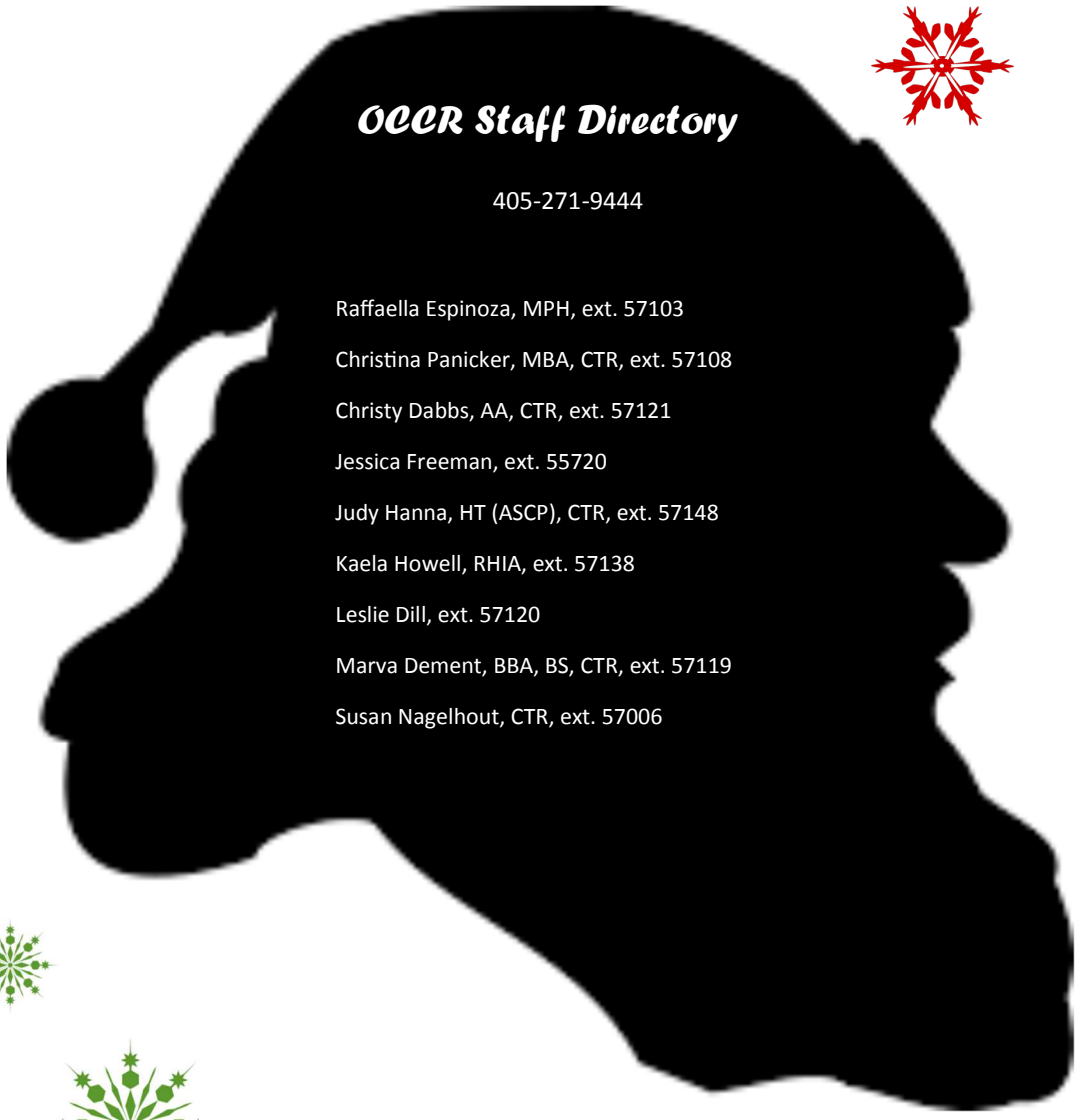
http://occr.health.ok.gov



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OKLAHOMA WORKS