REGISTRAR PIP

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Making a Good First Impression with Data – Part Two

More Background

Have you ever reviewed cases that you've abstracted and/or edited in the past and wondered, "I couldn't possibly have submitted that!" However, the electronic footprint shows clear evidence that we did, in fact, submit a few cases with glaring documentation omissions and obviously incorrect coding. Welcome to the world of, "No matter what our experience level, we will make mistakes."

The purpose of this edition of the newsletter is to continue to highlight a few areas where we need to improve performance in order to improve the overall consistency, accuracy, and completeness of our abstracts. Errors can occur when we don't understand abstracting expectations or coding rules. They can also occur when we are tired, distracted, have a hard time maintaining focus, or when we experience a lapse in short-term memory. When standard setters change data collection requirements that inevitably leads to increasing the level of detail captured, we might occasionally and inadvertently find ourselves in one of the following situations:

- **Missed the memo** regarding the change so we never implemented it
- **Got the memo** about the change, directed our focus to learn the new material but may have taken a misstep when applying the old (but still accurate) along with the new requirements

Let's face it, ever since we've had things to remember, we've needed reminders. With the start of the new year, we thought the timing was perfect to review additional data issues observed during the past year. Perhaps we will all discover that one or more of the following reminders will improve our future performance.

Demographic data items

Race – Documentation

- Text documentation is required to support the choice of codes used.
- Race text should be fully documented, rather than using abbreviations in order to avoid ambiguity. Reviewing the chart notes to confirm the correct Race code is essential in these types of situations in particular.
  - Documenting "AA" in the text is not a clear statement of race because it can refer to either an African American or Asian American.
  - Race documented as "Indian" is also problematic because it can refer to either an Asian Indian or American Indian. Typically, this is more of an issue when the race listed in the Demographics section of the medical record is coded/documented as "American Indian/Alaska Native" but the patient has a common surname from India (e.g., Patel).
- When Race is coded to 98 [Some other race], it is essential to document what the "other" stated race is.

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Address - Documentation

It is not an infrequent abstracting error to record the current address in both the ***address at diagnosis*** and the ***current address*** fields when we should not. It happens because most of the time these fields are abstracted using the same information.

We recognize that while ***analytic*** cases are reportable to the facility regardless of the documentation in the address at diagnosis and the current address fields, accuracy is especially needed in the ***address at diagnosis fields*** for three main reasons:

- Identifying out-of-state residents at diagnosis for WSCR data exchanges with other states.

- Producing rates at state, county, and census tract level by NPCR, SEER and Department of Health programs. (Accuracy in street , city, and zip code is needed for a central registry to accurately code census tract, a required central registry data item for submission to NPCR and SEER).

- Overlaying cancer data at diagnosis with other geographic data sets as demonstrated by Dr. Trang VoPham's Fred Hutchinson research projects that she presented at the December 15th, 2022 WSTRA Educational Meeting. Dr. VoPham is an epidemiologist and geospatial scientist whose research focuses on understanding the role of environmental exposures in health, which involves the use of patient address fields. Her work has included epidemiologic studies examining the associations between environmental exposures, such as particulate matter air pollution, dioxin, pesticides, radon, ultraviolet radiation, and circadian misalignment, and liver cancer, breast cancer, and lung cancer risk following linkages with the Nurses' Health Studies, SEER Program, and SEER-Medicare.

When editing abstracts with a SEER-region ***address at diagnosis***, the central registry staff must confirm the accuracy of that address at diagnosis information when we discover a prior biopsy or diagnostic procedure was performed in another state or outside the SEER-region in Washington. Granted, this can happen, but we need to know why it happened to ensure the accuracy of incidence reporting to the State and to the SEER Program. Text documentation is required to confirm the accuracy of the information abstracted in these situations.

Site-Specific Data Item (SSDI) (0 vs. 9)

Incorrectly assigning zeros versus nines in many different fields has resulted in coding inconsistency for literally decades. If there has been an issue debated more over the past forty years when coding various data items, we don't know what it is. How many of us have heard or read that for "analysis purposes, many fields coded to all zeros or all nines are lumped together"? If this is actually the case, why do standard setters keep trying to split this hair? The most likely reason is that researchers ***want*** to be able to use the more detailed information in their analyses, but they will not be able to do so until our coding accuracy and consistency improves.

This issue comes up with SSDI coding of biomarkers, lab tests and tumor characteristics (e.g., ulceration for melanoma). Zeros reflect that these tests were performed and the results were normal/negative or within normal limits. Keep in mind ***there must be text documentation to support the coding of a 0 for these fields.*** Without supporting text, the central registry will change the coding in these fields to 9 to reflect there is lack of documentation to support findings indicating tests were performed and values are normal/negative or within normal limits. A 9 indicates there is no documentation in the medical record regarding the test, the results cannot be determined, or that the test was either not done or it is unknown whether the test was done.

Documentation provided for many SSDIs remind us NOT to default to code 0 because this coding guideline represents a change in how we coded in the past. The type of instruction included varies based on the SSDI. For example, the following is the documentation included for the Ulceration SSDI for melanoma:

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"Change from Collaborative Stage v2 (CSv2): In ***CSv2***, if pathology report was available and there was no mention of ulceration, the registrar could assume that it was negative and code appropriately. For the SSDI, this assumption cannot be made. There must be a statement that ulceration is ***not present*** to code 0."

For example, many lung primaries have SSDIs for ALK and EGFR coded to zero as normal/negative (0). However, this information is not included on pathology reports received at the central registry nor is there any documentation in the abstract provided to confirm the date, type of test or test results. One of these two situations must occur or a code of 0 cannot be used.

Treatment date for bone marrow/stem cell transplant

Bone marrow and stem cell transplant dates are either not included in the export files from facilities or these dates are not being properly imported to the SEER*DMS at the central registry. To ensure these dates are accurately reflected in State and SEER submissions, record the information in the appropriate text location of the abstracting software when the patient received this form of treatment. The central registry staff will record the dates appropriately in the database to ensure inclusion of this information in export files to the State and SEER.

Staging

While the TNM coding fields can be "completed" according to the instructions registrars are provided, the associated text field needs to include information abstracted directly from the electronic medical record (EMR) that includes the physician's assessment of the TNM. In the TNM text field, the central registry staff needs to see who provided the TNM information recorded, when it was provided and how the case was staged. Sometimes there is not enough information documented in various diagnostic reports found in the EMR to determine tumor involvement. However, if central registry staff has confirmation in the TNM text field of the ***physician's*** assessment regarding involvement, this text information can be used to support the codes used in the TNM, EOD and Summary Stage fields.

When ambiguous or nonreportable terminology is used in a scan to describe either direct extension or metastasis, this information can be coded as involvement if there is TNM staging provided by the ***physician*** which supports involvement. For example, if documentation in a CT scan of the chest for a lung primary reveals, "mediastinal lymphadenopathy could be either reactive or metastasis" and TNM text field states, "cN2 per MD," then this statement can be used confirm that the regional mediastinal lymph nodes are considered involved per the physician. Without such ***physician*** provided text documentation, a TNM field indicated to have been coded by the registrar will not be used to code the EOD and Summary Stage fields.

Generally, TNM text information that is not properly labelled as to who provided the information and when it was provided, will be ignored by the central registry staff in completing the staging fields.

New primary?

Anus

We could potentially be overreporting AIN II and AIN III cases due to confusion over applying the anal Solid Tumor Rules (STR). When a patient has had ***negative biopsies*** following the initial diagnosis of this disease and ***no treatment*** has been given, DO NOT report a new primary simply because AIN II or AIN III now exists in recent biopsies performed more than a year after the patient was initially diagnosed. If no treatment was ever given, the patient is never considered disease free.

In addition, when an AIN II or AIN III diagnosed patient ***is treated***, should subsequent interval biopsies confirm only low grade neoplasia (e.g., AIN I), the patient is also not considered disease free. Such a patient having a biopsy confirming either AIN II or AIN III more than a year after the original diagnosis is also not considered to have a new primary.

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Breast

One way to help us decide whether a subsequent ipsilateral breast primary should be reported following a mastectomy-treated first breast primary, is to document whether the surgeon left any breast tissue behind during the original mastectomy procedure. **Helpful Hint**: Type in the word ***"residual"*** into the EMR system's SEARCH function to locate the potential use of the term in the original mastectomy operative report. If residual breast tissue was mentioned, apply the STR checking for disease free interval status, histologies and behavior codes to determine whether or not to report a new breast primary.

When a mastectomy was done and a subsequent tumor is identified and confirmed to be in the remaining chest wall, muscle, or skin AND there was no residual breast tissue identified in the resected specimen, this is a metastatic recurrence and not a new primary.

Use the EMR SEARCH function

A cancer patient oftentimes has a rather lengthy EMR. Take advantage of the system's SEARCH function to quickly identify reports to use to assess the patient's disease status over time. For example, keywords such as persistent, recurrence, disease-free, and even the word stable can take us right to an EMR note in which we might learn whether or not the patient has been disease free and for how long.

Conclusion

Admittedly, some errors will remain undetected and uncorrected regardless of quality assurance, editing, and auditing procedures in place. However, one thing we've learned over the years is that with the combination of an ongoing review of our work and the sharing of our findings, we create the opportunity to help improve the quality of the data we all help produce.

Bottomline, the value of registries depends on the quality of the data we maintain. Most importantly, high quality data will be sought and used to understand the disease process more fully from scientific, medical, and financial perspectives. It will assist those who need to make decisions more accurately and quickly to address the current and future patient needs related to screening, diagnostics, staging, treatment, and learning how to cope with a cancer diagnosis.

Never underestimate the value of the work we do and the importance of making a good impression on those who come to rely on it. While perfection isn't a realistic goal, excellence is.