

THE NAACCR NARRATIVE

Summer 2022 NAACCR Narrative IN THIS ISSUE

[The President's Message](#)

[Data Sharing for The Common Good: An Ethical Obligation?](#)

[The NCCR is Recruiting!](#)

[Research & Data Use Steering Committee News](#)

[Factors Impacting 2020 Case Completeness: Survey Results](#)

[NCCR Data Quality Working Group Updates](#)

[Virtual Pooled Registry Update](#)

[NAACCR Forum Twitter Contest](#)

[NAACCR Education and Training Program Update](#)

[Summer/Fall 2022 Education and Training Calendar](#)

[Highlights from the Program Manager of Standards](#)

Our thanks to Randi Rycroft, 2022 NAACCR Program Chair and fabulous game show hostess along with the consummate entertainer, Dr Chuck Wiggins! Speakers and presenters gave us all pause to consider possibilities as we move toward new dimensions in the world of cancer surveillance. Hopefully, the variety of speakers and topics provided something for everyone. We hope you enjoyed attending the Summer Forum and that it inspired you with ideas for implementation in your own registry.

I want to take this opportunity to thank the outgoing Board members, Angela Meisner (NM) and Mary Jane King (Ontario, Canada). Their thoughtful contributions to Board discussions and subsequent decisions have been most appreciated. We will miss their presence at the Board meetings.

I also want to welcome our new Board members, Lori Koch (IL) and Lihua Liu (CA), who will join returning elected Board member, Monique Hernandez (FL). Eagerly waiting in the wings is Wendy Aldinger, who joins the Board as the President-Elect! We know this dynamic incoming team will harmonize nicely with continuing Board members: Kevin Ward (GA), Sarah Nash (IA), Lorraine Shack (Alberta, Canada) and Randi Rycroft (serving the unexpired term created by Wendy Aldinger, as she transitions to the President-Elect position).

Congratulations to the incoming NAACCR Nominating Committee, Devbani Raha, (Chair) (Nova Scotia), Heather Stabinsky (NJ) and April Austin (NY).

As this past year has been "put in the books," I want to thank the NAACCR members for their volunteerism and unwavering dedication and commitment to the cancer surveillance community. The Board and the Strategic Management Work Group worked hard this year to

The President's Message



Winnie Roshala, BA, CTR
NAACCR President
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Hello NAACCR Community!

I hope you are all doing well as we enjoy the summer months. I'm happy to report that the NAACCR Summer Forum hosted by the Cancer Data Registry of Idaho (CDRI) was a huge success with over 600 registrants! Besides the participants from the US and Canadian registries, we had participants from 13 countries and territories, including Australia, Barbados, Brazil, China, Ethiopia, France, Guam, India, Puerto Rico, Slovenia, South Korea, and Trinidad and Tobago. Congratulations to the winner of the 2022 NAACCR Summer Forum Social Media Contest, Peter Eby, MD!

identify the critical factors and influences shaping the future of cancer surveillance and the role that NAACCR plays in that landscape. More work will continue to prioritize these efforts in the coming year.

NAACCR truly is an organization of agencies standing firm together, maintaining standardized data, promoting education and data use, while reaching out to our partner organizations to collaborate and advance cancer surveillance efforts and initiatives. Our volunteer base is strong, willing to assist each other and share knowledge for the greater good.

We are also very grateful for the amazing NAACCR staff, led by NAACCR Executive Director, Betsy Kohler. They are fabulous, dedicated experts in supporting all the aspects of NAACCR's mission.

Thank you all and we look forward to seeing everyone in-person in New Orleans, LA, in 2023!

Winnie Roshala, BA, CTR

[Data Sharing For The Common Good: An Ethical Obligation?](#)

T. Patrick Hill Ph.D.

Associate Professor Emeritus
Rutgers University

There is little doubt that, practically speaking, the sharing of data from state cancer registries in the interests of cancer surveillance and cancer research is a worthy undertaking. Since 1987, NAACCR has been a driving force in improving the quality and use of cancer data with uniform data standards, including aggregates of their data so critical for cancer surveillance, control and research and the equally critical purpose of minimizing the burden of cancer across the population. But, given these purposes, does data sharing at this level rise to the point of becoming an ethical obligation? It would if there is necessary relation between cancer surveillance and research and the common good. That however presumes there is such a thing as the common good and it is identifiable.

COMMON GOOD

Historically, there appears to be a general acceptance of its existence, even though in what the common good consists has been far more uncertain than certain. And that is because of the pluralism that characterizes human society. For example, given cultural, political, ethnic differences, how is it possible that a good that is literally common to all human beings exists, let alone be identifiable? Is it possible that despite such pervasive differences, there is a good that all human beings, as human beings, have in common?

SOCIAL CONTRACT

Yes, there is. And it is based on the fact that, as human beings, we are by nature purposive or intentional in our behavior. But that presumes a freedom without which human beings cannot pursue what must be autonomously determined purposes. Since, however, as human beings, we live in society, the freedom that one human being enjoys depends on how other human beings enjoy their freedom. In other words, living in society presumes the existence of an implicit social contract under which each of us is at once an independent individual and an interdependent subject, enjoying the collective benefits of interdependence but only on condition of individually contributing to the maintenance of those collective benefits.

When individual members of society fulfill their obligations under the contract, society, as distinct from all the individuals who are its members, must reciprocate by securing conditions under which individual freedom is secure so that purposiveness can be pursued. From this it becomes clear that there is a good that is shared by human beings as human beings which consists in freedom and purposiveness, the enjoyment of which requires a societal structure that makes this enjoyment both possible and predictable. In the absence of this structure, the integrity of our human nature is essentially compromised. If human beings are unable to enjoy freedom so as to be purposive, they are unable to behave as they ought to behave in order to behave humanly.

COMMON GOOD AND ETHICS

If then the good common to all human beings consists in freedom and purposiveness, without which our very identity as human beings is denied, both are indispensable. This means that when we invoke the notion of common good we do so to prescribe it, as something that ought to be secured. And since no one individual has the capacity to do this, it has to be done by individual members of society acting collectively and reciprocally to ensure it. This is what we mean by acting ethically.

Ethics functions to assess human behavior by answering the question, “What ought (not can) we do?” in situations where our behavior has consequences for others. The distinction is critical because much of what we can do we ought not do. Anyone can take the property of another without authorization, but ought not to do so as to avoid inflicting the harm of injustice. However, it is only when we can do something that it becomes imperative to ask whether we ought to do it.

When we ask this question, we are in effect assessing an action that is under consideration. That is because logically the word “ought” implies that we are justifying, or making just, the action under consideration. Now what justifies or makes ethical human beings doing something? That which is concordant with their rational and physical identities working in a manner that is both mutual and reciprocal.

MEANS AND ENDS

If then our question is “ought we to share personal health data?” we are asking what is a question for only ethics to answer by way of justifying or not this particular behavior which, as sharing, unavoidably has consequences for others. To arrive at a satisfactory answer, we must account for its purpose which is to enable cancer surveillance and cancer research. This is because data sharing is related to cancer surveillance and research as a means employed to achieve some end. Given this relationship, ethics requires us further to ask whether surveillance and research justify data sharing, recognizing that in all human behavior, whatever its purpose, the purpose or end does not necessarily justify the means.

Clearly, there is justification for both surveillance and research conducted in a manner that not only avoids harming persons but actually benefits them. But is there anything about data sharing that, as a means to achieve both, would not only compromise the integrity of either, but would also be harmful to the persons whose data are shared? Equally clear is that all three can occasion harm. This underscores the importance of protecting data privacy with the use of well-established electronic means available for this purpose. Assuming that the necessary precautions are taken to prevent the avoidable harm to persons occasioned by sharing data, and conducting surveillance and research, data sharing is clearly justified when undertaken to prevent or mitigate the unavoidable harm caused by cancer, once diagnosed. Consequently, undue emphasis on data privacy at the cost of data sharing is ethically unacceptable.

POSITIVE AND NEGATIVE OBLIGATION

The obligation to pursue the common good of freedom and purposiveness for human beings is at once positive and negative. Given the harm cancer inflicts on both freedom and purposiveness, data sharing meets the two aspects of the obligation, positively in its research role to find cures, negatively in its surveillance role to enhance prevention. In addition, the obligation falls on the individual member of society as the indispensable source of the data and on society as collectively the resource for the data. If then one asks whether society is justified in having data of such a personal nature, even though remaining under the ownership of the person, the answer is yes. Under the terms of the social contract, society is responsible for securing conditions conducive to the public's health. At the same time, individual members of society, in their legitimate expectation under the contract of benefiting from their membership in society, are responsible for supporting society's efforts in this regard by contributing their personal data. Should individuals complain that they have no choice, they are correct. They are benefiting from what already has been shared by others and now must sustain those benefits with their own contribution for the common good.

CONCLUSION

The good that is referenced here as common is the good of the United States as the sum of its semi-autonomous states, not the good of each state taken separately. Since cancer as a threat to the common good is no respecter of state boundaries, then each state has to act in such a manner that negatively does no harm to the common good but positively enhances it. For this reason, state legislation that interferes with data sharing between states or for cancer research endeavors is a threat to the common good and therefore unethical. Just as the individual member of society has a responsibility for maintaining the common good, so the individual states constituting the United States have a responsibility to maintain the common good of the Union. Individual members of society who refuse to contribute to the common good, even as they expect to enjoy the benefits of membership in society, are behaving unjustly by exploiting the contributions of those members who do contribute. Individual states, whose policies and regulations have the same outcome, are equally guilty of behaving in the same unjust manner. There is such a thing as the common good, the pursuit and maintenance of which by individual members of society and individual member states of the Union are not discretionary but an overriding, universal ethical obligation.

From the outset, it is hard not to think that the goals adopted by central cancer registries were not an implicit acknowledgement of this obligation. If so, it is hard not to think that when registries consider their present capacity for minimizing if not eliminating altogether the burden of cancer across the population, they can come to an explicit acknowledgement and reassess their approach to data sharing in the interests of the common good.

The NCCR is Recruiting!

NAACCR is currently looking for U.S. central registries interested in contributing data to the National Childhood Cancer Registry (NCCR)! There are currently 23 SEER and NPCR registries participating in the NCCR, and we have an opportunity to onboard a limited number of new registries over the next year. We will hold an informational webinar on Wednesday, September 7 at 2 pm ET. If you are interested in learning more about participating in the NCCR or would like to attend the webinar, please email shill@naaccr.org.

RD&U Steering Committee News



The Research and Data Use Steering Committee facilitates the expansion of data use for research, cancer prevention and control, and clinical outcomes; and improve access to pooled data across states and provinces for research.

RDU would like to showcase the new resources that the Data Security and Confidentiality Work group has completed over the past several months. The finished documents are available here:

<https://www.naaccr.org/data-security-confidentiality-issues/>.

Three other resource documents that will be available before the end of the year so keep an eye out for more resources to be posted soon.

NAACCR Research and Data Use Update



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FACTORS IMPACTING 2020 CASE COMPLETENESS: SURVEY RESULTS

One of the strengths of central cancer registry data is its representativeness with essentially 100% coverage of the US and Canada. However, high levels of case ascertainment are necessary to generate accurate estimates of cancer burden and support public health research.

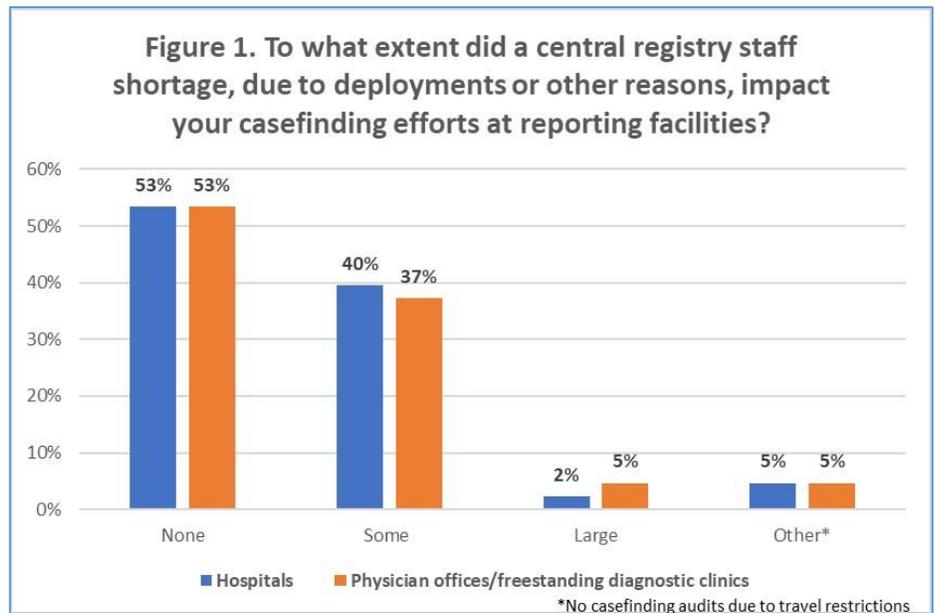
But what happens when the whole world is turned topsy-turvy by a global pandemic—creating issues with staffing, operations, and behaviors within cancer registries, hospitals, and other reporting facilities? Our cancer surveillance community is invested in high quality data, and many registries have undergone herculean efforts to capture and process 2020 cases. But many are still struggling to handle 2020 cases, and some are still waiting for facilities to report those cases. This makes it difficult to distinguish between true drops in cancer diagnoses and spurious drops due to issues with case ascertainment.

In follow-up to presentations at the Summer Forum by the National Program of Cancer Registries (NPCR) and Surveillance Epidemiology and End Results Program (SEER) regarding 2020 case completeness, NAACCR distributed the *Factors Impacting 2020 Completeness Survey* in late June. The goal of the survey was to assess the magnitude of each of these factors, and the impact on case counts and case ascertainment.

SURVEY RESULTS

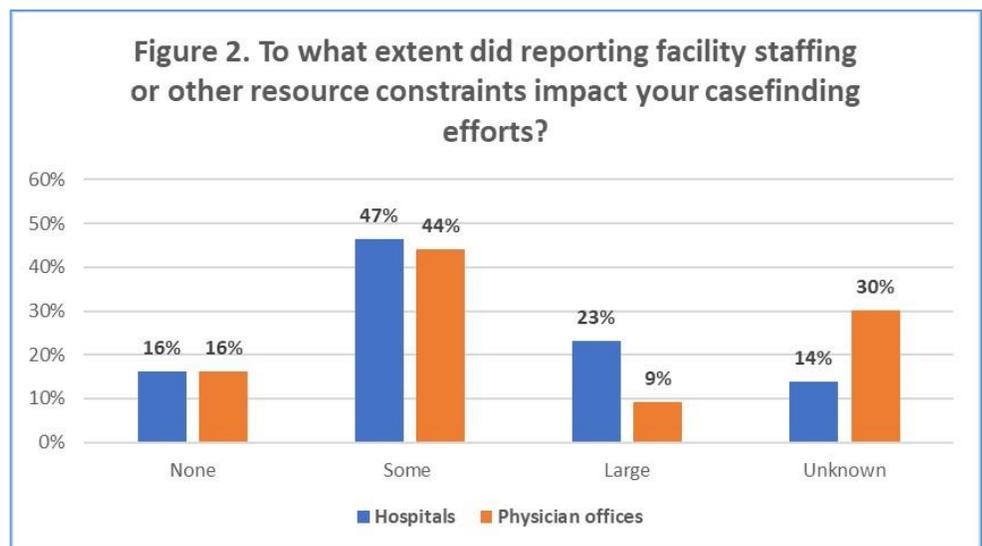
Of 13 Canadian registries, 31% completed the survey, and of 57 US registries, 68% completed the survey.

To assess the impact of staff shortages, we asked to what extent did registry staff shortages, due to COVID-19 deployments or other reasons, impact case-finding efforts (Figure 1). The majority, 53%, reported no impact on case reporting from facilities due to staff shortages. Two registries reported they were unable to complete case-finding audits due to pandemic-related travel restrictions. Of registries that reported no impact on case-finding due to COVID-related registry staffing issues and were able to



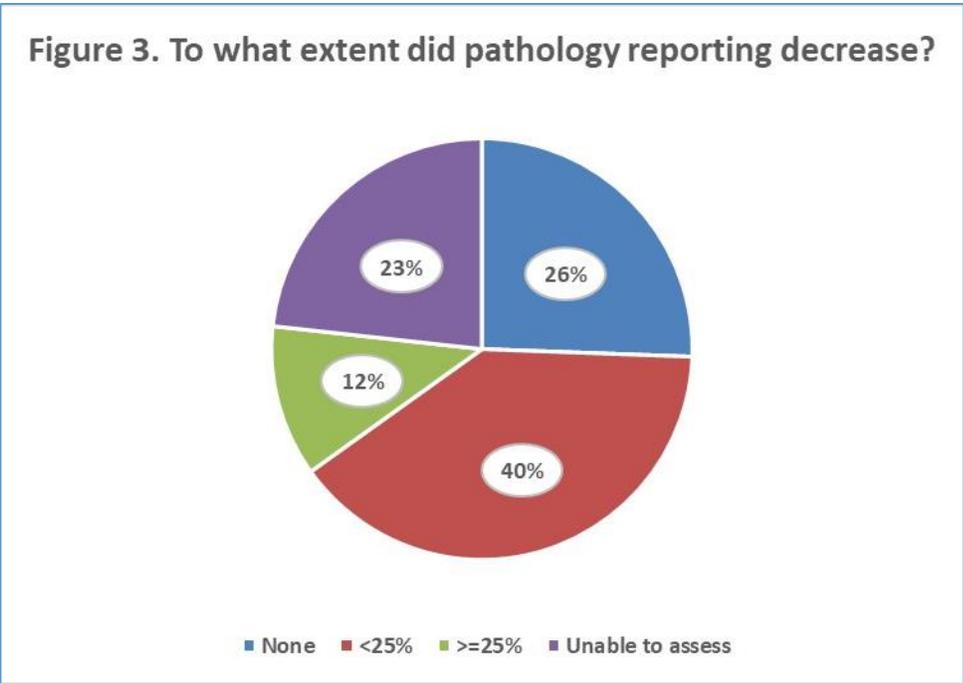
estimate completeness for 2020, the range in completeness was 77%-99%, with a mean estimated completeness of 88% at time of survey. Of registries that reported an impact on case-finding due to COVID-related staffing issues and were able to estimate completeness for 2020, the range in completeness was 72%-93%, with a mean estimated completeness of 83% at the time of survey.

We also asked to what extent reporting facility staffing or other resource issues impacted case-finding (Figure 2). The majority, 70%, reported at least some impact at hospital facilities, and 53% at physician offices. But 14% of the registries did not know if their hospitals were impacted, and 30% did not know if their physician offices were impacted. Of registries that reported no impact on case-finding due to registry COVID-related hospital constraints and were able to



estimate completeness for 2020, the range in completeness was 77%-99%, with a mean estimated completeness of 88% at time of survey. Of registries that reported an impact on case-finding due to COVID-related hospital constraints and were able to estimate completeness for 2020, the range in completeness was 72%-99%; with a mean completeness of 85% at the time of survey.

To assess potential drop in cancer diagnoses, we asked to what extent did registries show changes in the number of pathology reports (Figure 3). Over half, 52%, reported a decrease in numbers of pathology reports and 23% were unable to determine any change. Of those registries reporting a decrease in pathology cases, 30% are continuing to see a decrease in pathology reports for diagnosis year 2021; however, 43% of the registries were unable to assess the volume of 2021 pathology reports. Of registries reporting no



change in pathology report counts and were able to estimate completeness for 2020, the range in completeness was 72%-99%; with a mean estimated completeness of 86% at the time of survey. Of registries reporting a decrease in pathology report counts and were able to estimate completeness for 2020, the range in completeness was 80%-90%; with a mean estimated completeness of 88% at the time of survey.

It is important to note that 35% of the respondents were unable to evaluate their current case completeness, and 32% of US and 69% of Canadian registries did not respond to the survey. These registries may have experienced different pandemic impacts on their 2020 case completeness.

In such an unusual situation like this, how can and how should we calculate and use completeness estimates? How do we distinguish between low case ascertainment and meaningful changes in cancer care, access, and outcomes? How do we provide accolades to registries that are commensurate with their actual efforts? We are actively assessing the data. Our goal is to quantitatively assess the true decrease in case counts due to pandemic-related changes in medical care and use, and to minimize the impact of decreased case ascertainment due to disruptions in registry operations.

We would like to extend our thanks to registries who participated in this survey, and who offered explanatory comments and suggestions for assessing 2020 case completeness. Moving forward, based on the results of this survey and other input, NAACCR is collaborating with NPCR and SEER to determine if there will be any changes in this year's Call for Data or Certification. We will reach out to registries for additional input as we work through these extraordinary circumstances.

As always, if you have any questions, concerns, or revolutionary ideas in the NAACCR Research and Data Use area, please contact me rsheerman@naaccr.org.

NCCR Data Quality Working Group Updates



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The National Childhood Cancer Registry (NCCR) was developed under the NCI Childhood Cancer Data Initiative (CCDI) to identify and follow childhood cancer cases in the United States. Its primary goal is to provide a platform to better understand the causes, outcomes, effective treatments, and later effects of cancer among children, adolescents, and young adults in the U.S.

The NCCR contributes to the CCDI data ecosystem by serving as a linked infrastructure of central cancer registry data that will integrate several other childhood cancer data sources like research centers, health care administrations, and others—to enhance access to and utilization of childhood cancer and survivorship data. Currently, 24 central cancer registries are part of NCCR, including all SEER registries and five NPCR registries (Florida, Michigan, Ohio, Pennsylvania, and Tennessee).

In 2022, the NCCR formed a Data Quality Working Group (DQ WG) to develop appropriate methods to monitor quality and consistency in the NCCR data. The DQ WG is one of four NCCR working groups: Data Quality, Metadata, Data Products, and Data Access & Release. Each working group includes clinicians, researchers, epidemiologists, data specialists, and central cancer registries representatives. Gonçalo Forjaz (Westat) and I co-chair the DQ WG.

One challenge to working with pediatric cancer data is the lack of a standardized staging system. Clinicians use disease-specific staging systems that rely more heavily on prognostic factors than on tumor growth, as adult cancer staging does. As a result, cancer registries have long struggled with documenting stage for pediatric cancers. The Toronto Pediatric Cancer Stage Guidelines were developed by consensus and published in *The Lancet Oncology* in 2016. In fact, that same year the Guidelines were presented at the NAACCR Annual Conference in St. Louis, MO.

Over the past several months, the DQ WG has been collaborating with the NCCR Metadata Working Group, led by Dr. Sumit Gupta (The Hospital of Sick Children - University of Toronto) and Dr. Todd Gibson (NCI), to identify additional prognostic factors that could be collected in order to derive Toronto Staging. We also enlisted the expertise of Angela Costantini, a CTR specializing in pediatrics, to provide input for new Site-Specific Data Items (SSDI) to track prognostic features important to staging pediatric tumors. Many of these data items are already collected by CTRs at pediatric facilities, but in a non-standardized way. Suggestions for the new SSDIs were presented at the NAACCR Summer Forum. This work evolved into a well-defined, structured approach to SSDIs for the Toronto Pediatric Cancer Stage guidelines.

Jennifer Ruhl, who chairs the NAACCR SSDI Workgroup, with the help of Ms. Costantini, Dr Gupta, and Dr. Lindsay Frazier (Dana-Farber/Boston Children's Cancer and Blood Disorders Center – Harvard Medical School), developed a framework for incorporating the new data items into the NAACCR data standard. Joanne Aitken and Danny Youlden, from the Australian Pediatric Cancer Registry, also provided input

based on their experience, Australia being one of the only countries currently using the Toronto staging guidelines at the population level. The data items that the SSDI Work Group recommended have been collated into a document titled “Implementation Guide for Toronto Staging.”

The SSDI Work Group submitted a request to the Mid-Level Tactical Group on July 1 for consideration of these new stage and non-stage prognostic data items for implementation in 2024. In September 2022 the Kentucky Cancer Registry will field test the new data items in a pediatric hospital setting.

PEDIATRIC SSDI WG

In addition to the proposed new data items, there are many other non-standardized data items collected by pediatric registries. The SSDI WG has formed a sub-group, the Pediatric SSDI WG, to focus exclusively on pediatric data items. The work group will explore standardization of non-stage pediatric data items and possible inclusion in the NAACCR data standard. The Work Group’s first goal is to recruit pediatric registrars to help in the review, as well as in the development and testing of the Toronto Staging data items recommended for implementation in 2024.

Pediatric CTRs who are interested in being part of the new Pediatric SSDI WG, please contact me at fmichels@naaccr.org.

Visit [NCCR*Explorer](#) to access incidence and survival statistic based on NCCR.

Virtual Pooled Registry Update



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Hello and Happy Summer! I write this on the cusp of a week-long beach vacation and hope that your summers have also been filled with well-deserved down time, fun adventures, and relaxation. Not only have the temperatures in New Hampshire been hot, but so has the activity in the recently launched VPR.

STATUS OF VPR-FACILITATED LINKAGES

The VPR was launched in July with 12 pre-selected, federally funded studies. One study has declined participation due to internal budget cuts. The status of the remaining eleven Phase I studies is as follows:

Eight studies have submitted their Phase I linkage requests, which have undergone an initial NAACCR review and final review/approval by the VPR Research Review Committee (RRC), which consists of representatives from NCI, CDC, NAACCR, ACS, and three registries. The status is as follows:

- Approved by the RRC and linkage with registries has been completed.
 - Study on the Incidence of Cancer Diagnosis and Mortality among Military Aviators and Aviation Support Personnel: Cohort of 10.9M resulting in 539,983 high quality matches from 44 registries.
 - Community-based cohort study of disease incidence in Ohio and West Virginia: Cohort of 35K resulting in 6,311 high quality matches from 42 registries.
 - NYU Women’s Health Study: Cohort of 14K resulting in 6,843 high quality matches from 42 registries.
- Approved by the RRC and awaiting upload of the cohort file.
 - The Watch the Spot Trial: A Pragmatic Trial of More Versus Less Intensive Strategies for Active Surveillance of Patients with Small Pulmonary Nodules.
- Approved by the RRC and awaiting a signed DUA with IMS.
 - An Updated Cohort Study of Workers Exposed to Ethylene Oxide.
- Under review by the RRC.
 - Enabling a Paradigm Shift: A Preference-Tolerant RCT of Personalized vs. Annual Screening for Breast Cancer (WISDOM Study).
 - Gulf Long-Term Follow-Up Study.
 - Black Women’s Health Study.

Three studies have yet to submit their Phase I linkage request:

- Cancer Incidence and Cancer Mortality in the World Trade Center Health Registry: Working with IMS to complete their internal security review process.
- Lung Cancer Risk Associated with HIV and Substance Use (Including Cannabis) in a Long-Term Multi-ethnic Cohort.
- Breast Cancer Family Registry.

NEW DATA ITEMS TO IDENTIFY NON-RELEASABLE CASES

This year NAACCR developed two new data items that will be implemented in 2023 to standardize the coding of potentially non-releasable cases:

- No Patient Contact Flag [Item 1854]. Used to flag when a patient, family member, or provider notifies the central registry that the patient is not to be contacted for research purposes. This data item is assigned at the person-level.
- Reporting Facility Restriction Flag [Item 1856]. Used to flag tumor records that the central cancer registry may not be allowed to release for research and certain other types of uses due to the type of reporting facility (e.g., VA or DoD). This data item is assigned at the tumor-level based on the reporting facilities contributing to the consolidated record.

The goal is for these items to make it easier for central registries identify and exclude non-releasable cases when processing data requests, including VPR linkage studies.

Enjoy the rest of your summer!

Dr. Peter Eby Wins the NAACCR Summer Forum Social Media Contest

By Dan Curran, MS, CTR
Social Media WG Chair

#NAACCRcontest participant Dr. Peter Eby (@PeterEbyMD) sent this winning tweet from the 2022 NAACCR Summer Forum.



NAACCR Education and Training Program Update



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NAACCR WEBINAR SERIES

Every year we wrap up the season with our Coding Pitfalls webinar. We comb through the webinar we have presented all year to identify areas where registrars seemed to have problems. We also search the CAnswer forum and SEER SINQ to identify problem issues. We put that all together into a single 3-hour

webinar. Our guest host this season is Janet Vogel. Janet has years of experience and is a Compliance & Quality Auditor/Educator for Omega Healthcare.

October starts our new season! As you can see below, our first two sessions cover breast. In our first session we will focus on coding treatment. We will have a special emphasis on the new surgery codes and radiation. Our second session will focus on Solid Tumor Rules, SSDIs, and Staging.

Subscriptions are **available** for the 2022-2023 Season. We have “re-packaged” some of the products, but the prices are the same as last year.

<https://education.naaccr.org/next-year-webinar-series>

For more information or to subscribe see the NAACCR 2020-2021 Webinar Series page at <https://education.naaccr.org/2020-2021-webinar-series>

2022-2023 WEBINARS AT A GLANCE

- Breast 2022 Part 1: 10/06/22
- Breast 2022 Part 2: 11/03/22
- Esophagus 2022 12:/01/22
- Head and Neck 2023: 1/12/23
- Data Item Relationships: 2/2/23
- Boot Camp 2023: 3/02/23
- Prostate 2023: 4/06/23
- Lower GI 2023 Part 1: 5/04/23
- Lower GI 2023 Part 2: 6/01/23
- IT Worked for Me: In"FUN"matics in the Cancer Registry: 7/13/23
- Melanoma 2023: 8/03/23
- Coding Pitfalls 2023: 9/07/23

SEE [FULL WEBINAR DESCRIPTION](#)

NAACCR CTR PREP AND REVIEW

Registration is now open for the fall session of the CTR Prep and Review. This session is in preparation of the October Exam. Our first session is 8/23/22. We've had some really good feedback from the group that just finished taking the exam and will be making some changes based on that feedback.

The series consists of 8 live sessions that are recorded and posted to our learning management system. Participants have unlimited access to the recordings, quizzes, and other study tools until the last day of the exam. We also have a very active discussion board where participants share study tips and provide support for each other.

Additional information will be available at <https://education.naaccr.org/ctr>.

NAACCR TALK

NAACCR Talks are free webinar conducted by members of the cancer registry community! For a full calendar of upcoming NAACCR Talks, see our [Calendar of Upcoming Events](#)

Recordings of all NAACCR Talks can be found at: <https://education.naaccr.org/freewebinars>.

Do you have a topic that would be of interest to the cancer registry community? Contact Jim or Angela. Our contact info is below.

GLOBAL / INTERNATIONAL CANCER SURVEILLANCE EDUCATIONAL MATERIALS

We have some an exciting new e-learning product on our International Resources page!

Principles of Cancer Registry is new series of training modules that have been selected and adapted for online learning from the larger course, "From Data to Action: A Curriculum for Cancer Prevention and Control in Low- and Middle-Income Countries," which was created by CDC (U.S. Centers for Disease Control and Prevention) and TEPHINET (Training Programs in Epidemiology and Public Health Interventions Network.) NAACCR, with funding from NCI, is adapting the registry-related contents for web-based training to increase their accessibility. Although the course emphasis is cancer surveillance in low- and middle-income countries, the general principles covered are applicable worldwide.

The first two modules have been posted here: <https://education.naaccr.org/international>.

QUESTIONS

As always, if you have any questions about the plethora of NAACCR Education and Training products don't hesitate to contact [Jim Hofferkamp](#) or [Angela Martin](#)!

Summer and Fall 2022 Education and Training Calendar



Angela Martin, CTR
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UPCOMING WEBINAR PRESENTATIONS

August 2022

- | | |
|------------|---|
| 08/23/2022 | NAACCR CTR Exam Preparation and Review Webinar Series Session 1 |
| 08/ /2022 | V ° ##k #uk '- h k ‡ o o |
| 08/ /2022 | NAACCR December 2022 Call for Data Instructional Webinar |

September 2022

09/01/2022	NAACCR Webinar Series: Coding Pitfalls 2022
09/06/2022	NAACCR CTR Exam Preparation and Review Webinar Series Session 3
09/12/2022	NAACCR Talk: Update on the National Firefighter Registry and Plans for Cancer Registry Linkages
09/13/2022	NAACCR CTR Exam Preparation and Review Webinar Series Session 4
09/20/2022	NAACCR CTR Exam Preparation and Review Webinar Series Session 5
09/27/2022	NAACCR CTR Exam Preparation and Review Webinar Series Session 6

October 2022

10/04/2022	NAACCR CTR Exam Preparation and Review Webinar Series Session 7
10/06/2022	NAACCR Webinar Series: Breast 2022 Part 1
10/11/2022	NAACCR CTR Exam Preparation and Review Webinar Series Session 8

For more information about NAACCR education and training opportunities, or to register online, go to the Education and Training site <https://education.naaccr.org/upcomingevents> or contact Angela Martin (amartin@naaccr.org).

Highlights from the Program Manager of Standards



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Program Manager of Standards
lhavener@naaccr.org

XML USER DICTIONARY

Central registries with locally defined data items should create their XML user dictionary and post to the [XML Dictionary Submission Clearinghouse](#) by October 1, 2022. If a central registry does not need a user dictionary, please communicate this information as well. Visit the XML User Dictionary [website](#) for additional information (additional links, FAQs, Help with User Dictionaries).

NAACCR DATA STANDARDS AND DATA DICTIONARY V24 TIMELINE

NAACCR Data Standards and Data Dictionary (Volume II) Version 24 Implementation Timeline		
Activity	MLTG Deadlines	Comments
Proposed requests for new data items and revisions requiring field testing submitted to the Mid-Level Tactical Group (MLTG). <i>Note:</i> most new and some changed data items require field testing.	July 1, 2022	Data items approved by MLTG will be sent to the Uniform Data Standards Work Group (UDS WG) for preliminary review
Field testing initiated <i>Note:</i> MLTG is currently evaluating the field-testing process.	October 1, 2022	NAACCR will facilitate field testing
Proposed requests for changes to existing data items that do not require field testing submitted to MLTG for final review. Other planned changes (e.g., staging, ICD-O-3.2, SSDI schemas, etc.) reported to MLTG.	October 1, 2022	MLTG may elect to require field test on changes*
MLTG informs the High-Level Strategic Group (HLSG) of all planned changes for 2024.	January 1, 2023	
MLTG transmits new proposed standards to UDS WG for final review and approval.	January 1, 2023	UDS will review all information provided
Field test results reported to MLTG.	March 1, 2023	
HLSG reviews/approves changes to be implemented in 2024.	April 1, 2023	
HLSG/MLTG transmits new standards approved for implementation to UDS WG	April 1, 2023	UDS updates NAACCR Data Standards and Data Dictionary (Volume II)
Standard setters provide their requirements for the Data Standards and Data Dictionary, Required Status Table Chapter 8) and the Reportability table (Chapter 3).	May 1, 2023	
UDS WG final review/approval	June 1, 2023	
UDS WG submits NAACCR Data Standards and Data Dictionary (Volume II), Version 24 to the Standardization and Registry Development Steering Committee for review/approval	June 15, 2023	
NAACCR Data Standards and Data Dictionary (Volume II), Version 24 Released	July 1, 2023	

*Changes to existing data items that result from experience in collecting the data, questions received from registrars or reliability studies generally will not require field testing. However, changes to codes made for other reasons may require field testing to ensure that the new codes and coding instructions can be accurately applied in registry settings. Change requests made in October that the MLTG determine need to be field tested may postpone the implementation year.

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