IMPROVING DATA QUALITY
FCDS' DATA QUALITY PROGRAM
AUDITS, EDITS AND DATA QUALITY REPORTS

FCDS Webcast Series
Steven Peace, BS, CTR
December 13, 2012

Continuing Education Hours

<table>
<thead>
<tr>
<th>Date(s)</th>
<th>Event</th>
<th>Sponsor</th>
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<td>FCDS Annual Conference, St. Petersburg, FL</td>
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Presentation Outline

- National Data Collection Standards
- NPCR Program Standards
- FCDS Data Quality Program
  - Data Quality Program Goals
  - Data Quality Program Methods
  - Data Quality Program Policy
  - Data Quality Program Procedures
  - Data Quality Program Audits
  - Data Quality Program Reports
- FCDS Education and Training Program
- Current Coding and Data Quality Issues
- References and Resources
- Q&A
National Data Collection Standards

- Vol I - Data Exchange Standards and Record Description
- Vol II - Data Standards and Data Dictionary
- Vol III - Standards for Completeness, Quality, Analysis, and Management of Data
- Vol IV - NAACCR Standard Edits
- Vol V - Pathology Laboratory Electronic Reporting Standards
- Registry Operations Guidelines and Standards in Development

Rule Makers for National Data Collection

- CDC NPCR – FCDS Participates in NPCR
  - State and Central Registries – Covers 98% of US Population
  - Data Acquisition Manual

- ACoS Commission on Cancer - Hospitals
  - CoC approved hospital registries – Voluntary Program
  - FORDS

- NCI SEER Program
  - SEER Registries – Covers 28% of US Population – Selected Populations
    - 26 percent of African Americans, 41 percent of Hispanics, 43 percent of American Indians and Alaska Natives, 54 percent of Asians, and 71 percent of Hawaiian/Pacific Islanders.
  - SEER Program Manual

NPCR Program Standards, 2012-2017

All funded programs must meet the following standards:

- Legislative Authority
- Administration
- Data Collection, Content, and Format
- Electronic Data Exchange
- Data Completeness/Timeliness/Quality
- Linkages
- Data Quality Assurance and Education
- Data Use and Data Monitoring
- Data Submission
- Collaborative Relationships
NPCR Program Standards, 2012-2017

- Data being evaluated for the Advanced National Data Quality Standard (formerly known as the 12-Month Standard), must meet the following data quality criteria:
  - Data are 90% complete based on observed-to-expected cases as computed by CDC.
  - There is a 2 per 1,000 or fewer unresolved duplicate rate.
  - The maximum percent missing for critical data elements are:
    - 3% age
    - 3% sex
    - 5% race
    - 3% county
  - 97% pass a CDC-prescribed set of standard edits.

NPCR Program Standards, 2012-2017

- Data being evaluated for the National Data Quality Standard (formerly known as the 24-Month Standard), must meet the following five data quality criteria:
  - Data are 95% complete based on observed-to-expected cases as computed by CDC.
  - There are 3% or fewer death-certificate-only cases.
  - There is a 1 per 1,000 or fewer unresolved duplicate rate.
  - The maximum percent missing for critical data elements are:
    - 2% age
    - 2% sex
    - 3% race
    - 2% county
  - 99% pass a CDC-prescribed set of standard edits.

NPCR Program Standards, 2012-2017

- Data Quality Assurance and Education
  - The central cancer registry has an overall program of quality assurance that is defined in the registry operations manual.
  - The quality assurance program consists of, but is not limited to:
    - A designated certified tumor registrar (CTR) responsible for the quality assurance program.
    - Quality assurance activities should be conducted by qualified experienced CTR(s) or CTR-eligible staff.
    - At least once every 5 years, a combination of case-finding and re-abstracting audits from a sampling of source documents are conducted for each hospital-based reporting facility, and may include external audits by CDC or SEER.
    - Data consolidation procedures are performed according to the central cancer registry protocol and nationally accepted abstracting and coding standards as available.
    - Audits of a routine sample of consolidated cases at the central cancer registry.
    - Feedback is provided to reporting sources on data quality and completeness.
Data Quality Assurance and Education

The central cancer registry has an overall education program that is defined in the registry operations manual.

The education program consists of, but is not limited to:

- Training for central cancer registry staff and reporting sources to assure high quality data.
- A designated education/training coordinator who is a qualified, experienced CTR.
- Where feasible, the education/training coordinator may be regionally-based, such that CDC-NPCR applicants collaborate to identify one applicant to provide the education/training coordinator for activities to be carried out in the full region.

The FCDS Data Quality Program

[Diagram of FCDS Data Quality Pyramid]

- Education
  - REWARDS
  - REINFORCEMENT
  - TIMELINESS
  - ACCURACY/DATA QUALITY
  - COMPLETENESS
  - COMMUNICATION
Foundation - Communication/Education

- Technical Answers by Telephone or Email
- Email (E-Mail Blast for Urgent or Timely Information)
- Email (Individual for questions or if you are having problems)
- FCDS IDEA (QC Review, Edits/Corrections, Documentation)
- FCDS RECAP – FCDS Internal Tool for Data Processing
- FCDS Monthly Memo – now every-other month
- FCDS Register – FCDS’ Quarterly Newsletter
- FCDS On-Line Abstractor Training Course
- FCDS Annual Meeting – face-to-face
- FCDS Web Broadcasts

FCDS Data Quality Program - Goals

Goals:
- Population-Based Reporting
- Highest Quality Data Possible
- Confidentiality, Privacy, Data Security

Objectives:
- Improve Communications
- Improve Feedback Loop
- Improve Completeness
- Improve Timeliness
- Improve Data Quality
- Improve Usefulness
- Improve Reports
- Improve Education
- Improve Training
FCDS Data Quality Program - Methods

- Florida Cancer Reporting Legislation
- Florida Public Health Administration Rules
- FCDS Policy and Procedures (FCDS DAM)
  - Internal Policy and Procedures
  - External Policy and Procedures
  - Monitoring Data Quality and Performance
- Quality Assurance / Quality Improvement Activities
  - Monitor operations workflow and data quality and take action to improve future quality, maximizing correct reporting and characterizing the reporting process in measurable terms.
- Perform External Linkage to Improve Data
  - Obtain and/or validate data items by linking central cancer registry databases with clinical and non-clinical state and national databases
    - Using death certificate data to add missing vital status and race
    - Using claims data to complete first course of treatment data
- FCDS Data Quality Program - Policy
- FCDS Policy
  - FCDS Abstractor Code Requirement
  - FCDS EDITS Requirement
  - Text Documentation Requirement
  - Deadlines and IT Security
- FCDS Procedures
  - FCDS IDEA – Communication/Transmission
  - FCDS Internal Data Processing Monitoring
  - FORCES/CORRECTIONS/DELETIONS
  - Patient and Tumor Linkage & Consolidation
- FCDS Monitoring / Audits
  - Audits for Completeness
  - Audits for Timeliness
  - Audits for Accuracy
- FCDS Data Quality Reports
  - Quarterly/Annual Status Reports
  - Ad Hoc Reports
  - Audit Results
Congratulations!

FCDS Data Quality Program - Policy

FCDS Abstractor Code – A National Model for QC

APPENDIX 1. FCDS TEXT DOCUMENTATION REQUIREMENTS

Text documentation is an essential component of a complete electronic abstract and is strongly utilized in quality control, by validation data on three of FCDS and ARACY quality, and for special studies. Text documentation is required by policy/contractual values and to supplement information not transmitted with coded values. FCDS recommends that abstractors print and post this document for easy reference. Adequate text is a data quality indicator and will be major part of QC.

Text documentation shall always include the following components:

- Date(s) – Include date(s) referenced – this allows the reviewer to determine event chronology
- Details – Note what data are extracted (i.e., date of illness, illness site etc.)
- Location – Include facility/organization/other location where the event occurred
- Description – Include description of the event (e.g., treatment/office) – Include outcome/results
- Details – Be as detailed as possible – Document treatment plans even if treatment is deemed as planned
- Include “Note: any further patient/case information only – with your text documentation
- DO NOT Repeat Information (even once) in section
- DO NOT Omit Text if Data absent or Data available
- Include “NA” or “Not available” when no information is available related to any specific text area

APPENDIX 2. FCDS TEXT DOCUMENTATION REQUIREMENTS

APPENDIX 3. FCDS TEXT DOCUMENTATION REQUIREMENTS

APPENDIX 4. FCDS TEXT DOCUMENTATION REQUIREMENTS
FCDS transitioned from an Oracle-based edits program written by FCDS contractors to the National Standard EDITS Metafile in September 2010. Standard EDITS include Field-Item, Inter-Item and Intra-Item Edits:

- Edits validate codes, crosscheck relationships between data items (male with prostate cancer) and checks for blank fields.
- The FCDS EDITS Metafile was created for Florida, specifically to accommodate the reporting of historical cases among other FCDS special coding requirements.
- FCDS has also included edits in the metafile for common abstracting errors identified through re-abstracting audits.

FCDS Data Quality Program - Policy

- Deadlines and Data Monitoring Policy and Procedures
- Confidentiality of Protected Health Information
- IT Security Policy and Procedures
- Patient Privacy and HIPAA
- No Paper Policy
- Other

FCDS Data Quality Program - Procedures

- FCDS EDITS Metafile
- FCDS Correction / FORCE / Delete
- FCDS QC Review of Every 25th Record – Visual Editing
- Patient and Tumor Linkage and Consolidation Procedures
- FCDS Audit Findings Link Back to Education
- FCDS Data Use Link Back to Procedures
FCDS Data Quality Program - EDITS

Standard Sources for EDITS
- NCI SEER
- CDC NPCR
- ACOS COC
- Other States
- Collaborative Stage
- FCDS for Florida-Specific
- NAACCR EDITS Working Group

FCDS EDITS Check For Conditions
- Blank Field Checks – Single Item Edit
- Valid Code Checks – Single Item Edit
- Valid Date Checks – Single Item Edit
- Inter-Field Edits – Relationships Between Items
- Inter-Record Edits – Relationships Between Cases
- CS Edits – Core
- CS Edits – Staging
- CS Edits – SSFs
- Inter-Field CS and Other Item Edits (scope, surg)
- Link CS Stage and SSF Data to Treatment Plan
FCDS and National EDITS – Coming Soon!

- Updates to SEER Site/Type Table
  - 2012 Hematopoetic and Lymphoid Neoplasm Site/Type
  - 2013 ICD-O-3 Updates – New Histology Codes and Site/Type
  - General Updates to Site/Type Combinations

- Complex Inter-Field EDITS
- More Treatment EDITS
- More CS Core EDITS
- More SSF EDITS
- New Clinical Edit Checks
  - NCCN/ASCO Guidelines
  - NCDB Submission Edits
  - RQRS (Rapid Quality Reporting System)
  - CP3R (Cancer Program Practice Profile Reports)

Staying Current - FCDS EDITS

- Understand FCDS EDIT and what each is designed to do
- Review FCDS EDITS Messages – make them more clear
- Identify FCDS EDITS that are “FORCEABLE”
- Understand FCDS EDITS/CORRECTION/FORCE Process
- Understand FCDS FC/QC responsibilities and expectations
  - External FCDS EDITS Metafile to be used by Registrars
  - Internal FCDS EDITS Metafile used by FCDS
  - FCDS Metafile Excel Sheet documenting changes
  - Registrar Interest in Learning How to Use Edit Writer

News / Downloads

http://fcds.med.miami.edu/inc/downloads.shtml#fcdsdatafiles
### Staying Current - FCDS EDITS Metafile

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<td>All warnings for this version.</td>
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<td>Out of Range Edits</td>
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### Master List(s) – FCDS EDITS

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### Corrections/Deletions/FORCES

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### Corrections/Deletions/FORCES

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<td>Total Processed</td>
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### FCDS Data Quality Program – Every 25th

**FCDS QC Visual Review - Every 25th Record**

- **GOAL:** Evaluate whether or not the case makes sense as coded or is something missing or unusual that edits would not catch. Does the case make sense as coded or is something missing or “off” with case as coded.

  By selecting one of every 25th records received plus male breast and all pediatric cases, FCDS visually edits at least 5% of the total cases submitted each year. Other cases visually edited are cases being evaluated for FORCES, Corrections, Special Studies, and During Data Use (up to 10% of annual cases).

- The QC Abstract Review Process is a 3-step process - fully automated.
  - **Step 1:** Initial review 
  - **Step 2:** feedback to/from the registrar with opportunity to defend coding 
  - **Step 3:** third party mediation assesses the first reviewer’s findings, the facility’s comments, any recommended corrections, or feedback and come to a final determination on the case – the mediator’s decision is final

- Records with discrepant data must be resolved by the reporting facility.

- “Agree”, “OK”, “Done” are NOT Acceptable Responses to Inquiries

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### Visual Review – The Panoramic View

- Are there many blank spaces?
- Is code 9 (unknown) used frequently?
- Are there other numeric red flags (.8, 88, 8)?
- Are all dates in logical order?
- Are text fields significantly different from coded field translations?
- Is treatment appropriate for site and stage?
- Is there logical progression from stage at initial diagnosis to recurrence and recurrence sites?
- Does the abstract tell a complete story?
Visual Review – Demographic Items

- Surname – Spanish origin
- Race – Surname – Place of birth
- Area code – County
- Date of birth – Date of diagnosis
- Sex – Name
- Sex – Primary site
- Age – Occupation
- Age – Marital status
- Age – Primary site and histology
- Address – Place of diagnosis
- City – County

Visual Review – Diagnosis Items

- Primary site code – Text
- Histology code – Text
- Site – Laterality – Histology
- Behavior – Diagnostic confirmation
- Dx confirmation – Histology > 8000
- Are dates in logical sequence?
- Is Dx date the earliest documented?
- Class of case – Facility referred to/from
- Dx date – Place of diagnosis
- Site – Type of admission
- Sequence no. – Other primaries

Visual Review – Staging Items

- Stage – Primary site
- CS codes – Procedures text
- CS Extension – Summary stage – cT / pT
- CS Extension – SSFs (by site)
- Age – Pediatric stage
- CS Lymph Nodes – Summary stage – cN / pN
- CS Lymph Nodes – SSFs (by site)
- Tumor size > 100
- Nodes pos/exam – Surgery
- CS Mets at Dx – Summary stage – cM / pM
- Staging basis – Dates of treatment
Visual Review – Treatment Items

• Planned first course listed?
• Treatment – Primary site – Stage
• Treatment code – Procedure name
• Treatment – Facility referred from/to
• Surgery – Operative findings text
• Surgery – Pathology text
• Date 1st surg – Date most definitive surg
• Date most definitive surg – Date surg discharge
• Surg prim site – Margins
• Surg prim site – Scope reg LN
• Surg prim site – Reason no surg

Visual Review – Treatment Items

• Surgery – Radiation – RT/surgery seq
• Date RT start – Date RT end
• Location of RT – Facility referred from/to
• RT treatment volume – Reason no RT
• RT treatment volume – Boost volume
• Systemic tx – Primary site
• Systemic tx date – Chemo – Hormone – Immunotherapy
• Systemic tx date – Date most definitive surgery – Systemic/surgery sequence
• Hematologic Transplant & Endocrine Procedure – Primary site
• RT treatment volume – Palliative care

Patient and Tumor
Match, Link & Consolidate

BEST INFORMATION AVAILABLE FROM ALL SOURCES
Patient and Tumor Match, Link & Consolidate

FCDS Data Quality Program - Audits

- Introduction to FCDS Audits – Topic Selection / Protocol
- Audits to Assess Completeness
- Audits to Assess Timeliness
- Audits to Assess Accuracy
- Reconciliation Process
- External Audits
- Other

FCDS Data Quality Program - Audits

- Annual audits
  - Completeness
  - Timeliness
  - Data Quality/Validation
- Targeted audits
  - Identify extent of specific problems
  - Identify individual data collector training needs
  - Review and improve data quality in problem areas
- Random audits
  - Validate central registry data for research purposes
  - Identify unknown problem areas
  - Identify general data collector training needs
  - Review and improve data quality in unknown areas
FCDS Data Quality Program - Audits

- Annual audits
  - Data Validation and Feedback
  - Includes All Florida Reporting Facilities
  - Contractual Obligation – DOH and NPCR
  - Re-Abstracting/Validation Audits on a 5-year cycle

- Targeted audits
  - High risk – high volume
  - Major sites – problem sites
  - New staff
  - New software/conversions
  - High volume
  - History of problems

- Random audits
  - All facilities
  - All primary sites

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FCDS Data Quality Program - Audits

- Study/Audit Timeline
- Protocol Template
  - Introduction
  - Purpose
  - Description of Study
    - Sample size
    - Study population
  - Audit Notification
  - Audit Procedures
  - Resolution Procedures
  - Analysis plan
  - Feedback plan
  - Recommendations
- Protocol Review

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Audits to Assess Completeness

The NPCR/AERRO scope diagram shown above is a simple flow diagram that identifies hospital and central registry data sources in a ranked order, based on the quantity of useful data that are available and reported to the central cancer registry.
Audits to Assess Completeness

The extent to which all required cases have been reported to FCDS. FCDS file completeness is assessed using:

- ACHA (covers 100% audit of all In-Patient and Out-Patient Visits)
- FAPTP – Florida Association of Pediatric Tumor Programs
- Breast Cancer Early Detection Program Match
- Interstate Data Exchange
- Annual Death Clearance
- Field Casefinding Audits
- E-Path Matching
- Other Linkages
- NDI

NPCR Requires FCDS to be 95% complete 24 months after close of dx year – from all report sources

NPCR Requires FCDS to be 90% complete 12 months after close of dx year

Audits to Assess Completeness

- Patient and Tumor Consolidation
  - (aka: merging the “best” data from all available sources)
  - Electronic edits, Visual Editing, Patient and Tumor Matching
  - Comparison of individual data and data items
  - Records received are checked for duplicate reporting
  - Multiple reports for same patient are merged to capture most complete demographic data
  - Multiple reports for same patient are checked for new tumors (same vs. new primary)
  - Multiple reports for the same tumor are merged to capture most complete diagnostic, staging and treatment data

AHCA Clearance and Casefinding Audit

- AHCA is the Agency for Health Care Administration with a primary function of tracking ALL patient encounters (diagnosis, treatment, billing, etc.) for nearly all healthcare facilities in the state of Florida
- ANNUAL Match the FCDS Master File to the Florida AHCA files for both inpatient and outpatient/ambulatory patient encounters. All Facilities.
- FCDS provides each reporting facility with a list of Unmatched AHCA Cases (cases that appear in the AHCA files but have no matching record in the FCDS Master File) and available in FCDS IDEA on the FCDS website.
- Facilities must explain why they did not report the case – or must immediately abstract and submit the case to FCDS as a “late report”.
- When missed cases are abstracted and submitted, they are classified as a “missed case” found as a result of the audit and counted as a “late report”.

Audits to Assess Completeness
### Audits to Assess Completeness

#### Death Clearance and Casefinding Audit
- Many registrars do not recognize Annual Death Clearance as a casefinding audit, but it is. The Florida Bureau of Vital Statistics tracks every birth and death in the state of Florida and has for many years.
- FCDS Conducts an ANNUAL matching of the entire FCDS Master File (3.5 million records) to the annual Vital Statistics Mortality File
- Any “cancer-related” Florida deaths without a matched record in the FCDS Master File are followed back to the hospital or physician authorizing the VS report to determine why the facility/physician did not submit the case.
- Facilities must explain why they did not report the case – or must immediately abstract and submit the case to FCDS as a “late report”.
- When missed cases are abstracted and submitted, they are classified as a “missed case” found as a result of the audit and counted as a “late report”.

#### FAPTP Clearance and Casefinding Audit
- Many registrars do not recognize this as an audit, but it is. The Florida Association of Pediatric Tumor Programs (FAPTP) captures data on pediatric tumors diagnosed and/or treated within their consortium of hospitals and cancer programs.
- FCDS Conducts an ANNUAL matching of the entire FCDS Masterfile (3.5 million records) to the annual FAPTP File
- Any records found not to match the FCDS Masterfile but having been seen in the facility are followed back to determine why they did not send the case.
- Facilities must explain why they did not report the case – or must immediately abstract and submit the case to FCDS as a “late report”.
- When missed cases are abstracted and submitted, they are classified as a “missed case” found as a result of the audit and counted as a “late report”.

#### On-Site Casefinding Audits
- QC staff will periodically perform on-site review of casefinding procedures and casefinding sources within each facility (Medical Records, e-path, clinics, etc.).
- If any case is found to meet the cancer reporting requirements outlined in Section I, the case must be abstracted and reported to FCDS.
- For any case found that does not meet the cancer reporting requirements outlined in Section I, an explanation must be submitted to FCDS detailing the reason it will not be reported.
- Facilities must explain why they did not report the case – or must immediately abstract and submit the case to FCDS as a “late report”.
- When missed cases are abstracted and submitted, they are classified as a “missed case” found as a result of the audit and counted as a “late report”.
- FCDS will add matching and follow-back of e-path records to facility submissions in the future as an annual routine Casefinding Audit and will also be used for Data Validation comparing text-to-code assignments against the original e-path report.
Audits to Assess Timeliness

Timeliness is determined by measuring how long it takes from the time a patient walks through the door of your facility for a diagnosis to be made, treatment plan to be created and initiated, the case is abstracted, the case is uploaded to FCDS without error and more.

- Standard Set by NAACCR, CDC/NPCR, ACoS/CoC, FCDS:
  - 95% cases submitted within 6 months from date of service.
  - 100% of cases must be reported by June 30th.
- FCDS Annual June 30th Deadline
- FCDS Quarterly Status Reports
- Once-A-Year Submissions DO NOT Meet Reporting Requirements
  - Monthly Reporting is preferred so you stay current
  - Quarterly Reporting for Facilities with >500 cases/year

Audits to Assess Accuracy/Data Quality

The extent to which the data submitted has been correctly and consistently coded and reflects the clinical, diagnostic, descriptive, decisions for treatment planning, or other information contained in the medical record.

- FCDS Abstractor Code Required for Each Abstractor
- FCDS Abstractor Code Annual Renewal
- Policy for Data Submission
- Standard FCDS EDITS Metafile
- Text Documentation Requirements
- Case Corrections / Forces (Edit Override)
- QC Visual Editing – A 3-step Process
- Audits for Completeness
- Audits for Accuracy
- External Audits
- Data Use

Audits to Assess Accuracy/Data Quality

FCDS On-Site Validation/Re-abstracting Audits

- The FCDS Quality Control staff and/or outside contract agents working on behalf of FCDS perform on-site or remote access source record review of abstracting and coding by re-abstracting cases from original source paper or electronic medical records for cases previously submitted to FCDS.
- Re-abstracting/Validation Audits assess the consistency in interpretation, instruction and use of standard data definitions, coding rules and guidelines, reference resources, and policies and procedures; and serve to identify areas that may require further education and training.
- Reconciliation of Re-abstracting Audit Inconsistencies between original data and audited data is an Important Component: Key data items are evaluated and any discrepancy noted between the auditor’s findings and the original abstract findings are returned to the facility for reconciliation.
- NEW for 2012 – EMR Direct Access to Medical Records for audit and/or e-post of key electronic reports on FCDS IDEA (PDF, txt, doc, other formats) instead of on-site auditing of medical records for 2010 diagnosis.
External Audits

CDC NPCR Audits (Casefinding/Re-Abstracting/Consolidation)

- The CDC NPCR staff and/or outside contract agents working on behalf of NPCR perform on-site and/or remote review of FCDS Policy and Procedures Manuals, routine operations, standard FCDS EDITS, QC Review, Audits, and Record Consolidation operations and outcomes.

- The CDC NPCR staff and/or outside contract agents working on behalf of NPCR perform on-site and/or remote audits of sources records as well as consolidated FCDS Master File records by reviewing paper and/or electronic medical records, FCDS Master File records, and other available source records on cases previously submitted to FCDS.

- Reconciliation of differences between original data and audited data is an important component: Key data items are evaluated and any discrepancy noted between the auditor’s findings and the original abstract findings or consolidation findings are returned to FCDS for reconciliation.

- New for 2012 – Consolidation Outcomes Audit and Visual Editing Audit

FCDS Data Quality Program - Reports

- FCDS Upload EDIT Discrepancy Journal
- FCDS Quarterly Status Report
- FCDS Data Quality Indicator Report
- FCDS Re-Abstracting Study Report
- NPCR Data Quality Indicator Reports
- NAACCR Certification

Discrepancy Analysis Detail For Batch
FCDS Re-Abstracting Audit Report

- Major Difference
  - Affects incidence counts
  - Affects research
  - Examples: diagnosis year, primary site, sex
- Minor Difference
  - Does not affect incidence counts
  - Examples: quadrant of breast, type of resection
- Unknown-to-Known
  - Valid data found but initially coded as unknown
  - Difference depends on data item

NPCR Data Quality Reports
Other – Reinforcement

- Monitor Compliance with Feedback to Registrar and Administration
- Data Quality and Timeliness Reports to Administration
- Targeted Education and Training Programs
  - FCDS Annual Conference
  - FCDS Annual Series of Webcasts
    - 6-8 per year or as needed
    - Recorded and archived
  - FCDS On-Line Abstractor Training Course
  - Published Resources for Registrars
  - Monthly NAACCR Educational Webcast Series at 7 Locations in FL

Other – Incentives and Rewards

- Jean Byers Award including Publication of Name in Register
- Individual Abstractor Recognition Certificates
- Other Recognition – Future of Rewards

FCDS DATA QUALITY AND EDUCATION AND TRAINING
FCDS Education and Training

- New Registrar Recruitment
- Instruction: FCDS/National Coding Rules and Guidelines
- Instruction: FCDS/National Policy/Procedures
- Re-Instruction: Existing Rules/Procedures – Correct Problems
- Instruction: Changes To / New Rules/Procedures
- Continuing Education – Increase Knowledge Base
- Retention of Qualified Staff

FCDS Education and Training

- On-Line Abstracting Course for New Registrars
- Obtaining an FCDS Abstractor Code
- 2-Day FCDS Annual Conference
- 6-8 FCDS Annual Webcast Series
- 12 NAACCR Hosted Annual Webinar Series
- Ad Hoc Webcasts for New Programs/Policy/Procedure/Other
- Monthly In-Services – Cancer Registry Principles & Practices
- Monthly EDITS In-Services – Review New/Change FCDS EDITS
- Personalized Instruction
### Tracking Events

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<tr>
<th>#</th>
<th>Date</th>
<th>Name of Event</th>
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<td>Collecting Cancer Data: Pancreas</td>
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<td>Abstracting and Coding Boot Camp: Cancer Case Scenarios</td>
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### 2010 NAACCR Webcasts = 632ppts
Results

FCDS has achieved variable results depending on combination of one or more of the following:

- Topic of Interest
- Availability of Program
- Availability of Participants
- Method of Presentation
  - In-person Meeting
  - Live Broadcast (webinar/webcast)
  - Recorded Webinar/Webcast
  - Web-Enabled Self-Instruction
  - Telephone Assistance
  - Other Personalized Instruction

CURRENT CODING AND DATA QUALITY ISSUES

- FCDS has been correcting many more sex coding errors than we have had to correct in many, many years. Why??
- FCDS routinely checks Male Breast for Sex Coding Errors
- All Other Sex Coding Errors we find are incidental.
- PLEASE double check that you have coded SEX correctly.

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<td>2</td>
<td>Female</td>
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<tr>
<td>3</td>
<td>Other intersex</td>
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<td>4</td>
<td>Transsexual</td>
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<tr>
<td>5</td>
<td>Unknown/invalid</td>
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### Urinary System MPH Rules

**Rule M1** An invasive tumor, following a non-invasive or in situ tumor more than 60 days after diagnosis is a multiple primary. 

**Note 1:** The purpose of this rule is to ensure that the tumor is counted as a separate primary if the tumor is found at a subsequent visit.

**Rule M2** Malignant tumors with an explanation of the following histological, papillary carcinomas (970), transitional cell carcinomas (810-819), or papillary transitional cell carcinomas (804-811) are a multiple primary.

**Rule M3** Tumors diagnosed more than 7 years apart are multiple primaries.

**Rule M4** Unrelated tumors in two or more of the following sites are a single primary (see Table 1):
- Retinoblastoma (229)
- Central nervous system (CNS)
- Bladder (959.5)
- Gastroesophageal reflux disease (GERD)
- Central nervous system (CNS)

### Prostate - Clinical

- **Use Core CS Data Items**
  - CS Tumor Size
  - CS Ext
  - CS TI/Ext Eval
  - CS LN
  - CS LN Eval
  - CS Mets
  - CS Mets Eval

**Question:** Is the term “induration” still considered apparent/involvement for clinical extension for prostate ca?

**Answer:**

**Note 3:** Clinically apparent and inapparent tumor: A clinically inapparent tumor is one that is neither palpable nor reliably visible by imaging. A clinically apparent tumor is palpable or visible by imaging. If a clinician documents a “tumor,” “mass,” or “nodule”, this can be inferred as apparent. Do not infer inapparent or apparent tumor based on the registrar’s interpretation of other terms in the digital rectal examination (DRE) or imaging reports. A physician assignment of cT1 or cT2 is also a clear statement of inapparent or apparent respectively. Code to 300 (which maps to T2 NOS) in the absence of a clear physician’s statement of inapparent or apparent.

### Prostate - Pathologic

- **SSF 3 – Path Extension** – MUST HAVE PROSTATECTOMY for coding!!!

**Note 1:** Include information from prostatectomy and autopsy in this field and not in CS Extension - Clinical Extension.
- Only use histologic information from prostatectomy, including simple prostaticctomy with negative margins, and autopsy in this field.
- Information from biopsy of extraprostatic sites is coded in CS Extension - Clinical Extension;
- Information from needle core biopsy of prostate is coded in CS SSF14.

**Note 2:** Code 970 if there is no prostatectomy performed within the first course of treatment.

**Note 3:** Limit information in this field to first course of treatment in the absence of disease progression.

**Note 4:** AJCC considers “in situ carcinoma of prostate gland” an impossible diagnosis. Any case so coded is mapped to TX for AJCC stage and in situ Summary Stage.
Unknown Primary/Ill-Defined Site

- Rule H. Use the topography code provided when a topographic site is not stated in the diagnosis. This topography code should be disregarded if the tumor is known to arise at another site.

Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations
C80-C84, C30-C39
(Excludes lymphoma and leukemia – M9990 - 9999 and Kaposi sarcoma M9140)

When the point of origin cannot be determined, use a topography code for overlapping sites:
- C02.8 Overlapping lesion of tongue
- C08.8 Overlapping lesion of major salivary glands
- C14.8 Overlapping lesion of lip, oral cavity, and pharynx.

<table>
<thead>
<tr>
<th>Site Title</th>
<th>Site Code</th>
<th>Histology Title</th>
<th>Histology Codes</th>
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<tbody>
<tr>
<td>Skin, Arm</td>
<td>C44.6</td>
<td>Carcinoma, Melanoma, Merkel Cell, Mycosis Fungoides, Cutaneous T-Cell Lymphoma of Arm</td>
<td>8010, 8720-8970, 8747, 9700, 9709</td>
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<td>Soft Tissue, Arm</td>
<td>C49.1</td>
<td>Sarcoma</td>
<td>8800-8921</td>
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<td>Peripheral Nerve, Arm</td>
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<td>Bone, Arm</td>
<td>C40.3</td>
<td>Sarcoma (oste)</td>
<td>9180-9194</td>
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<td>Lymph Nodes, Arm</td>
<td>C77.3</td>
<td>Lymphoid Neoplasms</td>
<td>See Heme DB</td>
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</table>
Unknown Primary/Ill-Defined Site

Meningioma (C70.3) – (intra)cranial meninges, spinal meninges, NOS

Melanoma Skin

- 3 KEY FACTORS FOR STAGING OF MELANOMA SKIN
  - Measured Thickness or Breslow Depth of Invasion
  - Presence or Absence of Ulceration
  - Primary Tumor Mitotic Count or Rate

- All are in the SSFs

- Measured Thickness
  - 000 not a valid thickness – code 999
- Ulceration – Discussion
- Mitotic Count/Rate – Discussion and Problems Encountered

Non-Melanoma Skin Cancers

<table>
<thead>
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<th>Code</th>
<th>Term</th>
<th>Code</th>
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<td>Merkel Cell Carcinoma</td>
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<td>Sweat Gland Adenocarcinoma</td>
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<td>Non-Hodgkin Lymphoma</td>
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<td>Dermatofibrosarcoma</td>
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<td>Mycosis Fungoides</td>
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<td>8850/3</td>
<td>Liposarcoma</td>
<td>9709/3</td>
<td>Cutaneous T-Cell Lymphoma</td>
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</table>
Problem SSFs

• All Mitotic Count/Rate Factors – WHY?
• Melanoma Skin – Depth of Invasion, Mitotic Count
• Clinical Assessment of Regional Lymph Nodes
  • Stomach
  • Appendix
  • Colon
  • Rectum
  • NET Stomach
  • NET Colon
  • NET Rectum
  • Breast
  • Skin Melanoma
  • Skin Merkel Cell

Problem SSFs - Breast

• Easy to Find Site Specific Factors
  • ER
  • PR
  • HER2
  • Test Value
  • Test Result
  • Tally Results into Profile
• Difficult Site Specific Factors
  • # Positive Ipsilateral Level I-II Axillary Lymph Nodes
  • IHC of Regional Lymph Nodes
  • FISH or CISH Testing for HER2
  • Size of Invasive Component
  • Circulating Tumor Cells
  • Disseminated Tumor Cells

References / Resources


References / Resources


6. NPCR Educational Materials for Cancer Registrars
   - Volume 3: Data Editing and EDITS: Procedures for Central Registries
   - Volume 4: Coding and Visual Editing: Procedures for Central Registries
   - Volume 6: Audits: Casefinding and Reabstracting: Procedures for Central Registries

7. Unpublished materials provided by National Program of Cancer Registries

Thanks and Appreciation

- FCDS QC/Education Team
  - Mayra Espino, BA, RHIT, CTR
  - Gema Midence, MBA, CTR
  - Judy Bonner, RN, MS, CTR
  - Susan Smith-Pierce, CTR
  - QC Contractors, CTR

- FCDS Moodle Team
  - Melissa Williams
  - Jill MacKinnon, PhD
  - Mark Rudolph, MS

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Questions