Florida Cancer Data System

2022-2023 FCDS Data Quality Program

1

FCDS VIRTUAL ANNUAL CONFERENCE

8/11/2022

STEVEN PEACE, CTR

2019

2022

2020

1

CDC & Florida DOH Attribution

2

"Funding for this conference was made possible (in part) by the Centers for Disease Control and Prevention. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services, nor does the mention of trade names, commercial practices, or organizations imply endorsement by the US Government."

FCDS would also like to acknowledge the Florida Department of Health for its support of the Florida Cancer Data System, including the development, printing and distribution of materials for the 2022 FCDS Educational Products Series under state contract COHAW. The findings and conclusions in this series are those of the author(s) and do not necessarily represent the official position of the Florida Department of Health.

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FCDS Data Quality Program - Goals

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- Establish, perform, manage Quality Improvement/Quality Control projects
- Apply national and internal standards for data collection, aggregation, etc
- Systematically measure performance against those standards
- Assess outcomes and performance measures
- Develop measurement and evaluation tools
- Develop quality enhancement strategies
- Assess registry needs and satisfaction
- Monitor completeness, quality and timeliness
- Provide education and training to improve data quality

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FCDS Data Quality Program - Components

4

- FCDS Data Quality Program – Methods & Standards
- FCDS 2022 Abstractor Code Test – Standards, Policy & Procedures
- Annual AHCA/Mortality Casefinding Audit – Completeness
- Visual Editing – Data Quality Tool & Feedback to Abstractors
- Internal Visual Editing Summary Reports – Education
- FCDS Deadlines & Facility Reports in IDEA – Timeliness
- Management Reports in FCDS IDEA – Facility Feedback
- Data Quality Audits – Data Quality & Education - Tools
  - 2022 Data Quality Audit – Neuroendocrine System Cancers
  - 2022 Data Quality Audit – Lymphoid and Myeloid Neoplasms
- External Audits – NPCR DQE and Ad Hoc Reviews (Testis/Heme)
- NPCR & FCDS Annual Data Quality Indicator Report – Data Quality – Tools
- Technical Questions to Field Coordinator or FCDS Managers

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FCDS Data Quality Program - Methods

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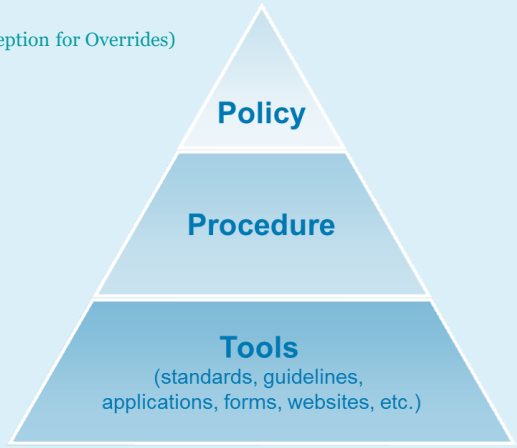
- **FCDS Policy**
  - FCDS Abstractor Code Requirement
  - FCDS Data Acceptance Requirement – Pass All Edits (Exception for Overrides)
  - FCDS Text Documentation Requirement
  - FCDS Deadlines and IT Security
- **FCDS Procedures**
  - FCDS IDEA – Communication/Transmission
  - Corrections/Deletions/Edit Overrides (Set by FCDS Only)
  - Patient and Tumor Linkage & Consolidation
- **FCDS Monitoring / Audits - Tools**
  - Visual Editing of Abstracts
  - Audits for Completeness
  - Audits for Timeliness
  - Audits for Accuracy
- **FCDS Data Quality Reports - Tools**
  - Quarterly/Annual Status Reports
  - QC Review Summary
  - Ad Hoc Reports
  - Audit Results



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FCDS 2022 Abstractor Code Test – Policy & Standards

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- 2022 Updates Incorporated in FCDS Abstractor Code Test on 7/1/2022
- 30-50 New or Updated Questions for 2022
- Gets a little harder each year –jobs demand more knowledge each year
- Gets a little harder each year – manuals, rules, instructions and resources change frequently
- We wanted to go to 30 questions – But, Registrars do too much agonizing over Q&A
- New Reportable/No Longer Reportable Cancers Questions
- More Solid Tumor Rule Questions & More Hematopoietic Questions
- Plenty of site/histology/behavior/grade Coding Questions
- New Confidentiality and HIPAA Questions
- More Treatment Type Questions

6

Annual AHCA/Mortality Casefinding Audit – Completeness

7

- Why do we do AHCA/Mortality or Consolidated Follow-Back Re-Casefinding Audits at 100% of facilities across the entire state of Florida – Every Year? We check all patient encounters and all deaths…why?
- Includes In-Patient and Ambulatory Patient Encounters for **100% of Hospitals & 100 of Surgery Centers**
- FCDS also identifies missed cases using our **combined e-path reporting and physician claims in CAPIS**.
  - FCDS identifies over 40,000 potentially missed cases from AHCA/Mortality Audit – EVERY YEAR
  - More than 10,000 cases per year are actually missed
  - These 'missed' cases are more than 2 years delinquent for reporting
  - Furthermore, more than 20,000 cases were (mis)coded as 'active cancer' by your medical records and billing department – But, these are returned to FCDS as 'not reportable'. Weight heaviest in ambulatory care codes.
  - Responses on more than 5,000 cases are never returned to FCDS – sad but true.

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2018 AHCA In-Patient Audit: Follow-Back Analysis

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AHCA In-Patient Follow-Back	2016	2017	2018	2019	2020
Total In-Patinet Follow-Back	24,717	22,758	27,010	28,257	26,167
Missed Cases - New Abstract	5,187	4,439	5,974	4,976	pending
Abstract Not Transmitted	702	1,109	1,049	1,151	pending
Total Missed Cases	5,889	5,548	7,023	6,127	pending
Total Not Reportable	17,619	17,210	19,820	22,130	pending

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2018 AHCA Ambi Audit: Follow-Back Analysis

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AHCA Ambulatory Follow-Back	2016	2017	2018	2019	2020
Total Ambulatory Follow-Back	14,059	13,593	14,170	14,417	14,098
Missed Cases - New Abstract	48,889	5,277	5,394	4,836	pending
Abstract Not Transmitted	657	1,050	1,096	1,188	pending
Total Missed Cases	5,546	6,327	6,490	6,024	pending
Total Not Reportable	55,397	7,266	6,302	8,393	pending

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Visual Editing – Data Quality & Feedback to Registrars

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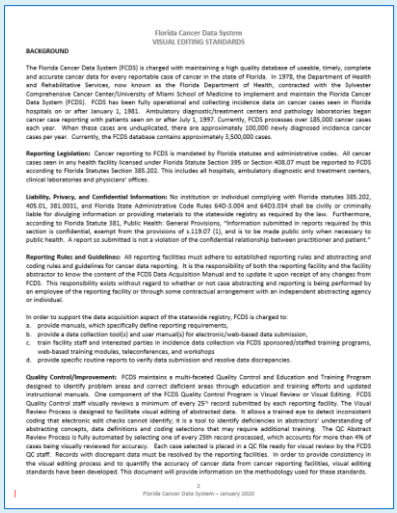
- **Purpose of Standard Electronic Edits & Volume of Changes**
- **FCDS Visual Editing Standards Document – Purpose & Process**
- Comparison of text documentation to coded fields
- Focus on Tumor Characteristics, Staging, SSDIs, Treatment
- Ensure the Case 'makes sense' as Coded – Site/Histology/Stage/Treatment
- Ensure Registrars are Using/Understand Coding Manuals/New Standards
- FCDS QC Sample for Visual Editing
  - 1/25 Records Submitted or 4% of Analytic Cases PLUS
  - All Pediatric Cases & All Male Breast Cases PLUS
  - Other 'at risk' Cases Identified with Frequent Abstracting Errors
- Visual Editing is a 3-step process with Multiple CTR Reviewers
  - First FCDS QC CTR Review – send to Facility
  - Facility Review – return to FCDS
  - Final FCDS QC CTR Manager Review – May be Resent to Facility or Complete Case
- Multiple opportunities to identify problems and rebut 'errors'
- Education and Training Tool for Individual Abstractor Feedback
- Summary of Findings Included in Annual Conference for Clarifications
- FCDS Memo Write-Up When Find 'Unique Problems' with New Manuals, etc.



Florida Cancer Data System
VISUAL EDITING STANDARDS

BACKGROUND

The Florida Cancer Data System (FCDS) is charged with maintaining a high quality database of useable, timely, complete and accurate cancer data for every reportable case of cancer in the state of Florida. In 1978, the Department of Health and Rehabilitative Services, now known as the Florida Department of Health, contracted with the Sylvester Comprehensive Cancer Center/University of Miami School of Medicine to implement and maintain the Florida Cancer Data System (FCDS). FCDS has been fully operational and collecting incidence data on cancer cases seen in Florida hospitals on or after January 1, 1981. Ambulatory diagnostic/treatment centers and pathology laboratories began cancer case reporting with patients seen on or after July 1, 1997. Currently, FCDS processes over 185,000 cancer cases each year. When these cases are unduplicated, there are approximately 100,000 newly diagnosed incidence cancer cases per year. Currently, the FCDS database contains approximately 3,500,000 cases.

Reporting Legislation: Cancer reporting to FCDS is mandated by Florida statutes and administrative codes. All cancer cases seen in any health facility licensed under Florida Statute Section 395 or Section 408.07 must be reported to FCDS according to Florida Statutes Section 385.202. This includes all hospitals, ambulatory diagnostic and treatment centers, clinical laboratories and physicians' offices.

Liability, Privacy, and Confidential Information: No institution or individual complying with Florida statutes 385.202, 405.01, 381.0031, and Florida State Administrative Code Rules 64O-3.004 and 64O1.034 shall be civilly or criminally liable for divulging information or providing materials to the statewide registry as required by the law. Furthermore, according to Florida Statute 381, Public Health: General Provisions, "Information submitted in reports required by this section is confidential, exempt from the provisions of s.119.07 (1), and is to be made public only when necessary to public health. A report so submitted is not a violation of the confidential relationship between practitioner and patient."

Reporting Rules and Guidelines: All reporting facilities must adhere to established reporting rules and abstracting and coding rules and guidelines for cancer data reporting. It is the responsibility of both the reporting facility and the facility abstractor to know the content of the FCDS Data Acquisition Manual and to update it upon receipt of any changes from FCDS. This responsibility exists without regard to whether or not case abstracting and reporting is being performed by an employee of the reporting facility or through some contractual arrangement with an independent abstracting agency or individual.

In order to support the data acquisition aspect of the statewide registry, FCDS is charged to:
a. provide manuals, which specifically define reporting requirements;
b. provide a data collection tool(s) and user manual(s) for electronic/web-based data submission,
c. train facility staff and interested parties in incidence data collection via FCDS sponsored/staffed training programs, web-based training modules, teleconferences, and workshops
d. provide specific routine reports to verify data submission and resolve data discrepancies.

Quality Control/Improvement: FCDS maintains a multi-faceted Quality Control and Education and Training Program designed to identify problem areas and correct deficient areas through education and training efforts and updated instructional manuals. One component of the FCDS Quality Control Program is Visual Review or Visual Editing. FCDS Quality Control staff visually reviews a minimum of every 25th record submitted by each reporting facility. The Visual Review Process is designed to facilitate visual editing of abstracted data. It allows a trained eye to detect inconsistent coding that electronic edit checks cannot identify; it is a tool to identify deficiencies in abstractors' understanding of abstracting concepts, data definitions and coding selections that may require additional training. The QC Abstract Review Process is fully automated by selecting one of every 25th record processed, which accounts for more than 4% of cases being visually reviewed for accuracy. Each case selected is placed in a QC file ready for visual review by the FCDS QC staff. Records with discrepant data must be resolved by the reporting facilities. In order to provide consistency in the visual editing process and to quantify the accuracy of cancer data from cancer reporting facilities, visual editing standards have been developed. This document will provide information on the methodology used for these standards.

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Submission Summary & QC Visual Review Sample

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WOW

Description	# Cases	% of Total
Total Cases Submitted to FCDS 1/1/2020-12/31/2020 – Sources (13,454 MD Only)	316,635	100
Total Cases – NO CHANGE – Pass ALL Edits – No Visual Review by FC or QC	294,802	93.1%
Total Cases – FC Visual Review *(FC Review to assess case for possible FORCE)*	21,833	6.9%
• FORCED *(EDIT Override Confirmed and FORCE was set - NOT an error)*	7,207	2.3%
• CORRECTED *(1 or more corrections made based on text – NOT a FORCE)*	11,553	3.6%
• DELETED *(duplicate case, not a reportable neoplasm, not a new primary)*	3,073	1%
Total Cases – Every 25th Case QC Review Sample/Visual Editing • *Sample includes **4% of analytic** hospital, radiation, surgery center cases* • *Sample includes **ALL pediatric** cases* • *Sample includes **ALL male breast** cases* • *Sample **does not include** dermatology or other **physician office cases***	14,737	4.7%
Cases Reviewed During Manual Review of Exception Cases During Consolidation	547	0.2%
Cases Visually Reviewed by FCDS in 2020 *(FC Reviews, Visual Editing, Consolidation)*	37,117	11.7%

Tumor Consolidation Exceptions Also Visually Edited >500/yr

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QC Review Sample / Visual Editing - Summary

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Description	# Cases	% of Total
Total Cases – Every 25th Case QC Review Sample/Visual Editing	14,737	4.7%
Total Cases – NO CHANGE on QC Review	9.987	67.8%
Total Cases Sent to Facility with Correction or Inquiry	4,750	32.2%
OF THE CASES THAT UNDERWENT 2nd or 3rd Review – 85% had Errors		
Total Cases Sent to Facility with Correction or Inquiry		
• NO CHANGE after Follow-Back to Facility	409	8.5%
• FORCED *(EDIT Override Confirmed - NOT an error)*	136	2.9%
• CORRECTED *(1 or more corrections made – NOT a FORCE)*	4,067	85.6%
• DELETED *(duplicate case, not a reportable neoplasm, not a new primary)*	138	2.9%

67.8% of 1st Review Cases No Change

14.4% of QC Cases Good After Review

85.6% of QC Cases had ERRORS

The only cases FCDS should be getting that fail edits are cases to be FORCED… **> 30% are actually errors.**

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QC Review Summary Report

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A new or enhanced QC Completion Analysis Report would benefit FCDS and registrars in the field if we would provide a QC Review Summary Report by Facility and by Abstractor Code that would include the following items or grouped items.

Three Summary Reports
- Summary by Facility
- FCDS State Summary
- Summary by Abstractor Code

Summary Items - General
- # Cases Reviewed with No Change
- # Cases Reviewed with Correction with Breakdown by Type of Correction
- # Cases Reviewed Requiring Force
- # Cases Reviewed and Deleted
- Total QC Review Cases

Summary Items from Correct Cases - Aggregated into 6 Major Groups for all Three Summary Reports

- Patient Demographic
- Tumor Description
- Stage and SSFs
- Treatment
- Text Documentation
- Other – includes FAC/ACC/SEQ and Class of Case

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Internal Visual Editing - Summary Report

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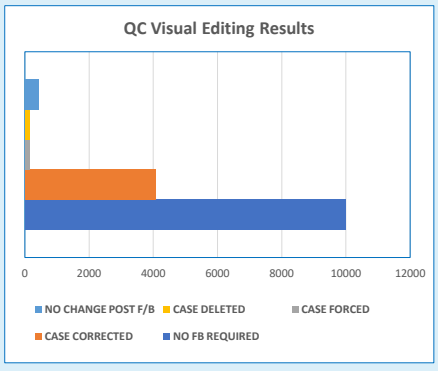

Reviewed	No FB	Cases to FB	Corrected	% Corrected	Forced	% Forced	Deleted	% Deleted	FB No Change	% No Change
45	33	12	11	24.44	0	0	0	0	1	2.22
31	20	11	10	32.26	0	0	0	0	1	3.23
17	9	8	7	41.18	0	0	0	0	1	5.88
42	31	11	8	19.05	0	0	0	0	3	7.14
36	18	18	15	41.67	0	0	0	0	3	8.33
46	38	8	5	10.87	0	0	0	0	3	6.52
102	85	17	12	11.76	0	0	0	0	5	4.9
56	36	20	19	34.55	0	0	1	1.82	0	0
30	20	10	10	33.33	0	0	0	0	0	0
1	0	1	1	100	0	0	0	0	0	0
6	4	2	2	33.33	0	0	0	0	0	0
1	1	0	0	0	0	0	0	0	0	0
1	1	0	0	0	0	0	0	0	0	0
9	3	6	4	44.44	0	0	0	0	2	22.22
36	21	15	9	25.71	1	2.86	1	2.86	4	11.43
5	3	2	1	20	0	0	0	0	1	20
14737	**9987**	**4750**	**4067**		**136**		**138**		**409**	

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Internal Visual Editing – Error Category Summary Report

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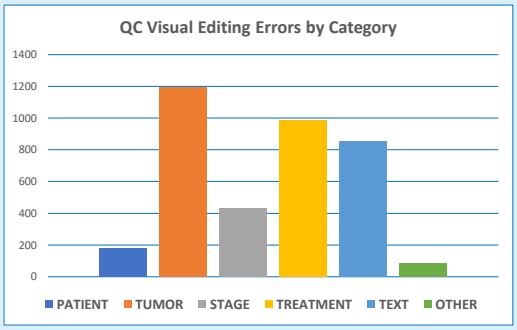

Corrected	Patient	Tumor	Stage	Treatment	Text	Other
11	1	2	1	4	2	0
10	0	0	1	6	1	1
7	0	1	1	3	0	1
8	0	2	1	2	2	0
15	0	4	3	4	1	0
5	0	1	0	1	0	0
12	0	2	0	4	5	0
19	0	7	0	6	4	0
10	0	4	1	1	2	0
1	0	0	0	0	0	0
2	0	0	0	1	1	0
4	0	1	0	0	0	0
9	0	2	0	3	0	0
1	0	0	1	0	0	0
8	1	1	3	0	0	1
3	0	1	0	1	1	0
4067	170	1197	432	985	856	83

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FCDS Visual Editing – Common/Recurring Issues

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- Registrars Ignore Deadline to Return QC Visual Editing – yes, there is a deadline – 3 months
- Problem Areas in Text Documentation and Coding Doesn't Match Text – race, sex, ethnicity, history, tumor markers, cases code as 'unstaged' when clinical staging is clearly present, localized lung cancers and breast cancers and colon cancers with no treatment or workup, coding nodes examined/nodes positive, scope regional lymph nodes surgery for FNA or other regional nodes (not distant nodes), no operative findings – only procedure, pathology reports, excessive abbreviations, treatment recommended or refused or coded as 99, missing neoadjuvant therapy, missing radiation modality, missing chemo agents, missing dates, coding grade is a BIG problem, lymphomas and leukemias NOS or no stage, text for stage is only TNM – there are no TNM/SS x-walks.
- CASES WITH POOR DOCUMENTATION – BAD ABSTRACTING HABITS – TELL US THE STORY – ALWAYS!!
- 'Not Eligible for Staging' – NO - Every Case is Eligible for Staging - even benign cases
  - Maybe not AJCC TNM Staging – BUT ALL CASES can be staged in SS2018
- Cytology Definition and Use of DX Confirmation = 1 or 2 (FNA, BM Aspiration, or Cytology)
- Pediatric Cancers at Pediatric Facilities – You Must Understand the Cancers You Abstract!!
- Diagnostic Confirmation = 9 or 5 – DO NOT USE THESE CODES – 1 exception
- Primary Site, NOS with Subsite in Text, Imaging, Path or Surgery
- Histology Code, NOS with Specific Histology in Pathology Report
- SSDIs missing on Analytic Cases or in Text but Not Coded
- Treatment, NOS codes – 80 or 90 Surgery
- More Details will be Presented in the FCDS Audit Presentation

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FCDS Deadlines & Facility Reports in IDEA - Timeliness

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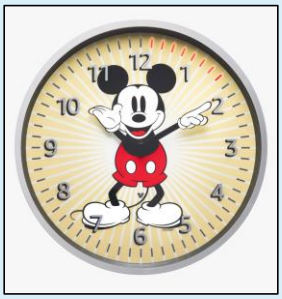
- FCDS Annual Reporting Deadline: 100% of cases must be submitted by June 30 of any given year. We still miss over 10,000 each year…which we identify during the Annual AHCA Statewide Patient Encounter (In-Patient, Ambulatory, Surgery Centers) and XRT Audits.
- What is FCDS Doing About 2021,2022, 2023 Deadlines?
  - 2020 COVID-19 Pandemic was our 2nd Delay – Complete
  - 2021 New Changes to Standards – Complete
  - 2022 More Changes to Standards – New Manuals – 70% at Deadline
  - How Can Anybody Possibly Stay Caught Up?
- Timeliness is assessed using:
  - Admissions by Facility Report
  - Facility Timeliness Report
  - FCDS Deadline – June 30th Every Year
  - Cases Received After FCDS Deadline Report
  - Submit Late Reporting Plans to FCDS in Writing
  - Communicate Regularly with Field Coordinators and/or Meg Herna



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2022-2023 Data Quality Audits and More - Data Quality

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- FCDS Timeliness/Deadlines – 2022/2023 Patient Encounters & Diagnosis Years
- Annual Re-Casefinding Audits – AHCA/Mortality/FAPTP – ALL Facilities
- Annual Data Quality Audit - Neuroendocrine System Tumors – Part II
  - 76 Facilities – 498 Abstracts and 391 E-Path Reports
  - 2019 Diagnosis Year - Analytic Cases Only – Completion 6/30/2022
- 2022 Annual Data Quality Audit – Lymphoid and Myeloid Neoplasms
  - 2020 Diagnosis year – Analytic Cases Only – Completion 12/31/2022
  - All Hospitals – 1000+ Cases – Focus on Histology, Stage, Treatment and Documentation
- FCDS Data MUST Meet or Exceed National Data Quality Standards to be used in Government Reports and the *Annual Report to the Nation on the Status of Cancer*:
- NPCR Evaluation Plan & NPCR Data Quality Evaluations – Quality & Completeness

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NPCR & FCDS Annual Data Quality Indicator Reports (DQIR)

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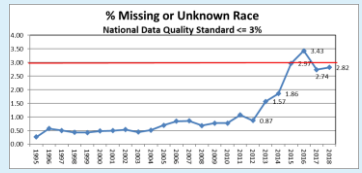
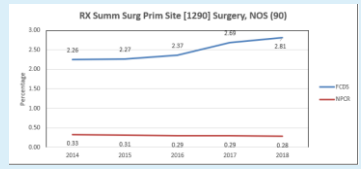
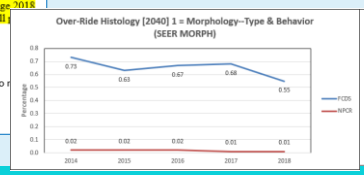
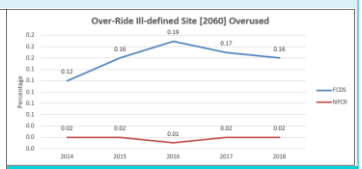
Summary of the DER Report for Florida
DX Years 1995-2019 & 2019
(24 month file is 2018)
(12 month file is 2019)

- 2018 DCO Rate = 1.75%
  - DCO Rate for 2017 went down from 1.66% to 1.47%... (late cases)
- Completeness met for 24 month data (2018); Missed target for 12 month data (2019)
  - 24 Month Standard: 95.00% FCDS 24 Month: 101.51%
  - 12 Month Standard: 90.00% FCDS 12 Month: 82.72%
- 24 month completeness met standard
- 12 month completeness is 7% below standard
- Race Unknown near or over the 3% threshold for National Data Quality Standard
  - 2018 % Race unknown (2.82%) near the National Data Quality Standard (<=3%)
  - 2017 % Race unknown (2.74%) near the National Data Quality Standard (<=3%)
  - 2016 % Race unknown (3.43%) over the National Data Quality Standard (<= 3%)
- It appears that the DER is in dire need of updating, there are no SSDI variables or Summary Stage 2018 in the DER and there are some Radiation variables that are no longer being collected that are still i the DER.
- 20 variable categories above NPCR median for 2018 data
  - 1 variables was below last year and are now higher
    - RX Summ Radiation [1360] Blank– however this variable is no longer collected so r sure why this is part of DER.
- 22 variable categories below NPCR median for 2018









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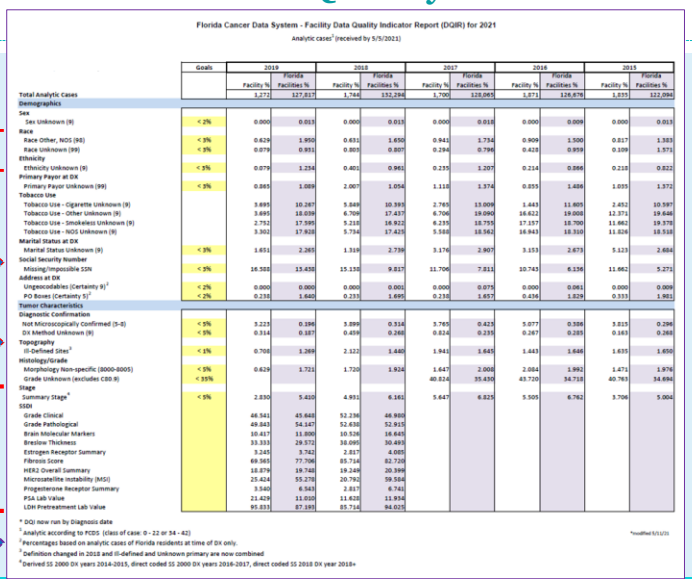
NPCR & FCDS Annual Data Quality Indicator Reports (DQIR)



Florida Cancer Data System - Facility Data Quality Indicator Report (DQIR) for 2021

Analytic cases[1] (received by 5/5/2021)

	Goals	2019 Facility %	2019 Florida Facilities %	2018 Facility %	2018 Florida Facilities %	2017 Facility %	2017 Florida Facilities %	2016 Facility %	2016 Florida Facilities %	2015 Facility %	2015 Florida Facilities %
Total Analytic Cases		1,272	127,817	1,744	152,294	1,700	128,065	1,871	126,878	1,835	122,094
Demographics											
Sex											
Sex Unknown (9)	< 2%	0.000	0.013	0.000	0.013	0.000	0.018	0.000	0.009	0.000	0.013
Race											
Race Other, NOS (98)	< 3%	0.629	1.950	0.631	1.650	0.941	1.734	0.909	1.500	0.817	1.383
Race Unknown (99)	< 3%	0.079	0.931	0.803	0.807	0.294	0.796	0.428	0.959	0.109	1.571
Ethnicity											
Ethnicity Unknown (9)	< 3%	0.079	1.234	0.401	0.961	0.235	1.207	0.214	0.866	0.218	0.822
Primary Payor at DX											
Primary Payor Unknown (99)	< 3%	0.865	1.089	2.007	1.054	1.118	1.374	0.855	1.488	1.035	1.372
Tobacco Use											
Tobacco Use - Cigarette Unknown (9)		3.695	10.267	5.849	10.393	2.765	13.008	1.443	11.805	2.452	10.597
Tobacco Use - Other Unknown (9)		3.695	18.039	6.709	17.437	6.706	19.090	16.622	19.008	12.371	19.646
Tobacco Use - Smokeless Unknown (9)		2.752	17.595	5.218	16.922	6.235	18.755	17.157	18.700	11.662	19.375
Tobacco Use - NOS Unknown (9)		3.302	17.928	5.734	17.420	5.588	18.582	16.943	18.310	11.828	18.518
Marital Status at DX											
Marital Status Unknown (9)	< 3%	1.651	2.265	1.319	2.739	3.176	2.907	3.153	2.673	5.123	2.684
Social Security Number											
Missing/Impossible SSN	< 5%	16.588	13.435	15.138	9.817	11.706	7.811	10.743	6.136	11.662	5.271
Address at DX											
Ungeocodables (Certainty 9)[2]	< 2%	0.000	0.000	0.000	0.001	0.000	0.075	0.000	0.061	0.000	0.009
PO Boxes (Certainty 5)[2]	< 2%	0.238	1.640	0.233	1.695	0.238	1.657	0.436	1.829	0.333	1.981
Tumor Characteristics											
Diagnostic Confirmation											
Not Microscopically Confirmed (5-8)	< 5%	3.223	0.196	3.899	0.314	3.765	0.423	5.077	0.356	3.815	0.296
DX Method Unknown (9)	< 5%	0.314	0.187	0.459	0.288	0.824	0.235	0.267	0.285	0.163	0.268
Topography											
III-Defined Sites[3]	< 1%	0.708	1.289	2.122	1.440	1.941	1.645	1.443	1.646	1.635	1.650
Histology/Grade											
Morphology Non-specific (8000-8005)	< 5%	0.629	1.721	1.720	1.924	1.647	2.008	2.084	1.992	1.471	1.976
Grade Unknown (excludes C80.9)	< 35%					40.824	35.430	45.720	34.718	40.763	34.694
Stage											
Summary Stage*	< 5%	2.830	5.410	4.931	6.161	5.647	6.825	5.505	6.762	3.706	5.004
SSDI											
Grade Clinical		48.341	45.645	52.236	48.930						
Grade Pathological		49.843	54.147	52.436	52.915						
Brain Molecular Markers		10.417	11.006	10.526	16.645						
Breslow Thickness		33.333	29.572	30.095	30.495						
Estrogen Receptor Summary		3.245	3.742	2.817	4.085						
Fibrosis Score		69.565	77.706	85.714	82.720						
HER2 Overall Summary		18.879	19.748	19.249	20.399						
Microsatellite Instability (MSI)		25.424	55.278	20.792	59.584						
Progesterone Receptor Summary		3.540	6.543	2.817	6.741						
PSA Lab Value		21.429	11.010	11.420	11.934						
LDH Pretreatment Lab Value		95.833	87.395	85.714	94.025						

* DQI now run by Diagnosis date

[1] Analytic according to FCDS (class of case: 0 - 22 or 34 - 42)

[2] Percentages based on analytic cases of Florida residents at time of DX only.

[3] Definition changed in 2018 and III-defined and Unknown primary are now combined

[4] Derived SS 2000 DX years 2014-2015, direct coded SS 2000 DX years 2016-2017, direct coded SS 2018 DX year 2018+

*modified 5/11/21

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NPCR SS2018 Errors

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- Errors effected 2018-2021 cases – some cases still coming in incorrectly
- Problems were in software, edits and SS2018 Instructions
- Issue #1 – Testis Stage – about 350 cases
  - An error in SS18, v2.0, for the testis chapter, schema ID 00590, was identified last year which incorrectly shifted cases to Regional by Direct Extension Only (code 2) or Regional by BOTH Direct Extension AND Regional Lymph Node(s) involved (code 4). As a result, the stage distribution was incorrectly inflated for these groups and reduced for 1 & 3.
- Issue #2 – Hematologic Malignancies – more than 15,000 cases
  - Two data quality issues were identified related to hematologic malignancies, an increase in unknown stage and localized stage for myeloma cases and an increase in HemeRetic cases coded to a stage other than Distant (7) for chronic and acute leukemia, MDS, MPN and other lymphoid and myeloid neoplasms with specific histologies.

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NPCR SS2018 Errors – Myeloid/Lymphoid/Plasma Cell Neoplasms

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- 184 Histology Codes/Stage for Review – 2010 and Later Diagnosis Year

ICD-O-	Name	Reportability
9590/3	Malignant lymphoma, NOS	for cases diagnosed 1978 and later
~~9591/1~~	~~Monoclonal B-cell lymphocytosis, non-CLL type~~	~~This neoplasm is not reportable~~
9591/3	Non-Hodgkin lymphoma, NOS	for cases diagnosed 1978 and later
9664/3	Hodgkin lymphoma, nodular sclerosis, cellular phase	for cases diagnosed 1978 - 2009
9670/3	Malignant lymphoma, small B lymphocytic, NOS	for cases diagnosed 1978 - 2009
9671/3	Lymphoplasmacytic lymphoma	for cases diagnosed 1978 and later
9673/3	Mantle cell lymphoma	for cases diagnosed 1992 and later
~~9680/1~~	~~EBV-positive mucocutaneous ulcer~~	~~This neoplasm is not reportable~~
9731/3	Solitary plasmacytoma of bone	for cases diagnosed 1978 and later
9732/3	Plasma cell myeloma	for cases diagnosed 1978 and later
9733/3	Plasma cell leukemia	for cases diagnosed 1978 - 2009
~~9740/1~~	~~Cutaneous mastocytosis~~	~~This neoplasm is not reportable~~
9740/3	Mast cell sarcoma	for cases diagnosed 1978 and later
~~9741/1~~	~~Indolent systemic mastocytosis~~	~~This neoplasm is not reportable~~
9742/3	Mast cell leukemia	for cases diagnosed 1978 and later
9762/3	Heavy chain diseases	for cases diagnosed 1992 and later
9808/3	Mixed-phenotype acute leukemia, B/myeloid, not otherwise specified	for cases diagnosed 2010 and later
9809/3	Mixed-phenotype acute leukemia, T/myeloid, not otherwise specified	for cases diagnosed 2010 and later
9811/3	B-lymphoblastic leukemia/lymphoma, NOS	for cases diagnosed 2010 and later
9812/3	B-lymphoblastic leukemia/lymphoma with t(9;22)(q34.1;q11.2); BCR-ABL1	for cases diagnosed 2010 and later
9813/3	B-lymphoblastic leukemia/lymphoma with t(v;11q23.3); KMT2A-rearranged	for cases diagnosed 2010 and later

text	lymphoid/non leukemia
text	SS2018 = 7 (correct)
text	S2018 not = 7 (error)
text	SS2018 = 7 (missed)
~~text~~	not reportable
~~text~~	not reportable/SS2018 not = 7

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NPCR SS2018 Errors – Testis Cases (LVI & Stage)

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325 Facility Cases/Stage for Review – 2019-2021 Diagnosis Years

Se	Original SS201	LV	Standard Phrasing Added to Abst Remarks Text	Status	Reviewed SS2018	Comments
0	2	1	2022 NPCR Testis Review - Error in SS2018 Manual	Corrected SS2018	1	confined to testis
0	2	1	2022 NPCR Testis Review - Error in SS2018 Manual	Corrected SS2018	1	invasion of rete testis - confined of testis
0	2	1	2022 NPCR Testis Review - Error in SS2018 Manual	7766	7766	physician augmentation only
0	4	1	2022 NPCR Testis Review - Error in SS2018 Manual	Corrected SS2018	1	invasion of rete testis - confined of testis
0	4	1	2022 NPCR Testis Review - Error in SS2018 Manual	no change	4	invasion of spermatic cord & hilar soft tissue with positive nodes
0	4	1	2022 NPCR Testis Review - Error in SS2018 Manual	no change	4	invasion of hilar soft tissue with positive nodes
0	2	1	2022 NPCR Testis Review - Error in SS2018 Manual	Corrected SS2018	3	invasion of rete testis with positive nodes
0	2	1	2022 NPCR Testis Review - Error in SS2018 Manual	Corrected SS2018	1	confined to testis
0	2	1	2022 NPCR Testis Review - Error in SS2018 Manual	7766	7766	physician augmentation only
0	2	1	2022 NPCR Testis Review - Error in SS2018 Manual	Corrected SS2018	1	confined to testis
0	2	1	2022 NPCR Testis Review - Error in SS2018 Manual	Corrected SS2018	7	regional retroperitoneal & distant mediastinal nodes on imaging
0	2	1	2022 NPCR Testis Review - Error in SS2018 Manual	Corrected SS2018	4	invasion of spermatic cord with positive nodes
0	4	1	2022 NPCR Testis Review - Error in SS2018 Manual	Corrected SS2018	3	invasion of rete testis with positive nodes
0	2	1	2022 NPCR Testis Review - Error in SS2018 Manual	Corrected SS2018	4	invasion of spermatic cord with positive nodes
0	4	1	2022 NPCR Testis Review - Error in SS2018 Manual	no change	4	invasion of spermatic cord with positive nodes
0	4	1	2022 NPCR Testis Review - Error in SS2018 Manual	no change	4	invasion of hilar soft tissue with positive nodes
0	2	1	2022 NPCR Testis Review - Error in SS2018 Manual	no change	2	invasion of hilar soft tissue
0	2	1	2022 NPCR Testis Review - Error in SS2018 Manual	no change	2	invasion of hilar soft tissue
0	2	1	2022 NPCR Testis Review - Error in SS2018 Manual	Corrected SS2018	1	confined to testis
0	2	1	2022 NPCR Testis Review - Error in SS2018 Manual	Corrected SS2018	1	invasion of rete testis - confined of testis
0	4	1	2022 NPCR Testis Review - Error in SS2018 Manual	no change	4	invasion of epididymis with positive nodes
0	2	1	2022 NPCR Testis Review - Error in SS2018 Manual	Corrected SS2018	1	confined to testis
0	4	1	2022 NPCR Testis Review - Error in SS2018 Manual	no change	4	invasion of epididymis, spermatic cord & scrotum with + nodes
0	2	1	2022 NPCR Testis Review - Error in SS2018 Manual	Corrected SS2018	1	invasion of tunica albuginea - confined of testis

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Please Remember to Call FCDS with Questions

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- Your Facility FCDS Field Coordinator, Meg Herna and Steve Peace are all available to answer technical questions or forward to someone else to answer.
- It is part of our job to provide this technical assistance.
- Please encourage your staff to call or email questions to FCDS rather than guess at answers. FCDS assembles common questions so we can add them to the FCDS Memo for everybody to learn.
- You may need to go to your manager first – but, we are always here to assist and direct you to resources to help you do your job better.
- We are all in this together. Thank you.
- ALL Data Quality Activities are Input to the FCDS Education & Training Program

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Questions

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