To begin training in Web Plus, contact the Delaware Cancer Registry (DCR) to obtain a User id and password for the Web Plus Training/Test site. You will be asked to complete State of Delaware IT access forms prior to beginning training.

Delaware Cancer Registry
Thomas Collins Building, Suite 11
540 S. DuPont Highway
Dover, DE  19901
Telephone: (302) 744-1033
Fax: (302) 741-9029

DCR Website: http://www.dhss.delaware.gov/dhss/dph/dcr/home.html

Web Plus Test Site*:
https://webplus-test.dhss.delaware.gov/logonen.aspx

*Use the Web Plus test site for training and practice

Web Plus Production Site**:
https://webplus.dhss.delaware.gov/logonen.aspx

**Use the Web Plus production site to submit real cases to the DCR. You will need to contact the DCR for a password for the production site to begin submitting real cases via Web Plus
**Background**

Founded in 1972, the Delaware Cancer Registry (DCR) is the state’s central cancer information center and was legally established in 1980 through the Delaware Cancer Control Act. DCR is part of the Delaware Division of Public Health. DCR is also supported by the National Program of Cancer Registries (NPCR) under cooperative agreement number U58/DP003870-02 from the U.S. Centers for Disease Control and Prevention (CDC). The NPCR was established to oversee cancer data collection by cancer registries across the country.

The Registry is a critical component of the State’s ability to respond to cancer; therefore, we encourage your full adoption of the Centers for Disease Control’s, National Program of Cancer Registries and Registry Plus/Web Plus Software for Cancer Registries.

These new tools will allow cancer reporters to electronically submit cancer data (including detailed tumor data), to upload supporting documentation, and to keep track of data submissions using the administrative functions. Administrative functionality includes the ability to review data history, data collectors, change passwords and other useful options. This tool will eliminate the need to maintain multiple data bases and improve Central Cancer Registry response times. The value of data in our continuing cause to reduce cancer incidence and mortality in Delaware is profound.
The DCR collects information on newly diagnosed cancer cases, cancer treatment, and cancer deaths following cancer patients through their lifetime.

**Why Non-Hospital Reporting?**

In recent years there has been a shift towards outpatient diagnosis and treatment. Reporting of cancer cases by physician’s offices and other non-hospital facilities has become crucial for assuring the completeness of information in Delaware’s central cancer database.

**Follow-up Data is required** per the Cancer Control Act. Non-hospital offices may be contacted by DCR to obtain additional information such as complete first course of treatment data and diagnostic and treatment information for cancer cases identified through death certificate review.

**What happens to cancer data reported to DCR through Web Plus?**

Prior to Web Plus, a paper case summary or abstract, for each cancer case was faxed, mailed, or emailed to the DCR for reporting. Now all of those functions will occur within the Web Plus Database. Each facility will enter information into Web Plus by creating an abstract or cancer case. Cases already reported by another source to DCR will be updated with additional demographic, diagnostic, treatment and follow-up data. Case information for out of state residents is reported to their respective state cancer registries to assure complete case finding.
Confidentiality of Data Exchange

The same rules apply, according to the *Delaware Cancer Control Act (Appendix A)*, “patient-identifying information may be exchanged among cancer control agencies as authorized by the Department and upon receipt by the Department of satisfactory assurances by those agencies of the preservation of the confidentiality of such information.”

According to **HIPAA privacy regulations**, the DCR is a public health authority authorized by law to collect and receive information for the purpose of preventing and controlling disease, injury or disability.

According to **HIPAA**, Non-hospital reporters such as physician offices and surgery centers can disclose cancer information to DCR without patient consent.

Reporting Requirements

Current amendment of the Delaware Cancer Control Act specifies reporting of cancer cases within 180 days of initial diagnosis or treatment, whichever is earlier. The schedule for reporting cases to the DCR is based on your center’s caseload/year; follow this schedule for reporting cases to the Delaware Cancer Registry:

<table>
<thead>
<tr>
<th># of Reportable Cases/Year</th>
<th>Reporting Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;75</td>
<td>Monthly</td>
</tr>
<tr>
<td>25-74</td>
<td>Every other month</td>
</tr>
<tr>
<td>&lt;25</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

Cancer data required to be reported to DCR by non-hospital reporters

- Cancer Site and cell type
- Demographic data
- Diagnostic information, including pathology report data
- Staging data to assess the extent of the disease
- Treatment(s)
“Pathology Laboratories, Physician’s Offices, Ambulatory Surgery Centers, Long-term Care Facilities And Hospices, Together With Hospitals, Play A Key Role In The Collection Of Information. “

We at the DCR understand the enormous amount of time and effort involved in collecting and reporting tumor data. Your work, as partners in this effort, ensures that we appropriately allocate and share resources, are able to respond to cancer trends, and coordinate statewide efforts to prevent, test and treat cancer in our state.

With this in mind we continue to streamline our efforts and workload. For the next several months, DCR will roll out in-person and onsite training programs (and other technical assistance) designed to meet the CDC’s performance standard for electronic reporting to Central Cancer Registries. The DCR requests that physician office and ambulatory surgery center reporters utilize the Web Plus database to collect cancer data.

We are well on our way to meeting the performance standard of electronic reporting. This manual is comprised of information that will show you how to create, save, update, print and delete cancer abstracts (cases). In addition, you will be able to upload scanned supporting documentation such as pathology and laboratory reports.

**Remember, cancer reporting is FACILITY specific. It is dependent upon you, the reporter, to complete the abstract as accurately as possible.** It is suggested that when your agency collects forms from patients that they are quickly reviewed for accuracy and completeness. If the forms are not complete, tell the patient why you need the information, and ask them for it again keeping in mind that patients may not
know or have access to specific data. Web Plus has features that will allow you to record this information.

**A word of caution!**

- When working in Web Plus, Save Early, Save Often! You do not want to lose unsaved work.
- Once you have released an abstract to the Central Registry, You will NO LONGER be ABLE to EDIT the ABSTRACT!
- The only way to release an ABSTRACT is for ALL ERRORS to be corrected!
- When uploading supporting documentation; save your documents with the Abstract Reference ID, for example:
  - ABSREFID_1774
- If you have any questions, please feel free to contact your central cancer registry at:

  **Delaware Cancer Registry**  
  **Delaware Division of Public Health**  
  **Thomas Collins Building, Suite 11**  
  **540 S. DuPont Highway**  
  **Dover, DE 19901**  
  **Telephone: (302) 744-1033**  
  **Fax: (302) 741-9029**

Web:  [http://www.dhss.delaware.gov/dhss/dph/dcr/home.html](http://www.dhss.delaware.gov/dhss/dph/dcr/home.html)
During the Introduction segment of the training, we will cover the following objectives:

- Training Manual Review and Overall Training Objectives
- Web Plus Features
- Web Plus Users
- Requirements for Access
Overall Learning Objectives

These are the overall learning objectives for the Web Plus Facility Abstractor Training:

- Learn the major functions of Web Plus
- Create abstracts in compliance with cancer registry standards
- Correct errors so that the abstract is error-free and complete
- Release abstracts
- Complete and release, or reject, follow-back abstracts
- View and modify the reports of Web Plus
The Web Plus Facility Abstractor Training Manual provides you with the information to understand and use this web application. In this manual you not only learn about the tools in Web Plus, you also create an abstract and follow the process of updating and correcting the abstract until it is complete and released to the central registry.

Although you will not be trained on the Follow-Back function today, you will hear a brief description about completing follow-back abstracts that have been partially-filled by your central registry and posted for you to complete. In addition, each chapter contains questions that test your knowledge of Web Plus and activities that allow you to practice your new skills on your own.

**Note:** Web Plus has electronic edits that need to be resolved/cleared before a case can be completed. The purpose of edits is to assure accuracy and completeness of data.
Web Plus Features

Web Plus is a web-based application that collects cancer data securely over the Internet. It is the recommended method of electronic reporting for central cancer registries. Web Plus supports three main functions:

- online abstracting
- file upload/download
- follow-back efforts.

The online abstracting capability of Web Plus is ideal for reporting from physicians’ offices and other low-volume reporting sources.

*The file upload feature can be used by non-hospital reporters to upload copies of supporting documents such as pathology reports.*

The Web Plus follow-back features enable your central cancer registry to upload partially-filled abstracts generated from death certificate and pathology lab files, and to notify you via e-mail to log in and update the abstracts.

All records are saved in a database at the hosting central cancer registry and cases entered by one facility or office are not visible to other facilities.

Data entered is validated by the CDC EDITS Engine running on a web server. Users, display types, and edit configurations are managed at the hosting central registry. Web Plus is hosted on a secure web server that has a digital certificate installed; the communication between the client and the server is encrypted with Secure Socket Layer (SSL) technology.
## Types of Web Plus Users

<table>
<thead>
<tr>
<th>Users</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Abstractor</td>
<td>Works in a facility or doctor’s office and handles patients’ medical records and paperwork. When a patient is diagnosed with cancer, the Facility Abstractor reports the case to the state’s central cancer registry. The Facility Abstractor also completes and submits any follow-back abstracts that the central registry has posted for their facility.</td>
</tr>
<tr>
<td>File Uploader</td>
<td>Uploads either files of abstracts in the appropriate NAACCR format that were not abstracted using Web Plus or non-NAACCR files in any format, views EDITs error report and cleans, or works with abstractors to clean, errors on rejected abstracts prior to resubmitting, downloads files posted by the central registry, and views reports.</td>
</tr>
<tr>
<td>Local Administrator</td>
<td>Manages local users of a facility.</td>
</tr>
<tr>
<td>Central Registry Administrator</td>
<td>Sets up facilities with access to the Web Plus software to report their data, manages facility accounts and users at both the central registry and facilities, configures display types, edit sets and system preferences, manages assignment of abstracts to central registry staff, exports data, and views reports.</td>
</tr>
<tr>
<td>Follow-back Supervisor</td>
<td>Uploads files of partially-filled follow-back abstracts, manually adds follow-back abstracts online, tracks follow-back abstracts by uploaded file or by facility, and generates and views Web Plus follow-back reports.</td>
</tr>
<tr>
<td>Follow-back Monitor</td>
<td>Monitors upload of files to the central registry, tracks file uploads and rejected abstracts by facility, communicates with facility to ensure resubmission of rejected abstracts, and views reports.</td>
</tr>
<tr>
<td>File Upload Supervisor</td>
<td>Tracks follow-back abstracts by assigned facility, generates and views Web Plus follow-back reports.</td>
</tr>
<tr>
<td>Central Registry Abstractor/Reviewer</td>
<td>Reviews abstracts submitted to the central registry for completeness and accuracy and may abstract additional data items from submitted text; also abstracts new cases.</td>
</tr>
</tbody>
</table>

### Reviewing Types of Web Plus Users

There are several types of Web Plus users based on tasks, please review the chart on page 15 for a more detailed explanation of Web Plus users.

**Note:** Although Follow-back Supervisor and Follow-back Monitor are mentioned, we will not explore these functions during this training. Stay tuned for Web Plus updates in the future. A handout of the list of Web Plus users is available in the back of the participant manual.
<table>
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<td>Monitors upload of files to the central registry; tracks file uploads and rejected abstracts by facility, communicates with facility to ensure resubmission of rejected abstracts, and views reports.</td>
</tr>
<tr>
<td>Central Registry Abstrator/Reviewer</td>
<td>Reviews abstracts submitted to the central registry for completeness and accuracy and may abstract additional data items from submitted text; also abstracts new cases.</td>
</tr>
</tbody>
</table>
Web Plus requires Microsoft Internet Explorer version 5.0 or later or a Mozilla browser to operate the system fully. Although Web Plus may work at 800 X 600 resolution, you may have trouble with some features; it can be best viewed at 1024 X 768 or higher resolution. It is highly recommended that you change your resolution to 1024 X 768 or higher when using the Web Plus application.
Module 2  THE BASICS

This lesson covers the basics of Web Plus. You’ll learn about Delaware Cancer Registry reporting requirements, logging in and out of Web Plus, and the key elements of Web Plus.
Learning Objectives

After reading this chapter, the user will know how to:

- Identify the menu options of Web Plus
- Understand the process of working on an abstract
- Log in and out of Web Plus
- Change your password
Logging In

This is the log in page to Web Plus training and test site. To log in, complete the following steps:

1. **Open your Internet browser** and type the Internet address in the Web Plus test site in the Address field.
   
   Practice Website: [https://webplus-test.dhss.delaware.gov/logonen.aspx](https://webplus-test.dhss.delaware.gov/logonen.aspx)

2. **Press Enter**.

   **The Result?** The Web Plus Test Log in page opens.

3. **Type in** the User ID and password provided to you by the central registry into the User ID and Password fields

4. **Click Log in**.

   **The Result?** Your Web Plus Test homepage opens, with a list of links to the facilities and roles that have been assigned to you.
Home Page

This is the home screen for selecting a source to work with. For the purposes of the training, we will use the Cancer Reporting Physician Source (or section)

Once you have completed the training and provided signed copies of the required user permission forms, Web Plus will open with a list of links that are assigned to you based on your permission level and source (for example, administrator, for changing passwords, ambulatory surgery center, or physician’s office).

Now let’s look more closely at the various links available in Web Plus.

**Note:** Reporting for Physicians offices is slightly more detailed than it is for ambulatory surgery centers. There are several data fields related to diagnosis and treatment that are required for physician offices, but not required for ambulatory surgery centers. In order to ensure that everyone has a full understanding of Web Plus features and data requirements, we will practice with several different kinds of abstracts.
Accessing Reporting Functions

Web Plus has 3 types of reporting functions:

1. Local Administration
2. Cancer Reporting Physician or Cancer Reporting Surgery Center
3. File Upload

Local Administration allows sites to manage users, review log-in history, update user profile information, and run reports. Web Plus provides reports for monitoring abstract reporting and system activity. You can view and print several types of reports. You can also set the date ranges for the information in the reports. We will review Web Plus reporting functions in more detail later. These reports will provide valuable information such as abstracting history to determine what has been submitted and when. There is no need to keep a separate database for these activities. Web Plus does it all for you!

For now, we will click on the Cancer Reporting Physician link in order to access the Physician Abstractor Facility Menu Click on Cancer Reporting Physician now, and notice the horizontal menu across the top.
Physician Abstractor Facility Menu

This is the Physician Abstractor Facility Menu. From this menu you can:

- Return to your home screen
- Create a New Abstract
- Find or open an existing abstract
- Release Abstracts
- View Reports
- Change Passwords *(Each user can change their own password whenever they wish.)*
- Click on Help and…
- Log Out

**Note**: You can only work in one reporting function at a time. For example, if you are in the abstracting function, you would need to return to your home page to access the file upload feature.
The Abstracting Process

Now that we have briefly reviewed the available links for working within Web Plus, let’s move right into the abstracting process. Web Plus allows Users to create an abstract, enter data, and release abstracts (records) to the central registry for quality review.

After you create an abstract, you can save your work and return to it later. In fact, so that you don’t lose what you’ve entered follow the computer data entry golden rule:

SAVE   SAVE   SAVE   SAVE

Before you can release an abstract, however, it must be accurately completed—the system will not allow you to move forward before making all necessary corrections. Most people make 3 common errors:

- Leaving data fields blank
- Not completing the critical data fields (marked with asterisks);
- Using an incorrect date format, e.g. MMDDYYYY rather than YYYYMMDD;

You can release the abstract to your central registry only after you have completed it and eliminated any errors it may contain. The process of generating an abstract includes the following steps:
1. Create the abstract with the patient’s name and social security number and save. You can add more information to the abstract and complete it whenever you want.
2. Enter codes using the codes supplied by the Web Plus application and text in the data entry fields. Save the abstract to retain the information you have entered.
3. Correct errors. Each time you open or save the abstract, Web Plus automatically edits the entered information for accuracy and completeness using the edit set and required fields chosen by your Web Plus Administrator.

4. After you have entered all your data and corrected all errors, save the abstract and the system will designate your new abstract as complete.

5. Release the completed abstract to the central registry. You can release abstracts individually or several at a time. Abstracts can be saved, and accessed later if needed to enter additional information such as complete treatment data.

We will explore this and more in detail as we learn to create, enter, edit, release, and delete abstracts.
Abstractor Data Entry Page

To open the Data Entry page and view its contents, follow these steps:

1. Log in to Web Plus using the User ID and Password that has been assigned to you.

2. On the Web Plus menu, click **New Abstract**.
   
   Result: Data Entry Page will open. The page has two main sections. The box on the left is for entering case information (abstracting) and the box on the right contains two tabs: one for Help and one to Edit Errors.

Note: Case information is entered on the Data Entry page. If you get kicked out of the system, just return to the Web Plus login page—the training site address is https://webplus-test.dhss.delaware.gov/logonen.aspx

Now let’s take a moment to scroll through key data labels and fields in the data entry box on the left.

The fields that you will see depend on your facility or center and the set up chosen by the Delaware Cancer Registry. The headings, such as Patient Information and Demographics, can vary. These are only headings; they do not signify a group of required fields. The Delaware Cancer Registry uses these headings to organize the fields for clearer viewing and to help with data entry.
Exploring the Tabs on the Right

We’ve just reviewed the various data labels located in the abstract data entry section of the screen. There are also tabs in a box on the right side of the screen for help and edit errors. We will discuss editing errors in more detail later in the course.

**Click on the tabs to see the contents.**

The edit errors tab provides guidance on how to correct an abstract before it is released to the central registry and the help tab provides a legend describing the data entry help icons available to the abstractor and briefly describes the process of saving your abstract.
# WebPlus Icons

<table>
<thead>
<tr>
<th>Icon</th>
<th>Description</th>
<th>Click the icon to . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="icon1.png" alt="Special Lookups" /></td>
<td>Special Lookups</td>
<td>open a listing of codes and terms to choose from. Find the term that best applies, and click on the code to the left of the term. When a specific code is clicked, it is automatically filled into the abstract for the data item.</td>
</tr>
<tr>
<td><img src="icon2.png" alt="Calculate Field Value" /></td>
<td>Calculate Field Value</td>
<td>calculate a value for a field from values in other fields.</td>
</tr>
<tr>
<td><img src="icon3.png" alt="Context-sensitive Help" /></td>
<td>Context-sensitive Help</td>
<td>open Help page with the NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary for information about the data item.</td>
</tr>
<tr>
<td><img src="icon4.png" alt="Print Preview" /></td>
<td>Print Preview</td>
<td>open page that shows all of the fields and the content you have entered in your abstract; this page allows you to print a copy of your abstract.</td>
</tr>
</tbody>
</table>
Changing Your Password

To change your password, complete these steps:

1. On the Home page menu, click Change Password.  
   **Result:** The Change Password page opens.
2. Type your current password in the Old Password field.
3. Type your new password in both of the New Password fields.
4. Click Change.  
   **Result:** Your password is successfully changed.

*Note - A strong password is required. Password must be between 8 to 20 characters, contain at least one digit, one alphabetic character and no special characters.*
Viewing Web Plus Version Information

To view Web Plus Version information, complete these steps:

1. On the Web Plus menu, point to **Help**.
2. Click on **About**.

   **The Result?** A page opens with information about the version of the Web Plus application, and the versions of other cancer registry utilities included in Web Plus.
Logging Out

To log out of the Web Plus application follow these steps:

1. Click **Log out** on the Home page menu.

**The Result?** You are now logged out. The Web Plus Log In page will open.

Now let’s turn our attention to module 3: Creating an Abstract
Overview

In this chapter you create an abstract that you continue to work with throughout this manual. In succeeding chapters you will complete and release this abstract. This chapter also introduces you to some basic data entry tools to help you enter information in Web Plus.
Learning Objectives

In this chapter, you will learn to:

- Enter information into the data entry fields
- Understand the process for completing an abstract
- Use these data entry tools: drop-down lists, Help, and Special Lookups
Activity 1 – Creating an Abstract

In this section, you create an abstract by entering essential data into the designated fields. You will also learn to use Help, drop-down lists, and special lookups. To create an abstract, complete these steps:

1. Log in, as described previously
2. On the Web Plus menu, click **New Abstract**.
   
   **Result:** The Data Entry page opens. Notice that the Abstractor field is pre-filled with your Abstractor ID.
Now, enter the following information and then save your new abstract:

- Your Last Name – then press enter

Notice that each time you enter data and press the enter key, the cursor advances to the next field which is now highlighted. When you enter name and address information into Web Plus, the application automatically capitalizes the entered text.
USING HELP, DROP-DOWN LISTS, AND SPECIAL LOOKUPS
Now **Click** the Help icon beside the Last Name field. The result is a separate window opens giving you information about the field. The context-sensitive Help information for Web Plus is from the NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary. *(one of the coding manuals used by state central cancer registries, including the Delaware Cancer Registry)*. Each field has a help icon that you can click to open a page with information about the field. Now, **Close** the Help window.

**Note:** Remember for the purposes of training use some of your own information for abstracting. For example, name, age, race; etc.
Using the Melanoma Sample Data Handout (Appendix B, pg 68), enter the corresponding data into the abstract fields First Name through City. Be sure to press **Enter** after each field to advance to the next field. Click **Save** to save your work.

**Result:** The Web Plus system saves your new abstract.
When you save the abstract the system displays edit errors. Notice that the Edit Errors tab is automatically opened on the right and displays the total number of errors including details of the edit errors contained in the abstract. The procedure for resolving edit errors are described in a later chapter in this manual.
Now let’s continue entering data. Press the **enter key** or tab into the **State** field, and click the arrow to display the drop-down list.

**Result:** A list of states appears in the pull-down menu.

Scroll down and **select** the value of **Delaware** by **clicking** on it.
Result: DE is filled into the State field in the data entry grid

Tip: If you know the two-letter code for the state, you can simply type it into the field.
1. Type 999999999 in the Zip Code field, and press Enter

2. Click on the magnifying glass icon to the left of the County field
   Result: The Select county code window opens, which provides a list of county codes.

3. In the search field type the county; Click Search
   Result: The system finds the county and its code.
Click the code number for county that you need-- I chose Sussex County--so, that’s the code that was filled in the field.

**Result:** The value of **005** is automatically entered into the data entry grid for the County field, and the Select county code window automatically closes.
Please continue abstracting entering the following fields:

Birth date
Place of Birth
Sex
Patient Race
Hispanic Ethnicity

Enter the information in the table above in the corresponding Web Plus fields, either by typing the value, using the drop-down list feature, or using the advanced search feature by clicking on the magnifying glass icon where available.

All dates are in the YYYYMMDD format because the NAACCR standards are so tightly integrated with Web Plus.

The Abstractor will enter dates in the new YYYYMMDD format as follows:

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

Note: The Delaware Cancer Registry is only asking reporters to enter one race code in Web Plus.
Adding Data to an Abstract

Learning Objectives

In this chapter, you will learn to:

- Find a specific abstract
- Enter information into text fields
- Identify and use tools necessary for entering information into an abstract
- Add comments to an abstract
- Preview an abstract for printing

Overview

In this chapter continue to enter data in the abstract that you have already started. This chapter will not address correcting edits; making corrections will be covered on the next chapter, "Correcting Errors," page 23. But first let’s find and open your abstract and then add data more data to the abstract.
Opening and Updating an Abstract

In this section, you will learn to find an existing abstract and open it, use a calculator field, and use pop-up window information. To update an abstract, follow these steps:

Log in, (if you are not already), as previously instructed.

On the Web Plus menu, click **Find/Open Abstract**.
Remember to Save Your Work!

The result of clicking the Find/Open abstract menu button is that the Find Abstract search screen appears. You can search for abstracts by:

- Name
- Social Security Number
- By status – whether incomplete or released

**Note:** You can also search for abstracts by source—in this case a cancer reporting physician. Central registry staff has the ability to search all sources.
A list of all abstracts that were input under the source Cancer Reporting Physician comes up.

You can search on a partial name and social security number too.

As you can see from the screen, there are column headers. Let’s briefly review what the column headers mean.
## Abstract List

**Column Headings**

<table>
<thead>
<tr>
<th>Column Head</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actions Action</td>
<td>You have the option to open or delete an abstract</td>
</tr>
<tr>
<td>AbsRefID</td>
<td>A system-generated number identifying the abstract</td>
</tr>
<tr>
<td>Last Name</td>
<td>Last name of patient</td>
</tr>
<tr>
<td>First Name</td>
<td>First name of patient</td>
</tr>
<tr>
<td>DxDate</td>
<td>Diagnosis date</td>
</tr>
<tr>
<td>Social Security</td>
<td>Patient’s social security number</td>
</tr>
<tr>
<td>Birth Date</td>
<td>Patient’s date of birth</td>
</tr>
<tr>
<td>Primary Site</td>
<td>The location of the major tumor Where the cancer originated (e.g., skin of arm, prostate, bone marrow)</td>
</tr>
<tr>
<td>Laterality</td>
<td>Code for the side of a paired organ, or the side of the body on which the reportable tumor originated</td>
</tr>
<tr>
<td>Abstractor</td>
<td>Code for the person who created the abstract</td>
</tr>
<tr>
<td>Edit Errors</td>
<td>The number of errors found in the edit process after an abstract has been saved</td>
</tr>
<tr>
<td>Status</td>
<td>Web Plus has three types of statuses:</td>
</tr>
<tr>
<td></td>
<td>• Incomplete (not all data have been entered)</td>
</tr>
<tr>
<td></td>
<td>• Complete (all errors have been addressed)</td>
</tr>
<tr>
<td></td>
<td>• Released (sent to the central registry)</td>
</tr>
<tr>
<td>Source</td>
<td>The type of Web Plus abstract; this is the name of the link that you clicked on your home page</td>
</tr>
</tbody>
</table>

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1. Click **Open** in the **Action** column of the incomplete abstract you that you started earlier
   **Result:** The Data Entry page opens and displays the previously entered data for the abstract. The heading above the entry field now reads “**Update Abstract**” because the abstract already contains some information.

2. Type the **Date of Diagnosis** in the field, using correct date format, and press enter.

3. In the **Age at Diagnosis** field, click the **calculator** icon.
   **Result:** The Age at Diagnosis (049) is automatically calculated and entered into the Age at Diagnosis field.

**Text Fields**

Text Fields are another type of data entry field. This is an area where you enter text to describe diagnostic information, such as information from a pathology report, and treatment information, such as radiation or surgery. The text fields displayed depend on those collected by your central registry.

You can use text fields to document supplemental information not contained within the coded values. You can also provide information that you are uncertain how to code so that a central abstractor/reviewer may code it properly in the data fields when the abstract is released to the central registry. The text is limited only by the maximum number of characters indicated for each field (for the majority of text fields, 1,000 characters are allowed).

Critical (required) fields are labeled with an asterisk (*).

**Note:** *It is very important to include the entire pathology report documents along with data submission abstracts. This step will allow central registry staff to conduct quality assurance activities to ensure that our state has accurate and timely submission of data.*
So far, for our first activity we created an abstract, for our second activity we will continue by entering data into our existing abstract. You can continue along with me as we enter the following data…

**Activity 2 – Adding Data, Part One**

Continue entering information into the abstract for your patient. Enter the following information in the appropriate fields (when necessary use the fields' magnifying glass icons or drop-down lists to enter the proper codes):

After you have finished entering the information, remember to **save** your work.

**Note:** *Abstracting Histologic Type – enter text in the Morphology Text data field. You do not have to code this field.*
Activity 3 – Adding Data, Part Two

Next you will add more data that pertains to the tumor being reported. Complete the coding for the Cancer Identification section by entering the following information into the following fields by

- typing the value
- using the drop-down list feature
- or using the fields’ magnifying glass icon:

Note:

Abstracting Morphology/Histologic Type – **enter text in the Morphology Text data field. The morphology of the cancer cell is found on the pathology report.**

The DCR is not requesting that you code histology, behavior, grade, etc. DCR staff will code using the text that you provide.
Activity 4 – Entering Text Fields

To practice entering text into text fields, enter the information from the table above into the corresponding text fields:
Adding Comments to an Abstract

It may be helpful to save notes about an abstract while you are in the process of abstracting it, or to relate supplemental information about the abstract to the central registry. Comments may be added to the abstract while abstracting it so that you can reference the information at a later time.

To add a comment to an abstract, complete these steps:

1. Click on **Add/View Comments** in the upper right-hand corner of the page
2. Enter your comments and click save. The abstract comments are available for viewing until you complete and release the abstract. After the abstract is released, the comments are then available for viewing by central registry staff.
Print Preview
The Print Preview feature allows you to view all of the fields and the content you have entered in your abstract. You can also print a copy of the abstract from the Print Preview window.

Steps to Access Print Preview:

1. Open an abstract.

2. Click Print Preview
Result: A separate window opens that displays all of your abstract entry fields and content.

3. To print a copy of the abstract, use your browser’s printer.
Activity 5 – Adding Information to and Deleting an Abstract
In this activity you will create an abstract, calculate age at diagnosis and then delete the abstract.

To create an abstract, follow these steps:

1. Log in, if you are not already, as described in “Log In,” page 4.
   Result: The Data Entry page opens.
3. Create a new abstract by typing Derrick Chung in the name fields and 891234567 as a Social Security Number.
4. Click Save.
   Result: The system saves the abstract to the database.

Now find the abstract that you just created so that you can calculate the age at first diagnosis.

   891234567.
2. Calculate the Age at Diagnosis, by first entering the patient's birth date and diagnosis date---you can make up dates for this purpose. Then click the calculator icon.
3. View a print preview of your abstract by clicking on the small printer icon just above the edits and help tabs.
Deleting an Abstract

To create and then delete an abstract, follow these steps:

1. Log in, if you are not already, as described in “Log In,” page 4.
2. On the Web Plus menu, click **New Abstract**.
   - **Result:** The Data Entry page opens.
3. Create a new abstract by typing **Derrick Chung** in the name fields and **891234567** as a Social Security Number.
4. Click **Save**.
   - **Result:** The system saves the abstract to the database.

On the Web Plus menu, click **Find/Open Abstract**.

- **Result:** The Find Abstract page opens.

Type **891234567** in the Social Security number field.

- **Result:** The results display the Chung abstract entry.

Click **Delete** in the **Action** column. Be sure to note the Abstract Reference ID (AbsRefID) number.

- **Result:** The Confirm Delete window opens. It displays the Abstract Reference ID number of the abstract you want to delete (ID number 1764 is an example; your Abstract Reference ID number will be different).

Click **Close**.

On the Find Abstract window, click **Find** and confirm in the results window that the system has deleted the abstract.
Learning Objectives

In this chapter, you will learn to:

- Correct edit errors
- Understand how edit sets affect the completion of an abstract
- Understand the edit error messages

Overview

In this chapter you continue working on your abstract, and will use the Edit Errors feature of Web Plus to find errors or blank required fields and work toward the completion of your abstract. You can only release completed abstracts which have no edit errors.

Understanding Edit Sets

Each abstract is edited for data quality and completeness whenever you save or open it. The edits applied to the information depend on the edit set selected for your facility by your Web Plus Administrator at your central registry. The edit set used for this training guide is “Central: Vs16 State Example-Incoming Abstracts.” As an abstractor you must correct all identified errors to complete your abstract before you release it to the central registry.
Edit Errors Tab

The edit errors pane lists edits (or corrections that must be made) in the abstract. The edit set runs each time the abstract is saved or re-opened. To correct abstract edit errors, complete these steps:

1. Find and open the abstracts that you created with your own names. On the Data Entry page, view the Edit Errors tab in the information pane on the right.

2. Click on the link for the first error listed in the Edit Errors list. Once you click on that link, it should take you to the abstract field for correction.

3. Utilizing the help screens, including content sensitive help, proceed to resolve the errors one by one.

4. After each change, save your abstract and continue to correct errors until your error list is clear.

Save the abstract to re-run the edits.

Result: The application re-runs the edits.

To resolve all edit errors, you continue to click on links to fields containing edit errors and enter correct values for the fields.
In this example, we clicked on error number 10. “Error is not a valid value for Addr at DX State” Clicking on the error takes you to the State field in the abstract. Use the pull down menu to select state that patient resided in at time of diagnosis.

**Save** the abstract to re-run the edits.

As you can see, once you enter the correct data; the edit errors list is reduced by one.
Uploading Supporting Documentation

1. From your home screen, click on the source/link “file upload”. You will notice that the menu bar changes to include:
   - New Upload
   - Previous Uploads
   - Download Files

2. **Click on New Upload**
   
   **Note:** Prior to uploading your file, please remember to name your file: ABSREFID_ABSTRACTIDNUMBER for example, ABSREFID_2262

3. **Select** Non-NAACCR File

4. **Browse your system for the file that you saved to select it**

   *Include any comments that you want to leave regarding the document for Central Registry Staff. Information like patient name, DOB, Social Security Number, Type of report, document, etc.*

5. **Click Upload**

   *You should get a message indicating that “The file has been uploaded as a Non-NAACCR File.”*

   You will also receive an email from Central Registry informing you that your file upload was successful.

Uploading supporting documents and releasing the related abstracts should occur in the same reporting period.
Module 5 - Completing and Releasing Abstracts
Learning Objectives

In this chapter, you will learn to:

- Complete an abstract
- Understand the two different ways to release a completed abstract to your central registry

Overview

In this chapter you complete working on your abstract, and will learn about the two different ways to release the completed abstract to your central registry. You can only release completed abstracts which have no edit errors.
Completing the Abstract

As mentioned, you must resolve all edit errors and fill in all critical (required) fields in order to complete an abstract. Once you have resolved all edit errors and completed all missing critical fields, upon the next save of the abstract, Web Plus informs you that the abstract is complete and ready for release to the central registry.
Activity 7 – Completing an Abstract
See Melanoma Sample Data for Abstract Completion Chart – Appendix B pg. 68

Continue correcting errors, saving the abstract and re-running Edits until no errors remain. Use the information in the melanoma sample data table to complete your abstract. Enter the information into the corresponding fields, typing the value, using the drop-down list feature, or using the advanced search feature by clicking on the magnifying glass icon where available.

As you abstract the data fields, remember to **save your work often**. It is good practice to click the Save button each time after you enter a few fields. If you do not click save often enough, you will lose the work you have done as Web Plus will log you out of the system due to inactivity.
When you have completed Web Plus training, you are ready to begin entering and submitting data to the DCR via Web Plus, using the following secure website:

https://webplus.dhss.delaware.gov/logonen.aspx

Contact the DCR at 302-744-1033 to request a User ID and password for the Web Plus production system.
Appendix A

Delaware Cancer Control Act
§ 3201. Short title.
This chapter may be cited as the Delaware Cancer Control Act. (62 Del. Laws, c. 334, § 1; 70 Del. Laws, c. 391, § 1.)

§ 3202. Purpose.
The intent of the General Assembly is to require the establishment and maintenance of a cancer registry for the State. This responsibility is delegated to the Department of Health and Social Services, along with the authority to exercise certain powers to implement this requirement. To ensure an accurate and continuing source of data concerning cancer and certain specified tumors of a benign nature, the General Assembly by this chapter requires certain health care practitioners and all hospitals, clinical laboratories and cancer treatment centers within the State to make available to the Department of Health and Social Services information contained in the medical records of patients who have cancer or tumors of a benign nature. It is intended that the product of these efforts will be a central data bank of accurate, precise and current information regarding the subject diseases. (62 Del. Laws, c. 334, § 1; 70 Del. Laws, c. 391, § 1.)

§ 3203. Definitions.
The following words, terms and phrases, when used in this chapter, shall have the meanings ascribed to them in this section, except where the context clearly indicates a different meaning.

(1) "Benign tumor" means any nonmalignant neoplasm, regardless of the tissue of origin, that appears on the American College of Surgeons most recently published annual list of reportable cancers and benign tumors.

(2) "Cancer" means any malignant neoplasm, regardless of the tissue of origin that appears on the American College of Surgeons most recently published annual list of reportable cancers and benign tumors.

(3) "Department" means the State of Delaware Department of Health and Social Services. (62 Del. Laws, c. 334, § 1; 70 Del. Laws, c. 391, § 1.)
§ 3204. Cancer Registry.
The Department shall adopt, promulgate, amend and repeal any rules and regulations that are consistent with law relative to this chapter and necessary to achieve the purpose and requirements of this chapter. These rules and regulations shall include provisions for:

(1) The establishment and maintenance of an up-to-date registry that shall document every occurrence of cancer and of benign tumor in this State;

(2) The establishment of a procedure for reporting to the Department, within 180 days of initial diagnosis or treatment, every occurrence of cancer and of benign tumor in this State. Such procedure shall include the reporting of specified information that the Department deems necessary and appropriate for the recognition, prevention, control or cure of cancer and benign tumors, and shall minimally include the reporting requirements of the National Cancer Data Base established by the American College of Surgeons, along with information regarding the patient's length of residency in Delaware, primary residential address in Delaware and the location and nature of the patient's primary past employment. Those required to report to the Department occurrences of cancer and benign tumors shall include:

   a. Any physician, surgeon, dentist, podiatrist or other health care practitioner who diagnoses or provides treatment for cancer or benign tumors;

   b. The designated representative of any hospital, dispensary, asylum or other similar public or private institution that diagnoses or provides treatment for cancer or benign tumors;

   c. The designated representative of any laboratory that examines tissue specimens which disclose the existence of cancer or benign tumor;

(3) The establishment of a procedure for the publication and distribution of forms, instructions and notices required by this chapter or necessary to accomplish the purpose of this chapter; and

(4) The establishment of a procedure to obtain follow-up information from those required to report occurrences of cancer and benign tumors pursuant to this chapter. Any follow-up information deemed necessary by the Department shall be submitted to the Department at least 1 time each year by those required to report occurrences of cancer and benign tumors.

This chapter and any rules or regulations issued pursuant to this chapter shall not apply to any person or private institution that, as an exercise of religious freedom, treats the sick or suffering by spiritual means through prayer alone. (62 Del. Laws, c. 334, § 1; 70 Del. Laws, c. 391, § 1; 73 Del. Laws, c. 431, §§ 1, 2.)

§ 3205. Confidentiality of reports.

(a) Any report of an occurrence of cancer or benign tumor made pursuant to this chapter shall not be divulged nor made public in any way that might tend to disclose the identity of the person to whom it relates. However, patient-identifying information may be exchanged among cancer control agencies as authorized by the Department and upon receipt by the Department of satisfactory assurances by those agencies of the preservation of the confidentiality of such information.

(b) No individual or organization providing information to the Department in accordance with this chapter shall be deemed to be, or held liable for, divulging confidential information. (62 Del. Laws, c. 334, § 1; 63 Del. Laws, c. 288, § 1; 70 Del. Laws, c. 149, § 148; 70 Del. Laws, c. 391, § 1.)
§ 3206. Compulsion prohibited.

Nothing in this chapter shall be construed to compel any individual to submit to any medical or public health examination, treatment or supervision. (62 Del. Laws, c. 334, § 1; 70 Del. Laws, c. 391, § 1.)

§ 3207. Violations.

Any person or entity who violates any provision of this chapter shall be fined $100 for each violation. (62 Del. Laws, c. 334, § 1; 70 Del. Laws, c. 391, § 1; 73 Del. Laws, c. 431, § 3.)

§ 3208. Audit and Abstraction of records by department.

(a) Upon request of a person or organization required to report by § 3204 of this title, the Department may audit records and abstract information that is required to be reported.

(b) Any person or organization failing to report as required by this chapter shall permit the Department to audit records and abstract information that is required to be reported.

(c) The Department may charge a fee to be established by regulation to persons and organizations subjected to an audit pursuant to subsection (a) or (b) of this section. Said person or organization shall reimburse the Department. (73 Del. Laws, c. 431, § 3.)

§ 3209. Reserved.

NOTICE: The Delaware Code appearing on this site was prepared by the Division of Research of Legislative Council of the General Assembly with the assistance of the Government Information Center, under the supervision of the Delaware Code Revisors and the editorial staff of LexisNexis, and includes all acts up to and including those from the 142nd General Assembly Regular Session.

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Appendix B

Melanoma Sample Handout
<table>
<thead>
<tr>
<th><strong>ABSTRACT FIELD</strong></th>
<th><strong>ABSTRACT FIELD CONTENT</strong></th>
<th><strong>ABSTRACT FIELD</strong></th>
<th><strong>ABSTRACT FIELD CONTENT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Place of Diagnosis-Test</td>
<td>Dermatology Office</td>
<td>Tumor Laterality</td>
<td>Right side</td>
</tr>
<tr>
<td>Last Name</td>
<td>Your Last Name</td>
<td>Morphology Text</td>
<td>Malignant Melanoma</td>
</tr>
<tr>
<td>First Name</td>
<td>Your First Name</td>
<td>Diagnostic Confirmation</td>
<td>positive histology</td>
</tr>
<tr>
<td>Middle Name</td>
<td>Your Middle Initial</td>
<td>Pathology text</td>
<td>2/1/2013 shave biopsy, rt posterior leg: malignant melanoma, Breslow thickness 0.76 mm; lesion extends to margin. 2/15/2013 re-excision; no residual melanocytic neoplasm present. Lesion completely excised with 1 cm margins.</td>
</tr>
<tr>
<td>Name Suffix</td>
<td>Blank</td>
<td>Lab Tests Text</td>
<td>None</td>
</tr>
<tr>
<td>Maiden Name</td>
<td>Blank</td>
<td>X-Ray-text</td>
<td>None</td>
</tr>
<tr>
<td>Social Security Number</td>
<td>9999999999</td>
<td>Staging Text</td>
<td>Local stage; Breslow thickness 0.76 mm; physician note this is thin type, no need to test lymph nodes</td>
</tr>
<tr>
<td>Number and Street</td>
<td>29345 Southern Way</td>
<td>Treatment Status</td>
<td>Treatment given</td>
</tr>
<tr>
<td>Supplemental Address</td>
<td>Blank</td>
<td>Treatment Remarks</td>
<td>None</td>
</tr>
<tr>
<td>ABSTRACT FIELD</td>
<td>ABSTRACT FIELD CONTENT</td>
<td>ABSTRACT FIELD</td>
<td>ABSTRACT FIELD CONTENT</td>
</tr>
<tr>
<td>----------------</td>
<td>------------------------</td>
<td>----------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>City</td>
<td>Milford</td>
<td>Surgery Date</td>
<td>20130201</td>
</tr>
<tr>
<td>State</td>
<td>Delaware</td>
<td>Surgery Text</td>
<td>Shave biopsy on 2/1/2013; re excision on 2/15/2013.</td>
</tr>
<tr>
<td>Zip Code</td>
<td>19963</td>
<td>Radiation Date</td>
<td>Blank</td>
</tr>
<tr>
<td>County</td>
<td>Your County</td>
<td>Beam Radiation Treatment Text</td>
<td>None</td>
</tr>
<tr>
<td>Birth date</td>
<td>19601010</td>
<td>Other Radiation Treatment Text</td>
<td>None</td>
</tr>
<tr>
<td>Place of Birth</td>
<td>Delaware</td>
<td>Chemotherapy Date</td>
<td>blank</td>
</tr>
<tr>
<td>Sex</td>
<td>Female</td>
<td>Chemotherapy – Text</td>
<td>None</td>
</tr>
<tr>
<td>Patient Race</td>
<td>White</td>
<td>Biological Response Modifier Text</td>
<td>None</td>
</tr>
<tr>
<td>Hispanic Ethnicity</td>
<td>No</td>
<td>Physician Information</td>
<td>Dr. Steven Scalpel</td>
</tr>
<tr>
<td>Usual Occupation</td>
<td>Teacher High School</td>
<td>Biological Response Modifier Text</td>
<td>None</td>
</tr>
<tr>
<td>Usual Industry</td>
<td>Education Delaware High School Milford</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ABSTRACT FIELD</td>
<td>ABSTRACT FIELD CONTENT</td>
<td>ABSTRACT FIELD</td>
<td>ABSTRACT FIELD CONTENT</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------------------</td>
<td>----------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Occu1</td>
<td>00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occu2</td>
<td>00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occu3</td>
<td>00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Length of residency in Delaware</td>
<td>15 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vital Status</td>
<td>alive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date Last Contact</td>
<td>20130501</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td>29345 Southern Way</td>
<td></td>
<td>Milford DE  19963</td>
</tr>
<tr>
<td>Date of Diagnosis</td>
<td>20130201</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age at Diagnosis</td>
<td>calculate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Site Text</td>
<td>Skin of Right Posterior Leg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Site Code</td>
<td>C447</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Both Ambulatory Surgery Centers and Physician Offices Complete These Fields

- Place of Diagnosis Test
- Patient Name
- Social Security
- Birth date
- Place of Birth
- Sex
- Patient Race
- Hispanic Ethnicity
- Usual Occupation
- Usual Industry
- Occup1
- Occup2
- Occup3
- Length of residency in Delaware
- Vital Status
- Date Last Contact
- Address
- Date of Diagnosis
- Age at Diagnosis
- Primary Site Text
- Primary Site Code
- Tumor Laterality
- Morphology Text

- Diagnostic Confirmation
- Pathology text
- Staging Text
- Treatment Status
- Treatment Remarks
- Surgery Date
- Surgery Text
- Radiation Date
- Beam Radiation Treatment Text
- Other Radiation Treatment Text
- Physician Information
Only Physician Offices Complete These Fields

- Lab Tests Text
- X-Ray Text
- Chemotherapy Date
- Chemotherapy Text
- Hormone Treatment Date
- Hormone Treatment Text
- Biological Response Modifier Treatment Date
- Biological Response Modifier Text