VISUAL EDITING STANDARDS

QUESTIONS AND ANSWERS

DISCREPANCIES

1. **If we transmit cases, and then discover and correct any errors, these are still added into our error rates.**

Reply: This is correct. The data are judged as they are originally submitted; the abstracts are reviewed as they are received in the transmit file. We do not include any corrections that are made after the file is sent to us.

2. **The region's feedback includes cases that were abstracted prior to the September 1999 distribution of the Informational Packet. Why can cases abstracted before this date be included in the accuracy rate?**

Reply: Standards documents (Volume I and SEER Extent of Disease manuals) have had no major changes since their 1998 distribution. The CCR and your regional registries have made exceptions, when appropriate, if updates have had an impact on the thirteen data items. The accuracy rate is based on when the abstract is visually edited and not when it was abstracted.

3. **Will there be a way for registrars to send cases to the CCR if we do not agree with our regional quality control correction?**

Reply: Yes. If a hospital registrar receives a discrepancy with which she or he disagrees, the registrar should send the abstract to the regional QC Supervisor. If the QC Supervisor agrees that this should not be a discrepancy, the discrepancy will be deleted and the registrar will be notified in writing that it was deleted. If the QC Supervisor believes that the correction is valid, she or he will provide documentation and/or additional explanation. If after review, the registrar still does not agree with the correction, she or he should return the abstract and documentation with a brief explanation. The QC Supervisor submits all documentation from both the hospital and the region to the CCR. The CCR will respond to the region with a copy to the registrar.

4. **How can we be sure a discrepancy that was not really an error is subtracted? How will the regional registries be able to keep track of the mistakes they make and subtract them? If there is a disagreement where the determination has been made in favor of the reporting facility will the error rate be re-calculated**?

Reply: For those regions using the CCR's automated software (CANDIS), discrepancies are tracked automatically by the program. If the regional registry makes a mistake, the discrepancy will be subtracted before the semi-annual accuracy rate is calculated. The subtraction of the discrepancy will be designated by the letter "N" on the monthly activity report. Disputed cases will be moved to another evaluation period if there is no resolution before the date that the accuracy rate is calculated. Automated non-CANDIS regions and regions not using automated software will provide registrars with similar information.

5. **How will you deal with abstracting changes where both abstractors and QC staff are waiting for clarification?**

Reply: When there are abstracting changes that need clarification, discrepancies will not be counted until there is statewide distribution of the clarification. The QC editor will check to be sure that the date the abstract was completed is at least one month later than the date the clarification was distributed before a discrepancy is counted.

6. **If the letter doesn't contain the specific errors, the hospital has no way to dispute the accuracy of the rate.**

Reply: We will send the specific discrepancies to the hospitals on a regular basis. In general this will be once a month; however, for large hospitals this may be weekly and for small hospitals this may be quarterly. You will have three weeks to disagree with any of the changes. None of the changes will be used in an accuracy rate without the hospital having a chance to disagree.

If you disagree with a change and the quality control supervisor agrees with you, the data item will be changed back to its original value and not counted as a discrepancy when the accuracy rate is calculated for the next time period. (The accuracy rates will be calculated twice a year.) If the supervisor agrees with the visual editor, she will explain her reasoning to you. If you still disagree, the case will be put into arbitration with the CCR. The case will be marked so that it is not used in the semi-annual report until it is resolved.

DATA ITEMS/CASES

7. Why are class 3 cases included?

Reply: Class 3 abstracts are included because all cancer cases need to be reported to a central registry in order to have accurate incidence rates. The Class 3 abstract is sometimes the only abstract available for a case, particularly for cancers that may be diagnosed and treated in a doctor's office, such as leukemia or prostate. The registrar should document whatever is available regarding the residency at diagnosis, the date of diagnosis, and the primary site.

Documentation in the medical record on Class 3 cases is often incomplete and inaccurate. A discrepancy is not counted due to limited information. A discrepancy is counted when text on an abstract is incorrectly coded. For example, an abstract states "prostate CA with bone mets at diagnosis" and the extension is coded as 99. The correct extension code is 85, because there is a statement of distant mets at diagnosis. The most common discrepancies on Class 3 cases are because the registrar is in the habit of using unknown for all of the EOD items, forgetting that sometimes the information to code them is on the abstract.

8. When will C/NET add edits for county/zip, first name/sex and Spanish surname? When will we have the same edits as do the regional registries?

Reply: The edits will be included in the May 2000 update of CNExT.

9. I find the items selected for visual editing acceptable with the exception of EOD coding. This is a matter of interpretation and is not objective.

Reply: Accurate staging is very important in the collection of cancer data. It would not seem reasonable to eliminate EOD coding as an item to be visually edited because then the CCR and/or other researchers could never include staging data in analysis with any real confidence. In the majority of cases, a discrepancy in an EOD code can easily be determined. In those cases where it is not, guidelines are being developed to assist visual editors in making a determination as to whether to count a discrepancy or not. These same guidelines will be shared with registrars.

10. I'm so glad that summary stage will not be edited. I think it was ridiculous to get errors on a field that no one else even uses.

Reply: Although we don't visually edit Summary Stage, it is collected by the majority of states in the United States and is widely used by researchers.

11. Why are surgery codes not included? Why would the state implement four different surgery codes and then not even do QC on these fields?

Reply: The CCR decided to implement the changes to the surgery codes to be in alignment with both ACOS and SEER. If we did not include the additional fields, then registrars in ACOS hospitals and SEER regions would be non-compliant with these standard-setting organizations. We decided to require these fields because we felt that we needed all of them to accurately reflect the surgical treatment given, i.e., Surgery of the Primary Site would not be sufficient. With regard to the addition of three procedure fields, researchers at the CCR felt that they needed a better picture of surgical treatment. Prior to this, it sometimes appeared that patients received surgery on the same day that they were diagnosed. As stated in the Informational Packet, our plan is to add these and other fields to the list of items which are visually edited as funds become available. In the interim, we are relying heavily on cancer registry abstractors to ensure the accuracy of these fields.

TECHNICAL ISSUES

12. Which cases will be included in the VE accuracy rate starting 1/1/2000?

Reply: Cases that are visually edited on or after 1/1/2000 will be included.

13. If we have to wait six months then this whole exercise is futile.

Reply: That's why we will be sending back changes on a regular basis. The quicker the feedback is, the more chance it will have an effect on the quality of your abstracting. (In general this feedback will be once a month; however, for large hospitals it may be more frequently and for small hospitals it may be less frequently.)

14. Why will the rates not be available by individual? I don't want my work judged by combining with another person's rate. Will there be a way for facilities to calculate individual registrar rates?

Reply: The regional registries are contracted with the reporting facilities; therefore, the quality of the data submitted is judged by facility, not individual. If a facility has a problem with quality and employs several abstractors, they may wish to calculate the rates by individual.

To calculate the rate by individual, take the monthly (weekly/quarterly) listings of cases that have been reviewed. (If you are comparing to a six-month accuracy rate, use the reports for the six months prior to that rate). Identify each case by abstractor. Take the number of cases that were submitted by each abstractor. Then, for each abstractor, count how many discrepancies they had and use this formula:

$$\frac{\text{\# discrepancies}}{\text{\# cases submitted X 13}}$$

Multiply the result by 100. Then subtract from 100% to get the accuracy rate. Repeat for each abstractor.

WHO IS NOTIFIED

15. These rates will undoubtedly be made public and be used in hiring practices.

Reply: The accuracy rates will be available only to the facility, the regional registry and the CCR. They are not available to anyone else including prospective employers.

16. Who at the hospital will receive the letters?

Reply: The reports with the changes made to the data will be sent to the registry or vendor who is responsible for the abstracting. (In general this will be sent once a month; however, for large hospitals this may be more frequently and for small hospitals this may be less frequently.) These will not be sent to hospital administration.

After the first year, the semi-annual accuracy reports will be sent to both the registry and hospital administration. Our contract is with the administration of the hospital; therefore, they are responsible for the quality of the data submitted. These letters will be sent to all facilities. This includes those serviced by vendors and by the region, itself.

Before we begin sending these letters, we will contact the registry or vendor to make sure that we have the correct name and address for the facility administrator. If your facility requests that other people on the staff also receive such letters, please also provide that information. You will be responsible for letting us know when personnel changes.

For regional registries that have already been sending letters to administrators about the quality of the data, they will continue to do so.

17. What are the consequences of not meeting the standard?

Reply: Based on the experience of those regional registries that have already distributed accuracy rates, the CCR expects most hospitals to meet the 97% standard. Registrars will have much less anxiety about the accuracy standard after the first results are reported. Procedures for hospitals that do not meet the standard will be developed after the results from all regional registries are reported to the CCR.

18. Why is the first letter to the hospital administrator being sent in August 2001?

Reply: The August 2001 date is later than the original date in the draft Informational Packet. The Task Force decided that the January 2001 date was too soon. Registrars would have only received one semi-annual report by this time, and this would not allow enough time for improvement, if necessary, before rates went to the administrator.

Also, please note that the implementation date for these standards is January 1, 2000, not the date that the letter goes to the hospital administrator.

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