Welcome
We’re Glad You Are Here
2017 FCDS Annual Meeting

July 26-27, 2017
Wyndham Grand Orlando Resort @ Bonnet Creek
Orlando, Florida

CDC & Florida DOH Attribution

“We acknowledge the Centers for Disease Control and Prevention, for its support of the Florida Cancer Data System, and the printing and distribution of the materials for the 2015-2016 FCDS Webcast Series under cooperative agreement DP003872-03 awarded to the Florida Department of Health. The findings and conclusions in this series are those of the author(s) and do not necessarily represent the official position of the Centers for Disease Control and Prevention”.

FCDS would also like to acknowledge the Florida Department of Health for its support of the Florida Cancer Data System, including the development, printing and distribution of materials for the 2015-2016 FCDS Webcast Series under state contract CODJU. The findings and conclusions in this series are those of the author(s) and do not necessarily represent the official position of the Florida Department of Health.
Agenda

Florida Cancer Data System Annual Meeting
Day 1 - Wednesday, July 26, 2017
Wyndham Grand Orlando Resort at Bonnet Creek

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00 pm</td>
<td>Welcome and Introductions</td>
</tr>
<tr>
<td>1:15 pm</td>
<td>DCF Update</td>
</tr>
<tr>
<td>1:30 pm</td>
<td>NGC Update - State of the State</td>
</tr>
<tr>
<td>1:45 pm</td>
<td>Medicaid Cancer Surveillance Project Update</td>
</tr>
<tr>
<td>2:00 pm</td>
<td>TDCS Survival Monograph</td>
</tr>
<tr>
<td>2:15 pm</td>
<td>Break</td>
</tr>
<tr>
<td>2:30 pm</td>
<td>Highlights from the NACCR 2017 Annual Conference</td>
</tr>
<tr>
<td>3:45 pm</td>
<td>Data Acquisition Summary</td>
</tr>
<tr>
<td>4:00 pm</td>
<td>2017 TDCS QC Audit Summary</td>
</tr>
<tr>
<td>4:15 pm</td>
<td>Updates on Physician Reporting &amp; CRPS System</td>
</tr>
<tr>
<td>4:30 pm</td>
<td>2017 TDCS Update - National Standards - 2D 3D 4D TDCS CRPS System Update</td>
</tr>
<tr>
<td>5:00 pm</td>
<td>Break</td>
</tr>
<tr>
<td>5:15 pm</td>
<td>2017 TDCS State Quality Audits (Long) 2016-2017 RCQC proposing new CRPS procedure</td>
</tr>
<tr>
<td>6:00 pm</td>
<td>2017 TDCS Update to National Standards - 2D 3D 4D TDCS CRPS System Update</td>
</tr>
<tr>
<td>6:15 pm</td>
<td>Break</td>
</tr>
<tr>
<td>6:30 pm</td>
<td>2017 TDCS Education and Training Plan Presentation</td>
</tr>
<tr>
<td>7:00 pm</td>
<td>Welcome Dinner</td>
</tr>
</tbody>
</table>

Recorded Sessions & Materials
https://fcds.med.Miami.edu/inc/educationtraining.shtml

Day 1
- The Basics of TDCS 1:00 pm - 1:45 pm
- Next Steps in eCRPS 2:00 pm - 2:45 pm
- The Basics of CRPS 3:00 pm - 3:45 pm
- TDCS Data Quality Evaluation 4:00 pm - 4:45 pm
- NCQA Data Quality Evaluation 5:00 pm - 5:45 pm
- NACCR Communication & Learning Community 6:00 pm - 6:45 pm
- TDCS and CRPS Training 7:00 pm - 7:45 pm

Day 2
- How to Use the NCQA Cancer Reporting Manual, 4th Edition 8:00 am - 9:30 am
- Use the Specific Field Resources for Reporting TDCS, CRPS 9:30 am - 10:30 am
- TDCS and CRPS Training 10:30 am - 11:30 am
- Next Steps in Cancer Reporting and Treatment 12:00 pm - 1:00 pm
Modernizing the Florida Cancer Data System

Tara Hylton, MPH
Administrator
Registries & Surveillance Section
Public Health Research
Division of Community Health Promotion

Modernizing FCDS – Current Steps

- **How to Accomplish:**
  - Increase cancer reports from ALL non-hospital sources
  - Increase external data linkages

- **Resources to Accomplish:**
  - Specialized staff
  - Develop processing software to assist in consolidation
  - Develop educational resources and tools
Modernizing FCDS – Current Steps

- Accomplished thus far:
  - Collecting claims data from select private physicians
    - Provides a new cancer abstract, if not already in the FCDS masterfile
    - Provides granular treatment information
  - Linkage with the Florida Veterans Administration (VA) Hospitals
  - Improved Learning Management System (LMS)
  - Improvements in data access and release (DREAMS)

Modernizing FCDS – Next steps

- How to Accomplish (with minimal burden to providers or systems):
  - Include comorbidity data
  - Include genetic information
  - Include screening data
- Resources to Accomplish:
  - Revising statute and administrative code, where needed
  - Specialized staff
  - Developing new partnerships
  - Develop processing software
Vision for FCDS

Modernized cancer registry ensures:
- Complete and high quality data **representative of all Florida** available for use by:
  - Researchers
  - Prevention, outreach, and education programs
  - Citizens of the state of Florida
  - Healthcare professionals
  - Policy makers
- Challenges of changing cancer management are accounted for in FCDS’ data collection procedures
- FCDS has a solid foundation upon which to develop further strategic and desired enhancements

FCDS UPDATE: THE STATE OF THE STATE

Gary M. Levin, BA, CTR
FCDS Annual Conference 7/26/2017
NAACCR Gold Certification
Fifteenth Consecutive Year!!

Your Hard Work and Dedication Makes this Possible - Thank You

Overall Data Accuracy Rate 99.1%

Your Hard Work and Dedication Makes this Possible - Thank You
New Accomplishments - DREAMS

- 101 Data Request Applications Entered Since Implementation
- Tracks Data Request from Start To Completion
  - Application
  - DOH Approvals/IRB Approvals/Vital Statistics Approvals
  - Secure Messaging between Requestor/FCDS/DOH
  - Secure Delivery of Requested Data to Requestor

Web Link: https://fcds.med.miami.edu/inc/datarequest.shtml

New Accomplishments - FLccSC LMS

- Joint Project between Florida and South Carolina CCRs
- Over ~200 Students Registered in Florida
- Current Courses
  - New Abstractor and Annual Renewal Code Test
  - Abstractor Basic Course (Updates coming)
- Administrator Controls Content, Quizzes & Student Registration
- Keeps History of Student
  - Courses Completed and Quiz Scores
  - CEU’s and Allows for On-Demand Printable Certificates

Web Link: https://fcds.med.miami.edu/inc/flccsc.shtml
Firefighter Cancer Linkage Project Update

David J. Lee1,2,3, Tulay Koru-Sengul1,2,3, Monique N. Hernandez1, Jill A. MacKinnon1, Alberto Caban-Martinez2,3, Laura A. McClure1,3, Erin Kobetz4

1Florida Cancer Data System (FCDS), University of Miami Miller School of Medicine
2Department Public Health Sciences, University of Miami Miller School of Medicine
3Sylvester Comprehensive Cancer Center, University of Miami Miller School of Medicine
4Department Medicine, University of Miami Miller School of Medicine

This work was supported by State of Florida appropriation #2382A

Firefighter Cancer Initiative (FCI) Goals

- To monitor, understand and address the excess burden of cancer among firefighters
- 13 interlocking projects designed to move innovative research from “bench” to “trench”
Annual Cancer Survey and Exposure Reporting

- Annually collect health information and cancer risk factors of active and retired Florida firefighters (n > 1000)
- Long-term goal is to use data to identify occupational and other exposures linked to cancer risk

Previous Research Using FCDS data

Cancer Incidence in Florida Professional Firefighters, 1981 to 1999

Fangchao Ma, MD, PhD
Lora E. Fleming, MD, PhD
David J. Lee, PhD
Edward Trapido, ScD
Terence A. Gerace, PhD

Objective: The objective of this study was to examine the cancer risk associated with firefighting. Methods: Standardized incidence ratio analysis (SIR) was used to determine the relative cancer risk for firefighters as compared with the Florida general population. Results: Among 34,796 male (413,022 person-years) and 2,017 female (18,843 person-years) firefighters, 970 male and 52 female cases of cancer were identified. Male firefighters had significantly increased incidence rates of bladder (SIR = 1.29; 95% confidence interval: 1.01–1.62), testicular (1.60; 1.20–2.09), and thyroid cancers (1.77; 1.08–2.73). Female firefighters had significantly increased incidence rates of overall cancer (1.63; 1.22–2.14), cervical (3.34; 2.93–3.85), and thyroid cancer (3.97; 1.45–8.65) and Hodgkin disease (6.25; 1.26–18.26). Conclusions: Firefighting may be associated with an increased risk of selected site-specific cancers in males and females, including an overall increased cancer risk in female firefighters. (J Occup Environ Med. 2006;48:883–888)
Results

Select High-Priority Cancer Standardized Incidence Ratios: FCDS Years 1981-2013

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>Standardized Incidence Ratios</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melanoma</td>
<td></td>
</tr>
<tr>
<td>Kidney and Renal Pelvis</td>
<td></td>
</tr>
<tr>
<td>Bladder</td>
<td></td>
</tr>
<tr>
<td>Rectum</td>
<td></td>
</tr>
<tr>
<td>Myeloma</td>
<td></td>
</tr>
<tr>
<td>Colon</td>
<td></td>
</tr>
<tr>
<td>Thyroid</td>
<td></td>
</tr>
<tr>
<td>Non-Hodgkin's Lymphoma</td>
<td></td>
</tr>
<tr>
<td>Lung and Bronchus</td>
<td></td>
</tr>
<tr>
<td>All Sites Combined</td>
<td></td>
</tr>
</tbody>
</table>

Standardized Incidence Ratios

Future Direction 2017-18

- Recent statute modification now allows for release of SS #; may help ‘recover’ cases among the 30,000 records we could not link
  - Will enable us to include vital missing female cases and will further strengthen case counts for males
- Relink with the cancer registry and undertake linkage with mortality file
Cancer Survival in Florida 1999-2003
or Why Rates are Harder Than Counts

Anders Alexandersson
Florida Cancer Data System

<table>
<thead>
<tr>
<th>Framework</th>
<th>Relative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cause-specific</td>
<td>Risk communication</td>
</tr>
<tr>
<td>Crude Measure</td>
<td></td>
</tr>
<tr>
<td>Registry-based randomized controlled trial (RRCT)</td>
<td></td>
</tr>
<tr>
<td>Net Measure</td>
<td></td>
</tr>
<tr>
<td>Causality with observational data</td>
<td>Life tables</td>
</tr>
</tbody>
</table>

Pohar Perme estimates

Florida’s New Distance Learning Platform

Jill MacKinnon, PhD
What is FLccSC

• Web based distance educational platform
  – Learning Management System (LMS)

FLccSC is the Umbrella Platform

• FLccSC is fully functioning LMS administered and maintained on a central server managed by the Florida Cancer Data System

• Each CCR LMS operates as a stand-alone customized platform (logos, branding and URL)
  ◦ Accessible via a link on the CCR web site

• Each CCR has a site administrator who maintains their respective CCR site
FLccSC Enrollment Statistics

• Over 200 active users as of Monday
  – Abstractor Basic Course
    • 47 students enrolled
    • 45 course in process
    • 2 completed
  – Abstractor Renewal Test
    • 125 abstractors enrolled
    • 14 test in process
    • 111 renewed their Abstractor Code

FCDS Abstractor Code Test

• Any abstractors working in the State of Florida must have an active abstractor code
  – Successful completion of the FCDS Abstractor Code Test is required for new or renewal codes
  – ALL Tests are now 20 questions – new or renewal
  – Abstractor codes are valid for 12 month
    • FCDS abstractor codes must be renewed annually

• If you do not have FCDS IDEA login credentials, please refer to the “New IDEA User” tutorial on the FCDS FLccSC/LMS page
How to Obtain and Renew your FCDS Abstractor Code

• Abstractors with an Abstractor Code or Abstractors wishing to get an Abstractor Code **MUST log into FLccSC through IDEA**

• Abstractors must login to FCDS IDEA, click the ‘Education/FCDS Tools’ menu item, select the Learning Management System option to access FLccSC in order to take the test

• Renewal: Abstractors will be notified via email one month prior to their code expiration date

Coming Soon

• Steve Peace’s FCDS Webcast Series
  – Webcasts will be presented live
    • Recorded Webcasts will also be available in FLccSC for individuals that didn’t have the opportunity to view it live
    • All quizzes will be in FLccSC
      – CEU’s will be awarded based on the successful completion of a quiz for each webcast – 3 to 5 questions
      – You will also get a Certificate of Completion for your records that will include the NCRA CEU information
Breaking Barriers in Cancer Surveillance
Plenary Sessions

- Breaking Barriers - International Cancer Surveillance
- Cancer Surveillance In Action: An International View
- Cancer Surveillance in American Indians/Alaska Natives/Canadian First Nations
- Registry of the Future: Surveillance in an Era of Emerging Technology and Precision Medicine

Conference Themes and Topics

- Expanding the role of cancer registries
- Registry data tools
- Improving cancer treatment linkage
- Cancer in native/indigenous peoples
- International Cancer Surveillance
- Cancer epidemiology
FCDS Presentations

Gary Levin
Fundamental Learning Collaborative for the Cancer Surveillance Community (FLccSC)
Advances in Integrating Health Claims Data Into Cancer Registry Data Systems

Anders Alexandersson
Probabilistic Record Linkage at the Florida Cancer Data System: A Data-Science Project
Using R and Stata

Dr. David Lee
Occupational Cancer Surveillance in the Age of Restricted Identifier Access: A Linkage of Florida Cancer Data System (FCDS) Data with Firefighter Certification Records

Dr. Monique Hernandez
Physician Medical Claims Reporting in Florida

Sasha Raju – Attendee
Steven Peace – Attendee
Data Acquisition Update

FCDS ANNUAL MEETING
JULY 26 AND 27

Reporting Entities Summary

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>252</td>
</tr>
<tr>
<td>Radiation Treatment Centers</td>
<td>127</td>
</tr>
<tr>
<td>Surgery Centers</td>
<td>453</td>
</tr>
<tr>
<td>Pathology Labs (CLIA's)</td>
<td>1092</td>
</tr>
<tr>
<td>Hematologists</td>
<td>23</td>
</tr>
<tr>
<td>Oncologists</td>
<td>187</td>
</tr>
<tr>
<td>Urologists</td>
<td>507</td>
</tr>
<tr>
<td>Dermatologists</td>
<td>943</td>
</tr>
<tr>
<td>Other States</td>
<td>42</td>
</tr>
<tr>
<td>Other Specialty Physicians</td>
<td>1165</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,791</strong> Reporting Entities</td>
</tr>
</tbody>
</table>
2016 Abstracts Received
As of July 1, 2017

- 182,134 Abstracts for the 2016 Data Year
  - Hospitals 168,870
  - Radiation Treatment Centers 1,556
  - AMBI Surg 97
  - Dermatology Physician Abstracts 10,897
  - Physician Claims 714

Abstract Counts at Deadline (6/30) and 1 year later

<table>
<thead>
<tr>
<th>Year</th>
<th>Deadline</th>
<th>1 Year Later</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009 Data (6/2010)</td>
<td>166,303</td>
<td>185,703</td>
</tr>
<tr>
<td>2010 Data (6/2011)</td>
<td>136,610</td>
<td>174,701</td>
</tr>
<tr>
<td>2011 Data (6/2012)</td>
<td>149,368</td>
<td>185,969</td>
</tr>
<tr>
<td>2012 Data (6/2013)</td>
<td>165,991</td>
<td>189,693</td>
</tr>
<tr>
<td>2013 Data (6/2014)</td>
<td>171,179</td>
<td>194,862</td>
</tr>
<tr>
<td>2014 Data (6/2015)</td>
<td>167,931</td>
<td>200,817</td>
</tr>
<tr>
<td>2015 Data (6/2016)</td>
<td>181,216</td>
<td>223,227</td>
</tr>
<tr>
<td>2016 Data (6/2017)</td>
<td>182,134</td>
<td></td>
</tr>
</tbody>
</table>

Average 29K cases up to one year late.....
Certification of Completeness

Reminder: the requirement to certify when you have completed your submission for the data year

- Provide complete view of who is complete and who is still working on their submissions
- Maintains a record of when a facility is done and maintains a record of any explanation of volume below expected
- Helps us focus on working with Late Reporters

Physician Reporting

Claims received by Year

- 2013 4,565,532
- 2014 3,241,465
- 2015 3,449,533
- 2016 3,884,936
- 2017 1,684,871
- Total 17,030,785

- 785 of 901 physicians have sent data (88%)
Physician Reporting

Dermatology Abstracts
- 2011: 5,691 abstracts reported
- 2012: 7,560 abstracts reported
- 2013: 7,647 abstracts reported
- 2014: 9,559 abstracts reported
- 2015: 11,333 abstracts reported
- 2016: 18,859 abstracts reported
- 2017 (as of July 1): 8,534 abstracts reported

Total since inception.....69,183 abstracts
- 729 of 943 have sent data (77% of registered)

2016 Physician Reporting

<table>
<thead>
<tr>
<th>Profession</th>
<th>Claims Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oncologists</td>
<td>519,211</td>
</tr>
<tr>
<td>Urologists</td>
<td>682,562</td>
</tr>
<tr>
<td>HEMA/ONC</td>
<td>2,519,398</td>
</tr>
<tr>
<td>Hematologists</td>
<td>13,030</td>
</tr>
</tbody>
</table>

(as of July 1, 2017)
2016-2017 QC Activities Summary

FCDS Annual Conference
Orlando, Florida
7/27/2016

Steven Peace, CTR

FCDS Data Quality Program - Methods

- **FCDS Policy**
  - FCDS Abstractor Code Requirement
  - FCDS EDITS Requirement
  - FCDS Text Documentation Requirement
  - FCDS 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
  - QC Review Summary
  - Ad Hoc Reports
  - Audit Results
### Submission Summary & QC Review Sample

#### Total Cases Submitted to FCDS 1/1/2016-12/31/2016 – All Sources

<table>
<thead>
<tr>
<th>Description</th>
<th># Cases</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cases Submitted to FCDS 1/1/2016-12/31/2016 – All Sources</td>
<td>212,547</td>
<td>100%</td>
</tr>
<tr>
<td>Total Cases – NO CHANGE – Pass ALL Edits – No Visual Review by FC or QC</td>
<td>201,087</td>
<td>94.6%</td>
</tr>
</tbody>
</table>

#### Total Cases – FC Visual Review (FC Review to assess case for possible FORCE)

- FORCED (EDIT Override Confirmed and FORCE was set - NOT an error) | 4,276 | 2.0% |
- CORRECTED (1 or more corrections made based on text – NOT a FORCE) | 5,046 | 2.4% |
- DELETED (duplicate case, not a reportable neoplasm, not a new primary) | 2,138 | 1.0% |

#### Total Cases – Every 25th Case QC Review Sample/Visual Editing

- Sample includes 4% of analytic hospital, radiation, surgery center cases
- Sample includes ALL male breast and ALL pediatric cases
- Sample does not include dermatology or other physician office cases

<table>
<thead>
<tr>
<th>Description</th>
<th># Cases</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cases – Every 25th Case QC Review Sample/Visual Editing</td>
<td>9,951</td>
<td>4.7%</td>
</tr>
</tbody>
</table>

#### Total Cases Visually Edited by FCDS in 2014 (combined FC and/or QC Review)

<table>
<thead>
<tr>
<th>Description</th>
<th># Cases</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cases Visually Edited by FCDS in 2014 (combined FC and/or QC Review)</td>
<td>21,411</td>
<td>10.1%</td>
</tr>
</tbody>
</table>

### QC Review Sample / Visual Editing - Summary

#### Total Cases – Every 25th Case QC Review Sample/Visual Editing

<table>
<thead>
<tr>
<th>Description</th>
<th># Cases</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cases – Every 25th Case QC Review Sample/Visual Editing</td>
<td>9,951</td>
<td>4.7%</td>
</tr>
</tbody>
</table>

#### Total Cases Sent to Facility with Correction or Inquiry

<table>
<thead>
<tr>
<th>Description</th>
<th># Cases</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cases Sent to Facility with Correction or Inquiry</td>
<td>3,077</td>
<td>30.9%</td>
</tr>
</tbody>
</table>

#### Total Cases Sent to Facility with Correction or Inquiry

- NO CHANGE after Follow-Back to Facility | 408 | 13.3% |
- FORCED (EDIT Override Confirmed - NOT an error) | 39 | 1.3% |
- CORRECTED (1 or more corrections made – NOT a FORCE) | 2,573 | 83.6% |
- DELETED (duplicate case, not a reportable neoplasm, not a new primary) | 57 | 1.9% |
### AHCA In-Patient: Follow-Back Analysis

<table>
<thead>
<tr>
<th>AHCA In-Patient Follow-Back</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missed Case - Abstract</td>
<td>5,257</td>
<td>4,091</td>
<td>3,480</td>
<td>3,479</td>
<td>2,848</td>
</tr>
<tr>
<td>Abstrated but Not Transmitted</td>
<td>705</td>
<td>669</td>
<td>632</td>
<td>851</td>
<td>693</td>
</tr>
<tr>
<td><strong>Total Missed Cases</strong></td>
<td>5,962</td>
<td>4,762</td>
<td>4,112</td>
<td>4,330</td>
<td>3,541</td>
</tr>
<tr>
<td>Not Reportable - NED</td>
<td>5,371</td>
<td>5,174</td>
<td>6,024</td>
<td>5,645</td>
<td>5,087</td>
</tr>
<tr>
<td>Not Reportable - Not Malignant</td>
<td>2,461</td>
<td>2,348</td>
<td>1,899</td>
<td>1,618</td>
<td>975</td>
</tr>
<tr>
<td>Not Reportable - Equivocal</td>
<td>3,466</td>
<td>3,396</td>
<td>3,640</td>
<td>3,253</td>
<td>2,145</td>
</tr>
<tr>
<td>Not Reportable - No Mention CA</td>
<td>3,164</td>
<td>3,865</td>
<td>4,656</td>
<td>4,103</td>
<td>1,596</td>
</tr>
<tr>
<td>Not Reportable - Other</td>
<td>2,112</td>
<td>2,342</td>
<td>2,237</td>
<td>1,709</td>
<td>4,498</td>
</tr>
<tr>
<td><strong>Total Not Reportable</strong></td>
<td>16,574</td>
<td>17,125</td>
<td>18,456</td>
<td>16,328</td>
<td>14,292</td>
</tr>
<tr>
<td>Follow-Back Not Returned</td>
<td>496</td>
<td>780</td>
<td>774</td>
<td>732</td>
<td>811</td>
</tr>
<tr>
<td><strong>Total AHCA In-Patient Follow-Back</strong></td>
<td>22,572</td>
<td>22,837</td>
<td>23,342</td>
<td>21,340</td>
<td>16,690</td>
</tr>
</tbody>
</table>

### AHCA Ambi: Follow-Back Analysis

<table>
<thead>
<tr>
<th>AHCA Ambulatory Follow-Back</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missed Case - Abstract</td>
<td>6,275</td>
<td>4,338</td>
<td>3,757</td>
<td>4,002</td>
<td>3,277</td>
</tr>
<tr>
<td>Abstrated but Not Transmitted</td>
<td>575</td>
<td>498</td>
<td>521</td>
<td>581</td>
<td>576</td>
</tr>
<tr>
<td><strong>Total Missed Cases</strong></td>
<td>6,850</td>
<td>4,836</td>
<td>4,278</td>
<td>4,583</td>
<td>3,853</td>
</tr>
<tr>
<td>Not Reportable - NED</td>
<td>2,573</td>
<td>2,573</td>
<td>2,361</td>
<td>2,651</td>
<td>2,455</td>
</tr>
<tr>
<td>Not Reportable - Not Malignant</td>
<td>2,599</td>
<td>2,576</td>
<td>793</td>
<td>798</td>
<td>716</td>
</tr>
<tr>
<td>Not Reportable - Equivocal</td>
<td>785</td>
<td>710</td>
<td>498</td>
<td>448</td>
<td>385</td>
</tr>
<tr>
<td>Not Reportable - No Mention CA</td>
<td>727</td>
<td>837</td>
<td>1,091</td>
<td>577</td>
<td>377</td>
</tr>
<tr>
<td>Not Reportable - Other</td>
<td>2,741</td>
<td>3,061</td>
<td>1,559</td>
<td>1,052</td>
<td>1,218</td>
</tr>
<tr>
<td><strong>Total Not Reportable</strong></td>
<td>9,425</td>
<td>9,757</td>
<td>6,302</td>
<td>5,562</td>
<td>5,151</td>
</tr>
<tr>
<td>Follow-Back Not Returned</td>
<td>1,549</td>
<td>2,366</td>
<td>1,304</td>
<td>1,559</td>
<td>2,089</td>
</tr>
<tr>
<td><strong>Total AHCA Ambulatory Follow-Back</strong></td>
<td>17,824</td>
<td>16,959</td>
<td>11,884</td>
<td>11,668</td>
<td>11,785</td>
</tr>
</tbody>
</table>
RQRS and FCDS Reporting

FCDS Data Submission Requirements
- Frequency – Quarterly/Monthly
- E-updates to Cases – NOT DONE
- Reportable Cancers – ALL
- Data Timeline – 6 months post dx/tx with June 30th Annual Deadline
- Data Quality – Pass All FCDS EDITS
- Data Completeness – DX/TX 1st Crs for ALL Analytic Cases – DO NOT SUBMIT CASES IF INCOMPLETE!!!
- June 30th – Use TX Recommended Codes for any still incomplete cases.

QC Review Summary Reports
QC Review Summary Reports

2017 Call for Data – NPCR DER Report

12 month completeness
Overuse of Surgery NOS Codes

RX Summ Surg Prim Site [1290]
Surgery NOS

Overuse of Radiation NOS Codes

Rad Regional RX Modality [1570]
NOS
Use the 2014 Grade Coding Instructions

**Two-grade system**

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
<th>Grade Code</th>
<th>Exception for Breast and Prostate Grade Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/2, 1/1</td>
<td>Low grade</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>3/2, 2/1</td>
<td>High grade</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

In transitional cell carcinoma for bladder, the terminology high grade TCC and grade TCC are coded in the two-grade system.

**Three-grade system**

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
<th>Grade Code</th>
<th>Exception for Breast and Prostate Grade Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/3</td>
<td>Low grade</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>2/3</td>
<td>Intermediate grade</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>3/3</td>
<td>High grade</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>
Feedback from QC Review Sample

- Registrars are too quick to send C80.9 with history of other cancers – must look at case to see if is really an unknown primary or recurrence from previous
- Registrars still sending cases with C76.* - Please Don’t Use.
- Registrars are too quick to send new primary when patient has recurrence of original primary – YOU MUST USE THE MPH Rules – Call with Questions !!!
  - Bladder
  - Other urinary
  - Female Genital
  - Lung
  - Breast
- Don’t just automatically abstract a new case and expect FCDS to fix it for you.
- Increased Use of NOS and ‘nothing’ codes – tumor description & treatment
- Importance of Coding 2014 Grade Rules - used by NPCR to evaluate FCDS

Feedback from QC Review Sample

- Surg Primary Site coded to 90 is a problem when your facility is analytic
- Scope Regional Lymph Nodes for FNA are missed a lot - 95 or blank
- Surg other regional distant sites should almost always = 0
- Missing dates in text cannot be audited
- Document everything these days
- Not Paying Attention to Summary Stage – but maybe renewed with SS2018
- What Treatment is required to Satisfy Pathologic Staging Criteria?
- Can you assign AJCC TNM to only part of the TNM that “fits”?
- What if nodal dissection is not required but the TNM Edit is requiring it?
- Neoadjuvant therapy – when is it neoadjuvant tx and when is it not?
Background

- Increase physician reporting
  - Capture missing first course treatment
  - Capture missing cases particularly in urological and hematopoietic

- Reduce burden on physicians to comply
  - 5010/837 reporting data standard
  - Duplicate claims submission and send to registry

- Process has evolved for almost 5 years
Background

- Received Over 17 Million Claims
  - Primarily Medical Oncologists and Dermatologists
- Registration of Physician
  - Over 2,000 Physicians Registered
  - Used Florida Licensure and NPI to Identify
  - Mass e-mail sent where e-mail available
  - EXTREMELY Labor Intensive
- Statewide Coverage

Results – Treatment Enhancing Abstracts

- Patient/Tumor Linked Successfully
- Shadow image of consolidated Patient and Tumor data
- Overlay all treatment information gleaned from claims
- Process, link and consolidate according to routine process
- Improves First Course Therapy
- Date of Last Contact – set to highest claims date
### Results – Treatment Enhancing Abstracts

<table>
<thead>
<tr>
<th>Year</th>
<th>Chemo</th>
<th>Surgery</th>
<th>Radiation</th>
<th>Hormone</th>
<th>BRM</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>1,298</td>
<td>0</td>
<td>6</td>
<td>73</td>
<td>4</td>
</tr>
<tr>
<td>2011</td>
<td>3,141</td>
<td>2</td>
<td>81</td>
<td>159</td>
<td>10</td>
</tr>
<tr>
<td>2012</td>
<td>3,481</td>
<td>20</td>
<td>409</td>
<td>257</td>
<td>101</td>
</tr>
<tr>
<td>2013</td>
<td>6,417</td>
<td>134</td>
<td>1,307</td>
<td>842</td>
<td>706</td>
</tr>
<tr>
<td>2014</td>
<td>8,158</td>
<td>181</td>
<td>1,953</td>
<td>1,239</td>
<td>1,177</td>
</tr>
<tr>
<td>2015</td>
<td>5,957</td>
<td>64</td>
<td>1,367</td>
<td>796</td>
<td>991</td>
</tr>
<tr>
<td>Total</td>
<td>28,452</td>
<td>401</td>
<td>5,123</td>
<td>3,366</td>
<td>2,989</td>
</tr>
<tr>
<td>Processed</td>
<td>54,163</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhancements</td>
<td>40,331</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chemo Improvement By Site</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung and Bronchus</td>
<td>7,782</td>
</tr>
<tr>
<td>Breast</td>
<td>6,830</td>
</tr>
<tr>
<td>Pancreas</td>
<td>1,617</td>
</tr>
<tr>
<td>Non-Hodgkin Lymphoma - Nodal</td>
<td>1,440</td>
</tr>
<tr>
<td>Rectum</td>
<td>1,031</td>
</tr>
<tr>
<td>Myeloma</td>
<td>825</td>
</tr>
<tr>
<td>Esophagus</td>
<td>752</td>
</tr>
<tr>
<td>Ovary</td>
<td>638</td>
</tr>
<tr>
<td>Urinary Bladder</td>
<td>630</td>
</tr>
<tr>
<td>Sigmoid Colon</td>
<td>582</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Radiation Improvement by Site</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostate</td>
<td>2,217</td>
</tr>
<tr>
<td>Breast</td>
<td>1,007</td>
</tr>
<tr>
<td>Lung and Bronchus</td>
<td>814</td>
</tr>
<tr>
<td>Rectum</td>
<td>179</td>
</tr>
<tr>
<td>Esophagus</td>
<td>78</td>
</tr>
<tr>
<td>Brain</td>
<td>74</td>
</tr>
<tr>
<td>Cervix Uteri</td>
<td>65</td>
</tr>
<tr>
<td>Anus, Anal Canal and Anorectum</td>
<td>64</td>
</tr>
<tr>
<td>Larynx</td>
<td>63</td>
</tr>
<tr>
<td>Corpus Uteri</td>
<td>57</td>
</tr>
</tbody>
</table>
Results – New Incidence Abstracts

- Claims Abstracts Not Matching Database
- Link claims abstract to Pathology Reports
- Visual Review (Labor Intensive)
  - Create case finding abstracts
  - Link to existing cases (missed automated linkage)
  - Send case to physician for follow back
  - Mark as non-cancer/non-reportable case
# Results – New Incidence Abstracts

<table>
<thead>
<tr>
<th>Dx Year</th>
<th>New Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>768</td>
</tr>
<tr>
<td>2011</td>
<td>5,968</td>
</tr>
<tr>
<td>2012</td>
<td>3,359</td>
</tr>
<tr>
<td>2013</td>
<td>8,400</td>
</tr>
<tr>
<td>2014</td>
<td>7,271</td>
</tr>
<tr>
<td>2015</td>
<td>9,455</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>35,221</strong></td>
</tr>
</tbody>
</table>

### New Case by Site

<table>
<thead>
<tr>
<th>New Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miscellaneous Heme/Lymph Malignancies</td>
</tr>
<tr>
<td>Non-Hodgkin Lymphoma - Extranodal</td>
</tr>
<tr>
<td>Chronic Lymphocytic Leukemia</td>
</tr>
<tr>
<td>Myeloma</td>
</tr>
<tr>
<td>Aleukemic, subleukemic and NOS</td>
</tr>
<tr>
<td>Non-Hodgkin Lymphoma - Nodal</td>
</tr>
<tr>
<td>Breast</td>
</tr>
<tr>
<td>Chronic Myeloid Leukemia</td>
</tr>
<tr>
<td>Acute Myeloid Leukemia</td>
</tr>
<tr>
<td>Other Lymphocytic Leukemia</td>
</tr>
<tr>
<td>Urinary Bladder</td>
</tr>
<tr>
<td>Melanoma of the Skin</td>
</tr>
<tr>
<td>Prostate</td>
</tr>
</tbody>
</table>
Update on Meaningful Use

Meaningful Use Cancer Reporting in Florida

Florida Cancer Data System Annual Meeting
Orlando, FL
July 26th, 2017
What is MU?

Meaningful Use Definition & Objectives

Meaningful Use Defined
Meaningful use is using certified electronic health record (EHR) technology to:
- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and family
- Improve care coordination, end population and public health
- Maintain privacy and security of patient health information
Ultimately, it is hoped that the meaningful use compliance will result in:
- Better clinical outcomes
- Improved population health outcomes
- Increased transparency and efficiency
- Empowered individuals
- More robust research data on health systems

Meaningful use sets specific objectives that eligible professionals (EPs) and hospitals must achieve to qualify for Centers for Medicare & Medicaid Services (CMS) Incentive Programs.

Ongoing Follow-up and Feedback

- Monthly review of onboarding status
- Communication with practice throughout process
- Check for file submissions/validate
- Send quality report
- Track Follow-up status in database
Future Steps

- Incorporate MU abstracts into workflow
- Integrate into FCDS claims/pathology workflow
- Streamline data validation and integration into registry database
- Continue to work with providers for registration, onboarding, and audit documentation.
Facility Follow Up System Usage Statistics

<table>
<thead>
<tr>
<th>Year</th>
<th># Users</th>
<th>Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>23</td>
<td>215,155</td>
</tr>
<tr>
<td>2015</td>
<td>18</td>
<td>139,352</td>
</tr>
<tr>
<td>2016</td>
<td>17</td>
<td>334,776</td>
</tr>
<tr>
<td>2017</td>
<td>10</td>
<td>80,754</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>770,037</td>
</tr>
<tr>
<td>Unique Users</td>
<td>43</td>
<td></td>
</tr>
</tbody>
</table>

Facility Follow Up System Concepts

- **Purpose**: Assist Facilities with Patient Follow Up
- **Facility Provides**: Facility, Accession, Sequence #
- **System Validates and Returns**: Consolidated Patient and Tumor Information for the requested cases
- **Results can vary**: from facility case since it is based on consolidation from many reporting sources
Facility Follow Up System
Concepts - Input

<table>
<thead>
<tr>
<th>NAACCR Data Item</th>
<th>Field Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>540</td>
<td>Reporting Facility</td>
</tr>
<tr>
<td>550</td>
<td>Accession Number--Hosp</td>
</tr>
<tr>
<td>560</td>
<td>Sequence Number--Hosp</td>
</tr>
</tbody>
</table>

Facility Follow Up System
How To Use – Input File
Facility Follow Up System
How To Use
Facility Follow Up System
How To Use

Facility Follow Up System
How To Use
Facility Follow Up System
How To Use

Facility Follow Up System
How To Use - Excel Format
Facility Follow Up System
How To Use - CSV Format

Facility Follow Up System
How To Use – Single Case Inquiry
National Program of Cancer Registries
2016 Data Quality Evaluation

Diagnosis years: 2008-2014
Contract Number: 200201461258003

FCDS Annual Meeting
July 26, 2017
Meg Herna, CTR
Steven Peace, CTR

Methodology

• FCDS prepared two extract files:
  • Diagnosis years 2008-2014
  • Primary sites of breast, colon, prostate, lung, bladder, and melanoma of the skin
  • Behavior 2 or 3

• A random sample of 438 cases were selected from the submitted data file.
  • These 438 cases were reconsolidated and compared to FCDS consolidated cases.
  • Cases were reviewed for the accuracy of code against the supporting text.

• Breast and colon cases were also run through the NPCR Clinical Check Edits to evaluate reported prognostic and treatment items for cancer cases with specific tumor characteristics.
Data Elements Reviewed

20  Patient ID Number
40  RegistryID
380 Sequence Number—Central
390 Data of Diagnosis
400 Primary Site
410 Laterality
440 Grade
522 Histologic Type ICD-O-3
523 Behavior Code ICD-O-3
540 Reporting Facility
820 Regional Lymph Nodes Positive+
830 Regional Lymph Nodes Examined+
1200 RX Date — Surgery
1201 RX Date — Surgery Flag#
1210 RX Date — Radiation
1211 RX Date — Radiation Flag#
1220 RX Date — Chemo
1221 RX Date — Chemo Flag#
1230 RX Date — Hormone
1231 RX Date — Hormone Flag#
1240 RX Date — BRM
1241 RX Date — BRM Flag#
1250 RX Date — Other
1251 RX Date — Other Flag#
1260 Date of Initial RX—SEER
1261 Date of Initial Rx—SEER Flag#
1270 Date of 1st Crs RX—CoC
1271 Date of 1st Crs RX—CoC Flag#
1290 RX Summ—Surg Prim Site
1292 RX Summ—Scope Reg LN Sur
1294 RX Summ—Surg Other Reg/Dx

Data Elements Reviewed

1360 Rx Summ—Radiation
1390 RX Summ—Chemo
1400 RX Summ—Hormone
1410 RX Summ—BRM
1420 RX Summ—Other
1570 Rad—Regional RX Modality
2520 Text—DX Proc—PE
2530 Text—DX Proc—X-ray/Scan
2540 Text—DX Proc—Scopes
2550 Text—DX Proc—Lab Tests
2560 Text—DX Proc—Op
2570 Text—DX Proc—Path
2580 Text—Primary Site Title
2590 Text—Histology Title
2600 Text—Staging
2620 RX Text—Radiation (Beam)
2630 RX Text—Radiation Other
2640 RX Text—Chemo
2650 RX Text—Hormone
2660 RX Text—BRM
2670 RX Text—Other
2680 Text—Remarks
2800 CS Tumor Size+
2810 CS Extension+
2830 CS Lymph Nodes+
2850 CS Mets at Ds+
2880 CS Site Specific Factor 1+
2900 CS Site Specific Factor 3+
3020 Derived SS2000
3250 RX Summ—Transplnt/Endocr
Number of Data Elements Reviewed by Site

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Data Elements (a)</th>
<th>Number of Abstracts (b)</th>
<th>Total Number of Data Elements (abstract-level) (c = a * b)</th>
<th>Number of Consolidated Tumors (d)</th>
<th>Total Number of Data Elements Audited (tumor-level) (e = a * d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bladder</td>
<td>23</td>
<td>160</td>
<td>3,680</td>
<td>73</td>
<td>1,679</td>
</tr>
<tr>
<td>Breast</td>
<td>23</td>
<td>158</td>
<td>3,634</td>
<td>73</td>
<td>1,679</td>
</tr>
<tr>
<td>Colon</td>
<td>23</td>
<td>151</td>
<td>3,473</td>
<td>73</td>
<td>1,679</td>
</tr>
<tr>
<td>Lung</td>
<td>23</td>
<td>154</td>
<td>3,542</td>
<td>73</td>
<td>1,679</td>
</tr>
<tr>
<td>Melanoma</td>
<td>23</td>
<td>154</td>
<td>3,542</td>
<td>73</td>
<td>1,679</td>
</tr>
<tr>
<td>Prostate</td>
<td>23</td>
<td>153</td>
<td>3,519</td>
<td>73</td>
<td>1,679</td>
</tr>
<tr>
<td>Total</td>
<td>138</td>
<td>930</td>
<td>21,390</td>
<td>438</td>
<td>10,074</td>
</tr>
</tbody>
</table>

DQE Results Case Consolidation

- Of a total of 10,074 possible data elements that could had errors, only 89 data elements (0.9%) were found to have errors.

- Data accuracy rate was **99.1%**.
**DQE Results**

Frequency of multiple primary errors across all sites

<table>
<thead>
<tr>
<th>Total number of cases analyzed</th>
<th>Number of cases with no errors</th>
<th>Number of cases with error</th>
<th>Accuracy proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1057</td>
<td>1015</td>
<td>43</td>
<td>96.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total number of patient level records analyzed</th>
<th>Number of patients with no errors</th>
<th>Number of patients with error</th>
<th>Accuracy proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>400</td>
<td>372</td>
<td>28</td>
<td>93.0%</td>
</tr>
</tbody>
</table>

**NPCR DQE Results**

FCDS’s overall data accuracy rate of merged data was 99.1 percent; FCDS is to be commended for this result.
2016 FCDS Lung Audits

(DX = 2014 or 2015)

FCDS ANNUAL CONFERENCE
ORLANDO, FLORIDA
7/27/2016

STEVEN PEACE, CTR
MEG HERNA, CTR

2016 Audit Process

- Eligibility:
  - Facilities will be selected according to enhanced 3 year selection criteria, as well as stratified by 2016 reporting year (selected for each program unit to be audited at least one cycle).
  - A facility may be selected for more than 1 cycle during the 3 year cycle using the enhanced facility selection criteria.
  - Case selection will be based upon the following criteria:
    - Date of Diagnosis: 01/01/2014 - 12/31/2015
    - Diagnosis:
      - Lung Cancer (ICD-10: C33, C34)
      - Other specified primary site(s) reported
      -Histology:
        - Non-small-cell
        - Small-cell
      - Case selection will be based on (1) diagnosis and/or (2) histology (3) other ICD-10 codes (4) metropolitan area (5) hospital type (6) treatment options
      - Cases will be selected from 2015 reporting year. (Cases will be selected from 2014 reporting year.}
  - Case selection will be completed by 2014 or 2015 reporting year (selected for primary lung cancer diagnosis from 2014 or 2015 diagnoses).
  - Facilities will be based on a predetermined report(s) with Cases of Diagnosis within 30 days of the original Date of Diagnosis plus at least 10 days as documented on the original claim.
### 2014 Selected Facilities & Cases

- **64 facilities**
- **557 total records**
- **359 e-path records**

![Image of 2014 Selected Facilities & Cases](image)

### 2015 Selected Facilities & Cases

- **68 facilities**
- **627 total records**
- **208 e-path records**

![Image of 2015 Selected Facilities & Cases](image)
Audit Summary Reports

FCDS 2016 Data Validation and E-Pathology ReAbstract Audit
Report Key
[Major, Minor and Text Errors Defined By Section of Audit Report]

<table>
<thead>
<tr>
<th>Major Error</th>
<th>Minor Error</th>
<th>Text Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Errors are errors that may result in significant changes to the case or may alter core data or key information on the case</td>
<td>Minor Errors are errors that will not result in significant changes to the case or will not alter core data/key information on a case</td>
<td>Text Errors are errors found in recoding data from original text, only. The original text resulted in minor coding or other error that was later resolved at time of facility reconciliation when text was provided after the fact</td>
</tr>
</tbody>
</table>

Example: Date of Diagnosis after final reconciliation was different by more than 1 month
Example: Date of Diagnosis after final reconciliation was different by less than 30 days
Example: There was no text documentation to identify the correct Date of Diagnosis — however, at the time of facility reconciliation sufficient text was provided to verify the dx date

Case Diagnosis Data Items

<table>
<thead>
<tr>
<th>Date of Dx &gt; 1 month</th>
<th>Date of Dx &lt; 1 month</th>
<th>Any Tumor Item Noted as Text</th>
<th>Laterality</th>
<th>Primary Sub Site Code</th>
<th>Morphology</th>
<th>Grade Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>CS Tumor Size/Extension</td>
<td>Tumor Size Value</td>
<td>Any Stage Item Noted as Text</td>
<td>CS Lymph Nodes</td>
<td># Regional Nodes Positive</td>
<td>CS Mets at Dx</td>
<td># Regional Nodes Examined</td>
</tr>
<tr>
<td>CS Tumor Size/Extension</td>
<td>Tumor Size Value</td>
<td>Any Stage Item Noted as Text</td>
<td>CS Lymph Nodes</td>
<td># Regional Nodes Positive</td>
<td>CS Mets at Dx</td>
<td># Regional Nodes Examined</td>
</tr>
</tbody>
</table>
Audit Technical Summary Report

- Tumor Size 000 (no evidence of primary tumor) vs. 999 (unk)
- Several Regional Lymph Node Issues
  - N1, N2 and N3 are ALL “regional lymph nodes”
  - Must look at whether hilar or mediastinal nodes – do not treat as same
  - Coding FNA of Regional Lymph Node in Scope of Reg Lymph Node Surgery
  - Coding Regional Lymph Nodes Examined / Regional Lymph Nodes Positive
  - Disconnect between Surgery of Primary Site Code 30 versus 33 and “regional” node definitions – often code 33 is for mediastinal node removal

Webcast: Lung Cancer Data Quality & Staging

- FCDS Webcast on 11/16/2017
- Lung Cancer Facts
- FCDS Audit Findings
- FCDS Audit Recommendations
- Review of Lung Anatomy for Staging
- Review of Lung Cancer Staging Issues
  - SS2000 and SS2018
  - AJCC 7th edition
  - AJCC 8th edition
  - SSFs - Site Specific Items Required for Staging
- Staging & Site Specific Items - Practice Cases
- Latest Research
- Q&A
2017 Audit Plan

- Genitourinary System
  - Kidney
  - Bladder
  - Prostate
- 2016 Diagnosis Year
- Analytic Cases Only
- ~65 Facilities
- ~500 cases
- Sample will include free-standing radiation therapy centers

- FOCUS: Grade Rules, MPH Rules, Staging, Treatment

2018 Updates to National Standards

- ICD-O-3 New Histology Codes
- ICD-O-3 Behavior Changes
- Solid Tumor MPH Rules & DB
- AJCC 8th edition
- SSF Items - Major Change
- New Treatment Items

- SS2018 & EOD 2018
- Gene Testing
- Biomarkers
- CAP Templates
- EDITSv18
- 'yp' & 'yc' TNM
Presentation Outline

- 2018 – A Year for Major Changes to Data Standards
- Major Changes to Site-Specific Data Items
- Many New Treatment Data Items
- Many New Staging Data Items
- 2018 Solid Tumor Rules
- 2018 Solid Tumors Database
- ICD-O-3 Code & Behavior Updates
- Updates to Reportable Cancers List
- Cancer Staging Updates
  - AJCC 8th ed. Implementation
  - SEER EOD 2018
  - SS2018
  - EDITS v18
- Medicare Beneficiary Identifier (MBI) replaces SSN for CMS Billing

Major Changes to Site-Specific Data Items

New Data Items – Old SSFs
New Codes & Instructions

- FIGO Stage
- Lymph Nodes Laterality.Vulva
- Lymph Nodes Laterality.Vagina
- Lymph Nodes Assessment Method Para-aortic.Vagina
- Lymph Nodes Assessment Method Pelvic.Vagina
- Lymph Nodes Assessment Method Femoral.Vagina
- Lymph Nodes Distant: Mediastinal, Scalene SSF 6.Vagina
- Lymph Nodes Distant: Mediastinal, Scalene SSF 7.Vagina
- Peritoneal Cytology.CorpUS
- Pelvic Nodes Number Positive SSF3.CorpUS
- Pelvic Nodes Number Positive SSF4.CorpUS
- Para-aortic Nodes Number Positive SSF 5.CorpUS
- Para-aortic Nodes Number Examined SSF 6.CorpUS
- CA 125 Pretreatment Value SSF1.Ovary

New Data Items – Old SSFs
New Codes & Instructions

- Prostate Pathological Extension SSF3-Prostate
- Gleason's Pattern Clinical SSF7-Prostate
- Gleason's Clinical Score SSF8-Prostate
- Gleason Pathological Patterns SSF9-Prostate
- Gleason Pathological Score SSF10-Prostate
- Gleason Tertiary Pattern SSF11-Prostate
- Number of Cures Positive SSF12-Prostate
- Number of Cures Examined SSF13-Prostate
- AFP Pre-Orchectomy Range SSF7.Testis
- hCG Pre-Orchectomy Range SSF9.Testis
- LDH Pre-Orchectomy Range SSF10.Testis
- AFP Post-Orchectomy Range SSF13.Testis
- hCG Post-Orchectomy Range SSF15.Testis
- LDH Post-Orchectomy Range SSF16.Testis

New Manual to Include ALL Site-Specific Data Items
New Optional Prognostic Data Items Not Approved Yet
Description of Test, Instructions and Codes
Many New Prognostic Site-Specific Fields

- HER2 ISH Dual Probe Ratio, new Draft, Breast 8th edition, CAP guidelines
- HER2 ISH Dual Probe Copy Number
- HER2 ISH Single Probe Copy Number
- Lymph Nodes Size of Metastasis, Head and Neck (Common SSF), SSF#1
- Bilirubin Pretreatment Total Lab Value, Liver, SSF #6
- Measured Basal Diameter, Uveal Melanomas, SSF #2
- Measured Thickness, Uveal Melanomas, SSF #3
- Extramedulillary Extension Clinical, Penis, SSF #17
- Extramedulillary Extension Pathological, Penis, SSF #17
- Microvascular Density, Uveal Melanomas, SSF #13
- Adenoid Cystic Basaloid Pattern, Lacrimal Gland, SSF #6
- Circumferential or Radial Resection Margin, Colon and Rectum, SSF #6
- Oncotype DX Recurrence Score-Invasive, Draft, Breast 8th edition, CAP guidelines
- Oncotype DX Recurrence Score-DCIS, Draft, Breast 8th edition, CAP guidelines
- Oncotype DX Risk Level-Invasive, Draft, Breast 8th edition, CAP guidelines
- Oncotype DX Risk Level-DCIS, Draft, Breast 8th edition, CAP guidelines
- Isolated Tumor Cells (ITC) in Regional Lymph Node(s), Merkel Cell Skin, SSF #18
- Profound Immune Suppression, Merkel Cell Skin, SSF #22
- Microsatellite Instability, Colon and Rectum, SSF #7
- KRAS, Colon and Rectum, SSF #9
- Kidney Tumor Extension, Kidney, SSF#1
- Major vein involvement, Kidney, SSF#7
- Ipsilateral Adrenal Gland Involvement, Kidney, SSF#3
- Sarcomatoid Features, Kidney, SSF#4
- JAK2, Heme Retic, SSF#1

Many New Treatment Data Items

<table>
<thead>
<tr>
<th>Radiation</th>
<th>Phase I Radiation Primary Treatment Volume (length 2)</th>
<th>Phase I Radiation to Draining Lymph Nodes (length 2)</th>
<th>Phase I Radiation Treatment Modality (length 2)</th>
<th>Phase I Radiation External Beam Planning Technique (length 2)</th>
<th>Phase I Dose Per Fraction (Session) (length 5)</th>
<th>Phase I Number of Fractions (Sessions) (length 3)</th>
<th>Phase I Total Dose (length 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Radiation Discontinued Early (Length 2)</th>
<th>Total Dose (length 6)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>FORDS Codes</th>
<th>STORE Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>00</td>
<td>No Radiation Treatment</td>
</tr>
<tr>
<td>21</td>
<td>01</td>
<td>External beam, photons, low energy</td>
</tr>
<tr>
<td>22, 23, 24, 25, 26, 27, 31, 41, 42, 43</td>
<td>02</td>
<td>External beam, photons, megavoltage</td>
</tr>
<tr>
<td>40</td>
<td>03</td>
<td>External beam, protons</td>
</tr>
<tr>
<td>38</td>
<td>04</td>
<td>External beam, electrons</td>
</tr>
<tr>
<td>30</td>
<td>05</td>
<td>External beam, neutrons</td>
</tr>
<tr>
<td>20</td>
<td>06</td>
<td>External beam, carbon ions</td>
</tr>
<tr>
<td>99</td>
<td>09</td>
<td>External beam, NOS</td>
</tr>
</tbody>
</table>

| 51          | 10         | Brachytherapy, intraosseous, LDR |
| 52          | 11         | Brachytherapy, intraosseous, HDR |
| 53          | 12         | Brachytherapy, Interstitial, LDR |
| 54          | 13         | Brachytherapy, Interstitial, HDR |
| 50          | 14         | Brachytherapy, electronic |
| 51          | 15         | Brachytherapy, NOS |
| 52          | 20         | Radioisotopes, Radium-223 |
| 86          | 21         | Radioisotopes, Strontium-89 |
| 62          | 22         | Radioisotopes, Strontium-90 |
| 55          | 29         | Radioisotopes, NOS |
| 98          | 98         | Other, NOS |
| 99          | 99         | Unknown |
FORDS to StORE Code Conversions

2018 Solid Tumor Rules

- Text Only – no flowchart or matrix
- Updates to Existing Solid Tumor Rules
- Takes into account problems from 2007 MPH Rules
- Takes into account WHO Classification Updates
- Takes into account new WHO Classification, 4th ed.
2018 Solid Tumors Database

- Genetics Data & Biomarkers
- Treatment(s)
- Abstractor Notes
- Signs & Symptoms
- Diagnostic Exams
- Recurrence & Metastasis
- Epidemiology & Mortality

STDB Example: Metaplastic Ca

Help me code for diagnosis year: 2001 and later

Site Category
Breast

Definition
Metaplastic carcinoma encompasses a group of neoplasms characterized by differentiation of the neoplastic epithelium into squamous cells and/or mesenchymal-looking elements, including but not restricted to spindle, chondroid, osseous, and rhabdomyoid cells. These neoplasms may be either entirely composed of metaplastic elements, or a complex admixture of carcinoma and metaplastic areas.

Differential diagnosis:
- Mucinous carcinoma: may have ducts with prominent mucin-secreting at periphery, diffusely S100+
- Myofibroblastic tumor
- Phyllodes tumor
- Primary breast sarcoma: no epithelial elements or keratin+ elements
ICD-O-3 Code & Behavior Updates

WHO Classification of Tumors
New or Revised Since 2010

- Digestive System (2010)
- Breast (2012)
- Soft Tissue and Bone (2013)
- Female Reproductive Organs (2014)
- Lung, Pleura, Thymus & Heart (2015)
- Urinary System & Male Genital (2016)
- Central Nervous System (2016 revision)
- Hematopoietic & Lymphoid (2016 revision)
- Head & Neck (2017)

http://codes.iarc.fr/usingicdo.php
ICD-O-3 Code & Behavior Updates

- 24+ NEW proposed ICD-O Codes
- 16+ Changes to Behavior Codes
- 54+ Preferred Names / Alternate Names
- Previously non-reportable GI terms now Reportable
- Thymoma – no longer must state “malignant”
### ICD-O-3 Updates - Breast

<table>
<thead>
<tr>
<th>Change</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>New behavior code</td>
<td>8507/3</td>
<td>Invasive micropapillary carcinoma</td>
</tr>
<tr>
<td>New behavior code</td>
<td>8983/3</td>
<td>Adenomyoepithelioma with carcinoma</td>
</tr>
<tr>
<td>New code</td>
<td>8519/2</td>
<td>Pleomorphic lobular carcinoma in situ</td>
</tr>
<tr>
<td>New behavior code</td>
<td>8460/2</td>
<td>Serous borderline tumor-micropapillary variant</td>
</tr>
<tr>
<td>New behavior code</td>
<td>8460/2</td>
<td>Non-invasive low grade serous carcinoma</td>
</tr>
<tr>
<td>New related term</td>
<td>8503/2</td>
<td>Intraductal papilloma with ductal carcinoma in situ</td>
</tr>
<tr>
<td>New code</td>
<td>8509/2</td>
<td>Solid papillary carcinoma in situ</td>
</tr>
<tr>
<td>New code</td>
<td>8509/3</td>
<td>Solid papillary carcinoma with invasion</td>
</tr>
<tr>
<td>New related term</td>
<td>8503/3</td>
<td>Invasive papillary carcinoma</td>
</tr>
</tbody>
</table>

### ICD-O-3 Updates - Lung

<table>
<thead>
<tr>
<th>Change</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>New related term</td>
<td>851/3</td>
<td>Acinar adenocarcinoma</td>
</tr>
<tr>
<td>New behavior code</td>
<td>8209/2</td>
<td>Minimally invasive adenocarcinoma, non-mucinous</td>
</tr>
<tr>
<td>New code</td>
<td>8257/3</td>
<td>Minimally invasive adenocarcinoma, mucinous</td>
</tr>
<tr>
<td>New code</td>
<td>803/3</td>
<td>NUT carcinoma</td>
</tr>
<tr>
<td>New behavior code</td>
<td>8482/3</td>
<td>Pulmonary Myxoid sarcoma with EWSR1-CREB1 translocation</td>
</tr>
<tr>
<td>New code</td>
<td>9086/3</td>
<td>Germ cell tumor with associated hematological malignancy</td>
</tr>
<tr>
<td>New related term</td>
<td>8259/3</td>
<td>Lepidic adenocarcinoma</td>
</tr>
<tr>
<td>New related term</td>
<td>8253/3</td>
<td>Invasive mucinous adenocarcinoma</td>
</tr>
<tr>
<td>New related term</td>
<td>8243/3</td>
<td>Mixed invasive mucinous &amp; non-mucinous adenocarcinoma</td>
</tr>
<tr>
<td>New term/behavior</td>
<td>8410/2</td>
<td>Adenocarcinoma in-situ, non-mucinous</td>
</tr>
<tr>
<td>New term/behavior</td>
<td>8253/2</td>
<td>Adenocarcinoma in-situ, mucinous</td>
</tr>
<tr>
<td>See comment</td>
<td>814/2</td>
<td>Adenocarcinoma in-situ</td>
</tr>
<tr>
<td>New code</td>
<td>8265/3</td>
<td>Micropapillary adenocarcinoma</td>
</tr>
<tr>
<td>New related term</td>
<td>8580/3</td>
<td>Metaplastic thymoma</td>
</tr>
<tr>
<td>New related term</td>
<td>8581/3</td>
<td>Type A thymoma</td>
</tr>
<tr>
<td>New related term</td>
<td>8590/3</td>
<td>Type A8 thymoma</td>
</tr>
<tr>
<td>New related term</td>
<td>8593/3</td>
<td>Type B1 thymoma</td>
</tr>
<tr>
<td>New related term</td>
<td>8594/3</td>
<td>Type B2 thymoma</td>
</tr>
<tr>
<td>New related term</td>
<td>8585/3</td>
<td>Type B3 thymoma</td>
</tr>
<tr>
<td>New related term</td>
<td>8590/3</td>
<td>Sclerosing thymoma</td>
</tr>
</tbody>
</table>
Updates to Reportable Cancers List

<table>
<thead>
<tr>
<th>Code</th>
<th>Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>8507/3</td>
<td>Invasive micropapillary carcinoma</td>
</tr>
<tr>
<td>8563/3</td>
<td>Adenomyoepithelioma with carcinoma</td>
</tr>
<tr>
<td>8460/3</td>
<td>Serous borderline tumor-micropapillary variant</td>
</tr>
<tr>
<td></td>
<td>Non-invasive low grade serous carcinoma</td>
</tr>
<tr>
<td>8441/2</td>
<td>Serous tubal intraepithelial carcinoma</td>
</tr>
<tr>
<td>8489/2</td>
<td>Atypical hyperplasia/Endometrioid intraepithelial neoplasia</td>
</tr>
<tr>
<td>8825/3</td>
<td>Low-grade myofibroblastic sarcoma</td>
</tr>
<tr>
<td>8842/3</td>
<td>Ossifying fibromyxoid tumor, malignant</td>
</tr>
<tr>
<td>8111/1</td>
<td>Myxoinflammatory fibroblastic sarcoma (MIFS)</td>
</tr>
<tr>
<td>8250/2</td>
<td>Minimally invasive adenocarcinoma, non-mucinous</td>
</tr>
<tr>
<td>8842/3</td>
<td>Pulmonary Myxoid sarcoma with EWSR1-CREB1 translocation</td>
</tr>
<tr>
<td>8311/3</td>
<td>Hereditary leiomyomatosis &amp; RCC-associated RCC</td>
</tr>
<tr>
<td></td>
<td>MIT Family translocation renal cell carcinoma (Important note: this histology IS NOT a synonym for hereditary leiomyomatosis &amp; RCC assoc RCC also coded 8811/3)</td>
</tr>
<tr>
<td>8071/2</td>
<td>Differentiated penile intraepithelial neoplasia</td>
</tr>
<tr>
<td>8410/2</td>
<td>Adenocarcinoma in-situ, non-mucinous</td>
</tr>
<tr>
<td>8253/2</td>
<td>Adenocarcinoma in-situ, mucinous</td>
</tr>
<tr>
<td>8620/3</td>
<td>Adult granulosa cell tumor</td>
</tr>
<tr>
<td>9341/3</td>
<td>Clear cell odontogenic carcinoma</td>
</tr>
<tr>
<td>9302/3</td>
<td>Ghost cell odontogenic carcinoma</td>
</tr>
</tbody>
</table>

ICD-11 and ICD-O-4

- ICD-10 is nearly 30 years old (1989 release)
- ICD-11 early release in 2017 (beta version)
- ICD-11 used for Death Certificates in 2018 (NCHS)
- ICD-11 uses ICD-10 as foundation + more detail
- 100% electronic will replace paper version

- ICD-O-4 in review starting in 2017
- ICD-O-4 will be compatible with ICD-11
  - Topography
  - Morphology
  - Laterality
  - Grade
  - Stage
  - Genetic Profile
  - More
AJCC 8th ed. Implementation

- AJCC Staging Manual, 8th edition
- New Required for Staging Site Specific Fields
- New Format for ALL Staging Site Specific Fields
- AJCC TNM Electronic Tools - API
- AJCC TNM API Availability, Licensing and Fees

Many New Staging Data Items

- Summary Stage 2018 (SS2018) – Direct-Coded Stage
- New EOD Coding System - SEER EOD 2018 Data Items
  - Tumor Size Clinical
  - Tumor Size Pathologic
  - EOD Primary Tumor
  - EOD Regional Nodes
  - EOD Mets
- New Site-Specific Data Items – old SSFs + new SSFs
- New Derived Stage Data Items
  - Derived SS2018
  - Derived EOD TNM 8th T
  - Derived EOD TNM 8th N
  - Derived EOD TMM 8th M
  - Derived EOD TNM 8th Stage Group – result is a mixed stage
Medicare Beneficiary Identifier (MBI)

SUBJECT: Social Security Number Removal Initiative (SSNRI)

The Centers for Medicare & Medicaid Services (CMS) is issuing this Informational Bulletin to inform states about the SSNRI. Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 (PL 114-10) on April 16, 2015. Section 501 of MACRA requires CMS to remove Social Security Numbers from Medicare ID cards and replace existing Medicare Health Insurance Claim Numbers (HICNs) with a Medicare Beneficiary Identifier (MBI). The MBI will be a randomly generated identifier that will not include a social security number or any personally identifiable information (PII). This step is being taken to minimize the risk of identity theft for Medicare beneficiaries and reduce opportunities for fraud. To comply with this statutory requirement, starting in early 2018, CMS will issue new Medicare cards with an MBI to approximately 60 million Medicare beneficiaries, including Dual Eligibles. A HICN will still be assigned to each Medicare beneficiary will still be used for internal data exchanges between CMS and the states, but the new MBI must be used in all interactions with the beneficiary, the provider community and all external partners.
2016 Jean Byers Award

• 2016 award for 2014 data awarded in 2017!
• Criteria for the award:
  • All deadlines met with respect to the 2014 cancer case admissions
    • b. Consolidated Follow Back Deadline – October 15, 2016
    • c. No more than 5% (or 35 cases, whichever number is greater) of the 2014 cancer case admissions reported to FCDS within 2 months (60 days) following the June 30, 2015 deadline.
    • d. No more than 10% of the 2014 cancer case admissions reported to FCDS within 12 months following the June 30, 2015 reporting deadline.

2016 Jean Byers Award

• Jean Byers Award: 91 Recipients
• Pat Strait Award: 211 Recipients

GREAT JOB!!!!
2016 Jean Byers Award

• Special Recognition
  • These facilities have won the award all 19 years
  • 2736 Baptist Hospital of Pensacola
  • 6203 Edward White Hospital

2017-2018 Education & Training Plan

• SS2018 & EOD
• Gene Testing
• Biomarkers
• CAP Templates

• ICD-O-3 Updates
• MPH Rules Updates
• AJCC 8th edition
• SSF Changes
2017-2018 Education & Training Plan

- FCDS Annual Meeting
- FCDS Webcast Schedule

- NAACCR Webinar Schedule
- NAACCR Webinar Host Sites
- NAACCR CTR Prep Webinars

- AJCC TNM 8th Edition & SSFs
- 2018 ICD-O-3 Updates for United States
- SEER 2018 MPH Rules - Solid Tumors

- FLccSC Transition
  - FCDS On-Line Educational Courses
  - FCDS Abstractor Code Testing
  - FCDS Webcast Series

FCDS Staff
In-Services for ALL Field Coordinators and Quality Control Staff

FCDS Annual Meeting

Welcome
We’re Glad You Are Here

2017 FCDS Annual Meeting

July 26-27, 2017
Wyndham Grand Orlando Resort at Bonnet Creek
Orlando, Florida
2017-2018 FCDS Webcast Schedule

<table>
<thead>
<tr>
<th>Date</th>
<th>Time Schedule 3rd Thursday</th>
<th>Presentation Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/17/2017</td>
<td>1:00pm – 3:00pm</td>
<td>Convention Brief: 2017 FCDS Annual Meeting Highlights</td>
</tr>
<tr>
<td>9/21/2017</td>
<td>1:00pm – 3:00pm</td>
<td>Biomolecular and Genetic Tumor Profiles: Classification and Characteristics of Disease, Required SSFs, CAP Biomarker Checklists, and Targeting Treatment</td>
</tr>
<tr>
<td>10/19/2017</td>
<td>1:00pm – 3:00pm</td>
<td>Lymphoid &amp; Myeloid Neoplasms: 2016 Revision of the WHO Classification &amp; You</td>
</tr>
<tr>
<td>11/16/2017</td>
<td>1:00pm – 3:00pm</td>
<td>Lung Cancer: FCDS Audit Findings, Anatomy, Staging Using the AJCC 8th ed., SSF Req’d to Stage</td>
</tr>
<tr>
<td>December</td>
<td>N/A</td>
<td>No Webcast Scheduled</td>
</tr>
<tr>
<td>1/18/2018</td>
<td>1:00pm – 3:00pm</td>
<td>2018 MPH Rules: MPH Rule Updates for Solid Tumors and Introduction to the Solid Tumors Database</td>
</tr>
<tr>
<td>2/15/2018</td>
<td>1:00pm – 3:00pm</td>
<td>AJCC Cancer Staging Manual 8th ed. and Summary Stage 2018</td>
</tr>
</tbody>
</table>

NAACCR Webinar Host Sites

- 7 FCDS-Hosted Sites
- Geographically Dispersed
- Registration Requested
- Encourage Attendance
- Recordings Available
- 3 CEUs per Webinar
- No Cost to Registrar/Host
NAACCR Webinar Recordings

- Available 24/7 on FCDS Website
- No Registration is Required
- Terms of Use Agreement
- Florida Registrars Only
- Password Protected
- Do Not Distribute
- All Materials
- CEUs

2017-2018 NAACCR Webinar Schedule

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Presentation Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/5/2017</td>
<td>9:00am</td>
<td>Collecting Cancer Data: Prostate</td>
</tr>
<tr>
<td>11/2/2017</td>
<td>9:00am</td>
<td>Collecting Cancer Data: Larynx</td>
</tr>
<tr>
<td>12/7/2017</td>
<td>9:00am</td>
<td>Collecting Cancer Data: Uterus</td>
</tr>
<tr>
<td>1/4/2018</td>
<td>9:00am</td>
<td>Collecting Cancer Data: GIST and Soft Tissue Sarcomas</td>
</tr>
<tr>
<td>2/1/2018</td>
<td>9:00am</td>
<td>Collecting Cancer Data: Stomach and Esophagus</td>
</tr>
<tr>
<td>3/1/2018</td>
<td>9:00am</td>
<td>Abstracting and Coding Boot Camp: Cancer Case Scenarios</td>
</tr>
<tr>
<td>4/5/2018</td>
<td>9:00am</td>
<td>Collecting Cancer Data: Pancreas</td>
</tr>
<tr>
<td>5/3/2018</td>
<td>9:00am</td>
<td>Directly Coded Stage</td>
</tr>
<tr>
<td>6/7/2018</td>
<td>9:00am</td>
<td>Collecting Cancer Data: Thyroid and Adrenal Gland</td>
</tr>
<tr>
<td>7/12/2018</td>
<td>9:00am</td>
<td>Hospital Cancer Registry Operations - Topic TBD</td>
</tr>
<tr>
<td>8/2/2018</td>
<td>9:00am</td>
<td>Multiple Primary and Histology Rules</td>
</tr>
<tr>
<td>9/6/2018</td>
<td>9:00am</td>
<td>Coding Pitfalls</td>
</tr>
</tbody>
</table>
NAACCR CTR Prep Webinars

- The NAACCR CTR Exam Preparation & Review Webinar Series offers online instruction with experienced faculty. The course includes eight 2-hour sessions, sample CTR Exam and a follow-up post exam session. All sessions are recorded and available for playback 24/7 via Drop Box.

- Individual Subscription for the Series is $400 – includes “live” sessions

- FCDS picks up the $400 fee for any Florida candidate CTR
  - This is NOT a Beginner Abstracting Course
  - Candidate CTRs must be planning to write the CTR Exam
  - Florida candidate CTRs must view recordings as part of agreement
  - This allows you to watch each session whenever time allows
  - All Course Materials including Sample CTR Exam are included
  - Contact and Feedback from Course Instructors is included
  - Next CTR Exam Prep and Review Series begins in mid-August

AJCC TNM 8th ed. – Webinars & Self-Instruction

AJCC Manual Chapter and Cancer-Specific Training Webinars – Schedule TBA

https://cancerstaging.org/CSE/Registrar/Pages/AJCC-Curriculum.aspx
SEER Instruction – 2018 Solid Tumor Rules

**FLccSC Transition**

- Direct Access through FCDS IDEA
- Direct Interface to FCDS IDEA for FCDS Abstractor Code
- FCDS Abstractor Code Test will produce a Certificate
- All New plus Updated ABC Course will produce Certificates
- CEU Tracking System will be replaced by Certificates
- FCDS Webcast CEUs – 5 Question Quiz For Certificate
- Questions will go into the FCDS Abstractor Code Test Q&A’s
- Major Revisions to ABC Course for 2018 Standards Updates
Review of ALL Q&A and References
Transition FCDS Abstractor Code Test to FLccSC Learning

Q&A Added – ICD-O-3 Updates, 2018 MPH Rules, AJCC TNM 8th ed.
SSFs Q&A Added - New Biomolecular and Genetic Tests

HOW TO USE THE AJCC CANCER STAGING MANUAL, 8TH EDITION

FCDS Annual Educational Conference
Orlando, Florida
July 28, 2017
Steven Peace, CTR
Purchase and Ordering Information

• COST:  $119.99
• ISBN: 978-3-319-40617-6
  • 1429 pages
  • 512 illustrations
  • 187 color illustrations
• Required - Florida Mandate
  • FCDS will not purchase
  • Facility may purchase
  • Individual may purchase
• https://cancerstaging.org
• http://springer.com
• 1-800-SPRINGER

Intro to AJCC Staging Manual, 8th ed.

• Enhanced Chapter 1 – Principles of Cancer Staging
• Enhanced Descriptions of Staging Rules – Chapter 1
  • Timing for Staging
  • Clinical Staging Criteria and General Rules
  • Pathologic Staging Criteria and General Rules
  • Rules for Assigning T, N, and M Category Codes
  • Rules for Determining Prognostic Stage Group
  • Timing and Criteria for Post-Therapy Staging (yc/yp)
• 12 new staging systems
• 83 total chapters defined by site/subsite and specific histologies
• New Site-Specific Fields – no more “factors” – but similar instructions and codes
Intro to AJCC Staging Manual, 8th ed.

- New Sections or Features within Chapters
  - AJCC Levels of Evidence for Changes to Staging Criteria
  - Guidance on the Use of Imaging to Evaluate Stage for Each Chapter
  - Prognostic Factors
    - Factors Required to Assign Prognostic Stage Group
    - Factors Recommended for Managing Patient Care
    - Emerging Factors
  - Risk Assessment Models
  - Clinical Stratification Recommendations

- Chapter-Specific Histology Codes – No longer uses range of acceptable codes –
- Histology Code List updated with 2018 MPH Rules to ensure all new for 2018 histology codes are included in appropriate chapter(s) – and to keep up with WHO Classifications

AJCC 8th Edition Staging Rules – Chapter 1

- Entire 30 pages devoted to Staging Rules and is Table-Driven with User Notes
- Definitions are included for vocabulary related to cancer staging
- Clarification on Use of “X”, <blank> and Zero (0)
- Clarification on Use of Clinical & Pathological Stage Descriptors
- Clarification on “Response to Neoadjuvant Therapy”
- Explanation for How to Apply Tables to Assign New Prognostic Stage Groups
- AJCC will be hosting webinar(s) on Key Elements of Chapter 1 – General Rules
- 2018 FCDS Abstractor Code Test Absolutely WILL Have Questions from Chapter 1
Importance of Cancer Genomics - NCI

- **Cancer is a genetic disease.**
- Cancer genomics research contributes to precision medicine by defining cancer types and subtypes based on their genetics and identify targets for new medicines.
- "targeted therapies" specifically combat characteristics of cancer cells that are different from normal cells of the body. This makes them less likely to be toxic for patients compared to other treatments such as chemotherapy and radiation that can kill normal cells.
- How do "targeted therapies" work?
  - Inhibit enzymes that trigger the abnormal growth and survival of cancer cells
    - Imatinib (Gleevec) inhibits overactivity of protein Bcr-ABL tyrosine kinase in leukemia patients
  - Block aberrant gene expression characteristic of cancer cells
    - Trastuzumab (Herceptin) controls hyperactive signaling pathway (HER2 tyrosine kinase) - breast
  - Halt molecular signaling pathways that are in overdrive in cancer cells
    - Erlotinib (Tarceva) and gefitinib (Iressa) both restrict activation of a protein (EGFR) in lung cancers
Site-Specific Fields Required for Staging

- Each Chapter includes the Site-Specific Fields Required for Staging (if any)
- You MUST also document ALL Site-Specific Field Values/Results in TEXT
- You MUST look for these tests and results – they are really important!
- Analytic Cases MUST include valid entries in these critical fields
- Non-Analytic Cases SHOULD include valid entries as available
- FCDS will monitor overuse of 999 default values
- Include same tests as CS SSFs for some cancers
- Instructions and Codes may differ from CS
- Field Length and Location of Decimal
- Site-Specific Fields Manual Pending
- Other – age, LVI, LN +/- exam, T Size

Site-Specific Fields – Emerging Factors

Identification of and Testing for Next Generation Biomarkers, Genetic Tests and Multi-Gene Profiles and Establishing Data Collection Standards for Emerging SSFs
Determining Prognostic Stage Groups

- MUST MEET THE CRITERIA FOR STAGING TO BE STAGED
- Verify ALL Required Variables Have Been Coded
- Clinical Prognostic Stage Group
- Pathological Prognostic Stage Group
- Response to Neoadjuvant Therapy (yp/yc)
- Proper Use of Clinical and Pathological Descriptor Fields

Helpful Information
https://cancerstaging.org
NEW SITE-SPECIFIC FIELDS “REQUIRED FOR STAGING” AJCC 8TH ED.

FCDS Annual Educational Conference
Orlando, Florida
July 28, 2017
Steven Peace, CTR

Required/Clinically Relevant/Investigational

Questions that can be answered by cancer biomarkers:
- Prognostic
- Diagnostic
- Predictive
- Pharmacodynamic
- Recurrence
- What's the optimal drug for my body?
- Will the cancer recur?

HOST FACTORS
Molecular dysfunction, genomics, and functional genomics
HEPATOCELLULAR CARCINOMA
Using Required SSFs to Assign Stage Group

Locating SSFs in AJCC Staging Manual, 8th ed.

Chapter Specific Prognostic Factors Section in Chapter Registry Data Collection Variables Listed in Chapter
New SSFs - Shared Across Chapters

AJCC Grade Clinical
AJCC Grade Pathologic
[16] Esophagus and Esophagogastric Junction
[15] Appendix – Carcinoma
[18] Bone (appendicular skeleton, spine, and pelvis)
[40] Soft Tissue Sarcoma of the Head and Neck
[41] Soft Tissue Sarcoma of the Trunk and Extremities
[42] Soft Tissue Sarcoma of the Abdomen and Thoracic Visceral Organs
[45] Soft Tissue Sarcoma – Unusual Histologies and Sites
[28] Breast

AJCC GIST Mitotic Count Clinical
AJCC GIST Mitotic Count Pathologic

AJCC Oropharyngeal p16
[10] HPV-Mediated (p16+) Oropharyngeal Cancer
[4] Oropharynx (p16−) and Hypopharynx

Revised LVI
All

163

New SSFs - Required to Assign Stage Group

AJCC Grade Clinical
AJCC Grade Pathologic
[16] Esophagus and Esophagogastric Junction
[15] Appendix – Carcinoma
[18] Bone (appendicular skeleton, spine, and pelvis)
[40] Soft Tissue Sarcoma of the Head and Neck
[41] Soft Tissue Sarcoma of the Trunk and Extremities
[42] Soft Tissue Sarcoma of the Abdomen and Thoracic Visceral Organs
[45] Soft Tissue Sarcoma – Unusual Histologies and Sites
[28] Breast

AJCC GIST Mitotic Count Clinical
AJCC GIST Mitotic Count Pathologic

AJCC Oropharyngeal p16
[10] HPV-Mediated (p16+) Oropharyngeal Cancer
[4] Oropharynx (p16−) and Hypopharynx

Revised LVI
All

164
What if the Required SSF Info is Missing?

Recipe Includes Ingredients AND Instructions

Coffee Cake with Streusel Topping

- 1 cup sugar
- 1 tsp. baking powder
- 1/2 tsp. salt
- 3/4 cup butter

For the topping:
- 2 cups flour
- 1/4 cup sugar
- 1 tsp. baking powder
- 1/2 tsp. baking soda
- 1/2 tsp. cinnamon
- 1/4 tsp. salt
- 1/2 cup brown sugar
- 1/4 cup butter
- 1/4 cup milk

Cake will be fine without using baking power – right?

I am in a hurry – Can I bake the cake @ 500° for 15 min?

No Substitutions

---

FCDS Prognostic Factors Webcast – 9/21/17

<table>
<thead>
<tr>
<th>Date</th>
<th>Time Schedule</th>
<th>Presentation Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/17/2017</td>
<td>1:00pm – 3:00pm</td>
<td>Convention Brief: 2017 FCDS Annual Meeting Highlights</td>
</tr>
<tr>
<td>9/21/2017</td>
<td>1:00pm – 3:00pm</td>
<td>Bioregulatory and Genetic Tumor Profiles: Classification and Characteristics of Disease, Required SSF, CAP Biomarker Checklists, and Targeting Treatment</td>
</tr>
<tr>
<td>10/5/2017</td>
<td>1:00pm – 3:00pm</td>
<td>Lymphoid &amp; Myeloid Neoplasms: 2016 Revision of the WHO Classification &amp; You</td>
</tr>
<tr>
<td>11/16/2017</td>
<td>1:00pm – 3:00pm</td>
<td>Lung Cancer: FCDS Audit Findings, Anatomy, Staging Using the AJCC 8th ed., 8SF Res’l’d to Stage</td>
</tr>
<tr>
<td>December</td>
<td>N/A</td>
<td>No Webcast Scheduled</td>
</tr>
<tr>
<td>1/18/2018</td>
<td>1:00pm – 3:00pm</td>
<td>2018 MPN Rules: MPN Rule Updates for Solid Tumors and Introduction to the Solid Tumors Database</td>
</tr>
<tr>
<td>2/15/2018</td>
<td>1:00pm – 3:00pm</td>
<td>AJCC Cancer Staging Manual 8th ed., and Summary Stage 2018</td>
</tr>
</tbody>
</table>
NPCR Release of EDITS 5.0 Tools

- **EDITS 4.0** – Uses .EMF and .RMF formats
- **EDITS 5.0** – Uses .SMF (SQLite) format for all tools including: Edit Engine, EditWriter, GenEDITS Plus
  - The Edit Engine runs edits more than twice as fast as the EDITS4.0 version.
  - The EDITS metafile is a SQLite database.
  - The EDITS5.0 API documentation are more powerful and easier to use.
- **EditWriter 5.0** – New Features
  - Edit logic syntax checker catches more errors and issues warnings
  - Edit set form generates a GenEDITS-style report
  - Table form supports copy/paste data from Excel-type spreadsheet
  - Import metafile module performs analysis of differences in 1-2 seconds (previous version took 20-30 min for analysis)
- **GenEDITS Plus 5.0** – New Features
  - Multiple-document interface allows opening multiple concurrent configurations.
  - EDITS run-time debugger lets power users drill down into the reasons a case passed or failed an edit unexpectedly.
  - Writes the results of the run into a SQLite database, available for ad hoc querying.
  - GenEDITS.dll and API simplify programming for custom software to process incoming data files at central registries.
How to “Figure Out” What/Where Error Is

Example 2 – Site/Histology Code Makes a Difference

Larynx, NOS (C32.9) – Any Histology

Glottis (C32.0) – Any Histology
### Example 2 – Site/Histology Code Makes a Difference

<table>
<thead>
<tr>
<th>Appendix - Carcinoid, NOS</th>
<th>Appendix – Goblet Cell Carcinoid Mucinous/Non-Mucinous Tumor Grade</th>
</tr>
</thead>
</table>

### Example 3 – Site-Specific Field(s) Make a Difference
Outline

- Revised Common Rule and Cancer Surveillance
- 2017 Incidence & Mortality Estimates
- AACR Cancer Progress Report 2016
- National Toxicology Program - 14th Report on Carcinogens
- ASCO 2017 Clinical Cancer Advances
- NCCN Annual Report 2016 – At Our Core
- Explosion of Data / Fragmented Data Sources
- CAP Solid Tumor Selected Tests by Tumor Type
- New Diagnostic Tools & Techniques
- Next Generation Genomic Sequencing
- Next Generation Immuno & Precision Therapies
- Questions
ASCO 2017 Clinical Cancer Advances

Financial Toxicity and Cancer Treatment

Colon Tumor Location and Treatment

Median Overall Survival by Tumor Location and Therapy

<table>
<thead>
<tr>
<th></th>
<th>Left-Sided Tumors</th>
<th>Right-Sided Tumors</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Patients</td>
<td>33.3 months</td>
<td>19.4 months</td>
</tr>
<tr>
<td>Patients Treated with Cetuximab</td>
<td>36 months</td>
<td>16.7 months</td>
</tr>
<tr>
<td>Patients Treated with Bevacizumab</td>
<td>31.4 months</td>
<td>24.2 months</td>
</tr>
</tbody>
</table>

Although patients whose tumors originated in the left colon lived substantially longer after treatment than patients whose tumors originated in the right colon, the survival improvement for patients treated with cetuximab was more pronounced. And patients with right-sided tumors had better outcomes when treated with bevacizumab.

Liquid Biopsy

- Liquid biopsy is a minimally invasive technology for detection of molecular biomarkers without the need for costly or invasive procedures.
- Circulating cancer cells or traces of the cancer’s RNA or DNA in the blood can give clues about which treatments are likely to work for a patient.
- Circulating nucleic acids are protected by extracellular micro-vesicles, mainly exosomes.
- Exosomes are cell-derived vesicles that are present in many and perhaps all eukaryotic fluids, including blood, urine, and cultured medium of cell cultures.
- Exosomes maintain specified “compartments” of micro and macro molecules. Cancers create an expulsion of key proteins and microRNAs resulting in mis-expression of intracellular molecules which in turn interrupt cancer’s intra and extra cellular communications pathways.
### Update on NCI MATCH Trial & SubProtocols

**Molecular Analysis for Therapy Choice**

<table>
<thead>
<tr>
<th>Sub Protocol</th>
<th>Mutation</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>A431 - A</td>
<td>Solid tumors in patients with activating mutations of EGFR</td>
<td>Standard EGFR inhibitor, Erlotinib EGFR TKI, Erlotinib 450mg QD PO</td>
</tr>
<tr>
<td>A431 - B</td>
<td>EGFR activating</td>
<td>Erlotinib 450mg QD PO</td>
</tr>
<tr>
<td>A431 - C</td>
<td>Tumor with MET amplification</td>
<td>Crizotinib 250mg BD PO</td>
</tr>
<tr>
<td>A431 - D</td>
<td>Tumor with MET Exon 14 deletion</td>
<td>Crizotinib 250mg BD PO</td>
</tr>
<tr>
<td>A431 - E</td>
<td>Tumor with EGFR V800L mutation in exon 20 of EGFR</td>
<td>Standard EGFR TKI, Erlotinib 450mg QD PO</td>
</tr>
<tr>
<td>A431 - F</td>
<td>Tumor with AXL amplification</td>
<td>Standard EGFR TKI, Erlotinib 450mg QD PO</td>
</tr>
<tr>
<td>A431 - G</td>
<td>ROS1 Translocations or Trametinib</td>
<td>Standard EGFR TKI, Erlotinib 450mg QD PO</td>
</tr>
<tr>
<td>A431 - H</td>
<td>BRAF mutation or V600E mutation</td>
<td>Standard EGFR TKI, Erlotinib 450mg QD PO</td>
</tr>
<tr>
<td>A431 - I</td>
<td>HER2 amplification or 3+ HER2 expression</td>
<td>Pertuzumab 840mg IV Q3W, Trastuzumab 6mg/kg BD PO</td>
</tr>
<tr>
<td>A431 - J</td>
<td>HER2 amplification in Caspase-3-negative cells</td>
<td>Pertuzumab 840mg IV Q3W, Trastuzumab 6mg/kg BD PO</td>
</tr>
</tbody>
</table>

**Questions**

*NCRA CLEU#32288*

Total Conference CLEU = 8.5 hours

Category A CLEU = 3.75 hours

*STAY FOCUSED*