

The Non-hospital Audit Protocol Work Group: Background and Recommendations

With the change in the organization of medical care over the last several years, many have asked the question about how the trend away from hospitalization for medical care and even the provision of care in non-hospital settings would affect cancer registries' ability to conduct complete case ascertainment. Since analysts were also noting a concomitant decline in cancer trends, many also asked if the two events were related.

NAACCR, with support from the CDC and through the contract with our Cancer Surveillance and Control Program, began a pilot project to determine the feasibility of auditing non-hospital sources to determine how many cases were being missed by more traditional reporting sources (e.g., hospitals). A work group was also convened to design a protocol for the audits. Two states were selected, Michigan and California, to participate in the pilot. The work group made several recommendations at the beginning: since very little was known about the number of facilities or the volume of cases, the pilot should follow a more purposive than random method for sampling; the pilot in two states should be used to expand our knowledge of non-hospital facilities and better define the parameters for how these facilities might be more scientifically sampled in the future; and finally, the pilot should focus on ambulatory surgery centers.

At the end of the pilot, not only were the two states widely disparate in laws and licensing governing the surgery centers, but the variation in the centers themselves within each state was very broad. Without similarities, it was impossible to draw valid general principles on which to develop auditing and sampling protocols. In addition, the yield in identifying previously unreported cases was very low.

The work group re-convened and added to their pool of information, audits that had been conducted by state cancer registries in Minnesota (pathology labs); Illinois (ambulatory surgical centers, radiation therapy centers, and pathology labs); California, Michigan, and the SEER program (record linkage with Medicare files). Although the work of the SEER program is still in progress, the efforts of the others did point to several common observations:

- a. An audit protocol can't be regimented; it can't be the same in every state. And in each place a sampling plan must be based on the reporting set up in the state. States vary widely in licensure and operations criteria for ambulatory facilities.
- b. The only reason to audit facilities is to assess that the mechanism for reporting is working. In many states, there is no reporting mechanism for non-hospital sources. Thus the focus, and the resources, should be moved to establishing reporting of non-hospital cases, not auditing them.
- c. A central registry needs to first focus on achieving a high case ascertainment from hospitals. Only after that is achieved should case finding resources be extended to non-hospital facilities. However, it is also possible for a registry to rely first on pathology lab reporting to achieve the most timely data base. This system, however, requires the devotion of resources to obtain key data elements from hospital reports at a later date.
- d. When case finding is the sole objective, it appears that reporting from pathology labs and ambulatory surgery centers is highly duplicative. However, if a registry is interested in treatment data, using both sources is highly complementary for the information that can be gleaned from each source.

Although, the group determined that we could not develop one protocol, even if restricted to ambulatory surgery centers, there was substantial interest in furthering our understanding of the importance of cancer care in the non-hospital setting. With this knowledge, it might be more possible to focus case finding efforts on specific cancer types or specific report sources. Three actions were discussed and recommended:

- a. Review the trend analyses for the annual U.S. report card with an eye toward both mortality and incidence trends. If either analyses were limited to just the SEER regions, then supplement findings with similar efforts for a broader representation of U.S. incidence.
- b. Develop a protocol to assess death certificate found (DCF) cases that eventually get cleared by an incident report. Use this information to identify common or frequent cancer types and report sources that contribute a disproportionate number of missed cases. This will elucidate the potential of more targeted case reporting efforts (either by report source or cancer type). Such a study could be conducted in New Jersey, Minnesota, Michigan, and California, or other places where DCFs are clearly distinguishable from DCOs.
- c. Join with representatives of the Commission on Cancer (CoC) who have recently completed a feasibility study of assessing class 6 cases (i.e., those diagnosed in physician offices). The conclusions of this group were not dissimilar to the NAACCR pilot. By combining efforts, the coordination would result in a joint plan or system with the same parameters that would meet both NAACCR and CoC standards.

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