APPENDIX C:
ELECTRONIC REPORTING

ELECTRONIC REPORTING INSTRUCTIONS

Definition of Electronic Reporting

Electronic reporting is the submission of reportable cases to the Virginia Cancer Registry (VCR) on diskette or other specified electronic medium using commercial, hospital-developed or AbstractPlus software. Written approval from the VCR is required to report electronically.

Who Reports Electronically

1. Registry Hospitals - Hospitals with cancer registries functioning as an integral component of a hospital cancer program are required to electronically report cases included in their registry using commercial or hospital-developed software when all approval criteria are met.

Initiating Electronic Reporting

To initiate the approval process for electronic reporting, the hospital shall first contact their VCR Cancer Surveillance Specialist. The Cancer Surveillance Specialist will provide a worksheet containing questions specific to the type of data collection currently being performed, either registry hospital or non registry hospital. The worksheet must be completed by appropriate hospital personnel and returned to the Cancer Surveillance Specialist. The Cancer Surveillance Specialist will review the electronic reporting specifications and the approval process with the hospital contact as described below.

Electronic Reporting Specifications

Hospitals must meet the following specifications before submitting a trial shipment to the VCR for evaluation:

1. Required Data Items - All data items required by the VCR must be transmitted electronically for each record submitted. A listing of the VCR Required Data Set is included in *VCR Manual Appendix K* Specific instructions for completion of each item are described in the *VCR Manual Part Three*.

2. Record Format - The VCR-required version of the NAACCR (North American Association of Central Cancer Registries) Data Exchange Record Format must be used for electronic reporting.

3. File Configuration - Files must be submitted in an ASCII text format, fixed length with no delimiters between fields. Both a carriage return and a line feed must be used to designate the end of each record.

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4. Medium for Electronic Transmission - Data must be submitted via email, on 3½" diskettes or Compact Discs (CDs) supplied by the facility. Diskettes and CDs are not returned after processing. Files must be checked for viruses prior to sending to the VCR. If a virus is detected by the VCR, the shipment will be returned unprocessed.

5. Backup - A backup file of all records must be maintained by the reporting facility until the VCR indicated there were no problems reading the file.

6. Text Information - The VCR requires all electronically-reported records to include text information in designated text fields to support codes and to describe pertinent diagnostic and treatment findings. Text information in electronic form replaces the requirement for supportive paper documentation. The purpose of text information is quality control. Text is used to validate data items, verify potential errors identified through standard edits, document explanations and clarifications, determine multiple primaries, and reconcile data item discrepancies when the same patient is submitted by several facilities. Defensive abstracting, as text information is often called, is an absolute necessity for quality data. Refer to the *VCR Manual Part Three* for text guidelines and requirements.

7. Edits - Standard data checks and cross-checks should be run and errors corrected prior to electronic transmission of the records to the VCR. Hospitals should work with their software vendors to ensure3 the version of edits used is compatible with the current NAACCR data exchange file format.

8. Blank Fields - Edits must be in place to flag required fields left blank in error. Blank fields must be completed before records are transmitted to the VCR.

9. Transmit List - With each file, a hard copy listing of all records being transmitted in the file must be sent to the VCR. This transmit list must contain at least the patient's name, tumor registry number, primary site, and diagnosis date.

10. Records Not Included in Hospital Registry (Registry Hospitals only) - Records reportable to the VCR but not included in the hospital cancer registry must still be reported electronically to the VCR.

11. Submit Records Only Once - Records transmitted electronically must be submitted only once, even if corrections or follow-up information are added to the file. The only time more than one record for the same patient is transmitted is for multiple primary cancers/reportable tumors. To eliminate duplicate cases, a flag must be included in the software that will not allow the same primary to be submitted more than once. If a duplicate record is transmitted in error, draw a line through the record on the transmit list and mark *delete.* The VCR will delete these records before they are added to VCR files.

12. Corrections - Corrections may not be transmitted electronically even if the registry software provides this capability. To correct records previously reported to the VCR, follow the instructions provided in *VCR Manual Part One, Changing/Deleting Information.*

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Responsibility for Electronic Reporting Specifications

Responsibility for making appropriate software changes to meet the above specifications is dependent upon the type of software used by the facility as follows:

1. Commercial Cancer Registry Software - The software vendor is responsible for enabling the facility to meet all electronic reporting specifications.

2. Hospital-Developed Cancer Registry Software - The hospital Information Systems Department is responsible for enabling the facility to meet all electronic reporting specifications.

Approval for Electronic Reporting

Hospitals must receive written approval from the VCR before records may be reported electronically on a monthly basis. Approval is based on review by the VCR of data reported electronically in the trial shipment against specified paper documentation. The trial shipment is evaluated for compliance to electronic reporting specifications, format, data quality, and completion of text fields. Written feedback is provided and problem areas must be corrected. Additional trial shipments may be requested until all aspects of the evaluation are satisfactory.

In addition to initiating electronic reporting in a registry or non registry hospital, this approval process is also used to evaluate data in previously-approved facilities when there is a new VCR contact, new software, updated reporting format, and for periodic quality control monitoring. See *VCR Manual Part Four, Quality Control: VCR.*

Electronic Reporting Approval Process

The steps required for approval of electronic reporting are as follows:

1. Trial Shipment - After all electronic reporting specifications have been met and records have been abstracted into the software, a trial shipment shall be prepared and submitted to the VCR for evaluation. The following must be included in the trial shipment:

    a. Electronic File - The electronic file must be submitted on diskette, CD, or secure website and contain actual records not previously submitted to the VCR. The number of records depends on the type of reporting hospital, registry or non registry:

        - Registry Hospital - 20 records of various primary sites.

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b. Paper Abstracts - An abstract from your software must be printed for each record on the trial shipment. All VCR required data items including text to support diagnostic findings, primary site, laterality, histology, behavior, grade, summary stage, and treatment must be printed on each abstract.

c. Copies of Supportive Documentation - Copies of supportive documentation from the medical record including pathology report, discharge summary, operative report, consultations, progress notes, radiology reports, and admission record must be included for each record on the electronic file. Paper documentation is used to verify the accuracy of required data fields reported in the electronic record.

2. Evaluation - The trial shipment is evaluated by the VCR for compliance to electronic reporting specifications, format, data quality, and completion of text fields. Hospitals may continue to abstract cases into their software system while the VCR is reviewing the trial shipment; however, no additional cases shall be submitted to the VCR until feedback is received on the current trial shipment.

3. Feedback - The VCR Cancer Surveillance Specialist will provide written feedback to the hospital contact to convey the results of the review. Errors and/or data items needing clarification will be identified and must be corrected or addressed in the trial shipment and for cases completed while the trial shipment was being reviewed. Additional trial shipments may be requested to resolve problems identified during evaluation(s).

4. Approval - When all aspects of the evaluation are acceptable, written approval for electronic reporting will be sent to the hospital contact. Approved hospitals do not have to send paper abstracts and supporting paper documentation with electronic files.

Records Accessioned by the VCR

After records are accepted and processed by the VCR, a report titled *Records Accessioned by the Virginia Cancer Registry* that lists records received by the VCR from that shipment. This listing should be reviewed carefully and promptly as described in *VCR Manual Part Four, Transmission Verification.* All listings should be kept as verification of records reported to the VCR.

When to Report

Trial shipments must be mailed as soon as the requested number of cases is complete and ready to transmit. Mailing files on the first working day of every month applies only after the facility receives final electronic reporting approval.

How to Report

Electronic shipments for submission to the VCR should be prepared according to the instructions documented in *VCR Manual Part One, How to Report.*