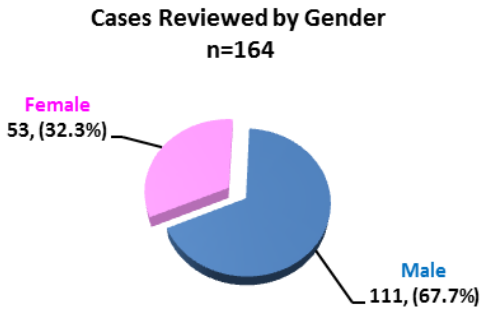
CCR INNOVATIONS

Production, Automation and Quality Control: A Gender Audit

In 2013, a ZenDesk ticket was submitted to the California Cancer Registry (CCR) by the Cancer Registry of Greater California (CRGC) regarding sex field (gender) often being coded to code "9" (unknown) for prostate cases. This was identified while conducting a mini-reliability study as part of the Comparative Effectiveness Research (CER) project for the Centers for Disease Control and Prevention (CDC). The ZenDesk ticket was forwarded to the Production Automation and Quality Control (PAQC) Unit for analysis.

The PAQC Unit decided to expand the analysis to include female organ cancers as well. The decision was made to determine how many male genital organ cancers (C600-C639) were not coded to code "1" (male) and how many female genital organ cancers (C510-C589) were not coded to code "2" (female). Queries were run to identify all cases in the database and were placed into spreadsheets for detailed analysis. The inquiry included patient ID, regional registry responsibility, primary site, gender code, visual editing status, visual editor, casefinding source, reporting source, and class of case. The decision was made by the PAQC unit to expand the detailed analysis into a focused audit.

There were a total of 164 cases meeting the criteria outlined above for this audit. Analysis revealed 111 (67.7 percent) male specific cancers that were not coded to 1 (male) and 53 (32.3 percent) female specific cancers that were not coded to 2 (female).



(Cont. Pg 2)

Inside this issue

The PAQC Unit Gender Audit also identified that 127 (77.4 percent) of the 164 cases evaluated were coded incorrectly. There were 77 (47.0 percent) that did not have text documentation to support the code, which also accounts for 60.6 percent of the 127 discrepant cases. The remaining 50 (39.4 percent) cases that were discrepant were due to one of the two following scenarios:

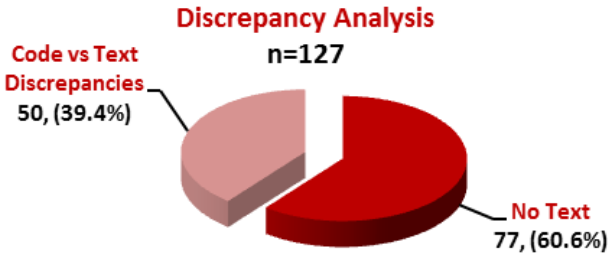
Discrepancy Distribution for Gender Specific Cancers

Codes		Discrepancies	
Original	Re-Code	Number of Discrepancies	Discrepancy Rate
9	1	67	**52.8%**
9	2	8	**6.3%**
4	1	15	**11.8%**
4	2	4	**3.1%**
3	1	13	**10.2%**
3	2	18	**14.2%**
3	4	2	**1.6%**
Total Cases		**127**	

Code Key
1 (Male)
2 (Female)
3 (Hermaphrodite/Inter-sexed)
4 (Transsexual/Transgendered)
9 (Unknown)

1. The case was coded to 9 (unknown) with text documentation of a specific gender.

2. The code that was provided in the case did not match the text documentation.



The chief outcome of this gender audit analysis is the significance of text documentation. Text documentation is what validates the codes entered by the abstractor. Per Volume I, Sections I.1.6.3 and IV.1.1, as well as the previously distributed memo by the Data Standards Quality Control Unit (DSQC Memo 2011-02), all codes must be supported by text documentation on an abstract and the text must be entered in a clear and concise manner. An audit discrepancy results if a code is not supported by documentation in an abstract. Since this audit was performed, an edit was added to the North American Association of Central Cancer Registries (NAACCR) Edit Metafile to identify an error when gender specific cancers are coded to "unknown" for gender. This type of edit error can be avoided by ensuring that gender is documented in text.

Mary Brant, BA, CTR
Analyst IV
California Cancer Reporting and Epidemiologic Surveillance (CalCARES) Program
Institute for Population Health Improvement
UC Davis Health System

Geocoding and Data Quality

The practice of geocoding, or associating a text address to its geospatial location and coordinates, has become a critical tool in the collection and analysis of cancer data. At the central cancer registry, we geocode patient's street address at the time of diagnosis. During a patient's tumor abstraction, registrars make their best effort to collect the highest quality tumor data. However, I would like to advocate that more emphasis be placed on collecting the most accurate patient address information. Both the North American Association of Central Cancer Registries (NAACCR) and the National Cancer Institute (NCI) require their members to geocode tumor patient data to the census tract level. NAACCR and NCI assess the completeness of geocoded data on a yearly basis and include this assessment in evaluating overall data quality, and in order to meet these stringent data quality measures we need to have complete and accurate address information.

In the latest iteration of geocoding for the NCI data submission, various data issues were identified related to address data. Unfortunately, the correction of address data creates a huge workload for central registry staff. In preparation for the NCI SEER data submission in October 2013, more than 80 hours of work time were spent on manually reviewing and correcting address information at the central registry; many more hours were most likely spent at the regional registry level. This is in addition to the thousands of dollars spent to outsource geocoding activities to external vendors who manually correct and geocode problem addresses. Many of the issues identified could be avoided and included misspellings, or abbreviations of street names. To mitigate this problem in the future, below are some helpful reminders when entering address data (from CCR Volume 1, Section III.2.5.2 Number and Street at DX):

- Direction (e.g., North, West) and street types (e.g., Avenue, Road) may be abbreviated (e.g., N MAIN ST). However, do not abbreviate a direction that is the name of a street (e.g., 123 NORTH ST).
- If the address is longer than the allowable 60 characters, omit less important information, such as apartment number or space number.
- If a street, or postal box address cannot be determined, enter "UNKNOWN" in the field.

The CCR Volume I is a great resource for determining how address data should be collected from the medical record. Below are a few important guidelines for collecting accurate address information:

- Enter the address of the patient's *Usual Residence* on the date of the initial diagnosis. *Usual Residence* is where the patient lives and sleeps most of the time and is not necessarily the same as the legal, or voting residence.
- If both a street address and a P.O. Box are given, use the street address.
- For military personnel and their families living on base, the address is that of the base. For

(Cont. Pg 4)

personnel living off base, use the residence address.

- If the patient is homeless, or transient with no usual residence, enter the street, city, and zip code as unknown but code county of residence to the county where the hospital is located and code the state to California.

Jennifer Rico, MA
Research Scientist
California Cancer Registry
Chronic Disease Surveillance and Research Branch
California Department of Public Health

Updates: Surveillance and Data Use Unit

Trends in Cancer Incidence and Mortality in California, 1988-2010

The Surveillance and Data Use Unit of the CalCARES program released a new report in August 2014 entitled "Trends in Cancer Incidence and Mortality in California, 1988-2010." This report presents trends in cancer incidence (new cases) and mortality (deaths) for all of the major cancer sites by sex and race/ethnicity for Non-Latino white, African-American, Latino, and Asian/Pacific Islander California residents. Annual percent changes in cancer rates are presented for the period from 1988 through 2010. A link to this report is now available at the UC Davis Institute for Population Health Improvement (IPHI) website: https://www.ucdmc.ucdavis.edu/iphi/resources/TrendsReport_web.pdf

2011 California Cancer Registry (CCR) data is now available!

The 2011 data is now available on the CCR website. The 1988-2011 Annual Statistical Tables for all cancer sites combined as well as for individual cancer sites are up on the CCR website. Additionally, 2011 data can now be accessed via the CCR's Data and Mapping Tool.

Updated site-specific sheets

The following five site-specific factsheets have been updated and are now available: Non-Hodgkin Lymphoma, Leukemia, Breast Cancer, Prostate Cancer and Thyroid Cancer. The updated factsheets include incidence and mortality rates through 2010, incidence and mortality trends, and five-year relative survival rates by stage at diagnosis. Besides the direct links to the factsheets above, they can also be accessed on the CCR website.

Cancer in California 1988-2009: An Overview of California's Recent Cancer Incidence and Mortality Statistics

This report highlights cancer in California, including the leading cancer sites by sex and race/ethnicity for 2009. The report also includes data on cancer trends in California, beginning in 1988 through 2009.

This report can be accessed at the following link:
http://www.ccrcal.org/pdf/Reports/Cancer_in_California_1988-2009.pdf

(Cont. Pg 5)

Obesity-Linked Cancers: A California Status Report, 1988-2009

Obesity's impacts on health are far reaching and can include such chronic conditions as coronary heart disease, type 2 diabetes, hypertension and certain types of cancer. This report focuses on obesity in California and specifically highlights the incidence and mortality rates of the types of cancer that have been linked to obesity and how these rates have changed since 1988.

The report can be accessed at the following link:
http://www.ccrcal.org/pdf/Reports/CA_California1988-2009_Obesity_v6.pdf

Sara N. Cook, MPH, CHES
Health Educator IV
California Cancer Reporting and Epidemiologic Surveillance (CalCARES) Program
Institute for Population Health Improvement
UC Davis Health System

Resources: SEER Inquiry System

The **SEER Inquiry System**, SINQ, is a collection of questions reported by CTRs related to how to code cancer cases. This resource can be used in addition to the CCR Inquiry System when you come across abstracting questions. To help bring together all of the different resources available to CTRs, each month the CCR will be reviewing new questions submitted to SINQ and providing summaries of relevant questions and answers here. We will also provide direct links to the discussed question for your convenience. This section will help make sure registrars across the state are aware of any updates that may affect their daily work efforts.

20130072
Question: For Lung cases, is Lepidic a new term for histology?

Answer: The term Lepidic will be addressed in the 2015 revision of SEER's Multiple Primary and Histology Rules. Lepidic" is a growth pattern meaning that tumor cells are growing along the alveolar septa. It is characteristic of bronchioloalveolar carcinoma (BAC), but not diagnostic of it; the diagnosis of BAC also requires no stromal, vascular, or pleural invasion. Lepidic growth may be seen in other adenocarcinomas, including metastases to lung from other sites. It is not considered a type/subtype of adenocarcinoma. For lepidic lung neoplasms, code the histology indicated, for example BAC.

20130009
Question: Grade rules state to code the grade from the primary tumor only, never from a metastatic site or a recurrence. If the primary tumor extends into a structure and that structure was biopsied and graded, can that grade be used? Is this considered part of the primary tumor, or does it have to be the primary organ/structure?

Answer: For one tumor involving a contiguous site, when there is no tissue specimen available from the primary site, you may code the grade based on the tissue from the tumor in the contiguous site. This instruction is included in SEER's **Instructions for Coding Grade for 2014**, under Coding for Solid Tumors – Rule 2a.

Eureka 13.1 Release

The functionality of Eureka, the California Cancer Registry's integrated cancer data management system, has been advancing with each new release. Eureka version 13.1 was released into production mid-July. We would like to keep you apprised of some of the projects included. Incorporated updates to this release include the projects listed below.

Casefinding Enhancements:

- Preprocessing Provider information and follow-back selection enhancements
- Preprocessing ePath modified to allow linkage to Admissions
- E-path case-finding provider information and follow-back selection enhancements
- CMR Path and XML E-Path processing
- CFAQ Filter by County

Data Items Revised or Enhanced:

- Multiple Follow back Enhancements
- Comorbidity and Race Multi-Document Consolidation-DB Reconsolidation
- Direct Abstracting-DB Inquiry
- Comorbidity and Race Global fixes
- Birth State dropdown
- New Reporting Source Module 73 Bugs & Enhancements
- 125 Eureka Bugs and Enhancements
- User Guide updated with Upload Package changes that went in 13.0 Release

Data Quality Assurance: Business Rules Management Solutions (BRMS)

- Three linkage Automation Rules have been automated in Eureka: Lung, Breast and Prostate
- 20 auto-change rules based on Volume III edits implemented

A summary of the notable changes made to Eureka with each release is available in the Eureka Release Notes. It is located in the Eureka database under the "Help" tab in "Release Notes." Referencing these each time a new version or patch is released will help keep you up-to-date in how Eureka is functioning. It is important for each user to know what enhancements are made so that they are able to work as efficiently as possible.

Mary Brant, BA, CTR*
Analyst IV

Sridevi Alla Venkata*
Senior Systems Reporting Analyst

* California Cancer Reporting and Epidemiologic Surveillance (CalCARES) Program
Institute for Population Health Improvement
UC Davis Health System

Merging Facilities

Quite a few reporting facilities have merged in 2012 and 2013, which created enough activity to warrant the development of procedures.

For the purposes of this article, the definition of *reporting facility* is a reporting source such as a hospital, surgery center, or radiation treatment center, where each facility has their own reporting source ID. The definition of *merger* is a combining of multiple reporting sources into one single reporting source using a single reporting source ID.

There are two types of facility mergers:

- Merging of the facilities in reporting responsibility only.
- Merging of the facilities including merging the data bases and reporting responsibilities.

During some of the past mergers, the regional registry was not aware until the process was well underway. This creates a little bit of a challenge for the regional registry and preparations must be made for this type of a change. Some of the major impacts of a merge-gone-wrong scenario include the inability to process correction or follow-up records, along with being unable to generate follow back information. Furthermore, your facility will be unable to report any new cases until all of the fixes can be made in Eureka. If a merge is done incorrectly, there will be many consequences.

Do not go through the process outlined below without first informing your regional registry. It is important they be made aware of this change, or potential change as early in the process as possible.

If your facility is considering merging with another facility, use the following checklist:

- Contact your regional registry so they are aware of the changes in reporting and can be prepared when your vendor sends in the files.
- If either one of the facilities are ACoS approved, you will need to get the plan approved by ACoS first. (This has been one of the issues encountered by one of the facilities merging in 2013). Note that it may take several weeks for the ACoS to respond.
- Contact your software provider. One of the software providers in California has completed a few facility mergers and is experienced in this situation.
    - ◊ If your software provider has never performed a merger, contact the regional registry or the CCR and we will provide your vendor with the procedures.

Your software provider will lead you through the process. If all is done correctly, the process is actually very smooth and most of the work is done behind the scenes. Let all parties know what is occurring so everyone can be prepared for the changes.

Please contact your regional registry for more information.

Kyle Ziegler, CTR

Above article was prepared and written by Kyle Ziegler, CTR prior to his departure from the CCR. Since authoring this article, Kyle accepted a position with CRGC and is no longer a PAQC Unit staff member. The above information is accurate and still relevant to current protocol.

Meaningful Use Stage 2

Preparations for Meaningful Use (MU) Stage 2 are now underway at the California Department of Public Health (CDPH). There is a lot of complex information available outlining what MU is and how Cancer Reporting is included. Let's take a step back and outline the concept of MU. MU is based on the five priorities of health outcomes policy:

- Improving quality, safety, efficiency, and reducing health disparities
- Engage patients and families in their health
- Improve care coordination
- Improve population and public health
- Ensure adequate privacy and security protection for personal health information

These improvements to our healthcare system are based on the use of EHR systems throughout all practices and hospitals. A set of requirements were outlined by the MU Public Health Objectives of the Centers for Medicare and Medicaid Services (CMS) Electronic Health Record (EHR) Incentive Program to ensure that providers and hospitals are using their EHR technology to help meet the five priorities outlined above. Included in these requirements is sending data to public health agencies, which is MU Stage 2.

In preparation for MU Stage 2, the CDPH Meaningful Use Team has launched the CDPH Health Information Exchange (HIE) Gateway website. This site will allow eligible healthcare professionals and hospitals to securely register and manage data submissions to the CDPH. For cancer case reporting:

- **Only physician offices** reporting for MU Stage 2 *need to register their intent* to send data through the HIE Gateway. The California Cancer Registry (CCR) will be able to receive MU Stage 2 data from physician offices by *January 1, 2014*.

- **Current entities reporting cancer cases** to CCR that are not part of MU Stage 2 do not need to register intent with the HIE Gateway at this time. Current entities reporting cancer cases to CCR are to continue to report through the existing system.

The inclusion of cancer reporting in MU will prove to be a great resource in collecting data for cases where patients receive their cancer treatment in an outpatient setting. The automation of this type of reporting will help ensure that all cases are accounted for in the Eureka database.

To regulate the data received from physician's offices, the Centers for Disease Control and Prevention (CDC)/National Program of Cancer Registries (NPCR) collaborated with North American Association of Central Cancer Registries (NAACCR), central cancer registries nationwide, clinicians, EHR vendors, and other partners to develop the *Implementation Guide for Ambulatory Healthcare Provider Reporting to Central Cancer Registries*. This guide standardizes data transmissions from a healthcare provider EHR using Health Level Seven Clinical Document Architecture (HL7 CDA) based standards. It provides business rules and specifications to:

- Identify reportable cancer cases
- Identify the specific data elements to be retrieved and included in the cancer event report

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- Create a valid HL7 CDA, Release two cancer event report
- Transmit the cancer event report to CCR over a secure electronic transmission mechanism

Analysis has been done to identify the next steps for how the cancer event reports will be utilized once they are transmitted to the CCR. The CDC/NPCR eMaRC Plus software is currently utilized to process pathology reports received in another HL7 format. It identifies reportable cases and maps and translates the HL7 message into the NAACCR new case abstract format/standards.

eMaRC Plus is now being modified to receive and prepare MU eligible provider cancer event reports for central cancer registry system processing, including these key functions:

- Match multiple event reports for the same patient and diagnosis as they are received
- Map and translate event reports from HL7 CDA to NAACCR new case abstract format/ standards
- Consolidate translated abstracts for subsequent event reports in case they are not cumulative
- Configure and perform exports of initial and updated/consolidated abstracts for upload into the CCR's Eureka system

CDC/NPCR staff now lead a national working group to take the project beyond creation of the implementation guide to also define detailed specifications for eMaRC Plus and to create guidelines for subsequent central registry processing and administrative activities to facilitate MU reporting. While a small CDC/NPCR subcommittee is actually writing/maintaining the eMaRC Plus specifications, the larger working group representing state registries and other interested parties is providing a lot of analysis, input, and feedback for them, and the CCR and its regional registries have been very involved in this process. Most recently, the CCR provided coordinated feedback for California on the *MU Mapping/Translation Rules for eMaRC Plus* and *Data Flow Specifications for Processing CDA Documents within eMaRC Plus* documents developed thus far.

Finally, since physician offices are now able to register their intent to send data, any questions regarding the steps they need to take can be directed to the CDPH Health Information Exchange (HIE) Gateway. And any general questions regarding MU can be directed to the CDPH Meaning Use Team via email: MeaningfulUse@cdph.ca.gov.

Also, make sure to check out the NPCR MU website, where the implementation guide and general FAQs can be found.

Jenna Mazreku, CTR
Senior Systems Analyst
California Cancer Reporting and Epidemiologic Surveillance (CalCARES) Program
Institute for Population Health Improvement
UC Davis Health System

Single Abstract Reporting for Network Facilities

Does your facility share a single, unified patient medical record with one or more affiliated facilities? In order words, each facility in the network has equal access to all components of a patient's medical record. Reporting facilities in this situation who share a single medical record may want to consider reporting a single abstract for each tumor.

While the American College of Surgeons' (ACoS) has designated a special approval category for these types of facilities, called a Network Cancer Program, there is also an opportunity for non-ACoS facilities with uniform medical records to report a single abstract to the California Cancer Registry (CCR).

The process of becoming an approved network reporting facility is quite simple:

1) The Form to Request a Network Reporting Facility Status must be completed by the reporting facilities within the network. Signatures from each reporting facility representative are required. Once the form is complete, it must be submitted to the respective regional registry.
2) The regional registry provides the network reporting information to the central registry for inclusion on the California Cancer Registry Approved Network Reporting Facility list.

Once approved and designated by the CCR as a network reporting facility, a single abstract can be submitted for a patient seen at multiple facilities within the network. The CCR has established the following guidelines for reporting cases:

Option 1

- The first facility to diagnose the case takes responsibility for reporting the case (this includes abstracting and transmitting the case). This includes reporting all work-up and treatment provided at any of the network facilities

Option 2

- One network facility may be designated to report all cases, regardless of which network facility diagnosed the case.

General Guidelines

- Hospital referred to and from:
  - If treated within the network only, there will be no coding of these fields.
- Treatment information:
  - Coding the Treatment Facility Number in the Treatment section by modality is strongly encouraged.
- Workup procedures:
  - If the workup was performed within the network, it is not necessary to document which facility performed each procedure.
- Follow-up:
  - The responsibility of patient follow-up is on the reporting facility which first diagnosed and reported the case or was designated to report the case.

Jenna Mazreku, CTR* **Senior Systems Analyst**

Cheryl Moody, BA, CTR* **Production Automation & Quality Control Manager**

* California Cancer Reporting and Epidemiologic Surveillance (CalCARES) Program
Institute for Population Health Improvement
UC Davis Health System

Quick Tips:
General Reminders

CS Mets at DX and CS Mets at DX-Bone, Brain, Liver, Lung

As a reminder, CS Mets at Diagnosis is correlated to CS Mets at Dx for Bone, Brain, Liver and/or Lung. Avoid edit errors by noting the coding tips below. These will assist in ensuring that all related CS Mets at Diagnosis fields are coded appropriately.

- CS Mets at DX-Bone, Brain, Liver or Lung = 1 (yes), then CS Mets at DX must not = 00 (none) or 99 (unknown)
- CS Mets at DX = 00, then CS Mets at DX-Bone, Bone, Brain, Liver or Lung must = 0
- CS Mets at DX = 98 (not applicable) and Primary Site is not C809 (unknown primary site), then CS Mets at DX-Bone, Bone, Brain, Liver or Lung must = 8 (not applicable)

Breast Schema

SSF 16: Code 998 (Not applicable: Information not collected for this case)

This field collects the results of ER, PR and HER2 tests into one code. You will receive an edit if you use Code 998 for cases with a diagnosis date of 2011 or later.

Bladder Schema

Surgery Code: 27 TURBT (Transurethral Resection Bladder Tumor)
And corresponding
CS TS/EXT Eval Code: 1

TURBTs do not meet AJCC pathologic staging criteria and are instead considered clinical procedures. Reference the Note on the CS Tumor Size/Ext Eval page in CS Bladder. This coding is reinforced by Eureka IF 827 CS TS Ext Eval, Surgery, Bladder Schema (CS).

Importance of Text Documentation

Text documentation must support all coded data items in your abstract. A discrepancy will result if a code is not supported within the text. See Sections I.1.6.3 Coding and IV.1.1 General Instructions of Volume I.

Have an abstracting question? Make sure to check out CCR Inquiry System!

The CCR Inquiry System on the CCR website is a great resource for resolving abstracting questions. If your question is not currently addressed, please first submit your question to your Regional Coordinator.

Resources: SEER*Educate

SEER has developed an easy to use education tool, SEER*Educate, that embraces the idea of "learning by doing." People come into the registry field with different educational backgrounds and work experience. The training curriculum was specifically designed to meet a wide variety of needs:

- Recent graduates preparing for a registry job
- Registrars studying for the CTR exam
- CTRs earning CE hours in Practical Application and Registry Operations
    - i.e., Users who select the Practical Application can earn between 5-15 CEs by coding cases in one of the available series

SEER*Educate is set-up to provide one-on-one training through the use of 295 case scenarios for abstracting experience and feedback. A coding form is used when completing case coding, which includes built-in look-ups. Answers are scored with immediate feedback provided that includes not only the correct answer, but also the detailed rationale. Answers and rationales for all materials were determined by a panel of experienced CTRs at the Seattle-Puget Sound SEER registry at the Fred Hutchinson Cancer Research Center. Resources used to draft answers and rationales included the following references:

- ICD-O-3
- SEER Program Coding and Staging Manual
- Collaborative Stage Data Collection System Coding Instructions
- SEER Summary Staging Manual 2000
- 2010 and 2012 Hematopoietic and Lymphoid Databases and Manuals
- Multiple Primary and Histology Coding Rules
- ACoS CAnswer Forum
- Ask a SEER Registrar
- SEER SINQ

Currently, there are four training modules available to users. The Demonstration training module provides an opportunity for a new user to become accustomed to the software. The General Knowledge training module is designed to ensure that users understand medical terminology. The Practical Application training module allows users to practice coding case scenarios by site. This provides an opportunity to strengthen skills in correctly interpreting reportability guidelines as well as coding principles. In March 2014, these scenarios will be updated for CSv02.05.There is also a CTR Prep training module, which currently includes three training areas which are covered in the CTR Exam: CoC Cancer Program Standards, Computer principles and Statistics.

During the beta release of SEER*Educate, the PAQC Unit has had an opportunity to participate in the testing of this product. We highly encourage CTRs or those new to the field to participate in this excellent training activity.

Cheryl Moody, BA, CTR
Production Automation & Quality Control Manager
California Cancer Reporting and Epidemiologic Surveillance (CalCARES) Program
Institute for Population Health Improvement
UC Davis Health System

Volume I: Content & Formatting

Now that you are accustomed to the new functions of Volume I, the California Cancer Registry (CCR) has decided to organize a comprehensive review in order to improve upon the content. This process is currently underway and has a tentative implementation of 2015, when the Annual Data changes are put into production. The team is made up of the following CCR staff: Cheryl Moody, Marilyn Scocozza, Jenna Mazreku, Mary Brant and Donna Hansen. The draft version will be made available for regional registry review and comment prior to final release.

The intention of the examination of Volume I performed by the team will be:

1. To provide recommendations on clarity and the overall relevance of the material in each section.
2. Inspect the documentation to make sure the information is up-to-date and represents current abstracting requirements. Identify parts of sections that may need to be rewritten, combined with another section, or possibly deleted, if not relevant.
3. Address specific sections that can be reformatted in order to clearly and concisely inform registrars of the instructions being presented.

With the collaboration of the Regional Registry staff who volunteered to be part of the analysis process, the CCR hopes to continue to streamline Volume I to help registrars find abstracting and coding answers quickly. Stay tuned for more information on the Content and Formatting of Volume I.

Mary Brant, BA, CTR
Analyst IV
California Cancer Reporting and Epidemiologic Surveillance (CalCARES) Program
Institute for Population Health Improvement
UC Davis Health System

NAACCR Gold Certification

We are happy to announce that the California Cancer Registry received the NAACCR Gold Certification for our 2011 incidence Data at the June 2014 NAACCR meeting.

In the next issue of CCR Innovations we will share more detailed information about the NAACCR conference along with four terrific poster presentations created by the PAQC unit.

Donna Hansen, CTR
Production Automation & Quality Control Unit
Auditor/Training Coordinator
California Cancer Reporting and Epidemiologic Surveillance (CalCARES) Program
Institute for Population Health Improvement
UC Davis Health System

Name Change

Please note that in response to a request from the California Department of Public Health (CDPH), the Institute for Population Health Improvement's California Cancer Registry Program has changed its name to:

California Cancer Reporting and Epidemiologic Surveillance (CalCARES) Program

No changes in the function or operation of the program are associated with the name change. As you may know, the administrative and management structure of the CCR program has changed from previous contract periods. CDPH has four separate grants - one each with UCD, PHI, CPIC and USC. Each of these four separate entities is viewed as a partner in helping CDPH to meet goals and objectives for the state mandated cancer registry program. In light of this change, and in order to distinguish ourselves from the state program, we have chosen a name to better reflect our contribution to CDPH.

Arti Parikh-Patel, PhD, MPH
Program Director
California Cancer Reporting and Epidemiologic Surveillance (CalCARES) Program
Institute for Population Health Improvement
UC Davis Health System

Call for Articles & Ideas

While reading through this edition, did you think of a great idea for an article or an abstracting tip? We encourage you to send us your ideas and become part of the CCR **Innovations** bulletin!

Please send your ideas in a Word document to our Managing Editor, Donna Hansen, CTR at ***dhansen@ccr.ca.gov***

We look forward to hearing from you!

1631 Alhambra Blvd., Suite 200
Sacramento, CA 95816
Tel: 916-731-2500
Fax: 916-454-1532