New Approaches to Old Ways: Follow-up and Casefinding Through Medical Record Indices

Donna M. Gress, RHIT, CTR

Abstract: Looking up patient names due for follow-up each month to determine if they have had contact with the hospital before sending letters can be a tedious process. Furthermore, if a patient has been readmitted with a cancer code the patient’s name is again looked up when performing casefinding. It is more efficient to let a computer determine which of the registry patients have had contact with the hospital for a certain time frame. This can be accomplished by setting up a data field in the hospital’s user-defined fields in the hospital database. This field would be marked for all registry patients. Reports can select the registry patients marked in the hospital database that meet the criteria of a hospital visit for a defined time period to provide follow-up information. This criteria can also be combined with the medical record indices diagnosis codes used for casefinding. A patient will then only appear once on the list and be used for casefinding and follow-up, instead of the registrar having to look up a patient twice, once for the medical record indices and once to determine if there is current follow-up prior to sending follow-up letters.

Introduction

There is a new and simple method for follow-up that can save valuable hours for the cancer registry. It creates one new data field, not in the registry database, but in the hospital’s main database. This small change can lead to a different approach to the old ways of performing follow-up tasks. Registrars will no longer have to manually look up patients each month to determine if they have been seen at the hospital before sending follow-up letters. A new approach to the medical record indices, incorporating this data field along with other organizational changes to the report, can save even more time. This data field can be used as a link between the registry and the hospital database without the two computer systems having to be compatible or physically linked. No additional hardware or software is required. Using this new data field can produce positive results not only for the registry in follow-up and casefinding, but also for administration in opening up a new realm of possibilities for valuable information.

Hospital Data Field Designated for Registry

All hospital computer systems have user-defined fields. The cancer registry needs to obtain permission to utilize one of these user-defined data fields to be designated as the “cancer registry” field. This field only needs to be one character in length. But it must be at the patient level, not at the individual visit or encounter level. For example, this compares to the cancer registry database, where we think about data items at the patient level, such as date of birth or social security number, and data items at the tumor level, such as Stage II lung cancer and Stage I colon cancer, both belonging to the same patient but different tumors or primaries. This field can be marked with any type of character, either alpha or numeric, such as a “y” for yes. This field will identify which patients in the hospital database are also in the cancer registry database.

The cancer registry must enter the agreed-upon character into the hospital’s data field for all living patients just one time only. As new cases are added to the database, they would be entered into the hospital system on a routine basis. Expired patients do not need to be entered, as there would not be any follow-up and most administrative reports would also only be looking at current patients. All registrars have access to the hospital database to look up patient visits, but the access may have to be changed to be able to add this information to the user-defined field, instead of just being able to view the screens. Access to the data field must be set up in the most efficient manner. Information Services is able to set up menu choices for the hospital computer system to quickly enter the appropriate screen to mark the registry patient in the hospital database, such as typing the medical record number of the patient and then putting the appropriate code into the field with a minimum of keystrokes. Using this type of efficient system, it is possible to enter at least 15 cases per minute, which translates into 900 cases per hour. This would enable a registrar to mark an entire registry database of 5000 cases in just 5½ hours. This is worthwhile, considering this is a one-time event, and adding new cases takes just a few seconds as compared to the number of hours that would otherwise be spent each month looking up cases due for that month’s follow-up.

Benefits of the Data Field

The first step in linking the cancer registry with the hospital database is convincing administration of the time savings for the registry and the potential for helpful administrative reports. There are a number of user-defined fields in the hospital database system, and a case needs to be made concerning why one of these should be designated for the cancer registry.
Each month before sending follow-up letters, most registries check those patient names against the hospital database to see if they have had a visit or encounter with the hospital, such as an emergency room visit or blood work in the lab, which could eliminate the need for the follow-up letter. By using this new data field the computer can scan the hospital database finding those patients who have had contact with the hospital during that month or the specified time period, and print out a list of those patients with their visit date. The registrar can then enter the new follow-up date in the registry database from this list. Thus, time spent by the registrar looking up every name due for follow-up to see which patients had hospital visits has been eliminated.

This is an efficient timesaver over the years. In just the first year, the registrar will have broken even in the time taken to look up patients before follow-up, versus time to look up the patients to put them in the new data field. Since the registry routinely looks up each patient due for follow-up, this one-time look-up will actually save time, since that patient would have been looked up multiple times throughout their life span (5, 10, or more years of survival and of follow-up). Sometimes patients are moved ahead a few months for follow-up, and therefore are looked up more than once a year, multiplied by those many years of survival! It is not such a daunting task to mark each cancer patient in the hospital computer system. This task can be broken down and performed as patients are due for follow-up, but it should be organized in such a way that patients who are only moved a few months ahead in follow-up are taken off a future list. Information Services may be able to program a way to merge the list of patients, but it may be too costly.

Administration would have access to information that was never easily obtained before. They would now know exactly which patients are those in the registry, as opposed to those with a cancer code from medical records but who received no cancer care at your facility. For example, a patient is admitted for a heart attack and also has lung cancer diagnosed at another facility recently. The hospital is only treating the heart attack, and is performing no work-up or treatment of the lung cancer. When running reports on diagnostic codes, there would be no easy way of distinguishing this patient from another one admitted with a heart attack who happened to have lung cancer diagnosed for the first time from the routine chest x-ray.

This data field enables administration to select the appropriate cancer cases and then run reports on any data field in the hospital system. The reports can range from financial reimbursement to the type of services used, enabling them to make better choices in future planning for cancer patients.

These are highlights of the time savings and information potential from using a cancer registry data field on the hospital database.

- It eliminates cases being looked up in the hospital computer system each month before sending follow-up letters.
- It is more efficient to enter patients once into the hospital database, rather than to look them up multiple times throughout their life span.
- The registry would receive a monthly list of all follow-up patients who had contact with the hospital, even if their visit did not include a mention of cancer. Without this mention of cancer, they would not appear on a regular medical record indices list. This would include inpatient admissions, outpatient services, radiology, lab, and emergency room visits.
- Administration would be able to run financial and other types of reports on cancer patients from the hospital database, as they now have a field on which to choose the appropriate patients.

This report of registry patients seen at the hospital can be run monthly to prepare for follow-up letters. It can also be merged into another report, the medical record indices, and save even more time.

**Integrating the Hospital Data Field**

If the new hospital data field is used in conjunction with the monthly indices based on the ICD-9-CM codes even more efficiencies are realized. When both these reports are merged into one, instead of seeing multiple patient names appearing on both reports, patients' names would only be dealt with once.

If the patient's name appears on the hospital data field report used for follow-up, the registry would go into their database, look up the patient, and update the follow-up date for this patient. Later when that same patient’s name appears on the medical record indices report for casefinding because they had been readmitted to the hospital, again the name would be looked up in the registry database. There would be no indication this record had already been on the previous follow-up list and looked up once already for the same hospital visit or encounter.

The medical record indices report could be run based on the reportable codes and also the hospital data field for the registry.

**Reformatting the Medical Record Indices**

The medical record indices report needs to be formatted differently to better organize the data and save time. Most registries request the list of reportable codes through a report writer in the hospital system, or the report has been written by Information Services. Since the data field requested is the diagnostic codes, many cases have more than one code meeting the reportable list. They may have a primary and metastatic cancer site code, and maybe even a history code. The list of cases are most times printed by the requested data field, the code number, so the same case may be found throughout the many pages of the report, wasting time when the name must be looked up again. The report should no longer be organized by these codes. Cases would still be chosen based on ICD-9-CM codes, and now also by the registry code in the newly acquired special hospital data field. However, the report should be sorted based on terminal digit medical record number. This organizes the same patient’s different code numbers together, so when the patient is listed more than once, the listings are grouped together and the patient's name is only looked up in the cancer software once. This also saves time in preparing a pull list for medical records, since charts are filed by terminal digit. The registry would already have the list in the proper order.

It would also save time to split the report into 2 reports. One would be inpatients and other designated types of visits where there is a need to review the chart. The other report would be cases where there is little information regarding the cancer to be obtained, such as emergency room, laboratory, x-ray visits. For this later category, the registry would simply update the database last date of follow-up with the date of the visit and not pull the chart unless deemed necessary.

When selecting the data fields to print on the report, there are some unusual ones to consider. The discharge code can be very useful for follow-up. It is helpful to know that the
A patient has been sent to a skilled nursing facility or another hospital, and upon review of the record the name of the facility can be obtained for future follow-up letters. Obviously, it is important to know that the patient expired, such as emergency room expirations, where the chart may not normally be reviewed and this could be missed.

The fields most useful for the report would be the following.
- medical record number in terminal digit order
- patient name
- admit date
- discharge date
- patient type major (acute/inpatient, outpatient)
- patient type minor (acute, day or outpatient surgery, outpatient services, psychiatric unit, home health)
- service codes (outpatient surgery, endoscopy procedures, emergency room, laboratory, radiology)
- discharge code (home, transfer to another hospital, skilled nursing facility, expired)
- cancer registry hospital data field code
- diagnostic codes (either the first 5, the primary and secondary diagnostic codes, or the ones that matched the criteria, based on the report capabilities)

**Working with the Medical Record Indices Reports**

Looking up all the names on the medical record indices is a long and tedious process. Changing the way the list is approached can save time. Use the list on a daily or weekly basis as cases are abstracted. Cross off patient names on the medical records indices reports as those month’s cases are being abstracted, instead of looking those names up later when using the list for casefinding. If this is done for all newly abstracted charts, and any other charts that are reviewed, there will be very few names that must be looked up to determine if they are missed cases.

It can also be helpful to make a list of medical record numbers of charts that have been reviewed for a particular month, if that indices report is not available. The list should be organized by month, by the discharge date, and have columns to organize by terminal digit order groups of numbers, for ease in comparing this to the indices when they are available.

Also when reviewing charts pulled from the medical records indices list for a particular month, many times there are other subsequent admissions in the chart. These should also be reviewed and marked off their respective indices list, or put on the list of reviewed charts.

**Conclusions**

The author developed the idea of a hospital data field for cancer registry patients in 1991 and has instituted the procedure at 3 different hospitals, all using different computer systems, with differing levels of Information Services capabilities and support. In each case, it has been something attainable and has saved countless hours of work. It has also organized medical records indices reports, making them easier to use.