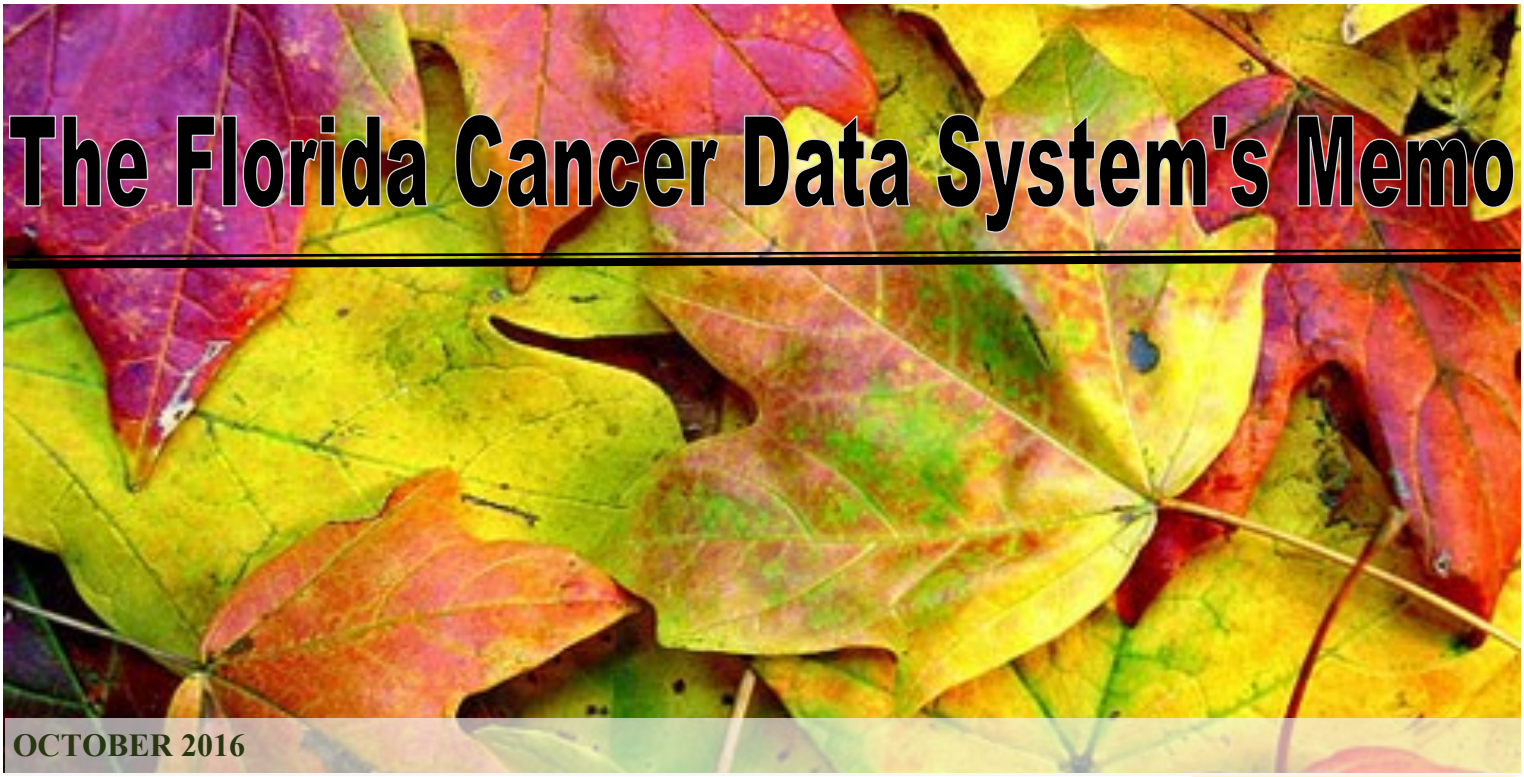
The Florida Cancer Data System's Memo



OCTOBER 2016

NEW FLORIDA CTR's

Prudence L.M. Ashley, Winter Haven

Heather Duque, Palm Harbor

Elizabeth Martinez, Miami

Kari Oliger, Naples

Laura Ortega, Estero

Carrie Scott, Tampa

WHAT'S NEW:

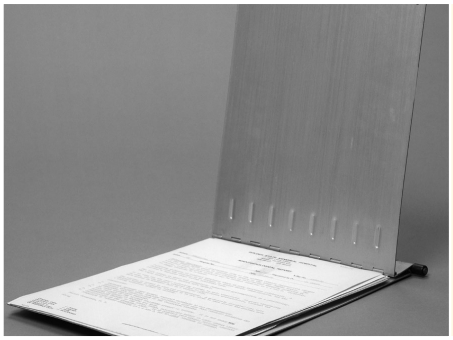
The following information is currently available on the FCDS website.

FLORIDA ANNUAL CANCER REPORT: INCIDENCE AND MORTALITY - 2013

FCDS/NAACCR EDITs Metafile
16C Metafile, posted on 10/26/2016.

FCDS/NAACCR WEBINAR SERIES:
NAACCR 2016-2017 Cancer Registry and Surveillance Webinar series - Collecting Cancer Data: Hematopoietic and Lymphoid Neoplasm 11/3/16, being held at 7 Florida facilities and requires registration.

Florida Statewide Cancer Registry



Florida Cancer Data System
Deadlines, Updates, & Reminders

FCDS Annual Conference

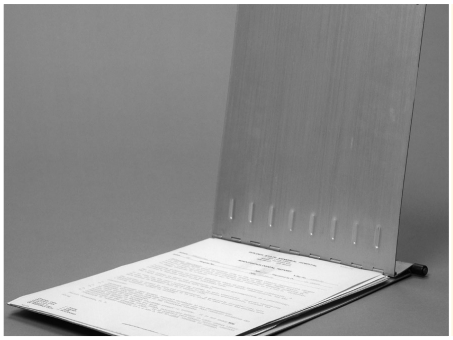
July 26-27, 2017

Wyndham Grand Orlando Resort
Bonnet Creek

Room Rates: $129.00 - Single/Double

Conference Registration Fee: $100.00

Hotel link: wyndhamgrandorlando.com More information coming soon.



Florida Cancer Data System
Deadlines, Updates, & Reminders

SSN Update – FCDS SSN Edit – FORCE Allowed

FCDS recognizes that SSN has become more difficult to collect for several reasons (registrar not allowed access, patient won't provide SSN, only last 4 digits, etc.).

FCDS has been monitoring FORCES for FCDS EDIT 1214 as well as cases entered with SSN 999999999 to understand how much this affects FCDS overall.

FCDS uses Patient SSN as a primary key to link multiple (same) patient records from all over Florida (hospitals, doctors office, AHCA, etc.). When it is missing or incorrectly coded, we may have problems linking up the same patient's records to complete the work required to merge all these data at the central registry.

The Social Security Administration has updated their methodology for assigning SSNs and now allows some numbers to be assigned that may fail the existing FCDS SSN Edit…and will need to be FORCED by FCDS. This does not mean that just any number will be accepted – you should still review edit failures for "made-up" SSNs.

The FCDS SSN Edit does work properly for SSN assigned prior to 6/25/2011 with SSN/DOB restrictions that were followed until July 2011…as long as the patient was born in the United States.

Social Security Number randomization took effect June 25, 2011. Per the Social Security Administration, SSA will allow issue of SSNs with the number "8" in position 1 of the SSN. No date of birth is specified in the latest randomization methodology being used by Social Security.

Please take care when identifying and entering SSN as this is still a critical data item that is required by Florida Statute to be included in your abstracts.

Q&A from AJCC Staging Webcast

Q: "I know you said that < 4weeks of hormone is not to be considered neoadjuvant therapy. Are we still to record it as treatment?"

A: YES – the hormone therapy is still part of first course treatment just does not qualify as neoadjuvant therapy per AJCC.

Q: "Definitions of timing used to include the phrases "whichever is shorter" (for clinical), and "whichever is longer" (for pathologic). Do these still apply?"

A: Do not use the phrases "whichever is shorter or whichever is longer" for the timing interval for staging. Staging should be based on diagnostic workup, initial treatment whether it is "clinical", "neoadjuvant - presurgical" or "surgical/pathologic", and progression or recurrence within the timing interval.

Q: "Regarding pre-surgical hormone given, not to be considered neoadjuvant, what date should we document to show this tx? Do we show it after the surgery only?"

A: Enter the date the endocrine therapy was started…just do not stage as though this was neoadjuvant hormone therapy.

Q: "Will yC replace C in abstract"?

A: No. yc staging will be in addition to pre-treatment clinical stage to document clinical evidence of response to treatment after clinical staging.

Q: "To clarify, we use surgical observations in path staging rather than clin stage?"

A: Correct - surgical observations from resection of primary site and regional nodes are included when assigning pathologic stage - not used for clinical stage. If surgery is less than resection of primary site plus/minus nodes based on chapter-specific surgical staging requirements - then pathologic stage cannot be determined - insufficient surgery to assign pathologic stage.

Q: Did I hear correctly that the AJCC 8th edition will not include TNM staging forms?

A: Correct, there will not be sample staging forms included with the AJCC 8th edition Staging Manual.

AJCC Staging Pointers from Kentucky

AJCC Staging Reminders
AJCC Staging Reminders Reproduced with Permission from the Kentucky Cancer Registry

Clinical Staging: Imaging, physical exam, endoscopic procedures, diagnostic biopsies

X = something was done (imaging, endoscopy, etc) BUT can't be assessed

Blank = nothing was done to assess

EXAMPLE: Screening colonoscopy revealed an obstructive mass in the sigmoid colon. BX obtained.
Path: Invasive adenocarcinoma. Imaging revealed mass in sigmoid with no LAD or METS noted.
Clinical: cTx cN0 cM0 cStage Unknown

Pathologic Staging: Clinical info + histologic exam of surgically resected specimen
Does your case meet criteria to be pathologically staged in one of these 3 ways?

- Surgical resection per the site chapter
- Highest T biopsied PLUS highest N biopsied
- Metastatic site histologically confirmed

Once a case is eligible to be pathologically staged, you cannot have any blanks.
The T, N and M must all have a value or an X.

If your case doesn't meet at least one of the 3 criteria listed above, your pathologic staging will be blank (except for stage group which will be 99 unknown).

If your case does meet one of the three criteria listed above, the pT, pN, pM and pStage group cannot be blank.

IN-SITU/NON-INVASIVE
In-situ cannot be determined on imaging alone and must be confirmed microscopically. No nodes are required to be evaluated for in-situ OR Stage IA melanoma cases only, per AJCC manual.
The cN0 and cM0 will move down to pathologic staging if applicable.
The correct AJCC clinical staging for in-situ is pTis cN0 cM0 cStage 0.
AJCC pathologic staging for non-invasive neoplasms may vary (see examples below).

Example One: R breast BX showing DCIS. Lumpectomy performed. Path: DCIS. No nodes examined.
Clinical: pTis cN0 cM0 cStage 0

(Continued on page 6)

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Pathologic: pTis cN0 cM0 pStage 0 (You can stage this pathologically only because the lumpectomy was performed).

Example Two: TURBT shows L lateral wall bladder non-invasive papillary TCC. No further treatment performed, observation only.

Clinical: pTa cN0 cM0 cStage 0
Pathologic: pTblank pN blank pM blank pStage 99/unknown. (case is not eligible for pathologic staging since a partial cystectomy or radical cystectomy was not performed).

MELANOMA

"By convention, clinical staging should be performed after complete excision of the primary melanoma (including microstaging) with clinical assessment of regional LN. "

NOTE: You can use information from the resection (surgical procedures) to code your cT, unlike other sites.

"Pathologic staging will use information gained from both microstaging of the primary melanoma and pathologic evaluation of the nodal status after SLN BX and/or complete regional LAD. Pathologic Stage 0 or Stage IA patients are the exception; they do not require pathologic evaluation of their lymph nodes."(AJCC manual, Melanoma chapter, pages 330, 338 **under stage group).

Example One: L leg abnormal mole. PE: No LAD in groin. Shave BX: L lower leg malignant melanoma, Clark's level III, 1.05 mm in depth with ulceration, negative margins. Wide excision w/ SLN BX performed. Path: No residual melanoma. SLN negative.

Clinical: cT2b cN0 cM0 cStage IIA
Pathologic: pT2b pN0 cM0 pStage IIA (The T2b is assigned both as cT and pT since there was evaluation of LNs performed).

Example Two: R upper arm suspicious skin lesion identified on PE. No LAD in neck or axillae. Shave BX: Superficial Spreading Malignant Melanoma, Clark's level II, 0.5 mm thickness w/out ulceration and mitosis < 1/mm2. No nodes examined.

Clinical: cT1a cN0 cM0 cStage IA
Pathologic: pT1a cN0 cM0 pStage IA (the cN0 can be moved down since this is a stage IA melanoma and LNs are not required to be evaluated per AJCC manual).

(Continued on page 7)

(Continued from page 6)

AJCC Pathologic Staging Examples

AJCC Staging Examples Reproduced with Permission from the Kentucky Cancer Registry

Case #1

Imaging reveals a R kidney mass measuring 1.2 cm with no evidence of renal vein or IVC involvement. No LAD or METS identified. R partial nephrectomy performed. Path: RCC, 1.3 cm, confined to kidney, no nodes examined, and margins negative.

Clinical: cT1a cN0 cM0 cStage I

Pathologic: pT1a pNx cM0 pStage Unk (the N category is needed to assign the stage group)

[*This case meets criteria for pathologic staging described above in scenario #1]

Case #2

Imaging reveals R kidney mass measuring 3.9 cm with evidence of renal vein involve-ment. No LAD or METS identified. R partial nephrectomy performed. Path: RCC, involvement of renal vein present, margins negative, no nodes examined.

Clinical: cT3a cN0 cM0 cStage III

Pathologic: pT3a pNx cM0 pStage III (the N category is not needed to assign the stage group, wouldn't make a difference if N0 or N1, both are Stage III)

[*This case meets criteria for pathologic staging described above in scenario #1]

Case #3

Imaging reveals LUL lung mass invading the mediastinum with bil hilar, bil mediastinal and bil supraclavicular LAD c/w regional nodal METS. Mediastinoscopy performed in which surgeon states he biopsied the mediastinal portion of the primary L lung tumor. Path: SCC. He also biopsied bil mediastinal LNs (R & L paratracheal & subcarinal) which were positive on path for metastatic SCC.

Clinical: cT4 cN3 cM0 cStage IIIB

Pathologic: pT4 pN3 cM0 pStage IIIB

[*This case meets criteria for pathologic staging described above in scenario #2]

Case #4

MRI reveals R frontal lobe mass. CT/PET reveals Sigmoid colon thickening. No LAD or METS identified. PT taken to surgery for resection of brain mass. Path: Metastatic
Adenocarcinoma c/w colorectal primary.

Clinical: cTx cN0 pM1a pStage IVA

Pathologic: pTx pNx pM1a pStage IVA

[*This case meets criteria for pathologic staging described above in scenario #3]

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AJCC Releases Cancer Staging Manual, Eighth Edition

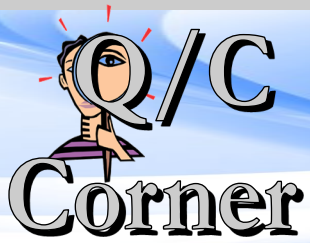
The American Joint Committee on Cancer (AJCC) has released the eighth edition of its Cancer Staging Manual, which reflects current understanding of cancer biology concepts and emphasizes a more individualized approach to cancer classification and treatment. This edition presents evidence-based revisions for staging cancer for a number of organ sites and includes the rationale and rules for staging; the definitions of tumor, lymph node involvement, and metastasis (TNM); stage groupings; and histologic grade.

Cancer staging provides patients and physicians with the standards for determining the best treatment approach for their disease and their prognosis. Mahul B. Amin, MD, FCAP, Editor-in-Chief of the eighth edition, noted that 430 experts from 184 institutions in 22 countries on six continents collaborated to produce this resource. Dr. Amin is professor and chairman emeritus, department of pathology and laboratory medicine, Cedars-Sinai Medical Center, Los Angeles, CA, and incoming chairman and endowed professor of the department of pathology and laboratory medicine at the University of Tennessee Health Sciences Center, Memphis.

Since the seventh edition was published in 2009, researchers and medical practitioners have learned that genomic alterations drive cancer and may vary considerably among tumors that, in the past, were thought to be in the same category, Dr. Amin said.

The American College of Surgeons Commission on Cancer will require accredited hospitals to use the eighth edition for all cancer cases diagnosed on or after January 1, 2017. The manual, developed in cooperation with the TNM Committee of the Union for International Cancer Control (UICC), is available for purchase online

Find additional information on licensing the content for electronic products at cancerstaging.org



QUESTIONS? ANSWERS. and CLARIFICATION

FCDS Annual Conference - Roundtable Q&A

Q: COTA – How is everyone dealing with them coming into facilities and "selling" their registry abstracting services to administration? Has anyone used them or tested their accuracy? What does FCDS think about what they are doing? COTA = Cancer Outcomes Tracking & Analysis

A: According to write-up in Bloomberg, "COTA, Inc. provides a cloud-based platform that collects select oncological patient level data to provide real-time functions for oncologists. It offers COTA (Cancer Outcomes Tracking and Analysis), a cloud-based platform that enables doctors and health plans to improve patient care and move from fee-for-service to value-based reimbursement models. The company's COTA is also used for cancer sorting; outcomes tracking in real-time of things that matter to oncologists and patients (e.g. OS, PFS, cost); and reporting of the data in desired format. COTA, Inc. is based in Hackensack, New Jersey." Apparently, this organization is contacting Florida hospitals and setting up face-to-face meetings with administrators touting their organization as being a big player in the Moonshot Initiative and tightly associated with ASCO and capturing cancer data automatically and electronically to leverage the EMR using natural language processing to replace cancer registrars and enhance cancer data for individual and network healthcare facilities. They are hiring data collectors (nurses). Unfortunately, they have not contacted FCDS about any of the Florida Statutory Cancer Reporting Requirements. So, we do not know if they have the ability to create cancer registry abstracts from EHR data that can populate a cancer registry abstract and pass required edits to meet Florida requirements. We also do not know if they are aware of or can meet CoC Cancer Program or NCDB Requirements. We believe they are trying to make inroads to cancer programs by stating the cancer registry is outdated in concept and execution…it is not. We will keep you posted as we learn more…and we do anticipate more healthcare informatics companies like this to emerge.

Table 1: Submission Summary

	Record Status						
Diagnosis Year	Records Received	Non-reportable Records	Reportable Records	Expected Inv. Records	Invasive Records*	In Situ Records	Benign Brain Records
2014	117438	0	117438	111523	103417	10563	3458
2013	122645	0	122645	110383	108268	10582	3795
2012	123490	0	123490	109622	109606	10000	3884
2011	123689	0	123689	109624	110701	9310	3678
2010	119603	0	119603	109448	108969	6806	3828
2009	120809	0	120809	109445	109648	7328	3833
<= 2008 **	1508082	0	1508082	1378696	1413745	77330	17007
Prior to NPCR Reference Year	0	0	0	0	0	0	3458
Total	2235756	0	2235756	2038741	2064354	131919	39483

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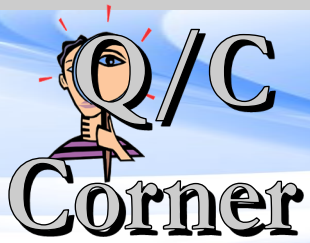

QUESTIONS? ANSWERS. and CLARIFICATION

(Continued from page 9)

Q: Has FCDS seen the total number cases reported to FCDS decrease the last few years?

A: No. FCDS continues to see an increase in both the total number of new cancers reported to FCDS and the total number of abstracts submitted (multiple abstracts may be submitted for a single cancer). Currently, FCDS processes more than 220,000 abstracts per year (includes: invasive, insitu, and benign/borderline brain and CNS tumors) and consolidates the data from multiple abstracts into a single Tumor Record which is used for our CDC and NPCR Calls for Data. Below is the most recent CDC/NPCR Call for Data Submission Summary with Details on Tumors Submitted.

Q: What are the FCDS abstract expectations regarding Class of Case 30-38 (non-analytic) cases? (Sometimes you send back QC Review Cases and what you get is all I have in the medical record.

A: FCDS' abstract expectations regarding Class of Case 30-38 (non-analytic) cases are the same as for analytic cases. We know that sometimes you have limited information in the medical record about the patient's cancer history. However, these cases are just as important to cancer program statistics and facility administration in terms of revenue generating visits as your analytic cases, despite the CoC not being interested in receiving them for NCDB. Non-analytic cases that are currently undergoing treatment for recurrence or progression are a part of your facility's overall oncology patient mix and bring in millions of dollars each year in treatment and follow-up patient visits. FCDS requires any non-analytic case submitted that currently has evidence of cancer at a minimum have as complete a patient history of their cancer documented in the medical record. This includes diagnosis, staging, initial course of treatment, recurrence, subsequent therapy, and most importantly you need to tell us why they were at your facility in the first place…not just code patient with evidence of disease and presume FCDS will let it go thru. You also need to code the first course of treatment as best you can…this is very important and often overlooked. The only time you can get away without a complete history and chronological documentation of patient's cancer care including why they presented at your facility and why you are reporting the case – is when the patient is NED for this cancer but you are reporting a second or third sequence that is undergoing therapy or was newly diagnosed.

Q: When you ask if a patient received certain treatment based on my codes (recommended or unknown if given) – how do I give this to you when you ask the question in QC Review Inquiry?

A: FCDS provides a secure communication messaging system in the QC Review Inquiry – simply write your response and FCDS QC Staff and/or Managers will take into account your response and update the record accordingly. Often when a case is QC Reviewed the reviewer looks for treatment that would be the standard of care. If the standard therapy is not addressed, given, or coded…you may get an inquiry asking you to follow-back to see if the patient ever got the treatment or if there is a note in the record

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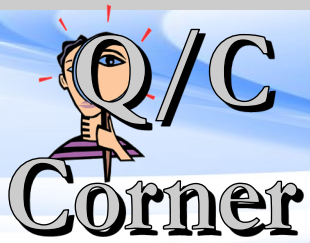

QUESTIONS? ANSWERS. and CLARIFICATION

(Continued from page 10)

somewhere – because the patient should have received tx.

Q: Do facilities that do not have CoC Accreditation need to complete TNM for 2016 cases forward?

A: YES. FCDS Reporting Requirements are the same for all cases submitted regardless of program accreditation.

Q: Will we be required to complete TNM on all cases, analytic and non-analytic, starting in 2016?

A: Please refer to the 2016 FCDS DAM for complete clarification. Below are the current requirements.

SEER SUMMARY STAGE 2000: Direct-Assignment of SEER Summary Stage using the SEER Summary Stage 2000 Manual is required for all cases abstracted and reported to FCDS regardless of diagnosis year.

COLLABORATIVE STAGE DATA COLLECTION SYSTEM (CSv2): Direct-Assignment of Core CS Data Items is required for all cases diagnosed before 1/1/2016 and seen at your facility for continuation of initial course of treatment or with evidence of recurrence or progression of cancer not previously reported to FCDS. This includes "non-analytic" cases with evidence of cancer. Minimal Historical Cases are not included and do not require staging.

AJCC TNM CANCER STAGING: Direct-Assignment of both clinical and pathologic AJCC TNM Cancer Staging is required for all cases diagnosed and reported to FCDS 1/1/2016 and forward.

Q: If we have already started our 2016 cases, do we need to complete the Collaborative Stage data items in addition to the TNM items? (I have heard that SEER is requiring both)

A: FCDS does not require both CS and TNM for the same case. The staging requirements depend on Date of Dx.

Q: Why would FCDS include questions regarding TNM in the FCDS Abstractor Code Testing this early when the most of us are confused and are still trying to learn (relearn) how to TNM?

A: FCDS added the basic questions about the 2016 AJCC TNM Instructions and New Category Codes after a year of national re-training on TNM and based upon the current reporting requirements as we always do with new information and/or reporting requirements. FCDS is charged with making sure registrars abide by the most current abstracting and coding rules and instructions and reference. This is one way that FCSD tries to ensure quality data.

Q: Are the physician claims data related to the AHCA data?

A: Physician Claims Data are not related to AHCA Data. Physicians do not report data to AHCA, only hospitals, surgical centers, and other facility types that are covered under the AHCA Mandate to collect financial data on all in-patient and ambulatory patient encounters (not just cancer).

Q: Why are Comorbidity Codes for current smokers

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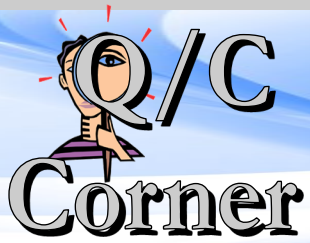

QUESTIONS? ANSWERS. and CLARIFICATION

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not accepted? How are these codes used?

A: The Comorbidity Codes currently included in standard Comorbidity Indices (Charlson or Elixhauser) are used as prognostic tools when applied in cancer data analysis. These codes are required for collection by CoC and NCDB but not by FCDS because we capture these data from AHCA and do not need to require abstractors to look for it. Comorbidities normally include chronic health conditions (diabetes, heart disease, COPD) rather than behaviors and are an established set of codes. While smoking status is important for assessing probability of success for some treatments such as stem cell or bone marrow transplant – this is not the same use of comorbidities that we see used as a standard in cancer surveillance and population research studies. Smoking would like fall under lung disorders.

Q: When will we be able to access the claims information to augment our hospital abstracts?

A: FCDS plans to "go-live" with the physician claims systems including augmentation of existing tumor records 11/1.

Q: Cancer Registrars have been collecting Collaborative Stage since 2004-2015. What has been learned from this data collection? Has it been useful? Why stop now?

A: Collaborative Stage Data Collection System was developed in the hopes of developing a standard methodology for capturing anatomic staging information that can be mapped into any anatomic staging system based on 3 staging systems; SEER Summary Stage 2000, AJCC TNM 6th and 7th editions. While the coding system proved successful for registrars to collect standardized data, the system could not be sustained and updated to accommodate the AJCC TNM 8th edition changes and the growing world of genetic and molecular biomarkers and prognostic testing that we have come to know as Site Specific Factors. The system could not keep up with the limited support and expertise available to keep it running, current, forward looking, and flexible. Also, researchers did not have a clue how to use the data. It was great for registrars but nobody else. So, we had to fall back on the AJCC TNM and Summary Stage.

Q: Colorectal – is a polypectomy with negative margins a definitive surgery that allows for pathologic stage when the rest of the colonoscopy is negative for other cancer in the colon?

A: Chapter 14 of the 7th edition of AJCC TNM is the Colon and Rectum Chapter. Always consult the AJCC

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Cancer Staging Manual for specifics about what constitutes "definitive surgery" sufficient to assign pathologic stage. The short answer is "NO" polypectomy is not sufficient a resection procedure to meet the AJCC requirement for resection that must include resection and a count of lymph nodes regardless of margins. The only exception is for non-invasive cancer in a polyp (in-situ adenocarcinoma) which can have a pTis and cN0 coded in the pathologic stage. See page 151 of the AJCC Cancer Staging Manual, 7th edition for specifics on what is required.

Q: Esophagus – is an endoscopic mucosal resection (EMR) with negative margins a definitive surgery that allows for pathologic staging?

A: Chapter 10 of the 7th edition of AJCC TNM is the Esophagus and Esophagogastric Junction Chapter. Always consult the AJCC Cancer Staging Manual for specifics about what constitutes "definitive surgery" sufficient to assign pathologic stage. The short answer is "NO" Endoscopic Mucosal Resection or EMR (regardless of margins) is not sufficient a resection procedure to meet the AJCC requirement for resection that must include resection and a count of lymph nodes regardless of margins. The only exception is for non-invasive cancer in a polyp (in-situ adenocarcinoma) which can have a pTis and cN0 coded in the pathologic stage. See page 109 of the AJCC Cancer Staging Manual, 7th edition for specifics on what is required.

Q: Can FCDS do a webinar on myelodysplastic syndromes and when they are considered "active" disease?

A: FCDS will add this to the list of suggested webcasts for next series – we have been waiting for new Heme Rules.

"Unknown" vs "Estimated" Date of Diagnosis

FCDS currently allows you to submit a case with an unknown date of diagnosis. However, FCDS strongly encourages every abstractor to estimate a date of diagnosis rather than leave this key data item blank. FCDS' reference date goes back to 1981…therefore an unknown date of diagnosis might go as far back as 1981 or be as recent as 2015. Please try to identify a best estimate of the date of diagnosis if no definitive date is provided in the medical record. It may help to only estimate the year of diagnosis and this is acceptable. However, when you leave date of diagnosis blank – the case will have to meet all of the most current reporting requirements including staging and SSFs.

NAACCR 2016-2017 Webinar Series

The Florida Cancer Data System is happy to announce that for another year we will be presenting the NAACCR Cancer Registry and Surveillance Webinar, 2016-2017 series at seven locations throughout Florida. Be sure to mark your calendars for each of these timely and informative NAACCR webinars.

- **Boca Raton Regional Hospital (Boca Raton)**
- **Moffitt Cancer Center (Tampa)**
- **M.D. Anderson Cancer Center Orlando (Orlando)**
- **Shands University of Florida (Gainesville)**
- **Gulf Coast Medical Center (Panama City)**
- **Baptist Regional Cancer Center (Jacksonville)**
- **Florida Cancer Data System (Miami)**

Special thanks to the hosting facilities for their participation and support. For a complete description of the webinars, click here: https://fcds.med.miami.edu/scripts/naaccr_webinar.pl All webinars start at 9am.

Please go to the FCDS website to register online for your location of choice. Registration link is: https://fcds.med.miami.edu/scripts/naaccr_webinar.pl. A separate registration will be required for each webinar. The number of participants allowed to be registered for each webinar will be dependent on space availability. For more information, please contact Steve Peace at 305-243-4601 or speace@med.miami.edu.

DATE	TOPIC
*10/6/16	Collecting Cancer Data: Melanoma
11/3/16	Collecting Cancer Data: Hematopoietic and Lymphoid Neoplasm
12/1/16	Collecting Cancer Data: Lung
1/12/17	AJCC Staging
2/2/17	Collecting Cancer Data: Colon
3/2/17	Abstracting and Coding Boot Camp: Cancer Case Scenarios
4/13/17	Collecting Cancer Data: Lip and Oral Cavity
5/4/17	Multiple Primary and Histology Rules
6/1/17	Collecting Cancer Data: Liver and Bile Ducts
7/13/17	Hospital Cancer Registry Operations Topic TBD
8/3/17	Collecting Cancer Data: Central Nervous System
9/7/17	Coding Pitfalls

*All NAACCR 2012-2013 Webinars presented in series are available on the FCDS website, on the Downloads page: http://fcds.med.miami.edu/inc/educationtraining.shtml

NAACCR CANCER REGISTRY AND SURVEILLANCE WEBINAR SERIES

Seven Florida facilities will host the 2016-2017 webinar series, *registration is required*

REGISTER FOR THE NEXT WEBINAR

FCDS *is the host site for Miami , FL with space for 10 participants.*

CEU information for the 2016 FCDS Annual Conference:

CE Hours: 8.25

NCRA Recognition Number: 2016-056

CEU information for the 2015 FCDS Annual Conference:

CE Hours: 8.75

NCRA Recognition Number: 2015-077

EDUCATION AND TRAINING

2016-2017 FCDS Educational Webcast Series

FCDS is pleased to announce the 2016-2017 FCDS Webcast Series schedule and topics. This year FCDS will be concentrating on preparing registrars and abstractors for direct-assignment of SEER Summary Stage 2000 (SS2000) and AJCC TNM, 7th edition. The SS2000 entry is a requirement for all 2015> cases. The AJCC TNM entry will be a requirement for all 2016> cases. FCDS does not plan to cover the basics of SS2000 or AJCC TNM staging as there are resources for self-instruction currently available. FCDS strongly recommends that registrars and abstractors attend ALL of the AJCC Self-Instruction Modules I-IV as well as work practice cases until they are comfortable assigning AJCC TNM for general use cases. FCDS will be covering site-specific stage.

Date	Time Schedule 3rd Thursday	FCDS Webcast Presentation Title	Program #	CE Hours Awarded
*8/18/16	1:00pm – 3:00pm	2016 Reporting Requirements: FCDS Annual Meeting Highlights	2016-100	2 CE hours
*9/15/16	1:00pm – 3:00pm	2016 AJCC TNM & Cancer Stage Review: 2016 Stage Instructions & Tools, Proper Use of "c" and "p" Prefix Descriptors, Codes & Definitions, TNM EDITS, SS2000	2016-101	2 CE hours
*10/20/16	1:00pm – 3:00pm	Staging Practice Cases (some cases will be staged prior to webcast – some "live")	2016-102	2 CE hours
11/17/16	1:00pm – 3:00pm	Male GU Sites: Kidney, Bladder, Testis, Prostate, Penis	2016-103	2 CE hours
December	N/A	No Webcast Scheduled		
1/19/17	1:00pm – 3:00pm	Female GYN Sites: Ovary, Adnexa & Peritoneum, Uterus, Cervix, Vagina, Vulva	2016-104	2 CE hours
2/16/17	1:00pm – 3:00pm	Biomolecular and Genetic Tumor Profiles: Classification and Characteristics of Disease, CAP Biomarker Checklists, and Targeting Treatment Options	2016-105	2 CE hours

Webcasts available on the FCDS website, on the Downloads page: http://fcds.med.miami.edu/inc/teleconferences.shtml

There is no fee and each 2-hour webcast will be recorded and available on the FCDS website, http://fcds.med.miami.edu/inc/teleconferences.shtml. Webcast materials are also available on the FCDS website.

Florida Cancer Data System
Cancer Reporting Completeness Report

TOTAL NUMBER OF CASES IN THE FCDS MASTERFILE AS OF OCTOBER 31, 2016

Total number of *New Cases* added to the FCDS Master file in OCTOBER, 2016: **13,310**

The figures shown below reflect initial patient encounters (admissions) for cancer by year.

Admission Year	Hospital	Radiation	Ambi/Surg	Physician Office	Derm Path	DCO	Total Cases	New Cases
2016	16,201	107	0	6,455	0	**Pending**	22,763	**9,231**
2015	180,051	4,490	173	10,850	0	**Pending**	195,564	**2,323**
2014	185,721	8,866	1,568	10,880	0	**Pending**	207,035	**1,756**

		Actual	Expected
% Complete for:	**2016**	**12%**	**33%**
	2015	100%	100%
	2014	100%	100%

Expected % based on 190,000 reported cases per year

Reminder:

The facility Quarterly Reporting Status is always available in IDEA under the Reports/Inquiries tab. Please remember to look at your current reporting status at least quarterly. Also, prior reporting quarters are available.

Missed an FCDS or NAACCR Webinar?

Did you know that both FCDS and NAACCR Webinars can be viewed after-the-fact. And, Continuing Education Hours are available to registrars that view recorded webinars? All FCDS Webcasts are recorded and posted on the FCDS Website (Education Tab). FCDS Webcast Recordings are available free of charge and can be viewed anytime/anywhere by anybody. Access to NAACCR Webinar Recordings is available only to registrars with Active/Current FCDS Abstractor Codes. Access to NAACCR Recordings is password protected. Contact FCDS for more information on viewing recorded webinars, or to obtain the password to view individual NAACCR Webcast Recordings.

FCDS Florida Cancer Data System

The Florida Cancer Data System (FCDS) is Florida's statewide, population-based cancer registry and has been collecting incidence data since 1981 when it was contracted by the State of Florida Department of Health in 1978 to design and implement the registry. The University of Miami Miller School of Medicine has been maintaining FCDS (http://fcds.med.miami.edu) since that time.

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