Presentation Outline

- Rule Makers for National Data Collection
- NPCR Program Standards 2012-2017
- NAACCR Certification Criteria
- FCDS Data Quality Program
  - Data Quality Goals
  - Data Quality Policy
  - Data Quality Activities
  - Data Quality Audits
  - Data Quality Reports
- FCDS Education and Training Program
- FCDS “Future Vision”
- Current FCDS QC Issues

Rule Makers for National Data Collection

- CDC NPCR – FCDS Participates in NPCR
  - State/Central Registries – 98% of US Population – State/Federal Legislation
  - Data Acquisition Manual
- ACoS Commission on Cancer
  - ACoS Cancer Programs – CoC Cancer Program Standards - Voluntary
  - National Program for Breast Centers – NAPBC Standards – Voluntary
  - FORDS
- NCI SEER Program
  - SEER Program – 28% of US Population – State/Federal Legislation
  - 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 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.

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.

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.

Annual Report to the Nation

NAACCR Gold Certification Criteria

• Case ascertainment = 95% or higher completeness.
• < 3% of cases are reported by Death Certificate Only.
  • < 0.1% duplicate case reports are in the file.
  • 100% error-free data.
• < 2% of cases are missing age, sex, or county.
• < 3% of cases are missing race.
• The file is submitted to NAACCR for evaluation within 23 months of the close of the diagnosis year under review.
The FCDS Data Quality Program

FCDS Data Quality Pyramid

Foundation - Communication/Education
- Technical Answers by Telephone or E-mail
- 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 On-Line Abstractor Training Course
- FCDS Annual Meeting – face-to-face
- FCDS Memo – every two months
- FCDS Web Broadcasts

FCDS Quality Improvement

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 Data Quality
  - Improve Usefulness
  - Improve Timeliness
  - Improve Education
  - Improve Reports
  - Improve Training
FCDS Data Quality Program - Goals

- 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

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 Abstractor Code – A National Model for QC

<table>
<thead>
<tr>
<th>Data Items Requiring Complete Text Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of DX</td>
</tr>
<tr>
<td>Sex</td>
</tr>
<tr>
<td>Primary Site</td>
</tr>
<tr>
<td>Laterality</td>
</tr>
<tr>
<td>Histologic Type</td>
</tr>
<tr>
<td>Grade</td>
</tr>
<tr>
<td>CS Tumor Size</td>
</tr>
<tr>
<td>CS Ext</td>
</tr>
<tr>
<td>CS Tumor Ext/Eval</td>
</tr>
<tr>
<td>CS LN</td>
</tr>
<tr>
<td>CS LN Eval</td>
</tr>
<tr>
<td>Regional Nodes Positive</td>
</tr>
<tr>
<td>Regional Nodes Examined</td>
</tr>
<tr>
<td>CS Mets</td>
</tr>
<tr>
<td>CS Mets Eval</td>
</tr>
<tr>
<td>Any Unusual Case Characteristics</td>
</tr>
<tr>
<td>All FCDS Req’d SSFs</td>
</tr>
<tr>
<td>Any Pertinent Patient/Family History</td>
</tr>
</tbody>
</table>
FCDS Data Quality Program - Policy

FCDS Text Documentation Requirements

APPENDIX 5: DQS TEXT DOCUMENTATION REQUIREMENTS

Text documentation is an essential component of a complete electronic abstraction and a foundation utilized in audits, reviews, and evaluations of FCDS and NPCR quality and effectiveness. Text documentation is compiled to ensure that all data are captured. When the data are abstracted in the presence of an FCDS customer, the patient should not be identifiable. Text documentation shall always include the following components:

- Data (e.g., include data on references – this allows the reviewer to determine event chronology)
- Date (e.g., include dates) are estimated (e.g., data are 9/25/2010 – 9/26/2010)
- Description – include description of the event (including treatment/therapy) – include any test results
- Details – include as much detail as possible – document treatment along with treatment if identifiable
- Include "other" if necessary; information is available related to any specific text area.

FCDS Data Quality Program - Policy

FCDS Text Documentation Requirements

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

FCDS EDITS Metafile and EDITS PASS Requirement

- 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 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

Number of Edits Over Time

Total Edit Failures Over Time

FCDS and National EDITS – Coming Soon!

- Updates to SEER Site/Type Table
  - 2013 Hematopoietic and Lymphoid Neoplasm Site/Type
  - 2014 Hematopoietic and Lymphoid Neoplasm Site/Type
  - 2015 ICD-O-3 Updates – New Histology Codes and New Site/Type
  - General Updates to Site/Type Combinations
- Increasingly Complex Inter-Field EDITS
- Treatment EDITS linked to cancer profile
- Treatment EDITS linked to cancer stage
- 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

Staying Current - FCDS EDITS Metafile

Master List(s) – FCDS EDITS

<table>
<thead>
<tr>
<th>Category</th>
<th>Error Code</th>
<th>Warning Flag</th>
<th>Force Flag</th>
<th>Description</th>
</tr>
</thead>
</table>
| Age Edits        | 81         | N            | Y          | Invalid Site and Morphology for patient over age 5 based on ICD-0-2
| Age Edits        | 82         | N            | Y          | Invalid Site for patient under age 15
| Class of Case Edits | 149        | N            | N          | Class of Case equal 38 (autopsy only) or 49 (DCO) and Vital Status not equal 0 (dead)
| Class of Case Edits | 520        | N            | N          | If Class of Case equal 38 (autopsy only), then Date of Diagnosis and Date of Last Contact must be the same date.
| Collaborative Staging Edits | 287 | N | N | If CS Extension is 950, CS Lymph Nodes cannot = 000 and CS Mets at DX cannot be 00
| Collaborative Staging Edits | 288 | N | N | If CS schema is not KaposiSarcoma, MelanomaSkin, Conjunctiva, MelanomaConjunctiva, MelanomaChoroid, MelanomaIris, MelanomaCiliaryBody, or LymphomaOcularAdnexa: If CS Extension = 950, then CS Tumor Size must = 000.
| Grade Code Edits | 1263       | N            | N          | Unknown Primary Site (C809), Grade must = 9
| Grade Code Edits | 1300       | N            | N          | Grade must = 5, 8, or 9 for this ICD-O-3 Morph code
| Invalid Codes Edits | 10        | N            | N          | Site not valid
| Invalid Codes Edits | 14        | N            | N          | Abstractor code not valid
| Morphology Code Edits | 839        | N            | Y          | Histology is not valid
| Morphology Code Edits | 840        | N            | Y          | Invalid Histology for in situ
| Out of Range Edits | 19         | N            | N          | County Residence Current out of range (11-77, 88 or 90) or not numeric
| Out of Range Edits | 22         | N            | N          | Hispanic Origin is out of range (0 through 7 or 9)
| Probable Duplicate Edits | 106 | N | Y | Probable duplicate detected in master file
| Sequence Edits    | 40         | N            | Y          | Sequence greater than zero with Ill-Defined primary site, Ill-Defined Lymphoma, or Ill-Defined Leukemia
| Sequence Edits    | 63         | N            | N          | If Date of 1st Contact is less than 1981, Sequence Number--Hospital cannot = 00 or 60
| Therapy and Date Edits | 113 | N | N | If Surgery Primary Site = 00 and Scope Reg LN Surg = 0 and Surg Oth/Reg/Dist = 0 then Surg Date must equal 00000000
| Therapy and Date Edits | 119 | N | N | If RX Summ--Chemo = 00, 82, or 85--87 (chemo not given) then RX Date--Chemo must be blank and RX Date--Chemo Flag field must = 11 (no chemo).
| Warnings          | 60         | Y            | N          | WARNING: Other Rx is greater than 0 or less than 9
| Warnings          | 359        | Y            | N          | WARNING: Please verify this case is reportable. Check Sect. I of the FCDS DAM for reportability guidelines

2012 Corrections/Deletions/FORCES

<table>
<thead>
<tr>
<th>Category</th>
<th>Receipt Date 2012</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Cases Processed</td>
<td>194,426</td>
<td>100%</td>
</tr>
<tr>
<td>Good</td>
<td>182,449</td>
<td>93.8%</td>
</tr>
<tr>
<td>Corrected</td>
<td>5,146</td>
<td>2.6%</td>
</tr>
<tr>
<td>Forced</td>
<td>2,866</td>
<td>1.5%</td>
</tr>
<tr>
<td>Deleted</td>
<td>1,965</td>
<td>1.0%</td>
</tr>
</tbody>
</table>
Visual Editing of Cases

- Rationale for Visual Editing
- Standards for Visual Editing
- Timing for Visual Editing
  - New Abstractor Review
  - Automated QC Review
  - Individual Case Corrections/Forces
  - Case Consolidation
  - Special Studies
  - Audits

FCDS Data Quality Program – Every 25th

- FCDS QC Visual Review - Every 25th Record
  - 2012 Added All Male Breast and All Pediatric Neoplasms to QC Review
  - 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

Visual Review – What We Are Seeing

- Treatment Documented in Text BUT NOT CODED
  - If you get a QC Review asking you to code treatment and in your system it is coded – FCDS didn’t get the code – you must contact your vendor to see why not transmitted.
  - Replies on QC Review still are lacking clear answers
    - “ok” – “updated abstract” – “agree” are NOT answers.

  - Replies on QC Change in Primary Site MUST include complete RESTAGING – this is often overlooked and must not only be restaged – but must be in text fields.

  - Treatment Planned versus Treatment Delivered - CONFIRM

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

- 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
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

Completeness
- Casefinding is not just a Discharge Diagnosis Index
- Pathology Casefinding is Critical because HIM misses 10% or more of all cases because they don’t have info available at time of discharge or for ambulatory surgeries
- FCDS will soon be conducting e-path completeness audits to ensure all cases are reported in addition to AHCA and Mortality and FAPTP as well as complete tx.
- Too many cases are being missed from pathology.
- Too much hospital-based treatment is not reported.

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.
**Complete Casefinding**

- Pathology Reports – up to 10% of cases missed by HIM
- Other Lab Reports – bone marrow, autopsy, addenda, etc.
- In-Patient Discharge Diagnosis Index
- Out-Patient Services Diagnosis/Procedures Index
- Other Ambulatory Patient Services
  - Specialty Clinics – melanoma, head & neck, GI, GYN, etc.
  - Breast Diagnostic/Treatment Center
  - Diagnostic Imaging Center
  - Radiation Oncology Center
  - Medical Oncology Infusion Center
- ICD-9-CM Required Codes
- ICD-10-CM Required Codes

**Audits to Assess Completeness**

**Casefinding Audits**

- QC staff will periodically perform an onsite review of casefinding procedures and casefinding sources within each facility. (Medical Records, in path, clinics, other).
- 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-up 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 Completeness**

**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**

**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 Master File (3.5 million records) to the annual FAPTP 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”.
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

2014 Change to CoC Standard 5.2

- CoC Standard 5.2 was the 6-month Abstracting Requirement
- 2014 Standard 5.2 was Changed to RQRS Reporting AND On-Time Completed Case Reporting to NCDB in January
- NO CHANGE IN FCDS ANNUAL JUNE 30 DEADLINE
- NO CHANGE IN FCDS 6-MONTH REPORTING
- SUBMIT COMPLETED CASE TO FCDS
- FCDS not yet set up to receive Update/Modify Records

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 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.
- 2014 – Intensive Visual Editing Audit and E-Path Data Validation

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 source 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.

FCDS Data Quality 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 Edit Check Discrepancy Journal

FCDS Quarterly Status Report

FCDS Data Quality Indicator Report

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

**Table 3: Percentage of Over-Rule Flagged Fields - Grouped by Site Name and Registration Year**

<table>
<thead>
<tr>
<th>Site Name</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site A</td>
<td>90%</td>
<td>80%</td>
<td>70%</td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td>Site B</td>
<td>95%</td>
<td>85%</td>
<td>75%</td>
<td>65%</td>
<td>55%</td>
</tr>
<tr>
<td>Site C</td>
<td>98%</td>
<td>88%</td>
<td>78%</td>
<td>68%</td>
<td>58%</td>
</tr>
</tbody>
</table>

**Notes**
- Site A has been consistently compliant with data quality standards.
- Site C showed significant improvement from 2017 to 2018.

### 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
    - 5 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 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
- FCDS Abstractor Code
- FCDS Annual Conference
- FCDS Annual Webcast Series
- NAACCR Cancer Registry Webinar Series
- NAACCR CTR Exam Prep and Review Webinar Series
- Ad Hoc Webcasts for New Programs/Policy/Procedure/Other
- FCDS Staff In-Services
- FCDS EDITS In-Services
- Personalized Instruction

FCDS Education and Training

<table>
<thead>
<tr>
<th>Event</th>
<th>CEU Education Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>FCDS Annual Meeting</td>
<td>8-10</td>
</tr>
<tr>
<td>FCDS Webcasts</td>
<td>10-16</td>
</tr>
<tr>
<td>NAACCR Webinars</td>
<td>36</td>
</tr>
<tr>
<td>NAACCR CTR Exam Prep</td>
<td>n/a</td>
</tr>
<tr>
<td>ANNUAL TOTAL FCDS-Sponsored</td>
<td>60+ hours of education offered FREE each year</td>
</tr>
</tbody>
</table>

Other New Education Portals

- Live Webinars
- Learning Modules
- Online Courses
- CTR Exam Study Materials
- Online CTR Exam Practice Test
- More to Come

http://www.CancerRegistryEducation.org
Other New Education Portals

Cyber Cancer Registry

- Information about the Cyber Cancer Registry
- Resources for cancer professionals and researchers
- Access to data and information on cancer epidemiology

Other New Education Portals

Medical Terminology
Computer Principles
ACoS/CoC Standards
Real-Life Case Scenarios

https://educate.ihcrc.org/

Prepare for CTR exam
Earn CEU credits free
Train on real-life case scenarios
Learning new coding schemes, rules, and guidelines
- 295 Practice Cases
- 12 Major Site Groups
- 60+ Data Items Coded

Other New Education Portals

http://moodle.med.miami.edu/server/moodle/

FCDS Online Abstracting Basics Course
FCDS Abstractor Code Initial Exam
FCDS Abstractor Code Renewal Exam
Other State Abstractor Code Exams
More to come
How is QC/Education Changing?

- FCDS Goals and Objectives have not changed.
- FCDS will continue all reporting requirements.
- FCDS making every attempt to make any changes minimal.
- FCDS making every attempt to make any changes seamless.
- FCDS will continue to plan for upcoming changes.
  - TNM, SS2000, physician reporting, and more.
- FCDS will continue enforcing deadlines/reporting compliance.
- FCDS will continue to be available for technical Q&A.

How is QC/Education Changing?

- Monitoring Activities will likely be enhanced.
- Feedback to Hospitals still being planned.
- Some QC Activities will be cut back.
  - FCDS will continue all EDITS requirements.
  - FCDS will continue to perform QC Reviews.
  - FCDS will continue to perform completeness audits with F/B.
  - FCDS will continue to perform validation audits and reconciliation.
- Some Education/Training Activities will be cut back.
  - FCDS will continue to offer NAACCR Webinars.
  - FCDS will continue to offer NAACCR CTR Prep Series.
  - FCDS will continue to host an Annual Meeting.
  - FCDS will continue to host a Florida Webcast Series.

Reportable Cases - Required

Reporting Historical Cancers to FCDS – FCDS DAM

- Although the American College of Surgeons/Commission on Cancer does not require accredited facilities to abstract historical cases, FCDS does require the collection and reporting of certain historical cancers.

- DEFINITION: A historical case (Class of Case 33) refers to a primary reportable neoplasm (malignant or benign/borderline brain/CNS tumors).

- Patients diagnosed with any cancer during their lifetime are many times more likely to develop new cancers. It is very important for researchers to know the number and types of any and all cancers each patient has during his/her lifetime in order to effectively research and evaluate cancer incidence.
Reportable Cases - Required

Reporting Historical Cancers to FCDS – FCDS DAM

If a patient has at least one primary reportable neoplasm which is active or under treatment, all other primary reportable neoplasms the patient has ever had (active or inactive), regardless of the date of diagnosis, must be reported. Each case of cancer must be abstracted and reported separately.

Information about these previous (historical) primaries may be sketchy. The abstractor should attempt to complete an abstract with as much information as is available in the medical record.
### Class of Case

<table>
<thead>
<tr>
<th>Non-Analytic Classes of Case</th>
<th>Analytic Classes of Case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient appears in person at reporting facility</td>
<td>Patient appears in person at reporting facility</td>
</tr>
<tr>
<td>Non-specialist physician or non-CoC-accredited clinic or other facility, not part of reporting facility, accessed by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)</td>
<td></td>
</tr>
<tr>
<td>Pathology or other lab specimen only</td>
<td></td>
</tr>
<tr>
<td>Non-analytic case of unknown relationship to facility (not for use by CoC-accredited cancer programs for analytic cases)</td>
<td></td>
</tr>
</tbody>
</table>

### Social Security Number

- SSN is a required data item
  - FCDS relies heavily on correct SSN in abstracts
  - Healthcare payments rely heavily on correct SSN on bill
  - AHCA only includes DOB and SNN—no names
  - Partial SSN
  - SSN not available
  - SSN not accessible to me
  - How to locate SSN in medical record
  - Future of SSN in cancer registration and FCDS
  - What to do when AHCA SSN and Registry SSN don’t match?

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### Inflammatory Carcinoma of Breast

- Inflammatory carcinoma of the breast is a clinico-pathologic entity characterized by diffuse erythema and edema (peau d’orange) of the breast, often without underlying mass.
- Inflammatory carcinoma is primarily a clinical diagnosis with skin changes that usually arise quickly in the affected breast.
- A biopsy is required to demonstrate cancer either within the dermal lymphatics or in the breast parenchyma itself.
- Involvement of dermal lymphatics alone does not indicate inflammatory carcinoma in the absence of clinical findings.
- Clinical findings should involve majority of the skin of breast.
- The term of inflammatory carcinoma should not be applied to a patient with neglected locally advanced cancer of the breast presenting late in the course of her disease.

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### Plasma Cell Neoplasm Staging

#### Table 1: The Durie-Salmon Staging System for Multiple Myeloma

<table>
<thead>
<tr>
<th>Stage</th>
<th>Hemoglobin</th>
<th>Calcium</th>
<th>Myeloma Protein</th>
<th>Bone Lesions</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>x 0.1 g/dl</td>
<td>Normal or 8.8 g/dl</td>
<td>&lt;35 mg/dl</td>
<td>Normal or normal hematopoiesis only</td>
</tr>
<tr>
<td>II</td>
<td>&lt;4 g/dl</td>
<td>x 1.5 mg/dl</td>
<td>&lt;3.5 mg/dl</td>
<td>&lt;5 out of 3</td>
</tr>
<tr>
<td>III</td>
<td>x 3.5 mg/dl</td>
<td>x 1.0 mg/dl</td>
<td>&lt;7 mg/dl</td>
<td>&lt;15 out of 3</td>
</tr>
</tbody>
</table>

- Stage I: No evidence of disease.
- Stage II: Less than 10% bone marrow involvement. Stages II and III are defined as having bone involvement.
- Stage III: Present with full-blown disease or life-threatening disease.

#### MyelomaPlasmaCellDisorder

**Plasma Cell Disorders Including Myeloma**

- **DTL** (Dyscrasia Thromboцитopenica Leukemia) - A rare, aggressive disease characterized by abnormal blood cell production and involvement of the myeloma lineage.
- **MGUS** (Monoclonal Gammapathy of Undetermined Significance) - A condition where blood plasma cells produce an abnormal protein (immunoglobulin) but are not cancerous.
- **IgM, IgA, IgG** - Different classes of antibodies produced by plasma cells.
- **Plasma Cell Disorders** - A group of diseases characterized by the overproduction of antibodies by plasma cells.

---
Plasma Cell Neoplasm Staging

- CS Extension
- Note 1: Osseous plasmacytomas are localized tumors occurring in the bone. There may be soft tissue extension.
- Note 2: Extraosseous (extramedullary) plasmacytomas are plasma cell neoplasms that arise in tissues other than bone. The most common sites are the upper respiratory tract, the gastrointestinal tract, lymph nodes, bladder, central nervous system (CNS), breast, thyroid, testis and skin.
- Note 3: Criteria for the diagnosis of multiple myeloma include: presence of clonal bone marrow plasma cells or plasmacytoma, presence of an M-protein in serum and/or urine, and the presence of related organ or tissue impairment. Do not use this criteria to determine the diagnosis of multiple myeloma. Code according to histologic confirmation or physician statement according to the AJCC 7th edition.
- Note 4: Multiple myeloma or plasma cell myeloma is a widely disseminated plasma cell neoplasm, characterized by a single clone of plasma cells derived from B cells that grows in the bone marrow. It is always coded to 810 or 820 for systemic involvement.

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.

First Course of Treatment

First course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence.

- Watch and Wait – If first course of treatment is to do nothing but watch and wait – as soon as the patient has a change in status (rising PSA, clinical evidence of disease, etc.) – the patient has disease progression and the first course of treatment (watch and wait) is OVER. Treatment given after the change in patient cancer status is subsequent TX.
- Do not code ancillary drugs as treatment – use SEER*Rx
Palliative Care or Palliative Treatment

The term “palliative” or “palliation” may be used in two different contexts: (a) as meaning non-curative and (b) as meaning the alleviation of symptoms. Either can be first course of treatment. Either can be subsequent treatment. Either can be end-of-life.

Some palliative treatments fall within the definition of cancer-directed treatment and some treat the patient but not the cancer.

Palliative treatment may qualify the patient as analytic if it is given as part of the planned first course of treatment.

Palliative treatment may qualify the patient as non-analytic, if it given as subsequent treatment for recurrence or progression.

Coding Surgery Fields Correctly

- Surgery of Primary Site
  - Do not code colostomy as 90
  - Do not code unknown if surgery performed as 99
  - Use best code available
- Scope of Regional Lymph Node Surgery
- Surgery of Other Regional or Distant Sites
- Reason No Surgery
- Date of Surgery – know what your vendor is sending FCDS
- Treatment Status – don’t forget watch & wait/observation
- Surg/Rad Seq
- Surg/Systemic Seq

References / Resources


Questions