SEER PROGRAM
CODING AND STAGING MANUAL 2010

SURVEILLANCE SYSTEMS BRANCH

SURVEILLANCE RESEARCH PROGRAM

DIVISION OF CANCER CONTROL AND POPULATION SCIENCES

NATIONAL INSTITUTES OF HEALTH

PUBLIC HEALTH SERVICE

US DEPARTMENT OF HEALTH AND HUMAN SERVICES

EFFECTIVE DATE: CASES DIAGNOSED JANUARY 1, 2010

NIH Publication Number 10-5581 U.S. Department of Health and Human Services National Institutes of Health National Cancer Institute

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EDITORS: MARGARET BELL ADAMO, BS, RHIT, CTR, NCI SEER; CAROL HAHN JOHNSON, BS, CTR, NCI SEER; JENNIFER L. RUHL, BBS, RHIT, CCS, CTR, NCI SEER; LOIS A. DICKIE, CTR, NCI SEER.

Suggested Citation: Adamo MB, Johnson CH, Ruhl JL, Dickie, LA, (eds.). *2010 SEER Program Coding and Staging Manual*. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD

ACKNOWLEDGEMENTS

Antoinette Percy-Laurry, MSPH	NCI SEER
Zaria Tatalovich, PhD	NCI SEER

SEER REGISTRY REVIEWERS

NCI SEER recognizes the essential role of the SEER registry reviewers who provided significant input to this manual.

Patricia A. Andrews, MPH, CTR	Louisiana
Eliza Cleaveland, BA	Connecticut
Leah Driscoll, BS, CTR	Kentucky
Cynthia L. Dryer, BA, CTR	Iowa
Raymundo Elido, CTR	Hawaii
Tiffany Janes, CTR	Seattle, Puget Sound
Linda Johnson, CTR	New Jersey
Michelle King, CTR	Los Angeles
Jan Kres, MSN, CTR	Atlanta
Bobbi Jo Matt, BS, RHIT, CTR	Iowa
SuAnn McFadden, CTR	Utah
Cheryl Moody, BA, CTR	Greater California
Mary Namiak, MPH, CTR	Louisiana
Patrick Nicolin, BA, CTR	Detroit
Laine Suggs, CTR	New Mexico

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PREFACE TO THE 2010 SEER PROGRAM CODING AND STAGING MANUAL

The *2010 Surveillance, Epidemiology and End Results (SEER) Program Coding and Staging Manual* is effective for cases diagnosed January 1, 2010, and forward. Previous editions of this manual are available on the SEER website, CD, or may be ordered through the SEER website. The *2010 SEER Program Coding and Staging Manual* includes all errata and revisions that apply to cases diagnosed January 1, 2010 and forward.

The 2010 changes and additions include

- New instructions for transmitting dates
- New data items
  - Date of Birth Flag
  - Date of Diagnosis Flag
  - Date of Multiple Tumors Flag
  - Date of Conclusive Diagnosis Flag
  - Date Therapy Initiated Flag
  - Date of Last Followup or Death Flag
  - Treatment Status
- Data item removed from SEER Manual
  - Casefinding Source

New data items, changes in codes, and changes in code definitions were approved by the Uniform Data Standards Committee of the North American Association of Central Cancer Registries.

This manual includes data item descriptions, codes, and coding instructions for cases diagnosed January 1, 2010, and forward.

Data items that are not required for 2010 diagnoses but were collected in years prior to 2010 must be transmitted to SEER as blanks for 2010 and subsequent years. Descriptions of historic data items, allowable codes, and coding rules can be found in historic coding manuals.

Technical questions may be emailed to askseerctr@imsweb.com. SEER regions may also submit technical questions to NCI SEER using the web-based SINQ system at http://seer.cancer.gov/seerinquiry/. The general questions and answers from askseerctr@imsweb.com and from the SINQ system will be incorporated into the next edition of the SEER manual.

This manual may be downloaded in electronic format from the SEER website http://seer.cancer.gov/.

Send suggestions or revisions to:

Peggy Adamo, BS, AAS, RHIT, CTR
Public Health Analyst
Surveillance, Epidemiology and End Results Program
Cancer Statistics Branch, Surveillance Research Program,
Division of Cancer Control and Population Sciences
National Cancer Institute
6116 Executive Blvd
Suite 504
Bethesda, MD 20892-8316

Fax: (301) 496-9949
Email: askseerctr@imsweb.com
SEER website: http://seer.cancer.gov

Collection and Storage of Date Fields

Dates may be collected and stored in any format, including the traditional format, (month, day, year [MMDDYYYY]), or the new date format, (year, month, day [YYYYMMDD]). The new format must be used for transmission (see below). See the 2010 NAACCR Implementation Guidelines and Recommendations for converting dates collected and stored in the traditional format to the new format and vice versa, and for deriving the date flags from information collected in the traditional format.

Transmission Instructions for Date Fields

As of January 1, 2010, date fields must be transmitted in the year, month, day format (YYYYMMDD). The new transmission requirements are intended to improve the interoperability, or communication, of cancer registry data with other electronic record systems. Date fields are fixed-length and left-justified. Replace any missing component with spaces. If there are no known date components, the date field will be completely blank. For example:

- YYYYMMDD – when complete date is known and valid
- YYYYMM – when year and month are known and valid, and day is unknown
- YYYY – when year is known and valid, and month and day are unknown
- Blank – when no known date applies

Date flags associated with each date field have been added as new data items in 2010. The date flags are used when all eight places of a date field are blank. The flags explain why the field is blank. Date flags replace nondate information that had previously been transmitted in date fields. Coding 99999999 to indicate "unknown" is an example of nondate information that was previously transmitted in date fields.

Note: Date of Diagnosis cannot be entirely blank. See the specific coding instructions for each date field.

Most SEER registries collect the month, day, and year. When the full date (YYYYMMDD) is transmitted, the seventh and eighth digits (day) will be deleted when the data are received by NCI SEER. The corresponding date flag is not affected (it will remain blank).

SEER Site-Specific Factors 1 - 6

Six new data items have been set aside as place holders. These data items are not in use and must be left blank.

NAACCR Item #	Item Name	Codes
3700	SEER Site-Specific Fact 1	Blank
3702	SEER Site-Specific Fact 2	Blank
3704	SEER Site-Specific Fact 3	Blank
3706	SEER Site-Specific Fact 4	Blank
3708	SEER Site-Specific Fact 5	Blank
3710	SEER Site-Specific Fact 6	Blank

INTRODUCTION
SEER PROGRAM

Two programs, the End Results Group and the Third National Cancer Survey, were predecessors of the Surveillance, Epidemiology, and End Results (SEER) Program.

SEER publishes the 2010 *SEER Program Coding and Staging Manual* to provide instructions and descriptions that are detailed enough to promote consistent abstracting and coding.

SEER CODING AND STAGING MANUAL CONTENTS

The *2010 SEER Program Coding and Staging Manual* explains the format and the definitions of the data items required by SEER.

For all cases diagnosed on or after January 1, 2010, the instructions and codes in this manual take precedence over all previous instructions and codes.

Documentation and codes for historical data items can be found in earlier versions of the SEER Program Code Manual. Earlier versions are available on CD and on the SEER website.

This coding manual does not prevent SEER contract registries or other registries that follow SEER rules from collecting additional data items useful for those regions.

REPORTABILITY

DATES OF DIAGNOSIS/RESIDENCY

SEER registries are required to collect data on persons who are diagnosed with cancer and who, at the time of diagnosis, are **residents** of the geographic area covered by the SEER registry. Cases diagnosed on or after January 1, **1973** are reportable to SEER. Registries that joined the SEER Program after 1973 have different reporting start dates specified in their contracts.

REPORTABLE DIAGNOSES

1. **In Situ and Malignant/Invasive Histologies**

   a. All histologies with a **behavior code** of **/2 or /3** in the International *Classification of Diseases for Oncology,* Third Edition (ICD-O-3).
   Note: AIN III of the anus or anal canal (C210-C211), VAIN III, and VIN III are reportable.

   b. ***Exceptions:*** In situ and malignant/invasive histologies **not required** by SEER

      i. **Skin** primary (C440-C449) with any of the following histologies
      Malignant neoplasm (8000-8005)
      Epithelial carcinoma (8010-8046)
      Papillary and squamous cell carcinoma (8050-8084)
      Basal cell carcinoma (8090-8110)
      AIN III (8077) arising in perianal skin (C445)

      Note: If the registry collects basal or squamous cell carcinoma of **skin** sites C440-C449, sequence them in the 60-99 range and do not report them to SEER

ii. Carcinoma **in situ** of **cervix** (/2) or cervical intraepithelial neoplasia (**CIN III**) of the cervix (C530-C539)

Note: Collection **stopped** effective with cases diagnosed 1/1/1996 and later except as required in individual contracts

iii. Prostatic intraepithelial neoplasia (**PIN III**) of the prostate (C619)

Note: Collection **stopped** effective with cases diagnosed 1/1/2001 and later

2. Benign/Non-Malignant Histologies

a. **Pilocytic/Juvenile astrocytomas** are reportable; code the histology and behavior as 9421/3

b. **Benign** and **borderline** primary **intracranial** and **CNS** tumors with a behavior code of /0 or /1 in ICD-O-3 are collected for the following sites, **effective with cases diagnosed 1/1/2004** and later. See the table below for required sites.

Required Sites for Benign and Borderline Primary Intracranial and Central Nervous System Tumors

General Term	Specific Sites	ICD-O-3 Topography Code
Meninges	Cerebral meninges	C700
	Spinal meninges	C701
	Meninges, NOS	C709
Brain	Cerebrum	C710
	Frontal lobe	C711
	Temporal lobe	C712
	Parietal lobe	C713
	Occipital lobe	C714
	Ventricle, NOS	C715
	Cerebellum, NOS	C716
	Brain stem	C717
	Overlapping lesion of brain	C718
	Brain, NOS	C719
Spinal cord, cranial nerves, and other parts of the central nervous system	Spinal cord	C720
	Cauda equina	C721
	Olfactory nerve	C722
	Optic nerve	C723
	Acoustic nerve	C724
	Cranial nerve, NOS	C725
	Overlapping lesion of brain and central nervous system	C728
	Nervous system, NOS	C729
Pituitary, craniopharyngeal duct and pineal gland	Pituitary gland	C751
	Craniopharyngeal duct	C752
	Pineal gland	C753

Note: Benign and borderline tumors of the cranial bones (C410) are **not reportable**.

DIAGNOSIS PRIOR TO BIRTH

SEER reportability requirements apply to diagnoses made in utero. Diagnoses made in utero are reportable **only when the pregnancy results in a live birth**. In the absence of documentation of stillbirth, abortion or fetal death, assume there was a live birth and report the case.

Disease Regression

When a reportable diagnosis is confirmed prior to birth and disease is not evident at birth due to regression, accession the case based on the pre-birth diagnosis.

REPORTABILITY EXAMPLES

Reportable

Example 1: Path report says "Atypical fibroxanthoma (superficial malignant fibrous histiocytoma)." The case is reportable because the information in parentheses provides more detail and confirms a reportable malignancy.

Example 2: Positive histology from needle aspiration/biopsy followed by negative resection. This case is reportable based on positive needle biopsy.

Example 3: Biopsy-proven squamous cell carcinoma of the nipple with a subsequent areolar resection showing foreign body granulomatous reaction to suture material and no evidence of residual malignancy in the nipple epidermis. This case is reportable. The fact that no residual malignancy was found in the later specimen does not disprove the malignancy diagnosed by the biopsy.

Example 4: Final diagnosis from dermatopathologist: "ulcerated histologically malignant spindle cell neoplasm, consistent with atypical fibroxanthoma. Note: An exhaustive immunohistochemical work-up shows no melanocytic, epithelial or vascular differentiation. Atypical fibroxanthoma is a superficial form of a malignant fibrous histiocytoma." This case is reportable. The pathologist has the final say on behavior for a particular case. In this case, the pathologist states that this tumor is malignant.

Example 5: "Aggressive adult granulosa cell tumor with one of two lymph nodes positive for malignant metastatic granulosa cell tumor." This case is reportable because malignant granulosa cell tumor is reportable. The lymph node metastases prove malignancy.

Example 6: Carcinoid of the appendix found on appendectomy. Patient returns later with metastases in regional lymph nodes. This case is reportable because of the metastatic lymph nodes. Code the diagnosis date to the date of the appendectomy and the first course of treatment date to the appendectomy date.

Example 7: Ovarian mucinous borderline tumor with foci of intraepithelial carcinoma. This case is reportable because there are foci of intraepithelial carcinoma (carcinoma in situ).

Example 8: "Squamous cell carcinoma of the anus, NOS." Squamous cell carcinoma of the anus is reportable unless the primary site is confirmed to be the skin of anus.

Not Reportable

Example 1: Left thyroid lobectomy shows microfollicular neoplasm with evidence of minimal invasion. Micro portion of path report states "The capsular contour is focally distorted by a finger of the microfollicular nodule which appears to penetrate into the adjacent capsular and thyroid tissue." Do not report this case based on the information provided. There is no definitive statement of malignancy. Search for additional information in the record. Contact the pathologist or the treating physician.

Example 2: Sclerosing hemangioma of the lung with multiple regional lymph nodes involved with sclerosing hemangioma. This case is not reportable. The lymph node involvement is non-malignant. According to the WHO Classification of Lung Tumours, sclerosing hemangioma "behaves in a clinically benign fashion...Reported cases with hilar or mediastinal lymph node involvement do not have a worse prognosis."

Example 3: Carcinoid of the appendix that extends into mesoappendiceal adipose tissue. This case is not reportable. Extension does not make a carcinoid of the appendix reportable. Benign and borderline tumors can and do extend into surrounding tissue.

Example 4: Carcinoid tumorlets are not reportable.

INSTRUCTIONS FOR SOLID TUMORS

Note: For hematopoietic and lymphoid neoplasms, see the Reportability Instructions in the *2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic Database.*

CASES DIAGNOSED CLINICALLY ARE REPORTABLE

In the absence of a histologic or cytologic confirmation of a reportable cancer, accession a case based on the **clinical diagnosis** (when a recognized medical practitioner says the patient has a cancer or carcinoma). A clinical diagnosis may be recorded in the final diagnosis on the face sheet or other parts of the medical record.

Note: A pathology report normally takes precedence over a clinical diagnosis. If the patient has a negative biopsy, the case would not be reported.

Exception 1: If the physician treats a patient for cancer in spite of the negative biopsy, accession the case.

Exception 2: If enough time has passed that it is reasonable to assume that the physician has seen the negative pathology, but the clinician continues to call this a reportable disease, accession the case. A reasonable amount of time would be equal to or greater than 6 months.

Brain or CNS "Neoplasms"

A brain or a CNS 'neoplasm' identified by diagnostic imaging is reportable even when no other information is available (from biopsy or resection, for example).

AMBIGUOUS TERMINOLOGY

Ambiguous terminology may originate in any source document, such as a pathology report, radiology report, or clinical report. The terms listed below are reportable.

Ambiguous terms that are reportable (used to determine reportability)

- Apparent(ly)
- Appears
- Comparable with
- Compatible with
- Consistent with

Favor(s)
Malignant appearing
Most likely
Presumed
Probable
Suspect(ed)
Suspicious (for)
Typical (of)

Do not substitute synonyms such as “supposed” for presumed or “equal” for comparable. Do not substitute “likely” for “most likely.”

HOW TO USE AMBIGUOUS TERMINOLOGY FOR CASE ASCERTAINMENT

1. **In Situ and Invasive** (Behavior codes /2 and /3)

   a. If any of the reportable **ambiguous terms precede** a word that is **synonymous** with an in situ or invasive tumor (e.g.: cancer, carcinoma, malignant neoplasm, etc.), accession the case.

      Example: The pathology report says: Prostate biopsy with markedly abnormal cells that are typical of adenocarcinoma. Accession the case.

      Negative Example: The final diagnosis on the outpatient report reads: Rule out pancreatic cancer. Do not accession the case.

   b. **Discrepancies**
      i. Accession the case based on the reportable ambiguous term when there are reportable and non-reportable ambiguous terms in the medical record.

         1. Do not accession a case when subsequent documents refer to history of cancer and the original source document used a non-reportable ambiguous term.

            Example: Report from the dermatologist is “probable melanoma.” Patient admitted later for unrelated procedure and physician listed history of melanoma. Give priority to the information from the dermatologist. The later information is less reliable in this case.

      ii. When there is a single report, accept the reportable term and accession the case when one section of a report uses a reportable term such as “apparently” and another section of the same report uses a term that is not on the reportable list.

         Example: Abdominal CT reveals a 1 cm liver lesion. “The lesion is consistent with hepatocellular carcinoma” appears in the discussion section of the report. The final diagnosis is “1 cm liver lesion, possibly hepatocellular carcinoma.” Accession the case. "Consistent with" is a reportable ambiguous term. Accept "consistent with" over the non-reportable term "possibly."

      Exception: Do not accession a case based ONLY on suspicious cytology.

   c. Use these terms when **screening** diagnoses on pathology reports, operative reports, scans, mammograms, and other diagnostic testing other than tumor markers.

i. Do not accession a case when resection, excision, biopsy, cytology, or physician's statement proves the ambiguous diagnosis is not reportable.

Example 1: Mammogram shows calcifications suspicious for intraductal carcinoma. The biopsy of the area surrounding the calcifications is negative for malignancy. Do not accession the case.

Example 2: CT report states "mass in the right kidney, highly suspicious for renal cell carcinoma." CT-guided needle biopsy with final diagnosis "Neoplasm suggestive of oncocytoma. A malignant neoplasm cannot be excluded." Discharged back to the nursing home and no other information is available. Do not accession the case. The suspicious CT finding was biopsied and not proven to be malignant. "Suggestive of" is not a reportable ambiguous term.

Example 3: Stereotactic biopsy of the left breast is "focally suspicious for DCIS" and is followed by a negative needle localization excisional biopsy. Do not accession the case. The needle localization excisional biopsy was performed to further evaluate the suspicious stereotactic biopsy finding. The suspicious diagnosis was proven to be false.

Example 4: Esophageal biopsy with diagnosis of "focal areas suspicious for adenocarcinoma in situ change." Diagnosis on partial esophagectomy specimen "with foci of high grade dysplasia; no invasive carcinoma identified." Do not accession the case. The esophagectomy proved that the suspicious biopsy result was false.

2. Benign and **borderline** primary **intracranial** and **CNS** tumors

a. Use the above "Ambiguous terms that are reportable" list to identify benign and borderline primary intracranial and CNS tumors that are reportable.

b. If any of the reportable **ambiguous terms precede** either the word "**tumor**" or the word "**neoplasm**", accession the case.

Example: The mass on the CT scan is consistent with pituitary tumor. Accession the case.

c. **Discrepancies**

i. Accession the case based on the reportable ambiguous term when there are reportable and non-reportable ambiguous terms in the medical record.

1. Do not accession a case when subsequent documents refer to history of tumor and the original source document used a non-reportable ambiguous term.

ii. When there is a single report, accept the reportable term and accession the case when one section of a report uses a reportable term such as "apparently" and another section of the same report uses a term that is not on the reportable list.

Exception: Do not accession a case based ONLY on suspicious cytology.

d. Use these terms when **screening** diagnoses on pathology reports, scans, ultrasounds, and other diagnostic testing other than tumor markers.

i. Do not accession the case when resection, excision, biopsy, cytology or physician's statement proves the ambiguous diagnosis is not reportable.

INSTRUCTIONS FOR HEMATOPOEITIC AND LYMPHOID NEOPLASMS

See the Reportability Instructions in the *2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual*.

CHANGING INFORMATION ON THE ABSTRACT

The information originally collected on the abstract should be changed or modified under the following circumstances.

1. To **correct** coding or abstracting **errors** whenever identified (for example, during quality control activities).

2. **When clarifications** or **rule changes** retroactively affect data item codes.

   Example: SEER adds codes to a data item and asks the registries to review a set of cases and update using the new codes.

3. **When better information** is available later.

   Example 1: Consults from specialty labs, pathology report addendums or comments or other information have been added to the chart. Reports done during the diagnostic workup and placed on the chart after the registrar abstracted the information may contain valuable information. Whenever these later reports give better information about the histology, grade of tumor, primary site, etc., change the codes to reflect the better information.

   Example 2: The primary site was recorded as unknown at the time of diagnosis. At a later date, the physician determines that the cancer is primary to the testis. Change the primary site from unknown to testis.

   Example 3: The original diagnosis was in situ. Metastases are diagnosed at a later date. Change the behavior code for the original diagnosis from in situ to invasive when no new primary has been diagnosed in the interim.

   Example 4: Patient seen in Hospital A. The pathologic diagnosis was negative for malignancy. Patient goes to Hospital B and the slides from Hospital A are re-read. The diagnosis at Hospital B is reportable. Hospital B sends their slide report back to Hospital A. Hospital A reports the case based on the info from Hospital B. Enter supporting documentation in a text field.

4. When the **date of diagnosis** is confirmed in retrospect to be earlier than the original date abstracted.

   Example: Patient has surgery for a benign argentaffin carcinoid (8240/1) of the sigmoid colon in May 2009. In January 2010 the patient is admitted with widespread metastasis consistent with malignant argentaffin carcinoid. The registrar accessions the malignant argentaffin carcinoid as a 2010 diagnosis. Two months later, the pathologist reviews the slides from the May 2009 surgery and concludes that the carcinoid diagnosed in 2009 was malignant. Change the date of diagnosis to May 2009 and histology to 8241 and the behavior code to malignant (/3).

DETERMINING MULTIPLE PRIMARIES: SOLID TUMORS

Apply the general instructions and instructions for determining multiple primaries in the *Multiple Primary and Histology Coding Rules Manual*.

Apply the site-specific multiple primary rules in the *Multiple Primary and Histology Coding Rules Manual*.

Site-specific multiple primary rules cover the following

- Head and neck — C000-C148, C300-C329
- Colon — C180-C189
- Lung — C340-C349
- Melanoma of the skin — C440-C449 with Histology 8720-8780
- Breast — C500-C509
- Kidney — C649
- Ureter/Renal pelvis/Bladder — C659, C669, C670-C679, C680-C689
- Benign brain — C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
- Malignant brain — C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
- Other sites — Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain

Site-specific rules do **not** cover lymphoma and leukemia (9590-9992).

DETERMINING MULTIPLE PRIMARIES: HEMATOPOIETIC AND LYMPHOID NEOPLASMS

Apply the Multiple Primary Rules in the *2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual.*

SECTION I
BASIC RECORD IDENTIFICATION

The Basic Record Identification fields provide a unique identifier for individual records or a set of records for each person and tumor in the SEER data system. The coded identifiers protect data confidentiality.

Note: For San Francisco, Los Angeles, San Jose/Monterey and Greater California the patient identifier identifies a unique patient across the entire state.

The combination of the SEER Participant Number, Patient ID Number, and Record Number identifies a unique patient record or tumor.

SEER PARTICIPANT

Item Length: 10
NAACCR Item #: 40
NAACCR Name: Registry ID

A unique code assigned to each SEER participating registry. The number identifies the registry sending the record and what population the data are based upon.

Code	Participant	Area Covered	Year SEER Reporting Started	Name
0000001501	Cancer Prevention Institute of California	5 counties	1973	San Francisco Oakland SMSA
0000001502	Connecticut Department of Public Health	Entire state	1973	Connecticut
0000001520	Karmanos Cancer Institute/Wayne State University	3 counties	1973	Metropolitan Detroit
0000001521	Research Corporation of Hawaii	Entire state	1973	Hawaii
0000001522	University of Iowa	Entire state	1973	Iowa
0000001523	University of New Mexico	Entire state	1973	New Mexico
0000001525	Fred Hutchinson Cancer Research Center	13 counties	1974	Seattle-Puget Sound
0000001526	University of Utah	Entire state	1973	Utah
0000001527	Emory University	5 counties	1975	Metropolitan Atlanta
0000001529	Alaska Native	Native American population of Alaska	1984	Alaska Native
0000001531	Cancer Prevention Institute of California	4 counties	1992	San Jose-Monterey
0000001533	University of New Mexico	Native American population of Arizona	1973	Arizona Indians
0000001535	University of Southern California	1 county	1992	Los Angeles
0000001537	Emory University	10 Counties	1978	Rural Georgia
0000001541	Public Health Institute, California	California except Los Angeles, San Francisco-Oakland, and San-Jose/Monterey	2000	Greater California
0000001542	University of Kentucky Research Foundation	Entire state	2000	Kentucky
0000001543	Louisiana State University HSC	Entire state	2000	Louisiana