# FCDS Text and Documentation Requirements: A Key Component to Providing High Quality Data

## 2011 FCDS Educational Webcast Series

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THE FLORIDA DEPARTMENT OF HEALTH

FCDS Florida Cancer Data System
A Joint Project of the Sylvester Comprehensive Cancer Center and the Florida Department of Health

UMSylvester
Comprehensive Cancer Center

# CDC-NPCR Requirement

- The National Program of Cancer Registries (NPCR) requires that documentation accompany all cases sufficient to substantiate the coding of key data items
- There MUST be documentation to support codes
- FCDS plans closer monitoring and tighter review requirements beginning with all 2011 cases
- **Why is text needed within an abstract ?**

# NAACCR Requirement

- Text documentation is an essential component of a complete electronic abstract
- Heavily utilized
  - Visual Editing / QC Review
  - Record Consolidation / Validation of Data
  - Other Central Registry Quality Control
  - National Program Quality Control
  - Research Studies
  - Other Studies

*NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Chapter X: Data Dictionary*

# Data Quality Assessment

- Data Validation
- Reabstracting studies
- Visual Review
  - Quality Control Sampling Reports (One of Every 25th Record)
  - Has become critical to central registry operations
- Edits and Edit Overrides (Forces)
  - Edits test the logical effects of coding rules
  - Edit Overrides (Forces) allow unique case data to pass edits

*NAACCR Standards for Cancer Registries Volume III: Standards for Completeness, Quality, Analysis, and Management of Data,*

# Text by Registrars

- Registrars do not always supply sufficient text to substantiate the coding of many of the required key data items – especially the new CS and SSF items

- "NA" or "NR" is often used when text is required but data or explanatory text is not available.

- Blanks just don't cut it.  If unknown – tell us.

*NAACCR Standards for Cancer Registries Volume III: Standards for Completeness, Quality, Analysis, and Management of Data,*

# NAACCR Guidelines for Text

- The text field must contain a description that has been entered by the abstractor independently from the codes – not as repetition – but as explanation & validation that coding and interpretation is correct

- If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values – repetition not validation

- PLEASE - NO AUTOCODING

*NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Chapter X: Data Dictionary*

# Your Text Should Tell a Story

# Fields Requiring Text

| Patient Demographics |
| --- |
| Text – Usual Occupation |
| Text – Usual Industry |

| Diagnosis and Staging |
| --- |
| Text – DX Proc PE |
| Text – DX Proc X-ray/ Scan |
| Text – DX Proc Scopes |
| Text – DX Proc Lab Tests |
| Text – DX Proc Operative Report |
| Text – DX Proc Pathology Report |
| Text – Staging |
| Text – Remarks |

| Tumor Information |
| --- |
| Text – Place of Diagnosis |
| Text – Primary Site Title |
| Text – Histology Title |

| Treatment |
| --- |
| RX Text – Surgery |
| RX Text – Radiation (Beam) |
| RX Text – Chemotherapy |
| RX Text – Hormone |
| RX Text – BRM |
| RX Text – Other |

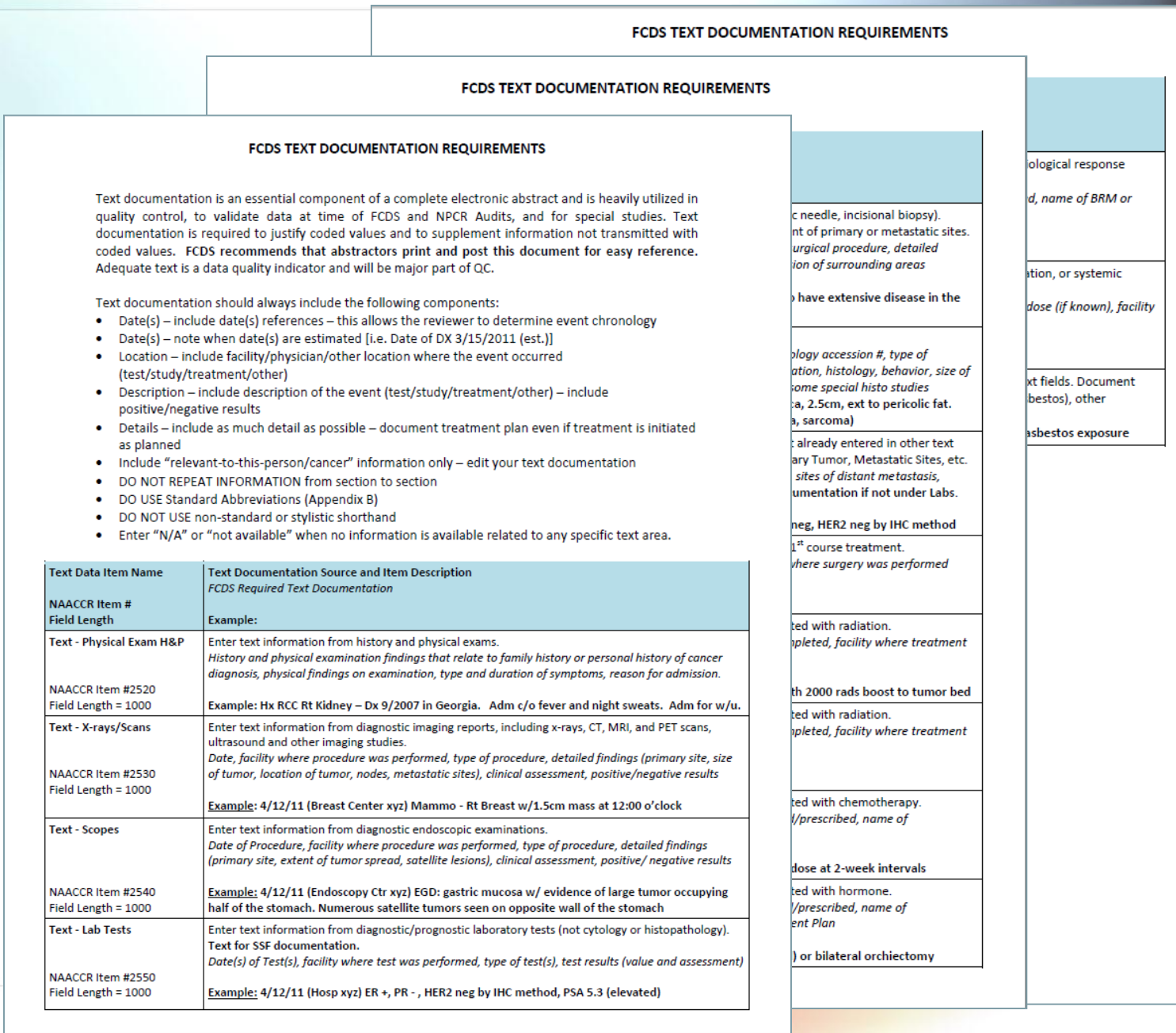
*NAACCR Standards for Cancer Registries, Version 11*
*Chapter VIII: Required Status Table*

# Fields Requiring Text

| Text Field Name | Text Field Length |
|---|---|
| Occupation / Industry | 100 characters each |
| Place of Diagnosis | 60 characters |
| Primary Site Title | 100 characters |
| Histology Title | 100 characters |
| ALL Diagnosis/Staging Fields | 1000 characters X 8 DX/Staging fields<br><br>= **8000 characters** |
| ALL Treatment Fields | 1000 characters X 6 TX fields<br><br>= **6000 characters** |

**YES – TEXT IS THAT IMPORTANT – SO, PLEASE DOCUMENT**

# 2011 FCDS Text Requirements



FCDS TEXT DOCUMENTATION REQUIREMENTS

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Text documentation is an essential component of a complete electronic abstract and is heavily utilized in quality control, to validate data at time of FCDS and NPCR Audits, and for special studies. Text documentation is required to justify coded values and to supplement information not transmitted with coded values. **FCDS recommends that abstractors print and post this document for easy reference.** Adequate text is a data quality indicator and will be major part of QC.

Text documentation should always include the following components:

- Date(s) – include date(s) references – this allows the reviewer to determine event chronology
- Date(s) – note when date(s) are estimated [i.e. Date of DX 3/15/2011 (est.)]
- Location – include facility/physician/other location where the event occurred (test/study/treatment/other)
- Description – include description of the event (test/study/treatment/other) – include positive/negative results
- Details – include as much detail as possible – document treatment plan even if treatment is initiated as planned
- Include "relevant-to-this-person/cancer" information only – edit your text documentation
- DO NOT REPEAT INFORMATION from section to section
- DO USE Standard Abbreviations (Appendix B)
- DO NOT USE non-standard or stylistic shorthand
- Enter "N/A" or "not available" when no information is available related to any specific text area.

| Text Data Item Name<br><br>NAACCR Item #<br>Field Length | Text Documentation Source and Item Description<br>*FCDS Required Text Documentation*<br><br>Example: |
|---|---|
| **Text - Physical Exam H&P**<br><br>NAACCR Item #2520<br>Field Length = 1000 | Enter text information from history and physical exams.<br>*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.*<br><br>**Example: Hx RCC Rt Kidney – Dx 9/2007 in Georgia. Adm c/o fever and night sweats. Adm for w/u.** |
| **Text - X-rays/Scans**<br><br>NAACCR Item #2530<br>Field Length = 1000 | Enter text information from diagnostic imaging reports, including x-rays, CT, MRI, and PET scans, ultrasound and other imaging studies.<br>*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*<br><br>**Example: 4/12/11 (Breast Center xyz) Mammo - Rt Breast w/1.5cm mass at 12:00 o'clock** |
| **Text - Scopes**<br><br>NAACCR Item #2540<br>Field Length = 1000 | Enter text information from diagnostic endoscopic examinations.<br>*Date of Procedure, facility where procedure was performed, type of procedure, detailed findings (primary site, extent of tumor spread, satellite lesions), clinical assessment, positive/ negative results*<br><br>**Example: 4/12/11 (Endoscopy Ctr xyz) EGD: gastric mucosa w/ evidence of large tumor occupying half of the stomach. Numerous satellite tumors seen on opposite wall of the stomach** |
| **Text - Lab Tests**<br><br>NAACCR Item #2550<br>Field Length = 1000 | Enter text information from diagnostic/prognostic laboratory tests (not cytology or histopathology).<br>**Text for SSF documentation.**<br>*Date(s) of Test(s), facility where test was performed, type of test(s), test results (value and assessment)*<br><br>**Example: 4/12/11 (Hosp xyz) ER +, PR - , HER2 neg by IHC method, PSA 5.3 (elevated)** |

# 2011 FCDS Text Requirements

- Text fields provide validation for “Required” Data Items

- Text documentation should always include the following components:

  - **Date(s)** – include date(s) references – this allows the reviewer to determine event chronology

  - **Date(s)** – note when date(s) are **estimated** [i.e. Date of DX 3/15/2011 (est)]

  - **Location** – include facility/physician/ other location where the event occurred (test/study/treatment/other)

# 2011 FCDS Text Requirements

- **Description of Event** – include description of the event (test/study/treatment/other) – positive/negative findings
- **Detailed Findings** – include as much detail as possible – included documented treatment plan even if treatment is not initiated as planned
- **Physician Interpretation of Findings -** Include anything "relevant to this person/tumor" information only
- **Edit your text documentation** – don't just copy/paste

# 2011 FCDS Text Requirements

- **DO NOT** REPEAT INFORMATION from section to section
- **DO NOT** USE non-standard or stylistic shorthand
- **DO** USE Standard Abbreviations (FCDS Appendix B)
- **DO** edit your text – keep it simple – but complete
- Critical to assessing data quality and training needs

# Suggestions Abbreviations list

**APPENDIX C**
**MISCELLANEOUS**

**NAACCR RECOMMENDED ABBREVIATION LIST**
**ORDERED BY WORD/TERM(S)**

| WORD/TERM(S) | ABBREVIATION/SYMBOL |
|---|---|
| | |
| Abdomen (abdominal) | ABD |
| Abdominal perineal | AP |
| Abnormal | ABN |
| Above | ^ |
| Above knee (amputation) | AK(A) |
| Absent/Absence | ABS |
| Abstract/Abstracted | ABST |
| Achilles tendon reflex | ATR |
| Acid phosphatase | ACID PHOS |
| Acquired Immune Deficiency Syndrome | AIDS |
| Activities of daily living | ADL |
| Acute granulocytic leukemia | AGL |
| Acute lymphocytic leukemia | ALL |
| Acute myelogenous leukemia | AML |
| Acute myocardial infarction | AMI |
| Acute Respiratory Distress (Disease) Syndrome | ARDS |
| Acute tubular necrosis | ATN |
| Acute renal failure | ARF |
| Adenocarcinoma | ADENOCA |
| Adenosine triphosphate | ATP |
| Adjacent | ADJ |
| Adult-onset Diabetes Mellitus | AODM |
| Admission/Admit | ADM |
| Adrenal cortical hormone | ACH |
| Adrenal cortex | AC |
| Adrenocorticotrophic hormone | ACTH |
| Affirmative | AFF |
| Against medical advice | AMA |
| AIDS-related condition (complex) | ARC |

# Fields Requiring Text

## Text -- Occupation

- Enter information about patients usual occupation, kind of work performed (i.e., Teacher, Brick Layer, Registrar)
- If usual occupation is unavailable, enter Unknown

## Text -- Industry

- Enter information about patients usual industry, field of work (i.e. Education, Construction, Healthcare)
- If usual industry is unavailable, enter Unknown

# Fields Requiring Text

## Text-- Place of Diagnosis

- Enter text information describing the place this person was diagnosed with this cancer
- If place of diagnosis is unavailable or unknown, enter Unknown

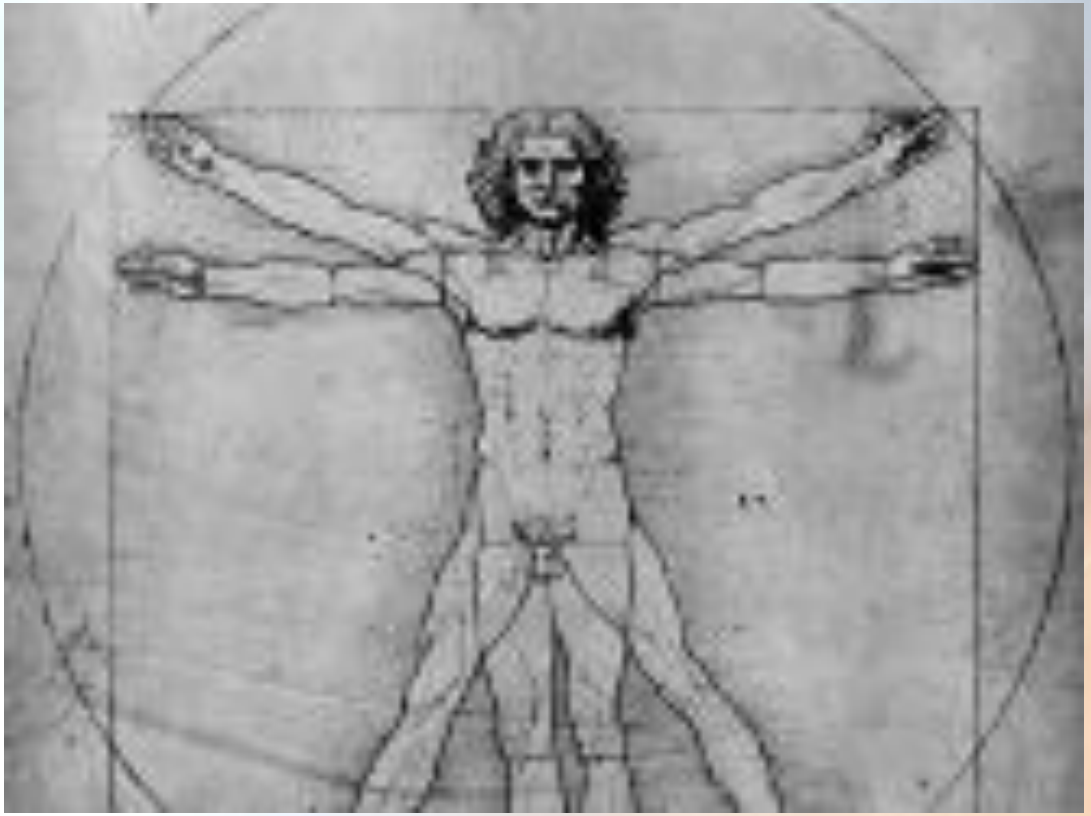
## Text-- Primary Site

- Enter text information for the primary site and sub-site, including laterality when applicable

  ***Example:*** *LEFT BREAST, UOQ*

## Text-- Histology

- Enter the information regarding the histologic type, behavior,and grade (differentiation) of the tumor being reported



*Vitruvian Man by Leonardo da Vinci*

# Text Documentation for Dx/Staging

# Fields Requiring Text

## Text-- DX Proc Physical Exam PE, H&P

- Report Clinical Findings and Personal History
  - Enter text information from history and physical exam
  - May include H&P from Consultation Summary
  - History and Physical Exam findings
  - Type of duration of symptoms
  - Personal history of cancer
  - Reason for admission
  - Family history

***Example:*** *PT HAS A HX OF RT NEPHRECTOMY FOR RENAL CELL CA IN 2004, A RECENT DX OF RECTAL CA ON BIOPSY 6/5/09 S/P NEOADJUVANT CHEMORADIATION W/ XELODA APPROX 7/15/09, LAR 10/4/09 AND THEN FOLFOX STARTED 11/9/09. HE IS HERE FOR THE SEASON AND WE WILL CONTINUE HIS FOLFOX WHILE HE IS IN THE AREA.*

# Fields Requiring Text

## Text-- DX Proc X-ray/ Scan

- Report diagnostic imaging/radiology services
  - Date of exam
  - Place examination was performed (Hosp abc)
  - Name of the exam CXR, CT Chest, MRI, PET, mammo, etc
  - Pertinent findings should be recorded to substantiate primary site, extent of disease, and other fields for quality assurance
  - Include positive and negative results – both are important as scans that indicate the presence/absence of disease or tumor.
  - Include radiologist interpretation of findings as well as details of findings as interpretation may make the details more clear.

***Example:*** *2/15/11- HOSP XYZ - CT CHEST - LG MASS LUL 4CM INVADING THE PLEURAL SURFACE, MULTIPLE LN SEEN MEDIASTINAL REGION – HIGHLY SUSPICIOUS FOR INVOLVEMENT BY TUMOR*

# Fields Requiring Text

## Text-- DX Proc Scopes

- Enter information from diagnostic procedures including all endoscopic (‘oscopy) examinations
  - Date of procedure
  - Place of where procedure was performed
  - Details of findings – what they saw through the scope
  - Physician interpretation of findings

***Example:*** *1/7/2011 – OUTPT SURGERY – CYSTOSCOPY/TURBT - PAPILLARY 5.0 MM BLADDER WALL LESION - HIGHLY SUSPICIOUS FOR UROTHELIAL CARCINOMA – LATERAL WALL OF BLADDER*

# Fields Requiring Text

## Text-- DX Proc Lab Tests

- Enter information on laboratory tests (urine, blood), blood chemistries, and tumor markers used to confirm type of tumor, patient overall performance status, or to determine extent of disease
  - Tumor Markers – ER/PR, PSA, CEA, AFP, BetaHCG, KRAS, CA-125, Her2/Neu FISH and/or CISH, LOH
  - Enter prognostic indicators for specific sites or histologies, and CS Site Specific fields (SSF) coded fields
  - Document only SSF's required by FCDS
  - Document other labs as needed

# Fields Requiring Text

## Text-- Operative Report

- Enter detailed observations from any surgery
  - Surgical findings (not surgical procedure performed)
  - Primary site location
  - Primary tumor size
  - Extent of involvement by primary tumor to surrounding area
  - Extent of involvement to surrounding nodes or adjacent organs
  - Extent of involvement to metastatic sites or distant organs
  - Document if there is residual tumor

***Example:*** *Primary Site: Ovary: 90% debulking performed*
***Example:*** *Primary site: Colon: No liver mets*
***Example:*** *Primary site: Breast with skin involvement and peau d'orange*

# Fields Requiring Text

## Text-- DX Proc Path

- Enter Details from Anatomic Pathology reports and/or CAP Checklist

  Tissue/tumor type, tumor size, extent of tumor spread, resection margins, grade, behavior, lymph node status, metastasis, etc

  - Date the specimen was obtained (include path accession #)
  - Location/Place specimen was obtained (Hosp abc, surg ctr)
  - Detail of primary site and extent of disease
  - Document the tumor size, and margins
  - Molecular and genetic tests performed on specimen

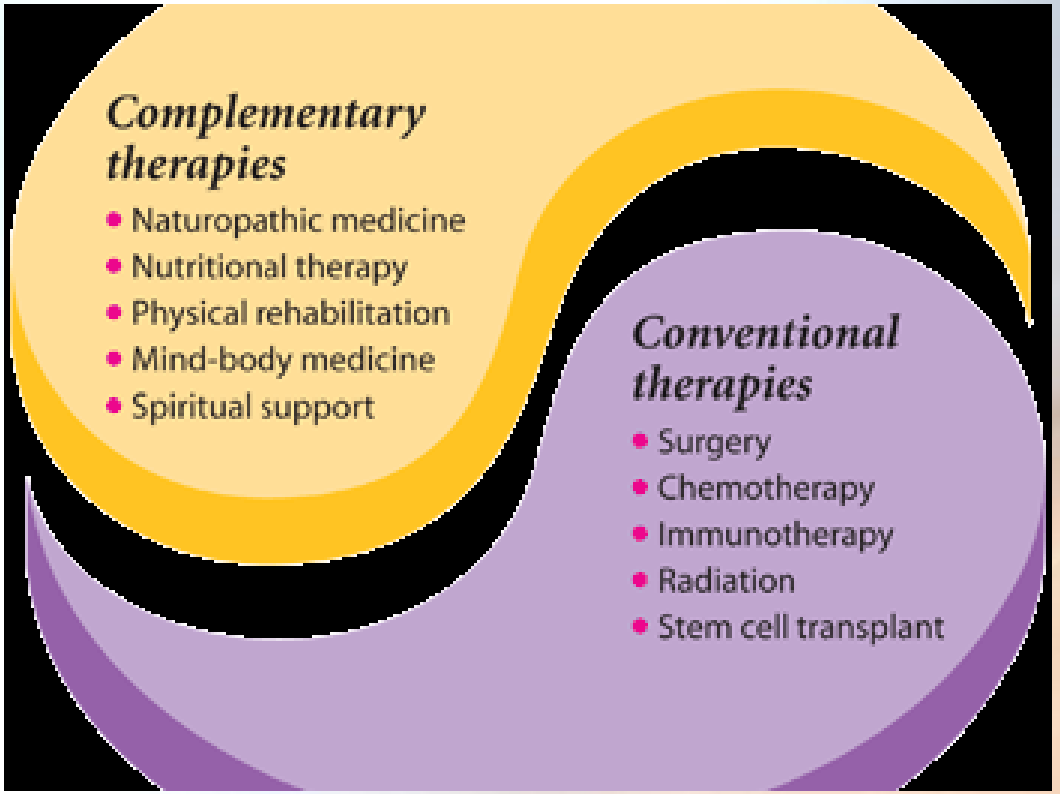
***Example:*** *6/5/09 – (Hosp abc) – 2011S000012 - RECTAL BX - MUCINOUS ADENOCA. SEGMENT OF RECTOSIGMOID WITH 3.2CM MOD TO P/D MUCINOUS ADENOCA ARISING IN A TUBILLOVILLOUS ADENOMA. 20 REG LNS OF 20 POSITIVE FOR MUCINOUS ADENOCA, MARGINS FREE*

# Fields Requiring Text

## Text -- Staging

- Additional text area for staging information not already entered in another Text field
- This might include some of the details of Collaborative Stage, SSFs, and other stage information not already entered in other text areas

***Example:*** *2/15/11 - T2AN1A PER PHYSICIAN, (stated as T2A), DISTANT METS IN LUNGS*




# Text Documentation for Treatment

# Fields Requiring Text

## Text-- Surgery (1st course treatment)

- Enter named surgical procedures including; oscopies, resections, and exploratory surgeries
  - Date of the surgical procedure
  - Place where the procedure was performed (Facility abc)
  - Name of procedure

***Example:*** *1/13/10 - Memorial – Cryoablation of Prostate*

***Example:*** *2/15/11 (Tampa General) Rt Hemicolectomy*

***Example:*** *NO TX, to Hospice for comfort measures only*

***Example:*** *Unknown – Hx no information*

***Example:*** *2/1/11- MSMC - MOD RAD Mast w/reconstruction*

# Fields Requiring Text

## Text – Radiation (1st course treatment)

- Enter details from radiation therapy procedures
  - Radiation Treatment Plan
  - Date radiation given or radiation course initiated/completed
  - Location/Place radiation therapy delivered (Facility abc)
  - Type of Radiation Therapy
  - Modality and dosage details

***Example:*** *3/2-5/3/11 – Radiation Center – IMRT – 7920 CGY in 43 Fractions, 180 CGY Boost in 1 FX*

***Example:*** *Unknown – Hx of radiation with no information*

***Example:*** *2/1/11- MSMC – Radioactive seed implants, unk total dose*

# Fields Requiring Text

## Text – Chemotherapy (1st course treatment)

- Enter details of chemotherapy plan and delivery
  - Use SEER*Rx to determine if agent/regimen is chemotherapy
  - Chemotherapy Treatment Plan
  - Date chemotherapy initiated/completed
  - Location/Place chemotherapy given (Dr.xyz, hosp infusion ctr)
  - Treatment details – chemotherapy agents and/or regimen

***Example:*** *2/2/10 Port Placement for Chemo*

***Example:*** *Plan FOLFOX6 regimen – unknown where or if given*

***Example:*** *2/2/2011-4/16/2011 – Infusion Ctr – Cape Ox Regimen standard dose, completed on 4/16/2011*

# Fields Requiring Text

## Text – Hormone (1st course Rx)

- Enter details of hormone treatment plan & delivery
  - Use SEER*Rx to determine if agent is hormone
  - Be alert to surgical procedures with hormonal effect
  - Hormone Therapy Treatment Plan
  - Date hormone therapy initiated/completed
  - Location/Place hormone therapy given (Dr.xyz)
  - Treatment information

***Example:*** *10/20/10 – Dr Jones – Lupron for downsizing*

***Example:*** *3/15/11(Dr Smith) tamoxifen (dose/duration not stated)*

***Example:*** *2/15/11 (Memorial Hosp) Bilateral orchiectomy*

# Fields Requiring Text

## Text – BRM/Immuno (1st course Rx)

- Enter details of BRM treatment plan & delivery
  - Use SEER*Rx to determine agent is BRM
  - BRM/Immunotherapy Treatment Plan
  - Date therapy initiated/completed
  - Location/Place therapy given (Dr.xyz)
  - Treatment information

***Example:*** *10/20/10 – Dr Jones – BCG for urothelial bladder cancer*

***Example:*** *3/15/11(Dr Smith) tamoxifen (dose/duration not stated)*

***Example:*** *2/15/11 (Memorial Hosp) Bilateral orchiectomy*

# Fields Requiring Text

## Text – Other Therapy (1st course Rx)

- Enter details of Other/Unconventional treatment plan & delivery
  - Date therapy initiated/completed
  - Location/Place therapy given (Dr.xyz)
  - Treatment information
  - FCDS Edit is just a WARNING

***Example:*** *10/20/10 – Dr Jones – high dose vitamin C for H&N*

***Example:*** *3/15/11(Dr Smith) shark cartilage (dose/duration not stated)*

# Example of Text Documentation

**Text - Dx Procedures - Physical Exam - PE**

1-14-10 LUNG MASS

**Laterality missing, finding missing.** If not available document **no information available**

**Text - Dx Procedures - X-ray/Scans**

ABNORMAL OUTSIDE X-RAY

**Findings missing**

**Text - Dx Procedures - Scopes**

1-14-10 BRONCHOSCOPY

**Findings missing**

**Text - Dx Procedures - Lab Tests**

NONE

# Example of Text Documentation

**Text - Dx Procedures - Operative Report**

1-14-10 LUL LOBECOTMY WITH NODE DISSECTION WEDGE RESECTION LLL LUNG LARGE SQUAMOUS CELL CANCER AS WELL AS A SATELLITE TUMOR IDENTIFIED

**Place, Findings**
Surgical procedure document in the Surgery text

**Text - Dx Procedures - Pathology Report**

WELL DIFF SQUAMOUS CELL CA LUL LUNG 4.6 CM LLL LUNG 1.7 CM PLEURAL MARGIN (-) NO LYMPHATIC INVASION 22 NODES (-) RIB (-)

**Date, Place, Findings ex** 7/15/2010 Shands Hosp

**Text - Staging**

SEPARATE NDOULE **Separate nodule site?**

**Text - Remarks**

# Example of Text Documentation

**Text - Dx Procedures - Physical Exam - PE**

PT WITH UNUSUAL HX - PRESENTED W/ CC - ESSENTIALLY THIS GENTLEMAN IS NOTED TO HAVE; SOME INCREASE IN ABDOMINAL GIRTH BUT NO FEVER, W/U IS POS FOR ENLARGED NODES - BX D W/ NO SPECIFIC PRIMARY NOTED - TXD AS UNK PRIM, 7/2010 PT GOES TO SLOAN KETTERING FOR 2ND OPINION - METASTATIC DZ FROM PROSTATE PRIM BY REVIEW OF PATHOLOGY - STARTED ON HORMONE THERAPY

**Adequate documentation**

**Text - Dx Procedures - X-ray/Scans**

AT DX PER PHY PET/CT POS FOR ELARGING RETROPERTONEAL NODES, F/U PET / CT WITH MINIMAL REDUCTION IN DISEASE

**Abbreviations used correctly**

**Text - Dx Procedures - Scopes**

NONE

**Text - Dx Procedures - Lab Tests**

PSA NOT DONE AT DX, 7/2010 PSA 9.0

**Lab test values documented correctly**

# Example of Text Documentation

**Text - Dx Procedures - Operative Report**

1/18/10 CT GUIDED RETROPERITONEAL LN BX

For findings 'read' the operative report

**Text - Dx Procedures - Pathology Report**

1/18/10 - CT GUIDED RETROPERITONEAL NODE BX, METASTATIC PD-ADENOCA ASSOCIATED W/ UNK PRIM, 7/2010 PATH REVIEW POS FOR METASTATIC ADENOCA C/W PROSTATE PRIM

Date, **place**, findings

**Text - Staging**

DISTANT - PROSTATE PRIM BY FINAL PATH W/ RETROPERITONEAL INVOLVEMENT

**Stage text** documented

**Text - Remarks**

# Suggestions

- Be brief but complete – use abbreviations correctly

  *Abbreviated text : 8/13/2010: Lobectomy RUL lung: mod diff inv adenoca. TS 2cm. 5 hilar LN removed, neg for ca. Margins neg.*

  - *SCC – Small cell carcinoma; Squamous cell carcinoma*

- Additional comments can be continued in empty text fields, including Remarks

- If information is missing from the record, state that it is missing or not available

- Focus on text validation for cancer identification, CS and SSFs, and treatment sections of the abstract

# THANK YOU