CLINICIAN/PHYSICIAN OFFICE REPORTING TO CANCER REGISTRY

Use case Steps:

1. **Physician documents patient encounter in the EMR.**

2. **EMR software determines the encounter is with a cancer patient.**

   BR: Data Source Software should use eligibility criteria established by a recognized cancer registry source in order to identify the patient as a cancer patient. (list of diagnoses/icd-9-cm code/cancer-related procedure codes that indicate this (any) is an encounter with a cancer patient.) (add Shared Vocabulary Service –PHINVADS, and/or RPE Trigger Registry)
   BR: The diagnosis must be confirmed/definitive. Include note about definitions of definitive,
   Alternate: If not a cancer patient, process stops.

3. **EMR Software determines physician performed cancer treatment on the patient and prepares a Cancer Report.**
   BR: Create a list of treatments.
   This list includes "Watchful Waiting" as a treatment decision. (Example: A physician may decide that a patient with cancer should just be watched until the cancer starts causing more significant symptoms)
   It also includes a decision to do nothing due to severity of disease and existing co-morbidities.
   BR: treatment includes: chemotherapy, biological response modifiers, surgery, (create a list of CPT codes)
   BR: Need time reference: Each treatment versus x months, etc.
   (Don't use current time standard, set a time standard that will reduce lag-time.)
   Need to document whether we want a report "intent to treat via chemo, brm, etc) or when treatment actually given
   BR: Need ability to identify new versus additional information report.
   BR: Need EMR to be able to identify that NO treatment will be given. (the decision not to treat is a treatment option.)
   BR: Registries with legal may not implement this step.
   Recommend Registries perform this step in the following manner:
   IF "Referred To" facility is a routine reporter:
   a. Delete report; OR
   b. use report for casefinding quality control of routine reporters
   IF "Referred To" facility is not a routine reporter
   Process report as a regular submission

4. **EMR Software determines the physician referred the patient to another Reporting Facility/Provider for care and prepares a Cancer Report.**
   BR: Must include Reporting Facility Contact information
   BR: Registries with legal or resource restrictions may not implement this step.
   Recommend Registries perform this step in the following manner:
   IF "Referred To" facility is a routine reporter:
   c. Delete report; OR
   d. use report for casefinding quality control of routine reporters
   IF "Referred To" facility is not a routine reporter
   a. Process report as a regular submission.

5. **EMR performed validation checks and receives no errors.**

6. **EMR transmits Cancer Report to the Central Cancer Registry.**
   BR: Include transmission requirements, security, etc

7. **EMR receives acknowledgement from the Central Cancer Registry that Cancer Report was received.**