The Surveillance, Epidemiology, and End Results Data Management System (SEER*DMS)
Meaningful Use (MU2) Work Group
Teleconference Summary
April 25, 2019
3:00 p.m. to 4:00 p.m. EDT

Representatives from NCI, IMS, and seven SEER registries participated in the SEER*DMS MU2 Work Group (WG) conference call on April 25, 2019. Participants included:

REGISTRIES:
Georgia
Idaho
Iowa
Louisiana (Brent Mumphrey, Chair)
Minnesota
New Jersey
Utah

NCI: Peggy Adamo, Melissa Bruno, Andrew Grothen, Marina Matatova

IMS: Suzanne Adams, David Angelaszek, Linda Coyle, Chuck May

The Scientific Consulting Group, Inc. (SCG): Kathryn Brown-Huamani, rapporteur

Action Items

- IMS will examine ways to associate facility with the type of information provided and the type of information the facility is expected to provide. The WG will discuss this issue during the next call.
- Marina agreed to investigate progress being made at the Centers for Disease Control and Prevention (CDC) in developing eMaRC Plus capabilities, particularly with regard to the consolidation of records from the same practice and same patient. She agreed to share her findings during the next WG call.
- Brent agreed to create a Squish issue with the document containing the questions raised by April Austin and the WG responses to those questions.
- Participants agreed not to discuss the Dashboard until April is available to participate in the call.

Dashboard

During the last MU2 WG call, participants agreed on the need to create a dashboard to report on data items available/missing. They agreed that CDAs could be classified as (1) linking to a patient set for follow up, which would require minimal information; (2) useful for updating follow up information, which would require dates; (3) linking to a CTC, which would require data on the cancer such as site and histology; and (4) automation-related with treatment information for casefinding. CDAs that only meet the first criteria would appear on the dashboard to determine what information was missing, so they could be sent back to the reporting facility. April Austin of the New York registry and James Robinson of the Iowa registry agreed to collaborate on drafting a dashboard design.

April was not present during this call. Linda indicated that April had sent in questions prior to the call and that she requested more input on what the registry staff wants from this dashboard. Participants noted that the primary goals of this dashboard would be to monitor data received from each practice and facilitate data quality reviews by reporting on missing data items. Participants discussed the types of CDA information the registries want and whether this information could be linked to SEER*DMS through the dashboard.

Discussion

The dashboard uses the date the CDA was created rather than the Event Date. Linda asked participants to indicate if they prefer Event Date or another date. Some participants indicated that the date of CDA creation was acceptable. Other participants pointed out that hematology oncology facilities that have automated reporting and clinics using a manual recordkeeping process might create the CDA long after the event date. Participants asked that a CDC representative join a future WG call to discuss guidelines for CDA creation. The CDC might require facilities to create a CDA within 90 days of an event. Participants wanted to know how close different types of facilities create the CDA after the event date, on average. Marina also expressed interest in examining the timeline for submitting event data to the registry. It is important to distinguish facilities that report late and those that submit few cases or incomplete data.

April would like to know what field is used to designate reporting facility and whether this varies by vendor. CDC's eMaRC uses Custodian Organization to define reporting facility. Registries usually use the National Provider Identifier (NPI) associated with physician or facility in the CDA. Linda suggested examining how this field differs from Custodian Organization. Marina proposed term mapping to consolidate name variations in the field. Linda proposed that IMS first show the WG some example values.

April also wanted to know whether the dashboard would require an intermediate table that can link Registry ID/Name to all submissions from a facility upon import. She also wanted to know whether vendor information could be included so that data quality by vendor could be examined. Vendor was optional in MU2 CDAs, and most registries appear to receive vendor information in the CDAs. Currently, the intermediate table is not officially linked to the facility table, only unofficially by NPI. Linda indicated that an intermediate table was not needed, but the linkage to NPI needed to be improved. Participants agreed that a near term goal for the WG would be to encourage registries to collect complete NPI information with IMS and NCI help.

Another question posed by April was whether registries need the ability to assess data quality of CDAs at the time of upload and track facility performance over time. Registries perform some work to evaluate the quality of the uploaded data. Primary site, patient name, certain identifiers, and required data items need to be included in the uploaded data. Participants indicated, however, that it still would be useful to be able to assess data quality at the time of upload based on a minimal set of variables needed to match with the patient set. Tumor information would not need to be assessed at that point, other than confirming that the CDA includes tumor information. Matching algorithms would be useful and should be developed in collaboration with IMS. If the CDA is rejected, registry participants did not want to receive an import error. They wanted to be able to use the dashboard to assess how often a facility is missing specific variables, which result in rejection of a CDA. Considering that ICD10 codes populate multiple fields, participants were asked to identify the minimal required data items that would be used to assess MU data quality. The minimal data items are noted in Squish Issue 7028. Once April has this information, the WG can discuss the approach to assessing data at the time of upload. A decision can be made about creating the capability to monitor data quality over time once that step is completed.

In response to another question about making data items configurable by registries, participants agreed to complete the action items already discussed and review the final dashboard before working on this enhancement. IMS is planning to create a SEER*DMS reporting module in the future.

In terms of data quality, participants indicated that they wanted to be able to identify missing data, null flavors, the coding system used, and coding system errors if there are any. Linda responded that blank and null values are combined. Participants would prefer to be able to distinguish missing values from those that are not available so that they can provide feedback to reporting facilities that will allow those facilities to identify problems in the EHR and correct those problems.

In response to a question about SNOMED codes, participants clarified that these codes are recorded and stored in the system, but no conversions are done. Participants wanted to examine how much information could be obtained through SNOMED codes and the feasibility of translating these codes. CDC has a SNOMED lookup table.

Content validation is not performed at present. Invalid values currently are stored. The representative from the New Jersey registry expressed interest in content validation. The registry would like to report invalid codes to the vendor. The goal is to identify core data items that tend to have invalid codes and vendors that are most likely to send invalid codes. The Iowa registry requires certain fields but wants to ensure that other fields that are received are correct.

Information on Reporting Clinics

Registries receive data about the practices that submit CDAs (e.g., reasons for submission) that is not included in the CDA itself. Registry staff were unsure what to do with this information. Participants discussed the types of information about practices that the registries might want to collect. The New Jersey registry uses a REDCap registration form to collect information on type of facility. This registry is creating a separate database to track clinic reporting. The Utah registry has an external database for tracking adherence to reporting requirements by the clinics. The Louisiana registry captures only the type of facility, but this registry has few reporting facilities. Another registry collects organizational and physician NPIs. Registries that collect information about reporting clinics mainly do so outside of SEER*DMS, if at all.

April had mentioned the possibility of linking practices to information on their surveillance requirements. Some registries receive this information but not information regarding non-required surveillance activities of the clinics. The Utah and Iowa registries collect information on clinic surveillance activities because the clinics sometimes require a letter from the registry confirming that they are adhering to cancer surveillance reporting requirements. Participants agreed to have IMS create a Squish issue on the collection of information about reporting clinics and to discuss the types of information would be useful to the registries during the next call.

The Minnesota registry representative suggested using the SEER*DMS Facility tab to identify facilities that submit MU data. She would like to be able to track facilities that have agreed to report MU, when they began reporting, and how many CDAs they are submitting within a specified time period. Participants agreed that the ability to track MU compliance by facility would be useful. Most participants preferred to have a separate checkbox for indicating MU data reporting facilities. Linda noted that the types of data submitted might change and proposed including fields to indicate the types of data expected from each facility. Participants generally agreed with this proposal but noted that NPI was not completed for many facilities. This problem would need to be corrected before reporting compliance could be effectively tracked in SEER*DMS. IMS will perform an extraction to match the data that are missing in SEER*DMS. The WG agreed to examine ways to associate facility with the type of information provided and the type of information the facility is expected to provide. The WG will discuss this issue during the next call.

In the past, IMS offered to develop a tool to assist registries in obtaining NPI information from the NPI databases. At this point, creating this tool might take more time to ensure that facilities and physicians are not duplicated in SEER*DMS. Participants agreed to revisit the option to develop this tool.

A participant asked about a hierarchy for identifying the source of a CDA. IMS participants clarified that the CDAs are identified by the facility noted on the electronic health record (EHR), not the import facility. Facility can be recorded in one of multiple fields. As a condition of onboarding, the Iowa registry requires the field where this information is most likely to be recorded, according to the CDC.

Participants clarified that registries need to quantify the number of CDAs submitted by each practice each month. Registries do not need to quantify the number of tumors reported by each practice, only the number of patients. The WG will need to determine the details regarding this requirement.
A participant noted that building CTCs using the EHRs would facilitate tracking of CDAs by facility. eMaRC Plus consolidates records from the same practice and same patient (by facility, not across all CDAs). Participants agreed that this capability would be useful for quantifying the number of CDAs by patient for each reporting facility.