Quality Control Visual Editing Findings Part 2

FCDS 2024 Virtual Annual Conference

Barbara DeArmon-Neyland, BS, ODS

Wednesday, April 30, 2025

Objectives

- Review FCDS visual editing processes
- Discuss FCDS quality control measures
- Review recurring edits from visual QC
- Review of common site-specific edits

Visual Editing Process

- Visual editing of abstracts is automated
- Initial review is performed by FCDS auditors (ODS)
- Feedback is provided to the facility
- Final review by quality control coordinators or FCDS Manager
- Cases is discrepancies must be resolved timely

Visual Editing What to Expect

Supporting text documentation

Provide an explanation if information is not available

Provide details to includes: history of cancer and reason for encounter at your facility

All data items should be well-documented

Data Quality Goals

- Monitor completeness, quality and timeliness
- Systematically measure performance against national standards
- Develop and perform quality checks
- Assess outcomes and performance measures
- Assess registry educational needs
- Provide education and training

Quality Control Procedures

FCDS TEXT DOCUMENTATION REQUIREMENT

FCDS DATA QUALITY REPORTS

AUDITS FOR COMPLETENESS AND ACCURACY

VISUAL EDITING OF ABSTRACTS

EDITS

Quality Control Measures

FCDS Abstractors Code

Visual Editing

Quarterly/annual submission status reports

Data Quality Annual Audits

Tumor Linkage and consolidation

FCDS Quality Control Measures

ANNUAL CONSOLIDATED FOLLOW BACK

INTERNAL VISUAL EDITING

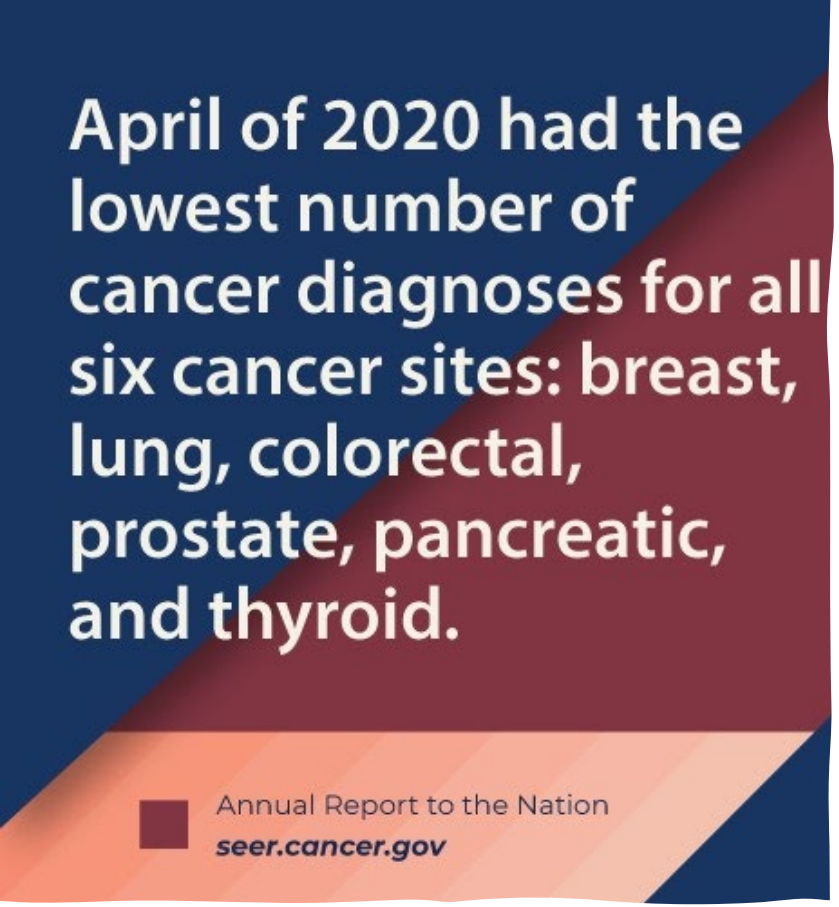
NPCR AND FCDS DATA QUALITY INDICATOR REPORT

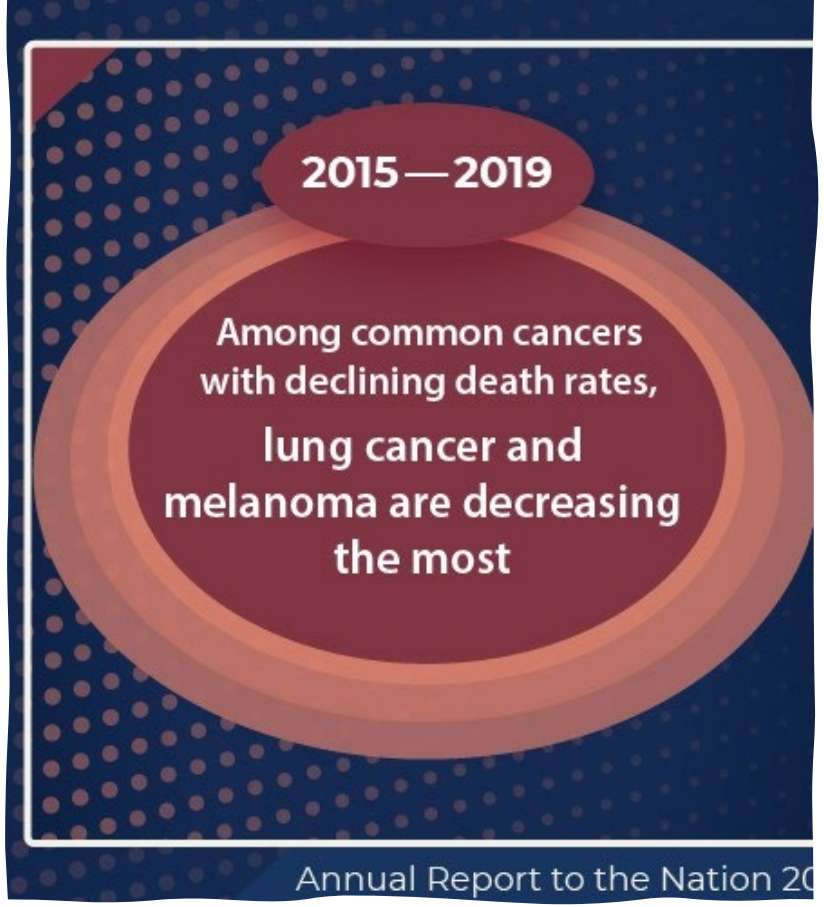
FCDS FACILITY MANAGEMENT REPORTS IN IDEA

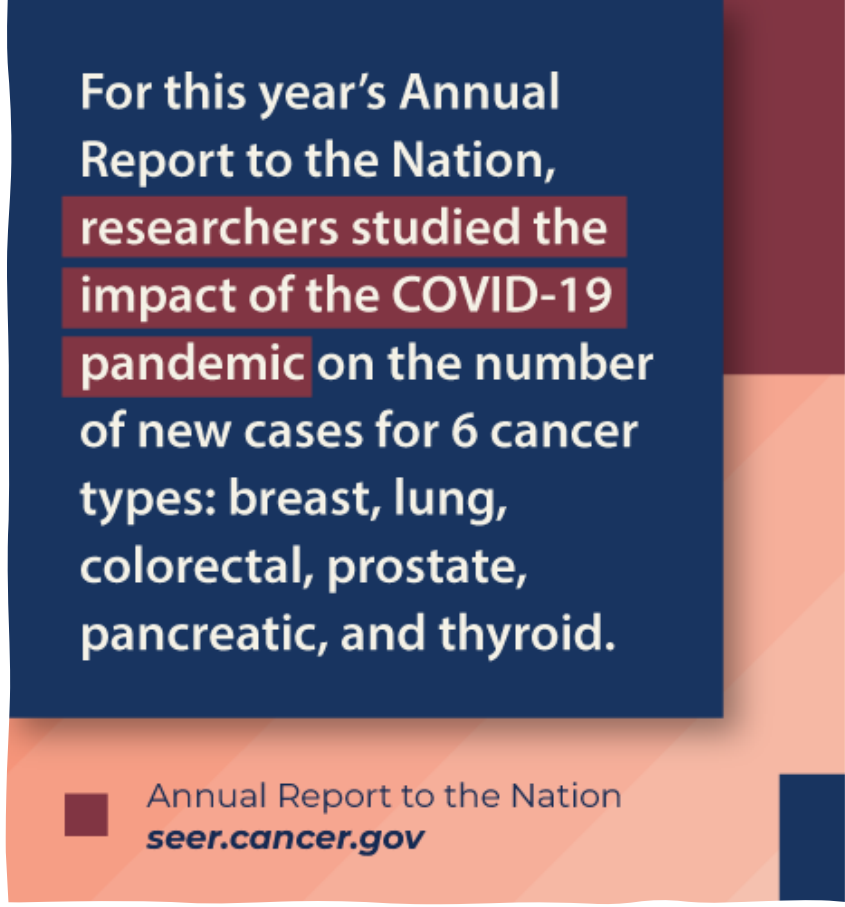
FCDS MANAGEMENT REPORTS

Visual Editing Process and Feedback to Abstractors

- Review of every 25th Record Processed
- 4% of analytic abstracts (reporting sources)
- All pediatric cases
- All male breast cases







Annual Report to the Nation on the Status of Cancer

- https://seer.cancer.gov/report_to_nation/

Top Common Errors 2023

Count	Error	Description
9042	94	Sequence already exists for this Accession Number in the master file
4820	357	Histologic Type ICDO3/Behavior Code ICDO-3 not valid with Primary Site
4567	106	Probable duplicate detected in master file
3488	1352	Surgery Rx Date must be less than 240 days after DX Date
3566	92	Sequence 02 being processed without a Sequence 01 in pending file or 00 or 01 in master file

Top Common Errors

Counts	Error	Description
3474	95	There are required Sequence(s) missing for this Accession Number
3272	91	Demographic information on Sequence in pending file does not match that in master file
3036	104	A Sequence 01 cannot exist without a Sequence 02.
2441	136	Radiation Rx Date must be less than 240 days after Diagnosis Date
3913	32	Patients has multiple primaries and Dx Confirmation is not equal to 1, 2, 4 or 5 on all sequences

Common Errors Noted on Histology ICD-0-3

8046 Non Small Cell is not recommended for this cancer

Morphology usually benign or borderline

Histologic type and behavior not valid with primary

Recurring Primary Sites with Edits

From Visual Review of every 25th Record

- Breast
- CNS Tumors
- Pediatric Cases
- Lung
- Hematopoietic neoplasm

COMMON ERRORS – BRAIN

If diagnostic confirmation = 5-9 brain molecular markers must =99

Brian Molecular marker must be coded to 86 for cases with benign or borderline behavior codes

Brain Molecular Marker must be valid for the histologic type of tumor

Morphology usually benign or borderline - based on ICD-O-3 - check behavior

https://apps.naaccr.org/ssdi/list/

Recurring Edits from Visual QC

Lack of text documentation

Missing sequences (History of Cancer)

Diagnostic confirmation

LVI

Coding grade

Why is Text Documentation Important?

List of FCDS Data Items - Require Text

County of Residence at Diagnosis
Sex
Race
Spanish/Hispanic Origin
Date of Diagnosis
Class of Case
Diagnostic Confirmation
Primary Site (and Subsite)
Laterality
Histologic Type
Behavior Code
Grade – Clinical
Grade – Pathological
Grade – Post Treatment – Clinical
Grade – Post Treatment – Pathological
Summary Stage 2018
All Required Site-Specific Data Items

RX Summ – Surg Prim Site 03-2022
RX Summ – Surg Prim Site 2023
RX Summ – Scope Reg LN Surgery
RX Summ – Surg Oth Reg/Distant
RX Date – Surgery
Phase I Radiation Treatment Modality
RX Date – Radiation
RX Summ – Chemo – List All Agents
RX Date – Chemo
RX Summ – Hormone – List All Agents
RX Date – Hormone
RX Summ – BRM/Immunotherapy - Agents
RX Date – BRM/Immunotherapy
RX Summ – Transplant/Endocrine - details
RX Date – Transplant/Endocrine
RX Summ – Other – include all details
RX Date - Other

Problem Areas in Text Documentation

- race, sex, ethnicity, history, tumor markers, cases code as ‘unstaged’ when clinical staging is clearly present, coding nodes examined/nodes positive, scope regional lymph nodes surgery for FNA or other regional nodes (not distant nodes), no operative findings – only procedure, pathology reports, excessive abbreviations, too much text documentation, treatment recommended or refused or coded as 99, missing radiation modality, duplicative text in treatment area, coding grade, lymphomas and leukemias NOS or no stage, text for stage is only TNM – there are no TNM/SS x-walks

Recurring Edits from Visual QC

Coding grade

SEER Summary Stage

Date of Diagnosis (based on BI-Rads)

Race (unknown)

Ethnicity (unknown)

Lymph Vascular Invasion

- Lymph-vascular invasion (LVI) indicates the presence or absence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels
- LVI includes lymphatic invasion, vascular invasion, and lymphovascular invasion
- Presence or absence of cancer cells in the lymphatic ducts or blood vessels is useful for prognosis
- This data item is primarily used with the AJCC Cancer Staging Manual and CAP

Spanish Surname – Appendix E

Code	Label
0	Non-Spanish; non-Hispanic (including Portuguese and Brazilian)
1	Mexican (includes Chicano)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic)
6	Spanish, NOS; Hispanic, NOS; Latino, NOS (There is evidence other than surname or r maiden name that the person is Hispanic, but he/she cannot be assigned to any category of 1-5.)
7	Spanish surname only (The only evidence of the person's Hispanic origin is surname or maiden name and there is no contrary evidence that the person is not Hispanic.)
8	Dominican Republic
9	Unknown whether Spanish or not

APPENDIX E

E-1

2020 CENSUS LIST OF SPANISH SURNAMES

ABAD	ABELLEIRA	ABREO	ACETY	AFANADOR
ABADIA	ABELLERA	ABREU	ACEUEDO	AFRE
ABADIANO	ABENDANO	ABREUS	ACEVDO	AGADO
ABADIAS	ABERASTURI	ABREUT	ACEVEDA	AGALA
ABADILLA	ABERASTURIA	ABREV	ACEVEDO	AGANZA
ABADIN	ABERGEL	ABREW	ACEVES	AGAPITO
ABAIGAR	ABESADA	ABREYO	ACEVEZ	AGEITOS

Appendix D – Race Coding Instructions

Code 01 White if the patient is known to be Spanish*, Spaniard

APPENDIX D

RACE CODING INSTRUCTIONS

AND

RACE AND NATIONALITY DESCRIPTIONS
FROM THE 2000 CENSUS AND BUREAU OF VITAL STATISTICS

RACE AND NATIONALITY DESCRIPTIONS
ALPHABETIC INDEX

Historical Cases

FCDS requires the submission of historical cases

Common edit missing sequences (Historical Cases)

There are two methods for reporting historical cases

Full-abstract or minimal dataset

Fields required to be completed

Sequence Number

Diagnosis Date

Primary Site

Histology/Behavior

Laterality

State of Residence at Diagnosis

County of Residence at Diagnosis

Schema Discriminator 1

Schema Discriminator 2

Corrections Categorized by Standard Setter rules

- Coding Grade
- SEER Summary Stage 2018
- Solid Tumor Rules
- ICD-0-3
- SEER General Rules

Coding Grade for Breast

Code	Description
1	G1: Low combined histologic grade (favorable), SBR score of 3-5 points Stated as Nottingham/Scarff Bloom-Richardson Grade 1
2	G2: Intermediate combined histologic grade (moderately favorable); SBR score of 6-7 points Stated as Nottingham/Scarff Bloom-Richardson Grade 2
3	G3: High combined histologic grade (unfavorable); SBR score of 8-9 points Stated as Nottingham/Scarff Bloom-Richardson Grade 3
L	Nuclear Grade I (Low) (in situ only)
M	Nuclear Grade II (interMediate) (in situ only)
H	Nuclear Grade III (High) (in situ only)
A	Well differentiated
B	Moderately differentiated
C	Poorly differentiated
D	Undifferentiated, anaplastic
9	Grade cannot be assessed (GX); Unknown

For invasive breast cancers when coding the grade codes 1-3 take priority over A-D

in situ cancer codes L, M, and H take priority over A-D

Only use the generic grades A-D when the preferred grading is not used

Coding Grade

- Assign the highest grade from the primary tumor. If the clinical grade is the highest grade identified, use the grade identified during the clinical time frame for both the clinical grade and the pathological grade.
- The grade pathologic must not be less than Grade clinical
- If resection is done of the primary tumor and there is no grade documented, use grade from clinical work up.
- If no residual disease use grade from clinical workup.

https://apps.naaccr.org/ssdi/list/

Use Grade from the Clinical Work Up-Pathological Grade (examples)

Surgical resection is done of the primary tumor and there is no grade documented from the surgical resection

- FNA breast: Grade 2 Ductal Carcinoma
- Lumpectomy: Microinvasive disease remaining, no grade listed

Surgical resection is done of the primary tumor and there is no residual cancer

- Rectal polypectomy + Moderately Differentiated Adenocarcinoma
- LAR Resection: No Residual

Surgical resection of the primary tumor has not been done, but there is positive microscopic confirmation of distant metastases during the clinical time frame

- Colonoscopy biopsy rectum+ moderately differentiated adenocarcinoma.
- Needle biopsy of liver + metastatic adenocarcinoma, CT/EUS show clinical T3, clinical N1 case.
- No resection is done

Coding Features and Differentiation

Subtypes/variant, architecture, pattern, and features ARE NOT CODED. The majority of in situ tumors will be coded to DCIS 8500/2.

Code the histology described as differentiation or features/features of ONLY when there is a specific ICD-O code for the “NOS

Do not code if there is no specific ICD-0 code.

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

Coding Grade for CNS Tumors – benign

- A patient that presents with a high-grade benign Glioma that has been resected the following is coded for pathologic grade:
- Pathologic grade must not be blank
- Codes 1-4 take priority over A-D, L and H
- If the behavior is coded to 0, you can only code 1 or 9
- If the behavior is coded to 1 grade pathologic must equal 1,2,3,L, or 9

https://apps.naaccr.org/ssdi/list/

CNS WHO Grading System

Table 1. CNS WHO Grading System for Some of the More Common Tumors of the CNS

Group	Type	Grade 1	Grade 2	Grade 3
Adult-type diffuse gliomas	Astrocytoma, IDH-mutant		X	X
	Oligodendroglioma, IDH-mutant and, 1p/19q co-deleted		X	X
	Glioblastoma, IDH-wildtype			
Pediatric-type diffuse low-grade gliomas	Diffuse glioma, MYB- or MYBL1- altered	X		
	Angiocentric glioma	X		
	Polymorphous low-grade neuroepithelial tumor of the young	X		
	Diffuse low-grade glioma, MAPK pathway-altered*			
Pediatric-type diffuse high-grade gliomas	Diffuse midline glioma, H3 K27-altered			
	Diffuse hemispheric glioma, H3 G34-mutant			
	Diffuse pediatric-type high-grade glioma, H3/IDH-wildtype			
	Infant-type hemispheric glioma*			
Circumscribed astrocytic gliomas	Pilocytic astrocytoma	X		
	High-grade astrocytoma with piloid			
	Desmoplastic myxoid tumor of the pineal region, SMARCB1-mutant*			
Cranial and peripheral nerve tumors	Schwannoma	X		
	Neurofibroma	X		
	Perineurioma	X		
	Hybrid nerve sheath tumor	X		
	Malignant melanotic nerve sheath tumor*			
	Malignant peripheral nerve sheath tumor*			
Meningiomas	Meningioma	X		X
	Atypical meningioma			X
	Clear cell meningioma			X
	Chordoid meningioma			X
	Anaplastic meningioma			
	Papillary meningioma	X		X
	Rhabdoid meningioma	X		X

When do you code 8340 for Thyroid?

- Code papillary carcinoma, follicular variant of thyroid (8340) when there are multiple papillary and follicular carcinoma subtypes/variants:
- Papillary thyroid carcinoma, NOS and follicular carcinoma, NOS Papillary carcinoma, follicular variant and papillary thyroid carcinoma OR
- Papillary carcinoma, follicular variant and follicular carcinoma OR
- Any papillary thyroid carcinoma subtype/variant and any follicular subtype/variant listed in Column 3, Table 12

Diagnostic Confirmation

Codes for Hematopoietic and Lymphoid Neoplasms (9590/3-9993/3)

Microscopically Confirmed

Code	Description
1	Positive histology • Includes: peripheral blood smear only
2	Positive cytology
3	Positive histology PLUS: • Positive immunophenotyping AND/OR • Positive genetic studies • Includes: peripheral blood smear followed by flow cytometry (***Effective for cases diagnosed 1/1/2010 and later)***
4	Positive microscopic confirmation, method not specified

Not Microscopically Confirmed

Code	Description
5	Positive laboratory test/marker study ***Note 1***: Includes cases with positive immunophenotyping or genetic studies and ***no*** histological confirmation ***Note 2:*** This does **not** include cases where a peripheral blood smear is done (code 1) and peripheral blood smear followed by flow cytometry (code 3)
6	Direct visualization without microscopic confirmation
7	Radiology and other imaging techniques without microscopic confirmation
8	Clinical diagnosis only (other than 5, 6 or 7)

Confirmation Unknown

Code	Description
9	Unknown whether or not microscopically confirmed; death certificate only

Coding Instructions continued on next page

Hematopoietic and Lymphoid Neoplasm Not Microscopically Confirmed

- **Code Description 5** Positive laboratory test/marker study if JAK2 only but the patient had abnormal blood counts, which is considered histologic confirmation, followed by JAK2 code 3 for diagnostic confirmation.
- **Note 1:** Includes cases with positive immunophenotyping or genetic studies and no histological confirmation.
- **Note 2**: This does not include cases where a peripheral blood smear is done (code 1) and peripheral blood smear followed by flow cytometry (code 3)

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

Coding Cancer-directed surgery on Endometrial cases

A400 Total hysterectomy (simple, pan-) WITH removal of tube(s) and/or ovary(ies). Code the Omentectomy in NAACCR Data Item (1294), Surgical Procedure/Other Site.

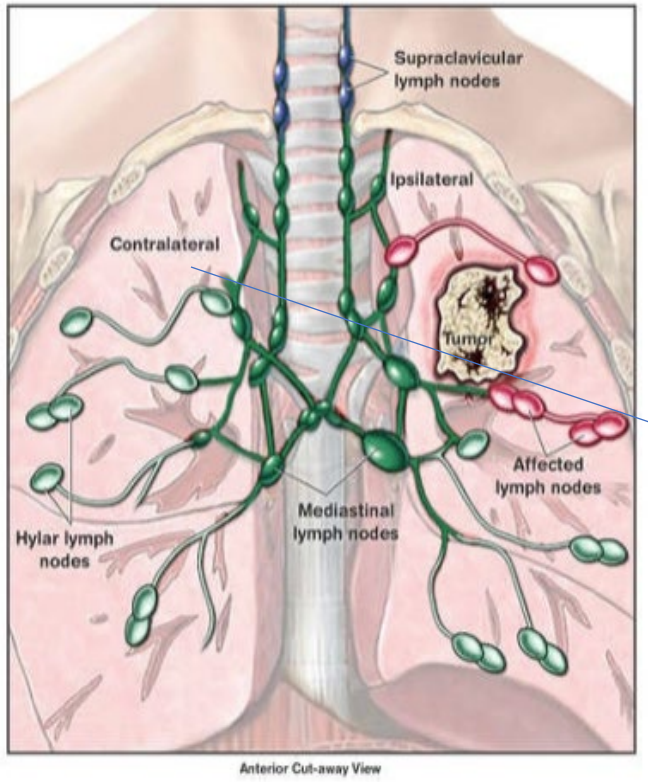
- Code the removal of regional or distant tissue/organs when they are resected in continuity with the primary site (en bloc) and that regional organ/tissue

Per SEER Summary Stage manual coding instructions, the omentum is considered a distant site for corpus uteri and is coded to 7 for the general stage.

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

Lung Contralateral Nodes

Mediastinum
Used with permission



7 Distant site(s)/lymph node(s) involved

- Distant site(s) (including further contiguous extension)
  - Abdominal organs
  - Adjacent rib
  - Contralateral lung/main stem bronchus
  - Heart
  - Inferior vena cava
  - Neural foramina
  - Pericardial nodules or pleural effusion (malignant) (ipsilateral, contralateral, bilateral, NOS)
  - Pleural tumor foci or nodules on ipsilateral lung (separate from direct extension) or contralateral lung
  - Rib
  - Separate tumor nodule(s) in contralateral lung
  - Separate tumor nodule(s) in a different ipsilateral lobe
  - Skeletal muscle
  - Skin of chest
  - Sternum
  - Vertebra(e) (vertebral body)
  - Visceral pericardium
- Distant lymph node(s), NOS
  - IPSILATERAL or CONTRALATERAL
    - Low cervical
    - Proximal root
    - Scalene (inferior deep cervical)
    - Sternal notch
    - Supraclavicular (transverse cervical)
  - CONTRALATERAL/BILATERAL nodes
    - Bronchial
      - Peri/parabronchial
    - Carinal
    - Hilar (bronchopulmonary) (proximal lobar) (pulmonary root)
      - Intrapulmonary
        - Interlobar
        - Lobar
        - Segmental
        - Subsegmental
    - Mediastinal

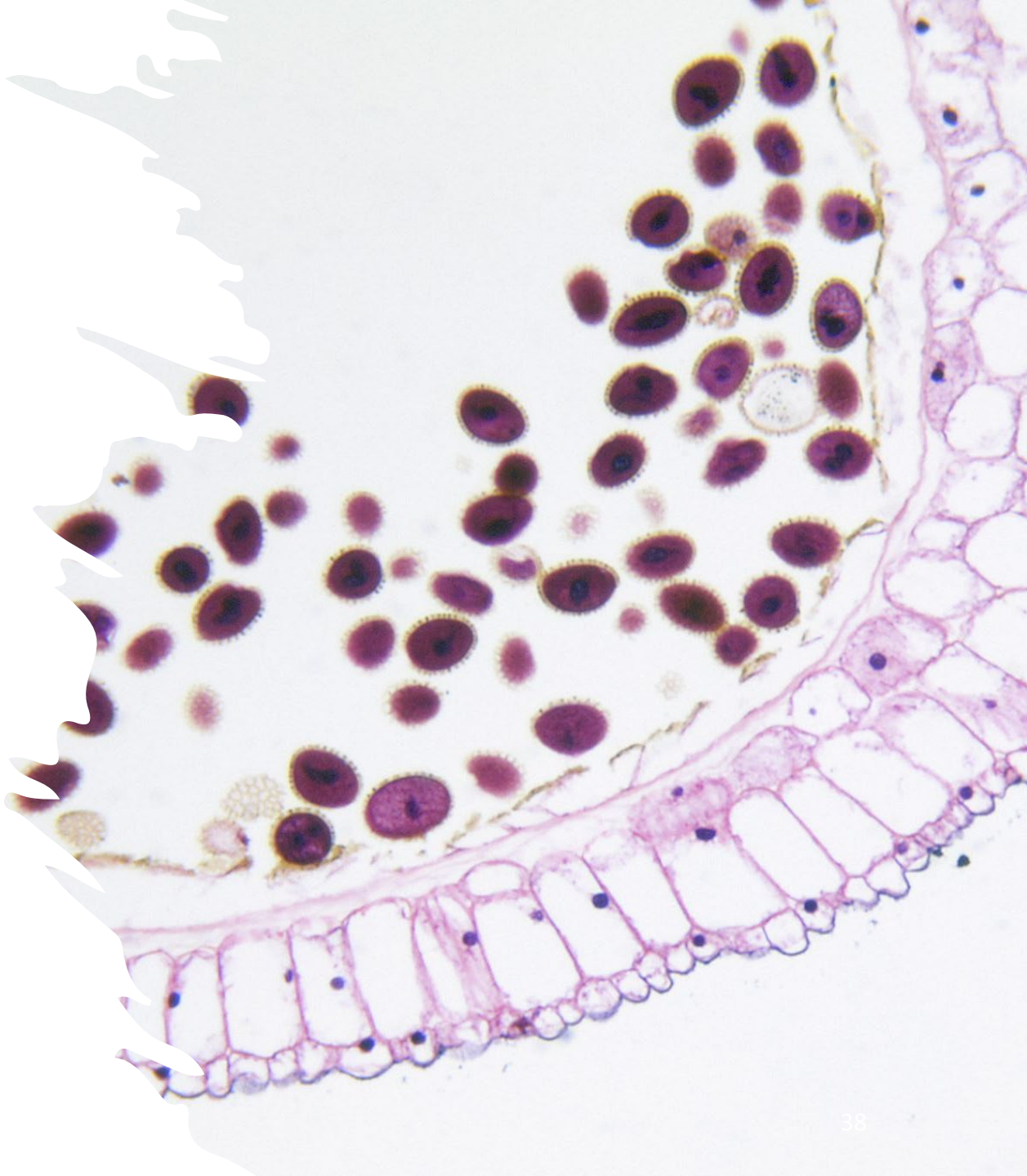
https://seer.cancer.gov/tools/ssm/

When do you code Lymph Node Involvement

- Use the following priority order for coding nodes;
  - Pathology
  - Imaging
  - Physical exam
- For solid tumors, the terms “fixed” or “matted” and “mass in the hilum, mediastinum, retroperitoneum, and/or mesentery” (with no specific information as to tissue involved) are recorded as the involvement of lymph nodes

Lymphoma

- If a lymph node is biopsied or removed to diagnose or stage lymphoma, and that node is NOT the only node involved with lymphoma, use code 02.
- **Note 5: Any mention of the terms including fixed, matted, mass in the hilum, mediastinum, retroperitoneum, and/or mesentery, palpable, enlarged, shotty, lymphadenopathy are all regarded as involvement for lymphomas when determining appropriate code**



Sequence 60

The following histologies should not be coded to 60;

- 8453 IPMN (C25)
- 8442, 8472 Papillary Serous cystadenoma borderline malignancy (C56) – not reportable
- 8583 Thymoma (C37) reportable as of 2021
- 8480 LAMN reportable effective 2022
- 9560 Schwannoma (C079), (C30) – not reportable

Pancreatic tumors (IPMN/IOPN/ITPN/CPEN)

Intraductal papillary mucinous neoplasms (IPMN)

Intraductal oncocytic papillary neoplasm (IOPN)

Intraductal tubulopapillary neoplasm of pancreas (ITPN)

Cystic pancreatic endocrine neoplasms (CPEN)

For reportability, the IPMN Path Description must include

- IPMN, with high-grade dysplasia
- IPMN, non-invasive
- IPMN, in-situ
- IPMN, associated with invasive carcinoma
- IPMN, invasive

Code 3 for Behavior

Reportable effective 2001

9950 Polycythemia vera (C421)

9975 Myeloproliferative neoplasm

9980, 9989 Myelodysplastic syndrome (C421)

Certification of Completeness

Case Abstracting Timeliness

FCDS requires that all cases be completed, abstracted, and submitted within six months of the encounter

Each facility must certify that they have completed the full year cycle of reporting each year

FCDS monitors the number and percentage of total cases submitted

Concurrent abstracting (RQRS)

RECOMMENDED TRAINING RESOURCES FOR NEW REGISTRARS

FCDS has put together a listing of available Training Resources for New Registrars. We hope this will help new registrars with reliable training resources to cover the primary topics necessary to learn how to abstract and understand what it takes to become a Cancer Registrar.

NAACCR also offers a FREE Cancer Registrar Training Guide on their Website that provides a 51-week guide to learning all things Cancer Registry Related including a Progress Tracking Form. Becoming a Cancer Registrar and becoming an Oncology Data Specialist (ODS) is a lengthy process. The NAACCR Cancer Registrar Training Guide, v4 was published in 2020 and is available at https://www.naaccr.org/wp-content/uploads/2020/05/Registry-Training-Guide-1.pdf

Recommended Resources for New Abstractor Training:

- **NCRA Accredited Cancer Certificate and/or Degree Programs** - https://www.ncra-usa.org/About/Become-a-Cancer-Registrar
- See FCDS DAM Section I – Required and Recommended Desktop References
- See Appendix P – Registrar Resources
- See FLccSC Learning Management System and FCDS IDEA for Access to Recordings
- NEED ACCESS TO ALL 2024 Manuals, Tools and Guidelines/Instructions – Appendix P and https://www.naaccr.org/v22referencepage/
- SEER Site-Specific Modules and Self-Instructional Training - https://seer.cancer.gov/training/
- NPCR NETS Modules – available on FLccSC
- NAACCR Cancer Registrar Training Guide - https://www.naaccr.org/wp-content/uploads/2020/05/Registry-Training-Guide-1.pdf
- NCRA offers basic courses, webinars, and ODS Exam Prep – http://www.ncra-usa.org
- NCRA also hosts ways to become a cancer registrar and becoming an ODS – http://www.cancerregistryeducation.org/become-a-cancer-registrar/
- 2024 SEER Tools – SEER*Rx, SEER*Heme Rules and Database, SEER*RSA, SEER Solid Tumor Rules, Casefinding Lists and much more available on the SEER Website @ http://seer.cancer.gov.
- SEER*Educate - https://educate.fredhutch.org/LandingPage.aspx
- 2024 FCDS Data Acquisition Manual - https://fcds.med.miami.edu/inc/downloads.shtml
- 2024 FCDS Webcast Series - https://fcds.med.miami.edu/inc/educationtraining.shtml
- FCDS Learning Management System – FLccSC - https://fcds.med.miami.edu/inc/flccsc.shtml
- 2024 NAACCR ODS Exam Prep and Review Webinar Series - https://education.naaccr.org/CTR
- American Cancer Society has cancer-specific educational materials in their Cancer A-Z Series - https://www.cancer.org/cancer.html
- National Cancer Institute has information – start here with the About Cancer Series – then go to specific cancer types to reinforce topics and concepts - https://www.cancer.gov/about-cancer
- AJCC has basic AJCC TNM Training – https://cancerstaging.org/

APPENDIX P – REFERENCES AND RESOURCES FOR REGISTRARS – updated February 2024

2024 References and Resources for Cancer Registrars		
Education and Training Resources		
FLccSC	Florida's Online Learning Management System – Fundamental Learning Collaborative for the Cancer Surveillance Community (FLccSC)	https://fcds.med.miami.edu/inc/flccsc.shtml
FCDS Continuing Education Webcast Series, NAACCR Series, FCDS Annual Conference	Recorded Webcasts, Webinars, Conferences and any associated background materials, exercises, quizzes	https://fcds.med.miami.edu/inc/flccsc.shtml
SEER Self-Instruction Training Website	SEER's Self-Paced Instruction and Training Website	http://training.seer.cancer.gov/
SEER*Educate	Online Training Platform for Cancer Registrars	https://educate.fhcrc.org/LandingPage.aspx
SEER Self-Instructional Training Resources	Solid Tumor Rules Training Glossary for Registrars Hematopoietic and Lymphoid Neoplasms Training SEER Self-Instructional Manuals for Tumor Registrars	http://seer.cancer.gov/training/
NCRA Education and Training	NCRA Annual Conference, CTR Exam Preparation materials, Recorded Webinars, Continuing Education including NCRA Center for Cancer Registry Education	https://www.ncra-usa.org/Education
ODS Examination Resources	NCRA Council on Certification	https://www.ncra-usa.org/ODS-Credential
NAACCR Registrar Training Guide (2020)	51-week guide for training new registrars	https://www.naaccr.org/wp-content/uploads/2020/05/Registry-Training-Guide-1.pdf
Understanding Central Cancer Registries	Self-paced self-instruction for central registries	https://education.naaccr.org/products/understanding-central-cancer-registries
AJCC TNM Education and Training	Self-Instruction Modules for AJCC TNM Training Recorded Resources for AJCC TNM Training	https://cancerstaging.org/CSE/Registrar/Pages/8thEditionWebinars.aspx https://cancerstaging.org/CSE/Registrar/Pages/default.aspx
NAACCR Education and Training	NAACCR Annual Conference, Monthly NAACCR Cancer Surveillance Webinar Series, ODS Exam Preparation Webinar Series, Continuing Education	http://www.naaccr.org
American Cancer Society	Learn About Cancer and Various Cancer Topics	http://www.cancer.org/cancer/index

APPENDIX P – REFERENCES AND RESOURCES FOR REGISTRARS – updated February 2024

Newsletters	Web Address	Notes
FCDS Memo	http://www.fcds.med.miami.edu/inc/publications.shtml	Florida Cancer Data System Memo written for registrars
FCRA Sun Times Newsletter	http://www.fcra.org/	Florida Cancer Registrars Association quarterly newsletter
COC Source	https://www.facs.org/publications/newsletters/coc-source	Commission on Cancer's newsletter.
The CoC Brief	http://www.multibriefs.com/briefs/acsorg/	Multi-Briefs for American College of Surgeons/CoC
The NAACCR Narrative	http://www.naaccr.org/AboutNAACCR/Newsletter.aspx	Newsletter for Central Cancer Registries in North America
NCRA News NCRA Connection The Journal of Registry Management	http://www.ncra-usa.org	NCRA Newsletter and Peer-Review Journal

https://www.fcdsmemo.com/featuredposts

Please Remember to Call FCDS with Questions

- Your Facility FCDS Field Coordinator, Meg Herna, and Quality Control Coordinators are all available to answer technical questions or forward to someone else to answer.
- It is part of our job to provide this technical assistance.
- Please encourage your staff to call or email questions to FCDS rather than guess at answers. FCDS assembles common questions so we can add them to the FCDS Memo for everybody to learn.
- ALL Data Quality Activities are Input to the FCDS Education & Training Program