FCDS Data Quality Audit

Diagnosis Year 2012 Cases

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AUDITOR ORIENTATION
AND
FACILITY RECONCILIATION INSTRUCTIONS

STEVEN PEACE, CTR
5/29/2014

FCDS Data Quality Audits

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- The CDC NPCR requires that all states receiving funding under this program meet all NPCR Program Standards as defined in the NPCR Program Manual, v2.0 and the NPCR Program Standards 2012-2017.
- These standards are based on authority provided to the CDC under the Public Health Service Act (Title 42, Chapter 6A, Sub-Chapter II, Part M, § 280e) and subsequent amendments, and apply to all reportable cancers as defined in the Act and any amendments.

FCDS Data Quality Audits

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- The Florida Department of Health (Florida DOH) also requires that Florida's statewide central cancer registry, the Florida Cancer Data System (FCDS), must meet all NPCR Program Standards as defined in the NPCR Program Manual, v2.0 and the NCPR Program Standards 2012-2017.
- FCDS operates the state cancer registry under contract with the Florida DOH.

FCDS Data Quality Audits

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- The quality of data collected and reported by cancer registries depends upon the completeness of case identification, the completeness and accuracy of case reports, on-time reporting of cases, data quality monitoring including editing and record review, and adherence to national program standards (i.e. text documentation).

- At least once every 5 years, a combination of re-casefinding (completeness) and re-abstracting (data validation) audits from a sampling of source documents are conducted for each hospital-based reporting facility in the state of Florida.

FCDS Data Quality Audits

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- Every Hospital is Audited at least Once Every 5 Years
- Audits to Assess Completeness of Case Identification
  - AHCA
  - FAPTP
  - E-Billing
  - E-Pathology
  - Vital Statistics
  - Special Studies

FCDS conducts annual re-casefinding audits via discharge diagnosis and procedures index submitted to the state Agency for Health Care Administration (AHCA) for 100% of in-patient encounters and 100% of ambulatory care patient encounters (hospital/non-hospital) occurring in the state of Florida each year.

- Audits to Assess and Validate Data Quality
  - Data Validation
  - Re-Abstract/Re-Code
  - Source Document Verification

FCDS Data Quality Audits

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- Examples of Facility-Based Source Documents & Access
  - History and Physical
  - Discharge Summary
  - Operative Report(s)
  - Consultation Report(s)
  - Pathology and Other Lab Report(s)
  - Access to Multiple EMR/EHR System(s)

- Examples of Central Registry Source Documents & Access
  - AHCA Data
  - Abstracted Cases
  - Death Certificates
  - Physician Office Data
  - Electronic Pathology Reports
  - Electronic Copies of Other Primary Documents
  - Remote Access to Electronic Records Systems
  - On-Site Access to Electronic Records Systems

FCDS Data Quality Audits

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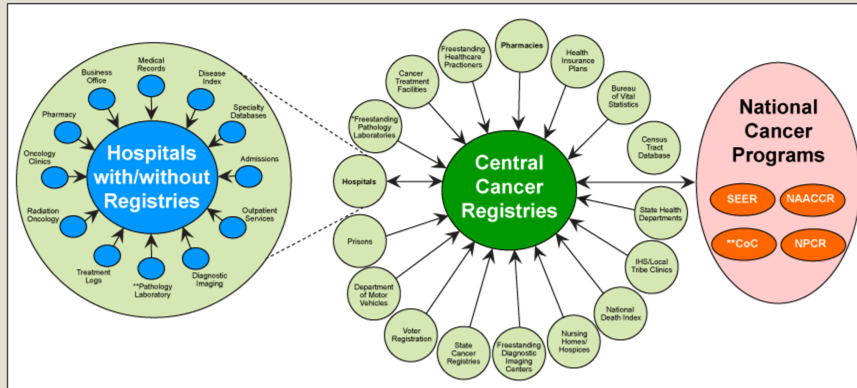
Source Documents, Report Sources, and Flow of Information



Data Validation with E-Path Verification

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- Audits may include manual/visual review of one or more source documents, data linkages of one or more electronic files from reporting facilities with the central cancer registry database with a cross-walk and/or comparison of output results.

- This audit has 2 components;
  - **First:** a focused review of analytic breast and colon cancer cases diagnosed/treated at the facility with validation (recoding) of data from text only;
  - **Second:** a focused review of e-pathology report(s) from any e-path report source matching hospital registry abstracts with recode of data from pathology report(s).

- Facilities are required to reconcile BOTH data sets for a best code.
- Additional documentation will be required if not available.

Data Validation with E-Path Verification

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- The visual editing validation and recoding of key data component of this audit is modeled after the NPCR Visual Editing Audit conducted early in 2013 for 2010 diagnoses and consolidation.
- This method utilizes FCDS standard visual editing/QC Review procedures used to convey review findings targeted to specific cancers (breast and colon) that were also part of the CER Project.
- NOTE: Text Documentation of specific data items has been both a state and national cancer reporting requirement for nearly two decades with requirements and expectations reinforced via QC Review or personal contact with registrars on a routine basis.

Text Documentation Required

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DATA ITEMS REQUIRING COMPLETE TEXT DOCUMENTATION	
Date of DX	RX Summ – Surg Prim Site
Seq No	RX Summ – Scope Reg LN Surgery
Sex	RX Summ – Surg Oth Reg/Distant
Primary Site	RX Date – Surgery
Subsite	RX Summ – Radiation
Laterality	Rad Rx Modality
Histologic Type	RX Date – Radiation
Behavior Code	RX Summ – Chemo
Grade	RX Date – Chemo
	RX Summ – Hormone
CS Tumor Size	RX Date – Hormone
CS Ext	RX Summ – BRM/Immunotherapy
CS Tumor Ext/Eval	RX Date – BRM/Immunotherapy
Regional Nodes Positive	RX Summ – Transplant/Endocrine
Regional Nodes Examined	RX Date – Transplant/Endocrine
CS LN	RX Summ – Other
CS LN Eval	RX Date - Other
CS Mets	
CS Mets Eval	Any Unusual Case Characteristics
All FCDS Req'd SSFs	Any Pertinent Patient/Family History

Text Documentation Required

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Text documentation should always include the following components:

- Date(s) – include date(s) references – event chronology
- Date(s) – note when date(s) are estimated [i.e. Date of DX 3/15/2014 (est.)]
- Location – include facility/physician/other location where the event occurred
- Description – include description of the event – positive/negative results
- Details – include as much detail as possible – document treatment plan
- Include "relevant-to-this-person/cancer" information only – edit your text
- DO NOT REPEAT INFORMATION from section to section
- DO USE Standard Abbreviations (Appendix C)
- DO NOT USE non-standard or stylistic shorthand
- Enter "N/A" or "not available" when no information is available for text.

Text Documentation Required

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Text Data Item Name NAACCR Item # Field Length	Text Documentation Source and Item Description FCDS Required Text Documentation Example:
Text - Physical Exam H&P NAACCR Item #2520 Field Length = 1000	Enter text information from history and physical exams. History and physical examination findings that relate to family history or personal history of cancer diagnosis, physical findings on examination, type and duration of symptoms, reason for admission. Example: Hx RCC Rt Kidney – Dx 9/2011 in Georgia. Adm c/o fever and night sweats. Adm for w/u and found to have enlarged axillary nodes which on biopsy revealed diffuse B-cell lymphoma.
Text - X-rays/Scans NAACCR Item #2530 Field Length = 1000	Enter text information from diagnostic imaging reports, including x-rays, CT, MRI, and PET scans, ultrasound and other imaging studies. Date, facility where procedure was performed, type of procedure, detailed findings (primary site, size of tumor, location of tumor, nodes, metastatic sites), clinical assessment, positive/negative results Example: 4/12/14 (Breast Center xyz) Mammo - Rt Breast w/1.5cm mass at 12:00 o'clock
Text - Lab Tests NAACCR Item #2550 Field Length = 1000	Enter text information from diagnostic/prognostic laboratory tests (not cytology or histopathology). Text for Collaborative Stage Site Specific Factor or SSF documentation. Date(s) of Test(s), facility where test was performed, type of test(s), test results (value and assessment) Example: 4/12/14 (Hosp xyz) ER +, PR - , HER2 neg by IHC method, PSA 5.3 (elevated)
Text - Operative Report NAACCR Item #2560 Field Length = 1000	Enter text information from surgical operative reports (not diagnostic needle, incisional biopsy). Include observations at surgery, tumor size, and extent of involvement of primary or metastatic sites. Date of procedure, facility where procedure was performed, type of surgical procedure, detailed surgical findings, documentation of residual tumor, evidence of invasion of surrounding areas Example: 4/12/14 (Hosp xyz) right colon resection - Pt was found to have extensive disease in the pelvis (carcinomatosis) and resection was aborted, no biopsies were taken, no specimen obtained.
DX Text - Pathology NAACCR Item #2570 Field Length = 1000	Enter text information from cytology and histopathology reports. Date of specimen/resection, facility where specimen examined, pathology accession #, type of specimen, final diagnosis, comments, addenda, supplemental information, histology, behavior, size of tumor, tumor extension, lymph nodes (removed/biopsied), margins, some special histo studies Example: 2/5/14 (Hosp xyz) – Path Acc # - Rectum: Final Dx: adenoca, 2.5cm, ext. to pericolic fat. 1/22 lymph nodes + , margins neg, S100 stain is positive (melanoma, sarcoma), pT3N1Mx
DX Text - Staging NAACCR Item #2600 Field Length = 1000	Enter Details of Collaborative Stage and other stage information not already entered in other text areas. Include specific information on Tumor Size, Extension of Primary Tumor, Metastatic Sites, etc. Organs involved by direct extension, size of tumor, status of margins, sites of distant metastasis, special consideration for staging, overall stage, etc. Text for SSF documentation if not under Labs. Example: 2/15/14 - T2aN1a per path, distant mets in lungs, ER/PR neg, HER2 neg by IHC method

Data Validation with E-Path Verification

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- Barriers and Limitations to Old Methodology
  - Access to ALL Electronic Medical Record Systems increasingly difficult
  - Not transferrable to non-hospital/free-standing tx center situation
  - Did not take full advantage of available e-data resources
  - Cannot find Florida CTR Auditors willing to travel
  - Cost of travel and time away from work
  - Data Security increasing daily

- Data Validation, Recode Audit and E-Path Verification Method intended to maximize available resources (people, time, travel) and utilize existing readily available "source" documents submitted by pathology labs (path reports) and hospitals (abstracts) across the state of Florida. Review of text and recoding of key data items will validate coded data and review text for compliance with FCDS Reporting Requirements with comparison of source abstracts and electronic pathology reports from across the state of Florida.

Data Validation with E-Path Verification

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- Objectives:
  - Identify discrepancies in the interpretation and use of national standard abstracting and coding rules and instructions,
  - Identify discrepancies in the interpretation and application of information available in patient records and what is recorded in the text documentation of the abstract,
  - Assess the validity and completeness of text, codes and text-supported codes provided to FCDS as part of routine submissions,
  - Assess the validity of data submitted when original source abstract codes (and text) are compared to e-pathology coded data (and text).

Eligibility

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- Facilities will be selected according to 5-year selection criteria
- Case Selection will be based upon the following criteria:
  - Date of Diagnosis 01/01/2012-12/31/2012
  - Primary Site = C180-C189 (colon) or C500-C509 (breast)
  - Behavior = 2 (in-situ) or 3 (malignant)
  - Central Sequence = 00 (only 1 cancer ever reported)
  - ICD-O-3 Histology Not = 9590-9992 (no lymphoma, leukemia, or other malignancy)
  - Class of Case = 10, 11, 12, 13, 14, 20, 21, 22 (hospital analytic – dx/tx at facility)
  - RX SUMM Surgery of Primary Site = 20-70 (resection of primary site performed)
- Selection will include at least 5 Breast Cases and 5 Colon Cases
- Selection will include no more than 10 Breast Cases and 10 Colon Cases
- Pathology Selection will be based on any e-pathology report(s) with Date of Specimen within 30 days of the original Date of Diagnosis (plus or minus 30 days) as documented/coded on the original case abstract.

Facility Selection

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It's Your Lucky Day!

1300	GULF COAST MEDICAL CENTER
1306	BAY MEDICAL CENTER
1505	CAPE CANAVERAL HOSPITAL
1506	PARRISH MEDICAL CENTER
1546	HOLMES REGIONAL MEDICAL CENTER
1548	WUESTHOFF MEDICAL CENTER MELBOURNE
1800	FAWCETT MEMORIAL HOSPITAL
1905	CITRUS MEMORIAL HOSPITAL
2000	ORANGE PARK MEDICAL CENTER
2347	UNIVERSITY OF MIAMI HOSPITAL
2372	U OF MIAMI HOSPITAL CLINICS
2606	SHANDS JACKSONVILLE MEDICAL CENTER
2636	BAPTIST REGIONAL CANCER CENTER-JAX
2648	MEMORIAL HOSPITAL JACKSONVILLE
3715	SPRING HILL REGIONAL HOSPITAL
3836	FLORIDA HOSPITAL HEARTLAND DIVISION
4105	INDIAN RIVER MEMORIAL HOSPITAL
4770	CAPITAL REGIONAL MEDICAL CENTER
5202	WEST MARION COMMUNITY HOSPITAL
5610	SACRED HEART HOSP EMERALD COAST
6206	LARGO MEDICAL CENTER
6704	GULF BREEZE HOSPITAL
7005	VILLAGES REGIONAL HOSPITAL
7405	BERT FISH MEDICAL CENTER
7406	HALIFAX HOSPITAL MEDICAL CENTER
7407	FLORIDA HOSPITAL DELAND
7446	FLORIDA HOSPITAL FISH MEMORIAL
7448	FLORIDA HOSPITAL MEMORIAL MED CTR

Case Selection

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- Date of Diagnosis 01/01/2012-12/31/2012
- Primary Site = C180-C189 (colon) or C500-C509 (breast)
- Behavior = 2 (in-situ) or 3 (malignant)
- Central Sequence = 00
- ICD-O-3 Histology Not = 9590-9992
- Class of Case = 10, 11, 12, 13, 14, 20, 21, 22
- RX SUMM Surgery of Primary Site = 20-70

FCDS Main Dashboard

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Re-Abstract Audit Status — ReabsStatus

Year: 2012
Beginning Facility: 1300-GULF COAST MEDICAL CENTER
Ending Facility: 7448-FLORIDA HOSPITAL MEMORIAL MED CTR
Contractor: Both

Total: 876
UnMatched: 875

Export to Excel
Complete Facilities

		Master Records		Re-Abstract Incomplete		Re-Abstract Complete		Facility		FCDS
Facility	List	Abshist	Path	Abshist	Path	Abshist	Path	Reconciliation	Recon	Reconciliation
1300-GULF COAST MEDICAL CENTER	Print	20	20	0	0	0	0	0	Print	0
1306-BAY MEDICAL CENTER	Print	20	12	0	0	0	0	0	Print	0
1505-CAPE CANAVERAL HOSPITAL	Print	20	20	0	0	0	0	0	Print	0
1506-PARRISH MEDICAL CENTER	Print	20	20	0	0	0	0	0	Print	0
		20	20	0	0	0	0	0	Print	0
		20	14	0	0	0	0	0	Print	0
1800-FAWCETT MEMORIAL HOSPITAL		20	20	0	0	0	0	0	Print	0
1905-CITRUS MEMORIAL HOSPITAL	Print	20	18	0	0	0	0	0	Print	0
		20	20	0	0	0	0	0	Print	0
		20	7	0	0	0	0	0	Print	0
2372-U OF MIAMI HOSPITAL CLINICS		20	17	0	0	0	0	0	Print	0
2606-SHANDS JACKSONVILLE MEDICAL CENTER	Print	20	10	0	0	0	0	0	Print	0
2636-BAPTIST REGIONAL CANCER CENTER-JAX	Print	20	20	0	0	0	0	0	Print	0
2648-MEMORIAL HOSPITAL JACKSONVILLE	Print	20	20	0	0	1	0	0	Print	0
4105-INDIAN RIVER MEMORIAL HOSPITAL	Print	20	20	0	0	0	0	0	Print	0
4770-CAPITAL REGIONAL MEDICAL CENTER	Print	20	20	0	0	0	0	0	Print	0
6206-LARGO MEDICAL CENTER	Print	20	20	0	0	0	0	0	Print	0
7005-VILLAGES REGIONAL HOSPITAL	Print	20	20	0	0	0	0	0	Print	0
Facility Count: 23		460	416			1				

Not all abstracts will havepath

Not all abstracts will have path

Data Items for Text-To-Code Audit

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Data Items to be Validated Abstract Review	
Date of DX	RX Summ – Surg Prim Site
Primary Site	RX Summ – Scope Reg LN Surgery
Laterality	RX Summ – Radiation
Histologic Type	Rad Rx Modality
Behavior Code	RX Summ – Chemo
Grade	RX Summ – Hormone
CS Tumor Size	RX Summ – BRM/Immunotherapy
CS Ext	RX Summ – Other
Regional Nodes Positive	
Regional Nodes Examined	Auditor Text Field(s)
CS LN	
CS Mets	
CS SSFs – Breast Only – SSFs; 1 (ER), 2 (PR), 15 (HER2)	

Data Items for E-Path Verification Audit

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Data Items to be Validated E-Path Review
Date of DX
Primary Site
Laterality
Histologic Type
Behavior Code
Grade
CS Tumor Size
CS Ext
Regional Nodes Positive
Regional Nodes Examined
CS LN
Auditor Text Field(s)

Auditor Instructions

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- Text-To-Code Validation
  - Only Original Text from the Abstract will be used to assign codes
  - Auditor will not be able to view any of the original codes
  - Auditor will code unknown/not available if no text
  - This is same criteria used by CDC Audit
  - Dates must be included in text
  - Standard abbreviations only
  - Auditor blinded to facility
  - Auditor blinded to case
  - Auditor may add text

- E-Path Re-Code Verification
  - Only Original Text from Pathology Report will be used to assign codes
  - Auditor will not be able to see any original codes
  - It is possible no pathology report is available
  - Auditor may add notes

Accessing Data Quality Audit through IDEA

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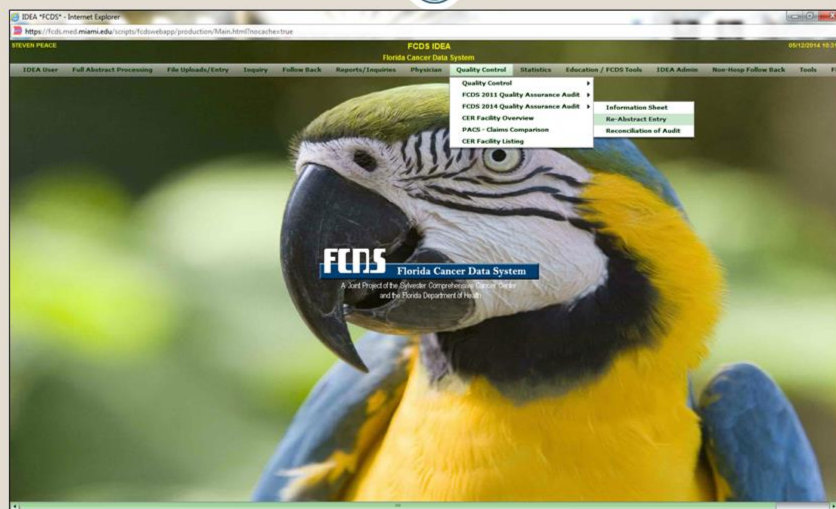

Auditor Re-Abstract Entry Main Page

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Abstract

FCDS ReAbtract Entry ReAbs2014

Selection | Abstract | Pathology

Contractor: Both — Audit Year: 2012

Type: (•) Both ( ) Abstract ( ) Path — Status: (•) All ( ) New ( ) Incomplete ( ) Complete — *** Double Click the record you wish to Re-Abstract ***

Type	Identifier	Status	Primary Site	Hist IDC03	Beh ICD03	Last Changed
Abstract	11285587	New				
Abstract	11290292	New				
Abstract	11297697	New				
Abstract	11322437	New				
Abstract	11322443	New				
Abstract	11357682	New				
Abstract	11358835	New				
Abstract	11358953	New				
Abstract	11358963	New				
Abstract	11358982	New				
Abstract	11371238	New				
Abstract	11373311	New				
Abstract	11373321	New				
Abstract	11373323	New				
Abstract	11373334	New				
Abstract	11373338	New				
Abstract	11373356	New				
Abstract	11374533	New				
Abstract	11374573	New				
Abstract	11376123	New				
Abstract	11376501	New				
Abstract	11378060	New				
Abstract	11390182	New				
Abstract	11399986	New				
Abstract	11400060	New				
Record Cnt:	876					

Auditor Re-Abstract Entry Main Page

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Path

FCDS ReAbtract Entry ReAbs2014

Selection | Abstract | Pathology

Contractor: Both — Audit Year: 2012

Type: (•) Both ( ) Abstract ( ) Path — Status: (•) All ( ) New ( ) Incomplete ( ) Complete — *** Double Click the record you wish to Re-Abstract ***

Type	Identifier	Status	Primary Site	Hist IDC03	Beh ICD03	Last Changed
Path	12865534	New				
Path	12865353	New				
Path	12864781	New				
Path	12841735	New				
Path	12707979	New				
Path	12663537	New				
Path	12644749	New				
Path	12626684	New				
Path	12594445	New				
Path	12592137	New				
Path	12540085	New				
Path	12532706	New				
Path	12524882	New				
Path	12492458	New				
Path	12492457	New				
Path	12492447	New				
Path	12492445	New				
Path	12482656	New				
Path	12475766	New				
Path	12475765	New				
Path	12475739	New				
Path	12448276	New				
Path	12448272	New				
Path	12424994	New				
Path	12415690	New				
Record Cnt:	876					

Auditor Re-Abstract Entry Main Page

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Re-Abstract Audit 2014 ReAbs2014

Selection | Abstract | Pathology

Contractor: Both

Type: Both / Abstract / Path   Status: All / New ...   *** Double Click the record you wish to ...

Tracking Status

Tracking Status

Type	Identifier	Status	Pr... Site	Hist IDC03	Beh ICD03	Last Change
Abstract	11906568	Completed	C187	8480	3	05/13/2014 12:52PM
Abstract	11813098	Completed	C180	8140	3	05/13/2014 12:13PM
Abstract	11599529	Completed	C509	8500	3	05/13/2014 09:03AM
Abstract	11758422	Completed	C504	8500	3	05/13/2014 11:54AM
Abstract	11758411	Completed	C504	8500	3	05/13/2014 09:59AM
Abstract	11680014	Completed	C182	8140	3	05/13/2014 09:33AM
Abstract	11599587	Completed	C187	8140	3	05/13/2014 09:27AM
Abstract	11599584	Completed	C180	8480	3	05/13/2014 09:15AM
Abstract	11541627	Completed	C509	8500	3	05/12/2014 04:33PM
Abstract	11541639	Completed	C505	8500	3	05/13/2014 08:52AM
Abstract	11541630	Completed	C502	8500	3	05/12/2014 04:45PM
Abstract	11541602	Completed	C185	8481	3	05/12/2014 03:11PM
Abstract	11541626	Completed	C508	8501	2	05/12/2014 04:01PM
Abstract	11465120	Completed	C508	8500	3	05/12/2014 03:01PM
Abstract	11373311	Incomplete	C505	8500	3	05/12/2014 01:58PM
Path	11373321	Incomplete	C180	8140	3	05/12/2014 02:31PM
Abstract	12491174	Incomplete	C180	8140	3	05/12/2014 11:34AM
Abstract	12482656	Incomplete	C505	8140	1	05/12/2014 11:32AM
Path	12482656	Incomplete	C505	8140		05/12/2014 01:16PM
Abstract	11736918	Incomplete	C180	8140	2	05/12/2014 03:05PM
Path	11373311	Incomplete	C509	8460	3	05/12/2014 02:25PM
Abstract	11451610	New				
Abstract	11438338	New				
Abstract	11438291	New				
Abstract	11481411	New				
Record Cnt:	874					

Summary List | Selection | Save / Complete | Save/Incomplete

Text-To-Code Validation Example

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All Text

Re-Abstract Audit 2014   Identifier: 11378060   ReAbs2014

Selection | Abstract | Pathology

Text-Primary Site: LEFT BREAST @ 2.00

Text-Histology: INVASIVE DUCTAL CARCINOMA. GRADE I

Physical Exam - PE
49-YEAR-OLD FEMALE WHO ON MAMMOGRAPHY WAS FOUND TO HAVE EXTREMELY DENSE AND HETEROGENEOUS BREASTS. NO DOMINANT MASSES OR SUSPICIOUS

X-ray/Scans
CCH 3/15/12 LYMPHOSCINTIGRAPHY. MULTIFOCAL UPTAKE TOWARDS LEFT AXILLA CONSISTENT WITH SENTINEL NODE ACTIVITY.

Scopes
NONE

Lab Tests
2/22/12 LEFT BREAST FNA AT 9:00 : NO MALIGNANT CELLS SEEN. 3/12/12 ESTROGEN RECEPTOR : POSITIVE (GREATER THAN 90%). PROGESTERONE RECEPTOR

Operative Report
TWO LYMPH NODES WERE FOUND DURING SENTINEL NODE BIOPSY. LUMPECTOMY WAS COMPLETED DOWN TO THE CHEST WALL.

Pathology Report
2/22/12 LEFT BREAST BX @ 2:00 : INVASIVE DUCTAL CARCINOMA, NOS. 3/15/12 LEFT BREAST LUMPECTOMY, LEFT AXILLARY SENTINEL LYMPH NODE SAMPLING. TUMOR

Staging
PATHOLOGIC TUMOR STAGE: I PT1B PN0 (SN) (I-) MX PANARESE T1B N0 STAGE IA.

Remarks
FAMILY HISTORY : THERE IS NO FAMILY HISTORY OF BREAST CANCER. SOCIAL HISTORY : PATIENT HAS NEVER SMOKED. NO ALCOHOL USE.

Surgery: 3/15/12 SENTINEL NODE BIOPSY, LEFT AXILLA. LEFT BREAST LUMPECTOMY.

RX Summ-Radiation: 5/3/12-6/20/12 LEFT BREAST 6MV, 25 FX. 4680

Rad - Reg RX Modality:

Chemotherapy: NONE

Hormone: AMOXIFEN 7/3/12

BRM/Immuno:

Other:

Re-Abstract Fields

Date of DX (YYYYMMDD)
Primary Site
Histology
Behavior: Select
Grade: Select
Laterality: Select
Tumor Size
Extension
Regional Nodes Positive
Regional Nodes Examined
Lymph Nodes
Mets at DX
Site Specific Factor: 1: 2: 15: 16:
(Only required for Breast)
RX Summ - Surg Primary Site: List
RX Summ - Scope Reg LN Surgery: Select Scope Surgery
RX Summ-Radiation | Hormone
Rad - Reg RX Modality | BRM/Immuno
Chemotherapy | Other
Comments:

Enter Codes

Dropdowns Available

Enter Comments/Text

SAVE !!

Summary List | Selection | Save / Complete | Save/Incomplete

Text-To-Code Validation Example

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View full text – double click

Text-To-Code Validation Example

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Popups/Dropdowns Available

Text-To-Code Validation Example

29

Don't Forget to Code Scope Reg LN Surg

Enter Comments/Text

SAVE !!

E-Path Re-Code Validation Example

30

Multiple Reports

Enter Codes

Dropdowns Available

Enter Comments/Text

SAVE !!

E-Path Re-Code Validation Example

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Multiple Reports

Entry Fields Carry Along

SAVE !!

E-Path Re-Code Validation Example

32

Enter Comments/Text

SAVE !!

Facility Information Sheet

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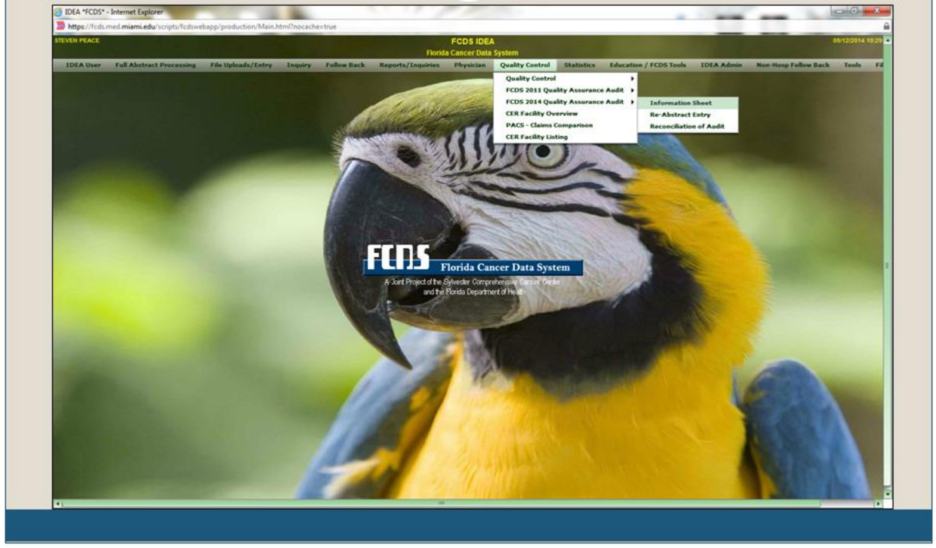

Facility Information Sheet

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FCDS Florida Cancer Data System

Florida Statewide Cancer Registry

2014 Data Validation Audit with E-Path Verification – Facility Information Sheet

The Florida Cancer Data System (FCDS) is charged with providing the highest quality data possible for annual cancer case reporting to the Florida Department of Health and the CDC National Program of Cancer Registries (NPCR). Data must meet rigorous quality standards to be included in local, regional, state, and national cancer rates, reports to Congress, and cancer-related health investigations. FCDS conducts many types of data processing and data quality checks including on-site and remote audits in various formats to ensure all data quality standards continue to be met and to identify areas that may require further education and training.

A Re-Abstracting (Data Validation) Audit will be performed for this facility using electronic copies of primary medical record documents submitted by this facility (electronic pathology reports plus cancer registry abstracts). The audit has been designed to assess the quality of abstracting and the accuracy of coded data items for cases submitted to the Florida Cancer Data System (FCDS). These audits allow FCDS to assess consistency in interpretation of data definitions, adherence to coding rules and guidelines, policies and procedures and to identify areas that require further education and training. A copy of the audit protocol is available from FCDS.

FCDS is utilizing a new approach this year, hoping to make better use of available electronic medical reports in an effort to reduce the burdens that come with on-site audits including: detailed planning, auditor travel, workspace, internet access, and other on-site coordination. There will be no in-person travel required. Code and data item reconciliation is required for each discrepant data item.

Up to 10 cases of primary breast cancer and up to 10 cases of primary colon cancer from calendar year 2012 diagnoses will be audited. Each case will be "hospital analytic" (e.g. patient diagnosed and/or all or part of first course of treatment performed at your hospital).

AUDIT PROCEDURES and INSTRUCTIONS

1. **To obtain a PDF copy or to reprint this Information Sheet,** please go to the FCDS website http://fcds.med.miami.edu and log in to FCDS IDEA. If you have Admin or QC User Role - go to the Quality Control Menu. Select FCDS 2014 Quality Assurance Audit then select Information Sheet. A PDF version of this letter will open which can be saved and/or printed at your discretion.
2. **Each Case will undergo Two Distinct Audit Evaluations** with distinct code comparisons and "best value" resolution required.
   a. The **first evaluation** will be a review/recode of abstracted text compared to original abstract codes as a "visual review" with "data validation" of key data items. Undocumented values will be recoded as "unknown/not available". Text is a critical element in all internal FCDS data quality assessments as well as external third party data quality assessment procedures. FCDS, CDC, and the Florida Department of Health have been requiring full text documentation for key variables since 1995.
   b. The **second assessment** will be a comparison of original abstract codes compared to recoded values from the text contained within the electronic pathology report from the surgery of the primary site. This part of the re-abstracting audit will identify areas where abstractors may have incorrectly read, interpreted or coded histology/behavior/grade of tumor; overlooked key staging information included in the surgical pathology report; or missed other information when coding the original abstract.
3. **Coding Inconsistencies** will be documented and returned to the originating facility to be reconciled by a facility registrar. This does not have to be the original case abstractor as this is an audit of overall facility-submitted data quality and not the abstractor.
4. **Reconciliation of Facility-Level Data Discrepancies** is **required this audit.** During this part of the audit, the originating institution has an opportunity to rebut any findings with additional documentation from the record or provide a rationale for not including required text or code(s) selected while abstracting the original cancer incident report. **Reconciliation is time sensitive.**
5. **4 Week Deadline for Reconciliation** - Facilities will have four (4) weeks to complete the reconciliation process and address any concerns or inconsistencies between the original text documentation, coded data and both sets of re-abstracted/re-coded data. The facility must select a "best value" for any data item found to have a coding and/or documentation discrepancy. If reconciliation has not been completed within this time frame, all audit recode findings will be reviewed with FCDS Review selected as "final".
6. **Final Reviews** will be conducted by the FCDS Senior Manager for Data Quality/Quality Control and Education.
7. **Audit Case Report:** Key data items will be audited following FCDS Standard Data Validation and Visual Editing Procedures with adherence to all national coding standards, rules and guidelines. Individual cases may be printed with all original and discrepant data, text, recodes, and final decisions including notes printed in a standard format that can be saved as a PDF.
8. **Facility Audit Summary Report:** Facility-specific audit summary findings will be aggregated by facility into a Facility Audit Summary Report. The report will be presented in FCDS standard format with major and minor annotated and summarized for comparison to the State Audit Summary Report. Recommendations for improvements may be included in your facility report.
9. **State Audit Summary Report:** All Facility Audit Summary Reports will be aggregated into a State Audit Summary Report.
10. **Education Planning:** Aggregate findings and recommendations will be used in planning statewide education and training events.

Questions: Please contact Steven Peace at 305-243-4601 or via email at speace@med.miami.edu.

Facility Information Sheet

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2014 Data Validation Audit with E-Path Verification – Facility Information Sheet

The Florida Cancer Data System (FCDS) is charged with providing the highest quality data possible for annual cancer case reporting to the Florida Department of Health and the CDC National Program of Cancer Registries (NPCR). Data must meet rigorous quality standards to be included in local, regional, state, and national cancer rates, reports to Congress, and cancer-related health investigations. FCDS conducts many types of data processing and data quality checks including on-site and remote audits in various formats to ensure all data quality standards continue to be met and to identify areas that may require further education and training.

A Re-Abstracting (Data Validation) Audit will be performed for this facility using electronic copies of primary medical record documents submitted by this facility (electronic pathology reports plus cancer registry abstracts). The audit has been designed to assess the quality of abstracting and the accuracy of coded data items for cases submitted to the Florida Cancer Data System (FCDS). These audits allow FCDS to assess consistency in interpretation of data definitions, adherence to coding rules and guidelines, policies and procedures and to identify areas that require further education and training. A copy of the audit protocol is available from FCDS.

FCDS is utilizing a new approach this year, hoping to make better use of available electronic medical reports in an effort to reduce the burdens that come with on-site audits including; detailed planning, auditor travel, workspace, internet access, and other on-site coordination. There will be no in-person travel required. Code and data item reconciliation is required for each discrepant data item.

Up to 10 cases of primary breast cancer and up to 10 cases of primary colon cancer from calendar year 2012 diagnoses will be audited. Each case will be "hospital analytic" (e.g. patient diagnosed and/or all or part of first course of treatment performed at your hospital).

Facility Information Sheet

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5. **4 Week Deadline for Reconciliation** - Facilities will have four (4) weeks to complete the reconciliation process and address any concerns or inconsistencies between the original text documentation, coded data and both sets of re-abstracted/re-coded data. The facility must select a "best value" for any data item found to have a coding and/or documentation discrepancy. If reconciliation has not been completed within this time frame, all audit recode findings will be reviewed with FCDS Review selected as "final".
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FCDS IDEA - Dashboard Notification

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Welcome - Dashboard

Your password will expire in 661 days. (MAR 04th 2016)

Recent System Activity

Date / Time	Action
05/13/2014 15:42:03	0:Login: speace
05/13/2014 14:48:58	952:Reconciliation of Audit menu item chosen.
05/13/2014 14:48:38	0:Login: speace
05/13/2014 14:45:08	952:Reconciliation of Audit menu item chosen.
05/13/2014 14:43:34	952:Reconciliation of Audit menu item chosen.

Record Count: 8

Items Needing Attention

Module to Review (double click to review)	Records
2012 QA Audit	19
Consolidated Follow Back	0
Discrepancy Review (Forces)	0
Disease Index	0
FAPTP Follow Back	0
Quality Control	0
Radiation Therapy	0

Go to Quality Control – 2014 QA Audit

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Quality Control
- Quality Control
- FCDS 2011 Quality Assurance Audit
- FCDS 2014 Quality Assurance Audit
  - Information Sheet
  - Re-Abstract Entry
  - Reconciliation of Audit
- CER Facility Overview
- PACS - Claims Comparison
- CER Facility Listing

Go to Quality Control – 2014 QA Audit

Select

Select

NOTE: You can only see Your Facility Records

Status

Discrepancies

Print Option

Re-Abstract Reconcilition Version 13.0 ReAbstractRecon_2014

Select a Facility

Selection | Reconciliation | Demographic | Address DX | Text | Text 2 | Treatment | Follow-Up | Pathology

Audit Year: 2012

Click the Record you wish to review

Facility	Accession	Seq	Status	Primary Site	Hist	Beh	Med Rec #	Discrepancies	Last Changed
		00	Reabstract	C180	8140	3		3	
		00	Reabstract	C501	8523	3		11	
		00	Reabstract	C182	8140	3		6	
		00	Reabstract	C180	8140	3		6	
		00	Reabstract	C508	8500	3		8	
		00	Reabstract	C185	8481	3		2	
		00	Reabstract	C508	8501	2		7	
		00	Reabstract	C509	8500	3		10	
		00	Reabstract	C502	8500	3		8	
		00	Reabstract	C505	8500	3		7	
		00	Reabstract	C509	8500	3		5	
		00	Reabstract	C180	8480	3		4	
		00	Reabstract	C187	8140	3		1	
		00	Reabstract	C182	8140	3		3	
		00	Reabstract	C50	8500	3		8	
		00	Reabstract		8500	3		7	
		00	Reabstra		8140	3		8	
		00	Re	C187	8480	3		6	
				C182	8140	3		5	
						Record Cnt:	20		

Summary List | Print Detail | Finish Case | Return to Selection Tab

Facility Reconciliation - Navigation

Use Abstract Section Tabs

Use Abstract Section Tabs

Pathology Tab

NOTE: You can only see Your Facility Records

Re-Abstract Reconcilition Version ... ession/Seq: ReAbstractRecon_2014

Select a Facility

Selection | Reconciliation | Demographic | Case Dx | CS | Text | Text 2 | Treatment | ollow-Up | Pathology

Tumor Information

Date of DX (YYYYMMDD) 2012-01-12 Flag

Primary Site C 180 Histology 8140 Discriminator 988 053 Colon

Description
Site Summary: C18.0, C18.2-C18.9
M-8000-8152,8154-8231,8243-8245,8247,8248,8250-8934,8940-9136,9141-9582,9700-9701
C18.0 Cecum
C18.2 Ascending colon
C18.3 Hepatic flexure of colon
C18.4 Transverse colon
C18.5 Splenic flexure of colon
C18.6 Descending colon
C18.7 Sigmoid colon
C18.8 Overlapping lesion of colon

Behavior 3 - Malignant

Grade 2 - Moderately Differentiated

Laterality 0 - None

Text-Primary Site CECUM

Text-Histology MD ADENOCARCINOMA

Summary List | Print Detail | Finish Case | Return to Selection Tab

Facility Reconciliation - Navigation

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Re-Abstract Reconcilition Version 13.0 | Current Facility/Accession/Seq: | ReAbstractRecon_2014

Select a Facility

Selection | Reconciliation | Demographic | Address DX | Case Dx | CS | Text | Text 2 | Treatment | Follow-Up | Pathology

Pathology Review - View Record 1 of 3

CLIA Number: | Specimen Date: 2012-01-16

Pathology Text

Diagnosis:
HEMATOCHEZIA IN PATIENT WITH NEW ONSET ATRIAL FIBRILLATION ON PRADAXA CECUM MASS RECEIVED IS A CONTAINER LABELED WITH THE PATIENTS NAME NUMBER AND CECAL MASS AN ENDOSCOPIC FINDING SHEET ACCOMPANIES THE REQUISITION THE SPECIMEN CONSISTS OF SIXIRREGULAR FRAGMENTS OF TAN TISSUE MEASURING FROM 1 UP TO 4 MM IN GREATEST DIMENSIONS THE SPECIMEN IS MARKED AND ENTIRELY SUBMITTED IN ONE CASSETTECECAL MASS BIOPSY ADENOCARCINOMA MODERATELY TO POORLY DIFFERENTIATED DR ROBERT E BARNES ALSO REVIEWED THE CASE AND CONCURS WITH DIAGNOSTIC INTERPRETATION

Clinical History:

Nature of Specimen:

Gross Pathology:

Microscopic Pathology:

Final Diagnosis:

Comments:

Reportable Term
NonReportable Term
Skin Term
Negation Term
Site Term
Skin Site Term

Summary List | Print Detail | Finish Case | Return to Selection Tab

NOTE: You can only see Path Reports That Match Your Facility Records

Facility Reconciliation - Navigation

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Re-Abstract Reconcilition Version 13.0 | Current Facility/Accession/Se | ReAbstractRecon_2014

Multiple Reports

Select a Facility

Selection | Reconciliation | Demogra | Case Dx | CS | Text | Text 2 | Treatment | Follow-Up | Pathology

Pathology Review - View Record 2 of 3

CLIA Number: | Specimen Date: 2012-01-20

Pathology Text

Diagnosis:
CECAL MASS RECEIVED IS A CONTAINER LABELED WITH THE PATIENTS NAME NUMBER AND CECUM THE SPECIMEN CONSISTS OF A PORTION OF COLON CECUM WITH ATTACHED FAT AND AN ATTACHED PORTION OFTERMINAL ILEUM THE SEGMENT OF COLON MEASURES 12 CM IN LENGTH AND RANGES FROM 3 CM IN DIAMETER DISTALLY UP TO 55 CM IN DIAMETER PROXIMALLY THE SEROSA HAS A PARTIALLY SMOOTHTO IRREGULAR PINKTAN TO RED APPEARANCE WITH SCATTERED ADHESIONS THE BASE OF THE CECUM EVIDENCES A 3 X 15CM PUCKERED APPEARING AREA THE ATTACHED SEGMENT OF TERMINAL ILEUMMEASURES 35 X 2 X 2 CM THE APPENDIX IS NOT PRESENT OPENING THE SEGMENT OF TERMINAL ILEUM REVEALS THE MUCOSA TO HAVE A FOLDED REDTAN APPEARANCE THE ILEOCECAL VALVE ISUNREMARKABLE OPENING THE COLON REVEALS THE MUCOSA TO HAVE A FOLDED DARK REDTAN APPEARANCE WITHIN THE BASE OF THE CECUM CORRESPONDING TO THE AREA OF SEROSAL PUCKERINGTHERE IS A RAISED TAN FUNGATING TUMOR WHICH MEASURES 45 X 35 CM THE SEROSA UNDERLYING THE AREA OF TUMOR IS STAINED WITH GREEN DYE SECTIONING THROUGH THE AREA OF TUMOR REVEALSA FIRM TAN CUT SURFACE THE AREA OF TUMOR EXTENDS TO BUT NOT GROSSLY THROUGH THE COLON WALL RANGING FROM 03 UP TO 12 CM IN THICKNESS SECTIONING THE ATTACHED COLONIC FATREVEALS SIXTEEN LYMPH NODE CANDIDATES RANGING IN SIZE FROM 04 UP TO 12 CM IN GREATEST DIMENSIONS REPRESENTATIVE SECTIONS CASSETTE 1 ILEAL RESECTION MARGIN CASSETTE 2TERMINAL ILEUM AND ILEOCECAL VALVE CASSETTES 3 6 AREA OF TUMOR TO DEMONSTRATE DEPTH OF INVASION TO INCLUDE ADJACENT MUCOSA CASSETTE 7 RANDOM SECTION OF COLON DISTAL TO THE AREAOF TUMOR CASSETTE 8 COLONIC RESECTION MARGIN CASSETTE 9 RADIAL SOFT TISSUE MARGIN CASSETTES 10 12 LYMPH NODE CANDIDATESCECUM RESECTION MODERATELY DIFFERENTIATED ADENOCARCINOMA SPECIMEN CECUM PROCEDURE PARTIAL COLECTOMY TUMOR SITE CECUM TUMOR SIZE 45 CM IN GREATEST DIMENSION HISTOLOGIC TYPE ADENOCARCINOMA HISTOLOGIC GRADE GRADE 2 MODERATELY DIFFERENTIATED GROSS TUMOR PERFORATION NOT PRESENT MICROSCOPIC TUMOR EXTENSION TUMOR INVADES AT LEAST INTO MUSCULARIS PROPRIA ADDITIONAL STAINS TO FOLLOW MARGINS PROXIMAL FREE OF TUMOR DISTAL FREE OF TUMOR RADIAL FREE OF TUMOR DISTANCE FROM CLOSEST MARGIN CIRCUMFERENTIAL LESS THAN 1 MM LYMPHVASCULAR INVASION NOT IDENTIFIED LYMPH NODES NUMBER EXAMINED 15 NUMBER INVOLVED 0 PATHOLOGIC STAGE TO FOLLOW IMMUNOHISTOCHEMICAL STAIN FOR DESMIN ON A SELECTED BLOCK OF TUMOR DEMONSTRATES THAT THE MUSCULARIS PROPRIA IS NOT INTACT AT THE DEEPEST PORTION OF PENETRATION BY TUMOR THE TUMORIS THEREFORE STAGED T3N0MX SOME IMMUNOHISTOCHEMICAL REAGENTS USED BY THIS LABORATORY ARE ANALYTE SPECIFIC REAGENTS THESE TESTS WERE DEVELOPED AND THE PERFORMANCE CHARACTERISTICS WERE DETERMINED BY MEMORIALLABORATORIES THEY HAVE NOT BEEN CLEARED OR APPROVED FOR USE BY THE US FOOD AND DRUG ADMINISTRATION THE FDA HAD DETERMINED THAT SUCH CLEARANCE OR APPROVAL IS NOT NECESSARY

Reportable Term
NonReportable Term
Skin Term
Negation Term
Site Term
Skin Site Term

Summary List | Print Detail | Finish Case | Return to Selection Tab

NOTE: You can only see Path Reports That Match Your Facility Records

Facility Reconciliation Example

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NOTE: You can only see Your Facility Records

Items to check

Navigate Using Tabs to Review Documentation from Abstract & Path Reports

Select Best Value

Check Value

You Must Justify Each Value

Save Each Item/Best Value

Finish Case After All Items Reconciled

Facility Reconciliation Example

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Navigate Using Tabs to Review Documentation from Abstract & Path Reports

Pop-Up Auditor Notes

Pop-Up Auditor Notes

Facility Reconciliation Example

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Re-Abstract Reconciliation Version 13.0 Current Facility/Accession/Seq: ReAbstractRecon_2014

Select a Facility

Selection | Reconciliation | Demographic | Address DX | Case Dx | CS | Text | Text 2 | Treatment | Follow-Up | Pathology

Discrepant Count: 3 Items needing reconciliation. Remaining to Review: 1

Field	Original Abstract	Re-Abstract	Path Re-Abs	Agree	New Value	Comment
Dx Date	20120112	20120112	20120116	O	20120112	First Dx on 1/12/12 with + biopsy
Grade	2	2	3	O	2	Path and Abstract Agree Mod Diff
CS Extension	200	200	400			

Which Value do you agree with? Original Value Re-Abstracted Value Path Re-Abs Value Neither Value

New CS Extension Value.

300

Justification (10 character Minimum, 1000 character Maximum)

Original, Re-Abstract, and Path Re-Abstract all incorrect on final review - code 300 based on path final dx extension....details....

documentation

Save Item/New Value

Save Item Reset

Summary List Print Detail Finish Case Return to Selection Tab

NOTE: You can only see Your Facility Records

Facility Reconciliation Example

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Re-Abstract Reconciliation Version 13.0 Current Facility/Accession/Seq: ReAbstractRecon_2014

Select a Facility

Selection | Reconciliation | Demographic | Address DX | Case Dx | CS | Text | Text 2 | Treatment | Follow-Up | Pathology

Discrepant Count: 3 Items needing reconciliation. Remaining to Review: 0

Field	Original Abstract	Re-Abstract	Path Re-Abs	Agree	New Value	Comment
Dx Date	20120112	20120112	20120116	O	20120112	First Dx on 1/12/12 with + biopsy
Grade	2	2	3	O	2	Path and Abstract Agree Mod Diff
CS Extension	200	200	400	N	300	Original, Re-Abstract, and Path R

Which Value do you agree with? Original Value Re-Abstracted Value Path Re-Abs Value Neither Value

Original Dx Date value.

20120112

Justification (10 character Minimum, 1000 character Maximum)

First Dx on 1/12/12 with + biopsy.

Save Item

Summary List Print Detail Finish Case Return to Selection Tab

Finish Case After All Items Reconciled

NOTE: You can only see Your Facility Records

Reconciliation Request - Sample Report

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FCDS **Reconciliation Request**
**Top Line=Master/Second Line=Reabstract/Third Line=Path Abstract **
(Shaded Areas not Compared)
6/2/2014 8:36:27 AM
Page: 3 of 64

Seq#: 00

Discrepancy Count: 11

FCDS **Reconciliation Request**
**Top Line=Master/Second Line=Reabstract/Third Line=Path Abstract **
(Shaded Areas not Compared)
6/2/2014 8:36:27 AM
Page: 4 of 64

Total Discrepancies: 11

Case Dx (Section Discrepancies = 10)

Reconciliation - Sample Notes

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FCDS **Reconciliation Request**
**Top Line=Master/Second Line=Reabstract/Third Line=Path Abstract **
(Shaded Areas not Compared)
6/2/2014 8:36:27 AM
Page: 27 of 64

Auditor's Comments:

Abstract:
no dates appear until wide resection on 5/22/12. when was original bx of rt breast before wide resection? primary site not documented - coded breast, NOS. path-microscopic focus well diff invasive ductal carcinoma - T1micN0Mx. balloon placed for brachytherapy - unk if done.

Path:
4/27/12 - initial bx rt breast - negative for neoplasm. 5/25/12 - microscopic foci of invasive ductal ca tubular pattern - wide resection, .78cm size, nottingham score 5, well diff. no LCIS, microinvasive ductal carcinoma tubular carcinoma, no lymph nodes examined, T1micNxMx

Reconciliation - Sample Saved Responses

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FCDS

Reconciliation Request

Top Line=Master/Second Line=Reabstract/Third Line=Path Abstract

(Shaded Areas not Compared)

5/15/2014 3:26:06 PM
Page: 1 of 46

Seq#: 00

Patient Demographics (Not Compared)

Address at DX (Not Compared)

Case Dx: P Date of Initial DX: 20120112 / 20120112 / 20120116

Tumor Info: Site: C180 / C180 / C180 — Hist: 8140 / 8140 / 8140 — Disc: 988 — Behavior: 3 / 3 / 3 — P Grade: 2 / 2 / 3 — Laterality: 0 / 0 / 0

Collaborative Staging: CS TumorSize: 045 / 045 / 045 — P CS Extention: 200 / 200 / 400

RegNode+: 00 / 00 / 00 — RegNodeExam: 15 / 15 / 15 — Lymph Nodes: 000 / 00 / 000

Mets at DX: 00 / 00 — Reg Nodes Eval: 03 — TS/Ext - Eval: 03 — Mets at Eval: 00

Site Specific Factor: (Compared only if Breast) 1: 2: 3: 999 4: 999 5: 988 6: 999 7: 988 8: 999 9: 999 10: 988 11: 988 12: 988 13: 988 14: 988 15: 16: 17: 988 18: 988 19: 988 20: 988 21: 988 22: 988 23: 988 24: 988

Treatment: Prime Site: 30 / 30 — Scope LN Surg: 5 / 05 — Other Reg/Distant: 00 — Date of Surgery: 20120123 — Reason for No Surgery: 0

Radiation: 0 / 0 Date: — Chemotherapy: 00 / 00 Date:

Rad-Reg RX Modality: 0 — BRM/Immunotherapy: 00 / 00 Date:

Hormone: 00 / 00 Date: — Other: 0 / 0 Date:

Surg/Rad Seq: 0 — Systemic Surg Seq: 0

Follow-Up: Vital Status: 0 — Cancer Status: 1 — Discrepancy Count: 3

FCDS

Reconciliation Request

Top Line=Master/Second Line=Reabstract/Third Line=Path Abstract

(Shaded Areas not Compared)

5/15/2014 3:26:06 PM
Page: 2 of 46

Total Discrepancies: 3

Case Dx (Section Discrepancies =)

Dx Date: Original: 20120112
Re-Abstract: 20120112
Path-Abs: 20120116
Agree: O Reason: First Dx on 1/12/12 with + biopsy. New Value: 20120112
FCDS: Agree:
Final Value:

Grade: Original: 2
Re-Abstract: 2
Path-Abs: 3
Agree: O Reason: Path and Abstract Agree Mod Diff - no mention of poorly differentiated New Value: 2
FCDS: Agree:
Final Value:

CS Extension: Original: 200
Re-Abstract: 200
Path-Abs: 400
Agree: N Reason: Original, Re-Abstract, and Path Re-Abstract all incorrect on final review - code 300 based on path final dx extension.....details.... New Value: 300
FCDS: Agree:
Final Value:

FAQs

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- How Many Cases Will I Have to Reconcile?
  - Up to 10 Breast Cases
  - Up to 10 Colon Cases
  - How Many Data Items Will I Have to Reconcile?
  - Depends on # Discrepant Data Item Values for Each Case
    - Up to 23 Items for Re-Abstract Breast Cases
    - Up to 11 Items for Re-Abstract and Re-Path Cases – shared items
    - Up to 20 Items for Re-Abstract Colon Cases
    - Up to 11 Items for Re-Abstract and Re-Path Cases – shared items
- How Long Do We Have to Reconcile Cases?
  - 4 weeks from notification – no exceptions
- What Happens if I Do Not Reconcile My Cases?
  - Cases will undergo Final Reconciliation by FCDS without your input and what FCDS decides sticks.

Audit Summary Reports

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- Facility-Specific
- State Comparison
- Major Errors
  - Incorrect Primary Site or Number of Primaries
  - Incorrect Histology
  - Incorrect Stage Group or Summary Stage
- Minor Errors
  - Incorrect Sub-Site
  - More Specific Histology
  - Incorrect Collaborative Stage Core Item or SSF (not for staging)
- Recommendations

Timeline

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01/2014	02/2014	03/2014	04/2014	05/2014	06/2014	7/2014	8/2014	9/2014	10/2014
Protocol Development	Protocol Development	Final Protocol							
		Software Development	Software Development	Software Development					
			Identify Audit Team	Train Audit Team	Follow-Up Audit Team				
				Audit	Audit	Audit			
					Reconciliation	Reconciliation	Reconciliation		
							Final Review	Final Review	
									Update FCDS Record
								Preliminary Audit Report	Final Audit Report

Questions

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