OCCR QUARTERLY

NEW HOME AT OKLAHOMA COMMONS

By Leslie Dill

It has been an exciting and challenging adventure, but finally, the Oklahoma Central Cancer Registry (OCCR) has relocated with the Oklahoma State Department of Health to our new home. We are now located at the Oklahoma Commons, a prominent skyscraper in downtown Oklahoma City at the corner of Robert S. Kerr Ave and Broadway.

Fax numbers, staff phone numbers and extensions have changed. Please refer to the Staff Listing on page 18 of this newsletter to update your contacts. You should begin to use our new contact information immediately.

To ensure that mail is received, address your correspondence using the following format:

Center for Health Statistics
Oklahoma Central Cancer Registry
ATTN: (recipient full name)
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste 1702
Oklahoma City, OK 73102

MEET OCCR'S NEW DATA ACQUISTION ADMINISTRATIVE PROGRAM MANAGER

By Alexandra Feld, MPH

OCCR is pleased to announce the addition of Jennifer Harper, Ph.D. as our Data Acquisition Administrative Program Manager. Dr. Harper began with the Center for Health Statistics and OSDH in November 2020. Her position includes providing management, oversight, and technical support to various programs, such as the OCCR, BRFSS call center, and hospital discharge data.

Dr. Harper brings over 15 years of experience in research methods, data modeling, and data science. Prior to joining OSDH, Dr. Harper was the program director for a quantitative doctorate program, where she supervised regional and national research programs. She has also worked internationally as a principal consultant using data science techniques and developing custom apps to automate data analytics. She holds a Ph.D. from Alliant International University and two data science certificates from HarvardX. Dr. Harper was also the recipient of two regional awards in data science and a national award in leadership. She has been invited to speak for numerous regional and national professional organizations on the application of research and analytics in the workplace.

Dr. Harper is originally from Canada and lived in California before moving to Oklahoma in 2020. When not at work, she gardens, trains horses, and looks forward to playing clarinet in an orchestra when large group gatherings are permitted. She spends her weekends training her two dogs in search and rescue.

AN OVERVIEW OF UPCOMING CHANGES FOR 2021

By Barbara Murray, CTR

> *The only constant in life is change – Heraclitus of Ephesus, ancient Greek philosopher*

Although approximately 2500 years old, this quote seems to have been written just for cancer registry professionals. Cancer data collection is an evolving field and change seems to happen continuously. Although adjusting to new guidelines can be stressful, being educated and prepared is a good defense. Please take some time to review these changes to the Solid Tumor Rules and ICD-O 3.

SOLID TUMOR RULES

1. Cutaneous Melanoma Solid Tumor Rules have been released for cases diagnosed beginning January 1, 2021. Please note this is cutaneous (skin) melanoma only. Other sites of origin such as eyes or mucosa are still reported using the Multiple Primary and Histology Coding Rules (MPH manual).

   https://seer.cancer.gov/tools/solidtumor/Melanoma_STM.pdf

2. Always review the Solid Tumor Rules General Instructions in conjunction with the site specific modules.

   https://seer.cancer.gov/tools/solidtumor/General_Instructions_STM.pdf

Although the Solid Tumor Rules are in downloadable PDF form, I recommend accessing them directly from the SEER website to ensure you are consulting the most current information available.

https://seer.cancer.gov/tools/solidtumor/

Module Updates

All site modules were updated in December 2020 with the following notable changes:

1. Across all modules, when neoadjuvant therapy is administered, priority order for using documentation to identify histology has changed.
2. “Majority”, “major”, and “greater than 50%” were removed from equivalent terms and definitions.
3. Bullet point added to all instances of the "same row rule" for site modules where histology tables contain nested subtypes/variants in column 3. The example below is from the “Breast Solid Tumor Rules.”

Continued on page 4

AN OVERVIEW OF UPCOMING CHANGES FOR 2021, Continued

Rule M13 Abstract a **single primary**[i] when **synchronous**, separate/non-contiguous tumors are on the **same row** in Table 3 in the Equivalent Terms and Definitions.

Note: The same row means the tumors are:

- The same histology (same four-digit ICD-O code) **OR**
- One is the preferred term (column 1) and the other is a synonym for the preferred term (column 2) **OR**
- A NOS (column 1/column 2) and the other is a subtype/variant of that NOS (column 3) **OR**
- A NOS histology in column 3 with an indented subtype/variant

New bullet

Specific and NOS/NST Terms and Code	Synonyms	Subtypes/Variants
Sarcoma NOS 8800/3 *Note 1*: Rhabdomyosarcoma **8900/3** is also a NOS with the following subtypes/variants: Alveolar type rhabdomyosarcoma **8920/3** Embryonal type rhabdomyosarcoma **8910/3** Pleomorphic rhabdomyosarcoma **8901/3** **Note 2:** Angiosarcoma **9120/3** is also a NOS with the following subtypes/variants: Hemangiosarcoma 9120/3 Lymphangiosarcoma 9170/3 Malignant hemangioendothelioma 9130/3	NOS histology with indented subtype/variant	Angiosarcoma **9120/3** Hemangiosarcoma Lymphangiosarcoma **9170/3** Malignant hemangioendothelioma **9130/3** Liposarcoma **8850/3** Leiomyosarcoma **8890/3** Osteosarcoma **9180/3** Rhabdomyosarcoma **8900/3** Alveolar type **8920/3** Embryonal type **8910/3** Pleomorphic **8901/3**

Individual site modules were also updated. All changes can be found here:

https://seer.cancer.gov/tools/solidtumor/revisions.html

ICD-O 3.2

Beginning with cases diagnosed January 1, 2021, ICD-O 3.2 will replace ICD-O 3 as an abstracting reference for cancer reporters. Some notable changes, whose details are documented on the NAACCR website (https://www.naaccr.org/icdo3/), are:

1. Sixteen newly reportable conditions due to code changes. For example, GIST, NOS was previously 8936/1 and will now be 8936/3.
2. Nine previously reportable conditions will no longer be required. For example, Langerhans cell histiocytosis, previously 9751/3, will be non-reportable 9751/1.
3. There are also re-assigned histology codes. Histology code 9364/3 in ICD-O 3 is assigned to peripheral neuroectodermal tumor. Beginning with cases diagnosed January 1, 2021, 9364/3 will belong to Ewing sarcoma, and Ewing sarcoma will no longer be coded to 9260/3.
4. Reportability rules have changed for 13 conditions that previously were only coded to behavior code /3 when a pathologist used "malignant" in the diagnosis. **The reverse is now true.** The behavior defaults to /3 and is only coded to /1 when the pathology report specifies "benign." For example, thymoma, NOS defaults to 8580/3 unless the pathology report specifies benign, and then the behavior is 8580/1.

Continued on page 5

AN OVERVIEW OF UPCOMING CHANGES FOR 2021, Continued

5. There are 12 new codes and terms. For example, myelodysplastic syndrome with ring sideroblasts and multilineage dysplasia now has its own histology code, 9993/3 and will no longer be reported as myelodysplastic syndrome with multilineage dysplasia, 9985/3.

All ICD-O 3.2 documentation can be found on the NAACCR website. There are 5 tables which explain in detail all of the changes briefly reviewed here. In addition, there is a complete ICD-O 3.2 in an Excel spreadsheet. An ICD-O 3.2 PDF document is planned, but was delayed due to the physicians on the project being called away due to COVID-19. I highly recommend reviewing these changes to familiarize yourself with them before the changes take place.

https://www.naaccr.org/icdo3/

SSDI Manual

There will also be changes to the SSDI manual (version 2.0) for use after conversion to the NAACR v21 layout. If you missed the NAACCR webinars "2021 Updates: ICD O 3.2 and Solid Tumor Rules" and "2021 SSDI Updates" they are still available for viewing on the NAACCR education site. Slides, Q&A, and recording links are available free of charge and include continuing education units.

https://education.naaccr.org/updates-implementation

DATA QUALITY: COUNTY CODES AND CENSUS TRACT

By Paula Marshall, BBA, CTR

Census tract codes allow central registries to calculate incidence rates for geographical areas having population estimates.

The Census Bureau provides population and other demographic data for census tracts. This allows for general surveillance for small area analysis or special geographical and socioeconomic analysis.

Census tracts are areas geographically nested within counties and designated with a 6-digit number code. This 6-digit code is commonly repeated within a state in different counties. Census tract numbers are only unique when paired with the state and the county codes. Therefore, a tract cannot be accurately identified without knowing the county.

An example from Massachusetts: In 2010, Rural Franklin County contains census tract 040600 with a population of 4,612 people. Urban Suffolk County contains the same numerical census tract 040600 with 2,444 people. The county code must be known in order to distinguish between the two census tract codes. Thus, in order to successfully utilize census tract codes, reporters must ensure that correct county codes are submitted in the abstract.

If an abstract is submitted with an incorrect county code this results in the incorrect identification of the census tract since county code must be paired with the census tract code to identify each census tract. Census tract codes are submitted with the annual national data submissions and used locally and nationally for cancer statistics and research. It's vital that both the county code and census tract codes are submitted correctly. This link is useful to look up correct counties using zip codes: https://www.getzips.com/zip.htm Once the correct county is identified, then the correct county code can be submitted with the abstract.

ROCKY MOUNTAIN CANCER DATA SYSTEM (RMCDS) CORNER

By Christy Dabbs, AA, CTR

RMCDS Version 18

With the ushering in of a new year, cancer reporting updates and changes are implemented. This year is no different. This article is dedicated to informing Oklahoma RMCDS users of new data items and changes effective with cases diagnosed January 1, 2021 for NAACCR version 21 record layout. Please carefully read through the information below.

RMCDS, along with all other cancer registry software vendors, have not yet released an updated version of the software to reflect these changes. They are working hard and hope to have the software ready around March. Cases diagnosed in January 2021 are not due to the central registry until July 2021. This should give you plenty of time to coordinate with your IT department to convert your software to version 21.

Important

If your facility abstracts the cases concurrently, meaning they are abstracted the month after diagnosis, the facility may abstract the cases in RMCDS version 18 but **DO NOT report them to the central registry** until your RMCDS has been updated to version 21. RMCDS will not have the correct record layout, data items, changes, or error check for 2021 cases. When the software is converted, the facility will also need to go back and review all 2021 cases abstracted in version 18 to ensure all 2021 data requirements are met.

> Example: January 2021 cases are abstracted in February 2021. Do not report these cases to the central registry until your software has been updated to version 21 and they pass all v21 error checks.

A formal email notification along with instructions will be sent to all RMCDS users when the software is ready to be converted to version 21.

Please remember to update RMCDS monthly. This will keep the software up-to-date with any small bug fixes that are made each month.

Applicable for cases diagnosed January 1, 2021 and forward

New for v21 NAACCR Item #	SSDI Name	Schema
3855*	**HER2 Overall Summary**	**Esophagus Squamous (00161)** **Esophagus (00169)** **Stomach (00170)**
3927*	**Schema Discriminator 2****	**Soft Tissue Abdomen and Thoracic (00421)** **Soft Tissue Trunk and Extremeties (00410)** **Soft Tissue other (00450)**
* These SSDIs exist in other schemas but are new to the schemas listed. The valid values and meanings in the new schemas differ from the existing definition. ** Schema Discriminator 2 [3927] is now required for C473, C475, C493-C495 with respect to Soft Tissue Abdomen and Thoracic or Soft Tissue Trunk and Extremities. These sites can be an external structure or internal viscera, and correct classification within a schema depends on this distinction. For those cases diagnosed in 2018-2020 and already collected, the value '8' should be automatically assigned to indicate the distinction was not captured and these cases will remain in Soft Tissue Abdomen and Thoracic. Code '8' may not be used for cases diagnosed in 2021 or later. Please see Appendix B, section 12.1 of the SSDI Manual, Version 2.0 (https://apps.naaccr.org/ssdi/list/) for additional information.		
yc Data Items		
Grade Post Therapy Clin (yc)		

Continued on page 7

This data item has the same valid value lists as the corresponding Post Therapy Path (yp) data items for each site. The notes associated with the lookups indicate when they should be left blank. Please refer to the Grade manual for this data item https://www.naaccr.org/SSDI/Grade-Manual.pdf.

Name—Birth Surname
Name—Birth Surname
The last name (surname) of patients at birth, regardless of gender or marital status, this data item is introduced in 2021 as a gender-neutral replacement for the NAACCR data item Name—Maiden [2390]. Allowable values for Name–Birth Surname [2232] are identical to those used for Name—Maiden. Your software conversion to v21will move values that have been in Name—Maiden. Other alternate names should continue to be recorded in the data item, Name—Alias. Although Name—Maiden has not been retired, it is expected that it will be retired with the subsequent update. Name-Maiden will not be used effective with this implementation.

Changed Data Items for v21

Phase I Radiation Treatment Modality	
Code 98 has been added to for *radiation was given but type of radiation unknown.* This was previously coded as 99 due to code 98 being left out of the v18 implementation. May be used for all cases abstracted after the v21 implementation regardless of diagnosis year.	
Name Changes	
LDH Lab Value	Previously known as LDH Pretreatment Lab Value
The change was made to clarify that LDH may be measured before or after surgical resection.	
Grade	
Grade Post Therapy (yp)	Previously known as Grade Post Therapy
Change made for clarity due to the addition of Grade Post Therapy (yc)	
Lacrimal Gland Grade fields	Codes A-D have been removed Code 4 has been added
The codes were streamlined to remove similar codes 1 and A, 2 and B and 3 and C. Code 4 added to capture undifferentiated, anaplastic cases.	
Lymphoma Ocular Adnexa Grade fields	Codes 5 and L have been removed Code 3 and 4 text revised Code 4 is now G4, more than 15 centroblasts per 10 HPF but without centrocytes. Cases that used to have Code 5 should be changed to Code 4. Code L, Low Grade (1 or 2) was determined to be a variation of Unknown, so cases that used to have L should be changed to Code 9.
Grade Table Notes	
Notes have been added to all the Grade tables in response to questions from registrars. Due to the addition of new notes, many of the note numbers have changed. These updates can be applied to cases diagnosed January 1, 2018 forward; however, registrars are not required to update previously coded grade information based on the new notes.	
ICD-O-3.2	
Beginning with cases diagnosed January 1, 2021, ICD-O-3.2 is the preferred morphology coding reference manual. This manual should be used jointly with the 2021 ICD-O Histology and Behavior Code Update tables, Hematopoietic and Lymphoid Neoplasm Database, and Solid Tumor (MP/H) rules. Edits will enforce the new codes/behaviors. **There has been no new ICD-O-3 manual published to date. Please use the coding table below** https://www.naaccr.org/wp-content/uploads/2020/10/Copy-of-ICD-O-3.2_MFin_17042019_web.xls	

Continued on page 8

ICD-O-3.2, continued

The Coding Guidelines, tables 1-7 and the annotated tables are located here
https://www.naaccr.org/icdo3/

Note: Use of these guidelines is required for determining reportability and accurate coding.

WEBINAR: The NAACCR December 09, 2020 webinar "2021 Updates: ICD O 3.2 and Solid Tumor Rules" can be viewed here https://education.naaccr.org/updates-implementation

Site/Histology Validation List
The SEER Site/Histology Validation List has been updated to include the new ICD-O-3.2 histologies and behaviors and posted on the SEER website https://seer.cancer.gov/icd-o-3/

Solid Tumor Rules

Cutaneous Melanoma Solid Tumor Rules	Revised for 2021 – Use for cases diagnosed 01/01/2021 and forward

The eight site groups updated in 2018 include minor updates for 2021 to include codes and terms from ICD-O-3.2 and the 2021 ICD-O Update added to tables.
Continue to use the **2007 Other Sites MP/H rules** for cases diagnosed 01/01/2007 to 12/31/2021. The Other Sites rules are currently being revised.
https://seer.cancer.gov/seertools/hemelymph/

SEER Hematopoietic and Lymphoid Neoplasm Database

The updated SEER Hematopoietic and Lymphoid Neoplasm Database will continue to be applicable for cases diagnosed 2010 and forward. There are a few minor changes to the database along with some NAACCR 2021 Implementation Guidelines, 16 new histology codes and some histologies that are no longer reportable (effective with cases diagnosed January 1, 2021). A change log will be made available for the database revisions.
https://seer.cancer.gov/seertools/hemelymph/

Summary Stage 2018

Summary Stage 2018 staging system will continue to be used for cases diagnosed on or after January 1, 2021.
https://seer.cancer.gov/tools/ssm/

Reportability

Reportability for cases diagnosed in 2021 is based on the ICD-O-Third Edition, Second Revision Morphology (ICD-O-3.2). The following changes are also applicable for cases diagnosed in 2021.

- **Early or evolving melanoma, in situ and invasive**: As of 01/01/2021, early or evolving melanoma in situ, or any other early or evolving melanoma, is reportable.
- As of 01/01/2021, **all GIST tumors are reportable** and classified as 8936/3 in ICD-O-3.2.
- As of 01/01/2021, **nearly all thymomas are reportable**; the exceptions are microscopic thymoma or thymoma benign (8580/0), micronodular thymoma with lymphoid stroma (8580/1), and ectopic hamartomatous thymoma (8587/0).

Scope of Regional Lymph Node Surgery

There are revised instructions related to Scope of Lymph Node Surgery code 1 (Biopsy or aspiration of regional lymph node, NOS). Do not count Scope of Lymph Node Surgery code 1 as surgery for the purpose of coding these data items.

- Date Therapy Initiated [SEER]
- Date First Course Treatment [CoC]
- Treatment Status · Date of First Surgical Procedure
- Radiation Sequence with Surgery
- Systemic Sequence with Surgery

WEB PLUS

By Christy Dabbs, AA, CTR

Web Plus Abstractors

Welcome to 2021! Now that we are in a new year we have new data item requirements and changes that are effective for cases diagnosed January 1, 2021 and forward. Web Plus is not yet updated with the new requirements and changes. It is estimated that the CDC will have the program updated sometime in March which is in line with all other cancer registry software vendors.

Important

If your facility abstracts cases concurrently, meaning they are abstracted the month after diagnosis, the facility may abstract the cases in Web Plus version 18 but **DO NOT release them until you are instructed to do so by the Oklahoma Central Cancer Registry.** Web Plus will not have the correct record layout, data items, changes or error check for 2021 cases. When the program is converted, the facility will also need to go back and review all completed 2021 cases abstracted in version 18 to ensure all 2021 data requirements are met.

> Example: January 2021 cases are abstracted in February 2021. Do not release these cases to the central registry until Web Plus has been updated to version 21 and they pass all v21 error checks.

A formal email notification will be sent to all Web Plus Abstractors when the software has been converted to version 21. This will include instructions on what needs to be done with your completed but not released abstracts.

All Web Plus Users

Soon, a challenge question will be implemented at login. More information to come on this. As a reminder each Web Plus user should have their own account. If you need a Web Plus account, please contact me at christyd@health.ok.gov.

DATA LINKAGES AND THE IMPORTANCE OF SSN

By Alexandra Feld, MPH

Each year, the OCCR performs multiple data linkages with various state and national data sources to improve the cancer registry data before submitting it to the North American Association of Central Cancer Registries (NAACCR) and CDC National Program of Cancer Registries (NPCR). These are some examples of the data linkages and data exchanges the OCCR performs:

- Indian Health Services Health Database
- Oklahoma Breast and Cervical Early Detection Program
- Social Security Death Index
- National Death Index
- NAACCR National Interstate Data Exchange Agreements
- Oklahoma Vital Statistics
- Oklahoma Hospital Discharge

Continued on page 10

Some of these linkages augment data within the surveillance system with either additional cases or information to provide a more complete tumor record. For example, linking the cancer database with Oklahoma Vital Statistics, the National Death Index, and the Social Security Death Index, allows us to update the database with information on individuals who died that we would not have known about. This can happen when an individual who may have been diagnosed with cancer in Oklahoma has since moved to another state and passed away. By linking with the national death indexes, we can capture this information and update the cancer database. Fields that we update include cause of death, date of death, death place, social security number (SSN), and date of birth.

One of the most important fields in the cancer database that is used for all linkages is SSN. When this field is missing or incorrect, it becomes more difficult to find and link an individual to their cancer or death records from other databases.

Each year, the OCCR team is dedicated to verifying and updating SSN in the cancer database, so that we may accurately reflect a patient's course of disease. Unfortunately, the verification process is a manual process where SSN are verified one at a time. The importance of double- and triple-checking SSN entries before they are submitted to the central registry cannot be overstated. When accurate SSN entries are received, all downstream processes can be performed smoother and quicker, from record consolidation to national database linkages.

THE IMPORTANCE OF TEXT DOCUMENTATION

By Kerri Torgler, AAS, RHIT

The Devil is in the Details…

This idiom refers to a catch or element hidden in the details, meaning that something might seem simple at a first look but will take more time and effort to complete than expected (Bartlett, 2002).

The National Program of Cancer Registries (NPCR) requires that documentation sufficient to substantiate the coding of key data items accompany all cases.

The North American Association of Central Cancer Registries (NAACCR) specifies that text documentation is an essential component of a complete electronic abstract.

In addition to these requirements, let's not forget that text documentation is vital for quality assurance and completeness of the medical record. It not only helps the central registry team understand where a tumor started, where it spread, how it was diagnosed, and how it was treated, but also validates the data or clarifies data entry errors in the record.

Text documentation is heavily utilized for:

- Visual Editing / quality control Review
- Record Consolidation / Validation of Data
- Research Studies
- Other Studies

After you have completed the abstract, be sure to do a visual review of the text documentation and the data items. Make sure they are complete, consistent, and accurate.

Afterall… the devil is in the details!

References:

Bartlett, John, Bartlett's Familiar Quotations: A Collection of Passages, Phrases, and Proverbs Traced to Their Sources in Ancient and Modern Literature, 17th ed., Little, Brown and Company, November 2002

PRIORITY ORDER FOR CODING HISTOLOGY—SOLID TUMORS 2021

By Barbara Murray, CTR

In the past, ICD-O 3 was the primary source for coding the correct histology/morphology for cancer cases. Beginning with diagnosis year 2018, when coding histology for the following sites, the Solid Tumor Rules took precedence:

- Breast
- Colon (includes rectosigmoid and sigmoid colon)
- Cutaneous Melanoma (beginning 1/1/2021)
- Head & Neck
- Kidney
- Lung
- Malignant CNS and Peripheral Nerves
- Non-malignant CNS
- Urinary Sites

The Solid Tumor Rules will continue to be the first resource for the above mentioned sites for diagnosis year 2021, followed by these resources listed in priority order:

ICD-O 3.2: https://www.naaccr.org/icdo3/#1582820761121-27c484fc-46a7

SEER Inquiry System: https://seer.cancer.gov/seerinquiry/index.php?page=search

Ask a SEER Registrar: https://seer.cancer.gov/registrars/contact.html

For all other solid tumor sites, including but not limited to, gynecological, male genital, and thyroid, the resources to use are the same as above except ICD-O 3.2 is the starting point.
Hematopoietic malignancies (leukemia, lymphoma, etc.) have their own set of rules for coding histology/morphology, primary site, and multiplicity. Please refer to the SEER Hematopoietic and Lymphoid Neoplasm Database and manual.

https://seer.cancer.gov/seertools/hemelymph/

For more detailed information regarding the Solid Tumor Rules and ICD-O 3.2 implementation, see the article in this newsletter "An Overview of Upcoming Changes for 2021".

UPCOMING NAACCR WEBINARS

By Leslie Dill

Watch for monthly emails from Barbara Murray to register for free recordings of the NAACCR 2020-2021 Cancer Registry & Surveillance Webinar Series. Ahead in the series are:

Lymphoma: February 4, 2021

Abstracting and Coding Boot Camp: March 4, 2021

Larynx: April 1, 2021

Pancreas: May 6, 2021

For more information contact OCCR Education Specialist, Barbara Murray, CTR by emailing BarbaraLM@health.ok.gov

NPCR AND NAACCR SUBMISSION UPDATES

By Christy Dabbs, AA, CTR

The Oklahoma Central Cancer Registry (OCCR) completed the data submission to the National Program of Central Registries (NPCR) and the North American Association of Central Cancer Registries (NAACCR) which included cancers diagnosed between 1997 and 2018. By the end of January we will have submitted preliminary 12-month data for evaluation which includes cancer cases diagnosed in 2019. Our goal is to meet or exceed the requirements from NAACCR for Gold Certification for 2018 cancer data.

To achieve Gold Certification, the data must meet all of the following criteria, set forth by NAACCR (NAACCR, Inc., 2020):

- Case ascertainment achieved 95% or higher completeness.
- Death certificate is the only source for identification of fewer than 3% of reported cancer cases.
- Fewer than 0.1% duplicate case reports.
- All data variables used to create incidence statistics by cancer type, sex, race, age, and county are 100% error-free.
- Less than 2% of the case reports are missing demographic information on age, sex, and county.
- Less than 3% of the cases are missing information on race.
- The data is submitted to NAACCR for evaluation within 23 months of the close of the diagnosis year under review.

In November of 2020 the OCCR submitted to NAACCR and NPCR 436,600 cases for diagnosis years 1997-2018 of which 22,579 were for diagnosis year 2018.

The OCCR prepares for submission each November and January throughout the year. There are several steps to prepare cancer data for submission. The same cancer case can be reported by hospitals, physician offices, treatment centers and pathology labs depending on where the patient was diagnosed and treated. As part of our case review process, the OCCR removes duplicate records from our database. A duplicate record is the same patient in the database more than once with the same primary and diagnosis date but with different central tumor registry numbers.

The next step in the OCCR process is to review cases that are flagged as a possible new primary. These cases are similar to a reported cancer that is already in the database, but the primary site or sequence reported in the new incoming case might be different. For example, a patient with a primary C50.4 is reported from one source, but another source reports it as C50.9. These cases are manually reviewed, and a determination is made whether it is the same primary or a new primary.

Lastly, the OCCR team consolidates reported cancer cases. If multiple reporting sources submit the same case it will be consolidated into one final abstract containing the most accurate information from all sources. This process takes all of the pieces of the puzzle, so to speak, and puts them together to create a complete picture of the patient's cancer and treatment.

The Oklahoma Central Cancer Registry appreciates all of your hard work in providing us with accurate and timely reported data. Your hard work does not go unnoticed as we all continue to do our part in the fight against cancer.

References: NAACCR, Inc. (2020, July 6). Certification Criteria. Retrieved December 07, 2017, from North American Association of Central Cancer Registries: https://www.naaccr.org/certification-criteria/

CANCER SURVIVORSHIP

By Julie (Bennett) Mahen, RHIT

There are millions of adults and children in the United States who are cancer survivors. Three out of every four American families will have at least one family member diagnosed with cancer . Many say that although they were relieved when treatment ended, it was hard to transition to a new way of life. It was like entering another world where they had to adjust to new feelings, new problems, changes in support, and different ways of looking at the world.

To help support survivors' unique needs, the National Cancer Institute (NCI) formed the Office of Cancer Survivorship (OCS) in 1996. The office is dedicated to enhancing the length and quality of life of people with cancer. OCS also promotes research that looks at the long- and short-term effects of cancer and its treatment. For more information about survivorship issues and OCS, visit online at http://cancercontrol.cancer.gov/ocs/.

To read the booklet for cancer survivors, see NCI's Facing Forward: Life After Cancer Treatment, https://www.cancer.gov/publications/patient-education/facing-forward, which is available in PDF, Kindle, ePub or you can order a free copy.

The booklet covers:

- Your new normal after treatment
- Getting follow-up medical care and how to talk with your doctor
- Following a care plan and changes to make for health and wellness
- Ways to manage physical changes from cancer or the disease
- Body changes and intimacy issues after treatment
- Coping with your feelings
- Going back to work and relating with friends and coworkers

As hard as treatment is, cancer survivors say that the experience led them to make important changes in their lives. It helped them learn the value of being grateful for each day and for the people in their lives.

Adapted and reprinted with the permission of the National Cancer Institute

OCCR will be conducting facility case-finding and re-abstracting audits throughout 2021 and 2022.

SUBMISSION SCHEDULE REMINDER

By Barbara Murray, CTR

It is January 2021 and compliant reporting facilities have submitted 50% or more of their 2020 cancer cases. Please see the contact year 2020 submission schedule.

SUBMISSION SCHEDULE, CONTACT YEAR 2020

Date of First Contact:	Required be Reported to OCCR in:
January 2020	July 2020
February 2020	August 2020
March 2020	September 2020
April 2020	October 2020
May 2020	November 2020
June 2020	December 2020
July 2020	January 2021
August 2020	February 2021
September 2020	March 2021
October 2020	April 2021
November 2020	May 2021
December 2020	June 2021

OCCR STAFF LISTING

Jennifer Harper, APM Data Acquisition Manager, (405) 426-8568, Jennifer.Harper@health.ok.gov

Alexandra Feld, Surveillance Coordinator, (405) 426-8010, AlexandraJF@health.ok.gov

Barbara Murray, Education & Compliance Specialist, (405) 426-8011, BarbaraLM@health.ok.gov

Christy Dabbs, Data Manager, (405) 426-8012, ChristyD@health.ok.gov

Judy Hanna, Pathology Laboratory Specialist, (405) 426-8013, JudyH@health.ok.gov

Paula Marshall, Quality Assurance & Operations Specialist, (405) 426-8014, PaulaM@health.ok.gov

Leslie Dill, Facility Consultant, (405) 426-8017, LeslieD@health.ok.gov

Julie (Bennett) Mahen, Facility Consultant, (405) 426-8016, JulieB@health.ok.gov

Lisa Fulkerson, Facility Consultant, (405) 426-8015, LisaF@health.ok.gov

Kerri Torgler, Facility Consultant, (405) 426-8018, Kerri.Torgler@health.ok.gov

Oklahoma Central Cancer Registry

Center for Health Statistics
Oklahoma Central Cancer Registry
Oklahoma State Department of Health
123 Robert S Kerr Ave, Ste 1702
Oklahoma City, OK 73102

Phone: 405-426-8030
Fax: 405-900-7604

Website: http://occr.health.ok.gov

OKLAHOMA State Department of Health

This publication is supported by the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $710,000 with 100 percent funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CDC/HHS, or the U.S. Government.

This publication was issued by the Oklahoma State Department of Health (OSDH), an equal opportunity employer and provider. A digital file has been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries in compliance with section 3-114 of Title 65 of the Oklahoma Statutes and is available for download at www.documents.ok.gov. | Issued January 2021 |