NEVADA CENTRAL CANCER REGISTRY
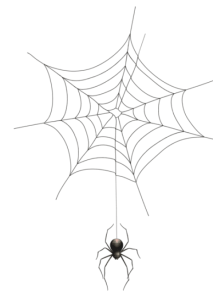
October Newsflash

NCCR Newsletter

Breast Cancer Awareness Month

#PaintNevadaPink and our partners at the Nevada Cancer Coalition (NCC) are hosting a series of events the entire month of October in both the North and the South to spread awareness for breast cancer screening.

Join NCC, Nevada Health Center's Mammovan for a Mammo-Rama Extravaganza or hang out with the Haus of Does Moore drag queens for a drag brunch. Check out the full list of activities happening near you and to learn how to take the pledge to get screened visit Paint Nevada Pink | Nevada Cancer Coalition.

Join us in spreading the message:

Mammograms Save Lives.

NCCR Updates

The Nevada Central Cancer Registry (NCCR) recently completed a Data Quality Evaluation (DQE) by the National Program of Cancer Registries (NPCR). In order to gage the validation and completeness of select cases in our database, the DQE activities followed the guidelines set by NPCR. The guidelines follow the program standards for completeness, timeliness, and the quality of data set forth by the National Cancer Registries Amendment Act (Public Law 102-515). The validation evaluation assessed the quality of specific data items for five primary sites: esophagus, stomach, liver and intrahepatic bile duct, brain (gliomas and embryonal tumors), and thyroid. The completeness evaluation reviewed data items for the same five primary sites and the proportion of cases coded to unknown or some variation of unknown.

This October Newsflash will focus on the conclusions of the DQE and specific recommendations for all cancer registrars/reporters in the state of Nevada.

The Process
In a nutshell, the reviewers performed a text to code re-abstraction study of every data element related to the evaluation and its associated text for each source-level case. Any discrepancy where the text did not support the code was flagged and sent back to NCCR for resolution, at which point, we either agreed with the reviewer's recommendation or disagreed and provided justification and rationale for the original

How We Did

The reviewers recommended that Nevada registrars review the rules and abstracting practices for *grade pathological*, *Summary Stage 2018*, *surgery of primary site*, and *date of first course of treatment* (FCOT). It was also noted that many discrepancies could have been resolved by reviewing the data item *text documentation*.

We are proud to announce that the overall data accuracy proportion rate was **96.9%**. This was calculated on major errors only for 365 cases diagnosed in 2019. NCCR recognizes Nevada registrars as the cornerstone for collecting and reporting high-quality cancer data and thanks you for your diligence and excellence in the abstraction of cancer cases.

GREAT JOB NEVADA REGISTRARS!

Accuracy Proportion by Site

The accuracy proportion is calculated by the sum of the total number of major errors divided by the total number of consolidated data elements reviewed X 100. Because the formula calculates the error rates, the proportion (sum) is then subtracted from 100 to create the accuracy rates. The formulas apply to the rows, and total counts apply to the columns.

Site	Number of consolidated tumors (a)	Number of data elements reviewed (b)	Total number of consolidated data elements reviewed (c=a * b)	Number of data elements w/ major errors (d)	Accuracy proportion (e)	95% Confidence Interval of the Accuracy Proportion (f)
Esophagus	73	43	3,139	100	96.8%	96.2%--97.4%
Stomach	73	43	3,139	106	96.6%	96.0%--97.3%
Liver and Intrahepatic Bile Duct	73	43	3,139	105	96.7%	96.0%--97.3%
Brain (gliomas and embryonal tumors)	73	44	3,212	135	95.8%	95.1%--96.5%
Thyroid	73	43	3,139	42	98.7%	98.3%--99.1%
Total	365	216	15,768	488	96.9%	96.6%--97.2%

Reference:
Westat. (2022, September 9). *Nevada Central Cancer Registry: Diagnosis Year 2019*. Data Quality Evaluation 2021-2022: Validation. Centers for Disease Control and Prevention (Contract Number: GS00F009DA).

Text Documentation: Review

Text documentation is an essential component of a complete abstract and is heavily utilized for quality control and special studies. During the DQE Visual Editing, errors resulted when text was either completely missing or incorrectly coded for various data elements. NCCR was encouraged to review basic abstracting principles with data reporters to emphasize that **text documentation to support data elements code selection is required**.

CYA "Cover Your Abstract" with High-Quality Text Documentation

Every cancer patient deserves to have their case abstracted as perfectly as possible which would include high-quality text documentation. High-quality text is important because it tells "the story" of a person's journey with cancer in readable language, provides an accurate and concise summary of the patient's experience, and facilitates consolidation of information from multiple reporting sources at the central registry.

Text Documentation: Review (continued)

NCCR still receives cases from facilities with blank text fields. Every text field needs to be populated for every case submitted. Data items for cases with limited history or cases diagnosed prior to admission with little or no information are "unknown". In general, if you code data items with 9's, it usually means the information for the code is not available. For example, if it is not known whether the patient is single, married, or widowed then "marital status, unknown" should be entered somewhere in a text field (usually Physical Exam or Remarks) to justify the code (9) you used. If the patient is divorced and you enter code "3" for the marital status data item, then the word "divorced" should also be included somewhere in a text field. In other words, you should be able to code your case by looking at your text without referring back to the chart. This is how you "cover your abstract."

Keep in Mind:

- include *dates* that allow event chronology (note when dates are estimated)
- include *location* (facility/physician where event occurred)
- include a *description* of the event (test/study/treatment/other)

- include *details* relevant to event (treatment plan interruptions, delays, cancellations, refusals)
- use "Recommended Abbreviations for Abstractors" (NAACCR Appendix G)
- do not repeat information

Answer YES to the following questions:

Does text validate the codes?

Does text define who, what, where, and when?

Does text support unusual site/histology combos?

Does text explain unusual abstract entries?

Does text document ambiguous terminology?

Does text eliminate the need to review the EMR?

NCCR recommends downloading and reviewing the series of "informational abstracts" for common cancers and viewing the presentation, *Using the Informational Abstracts in Your Registry*, that shows registrars how to use these important resources. This resource was created by the National Cancer Registrar's Association (NCRA) Education Committee to assist registrars in preparing abstracts. Click here or visit Registry Resources

Text Examples from DQE

Examples of cases where there was either a lack of supporting documentation or the text that was documented was misinterpreted.

Site	Discrepant Field	Example	Common Miscode	Recode To	Rationale
frontal lobe brain	Grade Pathological (13844)	HG GBM, IDH wildtype	H	4	Table 1 in STR with select CNS neoplasms and corresponding WHO grade; Glioblastoma, IDH-wildtype is WHO grade 4. Note 4 for Grade Pathological data item indicates codes 1-4 take priority over A-D, L and H; field; miscoded to "H" because pathology reads high-grade
brain	Surgery Prim Site (11290)	craniotomy resection	30	20	no info regarding if resection was partial, subtotal, debulking, gross, radical, total, or margin status for a procedure that would classify as more specific procedure
esophagus	SS2018 (1764)	METS to axillary LNs indicated on pre-TX scans	9	7	LNs are distant for esophagus
esophagus	Tumor Size Clinical	MALIG appearing circumferential friable mass extending from 25 CM to 29 CM	040	998	25 CM to 29 CM indicates location of mass (middle thoracic) and does not translate to 4 CM Clinical Tumor Size; per SEER Coding and Staging Manual: if no tumor documented for esophagus but mass described as circumferential code to 998.. (2018 p107-108 & 2022, p113-114)

References:

North American Association of Central Cancer Registries. (n.d.). Chapter III: Standards for Inclusion and Reportability. *Data Standards and Data Dictionary, Version 22*, Table2. Comparison of Reportable Cancers: CoC, SEER, NPCR, and CCCR. Retrieved September 21, 2022, from NAACCR Web Site.

North American Association of Central Cancer Registries. (n.d.). *Data Standards and Data Dictionary, Version 22*, Appendix G: Recommended Abbreviations for Abstractors. Retrieved September 26, 2022, from NAACCR Web Site.

Westat. (2022, September 9). Nevada Central Cancer Registry: Diagnosis Year 2019. *Data Quality Evaluation 2021-2022: Validation* (Contract Number: GS00F009DA). Centers for Disease Control and Prevention.

Grade Pathological: Review

Grade is a measure of aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers. For some sites, grade is required to assign the pathological stage group.

For detailed coding instructions and site-specific coding rules, use the most current version of the Grade Coding Manual and Grade Tables at https://apps.naaccr.org/ssdi/list/2.1. Do not rely on vendor drop down menu selections and guess. Use the manuals as designed to ensure the proper code is assigned for invasive and for non-invasive cancers. Some codes can only be used for in-situ cancer and some only for malignant cancers.

The grade pathological data item records the grade of a solid primary tumor that has been resected for which no neoadjuvant therapy was administered. *The field must not be blank.* If AJCC staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. This may include the grade from the clinical workup, as all information from diagnosis (clinical staging) through the surgical resection is used for pathological staging.

The codes used include 1-5, H, L, M, S, and 9. These codes take priority over generic grade definitions (codes A-E). Code 9 (unknown) is used when the grade is not documented, no resection of primary site, neoadjuvant therapy followed by resection, clinical case only, only one grade available (cannot determine whether clinical or pathological), or grade checked "NA" on CAP protocol.

Patient does not have a biopsy but does have a resection of the primary site Grade Clinical = 9 Grade Pathological = grade from resection of primary site	
Patient has a biopsy and a resection Grade Clinical = grade from biopsy Grade Pathological = grade from resection of primary site	**Patient presents with active cancer and no other information is available** Grade Clinical = 9 Grade Pathological = 9
Patient has biopsy and resection of primary tumor and there is no residual cancer. Grade Clinical = grade from biopsy Grade Pathological = grade from biopsy	**Patient has a biopsy and resection of primary site and there is no grade documented from surgery** Grade Clinical = grade from biopsy Grade Pathological = grade from biopsy
Assign the highest grade from the primary tumor. If grade from biopsy (clinical) is higher than the grade from resection (pathological), use the grade that was identified during the clinical time frame for both Grade Clinical and Grade Pathological (e.g., esophagus biopsy revealed a grade 3, poorly differentiated adenocarcinoma and esophagectomy revealed a grade 2, moderately differentiated adenocarcinoma) Grade Clinical = 3 (G3: poorly differentiated) Grade Pathological = 3 (G3: poorly differentiated)	

Examples from DQE

A discrepancy in the Grade Pathological data field is considered a **major** error.

Site	Discrepant Field	Example	Common Miscode	Recode To	Rationale
Stomach	GradePath (13844)	2/1/19 Cisplatin; 5/6/19 PATH from RESX revealed MOD DIFF ADENOCA	2	9	Note: 7 (page 57) from Grade Manual V2..01 instructs to use code 9 (unknown) when neo-adjuvant TX is followed by resection; patient stated neoadjuvant chemotherapy in February followed by a resection in May
Liver	GradePath (13844)	6/2/2019 liver BX revealed hepatocellular carcinoma; MOD DIFF	2	9	Note: 7 (page 46) from Grade Manual V2..01 instructs to use code 9 (unknown) when there is no resection of primary site; this case was biopsy only
Brain	GradePath (13844)	2/6/2019 BX revealed medulloblastoma, classic type	4	9	AJCC Brain chapter (page 875) Table 72.2 WHO grading system for selected tumors of CNS; medulloblastoma listed as tumor type Grade IV; TX fields do not indicate RESX; Note: 7 (page 189) from Grade Manual V2.01 instructs to code 9 (unknown) when no resection of primary site; biopsy only case

Reference:
Ruhl J, Ward E, Hofferkamp J, et al. (August 2021). Grade Manual. NAACCR, Springfield, IL 62704-4194.

Summary Stage 2018: Review

The importance of determining accurate stage in your abstract cannot be overemphasized. This field is considered critical because it can be used to determine the best treatment options, prognosis, and recurrence. Nevada registrars are required to directly assign SS for all cases diagnosed and reported to NCCR 1/1/2018 forward.

Always refer to the most current version of the SEER Summary Stage 2018 (SS2018) General Coding Instructions for site-specific coding instructions. As of 9/24/2022, the most current version was published September 2020. Visit https://seer.cancer.gov/tools/ssm/ to view the manual online.

The 6-category coding structure applies to every site and/or combination, including lymphomas and leukemias; and uses all information available in the medical record (combination of imaging, pathologic, operative, and clinical assessments). This should include all information available within **four months** of diagnosis in the absence of disease progression or upon completion of surgery in first course of treatment, whichever is longer.

The answers to 4 basic questions will determine the correct Summary Stage. Make sure to read the details of how to answer those questions by reviewing the SS2018 Coding Manual v2.1 (page 22, "How to assign Summary Stage").

Code	Definition
0	In situ
1	Localized only
2	Regional by direct extension only
3	Regional lymph nodes only
4	Regional by BOTH direct extension AND lymph node involvement
7	Distant site/lymph node or both involved
8	Benign/borderline
9	Unknown

1. Where did the cancer start?
2. Where did the cancer go?
3. How did the cancer spread to the organs or structure?
4. What are the stage and correct code for this cancer?

The most important take-away that we'd like to emphasize regarding SS2018 is to make sure and READ the manual and be familiar with the navigation. We recommend reading:

   Guidelines by Stage (pages 6-17)
   General Instructions (page 18-19)
   Guidelines (page 20-21)

Examples from DQE

Site	Discrepant Field	Example	Common Miscode	Recode To	Rationale
esophagus	SS2018 (1764)	10/9/19: NV HOSP -R retroperitoneal LN BX: METS squamous cell CA; No grade given, NOS	9	7	Recoded from 9 to 7 because retroperitoneal lymph nodes are distant for middle third of esophagus.
stomach	SS2018 (1764)	7/09/19 NV Hosp: EGD w/EUS: lesion between 44-45 cm, no ulceration or erosion; mucosal involvement only w/possible submucosal involvement; no evidence for esophageal or gastric LAD.	9	1	Recoded from 9 to 1 because tumor involves only mucosa.
liver	SS2018 (1764)	3/25/20 NV Hosp: CT A/P: cirrhotic liver with large approx. 16 cm mass R hepatic lobe; Multiple small masses in the L hepatic lobe, favor diffuse/ infiltrative HCC.	9	2	Recoded from 9 to 2 because on CT it was identified that there are liver masses in both liver lobes.

SS2018: Examples (continued)

Site	Discrepant Field	Example	Common Miscode	Recode To	Rationale
brain	SS2018 (1764)	12/24/19 NV Hosp: MRI HEAD Large mass centered in the right frontal lobe with spread across the corpus callosum anteriorly and significant mass effect highly suspicious for GBM.	9	2	Recoded from 9 to 2 because the involves the corpus callosum.
thyroid	SS2018 (1764)	4/23/19 Path: Thyroid: multifocal papillary thyroid carcinoma right lobe-0.7cm and left lobe-3.1cm without lymphatic and angioinvasion identified. Margins: The left peripheral soft tissue resection margin is focally positive for carcinoma. Lymph nodes: 9 of 12 regional nodes positive for malignancy	3	4	Recoded from 3 to 4 because there is soft tissue extension and regional lymph node involvement.

References:
Ruhl JL, Callaghan C, Schussler N (eds.) *Summary Stage 2018: Codes and Coding Instructions*, National Cancer Institute, Bethesda, MD, 2021
Westat. (2022, September 9). Nevada Central Cancer Registry: Diagnosis Year 2019. *Data Quality Evaluation 2021-2022: Validation* (Contract Number: GS00F009DA). Centers for Disease Control and Prevention

Surgery of Primary Site: Review

This data item describes the surgical procedure used to treat the primary site of the reportable tumor. The surgery should be *cancer-directed* and encompass a procedure that aims at controlling, modifying, removing, or destroying cancerous tissue at the site where the cancer arose. Do not code any *non-cancer directed* treatment is this field. Most of the codes for this field are site specific and require review of the schema for the primary site you are abstracting.

Use the operative report as the primary document to determine the surgical procedure. The operative report will help the CTR identify the surgeon's planned procedure as well as a description of the procedure that was actually performed.

For this data item, we recommend training at the SEER Training Module on Cancer Treatment: Surgery. Look to understand the difference between what is considered *non-cancer directed* and *cancer-directed treatment* because they are recorded differently in the cancer data fields.

You can find the site-specific surgery codes in either *Appendix A* from the STORE Manual or *Appendix C* from the SEER Coding and Staging Manual. Both resources use the same terminology for the procedures, but SEER goes a bit further providing extra "SEER Notes" that help either explain the procedure in more detail or gives examples of procedures included for that code.

- Code 00 if no surgery performed on primary site
- Codes 10-19 are site-specific: tumor destruction; no pathologic specimen; or unknown
- Codes 20-80 are site-specific and describe resections with pathologic specimens
- Code 90 for surgery, NOS: no information on the type of surgical procedure is provided
- Code 98 for special site-specific procedure
- Code 99 for unknown when record doesn't state surgery performed; death certificate only

For more detailed coding instructions you should refer to STORE 2022 "Surgical Procedure of Primary Site" (page 219), SEER Coding and Staging Manual 2022 "Surgery of Primary Site" (page 171), and the NAACCR Data Dictionary: RX Summ-- Surg Prim Site (Item 1290).

Surgery of Primary Site: Review (continued)

Examples from DQE

Site	Discrepant Field	Example	Common Miscode	Recode To	Rationale
esophagus	RXSummSurg-PrimSite (I1290)	6/16/2020 NV Hosp Esophagogastrectomy	80	52	Recoded from 80 (Esophagectomy, NOS) to 52 (Esophagectomy with gastrectomy, NOS) because the surgical procedure is described on text fields as esophagogastrectomy.
stomach	RXSummSurg-PrimSite (I1290)	6/12/19 NV Hosp: Total gastrectomy, partial liver resection and partial diaphragmatic resection: Tumor site: Fundus: MD adenoca, 6.2 cm, invades adj structures/organs (liver), margins neg, tx effect: extensive residual ca with minimal evidence tumor regression (poor response, score 3), LVI present, perineural inv present, distal greater curvature intramural/ subserosal satellite nodule, (2.2 cm), 5/15 pos RLNs.	60	63	Recoded from 60 to 63 because surgical procedure is stated as total gastrectomy with partial liver and partial diaphragm resection.
liver	RXSummSurg-PrimSite (I1290)	Surgery Text Box was left blank.	0	99	Recoded from 00 (none) to 99 (unknown) because according to NCCN guidelines this is a usually recommended treatment for this primary and/or stage, and it is unknown if it was administered or given.
brain	RXSummSurg-PrimSite (I1290)	3/04/19 NV Hosp: RT temporal craniotomy and microsurgical excision of the tumor.	55	30	Recoded from 55 to 30 because text fields state that a complete resection of mass was achieved. There is no statement of a Gross resection of lobe (lobectomy).
thyroid	RXSummSurg-PrimSite (I1290)	2012 OSF: Rt partial thyroidectomy w/ benign pathology report. 11/15/19 NV Hosp: Left thyroid lobectomy/isthmusectomy (Completion thyroidectomy)	23	50	Recoded from 23 to 50 because the patient had a prior partial thyroidectomy and the remaining thyroid tissue was removed on this procedure.

References:
Adamo M, Groves C, Dickie L, Ruhl J. (September 2021). Surgery of Primary Site. In *SEER Program Coding and Staging Manual 2022* (p. 171). Bethesda: National Cancer Institute.
Commission on Cancer. (2022). Surgical Procedure of Primary Site. In *Standards for Oncology Registry Entry* (p. 219). Chicago: American College of Surgeons.
Westat. (2022, September 9). Nevada Central Cancer Registry: Diagnosis Year 2019. *Data Quality Evaluation 2021-2022: Validation* (Contract Number: GS00F009DA). Centers for Disease Control and Prevention

Date of First Course of Treatment: Review

FirstRxDateCoC (1270)
This field is important because it measures the delay between diagnosis and the onset of treatment and acts as a starting point for survival statistics. This data item records the date treatment started. This includes all methods of cancer-directed treatment recorded in the treatment plan and administered to the patient *after* the original diagnosis of cancer in an attempt to destroy or modify the cancer tissue. This data item also records the date on which active surveillance is chosen, a physician decides not to treat a patient, or the patient or guardian refuses or declines treatment.

Coding
Use the documented first course of therapy (treatment plan) from the medical record. This will be your guide to help you determine the correct date for this field.

Instructions

- Record the earliest start date from the following data items:
  - ⇒ Date of First Surgical Procedure (1200)
    - ∗ Record earliest date of surgical procedure of the types coded as Surgical Procedure of Primary Site (1290), Scope of Regional Lymph Node Surgery (1292), or Surgical Procedure/Other Site (1294)
  - ⇒ Date Radiation Started (1210)
  - ⇒ Date Systemic Therapy Started (3230)
  - ⇒ Date Other Treatment Started (1250)
- Record the date of excisional biopsy when it is the first treatment.
- Record the date the decision was made if the physician opts for active surveillance (Rx Summ-Treatment Status should be coded "2" for active surveillance).
- Record the date the decision was made if a physician decides not to treat a patient.
- Record the date the patient refuses or declines treatment.

Examples from DQE

Site	Discrepant Field	Example	Common Miscode	Recode To	Rationale
esophagus	FirstRxDateCoC (1270)	Text fields indicated that the patient refused treatment on 11/12/2019	Blank	20191112	Recoded from blank to 20191112 because STORE instructs to record the date the patient or guardian refuses or declines treatment
stomach	FirstRxDateCoC (1270)	Text fields indicated patient sent home with hospice care on 11/2/2019	Blank	20191102	Recoded from blank to 20191102 because STORE instructs that without any other treatment recommendations, record the date the decision was made to not treat
brain	FirstRxDateCoC (1270)	Craniotomy and biopsy on 2/23/2019 revealed glioblastoma; medical oncology note on 3/1/2019 states that patient has poor prognosis and was recommended hospice care; no surgery or chemotherapy was recommended	20190223	20190301	Recoded from 20190223 to 20190301 because craniotomy / biopsy is coded as diagnostic and staging procedure. STORE instructs to record the date the decision was made if physician decides not to treat.
brain	FirstRxDateCoC (1270)	CT scan on 7/26/2020 revealed evidence that surgery was done to the patient (date of that surgery is unknown)	20200101	Blank or 2020 are acceptable values	Recode from 20200101 to 2020 (estimated year) because there is no evidence surgery was performed on 1/1/2020 **OR** recode from 20200101 to blank with a flag 12
thyroid	FirstRxDateCoC (1270)	RLN biopsy on 5/7/2019 was (+) for papillary carcinoma; thyroidectomy on 9/25/2019 showed papillary thyroid carcinoma	20190925	20190507	Recoded from 20190925 to 20190507 because STORE manual states that these types of procedures must be coded in Date of First Course of Treatment (1270): date of first surgical procedure (1200) & **scope of regional lymph nodes (672) (if done prior to a surgery to the primary site).** STORE (p. 232) Record the earliest of the following dates: **Date of First Surgical Procedure (1200)**, Date Radiation Started (1210), Date Systemic Therapy Started (3230), or Date Other Treatment Started (1250).

References:

Commission on Cancer. (2022). Date of First Course Treatment. In *Standards for Oncology Registry Entry* (p. 212). Chicago: American College of Surgeons.

Westat. (2022, September 9). Nevada Central Cancer Registry: Diagnosis Year 2019. *Data Quality Evaluation 2021-2022: Validation* (Contract Number: GS00F009DA). Centers for Disease Control and Prevention

Don't Forget About...

[Nevada Cancer Registrars Association (NVCRA) Quarterly Meeting](#)
October 18, 2022 10:00 AM
This is the quarterly members meeting for cancer registrars working in Nevada. October's meeting will be filled with exciting updates so don't miss out!

Feel free to reach out with questions or concerns to Larraine Tooker.
Email ltooker@health.nv.gov

The Newsflash newsletter is created monthly and sent out by NCCR. Current and past articles are topic specific and based on data which have been identified as needing review and/or clarification. The newsletters are not designed to provide complete training information for all data fields related to a specific primary site and do not replace the need to use the usual coding references for data collection.

Current and past newsletter issues are available in FLccSC ("flossy"). To access your existing flossy account or [register as a new user](#) click [here](#).

To access:
- Login to flossy; Click on "Courses" and select the course category "Newsflash Newsletter 2022"
- Find the newsletter issue you wish to review and "enroll"
- "Enrolling" will move the newsletter to your Enrolled Courses tab where you can open it for review online or download directly to your computer for saving
- Once you've reviewed the newsletter and "finished" it will move to your Completed courses tab where it will remain indefinitely for review as needed

---

NCCR is currently working on activities for this year's Call for Data which means the next Newsflash will go out sometime in December or January 2023.

Questions regarding information in this newsletter or suggestions for future issues can be emailed to Larraine Tooker, ltooker@health.nv.gov.

NCCR is Nevada's legislatively mandated population-based cancer registry and has been collecting incidence data since 1989.

The registry is housed under the Nevada Department of Health and Human Services (DHHS) of the Office of Public and Behavioral Health and supported by the National Program of Cancer Registries (NPCR) through the Centers for Disease Control and Prevention (CDC).

Program Manager:
Aundrea Ogushi

Data Manager:
Rani Reed

Education & Training Coordinator:
Larraine Tooker, CTR

Quality Assurance Manager:
Catherina Short, CTR

Cancer Registry Specialist:
Anthony Pineda, CTR

Administrative Assistant:
Savannah Pimentel

NCCR
4126 Technology Way, Suite 200
Carson City, NV 89706

Phone: 775-684-5968
Fax: 775-684-5999