CCR INNOVATIONS

Increasing Trends of Kidney Cancer in California

The incidence of kidney cancer in the United States (U.S.) has increased consistently since the 1970's. California Cancer Reporting and Epidemiologic Surveillance's (CalCARES) new report on cancer trends shows that the incidence (i.e., new cases) of kidney cancer in California has increased steadily among men and women of all racial/ethnic groups. Mortality rates, however, have not increased significantly since 1988, and have actually declined among white men and women. Researchers in the Surveillance and Data Use (SDU) unit were intrigued by these facts, and are currently studying in more detail potential reasons behind these trends.

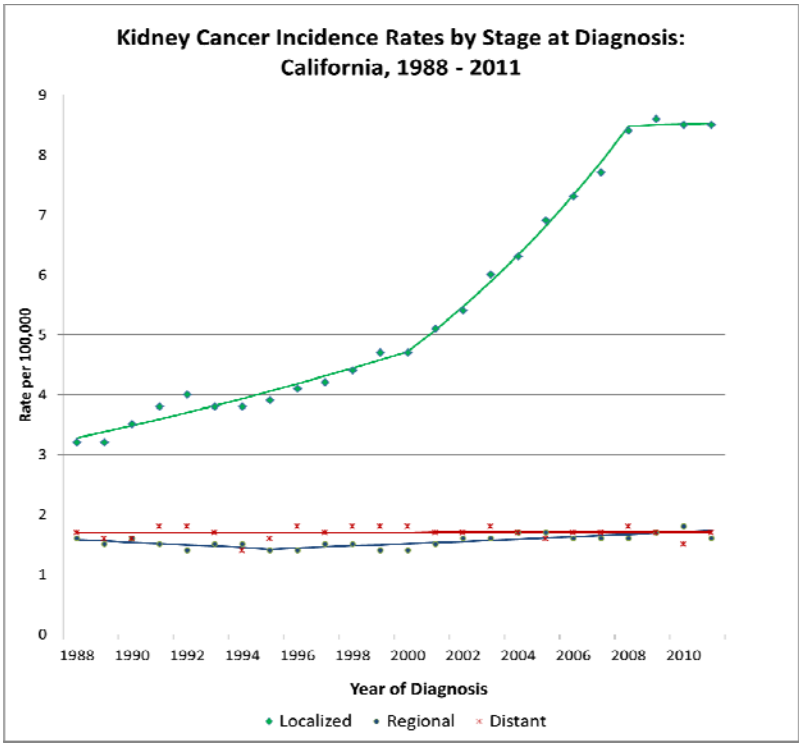
Risk factors for kidney cancer include smoking, obesity, hypertension, long-term dialysis, and other less common conditions and exposures. Could any of these factors be responsible for the increase in kidney cancer cases? In California, smoking has declined dramatically from 25 percent in 1984 to 12 percent in 2010. Obesity, on the other hand, is reaching almost epidemic proportions and could be one of the factors contributing to the increase in kidney cancer incidence. However, obesity does not explain why mortality rates are not increasing together with incidence. Preliminary analysis of California Cancer Registry (CCR) data shows that the increase in incidence is mostly limited to an increase in kidney cancers diagnosed at localized stage (and at a lesser extent, to those diagnosed at regional stage). This finding is consistent with mortality being stable over time: when diagnosed and treated at early stage, kidney cancer has a very favorable prognosis.

The next question to be addressed is: in the absence of any screening program, why are so many kidney cancers being diagnosed at early stage? Although this question cannot be answered by data items currently collected by the CCR, many

(Cont. Pg 2)

Inside this issue

sources in the press have reported that the use of diagnostic imaging tests has increased across the board in the U.S. Some of these imaging tests may be able to detect tumors by chance, before symptoms develop. Therefore, it is possible that a higher use of Computed Tomography (CT) scans and Magnetic Resonance Imaging (MRI) are associated with the increase in the incidence of kidney cancer. The study is still in progress, but stay tuned for updates!



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Investigating the Incidence of Childhood Leukemia in California by Ethnicity

A collaborative research project between investigators at the California Cancer Reporting and Epidemiologic Surveillance (CalCARES) Program and UC Berkeley's Center for Integrative Research on Childhood Leukemia and the Environment is currently underway. The motivation for this research project came from a finding published in the Surveillance, Epidemiology, and End Results (SEER) Program's Cancer Statistics Review, 1975-2011 which indicated that the incidence of childhood leukemia increased 55.5 percent between 1975 and 2011 in nine SEER regions. This large increase aroused curiosity regarding the status of childhood leukemia in California and highlighted the need to publish current California-specific trends. The objectives of our study

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were to provide current information on the trends in childhood leukemia incidence in California and compare what is happening in our state to what is happening nationally. Second, given the large Hispanic population in California, we aimed to provide an in-depth analysis of the differences in childhood leukemia incidence among non-Hispanic white and Hispanic children.

We found that the incidence of Acute Lymphocyctic Leukemia (ALL) significantly increased among California children aged one to 14 years by 1.2 percent per year between 1988 and 2010. When ALL incidence was stratified by age at diagnosis, gender, and ethnicity, significant increases in ALL incidence were also observed among males, females, children aged one to four years, children aged 5 to 14 years, and Hispanics. These findings are similar to trends published for the U.S. as a whole. A noteworthy and novel finding of our study was that ALL incidence among Hispanic female children increased more rapidly during the study period than among Hispanic male children (Figure 1). If this trend continues, the incidence of ALL among Hispanic female children in California will reach that of Hispanic male children, whom historically have the highest incidence. To our knowledge, this increase in ALL incidence among Hispanic female children has not been previously reported.

Our study revealed that Acute Myeloid Leukemia (AML) incidence among children aged 1 to 14 years in California remained relatively stable. This is different from the increasing trend reported by SEER for children aged 0 to 14 years between 1975 and 2011. This difference is most likely explained by the fact that our study excluded infants. When AML incidence was stratified by ethnicity, a significant increase in AML incidence among Hispanic children was observed (Figure 2). To our knowledge, no other study has reported an increasing trend in childhood AML incidence among Hispanics.

Our ability to conduct a detailed analysis of the trends in childhood leukemia by ethnicity was possible because of California's large Hispanic population and also because the California Cancer Registry captures detailed information on the race and ethnicity of patients. Given the large number of data items Certified Tumor Registrars (CTR) are expected to abstract from the medical record, it may seem as though capturing a patient's race and ethnicity is not a high priority. However, researchers are very interested in investigating differences in all areas of the cancer continuum from diagnosis, to treatment, to death from cancer or by race/ethnicity. In fact, a simple search of Google Scholar using the keywords "cancer and race" returned 959,000 publications related to this topic! In order to identify and address racial/ethnic differences in the cancer burden, we must continue to obtain the most accurate and complete race/ethnicity information possible.

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It all Hinges on TEXT

Text documentation is an essential component of a complete abstract. While this topic is frequently addressed by visual editors, recent California Cancer Registry (CCR) data quality audits revealed that insufficient text documentation on the abstract continues to be a "missing link" which warrants revisiting this topic.

Why is text needed? Text provides the patient's cancer information in a readable format. It is necessary to support coded information on the abstract, to document unusual occurrences, and to verify edit checks. Text also provides information for recoding audits, researcher use, facility use, and re-abstraction of historical data for comparisons.

Here are a few general guidelines about text documentation.

- Text fields must contain supporting information entered by the abstractor independently from the coded data.
- Text should document the patient's cancer journey from diagnosis through treatment.
- Text should document the When, What, Where and Who as it pertains to the site-specific cancer diagnosis.
- Only approved abbreviations should be used on the abstract. See Volume 1 Appendices M.1 and M.2 (links below).
    - Appendix M.1 Common Acceptable Symbols and Abbreviations in Term Order
        - http://www.ccrcal.org/PAQC_Pubs/V1_2014_Online_Manual/index.htm
    - Appendix M.2 Common Acceptable Symbols and Abbreviations in Abbreviation Order
        - http://www.ccrcal.org/PAQC_Pubs/V1_2014_Online_Manual/index.htm

Identifying the site-specific information to record on the abstract and the most concise way to document information is the challenge for cancer registrars. I would like to introduce you to a terrific text documentation resource developed by Meryl Leventhal, MA, CTR, Data Collection Manager from the Los Angeles Cancer Surveillance Program, Keck School of Medicine at the University of Southern California. Meryl gave a presentation at the Abstracting 101 Boot Camp which was a preconference workshop as part of the California Cancer Registrar's Association Annual Education Conference this past November. In this resource, Meryl provides step-by-step guidelines for text documentation with specifics including what information to select from the medical record, what information to record on the abstract, and the format for recording the information concisely.

This document is a wonderful stand-alone-resource that both new and experienced cancer registrars will find beneficial and worthy of inclusion in your personal collection of abstracting resources!

Click here to view "**Text Documentation Essentials**" by Meryl Leventhal, MA, CTR

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Recording Address at Diagnosis

Hospital cancer registrars and central/regional registry staff work together to collect and report high quality cancer data. The data are used for both clinical medicine and for public health.

As noted in Volume I, the main purpose of a hospital cancer registry is to provide physicians with the data needed to maintain quality of care through peer review and to compare performance with recognized standards.

Hospital-based registries collect cancer data for the patients in their "service area" or from outside their service area if they provided specialized services.

A more comprehensive level of reporting is required by state law and that level is supported by the California Cancer Registry (CCR) and the network of regional cancer registries within the state. Information is gathered primarily for use in epidemiological research and for monitoring the occurrence of cancer in the state and in the nation.

The network of regional cancer registries in California are population-based registries that capture information on cancer incidence occurring in defined geographic areas. Each central/regional registry acts as a multiple purpose population-based incidence registry. A multipurpose registry combines incidence reporting with survival results, patient care and various other research and cancer-control activities.

Population-based cancer registries are able to calculate the incidence of cancer in their defined populations. A standard incidence rate is reported as the number of cancer cases per 100,000 population. For incidence rate calculations, the numerator figure includes all of the eligible cancer cases. The denominator figure includes all of the eligible residents of the defined geographic area. For accurate population-based cancer incidence rates, each incident case must be counted, only once, at the time of initial diagnosis. The incident case must also be represented in the denominator figure. This means that the incident case must be a member of the population at risk (a resident of the defined geographic area).

Certain criteria must be met for a cancer case to be included as an incident case for a population-based registry:

1. The tumor must meet reportability requirements.
2. The patient's residence must meet residence requirements.

The main purpose of the address (at diagnosis) field, therefore, is to identify the patient's **residence at the time the cancer was first diagnosed**, not the patient's current address.

The two address fields on the cancer reporting abstract, Address at Diagnosis and Current Address, may, or may not be coded the same because they serve two different functions. The Address at Diagnosis field is the patient's residence at the time the cancer was first diagnosed and it is used for reporting cancer incidence in specific geographic areas. The Current Address field is used for follow-up activities.

Volume I contains specific rules and instructions for determining and collecting residence at the time of diagnosis. The rules for determining residence (address) at diagnosis are either identical, or comparable to rules used by the U.S. Census Bureau, to ensure comparability of definition of cases (numerator) and the population at risk (denominator). Some of the rules and guidelines were described in the October issue of CCR Innovations "Geocoding and Data Quality."

The residence reporting rules documented in Volume I are common to all of the registries in the

(Cont. Pg 6)

U.S. that report data to Surveillance, Epidemiology, and End Results (SEER) Program. Geographic location of residence at diagnosis is reported to SEER. Current address is not. This ensures comparability of national cancer incidence rates that are reported by the National Cancer Institute (NCI).

Rules for recording address instruct the cancer registrar to enter the address of the patient's **Usual Residence** on the date of the initial diagnosis. **Usual Residence** is defined as the place where the patient lives and sleeps most of the time and is not necessarily the same as the legal or voting residence.

In a discussion about residence at diagnosis, it is important to note that a post office box is not a reliable source to identify the residency at diagnosis. Post office box addresses do not provide accurate geographical information for analyzing cancer incidence. Use the post office box address ONLY if no street address information is available after follow-back.

Determining a patient's residence at the time of diagnosis can be challenging in our transient society. Folks are continuously on the move. Patients diagnosed with a serious illness may move to another area after diagnosis to be closer to relatives, or friends for support. In order to accurately record the address at the time of initial diagnosis, the abstractor should review the clinical history information in the medical record. This is because the face sheet may, or may not reflect the residence at diagnosis. It may reflect a new post-diagnosis address.

Another challenge facing cancer registrars in California is the number of large referral hospitals offering state-of-the-art care. Cancer patients from around the world flock to areas that are known to provide high quality or innovative care. Some patients stay with friends, or relatives as they consult with cancer experts. Some patients take up temporary residence in a region for extended cancer treatment protocols. The new and/or temporary address they provide is not to be recorded as the address at the time of initial diagnosis.

At the time of cancer case abstraction, the cancer registrar should be alert to indicators that may suggest that the address on the face sheet does not reflect the patient's address at the time of initial diagnosis. Some questions the abstractor should be asking are:

- Was the patient diagnosed in a different geographical area? If so, why?
- Does the patient usually live in a different geographical area?
- Is the patient here for consultation or treatment only?
- Has the pathology department been asked to review slides from a hospital located in another state?

The answers to these questions must be viewed with caution. The answers may indicate an out-of-area residence at the time of diagnosis. However, the answers may also identify residents of your region who were diagnosed while they were away from their usual residence.

If complete information on address at diagnosis is not available, enter as much information into the Address at Diagnosis field as is known. For example, the abstractor is able to ascertain only that the patient was a resident of Nevada at the time of diagnosis. State is recorded as Nevada while street address, zip code and county are recorded as "unknown."

(Cont. Pg 7)

Care should be taken to ensure that the patient's address at diagnosis is recorded in the Address at Diagnosis field on the abstract. Information that is documented only in a text field may be missed. For example, a case may bypass visual editing, and text fields will not be reviewed.

It is important for cancer registrars to help educate hospital staff about the contribution residence documentation has in developing public health policies and in cancer surveillance. An accurate address at diagnosis provides population-based registries with accurate geographic information for each incident case. Geographic information is used in a variety of ways, such as mapping cancer incidence by variable (site, stage, race/ethnicity, etc) for use in cancer control and public health activities.

As cancer registrars, in addition to our responsibilities of recording accurate data for clinical use, we all also carry the responsibility of recording accurate data for public health use. Abstractors should take the same amount of care to determine and record residence at diagnosis as they do to determine and record tumor reportability and class of case.

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Cancer Prevention Institute of California

Automation Activities

The Production Automation and Quality Control (PAQC) Unit has taken a proactive approach to streamlining case completeness in our database. Our goal is to make California cancer cases research ready as quickly as possible. System processes that may interfere with a case being complete and ready for research include at least the following: edit errors, visual editing tasks, tumor linkage, and consolidation activities. In order to accomplish the goal of decreasing the time from cancer case file upload to research-ready, our project team members evaluate those processes within the central registry database which currently require manual assistance in order to complete the case. Examples of cases requiring some degree of manual work effort are outlined below:

- Cases with edit errors that require a visual editor to correct and complete the case.
- Cases with more than one tumor in the database that require a visual editor to evaluate and choose either to link to an existing case, or create a new tumor for the patient.
- Cases requiring consolidation conflict resolution where there are multiple admissions for the same tumor, but with conflicting information requiring a visual editor to consolidate information accurately.

PAQC Unit automation projects were developed to address these types of cases and through the application of an automation solution, reduce the amount of time a staff member directs towards those activities. In this manner, regional staff can re-direct and/or refocus on those activities that are not appropriate for an automation alternative, such as visual editing complex cases, auditing and educating abstractors.

(Cont. Pg 8)

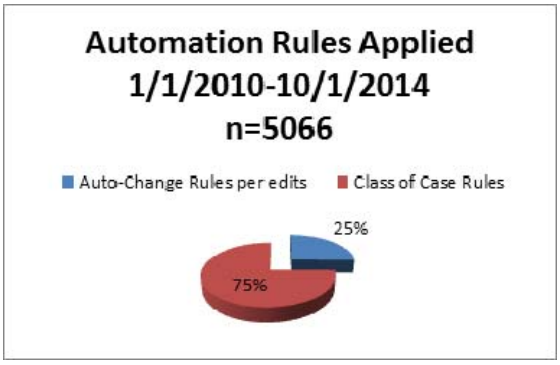
PAQC Unit automation activities are concentrated on evaluating existing edits where there is only one feasible coding option. The project team creates auto-change rules that are applied to each case any time a change is made (such as file upload, database inquiry changes, visual editing, corrections, etc). California's Cancer Reporting Standards, Volume III which contains all edits and allowable values is reviewed for possible auto-change rules. Analysis of cases currently in the database meeting the proposed auto-change rule criteria are performed and an auto-change rule is drafted as deemed appropriate. The drafted rule is programmed and thoroughly tested prior to being implemented in the database. At the present time, 32 of these auto-change rules based on existing edits have been implemented in the central registry database.

A second automation work activity is focusing on cases requiring manual tumor linkage. Our project team developed auto-linkage rules for incoming tumors that exactly match to existing tumors in the database. Prior to the implementation of this "exact-match tumor linkage rule," a visual editor would need to manually review both the incoming tumor and existing tumor data to determine whether or not an exact match situation existed, and then proceed to perform a manual tumor linkage. In addition, the project team has written tumor linkage rules to auto-link tumors based on Surveillance, Epidemiology, and End Results (SEER) Program's Multiple Primary and Histology (MP/H) rules. To-date, auto-tumor linkage rules have been implemented to mimic SEER MP/H rules for Prostate, Breast, Lung, Colon, and Kidney. The project team is currently working on site-specific auto-linkage rules for Head and Neck cancers, Melanoma, Benign Brain/Central Nervous System (CNS), Malignant Brain/CNS tumors and Thyroid. These site-specific auto-linkage rules replace the manual work effort of visual editors attempting to determine if incoming tumors should, or should not be linked to an existing tumor. The auto-linkage rules will either auto-link to an existing tumor if appropriate, or create a new tumor per the MP/H rules. Cases that cannot be automated will still go Manual Linkage Resolution.

Automation Rules January 2010 - October 2014

The table below illustrates the automation activity of the auto-change rules based on edits.

AUTO-CHANGE RULES Based on Edits	Admissions Corrected	# Rules Applied
Auto-change Breast	55	64
Auto-change-ColonRectum	254	271
Auto-change-NonSite	755	937
Auto-change-Sex	1	1
Total	1010	1273



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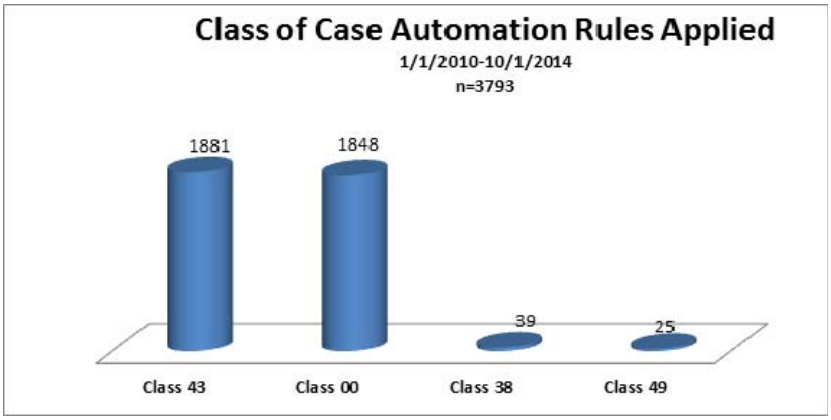
Our third automation work activity is to focus on consolidation activities and attempt to implement automation enhancements where feasible. In analyzing the consolidation work activity of visual editors, the project team quickly realized that consolidation decisions were sometimes based on Class of Case. In order to mimic a visual editor's thought processes with an automation solution, the team decided that Class of Case would need to be a reliable data field. To that end, automation rules have been developed and continue to be developed to automate Class of Case. At the present time, any case uploaded, or changed in our database will have these Class of Case automation rules applied. Data fields incorrectly coded will be auto-corrected in accordance with these implemented rules. Currently, Class of Case 49 (Death Clearance Only), Class 38 (Autopsy Only), Class 43 (Path Only), Class 00 (diagnosed at reporting facility, known to be treated elsewhere), Class 34 and 36 have been implemented. Class 20-22 and Class 10-14 are also planned for implementation by June, 2015.

The table below illustrates the automation activity based on the Class of Case rules.

CLASS OF CASE RULES	*Admissions Corrected*	*# Rules Applied*
Class 00	1824	1848
Class 43	1548	1881
Class 38	30	39
Class 49	20	25
Total	3422	3793



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Edit Errors on File Upload

One of the data quality checks that the central registry performs is to evaluate files submitted from California facilities, vendors and/or abstractors to determine whether they had edit errors at the time of file upload into the California Cancer Registry's (CCR) database.

Below is the status for cases uploaded during the time period of August 1 - August 31, 2014:

Edit Errors on File Upload

From 8/1/2014 To 8/31/2014

Top Edit: ER1138 (32) (expand for top 10 Edits)

Edit Number	Edit Name	Count Errors
ER1138		32
IF992		26
ER1137		24
ER1144		14
ER1140		14
ER1139		12
ER1141		12
ER1145		9
ER1142		8
ER1143		7
	Total	158

How would an abstractor find out the edit criteria for one of these edit errors? By using Volume III as a reference source (ccrcal.org/Registrar Resources/Volume III), an abstractor can determine what the edit is checking and then correct their codes as appropriate. Once the link to Volume III is accessed, enter the Interfield (IF) edit number in the search bar at the top left. Click on the edit and the edit message will be displayed.

Note that the Production Automation and Quality Control (PAQC) Unit staff analysis determined that all Allowable Value Edits (ER) edit errors (ER1138-ER1143) were related to invalid values for comorbid/ complications. IF992 indicates an incorrect treatment code for a Class 00 case. Remember, Class 00 indicates that the patient was diagnosed at the reporting facility but first course treatment was given elsewhere, and treatment as well as the treating facility which is not the reporting facility is identified.

For Class 00 to be appropriately coded (and avoid encountering this edit error), the following must be true and coded appropriately:

- DATE OF DIAGNOSIS has all known values.
- DATE OF FIRST CONTACT has all known values.
- DATE OF DISCHARGE has all known values or is blank.
- DATE OF DIAGNOSIS is equal to or greater than DATE OF FIRST CONTACT.
- DATE OF DIAGNOSIS is less than DATE OF DISCHARGE (if not blank).
- DIAGNOSTIC CONFIRMATION is less than nine.
- RX Hosp No Proc 1-3 is not equal to REPORTING FACILITY number.
- At least one Treatment RX Summ Field (see definition below)* does not equal 0, 00, 9 or 98 and RX SUMM TREATMENT STATUS = 1.
- OR, all Treatment Rx Summ Fields equal 0, 00 9 or 98 and Rx Summ Treatment Status = 2.

(Cont. Pg 11)

- At least one Treatment RX Summ Field (see definition below)* does not equal 0, 00, 9 or 98 and RX SUMM TREATMENT STATUS = 1.
    - OR, all Treatment Rx Summ Fields equal 0, 00 9 or 98 and Rx Summ Treatment Status = 2.

    * *"Treatment RX Summ Fields" is being used to refer to ALL of the following fields.*
        - *RX SUMM – BRM*
        - *RX SUMM – CHEMO*
        - *RX SUMM – HORMONE*
        - *RX SUMM – OTHER*
        - *RX SUMM – RADIATION*
        - *RX SUMM – SCOPE REG LN SUR*
        - *RX SUMM – SURG OTH REG/DIS*
        - *RX SUMM – SURG PRIM SITE*
        - *RX SUMM – Transplnt/Endocr*

It is important to stay current with your abstracting software vendor's notification of latest Edit Metafile updates. By remaining current with the latest Edit Metafile and following vendor's instructions for uploading it into abstracting software, abstractors have the latest edit sets with which to check their data PRIOR to submitting to either their region, or directly to CCR (for abstractors utilizing Direct Access). In this manner, edit errors such as noted above will be avoided.

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Eureka Release 13.3

Eureka, the California Cancer Registry's integrated cancer data management system, version 13.3 was released into production late-December, 2014. The Eureka updates for this release included the projects listed below.

Notable Changes:

- New Follow-back screens implemented with increased flexibility.
- Improvements were made to Follow-back Package Generation.
- Updated Eureka for IE-10 Compatibility.
- Approximately 240 Eureka Bugs and Enhancements.
- User Guide updated with Upload Package changes that went in 13.3 Release.

Data Quality Assurance: Business Rules Management Solutions (BRMS)

- Class of Case 34 and 36 Rules have been automated in Eureka.
- Two Linkage Automation Rules have been automated in Eureka: Head and Neck and Benign Brain and CNS.
- Modifications to Breast, Kidney and Lung Linkage Rules that take into consideration of class of case.

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Please note that a summary of the notable changes made to Eureka with each release is available in the Eureka Release Notes. This can be accessed 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 apprised as to how Eureka is functioning. As users, it is important to know what enhancements are made in order to work as efficiently as possible

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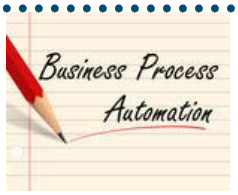

The PAQC Unit
NAACCR Automation Posters

The Production Automation and Quality Control (PAQC) Unit had the opportunity to participate in the North American Association of Central Cancer Registries (NAACCR) 2014 Conference in Ottawa, Canada. The PAQC Unit prepared and provided four posters focusing on current automation activities. An excerpt from the background and/or objective for each automation activity is noted below as an introduction to the poster. I strongly encourage you to review in detail our findings and conclusions which resulted from the ongoing automation work efforts by the PAQC unit of the California Cancer Reporting and Epidemiologic Surveillance Program (CalCARES). Please use the links provided below to view each poster in its entirety.

- **TUMOR LINKAGE - California's Approach**
  - Marilyn Scocozza, CTR
  - **Background:** As resources and budgets shrink, a business decision was made to evaluate those manual processes and analyze the feasibility of applying automation solutions as an alternative and as a means to re-redirect staff resources to the more complex processes that are not readily adaptable to an automation solution thereby requiring skilled Certified Tumor Registrars (CTR) to manually complete.
  - Click **here** to view poster.

- **PROCESSING CORRECTIONS: How do we efficiently get the most important data?**
  - Scott Wood, BA
  - **Background:** In 2013 the California Cancer Registry (CCR) processed nearly 775,000 correction records. Some corrections update the data without any user interaction, others require user interaction to either link to correct patient or to consolidate into existing data. In order to be more efficient, the CCR has created a project to analyze corrections and determine what can be done to reduce manual work efforts without compromising the quality of the data.
  - Click **here** to view poster.

(Cont. Pg 13)

- **EDIT ERRORS ON FILE UPLOAD: Use of Report Analysis to Improve Data Quality**
  - Jenna Mazreku, CTR
  - **Background:** In an effort to improve data quality, the PAQC unit of the CalCARES began a focused analysis of edit errors identified when admission level abstracts are uploaded into Eureka, our integrated cancer database management system. The targeted months used in this analysis were August, September, and October of 2013. The Edit Errors on File Upload Summary report was utilized to capture these edit errors and provide documentation for how many initial edits are received on an admission.
  - **Objective:** The primary goal of this analysis was to find a strong business solution that would meet central and regional registry needs. The PAQC unit also looked for new opportunities for automation and target areas in need of education. Focus was also put on how the existing Edit Errors on File Upload report could be improved for ease of use.
  - Click **here** to view poster.

- **AN AUDIT OF GENDER CODES FOR GENDER SPECIFIC CANCERS - California's Results**
  – Mary Brant, BA, CTR
  - **Background:** In the summer of 2013, one of the SEER regional cancer registries in California, the Cancer Registry of Greater California (CRGC), conducted a mini-reliability study as part of the Comparative Effectiveness Research (CER) project for the Centers for Disease Control and Prevention (CDC). CRGC reviewed their prostate cancer cases and identified that the sex field (gender) was often coded to "9" unknown. They assumed code 9 may be a default code in the direct entry screens, and a request was submitted to the California Cancer Registry (CCR) trouble ticket system to change the default. The PAQC Unit at the central registry investigated CRGC's findings and made the decision to expand the original analysis to a statewide audit which would include both male and female organ cancer. Cases from each of the three California SEER regions were included in the audit (Region 1/8-Cancer Prevention Institute of California; Region 9-Cancer Surveillance Program; and CRGC-Regions 2, 3,4,5,6 and 7/10.
  - **Objective:** Determine the confidence level of the quality of gender data in the Eureka DMS data base. Determine if an edit could be created or modified to disallow code "9" for gender specific cancers.
  - Click **here** to view poster.

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Scott Wood, BA* **Programmer Analyst**

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

Mary Brant, BA, CTR* **Business Analyst**

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Call for Articles and Ideas

Do you have a great idea for an article for the CCR Innovations? We encourage you to send us your ideas or a draft article and become part of the CCR Innovations Bulletin! All topics considered.

Possible topics:

Abstracting Tips & Education:

- What educational topics would you like to see covered?
- Do you have a great abstracting tip to share?
- Certified Tumor Registrars (CTR), what is your preferred method for continuing education activities and why?

Hospitals:

- What have been your cancer registry challenges or successes within an American College of Surgeons (ACoS)/Commission on Cancer (CoC) accredited facility?
- Tell us about your successful data quality control processes when managing remote cancer registry staff.
- Contract CTRs - Share your experiences and tips to become a successful independent contractor performing cancer reporting for a hospital.

Regional Registries:

- Highlight data quality activities within your regional registry. What's the Good - What's of Concern? Special projects or audits outcomes you want to share?
- Regional Visual Editors- What are the mechanics, processes, challenges and rewards of visual editing?

Researchers:

- How have California Cancer Registry data contributed to your ongoing research topics and activities. Data challenges, data confidence, data wish list? Please share with us your resulting research reports which utilized California cancer registry.

General :

- How the job of a CTR may be different 10 years from now?

Please email ideas or a draft Word document to our Managing Editor, Donna M. Hansen, CTR at dhansen@ccr.ca.gov .

We look forward to hearing from you!

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