

# Unlock the Potential of the Cancer Registrar



## *Dual responsibilities—good for staff, better for programs*

**T**he cancer registry profession is best known for its data collection and dissemination of cancer incidence, stage, and survival information. Cancer registrars—the backbone of cancer programs—historically have been limited to gleaning information from charts, preparing facility data reports, and conveying this data to the National Cancer Database. This database, jointly sponsored by the American College of Surgeons' Commission on Cancer (CoC) and the American Cancer Society (ACS), receives data from accredited cancer programs (about 30 million historical records) and provides public data on approximately 70 percent of newly diagnosed cancers nationwide.<sup>1</sup>

Registrars prepare abstracts for each cancer patient that include demographic information, cancer identification, treatment, follow-up, and survivorship. The data must be accurate, and registrars are charged by facility, state, and national requirements to ensure that the data are complete. During the case-finding process, registrars review facility records (both inpatient and outpatient cases), diagnostic radiology, pathology, medical, and radiation oncology records. Follow-up tasks include tracking patients from the time of diagnosis through death, using as many reliable sources as possible to ascertain whether or not a cancer patient is still alive, is recurrent, or is disease free.

While this data collection is crucial in understanding cancer incidence rates and to help in the management of a cancer patient's care and treatment, more and more registrars are becoming involved in other aspects of their cancer program. In a day and

age when multi-tasking is becoming the norm, cancer registrars are doing far more than case-finding, abstracting, and follow-up.

### **Other Duties as Assigned**

For larger institutions, there are often too many cancer cases for the registrar to move beyond the traditional registry responsibilities discussed above. However, for many community cancer programs (programs that accession more than 100, but less than 500 newly diagnosed cancers each year<sup>2</sup>), a cancer registrar often has the time to become involved with other aspects of the cancer program. This includes, but is not limited to:

- Cancer conference activities
- Oncology committee projects
- Screening and prevention initiatives
- Community outreach programs.

Cancer registrars have a strong working knowledge of the information captured in the cancer registry database. They work with the cancer data on a continuous basis through collection and dissemination of the information, and their attention to detail makes them a natural resource to tap when developing cancer program initiatives. This expertise can prove to be good for staff and even better for the patients and the community served by the cancer program. Here is the story of how Eastside Medical Center, Snellville, Ga., and Atlantic General Hospital, Berlin, Md., are

using their cancer registrars to fill a critical role in each facility's lung cancer screening program.

### How LDCT Changed the Landscape

According to the American Cancer Society (ACS), lung cancer is the leading cause of cancer deaths, and it is estimated that there will be a total of 158,040 deaths (both men and women) from lung cancer in the United States in 2015.<sup>3</sup> Until recently, studies for early lung cancer detection were limited to chest X-rays, sputum, and bronchoscopic studies. Unfortunately, these studies did not lead to a reduction in the disease. It was not until the use of low-dose computed tomography (LDCT) and its ability to detect small, early-stage lung cancers that a reduction in mortality occurred. In fact, two clinical trials in the United States and Europe both found a 20 percent reduction in lung cancer deaths in current smokers who used LDCT screening as a diagnostic tool. Based on the results of these studies and others, including the National Lung Screening Trial, the ACS issued guidelines for lung cancer screenings in 2013.<sup>3</sup> In December 2013, the U.S. Preventive Services Task Force (USPSTF) recommended that patients between the ages of 55 and 80 with a history of smoking receive annual screenings for lung cancer with LDCT. Patients who had a 30 pack per year smoking history or those who had quit within the last 15 years were eligible for this screening.<sup>4</sup> On February 5, 2015, the Centers for Medicare & Medicaid Services (CMS) issued a final national coverage determination for LDCT for Medicare beneficiaries who meet established criteria.<sup>5</sup>

### The Eastside Medical Center Experience

In 2013, after reviewing its statistics, Eastside Medical Center, a CoC-accredited community cancer program, felt that it should consider LDCT screening as part of its lung cancer detection and prevention program. Eastside Medical Center is a 300-plus bed facility located in the southeastern portion of Gwinnett County, Ga. Lung cancer accounts for approximately 15 percent of the annual accession rate; 35 percent of the cases are Stage 4 disease. After journal reviews, as well as analysis of the National Lung Screening Trial, Eastside felt that it would be in the best interest of the community to implement an LDCT lung cancer screening program.

Under the guidance of its Oncology Committee, Eastside Medical Center established a subcommittee that included the center's administration, cancer registrar, and staff representatives from the medical and radiation oncology, pulmonology, diagnostic radiology, and thoracic surgery departments. The subcommittee developed a lung screening schema and patient-care path (Figure 1, right).

From the time the screening program was initiated, the cancer registrar played a critical role, assisting the oncology director in patient scheduling, order form development, patient follow-up documentation, and the creation of marketing materials. Eastside

produced a "self-pay" order form, and members from the hospital's registration department worked with the oncology director and cancer registrar on patient intake and payment. The oncology director took on the role of lung screening patient navigator, with the registrar providing documentation on the screenings to the director, key physicians (diagnostic radiology, primary care, and pulmonology), and patients.

From the time the screening program was initiated, the cancer registrar played a critical role, assisting the oncology director in patient scheduling, order form development, patient follow-up documentation, and the creation of marketing materials.

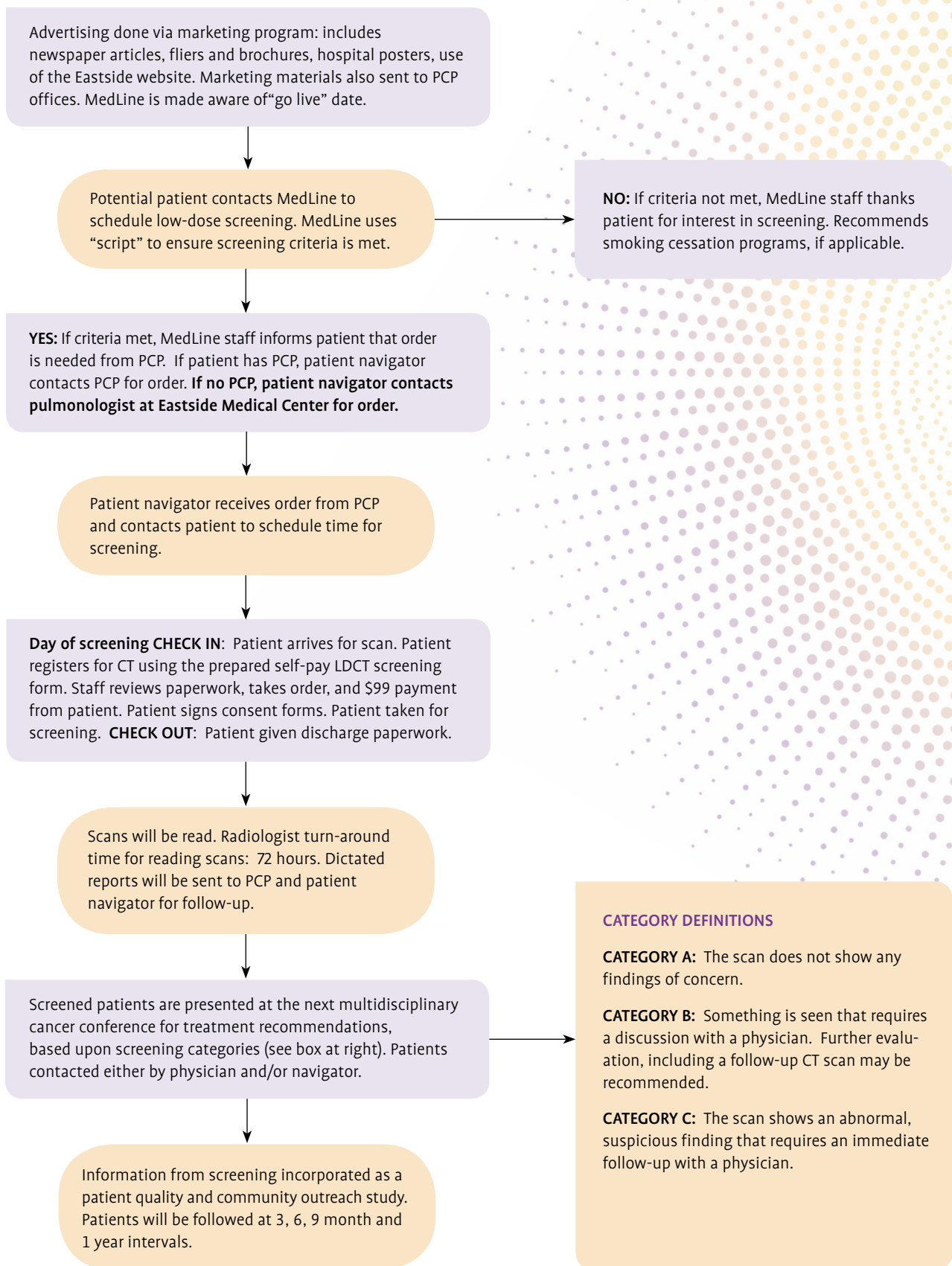
Eastside Medical Center marketed the program in the Gwinnett County area, and was able to provide a self-pay, low-dose CT lung cancer screening that initially cost \$149. At that time, the only other hospitals providing these services were located in the northwest Atlanta corridor, and they were charging \$249 per self-pay screening. On the day the LDCT lung cancer screening program was launched, nine patients were screened and the registrar—under the instruction of the oncology director—contacted referring physicians with the patients' results. All nine cases were discussed at a special multidisciplinary lung screening conference, and recommendations from the physicians at the conference were provided to the patients' referring or primary care (PCP) physicians.

As the LDCT lung cancer screening program evolved, the cost was reduced to \$99 and the cancer registrar became more involved with the patient navigation role through patient navigation software and related training provided by the Sarah Cannon Cancer Institute. By mid-2014, the cancer registrar had officially assumed the role of lung screening patient navigator. Today, the registrar is the lead staff person managing Eastside Medical Center's LDCT Lung Cancer Screening Program.

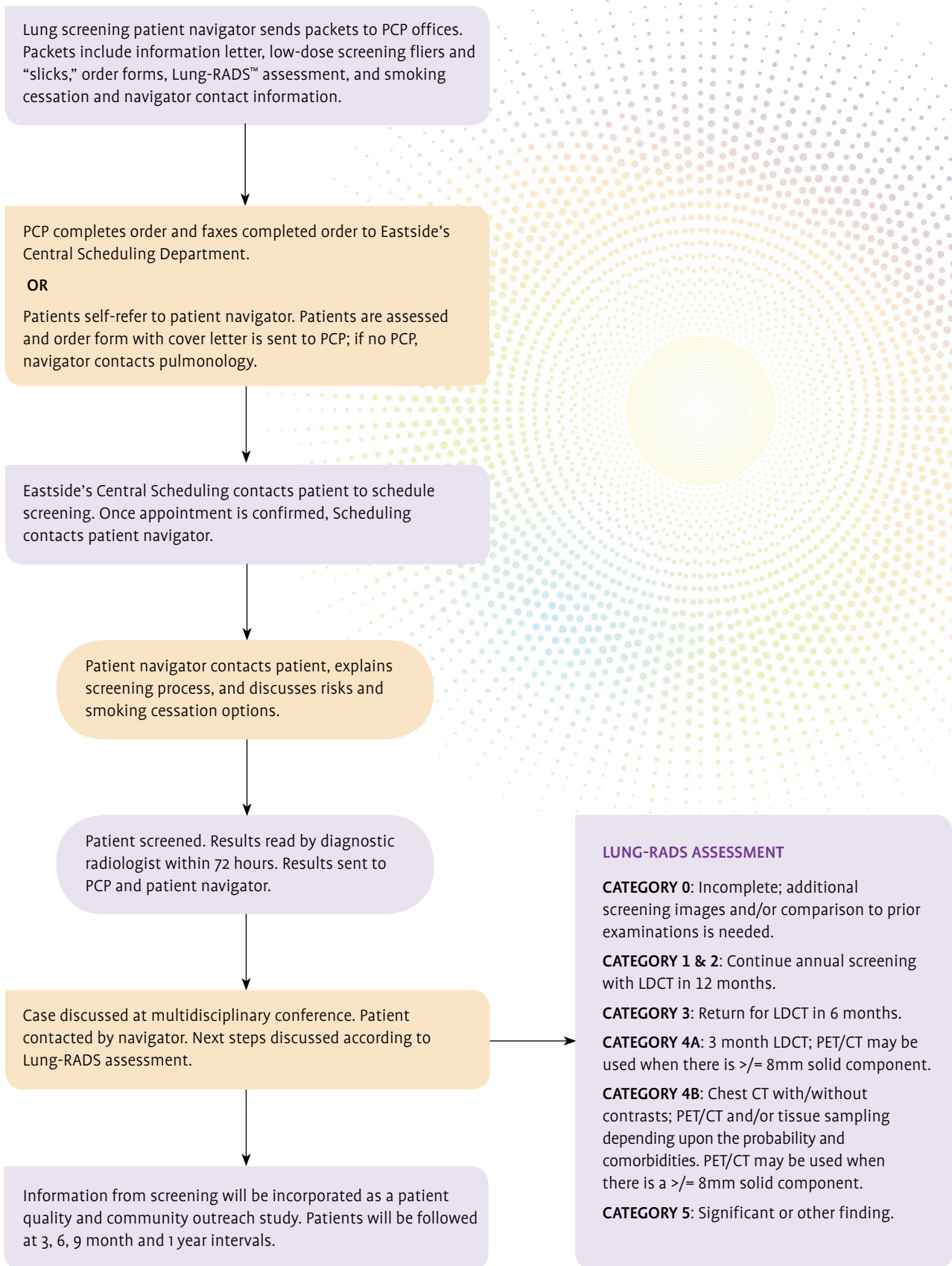
Since the program's inception in December 2013, the number of lung cancer screenings has continued to grow, with nine screenings in the first month of the program to more than 15 screenings in July 2015. In 2014 Eastside Medical Center became a member of the national Lung Cancer Alliance (LCA), and was named a Low-Dose Lung Screening Center of Excellence. The facility is

*(continued on page 39)*

**Figure 1. Eastside Medical Center's 2013 Lung Cancer Screening Schema**



**Figure 2. Eastside Medical Center’s Current Lung Cancer Screening Schema**



(continued from page 36)

listed on the National Lung Cancer Alliance website. As a result, Eastside Medical Center receives many inquiries from other facilities about how to replicate its successful screening program. Eastside promotes its affiliation with Lung Cancer Alliance and its designation as a center of excellence to help educate the community on the importance of low-dose screenings, using many LCA materials to promote lung cancer screening and Lung Cancer Awareness Month in November. (In 2015 ACCC also partnered with LCA to identify lung cancer resources, including member-shared tools that are available at: [accc-cancer.org/lung](http://accc-cancer.org/lung).)

Based on USPSTF recommendations, Eastside Medical Center decided to streamline the processes for its LDCT lung cancer screening program in 2015 (Figure 2, left). To that end, the registrar met with members of the hospital's revenue integrity department, who provided payer codes and details for Medicare billing. Initially, as the Centers for Medicare & Medicaid Services (CMS) had not set a pay scale for Medicare patients, Eastside Medical Center decided to hold for payment all Medicare billings. In April 2015, CMS released coding guidance and a pay scale for screening and the registrar developed a new LDCT lung cancer screening form based on the new guidelines. After hospital approval, the registrar sent copies of the form to registration personnel and the central scheduling department; the registrar also performed an in-service with both departments. Marketing collateral was revised, and these updated fliers and information cards were posted on the hospital's website. The registrar worked with two diagnostic radiologists who would exclusively read the low-dose scans. Using the American College of Radiology's Lung-RADS™ (Lung CT Screening Reporting and Data System), patients are now placed into categories according to their results (see Table 3, page 40).

Marketing to physicians has been very beneficial to Eastside Medical Center's LDCT lung cancer screening program. With assistance from the Oncology Committee, marketing, and physician-support representatives, the registrar developed information packets specifically for primary care physicians that contained pertinent information, such as direct phone numbers and screening forms. Working with physician-support representatives, these packets were distributed at quarterly physician meetings, directly to PCP offices, and at a Primary Care Symposium sponsored by Eastside Medical Center in November 2015. The packets were well-received by the physicians and their staff.

These efforts have paid off in a number of ways. Because of the streamlined process, Eastside Medical Center was able to eliminate the use of MedLine, the company that provided the original patient intake services. Now patients can either contact the lung screening patient navigator (i.e., the cancer registrar) directly to schedule an appointment or can be referred directly by their physician to Eastside Medical Center's central scheduling department via the new LDCT lung cancer screening orders. If contacted directly by a potential

screening applicant, the lung screening patient navigator can explain the process for qualifying for a LDCT screening. In this scenario, the registrar takes the lead, contacting the patient and ensuring that a low-dose screening order form is completed by the physician and then sent to Eastside Medical Center's central scheduling department. When a screening form is sent directly to the central scheduling department, a daily report is provided to the lung screening patient navigator, who in turn contacts the patient. The lung screening patient navigator calls patients to gauge their understanding of the LDCT screening process. During the conversation, the navigator confirms that patients were informed about the risks of LDCT, discusses smoking cessation programs, and helps allay any patient fears. The one-on-one call affords an excellent time for patients to ask and have questions answered. This process also allows the lung screening patient navigator to further educate patients about the screening process.

---

To date, Eastside Medical Center has screened nearly 100 patients at its LDCT lung cancer screening program—an impressive number for a community hospital of its size.

---

Once the LDCT screening is completed and read, the lung screening patient navigator receives the report and contacts the referring physician's office. All recent screening cases are presented at the multidisciplinary conference for discussion and recommendations. Once the case is reviewed, the lung screening patient navigator contacts the patient via phone or letter. Patients are also provided information on the Lung Cancer Alliance and are given literature on the American Cancer Society's *FreshStart*® program ([acsworkplacesolutions.com](http://acsworkplacesolutions.com)), including current class times, dates, and locations.

To date, Eastside Medical Center has screened nearly 100 patients at its LDCT lung cancer screening program—an impressive number for a community hospital of its size. This is not to say that there have not been challenges. As with all programs, the LDCT lung cancer screening program is a work in progress, and all parties are continuing to make the process more efficient. Some adjustments include the revenue integrity department reviewing each LDCT screening to ensure that Medicare-eligible cases are placed on hold. Registration has become much easier with the new forms, since self-pay is no longer a requirement. The central scheduling department developed and built new

dictionaries and reference lists for ease of scheduling. New schedulers are provided with the specifics for the LDCT screenings and are in contact with the lung screening patient navigator. Most questions relate to use of the proper form. When schedulers call to inform the lung screening patient navigator that an improper screening form was sent by a physician office, the navigator contacts the physician office, sending a copy of the form and asking for completion and resubmission.

### But What about the Registry?

The cancer registry at Eastside Medical Center has only one registrar on staff who is responsible for all aspects of the registry. Extra time is required for the LDCT lung screening program, which many might think is an added burden for the registrar, but it is not. Cancer registrars pride themselves on their ability to be self-sufficient and manage their time. Many registrars have an innate capability to juggle many different tasks and responsibilities. Eastside Medical Center averages approximately three LDCT lung cancer screenings per week. With the new process, the

**Table 3. Lung-RADS™ Version 1.0 Assessment Categories**

| CATEGORY DESCRIPTOR           | CATEGORY DESCRIPTOR   | PRIMARY CATEGORY | MANAGEMENT  |
|-------------------------------|---|------------------|---|
| Incomplete                    | N/A   | 0                | Additional lung cancer screening CT images and/or comparison to prior chest CT examinations is needed   |
| Negative                      | No nodules and definitely benign nodules  | 1                | Continue annual screening with LDCT in 12 months  |
| Benign Appearance or Behavior | Nodules with a very low likelihood of becoming a clinically active cancer due to size or lack of growth                                   | 2                |   |
| Probably Benign               | Probably benign finding(s); short term follow up suggested, includes nodules with a low likelihood of becoming a clinically active cancer | 3                | 6-month LDCT  |
| Suspicious                    | Findings for which additional diagnostic testing and/or tissue sampling is recommended  | 4A               | 3-month LDCT; PET/CT may be used when there is a $\geq$ 8mm solid component   |
|                               |   | 4B               | Chest CT with or without contrast; PET/CT and/or tissue sampling depending on the probability of malignancy and co-morbidities; PET/CT may be used when there is a $\geq$ 8mm solid component |
| Significant-Other             |   | S                |   |
| Prior Lung Cancer             |   | C                |   |

registrar receives a daily report of all cancer screenings. After each screening, the registrar is able to document data on each patient through the navigation software, prepare for the next lung screening conference, and perform follow-up on each case. This work averages about 30 minutes per case. With three cases per week, the average is 1.5 hours of registry time—or about the time it would take to perform case-finding on two cases or abstract two cases.

Involving the registrar in screening initiatives benefits both the registrar *and* the cancer program. Registry life revolves around data collection and usage—with little to no interaction with patients. By offering its registrar a dual or multi-faceted role that includes the added responsibilities of a LDCT lung cancer screening program, Eastside Medical Center has given its registrar the opportunity to work directly with patients. Moreover, the registrar has greatly enjoyed the move from a behind-the-scenes environment to actual patient interaction. The registrar is more involved with cancer center patients and now sees them as more than just data in a cancer database. Another benefit is that the registrar becomes more engaged with the cancer program itself. This involvement creates opportunities for professional growth and to advance the cancer registry department as a whole. Collecting cancer data will always be first and foremost for a registrar, but becoming more involved in different levels of patient cancer care is a plus. The cancer program benefits too, because now the registry data has more meaning. The cancer registrar's added responsibilities have brought about an even better understanding of the patient data, leading the registrar to suggest additional studies and other uses of the data to improve screening processes and adjust patient navigation systems. Eastside Medical Center has learned much from its LDCT lung cancer screening program.

### **The Atlantic General Hospital Experience**

Atlantic General Hospital is a not-for-profit 62-bed community hospital in Berlin, Md. With more than 20 community-based physicians; it is part of the larger Atlantic General Health System. As its oncology program grew, Atlantic General began building the case to hire a cancer registrar. According to Ann Bergey, vice president, Quality and Medical Staff Services, Atlantic General Hospital, the decision to include lung cancer screening data collection and patient monitoring in the job description for the new cancer registrar made perfect sense since the cancer registrar would be coordinating the cancer conference where the screening patients would be discussed. Once the registrar was on board and the process to select registry software began, it was clear that the software could also serve a dual purpose. Customizable letters using mail merge, along with user-defined fields in a separate tabbed location, enabled Atlantic General Hospital to actually build the lung cancer screening criteria into OncoLog, the chosen cancer registry software.

---

As the lung cancer screening program moves into year two, the hospital looks to measure the impact of smoking cessation counseling and interventions as those fields are now collected by the registrar.

---

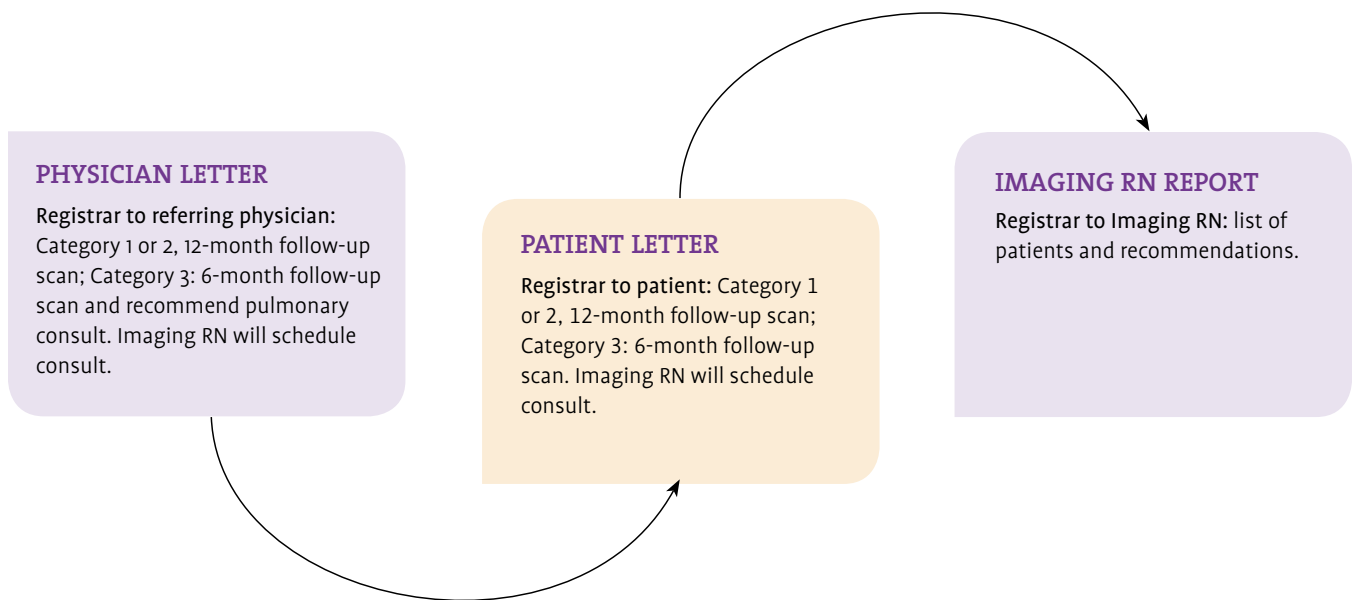
Atlantic General Hospital has only been screening for lung cancer for a little more than a year and continues to make adjustments and refine its patient pathway, as well as the fields collected by the registrar. Registry software programs are rich with standard fields that can be used by a cancer program to analyze a lung screening program's impact on the community and plan for the future. What cities and counties in the hospital's service area have the highest utilization of the lung screening program? Does this utilization match the rate of diagnosed lung cancer for that area? The annual Community Needs Assessment outlines a variety of demographics for a hospital's service area, allowing the registrar to use the software to determine if lung cancer screening patients mirror those demographics. Collecting the insurance payer-type of lung screening patients also provides the marketing department more information on who is utilizing this service.

Additionally, patients' smoking status, along with their pack years, is part of the screening criteria and is assessed at each follow-up exam. As the lung cancer screening program moves into year two, the hospital looks to measure the impact of smoking cessation counseling and interventions as those fields are now collected by the registrar.

Being an American College of Radiology (ACR) Designated Lung Cancer Screening Center, Atlantic General Hospital has also incorporated the ACR Lung-RADS assessment categories into the radiologist's impression on the LDCT report. It is the responsibility of the cancer registrar to review the dictated impression in each report the day after patients have their scan. The pulmonologist and radiologist associated with the lung screening program developed a plan of action based on Lung-RADS and collaborated with the cancer registrar to craft letters specific to each category. Figure 3, page 42, shows the workflow for the cancer registrar for Lung-RADS categories 1, 2, and 3. The workflow for these categories mainly requires reviewing the radiologist's impression on the LDCT, sending letters, and then notifying the imaging nurse. When the radiologist's impression on the lung screen is either a Lung-RADS 4A or 4B, several additional steps are required, and this is where a cancer registrar's



Figure 3. Atlantic General Hospital’s LDCT Post-Scan Pathway for Lung-RADS Categories 1, 2, & 3



unique set of skills becomes critical. Attention to detail and follow through are demonstrated on a daily basis in the work of the cancer registrar, so incorporating the registrar into the lung screening workflow can be an effective use of resources.

For patients with Lung-RADS categories 4A and 4B, Atlantic General Hospital decided that a consult with a pulmonologist is warranted. These cases are then presented to the multidisciplinary group at cancer conference. The cancer registrar calls the pulmonologist’s office, as a courtesy to the referring physician, and schedules an appointment for the patient. The registrar then calls the referring physician, notifying them of the results of their patient’s lung screening, outlining the next steps (including the need for a pulmonologist’s evaluation), and offering the courtesy appointment. Referring physicians are responsible for notifying their patients. Following these phone calls, letters are then generated from the cancer registry software and sent to referring physicians and patients, indicating the need for a consult with a pulmonologist. The community-based pulmonologist at Atlantic General Hospital evaluates patients in the office as soon as possible. As a result, the pulmonologist will have first-hand knowledge of patients and their history and is able to present patient cases at the first available cancer conference. The cancer registrar schedules the patient cases to be presented by the pulmonologist


at the cancer conference and invites the referring physician to attend. If the referring physician is unable to attend, the pulmonologist will communicate conference recommendations back to the referring physician. In the first year of offering lung cancer screening, Atlantic General Hospital screened 34 patients:

- 73 percent needed a follow-up scan in 1 year
- 12 percent needed a follow-up scan in 6 months
- 15 percent needed a consult with a pulmonologist, resulting in 6 percent being diagnosed with lung cancer.

### Expanding the Role of the Registrar

In the ACCC 2015 *Trends in Cancer Programs* survey, 77 percent of respondents reported having a lung cancer screening program in place—up from the 51 percent that reported having such a program in 2014. Interestingly, none of the respondents listed cancer registrars as members of their lung cancer screening team. When cancer programs were asked what they planned to do to increase revenue, 44 percent said they would be increasing screening activities. For cancer programs planning to increase their screening efforts to include lung cancer, expanding the role of cancer registrars to include the dual responsibility of managing the registry and a lung cancer screening program is an option worth considering. The specific job duties of cancer registrars

who help with lung cancer screening programs are as varied as the programs they support. In the case of Eastside Medical Center, the cancer registrar acts as the lung screening navigator to interact directly with patients being screened. This type of personalized service not only distinguishes the center's LDCT lung cancer screening program from others in the area; it has led to higher job satisfaction for the cancer registrar. The cancer registrar at Atlantic General Hospital also reports a higher job satisfaction, noting that analyzing the data for the purpose of supporting the screening program, helping to track patients, and being a part of the team that finds a lung cancer early, is enormously rewarding.

Beyond the cancer registrar having dual responsibilities with the lung cancer screening program, the cancer registry software program can also serve dual functions. As stated earlier, most software programs have a variety of standard and user-defined fields and these can be utilized to gather much needed data for programs with a specific goal of growing their lung cancer screening services. Cancer registrars are familiar with outmigration reports to administration, which highlight or identify procedures and treatments not offered at their hospital. This data is often used to support proposals to purchase new equipment or recruit specialists to the hospital. If specific lung screening data is collected by the registrar, this same process of data reporting could be used to determine if it makes sense for the hospital to add a PET, start offering endobronchial ultrasound procedures, or even recruit a thoracic surgeon. As shown in these two case studies, allowing cancer registrars to assume a greater role in lung cancer screening initiatives can benefit the cancer program and cancer registrars, allowing them to grow professionally and apply their unique, in-depth knowledge of the cancer registry database to enhance services. 

*Paulette Zinkann, BS, CTR, is a cancer registrar at Eastside Medical Center, Snellville, Ga., and education director at the National Cancer Registrars Association (NCRA). Linda Corrigan, MHE, RHIT, CTR, is a cancer registrar at Atlantic General Hospital, Berlin, Md., and NCRA president-elect.*

## References

1. American College of Surgeons and the American Cancer Society. National Cancer Database. Available online at: [facs.org/quality-programs/cancer/ncdb](https://facs.org/quality-programs/cancer/ncdb). Last accessed Nov. 17, 2015.
2. American College of Surgeons. Cancer Accreditation Categories. Available online at: [facs.org/quality-programs/cancer/accredited/about/categories#ccp30](https://facs.org/quality-programs/cancer/accredited/about/categories#ccp30). Last accessed Nov. 17, 2015.
3. American Cancer Society. Cancer Prevention and Early Detection Facts & Figures, 2015-2016. Available online at: [cancer.org/acs/groups/content/@research/documents/webcontent/acspc-045101.pdf](https://cancer.org/acs/groups/content/@research/documents/webcontent/acspc-045101.pdf). Last accessed Nov. 17, 2015.
4. U.S. Preventive Services Task Force. Lung Cancer: Screening. Available online at: [uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/lung-cancer-screening](https://uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/lung-cancer-screening). Last accessed Nov. 17, 2015.
5. CMS. Decision Memo for Screening for Lung Cancer with Low Dose Computed Tomography (LDCT) (CAG-00439N). Available online at: [cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=274](https://cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=274). Last accessed Nov. 30, 2015.