Discussion Notes:

Processes to make a CTC “Submission Ready”

SEER*DMS CCAB Workshop

March 22, 2022

- Facilitated by Marina Matatova (NCI), Linda Coyle (IMS), Suzanne Adams (IMS)
- Participants include SEER registry, NCI Surveillance Research Program, and IMS staff.

Today’s Topic

What processes does your registry require in order to consider a CTC “submission-ready” ?

Discussion Points

1. What does it mean for a case to be ready for submission? Please focus on the 1st submission of the CTC to SEER, NAACCR, or NPCR.
2. Do you use edits or flags to force a manual review of every new case?
   - If not, would you require a manual review for a case that was not failing any standard setter edits?
   - Do you have targeted reviews of treatment data (not triggered by SEER or NPCR edits)?
   - Do you have targeted reviews of staging data (not triggered by SEER or NPCR edits)?
3. February Submissions
   - Why would you think that a case could not be submitted at 2 months, that is, submitted in February when diagnosed in the prior year?
   - What concerns do you have for submitting at 2 months?
4. Visual Editing
   - What processes do you do in terms of visual editing?
   - What are your registry's rules for requiring visual editing?
   - Registries who are visually editing 100% would like to understand the QC processes of registries that do not visually edit 100%

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Name & Registry	Comment
Scott Riddle (CCR)	Age = date of diagnosis and date of birth
Meichin Hsieh (LA)	Ready for which submission? 2 month, 14 month, or 22 month?
Marina Matatova (NCI)	To be provided – written description of definition - What it means for 2 months, vs 14 month, vs 22 month submission
Marina Matatova (NCI)	What are some of the things in your workflow (in DMS and external) that can give insight in a technical perspective
Colleen Sherman (NY)	NY cannot do 100% VE. Make sure that any record that is not linked gets linked to the proper tumor. Any 2020 DX and 2019 records will be linked this year (2022). Next thing is making sure that any consolidation task that has edit failures are flagged as high priority tasks. DQ staff looking for edit failures not in consolidation. Those become QC tasks. Closer to call for data, we have a lot of non-hospital records. We work with Nicki on mass changes to reduce edit failures. Every day – checking for incoming cases. Processing non-analytic records throughout the year – up to the submission time. Linking, CTC not failing edits, no inter-record edit.
Bobbi Matt (IA)	To be ready – verify that it is SEER reportable based on SEER requirements. If it is ambiguous then we want to make sure it is based on SEER definition. As records are processed, CTCs are created. For February – just make sure it is valid (IA resident and reportable). For Nov submission – clear edits. Prior to Nov submission, we would do QC tasks looking for unknown values and continue to review edits. Ready to submit = at least SEER reportable. CTCs from NA records, no problem. I would be more concerned about CTCs created from path reports. Those would need some review to confirm they are reportable.
Serban Negoita (NCI)	Which cases do you review for reportability?
Bobbi Matti (IA)	Comfortable with abstracts and reportability; working on ways to reduce VE of those.

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Serban Negoita (NCI)	If you have to build a case from path report then it would need to be reviewed for reportability?
Bobbi Matt (IA)	Yes, path reports coded for site, hist, etc. But need to review text to make sure it is actually conclusive or based on ambiguous terminologies that SEER required.
Colleen Sherman (NY)	Agree, that is where I am concerned. We have path reports based on history of. We're finding 10s of thousands that are not reportable, but need reviewed.
Serban Negoita (NCI)	Yes, we are working on algorithms but realize that path report reviews require large effort.
Meichin Hsieh (LA)	We process data similar to IA and NY. We use path reports to identify reportable cases. One team does path report screening to identify reportable cases. That screener cannot be sure it is reportable because they are only seeing the path report. Once identified then we go through routine data processes. Another team – editors – editing and consolidation. Do not separate consolidation from VE. Review text and codes during consolidation. Close to submission – run external edit programs including GenEDITs, IR edits, and SEER*Edits. Don't rely exclusively on SEER*DMS because it may still fail externally.
Meichin Hsieh (LA)	Believe that some cases that are not truly new primaries would be included in a 2 month submission.
Linda Coyle (IMS)	Asked if showing the CTC table in path screening would help identify reportable cases.
Meichin Hsieh (LA)	Screening criteria is intentionally loose so that the registry does not miss cases.
Lisa Pareti (LA)	Adding the CTC info would help for some but followback is required for some cases.

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Serban Negoita (NCI)	Path reports are auto-linked to a patient set when first loaded
Meichin Hsieh (LA)	HL7 links to patient level, not CTC. System cannot determine CTC linkage unless path site, hist are coded. If path report can link then no review required; if not then need FB to determine if new primary.
Lisa Pareti (LA)	There are situations where the pathologist can't make a determination; differential diagnosis. Need to followback to see what the conclusive diagnosis is.
Meichin Hsieh (LA)	Use path report to identify cases; do not use it as a single source for a case unless dermatology report. Need to abstract to be ready to submit complete information.
Bobbi Matt (NCI)	HL7s come in. Go through path screening & algorithm. Those get sent to hospital staff to abstract. The ones that can auto-link to patient, but site or dates can be slightly off. They stay linked at patient level. We review those to see if we can link at tumor level. If not then we send FB to request an abstract. With new process to create CTCs from path, we would need some mechanism to review to see if it is conclusive and should build.
Rocky Feuer (NCI)	Can you guess – what % of path reports could be used to build?
Bobbi Matt (IA)	Approx 75%. Maybe 25% should be hold off. But would need to look.
Marina Matatova (NCI)	When PR gets sent to hospital staff, how is that done? SEER*Abs abstractors get it in their SEER*Abs workflow (upload of AFL file). For others, we send an Excel list.

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Marina Matatova (NCI)	Do all registries use external edit tools?
Linda Coyle (IMS)	All registries are required to run SEER*Edits and GenEDITS.
Serban Negoita (NCI)	What we've heard so far is that there are 2 types of issues related to workflow: amount of time to verify CTC linkages for path reports when an abstract is not available; would not have time to do a FB within 2 months to make it ready for Feb submission
Cathy Phillips (CT)	We still receive a lot of PR as paper or in scanned image files. They don't come in until the abstract is due. There's no way to auto-code these using text mining algorithms. CT would need to revise our statute in order to meet the 2 month submission timeline.
Serban Negoita (NCI)	Need to review registry operation manuals and processes for creating CTCs from path reports
Mona Highsmith (MN)	MN path coders determine reportability, those reportable, are coded and then enter the workflow. Ideally I would want them to create a CTC, auto link, or create a consolidattion task. The CTRs then review the AFLs, send missing lists to facilities for missing cases, or abstract them themselves via EMR or follow-back letter. To be submission ready, I would want them edit free, even if the fields were unknowns and the AFL is left open in order to continue to abstract or request. AFL = abstract facility lead.
Mona Highsmith (MN)	oh, one thing about auto-coding by DMS, we need QA on those, especially consult slides, which will typically have the wrong specimen collect date, thus can end up with wrong date of dx. Need a flag – most reference labs set the date as the date they receive it. The date and specimen path number are in the text. If they are reviewing cases several years prior then it would be a cancer for the wrong year.
Marina Matatova (NCI)	Do other registries have issues with dates from specific facilities?
Multiple registries	SE, NY, CT, NM – have all seen this issue.

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Serban Negoita (NCI)	Should path screening include a review of the date specimen collected?
Mona Highsmith (MN)	MN knows the path number prefixes for reports that are consults.
Marina Matatova (NCI)	Do other states have this problem with reports that are not consults?
Cathy Phillips (CT)	CT sees this for reports related to a historical case.
Valerie Yoder (UT)	most of utah's epath has a correct specimen collected date & specimen received date so it's not a big problem on epath (but spec collec date isn't always dx date)
Jennifer Hafterson (SE)	Seattle creates a significant volume of CTCs with dx year 9999 if we cannot confirm disease reportability or address at diagnosis. We use some external sources to try to supplement address info.
Serban Negoita (NCI)	SE verifies reports before loading into DMS. Other registries – how often is address verification necessary for path reports?
Chris Johnson (ID)	One part of being a reportable case is state of residence. ID looks at a bunch of things – the NAACCR state of diagnosis field; confirm that out of state residents are really OOS; and in state are in state. Also review addresses with low geocoding quality. Use LexisNexis batch processes, Accurint, State Death Certs, and claims data.

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Serban Negoita (NCI)	Will LexisNexis work with path reports?
Chris Johnson (ID)	Externally, we use to look for state of residence.
Serban Negoita (NCI)	Can you use the data in a pathology report to find an entry in Accurint or LexisNexis?
Chris Johnson (ID)	ID uses a batch process to find that – especially to find missing SSN.
Meichin Hsieh (LA)	LA uses Accurint to find missing addresses. Accurint also helps identify race and gender. If path report does not have SSN Then it makes linkages more difficult. This year, we use diagnostic index identifier as way to find SSN and address. HHD identifier.
Jennifer Hafterson (SE)	Seattle screens path outside DMS (with wide net similar to Louisiana). Address verification happens on path loaded in DMS.
Jennifer Hafterson (SE)	Seattle is not receiving full SSN or even full DOB on our LexisNexis lookups. That's a problem.
Tina Lefante (LA)	Accurint linkage that we use for HL7s is a batch linkage. It's not the people search. You need the separate batch contract; there is a separate cost. Accurint lookups don't give us full SSN. The less information we give then the less likely there will be a match.
Serban Negoita (NCI)	Does NY do linkages of HL7 path to obtain address?
Colleen Sherman (NY)	I don't think so, but need to check.

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Kyle Ziegler (GC)	We here at CRGC do utilize LexisNexis to find the missing information on incoming path reports; however, it doesnt work very well when you have a common name...it becomes very challenging, especially with the hispanic population
Jennifer Hafterson (SE)	Seattle, in our limited experience, sees multiple addresses on our LexisNexis lookups with overlapping dates. Our confidence level isn't high for residency at this point.
Mona Highsmith (MN)	MN requires address on our HL7s, there are very few path labs who don't provide it. For those with no address we look them up in Accurint.
Kyle Ziegler (GC)	Handful of labs – large volume – that do not send in address, SSN. We do what we can to find the information. Send followback to get the information. LexisNexis can be very challenging, especially for common names.
Barbara Evans (NM)	NM agrees with Seattle. We find multiple address and have found batch matches returning many false matches.
Colleen Sherman (NY)	NY. While I don't think we've completed any large linkage with HL7s, we do have staff look them up in Lexis Nexis

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Kyle Ziegler (GC)	No time to do followback for a 2 month submission.
Serban Negoita (NCI)	Any other comments from CA registries re 2 month submission?
Andrea Sipin-Baliwas (LAX)	LAX. Echoing what Kyle said. I would be cautious to use our epath for this approach. The path reports have problematic quality issues.
Jennifer Hafterson (SE)	Seattle does have some CTCs that end up being deleted. We can work with IMS to look at this volume and see if there is anything we can see from the results.
Daphne Lichtensztajn (GB)	We have the same issues defined by Andrea, Kyle, and others.
Jenna Mazreku (CCR)	CCR. Context – the demographic piece has different language in state legislation that define reporting requirements. That is the root concern. We do create CTCs as epath comes in – with associated admissions. Need to look at timeliness rules for data sources (hospitals, physician offices, etc).
Marina Matatova (NCI)	FB may be a barrier for 2 month submission. Do registries have a feeling for the minimum amount of time for a check on records? 4 months, 6 months, etc ?
Jennifer Hafterson (SE)	Abstracts or path?

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Jennifer Hafterson (SE)	Many of us would have to modify our state reporting requirements. Ours is 6 months of patient being treated or seen.
Marina Matatova (NCI)	6 months for path or just abstracts?
Jennifer Hafterson (SE)	SE. Most epath labs report daily, weekly, monthly. Some smaller labs report via paper. Derm, GI, and a couple of others are delayed but that is a small volume compared to case load. Rocky could model.
Colleen Sherman (NY)	Path. It's a matter of shifting our focus and we could get to a point where we screen the majority of 2021's by feb 2022. That wouldn't allow for doing followback by the 2 month submission, but it would identify the reportable cases. The followback would be done to get the full abstracts. Shift focus to work on HL7s first.
Ginger Williams (NM)	Definitely a shift in focus. We could probably get the path reports abstracted in the 2 months, but would not have the time to do followback. Hospitals are far behind due to Covid.
Jennifer Hafterson (SE)	I received word that hospital registry hours have been cut. Impact of covid on hospital registry staff and resources.
Meichin Hsieh (LA)	Yes, but beside pandemic issues the hospital registrars are also short of CTRs
Ginger Williams (NM)	NM agrees.

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Suzanne Schwartz (NJ)	Yes, agree
Mona Highsmith (MN)	Switched to manual consolidation in DMS compared to legacy system. We're coming full circle that we will create CTC from path. The AFL will stay open until abstract comes in or someone manually closes it.
Jennifer Hafterson (SE)	Seattle - We need more help from DMS in handling updated abstracts from hospital registries. Currently, we can't handle the volumen.
Mona Highsmith (MN)	Do have skins that auto buid right away. Edits failed, but all edits cleared when abstract linked to the CTC.
Marina Matatova (NCI)	Do other registries believe the change in focus would increase productivity?
Jennifer Hafterson (SE)	Changing processes to speed up reporting – it was a long process and didn't happen in a matter of months.
Marina Matatova (MN)	Are there any other processes beside FB that are needed to consider a record ready for submission.
Carrie Bateman (UT)	UT. One of the things that we would need be are our passive FUP linkages. We would need to do those ahead of the submission to have race completeness; address.

Name & Registry	Comment
Meichin Hsieh (LA)	Dealing with different diagnosis years for the Feb submission than for the Nov submission. Creates difficulty to focus on year dx = 2021 for Feb 2022; and then shift focus to year dx = 2020 for the Nov 2022 submission. The Nov submission requires 98% completeness but also requires high quality. How can we work on multiple years simultaneously and still achieve high quality? Need some balancing.
Marina Matatova (NCI)	I wonder – do you feel a prioritization of submissions would help?
Meichin Hsieh (LA)	Would need to understand the purpose of the 2month submission
Jennifer Hafterson (SE)	Seattle sends quarterly race letters to MDs.
Rocky Feuer (NCI)	Have heard a number of things today that we need to discuss. Need to define the 2 year submission; discuss whether there is another date that is more reasonable?
Marina Matatova (NCI)	We will discuss internally and then define other questions that registries could answer.
Kacey Wigren (UT)	UT- I have the same concerns of Meichin. It will take some time to shift focus, but prioritizing and balancing is a concern.
Rocky Feuer (NCI)	Statistical models can build on consistent, high quality data. The lessons learned from this conversation need to be reviewed to determine practices to submit good, consistent data.
Randi Rycroft (ID)	Also remember that not all registries have robust reporting streams from pathology labs. This will significantly affect and bias our 2-month reporting.
Robin Billett (GA)	We need to better understand what is wanted for a 2 month submission. I don't see our hospitals being able to submit abstracts at 2 months after dx so the incidents would primarily have to come from our path screening activities and I don't know if we could keep up with all the path reports we have to screen to submit incidents every 2 months. GA has hundrerds of thousands of paths to screen each year that our staff of 12 editors screen.

Name & Registry	Comment
Marina Matatova (NCI)	Are there times when you hold back cases from Nov submission?
Meichin Hsieh (LA)	LA. There are cases where we have a path report and waiting for an abstract from a CoC hospital. If we do not receive the data then we would build from a path report. We would still submit those cases. Would not hold a case back unless we do not know if it is reportable.
Lyn Almon (GA)	GA. Would never hold a case back if we know it is reportable. We would consolidate all records that we have available and submit it.
Robin Billett (GA)	GA. We generally wait to make cases out of NCF records to see if we can get a NA for them
Linda Coyle (IMS)	GA would wait to make the case until they have an abstract; but would not hold the case back from the submission.
Marina Matatova (NCI)	Add this as a question to registries – do you hold any case back in Nov?
Jennifer Hafterson (SE)	SE. More likely that we are not trying to work on our questionable Feb submission cases for the Nov dx year until the summer. But, that activity may need to be moved up.

5. Other thoughts, did we miss any points related to today's topics?
   - Questions?
   - Feedback - Do you have any comments related to today's workshop?

Name & Registry	Comment
Marina Matatova (NCI)	We will also post this as a follow up question in Squish
Marina Matatova (NCI)	F2F vs webcasts? What are your thoughts? Better, worse, or need a mix?
Winnie Roshala (GC)	How do clinically diagnosed only cases fit into this ? HL7 are majority of cases, but some cases are clinically only and would not have a path report. That component needs to be addressed in this discussion.
Peggy Adamo (NCI)	Linda did a great job taking notes!! Hard to do!!
Robin Billett (GA)	I really like being able to see the notes typed out. That was very helpful for retaining the information
Jennifer Hafterson (SE)	Seattle's clinically diagnosed cases lag behind our path. They do take longer.
Henry Lewis (NJ)	NJ. One: HL7 data and other non-hospital sources frequently do NOT include race, Two: our normal Accurint lookup access also does not include race. It was mentioned that a batch process with them can obtain some races. Can this be made available to all of us in DMS?
Lisa Pareti (LA)	Staffing is a real issue that needs to be considered as well. We lost many CTRs and are having a very difficult time filling those positions. With limited staff and increasing SEER requests it makes it increasingly difficult for us to meet all those requests and perform our routine work when the same people are being asked to do more and more. Our remaining staff is stretched very thin at this point.