ERS
Cancer Program
Management & Analytics

Productivity: Unraveling the Mystery Complete Q & A

Q. Our facility is an academic center and receives a lot of referrals from other places. Often there are lots of records not just to review from our facility but 1 or more other facilities which sometimes takes a long time to review to get all the information needed to fully quality abstract the case. Some cases are taking me hours to just read/review and collect data from those charts (not the 1.5 to 2 hours per cases that our productivity standards say it should take) should someone be penalized for these cases taking longer?

A. This is a great question. Remember the goal of productivity standards isn't punitive. Prior to reaching that point we need to look at few things. First, how were the productivity standards created? Was there a time study done or was this selected just from industry standards? Second let's look at the team as a whole. Is everyone struggling with productivity or just one or two people? If a majority of the team is struggling, then we need to re-look at the standard.

Remember when reviewing productivity, it is an average of all work for the week not each individual case. Some cases take more time, and some take less. It's the average of all cases for the CTR for the week that we are reviewing.

If it's just one or two CTRs struggling, then we want to work with them to see how we can help. I would look at how the EMR is being filtered. Could we filter more? Also, which notes are being reviewed? Is the CTR reviewing nursing notes in addition to physician notes? Remember we are only abstracting from physician notes not nursing notes. Is the CTR reading the entire note or are they skimming to look for pertinent information? There are many sections of a physician note that are duplications of other areas being reviewed. There is no need to read that information twice. I find the first part of the note where we get the history of why the patient is there and the end of the note where the final findings are located to be the most pertinent areas to review. Most of the time, these areas let us know if the rest of the note needs to be reviewed in further detail or if this note is not pertinent to the cancer case.

In the past, I have worked with a facility that was an academic facility that fully abstracted all courses of treatment. As a result, there would be years of notes pertinent to the cancer. These cases took longer, and productivity was set at 3 hours per case. Each facility is different and needs to analyze their registry to set their unique productivity. While productivity is not intended to be punitive and managers should do whatever they can to work with individual CTRs, there will be times where productivity still doesn't improve. At that time managers will have to follow hospital policies on how to proceed.

Q. I teach in a CDM program and the facilities that we contract for our students for Practicum all use the standard recommended registry of 1.5 hours/case. Do you know where this came from? Everyone I have asked does not know. They just know that it's 1.5 hours.

A. The average discussed in this webinar represents my experience working with over 75 facilities of varying sizes/types across the country over the past 7 years. Productivity overall is around 1.5 hours per case. There are facilities that are higher due to complexity on average or lower due to being more simplistic with less information gathered.

Q. What if I am the only CTR at my facility? Should I track my productivity? I have no problem getting all the work done.

A. If you are sufficiently completing your tasks and in a single CTR registry this isn't necessary. However, if you find you are stretched too thin, a timesheet is a great tool to show all the work that is being done and why additional staff is needed.

Q. My typing seems to slow me down. What can you do to increase your productivity when the EMR doesn't allow you to cut and paste?

A. Some facilities provide voice to text software that allow you to speak into a microphone and have the text typed out. This is also available to be purchased personally. Another option is an online typing course that can help teach you to type more quickly.

Q. Our main casefinding source are the daily path reports which are received via our printer at the end of the day. Could you address how you would establish productivity for this?

A. Productivity for pathology specifically wasn't directly addressed in this webinar due to the vastly varying productivity depending on how these are processed. If you are reviewing paper documents, I recommend gauging productivity in pages per hour. Many facilities I have worked with can see upwards of 100 pages/patients reviewed per hour due to only needing to review the final pathology determination.

Q. You mentioned "national production standards." They all seem to be old. Are there newer standards that can be helpful?

A. The standards reviewed in this presentation are reflective of what I have seen up to the past year.

Q. How do you take into consideration changes to coding rules that start each new diagnosis year?

A. This depends on the year and what has been changed. Some years we have a complete overhaul. In these years you will see productivity increase while the team gets used to the new fields and rules. Over time (6 months or so) you should see the productivity level out. Most years we may have a couple of fields added and some retired. This typically means productivity doesn't change, but you do need to keep an eye on your team's productivity as you start abstracting cases for the new year to see if productivity needs to be reviewed/adjusted.

Q. Some of us work on RCRS cases that need more information and treatment added later. This is not currently figured into our productivity standard for abstracting at our facility since we are told our task is abstracting only. Can you address this?

A. The concurrent abstracting section of the webinar is referencing these situations. Productivity for these should be looked at in multiple sections:

1. The initial abstract. Likely, you will see this will be significantly lower than the average we discussed as most information will not yet be available. So, you will be only adding in the diagnostic and perhaps staging information.

2. Case updating. I strongly recommend this be a separate productivity that is monitored. This productivity will be dependent on setting up an efficient way to ensure you aren't constantly reviewing cases that still don't have information available to update the abstract.

Q. Do you have any suggestions on site groupings? To help with new CTRs learning abstracting?

A. I would recommend giving easiest sites first. I like to start with urinary sites as these are typically straightforward. You could then move gradually to more complex sites. Important things to consider are:

1. Which sites have the clearest documentation in your EMR. If you know your urologist doesn't do a good job documenting, these may not be the easiest cases.

2. Complexity of the primary site and it's anatomy.

Q. I noticed at our facility that some CTRs don't document much in text fields and others do a better job. Those that don't document much get more cases done. Should the more quality documentation CTRs be punished compared to the others?

A. Text is a tricky topic. Thorough text is required. When you think about "thorough," this doesn't mean wordy. It means the appropriate information is included to validate coding values. Also, NAACCR abbreviations should be utilized. The goal of text in the registry is to be clear and concise. Concise is very important as text fields do have value limits.

Q. When concurrent abstracting, is it better to abstract as much as you can initially? Or get the bare minimum at first and then complete the abstract when treatment is done?

A. My recommendation is always to abstract to the fullest extent possible at the time of abstraction. If the information is available to the registrar, then it should be in the abstract.

Q. My IT department has been working on making our pathology reports electronic for over a year. Should they be working with you in order to do this? It is taking a very long time.

A. We would be happy to assist in making pathology reports electronic for user initiated or automated import into the Cancer Registry.

Q. If text is applicable for standards (i.e., NAPBC or CoC) that assist in their standard reporting for their CCM, will completing the abstract take a little longer. Will the abstractor be penalized on their productivity?

A. Each facility should determine what documentation is needed. This should be taken into consideration when doing a time study to determine productivity.

Q. Can you speak to all CTRs working on the same site at one time? Same primary? This might reveal who is struggling?

A. I wouldn't recommend all CTRs abstracting one primary to determine issues. Each case will be different, and productivity is an average of all work done for the week. It's important to note that one CTR may be faster on site A and slower on site B and a different CTR at the same facility may be faster on site B and slower on Site A.

Q. How do you include staff continual education under a productivity plan or standards?

A. This time would be factored into the administrative 4 hours per week that was discussed in the presentation. A full-time CTR would have 36 hours of "productive work" and 4 hours of administrative tasks. If more than this is needed, the managerial staff need to factor this in when determining productivity by reducing the hours the CTR is available for "productive work."