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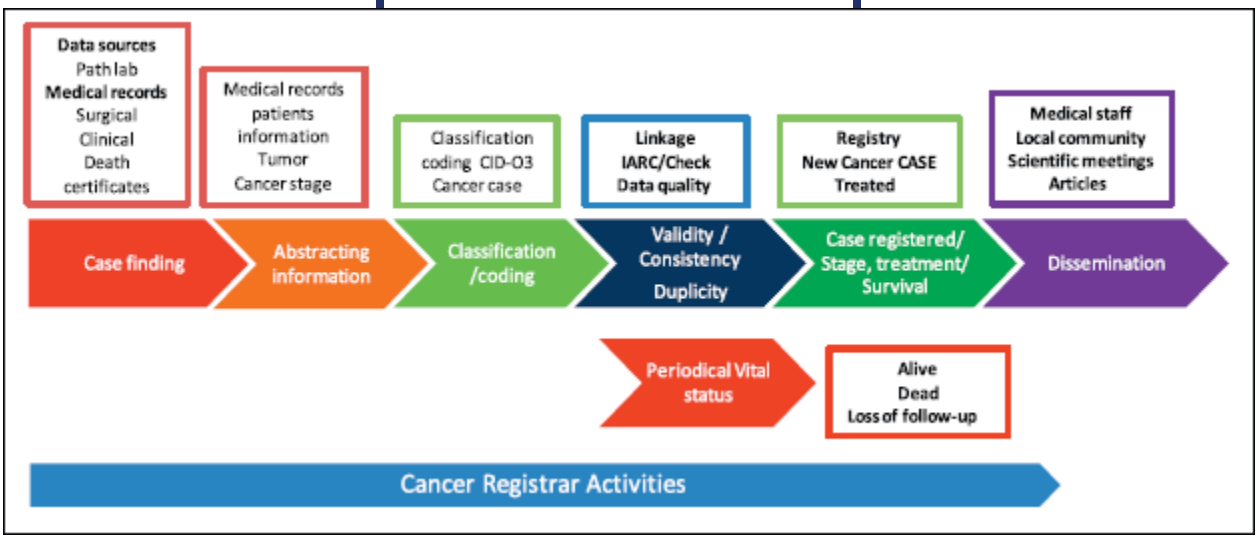
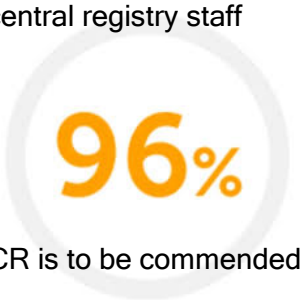


This year has been an interesting and challenging year to say the least. In mid-March we were in full-force coronavirus pandemic mode. I am sure many of you continue to experience challenges with additional staff responsibilities, reassignments, vacancies and furloughs. I thank all of you for your patience during the coronavirus pandemic. There is good news!!!!

- ASCR is one of forty-two cancer registries recognized as a CDC/NPCR Registry of Distinction and *U.S. Cancer Statistics Registry for Surveillance*.
- ASCR achieved the NAACCR Gold Certification for 2017 cases.
- One-time funding from CDC afforded the ASCR an opportunity to host a successful inaugural Data Quality Evaluation (DQE) Training held March 2020 in Point Clear, AL. The ASCR and CDC staff presentations included the cancer registry historical perspective, data reporting program standards, and best practices.
  DQE training participants engaged in three focus group discussions and provided suggestions to improve our 12-month data submission. This training also allowed reporting facilities to network and share ideas, resources, and lessons learned.
- The ASCR staff participated in the NAACCR 2020 Annual Conference, where virtual educational opportunities and free sessions were offered for conference registrants.
- The entire ASCR staff participated in NCRA's Virtual 2020 Annual Education Conference.
- The ACRA 2020 Virtual Conference was held October 1-2, 2020 and the central registry staff presented detailed cancer registry program updates.

The NPCR DQE Audit conducted by Westat, Inc. post evaluation results are in!!!!



CDC's conclusion and recommendations:

- ✓ "ASCR's overall data accuracy rate of merged data was 96.6 percent: ASCR is to be commended for this result."
- ✓ During the Visual Editing results, errors resulted when text was either completely missing or incorrectly coded for various data elements.
- ✓ The ASCR is encouraged to continue conducting visual editing to maintain data quality in the State, in addition to reviewing basic abstracting principles with staff and data reporters; and emphasizing to all reporting facilities that text documentation to support data element code(s) selection is required. Text documentation should support all coding and consolidation decisions.

We are committed to assisting you with your requests and providing updates as soon as possible. The ASCR appreciates your hard work and commitment to reduce the burden of cancer in Alabama. As we approach the fall/winter season we hope that you all stay safe and well.

~Aretha

ASCR REPORTING REQUIREMENTS

All healthcare facilities and/or providers diagnosing or providing treatment to cancer patients shall report complete abstracts on each case of confirmed cancer/benign reportable tumor monthly, before the 10th of the following month, in the prescribed format and within 180 days of admission or diagnosis.

Example: January cases will be reported by July 10th, February cases reported by August 10th, etc.

This method allows the ASCR to receive continuous reporting in a timely manner.

Casefinding Information – Pathology Reports, Cytology Reports, Disease Index, X-rays/Scans, Radiation Oncology Logs, Medical Oncology Logs and Surgery Schedule as this pertains to your facility.

~Diane

2020 DX cases Hospital Reporting Schedule

Current Date	Level of Completeness	Dx Date of Cases (Timeliness)
Jul 2020	8%	Jan 2020
Aug 2020	17%	Feb 2020
Sept 2020	25%	Mar 2020
Oct 2020	33%	Apr 2020
Nov 2020	42%	May 2020
Dec 2020	50%	Jun 2020
Jan 2021	58%	July 2020
Feb 2021	67%	Aug 2020
Mar 2021	75%	Sept 2020
April 2021	83%	Oct 2020
May 2021	92%	Nov 2020
Jun 2021	100%	Dec 2020

QA CORNER

STORE Manual

FIELD: RADIATION/SURGERY SEQUENCE ITEM # 1380

How to choose the correct code for this field can be confusing when both Radiation and Surgery are "unknown." When treatment is unknown for other treatment fields, the correct codes are either "9" or "99". When the criteria below are "true" for "Radiation/Surgery Sequence," the correct code would be "0":

"Radiation treatment" and "Surgical Procedure of Primary Site," "Scope of Regional Lymph Node Surgery," "Surgical Procedure/Other Site," are all "unknown."

See STORE Manual 2018 for complete instructions – pages 338, 339.

Coding Primary Site – Head, Face or Neck

In my QA review, I have identified cases in which the primary site is coded to unknown (C80.9). However, in the text provided it states that the primary site is located within the head, face or neck area. The appropriate primary site code would be "C76.0".

Solid tumor rule "Head, face or Neck" - H. C760 Head, face or neck NOS (organs involved unknown/not documented). Note: This code is used in circumstances such as: biopsy of lymph node and no information about primary site, patient lost to follow-up, no further information available; patient and family declined further work-up or treatment.

~Mark

Diagnostic Confirmation
STORE 2018

https://www.facs.org/-/media/files/quality-programs/cancer/ncdb/store_manual_2018.ashx

Description

Records the best method of diagnostic confirmation of the cancer being reported at any time in the patient's history. The rules for coding differ between solid tumors; hematopoietic and lymphoid neoplasms.

Rationale

This item is an indicator of the precision of diagnosis. The percentage of solid tumors that are clinically diagnosed only is an indication of whether casefinding includes sources beyond pathology reports.

Complete casefinding must include both clinically and pathologically confirmed cases.

The codes are in **priority order**; code 1 has the highest priority.

~Diane

Code	Label	Definition
1	Positive histology	Histologic confirmation (tissue microscopically examined).
2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).
3	Positive histology PLUS • Positive immunophenotyping AND/OR • Positive genetic studies	Histology is positive for cancer, and there are also positive immunophenotyping and/or genetic test results. For example, bone marrow examination is positive for acute myeloid leukemia. (9861/3) Genetic testing shows AML with inv(16)(p13.1q22) (9871/3). (Used only for hematopoietic and lymphoid neoplasms M-9590/3-9992/3)

Code	Label	Definition
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer.
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
8	Clinical diagnosis only, other than 5, 6 or 7	The malignancy was reported by the physician in the medical record.
9	Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually nonanalytic).

Tips for Coding Grade on cases diagnosed 2018 and higher

https://www.naaccr.org/SSDI/Grade-Manual.pdf

Grade Clinical - The grade of a solid primary tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant).

Grade Clinical Coding Guidelines:

Note 1: Clinical grade is recorded for cases where a histological (microscopic) exam is done, tissue is available, and grade is recorded. This includes FNA, biopsy, needle core biopsy, etc.

Note 2: Clinical grade must not be blank.

Note 3: Assign the highest grade from the primary tumor assessed during the clinical time frame.

Note 4: Code 9 (unknown) when:

- a grade is not documented, or
- clinical staging is not applicable (for example, cancer is an incidental finding during surgery for another condition).

* If there is only one grade available and it cannot be determined if it is clinical or pathological, assume it is a clinical grade and code appropriately per clinical grade categories for that site; and then code 9 (unknown) for pathological grade and blank for post therapy grade.

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Grade Pathological - The grade of a solid primary tumor that has been resected and for which no neoadjuvant therapy was administered.

Grade Pathological Coding Guidelines:

Note 1: Pathological grade is recorded for cases where a surgical resection has been done.

Note 2: Pathological grade must not be blank.

Note 3: Assign the highest grade from the primary tumor. If the clinical grade is the highest grade identified, use the grade that was identified during the clinical time frame for both the clinical grade and the pathological grade.

* If a resection is done of a primary tumor and there is no grade documented from the surgical resection, use the grade from the clinical workup.

* If a resection is done of a primary tumor and there is no residual cancer, use the grade from the clinical workup.

Note 4: Code 9 (unknown) when:

- a grade not documented,
- there is no resection of the primary site,
- no neoadjuvant therapy followed by a resection,
- a clinical case only, or
- there is only one grade available and it cannot be determined if it is clinical or pathological.

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Grade Post Therapy - The grade of a solid primary tumor that has been resected following neoadjuvant therapy. Neoadjuvant therapy is treatment given as a first step to shrink a tumor before the main treatment, which is usually surgery.

Grade Post Therapy Coding Guidelines:

Note 1: Leave post therapy grade blank when:

- there is no neoadjuvant therapy,
- a clinical or pathological case only, or
- there is only one grade available and it cannot be determined if it is clinical, pathological or post therapy.

Note 2: Assign the highest grade from the resected primary tumor assessed after the completion of neoadjuvant therapy.

Note 3: Code 9 (unknown) when:

- a surgical resection is done after neoadjuvant therapy and grade from the primary site is not documented, or
- a surgical resection is done after neoadjuvant therapy and there is no residual cancer.

~Diane

As Follow-Back Coordinator, I want to thank my facilities for your hard work and timely response when reporting cancer cases monthly.

Just a reminder, the second 2018 Death Clearance Follow-Back form is due back. If you have not done so, please complete the form as soon as possible. The form can be sent to my attention by email or fax.

- Required fields to be completed on the forms are: fields with an asterisk (*) such as the date of diagnosis, primary site, and histology. These fields are very important.
- If there is no more information on the patient, please indicate this. PLEASE DO NOT RETURN THE FORM BLANK.
- If you will abstract the case(s), please select YES. If you will not abstract the case(s) please select NO explaining the reason why.

~Cassandra

Text Documentation

Coding Pitfalls in Context of Text Documentation:

- Text documentation is a requirement for abstracting.
- We all make abstracting and coding mistakes.
- Our abstracts are not just a bunch of codes.
- It explains the continuum of cancer care.
- It helps identify missing information, improve abstract quality; and improves overall data quality.
- Text documentation is a valuable resource, as not everything gets coded.

Purpose and Use of Text Documentation:

Purpose: Describe the patient's continuum of cancer care from presentation symptoms to diagnosis, from work up to staging, from treatment to progression and any care posttreatment until the end of life whether due to cancer or not.

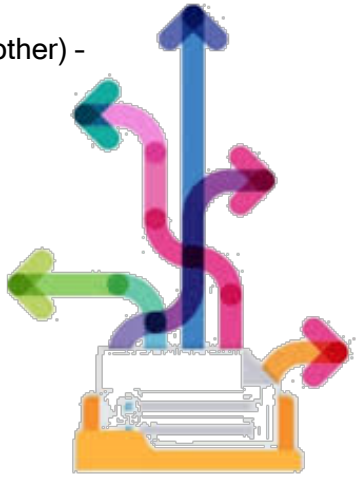
Text documentation helps reinforce critical data items and helps identify where abstractors and coders have problems or do not understand certain new (and older) concepts, instructions, etc. Your text documentation should tell a story.

Who uses text and how do they use it?

- New Registrar Learning to Abstract
- Hospital Registrar and Physicians
- Central Registry and Data Quality
- Clinical Research and Other Data Users
- Epidemiologist and Use of Text
- Feedback to Individual and for Training

Text documentation should always include the following components:

- Date(s) -include date(s) references -this allows the reviewer to determine event chronology.
- Date(s) -note when date(s) are estimated [i.e. Date of DX 3/15/2014 (est.)].
- Location - include facility/physician/other location where the event occurred (test, study, treatment, or other).
- Description -include description of the event (test/study/treatment/other) - include positive/negative results.
- Details -include as much detail as possible
- Document treatment plan even if treatment is initiated as planned.
- Include "relevant-to-this-person/cancer" information only.



- DO EDIT your text documentation.
- DO NOT REPEAT INFORMATION from section to section.
- DO USE NAACCR Standard Abbreviations.
- DO NOT USE non-standard or stylistic shorthand.

* When Information is Missing or Incomplete in the Medical Record -document info is not there.

~Angela

Casefinding-Determining Eligibility

Ambiguous Terms at Diagnosis

As part of the registry casefinding activities, all diagnostic reports should be reviewed to confirm whether a case is required. If the terminology is ambiguous, use the following guidelines to determine whether a particular case should be included. Words or phrases that appear to be synonyms of these terms do not constitute a diagnosis.

For example, "likely" alone does not constitute a diagnosis.

STORE 2018 *Case Eligibility*

Ambiguous Terms that Constitute a Diagnosis	
Apparent(ly)	Presumed
Appears	Probable
Comparable with	Suspect(ed)
Compatible with	Suspicious (for)
Consistent with	Tumor* (beginning with 2004 diagnoses and only for C70.0–C72.9, C75.1–75.3)
Favors	Typical of
Malignant appearing	
Most likely	
Neoplasm* (beginning with 2004 diagnoses and only for C70.0–C72.9, C75.1–75.3)	

* additional terms for non-malignant primary intracranial and central nervous system tumors only

EXCEPTION: If cytology is identified only with an ambiguous term, do not interpret it as a diagnosis of cancer.

Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

Examples of Diagnostic Terms:

- The inpatient discharge summary documents a chest x-ray *consistent* with *carcinoma* of the right upper lobe. The patient refused further work-up or treatment. *Consistent with carcinoma* is indicative of cancer.
- The pathology report states *suspicious for malignancy*. *Suspicious for malignancy* is indicative of cancer.

Ambiguous Terms that do not constitute a diagnosis without additional information:

STORE 2018 *Case Eligibility*

Ambiguous Terms That *Do Not* Constitute a Diagnosis *without additional information*	
Cannot be ruled out	Questionable
Equivocal	Rule out
Possible	Suggests
Potentially malignant	Worrisome

Examples of Nondiagnostic Terms:

- The inpatient discharge summary documents a chest x-ray *consistent with neoplasm* of the right upper lobe. The patient refused further work-up treatment. *Consistent with neoplasm* is not indicative of cancer. While "consistent with" can indicate involvement, "neoplasm" without specification of malignancy is not diagnostic except for non-malignant primary intracranial and central nervous system tumors.
- Final diagnosis is reported as *possible carcinoma* of the breast. *Possible* is not a diagnostic term for cancer.

Genetic findings in the absence of pathologic or clinical evidence of reportable disease are indicative of risk only and do not constitute diagnosis.

~Diane

Greetings,

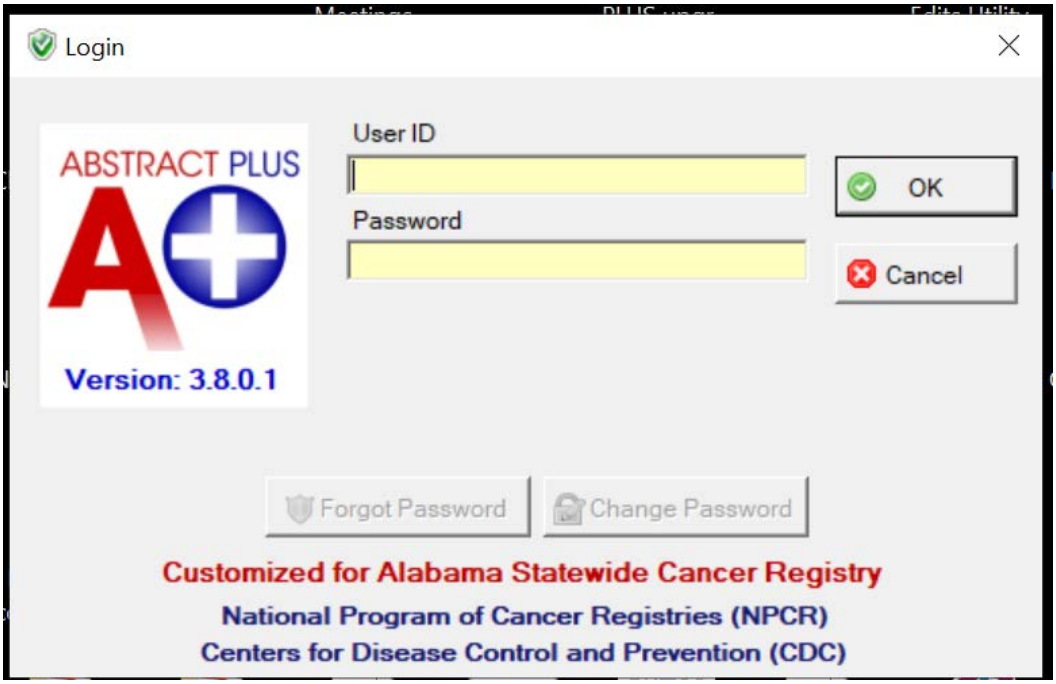
I am Elaine Wooden, and I will be serving as the new Non-Hospital Reporting Source Coordinator. Although I am new to this position, I am not new with the ASCR. Please be patient with us as we make the necessary transitions to better serve you.

~Elaine

Software Update

Please make sure your facility has upgraded to the most recent version of Abstract Plus.

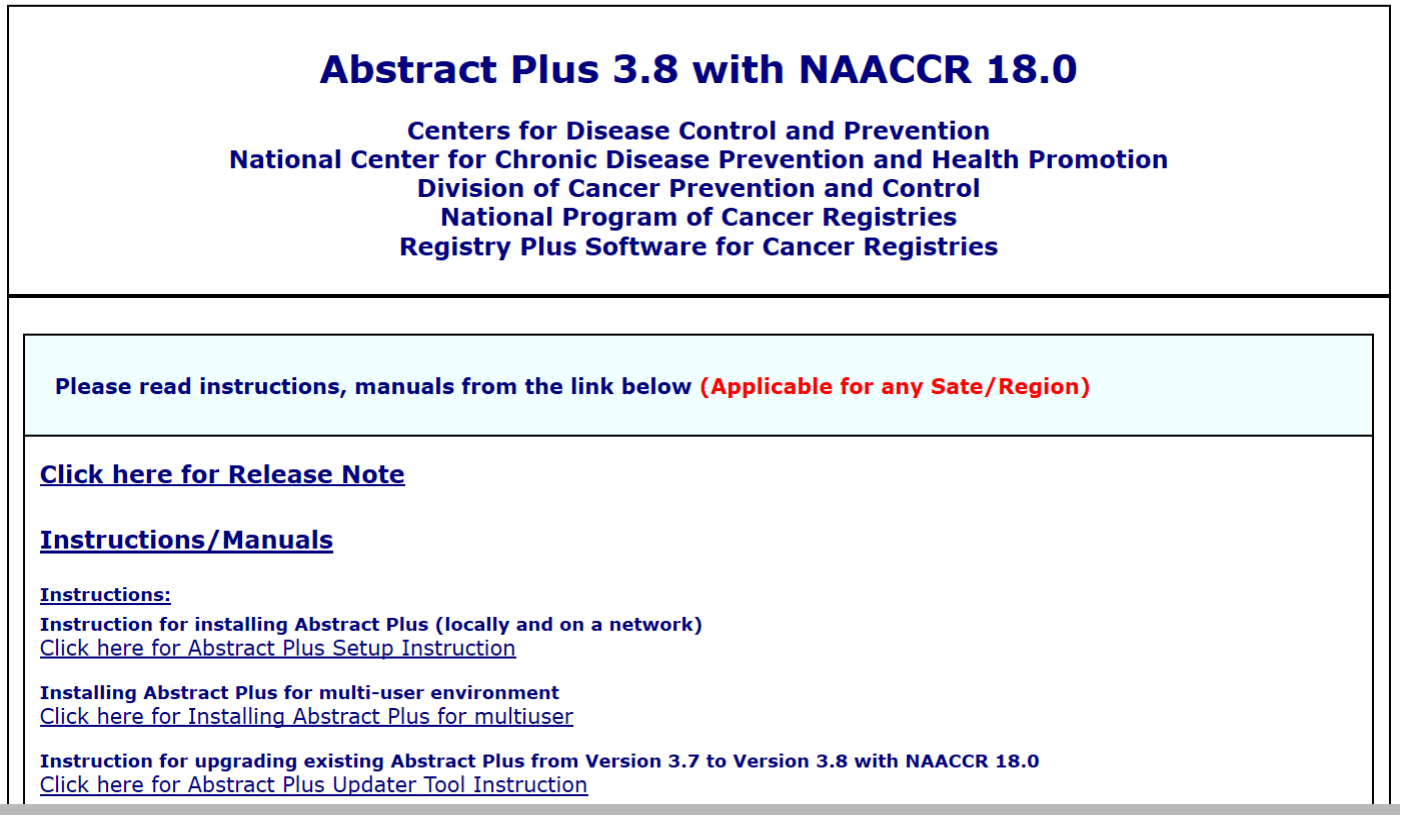
Abstract Plus version 3.8.0.1 includes **V18d NAACCR edits.**



Download and install Abstract Plus V3.8 using the link below.

https://ftp.cdc.gov/pub/NPCR-AP-UPDATES/AbstractPlus/customizations/V180-V38/Index.html

When you open the link, you will see the following to download instructions and manuals:



Abstract Plus 3.8 with NAACCR 18.0

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Division of Cancer Prevention and Control
National Program of Cancer Registries
Registry Plus Software for Cancer Registries

Please read instructions, manuals from the link below (Applicable for any Sate/Region)

Click here for Release Note

Instructions/Manuals

Instructions:
Instruction for installing Abstract Plus (locally and on a network)
Click here for Abstract Plus Setup Instruction

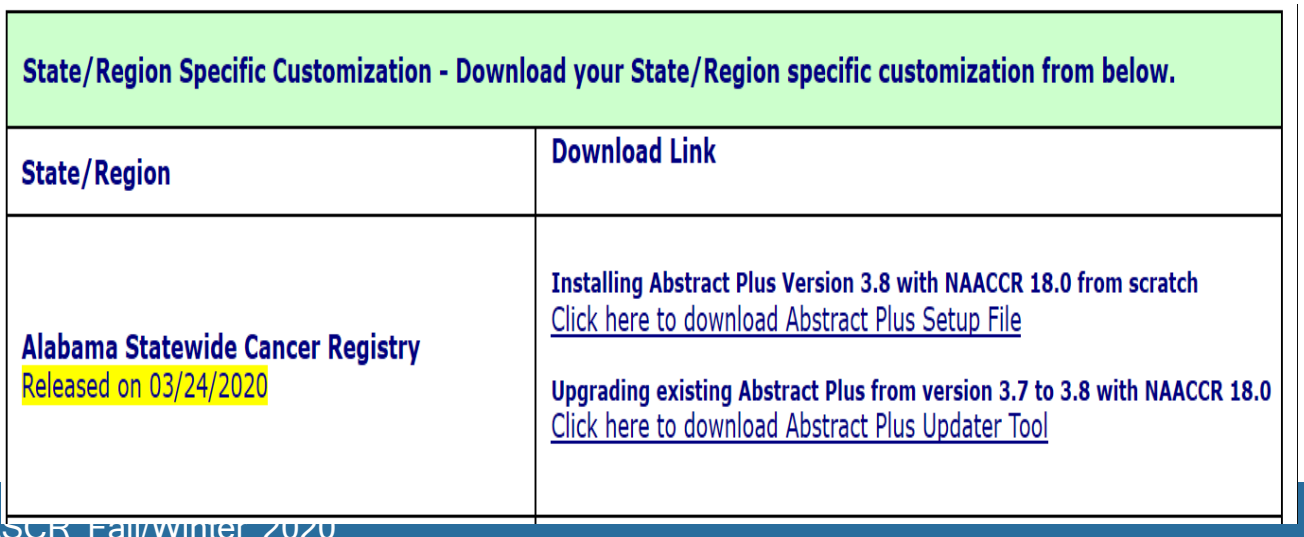
Installing Abstract Plus for multi-user environment
Click here for Installing Abstract Plus for multiuser

Instruction for upgrading existing Abstract Plus from Version 3.7 to Version 3.8 with NAACCR 18.0
Click here for Abstract Plus Updater Tool Instruction

Scroll down the page and locate the State/Region Specific Customization for the Alabama Statewide Cancer Registry.

If you are installing Abs Plus for the first time, please download **Abstract Plus Setup File.**

If you are currently on V3.7, please download the **Updater Tool** to upgrade to V3.8 with NAACCR 18.0:

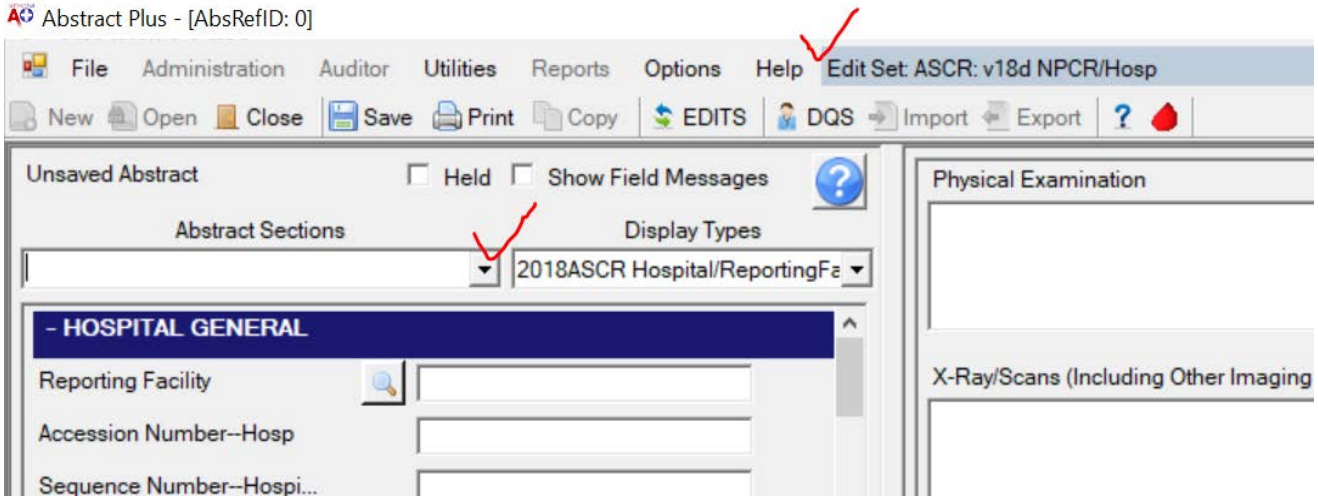


State/Region Specific Customization - Download your State/Region specific customization from below.

State/Region	Download Link
Alabama Statewide Cancer Registry Released on 03/24/2020	**Installing Abstract Plus Version 3.8 with NAACCR 18.0 from scratch** Click here to download Abstract Plus Setup File **Upgrading existing Abstract Plus from version 3.7 to 3.8 with NAACCR 18.0** Click here to download Abstract Plus Updater Tool

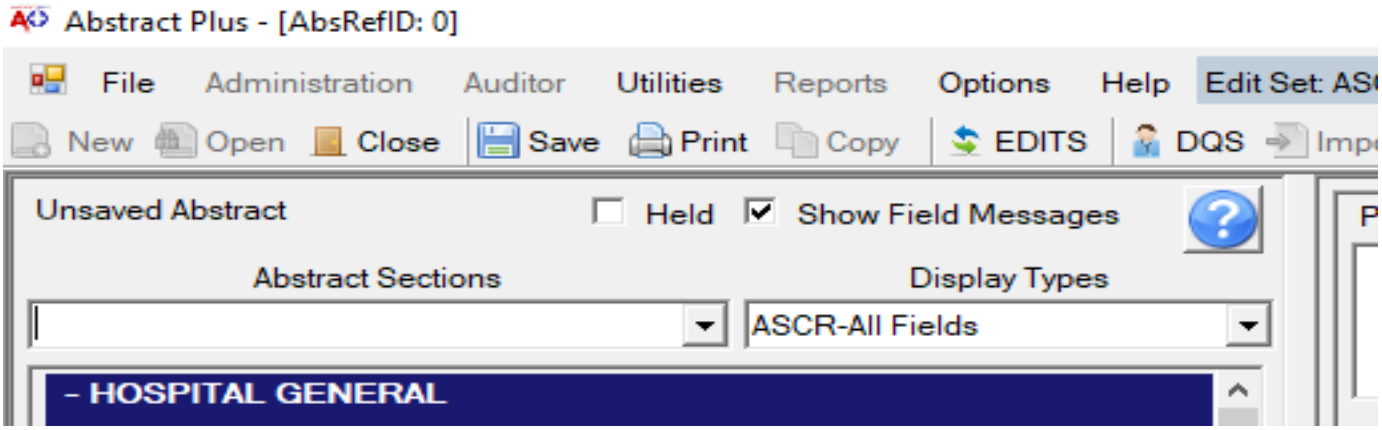
After upgrading Abstract Plus to Version 3.8, please make sure you are using the correct Edit Set:

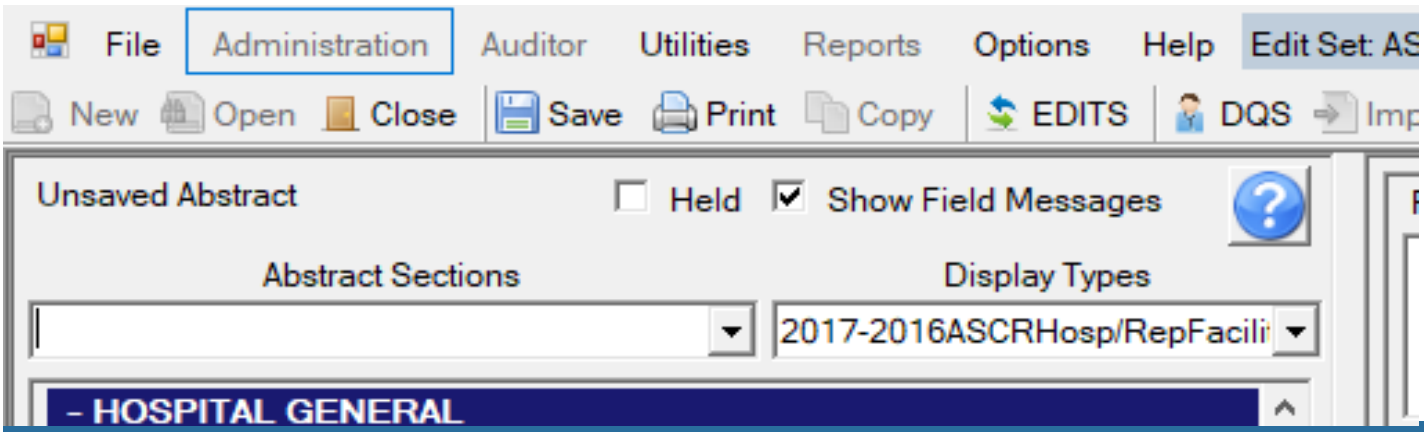
ASCR:v18dNPCR/Hosp and display type, **2018 ASCR Hospital/Reporting Facility** like below:



DISPLAY TYPES

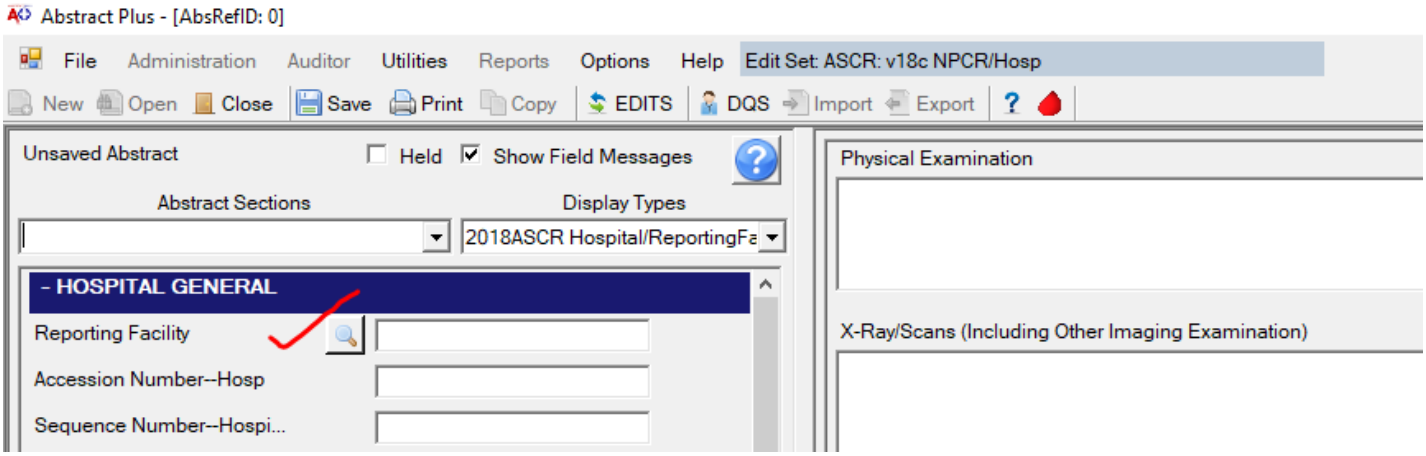
If you need to abstract 2017 and prior diagnosed cases, please use the other two displays which are ASCR-All Fields and 2017-2016 ASCR Hospital/Reporting Facility.



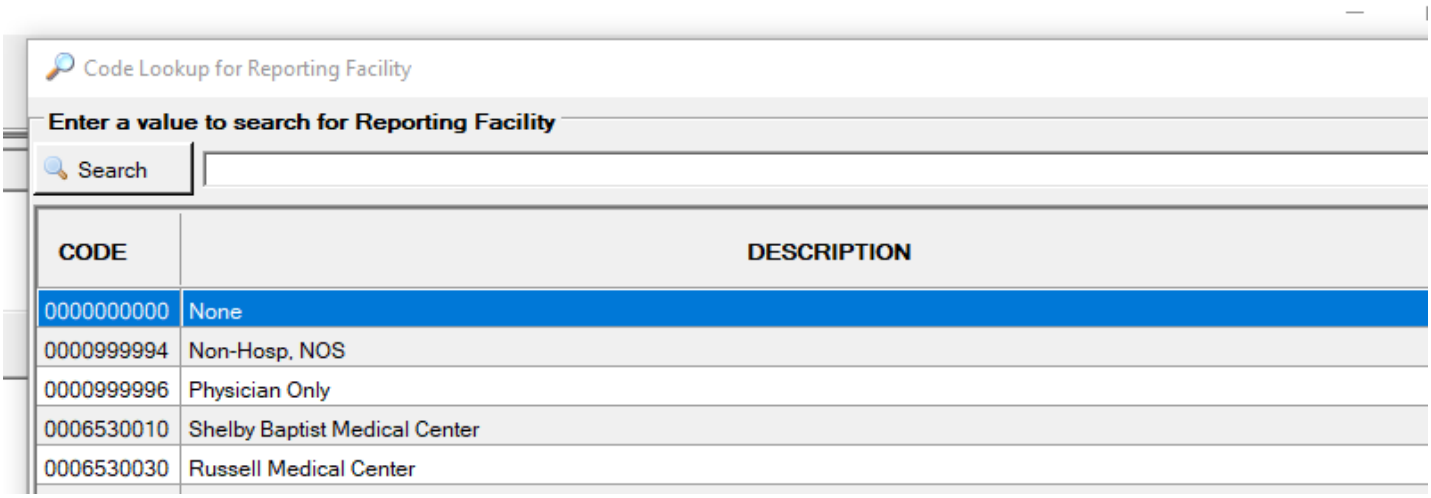


HOSPITAL CODE for Reporting Facility

Please make sure you are using the correct hospital code. You can find your hospital code by using the lookup icon (magnifying glass). See the screen shot below:



Then you can start typing the name of your facility in the search box. It will bring up the code and facility name.



Please contact Farzana or Katelynn and we will be happy to assist you with the installation of Version 3.8.

~ Farzana and Katelynn