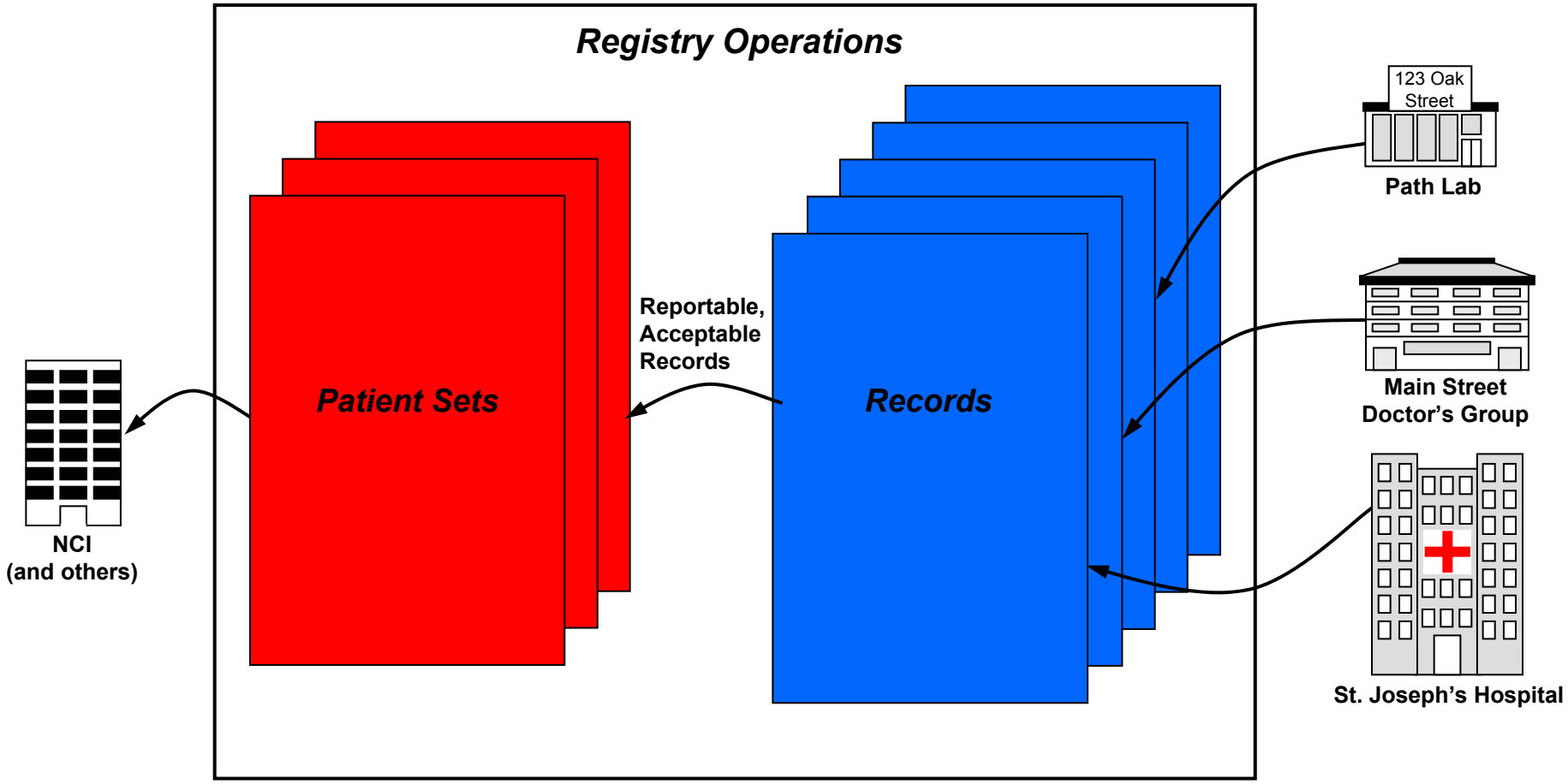
Registry Operations: The Basics



What Are the Types of Records?

There are three categories of records. Every type of record that can be processed in Registry Operations falls under one of these three:

Health Records – A set of information that contains medical information, including vital status. Types of Health Records include:

-- Abstract
-- Autopsy Report
-- Correction Record
-- Cytology Report *
-- Death Certificate
-- Death Index
-- Disease Index/Hospital Discharge File
-- Follow-Up Record
-- Follow-Up Abstract
-- Hematology Report *
-- Indian Health Services (IHS) Record
-- Obituary
-- Oncology Report *
-- Path Report *
-- Radiology Report *
-- Radiotherapy Report
-- Special Study Record (?)
-- Surgery Log

* A type of lab or imaging report.

Supplemental Record – A collection of related data with no health information, generally used to verify personal data and update follow-up information:

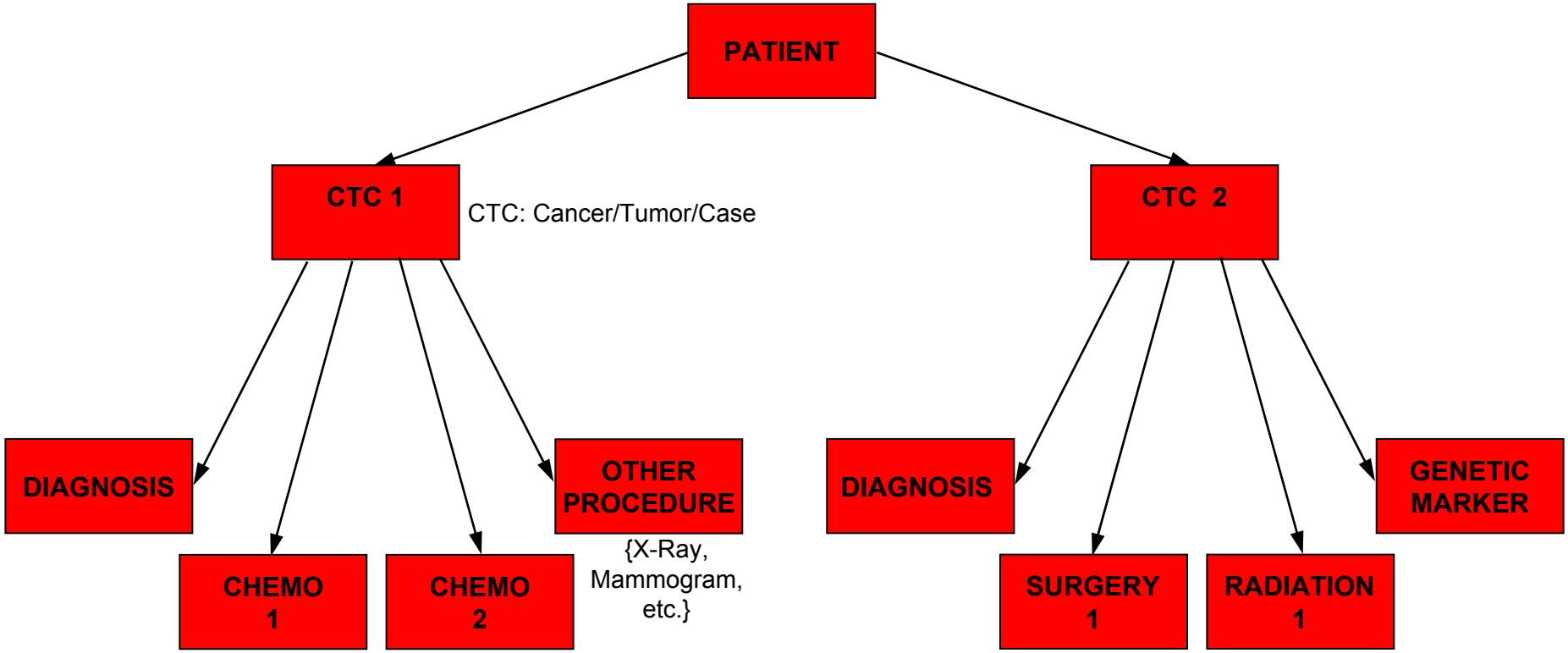
-- CMS (HCFA) File
-- DMV Record
-- Insurance Demographic Information (HMO)
-- IRS Record
-- SSA Death Record
-- State Birth Record
-- Voters Registration

Other – A collection of data with no health or person information. Only includes:

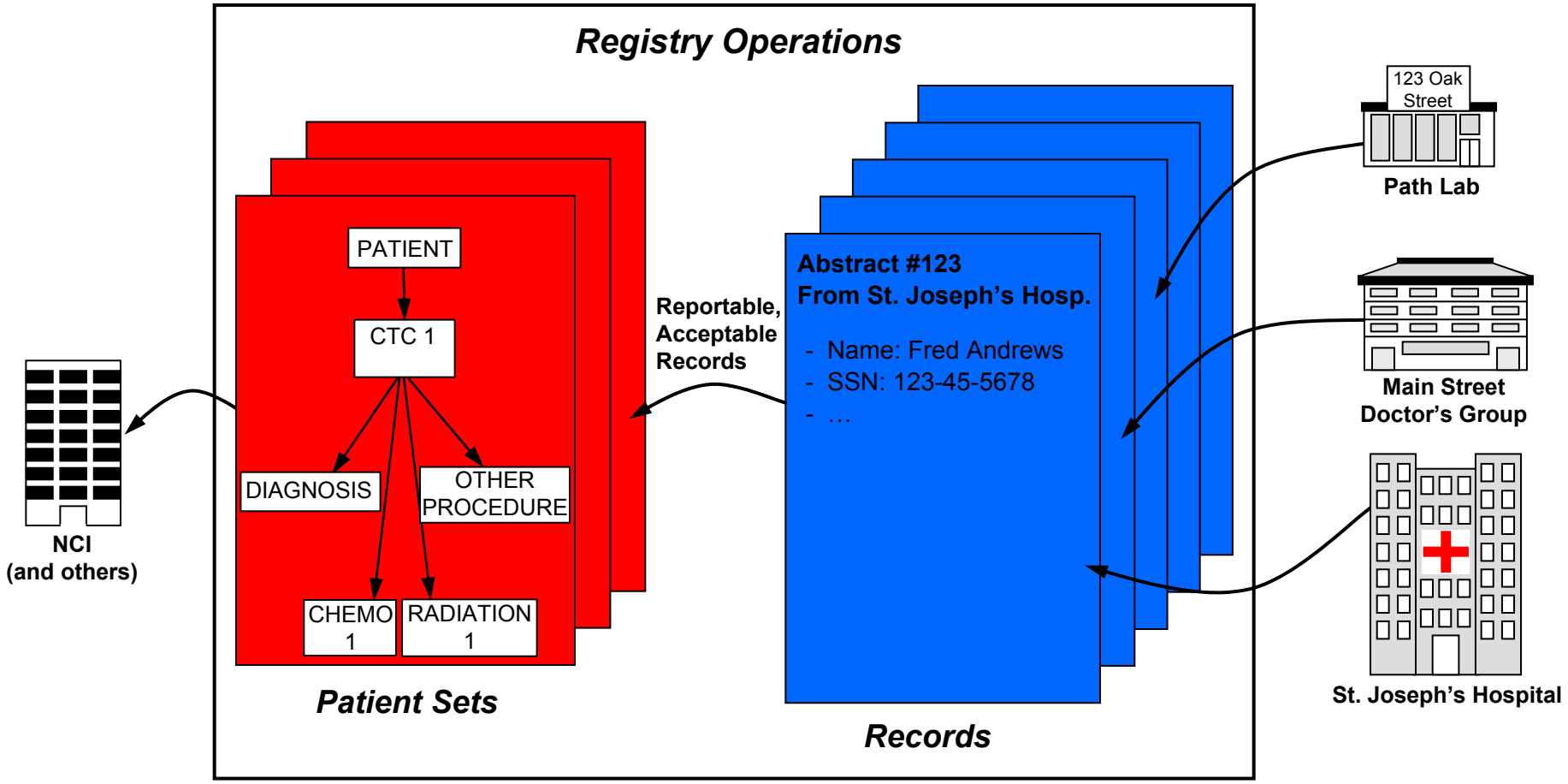
-- Census Tract
-- Name List for Race/Ethnicity

What is in a Patient Set?

Here is an example of what might be in a single Patient Set. Each entity (box) represents an object about which the Registry might collect information. This example is not exhaustive of all that might be included:

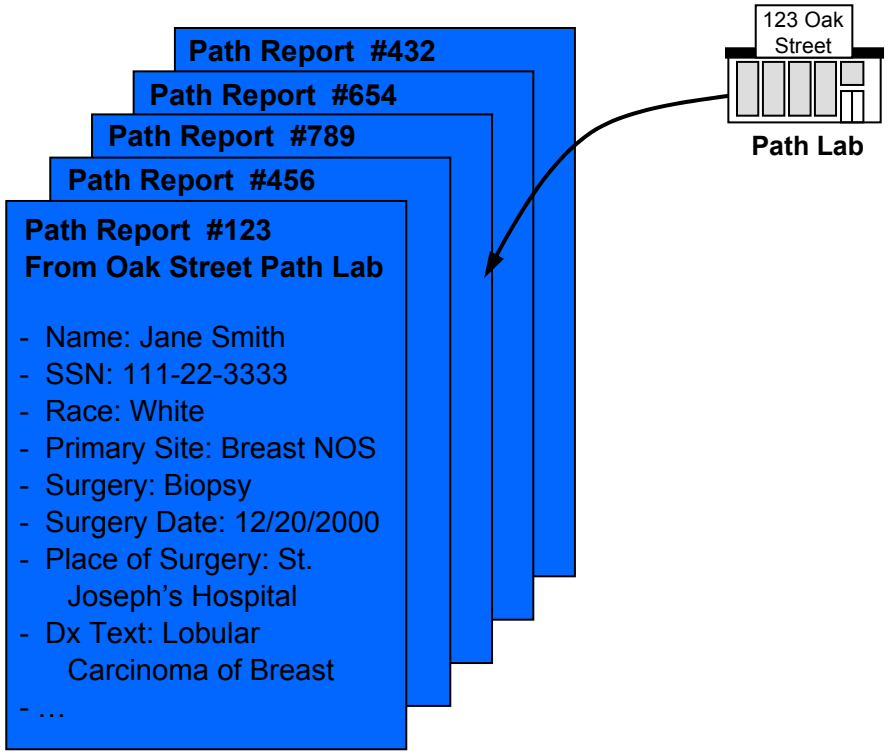


Registry Operations: The Basics Revisited



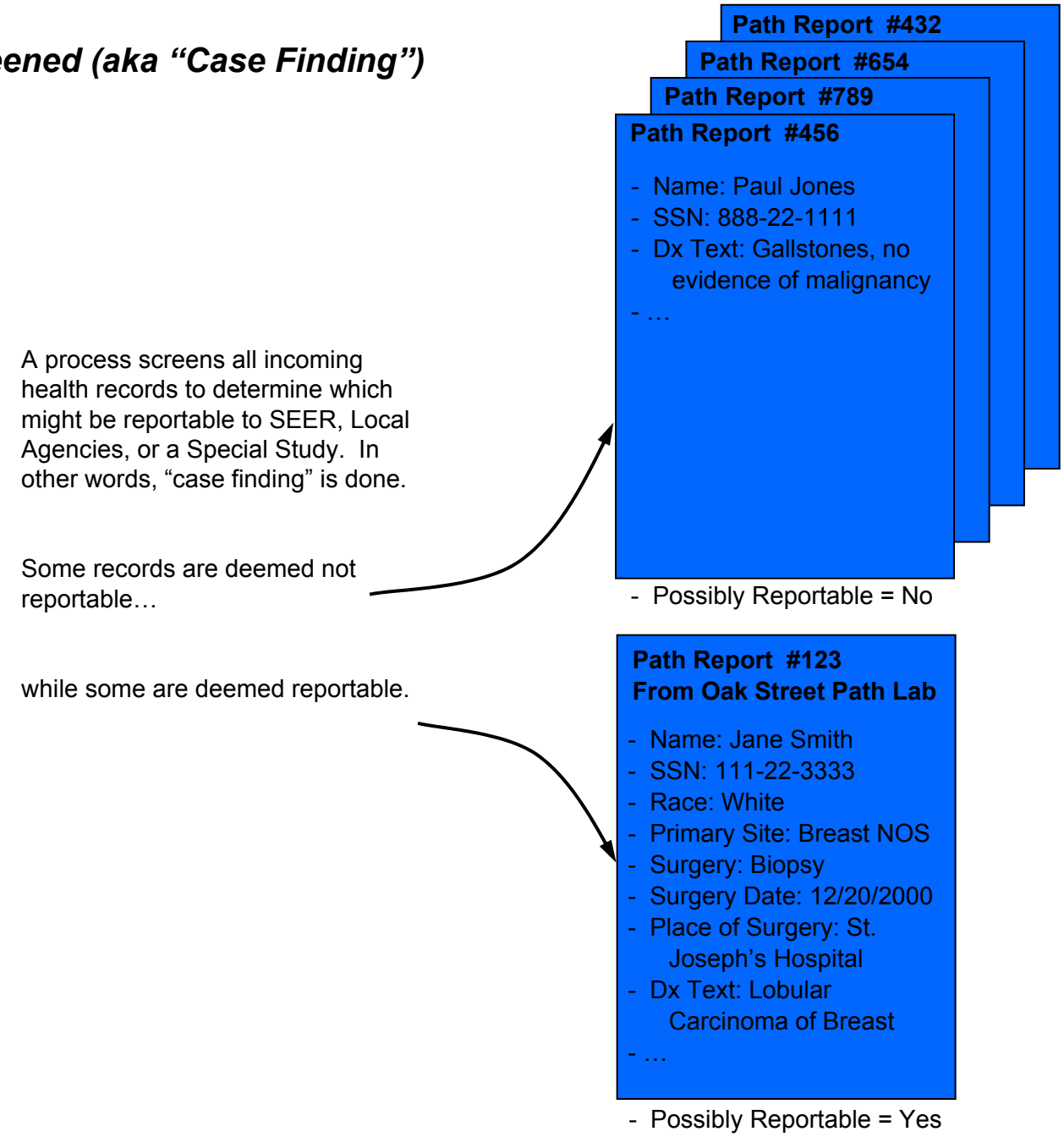
The Story: Step 1

The Registry Receives Path Reports



The Story: Step 2

Path Reports Are Screened (aka "Case Finding")



The Story: Step 3
Path Reports May be Visually Edited

Based on registry policy, any incoming health record may undergo visual editing. Any changes can be flagged as updated to be returned to the data source (here, the Oak Street Path Lab).

Returned updates can be used to determine where additional training may be needed and to keep the information in the central registry and in hospital registries synchronized.

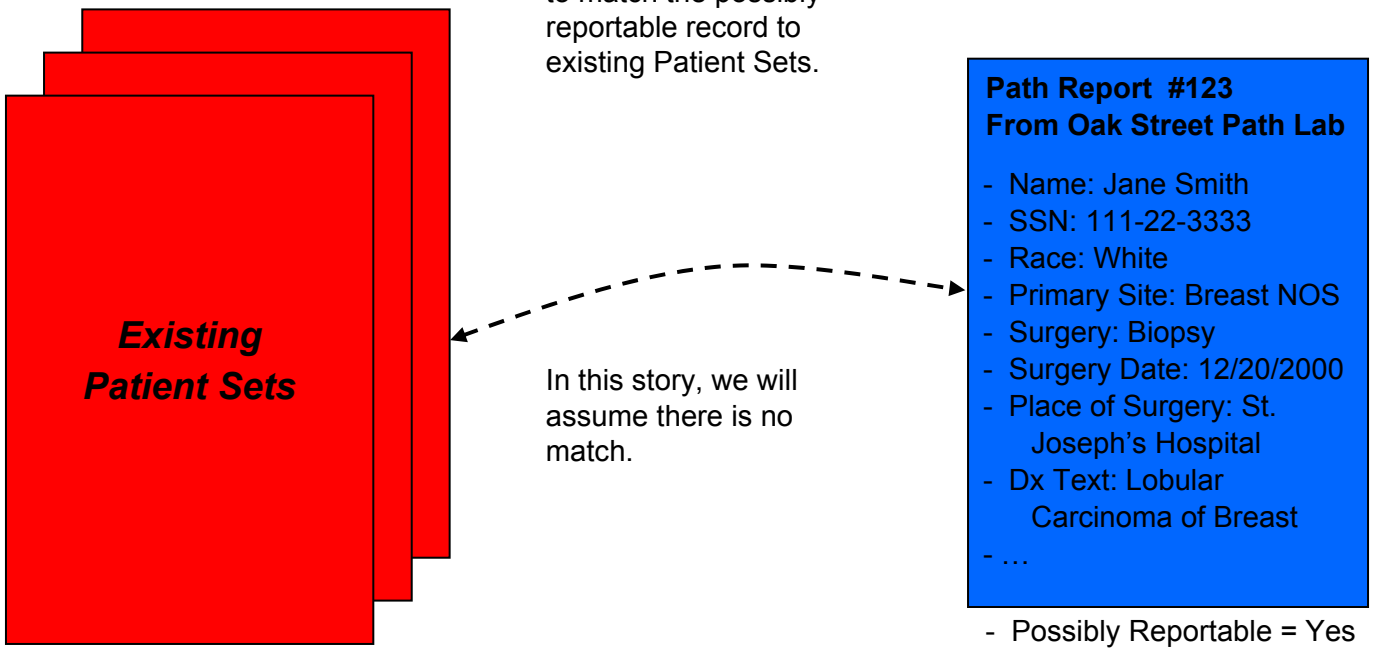
We will assume in this registry that only Abstracts are visually edited.

Path Report #123
From Oak Street Path Lab

- Name: Jane Smith
- SSN: 111-22-3333
- Race: White
- Primary Site: Breast NOS
- Surgery: Biopsy
- Surgery Date: 12/20/2000
- Place of Surgery: St. Joseph's Hospital
- Dx Text: Lobular Carcinoma of Breast
- …

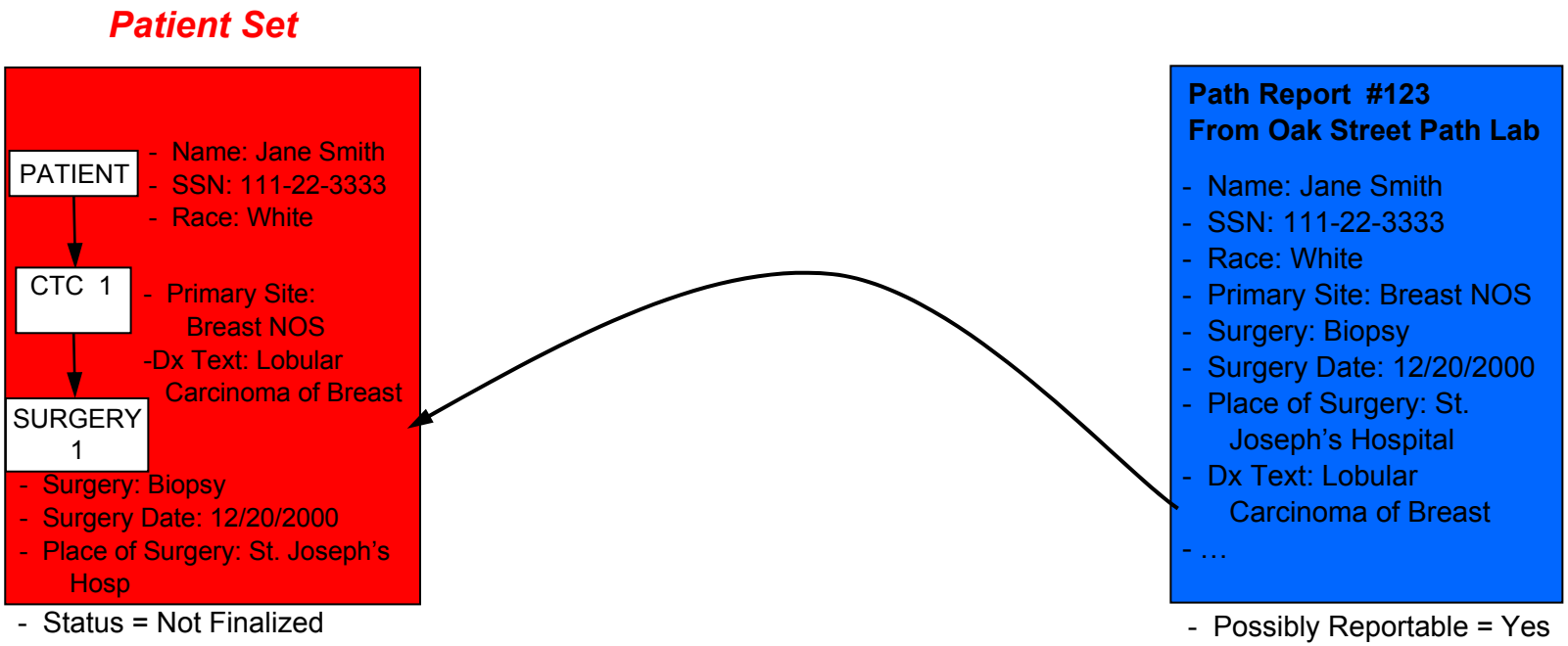
- Possibly Reportable = Yes

The Story: Step 4
The Reportable Path Report is Matched



The Story: Step 5

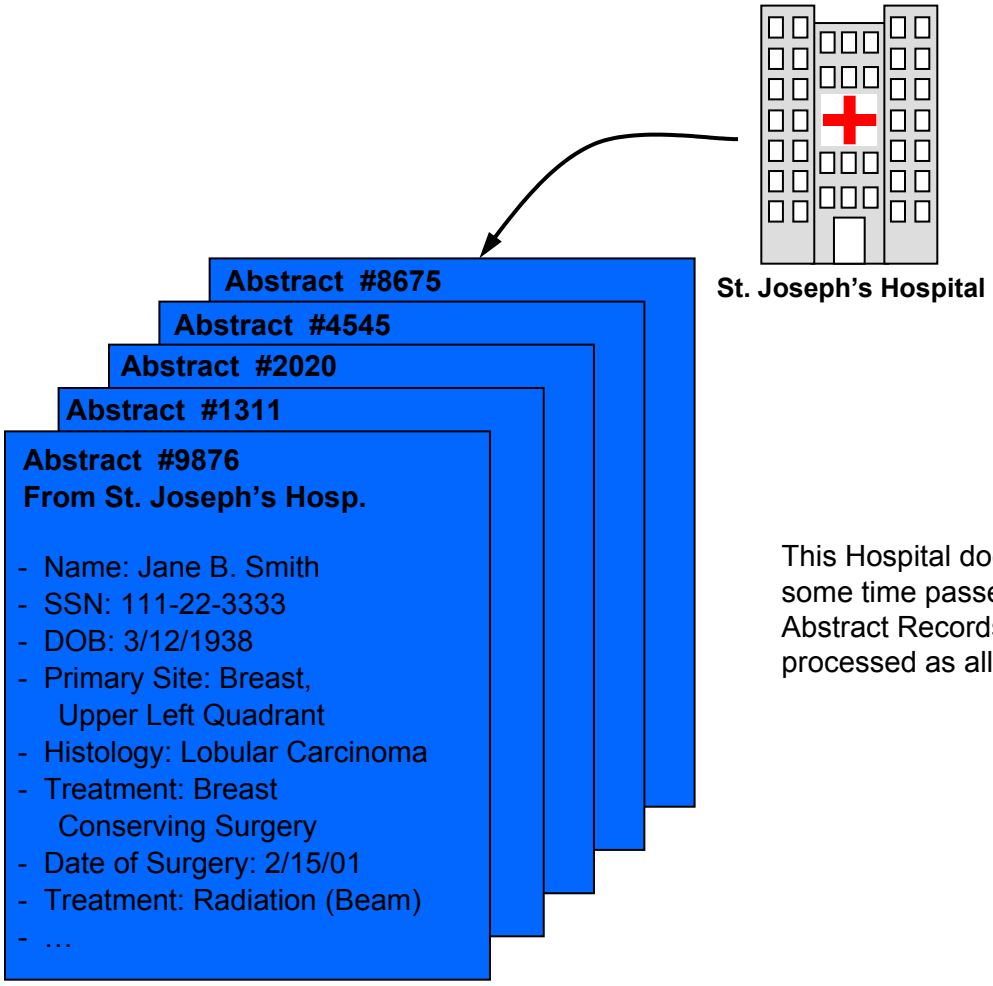
A New Patient Set is Created From That Path Report



Because there was no match to an existing Patient Set, a new one is added. This represents the best information known by the registry about Jane Smith. The patient set is flagged as not finalized, meaning it won't be used for reporting until the Registry deems it ready (hopefully, when the Registry receives and consolidates an Abstract).

The Story: Step 6

The Registry Creates or Receives Abstracts



This Hospital does its own abstracting. After some time passes, St. Joseph's sends Abstract Records to the Registry to be processed as all Health Records are.

The Story: Step 7
The Abstract is Screened and Visually Edited

The new Abstract is screened and found to be possibly reportable.

Again, in this registry, Abstracts are visually edited.

An audit log is created to track all changes. Any change may be flagged as one which needs to be reported back to the data source (St. Joseph's Hospital).

Here, there is one change and the facility is to be notified about the change.

Abstract #9876
From St. Joseph's Hosp.

- Name: Jane B. Smith
- SSN: 111-22-3333
- DOB: 3/12/1938
- Primary Site: Breast, Upper Left Quadrant
- Histology: Lobular Carcinoma
- Treatment: Breast Conserving Surgery
- Date of Surgery: 2/15/01
- Treatment: Radiation (Beam)
- …

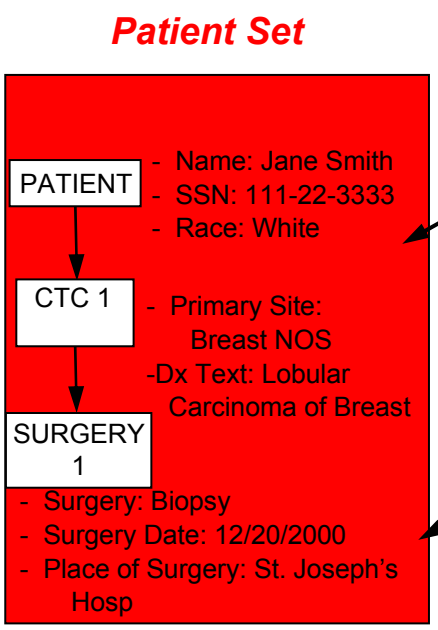
- Possibly Reportable = Yes

Audit Log

1. ICD-10 site code

from	C503 to C502
on	8/26/01
by	Reg Smith
why	Code did not match text
Fac notification?	Yes

The Story: Step 8
The Abstract is Matched



Path Report #123
From Oak Street Path Lab

- Name: Jane Smith
- SSN: 111-22-3333
- Race: White
- Primary Site: Breast NOS
- Surgery: Biopsy
- Surgery Date: 12/20/2000
- Place of Surgery: St. Joseph's Hospital
- Dx Text: Lobular Carcinoma of Breast
- …

- Possibly Reportable = Yes

The new Abstract is matched, and a match is found on Patient and CTC.

Abstract #9876
From St. Joseph's Hosp.

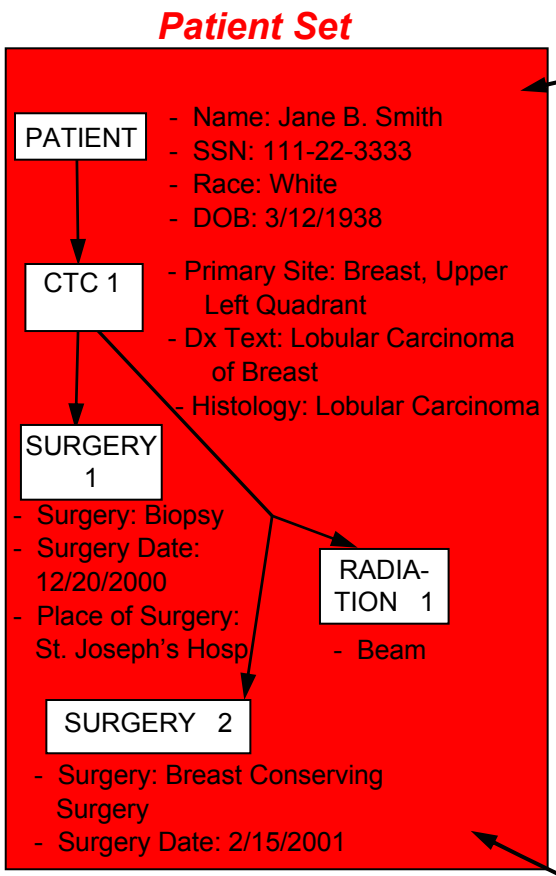
- Name: Jane B. Smith
- SSN: 111-22-3333
- DOB: 3/12/1938
- Primary Site: Breast, Upper Left Quadrant
- Histology: Lobular Carcinoma
- Treatment: Breast Conserving Surgery
- Surgery Date: 2/15/01
- Treatment: Radiation (Beam)
- …

- Possibly Reportable = Yes

Audit Log
1. ICD-10 site code

The Story: Step 9

The Patient Set is Consolidated



- Status = Not Finalized

Audit Log

1. Name
   - from: Jane Smith to Jane B. Smith
   - on: 8/26/01
   - by: Reg Smith
   - why: St. Joseph's Abstract received
2. DOB
3. Primary Site

…

Path Report #123
From Oak Street Path Lab

- Name: Jane Smith
- SSN: 111-22-3333
- Race: White
- Primary Site: Breast NOS
- Surgery: Biopsy
- Surgery Date: 12/20/2000
- Place of Surgery: St. Joseph's Hospital
- Dx Text: Lobular Carcinoma of Breast
- …

- Possibly Reportable = Yes

The information from the edited St. Joseph's Hospital Abstract is consolidated into the Patient Set. This provides the complete, best information the Registry knows about Jane B. Smith's breast tumor.

An audit log is created to track the changes made in the patient set. Global reason (St. Joseph's abstract received) may be assigned to a set of changes. Specific reason may be assigned to each change.

Abstract #9876
From St. Joseph's Hosp.

- Name: Jane B. Smith
- SSN: 111-22-3333
- DOB: 3/12/1938
- Primary Site: Breast, Upper Left Quadrant
- Histology: Lobular Carcinoma
- Treatment: Breast Conserving Surgery
- Surgery Date: 2/15/01
- Treatment: Radiation (Beam)
- …

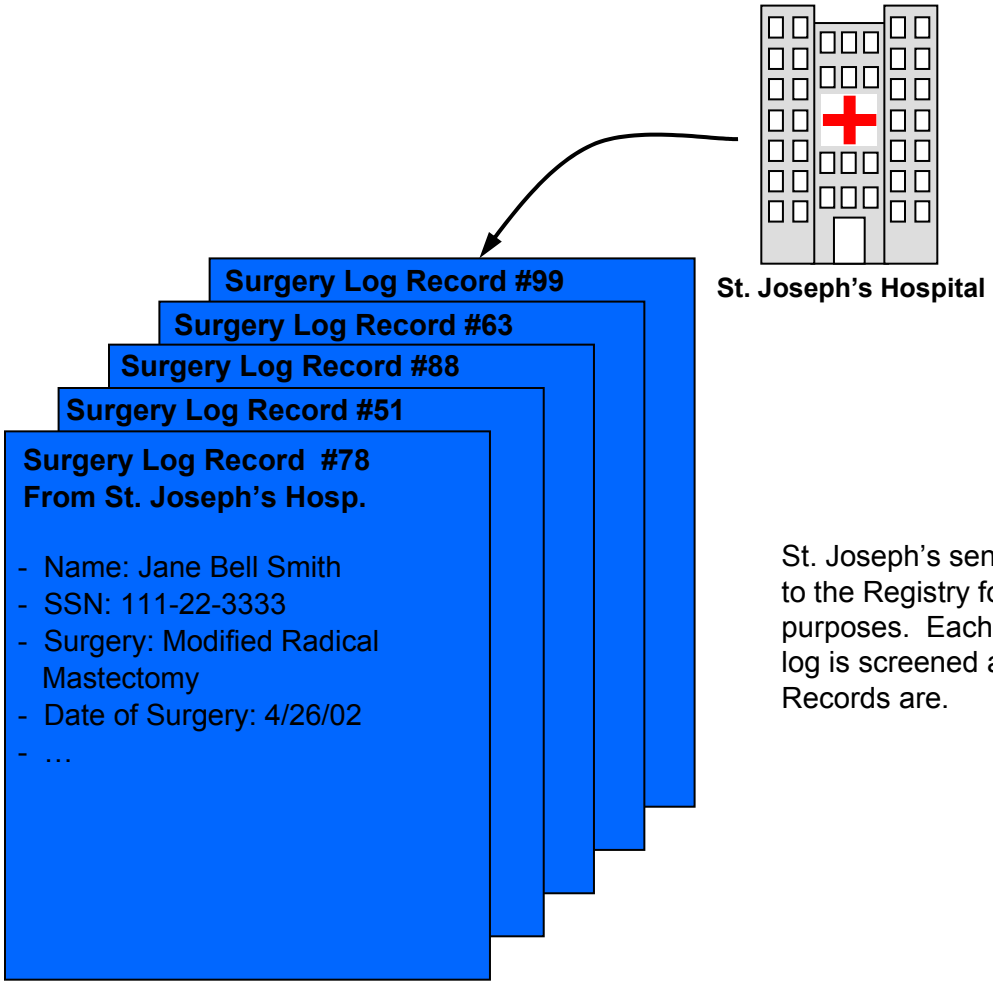
- Possibly Reportable = Yes

Audit Log

1. ICD-10 site code

The Story: Step 10

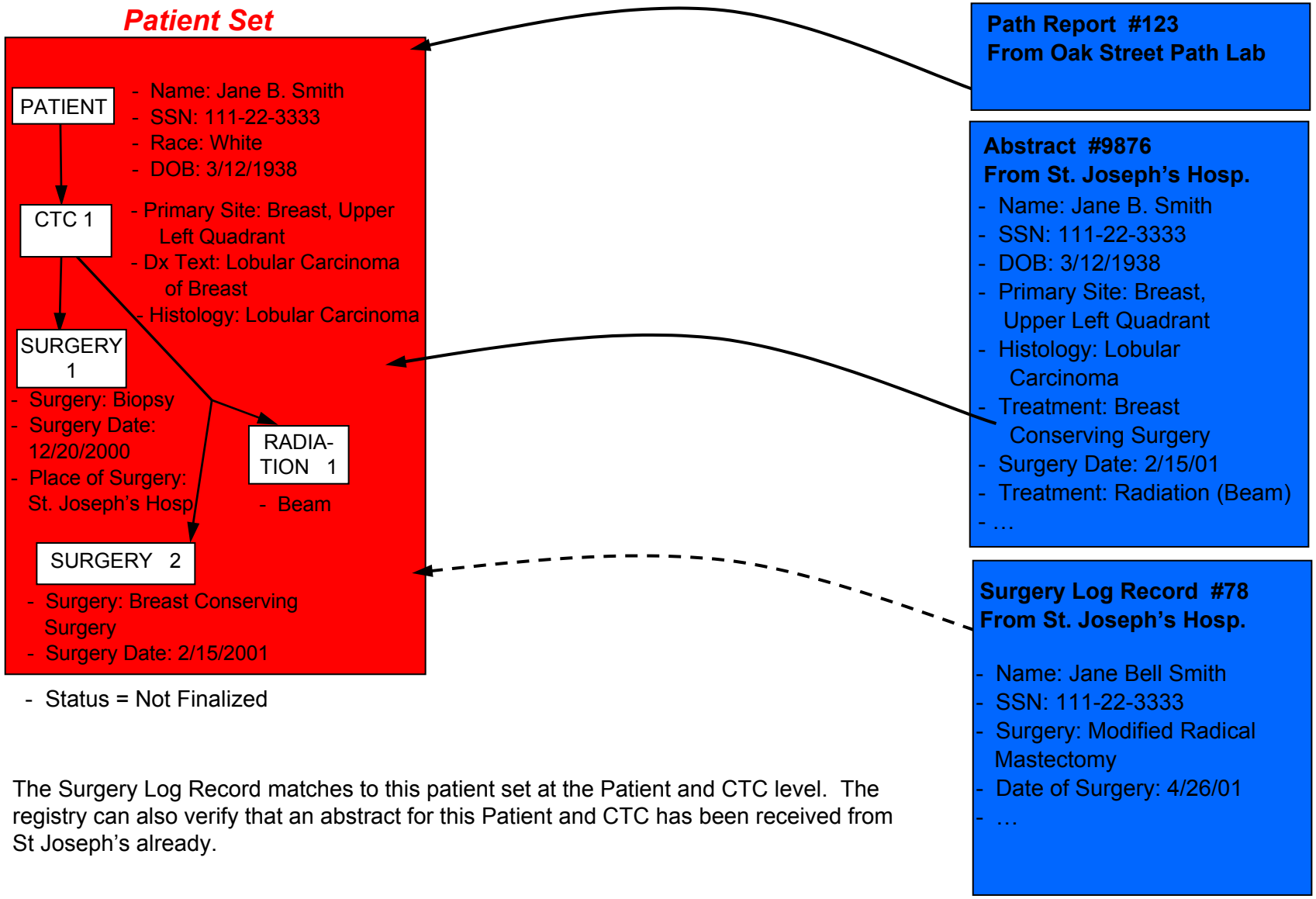
The Surgery Log is Sent by the Hospital and Screened at the Registry



St. Joseph's sends its Surgery Log to the Registry for Quality Control purposes. Each Record within the log is screened as all Health Records are.

The Story: Step 11

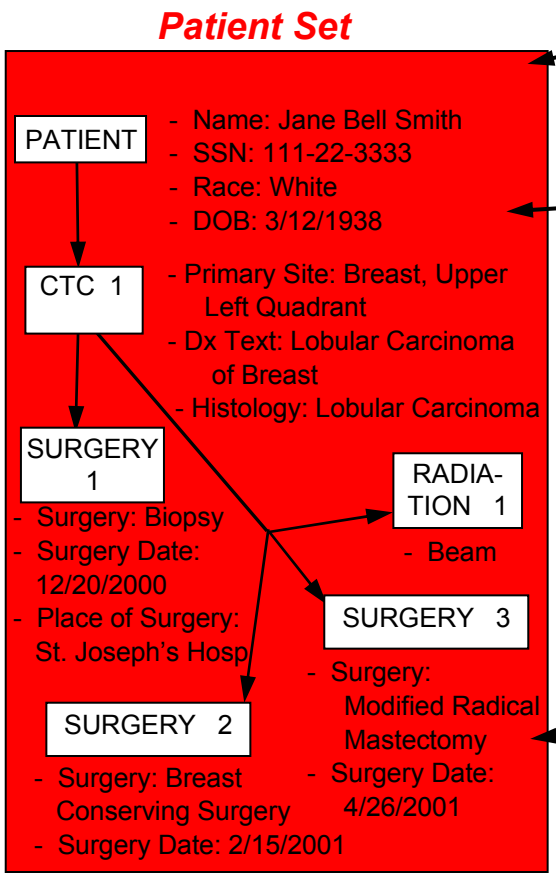
The Surgery Log Matches a Patient and CTC Within a Patient Set



The Surgery Log Record matches to this patient set at the Patient and CTC level. The registry can also verify that an abstract for this Patient and CTC has been received from St Joseph's already.

The Story: Step 12

The Surgery Log is Consolidated into the Patient Set



- Status = Not Finalized

Audit Log

1. Name

…

15. Name

from	Jane B Smith to Jane Bell Smith
on	10/15/01
by	Jess White
why	St. Joseph's surg log received

…

Path Report #123
From Oak Street Path Lab

Abstract #9876
From St. Joseph's Hosp.

- Name: Jane B. Smith
- SSN: 111-22-3333
- DOB: 3/12/1938
- Primary Site: Breast, Upper Left Quadrant
- Histology: Lobular Carcinoma
- Treatment: Breast Conserving Surgery
- Surgery Date: 2/15/01
- Treatment: Radiation (Beam)
- …

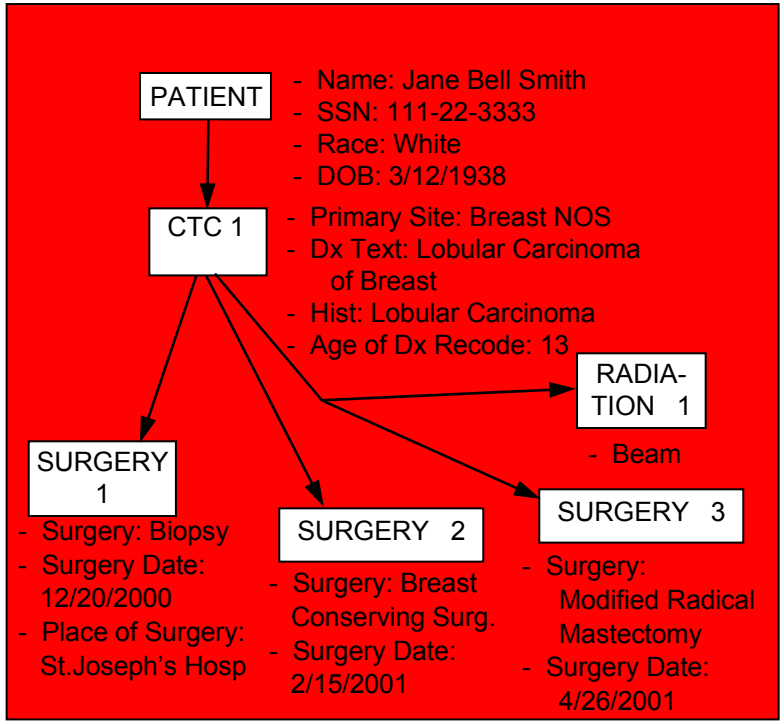
The Surgery Log Record is consolidated into the Patient Set, giving the Registry the best information that it has of Jane Bell Smith's breast tumor. Again, an audit log is created to track changes.

Surgery Log Record #78
From St. Joseph's Hosp.

- Name: Jane Bell Smith
- SSN: 111-22-3333
- Surgery: Modified Radical Mastectomy
- Date of Surgery: 4/26/01
- …

The Story: Step 13
The Patient Set is Finalized

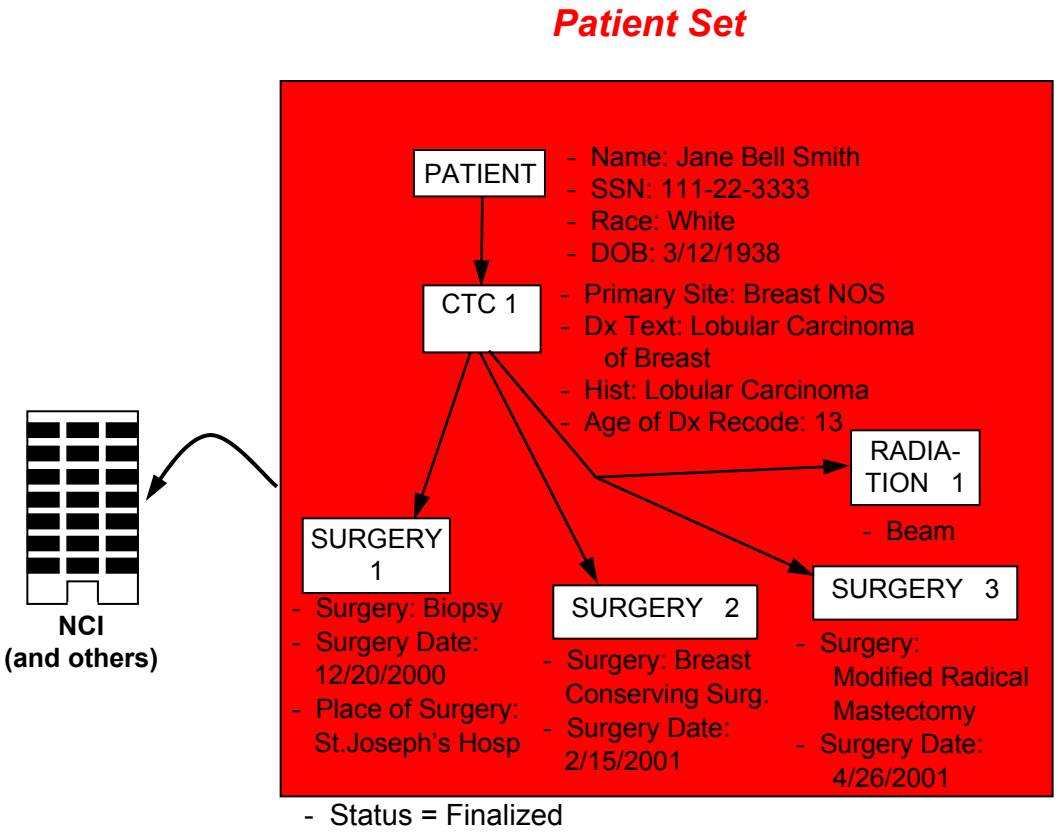
Patient Set



The Patient Set has been consolidated, but not "polished up". At this point, to finalize the Patient Set, the census tract is assigned, ethnicity is assigned, age recode is generated, survival time is calculated, etc.

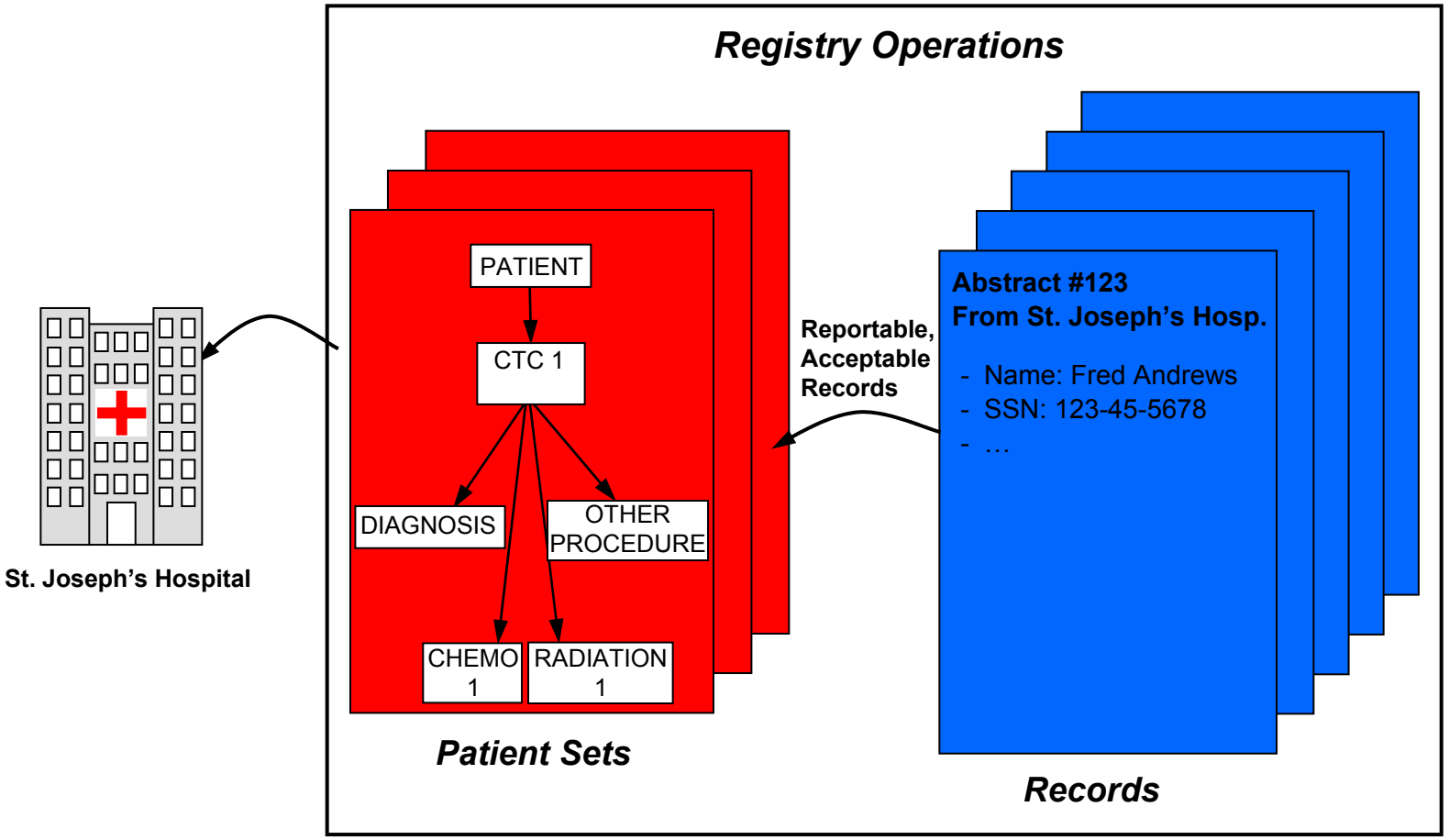
The status is changed to finalized, meaning this information can now be provided to SEER, etc. Finalized is <u>not</u> meant to imply that the patient set will never change again.

The Story: Step 14
Provide Data to SEER and Others



The information in the Patient Set is now ready to be submitted to SEER, etc. Only Patient Sets where Status = Finalized are used for reporting.

The Story: Step 15
Provide Data to Data Sources



Data may be returned to the Data Sources in many ways.

1. Reports may be generated on the Patient Sets, returning information for all Patient/CTCs with which the source has interacted.
2. Communications may be created based on Health record updates which are marked 'Facility Notification=Yes'
3. Reports may be generated on the raw Health Records, providing a summary for each patient of the information reported by the facility.
4. Follow-back queries may be generated to notify the data source that different records have conflicting information.