DRAFT FINAL REPORT

2021 Field Testing

Surveillance, Epidemiology, and End Results (SEER) Program

National Cancer Institute

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Contents

[Executive Summary 4](#_Toc94163396)

[**Study Purpose** 4](#_Toc94163397)

[**Study Participants** 4](#_Toc94163398)

[**Study Cases** 4](#_Toc94163399)

[**Preferred Answers** 5](#_Toc94163400)

[**Study Timing** 5](#_Toc94163401)

[**Findings/Results** 5](#_Toc94163402)

[**Conclusions** 6](#_Toc94163403)

[Background 7](#_Toc94163404)

[Method 7](#_Toc94163405)

[**Study Mechanism** 7](#_Toc94163406)

[**Case Selection** 7](#_Toc94163407)

[**Number of Cases** 7](#_Toc94163408)

[**Preferred Answers** 7](#_Toc94163409)

[**Invitation to Participate** 8](#_Toc94163410)

[**Requirements for Participation** 8](#_Toc94163411)

[**Participation Registration** 8](#_Toc94163412)

[**Study Participants-Demographics** 8](#_Toc94163413)

[**Assignment of Cases** 9](#_Toc94163414)

[**Continuing Education Credits** 9](#_Toc94163415)

[**References** 9](#_Toc94163416)

[Study Results 10](#_Toc94163417)

[**Reconciliation** 10](#_Toc94163418)

[Data Analysis 11](#_Toc94163419)

[Evaluation of Data Items 12](#_Toc94163420)

[Did you find the SEER Software easy to use? 12](#_Toc94163421)

[Question: Do you have any suggestions on how to improve the field testing process? 15](#_Toc94163422)

[**p16 (Cervix)** 17](#_Toc94163423)

[**ER/PR/HER2 Summary, Case #1 (Breast)** 18](#_Toc94163424)

[**ER/PR/HER2 Summary, Case #2 (Breast)** 20](#_Toc94163425)

[**Visceral and Parietal Pleural Invasion (Lung)** 22](#_Toc94163426)

[**Residual Tumor Post Cytoreduction (Ovary)** 23](#_Toc94163427)

[**High Risk Cytogenetics (Plasma Cell Myeloma)** 24](#_Toc94163428)

[**Number of Cores Positive and Number of Cores Examined (Prostate)** 26](#_Toc94163429)

[**Reliability Software Comments** 29](#_Toc94163430)

[**Field Testing Process-Suggestions for future studies from Field Testing Chair** 30](#_Toc94163431)

[Appendices 31](#_Toc94163432)

# Executive Summary

## **Study Purpose**

The 2021 Field Testing was conducted to

* Meet the need of the NAACCR Mid-Level Tactical Group requirement that all proposed new data items be field tested
* Assess the availability of several data items that standard setters are interested in collecting (accessibility)
* Assess how well registrars can code the proposed new data items based on the current codes and definitions (feasibility)
* Determine educational needs

The results of this study

* Have been used to evaluate the functionality of the proposed rules, coding instructions and data item set up for the proposed new SSDIs and update of Skin Surgery codes
* Will be used to make adjustments/clarifications to the proposed and current data items
* Will be used to develop educational material

The 2021 study was not intended to evaluate the performance of individual participants or registries. Therefore, no error rates or accuracy goals were established for this study.

## **Study Participants**

The study was open to cancer registrars and other health professionals who wished to participate.

* 236 participants filled out the demographics information and started cases
* 210 participants completed at least one group of cases, with several participants completing more than one set
	+ Note: There was only set of questions for the Histology Subtype

## **Study Cases**

The study included three proposed SSDI, proposed Skin Surgery Codes and several data items requesting information on availability.

For the SSDIs, medical records of actual cases were expunged of identifiers. Due to time constraints of study participants, information in the records not relevant to the study was removed.

The study was conducted online using the SEER Reliability Software, which was specifically developed for SEER by Information Management Services (IMS), Inc.

The study was divided into two major parts

**Part 1 covered the new proposed SSDIs and the proposed Surgery Codes for feasibility**

* Primary Tumor Location
* Histology Subtype (Appendix)
* Surgery of Primary Site (Melanoma Skin)
* Margin Measurement (Melanoma Skin)

**Part 2 covered the data items for accessibility**

* p16 (Anus)
* PD-L1 (Lung, Melanoma Skin)
* HER2 (Colon and Rectum)

There were 5 groups of unique cases for Primary Tumor Location, Surgery of Primary Site and Margin Measurement.

There was one set of 5 scenarios for the Histology Subtype. This same set was used in all 5 groups and registrars only coded these one time.

## **Preferred Answers**

Preferred answers were developed for use in the study by the team lead and co-lead of the field testing. Due to extenuating circumstances, volunteers from NCRA were not able to be used this year. In addition, two physicians helped with the cases and preferred answers (Primary Tumor Location, Histology Subtype) and representatives from CoC, and NAACCR helped with Surgery of Primary Site (Melanoma Skin) and Margin Measurement data items.

Comments received back from the study participants were reviewed and additional review by other registrars was done to determine the final answers (post reconciliation preferred answers) and revised rationales for select data items.

## **Study Timing**

The study was conducted via the secure website, https://reliability.seer.cancer.gov, from November 1, 2021-December 31, 2021. Post-study reconciliation of the answers took place January-February 2022.

## **Findings/Results**

Overall findings

* Fewer registrars (almost 100) participated in this study than in 2019 and 2020
* Over a 1,000 comments received, approximately three times as many as previous years
	+ Many of these comments were identical, which enforced where the problems area were
* Registrars appeared to understand the intent and directions for Primary Tumor Location. There were a lot of comments regarding Brain Anatomy, what is a skull base site and how the data item related to the Primary Site data item
	+ Further discussion by SSDI and clinical experts are ongoing as to how better documentation on what is a skull base tumor can be developed and provided to registrars
* Registrars appeared to understand the intent and directions for Histology Subtype. Based on comments received, some additional notes were added, and clarifications noted
* In terms of the proposed changes to the surgery codes, there was a lot of confusion regarding the purpose of the data items. Part of the confusion was due to the following
	+ Change in code format
	+ Margins being removed from the surgery codes (although many registrars commented this was an excellent idea)
	+ Requirements to code all relevant procedures, not just the most extensive one. This instruction was more for the hospital registrars, who are currently doing this, but there were many central registrars participating who only code the most invasive procedure.
	+ For the Margin Measurement, confusion over where the margins can come from and how they are recorded
	+ Note: Based on comments received, CoC reviewed the comments and worked with their clinical experts to revise the codes, code descriptions and instructions for both the surgery codes and the margins data item
* This Field Testing was the first time that availability of information was collected
	+ In general, the process used did not work very well
	+ Comments received back included that a prospective approach of determining availability (while they are abstracting) is much more effective than a prospective approach
	+ For each question, anywhere from25-78% of the registrars did not answer (blank)
	+ Of those who answered, many stated didn’t know, weren’t sure, or unknown
	+ Although some registrars did fill in numbers, these were very few and did not give a good indication of how available the data was
	+ Also, with such a low participation this year, it is unknown how well the participants represented availability of the US as a whole

## **Conclusions**

Although this year’s study had much fewer participants than fewer years, the registrars who did participate were very active with their comments. The comments received pointed out very clearly where problem areas were and the issues that needed to be addressed.

Overall, a good study which did determine what changes needed to be done to the proposed data items, and also what the educational needs are.

It also pointed out that a different approach to determining availability is needed.

# Background

Field testing is now required by the NAACCR’s Mid-Level Tactical Group for any new data items that are being introduced to the registry community. Since NCI SEER conducts reliability studies as a vital part of the quality improvement process, SEER has the infrastructure available to do field testing. SEER agreed to manage the Field Testing. The protocol addresses the new data items for implementation in 2022 that are being proposed by the NAACCR SSDI Workgroup, SEER, and AJCC.

# Method

## **Study Mechanism**

A formal study protocol was developed and followed (See Appendix 1: 2021 Field Testing). The 2021 Field Testing was a web-based study. Participants were required to use a computer with access to the Internet. Study cases were placed on the SEER website and participants completed the study online. The study was open for 9 weeks starting November 1st and closed December 31, 2021. The study was conducted online using the Reliability Software specifically developed for SEER by Information Management Services (IMS), Inc., a biomedical computing contractor with NCI SEER. The reliability software used had two major improvements compared to software used for prior SEER reliability studies.

* Preferred answers and rationales available to participant immediately after a data item was answered
* Participant able to provide immediate comments on the preferred answer and rationale

Practice cases were not included for the field testing.

## **Case Selection**

A call for cases was issued to all hospital central registries in the US and Canada (See Appendix 1: 2021 Field Testing Protocol, Appendix C: Call for Cases). Approximately 40 records were received in response to the call for cases. The study coordinator at SEER and the study co-coordinator from Westat reviewed the submitted cases. In addition, 20+ cases were received from two neurosurgeons for the Primary Tumor Location data item. Case scenarios for the Melanoma Skin Surgery codes and Margin Measurement were received from NAACCR and CoC.

Study cases were selected for each of the schemas to be tested. The remaining cases were stored in the NCI SEER case database for future reliability studies. The criteria for the study cases was for primary sites to be from the schemas requested, along with information on the SSDIs for those schemas. Personal and facility-identifying information was removed from the cases by the registry prior to sending to NCI SEER. After receipt, the cases were further de-identified, if needed. Each case selected was then assigned an identifier and this identifier was added to each page of the case. IMS converted the cases to HTML for placement on the study website.

## **Number of Cases**

The 2021 Field Testing was conducted by having participants abstract and code the following

* Primary Tumor Location (4 cases per group, 20 unique cases)
* Surgery of Primary Site (Melanoma Skin) (2 cases per group, 3 Surgery data items each, 10 unique cases)
* Margin Measurement (Melanoma Skin) (2 cases per group, 10 unique cases)
* Histology Subtype (Same group of case scenarios for all registrars)

## **Preferred Answers**

Preferred answers were developed for use in the study by the team lead and co-lead of the field testing. Due to extenuating circumstances, volunteers from NCRA were not able to be used this year. In addition, two physicians helped with the cases and preferred answers (Primary Tumor Location, Histology Subtype) and representatives from CoC, and NAACCR helped with Surgery of Primary Site (Melanoma Skin) and Margin Measurement data items.

Comments received back from the study participants were reviewed and additional review by other registrars was done to determine the final answers (post reconciliation preferred answers) and revised rationales for select data items.

## **Invitation to Participate**

The Chairs of the Mid-Level Tactical Group issued an invitation to participate in the study (See Appendix 1: 2021 Field Testing Protocol, Appendix A: Invitation to Participate). The invitation to participate was distributed via email on October 1, 2021. The email was sent to the SEER registries. An email was also sent out via the NAACCR listserv, and NCRA sent out the announcement in one of their member communications.

## **Requirements for Participation**

Study participants were required to use a computer with Internet access. The reliability study was web-based and located on a secure website.

## **Participation Registration**

Registration took place via the web. The study website opened for registration on October 1, 2021, one month before the actual study began. If a registrar had participated in a previous reliability study (2011 or later), they could use their existing username and login (forgot username and password links available). If a registrar had not participated in a reliability study before, instructions were provided in the invitation to participate for them to set up an account. Each registrant chose a unique username and password and provided their demographic information (See Appendix 1: 2021 Field Testing Protocol, Appendix B: Functional Requirements Document). Per all SEER Reliability studies, demographic information was required to participate in the study.

## **Study Participants-Demographics**

The study was open to all registrars in the United States. It was recommended that registrars in SEER program areas participate. There were no mandatory requirements for participation.

|  |  |  |
| --- | --- | --- |
| **Agency** | **Number of Participants** | **Percentage** |
| Central Cancer Registry | 112 | 51.6% |
| Hospital Cancer Registry | 101 | 46.5% |
| Other | 4 | 1.8% |
| Total | 217 | 100 |

| **CTR?** | **Number of Participants** | **Percentage** |
| --- | --- | --- |
| No | 36 | 15.3% |
| Yes | 200 | 84.7% |
| Total | 236 | 100 |

| **CoC Accredited** | **Number of Participants** | **Percentage** |
| --- | --- | --- |
| Yes | 93 | 92.1% |
| No | 8 | 7.9% |
| Total | 101 | 100 |

| **Years of Experience** | **Number of Participants** | **Percentage** |
| --- | --- | --- |
| 0 | 8 | 3.4 |
| 1-5 | 56 | 23.7 |
| 6-10 | 34 | 14.4 |
| 11-15 | 44 | 18.6 |
| 16-20 | 46 | 19.5 |
| >20 | 48 | 20.3 |
| Total | 236 | 100 |

| **Cases Personally Abstracted****Per Year** | **Number of Participants** | **Percentage** |
| --- | --- | --- |
| 1-250 | 78 | 33.1 |
| 251-500 | 47 | 19.9 |
| 501-1000 | 51 | 21.6 |
| 1001-2000 | 18 | 7.6 |
| 2001 or more | 6 | 2.5 |
| Unknown | 36 | 15.3 |
| Total | 236 | 100 |

## **Assignment of Cases**

Each participant was randomly assigned one set of cases. Assignment of the set was based on the set group that was next in line. The first participant entering the study was assigned the first set, the second participant, the second set, and so on. This procedure continued until all participants entered the study.

Registrars could complete all 5 groups of cases comprising select data items since there were no repeated cases for some items.

## **Continuing Education Credits**

NCI SEER requested and NCRA awarded continuing education credits (CEs) for participating in the reliability study. Completion of 1 set entitled the participant to 1 CEs and completion of 2 sets entitled the participant to 2 CEs. A certificate showing the event number and the number of CEs was made available to the participant following completion of their set.

* 2021-186: Field Study Testing – Accessibility and Feasibility of proposed and potential new data items

## **References**

Resources needed for the 2021 Field Testing were provided on the SEER website reliability study and included

* Draft of the new SSDIs
* Draft of the new Surgery Codes

# Study Results

## **Reconciliation**

The objectives of the post-study reconciliation were to

* Determine the final answer for each data item included in the study
* Identify areas in the appropriate manuals needing revision or clarification
* Identify educational needs

Eligibility for reconciliation was determined by the percent of participants disagreeing with the preferred answer. Data items with less than 85% agreement were eligible for review of the preferred answer. Additionally, each comment received, even on data items with 85% or greater agreement, was reviewed.

The study coordinators reviewed each of the applicable data items to determine if a change to the preferred answer was needed. In reviewing comments, questions were sent out to other registrars (AJCC, SEER, CoC, SSDI Workgroup) to help determine the final preferred answer.

Final answers were updated from the initial preferred answers on 4 data items out of 38 unduplicated total SSDIs (10.5%). Answers were changed based on comments reviewed, additional review done, and discussion of data items in question with other experts. Table 2 lists each case and data item changed with a brief explanation of the reason for the change. For more extensive rationales, see Appendix 2: 2021 Field Test-Final Answers and Rationale, which has a complete listing of all the data items and the final answers. Review of participant comments resulted in updating rationales for many data items without answer changes.

Table 1: List of Data Items and Number of Preferred Answers Changed

| **SSDI** | **Total Items** | **Answers Changed** |
| --- | --- | --- |
| Primary Tumor Location | 20 | 0 |
| Histology Subtype | 5 | 1 |
| Surgery of Primary Site  | 30 | 0 |
| Margin Measurement | 10 | 0 |

Table 2: List of Answers Changed by Case # and Data Item

| **Group(s)** | **SSDI** | **Pref Ans** | **Final Ans** | **Reason for Change** |
| --- | --- | --- | --- | --- |
| **All** | Histology Subtype, Case Scenario #3 | 2 | 1 | Pathology report sated “Appendix, appendectomy: Low grade appendiceal mucinous neoplasm (LAMN) with focal high grade mucinous neoplasmBased on the Solid Tumor Rules, the “focal” would be ignored. Follow up with a GI pathologist was also done, who also stated that the focal would be ignored and this would be coded as LAMN |

### Data Analysis

Data were analyzed by case and by data item based on the percent of participants agreeing with the preferred answer and based on comments submitted by participants. Preferred answers were updated based on post-study reconciliation. Individual participant performance was not examined.

The results of agreement with the post-study reconciliation final answers are shown in Tables 3.1 and 3.2. The cells highlighted in yellow indicate less than 85% agreement with the preferred answer.

* Primary Tumor Location had 4 cases per group. The percentage shown is the overall percentage based on all 4 cases
* Surgery of Primary Site had 2 cases per group, and three different surgery data items per case. The percentage show is the overall percentage based on all cases and data items
* Margin Measurement had 2 cases group. The percentage show is the overall percentage based on both cases

For Table 3.2 (Histology Subtype), these were case scenarios that were the same for all 5 groups.

Table 3.1: Agreement with Final Answers (SSDIs and Surgery of Primary Site)

| **Data Item** | **Group 1** | **Group 2** | **Group 3** | **Group 4** | **Group 5** |
| --- | --- | --- | --- | --- | --- |
| Primary Tumor Location | 72.1% | 82.7% | 77.4% | 94.6% | 86.7% |
| Surgery of Primary Site (Melanoma) | 78.9% | 61.1% | 56.9% | 80.7% | 68.5% |
| Margin Measurement | 78.9% | 48.3% | 92.3% | 43.9% | 85.0% |

Table 3.2: Agreement with Final Answers (Histology Subtype)

| **Histology Subtype** | **Group 1** | **Group 2** | **Group 3** | **Group 4** | **Group 5** |
| --- | --- | --- | --- | --- | --- |
| Case Scenario 1 | 97.9% | 92.7% | 98.0% | 91.2% | 95.7% |
| Case Scenario 2 | 63.8% | 56.1% | 60.0% | 47.1% | 61.7% |
| Case Scenario 3 | 42.6% | 22.0% | 40.0% | 38.2% | 38.3% |
| Case Scenario 4 | 89.4% | 97.6% | 94.0% | 100.0% | 83.0% |
| Case Scenario 5 | 97.9% | 95.1% | 96.0% | 100.0% | 100.0% |

# Evaluation of Data Items

## **Primary Tumor Location**

Each group had 4 cases, with a total of 20 cases tested. Results are based on the preferred answers and combining the results of the four cases from each group.

|  |  |  |  |
| --- | --- | --- | --- |
| **Group** | **# Agreement with Answer** | **Total Answers** | **Percent Agreement** |
| **1** | 191 | 265 | 72.1% |
| **2** | 206 | 249 | 82.7% |
| **3** | 205 | 265 | 77.4% |
| **4** | 217 | 240 | 94.6% |
| **5** | 234 | 270 | 86.7% |

**General Comments:**

Comments received on this were numerous and quite varied. Some registrars appeared to understand exactly what was being asked, while others were confused about the purpose of the data item and how it related to data item Primary Site.

Major concerns were exactly what locations in the Brain were a skull base tumor. Some of the cases tested were not Skull Base tumors and those were the cases that registrars appeared to have the greatest difficulty with. The other cases that caused difficulty were those where overlapping sites within the Skull Base were involved and it was not clear what the proposed SSDI would be coded to. Preferred answers defaulted to a specific subsite, while many of the respondents felt that overlapping structures (unique code) was more appropriate.

The main request for this data item was a detailed resource of what is and is not a Skull Base Tumor. Since Brain tumors have historically been difficult concerning Primary Site, a need for a more thorough resource which includes coding of Primary Site and the SSDI is needed.

Due to the numerous comments received on this particular data item (many of which were the same), only select comments are included in this table.

| **Participant Comments** | **Response** |
| --- | --- |
| Maybe a diagram of the different portions of the brain along with the SSDIs | As noted above in the comments section, a resource detailing primary site and this proposed SSDI would be needed to help registrars determine the appropriate codes |
| In the past we were taught that the sight of a meningioma was in the meninges then; now it is coded 85 which is site unknown. Confusing | This is confusing Primary Site coding instructions with the instructions for the SSDI. This will need to be addressed in the instructions for the SSDI |
| This information would be difficult to collect at the central registry level. Abstracts sent to us often have incomplete information in the OP report section. Without a full OP report, it would be difficult to code this item from potentially incomplete abstracts.  | **Agree with this. Most of the specific coding would be available at the hospital level.**  |
| This operative report was very detailed. We don't always see such details. | **The operative and pathology reports were from specialty physician in neurosurgery, whose focus was on skull base tumors** |
| Please explain if all pituitary adenomas should be coded as 20, if so, this seems redundant since the primary site is already implying subsite in the skull base. | **This registrar is correct that pituitary tumors are collected in a specific primary site; however, also included in that primary site is the brain stem. The pituitary tumors cannot be separated out, and there is great interest in collecting information on pituitary tumors.** |
| This requires a lot of interpretation of surgeon's wording. Are we going to have a list of ambiguous terms that qualify as involvement? This should only be collected if a required component of the CAP protocol. | **The CAP protocol lists the following for primary site. Any site covered in the brain would be marked using one of the definitions below. Specific locations should be documented, as noted in the descriptions. Primary Stie is a required field on the CAP Protocol****Skull (specify precise location, if known)****Dura (specify precise location, if known)****Leptomeninges (specify precise location, if known)****Brain****Cerebra lobes (specific precise location if known)** **Deep grey matter (specify precise location, if known)****Ventricle (specify precise location if known)****Cerebellum (specify precise location if known)****Brain stem (specify precise location if known)****Other (specify, if known)****Cerebellopontine angle****Sellar/Suprasellar/Pituitary** **Pineal****Cranial nerve (specify I-XII, if known)****Spine/vertebral column (specify precise location if known)****Spinal cord (specify precise location if known)****Spinal nerve root(s) (specify precise location if known)****Other (specify)****Not specified** |
| I'm not sure this level of detail will be available in my facility | **For many hospitals, if a patient is diagnosed (via imaging) with a Skull Base Tumor, it is likely they will be transferred to a specialty hospital. Many smaller and community hospitals may not have the specialists needed for these types of cases. This comment was not surprising** |
| I just noticed that there aren't actually any clearly defined coding instructions, just 3 notes about the codes and a table. Would be really helpful to have Note 3 be an actual instruction. For example: 1. Code the subsite from the Operative Report information. If the operative report is not available, use the imaging, physician's statement or pathology (in that order of priority). Also, Note 2 is super confusing. Why are we getting primary site coding instructions here? And why are we being referenced to the SSDI manual (isn't this already a part of the SSDI manual)?  | **Precisely the type of feedback that is needed during Field Testing. These recommendations are extremely helpful and will be implemented****As for primary site coding instructions: We still need to determine the best way to document instructions in relation to coding primary site. These two data items need to be coded together.** |
| Where is Meninges, NOS or cerebral meninges in the description? | **This comment has to do with the Primary Site Coding Instructions, which states to code all Meningiomas to the Meninges Primary Site Codes. Will need to develop instructions that will enforce how the Meninges are coded for Primary Site, yet a more specific code can be allowed for the SSDI**  |
| The one thing that was slightly confusing was the codes starting with coded 80 on, it wasn't as clear as I thought it could be | **These codes can be reviewed and determined if they can be combined or defined better** |
| What should be coded if it appears the tumor overlaps different sites and the "origin" is not clearly stated, as in this case? | **We do have a code for “overlapping structures”; however, several of the cases we had did have several structures involved, yet we determined a specific code. Better instructions on coding overlapping structures do need to be developed.** |
| Usually location first seen on MRI, for non-surgically treated cases (ex. active surveillance/observation alone; GKRS) MRI would be key to identify location. Note 3 should expand to include these type of cases where op report is not "not available" as so much not applicable | **This goes along with priority order, and also for hospitals where the surgery, or further identification of primary site, is not available** |
| How to code when multiple meningiomas at different locations but single primary (rule M9)? | **If the two locations are both skull base locations, then a specific coding instruction would need to be developed. If at least one of the meningiomas is not a skull base location, then need to determine how the SSDI would be coded** |

## **Histology Subtype**

Note: There were 5 case scenarios. All registrars coded the same cases. The results for each scenario are presented together and are based on the final answers.

|  |  |  |  |
| --- | --- | --- | --- |
| **Scenarios** | **# Agreement with Answer** | **Total Answers** | **Percent Agreement** |
| **Case Scenario #1** | 209 | 219 | 95.4% |
| **Case Scenario #2** | 128 | 219 | 58.4% |
| **Case Scenario #3** | 80 | 219 | 28.8% |
| **Case Scenario #4** | 202 | 219 | 92.2% |
| **Case Scenario #5** | 214 | 219 | 97.7% |

**General Comments:**

In general, registrars appeared to understand the rules for this data item. Scenarios 2 and 3 did pose some problems.

Case Scenario 2 had “Low grade (well diff) appendiceal adenocarcinoma,” which many registrars believed was LAMN. They did not realize that this was an Adenocarcinoma, with a grade of well differentiated. Per consult with GI pathologist, for this to be LAMN would have required mucinous to be part of the description.

Case Scenario 3 had “Low grade appendiceal mucinous neoplasm (LAMN) with focal high grade mucinous neoplasm.” Originally this was coded to HAMN. Multiple comments received back stated that this contradicted the Solid Tumor Rules which stated that “focal” is ignored when assigning histology. Follow up with the Solid Tumor Rules expert and the GI pathologist confirmed that this should have been coded as LAMN (answer changed). Agreement with the preferred answer was about 50%, while agreement with the final answer is only 36.5%.

Based on discussion with the SSDI work group, notes were modified stating that registrars are to follow the Solid Tumor Rules for assigning histology and then code the SSDI based on that histology. Examples from the Field Study were also suggested to be added to the new SSDI.

| **Participant Comments** | **Response** |
| --- | --- |
| It might be helpful to add the histology code (8480) again in the Code 3 definition, and/or add an edit to catch this if Histology is coded other than 8480 and this SSDI is not coded as 0 | SSDI modified to include the histology again in Code 3 definitionWill be working with edits committee to have edits developed |
| Either give the histology numbers or list them separately without the this/that/and this/and that /confusing /poorly/written. | Instead of using / to indicate the different terminology, have changed so that each alternate name is listed separately on its own line |
| I guessed on all 5 of these. Instructions need to be clearer and specific. Are we to use Solid Tumor Rules? | **Added coding instruction to use the Solid Tumor Rules to determine histology code** |
| Add some Notes about how to deal with pseudomyxoma peritonei/mucinous carcinoma peritonei/mets | **This is one of the examples, which will be added. Will work with the Solid Tumor Rules expert to determine if this needs to be added to the Solid Tumor Rules** |
| The confusing part was the "Mucinous/Mucus...." I was thinking along the line ""mucinous adenocarcinoma". What does the "mucinous" by itself stand for? | **These are alternate names for mucinous adenocarcinoma. The “mucinous” component changes the histology from 8140 to 8480** |
| Code 2 gave me the impression that it had to be stated exactly as written High grade appendiceal mucinous neoplasm. I was actually going to go with this answer and then changed it because it only stated High grade mucinous neoplasm. So a note saying if the primary is the appendix, it does not have to state appendiceal would be helpful. "High grade mucinous neoplasm" did not contain the word "appendiceal" so I didn't consider it HAMN. This may be ignorance on my part | **This is related to the “focal high grade mucinous neoplasm.”** **For a true HAMN, if “high grade mucinous neoplasm,” is documented in the pathology report and the site is appendix, it can be coded as HAMN****In this particular case, this would have been coded to LAMN, which was the diagnosis, with “focal” high grade mucinous neoplasm. Answer has been changed** |
| Provide an example using this exact scenario or provide instruction about ambiguous terminology and coding subtype for this SSDI.  | **These examples will be added to the SSDI instructions** |
| Confusing - this cases had LAMN with focal HAMN -- so why is the answer Code 2 and NOT Code 1? Are you saying that if a case has both LAMN and HAMN then the "higher grade" should be used to code the SSDI? If so, please add this information to the SSDI Coding Instructions | **The answer to this Case Scenario was changed. Received over 20 comments regarding not using “focal” to assign histology, which would affect the SSDI as well** |
| The more specific histologies you add to the "Description" the better and more helpful it will be for the registrars | **We used ICD-O-3.2 to determine which histologies should be included; however, we will double check that all histologic descriptions that are applicable to 8480 are included** |
| The scenarios says Code 7 is other terminology, but the instructions say Code 4 is other terminology | **This will be corrected** |
| At first, I was searching for a special code for appendiceal adenocarcinoma. I was wondering if it had to say mucinous adenocarcinoma to code 8480 | **Yes, to code as 8480, it has to state mucinous, and it also has to state “low grade mucinous” or “high grade mucinous.” Appendiceal adenocarcinoma by itself would be 8140/3** |
| Again, I do not see these often. The term "mucinous" does not need to be specified in order to use code 3? | **Histology 8480 by definition is “mucinous,” or alternate name of colloid adenocarcinoma.** **If mucinous is not part of the histology description, then the histology code is not 8480 and this SSDI would be coded to 0** |

## **Surgery of Primary Site (Proposed Skin Surgery Codes from CoC)**

Note: Each group had 2 cases to code, with each Case Scenario having 3 surgical procedures to fill out (including “not applicable” when a second or third surgical procedure was not done). Percentages are based on the overall percentage of each of the case and agreement with the preferred answers for that group.

|  |  |  |  |
| --- | --- | --- | --- |
| **Scenarios** | **# Agreement with Answer** | **Total Answers** | **Percent Agreement** |
| **Group 1-Case 1** | 127 | 192 | 66.1% |
| **Group 1-Case 2** | 176 | 192 | 91.7% |
| **Group 2-Case 1** | 131 | 180 | 72.8% |
| **Group 2-Case 2** | 89 | 180 | 49.4% |
| **Group 3-Case 1** | 110 | 195 | 56.4% |
| **Group 3-Case 2** | 112 | 195 | 57.4% |
| **Group 4-Case 1** | 159 | 171 | 93.0% |
| **Group 4-Case 2** | 117 | 171 | 68.4% |
| **Group 5-Case 1** | 147 | 192 | 76.6% |
| **Group 5-Case 2** | 114 | 189 | 60.3% |

**General Comments:**

This is the first time that a non-SSDI has been included in the Field Testing. Based on the comments received, the instructions were not clear on how to code these cases. CoC requested to use the Field Testing process to field test their new proposed surgery codes, which will be implemented in 2023. These new surgery codes were also tested with a proposed SSDI: Margin Measurement. Currently, the surgery codes and the margin assessment are coded together. This type of coding has been difficult for registrars. Many registrars commented that were happy that the surgery of primary site and margin measurement were being separated.

Part of the confusion stemmed from having to code all the specific procedures (biopsy, wide excision, re-excision). Although this is standard procedure for CoC registrars, some of the central registry participants were confused on why all the different procedures had to be coded. In the central registry, only the most extensive surgery is coded.

There were also many comments stating that there was redundant coding, for example:

* Procedure 1: Coded as shave biopsy (unique code)
* Procedure 2: Coded as shave biopsy followed by wide excision (unique code)

Registrars felt this was redundant coding and did not understand why two different surgery procedures had to be completed.

Other confusion stemmed from the “not applicable” code for 2nd or 3rd procedures. Some of the cases had 3 procedures, which is why the study was set up this way.

Additionally, if a shave/punch biopsy is done and the margins are negative, currently this is coded as incisional biopsy in the Surgery of Primary Site; however, if the margins are positive, then this would be coded in the Diagnostic Staging Procedures for CoC. The process of coding these biopsies, regardless of margin status, is changing with the new surgery codes and that was not made clear to the participants in the instructions.

There was also some confusion based on the new format of the codes.

Due to the numerous comments received on this particular data item (many of which were the same), only select comments are included in this table. If implemented, extensive training should be done on these items/codes.

| **Participant Comments** | **Response** |
| --- | --- |
| I really like these new codes | There were several like comments that supported the new code structure, especially with removing the margins from the Surgery of Primary Site |
| Specify that each "PROCEDURE" should be coded separately, not just those qualifying as "surgery" (a biopsy with pos margins in the past was not coded as surgery unless later proven to be excisional after further resection)Since shave biopsy has previously not been considered surgery to primary site unless all tumor is removed (not applicable to this case), some information addressing this change would be helpfulDefinitions of incisional and excisional should be added | The current rules states that a biopsy with negative margins is coded in the Surgery of Primary Site, while a biopsy with positive margins is coded in Diagnostic Staging ProceduresThis will change with the new surgery codes and needs to be documented clearly in the coding instructions for the Skin Surgery CodesIt also has to be documented very clearly if this change will affect other sites, or if this rule will be only for Skin |
| Better information as to what exactly is being asked of registrar. I don't feel like it’s clear when there should be multiple procedure codes in there, vs one 'combo' codeI am used to coding overall summary and not individualWHY IS THERE A CUMULATIVE CODE FOR PUNCH BX & WIDE EXC IF WE ARE SUPPOSED TO CODE THEM SEPARATELY? These are inadequate instructions to properly code this.Why are we coding this level of detail in an abstract? You need to make it clearer on the timing or a different name than primary site surgery code... that makes it seem like the biopsy and excision should be coded separately... like what you want is to see what surgeries are being performed on that particular melanoma. A note under the biopsy options that says if a WLE is also done please see these options. I can't see why you would need more than 1 option for these? | CoC hospitals generally code all procedures; however, Central Registries code the most extensive procedureThe standard setters need to determine which procedures they will require to be coded |
| It should be spelled out that a slow Mohs is not coded as one Mohs for each day. Most registry software allows multiple entries for surgery, so each different date would get an entry. Guessing from the preferred answers that only the 2-step MOHS should be entered as single entry. Is it the date of the 2nd stage that gets entered?At first, I was confused between the difference between B300 and B310. B300 says Mohs surgery, NOS and B310 says Mohs surgery performed on same day. Since I got this wrong, I am assuming B300 is for when you don't know how many days the Mohs surgery took? If so that does make sense now. I think there needs to be info that any Mohs surgery is coded in B300 series. Based on the last test, I combined the Mohs and subsequent excision, and it seemed B550 was the best match in this caseThis patient had a shave biopsy, then a Mohs, then a wide excision. The instructions did not indicate that when choosing a combined surgery code, the Mohs should take precedence over the shave biopsy | **Several comments regarding coding Mohs surgery. Better instructions/examples need to be developed on how to code Mohs, especially in relation to shave/punch biopsies and/or wide/re-excisions****Some registrars commented that they never see Mohs being done** |
| Punch Bx codes does not break down into superficial or deep - that is listed for the shave bx. Punch bx is broken down by incisional or excisional bx and since they talked about the margins being involved, I took this as an excisional bx. Honestly, this rationale makes no sense because the instructions for the shave and punch bx seem to be getting mixed upActually explain that each procedure needs to be coded separately. Also, punch bxs are NEVER described as incisional or excisional on the minimal info we get for melanoma primaries, so these are essentially useless codes unless further information is provided as to when we get to use them, or WHY registrars can't assume a punch was really incisional (and not excisional/first course treatment) when residual tumor is present on the wide excision | **This registrar is commenting on the current rules where the margin status determines if it is a Diagnostic Staging Procedure or a Surgery code.****These new rules need to be made much clearer for the registrars on how punch biopsies are to be coded.** |
| I wasn't looking in the right place on the document and didn't see all the codes/choices available. But I agree. When these codes go into effect (if you use them), please include that statement or instructions above to help guide us to use the NOS code in this situation (B200). The examples help. The more the better. | **Recommend that examples from the Field Testing be included in the revised coding instructions** |
| Actually provide instructions that indicate how to code hx only cases and that actually indicate multiple procedures are codedWhy are we coding a procedure that we don't know about? Why are there combination codes if we're supposed to code individual data items. The instructions don't cover any of thisInstructions should indicate if previous procedure, assumed done elsewhere without specific documentation, should be coded | **One case had a pathology report that stated, “history of excised melanoma.” Great deal of confusion on how the coding was done and how these types of cases should be handled.** |
| If it is really necessary to include the initial procedure in the second/most definitive surgery code, then maybe a code should be added for "Excisional Biopsy followed by wide excision". However, again it seems much preferable/clearer to simplify the re-excision codes to stand on their own as Mohs 300-320 and Wide/Re-excision 500 only, without referencing the prior procedure -- as is standard for other primary sitesI am a proponent of coding each individual procedure and allowing registrars to capture all procedures rather than trying to code combos. In this example, I am able to code 'shave biopsy' for procedure #1, but I am unable to code 'wide excision' as a standalone procedure #2. Instead, the 'wide excision' is captured by a code that's a combination of two separate procedures (shave plus wide excision). In essence, you've now captured twice the fact of a shave biopsy | **Many comments regarding the combination codes. There appears to be a lot of confusion on the reasons for this. This type of change, and the reason behind it, needs to be explained more clearly so that registrars will understand better what we is being asked of them.** |
| Two surgical procedures were NOT performed. One surgical procedure was performed, and another procedure at another facility was referenced in the patient history. If it didn't happen at this facility, why would I code it especially if there is no supporting documentation? | **Many comments regarding the history case. For purposes of the field study, we wanted them to code all 3 procedures. This may have caused greater confusion and contributed greatly to some of the poor responses.** |
| If a re-excision following a wide excision is not to be coded this should be made clear in the instructions as I coded this as part of first course treatment | **Clearer instructions on how to code re-excisions after a wide excision are needed** |

## **Margin Measurement (Proposed SSDI for Melanoma Skin)**

Note: Each group had 2 cases to code

|  |  |  |  |
| --- | --- | --- | --- |
| **Scenarios** | **# Agreement with Answer** | **Total Answers** | **Percent Agreement** |
| **Group 1-Case 1** | 44 | 64 | 68.8% |
| **Group 1-Case 2** | 57 | 64 | 89.1% |
| **Group 2-Case 1** | 16 | 60 | 26.7% |
| **Group 2-Case 2** | 42 | 60 | 70.0% |
| **Group 3-Case 1** | 58 | 65 | 89.2% |
| **Group 3-Case 2** | 62 | 65 | 95.4% |
| **Group 4-Case 1** | 10 | 57 | 17.5% |
| **Group 4-Case 2** | 40 | 57 | 70.2% |
| **Group 5-Case 1** | 51 | 64 | 79.7% |
| **Group 5-Case 2** | 57 | 63 | 90.5% |

**General Comments:**

Currently, registrars code the surgical procedure and margin status in the same data field, Surgery of Primary Site. This has caused great confusion for registrars over the years. Many comments from participants supported separating out the Surgery of Primary Site and the margin status.

In general, the proposed SSDI was well understood; however, there was still a great deal of confusion regarding coding. The major issues associated with this proposed SSDI were:

* When multiple margins are available, are they added together
* How to code if there are negative margins with no other information available
* How to code when there are positive margins
* Although priority order was provided, there was still some confusion on when margins from the pathology report could be used

| **Participant Comments** | **Response** |
| --- | --- |
| The Description for XX.7 also says "No surgical resection done". Isn't a biopsy with negative margins a surgical resection? This patient had bx and margins not stated. XX.9 says "procedure performed, but clinical margins not documented" | **Registrar is probably referring to current rules stating what is a surgical resection. Clearer instructions need to be developed for when XX.7 would be used and XX.9 would be used for no procedure performed** |
| Helpful if the Melanoma In situ language is added to instructions for choosing XX.7 | **Need to determine if in situ Melanomas would be treated any differently** |
| No, just that I didn't realize we could use margins from a scar, I feel like that was not allowed before. Just making sure I am understanding that instruction correctlyIf there is no residual melanoma, but the margin is stated to be X distance away from the biopsy scar, how would this item be coded? | **This probably needs to be clarified more clearly in the instructions, although it is mentioned** |
| I read XX.9 very carefully and the "clinical" margins is interesting. Is clinical a distinction for a reason? Reading the path for margins to code this field would make me think that if I see a margin in the pathology report that it's a pathology margin. Could be confusing if there is a literal interpretationNote 1 states that the priority order for sources to assign surgery codes is: "Operative report, statement from a physician, description of the surgical procedure on a pathology report, result of the pathology report." Following this instruction for priority order I'd use the Operative Report, which only states "skin left ear biopsy". The instruction doesn't say to use one of the other reports in addition to the first available source (following the priority order) | **Need to define better how “clinical margins” is being defined. Also need to make clearer when margins from the pathology can or cannot be used.** |
| Maybe spell out the usage of xx.9 to include positive margins | **Need to add documentation on how to code if there are positive margins** |
| Add instructions for margins negative= xx.9 | **Margins were negative on the pathology report, but these were not the margins that were being asked for****Clearer instructions on what is being coded need to be developed** |

# Availability/Feasibility Testing

The 2021 Field Testing included a new section this year which focused on determining if potential SSDIs are available in the medical record documentation. This type of testing was developed to determine if information is available prior to spending time developing a proposed SSDI.

For the 2021 Field Testing, several questions were developed for the registrar to answer

* How many cases of the interested site were seen in the last 6 months
* How many cases in that interested site had the specific test
* Additional questions were also asked about specific tests results

The current potential data items asked about

* p16 Anus
* HER2: Colon and Rectum
* PD-L1: Melanoma Skin
* PD-L1: Lung

On average, responses to questions had 1/3 to 2/3 blank answers, with a majority of the remaining participants answering I don’t know, few, unknown. Some registrars did document numbers; however, those were few and not very helpful.

One registrar commented that a prospective study would be much better than this retrospective study. Having registrars collecting information on potential SSDIs availability as they are abstracting the case would be a much more effective way of collecting this type of information.

Standard setters should consider alternate ways of assessing availability/feasibility for data items of interest, such as querying individual registries instead of registrars who may not know the information especially during a testing session.

# Field Testing: General Questions and Comments

**Did you find the SEER Software easy to use?**

| **Participant Comments** | **Field Testing Lead Comments** |
| --- | --- |
| The user interface for SEER DMS was changed in the past couple of years. I was previously able to use the tab key to move through the pages, now I have to use the mouse to click to the various data Fields. Where before I was able to do the majority of my work in DMS only using my keyboard, the new interface requires me to use the mouse as well and slows me down significantly | Will address these comments with IMS, although not sure how DMS affects the use of this software. This testing site is not using DMS software. |
| It would be easier to see at least 2 of the 3 items (SSDI & Med record) at the same time | If there are multiple data items related to one case, this might be advantageous.Need to discuss with IM.S |
| Why do I have to enter something in a test that isn't required? | This is probably for the availability, which we have already determined needs to be changed |
| Flipping back and forth to read info | This is probably someone that has only one screen. If a user has two screens, then they can open the medical record on one screen and the software to enter the information on another screen. We could suggest using two screens in the testing instructions if possible. |
| I'm not aware of every having used SEER software | NA |

**Question: What do you think of the field testing process?**

| **Participant Comments** | **Field Testing Lead Comments** |
| --- | --- |
| User friendly |  |
| Easier than I thought it would be |  |
| I think it is a good process and helps us learn the new SSDI's and give input |  |
| Appreciate the opportunity to have participate |  |
| Interesting process and way to report more specific information for the various tumor |  |
| Very straight forward instructions and easy to understand |  |
| Informative. If any changes are made to preferred answers, will changes be made available to participants? | Yes, the preferred answers will be made available. There is now a NAACCR webpage where the final report, along with the final answers will be posted |
| I think that the field-testing process is a great way to identify how registrars code certain data items |  |
| Field testing is vital and so glad SEER is doing these studies! | Need to educate registry community that this is not only SEER that is doing this, but the entire registry community |
| It was helpful to attempt and see rationale for incorrect answers. |  |
| Great way to test new data fields. |  |
| Overall this is an excellent tool. It is great to be able see the correct answer/rationale and to give immediate feedback. When considering SSDI to add, is there consideration of looking at CAP protocol to see if these potential new items are being required on pathology reports? | We do look at the CAP protocols when working on potential SSDIs. For the SSDIs in this study, none of the data items would have been on the CAP protocols |
| I like that we have a chance to "try out" new coding items before they go live. I feel like it will be helpful to know what problems or misunderstandings registrars will have, and hopefully upgrades and changes won't be needed so much. This should make it possible for clarifications to be added to the rules from the beginning | This is precisely the purpose of the Field Testing |
| There are too many codes to look at at this point, please don't add more. Will the codes help stage or determine treatment for the cancer? Why bother? | Probably a comment based on the new surgery codes |
| I thought that it was very user friendly. I liked that the medical record and coding instructions each opened in different tabs, thus allowing me to drag them to my other screen, as well as elsewhere on my main screen, enabling me to move between the different documents/panes more easily |  |
| Not bad. The new melanoma surgery codes are quite challenging to comprehend though. |  |
| I think the instructions need to be more well thought out and more clearly written. Has SEER thought about hiring professional writers and editors to bring more clarity and consistency and less ambiguity to their instructions? |  |
| Field testing seems fundamentally flawed by concept because a cancer abstract seems like it should be very straightforward. It should be a handful fields, most of which are binary. Surgery? Yes/no. Radiation? Yes/no. Types of surgery, intensities of radiation, what dermatome testing was done; that seems far, far, FAR outside of the purview of a cancer abstract. That's the realm of path reports and patient records; not incidence data. | It sounds like this registrar wants cancer abstracts to only include yes/no answers, which is not feasible |
| I think it is great to ask Registrars to participate. I am encouraged that this will make collecting information easier and will cause changes to make the information better for physician research purposes |  |
| I liked the new codes for the brain and skin. What I feel we have now is kind of taking a stab in the dark as what to use. These are much more defined as well as the meningioma or brain cases |  |
| I think it's great and appreciate the opportunity for input ahead of implementation. However, not sure it's the right place to ask about availability of potential SSDIs -- at least for me as central registry staff, that part was too time consuming to complete, though maybe it's more feasible for hospital registrars | Common issue with the availability, especially from a central registry viewpoint. The availability really does need to come from the hospitals. |
| I think it's a good idea to get feedback from CTR's who are actually doing cases | Precisely why we are doing the field testing |
| Some improvement on instructions is needed. I do like the new surgical codes |  |
| It's good that comments/feedback are welcome. I found the Surgical Procedure of Primary Site/Surgery of Primary Site data item for Skin quite problematic. It needs much more clarification, or we will get more coding errors/ inconsistencies again. I'm guessing that other CTRs will have the same questions & points of confusion that I had. I recommend you do additional testing/discussions with the CTR community, especially with people who abstract regularly. | This comment aligns with the low percentage of correct answers. The comments received on the Surgical Procedure of Primary Site (Melanoma) have been reviewed and there is agreement that the instructions need to be reviewed and modified |
| Not clear on what you want. Waste of time | Registrar appears to be confused by the purpose of the Field Study, although this comment may be directly related to the availability testing, which did not go very well |

**Question: Do you have any suggestions on how to improve the field testing process?**

| **Participant Comments** | **Field Testing Lead Comments** |
| --- | --- |
| Talk about it more in the NCRA resources and NAACCR webinars | Agree, this should be discussed more at NCRA and NAACCR. We have also gotten a NAACCR webpage set up for the Field Study, which should also help |
| I would wonder how what the distribution is for type of facility. Perhaps include NCI and teaching facilities not just CoC approved. Results may be more relevant | Results can be done on type of facility. Agree that the NCI and teaching facilities are going to have more information than the smaller hospitals |
| Training on how to read the special stains/labs | Agree that this type of training is needed |
| Anyway can be more streamlined, is good...might have to simplify the PD-L1 instructions... | Instructions for PDL-1 have not been implemented, but the questions for availability were very complicated |
| Leave things as they are....there's no sense the registry processes constantly change | Unfortunately, things continue to change as clinical medicine continues to change |
| On the potential SSDIs about the frequency and availability of clinical indicators. Maybe we can have a drop down that provides a couple answers that would work for answers, if the answer was sometimes. | This is something that would have been helpful for this study, giving registrars an easy way to indicate the frequency. As stated before, a better approach for Availability needs to be developed |
| The one melanoma case I could only view a path report and they were asking me for the surgery code. I found this difficult to code. | This case was purposely added to the study for this very reason. For an actual case, the registrar would only code the one procedure from a single pathology report, unlike in the Field Testing which required coding all three surgical questions |
| Consider holding field testing at another time of year that does not conflict with the holidays, as that may result in greater participation | This has been discussed quite extensively. Due to current timelines for getting information processed and developed, along with working about submission dates, November and December seem to be the best months to have the study. We realize that this may not work for everyone |
| Yes, stop. Primary site, basic histology/morphology, and general treatment status. Types of surgery and modalities of radiation are wastefully superfluous. | None |
| Not off hand. But I hope that you can allow us to continue to test data fields before they are adopted for use. | This is now a requirement for all new data items, so Field Testing will continue to be annual event (as needed) |
| Questions for potential fields may need to be written more clearly and it would be helpful to provide tips to registrars for searching their database, although it is difficult to give exact numbers on things on cases not already being collected.It would be helpful for example to say "how many cases of colon & rectum cases does your facility see in an average year" instead of "last 6 months" especially as registries are not abstracting in real time - many are still catching up (2018 changes, COVID furloughs, etc) | Another good point on the problems associated with how this year’s availability testing was set up. Another format for this type of testing will need to be developed |
| We need to encourage more participation and not make this "optional". Actually, SEER should tell the registries they fund that they must have their employees participate as part of their contract | This is not just a SEER activity but is something that is supported by all Standard Setters. The Field Testing Team has recommended other incentives to encourage registrars to participate; however, at this point, this activity cannot be required |
| No, you are doing a great job. Thank you for doing this. | None |
| List instructions separately for each section instead of having the same long list to scroll through | This can be done, which would make things easier for registrars |
| I would like the medical record to be a little easier to read. The words are too small and too close together, it makes it more difficult to skim to get to the important information | Using actual medical records has been problematic in the three studies. We will look into ways that the medical records can be clearer and easier to follow |
| I found the feasibility portion on proposed fields difficult to answer accurately because you are asking retrospective questions. I imagine it would be difficult for a CTR to go back through let's say 100 melanoma cases and open each and every chart to answer your questions. CTRs are currently not being asked to collect the information you are asking about. So they probably did not pay much attention when reviewing the charts. You might get better information if you do a prospective pilot study asking abstractors at different kinds of facilities to note these data items as they move through their cases. | Agree with this registrar that a prospective approach to availability would be much better than retrospective. As noted before, we found that the process we used for this year did not work very well and that a different approach needs to be developed |
| A tutorial on how the testing site works would be helpful. When do you use save, when do you use finalize. | This request has been sent to the software development team. This would be a good idea, especially for new registrars who haven’t used the site before. When developed, we will have several registrars from the community review the proposed tutorial before implementing |

**Field Testing Process-Suggestions for future studies from Field Testing Chair**

| **Topic** | **Issue** |
| --- | --- |
| **Timeline** | If this is to become an annual process, there needs to be a formal timeline developed which includes all the steps to recommending a new data item to making it part of the Field TestAlso, depending on how we determine the best way to do Availability Testing, we may need to modify the timeline |
| **Notice of Studies/****Promotion** | For future field testing, the information regarding the study should probably come from NAACCR instead of SEER. Many comments received noted how they like what SEER was doing (or some didn’t like what SEER was doing). Somehow we need to make people understand this is not just SEERNAACCR now has a webpage for the Field Testing. We are still determining what needs to be on the webpage, but I think this is a great first step |
| **Participation** | Very poor participation this year (~200, compared to previous years of over 300). We did come to an agreement with CoC that they would be glad to send out notices provided they could provide a link. This was the major reason that the NAACCR web page was set up. Due to extenuating circumstances, we were not able to get the NAACCR webpage until right before the study started. CoC did send out a notice, but once again, this was very late.We need more incentives to get participation, especially from the hospital registries. Less than half the participants are coming from the hospitals, about 55% are central registries, probably most from SEER statesAre their additional incentives that CoC could implement to get greater participation? Could participation in a Field Study be counted in the standards, or be counted as “bonus points?”  |
| **Reliability Website** | For future field testing, there should probably be a unique website developed just for Field Testing, where the NAACCR logo may be shown (if possible). Try to make it look less like a SEER productSEER would still be mentioned as the provider of the software, but I think we need to make the actual website not so SEER centered |

# Appendices

* Appendix 1: 2021 Field Testing-Protocol
* Appendix 2: 2021 Field Testing-Final Answers and Rationale
* Appendix 3: 2021 Field Testing-Answer Distribution