The Surveillance, Epidemiology, and End Results Data Management System (SEER*DMS) Change Control Board (CCB) Meaningful Use (MU2) Work Group (WG)
Teleconference Summary
March 22, 2018
1:00 p.m. to 2:00 p.m. EDT

Representatives from NCI, IMS, the Scientific Consulting Group, Inc. (SCG), and seven SEER registries participated in the SEER*DMS MU2 WG conference call on March 22, 2018. Participants included:

REGISTRIES:
Hawaii
Iowa
Minnesota
New Jersey
New York
Utah
Seattle

NCI: Andrew Grothen, Marina Matatova, Kai Wong

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

Westat: Laura Lourenco

SCG: Kathryn Brown-Huamani, rapporteur

Action Items

- IMS will map all data items in SEER*DMS (unless they obviously are not needed) and notify registries when this task is complete.
- David Angelaszek agreed will refresh the Utah registry's data.
- David will check the feasibility of obtaining Payer Type, Payer Name, and Policy Number data items.
- Brent Mumphrey (MU2 WG chair) and Linda Coyle agreed to verify that CDAs only are appended to the most recent record.
- IMS will make system queries available with instructions. Brent agreed to disseminate the query via Squish.
- IMS will develop a proposal for reducing the number of apparent duplicate CDAs and present this proposal at the next MU2 WG meeting.
- April Austin of the New York registry agreed to create a Squish issue with problematic histology data for IMS review.
- Marina Matatova agreed to speak with her contact at the Centers for Disease Control and Prevention about SNOMED conversion. She also agreed to confirm that only the latest records are sent with appended CDAs.
- Jamal Johnson at the New Jersey registry agreed to submit a tech support issue regarding a problem with some display values labeled as regular values.
- April agreed to send Stage 3 dummy data to IMS for review.
- Linda agreed to distribute the template spreadsheet developed by Brent Mumphrey via a Squish issue.

Data Items Imported Into DMS

Brent updated the WG on the status of importing CDA data items directly into SEER*DMS. IMS prefers not to retrospectively add data items to SEER*DMS because of the additional processing time involved. The participants agreed that among the items (fields) not yet imported, Patient's Gender is redundant because Patient's Gender Code is already loaded. The fields with the word Suffix (e.g., Author's Name Suffix) will be imported. The participants agreed that all non-imported fields should be mapped unless it

is apparent that this is unnecessary. Once items are mapped, IMS will let registries know when their data can go into production. The data will be viewable in the Patient Set Editor.

Discussion

Participants noted that different vendors have different coding systems for primary site and histology and asked how these differences will be accommodated during the mapping process. All raw data are stored and converted into the JSON data structure. Algorithms exist to convert the data to the current ICD system but this process is imperfect. Registries should indicate what coding system they use to avoid this problem. April of the New York registry agreed to create a Squish issue with the problematic identification numbers for IMS review. IMS will check mapping accuracy and define the difference between the fields: Author and Custodian.

Registries are seeing some SNOMED cases. For example, the New Jersey registry is receiving many cases from Flatiron that are in the SNOMED format. The Centers for Disease Control and Prevention (CDC) might have a reliable SNOMED conversion algorithm. Marina agreed to contact Wendy at CDC about this potential solution.

April would like Payer Type, Payer Name, and Policy Number to be mapped because the Stage 3 implementation guide is requesting these data items. IMS will map these items when SEER is required to use Stage 3 in 2019. Some vendors in New York already are certified for Stage 3, however. April agreed to send some Stage 3 dummy data to IMS. David agreed to review these data and another sample he has.

CDA Data Analysis

Brent reviewed CDA data received from a hematology-oncology ("hemoc") clinic in Louisiana. Patient records were categorized according to whether they were (1) loaded into DMS, (2) matched to a patient set, or (3) matched at the CTC level. Sample data from each category were used for developing a template for analyzing data streams. Brent limited the cases reviewed to those diagnosed from 2014 to 2016. Out of the 39 cases reviewed, 10 missed cases were found, seven were possible missed cases requiring follow back, eight should have linked to a patient set, but did not, and others had problems with Social Security Numbers (SSNs). IMS is interesting in knowing why eight cases did not link.

Brent reviewed 50 distinct patient sets from another Louisiana clinic for patient level match. Seven new cases were found but the event date was 2017 so they likely would have been resolved. A few cases from 2011 and 2012 were missed. Eleven of these cases provided useful information. Twenty-eight cases should have linked to an existing CTC. An additional 50 cases were reviewed for CTC level match. All cases matched and 10 provided useful information.

Discussion

Linda proposed creating a template spreadsheet for problematic cases that all registries could use. Participants generally agreed to use the template created used by the Louisiana registry, which Brent agreed to share. The Hawaii registry representative was willing to use the template but the registry is not ready to submit the information that would be included in the template. The Minnesota and New Mexico registries also have no data to analyze. The New Jersey, Utah, Georgia, and New York registries have data and were interested in using Brent's template. The Seattle registry representative agreed to speak with other staff at her registry about their willingness to use the template and notify IMS. The Iowa registry has developed a similar template spreadsheet, which the registry will continue to use. Linda indicated that registries could use their own templates, if they have them. She also agreed to distribute Brent's template via a Squish issue (#6170).

Participants noted that the implementation guide indicated that multiple CDAs should be appended to the latest record. Brent agreed to check the data he reviewed to determine if this was the case for all CDAs. Several participants discussed the issue of cumulative records. The Utah and Iowa registries want to choose, by provider, whether to keep the latest CDA. Providers at several registries seem to be sending some CDAs that are not cumulative. Participants noted that the problem likely was vendor specific. IMS wants to attempt to improve the algorithms before creating an option to select by provider or vendor. If possible, NCI wants to know the percent of cumulative versus non-cumulative CDAs received by vendor. Vendors can change their processes in response to consumer requests.

IMS staff are working on a solution to reduce the number of apparent duplicates. IMS will present a proposal for this solution during the next MU2 Work Group call.

Jamal is participating in calls with vendors that the CDC is conducting. He recommended that Brent also participate in those calls. Participants do not need to represent a National Program of Cancer Registries registry.

Next MU2 Work Group Call

The next MU2 Work Group call is scheduled for April 26, 2018.

APPENDIX

Upon adjournment of the March 22, 2018 meeting, Brent and IMS and NCI participants discussed next steps. IMS agreed to develop two templates; one to summarize data and another for problematic cases.

Marina mentioned that NCI and CDC staff are discussing the possible alignment of their informatics and the registry activities. IMS and Brent agreed to invite Wendy from CDC to future MU2 meetings. Brent and Linda also could present an update on MU2 WG activities to the CDC.