

## Chapter 9: Screening for Reportability

SEER\*DMS uses a combination of automated and manual screening tasks to determine whether a record contains data related to a reportable cancer. An automatic screening task will evaluate the record and attempt to set the reportability flag. If the auto-screener cannot set the flag, an editor will set the flag in a manual Screening task or Pathology Screening task. Record type and registry preferences determine which of these manual tasks is created, as described below.

- The standard Screening task (Screen for Reportability) is used for abstracts and other types of records that are submitted with coded values for site, histology, and behavior. The auto-screener evaluates these fields and attempts to set the reportability flag. The auto-screener will set the flag for nearly all of these records; a manual Screening task will only be necessary for a small percentage. The manual task is created if the auto-screener cannot determine reportability; or if, according to your registry's screening algorithms, the reportability value calculated by the auto-screener requires review.
- A manual Pathology Screening task is typically created for records containing data from electronic pathology reports. This task has a specialized interface that highlights keywords in text fields to facilitate the coding of site, laterality, histology, behavior, and grade. The user completing the task also sets the reportability flag for the record.

In this chapter, you'll learn about

- Values of the Reportability Flag
- Pathology Screening Tasks
- Standard Screening Tasks
- Requesting Follow-back Information
- Viewing a Record's Reportability Status

### Values of the Reportability Flag

The possible values for the reportability flag are described below. Some values are not relevant for all record types (e.g., death certificate records can be non-reportable, but abstracts in many registries cannot be set to non-reportable). The criteria used to define each value are defined in the registry's configuration settings and documented on the Screening help page.

- **Reportable** – The record contains data related to an eligible case as defined by your registry's criteria. The record continues through the workflow, ultimately becoming part of a patient set in the database.
- **Auditable** – The record contains cancer-related data but is not a reportable case. The record is retained for use in casefinding audits. SEER\*DMS processes the record to obtain potential follow-up information. If the record matches an existing patient set, the record should be linked at the patient level but not to a CTC. In some registries, the auto-screener is configured to force a review of auditable records in a manual screening task.
- **Non-reportable** - The record contains data for a disease that is of no interest to your registry. It is not reportable and would not be included in audits. SEER\*DMS processes the record to obtain potential follow-up information. If the record matches an existing patient set, the record will be linked at the patient level but not to a CTC.
- **Unknown** – The reportability flag has not been set. The record may not have been screened at all; or the screening task may need to be completed in a manual Screening or Pathology Screening task.

- **Not applicable** – The record is not a medical record and does not require screening, for example, it may be a supplemental record from the department of motor vehicles. The record will not be processed in any of the automated or manual screening tasks.

## Pathology Screening Tasks

Requires system permission: *screening* and *rec\_edit*

A manual Pathology Screening task is created to review and code HL7 records and other types of records containing data from electronic pathology reports. The text from the pathology report is displayed with keyword highlighting. You will review the text and determine whether the data represent a reportable cancer, a cancer that is not reportable but should be kept for casefinding audits, or a non-reportable disease.

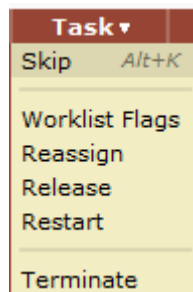
If it is a reportable record, you will code the site, laterality, morphology, grade, and the reportability flag for each primary cancer documented in the pathology report.

To open a Pathology Screening task:

1. Filter the worklist by Task Type = **Pathology Screening**. Click a task ID to open a Pathology Screening Task.



As you complete each task, the next task in the list will open automatically. The current Task ID is shown in the title bar.



The Task menu allows you to skip a task and move to the next task. The task that you skipped will still be assigned to your account. You can also press Alt+K to skip a task.

You may also use the Task menu to set worklist flags, assign the task to another user, or release it to the unassigned list. (Restart and Terminate will also be options if you have the *system\_administration* permission.)

An example of a Pathology Screening task is displayed below.

**Pathology Screening (TSK-5186277)** no flags Task View Manage Tools System Help

**HL7 E-Path**

Keywords	N	Score
sentinel	6	6
carcinoma	4	4
mastectomy	2	2
no residual	2	2
malignancy	1	0
negative for malign	1	-1
progesterone rece	1	1
invasive	1	1
Lymph nodes	1	1
HER-2	1	1
chemotherapy	1	1
DCIS	1	1
estrogen receptor	1	1
ductal carcinoma	1	1
<b>Total</b>	<b>24</b>	<b>21</b>

Positive: 22 Negative: 1 Other: 1

**Demographic (HL7 E-Path REC-101257012)**

Name: SQUAREPANTS, SPONGEBOB SSN: Birth Dt: 07-14-1986  
Maiden: Alias:  
Med Rec#: 00000000 Sex: 1 Dt Spec Collected: 01-04-2016 Specimen Rec: 01-06-2016  
Address(DX):  
Address(Cur): 105 CONCH ST; BIKINI BOTTOM, NJ 07444

Demographic Reportable Auditable Non-Reportable Save Close

**Text Fields Images Edits**

**EPath Sites**  
C77.8 C90.1 C91.0 C77.3 C90.2 C50.9 C50.0 C44.9 C44.5 C77.9 C76.1 C50.6 C50.3 C49.9 C50.2 C50.4 C50.5  
AIM131.1 AIM140.2

**EPath Morph**  
M-80103 M-80001

**Gross Path**  
GROSS DESCRIPTION:  
1. The specimen is received fresh for frozen consultation, labeled "left axilla, sentinel node #1" and consists of a 1.0 x 0.8 x 0.5 cm, soft, ovoid, tan-pink lymph node which is bisected and entirely submitted for frozen section in one cassette.

**Final DX**  
DIAGNOSIS:  
1. Left axillary sentinel lymph node #1, excision: One benign lymph node (0/1).  
2. Left axillary sentinel lymph node #2, excision: One benign lymph node (0/1).  
3. Left axillary sentinel lymph node #3, excision: One benign lymph node (0/1).  
4. Left breast, mastectomy:  
a. Histologic type of invasive carcinoma: NO RESIDUAL CARCINOMA identified following neoadjuvant chemotherapy.  
b. Histologic grade: Not applicable.  
c. Tumor focality: Not applicable.  
d. Ductal carcinoma in-situ (DCIS): Not identified.  
e. Skin and nipple: Negative for malignancy.  
f. Margins: Negative.  
g. Lymph nodes: See specimens 1,2, and 3 above.  
h. Treatment effect: No residual carcinoma, consistent with complete therapeutic response.  
i. Lymphovascular invasion: Not applicable.  
j. Pathologic staging: ypT0, (sn)ypN0  
k. Ancillary studies (from prior biopsy, see report:  
: Estrogen receptor: Negative (0%)

**Info**

Import ID: IMP-5092  
Import Type: HL7 NAACCR  
Source: FAC-11403  
Patient ID: unlinked  
Managing Physician:  
Date Loaded: 01-07-2016 05:40:52AM

To screen a pathology report:

1. Review the pathology text fields that are displayed on the text tab.
  - a. Key terms will be highlighted using a color scheme to designate positive for cancer, negative, or other (neutral).
    - i. Keywords found in the text are listed on the left. The N column shows the number of times each keyword appears in the text. The Score = (N \* the weight assigned to the keyword). The list is sorted by N. The totals of N for Positive, Negative and Other are shown below the total line.
    - ii. The keyword list is maintained by your registry. If you see a term that should be highlighted, select **New Keyword** from the record menu and propose a new word or term for consideration. The keyword will not become effective and will not be highlighted in text until it is approved by a registry manager (see the *Pathology Keywords* section of *Chapter 27: System Administration*).
  - b. The pathology text fields are displayed in an order that is based on a registry configuration parameter (*screening.pathology.fields*). Confer with registry staff to determine an order that is appropriate for your registry. Submit a technical support issue if the order needs to be modified.

- c. Determine whether the record is reportable, auditable, or non-reportable. These terms are defined in the *Values of the Reportability Flag* section of this chapter. You may also need to consult with a registry manager for the coding rules specific to your registry.
2. Choose a value for reportability by using your mouse or a keyboard command to depress the **Reportable** (ALT + R), **Auditable** (ALT + A), or **Non-Reportable** (ALT + N) button. Select **Help > Shortcuts** to view the keyboard shortcuts for the current page.

A data entry panel will be displayed. The panel will have a slightly different set of fields, depending on the value that you selected for reportability, as described below. Use the auto-complete feature to enter values, as described in step 4.

- a. **Reportable.** The data entry panel will include site, laterality, morphology, grade, site title, and histology title. If the pathology report indicates multiple primaries, click **Add Primary**. You are required to enter values for site, histology, and behavior for each primary. Site title, histology title, laterality, and grade are optional fields.

- b. **Auditable.** The data entry panel will include the fields defining one primary cancer. In most registry configurations, you will be required to enter a coded value and/or comment to document the reason that the record is auditable.

- c. **Non-reportable.** You may enter a coded value and comments to document the reason that the record is non-reportable. In some registry configurations, you will also be able to code site, histology, and other variables for a single cancer site.

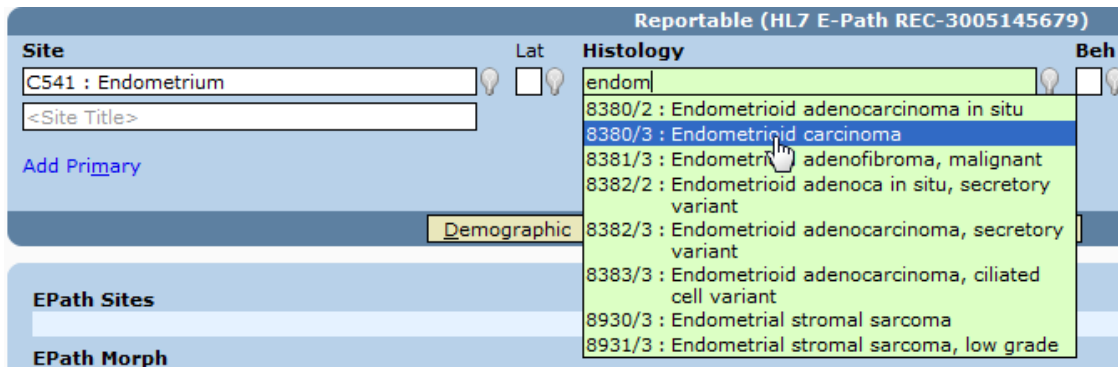
3. You can either use your mouse or arrow keys to scroll through the text. If a data entry panel is displayed and you prefer to use keyboard controls, press **ALT+T** to set the focus to the text panel. This will allow you to use the arrow keys to scroll through the text. Pressing

**ALT +** the letter assigned to the value that you selected for reportability will return focus to the data panel.

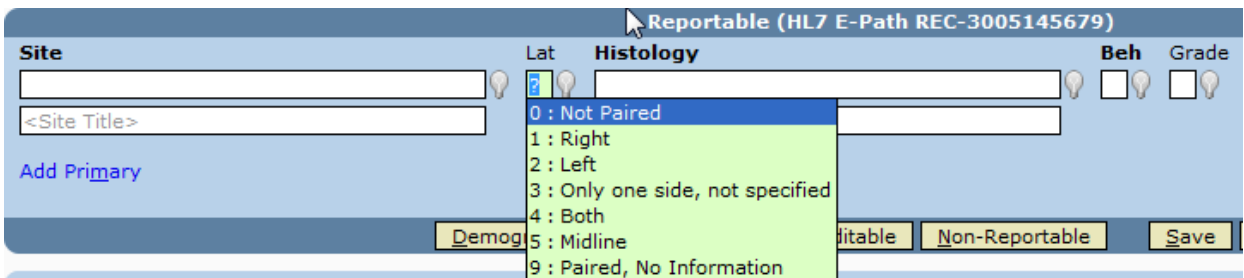
4. Enter search text or codes into each field. An auto-complete feature is implemented for the coded fields: site, laterality, histology, behavior, grade, and the non-reportable reason code. Auto-complete is not used for the free text fields: site title, histology title, and the non-reportable comment field. Methods for entering values are described below.

**Option 1:** Type the full value and press either Tab or Enter to move to the next field. For example, you could type C541 for Site and press Enter.

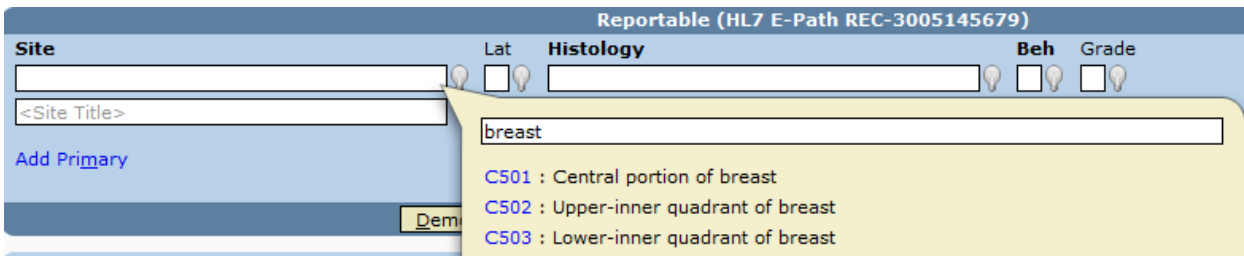
**Option 2:** Enter medical terms to search for a value. This technique can be used on any field. As an example, enter "Endom" for histology. A list of terms will appear as you type. You can either continue to type; or use your arrow keys or mouse to select a value for morphology. This will assign codes to both histology and behavior.



**Option 3:** Enter a question mark (?) to view all values in the field's lookup. Use your arrow keys to scroll to a value. Press Enter.



**Option 4:** Click the light bulb to open the standard lookup. If there are too many values to list at one time, then a search box will be displayed.



5. Completing or exiting Pathology Screening tasks:
  - a. Click **Save** or press **ALT+S**. The next Pathology Screening task will open. The list of tasks is based on the worklist filter settings that you were using when you started screening records. You will be returned to the worklist when you finish the last task in the list.

- b. If you wish to stop screening before finishing all tasks, you may either click **Close** or **Release** to end the current task without saving any changes (the keyboard shortcut for Close is **ALT+C**). If you use Close, the task will be assigned to your user account. If you use Release, the task will be unassigned. In both cases, you will exit the task and return to the worklist.

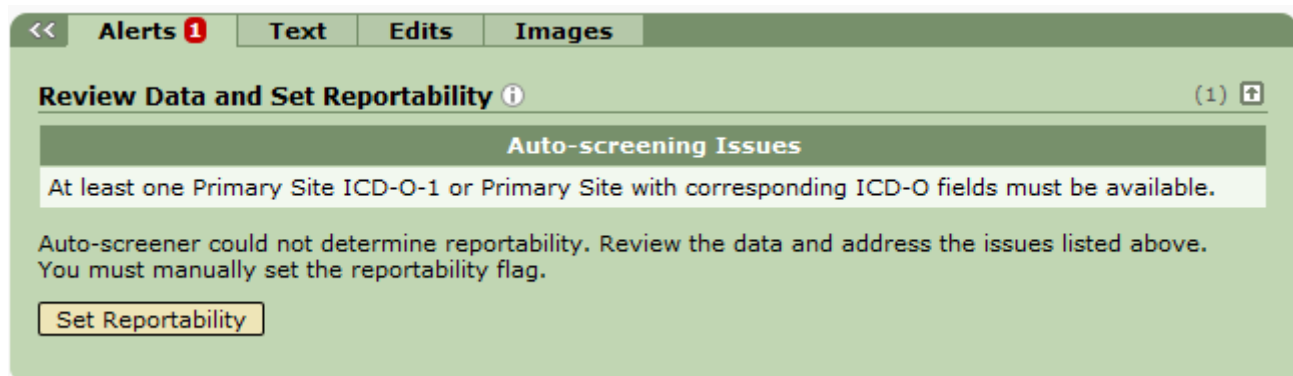
## Standard Screening Tasks

Requires system permission: *screening* and *rec\_edit*

A manual Screening task is created if the result of the auto-screener requires a manual review. For example, auditable abstracts require manual screening. The manual Screening task is also created if the auto-screener could not determine reportability based on the coded values for site, morphology, and other fields. This task is created for records, such as abstracts, which are submitted to the registry with coded fields. In contrast, the Pathology Screening task is designed to allow a registrar to code site, morphology, and other fields based on text fields.

To open a screening task, click a **Screening** link in the worklist summary on the home page. The Information column for each task will show a message from the auto-screener. For example, the auto-screener requires a valid value for site. If site was missing or blank then the auto-screener message would be "missing site". A similar message would be listed if the record failed other Auto-Screener Rules. The auto-screener rules and algorithms are described on the Screening help page.

Once you open the task, the record will be displayed in the record editor. Messages from the auto-screener will be displayed in the **Alerts** tab in the right panel of the record editor. In this example, the auto-screener could not determine reportability because there is no value for primary site.



To set a record's reportability flag in a standard Screening task:

1. Review the auto-screener messages displayed on the **Alerts** tab.
2. Review the record to ascertain reportability:
  - a. Click the links in the left navigation panel to review fields on other data pages.
  - b. If text is not displayed on the main data panel, click **Text** to open a pop-up window showing the text fields or go to the Text tab in the right panel.
3. If you are able to ascertain reportability for this record, set the reportability status field:
  - a. Click **Set Reportability** on the Alerts tab.
  - b. Select a **Reportability** value from the drop-down list.

- c. If you have selected *Auditable* or *Non-Reportable*, document your findings by selecting a coded value in the **Non-Rpt Reason** field and entering text for the **Non-Rpt Comment**.
4. If you are unable to determine reportability, use one of these options.
  - a. If further information from the abstractor or physician is required, you may submit a request for follow-back information (see the *Requesting Follow-back Information* section of this chapter).
  - b. If you require assistance, you may reroute the screening task to your manager or a colleague by following the instructions in *Chapter 4: Using the Worklist*.
5. Click **Save**.
6. Click **Save & Exit**.

## Requesting Follow-back Information

Requires system permission: *screening*, *rec\_edit*, and *fb\_initiate*

In SEER\*DMS, a request for follow-back information is referred to as a “follow-back need”. If you determine that additional information must be obtained from the reporting facility, you should submit a follow-back need. Your request will be associated with the record, allowing all users to review pending follow-back issues when reviewing the record data. If the information is required to ascertain reportability, you should save the record in a screening task so that the task can be completed at a later time. Otherwise, you should set the reportability status and move the record forward in the workflow. Methods for saving the record and exiting the task are described in the *Pathology Screening Tasks* and *Standard Screening Tasks* sections of this chapter.

You will receive an e-mail notification when a response is processed and the follow-back need is closed. You or another staff member may update data fields based on the new information.

*To submit a new follow-back need:*

1. Select **Add Follow-back** from the record menu.
2. Complete the necessary fields and click **Save**.

See *Chapter 22: Follow-back* for more details on submitting follow-back needs.

## Viewing a Record’s Reportability Status

If you are editing an unlinked record, the reportability status is displayed in the Info box of the record editor. An information icon will appear next to the value if a comment was made by the user who set the reportability flag or a reason not reportable was coded.

## Record Editor

**Health Record** →

Save Validate Cancel

**Demographics**

CTC  
Staging  
Summary TX  
Facility-Adm, TX  
Path  
TXr

AL 7 Img 0 SS 0  
FB 0 AFL 0

---

**Info**

Import ID  
IMP-50760 ⓘ

Import Type  
NAACCR 15 Full Abstract [DT]

Source  
FAC-0022 ⓘ

Reportability  
Reportable ⓘ

Patient ID  
*unlinked*

Date Loaded  
03-04-2016 03:41:48PM

Date Last Modified  
06-27-2016 10:14:41AM

Event Date  
01-01-2009

**Text** Demographics (Health Record REC-30081

**Name:** SQUAREPANTS, SPONGEBOB **SSN:** 999-99-9999 **DOB:** 07-14-1986 **R:** 01  
**Site:** C189-9 **Morph:** 8140/3 **Grade:** 9 **Seq:** 00 **Date:** 0

**Demographics** Reviewed  ⚡ Rev Fl  Abstd Rec Type IANON ⚡

Pat ID#

Pre  Last SQUAREPANTS First SPONGEBOB M

Maiden  Alias

Birth State ZZ ⚡ Country ZZU ⚡ Birth Place 999 ⚡ Birth Dt

Race 01 ⚡ 88 ⚡ 88 ⚡ 88 ⚡ 88 ⚡ Hispanic 0 ⚡

NAPIIA  ⚡ Cmptd Eth  ⚡ Cmptd Eth Src  ⚡ NHIA  ⚡ IHS  ⚡

**Follow-up**

DOLC 08 14 2015 Vital Status 4 ⚡ Autopsy 9 ⚡ Sur

FU Source  ⚡ Next FU Src  ⚡ SEER Type FU  ⚡ FU Src Cntl  ⚡

Follow Reg  NPI Follow Reg  Lst FU Hosp

DC File#  Death State  ⚡ Country  ⚡ D

COD Rev#  ⚡ COD

COD Desc

Num  Dir  ⚡ Street

Suppl

City  ⚡ Cnty Code 999 ⚡

Comment Reportable , malignant per SH

## Patient Set Editor

**PAT-10993643** →

Save Validate Cancel

**Demographics**

CTC 00 (C446-2) ⓘ

AL 13 Img 0 SS 0  
FB 0 AFL 1

---

**Pending (1)** ⓘ

FAC-0086 (1) ⓘ

NM 06-13 C446-2 ⓘ

**Consolidated (8)** ⓘ

FAC-0086 (5) ⓘ

NA 06-13 C446-2 [C00]

HL7-N 07-13 [C00]

HL7-N 10-14 [P]

HI 07-13 C446 [C00]

HI 10-14 C447 [P]

FAC-0130 (1) ⓘ

NA 06-13 C446-2 [C00]

FAC-0145 (2) ⓘ

HL7-N 03-11 [C00]

HL7-N 06-13 [C00]

REC-3006432069 / Non-Reportable

To view the reportability status of a linked record in the patient set editor, hold your mouse over the Record Type. The Record ID and reportability status will be shown in a box just below type.

The letter "N" or "A" will also appear after the record type to indicate reportability. For example, a non-reportable HL7 will appear as "HL7-N". A record type without a following letter is reportable.



The following icons are used throughout SEER\*DMS to indicate the record's reportability status:

- N Non-reportable
- A Auditable
- U Unknown (the record has not yet been screened)
- N/A Not applicable; the record type is not screened (e.g., supplemental records)

The icons are displayed in the Type column of search and match results tables. If an icon is not displayed next to the record type, the record is reportable.

Score	Type	ID	Last Name
506	Health Record	<a href="#">REC-1203760609</a> ⓘ	DOE
506	Casefinding	<a href="#">REC-187324</a> ⓘ	DOE
506	Death Certificate <input type="checkbox"/> N	<a href="#">REC-3001075471</a> ⓘ	DOE
506	Death Certificate <input type="checkbox"/> N	<a href="#">REC-3001102494</a> ⓘ	DOE

The icons are also shown next to the Type field for the Incoming Record of a Match task. In the figure below, the incoming record is not reportable.

Match (TSK-23413125)

Facility  ⓘ City  State  Tumor Registry

Score	Type	ID	Last	First	Middle	Suf
<b>Incoming Record</b>						
<input type="checkbox"/> HL7 <input type="checkbox"/> N		<a href="#">REC-3008109902</a> ⓘ	TENTACLES	SQUIDWARD	L	
<b>Matches (0 selected)</b>						
<input type="checkbox"/>	793 HI	<a href="#">REC-3007241054</a> ⓘ	TENTACLES	SQUIDWARD	A	

Matched in < 1s. [View Matching Algorithm](#)

Complete