



# User Manual

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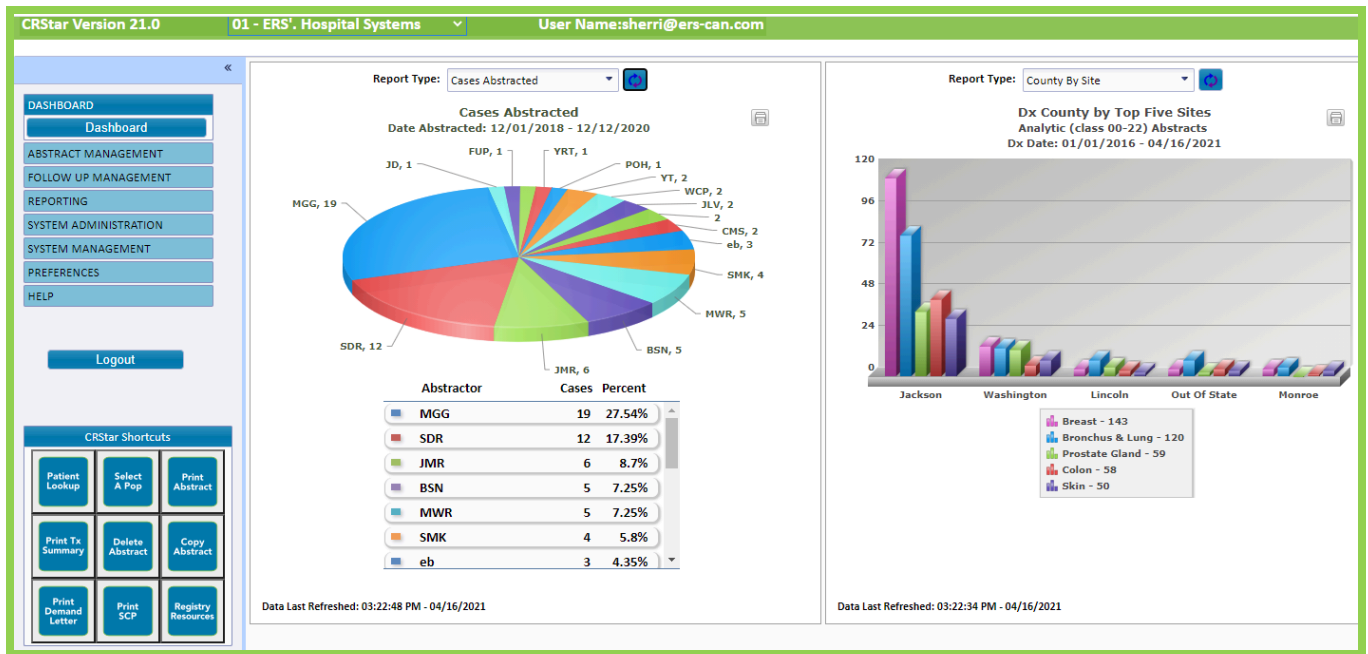


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## Chapter 1 DASHBOARD

Dashboards let the user visualize summarized registry data at a glance and provide managers with the most up-to-date information based on key performance indicators.



- The Dashboard configurations are set per facility. For the user to display the Dashboard reports for individual facilities, that facility must be chosen from the Facility Selection drop down menu, or groups of facilities may be chosen in the dashboard configuration.
- The Dashboard displays two reports on screen.
- The user may change the report by clicking on the Report Type arrow.
- To refresh the report, click on the Refresh icon beside the report name. Note: The report does not refresh when the user logs out and back in. User must click the refresh icon.
- The data displayed in the reports is generated from the settings in Dashboard Configuration tab.
- The following reports are available through the Dashboard:
  - Cases Abstracted: This report selects off the Date Abstracted.
  - Cases Completed: This report selects off the Date Case Complete (CoC).
  - Class by Site: This report selects off the Diagnosis Date.
  - County by Site: This report selects off the Diagnosis Date.
  - Follow Up Calculations: This report selects off the Diagnosis Date (150) three years before the current calendar year + Accession year (151) >=Reference Year (Excludes non-analytic cases). Reference year needs to be 2006 or later.
  - Follow Up Entered: This report selects off the Date Follow up Entered.
  - \*In/Out Migration: This report selects off the Diagnosis Date.
  - Last Follow Up Entered: This report selects off the Date Last Follow up Entered.
  - Quality Measures: This report selects off the Diagnosis Date.
  - Referred From: This report selects off the Diagnosis Date.
  - Referred To: This report selects off the Diagnosis Date.
  - Staged By: This report selects off the Diagnosis Date.
  - Suspense by Site: This report selects off the First Contact Date.
  - Timeliness of Abstracting: This report selects off the First Contact Date.
  - Top 5 Sites: This report selects off the First Contact Date.

\*Breakdown of analytic cases for the In/Out Migration report:

When Class In ('00') Then 'Diagnosed Here and Treated Elsewhere'  
When Class In ('10','11','12','13','14') Then 'Diagnosed and Treated Here'  
When Class In ('20','21','22') Then 'Diagnosed Elsewhere and Treated Here'

## Helpful Hints for Dashboard Reports

- **Helpful Hint #1:** When the end date is left blank, the report generates from the start date entered to the current date. This eliminates the need for the user to modify the end dates to view data as of a current date.
- **Helpful Hint #2:** In a Multi-Hospital setting the user may choose the facilities to include in each graph or to isolate to a single facility. This is accomplished as shown below. Enter the facility followed by a comma and no space. If no hospital code is entered, the reports display data from the facility in the green drop down.

**Genedit's Dashboard**

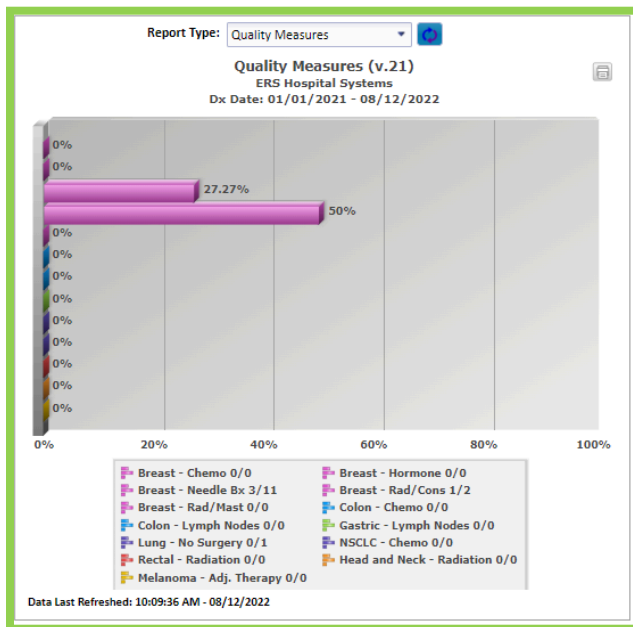
Hospital: 01 ERS Hospital Systems  
 Reference Year: 2006  
 Pediatric Facility

	Begin Date	End Date	Hosp List	Admin Only
Cases Abstracted:	01/01/2022		01	<input checked="" type="checkbox"/>
Cases Completed:	11/12/2017		01	<input checked="" type="checkbox"/>
Class by Site:	01/01/2016		01	<input type="checkbox"/>
County by Site:	01/01/2016		01	<input type="checkbox"/>
In/Out Migration:	01/01/2016		01	<input type="checkbox"/>
Follow Up Calcs:	N/A	N/A	01	<input type="checkbox"/>
Follow-Up Entered:			01	<input type="checkbox"/>
Last Follow-Up Entered:			01	<input type="checkbox"/>
Quality Measures:	01/01/2022	12/31/2022	N/A	<input type="checkbox"/>
Referred From:	01/01/2016		01	<input type="checkbox"/>
Referred To:	01/01/2016		01	<input type="checkbox"/>

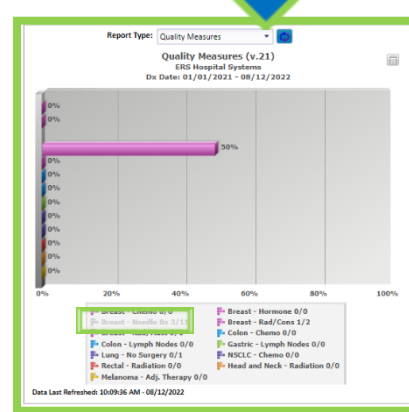
Stage by Physician: 01/01/2015, End Date, Hosp List 01,02,03   
 Suspense by Site: 01/01/2022, End Date, Hosp List 01   
 Timeliness: 01/01/2017, End Date, Hosp List 01   
 Top 5 Sites: 01/01/2018, End Date, Hosp List 01

REFERENCE\_YEAR - 2006

- **Helpful Hint #3:** The Quality Measures dashboard report currently looks at the cases that match the eligibility criteria for each measure. This report also looks at only the facility chosen in the green drop down.



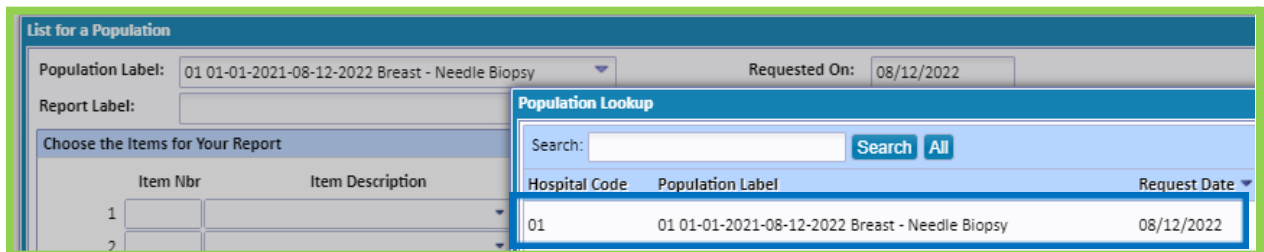
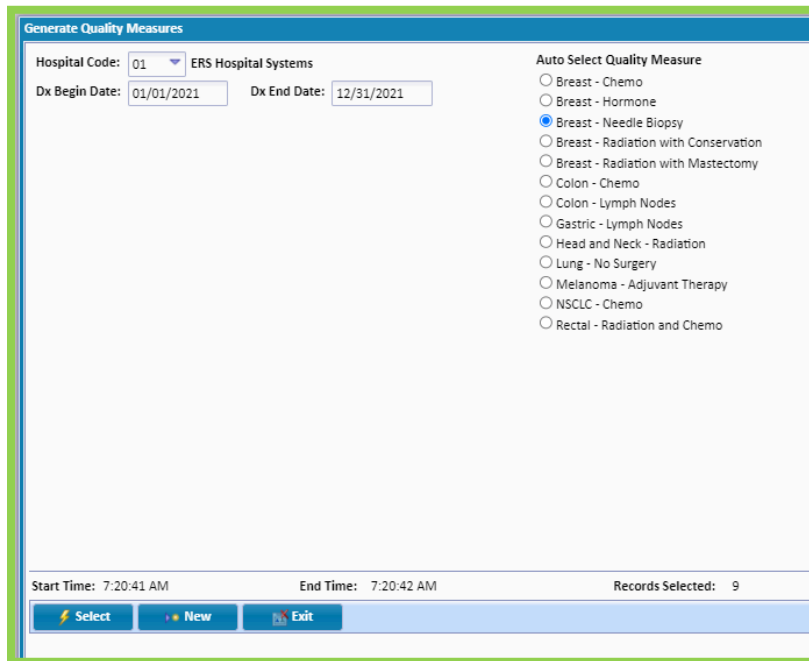
By clicking on the Measures in the legend, the user can add/delete them from the graphic display.



When running the Quality Measures in CRStar, the system tells the user how many cases match the criteria for the study. In the example above, for the Breast Needle Biopsy measure, 11 cases are eligible to receive the recommended treatment, but only 3 met the measure. The system auto selects a population, and it is stored in the Select a Population, so that the user can take the population and run various reports, graphs, and letters.

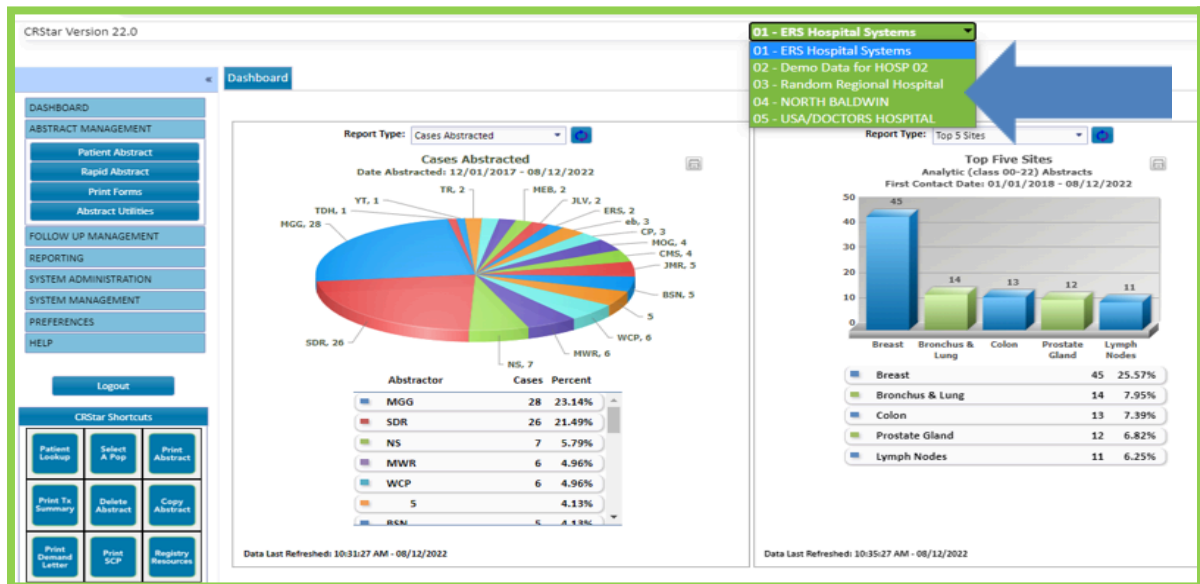
Below are the steps to run the Quality Measures

- Click on Reporting
- Click on CPM Reports Menu,
- Click Qlty Measures Tab
- Enter Hospital Code or leave it blank to include All Facilities
- Enter Begin/End Date (If end date left blank, it will auto-fill to today's date)
- Click Select



Chapter 2 FACILITY SELECTION DROP DOWN BAR

The Facility Selection Drop Down Bar is located on the green bar at the top of the CRStar screen. The user can click on the drop-down arrow and change the facility selection. The drop down includes all facilities in the user's database.



Below are the functions that the Facility Selection Drop Down controls:

- The Dashboard configurations are set per facility. For the user to display the Dashboard reports for individual facilities, that facility must be chosen from the green drop-down menu. If the user wishes to configure the dashboard reports to include more than the facility in the green drop down, the facilities to be included should be entered in the dashboard configuration.
- When running follow up letters for different facilities, if the user does not select a specific facility letter (i.e., DOC 01, DOC 02, and DOC 03) CRStar chooses the letters associated with the facility shown in the Facility Selection Drop Down (green bar). In this example, the user needs to change the facility from the drop down. Note: If a facility letter with the hospital number is chosen, selecting the facility from the drop down is not necessary.
- The state of the facility displayed on the green bar drives which state screen is displayed in the abstract. For users that have facilities in multiple states, the drop down needs to be changed before abstracting a case in that particular state.
- The county codes in the address fields are driven by the state of the facility displayed in the green bar. Again, this would apply to users with facilities in multiple states.
- The state exports are driven by the state of the facility displayed on the green bar. If the user submits data to multiple states, the facility must be changed in the drop down before using the state export function.

## Chapter 3 ABSTRACT MANAGEMENT

- Patient Abstract and Rapid Abstract
  - Lookup -CRStar Shortcuts-Patient Lookup
  - Quick Links and Help Notes
  - Suspense
  - Patient

- Diagnosis
- Lookups and Searches
- Staging
- Treatment
- Outcomes
- State Specific
- Cancer Program Maintenance
- Breast Program Maintenance
- Rectal Program Maintenance
- User Defined
- Case Admin
- Clinical
- Research
- Retired
- Print Forms
  - Abstract
  - Tx Summary/Custom
  - QA
  - SCP
- Abstract Utilities
  - Delete Abstract
  - Copy Abstract
  - Combine Patients



# Patient Abstract

## Lookup-CRStar Shortcuts-Patient Lookup

Shortcuts allow the user to access routines used frequently without having to use the main menu options. They include: Patient Lookup, Select a Population, Print Abstract, Print TX Summary, Delete an Abstract, Copy Abstract, Print Demand Letter, Print SCP-Survivorship Care Plans, Registry Resources (Web "Quick" Links).

S/A	SSN	MRN	Last Name	First Name	Middle Name	DOB	Site	Seq	Topo	Histology
A	522335417	420425765	LARYNX	MEDFORD	H	10/25/1933	32	00	C320	80713
A	141106873	419032546	URINARY BLADDER	ALBERT		02/05/1910	67	00	C679	81203
A	517489167	249985459	CORPUS	MARGARET	J	06/29/1948	54	00	C549	80103
A	121451164	417729561	COLON	BEATRICE	C	03/11/1945	18	00	C183	81403
A	127390164	420543830	COLON	BERTHA	L	05/04/1939	18	00	C187	81403
A	781165485	422016555	lung	RUBY	E	04/02/1916	34	00	C341	80123
A	218431776	274387591	STOMACH	DAVID		10/01/1943	16	00	C163	81402
A	218124721	704057064	RECTUM	DAVID	A	11/05/1912	20	00	C209	81403
A	317217172	417149887	BREAST	HARRIETTE	J	08/02/1921	50	00	C504	85003

S/A	SSN	MRN	Last Name	First Name	Middle Name	DOB	Site	Seq	Topo	Histology	Laterality	Ox Date	Hosp	Class	Patient Status	Last Contact	Acc Nbr		
A	317217172	417149887	BREAST	HARRIETTE	J	08/02/1921	50	00	C504	85003	1	10/16/1995	01	35	0	03/18/2009	0119560748		
A	517489167	249985459	BREAST	MARY	R	05/15/1932	50	02	C509	80103	1	06/01/1990	01	52	0	01/29/2001	01195700137		
A	524651372	518181725	BREAST	NEIL	B	11/12/1916	50	00	C504	85003	1	06/15/1984	01	35	0	07/15/1986	0118400634		
A	1174751372	424667735	BREAST	CAROL		12/09/1947	50	00	C509	85003	1	09/16/2011	01	43	1	09/26/2011	01201101340		
A	6774581372	424669608	BREAST	OTTIE	M	08/24/1945	50	00	C504	85003	1	04/17/2007	01	10	1	05/07/2016	01200700551		
A	7814281372	422549295	BREAST	RUBY		06/23/1942	50	00	C509	85002	2	09/27/2000	01	35	1	05/15/2015	0120000884		
A	250671372	416262811	BREAST	EMMA	O	10/24/1907	50	00	C502	85003	1	09/13/1991	01	35	0	09/29/1996	01199101039		
A.A	417291372	42061429	BREAST	KAREN	A	03/26/1952	50	00	C503	85003	1	07/11/2008	01	02	10	00	01/13/2016	0120000164	
A	4174281372	424669608	BREAST	JARICA	ANN	07/07/1942	50	00	C504	85003	1	04/02/2002	03	10	0	05/02	01	01200200072	
A.A	117508164	421704526	COLON	CAROL	A	12/08/1950	50	01	C483	87202	1	08/10/2012	01	01	21	14	1	04/13/15	01201201247
A.A	117508164	421704526	COLON	CAROL	A	12/08/1950	18	02	C180	81403	1	03/16/2016	01	01	21	14	1	04/13/15	01201201247

- The Lookup Feature is located under Abstract Management, or under the CRStar Shortcuts Tab-Patient Lookup.
- The Lookup feature allows the user to lookup Suspense cases, Abstracted cases, or Non-Reportable cases.
- Each patient is listed once with subsequent primaries listed below. See patient highlighted example above.
- Patients can be searched by the following criteria:
  - o First and/or Last Name
  - o Social Security Number
  - o Date of Birth
  - o Accession Number
  - o Medical Record Number
  - o Site Code
  - o Hospital Code
- The Lookup feature displays the following patient information:

- o Location of Case: Suspense/Abstract
  - o Social Security Number
  - o Medical Record Number
  - o Last Name, First Name, Middle Name
  - o Date of Birth
  - o Site Code, Sequence of Primary, Topo Code, histology, and laterality
  - o Diagnosis Date
  - o Hospital Code
  - o Class of Case
  - o Patient Status
  - o Date of Last Contact
  - o Accession Number
- To search for a patient, the user may enter full or partial first or last name of the patient and click Search or Enter key.
  - To go from page to page, the user can click on the page numbers or forward or backward arrows under the displayed list.
  - All column headers may be sorted alphabetically or numerically by clicking on the header.
  - When the patient is displayed click the patients name and the system moves to the Patient Maintenance screen of the abstract.

S/A	SSN	MRN	Last Name	First Name	Middle Name	DOB	Site	Seq	Topo	Histology	Laterality	Dx Date	Hosp	Class	Patient Status	Last Contact	Acc Nbr
						mm/dd/yyyy											012021
S			SSDI	TEST		10/10/1945	25	00	C251	81403	0	02/21/2021	01	14			01202100005
A		20322561	Snappy	Snap		10/15/1969	71	00	C716	99303	0	03/21/2021	01	14			01202100009
A			Auto	Test		12/12/1957	44	00	C445	87203	-	08/12/2021	01	14			01202100015
A S		5555555555	NA DEFAULTS			12/31/1969	64	00	C649	80703	-	04/01/2021	01	01	32 10 1	04/05/2021	01202100008
A	999999999	9876543	Lung	Nicki		05/01/1947	34	00	C349	81403	1	03/01/2021	01	14			01202100116
S			Test			12/12/1959	25	00	-	-	-	12/12/2021	01	22			01202100136
A	165514172	114574	BREAST	BONNIE	BLUM	05/01/1951	50	01	C504	85003	1	04/20/2021	01	10 1		07/12/2022	01202100140
A	999999999	0101010101	PATRICK	MODERN		06/06/1970	25	01	C252	85003	0	01/01/2021	01	10 1		01/05/2022	01202100021
A	999999999	2111333	Lymphoma	Metaatdx	E	11/15/1948	77	01	C771	96713	0	01/21/2021	01	14 0		08/28/2021	01202100006
A	999999999	6524151	CERVIX	MARY		12/12/1949	53	00	C539	80703	0	03/21/2021	01	14 1		07/10/2021	01202100010

- Click Clear Results for a new search.
- Clicking New Patient opens the Patient Maintenance screen of the abstract, where the user can enter a new case.

Lookup Patient Diagnosis Staging Treatment Outcomes State Specific CPM BPM RPM User Defined Case Admin Clinical Research Retired

Soc Sec Nbr:

MBI:

Id Nbr:

Name Prefix:

Last:

First:

Middle:

Birth Surname:

Alias:

Name Suffix:

Phone nbr:

Phone nbr 2:

Email:

Curr Add:

Curr Add 2:

Curr City:

Curr St:

Zip:

Curr Country:

Curr Country:

DOB:  mm /  dd /  yyyy

Birth Country:

Birth State:

Sex:

Patient Contacts Remarks

Race1:  Fam Ca Hist:

Race2:  Tobacco Hist:

Race3:  Alcohol Hist:

Race4:  Religion:

Race5:

Ethn:

Usual Occ:

Usual Bus Ind:

Comments:

S/A	Flag	Site	Seq	Hsp	Class	Diagnosis Date	Acc Nbr	Med Rec Nbr
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	mm / dd / yyyy	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	mm / dd / yyyy	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	mm / dd / yyyy	<input type="text"/>	<input type="text"/>

New Primary

Date of Last Contact: 02/15/2020 Patient Status: 1

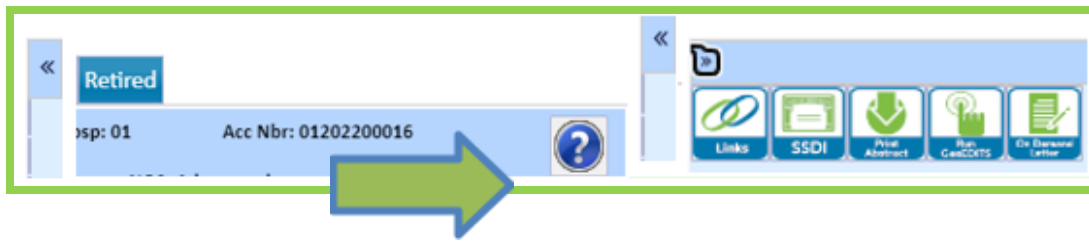
SOC\_SEC\_NBR -

Save Exit

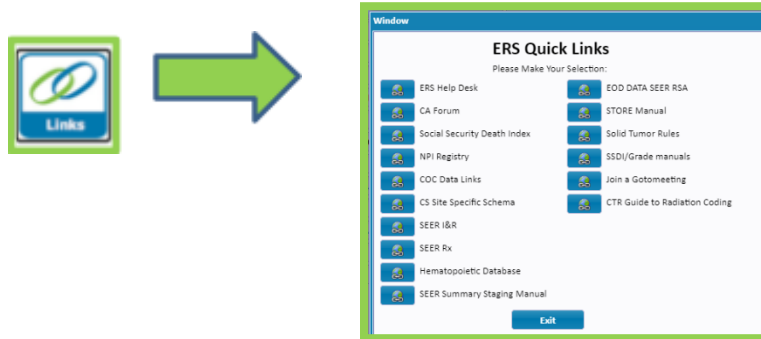
- Clicking Exit exits the Lookup screen taking the user back to the Main Menu screen.

## Quick Links and Help Notes





- In the upper right and left corner of each screen of the abstract, there is a shift icon (<<) highlighted in blue. Click on the right icon to bring up the **Quick Links** selection icons. Note: Quick Links is only visible when in an active abstract.
- The Quick Links can be collapsed by clicking on the right (>>) icon. To collapse the left side click the shift icon (>>) in the upper left corner.
- In addition, each screen displays a question mark icon at the top right corner of the screen. In any field within the abstract, while in the field, clicking the (?) or the F1 key displays Help Notes for that field. If the field is a required field by the CoC, the Help Notes are from the STORE manual.
- By clicking on the Links icon, the Health Catalyst Quick Links below are accessible:



While in a patient's abstract the SSDI icon can be selected. If that patient is expired and has been entered in the SSDI, the user is taken to that patient's entry within the SSDI. If the patient is not in the SSDI, the user receives a message that the patient does not exist. (Note as of 2013 SSDI does not display SSDI records for individuals who have died within the previous 3 years.)



- Print Abstract Utility



• Run GenEdits on any screen of the abstract once inside the primary, Edits cannot be run on the Patient Maintenance screen.



- Run letters on demand on any screen.

## Suspense

Code	Description
A	Abstract
S	Suspense

Code	Description
C	Corrections
I	Incomplete Case
N	Do Not Transfer to State
T	Case Has Been Transferred to State
Y	Transfer to State

- In CRStar, the status of the case is recorded in the Primary grid (located in the lower right corner of the Patient Maintenance screen) and the State Report Flag (“Flag” field). Both fields are located in the Primary grid, located in the lower right corner of the Patient Maintenance screen.
- The 2-digit site code is used in CRStar to calculate the correct site group for canned reports, such as the Site Distribution table. This code is not exported to your State or the NCDB. In most cases, the 2-digit code will be the same as the first two numerical digits in the Topography code (the “Cxxx” code). **NOTE:** Lymphomas and Extranodal Lymphoma sites are the exception: each category is coded differently in CRStar. The two-digit site code for **All Lymphomas** must be coded to “77” (lymph nodes). The actual location of the cancer (lymph nodes or extranodal site) is coded in the Topography field located on the Diagnosis Maintenance screen. The Topography Code **IS** exported to your State and the NCDB. The Topography Code for Nodal Lymphomas will be the appropriate lymph node code (C770 – C779). The Topography Code for Extranodal Lymphomas should be coded to the Extranodal site. For example, in the case of Lymphoma of the Stomach, code Site to 77 and Topography Code to C160 – C169.
- To enter a Suspense case, go to Abstract Management, Patient Abstract and Lookup. Click New Patient and the Patient Maintenance screen appears for entry of the New patient. Only use this option when a patient does not exist in the database.
- Enter all necessary demographic information available.
- When entering the site, sequence, etc. information in the multi valued fields in the lower right section of the screen, click on the field labeled S/A and choose ‘S’ Suspense.
- The State Report Flag field has been added to the Patient screen and retained on the Case Admin screen for user convenience.
- A Suspense Remarks text field is available.
- The user **MUST** go to the Diagnosis Maintenance screen to enter either the Date of Discharge or the Date of First Contact to run Suspense reports. This is because these two fields are “primary” specific and must be located within the abstract of each primary. **Note:** See Imports configuration and note that if the Date of First Contact is blank then the next import defaults the new date in Date of first Contact.
- All fields on all screens may be collected while the patient is in Suspense if that information is available to the user.
- Date Case Initiated auto fills with the current date. This field is located on the Case Admin screen of the abstract.
- To run a Suspense report, please see section under Reporting.

## Entering Non-Reportable Cases

### Suggestions on how to mark cases as Non-Reportable in the Database

#### 1. Patient Maintenance Screen

- S/A field must be coded to an "S" for Suspense
- Flag field must be coded to an "N" for not reportable [Rationale: By marking the cases with an N in this field, can easily exclude these cases from being pulled into the list of Suspense Cases to abstract.]
- Optional: Suspense Remarks Box enter the date the case was reviewed, the abstractor initials of who reviewed the case and the reason the case is Not Reportable [Rationale. If this is in the Suspense Remarks Box, it is easier when re-reviewing or case finding initially because users do not have to leave the patient maintenance screen.]

The screenshot shows the Patient Maintenance Screen. A red arrow points down to the screen. The screen is divided into several sections: Patient Information (Soc Sec Nbr, MBI, ID Nbr, Name Prefix, Last, First, Middle, Birth Surname, Name Suffix, Alias, Phone Nbr, Phone Nbr 2), Address (Email, Curr Add, Curr Add 2, Curr City, Curr St, Zip, Curr Country, Birth Country), and a table for Contacts. The Contacts table has columns for S/A, Flag, Site, Seq, Hsp, Class, Diagnosis Date, Acc Nbr, and Med Rec Nbr. A red box highlights the 'S/A' column in the table. Below the table are buttons for 'New Primary', 'Save', and 'Exit'. The status bar at the bottom shows 'SOC\_SEC\_NBR - 317-21-7172'.

#### 2. Diagnosis Maintenance Screen – Located within the text screen. Click the TextPad button.

- Dx Comment Field Enter the date the case was reviewed, the abstractor initials of who reviewed the case and the reason the case is Not Reportable [Rationale. If the registry plans to pull the N cases out into an excel spreadsheet to contain a tally sheet or end of year summary, etc. this field could be utilized in the report to match the Site-Specific Code. This is better for a report than the Suspense Remarks Field because the Suspense Remarks box could contain information regarding additional admission dates for Other Sites if it were chosen to be utilized for the imports.]

- Delete the Date of First Contact OR Admit Date OR Discharge Date (whatever is appropriate for the facilities Import options.) [Rationale. If a "trigger" is required to know

that these NR cases came back to re-review, there is an option in the import configuration to UPDATE date of first contact OR admit date OR discharge date of existing suspense cases... so If the facility is using this option, then delete the date (of choice) when it is marked N... because the import will only update the date of choice if it is EMPTY.

The screenshot displays a patient record for 421158397, BREAST, SUSIE. The interface includes fields for address, demographics, and clinical data. A red box highlights the date fields: First Contact Date (01/10/2021), Admit Date (01/10/2021), and Discharge Date (01/17/2021). Other visible fields include Topo Code (C504), Class (21), DoB (09/01/1976), Diagnosis Date (01/12/2021), and Histology (Invasive carcinoma of no special type [C50\_] [BREAST ONLY]). The right side of the screen shows a list of providers and their roles, such as Prim Surg (JUDY JONES) and Ref Phys (CHARLES ROGERS).

To exclude non-reportable cases from the Suspense list:

- Select the population, Click the radio button for Suspense Cases Only and enter the range of dates needed.
- Enter item number 200 State Report Flag NOT EQUAL to N as shown below.

**Select a Population**

Population Label:

Requested By:  Request Date:

Hospitals:  ERS Hospital Systems

New Label:

Include Duplicates of Shared Patients

Dx Date   
  1st Contact Date   
 From:    
 To:

Abstract/Suspense Cases

Abstract Cases Only  
 Suspense Cases Only  
 All Cases

Case Type

Analytic Cases Only  
 Complete Cases Only  
 Incomplete Cases Only  
 Non-Reportable State Flag

**Site Codes**

Site	Site Description
1	<input type="text"/>
2	<input type="text"/>
3	<input type="text"/>

**Selection Criteria**

Item Nbr	Item Description	Relation	Data Values	Logic	
1	200 State Report Flag	<>	N	And	<input type="button" value="Copy"/>
2	862 First Contact Date	>=	01/01/2023	And	<input type="button" value="Copy"/>
3	862 First Contact Date	<=	01/31/2023	And	<input type="button" value="Copy"/>

## Patient (Patient Maintenance)

SOC\_SEC\_NBR - 999-99-9999

- To move from field to field, use the Tab key or mouse.
- The CRStar screens can be collapsed from both the top left and right. Click << to collapse the left side hiding the CRStar Modules. Click >> to open the quick links window.
- Online help is available for all fields. Click the (?) icon in the upper right corner to bring up the Help Notes or hit F1.
- Entries can be done in upper or lower case. Keep in mind, the case used is how reports are displayed.
- Cases should be coded here as to their case status, i.e. Suspense, Abstract or Non-Reportable.
- The field State Report Flag has been added to this screen and retained on the Case Admin screen. If a change is made to this field, it automatically updates on the Case Admin screen.
- Addresses: After entering the street address, enter the Zip Code and the city and state autofill.
- Secondary Contact information is located on this screen. Click on the Contact tab to view or enter data.
- The Patient tab allows data entry for race, history, occupation, etc.
- The user can click the TextPad button to type in any of the text fields. The character count (Current Length) is located at the bottom center of the screen. The number of characters turns red once the user has exceeded the character count exported to the state per text field.
- The user can cut, copy, and paste from one text field to the other or from other applications.
- The user can choose codes and descriptions from the drop down or manually enter the codes.
- Multiple primaries are displayed in the multi valued section in the lower right section.
- To add an additional primary, enter the information on the next available line.
- Clicking on Add Primary adds a new row.
- Cases that are shared between facilities in a multi hospital database are listed in the multi valued section.
- The user may enter the year date as the last two digits and the century auto fills.
- True unknown dates or partial unknown dates are allowed. For example, 99/99/9999, 02/99/2013, etc.
- Key fields may be changed on the screen. Key fields include Site, Sequence, Hospital Code, Accession Number, ID number and Medical Record Number.
- **NOTE: The HOSPITAL CODE must be filled out with the two digit facility code for ALL cases entered into CRStar. Omitting this code will keep the case in "Inquiry Mode".**



- If the case is flagged as an "A" abstract, the key fields must be filled out. If the case is marked as a Suspense or Non-Reportable case, the hospital code, site, and sequence must be entered. Accession number may be left blank for these cases. Note: The hospital field must be coded to run reports.
- Data saves as the user advances to the next screen or clicks Screen Tab or Previous button..
- To move to the Diagnosis tab, the user must choose Select beside the primary to view.
- Accession Number is preceded by the Hospital Number in CRStar (it is an 11-digit field. The 9-digit standard field is exported to standard setters). Accession Numbers can be configured to automatically assign the next available Accession Number (refer to the "Initialize Accession Numbers" portion of this manual). If the numbers have been initialized, just enter the Accession Year and the rest of the number will be automatically assigned. For example, if you are abstracting a 2023 case for Hospital 05, if you enter "2023" in the Accession Number field, CRStar will assign the next available 2023 number (i.e. 05202300025).
- A Patient's primary may be deleted from this screen using the delete key next to the primary. **VERY IMPORTANT!!!!!!** This will only delete the one selected primary abstract. It will not delete the entire patient record. To delete the entire patient, use the Delete an Abstract function!

## Diagnosis (Diagnosis Maintenance)

Quick

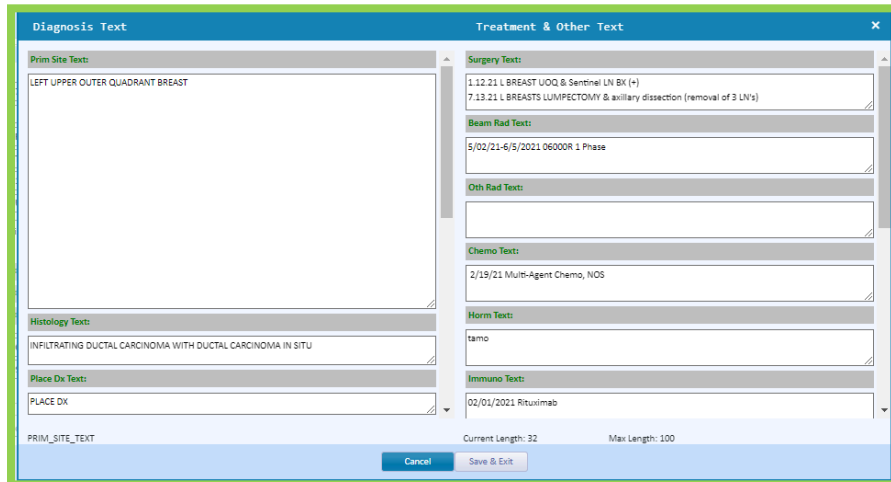
- The Links are located by clicking the << at the far right top of the CRStar screen.
- Quick Links available include:
  - Quick Links websites:
    - Health Catalyst Help Desk
    - Cancer Forum
    - SSDI
    - NPI Registry
    - CoC Datalinks
    - CS Site Specific Schema
    - SEER I&R
    - SEER Rx
    - Hematopoietic Database
    - SEER Summary Staging Manual
    - EOD Data SEER RSA
    - STORE Manual
    - Solid Tumor Rules
    - SSDI Grade/Manuals
    - Join a GoToMeeting
    - CTR Guide to Radiation Coding
  - Print Abstract
  - SSDI
  - Run Edits
- The CRStar screens can be collapsed from both the top left and right. Click << to collapse the left side hiding the CRStar Modules. Click >> to open the quick links window.
- Tab through the Dx Address information for it to auto fill from the Current Address. Only change the Dx Address if it differs from the Current Address on the Patient screen.
- Comorbidities and Complications Codes display when ICD9 is selected. Secondary Diagnosis Codes display when ICD10 is selected. Click the drop-down arrow to search for codes and descriptions or manually enter.
- Click drop down arrow for Hospital referred to and from or manually enter. If the hospital is not on the list, the user can add it without leaving the page. Click the New Hospital tab to add.
- Age at Diagnosis is automatically calculated when the user enters DOB and Date of Diagnosis.
- When the Date of First Contact is entered, the Accession year will auto default.
- Two user defined fields are available on the Diagnosis Maintenance screen. Refer to the System Admin chapter of creating user defined fields.

- Click on the Phys field to enter each specialty. Click the drop-down arrow to search for a physician or manually enter the physician’s ID number. If the physician is not on the list, the user can add it without leaving the page. Click the New Physician tab to add.
- The Non-Analytic Default can be used for Non-Analytic cases where some fields may be unknown to the user. Setting the Non-Analytic default will default the following fields to unknown values:
  - Diagnosis Date
  - Tumor Size
  - Grade
  - Lymph Nodes Positive and Examined
  - Primary Payer
  - Dx Marital Status
  - Diagnostic text fields/Rx text
  - Diagnosis Address (Note: If known, the user may tab through these fields to fill in from the current address before clicking Non – Analytic Default)
  - General Stage and General Stage text
  - Date of Initial Treatment
  - All Rx texts

Adding Physicians and Diagnostic Text

			FU Phys Order
Prim Surg:	100577	FRED CLEMENZ	<input type="checkbox"/>
Ming Phys:	009792	MARCEL CONRAD	<input type="checkbox"/> 2
Fol Phys:	006021	HAWKEYE PIERCE	<input type="checkbox"/> 1
Rad Oncol:	008683	KENNETH ELLINGWOOD	<input type="checkbox"/>
Med Oncol:	007158	MICHAEL MESHAD	<input type="checkbox"/> 3
Qa Phys:			<input type="checkbox"/>
Ref Phys:			<input type="checkbox"/>
Oth Phys 1:			<input type="checkbox"/>
Oth Phys 2:			<input type="checkbox"/>
Oth Phys 3:			<input type="checkbox"/>
Oth Phys 4:			<input type="checkbox"/>
Rad Onc Consult:	1		
Med Onc Consult:	1		

Note: The only physician that auto copies to the Outcomes screen is the Follow-up physician. User can number the physicians in the second column in sort order of physicians to follow up and they will copy into the outcomes screen.



- Click on the individual text fields to enter Diagnostic (Clinical) text. Click in any of the text boxes or headers to bring up the text editor.

- The user can cut, copy, and paste text from one text field to another or from other applications.  
NOTE: Text copied from other programs should be pasted into Word prior to pasting into CRStar to capture invisible characters. These characters can prevent reports from running completely.

- Each text field displays the number of characters exported to the state.
- When typing in the text boxes once the maximum number of characters has exceeded the number of characters turns red, the user may continue to add text in the box and it will be saved.

### Diagnosis Maintenance Screen-Lookups and Searches

- There are many Lookup tables on the Diagnosis Maintenance Screen. Some are:
  - Comorbidities and Complication/Secondary Diagnosis Codes
  - Hospital Referred To and From
  - ICDO-3 Topography Codes
  - ICDO-3 Morphology Codes
  - Physicians
- The functionality in each lookup is the same. In this example, ICDO-3 Morphology Codes are used.

Histology		
Code	Description	Description
800		neop
80000	Neoplasm, benign; Tumor, benign; Tumor, benign, unclassified	Neoplasm, benign; Tumor, benign; Tumor, benign, unclassified
80001	Neoplasm, uncertain whether benign or malignant; Neoplasm, malignancy; Tumor, unclassified, uncertain whether benign or malignancy; Unclassified tumor, uncertain whether benign or malignancy	Neoplasm, uncertain whether benign or malignant; Neoplasm, malignancy; Tumor, unclassified, uncertain whether benign or malignancy; Unclassified tumor, uncertain whether benign or malignancy
80002	Neoplasm; Obsolete code	Neoplasm; Obsolete code
80003	Neoplasm, malignant; Blastoma, NOS; Cancer [see coding guidelines]; Tumor, malignant, NOS; Tumor, malignant, unclassified; Tumor, malignant	Neoplasm, malignant; Blastoma, NOS; Cancer [see coding guidelines]; Tumor, malignant, NOS; Tumor, malignant, unclassified; Tumor, malignant
80006	Neoplasm, metastatic; Embolus, tumor; Metastatic neoplasm; Secondary neoplasm; Secondary tumor; Tumor embolus; Tumor embolus	Neoplasm, metastatic; Embolus, tumor; Metastatic neoplasm; Secondary neoplasm; Secondary tumor; Tumor embolus; Tumor embolus
80009	Neoplasm, malignant, uncertain whether primary or metastatic; Tumor, unclassified, malignant, uncertain whether primary or metastatic; Unclassified tumor, malignant, uncertain whether primary or metastatic	Neoplasm, malignant, uncertain whether primary or metastatic; Tumor, unclassified, malignant, uncertain whether primary or metastatic; Unclassified tumor, malignant, uncertain whether primary or metastatic
80010	Tumor cells, benign	Unclassified tumor, malignant, uncertain whether primary or metastatic
80011	Tumor cells, uncertain whether benign or malignant; Tumor cells	Differentiated penile [or vulvar] intraepithelial neoplasia (C60.0-9) [2018+ CASES ONLY]; Penile intraepithelial neoplasia (C60.0-9) [2018+ CASES ONLY]; Intraepithelial neoplasia, penile [or vulvar] differentiated-type (C51.0-9) [2018+ CASES ONLY]; Intraepithelial neoplasia, vulvar differentiated-type (C51.0-9) [2018+ CASES ONLY]
80013	Tumor cells, malignant	
80023	Malignant tumor, small cell type; Small cell type, malignant; Small cell type, malignant	

- o If the code is known, it can be entered or start typing in the description field.
- o Typing in the code or description will start generating a list in order of characters as typed.
- o To select a code and description, single click on selection.
- o Click Cancel to return to the field.

## Staging (Maintenance) SEER

421158397 BREAST SUSIE Seq Prim: 01 Hosp: 01 Acc Nbr: 0120210003  
 Topo Code: CS04 Class: 21 Dob: 09/01/1976 Diagnosis Date: 01/12/2021 Histology: Invasive carcinoma of no special type (CS0\_) [BREAST ONLY]; Ade...

Staging: Site-Specific Data Items AJCC TNM Staging

-Lymph Nodes Positive: <input type="text"/> Examined: <input type="text"/> Lymph Vascular: <input type="text"/>	Schema Qualifiers (discriminators appear if needed)  SEER Sum Stages: <input type="text"/> EOD Prim Tumor: <input type="text"/> EOD Reg Nodes: <input type="text"/> EOD Mets: <input type="text"/> EOD Prostate Pathologic Extension: <input type="text"/> SEER SSF 1: <input type="text"/>	-Pediatric Stage Stage System: <input type="text"/> Stage: <input type="text"/> Staged By: <input type="text"/>  -User Defined Staging User 1: <input type="text"/> Staging User 2: <input type="text"/>
--	---	---

AJCC\_BASIS - Pathological Classification

Save Previous Next Exit Text

## Staging (SSDI)

421158397 BREAST SUSIE Seq Prim: 01 Hosp: 01 Acc Nbr: 0120210003  
 Topo Code: CS04 Class: 21 Dob: 09/01/1976 Diagnosis Date: 01/12/2021 Histology: Invasive carcinoma of no special type (CS0\_) [BREAST ONLY]; Ade...

Staging: Site-Specific Data Items AJCC TNM Staging

Schema ID: Breast

Lymph Nodes Positive Axillary Level I-II: <input type="text"/>	HER2 ISH Dual Probe Copy Number (2018-2020): <input type="text"/>
ER (Estrogen Receptor) Summary: <input type="text"/>	HER2 ISH Single Probe Copy Number (2018-2020): <input type="text"/>
ER (Estrogen Receptor) Percent Positive or Range: <input type="text"/>	Ki-67 (MIB-1): <input type="text"/>
ER (Estrogen Receptor) Total Allred Score (2018-2022): <input type="text"/>	Oncotype Dx Recurrence Score - Invasive: <input type="text"/>
PR (Progesterone Receptor) Summary: <input type="text"/>	Oncotype Dx Risk Level-Invasive: <input type="text"/>
PR (Progesterone Receptor) Percent Positive or Range: <input type="text"/>	Oncotype Dx Recurrence Score - DCIS: <input type="text"/>
PR (Progesterone Receptor) Total Allred Score (2018-2022): <input type="text"/>	Oncotype Dx Risk Level-DCIS: <input type="text"/>
HER2 Overall Summary: <input type="text"/>	Multigene Signature Method: <input type="text"/>
HER2 IHC Summary (2018-2020): <input type="text"/>	Multigene Signature Result: <input type="text"/>
HER2 ISH Summary (2018-2020): <input type="text"/>	Response to Neoadjuvant Therapy: <input type="text"/>
HER2 ISH Dual Probe Ratio (2018-2020): <input type="text"/>	

LN\_Pos\_Axillary\_Level -

Save Previous Next Exit Text

SSDI Fields generate dependent of sites with Site Specific Data Items assigned.

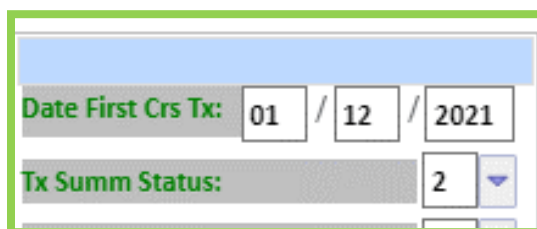
## Staging (AJCC)

- SEER, SSDI, AJCC/Grade AJCC Manual\* are all in one screen with individual tabs for 2018+ diagnosis.
- **IMPORTANT:** AJCC Stage Basis MUST be coded to use field index number 568 Summary AJCC Stage in reports. Note: Summary AJCC Stage only populates cases with a P or C (**Only cases with an AJCC Basis of C or P are included in reports AND must have the respective group assigned**).
- Path, Clinical and Post TNM codes and descriptions are site specific.
- Stage Group field displays all the AJCC\* site-specific group combinations. This field does not auto fill.
- **IMPORTANT:** The staging User Defined Fields in the bottom-third section labeled Staging User 1: and Staging User 2: fields are for internal use only. These fields are not exported to the state or NCDB, however may be used in reports.
- Click the (?) icon for individual Help Notes

## Treatment (Treatment Summary)

CRSt

- The Treatment Summary screen is a summary of all treatment modalities entered on individual treatment screens.
- Treatment text is entered using the TextPad button or on the individual treatment modality screens.
- Users must **SAVE** data entered on the treatment summary page prior to editing individual treatment modalities or complete this page after adding individual treatment modalities.
- To enter data for individual modalities, click **EDIT**.
- Date of Initial Treatment and Date of First Systemic Treatment are calculated automatically.
- **IMPORTANT:** When a patient is **NOT TREATED** for any reason (i.e., refused treatment, co-morbid conditions, expired, Active Surveillance etc.), code the Treatment Summary Status as 0, 2 OR 9. When any of these codes is entered, the Date of First Course Treatment becomes active and the user may enter the date no treatment was decided, refused, etc. See example below.



The screenshot shows a portion of a software interface. It features two rows of input fields. The first row is labeled 'Date First Crs Tx:' and contains three separate input boxes for the day, month, and year, with slashes between them. The values entered are '01', '12', and '2021'. The second row is labeled 'Tx Summ Status:' and contains a single input box with the value '2' and a small downward-pointing arrow to its right, indicating a dropdown menu.



## Treatment-Surgery Maintenance

421158397
BREAST
SUSIE
Seq Prim: 01
Hosp: 01
Acc Nbr: 0120210003

Topo Code: C504
Class: 21
Dob: 09/01/1976
Diagnosis Date: 01/12/2021
History: Invasive carcinoma of no special type (C50\_) [BREAST ONLY]: A...

**Common** Breast 2022

Rsn No Surg: 0

Surg User 1:

Surg User 2:

Mesorectum:

Regional LN Dissection: 07 / 13 / 2021

Sentinel LN Biopsy: 01 / 12 / 2021

Sentinel LN Positive: 01

Sentinel LN Examined: 04

**Surgery Text**

1.12.21 L BREAST UOQ & Sentinel LN BX (+)  
7.13.21 L BREASTS LUMPECTOMY & axillary dissection (removal of 3 LN's)

**Surgery Date:** 01/12/2021

**Surgery Code:** 22

**Surg Here:** 22

**Def Surg Dt:** 07/13/2021

**Dx Stg Code:** 02

**Dx Stg Here:** 00

**Surg Disch Dt:** 07/13/2021

**Readmit 30 Days:** 0

**Scp Ln Surg:** 7

**Scp Ln Surg Here:** 7

**Oth Reg Sites:** 0

**LN Removed:** 03

**Days From Dx:** 0

Surgery Date	Dx Stg	Surg	SUNS	LNR	SORS	Surg Disch Date	Readmit	F/S Flag	Physician	Hospital
01 / 12 / 2021	02		2			mm / dd / yyyy		F		530597
07 / 13 / 2021	22		7	03		07 / 13 / 2021	0	F		01
mm / dd / yyyy						mm / dd / yyyy				
mm / dd / yyyy						mm / dd / yyyy				
mm / dd / yyyy						mm / dd / yyyy				

RSN\_NO\_SURG - Cancer Directed Surgery Performed

- Note this screen has two tabs labeled Common and Breast 2022.
- Fields with drop down arrows contain codes and descriptions. Values may be manually entered or click the down arrow to display codes and description.
- Two User Defined fields are available to use to record extra information for Surgery.
- Surgery text may be entered on this screen or on the TextPad screen.
- All text fields have Copy/Cut and Paste functionality.
- Dates are entered as MM/DD/YYYY. The cursor will auto advance from MM to DD to YYYY.
- The use of unknown dates is allowed. For example: 99/99/9999, 10/99/2013, 99/99/2013, etc.
- F/S Flag is to record whether the treatment is First or Subsequent treatment. This field **MUST** be filled out.
- Record the treating physician number. If the number is not known, click on the arrow to look up the treating physician. If the physician is not on the list, the user can add it without leaving the page. Click the **New Physician** tab to add. This is an optional field.
- Record the treating hospital number. If the number is not known, click on the arrow to look up the treating facility. If the hospital is not on the list, the user can add it without leaving the page. Click the **New Hospital** tab to add.
- Diagnostic and Staging Procedures (01-09) AND Cancer Directed surgery codes (A000-A990) may be entered.
- To add a row of treatment, click the Add button icon.
- To delete a row of treatment, click the Delete button icon.
- The information in the top right corner of the screen is automatically calculated and displayed on the Treatment Summary screen.
- When data entry is completed, click SAVE and then EXIT.

## Treatment-Radiation Maintenance

- Fields with drop down arrows contain codes and descriptions. Values may be manually entered or click the down arrow to display codes and description.
- Two User Defined fields are available to record extra information for Radiation.
- Radiation text may be entered on this screen or via the TextPad button screens.
- All text fields have Copy/Cut and Paste functionality.
- Dates are entered as MM/DD/YYYY. The cursor auto advances from MM to DD to YYYY.
- The use of unknown dates is allowed. For example: 99/99/9999, 10/99/2013, 99/99/2013, etc.
- Phase is used to record the treatment types 1,2,3, or Subsequent treatment, click drop down Choose S.
- Record the treating physician number. If the number is not known, click on the arrow to look up the treating physician. If the physician is not on the list, the user can add it without leaving the page. Click the **New Physician** tab to add. This is an optional field.
- Record the treating hospital number. If the number is not known, click on the arrow to look up the treating facility. If the hospital is not on the list, the user can add it without leaving the page. Click the **New Hospital** tab to add.
- Completion status, Reason for stopping and Physician fields have been added. These fields are not required and not exported to any standard setter.
- Total Dose is a manual entry. This is a required field.
- To add a row of treatment, click the Add button icon.
- To delete a row of treatment, click the Delete button icon.
- The information in the top right corner of the screen is automatically calculated and displayed on the Treatment Summary screen.
- End date summary is a manual entry and is a required field if radiation is administered.
- When data entry is completed, click SAVE and then EXIT.

## Treatment-Chemo Maintenance

- Fields with drop down arrows contain codes and descriptions. Values may be manually entered or click the down arrow to display codes and description.
- Six User Defined fields are available to use to record extra information for Chemo.
- Chemo text may be entered on this screen or via the TextPad button screen. This field is the only chemo text field exported to the state and NCDB.
- Three User Defined Text fields have been added.
- All text fields have Copy/Cut and Paste functionality.
- Dates are entered as MM/DD/YYYY. The cursor will auto advance from MM to DD to YYYY.
- The use of unknown dates is allowed. For example: 99/99/9999, 10/99/2013, 99/99/2013, etc.
- F/S Flag is to record whether the treatment is First or Subsequent treatment. This field **MUST** be filled out.
- Record the treating physician number. If the number is not known, click on the arrow to look up the treating physician. If the physician is not on the list, the user can add it without leaving the page. Click the **New Physician** tab to add. This is an optional field.
- Record the treating hospital number. If the number is not known, click on the arrow to look up the treating facility. If the hospital is not on the list, the user can add it without leaving the page. Click the **New Hospital** tab to add.
- **Intent, Drug, Regimen, Toxicity, Response, Completion status, and Reason for stopping** fields are provided for optional internal use. These fields are not required and not exported to any standard setter.
- To add a row of treatment, click the Add button icon.
- To delete a row of treatment, click the Delete icon.
- The information in the top right corner of the screen is automatically calculated and displayed on the Treatment Summary screen.
- When data entry is completed, click **SAVE** and then **EXIT**.

## Treatment-Hormone Maintenance

- Fields with drop down arrows contain codes and descriptions. Values may be manually entered or click the down arrow to display codes and description.
- Two User Defined fields are available to use to record extra information for Hormone.
- Hormone text may be entered on this screen or via the TextPad button screen.
- All text fields have Copy/Cut and Paste functionality.
- Dates are entered as MM/DD/YYYY. The cursor will auto advance from MM to DD to YYYY.
- The use of unknown dates is allowed. For example: 99/99/9999, 10/99/2013, 99/99/2013, etc.
- F/S Flag is to record whether the treatment is First or Subsequent treatment. This field **MUST** be filled out.
- Record the treating physician number. If the number is not known, click on the arrow to look up the treating physician. If the physician is not on the list, the user can add it without leaving the page. Click the **New Physician** tab to add. This is an optional field.
- Record the treating hospital number. If the number is not known, click on the arrow to look up the treating facility. If the hospital is not on the list, the user can add it without leaving the page. Click the **New Hospital** tab to add.
- Drug, Regimen, Completion status and Reason for stopping and Physician fields are provided for optional internal use. These fields are not required and not exported to any standard setter.
- To add a row of treatment, click the Add Button icon.
- To delete a row of treatment, click the Delete button icon.
- The information in the top right corner of the screen is automatically calculated and displayed on the Treatment Summary screen.
- When data entry is completed, click **SAVE** and then **EXIT**.

## Treatment-Immunotherapy Maintenance

- Fields with drop down arrows contain codes and descriptions. Values may be manually entered or click the down arrow to display codes and description.
- Two User Defined fields are available to use to record extra information for Immunotherapy.
- Immunotherapy text may be entered on this screen or via the TextPad button screen.
- All text fields have Copy/Cut and Paste functionality.
- Dates are entered as MM/DD/YYYY. The cursor will auto advance from MM to DD to YYYY.
- The use of unknown dates is allowed. For example: 99/99/9999, 10/99/2013, 99/99/2013, etc.
- F/S Flag is to record whether the treatment is First or Subsequent treatment. This field **MUST** be filled out.
- Record the treating physician number. If the number is not known, click on the arrow to look up the treating physician. If the physician is not on the list, the user can add it without leaving the page. Click the **New Physician** tab to add. This is an optional field.
- Record the treating hospital number. If the number is not known, click on the arrow to look up the treating facility. If the hospital is not on the list, the user can add it without leaving the page. Click the **New Hospital** tab to add.
- Drug, Regimen, Completion status and Reason for stopping and Physician fields are provided for optional internal use. These fields are not required and not exported to any standard setter.
- To add a row of treatment, click the Add button icon.
- To delete a row of treatment, click the Delete button icon.
- The information in the top right corner of the screen is automatically calculated and displayed on the Treatment Summary screen.
- When data entry is completed, click **SAVE** and then **EXIT**.

## Treatment-Hematopoietic Maintenance

- Fields with drop down arrows contain codes and descriptions. Values may be manually entered or click the down arrow to display codes and description.
- Two User Defined fields are available to use to record extra information for Hematopoietic treatment.
- Hematopoietic text may be entered on this screen or via the TextPad button screen.
- Palliative, Hematopoietic and Other treatment share the same text field
- All text fields have Copy/Cut and Paste functionality.
- Dates are entered as MM/DD/YYYY. The cursor will auto advance from MM to DD to YYYY.
- The use of unknown dates is allowed. For example: 99/99/9999, 10/99/2013, 99/99/2013, etc.
- F/S Flag is to record whether the treatment is First or Subsequent treatment. This field **MUST** be filled out.
- Record the treating physician number. If the number is not known, click on the arrow to look up the treating physician. If the physician is not on the list, the user can add it without leaving the page. Click the **New Physician** tab to add. This is an optional field.
- Record the treating hospital number. If the number is not known, click on the arrow to look up the treating facility. If the hospital is not on the list, the user can add it without leaving the page. Click the **New Hospital** tab to add.
- Completion status, Reason for stopping and Physician fields are provided for optional internal use. These fields are not required and not exported to any standard setter.
- To add a row of treatment, click the Add Button icon.
- To delete a row of treatment, click the Delete Button icon.
- The information in the top right corner of the screen is automatically calculated and displayed on the Treatment Summary screen.
- When data entry is completed, click **SAVE** and then **EXIT**.

## Treatment-Palliative Maintenance

**Palliative Maintenance**

421158397      BREAST      SUSIE      Seq Prim: 01      Hosp: 01      Acc Nbr: 01202100003

Topo Code: C504      Class: 21      Dob: 09/01/1976      Diagnosis Date: 01/12/2021      Histology: Invasive carcinoma of no special type (C50\_) [BREAST ONLY]; A...

Hema / Other / Palliative Text:

Start Dt Sum:   
 Pall Summ:   
 Pall Here:   
 Days From Dx:

	Start Date	End Date	Pall	Comp St	Rsn Stop	F/S Flag	Physician	Hospital
1	mm / dd / yyyy	mm / dd / yyyy	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	mm / dd / yyyy	mm / dd / yyyy	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	mm / dd / yyyy	mm / dd / yyyy	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	mm / dd / yyyy	mm / dd / yyyy	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	mm / dd / yyyy	mm / dd / yyyy	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Add Delete

HEMA\_TEXT -

Save Previous Next Exit

- Fields with drop down arrows contain codes and descriptions. Values may be manually entered or click the down arrow to display codes and description.
- Palliative text may be entered on this screen or on the Summary screen.
- Note: Palliative, Hematopoietic and Other treatment share the same text field
- All text fields have Copy/Cut and Paste functionality.
- Dates are entered as MM/DD/YYYY. The cursor will auto advance from MM to DD to YYYY.
- The use of unknown dates is allowed. For example: 99/99/9999, 10/99/2013, 99/99/2013, etc.
- F/S Flag is to record whether the treatment is First or Subsequent treatment. This field **MUST** be filled out.
- Record the treating physician number. If the number is not known, click on the arrow to look up the treating physician. If the physician is not on the list, the user can add it without leaving the page. Click the **New Physician** tab to add. This is an optional field.
- Record the treating hospital number. If the number is not known, click on the arrow to look up the treating facility. If the hospital is not on the list, the user can add it without leaving the page. Click the **New Hospital** tab to add.
- Completion status, Reason for stopping and Physician fields are provided for optional internal use. These fields are not required and not exported to any standard setter.
- To add a row of treatment, click the Add button icon.
- To delete a row of treatment, click the Delete button icon.
- The information in the top right corner of the screen is automatically calculated and displayed on the Treatment Summary screen.
- When data entry is completed, click **SAVE** and then **EXIT**.

## Treatment-Other Maintenance

- Fields with drop down arrows contain codes and descriptions. Values may be manually entered or click the down arrow to display codes and description.
- Two User Defined fields are available to use to record extra information for Other treatment.
- Other text may be entered on this screen or via the TextPad button screen.
- Palliative, Hematopoietic and Other treatment share the same text field
- All text fields have Copy/Cut and Paste functionality.
- Dates are entered as MM/DD/YYYY. The cursor will auto advance from MM to DD to YYYY.
- The use of unknown dates is allowed. For example: 99/99/9999, 10/99/2013, 99/99/2013, etc.
- F/S Flag is to record whether the treatment is First or Subsequent treatment. This field MUST be filled out.
- Record the treating physician number. If the number is not known, click on the arrow to look up the treating physician. If the physician is not on the list, the user can add it without leaving the page. Click the **New Physician** tab to add. This is an optional field.
- Record the treating hospital number. If the number is not known, click on the arrow to look up the treating facility. If the hospital is not on the list, the user can add it without leaving the page. Click the **New Hospital** tab to add.
- Completion status, Reason for stopping and Physician fields are provided for optional internal use. These fields are not required and not exported to any standard setter.
- To add a row of treatment, click the Add button icon.
- To delete a row of treatment, click the Delete button icon.
- The information in the top right corner of the screen is automatically calculated and displayed on the Treatment Summary screen.
- When data entry is completed, click SAVE and then EXIT.



## Outcomes (Outcomes Maintenance)

### OUTCOMES

- Enter the Date of Last Contact
- F/U Notes is a free text field.
- Source may be entered for each occurrence (required in some States/optional in others)
- Entered and Entered By are auto filled by the software.
- Date Cancer Status Last Changed is a manual entry.
- Survival Months is auto calculated.
- If a Treatment Date is entered that is more current than the Date of Last Contact, the Treatment Date is copied here, along with the previous patient and cancer status.
- Date of Last Contact and patient status is copied to other primaries or for primaries shared in multiple facilities.

### LETTERS

- To enter a Following Physician, enter the ID number or click the down arrow to search for the physician by name. The Physician Name will auto fill.
- Letter Type is auto filled when a letter is generated.
- The field "Default Letter Types based on" must be coded to the enhanced follow up template.
- When a letter is generated the Date Sent will auto fill.

### RECURRENCE

- Enter the Date of Recurrence.
- Enter Recurrence Type by clicking on the down arrow.
- To add rows, click the Add button icon. To delete rows, click the Delete button icon.
- If Recurrence is unknown, enter 99/99/9999 for the date and 99 as Recurrence Type.
- If patient was never disease free, leave the date blank and enter 70 for Recurrence type.
- If the patient had a valid recurrence (local, regional, or distant) enter a valid date and the appropriate Recurrence type code.
- If Recurrence type is left blank, the field exports with a 00.

### LABS

- Multi valued fields to collect repeating Lab Values are provided.
- These fields are not required and not exported to any standard setter.
- The fields Collected and Value are free text fields.

- To add rows, click the Add button icon. To delete rows, click the Delete button icon.

### State Specific (State Maintenance)

If a state collects information not required by NAACCR or the CoC, Health Catalyst provides a state screen to collect these data elements. The State screen follows the Outcomes screen. Click Next or State Specific screen tab. State screens and the data collected vary from state to state.

CA Specific Fields Maintenance

421158397 BREAST SUSIE Seq Prim: 01 Hosp: 01 Acc Nbr: 01202100003

Topo Code: C504 Class: 21 Dob: 09/01/1976 Diagnosis Date: 01/12/2021 Histology: Invasive carcinoma of no special type (C50\_) [BREAST ONLY]; Ade...

CA STATE 1 CA STATE 2

First Name Alias:   
 Mother First Name:   
 Reg Id Nbr:   
 Reg Tum Nbr:   
 Code Procedure:   
 Discovered by Screening:   
 Last Follow-Up Hosp:   
 Next Follow-Up Hosp:   
 Last Tumor Follow-Up:   
 Last Patient Follow-Up:   
 Tumor Marker (Her2/Neu):

Height (inch): 62  
 Weight (lbs): 131  
 Source Comorbidity:   
 Tobacco Use Cigarette:   
 Tobacco Use Other:   
 Tobacco Use Smokeless:   
 Tobacco Nos:   
 Religion:   
 Primary Payer Dx:   
 Pay Source 2:   
 Patient Contact:

Diagnosis / Treatment Report

	Month	Day	Year	Number	Type	Facility ID
1	mm	dd	yyyy	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	mm	dd	yyyy	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	mm	dd	yyyy	<input type="text"/>	<input type="text"/>	<input type="text"/>

Trans Remarks:   
 Pay Source Txt:

CA\_FIRST\_NAME\_ALIAS -

Save Previous Next Exit Text


## CPM Accreditation Audit Screens

In order to assist programs with the required chart reviews and provide a way to report on this respective data, CRStar has added an audit screen to correspond with the American College of Surgeon's three cancer programs.

### General Audit Screen Information

Audit screens have been designed for an easy point and click experience as you process through the medical record. The audit screen can be found in the **CPM**, **BPM** and **RPM** tab along the top of the abstract.



- To view help notes, select the applicable line, then choose the  icon in the top right of the screen
- Labels will include the standard number and the subsequent audit elements that fall within each standard
- Users will notice that fields that previously resided on the accreditation screens that are now part of the audit checklist, have been relocated from their previous positions to the audit screens
- Audit note text fields have been added for each screen
- Field index numbers for reporting have been added to the illustrated and Excel lists found on the CRStar Resource page
- Answer choices for each question include: No, Yes, N/A, Unk

## CPM (Cancer Program Maintenance)

The screenshot displays the 'CPM Chart Audit' interface, specifically the 'Cancer Conferences & Clinical Trials' section. It features two columns of audit standards (Std 4.4 to Std 5.8) with corresponding radio button options for 'No', 'Yes', 'N/A', and 'Unk'. Below the standards, there are input fields for 'Patient Nav Process', 'Screening Date', and a table for recording conference data. The table has columns for 'Cancer Conf Date', 'Discip', 'CC Pres', 'Attendees', 'CC Comments', 'Stage Comp', 'Clinical Stage Disc', 'Path Stage Disc', 'Prognost Indicat Disc', 'National Guide Disc', 'Clinical Trial Disc at CC', 'Genetic Ref Disc', 'Support Care Ref Disc', 'Tx Init Before Present', and 'Tx Rec by Multidisc Team'. A date picker is visible at the bottom left of the table area.

- An Accreditation Audit screen to collect, monitor and report on Cancer Program standards has been provided.
- Answer choices for each question include: No, Yes, N/A, Unk
- These fields are not required and not exported to any standard setter. They are extremely valuable for tracking and reporting on program standards and initiatives.
- Cancer Conference fields are multi valued to collect multiple conferences.
- Unknown Dates may be used. For example, 99/99/9999, 99/99/2013, etc.
- Attendees and CC Comments are free text fields.
- The user can code staging completeness, clinical stage discussed, and national guidelines discussed for individual conferences.
- Click the down arrow to select codes and descriptions. Must use the tabs to go from one screen to another.
- To add rows, click the Add button icon. To delete rows, click the Delete button icon.
- Clinical Trial fields are multi valued to collect multiple trial information.
- Trial Name can be either free text or codes and descriptions can be set up in the Global Dictionary.
- F/U (Following status) is a user defined field and can have codes and descriptions set up in the Global Dictionary.
- Enter the Tracking Physician's ID number or click the drop-down arrow to look up the physician. Highlight the Physician name in the list and click to enter.
- Reason Withdrawn from Trial is a free text field.
- An array of fields is available to collect Continuum of Care information. Click the drop down for codes and descriptions.
- Five Customizable User Defined fields are available to collect additional information. Please see Chapter on setting up User Defined fields in the System Administrator section of this manual.



## BPM (Breast Program Maintenance)

		No	Yes	N/A	Unk
<b>Std 5.2</b>	<b>Diagnostic Imaging of the Breast and Axilla</b>				
	Image and Pathology Concordance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Bx Path results w/ pt	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Std 5.5</b>	<b>Genetic Evaluation and Management</b>				
	Personalized genetic risk assessment and eval	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Documentation of pertinent family Hx	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Genetic eval and testing discussed with Pt	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Discussion of family members appropriate for testing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Std 5.6</b>	<b>Eval and Tx Planning for Newly Dx Cancer Patient</b>				
	Staging assigned appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Biopsy slides reviewed prior to treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	For Pt w/ no slide review - discussed w/ Pt	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Imaging reviewed or redone by facility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Metastatic Workup completed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Laboratory workup completed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Std 5.7</b>	<b>Comprehensive Eval of PT Factors Before Treatment</b>				
	Patient provided a navigator through journey	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Std 5.9</b>	<b>Surgical Care</b>				
	Evidence-based guidelines followed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Pre-op & post-op pt education provided	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Pre-op & post-op functional assessment & referrals provided	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Proper pain management strategies utilized	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Std 5.10</b>	<b>Reconstructive Surgery</b>				
	Pre-op referral/discussion for reconstruction/plastic surgeon	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Multidisciplinary input on impact of reconstruction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Std 5.11</b>	<b>Medical Oncology</b>				
	Evidence-based guidelines followed, if not discussed at MCB	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Exercise therapy recommendations discussed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Std 5.12</b>	<b>Radiation Oncology</b>				
	Evidence-based guidelines followed, if not discussed at MCB	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- Two Accreditation Audit screens to collect, monitor and report on Breast Program standards has been provided.
- Answer choices for each question include: No, Yes, N/A, Unk
- There are five User Defined screens. Use the tabs to go from one BPM screen to another.
- These fields are not required and not exported to any standard setter. These are extremely valuable for tracking and reporting on program standards and initiatives.
- Click the down arrow to select codes and descriptions.
- Five Customizable User Defined fields are available to collect additional information. Please see Chapter on setting up User Defined fields in the System Administrator section of this manual.

## RPM (Rectal Program Maintenance)

Topo Code: C180      Class: 14      Dob: 04/20/1942      Diagnosis Date: 04/07/2014      Histology: Adenocarcinoma, NOS, Acinar adenocarcinoma (C61.9 ONLY) [D... ?]

RPM Chart Audit: Continuum of Care Services

	No	Yes	N/A	Unk
<b>Std 5.1 Review of Diagnostic Procedures</b>				
Biopsy Path Slides/Rpt Reviewed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Re-biopsy performed on site	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Std 5.2 Staging before Definitive Treatment</b>				
Clinical staging in MR prior to treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Std 5.3 Standardized Staging Reporting for MRI Results</b>				
Pre-treatment MRI read by member of RC-MDT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MRI staging including required elements in synoptic format	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Std 5.4 Carcinoembryonic Antigen Level</b>				
CEA performed prior to definitive treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Std 5.5 Rectal Cancer Multidisciplinary Team Tx Planning Discussion</b>				
Tx planning discussed with RC-MDT prior to tx	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Std 5.6 Treatment Evaluation and Recommendation Summary</b>				
Tx eval and recommendation provided to treating physician	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Std 5.8 Surgical Resection and Standardized Operative Reporting</b>				
Operative report in required format	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Std 5.9 Pathology Reports after Surgical Resection</b>				
Path reviewed by team member	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Path report w/ correct components w/in 2wks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Std 5.10 Photographs of Surgical Specimen</b>				
Photo appropriate and discussed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Std 5.11 Multidisciplinary Team Post-Surgical Tx Outcome Discussion</b>				
Post-Surg RC-MDT w/in 4wk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Std 5.12 Post-Surg Treatment Outcome Discussion Summary</b>				
Post-Surg Tx summary to tx physician	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Std 5.13 Adjuvant Therapy after Surgical Resection</b>				
Adj Tx begun w/in 8 wk of def resection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

RPM Audit Notes

RPM\_BIOPSY\_REVIEWED - No

Save Previous Next Exit Text

- A screen to collect, monitor and report on Rectal Program standards has been provided.
- Answer choices for each question include: No, Yes, N/A, Unk
- These fields are not required and not exported to any standard setter. These are extremely valuable for tracking and reporting on program standards and initiatives.
- Click the down arrow to select codes and descriptions.
- Five Customizable User Defined fields are available to collect additional information. Please see Chapter on setting up User Defined fields in the System Administrator section of this manual.

## User Defined (User Defined 1)

- There are two User Defined screens.
- These fields are not required and not exported to any standard setter.
- To select a screen, click on User Def 1 or User Def 2 at the top of the screen.
- Click next while on the User Def 1 tab, the system will bypass User Def 2 and go to the Case Admin screen. Must use the tabs to go from one User Def screen to another.
- Dates are entered as MM/DD/YYYY. The cursor will auto advance from MM to DD to YYYY.
- Unknown dates can be entered. For example, 99/99/9999, 99/99/2013, etc.
- All the UDF fields, except the 10 date fields (41-50) can hold 50 characters.



## User Defined (User Defined 2)

The screenshot shows a software interface for configuring user-defined fields. At the top, patient information is displayed: DEMO, MELANIE, Seq Prim: 01, Hosp: 01, Acc Nbr: [blank], Topo Code: C502, Class: 10, Dob: 03/10/1959, Diagnosis Date: 08/12/2018, and Histology: Invasive carcinoma of no special type (C50\_) [BREAST ONLY]; Ade... A help icon is visible in the top right corner.

Below the patient information, there are two tabs: "User Def 1" and "User Def 2". The "User Def 1" tab is active, showing a list of 30 user-defined fields arranged in four columns. Fields 46-50 are date fields with a date mask (mm/dd/yyyy). Fields 51-55 are dropdown menus with labels: "Anti Coagulation", "Hx of Wound IFXN", "HX of Staph Carri", "Skin Ca Syndrome", "Immunosuppression", "Mohs Indication", "17315 Units bille", "Special Stains", "Referral repair", "Timing Repair", and "Prophylactic ABX". Fields 56-59 are dropdown menus with labels: "Post Rx Tests", "Pat. Satisf.", "Udef 64", "Udef 65", "Udef 66", "Udef 67", "Udef 68", and "Udef 69". Fields 70-74 are dropdown menus with labels: "Udef 70", "Udef 71", "Udef 72", "Udef 73", and "Udef 74". The "COVID TEST:" field is also a dropdown menu.

At the bottom of the form, the text "UDEF\_46 -" is displayed. Below this, there are five buttons: "Save", "Previous", "Next", "Exit", and "Text".

- These fields are not required and not exported to any standard setter.
- Seventy-five user defined fields are available for use.
- User Defined 41-50 are true date fields.
- Field labels can be changed.
- Codes and descriptions can be created to fit the user's needs.
- All UDF are available to use in the Reporting module.
- Help Notes can be created for each UDF.
- Color coding and required status may also be utilized.
- See the Chapter on User Defined fields in the System Administrator section of this manual.

## Case Admin (Case Admin Maintenance)

- Date Abstracted automatically fills with the current date.
- Abstractor's Initials will default based upon the user's login.
- RCRS Case field is a non-required field, however helpful in tracking RCRS cases.
- State Report field allows the user to indicate if the case is reportable and ready to be submitted to the state, non-reportable, Incomplete, etc. This flag must be coded to a Y to be able to be exported to the state. This field has no bearing on NCDB case selection.
- When a population of cases has been submitted to the state, the Y will change to a T to indicate they have been transmitted and the date of the export will auto fill on each case in the field State Report Date. This date will never be overwritten.
- If a case is re-exported for any reason the date will auto fill in the field Last Export to State.
- Date Case initiated auto fills when the case is entered manually or through a merge.
- Date Case Comp Coc auto fills when all the fields required by the CoC are filled (depending on Class of Case).
- Date Last Modified and last Modified By is auto filled each time an existing record is updated/modified.
- Last Export To State records the most recent date the case has been re-exported.
- CoC Coding Systems are generally filled in based on diagnosis date and rarely need review or change. To access a field, click the down arrow.
- Overrides should be set only if edits are run and an edit indicates that a case must be reviewed and that an override is appropriate to set. Only set the override that is indicated in the edit error message.
- This screen is the last required screen of the abstract. Click Save. Click the quick links to access the GenEdits box to run state specific edits, standard NAACCR edits, NCDB edits and RCRS edits. After a correction is made to a field on any screen, click save and the Quick link to re-run the edit to ensure the edit cleared.

## Clinical (Clinical Maintenance)

- These fields are not required and not exported to any standard setter.

## Research (Research Maintenance)

DEMO MELANIE Seq Prim: 01 Hosp: 01 Acc Nbr: ?

Topo Code: C502 Class: 10 Dob: 03/10/1959 Diagnosis Date: 08/12/2018 Histology: Invasive carcinoma of no special type (C50\_) [BREAST ONLY]; Ade...

History and Physical: <input type="checkbox"/>	Abd/Pelvic Ct: <input type="checkbox"/>	Alkaline Phos: <input type="checkbox"/>	Needle BX: <input type="checkbox"/>
Pathology Review: <input type="checkbox"/>	Chest CT: <input type="checkbox"/>	ERA: <input type="checkbox"/>	DRE: <input type="checkbox"/>
Pathologic Confirmation: <input type="checkbox"/>	Pelvis CT: <input type="checkbox"/>	PRA: <input type="checkbox"/>	Gleason Scoring: <input type="checkbox"/>
Multi Team Eval: <input type="checkbox"/>	Chest Imaging: <input type="checkbox"/>	HER2: <input type="checkbox"/>	PSA: <input type="checkbox"/>
Xrays: <input type="checkbox"/>	Bone Scan: <input type="checkbox"/>	Colonoscopy: <input type="checkbox"/>	Smoking Cessation Counseling: <input type="checkbox"/>
MRI: <input type="checkbox"/>	PET Scan: <input type="checkbox"/>	Kras Gene Status: <input type="checkbox"/>	PFT: <input type="checkbox"/>
Abdomen Mri: <input type="checkbox"/>	CBC: <input type="checkbox"/>	Site Mapping: <input type="checkbox"/>	Bronchoscopy: <input type="checkbox"/>
Brain Mri: <input type="checkbox"/>	Platelets: <input type="checkbox"/>	Date Site Mapping: mm / dd / yyyy	Mediastinoscopy: <input type="checkbox"/>
Spine Mri: <input type="checkbox"/>	LFT: <input type="checkbox"/>	Bx First Recur: <input type="checkbox"/>	Thoracentesis: <input type="checkbox"/>
US: <input type="checkbox"/>	Chemistry Profile: <input type="checkbox"/>	Proctoscopy: <input type="checkbox"/>	Thoracoscopy: <input type="checkbox"/>
Abdomen Us: <input type="checkbox"/>	CEA: <input type="checkbox"/>	Enterostomal Therapist: <input type="checkbox"/>	

HISTORY\_AND\_PHYSICAL -

Save Previous Next Exit Text

- These fields are not required and not exported to any standard setter.

Retired (Retired Maintenance)

DEMO MELANIE Seq: 01 Hosp: 01 Acc Nbr: [?]  
 Topo Code: C502 Class: 10 Dob: 03/10/1959 Diagnosis Date: 08/12/2018 Histology: Invasive carcinoma of no special type (C50\_) [BREAST ONLY]: Ade...

Retired 1 Retired 2

Extn Prost Path: [v]	Date Conclusive: mm / dd / yyyy	OT: [v]	Sex Suffix: [v]	Date Entered: mm / dd / yyyy
Tumor Marker 1: [v]	Date Mult Tumor: mm / dd / yyyy	ON: [v]	Dx Census Tract: [v]	Entered By: [v]
Tumor Marker 2: [v]	Mult Tumor Report As One: [v]	OM: [v]	Census Code Sys: [v]	Site Dist 1: [v]
Tumor Marker 3: [v]	Multiplicity Counter: [v]	OAjcc Grp: [v]	Census Poverty Ind: [v]	Site Dist 2: [v]
Tum Rec Nbr: [v]	Ambig Term: [v]	OS Staged By: [v]	Dx Occupation: [v]	Site Dist 3: [v]
Ref To Support: [v]	Size: [v]	OSTg Descriptor: [v]	Dx Industry: [v]	Recur Other: [v]
Pos Dx Date: mm / dd / yyyy	Rx Intent: [v]	OTH Stg Sys: [v]		
Surg Approach: [v]	Reg Dose Cgy: [v]	OTH Stg: [v]		
Rsn No Chemo: [v]	Boost Dose Cgy: [v]			
Rsn No Horm: [v]	Rad Comp St: [v]			
Rad Br Cx: [v]	Rad Vol: [v]			
Recon Surg: [v]	Rad Nbr Vol: [v]			
Recon Delayed: [v]	Loc Cntr St: [v]			

O Stage Desc [v] C Stage Desc [v] P Stage Desc [v]

Recur Date: 1 mm / dd / yyyy Met 1 Met 2 Met 3

EXTN\_PROST\_PATH - Save Previous Next Exit Text

DEMO MELANIE Seq: 01 Hosp: 01 Acc Nbr: [?]  
 Topo Code: C502 Class: 10 Dob: 03/10/1959 Diagnosis Date: 08/12/2018 Histology: Invasive carcinoma of no special type (C50\_) [BREAST ONLY]: Ade...

Retired 1 Retired 2

Drug			Chemotherapy		Radiation						
Drq Code	Amt Bld	Len Stay	Chemo Date	Chemo Type	Rad Date	Rad Sites	Nbr Rads	Fxs	Modality		
[v]	[v]	[v]	mm / dd / yyyy	[v]	mm / dd / yyyy	[v]	[v]	[v]	[v]		
[v]	[v]	[v]	mm / dd / yyyy	[v]	mm / dd / yyyy	[v]	[v]	[v]	[v]		
[v]	[v]	[v]	mm / dd / yyyy	[v]	mm / dd / yyyy	[v]	[v]	[v]	[v]		

Alcohol Usage: [v] Family History: [v] Smoking: [v] Pack Yrs: [v] Diagnosis of AIDS: [v] AIDS Dx Date: [v]

DRG\_CODE - Save Previous Next Exit Text

- These fields are no longer required and are only exported to a standard setter for applicable historical cases.

## Rapid Abstract

CRStar has a Rapid Abstract feature. The Rapid Abstract enables users to disable fields either not required by a standard setter or not collected at the facility. When a field is "turned off", it greys the field out for an easy visual indicator. The user's cursor will skip any fields that have been excluded in the Rapid Abstract when tabbing through the fields. Note: The Rapid Abstract tab activates on the Abstract Management Menu once a field has been set. The Rapid Abstract feature can streamline abstracting when facilities do not collect all fields. Facilities should consider their individual data collection needs to see if the Rapid Abstract is right for all cases or for collecting select cases. Possible uses of the feature beyond the full abstract may include state reporting only cases, non-analytic cases, reportable by agreement or special study cases. Note: Users may view the same case in the full abstract as well as in the Rapid Abstract.

The Rapid Abstract is located under Abstract Management. When a user clicks the Rapid Abstract tab, the Rapid Icon will appear in the top left corner of the screen. Note: At least one field needs to be disabled before the rapid tab is accessible.

	Patient	Diagnosis	Staging	Treatment	Outcomes	State Specific	CPM	BPM	RPM	User Defined	Case Admin	Clinical	Research	Retired
A	522335417	420425765	LARYNX	MEDFORD	H									
A	141106873	419032546	URINARY BLADDER	ALBERT										
A	141106873	5459	CORPUS	MARGARET	J									
A	127390164	420543830	COLON	BERTHIA	L									
A	781165485	422016555	lung	RUBY	E									
A	218431776	274387591	STOMACH	DAVID										
A	218124721	704057064	RECTUM	DAVID	A									
A	733419495	425785499	LYMPH NODES	SHIRLEY	A									
A	155190615	237160590	PANCREAS	ANNIE	B									

Below is an example of the Diagnosis Maintenance screen with the Rapid Abstract set up with desired fields disabled. Note: The Non-Analytic default is available in the Rapid Abstract.

The screenshot shows the 'Diagnosis Maintenance' screen for patient 'JOE'. The patient's information includes: Topo Code: C209, Class: 13, Dob: 01/01/1945, Diagnosis Date: 12/28/2019, and Histology: Adenocarcinoma, NOS; Adenocarcinoma, usual type; Carcinoma ... The 'Reporting Source' field is set to '1'. A blue arrow points to this field. The 'Non-Analytic Defaults' button is located at the bottom right of the screen.

### Helpful Hints:

- In a Multi hospital setting, the Rapid abstract is set for all facilities.
- When excluding dates, the user must exclude the day, month and year dates which are separate field index numbers.
- Also remember entire screens of the abstract may be hidden if not collected per user by going to System Admin, Security Maintenance and User security.
- When setting up the Rapid Abstract, use the CRStar Field Index Number Illustrated List as a guide. This document is located on the CRStar Resources page under the Reporting Insights.
- To disable fields, go to System Admin, Utilities, Global Directory

Both the Full Abstract and the Rapid can be utilized depending on the type of case.

The screenshot shows the 'User Security' configuration screen for user 'Melanie Rogan'. The 'Menu Items' section is visible, showing a list of 'Available Items' on the left and 'Unavailable Items' on the right. A blue arrow points from 'Case Admin Maintenance' in the 'Available Items' list to 'Cancer Program Maintenance' in the 'Unavailable Items' list.

## Print Forms

### Print Abstract

The Print Abstract function is located under Abstract Management, Print Forms, and Abstract. This utility is also available within the abstract with the Quick Links.

The screenshot shows the 'Print Abstracts' interface. At the top, there are tabs for 'Abstract', 'Tx Summary/Custom', 'QA', and 'SCP'. Below the tabs, the 'Print Abstracts' section contains a search area with fields for 'Patient Name', 'Site', 'Sequences', 'Hospital', 'Med Rec Nbr', and a 'Population Label' dropdown. To the right of the search area, there are two columns of checkboxes for selecting content to print. The first column is under 'Patient Abstract - Full' and includes checkboxes for 'Patient Demographics', 'Care Team', 'Diagnosis', 'Staging', 'Treatment Summary', 'Surgery', 'Radiation', 'Chemo', 'Hormone', 'Immunotherapy', 'Hematopoietic', 'Palliative', and 'Other Treatment'. The second column is under 'Patient Abstract - Summary' and includes checkboxes for 'Outcomes', 'Case Administration', 'Cancer Program Info', 'Breast Program Info', 'Rectal Program Info', 'User Defined', 'Clinical', 'Research', 'State Specific', and 'Retired'. At the bottom of the interface, there are 'Run' and 'New' buttons.

1. Click the magnifying glass to open the patient lookup. The patient may be searched by name, social security number, DOB, accession number, site code, hospital code or medical record number. When searching, the full or partial names and numbers may be used. (Note Population Label will remain blank if printing an individual case.)
2. Click the drop-down arrows beside the Site, Sequence and Hospital number of the primary to print. Note: If only one primary exists in only one hospital, this can be left blank, click enter.



3. Choose either Patient Abstract – Summary or Patient Abstract -Full, which has many more screen options. When the full abstract option is chosen, the default of the screens to print are the required screens (Demographics, care team, diagnosis, staging, treatment summary, outcomes, and case admin). Caution: Printing all screens will result in many pages. Both versions may be viewed on screen and/or printed. The Printed Abstract of both is in portrait format. To display with the shaded section headers, while in print preview, go to more settings. Check the background graphics box.
4. Click RUN.
5. To print multiple abstracts at one time, the user may first select a population of cases under the Reporting tab. **NOTE: The program is written to print less than 300 cases at a time. The system will give the user a message that the population is too large to print.**

### Print TX Summary

The Treatment Summary feature is located under Abstract Management, Print Forms and TX Summary\Custom. These can be printed individually or in a batch by selecting a population.

In addition to the Treatment Summary provided, the user can create custom forms that can be printed from this tab. This is addressed later in the instructions.

#### To print individual forms:

The screenshot shows a web-based form titled "Print Tx Summary". It includes several input fields: "Patient Name" with the value "THELMARINE" and a dropdown for "lung"; "Site" with a dropdown showing "34" and "BRONCHUS & LUNG"; "Sequence" with the value "00"; "Hospital" with a dropdown showing "01" and "ERS Hospital Systems"; and "Med Rec Nbr" with the value "422988834". Below these is a "Population Label" dropdown. At the bottom left, there is a "Send Form To" section with two radio buttons: "Screen" (which is selected) and "Excel". To the right of this is a "Forms" dropdown menu currently set to "Original Treatment Summ". At the very bottom of the form, there are two buttons: "Run" and "New".

1. Click on the magnifying glass to do a Patient Lookup, click on the desired patient name.
2. Use drop down arrow to select which primary Site to print.
3. Use drop down arrow to select the Form to print.
4. Choose to send the Form to the Screen or Excel. Note: If Excel is chosen the form will default to the treatment summary. This is because the treatment summary is the only form that CRStar is providing and it is hard coded in Excel. If the screen option is chosen and the user has created custom forms, those forms are available in the drop down. See next page for illustration.
5. Click Run. Depending on browser settings, either Excel will open automatically, or the user will receive a message to open or save the abstract to a specific location.
6. Once in Excel, the form may be modified, saved, or printed.

## To print population of forms:

Print Tx Summary

Patient Name:

Site:

Sequence:

Hospital:

Med Rec Nbr:

Population Label:

Sort Order:

Print One Form Per Patient

Print One Form Per Primary

Send Form To

Screen

Excel

Forms:

FORM\_LABEL - Original Treatment Summary

1. First select a population of cases, under the Reporting tab.
2. Use the drop-down arrow to click and choose the Population of cases to print.
3. Choose a Sort order. The default is alphabetic, but other choices are available by clicking on the drop-down arrow.
4. Choose the appropriate radio button for what to print.
  - a. Print one form per patient will only print one form even if the patient has multiple primaries. In doing so, the program first looks at the sort option. Then selects the first patient that it finds. This is based on the first case entered in to CRStar; usually, but not always being the first primary. Some examples of when the user might select one form for patient would be things that are patient driven and not primary driven. Two examples: If the user created a patient satisfaction survey or a patient registration form for a screening, clinical trial, or special study.
  - b. Print one form per primary will print a form for each primary that exist for that patient within the population selected.
5. Choose to send the Form to the Screen or Excel. Note: If Excel is chosen the form will default to the treatment summary. This is because the treatment summary is the only form that CRStar is providing and it is hard coded in Excel. If the screen option is chosen and the user has created custom forms, those forms are then available in the drop down. See next page for illustration.
6. Click Run. Dependent on browser, Excel will open automatically.
7. Once in Excel, the form may be modified, saved, or printed.

When the screen option is chosen, other form templates the user may have created are visible from the drop down as shown below.

The screenshot shows the 'Print Tx Summary' interface. It includes fields for Patient Name, Site, Sequence, Hospital, and Med Rec Nbr. Below these are dropdown menus for Population Label (set to '2018 rad test') and Sort Order (set to 'Alphabetic by Last Name, First Name'). There are radio buttons for 'Print One Form Per Patient' and 'Print One Form Per Primary' (selected). Under 'Send Form To', 'Screen' is selected. A 'Form:' dropdown menu is open, showing a list of form templates with their corresponding 'Hosp Code'. A green arrow points to the dropdown menu.

Form	Hosp Code
Fax cover Sheet	01
ghj	01
First Contact Date Test	01
NEW PLACEHOLD TEST	01
Original Treatment Summary	01
PAT SATISFACTION	01
Physician QA Form	01
scp	01
Testing Placeholders	01
Text Only	01
Treatment Summaryq1	01
A New Test	

The Treatment Summary template can be found under Systems Management, then Custom Forms. Click on the arrow to display the drop-down menu. Note: There is one Treatment Summary labeled Hospital 01. In a multi hospital system this template can be used for all facilities. The only time the

user would need one per facility would be if different facilities wanted to modify the template to meet their own needs. The template can be copied from one facility to another and then modified as shown below.

The screenshot shows the 'Custom Forms' tab in a software interface. The 'Form Name' is 'Treatment Summaryq1' and the 'Form Type' is 'Treatment Summary'. The 'Hospital Code' is '01'. The 'Form Content' area contains a rich text editor with a table:

	Patient Identification	Care Team
Med Rec Nbr	{Med-Rec-Nbr}	Surgeon [20]{{Prim-Surg-FN}} {Prim-Surg-LN} {Prim-Surg-Title}
Patient Name	{Pat-FN} {Pat-LN}	Med Oncologist [20]{{Med-Onc-FN}} {Med-Onc-LN} {Med-Onc-Title}
Date of Birth	{Dob}	Rad Oncologist [20]{{Rad-Onc-FN}} {Rad-Onc-LN} {Rad-Onc-Title}
Age at Dx	{Age-Dx}	Managing Phys [20]{{Mng-Phys-FN}} {Mng-Phys-LN} {Mng-Phys-Title}
Race	{Race-Desc}	Following Phys [20]{{Fol-Phys-FN}} {Fol-Phys-LN} {Fol-

Below the table is the text 'LETTER\_TYPE - Treatment Summary' and a toolbar with buttons for 'New', 'Save', 'Preview', 'Copy', and 'Delete'.

1. Click on the form name and select the form to copy. In this example, Treatment Summary Hosp Code 01.
2. Choose the copy feature.
3. Enter a new form name and the hospital code to copy to.
4. Click OK.

Form	Hosp Code
TEST REGISTRATION FORM	01
Treatment Summary	01
Treatment Summary	02
Tumor Board Discussion	

← After Copy

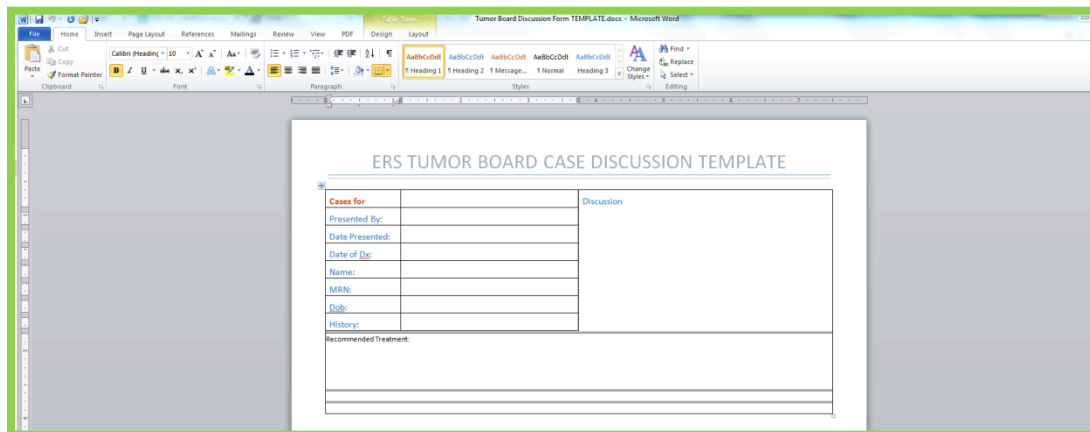
Important: The Follow Up letters and the Forms share the same table. If a Follow Up letter already exists, for example named Treatment Summary, the Form must be given a different name and vice versa. If not given a different name, the form will not copy.

### Print TX Summary-CUSTOM FORMS

Users can create Custom Forms. Forms may be created in Word in a table format and copied into the form template. Note: When creating a table in Word to copy, it is suggested to make all updates to

the table prior to copying into the form template in CRStar. Below is an example of creating a table in Word and copying it into the form template. This example is a Tumor Board Case Discussion form.

After the form template, has been created in Word:

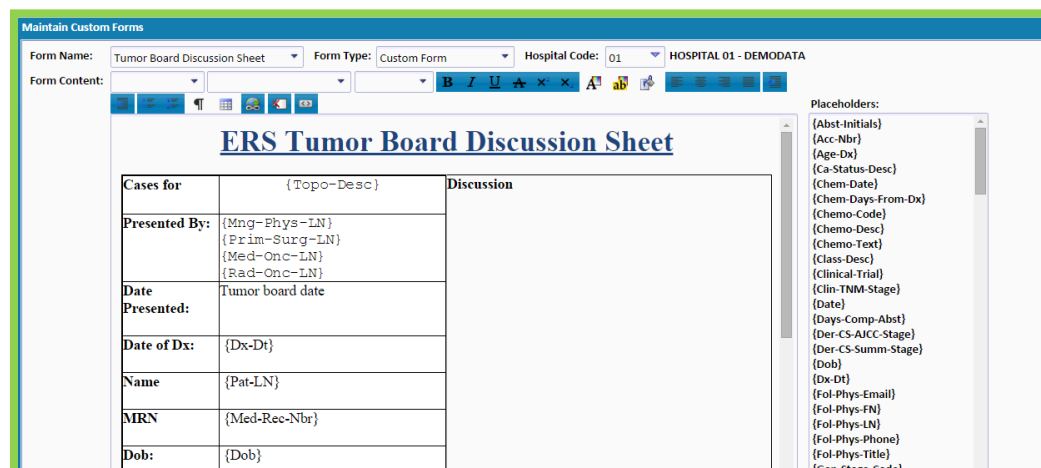


1. Copy

the form in Word.

2. Go to Systems Management, then Custom Forms.
3. Enter a form name and the appropriate hospital code.
4. Paste into the body of the form template in CRStar. (Special Note: It is ok to copy letter templates from Word, but when doing so the whole letter should be copied at the same time so it all has the same hidden formatting. It can mess things up with the hidden formatting if someone enters the header in CRStar, but then copies a block of text from Word, then goes back to editing in CRStar. Word uses some different formatting than regular html, so our advice is that whenever a letter template is going to be copied from Word, be sure to copy the whole letter template and not just cut portions of the letter from different sources. If this was not done and the letters do not appear to be printing correctly: To fix the issue, copy the template to Notepad which strips out all the hidden formatting, and then copy back to CRStar. (This could be useful if the user has changed the font to something other than Courier New and later decide to change back to Courier New. They can start from a clean slate by copying from Notepad.)
5. Customize as needed, changing fonts, size, colors, etc.
6. Place holders are provided for fields that exist in the abstract to auto fill into the form. The user can drag and drop a placeholder to a certain location or copy and paste.
7. Use Preview to see how the form will look when printed.
8. Click Save.

The form template after it has been copied from Word:

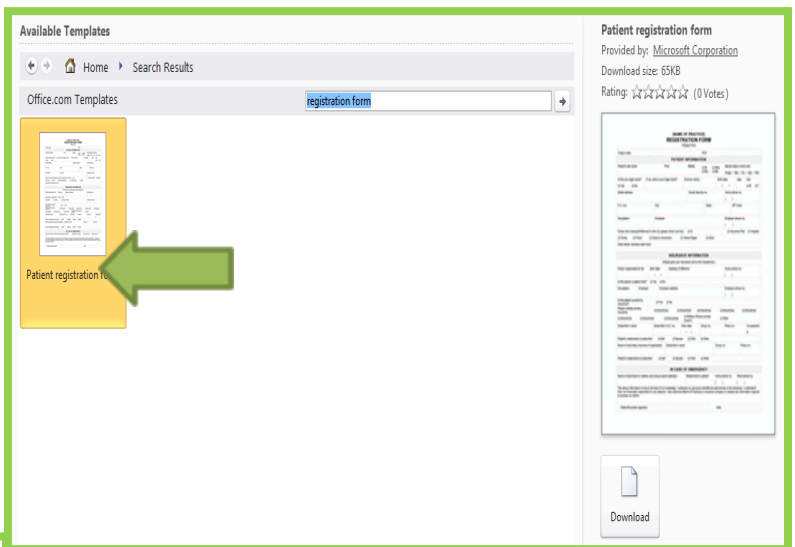
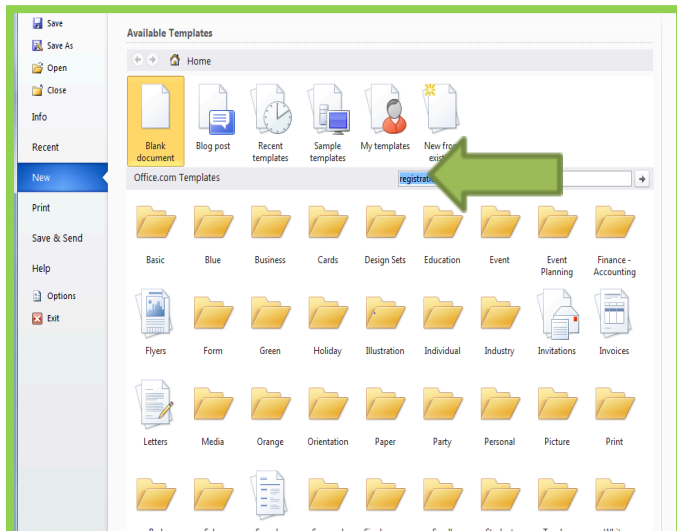


The form after it has been printed:

<b><u>ERS Tumor Board Discussion Sheet</u></b>		
<b>Cases for</b>	Upper-inner quadrant of breast	<b>Discussion</b>
<b>Presented By:</b>	KNIFE COLLINS GoLucky ELECTRA	
<b>Date Presented:</b>	Tumor board date	
<b>Date of Dx:</b>	04/03/2013	
<b>Name</b>	DEMO, DIANE	
<b>MRN</b>	534500350	
<b>Dob:</b>	01/16/1945	
<b>History</b>		
<b>Recommended Treatment:</b>		

## Helpful Hint:

There are many templates available in Microsoft Word. Use these forms as a basic template and customize and save to meet individual needs. These template folders can be searched for various types of templates. See below.



REGISTRATION FORM					
(Please Print)					
Today's date:		PCP:			
PATIENT INFORMATION					
Patient's last name:		First:		Middle:	
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.		<input type="checkbox"/> Miss <input type="checkbox"/> Ms.		Marital status (circle one)	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name?		(Former name):	
Street address:		Social Security no.:		Birth date: / /	
P.O. box:		City:		State: ZIP Code:	
Occupation:		Employer:		Employer phone no.:	
Chose clinic because/Referred to clinic by (please check one box): <input type="checkbox"/> Dr. <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital					
<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other					
Other family members seen here:					
INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:		Birth date: / /		Address (if different):	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No		Occupation:		Employer address:	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Employer phone no.:		Employer address:	
Please indicate primary insurance: <input type="checkbox"/> [Insurance] <input type="checkbox"/> [Insurance] <input type="checkbox"/> [Insurance] <input type="checkbox"/> [Insurance] <input type="checkbox"/> [Insurance] <input type="checkbox"/> [Insurance]					
<input type="checkbox"/> [Insurance] <input type="checkbox"/> [Insurance] <input type="checkbox"/> [Insurance] <input type="checkbox"/> Welfare (Please provide coupon) <input type="checkbox"/> Other					
Subscriber's name:		Subscriber's S.S. no.:		Birth date: / /	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Group no.:		Policy no.:	
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Policy no.:		Co-payment: \$	
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):		Relationship to patient:		Home phone no.:	
				( ) ( )	
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.					
Patient/Guardian signature				Date	

This is an example of a Registration Form Template that could be customized in Word and saved as a Custom Form in CRStar.

**Special Note:** When using letter templates from Word, the entire letter template must be used to

retain the hidden format. Html formatting differs from offline formatting and can create errors. An example is entering a header in CRStar and then copying a block of text from Word and editing that text in CRStar. If there is hidden formatting creating issues, copy the template to Notepad which strips out all the hidden formatting. Once hidden formatting is stripped, copy, and paste the text back into CRStar (this step is useful if the user has changed the font to something other than Courier New and then decides to return to Courier New.)


### [Print QA Form](#)

The QA Form feature is located under **Abstract Management, Print Forms and QA**. These can be printed individually or in a batch by selecting a population.

To print forms:



Print QA Form

Patient Name:	TERRY	lung	
Site:	34	BRONCHUS & LUNG	
Sequence:	00		
Hospital:	01	ERS Hospital Systems	
Med Rec Nbr:	458720393		
Population Label:			

Start Time: 12:14:31 PM End Time: 12:14:31 PM

1. Click on the magnifying glass to do a Patient Lookup, click on the desired patient name.
2. Use drop down arrow to select which primary Site to print.
3. After the patient or population has been selected, click Run.
4. The QA form auto populates the screen.
5. The QA form can be printed or saved as a PDF document.

## Print Survival Care Plan

The SCP Form feature is located under Abstract Management, Print Forms and SCP. These can be printed individually or in a batch by selecting a population. For more information, please see the Insight titled NEW Survivorship Care Plan under the Abstracting Category located on the CRStar Resource page. A link to the Resource Page is available under the "Help" menu in CRStar.

### To print SCP:

Print Survivorship Care Plan

Patient Name: TERRY lung

Site: 34 BRONCHUS & LUNG

Sequence: 00

Hospital: 01 ERS Hospital Systems

Med Rec Nbr: 458720993

Population Label:

Start Time: 12:16:53 PM End Time: 12:16:53 PM

Run New

1. Click on the magnifying glass to do a Patient Lookup, click on the desired patient name.
2. Use drop down arrow to select which primary Site to print.
3. After the patient or population has been selected, click Run.
4. The SCP form auto populates to the screen.

Survivorship Care Plan

Treatment Summary and Survivorship Care Plan for Breast Cancer

**Patient Identification**

Medical Record Number: 421158397 Address: 713 RIPLEY

Patient Name: SUSIE BREAST City/State/Zip: MOBILE, AL 36604

Date of Birth: 09/01/1976 Phone: (999) 999-9999

Email:

**Care Team**

Surgeon: JUDY D JONES (334) 476-6330

Medical Oncologist:

Radiation Oncologist: JOHN R RUSSELL (251) 435-3549

Managing Physician: JUDY D JONES (334) 476-6330

Following Physician: ALANIS C MORRISSETTE (601) 268-5185

Other Physician:

Print Exit Forms

5. All fields are editable from the screen prior to printing.
6. Check boxes are active and can be checked on the screen prior to printing.
7. The SCP form can be printed or saved as a PDF document.

## Abstract Utilities

### Delete Abstract

The Delete an Abstract utility is located under Abstract Management, Abstracting Utilities, and Delete Abstract.

The screenshot displays the 'Delete Abstract' utility interface. At the top, there are three tabs: 'Delete Abstract' (selected), 'Copy Abstract', and 'Combine Patients'. Below the tabs, there is a form with the following fields: 'Patient Name' (with input fields for 'TEST' and 'GIST'), 'Site' (with a dropdown menu showing '16' and a text field for 'STOMACH'), 'Sequence' (with a text field for '00'), 'Hospital' (with a dropdown menu showing '02' and a text field for 'Demo Data for HOSP 02'), and 'Med Rec Nbr' (with an empty text field). A 'Confirm Deletion' dialog box is overlaid on the right side of the form, containing the text 'Are you sure you want to delete Abstract site: 16, Seq: 00, Hosp: 02 from this patient?' and two buttons: 'Yes' and 'No'. At the bottom of the interface, there are two buttons: 'Delete' and 'New'.

1. Click the search icon to display the lookup, select patient. The patient may be searched by name, social security number, DOB, accession number, or medical record number. When searching, enter partial names, dates, or accession numbers. For example, when entering SM for a name, the system will search for any last name beginning with SM. If 012022 is entered in the accession number search field, the search will bring up all 2022 cases. Important! Remember to enter the hospital number before the accession number.
2. Click the drop down to display all the patient's primaries and hospitals if they are a multi facility. Choose the abstract to delete. If site and sequence is not filled out the ENTIRE patient is deleted from the database.
3. Click Delete.
4. A message pops up as shown to alert the user the case is going to be deleted. **Caution: If deleting a case that has more than one primary, please ensure that the message pop up, states the patient's Site, Sequence, and correct Hosp. If the message only states the patient MR#, all cases belonging to that MR# will be deleted. It is especially important when entering the case identifiers on the patient screen that the site, sequence and hospital code are entered. These key fields identify which case should be deleted.**

5. To continue, click OK.

- If a patient has an abstract record and Suspense Record and you only want to delete the Suspense Record, use the "Delete" button on the primary grid of the Patient Maintenance screen and click "Save".
- If you want to delete an entire record demographics and all, use the Delete an Abstract function under Abstract Utilities.
- Please watch the video titled V. ABSTRACT UTILITIES under the Video Tutorial Library category located on the CRStar Resource page. A link to the Resource Page is available under the "Help"

## How to Find and Delete Cases with Demographics Only with No Associated Primary Site

The screenshot shows a patient record form. On the right side, there is a 'Contacts' table with columns: S/A, Flag, Site, Seq, Hsp, Class, Diagnosis Date, Acc Nbr, and Med Rec Nbr. Below the table is a 'New Primary' button. A green circle highlights the 'Contacts' table and the 'New Primary' button. The form also includes fields for patient demographics, contact information, and medical history.

1. Click Abstract Management Tab
2. Click Abstract Utilities Tab
3. Click Delete Abstract Tab
4. Click magnifying glass to do a lookup.
5. Click on the Site in the top blue bar to sort by Site (The ones without a site will appear on the top).
6. Click and delete each one that comes up without a site



S/A	SSN	MIRN	Last Name	First Name	Middle Name	DOB	Sit...	Seq	Topo	Histology	Laterality	Dx Date	Hosp	Class	Patient Status	Last Contact	Acc Nbr
						mm/dd/yyyy											
	517399164		COLON	MARK		11/22/1939											
	644452164		COLON	OLLIE		10/13/1945											
	346476164		COLON	GLORIA	B	10/06/1947											
	117543164		COLON	BARBARA	G	02/17/1954											
	415344164		COLON	JAMES	PRENTISS	10/23/1934											
	767437164		COLON	ROSIE	L	11/22/1943											
	644299164		COLON	OLLIE		11/02/1929											
	134342164		COLON	BILLY	R	04/21/1934											
	463311743		SKIN	JOHN	P	05/16/1931											
	271343164		COLON	FRANKLIN	D	11/22/1934											

## Copy Abstract

The Copy Abstract utility is located under Abstract Management, Abstracting Utilities, and Copy Abstract.

The screenshot shows a web form for copying an abstract. The fields are as follows:

Patient Name:	SUSIE	BREAST
Site Code:	50	50
Sequence:	03	
Med Rec Nbr:	458054851	
Old Hospital Code:	01	ERS Hospital Systems
New Hospital Code:	03	Random Regional Hospital

Abstract copied to Hospital 03

Buttons: Copy, New

1. Click the magnifying glass for the lookup. The patient may be searched by name, social security number, DOB, accession number, site code, hospital code or medical record number. When searching, the full or partial names and numbers may be used. The patient may be searched by name, social security number, DOB, accession number or medical record number. Important! Remember to enter the hospital number before the accession number.
2. Click the drop down to display all the patient's primaries and hospitals if they are a multi facility. Choose the abstract to copy.
3. In New Hospital Code enter the facility number to copy the abstract into.
4. Click Run.

**NOTE:** Once the abstract has been copied into the new facility, it is necessary to fill in the hospital specific fields in the new abstract to complete the abstract:

- Class of Case
- Accession Number
- Medical Record Number
- Secondary Diagnosis/Comorbidity & Complications
- Hospital Referred to and From
- First Contact Date
- Accession Year
- Surgical Approach 2010
- Radiation Location
- Date Abstracted
- Abstractor initials
- State Report Flag

## Combine Patients

The Combine Patients utility is located under Abstract Management, Abstracting Utilities and Combine Patients.

CRSta

If a patient has accidentally been entered multiple times in the database, creating duplicate cases, these cases can be combined. The Combine feature is in the Abstract Management Module under the Abstract Utilities tab and Combine Patients.

For example, Margaret Demo has been entered twice for the same primary but

Records: 5

S/A	Soc Sec Nbr	Id Nbr	Last Name	First Name	Middle Name	Dt Birth	Pt Status	Topo	Site	Seq	Hosp	Class	Dt Lst Cont
A	999999999	234500009	DEMO	MARGARET	C	12/06/1940	0	C252	25	01	01	35	02/09/1996
A	234500350	234500350	DEMO	DIANE	S	01/16/1945	1	C502	50	00	01	14	09/13/2013
A	999999999	15877	DEMO	JANET	L	04/23/1954	1	C341	34	00	01	14	04/28/2014
A	999999999	15877	DEMO	JANET	L	04/23/1954	1	C341	34	00	01	14	04/28/2014
A	999999999	356500009	DEMO	MARGARET		12/06/1940		C252	25	01	02	22	

10 Records per page

Merge Patients

**Select Patient 1**

Name: MARGARET C DEMO  
 Dob: 12/06/1940  
 SSN: 999999999

S/A	Site	Seq	Hosp	Class	MRN
1	A	25	01	01	534500009
2					
3					

**Select Patient 2**

Name: MARGARET DEMO  
 Dob: 12/06/1940  
 SSN: 999999999

S/A	Site	Seq	Hosp	Class	MRN
1	A	25	01	02	568971
2					
3					

Merge Primaries into Patient 1 and Delete Patient 2

- To combine a patient, go to Abstract Management, Abstract Utilities, and then Combine Patients. **Note: See page titled Important Helpful Hints when combining patients.**
- Click Select Patient 1. This will take the user to the Lookup screen to select the correct patient that Patient 2 is to be combined with.
- Click Select Patient 2. This will take the user to the Lookup Screen to select the patient to combine with Patient 1.

- In the middle of the screen, click Merge Primaries into Patient 1 and Delete Patient 2.

**Merge Patients**

**Select Patient 1**

Name: MARGARET C DEMO  
 Dob: 12/06/1940  
 SSN: 999999999

S/A	Site	Seq	Hosp	Class	MRN	
1	A	25	01	01	35	534500009
2	A	25	01	02	22	568971
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						

**Select Patient 2**

Name:  
 Dob:  
 SSN:

S/A	Site	Seq	Hosp	Class	MRN
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

Merge Primaries into Patient 1 and Delete Patient 2

*Merge Complete*

[New](#) [Exit](#)

**Patient Maintenance**

Id Nbr: 234500009

Soc Sec Nbr: 999-99-9999

Name Prefix: Ms

Last: DEMO

First: MARGARET

Middle: C

Maiden:

Name Suffix:

Alias:

Phone Nbr: (999) 999-9999

Phone Nbr 2: ( ) -

Email:

Cur Add: 25000 Frederick Blvd

Cur Add 2:

Cur City: WINSTON SALEM

Cur St: NC

Zip: 27105

Cur City:

Cur Country:

Dob: 12 / 06 / 1940

Birth Country: USA

Birth State: OH

Sex: F

**Patient** **Contacts**

Race 1: 0  
 Race 2:  
 Race 3: Alcohol Hist: 0  
 Race 4: Religion: 21  
 Race 5:  
 Ethn: 0

Comments:

S/A	Site	Seq	Hosp	Class	Diagnos Date	Acc Nbr	Med Rec Nbr
A	25	01	01	05	05 / 13 / 1996	01199600035	534500009
A	25	01	02	22	05 / 13 / 1996	02199600568	568971

[New Primary](#)

Date of Last Contact: 02 / 09 / 1996

*ID\_NBR - 234500009*

[New](#) [Save](#) [Previous](#) [Next](#) [Exit](#) [Goto](#)

The Patient screen after the cases were combined.



**LookUp**

S/A	Soc Sec Nbr	Id Nbr	Last Name	First Name	MI	Dob	Site	Seq	Hosp	Class	Diagnos Date	Acc Nbr	Med Rec Nbr	Cont
A	999999999	234500009	DEMO	MARGARET	C	12/06/1940	1	C252	25	01	01	35	05/12/2014	
A								C252	25	01	02	22		
A	234500350	234500350	DEMO	DIANE	S	01/16/1945	1	C502	50	00	01	14	09/13/2013	
A	999999999	15877	DEMO	JANET	L	04/23/1954	1	C341	34	00	01	14	04/28/2014	
A								C341	34	00	02	21		
A	999999999	15877	DEMO	JANET	L	04/23/1954	1	C341	34	00	01	14	04/28/2014	
A								C341	34	00	02	21		

The LookUp screen after the cases were combined.



## IMPORTANT HELPFUL HINTS WHEN COMBINING PATIENTS

- When combining cases together, the system is merging primaries to eliminate duplicate cases. It is important for the user to rigorously evaluate which patient should be kept and which should be combined and deleted.
- It is very important to ensure that the patients being combined are the same patient and not different patients.
- Only one patient can be combined at a time.
- Patient 1 should be considered the patient to keep.
- Patient 2 is the patient that is combined with patient 1 and deleted.
- If the user is trying to combine two patients and either the name, DOB or Social Security # do not match, a warning message will pop up. The user should review the case to ensure that it is the same case.
- Any information the user wishes to retain from the Patient screen for Patient 2 should be entered on the Patient screen for Patient 1 prior to combining. For example, if the user wishes to retain the Comments from Patient 2, they can be copied and pasted into the comment field for Patient 1.
- All screens are primary specific. Any information past the Patient screen will copy over or combine as is.
- After combining a case, review treatment and follow up information for same primaries shared between hospitals.
- Review Sequence numbers for accuracy after combining patients.
- A back up is not required before combining patients, this feature is not actually deleting the abstract, rather combining the primaries together. The only information that is deleted is the information on the patient screen of Patient 2.



## Chapter 4 FOLLOW UP MANAGEMENT

- Follow Up
  - F/U Letters
  - On Demand
  - F/U Calcs

### Follow Up

Special Note: The Method field located on the Outcomes Maintenance Screen of the patient abstract is one of the determining factors of whether a case is included in the follow up list or letters.

These cases are included in both the Letters and FU List - if Method coded to:

The screenshot displays a patient abstract interface for a patient named MELANIE. The header includes patient information: Topo Code: C502, Class: 10, Dob: 03/10/1959, Diagnosis Date: 08/12/2018, Seq Prim: 01, Hosp: 01, and Acc Nbr. The Histology is noted as Invasive carcinoma of no special type (C50...) [BREAST ONLY]; Ade... A 'Method' dialog box is open, showing a table with columns 'Code' and 'Description'. Below the dialog, the 'Outcomes' section is visible, featuring a table with columns 'Date Last Contact' and 'Pr'. The first row shows a date of 09/20/2020. To the right, there are fields for 'Surv Months: 25', 'Icd Cause', 'Icd Rev', and 'Recurrence'.

Code	Description
------	-------------

Date Last Contact	Pr
09/20/2020	

- 1 Physician Letter
- 2 Patient Letter

FU List includes.  
Method coded to:  
Blank, 0, 1, 2, 3, 4, 5

These cases are included in FU List but not Letters - if Method coded to:

- Blank
- 0 Chart Requisition
- 3 Phone Call
- 4 Other Hospital Contact
- 5 Other

These cases do not appear in List or Letters- if Method coded to:

- 8 Foreign Residents
- 9 Not Followed

These cases are included in Lost To Follow Up Calculations and Lost Lists per COC standards.

See page 77 for detailed information on the calculation.

## Follow Up-F/U Letters-Generate Follow-up List and Letters

Generate Follow-up List and Letters

Reference Year: 2008  
Hospital Code: 01 ERS Hospital Systems  
Begin Date: 08/01/2017 End Date: 08/31/2017

Letter:   
Fu Doctor Nbr:

Date Range Entered Only  
 Repeat for All Years Prior to End Date  
 Use Enhanced Follow Up

Analytic 10-22 Cases Only  
 Include Class 00  
 Include Benign Cases  
 Include Basal and Squamous Cell Ca  
 Include Expired Cases  
 Update Letters Sent Flag

Create Population Labels  
 Based on Follow-Up List:  
 Based on Letters Generated:

Start Time: End Time:  
Run New Exit

1. Select the appropriate facility from the Facility Selection Drop Down Bar
2. Click on Follow Up
3. Click F/U Letters Tab
4. Enter Reference Year to exclude all cases with accession year prior to facility's reference year. If this field is left blank, all eligible cases in the database are included.
5. Enter the Hospital Code.
6. Enter the Begin Date and End Date\* of the timeframe requested to generate Follow-up List and/or Letters. (example: 08/01/2017 to 08/31/2017)
7. Letter- Leave blank and the list and letters are based off the Method. To force which type of letter is sent, click the down arrow to choose the type of letter to be sent. This will override whatever is listed in the Method field and will send the letter specified regardless of what is coded in the Method.
8. Fu Doctor Nbr- Leave blank and all physicians listed on the Outcomes Maintenance page of the patient abstract will get a letter printed. To specify which physician should receive a letter, enter 1 to send letter to only the first doctor listed on the Outcomes Maintenance page of the patient abstract, 2 to send to the second doctor listed in the Outcomes Maintenance page of the patient abstract, and so on.
9. Create Population Labels-
  - a. Based on Follow-Up List if checked, a population of cases is created for the eligible cases on the follow up list. (Those eligible cases whose Method is coded to Blank, 0, 1, 2, 3, 4, 5) Must enter the name of the population to be created.
  - b. Based on Letters Generated-if checked, a population of cases used for printing labels is created. These labels consist of physician, contact, and patient labels. If a physician has multiple letters only ONE label per physician will print. There are 3 labels per row. The list of cases is created for the eligible cases that will receive letters. (Those eligible cases whose Method coded 1,2.) must enter the name of the population to be created.
10. Select type of Date Range. \*Date Range = Date of Last Contact.

- Date Range Entered Only- only selects eligible cases whose date of last contact is between the Begin Date and End Date. (In this example eligible cases whose date of last contact is in August 2017 are selected.)
  - Repeat for All Years- selects cases for the month listed in Begin and End Date for the current year all the way back to the reference year. (In this example if today's date was in the year 2018, eligible cases whose date of last contact is in August 2018+ August 2017+ August 2016+ August 2015+ August 2014+August 2013+August 2012, etc. back to August 2008 are selected.)
  - Repeat for All Years Prior to End Date- selects cases for the months listed in Begin and End Date for each year all the way back to the reference year. (In this example eligible cases whose date of last contact is in August 2017+ August 2016+ August 2015+ August 2014+, back to August 2008 are selected.)
  - Use Enhanced Follow Up-selects eligible cases within a 4-month range. Letters are generated based on the "Enhanced Follow-Up Order" on the Outcomes Maintenance Screen. (Please refer to Enhanced Follow Up section of the manual for more details.)
11. Select Option(s) for Cases to be included in the follow up process. The options chosen depend upon the needs of the facility. **REMINDER:** Letters and list are also dependent on what is coded in the Method field on the Outcomes Maintenance page of the abstract.
- Analytic 10-22 Cases Only- These are cases required to be followed by the CoC.
  - Include Class 00-The CoC does not require that these cases be followed, inclusion of these cases in follow up procedures is strictly up to the facility. Whether these cases are lost or found has no effect on the Lost to Follow Up Calculations, these cases are excluded from Lost to Follow Up Calculations.
  - Include Benign Cases- The CoC does not require that these cases be followed, inclusion of these cases in follow up procedures is strictly up to the facility. Whether these cases are lost or found has no effect on the Lost to Follow Up Calculations, these cases are excluded from Lost to Follow Up Calculations.
  - Include Basal and Squamous Cell Ca- The CoC does not require that these cases be followed, inclusion of these cases in follow up procedures is strictly up to the facility. Whether these cases are lost or found has no effect on the Lost to Follow Up Calculations, these cases are excluded from Lost to Follow Up Calculations.
  - Include Expired Cases- Check this box to include expired patients.
12. Select Run
13. The Status Box will appear showing the progress of the request. Use the cancel button to cancel the process.
14. When the process is complete, a pop-up box will appear with a copy of the Letters and List. Toggle between the two reports by clicking on either List or Letters at the bottom of the pop-up box.
15. Option to Print, Data Xfer to Excel, or Exit.
- o Print sends either the List or the Letters to the printer, depending upon which is viewed. (**SPECIAL NOTE:** Notice on the bottom right of the

pop-up box the Update Letters Sent Flag option. If viewing Letters, the default is set to Update Letters Sent Flag once the Letters Print. If viewing List, the default is not set to Update Letters Sent Flag, is not updated if the list is printed or if the Data is transferred to Excel unless the box is clicked/checked.)

- o Data Xfer downloads the List/Letters Excel document. (The steps to open or save the Excel document is dependent on browser type.) One tab of the Excel Spreadsheet titled Letters Data displays a list of the cases to receive letters. (Eligible cases that method is coded to 1,2)
  - o The other tab of the Excel Spreadsheet titled Follow-Up List displays a list of the cases due for follow up. (Eligible cases that method is coded to a Blank, 0, 1, 2, 3, 4, 5).
  - o If using Enhanced Follow Up, another tab of the Excel spreadsheet titled No Additional Contacts displays a list of the cases due for follow up that have no additional contacts available. (Be sure to work this list to make sure additional contacts are coded on the Outcomes Screen of the individual records if possible.)
- Exit exits the process.

Enhanced Follow Up

DEMO MELANIE Seq Prim: 01 Hosp: 01 Acc Nbr: ?

Topo Code: C502 Class: 10 Dob: 03/10/1959 Diagnosis Date: 08/12/2018 Histology: Invasive carcinoma of no special type (C50...) [BREAST ONLY]; Ade...

---

Outcomes

	Date Last Contact	Pt St	Ca st	QL	Fu Notes	Source	Entered	Entered By
1	09/20/2020	1	2		MAMMO		08/12/2022	sherri@ers-
2	09/26/2019	1	1		MD		08/12/2022	sherri@ers-
3	09/30/2018	1	1		MD		08/12/2022	sherri@ers-can.com

Add Delete

---

Surv Months: 25 Icd Cause: Icd Rev:

Outcomes: Method: 1 Death Cause: Autopsy: 0 Pod: Pod-State: Pod-Country:

Recurrence: 1 Recur Date: 09 / 20 / 2020 Type: 10 Add Delete

---

Follow-Up Physicians and Enhanced Follow-Up Order

	Fu Physician	Fu Physician Name	Letter Sent	Letter Type
1	002257	WILLIAM FAULKNER		DOC
2	Patient	Patient		Patient
3	Contact	Secondary Contact 1		CON

Default Letter Types Based on: NORMAL FOLLOW UP Add Delete

Date Cancer Status Last Changed: 09/20/2020

Letters:

	Date Sent	Letter Type
1		
2		
3		

Labs Date: 09 / 20 / 2020 Collected: MAMMO Value: POSITIVE Add Delete

FU\_PHYS -

Save Previous Next Exit Text

- If using Enhanced Follow Up, it is suggested, if possible, four physicians/contacts be listed in the Fu Physician Fields of the Outcomes Maintenance Screen of the patient Abstract. When using Enhanced Follow Up, four entries will give the greatest opportunity for collecting follow-up and keeping the case from going on the Cases with No Additional Contact list and quite possibly the Lost List after that.
- The field "Default Letter Types based on" must be coded to the enhanced follow up template to order the physicians in the order selected for that template.
  - Enter the individual FU Physician codes by clicking on the down arrow, then entering the Physicians last name in the Description box and clicking on the selection.
  - Enter Patient for a patient letter to be sent to the patient.
  - Enter Contact1, Contact2, Contact3, etc. for a contact letter to be sent to the corresponding Contacts listed in the Patient Maintenance screen of the abstract.

**To Create an Enhanced Follow Up Template**, from the main menu, go to Systems Management, then the Follow up Order tab. The user may enter as many templates as desired, and up to four contacts for each template.

1. Name the template by typing in the field directly. If a template already exists and the user wishes to modify it, it can be chosen from the drop down.
2. Enter the hospital code.
3. Enter the contacts in the order in which they will be scheduled. Up to four lines.
4. The user may type in MANAGING or MAN and tab through the fields and the first and last name will auto fill. Other examples FOL or FOLLOWING, RAD or RADONC, etc.
5. Click Save.

**Below are two examples of templates:**

The screenshots show the 'Follow-up Order' interface. The top navigation bar includes tabs for Hospitals, Registrars, Physicians, Phys Roster, Initialize Acc, Follow-up Order (highlighted), Follow-up/QA Letters, and Custom Forms.

**Example 1: TREATING PHYSICIANS**

Follow Up Order Template: TREATING PHYSICIANS  
 Hospital Code: 01

	Contact/Physician	First Name	Last Name	Letter
1	MANAGING	Mng. Phys	Managing Physician	DOC
2	PRIMARY	Prim. Surg	Primary Surgeon	PRIM SURG
3	RAD ONC	Rad Onc	Radiation Oncologist	RAD ONC
4	MED ONC	Med Onc	Medical Oncologist	MED ONC

**Example 2: NORMAL FOLLOW UP+**

Follow Up Order Template: NORMAL FOLLOW UP+  
 Hospital Code: 01 ERS Hospital Systems

	Contact/Physician	First Name	Last Name	Letter
1	MANAGING	Mng. Phys	Managing Physician	DOC
2	PRIMARY	Prim. Surg	Primary Surgeon	PRIM SURG
3	RAD ONC	Rad Onc	Radiation Oncologist	RAD ONC
4	MED ONC	Med Onc	Medical Oncologist	MED ONC

**Generate Follow-up List and Letters**

Reference Year: 2008

Hospital Code: 01 ERS Hospital Systems

Begin Date: 08/01/2017      End Date: 08/31/2017

+ 07/01/2017      to 07/31/2017

+ 06/01/2017      to 06/30/2017

+ 05/01/2017      to 05/31/2017

Date Range Entered Only  
 Repeat for All Years Prior to End Date  
 Use Enhanced Follow Up

Analytic 10-22 Cases Only  
 Include Class 00  
 Include Benign Cases  
 Include Basal and Squamous Cell Ca  
 Include Expired Cases  
 Update Letters Sent Flag

Create Population Labels

Based on Follow-Up List:  
 Based on Letters Generated:

Start Time:      End Time:

- Use Enhanced Follow Up- selects eligible cases within a 4-month range. Letters are generated based on the "Enhanced Follow-Up Order" on the Outcomes Maintenance Screen.
  - Eligible Cases with last contact in the first line of the Begin/End boxes will have letters sent to whoever is listed in the first line of the Fu Physicians box on the Outcomes Maintenance Screen.
  - Eligible Cases with last contact in the second line of the Begin/End box will have letters sent to whoever is listed in the second line of the Fu Physicians box on the Outcomes Maintenance Screen.
  - Eligible Cases with last contact in the third line of the Begin/End box will have letters sent to whoever is listed in the third line of the Fu Physicians box on the Outcomes Maintenance Screen.
  - Eligible Cases with last contact in the fourth line of the Begin/End box will have letters sent to whoever is listed in the fourth line of the Fu Physicians box on the Outcomes Maintenance Screen.

○



## Follow Up-On Demand (Generate Demand Letters)

Generate Demand Letters

Population Label:  Hospital Code:

Letter:  Fu Doctor Nbr:   Update Letters Sent Flag

Med Rec Nbr	Last Name	First Name	Site	Seq	Hosp
1					
2					
3					
4					

Physicians	Last Name	First Name
1		
2		
3		
4		
+		

Start Time:  End Time:

1. Select the appropriate facility from the Facility Selection Drop Down Bar
2. Click on FOLLOW UP Tab
3. Click on Demand Tab
4. Choose a previously selected Population Label OR manually enter the MR Number of the patient(s) to receive a letter.
5. If manually demanding a letter for individual cases, either enter the MR number directly into the MR Number field or click on the arrow and do a search for the patient case to receive a letter, highlight the chosen case and the information auto defaults into the box.
6. Enter the Hospital Code.
7. Clicking the box to Update Letters Sent Flag autofills the date of letter sent.
8. Choose the type of Letter to be printed for the selected case(s), it will override whatever is coded in Method in the Outcomes Maintenance page of the abstract. Leave Letter blank and it will default to the Method coded in the Outcomes Maintenance page of the patient abstract.
9. Fu Doctor Nbr- Leave blank and all physicians listed on the Outcomes Maintenance page of the patient abstract will get a letter printed. To specify which physician should receive a letter, enter 1 to send a letter to only the first doctor listed on the Outcomes Maintenance page of the patient abstract, 2 to send to the second doctor listed in the Outcomes Maintenance page of the patient abstract, and so on.
10. Special Note: If demanding a letter from individual cases, the box at the bottom will show the physicians listed on the Outcomes Maintenance page of the patient abstract for the Id Number selected. To add or delete more lines for case selection use the "+" or "X" buttons. If demand letter is from a population the Physicians box will remain blank.
11. Select Run.

12. The Status Box will appear showing the progress of the request. Users may hit the cancel button to cancel the process.
13. When the process is complete a pop-up box appears with a copy of the Letters and List. Toggle between the two by clicking on either List or Letters at the bottom of the pop-up box.
14. Option to Print, Data Xfer to Excel.
  - Print sends either the List or the Letters to the printer, depending upon which is being viewed. (**SPECIAL NOTE:** Notice on the bottom right of the pop-up box the Update Letters Sent Flag option. If viewing Letters, the default is set to Update Letters Sent Flag once the Letters Print. If viewing List, the default is not set to Update Letters Sent Flag, Letters Sent field is *not* updated if the list is printed or if the Data is transferred to Excel unless the box is clicked/checked.)
  - Data Xfer downloads the List/Letters Excel Document. (The steps to open or save the Excel document is dependent on browser type.)
    - The first tab of the Excel Spreadsheet titled Letters Data displays a list of the cases to receive letters.
    - The next tab of the Excel Spreadsheet titled Follow-Up List displays a list of the cases to receive letters.
15. Click the X at the top of the pop-up box to exit.
16. Tip: This screen is accessible via the shortcuts on the main screen. Or, within the abstract, by clicking the << at the top right of the screen to bring up the Quick Links, then Click on the mail icon.

## Follow Up-F/U Calcs (Generate Follow-up Calculations)

Population Label:

Reference Year:  Follow-Up Calculations from: 2006-2020

Hospital(s):

Sort Order:

Pediatric Facilities (Exclude patients greater than 26 years of age)

Death List Export

Create Population of Lost Cases

Send Report To:

Excel

Screen

Start Time:  End Time:

1. Click FOLLOW UP MANAGEMENT Tab.
2. Click Follow Up Tab.
3. Click F/U Calcs Tab.
4. Enter Reference Year. **Note:** Calculates from three years before the current calendar year.
5. Enter the Hospital Code(s) or leave BLANK to select all cases from ALL hospitals. To enter multiple facilities at one time, enter the facility number followed by a comma, no spaces, then enter the other facility/facilities.
6. Choose the Population Label if requesting follow up calculations from a previously selected population, **otherwise Leave Blank.**
7. Sort Order will auto default to Alphabetic by Last Name, First Name. To change the sort order, choose other options available.
  - Alphabetic by Last Name, First Name
  - Numeric by Social Security Number
  - Numeric by Medical Record Number
  - By Date of Last Contact
  - By Hospital Code
8. Click Pediatric Facilities (Exclude patients greater than 26 years of age) box, if running Lost to Follow-Up Calculations for a Pediatric Facility, **otherwise Do Not Check.**
9. Click the Lost List radio button to review a list of lost cases. Print list or Exit.
  
10. Click Death List Export if sending cases to other sources for follow up information, **otherwise Do Not Check.**
  - If this option is checked after the report is run and lists are created, a small Icon titled Download Deathlist appears on the screen next to the Death List Export choice, click

on that Icon and the report pops up in Notepad. Save this file to send to other sources for follow up information. Follow facilities HIPAA procedures before exporting PHI to outside sources.

11. Click Create Population of Lost Cases if the creation of a population of Lost Cases is desired, **otherwise Do Not Check.**
  - If this option is checked the Lost Population Label box will appear, to create the population, a name must be entered.
12. Check desired output of report, Click either Excel or Screen.
13. Click Run, the Status Box will appear showing the progress of the request. Click the cancel button to cancel the process.
14. The report will appear.
  - Excel option downloads the Lost to Follow- Up Documents. (The steps to open or save the Excel document will depend on what browser the client is using.) The first tab of the Excel Spreadsheet displays the Lost to Follow-Up Report; the second tab displays the Lost to Follow-Up List of cases.
  - Screen option downloads Lost to Follow-Up Documents to a pop-up box on the screen. Toggle between the two reports by clicking on either Follow-Up Report or Lost List at the bottom of the pop-up box. Click the Print option to print the chosen reports directly from the screen. Click Exit to close the pop-up box.

15. Click Exit to close the Generate Follow-Up Calculations Process.

**Note:** The Lost to Follow Up calculations and list look at the criteria set by the CoC for cases to be included for follow up, based on Class of Case (Only Analytic Cases), etc. The cases are included in both the list and calculation regardless of what the method of Follow up is coded to on the Outcomes screen.

Notes:

- Counts # of People, not # of Tumors.
- Calculations are based on the month of last contact.
- Only runs calculations on Abstracted Cases
- Population based on (Diagnosis Date  $\geq$  01/01/Ref Year) and (Accession Year  $\geq$  Ref Year)
  - If Accession Year is Blank, case is excluded.



## Chapter 5 ENHANCED REPORTING

- Select a Population
- Suspense Reports
- Canned Reports
  - Site Distribution
  - Rx Distribution
  - Survival by Stage
- Admin Reports
  - Accession Register
  - Master Patient Index
  - Request Log
  - Report for a File
- CPM Reports
- Adhoc Reports
  - List for a Population
  - Graph for a Population
  - Cross Tab Reports
- Miscellaneous Reports
  - Productivity
  - Timeliness
  - Age By Sex
  - Stage by Sex
  - TNM Stage Graph
- Data Exports
  - State Export
  - NCDB Export
- Reporting Utilities
  - Clear Populations

## Select a Population

Selecting a population is a process used to

identify and retain cases in an electronic queue. Case information is not displayed until the user utilizes the multiple reports in CRStar. This Select a Population function must be run to generate reports or graphs. With each selection, the population identifies all cases meeting the criteria. **Select populations may be created in the Select a Population tab or on the same screen where the report features are selected. When a population in Select a Population yields 0 cases, that population is not available in the population list for reports under the tabs of: List Pop, Graph Pop, and Xtab.** If the user does not wish to include additional cases, do NOT re-select the population before running canned report.

1. Select A Population for Reporting: (Click on ENHANCED REPORTING TAB, then Select a Population tab). Either Select a Pop Label: Click on ↓ (down arrow) - a complete list of all previously saved populations appears on the screen – highlight selection. Or, if this is a new request type in the name of population at Population Label (i.e. 2016 ANALYTICAL CASES ERS HSP). **Note: Special characters such as dashes, quotes, etc. should not be used when naming a population label.**
2. New Label: Does not appear unless the user chooses a previously selected population. This is used for selecting a sub-population. (i.e. 2016 Analytical Cases has been selected - to select a sub-population of male cases – type in new label 2016 Males and add item number 9 SEX = 1 then click select – a new population is selected on 2016 males).
3. Request Date: System will auto-fill the date. **IMPORTANT: Users can Generate a Request Log of these populations by clicking on the Admin tab under the ENHANCED REPORTING tab.** Requested By: The system will auto-fill based upon user log-in, user may also type name of requester directly over the auto-filled data. This information prints out under Request Log.
4. Hospital: Type in the hospital number for selection OR
  - a. For multi-facilities, a feature has been added that will include duplicate cases of shared primaries if checked or exclude if Include Unique Primaries is checked. By leaving hospital code blank in a multi hospital system it will select all primaries for all hospitals unless the unique Primaries button is used. **Note: The user must have access to report on all data to be able to leave the hospital code blank.**

- b. To pull cases in select facilities, the user may enter select hospital codes separated by commas. For example, entering 01,03,05 will select primaries for the facilities entered or to select cases in select facilities, the user may enter select hospital codes separated by commas. Using the Hospital Lookup gives the user the ability to select multiple facilities at once by checking the box beside the hospital name.
  - c. To select only unique primaries for specific facilities, leave the hospital code blank and enter the hospital codes desired in the selection criteria. For example, enter 54 Hospital Code = 01,02,03. If the Include Unique Primaries button is not chosen the report defaults to select all primaries.
5. **Date Options:** None is the default. User can choose to enter dates to pull by either date of Dx Date or 1<sup>st</sup> Contact Date. These options can be left blank and selected via the Selection Criteria.
  6. **Abstract/Suspense Cases:** Use these boxes during selection to indicate **Abstracted Cases Only, Suspense Cases Only or All Cases.** **Note: Non-Reportable cases can be selected by entering item number 200 State Report Flag equal to N.**
  7. **Case Types:** Bubble help has been added to Case Type to alert the user of the criteria used for case selection.
    - a) **Analytic Cases Only shortcut:** Check the box marked Analytic Cases only to select Class of Case codes 00-22. If selection criteria are limited to fewer analytic codes, use item number 147 (Class of Case) = the proper codes.
    - b) **Completed Cases Only shortcut:** Check the box marked Complete cases only to select cases where the field State Report Flag on the Case Admin screen is coded to a Y (Transfer to State), T (Transmitted to State). N (Do Not Transmit to State) or C (Correction Case). \*Note code C only applies to those states that require corrected cases to be resubmitted.
    - c) **Abstract/Suspense Cases:** Use these boxes during selection to indicate **Abstracted Cases Only, Suspense Cases Only or All Cases.**
    - d) **Non-Reportable cases Only** Check the box marked Non Reportable Cases Only to select case flagged as Non-Reportable. *Note:* Non-Reportable cases can be selected by entering the item number 200 State Report Flag equal to N.
  8. **Site Codes:** Type in the two-digit code or click the down arrow for a list of all sites or leave blank to select all sites. The user may also begin typing in the site name under Site Description and the descriptions that match will come up automatically. Select as many sites as wanted - but only one site per line.
  9. **Selection Criteria: Item Nbr:** Click the arrow for a listing of the Item number codes. The user may also manually type in the item number if known. In item description, the user may begin typing a key word and a list of descriptions with that key word will appear.
 

Relation: A code must be entered to relate the data item selected (dictionary item) to the codes in the field. Click the down arrow in this field to reveal these codes. Pressing tab or clicking in the Relation box with mouse will default to =. (Note = Equal to is the only relationship where more than one value can be entered on a single line).

Data Values: Data values refer to the valid codes for the dictionary item selected.

#### RULES FOR SPECIFYING DATA VALUES

- When RELATION code is = may select multiple values separating each value by a comma but no spaces or dashes. The comma (,) indicates the logic "or".
- All dates must be in the format MM/DD/YYYY.
- Click on the drop-down arrow in data values for available data items for selection. Select multiple items from the list by highlighting choices one at a time. For any relationship other than = Equal To only one data value is allowed in the field.



- Type in the Data Values (i.e. 151 Accession Year = 2013 or 3783 First Contact Date Year= \*16 (using the asterisk before the number will give all dates ending in 16 which would be all dates in 2016). (SPECIAL NOTE: Do not use MULTIPLE wildcards in a date field.).

Relation	Description
=	Equal To
>	Greater Than
>=	Greater Than Or Equal To
<	Less Than
<=	Less Than or Equal To
<>	Not Equal To

- The following commands are located at the bottom of the screen:
    - Select: Clicking on Select will search and save the population.
    - Delete Label: Clicking on Delete will delete Population currently listed in Population Label. Use this function to delete previous saved populations that are no longer needed.
    - Edit Selection: Clicking on Edit Select will open a box to review the query selection.
    - New: Clicking on New will refresh the screen.
10. New Label: Does not appear unless the user chooses a previously selected population. This is used for selecting a sub-population. (i.e. 2016 Analytical Cases has been selected - to select a sub-population of male cases – type in new label 2016 Males and add item number 9 SEX = 1 then click select – a new population is selected on 2016 males).
11. Adding a row: Click the Add button.
12. Deleting a row: Click the Delete button.
13. Copy a row: Click the Copy button.
14. Insert a row: Click the insert key from the keyboard.

Below is an example of a NON SMALL CELL LUNG CARCINOMA population.

The screenshot shows a query configuration interface. At the top, the 'Population Label' is '2016 NON SMALL CELL LUNG' and the 'New Label' is empty. Below this, 'Requested By' is 'Training Registrar Defa' and 'Request Date' is '02/03/2024'. There are several filter options: 'Include All Primaries' (checked), 'None', 'Dx Date', and '1st Contact Date'. Under 'Abstract/Suspense Cases', 'All Cases' is selected. Under 'Case Type', 'Analytic Cases Only' is selected. At the bottom, there is a table for 'Site Codes' with columns 'Site' and 'Site Description'.

Site	Site Description
34	BRONCHUS & LUNG

- The ASTERISKS (\*) are “wild cards”. Placing the \* behind a number or text in Data Values will search for all values starting with that text or number. Placing the \* in front of a number or text in Data Values will search for all values ending with that text or number. **Do not use MULTIPLE wildcards in a date field.**

Site Codes

<u>Line</u>	<u>Sites</u>	<u>Site Description</u>
1	34	BRONCHUS & LUNG (Selects all lung sites)

Checking the box Analytic case only box will select class of case 00-22

Selection Criteria

<u>Line</u>	<u>Item Nbr</u>	<u>Item Description</u>	<u>Relation</u>	<u>Data Values</u>	<u>Logic</u>
1	3732	First Contact Date-Year	=	2016	
And					
<ul style="list-style-type: none"> <li>• Selects all dates ending with 2016, therefore selecting the entire year</li> </ul>					
2-25	153	Histology	<>	8041*	
<ul style="list-style-type: none"> <li>• Excludes histologies that begin with the code 8041</li> <li>• Repeat on the next lines &lt;&gt; 8042* Etc....</li> <li>• (EACH HISTOLOGY MUST BE LISTED ON A SEPARATE LINE)</li> <li>• Note: Utilize the copy row feature to copy the above criteria to subsequent rows, only changing the data values</li> <li>• To add extra rows, click the Add button</li> </ul>					

**REMINDER:** (=) “Equal To” is the only REL code where multiple values can be requested. When the REL is >GT, >=GE, <LT, <=LE and <>NE only one value per line is allowed.



## Selecting Cases Per Facility for Multi Hospitals

The user may enter multiple hospital codes in the "Hospitals" box at the top of the Select a Population screen. As a result, it is no longer necessary to use the "Edit Selection" box to select all cases vs. unique primaries. To select cases in a multi hospital system for cases in all facilities, cases for select hospital groups and unique primaries, see examples below. **Note: The examples below are using our test database that has 10 facilities.**

1. The population below shows how to select all unique primaries in a multi hospital system for analytic cases diagnosed in 2017. By leaving hospital code blank, the system will select all 2017 unique analytic primaries for hospitals 01-10 in our database.

Results = 634 total cases  
for hospitals 01-10

By clicking Edit Selection, the user can see the selection criteria of the population.

1. Choose to either create a new population label or select an existing population from the drop-down menu
  - a. From all report screens within this module, in order to create a new population, the box beside Create a Population will need to be checked. Once checked Select a Population options will become available

Enter desired Hospital numbers or choose from the drop-down menu and choose to include or exclude duplicates of shared cases. **Note: The user must have access to report on all hospitals data to be able to leave hospital code blank.**
2. If this is NOT selected, the class of case order that is used to determine which shared primary will be selected for the report is:  
14,13,12,11,10,22,21,20,00,40,32,31,30,37,35,33,38,43,49,34,36,41,42,99
3. Choose date type/range if applicable and enter dates
4. Choose Abstracts, Suspense cases or All
5. Choose Case Type
  - a. Analytic cases selection will include class of cases: 00,10,11,12,13,14,20,21 or 22

- b. Complete cases selection will include State Report Flags of cases with: "T, Y, or C "
  - c. Incomplete
  - d. Case selection will include State Report Flags of "I"
  - e. Non-Reportable selection will only include cases with State Report Flags of "N"
6. Enter site if applicable
  7. Enter any remaining selection criteria as needed
  8. Click Select

**Select a Population**

Population Label:

Requested By:  Request Date:

Hospitals:   Include All Primaries  Include Unique Primaries

None  Dx Date  1st Contact Date From:  To:

Abstract/Suspense Cases Case Type

Abstract Cases Only  Analytic Cases Only

Suspense Cases Only  Complete Cases Only

All Cases  Incomplete Cases Only

Non-Reportable State Flag

Site Codes	
Site	Site Description
1 18	COLON
2 19	RECTOSIGMOID JUNCTION
3 20	RECTUM

Add Delete

Selection Criteria					
Item Nbr	Item Description	Relation	Data Values	Logic	
1					Copy
2					Copy
3					Copy

Add Delete

Start Time: 5:28:10 PM End Time: 5:28:11 PM Records Selected: 259

Select Delete Label Edit Selection New

Selecting Subpopulations (New Label)

**Select a Population**

Population Label:  New Label:

Requested By:  Request Date:

Hospitals:  ERS Hospital Systems  Include All Primaries  Include Unique Primaries

None  Dx Date  1st Contact Date

Abstract/Suspense Cases Case Type

Abstract Cases Only  Analytic Cases Only

Suspense Cases Only  Complete Cases Only

All Cases  Incomplete Cases Only

Non-Reportable State Flag

Site Codes	
Site	Site Description
1 50	BREAST
2	
3	

Add Delete

Selection Criteria					
Item Nbr	Item Description	Relation	Data Values	Logic	
1 3732	Date of Diagnosis - Year	=	2016	And	Copy
2					Copy
3					Copy

Add Delete

1. Begin with an existing population. To select an existing population, click on the down arrow at Population Label. Highlight the desired label to select. In this example the original population label is 2016 BREAST CASES.
2. Enter a New Label as shown below. (2016 STAGE 2 BREAST CASES)
3. Add the additional criteria as shown. (568 Summary AJCC Stage Group = 2\*)
4. Click Select. The original population has been saved and a subpopulation with the new criteria has been selected and saved.

Select a Population

Population Label: 2016 breast cases

New Label: 2016 Stage 2 Breast Cases

Requested By: Jonathan Rakestraw

Request Date: 01/17/2024

Hospitals: 01

Include All Primaries
  Include Unique Primaries

None
  Dx Date
  1st Contact Date

Abstract/Suspense Cases  
 Abstract Cases Only  
 Suspense Cases Only  
 All Cases

Case Type  
 Analytic Cases Only  
 Complete Cases Only  
 Incomplete Cases Only  
 Non-Reportable State Flag

Site	Site Description
1	50 BREAST
2	
3	

Add
Delete

Item Nbr	Item Description	Relation	Data Values	Logic	
1	3783 First Contact Date - Year	=	2016	And	<span style="border: 1px solid #ccc; padding: 2px 5px;">Copy</span>
2	568 Summary Ajcc Stage Group	=	2*	And	<span style="border: 1px solid #ccc; padding: 2px 5px;">Copy</span>
3					<span style="border: 1px solid #ccc; padding: 2px 5px;">Copy</span>

Add
Delete

Start Time: 10:19:29 PM

End Time: 10:19:30 PM

Records Selected: 20

Select

Delete Label

Edit Selection

New


## Wild Cards, Relations, and Logic in Select a Population

Below is an example of selecting dates by using the asterisk (\*)

- \*17– using the asterisk before the number gives all dates ending in 17 which would be all dates in 2017.
- 09\*– using the asterisk after the number gives all dates beginning in 09 (September).
- \*09\* – using the asterisk before and after the number gives all dates beginning in 09 (September) the 9th day of the month regardless of month or year and all the 2009 years. Possible combinations 09/20/93 or 09/26/98 or 05/09/01 or 08/09/07 and all the cases in 2009 - 01/01/09 etc.
- Below is an example of selecting text by using the asterisk \*\*  
Asterisks surrounding the value are best used for selecting text  
(i.e. Cancer conference comment - Presented by Dr. Baker –  
Item number 258 CC Comment = \*Baker\* selects all the cases presented by Dr. Baker).

Relation Codes: What they can and cannot do!

- NEVER List multiple values in data values unless the REL is Equal To =. The most common error is using the REL Code of Not Equal To <> and then listing 1, 2 or whatever value that needs to be excluded from the population and it does not work. To exclude more than one value in a population it must be listed on different lines (i.e. 153 Histology <> 8041\* AND 153 Histology <> 8042\*, etc. to exclude small cell lung cancer from the population).



A screenshot of a dialog box titled "Relation Description" with a list of relation codes and their descriptions. The list is as follows:

Relation	Description
=	Equal To
>	Greater Than
>=	Greater Than Or Equal To
<	Less Than
<=	Less Than or Equal To
<>	Not Equal To

## Logic: When to use "And" and "Or"

- What this logic would select:

<u>Item Nbr</u>	<u>Item Description</u>	<u>Relation</u>	<u>Data Values</u>	<u>Logic</u>
14	Age at Diagnosis	>	45	And
9	Sex	=	1	And

Selects all males diagnosed over age 45.

- What this logic would select:

<u>Item Nbr</u>	<u>Item Description</u>	<u>Relation</u>	<u>Data Values</u>	<u>Logic</u>
14	Age at Diagnosis	>	45	Or
9	Sex	=	1	Or

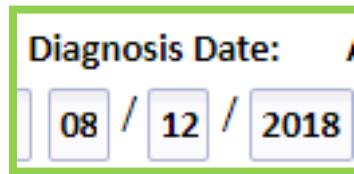
Selects all sexes over 45 but will also list all males regardless of age.

**Do not mix "AND" and "OR" when selecting populations.**



## Using the Correct Date in Reports

The user will notice that the date fields in the abstract of CRStar are three separate fields on the screen. However, there are four date fields. All four fields have Global Dictionary numbers used for reporting.



For example, Diagnosis Date has:

- Date of Diagnosis (Item # 150) displays the entire date- 08/12/2018
- Date of Diagnosis Month (Item # 3730) displays the two-digit month- 08
- Date of Diagnosis Day (Item # 3731) displays the two-digit day-12
- Date of Diagnosis Year (Item # 3732) displays the four-digit year-2018

150	Date of Diagnosis
3731	Date of Diagnosis - Day
3730	Date of Diagnosis - Month
3732	Date of Diagnosis - Year

Field Index Number 150 use in reports

Field index numbers 3730, 3731,3732 use in selecting populations

When selecting a population of cases diagnosed in the year 2015, use Global

Dictionary Number 3732 as shown below. Note, using the wild card (\*) before the year is not necessary when selecting on the single field Date of Diagnosis

The screenshot shows the 'Select a Population' interface. The 'Population Label' is 'ANALYTIC CASES DXD IN 2015'. Under 'Selection Criteria', item 3732 'Date of Diagnosis - Year' is set to '2015'. A red box highlights a note: 'Note multiple years may be selected using a comma when using 3732. For example: 3732 Date of DX Year = 2012,2013,2014,2015'. The interface also shows 'Site Codes' and 'Case Type' options.

When

displaying dates in reports use the combined date that shows the entire date in one field versus three separate fields. In this example, use Global Dictionary Number 150 Date of Diagnosis.

List Page Graph Page

Create a Population Label      Population Label: 2016 Analytic Cases

Delete Label     Edit Selection

Report Label: combined Data Items      Created By: Training Registrar Default      Requested On: 11/14/2016

Choose the Items for Your Report

Item Nbr	Item Description	B/S/L	C/D	Display Length	Limiting Values
132	Accession Nbr	L	C	20	
117	Site Code	L	C	20	
150	Date of Diagnosis	L	C	20	
862	First Contact Date	L			
5					
6					
7					
8					
9					
10					

Heading:       File Name:

Start Time: 8:32:09 PM      End Time:

Adhoc Report combined Data Items for 2016 Analytic Cases

	Accession Nbr	Site Code	Date of Diagnosis	First Contact Date
1	01201000083	53	12/13/2016	12/13/2016
2	01200401170	16	08/24/2016	08/20/2016
3	01188901101	50	12/15/2016	12/15/2016
4	01201301848	61	12/09/2016	12/09/2016
5	01201000044	44	01/04/2016	01/04/2016
6	01200400003	50	01/04/2016	01/04/2016
7	01201000039	37	01/07/2016	01/07/2016
8	01200900039	34	01/07/2016	01/07/2016
9	01201000042	22	01/08/2016	01/08/2016
10	01201000051	34	01/11/2016	01/11/2016
11	01201000045	34	01/11/2016	01/11/2016
12	01201000052	25	01/11/2016	01/11/2016
13	01201000047	34	01/13/2016	01/13/2016
14	01201000053	34	01/13/2016	01/13/2016

## Suspense Reports: Select a Population for a Suspense List

1. Name the Population Label. Note: If the label is given a generic name as shown, the user can reuse the population by changing the dates each month.
2. Enter a Hospital Code.
3. Requested by and Requested Date are defaulted but can be changed by clicking in the box and typing over the auto-filled data.
4. Under Abstract/Suspense Cases Choose Suspense Cases Only.
5. In Selection Criteria Click the 1<sup>st</sup> Contact Date option and enter the date range. Or:
  - a. Click the Dx Date option and enter the date range.
  - b. enter 862 First Contact Date Less than or equal to an End Date (The rationale behind this is that any BLANK First Contact Dates or First Contact Dates with typos, or any straggler cases entered since the last time the Suspense list ran, all these are captured in report.)
6. **IMPORTANT NOTE:** Please refer to the facilities procedures on date used when entering Suspense cases manually or when using the Merge (Automatic Casefinding Interface). Some facilities may use Discharge Date.
7. Click Run.
8. Add a row: Click the Add button.
9. Delete a row: Click the Delete button.
10. Copy a row: Click the Copy button.
11. Insert a row: Click the insert key from the keyboard

## Suspense Reports: Using Adhoc List for a Population to Generate a Suspense List:

This is a suggested Suspense List. The user can choose report criteria as desired. For more detailed information on the List for a Population, refer to the Adhoc section of this manual.

The screenshot shows the 'List Pop' interface. At the top, there are tabs for 'List Pop' and 'Graph Pop'. Below the tabs, there is a 'Create a Population Label' checkbox and a 'Population Label' dropdown menu set to 'ERS sSUPPORT REPORT'. There are buttons for 'Delete Label' and 'Edit Selection'. Below that, there is a 'Report Label' dropdown set to 'SUSPENSE REPORT', a 'Created By' field with 'CRStar User', and a 'Requested On' field with '10/20/2023'. The main section is titled 'Choose the Items for Your Report' and contains a table with the following columns: Item Nbr, Item Description, B/S/L, C/D, Display Length, and Limiting Values. The table has 10 rows, with the first row selected. Below the table are fields for 'Heading' and 'File Name', a checkbox for 'Include Column Headers', and a 'Reporting Device' section with radio buttons for 'Excel', 'File Delimited', 'File Fixed-Width', 'Screen', and 'Xml'. At the bottom, there are 'Start Time' and 'End Time' fields, and a 'Run' button.

1. Insert previously selected Population Label. (Click on the down arrow to retrieve saved population.)
2. Name the Report Label. Note: The report label is saved for future use.
3. Requested On and Created By are defaulted but can be changed by clicking in the box and typing over the auto-filled data.
4. Choose the items to be displayed on the report. Enter the item number if known. If not known, click the drop-down arrow under item description to display a numerical listing with descriptions. The Global Lookup window pops up with the numeric listing and a search field. To search for a field, type in the description or partial description of needed item in the search field. Click the search button to show possible options under the Item Description, click item from the list generating field into the report.
5. Choose to B Break, S Sort or L List the items. B breaks up the report by the item chosen, listing in order of each break with a tally for each break. S sorts report list in order by item chosen. L gives an unsorted list of items.
6. Choose to display the item numbers as C Codes or D Descriptions.
7. The Display Length defaults as to how many characters are displayed on a printed report. This can be changed to avoid text wrapping.
8. Limiting Values leave blank unless wanting to limit report display to certain values.
9. To insert a row, click the insert key on the keyboard.
10. To add a row, tab. To delete a row, click the delete key on the keyboard.
11. Type in a heading for the report if desired.
12. Name the Filename if the report device chosen is File CSV or File Fixed Width.
13. Choose Reporting Device. Note: If Excel is chosen the Excel document is created and the steps to open or save the Excel document is dependent on browser type.
14. Select Run.

15. Add a row: Click the Add button.
16. Delete a row: Click the Delete button.
17. Insert a row: Click the insert key from the keyboard

## Canned Reports

- Site Distribution
- Treatment Distribution
- Survival by Stage

## Canned Reports-Site Dist (Site Distribution)

The Site Distribution report is in the Enhanced Reporting module under Canned Reports. The Site Distribution table breaks cases into Site groups and sub sites. Note Small Cell and Non-Small cell lungs are broken out individually as is Hodgkin's and Non-Hodgkin's Lymphomas.

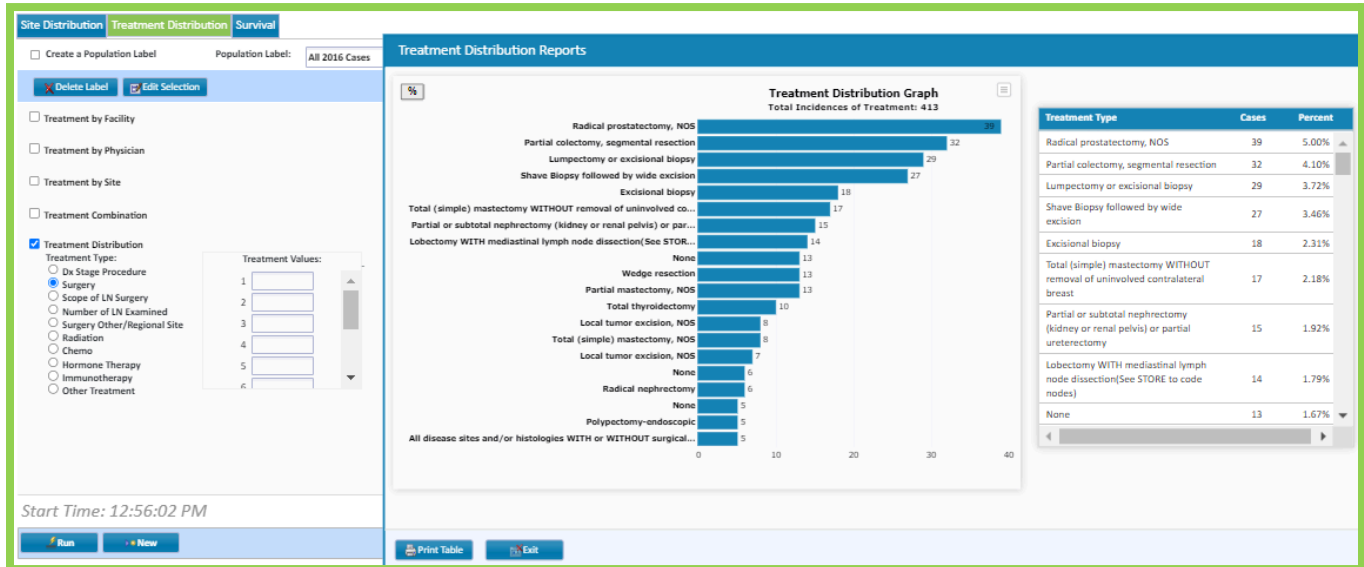
The screenshot shows the 'Site Distribution' report interface. On the left, there are several filter options: 'Age at Diagnosis' (checked), 'Ethnicity' (unchecked), 'Insurance' (checked), 'Race' (unchecked), 'Sex' (checked), 'Stage' (checked), 'Zip Code' (checked), and 'Display Percentages' (unchecked). The 'Stage Type' is set to 'AJCC'. Below these are options for 'Ca in-situ cervix, squamous and basal skin cell, and intraepithelial' (unchecked) and 'Send Report To:' (Excel and Screen are selected). At the bottom left, it says 'Start Time: 9:25:51 AM'. The main report area shows a table with the following data:

Primary Site	Total	Class	Sex	AJCC Stage	Age at Dx												
		A	N/A	M	F	0	I	II	III	IV	Unk	N/A	Under 20	20-29	30-39	40-49	
All Sites	615	468	147	335	280	46	149	64	44	60	206	46	5	9	17	36	
Head/Neck	17	8	9	10	7	1	0	0	0	0	4	8	1	0	0	1	1
Lip	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Tongue	6	2	4	5	1	1	0	0	1	1	3	0	0	0	0	0	0
Oropharynx	1	1	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0
Hypopharynx	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	10	5	5	5	5	0	0	0	2	2	5	1	0	0	1	1	1
Lung/Trachea System	119	100	17	80	39	0	35	17	8	17	39	5	0	0	2	5	5
Hodgkin's	11	10	1	9	2	0	5	1	1	4	2	0	0	0	0	0	0
Stomach	9	9	0	8	1	0	3	0	1	2	3	0	0	0	0	0	0
Colon	26	25	0	24	14	0	9	4	3	4	17	1	0	0	0	0	1

1. Choose either to create a population or use a previously selected population from the drop down. Note: Only use a population that has all the cases with coded histology.
2. Check boxes of data items to be displayed within the report.
3. Choose a Stage Type. AJCC or General
4. Zip Codes leave field blank to include all or limit to a selection of zip codes.
5. Include or exclude non-reportable cases, i.e. basal and squamous of the skin, ca in situ of the cervix, etc. Note: If exclude is chosen, the number of excluded cases is listed at the bottom of the report.
6. Choose report device. The report can be exported to Excel or viewed on screen as shown, where the report can be printed. If Excel is chosen, the Excel document is created and the steps to open or save the Excel document is dependent on browser type.
7. Select RUN.

## Canned Reports Rx Dist (Treatment Combination/Distribution)

The Treatment Combination and Treatment Distribution reports are located in the Enhanced Reporting module under Canned Reports. The codes selected are for definitive cancer surgery. If no codes had been entered under RX Values, all cancer directed surgery codes would have been displayed by default.



1. Choose either to create a population or use a previously selected population from the drop down.
2. Leave the Hospital Number blank if all treatment regardless of the treating hospital is desired. Only enter a hospital number if the report should be limited to a particular treating hospital/s.
3. Enter RX Values if the report should be limited to a certain treatment. Leave RX Values blank to include all treatment.
4. Choose the course of treatment.
5. Choose the type of Report to run, Treatment by Facility, Treatment by Physician, Treatment Combination and Treatment Distribution.
6. Choose report device. The report can be exported to Excel or viewed on screen as shown, where the report can be printed. If Excel is chosen, the Excel document is created and the steps to open or save the Excel document is dependent on browser type.
7. Select RUN.

## Treatment Distribution

### Sample Outputs for Treatment Distribution Reports

(Treatment Combination Distribution by Facility, Physician and Treatment Type)

Site Distribution Treatment Distribution Survival

Create a Population Label Population Label: 2021 ANALYTIC BREAST CASES

Delete Label Edit Selection

Treatment by Facility  
 Dx Stage Procedure  Surgery  Chemo  Radiation  Immuno  Hormone  Other Treatment

Treating Hospital(s): 01

Treatment by Physician  
 Dx Stage Procedure  Surgery  Chemo  Radiation  Immuno  Hormone  Other Treatment

Course of Treatment:  
 First Course  
 Subsequent  
 All Courses

Treatment by Site

Treatment Combination

Treatment Distribution  
Treatment Type:  
 Dx Stage Procedure  
 Surgery  
 Scope of LN Surgery  
 Number of LN Examined  
 Surgery Other/Regional Site  
 Radiation  
 Chemo  
 Hormone Therapy  
 Immunotherapy  
 Other Treatment

Treatment Values:	
1	10-99
2	
3	
4	
5	
6	

Send Report To:  
 Excel  
 Screen

Start Time: 11:55:33 AM End Time: 11:55:46 AM

Run New

1. Choose treating hospital(s) to be included in the report by selecting the checkbox beside the hospital (see illustration on page 8-9) or users can manually enter hospital numbers separated by commas. Note: When this field is left blank, the report will include all treating facilities.
2. Select Course of Treatment
3. Choose type of Report:
  - a. Treatment by Facility
    - i. Choose the treatment types to include
  - b. Treatment by Physician
    - i. Choose the treatment types to include
  - c. Treatment Combination
  - d. Treatment Distribution



- i. Select Treatment Type: Surgery, Scope of LN Surgery, Number of LN Examined, Surgery Other/Regional Site, Radiation, Chemo, Hormone Therapy, Immunotherapy, Other Treatment
  - ii. To limit the report to certain treatment values user will type individual treatment values. Ranges can be placed in these spaces as well. See example of limiting Surgery codes to codes 10-99 as shown on page 8
4. Choose to run the report to the screen or Excel
  5. Click Run

### Treatment by Facility

**Treatment Distribution Reports**  
*January 24, 2023* *Treatment by Facility for: 2021 BREAST CASES*

Surgery	Treatment Description	Grand Total	Ers 2022 Hospital Erslst01	St Elsewhere Testlist01
Breast	Modified radical mastectomy, NOS	2		2
	<b>Grand Total</b>	2		2
Radiation	External Beam, Photons	2	1	1
	<b>Grand Total</b>	2	1	1
Chemo	None, Not Part of First Course of Rx	1		1
	Chemotherapy Multiple Agents As First Course Rx	3	1	1
	Chemotherapy Not Recommended, Contraindicated Due to Risk Factors	1		1
	<b>Grand Total</b>	5	1	2
Hormone	None, Not Part of First Course of Rx	1		1
	Hormone Therapy As First Course Rx	1	1	

**Treatment Distribution Reports**  
*January 24, 2023* *Treatment by Physician for: 2021 ANALYTIC BREAST CASES*

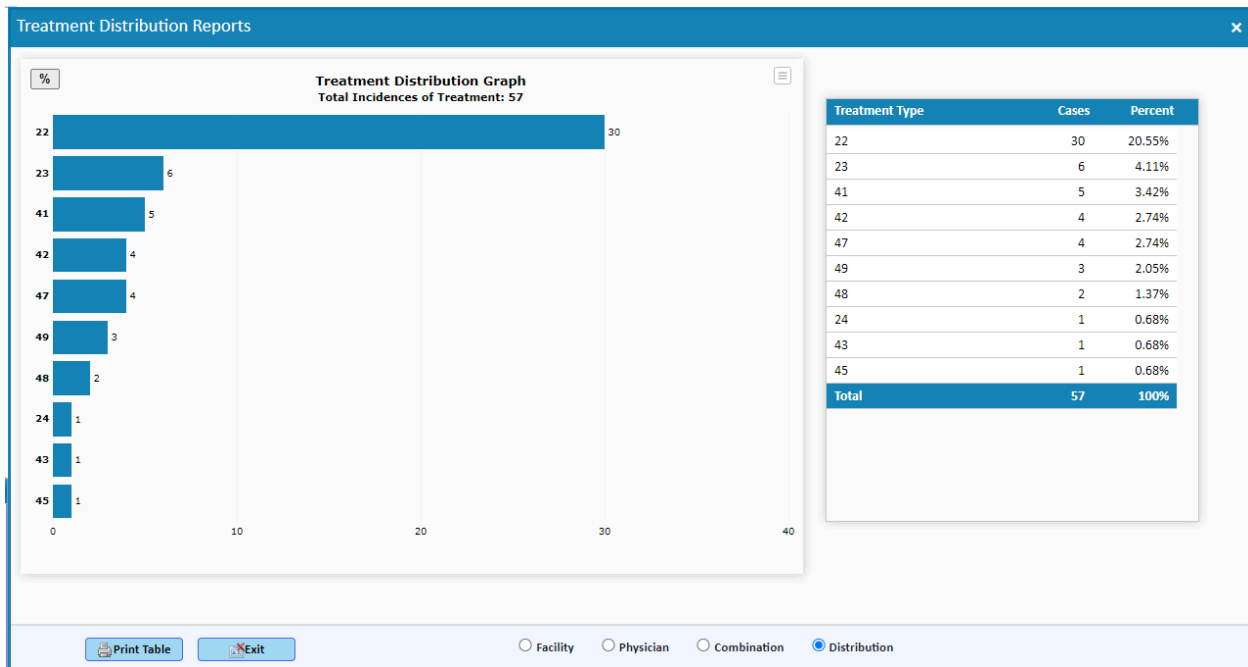
Surgery	Treatment Description	Grand Total	Ronald Y Myers	Jan Thompson	Judith Sears	Jennifer Lee	Janet Hines	Donald Baker	Matthew B Garrett
Breast	Modified radical mastectomy, NOS	2						2	
	<b>Grand Total</b>	2	0	0	0	0	0	2	0
Radiation	External Beam, Photons	2	1		1				
	<b>Grand Total</b>	2	1	0	1	0	0	0	0
Chemo	None, Not Part of First Course of Rx	1					1		
	Chemotherapy Multiple Agents As First Course Rx	3		1		1			1
	Chemotherapy Not Recommended, Contraindicated Due to Risk Factors	1					1		
	<b>Grand Total</b>	5	0	1	0	1	2	0	1
Hormone	None, Not Part of First Course of Rx	1					1		
	Hormone Therapy As First Course Rx	1		1					

[Print Table](#) [Exit](#)

### Treatment by Physician

### Treatment Combination

## Treatment Distribution



## Survival-Select a Population of Cases for Survival

### Survival by Stage

1. Select or create a population.
2. Choose Survival Method: Observed Survival, Observed (Kaplan Meier Method), Adjusted Survival or Relative Survival
3. Choose Stage Type: General or AJCC
4. Choose Start Date: Diagnosis or Treatment
5. Choose End Date: Last Contact or Recurrence
6. Choose to send the report to Excel or the screen
7. Enter Number of years desired if different from 5 (5 is the default)
8. Click Run

Site Distribution Treatment Distribution **Survival**

Create a Population Label Population Label: BREAST SURVIVAL

Delete Label Edit Selection

Survival Method

Observed Survival  
 Observed (Kaplan Meier Method)  
 Adjusted Survival  
 Relative Survival

Stage Type

General  
 AJCC

Start Date

Diagnosis  
 Treatment

End Date

Last Contact  
 Recurrence

Send Report To

Excel  
 Screen

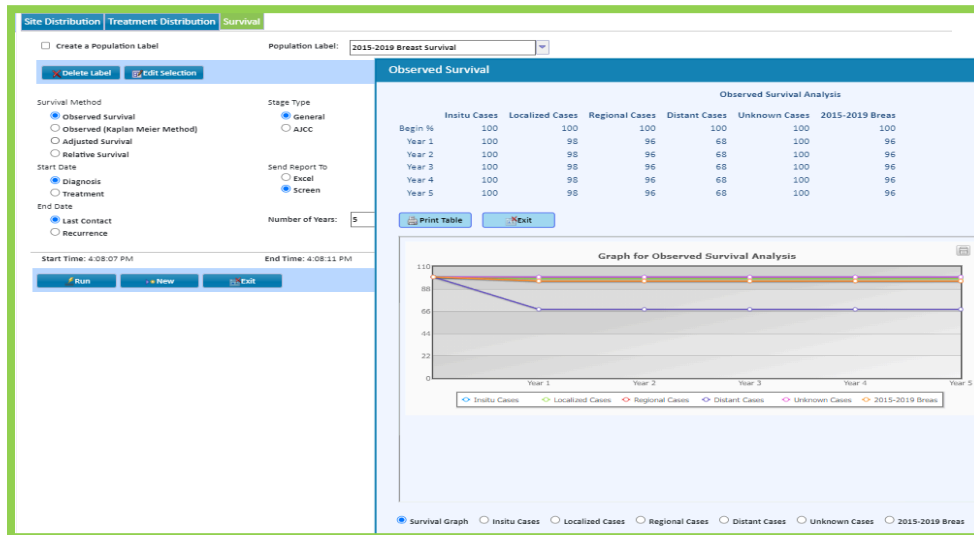
Number of Years: 5

Start Time: - End Time: - Records Selected: 2179

Run New Exit

IMPORTANT: AJCC Stage Basis MUST be coded to use field index number 568 Summary AJCC Stage in reports. Note: Summary AJCC Stage only populates cases with a P or C (Only cases with an AJCC Basis of C or P are included in reports AND must have the respective group assigned). Otherwise they are counted as NA and Unknown.

## Survival (Survival by Stage)



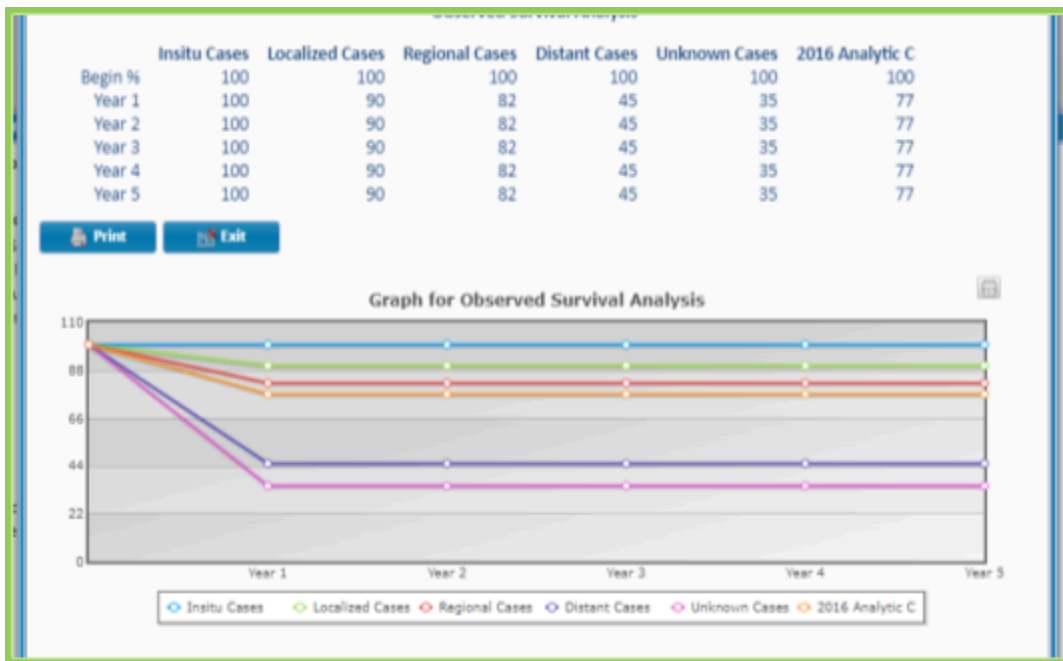
1. Select or

create a population.

2. Click on the Enhanced Reporting Tab, then Canned Reports Tab, then on the Survival Tab.
3. Choose the Population Label name of the population previously selected (i.e. BREAST-SURVIVAL 2003-2008)
4. Check Survival Method: NCDB Benchmark uses Observed Survival
5. Check Stage Type. NCDB uses AJCC Stage
6. Defaults are checked for Start Values: Diagnosis and End: Last Contact Date. Note: Date of First Treatment and Date of First Recurrence can be chosen for Disease free survival.
7. Choose output device: Excel or Screen. Note: If Excel is chosen the Excel document is created and the steps to open or save the Excel document is dependent on browser type. There is a print option from the screen.
8. Click Run. The system will create a survival by stage graph automatically.

## Survival by Stage Output Reports

Multiple reports are generated and displayed when running survival by stage. A line graph plotting the five-year survival by stage is displayed first as shown below. In this example, the screen output was chosen. The user may print directly from the screen. At the bottom of the screen Survival graph is chosen. All other reports can be displayed by selecting the correct radio button. A report has been created for each stage using the Actuarial Life Table Method. See example of Stage 1 cases below.



**Survival Rate Calculation by Actuarial (Life Table) Method**  
Population for this study: Regional Cases

	Dead in Month	Last Seen In Month	Exposed To Risk	Prop. Dying	Prop. Surv
58	2	3	56.5	0.035398	0.964602
53	0	3	51.5	0	1
50	0	4	48	0	1
46	0	3	44.5	0	1
43	0	3	41.5	0	1
40	0	4	38	0	1
36	0	5	33.5	0	1
31	0	2	30	0	1
29	0	7	25.5	0	1
22	0	2	21	0	1
20	0	0	20	0	1

Localized Cases 
  Regional Cases 
  Distant Cases 
  Unknown Cases 
  2015-2019 Breas

- Admin Reports
  - Accession Register/ Master Patient Index
  - Request Log
  - Report for a File
- CPM Reports
- Adhoc Reports
  - List for a Population
  - Graph for a Population
  - Report for a File
  - Cross Tab Reports
- Miscellaneous Reports
  - Productivity
  - Timeliness
  - Age By Sex

### ADMIN Reports-Accession Register/MPI

- Accession Register and MPI Listing are combined into one report and located under Enhanced Reporting module under Admin tab.
- User can choose multiple hospitals to run at once

The screenshot shows a web interface for generating reports. It includes a dropdown menu for 'Hospital Code' with '01' selected and 'ERS Hospital Systems' as the label. Below it is a text input field for 'Years' containing '2016'. At the bottom, there are two sections: 'Sort By' with radio buttons for 'Accession Number' (selected) and 'Name', and 'Send Report To' with radio buttons for 'Excel' and 'Screen' (selected).

1. Choose Hospital(s) To select multiple hospitals, choose the dropdown icon and check the boxes beside the hospitals to be included in the report or enter hospital numbers separated by commas.
2. **Choose accession year(s).** If selecting multiple years type the years separated by a comma.
3. **Choose** to sort by Accession Number or Name.
4. **Choose** to send the report to Excel or the screen.
5. Click Run.
6. Click Exit

## ADMIN Reports-Request Log

The Request Log report is in the Enhanced Reporting module under Admin. The Request Log is generated from the saved populations in Select a Population. It lists the Requested Date, the name of the population and Requested By.

Request Log			
January 17, 2024			
Request Date	Population Name	Requested By	
1	01/10/2023	2017nlvs 2022	Training Registrar Default Login
2	01/10/2023	2017 only base	Training Registrar Default Login
3	01/10/2023	CLRT POP 2	Carl Patrick
4	01/10/2023	Nicki all cases	Training Registrar Login
5	01/16/2023	last name test	Bonnie Nelson
6	01/17/2023	05-05-2019-12-31-2022 Breast - Chemo	Nicki Skipper
7	01/17/2023	05-05-2019-12-31-2022 Breast - Hormone	Nicki Skipper
8	01/16/2023	2021	Sherril Chico-Rosell
9	01/16/2023	2021 Suspense	Sherril Chico-Rosell
10	01/16/2023	2021 Abstracted	Sherril Chico-Rosell
11	01/16/2023	4001	Sherril Chico-Rosell
12	01/24/2023	test reports	Eliah Login
13	01/26/2023	test #6	Training Registrar Default Login
14	01/26/2023	01200700230	Training Registrar Default Login
15	01/31/2023	05-Accruals-NCDB-2020	Bonnie Nelson
16	02/01/2023	060900000	Kathryn Nelson
17	02/06/2023	Breast 2018 to 2021 chemo or ht base	Nicki Skipper
18	02/06/2023	Breast 2018 to 2021 chemo or ht SA	Nicki Skipper
19	02/07/2023	NCDB pop test	Jonathan Robinson
20	02/07/2023	FGDS State report pop	Jonathan Robinson
21	02/08/2023	Duplicates by SSN	Nicki Skipper
22	02/09/2023	05-Accruals-NCDB-2021	Bonnie Nelson

1. Enter a Begin and End Date. This report can be generated in any selected date range, i.e. one week, month, quarter, or year.
2. Send report to Excel or screen. Note: If Excel is chosen the Excel document is created and the steps to open or save the Excel document is dependent on browser type. There is a print option from the screen.
3. Click Run.
4. Click Exit



## Admin Reports-Report File (Report for a File)

It is recommended to seek advice from a member of the Health Catalyst Support Team if you are not yet familiar with this function. This function can be utilized in MANY ways to create reports from a table in the database.

1. Go to Enhance Reporting tab, then Admin, then click on the Report File Tab.
2. Type in the name of the report or select one from the drop-down menu for Label if a report already exists. CRStar defaults "Reporter- " in front of any label name.
3. Select the Table Name from the drop-down menu in which you would like to select data from.
4. Once the table is selected, the attributes are then activated with options. Choose a Selection Attribute or leave it blank if wanting the entire table of data. By choosing a selection attribute to limit the search by, the Relation is required, select option from the drop-down menu (Equal to, Greater than, Less than, etc.) enter the Data Value. As an example, of a selection attribute row: Discharge Date (attribute) greater than (Relation) 02/12/2012 (Data Value).
5. Choose the Reporting Attribute based on which information is needed to display in the report.
6. By using the TAB key, the display length and B/S/L will default; OR set them as desired. The display length is modifiable, increase or decrease as needed.
  - B = BREAK the data into sections with total sum by item
  - S = SORT the data numerically/alphabetically
  - L = LIST the data

Depending on which line they are set, that is the attribute executing the command. For instance, if State in the example above was set to "S" instead of "L" – then the report would sort the rows of data by the STATE column. And if State was set to "B" – the report would group all the Hawaii's together and after a line break, then the next state group would begin and so forth.

7. The number of rows is limitless, to add a row to the Selection Attribute and/or the Reporting Attribute, click the insert row icon to the right of each row or insert a row by clicking inside the row, press the "insert key" on the keyboard. This inserts the row above the field the command commenced.
8. To add a row to the bottom, click the green (+)/to delete a row, click the red (X).
9. On the top right corner of the window, select the Reporting Device preference. The Excel, File CSV, File Fixed-Width and XLM choices dictate designation and report file type. If screen is chosen, the option to print is available once the report is complete.
10. Click RUN, to view, print from screen or save the excel report. EXIT.

### Admin Reports-Rpt File (CRSTAR AUDIT TRAIL REPORT)

The Audit Trails track and log inserts, changes and deletions on fields and entire cases for both Suspense and Abstracted cases.

Reports can be generated using the Report for a File, located in the Enhanced Reporting Module Admin Reports and Report File. Things to remember when generating reports:

- When creating an Audit report, the table name to use is AUDITLOGVIEW, as shown in the examples.
- Usernames are how a user signs into CRStar, with underscores (\_) substituted for hyphens (-) and periods (.). For example, the user's log in to the software is [melanie@ers0100.com](mailto:melanie@ers0100.com), the username for the audit report is melanie@ers0100\_com
- There are three types of reports the user can select. Type is one of the Selection Attributes:
  - I-Insert-cases that have been added.
  - U-Update-cases that have had updates or changes made to fields within the case. Old and New values of the fields changed can be listed in the report. Audit tracking also recognizes changes made behind the scenes, such as a field that auto copies to another field, a field that would trigger a change in a derived field, survival months, etc.
  - D-Delete-cases or primaries that have been deleted.
- The Audit Trails include changes made during global data changes and imports.
- Reports can include the date, time, and user ID of who made the modifications.
- Attributes available for selection and listing in reports:
  - Abstract/Suspense Flag
  - Accession Number
  - Class of Case
  - Date
  - Date of Birth
  - Field Name

- o First Name
- o Hospital Number
- o ID Number
- o Last Name
- o Medical Record Number
- o Middle Name
- o New Value
- o Old Value
- o Sequence of Primary
- o Social Security Number
- o Table Name
- o Time
- o Topography Code
- o Type (Insert, Update, Delete, View)
- o User Name

Below are various examples of running reports based on three classifications (I, U, D,)

INSERT-NEW SUSPENSE OR ABSTRACT CASES

Label: Reporter-AUDIT INSERTED CASES

Requested By: Melanie

Reporting Device

Table Name: AUDITLOGVIEW

Request Date: 10/23/2017

- Excel
- File CSV
- File Fixed-Width
- Screen
- Xml

	Selection Attribute	Relation	Data Values	
1	Type	=	I	<input type="button" value="Insert"/>
2	DATE	>=	2017/09/01	<input type="button" value="Insert"/>
3	DATE	<=	2017/09/30	<input type="button" value="Insert"/>

	Reporting Attribute	Display Length	B/S/L	
1	Abst_Suna_Flag	20	S	<input type="button" value="Insert"/>
2	Med_Rec_Nbr	20	L	<input type="button" value="Insert"/>
3	Last_Name	20	L	<input type="button" value="Insert"/>
4	First_Name	20	L	<input type="button" value="Insert"/>
5	Topo_Code	20	L	<input type="button" value="Insert"/>

Start Time: -

End Time: -

Records Processed: 25

## UPDATED CASES

Acc Register/MPI
Request Log
Report File

Label:

Table Name:

Requested By:

Request Date:

Reporting Device

Excel

File CSV

File Fixed-Width

Screen

Xml

#	Selection Attribute	Relation	Data Values	
1	Type	=	U	Insert
2	DATE	>=	07/01/2021	Insert
3	DATE	<=	07/28/2021	Insert

#	Reporting Attribute	Display Length	B/S/L	
1	FieldName	20	S	Insert
2	DATE	20	L	Insert
3	UserName	20	L	Insert
4	Med_Rec_Nbr	20	L	Insert
5	TableName	20	L	Insert
6	OldValue	20	L	Insert
7	NewValue	20	L	Insert

Start Time: -
End Time: -
Records Processed: 59

## DELETED CASES

Acc Register/MPI
Request Log
Report File

Label:

Table Name:

Requested By:

Request Date:

Reporting Device

Excel

File CSV

File Fixed-Width

Screen

Xml

#	Selection Attribute	Relation	Data Values	
1	Type	=	D	Insert
2	DATE	=	10/23/2017	Insert
3				Insert

#	Reporting Attribute	Display Length	B/S/L	
1	Med_Rec_Nbr	20	L	Insert
2	Topo_Code	20	L	Insert
3	Seq_Primary	20	L	Insert
4	UserName	20	L	Insert
5				Insert

Start Time: -
End Time: -
Records Processed: 0

If assistance is needed, please log on to the Support Portal and submit a ticket.

## CPM Reports-Quality Measures

The Quality Measures report is in the REPORTING module under CPM Reports. When running the Quality Measures, the system tells the user how many cases match the criteria for the study. In this example, for the Breast Radiation with Conservation measure, 31 cases are eligible to receive the recommended treatment. The system auto selects a population, and it is stored in the Select a Population, so that the user can take the population and run various reports, graphs, and letters example below.

### To Generate the Selections:

- Enter the Hospital code (leave blank to include all facilities)
- Enter the Start Date and End Date (leave End Date Blank to include case up to diagnosis date of the current date ran)
- Select the study to run
- Click Select

The populations below can be used to create custom reports and graphs.

Hospital Code	Population Label	Request Date	Requested By	Nbr Cases
01,02	toddttest	07/28/2021	Todd Carter	2
01	01 01-01-2020- Breast - Radiation with Conservation	07/23/2021	Sherri Chico-Rowell	1
01	01 01-01-2020-12-31-2020 Breast - Radiation with Conservation	07/23/2021	Sherri Chico-Rowell	0
01	01 01-01-2020-12-31-2020 Breast - Radiation with Mastectomy	07/23/2021	Sherri Chico-Rowell	0
01	01 01-01-2020-12-31-2020 Breast - Hormone	07/23/2021	Sherri Chico-Rowell	0
01	01 01-01-2020-12-31-2020 Colon - Chemo	07/23/2021	Sherri Chico-Rowell	0

- Adhoc Reports
  - List for a Population
  - Graph for a Population
  - Cross Tab Reports
- Miscellaneous Reports
  - Productivity
  - Timeliness
  - Age By Sex
  - Stage by Sex
  - TNM Stage Graph

## Adhoc Reports-List Pop (List for a Population)

The List for a population is in the Enhanced Reporting module, under Adhoc Reports, then List Pop. This report is especially useful for limiting criteria on a previously selected population.

Designing population reports according to

wanted to retrieve. The example above is designed to break by AJCC stage (#568 AJCC summary stage looks at the stage basis ["P", "C" etc.] and selects the stage from that code. This ensures only one stage is selected for each case). Notice several values have been added to the last column, Limit Values. This saves time by not having to select a new population to display a portion of the data. Other items that users may want to consider adding to this report are Cancer Directed Surgery #827 and Chemotherapy Code #839. This would provide information on the cases that had surgery and chemotherapy.

reports for a varies the data

All the criteria for this report are saved by the name given on the Report Label. Click on the arrow to view any previously saved report labels. Always name the Report Label after the criteria requested, not the population's label. This creates a template for future use for populations needing the same criteria.

1. Population Label: Select or create a population.
2. Report Label: Always name the Report Label a generic name, not the name of the population. Once the report is generated the Report Label and the items with break/sort/list options are saved and can be used repeatedly. This saves time when requesting the same report on a different population. To review or select previously saved reports click on the right down arrow.
3. Item Number: Type in the item number desired or click the arrow to bring up codes and descriptions. Also, in item description type in the description of the field. After entering the item number hit tab to fill in the description.
4. B/S/L:  
 B = Break - Sorts the report on the data item selected and generates a sub-total on each data value.  
 S = Sort - Sorts the report on the data item selected.  
 L = List - Lists the data items on the report (default value).



5. C/D:
  - C = Code - Displays the code for data item selected (default value).
  - D = Description - Displays the description for data item selected.
6. Display Length: This number is preset and indicates how many characters are displayed on a printed report prior to text wrapping. This number may be changed to increase the amount of characters displayed.
7. Limit Values:

Enter values for this data item to limit the details of the report. Multiple values may be entered using a comma between the data values. Entering values in this field limits the details of the report. For example, entering 0,1,1A,1B,2,2A,2B for Stage limits the report to only those Stages requested.
8. Add/Delete Rows: Use the ADD or DELETE buttons.
9. Heading: Type in a heading to display on report.
10. Filename: Type in a file name if saving the report to a File Delimited or fixed length format. For example:  
breast.dat
11. Reporting Device: Choose to send report to:
  - Excel
  - File Delimited
  - File Fixed Length
  - Screen
  - Xml
12. Click Run.

## Adhoc Reports-List Pop (Exporting Text to Excel)

How to display LONG text fields using the Adhoc List for a Pop from CRStar. The Excel output option creates an .xlsx file that will truncate any text over 255 characters. By utilizing the File Delimited output option, this enables the user to display their long text boxes all at once by following the steps below.

To get all text characters to export to Excel, the user should follow the steps below:

1. In the Adhoc List for a Pop, set the display length to 4000 characters.
2. Choose the File Delimited option.
3. Once the file is downloaded and saved, simply open Excel, and then open the CSV file using Excel. All the text information is there. Below is an example of a CSV file opened using Excel. The text box had 996 characters.

Population Label: 2014 Analytic Cases

Report Label: TEXT DX COMMENTS Created By: Malaria Rogan Requested On: 12/14/2020

Item Nbr	Item Description	B/S/L	C/D	Display Length	Limiting Values
199	Dx Comments	L	C	1000	
206	Pft	L	C	1000	
514	Operative Findings	L	C	1000	
515	Physical Exam	L	C	1000	
516	X-ray and Scan	L	C	1000	
517	Scopes and Labs	L	C	1000	
855	Labs Text	L	C	1000	
518	Pathology	L	C	1000	

Reporting Device:  Excel  File Delimited  File Fixed-Width  Screen  Xml

Field Delimiter: , Include Text Qualifier:

	A	B	C	D	E	F
1	<b>Dx Comments</b>	<b>Place of Dx</b>	<b>Operative Findings</b>	<b>Physical Exam</b>	<b>X-ray and Scan</b>	<b>Scopes and Labs</b>
	DX COMMENT	County Hospital South	9/20/19- NEEDLE LOC LUMPECTOMY AND SENTINEL LN BX	52 YOWF PRESENTED ASYMPTOMATIC FOR ROUTINE SCREENING MMG	9/08/19 SCRNM MMG SHOWED SUSPICIOUS AREA OF CALCIFICATION LOQ LEFT. 9/10/19 DX MMG/US- 1.3 CM DISCREET MASS WITH CALCIFICATIONS HIGHLY SUSP FOR MALIGNANCY	N/A
2						
3						
4						
5	DX	PLACE	OP	EXAM	XRAY	SCOPE
6						
7	TEXT	TEXT	TEXT	TEXT	TEXT	TEXT

## Adhoc Reports-Graph Pop (Graph Item)

The Graph for a Population is in the REPORTNG module under Adhoc Reports, then Graph Pop. Graphs are available on all selected populations and can be generated on any one of the data items in the global dictionary. The user can select between pie, bar, or line graphs.

1. Select or Create a population. Click the down arrow for all saved populations.

Graph for: 2011 analytical breast cases

Summary Staged By for 2011 analytical breast cases

Summary Staged By	Cases	Percent
1 Pathologist	532	35.05%
2 Managing Physician	403	26.53%
3 Any Comb. of 5 with 1-4	214	14.10%
4 Registrar	172	11.33%
5 Pathologist and Managing Physician	157	7.05%
6 Not Staged	68	4.48%
7 -	18	1.19%
8 Another Facility	3	0.20%
9 Not Eligible for Staging	1	0.07%
Total	1518	100%

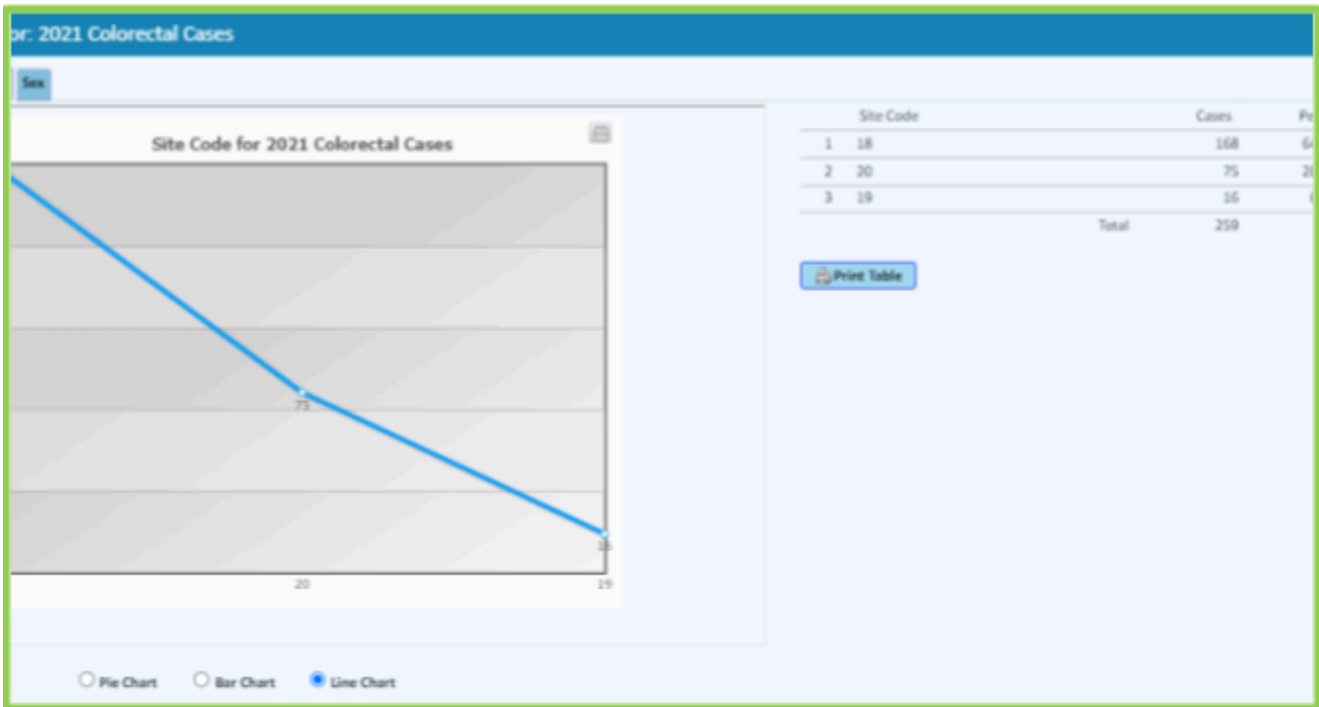
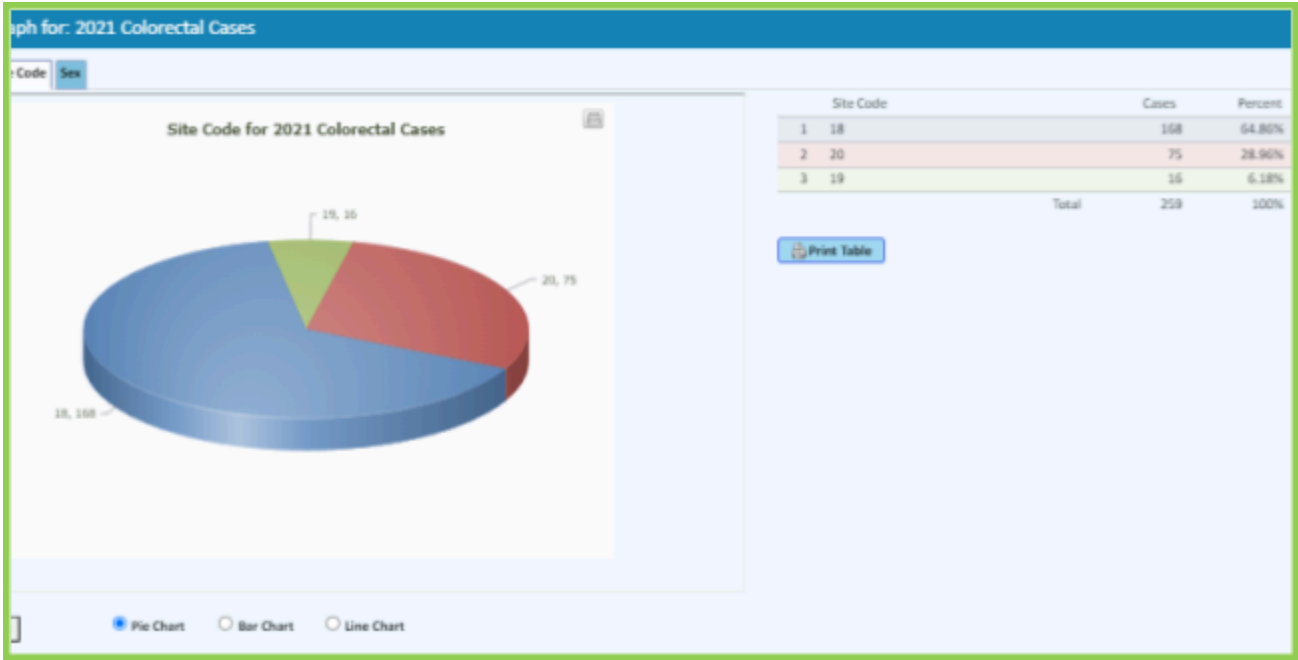
Send Report To:  Excel  Screen

Start Time: 6:45:40 PM End Time: 6:45:41 PM Records Selected: 791

Run New Exit

2. Under Report Elements, Choose the item number from the Global Dictionary. Manually enter the item number or click the down arrow for a list. The user may also type in a description of the item number and the field will come up.
3. Choose to display Codes or Descriptions.
4. Select Graph type. If more than four reports are needed, click the ADD button for additional graph rows.
5. Choose to send the report to Excel or view on the screen. If screen is selected, user may choose the color of the graph Note: The graph is customizable in Excel. In screen view, there is a print option.
6. Exporting to screen each graph displays in individual tabs.
7. The Style of the graph may be changed by clicking a radio button of desired style.
8. Choose a graph type: Pie, Bar or Line.
9. Bar and Line Color Selection: This option is only visible to the user when either Bar or Line is chosen. This allows the user to select the color of the graphs.
10. Click Run.

Additional examples of Pie and Line graphs



## Adhoc Reports-Xtab (Generate Cross Tabulation Report)

The Cross Tabulation report, also referred to as the Xtab report is in the REPORTING module under Adhoc Reports. The Xtab report compares any two variables and displays data vertically and horizontally. Both numbers and percentages are displayed. Xtab reports can be generated using any items in the Global Dictionary. Several examples of using the Xtab report are shown on the following pages.

1. Choose a previously selected population from the drop down.
2. Name the Report Label or choose an existing label from the drop down.
3. Type in a heading for the report.
4. In the Row section, enter the global dictionary number of the field to be used or type in the description, i.e. Site Code and the global dictionary number is displayed.
5. Choose to display in Codes or Descriptions.
6. To limit values, enter a value. For example, entering a 10 limits the report to the top 10 sites. If left blank, the report is generated based on all sites in the population.
7. To add a row to the bottom, click the green (+) to delete a row, click the red (X).
8. In the column section, enter the global dictionary number of the field to be used or type in the description, i.e. Site Code and the global dictionary number are displayed.
9. Repeat steps 5-8.
10. Click Run.

## Histology by Top Five sites using Limit Values

The Cross-tab enables the user to limit the values to a specific number in either or the row or the column.variable. This is useful for multiple reports, but especially to easily determine the top five sites (or any number) compared to histology. Below are the directions on using this feature in the cross-tab. NOTE: Do not put any values or descriptions in the columns when using limit values. Please refer to

**Generate Cross Tabulation Report**

Population Label: 2017 ANALYTIC CASES  
 Report Label: Top 5 Histologies by 5 Top Sites b

Send Report To:  
 Excel  
 Screen

**Row**

Heading:

Variable: 153 Histology

Display As:  Codes  Descriptions Limit Values: 5

	Values	Descriptions
1	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>

**Column**

Variable: 117 Site Code

Display As:  Codes  Descriptions Limit Values: 5

	Dep Values	Dep Descriptions
1	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>

Start Time: End Time:

Run New Delete Exit

Appendix Listing Field Index Numbers in the CRStar manual if you wish to choose the values for the cross-tab.

1. Select the population to limit the values (i.e. **2017 ANALYTICAL CASES**)
2. Click on the REPORTING Tab
3. Then on the Adhoc Reports Tab
4. Then on the Xtab.
5. Insert the Population Label name of the population (i.e., **2017 ANALYTICAL CASES**) or use dropdown menu to select the pop.
6. Name the Report Label. (i.e. FIVE TOP HISTOLOGIES BY FIVE TOP SITES)
7. Enter 153 HISTOLOGY in Row Variable if using this example.
8. Heading defaults to Histology
9. Display as: click Description (if code is checked the code numbers display on the report).
10. Limit values: put in 5 (or the number of values to limit i.e. 10) Note: Leave Values and Descriptions blank to list all values.
11. Enter 117 SITE CODE in Column Variable if using this example.
12. Display as: click Description (if code is checked the code numbers display on the report).
13. Limit values put in 5 (or the number of values to limit i.e. 10)
14. Output is limited to the top five (or whatever number was in the limit values) Histologies and Site codes:
15. Send report to Excel. Note: If Excel is chosen the Excel document is created and the steps to open or save the Excel document are dependent on browser type.
16. Send report to screen. There is a print option from the screen.

## Using Dashes in the Cross -Tab report

The Cross-Tabulation report allows dashes to select a range of numbers. This is helpful in selecting numbers or dates. The example below is a productivity report by quarter for cases abstracted in 2011. This same report can be used for any accession year to determine the sites diagnosed (#150 Diagnosed Date) by quarter or first contact date (#862 First Contact Date) by site and quarter. Just change the Pop Label (i.e.: 2011 Analytical Cases) and Dep (i.e.: 862 First Contact Date - Dashes can be used for any range of numbers. This also is helpful in sorting age groups (i.e. 00-19, 20-29 etc.)

The screenshot shows the 'Generate Cross Tabulation Report' interface. It includes the following fields and sections:

- Population Label:** 2017 ANALYTIC CASES
- Report Label:** Site by Quarter
- Send Report To:** Excel (selected), Screen
- Row Section:**
  - Heading:** (empty)
  - Variable:** 117 Site Code
  - Display As:** Codes, Descriptions (selected)
  - Limit Values:** (empty)
  - Table:** A table with columns 'Values' and 'Descriptions'. It has 4 rows, each with a dropdown menu and a 'Limit Values' field.
- Column Section:**
  - Variable:** 126 Date Abstracted
  - Display As:** Codes, Descriptions (selected)
  - Limit Values:** (empty)
  - Table:** A table with columns 'Dep Values' and 'Dep Descriptions'. It has 4 rows, each with a dropdown menu and a 'Limit Values' field. The values are: 1. 01/01/2017-03/31/2017 (First Quarter), 2. 04/01/2017-06/30/2017 (Second Quarter), 3. 07/01/2017-09/30/2017 (Third Quarter), 4. 10/01/2017-12/31/2017 (Fourth Quarter).

1. Population Label: Enter the name of population or click on left arrow next to Pop Label to review all saved populations.
2. Report Label: SITE BY QUARTER
  - Always name the Report Label a generic name, not the name of the population. Once the report is generated; the Report Label options are saved and can be used repeatedly. This saves time when requesting the same criteria on a different population.
  - Click on the right arrow next to the Report Label to view all the saved report names.
  - Click on Delete Report to delete report labels that are no longer useful.
3. Row Variable: 117 SITE CODE
  - Enter the Global Dictionary number of the controlling data item or type in a partial description of the data item followed by the "\*" and select it from the cross-reference list. The Controlling data item is listed vertically along the left side of the report. For example, to use the SITE CODE as the controlling data item, enter the Global Dictionary number 117, or type Site and choose 117 Site code.
4. Values: Leave blank to list all the values.
  - Or enter the values to be listed vertically along the left side of the report. Entering the values limits the report to those values. Multiple values may be listed on a single line of the report by entering values separated by commas in the values field or using dashes for sequential data. For coded data items, such as site code, click on the arrow to list values available for the

controlling data item. May select values from this list to be included on the current row of the report.

5. **Heading:** Type in a heading for this field.
6. **Display As:** Select Codes or Descriptions
7. **Column Variable:** 126 DATE ABSTRACTED
8. Or enter the **GLOBAL DICTIONARY** number as explained in step 3. The column data item (Column Variable) is listed horizontally across the top of the report.
9. **Display As:** Select Codes or Descriptions
10. **Dep Values:** Copy the values in column one and the description in column two. Or leave blank to list all the values. **NOTE:** Assigning a number in values, only pulls those that apply. Example, entering a 5 returns the top five and are displayed in order of total occurrence.
11. **Output:** Select output device – Screen or transfer to Excel - then **Click Run**.



## Small Cell vs. Non-Small Cell Lungs in Cross Tabs

This is another example of using ranges and dashes in the Xtab report. This report is selecting ranges of Small Cell Lung cases vs. Non-Small Cell Lung.

### NCDB Histology Ranges:

Small Cell 8040-8045

Non-Small Cell 8012-8035, 8046-85763

Other Types 8000-8011, 8580-9582

### Histology Ranges based on MPH Rules:

Small Cell 80412-80453, 82402-82493

Non-Small Cell 80122-80153, 80222-80353, 80462-82303, 82502-85763

Other Carcinoma Nos 80002-80013, 80102-80113, 80202-80213, 85802-95823

Generate Cross Tabulation Report

Population Label: 2011 lung cases      Send Report To:  Excel  Screen

Report Label: small cell vs non small cell

**Row**

Heading:

Variable: 153      Histology

Display As:  Codes      Limit Values:

Descriptions

	Values	Descriptions
1	80122-80153,80222-80353, ▾	Non Small Cell
2	80412-80453,82402-82493 ▾	Small Cell
3	80002-80013,80102-80113, ▾	Other, NOS
4	<input type="text"/>	<input type="text"/>

**Column**

Variable: 117      Site Code

Display As:  Codes      Limit Values:

Descriptions

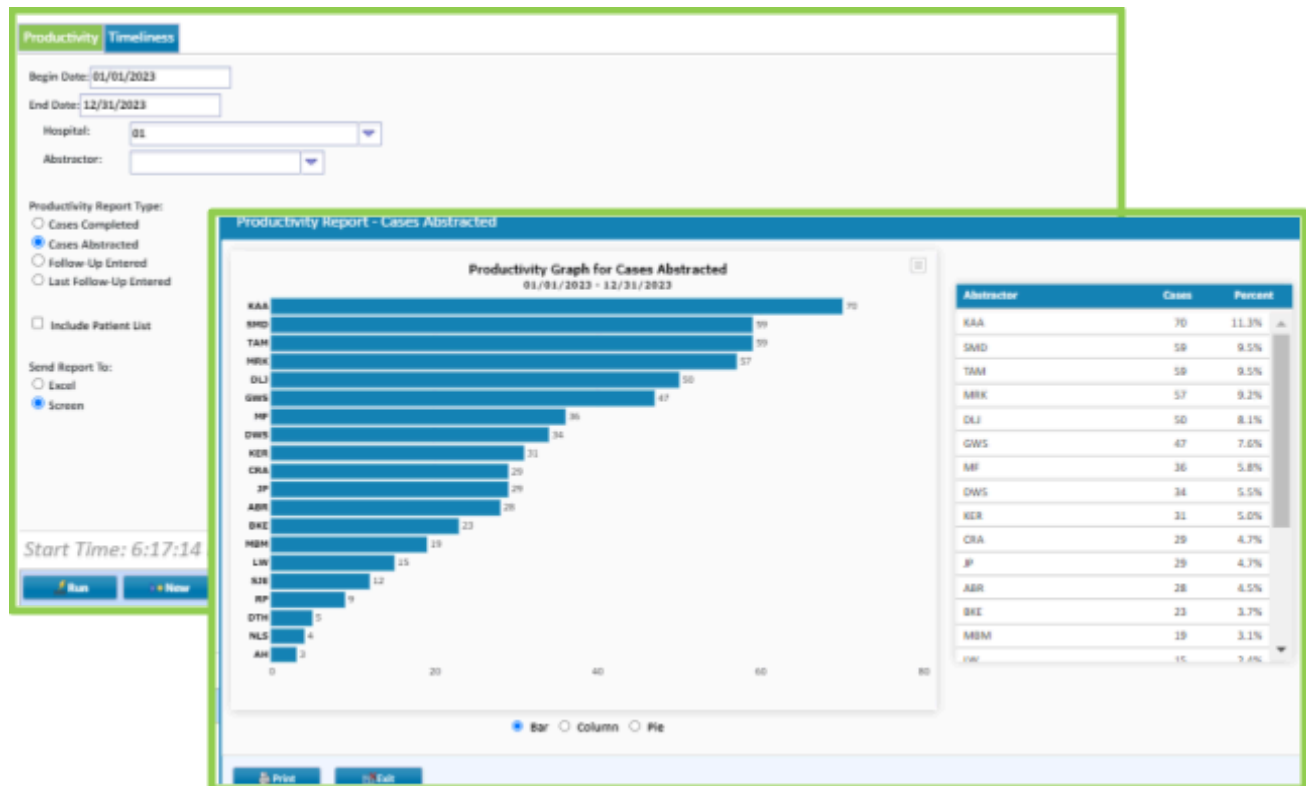
	Dep Values	Dep Descriptions
1	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>

Start Time:      End Time:

Run      New      Delete      Exit

## Registry Mngt Reports-Productivity (Generate a Productivity Report)

The Productivity Report can be used to monitor productivity with cases abstracted, on cases complete CoC, and Follow up. This report can be generated at any given time period. In this example, the report is based on cases abstracted in one week, i.e. 06/11/2012-06/15/2012.

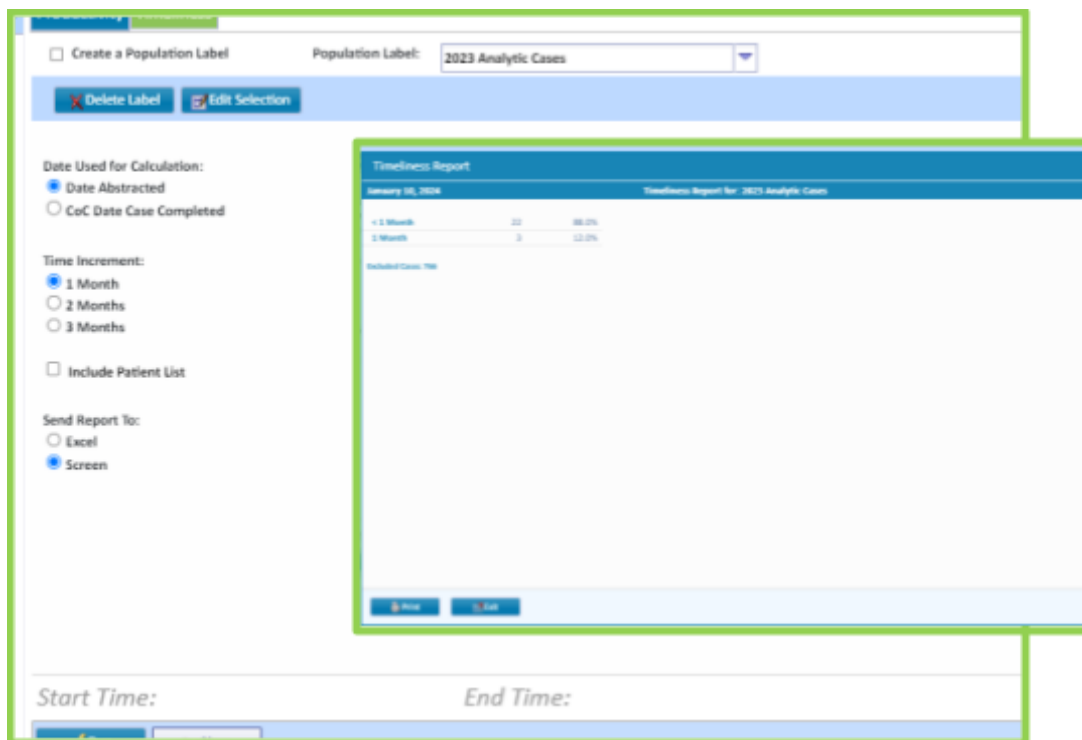


1. Enter date range with a begin and end date.
2. Enter a hospital number. This may be left blank for a single hospital. For multi hospital facilities, if left blank, the report is generated on all facilities in the multi hospital system. Manually enter the hospital code or begin typing the name of the facility in the display field, i.e. HOSPITAL ONE.
3. Choose Productivity report type:
  - Cases Completed: Generate from the Date Case Complete (CoC) field on the Case Admin screen.
  - Cases Abstracted: Generate from the Date Abstracted field on the Case Admin screen.
  - Follow Up Entered: Caution using this one for productivity. This will give ALL follow up entered on a given patient.

- Last Follow Up Entered: Use this for productivity. This displays the most current entry or Last Follow Up entered.
4. Choose to send report to Excel or view and print from screen. If Excel is chosen, the Excel document is created and the steps to open or save the Excel document are dependent on browser type. There is a print option from the screen.
  5. Click Run.

### Registry Mngt Reports-Timeliness (Generate Timeliness Report)

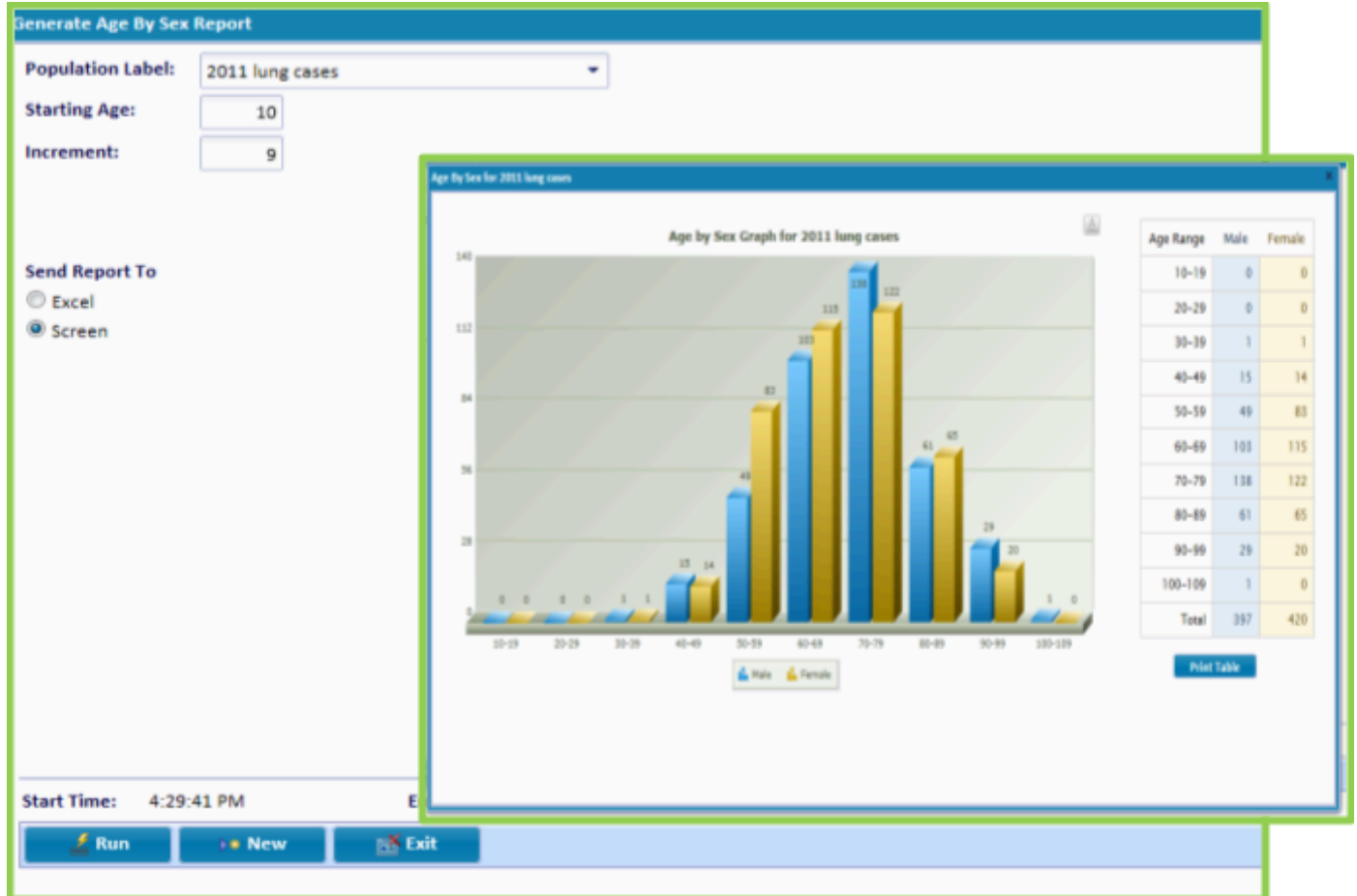
The Timeliness Report automatically creates a report in Excel or on screen listing the First Contact Date and the Date Case Complete (CoC), also calculating the number of days and months from the First Contact Date to the Date Case Complete (CoC), and the percentage of cases abstracted less than or equal to six months and greater than or equal to seven months. The report contains Accession Number as a patient identifier if any cases need review. It is suggested to review the report for any blank dates. Blank dates would cause the case to be excluded from the Timeliness calculation.



1. Select a previously saved population. In this example 2014 case completed to date was used.
2. Choose to send report to Excel or view and print from screen. If Excel is chosen, the Excel document is created and the steps to open or save the Excel document are dependent on browser type. There is a print option from the screen.
3. Click Run.

## Miscellaneous Reports-Age by Sex (Generate Age by Sex Report)

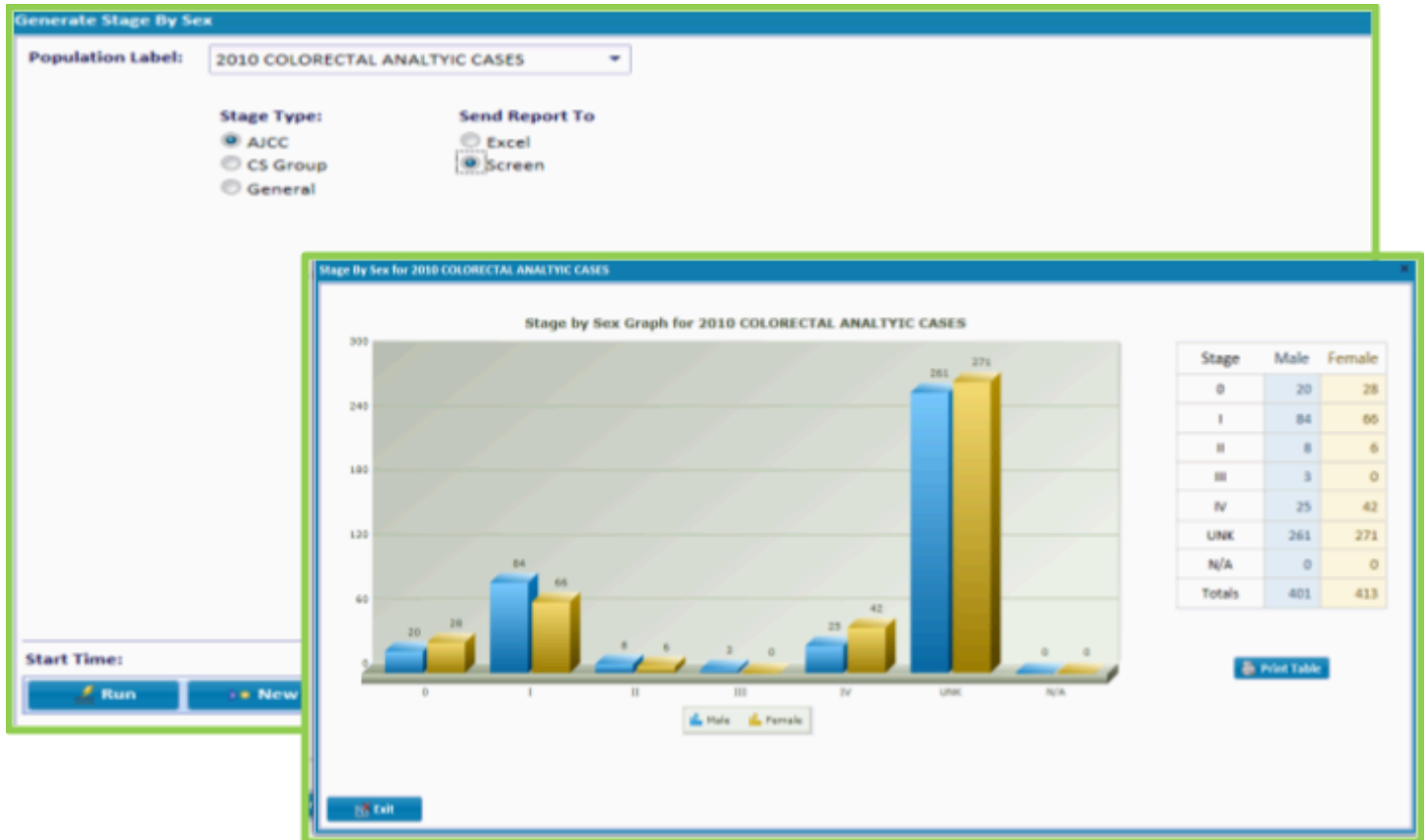
The Age by Sex graph is in the REPORTING module under Miscellaneous Reports.



1. Select a previously saved population from the drop-down arrow.
2. Starting age and Increment are preset. However, they may be changed by simply replacing each value. In this example, the starting age begins at 10 years of age and has a range of 9 years. For example, 10-19,20-29,30-39, etc.
3. Choose to send the report to Excel or to the screen. If Excel is chosen, the Excel document is created and the steps to open or save the Excel document are dependent on browser type. Once the Excel Document is opened the graph can be customized. There is a print option from the screen.
4. Click Run.

## Miscellaneous Reports-Stage by Sex (Generate Stage By Sex)

The Stage by Sex graph is in the reporting module under Miscellaneous Reports. It can be generated on any selected population of cases. This report can display the stage as General (SEER Summary), AJCC or CS stage.



1. Select a previously selected population label.
2. Choose a Stage Type.
3. Send report to Excel or view on screen. Note: If Excel is chosen the Excel document is created and the steps to open or save the Excel document are dependent on browser type. There is a print option from the screen.

## Miscellaneous Reports-TNM Stage Graph

The TNM Stage graph can be run on any selected population of cases and can be run on AJCC TNM stage or CS Stage Group.

The screenshot displays the TNM Graph interface. At the top, there is a section for 'Create a Population Label' with a dropdown menu set to 'All 2016 Breast Cases'. Below this are buttons for 'Delete Label' and 'Edit Selection'. The 'Send Report To:' section has radio buttons for 'Excel' and 'Screen', with 'Screen' selected. The main area is titled 'TNM Graph' and contains a bar chart labeled 'Combined Summary Stage' and a table titled 'Combined Summary TNM'. The bar chart shows the distribution of cases across AJCC TNM stages: 0 (16), I (36), II (21), III (1), IV (1), N/A (0), Blank (3), and Unknown (3). The table provides the following data:

AJCC	Cases	Percent
0	16	19.8%
I	36	44.4%
II	21	25.9%
III	1	1.2%
IV	1	1.2%
N/A	0	0%
Blank	3	3.7%
Unknown	3	3.7%
<b>Total</b>	<b>81</b>	<b>100.0%</b>

At the bottom left, a 'Start Time: 12:' is visible. At the bottom right, there are 'Print' and 'Exit' buttons.

1. Create a population or Select population from the drop down.
2. Choose report device. The report can be exported to Excel or viewed on screen as shown, where the report can be printed. If Excel is chosen, the Excel document is created and the steps to open or save the Excel document are dependent on browser type. There is a print option from the screen.
3. Select RUN.

## Data Exports-State Export (Export State Data)

**Select a Population**

Population Label: STATE EXPORT      New Label:

Requested By: Sheri Chico-Rowell      Request Date: 06/06/2023

Hospitals: 02      Demo Data for HOSP 02       Include All Primaries       Include Unique Primaries

None       Dx Date       1st Contact Date

Abstract/Suspense Cases      Case Type

Abstract Cases Only       Analytic Cases Only

Suspense Cases Only       Complete Cases Only

All Cases       Incomplete Cases Only

Non-Reportable State Flag

Site	Site Description
1	
2	
3	

Add Delete

Item Nbr	Item Description	Relation	Data Values	Logic	
1	200	State Report Flag	=	Y	And
2					
3					

Add Delete

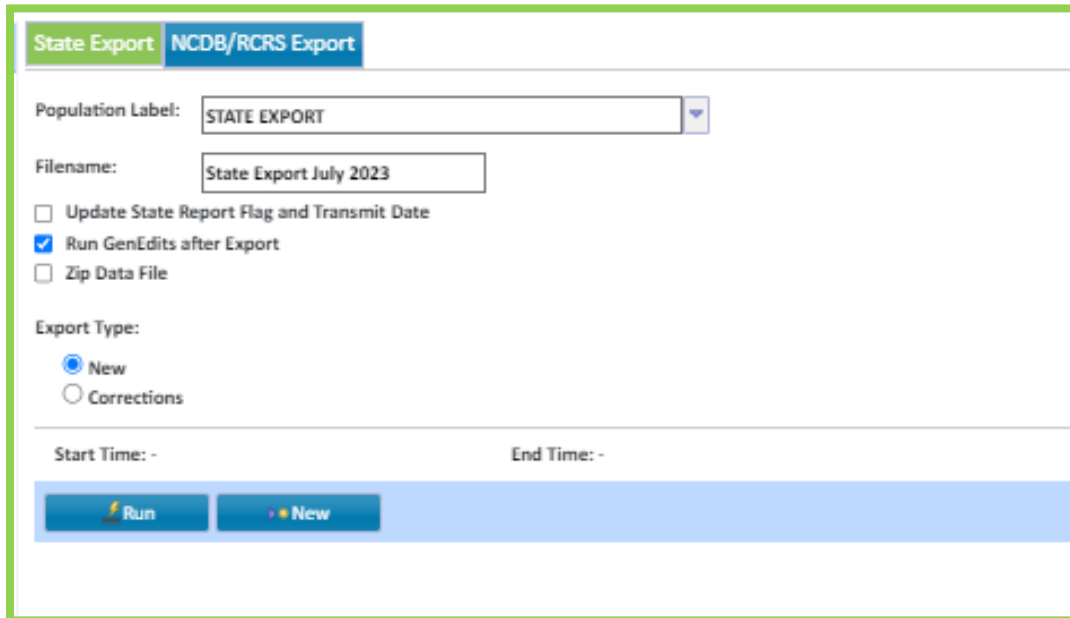
Start Time: -      End Time: -      Records Selected: 189

Select      Delete Label      Edit Selection      New

### Step I. Select the population of cases ready to go to the state.

1. Click CRStar Enhanced Reporting Tab
2. Click Select a Population Tab
3. Enter the of name the Populated Label – STATE EXPORT
4. Enter the Hospital Number for the cases to Export
5. Go down to the Selection Criteria box and enter Item 200 STATE REPORT FLAG = Y And
6. Click Select
7. After the process is complete the user will see in the task bar a Start Time, End Time, and Records Selected
8. Click Exit after case selection complete

## STATE EXPORT CONTINUED:



The screenshot shows a web interface for 'State Export' with two tabs: 'State Export' (active) and 'NCDB/RCRS Export'. The 'Population Label' dropdown is set to 'STATE EXPORT'. The 'Filename' text box contains 'State Export July 2023'. There are three checkboxes: 'Update State Report Flag and Transmit Date' (unchecked), 'Run GenEdits after Export' (checked), and 'Zip Data File' (unchecked). Under 'Export Type', 'New' is selected with a radio button, and 'Corrections' is unselected. At the bottom, there are 'Start Time' and 'End Time' fields, both empty. A blue bar at the bottom contains two buttons: 'Run' and 'New'.

- Step II. After the population has been selected, create the State Export file
  1. Select the appropriate facility from the Facility Selection Drop Down Bar.
  2. Click the CRStar Enhanced Reporting Tab.
  3. Click Data Export Tab.
  4. Click State Export Tab.
  5. Choose the name of the Population to export. (In this example chose the population named STATE REPORT).
  6. Name the Filename: In this example, State Export July 2023 indicating the file was created and submitted in July 2023. When the export runs, the file is downloaded to the computer. **Note: Depending on the browser (and browser version) the file will then either be placed automatically in the download folder, or the user receives a message box to choose where to download the file. Google Chrome automatically saves it to the Download folder. The user can copy and save to the location of choice.**
  7. Check Run GenEdits after Export.
  8. Click Run.
  9. After the GenEdits REPORT RUNS, print the report, and Fix all errors.
  10. Then repeat Steps 1-7, but this time also click UPDATE State Report FLAG and Transmit Date.
  11. MAKE SURE TO SUBMIT THE FILE CREATED TO THE STATE!



## Data Exports-NCDB Export

Clients are provided with specific instructions and documentation for each year's Call for Data. Please reference these materials. This documentation is located on the CRStar Registry Resources under Webinars.

## Data Exports-NCDB Export-RCRS EXPORT

1. Select Population of cases based on the RCRS criteria below. Use the same Population for each submission, "re-selecting" prior to each export to capture additional cases.

- a. Select the appropriate facility from the Facility Selection Drop Down Bar
- b. Click Enhanced Reporting Tab
- c. Click Select a Population Tab
- d. Enter Population Label RCRS
- e. Enter Hospital Code
- f. Select Analytic Cases Only Button
- g. Select Abstract Cases Only Button
- h. Enter criteria as seen below
- i. Click Select

NOTE: In subsequent months going forward, the same population can be used repeatedly, just update the Date Last Modified to the last date the population was selected (ex: January export pop selected on 1/15/21, so February population will need date last modified  $\geq$  1/15/21). This will capture all new and modified records since the last selection.

Item Nbr	Item Description	Relation	Data Values
1	391	Date Last Modified	>= 09/16/2020
2	3732	Date of Diagnosis - Year	>= 2004
3			

The Date of Dx year should be set to 2004 unless the facility's reference year is after 2004, in which case, enter the reference year.

Just keep in mind:

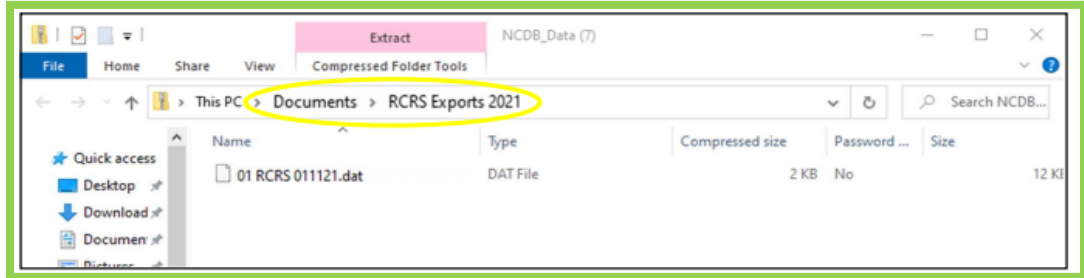
- Only cases diagnosed 2004, and later are accepted.

## 2. Export RCRS Data using NCDB Export Data

- a. Click Enhanced Reporting Tab
- b. Click Data Exports Tab
- c. Click NCDB Export Tab
- d. Select Use Existing Population button
- e. Choose RCRS Population
- f. It is recommended that the file name be changed to add the date (example: 01 RCRS EXPORT 02222021)
- g. Select Export Data For RCRS
- h. Click Run

The screenshot displays the 'NCDB/RCRS Export' configuration window. At the top, there are two tabs: 'State Export' and 'NCDB/RCRS Export'. Below the tabs, there are two radio buttons: 'Auto Select' (selected) and 'Use Existing Population'. A section titled 'Auto Selection Criteria' contains a 'Hospital:' dropdown menu set to '01' with 'ERS Hospital Systems' listed below it. There are two radio buttons for 'Cases Diagnosed in 2021' (selected) and 'Cases Diagnosed in'. A checked checkbox 'Exclude Cases Prior to Reference Year' has a 'Year:' input field set to '2007'. Below this, the 'Filename:' input field contains 'NCDB Export'. Under 'Export Data For:', there are two radio buttons: 'NCDB' (selected) and 'RCRS'. At the bottom, there are 'Start Time:' and 'End Time:' fields, both currently empty. The interface concludes with a blue bar containing a 'Run' button with a lightning bolt icon and a 'New' button with a plus icon.

3. A list of the cases in the export displays on the screen. Print or Download the list. Exit.
4. Once the NCDB/RCRS Export is executed, the file is created in proper XML format and timestamped and will be in a zip folder in the downloads. Within the zip file are the individual file(s) to submit to NCDB/RCRS. Open/Extract the zip file/s.
5. DO NOT FORGET TO UNZIP/EXTRACT THE FILE TO A NEW LOCATION!!! FAILURE TO DO THIS STEP PREVENTS ABILITY TO RUN THE ZIPPED FILE IN GENEDITS PLUS INHIBITING SUCCESSFULL SUBMISSION OF THE RCRS FILE.  
**DO NOT FORGET THIS STEP!**



6. Run edits on the un-zipped RCRS export through GenEdits Plus using the most current RCRS metafile. Correct cases if errors found/repeat steps and submit to RCRS.

**NOTE: For any and all assistance with GenEditsPlus please Contact NCDB at [NCDB@facs.org](mailto:NCDB@facs.org)**

## Reporting Utilities-Clear Populations

Clear Populations allows the user to delete multiple populations at once. The feature is located under the Reporting Tab, Reporting Utilities and Clear Populations.

To clear more than one population or groups of populations:

1. The user may either search for a particular population to delete or scroll through the list of populations. Note: The user may change the view to view up to 1000 populations at a time.
2. Put a check beside the population labels(s) to delete. The labels will turn from black to blue, highlighting the labels for an easy manual review.
3. Click Delete labels.
4. Window message below pops up asking to confirm the deletion of the selected populations. Click OK to delete. Otherwise, click cancel.

NOTE: These populations should be reviewed for clearing on a routine basis. The maximum number of reports that can be stored is 2100. If this number is reached, further populations cannot be created.

The screenshot displays the 'Clear Populations' interface. At the top, there is a search bar. Below it is a table with columns for Hospital Code, Population Label, Date, User, and Count. Two rows are selected, highlighted in blue. A 'Confirm Deletion' dialog box is overlaid on the table, asking for confirmation to delete the selected population labels. The dialog has 'Yes' and 'No' buttons. At the bottom of the interface, there is a 'Delete Labels' button and a pagination bar showing '15' items per page and '616 - 630 of 878 items'.

Hospital Code	Population Label	Date	User	Count
01	2018 RAD UNK	02/05/2020	Sherri Chico-Rowell	1
<input checked="" type="checkbox"/>	2019 Incomplete Cases	02/19/2020	Sherri Chico-Rowell	4
01	377 NE Blank	02/21/2020	Sherri Chico-Rowell	22599
01	Surgery Here by month	02/26/2020	Sherri Chico-Rowell	3
01	All Analytic cases 2004 thru 2018	02/28/2020	Sherri Chico-Rowell	925
<input checked="" type="checkbox"/>	2018 sub pop	03/04/2020	Sherri Chico-Rowell	3
01	Corrected Cases for resubmit	03/18/2020	Sherri Chico-Rowell	3
01	01201800057	04/09/2020	Sherri Chico-Rowell	1
	97003	05/06/2020	Sherri Chico-Rowell	12
01	01201800080	05/07/2020	Sherri Chico-Rowell	1
01	01201800120	05/07/2020	Sherri Chico-Rowell	1
01	01201800158	05/07/2020	Sherri Chico-Rowell	1
01	01201600099	08/04/2020	Sherri Chico-Rowell	1

## Chapter 6 SYSTEM ADMINISTRATION

- System Administration is the most powerful of all the functions in the CRStar system. This feature allows the system administrator to issue passwords, control security of the users, do

global changes, mass deleting, etc. In addition, this is where all the functions are located to maintain the system. The person assigned as the system administrator should be a knowledgeable registrar familiar with the system. It is the responsibility of the administrator to restrict this function.

- Security Maintenance
  - User Logins
  - Password Policy
  - Locked Users
  - User Security
- Data Management
  - Global Data Change
  - Import
  - Mass Delete
- Utilities
  - Global Dictionary
    - Global Dictionary-Color Coding
    - Global Dictionary-Creating User Defined Fields
  - Import Config
  - DB Validation

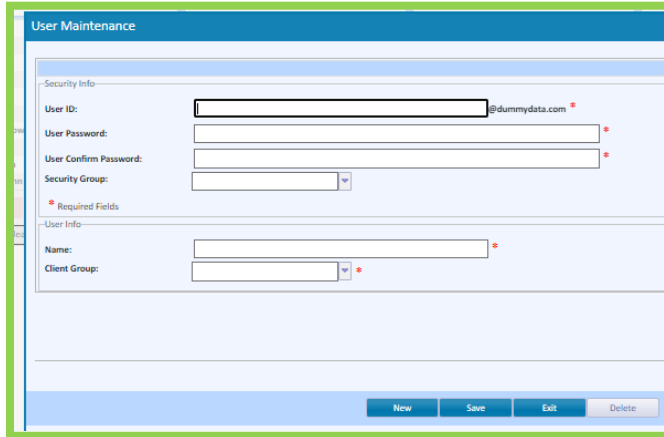
## Security Maintenance

### System Administration-Security Maintenance (User Logins)

The System Administrator can access the security maintenance tab by going to SYSTEM ADMINISTRATION then SECURITY MAINTENANCE. This is accessible to any user who is part of the "Client Admin" security group.

Available maintenance tab options are: User Logins, Password Policy, Locked Users and User Security

**Create New User Login:** Click on User Logins and then click on the NEW USER button and the following screen will appear:



The screenshot shows a web form titled "User Maintenance". It is divided into two main sections: "Security Info" and "User Info".

- Security Info:** Contains four fields: "User ID:" (text input with "@dummydata.com" pre-filled), "User Password:" (password input), "User Confirm Password:" (password input), and "Security Group:" (dropdown menu).
- User Info:** Contains two fields: "Name:" (text input) and "Client Group:" (dropdown menu).

At the bottom of the form, there are four buttons: "New", "Save", "Exit", and "Delete". A legend indicates that fields with a red asterisk are required.

1. Enter UserID for the new user; this is not case sensitive but is recommended to be all lower case and follow a pattern of user's first initial followed by last name.
2. The @ers###.com is automatically defaulted as this is specific to each database. (Note: above example uses @dummydata.com)
3. Once the UserID is filled in, click the Save button, then click the Exit key.
4. Enter a temporary password, Confirm password (this password forces a re-set the first time the user logs in).
5. Select the appropriate security group that this user belongs to.
6. Enter the user's full name (First and Last Name).
7. Select the client group.
8. Click SAVE.
9. Exit or select NEW to enter another new user.
10. After the user's name has been created, the System Admin must add the registrar's initials under System Management - Registrars. The registrar initials can be 2 or 3 characters. Enter the registrar's name and state ID if your state requires it. If not, leave blank. The CRStar User ID should be first initial, last name @ers#.com. For example: jdoe@ers0601.com.  
(DO NOT FAIL TO COMPLETE THIS STEP!) If this step is not completed the registrar's initials will not automatically save when a case is abstracted, modified, or follow up entered. This is a crucial step!
11. Click SAVE.

### Deleting a UserID:

1. Once a USERID has been created – the actual USERID CANNOT be MODIFIED and/or CHANGED (userID@dummydata.com – for example). If a change does need to occur, a NEW USERID must be created to make that change. Then the old USERID can be deleted.
2. Select User Logins and search for the USER Name to delete, select the name.
3. Once the USERID is selected, click the DELETE button a message pops up asking for confirmation.
4. Select “yes” if this is the USERID you wish to delete.
5. **Do not delete the Registrar’s Initials in System Management!!** It is important to leave those initials for historical purposes.
6. The System Administrator must ALSO disable the user in the Support Portal. Instructions are available on the CRStar Resource Page in the “Health Catalyst Policies & Procedures” section

### Modifying an existing UserID:

1. Includes changing and/or re-setting password because this form CANNOT be saved until a new password has been entered. User is prompted to change it when they login again.
2. A modification may include any of the following:
  - a. Change Security Group
  - b. Spelling of the User’s Name
  - c. To update the user’s security group
  - d. Only one client group choice exists so this may not be changed.
3. Once changes have been made and the password has been filled in, click SAVE.

### Password Policy

Allows the Client Admin to define the password restrictions/policy for the database.



- Lockout UserID – After the number of failed login attempts, the UserID is locked and unable to login until the account becomes unlocked.
- The UserID unlocks automatically after the “set” minute timeframe OR a client admin can use the DISPLAY LOCKS button on this screen to choose to unlock the user manually. This can also be done from the LOCKED USERS tab from the top as well.

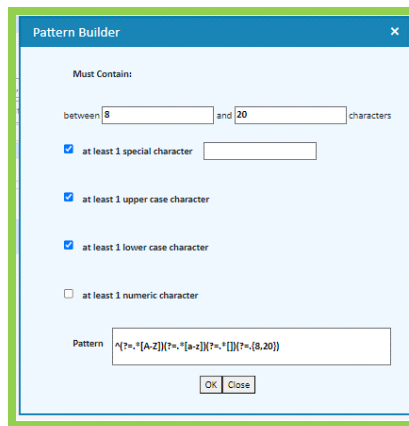
User Id	Locked Util
christine@ers-can.com	07/06/2023 03:57:13 35 pm

CRSTAR default settings for this screen are:

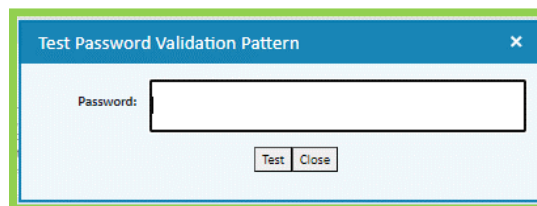
- Lockout a user after 3 failed attempts for 15 minutes
- Require a user to change their password every 90 days
- Prevent using the past 3 passwords: Password patterns of: Must contain at least one digit, one lowercase character, one uppercase character and be between 8 and 20 characters long
- Pass Validation Msg: the default text is shown in the above screen shot, but if the client admin changes the pattern then they should also re-type the text to match – this is the “message” that users see if they attempt to set a password that does not meet the set pattern selected for the database.

**NOTE:** It is highly recommended to remind all users to set a strong password which usually contains a mix of upper and lower-case characters, numbers, symbols, and is NOT a word that can be found in any dictionary and does not include normal substitutions in a word (i.e. H0use – this is NOT a strong password just because the “o” is substituted with a zero).

The Client Admin can reset these settings as needed to meet their database security policy. The password validation pattern can be set using the EZ builder button or the pattern can also be typed in with any REGEX pattern. Click on the EZ Builder button for a user-friendly way to build the pattern using a few common restrictions:



- Once the Password Policy screen is edited, click SAVE.
- A TEST button is available to test settings of the password pattern if needed:



## System Administration-Security Maintenance (User Security) (Hide Screens/Tabs)

The User Security Definition allows the administrator of the system to limit access to different functions in CRStar. This function hides the screens (tabs) per user.

1. Important: Do not change anything if there are no limitations to the user.
2. Go to System Administration > Security Maintenance > User Security. Choose the user name.
3. Highlight each function to remove from the user, use the > option to move the tab to the unavailable side.
4. Click Save and Exit.

5. When the user signs in, changes are immediately seen across the top of the abstract.

The screenshot shows the 'User Security' tab selected in the top navigation bar. On the left is a sidebar menu with categories: DASHBOARD, ABSTRACT MANAGEMENT, FOLLOW UP MANAGEMENT, REPORTING, SYSTEM ADMINISTRATION, and SYSTEM MANAGEMENT. Under SYSTEM ADMINISTRATION, there are buttons for Security Maintenance, Data Management, and Utilities. The main content area is titled 'User Security' and contains a 'User Lookup' form with fields for 'UserID' and 'User Name', and a 'Search' button. Below the form, it says 'Records: 77' and displays a table of users:

User Name	UserID
Matt Bavis	matt@ers-can.com
Bonnie Nelson	bonnie@ers-can.com
Kent Andrews	kent@ers-can.com
Dwight Bauer	dwright@ers-can.com

The screenshot shows the 'Menu Items' configuration screen. It is divided into two columns: 'Available Items' and 'Unavailable Items'. The 'Available Items' list includes: State Specific Fields Maintenance, User Defined Maintenance, Case Admin Maintenance, and Retired Maintenance. The 'Unavailable Items' list includes: Cancer Program Maintenance, Breast Program Maintenance, Clinical Maintenance, and Research Maintenance. Navigation arrows (right-pointing > and left-pointing <) are located between the two columns. A yellow highlight is on the right arrow, and a blue arrow points from the 'Cancer Program Maintenance' item in the 'Unavailable Items' column towards the next screenshot.

Choose the tabs to remove and click on the > option to move to the Unavailable items side and click save.

The screenshot shows a patient abstract for ID 654984, patient name 'followup', and test name 'test'. The top navigation bar has tabs for: Lookup, Patient, Diagnosis, Staging, Treatment, Outcomes, State Specific, RPM, User Defined, Case Admin, and Re. The patient information section includes: Topo Code, Class: 00, Dob: null/null/null, and Diagnosis Date: 01/01/2017. Below this are sections for 'Dx Address Info' with fields for Address and Address 2, and 'First Contact Date', 'Admit Date', and 'Discharge Date' with date pickers. On the right side, there are fields for Tobacco 22+, Prim Payer Dx, and Casefinding Source.

## Data Management

### Data Management-Global (Global Data Change)

Before making any Global data changes, it is recommended to seek advice from a member of the Health Catalyst Support Team. In addition, it is especially important to request a backup of the database prior to any global change.

1. Select a population of cases for the global data change.
2. Insert the selected population. Click on the down arrow for a list of saved populations.
3. Enter the item number of the field requiring the global change. To access the item numbers, click the drop-down arrow for a list of item numbers or begin typing the name of the field in the description field.
4. In "Change from" enter the old value. Note: If changing the entire population regardless of the values in the field, type the word "ALL". If "Change to" is to be a blank value, leave the field blank (empty). If the field is a coded field, click the drop-down arrow for choices.
5. Note: Changes may be made on a data field or multiple changes in the selected field.
6. Click OK. The Confirm Global Change message pops up. User is asked "Please confirm that you would like to proceed with this Global Change and that you have a backup of your data. Click "Ok" to continue, otherwise click "Cancel"." Click OK. Once completed, the system indicates the global change has been made. Click Close on the Global Change Results Box.
7. Click New to make another global or Exit to leave the screen.

\*Special Note to remember, if making a global change on a Date, each of the Month/Day/Year and Summary Fields must be changed.

### Data Management-Import (Import Function)

The Import function imports data from other sources for casefinding and follow-up, such as from the facility's Medical Record software, Redsson, EPath, etc. The import function must be custom written by our technical team prior to using. A support request should be submitted by the client to begin the process.

It is recommended to seek advice from a member of the Health Catalyst Support Team if unfamiliar with this function. In addition, it is especially important to have an import configuration set-up that correlates to the data file type for import before that file type is imported the first time.

The screenshot shows the 'Import' window with a file named 'fixed width merge file.txt' uploaded. The 'Select An Import Option' dropdown is set to 'DEMO MERGE'. A checkbox for 'Create Population Label of New Cases Added to Suspense' is checked. The 'DEMO MERGE' report displays 11 records processed, with summary statistics: New Patients: 0, New Primaries: 3, and New Last Contact Dates: 0 as of 08/21/2014. The report table is as follows:

	Hospital C	Last Name	First Name	MRN	Admit Date	Disch Date	ICD Code 1	Status/Action Taken
1	01	Breast	Cheryl	48628	02/13/2014	03/13/2014	29300	New Primary
2	01	Lung	Victor	49386	02/23/2014	03/13/2014	16200	New Primary
3	01	Prostate	Mark	48578	02/10/2014	03/10/2014	28800	New Primary
4	01	Breast	Elizabeth	49261	02/13/2014	03/13/2014	68260	Abstracted - No New Contact
5	01	Bronchus	Kathy	01134	01/14/2014	02/14/2014	V7632	Abstracted - No New Contact
6	01	Kidney	Paul	48677	01/13/2014	02/13/2014	73007	Abstracted - No New Contact
7	01	Lung	Henry	49329	02/23/2014	03/24/2014	47300	Abstracted - No New Contact

A callout box points to the 'Status/Action Taken' column, stating: 'In the last column Status/Action taken, the user can identify if the case is a new case for Suspense or an already abstracted case where the follow-up information has been updated.'

1. Go to System Administration tab, then Data Management, and click on the Import tab.
2. Select the data file type to import by clicking on UPLOAD FILE and finding the file location on the computer.
3. Select the name of the IMPORT OPTION from the drop-down list.
  - a. NOTE: If you do NOT see the appropriate option that matches the data file type you wish to import, then your facility needs to set one up using the Import Config screen first.
4. Check the appropriate boxes on the right if you would like to have a population automatically created under the reporting tab for further report needs. This step is always Strongly Recommended.
5. Click on IMPORT DATA FILE. NOTE: If the import is in use by another user, a message pops-up.
6. A window appears that displays the completion status of the import file
7. Once the file is completely imported, a report is displayed to the screen with the information that was set up in the configuration function for this file type. Choose print or download the report to Excel and/or exit the screen when complete.

## Data Management-Mass Delete

It is recommended to seek advice from a member of the Health Catalyst Support Team if unfamiliar with this function. **In addition, it is especially important to have a good backup BEFORE deleting files.** There are multiple ways to utilize this function and can be used to delete multiple abstracts, suspense cases, physician files, and other files from the database.

The screenshot shows the 'Mass Delete' window. It includes the following fields and options:

- 'Select a Pop Label:' dropdown menu.
- 'Report for a File Label:' dropdown menu.
- 'Abstract/Suspense Cases' section with two radio buttons:
  - Single Table
  - Abstracted Primary
- 'Table Name:' dropdown menu.

1. Go to System Administration tab, then Data Management, then click on the Mass Delete tab.
2. Select the Population OR the Report for a File name that contains the data to delete from the appropriate drop-down list at the top.
3. Choose Single Table if deleting from a single table, then select the name of the table from the drop-down list: TABLE NAME.
4. Choose Abstracted Primary if deleting cases whether they are complete abstracts, or incomplete cases.
5. Click OK.
6. When complete, click EXIT.

## Utilities

### Utilities-Global Dir (Global Dictionary)

The Global Dictionary is where all fields in CRStar reside and where codes, descriptions and Help Notes are maintained. These include required, non-required and user defined fields.

#### SEARCHING FOR GLOBAL DICTIONARY NUMBER

Global Dir Maintenance

Search

Item Nbr:

Item Desc:

[Clear Search Criteria](#)

Records: 1,961

Item Nbr	Item Desc
1	Last Name
2	Middle Initial
3	Diagnosis Address
4	Diagnosis Zip Code
5	County Code
6	Place of Birth
7	Date of Birth
8	Ethnicity
9	Sex
11	Current Address

First Prev 1 2 3 4 5 6 7 8 9 10 of 197 [Next](#) [Last](#) 10 Records per page

Global Dir Maintenance

Search

Item Nbr:

Item Desc:

[Clear Search Criteria](#)

Records: 56

Item Nbr	Item Desc
382	User Defined 11
383	User Defined 12
384	User Defined 13
386	User Defined 15a
1782	User Defined 16
1783	User Defined 17
1784	User Defined 18
1785	User Defined 19
1786	User Defined 20
1787	User Defined 21

First Prev 1 2 3 4 5 6 of 6 [Next](#) [Last](#) 10 Records per page

- To search by global number, enter the field item number and click search. Item numbers are listed in numerical order as shown. The user can go from page to page. The number of records shown per page may also be changed.
- To search by item description, type in the entire description and click search or type a partial description followed by an asterisk (\*) as shown and click search. The (\*) is a wildcard.

Global Dictionary Maintenance

Item Nbr:

Item Desc:   Rapid Abstract

Column Name:

File Name:

Attr Nbr:

Sm Code:

Code File:

Sub Name:

Date Type:

Format Data:

Label Color:

Label Background Color:

Required  Reportable

State Corrections:

State Field Nbr:

Code	Code Desc
1 00	First Dc at Your Hosp, All Rx (Dr a Decision Not to Treat) Etc
2 10	1st Dc at Your Hosp or an Office of a Physician with Admitt
3 11	First Dc in an Office of a Physician with Admitting Privileges
4 12	First Dc in an Office of a Physician with Admitting Privileges
5 13	First Dc and Part of 1st Course Rx at Your Hosp
6 14	First Dc and All 1st Course Rx (Dr a Decision Not to Treat) Etc

Help text:  
 <br>Description<br>
 Class of Case divides cases into two groups. Analytic cases (codes 00 22) are those that are required by CoC to be abstracted because of the program's primary responsibility in managing the cancer. Analytic cases are grouped according to the location of diagnosis and first course of treatment. Nonanalytic cases (codes 30 49 and 99) may be abstracted by the facility to meet central registry requirements or in response to a request by the facility's cancer program. Nonanalytic cases are grouped according to the region a patient who received care at the facility is nonanalytic, or the reason a patient who never received care at the facility may have been abstracted.<br>
 <br>Rationale<br>
 Class of Case reflects the facility's role in managing the cancer;

StatusBar

## Utilities-Global Dir -Color Coding

The screenshot displays the 'Global Dictionary Maintenance' window. On the left, there are input fields for 'Item Desc' (Prim\_Surgeon), 'Column Name' (Prim\_Surgeon), 'File Name' (Diagnosis), and 'Attr Nbr'. A 'Label Color' section shows a red color swatch selected for 'Sample Text'. Below it, a 'Label Background Color' section shows a yellow color swatch selected for 'Sample Text'. There are also checkboxes for 'Required' and 'Reportable'. The main area shows a patient record for 'C504' with various fields like 'Address', 'City', 'State', 'County', 'Country', 'Age Dlx', 'Sex', 'Marital Status', 'Topo Codes', 'Lat Codes', 'Hist Codes', 'Diagnosis User Defn', 'Hosp Ref From', and 'Hosp Ref To'. A 'Status Bar' at the bottom contains buttons for 'New', 'Save', 'Exit', and 'Delete'.

In the Global dictionary, users have the option of choosing the color scheme for the Field Label Text and Background. Users may decide to color code required fields or shade the fields that are not required. If a color coding system is created by the user, be sure to include instructions in the facilities policy and procedure manual to define the color coding scheme. (Note this is optional and the color scheme does not have to be changed.) **Please submit a portal call for a list of suggested fields to color code.**

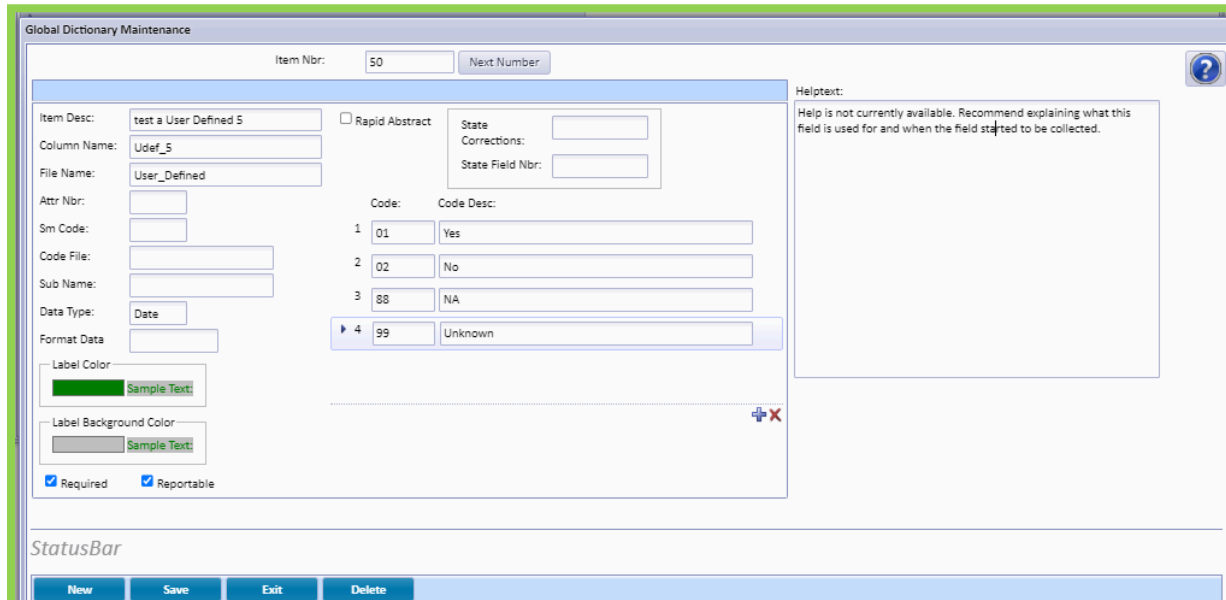
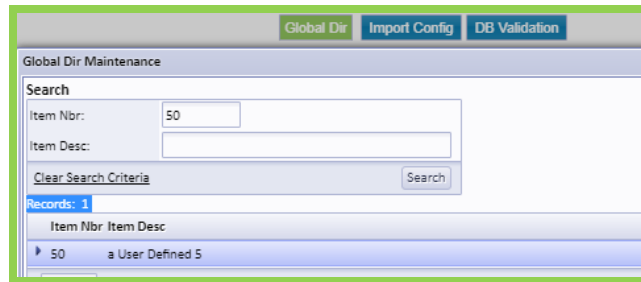
### Instructions to Color Code:

- Click SYSTEM ADMINISTRATOR tab
- Click Utilities
- Click Global Dir
- Enter the Item Number to code (from the Field Index list).
- Choose the label and/or background color
- Check Rapid Abstract Box
- Click Save.
- Log out of CRStar

## Utilities -Global Dictionary- Creating User Defined Fields

There are seventy-five customizable user defined fields in the abstract located in the User Defined section. Customize by changing the field name. Add codes with descriptions and create help notes. In addition, each screen of the abstract contains several user defined fields.





1. Enter the item number of the user defined field to create. Click search. Or type in the description of the user defined field or partial description followed by the asterisk (\*). For a complete list refer to Appendix I.
2. Add the name of the new UDF in front of the Item Desc: See Example above.
3. Create codes and descriptions as shown. Accepts up to 50 alphanumeric characters.
4. To add rows, click the (+) icon. To delete rows, click the (X) icon.
5. Type in help notes as shown. Accepts alphanumeric characters.
6. Change the Label and Background Color by clicking on the arrow and selecting a new color scheme. (Optional.)
7. Click Save.

## Utilities-Global Dir -Rapid Abstract

The screenshot displays the 'Global Dictionary Maintenance' window. At the top, there are tabs for 'Global Dir', 'Import Config', and 'DB Validation'. The main window is titled 'Global Dir Maintenance' and shows a search for item number 818. Below this, the 'Global Dictionary Maintenance' window is open, showing details for item 818. The 'Item Desc' is 'Medical Oncologist' and the 'Column Name' is 'Med\_Oncologist'. The 'Rapid Abstract' checkbox is unchecked. The 'Code' field is highlighted with a blue arrow. The 'Help:Text' area contains the following text: '<b>Description</b></p><p>Records the NPI for a physician involved in the care of the patient. The Commission on Cancer recommends that this data item identify the physician who gives the most definitive systemic therapy.</p><b>Rationale</b></p><p>Administrative, physician, and service referral reports are based on this data item. It also can be used for follow-up purposes.</p><b>Coding Instructions</b></p><p>- Record the 10-digit NPI for the physician.</p>'. The 'Status Bar' at the bottom has buttons for 'New', 'Save', 'Exit', and 'Delete'.

In the Global dictionary, users have the option of choosing fields to bypass by graying them out. To set up the Rapid Abstract, the user must have System Admin rights. We suggest utilizing the Illustrated Field Index Number document located on the CRStar Resources page. This gives the user copies of each screen of the abstract, the fields and the field index numbers for each field.

- Click SYSTEM ADMINISTRATOR.
- Click the Utilities tab.
- Click Global Dir tab.
- Enter the Item Number to exclude. Example shows field# 818 (from the Field Index list)
- Uncheck the Rapid Abstract Box to remove the check mark.
- Click Save
- Log out of CRStar and back in to see the changes.

**CAUTION:** DO NOT USE  
THIS FUNCTION UNLESS  
UNDER DIRECT  
SUPERVISION OF A  
MEMBER OF THE HEALTH  
CATALYST SUPPORT  
TEAM!!!!!!!

## Utilities -DB Validation- Database Validation Checks

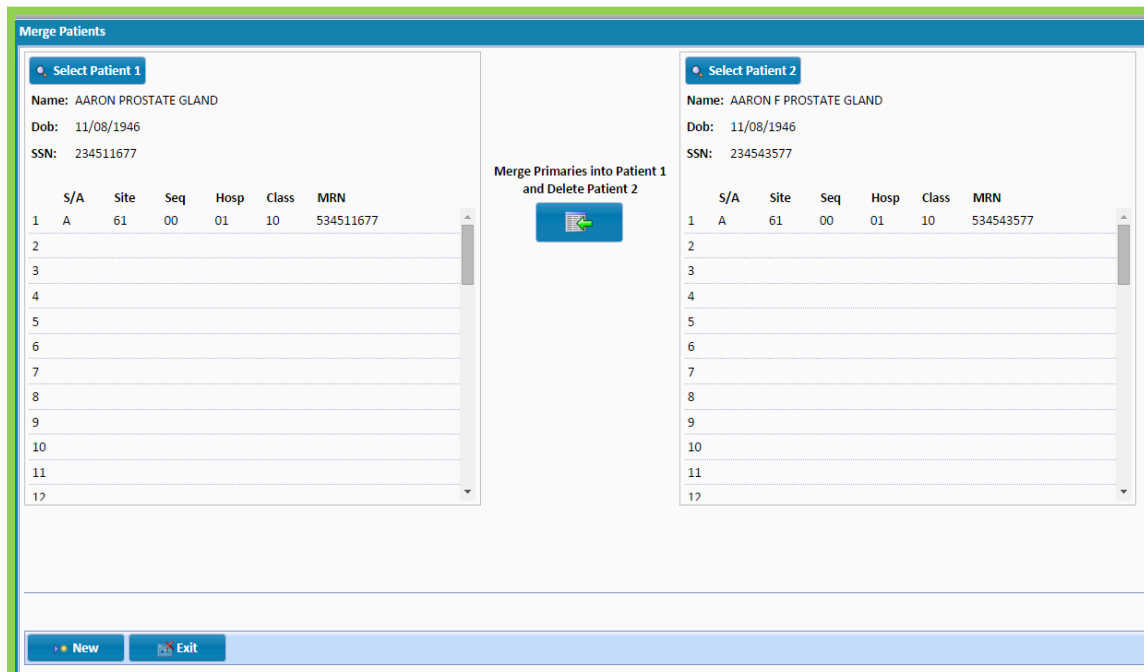
The Database Validation report is used to identify possible duplicate cases. Located under the System Administrator tab, Utilities and DB Validation, the user has the choice of two reports. The first report checks for duplicate last names and dates of birth. For example, a patient could exist in the database with the Last Name Doe and Name Suffix JR. The same patient may similarly be entered with the Last Name Doe, JR, and the Name Suffix blank. The second report checks for duplicate Social Security numbers for different patients. In the example below, Aaron Prostate Gland DOB 11/08/1946 has been entered twice with two different social security numbers. **Note: This is a test database. All names, social security numbers, etc. are fictional.**

The screenshot shows the 'Database Validation Checks' utility in the CRStar system. The interface includes a sidebar with navigation options like 'Dashboard', 'Abstract Management', and 'System Administration'. The main area is titled 'Database Validation Checks' and has tabs for 'Global Def', 'Import Config', and 'DB Validations'. Under 'Type of Duplicate Check', the 'Check for Duplicate Names and Dates of Birth' option is selected. The 'Send Report To' options are 'Excel' and 'Screen', with 'Screen' selected. Below these are fields for 'Start Times' and 'End Times'. A 'Duplicate Check' pop-up window is overlaid, showing a table of results for 'Cases with Duplicate Names and Dates of Birth' as of June 7th, 2023. The table has four columns: First Name, Last Name, Date of Birth, and Soc Sec Nbr. The data includes several entries, such as 'testing' with no last name and date of birth, and 'ADELA BREAST' with a date of birth of 04/04/1976 and social security number 101017101. Other entries include 'ANDY PROSTATE', 'ALEJANDRO LYMPH NODE', 'ALEKSANDR CONNECTIVE SUBCUTANEOUS', 'Amanda THYROID', 'ANDRE PROSTATE', 'ANDREW PROSTATE', and 'Angela LUNG'.

First Name	Last Name	Date of Birth	Soc Sec Nbr
testing			
testing			521123654
ADELA	BREAST	04/04/1976	101017101
ADELA	BREAST	04/04/1976	111017111
ANDY	PROSTATE	01/18/1955	132557676
ANDY	PROSTATE	01/18/1955	132557676
ALEJANDRO	LYMPH NODE	04/04/1968	104016104
ALEJANDRO	LYMPH NODE	04/04/1968	104016104
ALEKSANDR	CONNECTIVE SUBCUTANEOUS	11/04/1990	101029101
ALEKSANDR	CONNECTIVE SUBCUTANEOUS	11/04/1990	131029131
Amanda	THYROID	11/06/1990	157029157
Amanda	THYROID	11/06/1990	157029157
ANDRE	PROSTATE	09/25/1949	106004106
ANDRE	PROSTATE	09/25/1949	106004106
ANDREW	PROSTATE	01/15/1949	152496676
ANDREW	PROSTATE	01/15/1949	152496676
Andrew	PROSTATE	09/11/1958	106015106
ANDREW	PROSTATE	09/11/1958	146015146
Angela	LUNG	09/29/1949	104014104

The user has the option of sending the report to Excel and saving or viewing on screen, then printing if desired. After the user reviews the reports and identifies a case or cases that are duplicates, the Combine Patient feature can be utilized to merge the two cases together and delete the duplicate. This feature is located under the Abstract Management tab, Abstract Utilities and Combine Patients. To combine the two Aaron Prostate patients:

1. Select Patient Number 1. This is the correct case.
2. Select Patient Number 2. This is the duplicate case.
3. Click Merge Primaries into Patient 1 and delete Patient 2.
4. Reference Pg. 70 [Combine Patients](#).



## IMPORTANT HELPFUL HINTS WHEN COMBINING PATIENTS

- When combining cases together, the system is merging primaries to eliminate duplicate cases. It is important for the user to closely evaluate which case should be kept and which should be combined and deleted.
- It is particularly important to ensure that the patients being combined are the same patient and not different patients.
- Only one patient can be combined at a time.
- Patient 1 should be considered the case to keep.
- Patient 2 is the case that is combined with Patient 1 and deleted.
- If the user is trying to combine two cases and either the name, DOB or Social Security # do not match, a warning message will pop up. The user should review the case to ensure that it is the same case.
- Any information the user wishes to retain from the Patient screen for Patient 2 should be entered on the Patient screen for Patient 1 prior to combining. For example, if the user wishes to retain the Comments from Patient 2, they can be copied and pasted into the comment field for Patient 1.
- All screens are primary specific. Any information past the Patient screen will copy over or combine as is.
- After combining a case, review treatment and follow up information for same primaries shared between hospitals.
- Review Sequence numbers for accuracy after combining patients.
- A back up is not required before combining patients as user is not actually deleting the abstract but combining the primaries together. The only information that is deleted is the information on the patient screen of Patient 2.

## Chapter 7 SYSTEM MANAGEMENT

The System Management section in CRStar enables the user to define hospitals, physician's names, zip codes, county codes and multiple other fields available in the abstract. This menu allows the user to maintain the data files that are used as parameters throughout the CRStar system.

Important: Most of the codes have already been defined; however, it is sometimes necessary to make changes and updates. The contents of these files interact with all other areas of the system; therefore, changes affect the entire system.

Please ask a member of the Health Catalyst Support team for assistance with site, topo, morpho, surgery and TNM codes!

- System Management:
  - Hospitals
  - Registrars
  - Physicians
  - Physician Roster
  - Initialize Accession Numbers
  - Follow-up Order
  - Follow Up/QA Letters
  - Custom Forms
  
- Codes Maintenance
  - Site Codes
  - Topography
  - Morphology
  - County Codes
  - Zip Codes
  - Surgery Codes
  - TNM Codes

# System Management

## System Management-Hospitals

Hosp Nbr	Hosp Name	City	State
<input type="text"/>	BAP	<input type="text"/>	<input type="text"/>
540080	BAPTIST MEMORIAL HOSPITAL BOONEVILLE	BOONEVILLE	MS
530161	BAPTIST MEDICAL CENTER- MONTCLAIR	BIRMINGHAM	AL
530705	BAPTIST MEDICAL CENTER	MONTGOMERY	AL
390308	BAPTIST MEDICAL CENTER	JACKSONVILLE	FL
540201	BAPTIST MEMORIAL HOSPITAL - GOLDEN TRIANGLE	COLUMBUS	MS
390792	BAPTIST HOSPITAL	PENSACOLA	FL
540693	BAPTIST MEMORIAL HOSPITAL-- NORTH MISSISSIPPI	OXFORD	MS
530313	BAPTIST MEDICAL CENTER- CHEROKEE	CENTRE	AL
390578	BAPTIST HOSPITAL OF MIAMI	MIAMI	FL

Navigation: < 1 2 >

Buttons: New Hospital, Clear Results

1. To search for a hospital, enter the hospital number if known, or part of the number if known, Click enter key.
2. If the number is not known, type in the complete hospital name or partial name and click the enter key.
3. Click Search and the items that match will appear as shown above.
4. Highlight the hospital to select it.
5. To view another page click the page numbers or arrows.
6. Columns can be sorted alphabetically and numerically by clicking on the column header.
7. Click New Hospital to add a new facility.

Hosp Nbr	Hosp Name	City	State
<input type="text"/>	BAPTIST HOSP	<input type="text"/>	<input type="text"/>
90792	BAPTIST HOSPITAL	PENSACOLA	FL
90578	BAPTIST HOSPITAL OF MIAMI	MIAMI	FL

Navigation: < 1 >

Buttons: New Hospital, Clear Results



The screenshot shows a web-based data entry form for hospital information. The form is titled "R\_DSP - 01" and has a blue header bar with "Save", "Exit", and "Delete" buttons. The form is divided into several sections:

- Left Sidebar:** Contains fields for hospital name ("ERS Hospital Systems"), doctor name ("Dr. R. Neumann"), phone number ("(513) 771-7330"), address ("155 Tri County Pkwy"), zip ("2260"), and other identifiers ("1609850950", "06").
- Main Address Section:** Contains fields for "Address" ("155 Tri County Pkwy"), "City" ("STATEN ISLAND"), "State" ("FL"), "Zip" ("10330"), "Country" ("USA"), "Term Digit Sort" ("222"), "Fax", "ACoS Approved" ("1"), "ICD Revision" ("1"), "NAACCR Version" ("22"), and a "Text Popups" checkbox (checked).
- Treating Hosp Aliases Section:** Contains a table with one row and an "Add" and "Delete" button.
- Counties Section:** Contains a table with four rows and an "Add" and "Delete" button.

8. NOTE: A single hospital facility must be identified as Hospital 01. This impacts all the export functions. The facility may also be listed with the ACoS number, but do not delete hospital 01. This is also for adding facilities into the database. Multi hospital facilities must be listed as 01 ,02, 03, etc.
9. Reporting Hospital ID: This is the State number assigned to the facility. It must be filled in, even if it is the same as the ACoS number, to export data to the State.
10. ACoS Hospital ID: This is the facility's ACoS number and must be filled into export data to NCDB.
11. NPI: The NPI (National Provider Identifier) code that represents the data transmission source. This item stores the NPI of the facility registry that transmits the record.
12. Rx. Aliases: Use this field for other facilities whose treatments are considered done at the main hospital. Using this field allows the user to track the treatments done at that facility (record number in grid under RX Hospital) and is recorded as treatment done here on the next page).
13. Address, City and State: The State screen (if any) is in the abstract of the state recorded in this field. If the state field is not recorded, the state screen is not available in the abstract.
14. Term Digit Sort: This field must be filled in to do a terminal digit sort. Terminal digit sort is a file system used by most Health Information Departments. (i.e. 2222 would be the last two digits, followed by the third two digits, followed by the second two digits, followed by the first two digits).
15. Facility Association Number: The Commission on Cancer assigns this number - first 3 characters are for State, next 2 for type of institution, and last 5 for facility ownership.
16. ACoS Approved: Code status as approved or not an approved facility. This field may affect edits.
17. ICD Revision Number for Co-Morbidity Codes: This is to record which version of the ICD manual the facility is using, ICD 9-CM or ICD 10-CM for the co-morbidity codes in the abstract.
18. NAACCR Version: Shows current metafile version in use at this facility.
19. State Counties: To collect county codes from more than one state, list the states including the main facility in this field. The counties listed are listed under the counties in the abstract. Note: The more county codes, the longer it takes to display when using the look up function. In the abstract, it is particularly important that the hospital address fields be filled.

20. In the Example above, the Ohio County codes listed first, then the Michigan County codes listed second under state counties, and finally PA county codes listed third.
21. Click Save.

## System Management-Registrars

1. To search for a registrar, enter the initials if known.

Hospitals	Registrars	Physicians	Phys Roster	Initialize Acc	Follow-up Order	Follow-up/QA Letters	Custom Forms
Initials	First Name	Last Name					
<input type="text"/>	<input type="text"/>	<input type="text" value="brin"/>					
SPB	Sarah	Burton					
KAN	Katelyn	Lawson					
SDR	Sherri	Rowell					
FUP	FOLLOW-UP	CLERK					
SMK	Sally	Kruse					
BSN	Bonnie	Nelson					
POH	Paula	Registrar					
MGG	Monica	Guistwite					
MEB	Matt	Bavis					
AMJ	Anne	Josephs					
<div style="text-align: center;"> <span>◀</span> <span>◀</span> <span>1</span> <span>2</span> <span>3</span> <span>4</span> <span>▶</span> <span>▶</span> </div>							
New Registrar		Clear Results					

2. If the initials are not known, type in the complete registrar's name or partial name.
3. Click the Enter button and the items that match will appear as shown below.
4. Highlight the name, click to select it.

- To view another page, click the arrows to move forward and back or click the page number.
- Columns can be sorted alphabetically and by clicking on the column header.
- Click New Registrar to add a new registrar.

Hospitals	Registrars	Physicians	Phys Roster	Initialize Acc	Follow-up Order	Follow-up/QA Let
Initials	First Name	Last Name ↑				
<input type="text"/>	<input type="text"/>	<input type="text" value="pat"/>				
WCP	WILLIAM	PATRICK				
CP	CURT	PATRICK				
◀ ◁ 1 ▷ ▶						
New Registrar		Clear Results				

Initials:

First Name:

Last Name:

Dept:

Phone Nbr:

State Id:

CRStar Userid:

STATE\_ID -

8. Enter the new registrar's information as shown.
9. Registrar's initials must be a minimum of 2 characters, maximum of 3 characters.
10. Department may be left blank.
11. State ID: This field is used for those states that have assigned ID numbers to the abstractors. This allows the abstractor to use their initials in the abstract and the state ID number exports to the state. (I.e. HLM in the abstract will export as HQ7). Leave this field blank and the initials in the abstract will export to the state. Please check with the central registry for requirements.
12. Enter the CRStar User ID used to log in to CRStar. **IMPORTANT:** The user id format is [FirstInitialLastName@ersfacilitynumber.com](#). Example above: [hmorton@ers0794.com](#). The purpose of entering the user ID in the Registrar file is to have the system auto fill the abstractor's initials on the Case Administration screen of the abstract. If this field is blank, the initials will not auto fill.
13. Click Save.

## System Management-Physicians

Hospitals	Registrars	Physicians	Phys Roster	Initialize Acc	Follow-up Order	Follow-up/QA Letters	Custom Forms
Physicians Id	Last Name	First Name	Middle Name	Address 1	City	State	Specialty
006675	DOE	TOM	S	3719 DAUPHIN ST 5A	BRADENTON	FL	INT MED
000536	SMITH	J'OE	J	1401 SPRINGHILL AVENUE	JOHNSON CITY	TN	FAMILY PRACTICE
010960	JONES	JUDY	D	1923K DAUPHIN ISLE P	MOBILE	AL	FAMILY PRACTICE
003449	JETSON	GEORGE	E	500 SPACEWAY RD	CHICAGO	IL	ONCOLOGIST
100719	MORRISSETTE	ALANIS	C	5001 W HARDY ST	HATTIESBURG	MS	INTERNAL MEDICINE
100720	ANT	ADAM		4511 HOSPITAL ROAD	CHARLESTON	IL	GENERAL SURGEON
002257	FAULKNER	WILLIAM	I	1530 3RD AVENUE SOUTH	FORT MYERS	FL	ONCOLOGY- HEMATOLOGY
X9999991	FRAMPTON	PETER	O	3 MOBILE INFIRMARY CIRCLE SUITE 410	BROOKLYN	NY	RADIATION ONCOLOGIST
00028181	ADAMS	AMY	DEVASHER		BEVERLY HILLS	CA	INTERNAL MEDICINE
012033	DOE	JOHN		P O BOX 633	MONTROSE	AL	FAMILY PRACTICE

Navigation: 1 2 3 4 5 6 7 8 9 10 ...

Buttons: New Physician, Clear Results

1. To search for a physician, enter the Physician ID if known.
2. If the Physician ID is not known, type in the complete physician's name or partial name.
3. Click the Enter button and the items that match will appear as shown below.
4. Highlight the name, click to select it.
5. To view another page, click the arrows to move forward and back or click the page number.
6. Columns can be sorted alphabetically and numerically by clicking on the column header.

Hospitals	Registrars	Physicians	Phys Roster	Initialize Acc	Follow-up Order	Follow-up/QA Letters	Custom Forms
Physicians Id	Last Name	First Name	Middle Name	Address 1	City	State	Specialty
	JONES						
010960	JONES	JUDY	D	1923K DAUPHIN ISLE P	MOBILE	AL	FAMILY PRACTICE
016116	JONES	JAMES	E	P O BOX 1338	CHATOM	AL	FAMILY PRACTICE
100821	JONES	E	M	1410 20TH AVENUE	MERIDIAN	MS	
100262	JONES	A		1500 E WOODROW WILSO	BILOXI	MS	
041296	JONES	YOLANDA	ALAMILLA	1851 N MCKENZIE ST	FOLEY	AL	OB/GYN
011341	JONES	HENRY	E	PO BOX 1106	FAIRHOPE	AL	DERMATOLOGY
008808	JONES	CHARLES	F	Ophthalmology Associates of Mobile, PC	MOBILE	AL	OPHTHALMOLOGY

## Add A New Physician

Physicians Id: 12345

First Name: Jules Middle Name: J Last Name: Jones

Title: MD

Address 1: 128 Park Lasne

Address 2: Suite 402

City: ZEPHYR COVE State: NV Zip: 89448

Phone Nbr: (775) 415-4545

Fax Nbr:

Email: jjones@esrsmc.com

Specialty: Medical Oncologist

NPI: 1679642578

Remarks:

Do Not Contact

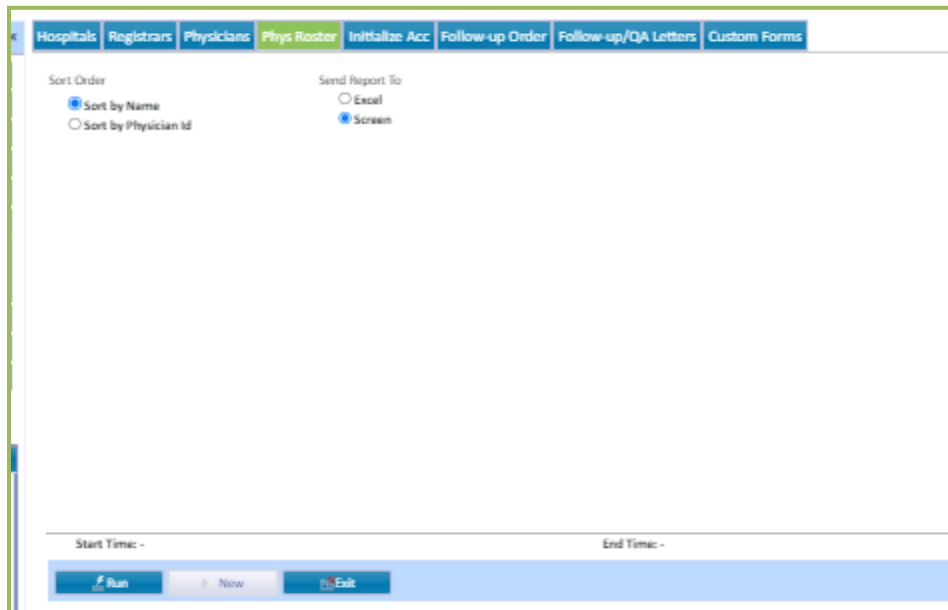
REMARKS -

New Save Exit Delete

7. Click New Physician to add a new physician.
8. Physician ID number can be alphanumeric. Use Numbers, letters, or a combination.
9. Enter a title, i.e. MD. PhD, etc. Be consistent with MD vs. M.D.
10. Do not delete physicians that are in the database to avoid data validation errors.
11. Enter a specialty if known. Various reports can be generated by specialty.
12. Enter the 10-digit NPI number. VERY IMPORTANT!!
13. Remarks: This is an excellent place to record if the physician has retired, moved, etc.
14. Check Do Not Contact and a follow up letter will not be generated for this physician.
15. Click Save.

## System Management-Phys Roster- (Generate Physician Roster)

This feature is used to obtain a list of physicians entered in the system. The Physician Roster lists the ID, Physician Name, Address, City, State, Zip and Phone Number.



The screenshot shows a web application interface for generating a physician roster. At the top, there is a navigation bar with tabs: Hospitals, Registrars, Physicians, Phys Roster (highlighted), Initialize Acc, Follow-up Order, Follow-up/QA Letters, and Custom Forms. Below the navigation bar, there are two sections: 'Sort Order' and 'Send Report To'. Under 'Sort Order', there are two radio buttons: 'Sort by Name' (selected) and 'Sort by Physician Id'. Under 'Send Report To', there are two radio buttons: 'Excel' and 'Screen' (selected). At the bottom of the interface, there are two input fields labeled 'Start Time: -' and 'End Time: -'. Below these fields is a blue bar containing three buttons: 'Run', 'New', and 'Exit'.

1. Check the Sort Order of the printed physician roster, either by Last Name or Physician ID.
2. Check desired output of report, Click either Excel or Screen. (The steps to open or save the Excel document are dependent on browser type).
3. Click Run.

## System Management -Initialize Acc (Initialize Accession Numbers)

The STORE Manual states that: "Numeric gaps are allowed. When a case is deleted from the database, do not reuse that accession number for another case. This will avoid any chance of two cases having the same accession number."

Hospitals Registrars Physicians Phys Roster Initialize Acc Follow

Hosp Code: 01 ERS Hospital Systems

Acc Year: 2023

Next Acc Nbr: 01202300001

NEXT\_ACC\_NBR -

New Save Exit Delete

NOTE: Individual States keep track of accession numbers and will reject a case with duplicate numbers.

1. Enter the Hospital code, i.e. 01, 02, 03, etc.
2. Any number of years can be initialized. Simply choose the year to initialize by entering in the year.
3. Important: The accession number must be preceded by the hospital number followed by the year and then case number (01202200005). Enter the next 11 digit accession number to use: (HSP# = 2 Digits, Year = 4 Digits, Case # = 5 Digits. The system will automatically assign the next number to the abstract when the year is typed in.
4. To initialize accession numbers at the beginning of a new year, enter the next accession number as shown above, i.e. 01202300001.
5. Click Save.



## System Management-Follow-up/QA Letters

Follow Up letters are provided in CRStar. The letters may be changed or modified to suit individual facility's needs. The letters provided are by individual hospital codes. For multi hospitals, letters can be copied from one facility to another and then modified if needed.

The following are the types of letters provided:

- Patient Follow Up
- Patient Follow up in Spanish
- Secondary Contact Follow Up
- Physician Follow Up (this letter is also used to send to other Cancer Registries)
- Physician QA letter
- Physician TNM Staging Letter

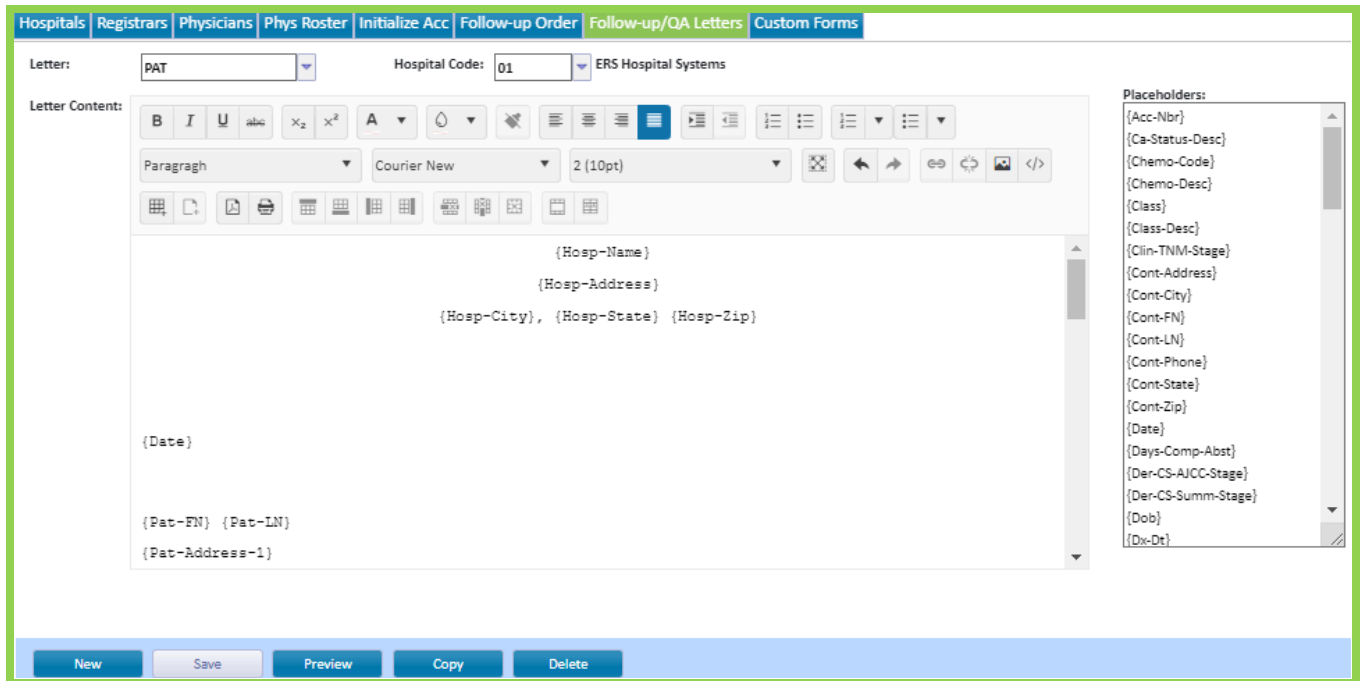
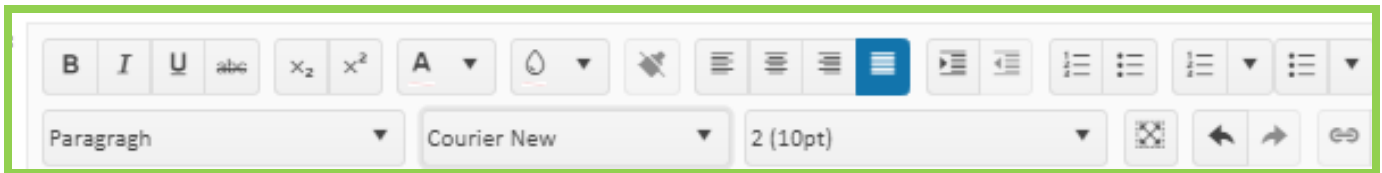
**SPECIAL NOTE: Every System must have a letter named Pat, Doc, QA, and Con. DO NOT DELETE THESE LETTERS FROM CRSTAR EVER!** They can be modified, but NEVER EVER DELETED! These are the letters that default when method is coded to Physician, Patient, or Contact, unless otherwise specified.

The letters can be used with hospital letterhead or plain paper. If plain paper is used the Hospital name and address is centered at the top of the letter as shown.

{Hosp-Name}  
{Hosp-Address}  
{Hosp-City}, {Hosp-State} {Hosp-Zip}

If letterhead paper is used, the user will need to modify the letters depending on where the letterhead is located. Note: This may take a little trial and error!

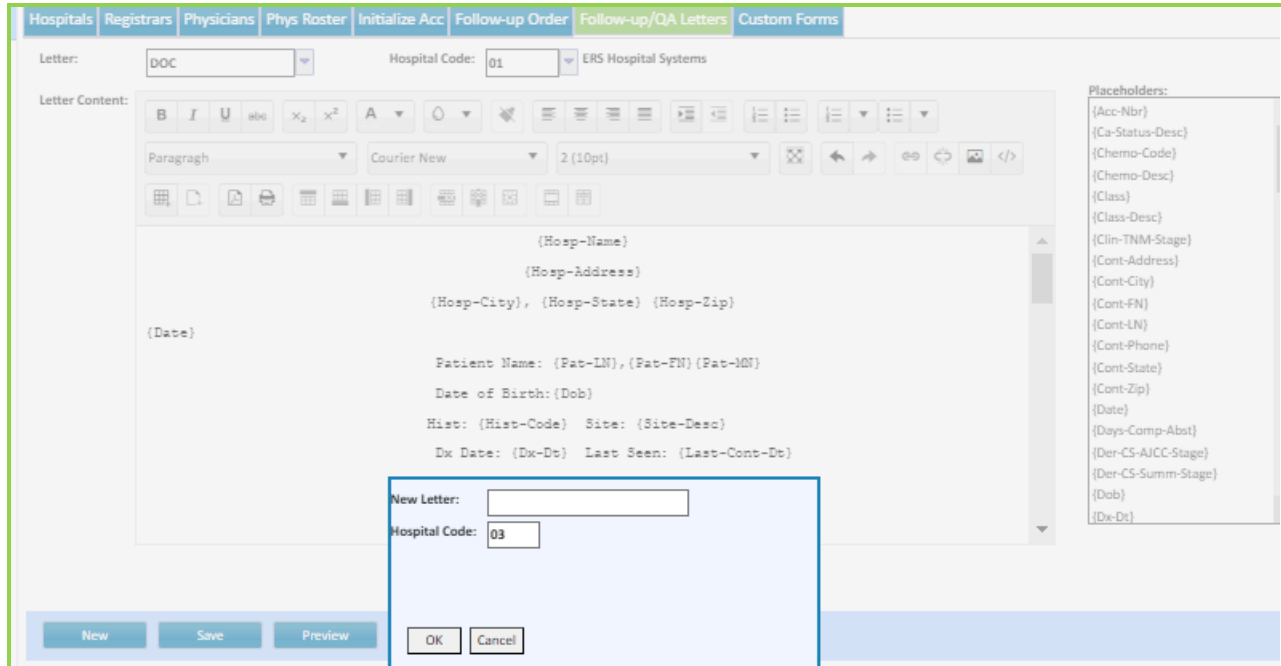
The letters provided contain similar features to a Word document. The user can utilize any of these features to customize a letter. Some options are shown below:



- To choose a letter type to modify, click the drop-down arrow. Each letter will have a Hospital Code, i.e. 01PAT, 02PAT, 03PAT.
- Standard and Recommended settings should be:
  - o Letter Content-Normal
  - o Font- Courier New
  - o Font Size- 2 (10pt)

**SPECIAL NOTE:** The only font that can be used for letters requiring columns or fixed spacing is Courier New. If font is changed from the fixed-width Courier New, it **CANNOT** be set back. So, if someone changes the font, and then realizes they need columns aligned; you would have to create a new letter to get the Courier New font again.
- Placeholders are data items that can be used in the letters. To add a placeholder, highlight it in the list on the right, right click on it, copy it, then right click, and paste the placeholder name in the letter where it should appear. It is recommended that placeholders are added by copying and pasting instead of trying to type them manually.
- If any changes have been made to the letter, the Save button at the bottom is activated and changes need to be saved before exiting the letter.
- The Preview button at the bottom of the screen allows for a preview of how the letter will print.

- To copy a letter from one facility to another, select the letter to copy as shown:
  - Click Copy.
  - Enter a title for the new letter. Note: Only do this if a different title is needed. If the letter should be named the same, leave New Letter blank.
  - Enter the number of the hospital code where the letter should be copied to.
  - Click OK.



- To delete a letter, click Delete. A message will pop up asking to delete the letter. Click OK.
- Click PREVIEW to preview changes or modifications.
-

## QA Letter

- A Physician QA letter is provided. This letter contains all required data fields to meet CoC Standard 1.6. It is recommended **NOT** to change this letter. **DO NOT CHANGE THE FONT!** Courier New is a fixed width font, if the font is changed, the columns will not align properly.
- Note: As indicated by the green arrows, codes, and text in certain fields to be displayed in the letter have been assigned certain character values. **Do NOT Change These**. The number is not visible when the letter prints.
- Letters can be created in WORD and copied and pasted into CRStar, then modified to add the place holders.

The screenshot displays the CRStar Custom Forms editor for a 'Treatment Summary' form. The form content area is divided into several sections:

- Patient Identification:** Includes fields for Med Rec Nbr, Patient Name, Date of Birth, Age at Dx, and Race.
- Care Team:** Lists roles such as Surgeon, Med Oncologist, Rad Oncologist, Managing Phys, and Following Phys, each with associated placeholder codes.
- Outcome Data:** Contains fields for Histology Grade, Lateralit y, Nodes Examine d, Nodes P ositive, Tumor Size, Date Last Cont, Vital Status, Cancer Status, and Recur Date.
- Treatment Summary:** Includes Surgery Date, Surgery Text, Radiation Date, Radiation Text, Chemo Date, and Chemo Text.

Placeholder codes are listed on the right side of the editor. Two green arrows highlight specific fields: one points to 'Histology Grade' (placeholder: [20]{Hist-Desc}) and another points to 'Radiation Text' (placeholder: [200]{Rad-Text}).

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## Codes Maintenance-County Codes

The County Codes for all states have already been entered in the software.

County Codes Maintenance

County Code Lookup

County State

County Name

[Clear Search Criteria](#)

Records: 3,468

County Code	County State	County Name
023	AL	CHOCTAW
189	GA	MCDUFFIE
273	GA	TERRELL
133	IL	MONROE
203	IL	WOODFORD
193	IL	WHITE
039	NJ	UNION
007	NY	BROOME
137	OH	PUTNAM
115	VA	MATHEWS

First Prev 1 2 3 4 5 6 7 8 9 10 of 347 Next Last  Records per page

1. To search for county codes in a state, enter the state abbreviation.
2. The county code, state and name columns can be sorted by clicking the column header.
3. To search for a county by name, type in the full County name or partial name.
4. Click the Enter button and the items that match will appear as shown below.
5. Highlight the name to select it.
6. To view another page, click the arrows to move forward and back or click the page number.
7. Click New County to add a new county code.
8. Enter the County code and the state. The state can be chosen by clicking the drop-down arrow.
9. Enter a Township code and name if applicable. Note: Only a few states have township codes.
10. Click Save.

County Codes Maintenance

County Code Lookup

County State

County Name

[Clear Search Criteria](#)

Records: 3

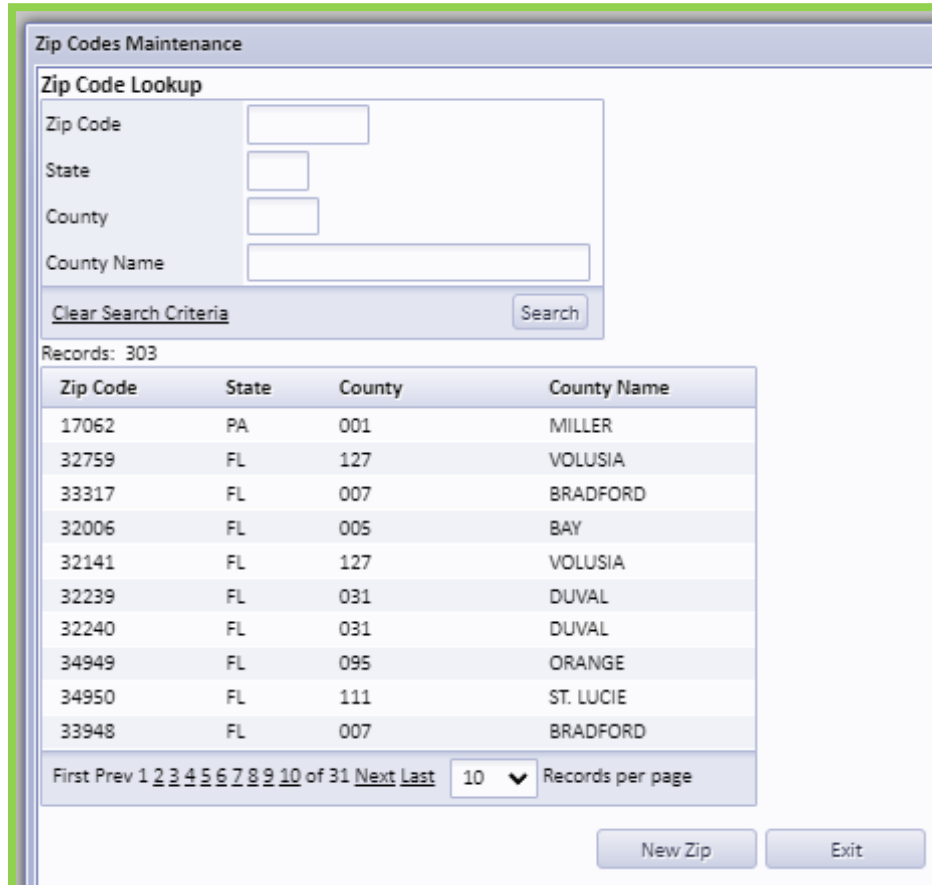
County Code	County State	County Name
057	MO	DADE
086	FL	DADE
083	GA	DADE

Records per page



## Codes Maintenance-Zip Codes

In CRStar the City/State Suggestions for entered Zip Codes come from the US Postal Service. We cannot add an additional city to our zip code tables and expect it to affect the CRStar lookups because they come from the US Postal Service. If when entering a zip code in the abstract and an edit appears, that the zip code has not been indexed, or that the City and State does not match the city, state or county on file, manually enter the corrections/additions in these fields and save. Ignore (click cancel) the popup.



The screenshot shows a software window titled "Zip Codes Maintenance". Inside, there is a "Zip Code Lookup" section with four input fields: "Zip Code", "State", "County", and "County Name". Below these fields are "Clear Search Criteria" and "Search" buttons. A message "Records: 303" is displayed above a table. The table has four columns: "Zip Code", "State", "County", and "County Name". The table contains ten rows of data. At the bottom of the table, there is a pagination control showing "First Prev 1 2 3 4 5 6 7 8 9 10 of 31 Next Last" and a dropdown menu set to "10" with the text "Records per page". At the bottom right of the window are "New Zip" and "Exit" buttons.

Zip Code	State	County	County Name
17062	PA	001	MILLER
32759	FL	127	VOLUSIA
33317	FL	007	BRADFORD
32006	FL	005	BAY
32141	FL	127	VOLUSIA
32239	FL	031	DUVAL
32240	FL	031	DUVAL
34949	FL	095	ORANGE
34950	FL	111	ST. LUCIE
33948	FL	007	BRADFORD

1. To search for zip codes in a state, enter the state abbreviation or enter the zip code.
2. The zip code and state columns can be sorted by clicking the column header.
3. Click the Enter button and the items that match appear as shown below.
4. Highlight the name to select it.
5. To view another page, click the arrows to move forward and back or click the page number.
6. Click on the down arrow to change the number of records displayed on a page.

## Codes Maintenance: Zip Codes Continued:

The screenshot shows a web application window titled "Zip Codes Maintenance". Inside, there is a "Zip Code Lookup" section with four input fields: "Zip Code" (containing "34209"), "State", "County", and "County Name". Below these fields are "Clear Search Criteria" and "Search" buttons. A "Records: 1" indicator is shown above a table with the following data:

Zip Code	State	County	County Name
34209	FL	081	MANATEE

Below the table is a "Records per page" dropdown menu set to "10". At the bottom right of the window are "New Zip" and "Exit" buttons.

7. Enter the county code. **Note: Entering the county code will allow for automatic fill in the abstract. When entering a zip code, the system will automatically fill in the appropriate county code.** For cities with more than one county the system will default to the county on the first line but will not generate an edit for any other counties listed. **NOTE:** To do this, the county code and name must be entered here. However, if the county code is not entered, the system will allow manual entry.

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## Chapter 8 PREFERENCES

- System Configuration
  - Genedits
  - Dashboard

## System Configuration

### System Configuration- Genedits- (Genedits Settings)

The Genedits utility is located under PREFERENCES, then System Configuration, then Genedits. Edits need to be defined for State specific or the standard NAACCR, NCDB and RCRS metafiles. The metafiles only need to be loaded once for each set.

State	Metafile	
CA - C	CA_v22B	Browse
OH - C	OH_v22B	Browse
FL - FI	FL_v22B	Browse
CO - C	CO_v22B	Browse
WI - V	WI_v22B	Browse
WV -	NACRv22B	Browse
AR - A	AR_v22B	Browse
TX - T	TX_v22B	Browse

Add Delete

RCRS Metafile: RCRS\_v22B Browse

NCDB Metafile: NCDB\_v22B Browse

Add. State Metafile: NACRv22B Browse

1. To set the State specific metafiles, first Choose the Appropriate State, then put the cursor in the Metafile field and click browse. A window with an alphabetic listing of all metafiles opens. Use the scroll bar to view the metafiles. Choose the correct metafile by highlighting it. Users reporting to multiple states can set several state metafiles. These edits begin with the state abbreviation. Note: This section is for state specific metafiles. If the user does not use state specific metafiles, the standard NAACCR edits should be used here. Running edits from this location use the NAACCR export.
2. To set the RCRS edit metafile, click browse. Use the scroll bar to view the metafiles. Choose the correct metafile by highlighting it. These edits begin with RCRS. Running edits from this location use the NCDB export.
3. To set the NCDB edit metafile, click browse. Use the scroll bar to view the metafiles. Choose the correct metafile by highlighting it. These edits begin with NCDB. Running edits from this location use the NCDB export.
4. Additional state metafiles may also be loaded. If state specific metafiles are used, it is recommended to load the standard NAACCR edits in this section and run both sets of edits. This may save valuable time clearing edits at NCDB submission time as the NCDB uses the standard NAACCR edit set. Some state specific edit sets may not have all the standard edits turned on. Running edits from this location use the NAACCR export. To set the additional metafiles, click browse. Use the scroll bar to view the metafiles. Choose the correct metafile by highlighting it.

## System Configuration- Running Individual Edits (Edits)

1. On any screen past the Patient Maintenance screen, click the << located at the far right top of the screen to bring up the Quick link window.
2. Click the Run Genedits Icon.
3. Choose the metafile to run.
4. Click Run for the report to display.

The screenshot displays a patient record for MELANIE, DOB: 01/10/1959, with a diagnosis of Invasive carcinoma of no special type (C50\_) [BREAST ONLY]. A 'Quick Links' window is open, showing icons for Links, SSDI, Print Abstract, Run Genedits, and On Demand Letter. The 'Run Genedits' icon is selected, opening a 'Genedits Check' dialog. In this dialog, the State is set to FL, and the 'State Metafile' radio button is selected. Below the dialog, the 'Edit Summary Report' is visible, showing two edit results:

Edit ID	Description	Start Pos	Value	Location
OH4393	OH SSDI for Brain, CNS, Blank for Other Schemas (NAACCR)			
M:	If Schema is not Brain,CNS, Brain Molecular Markers must be blank			
E:	Conflict between schema and coded SSDI items			
	Schema ID #3800	19574	[00723]	Located on StagingMaint - Staging Data
	Brain Molecular Markers #3816	19619	[86]	--Current Value--
	Date of Diagnosis #390	488	[20200214]	Located on PatientMaint - Patient Demo
N4010	SSDI for Brain, CNS, Blank for Other Schemas (NAACCR)			
M:	If Schema is not Brain,CNS, Brain Molecular Markers must be blank			
M:	If Schema is not Brain,CNS, Chromosome 1p: Loss of Heterozygosity must be blank			
M:	If Schema is not Brain,CNS, Chromosome 19q: Loss of Heterozygosity must be blank			
M:	If Schema is not Brain,CNS, Methylat O6-Methylguanine-Methyltransf must be blank			
E:	Conflict between schema and coded SSDI items			
	Schema ID #3800	19574	[00723]	Located on StagingMaint - Staging Data
	Brain Molecular Markers #3816	19619	[86]	--Current Value--
	Chromosome 1p: Loss of Heterozygosity (LOH) #3801	19579	[9]	--Current Value--
	Chromosome 19q: Loss of Heterozygosity (LOH) #3802	19580	[9]	--Current Value--
	Methylation of O6-Methylguanine-Methyltransferase #3889	19761	[9]	--Current Value--
	Date of Diagnosis #390	488	[20200214]	Located on PatientMaint - Patient Demo

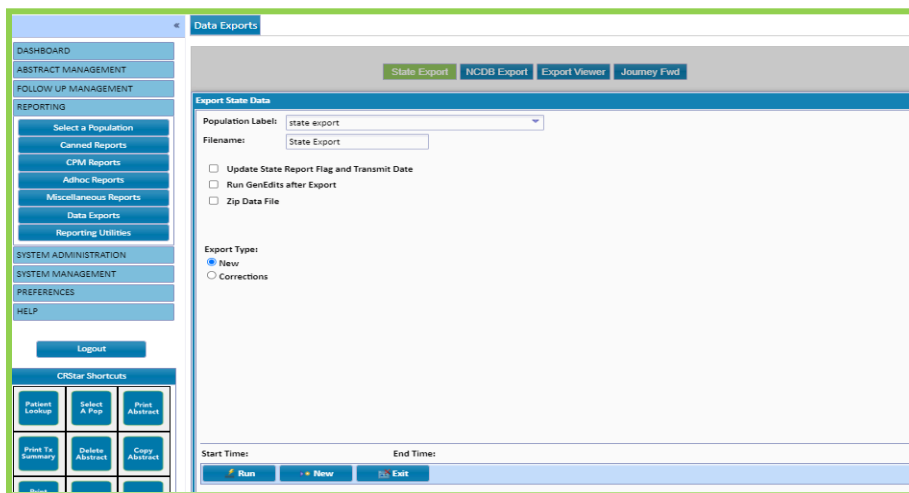
Total Edits for this Record: 2

Thursday, July 6, 2023 5:08:38 PM

1. Click Modify to make the edits interactive.
2. Make corrections to the fields that are editable by correcting the field directly on the edit screen or choose Goto from the edit screen to go directly to the screen within the abstract.
3. Click Save and Re-run.

## System Configuration- Running State Export Edits (Edits)

1. Go to Reporting.
2. Go to Data Exports.
3. Go to State Export.
4. Insert pre-selected population.
5. Name the Filename. Do not use characters such as /or \* in the file name.
6. Check Run Genedits after export.
7. Check update State report flag and transmit date ONLY if they are ready to transmit as clean cases.
8. Click Run.
9. Choose the type of Export if applicable for your state, i.e. New Case, Corrections, Follow Up, etc.



- A list of all the cases in the export is created. The user can print the list if desired.
- Download will create another export file.
- Exit exits the report.

Data Exported						
Cases Exported for the State of FL				Number of Cases: 155		March 26, 2019
Acc Nbr	Med Rec Nbr	Last Name	First Name	Site	Seq	Dx Date
200400124	422948062	SKIN	MARGARET	44	00	01/11/2018
199600035	419186790	PANCREAS	LYDA	50	00	01/13/2018
198401395	417149898	PROSTATE	RICHARD	61	00	06/01/2018
199300251	422056493	PROSTATE	SAMUEL	61	00	01/05/2018
200600076	418562949	PROSTATE	PAUL	61	00	02/13/2018
201810027	263332489	Check	BEVERLY	48	01	06/30/2018
201100178	363600777	CERVIX	SHERYL	53	00	01/15/2018
198000645	416126986	PROSTATE	THEODORE	61	00	01/15/2018
200500694	419963222	BREAST	DEBORAH	50	00	04/12/2018
198000587	417039132	PROSTATE	NORMAN	61	00	07/15/2018
200100771	418521575	PROSTATE	JOHN	61	00	12/11/2018
199600631	422017785	BREAST	M	50	00	08/05/2018
200500091	428663431	PROSTATE	KENNETH	61	00	01/19/2018
200400281	426589175	lung	RILEY	34	00	03/16/2018
200000148	422174939	RECTUM	RACHEL	20	00	02/23/2018
200801779	420069017	PROSTATE	JAMES	61	00	06/27/2018
201201563	425579082	OTHER MOUTH	LANCE	06	00	09/27/2018
201100919	417669600	lung	CAROL	34	00	07/12/2018
200000817	424306762	BREAST	FRANCES	50	00	08/30/2018
198900234	417221220	lung	BURKETT	34	00	02/15/2018
200701330	225307169	PROSTATE	HARVEY	03	00	01/22/2018
199000815	424380390	BREAST	MILDRED	50	00	05/07/2018
200600016	424229178	COLON	DONALD	18	00	01/23/2018
201801899	417765025	PROSTATE	BONNIE	61	00	09/26/2018
200601508	423368050	BREAST	ANTOINETTE	50	00	10/16/2018



The edit print out will appear behind the list. See next page.

System Configuration- [Edit Display \(Edits\)](#)

GenEdits Report

NAACCR v18 - Florida Wednesday, March 27, 2019

**Record: 1** Accession Number/Seq: 201203410/00 ♦ Topography: C619 ♦ Histology: 81403 ♦ Diagnosis Year: 2018 ♦ Abstracted By: DSW

Text--Staging (FCDS) [FL1525]  
**E: 0934: Text--Staging cannot be blank**  
 Text--Staging #2600 (Start Pos: 13135) Value: --blank--

\_SYS Schema ID, Date of Diagnosis (NAACCR) [N2823]  
**E: 1883: Schema ID must not be blank for cases diagnosed 2018 and later**  
 Schema ID #3800 (Start Pos: 1726) Value: --blank--  
 Date of Diagnosis #390 (Start Pos: 544) Value: [20180628]

Total Edits for this Record: 2

---

**Record: 2** Accession Number/Seq: 200100735/00 ♦ Topography: C502 ♦ Histology: 85203 ♦ Diagnosis Year: 2018 ♦ Abstracted By: CSI

Height (FCDS) [FL1540]  
**E: 0963: Height must = 01-99**  
 Height #9960 (Start Pos: 1656) Value: --blank--

RX Summ--Treatment Status (FCDS) [FL1452]  
**E: 0860: <BLANK> is not a valid value for RX Summ--Treatment Status**  
 RX Summ--Treatment Status #1285 (Start Pos: 2224) Value: --blank--

Text--Dx Proc--Scopes (FCDS) [FL1521]  
**E: 0930: Text--Dx Proc--Scopes cannot be blank**

---

**Record: 3** Accession Number/Seq: 200601768/00 ♦ Topography: C619 ♦ Histology: 81403 ♦ Diagnosis Year: 2018 ♦ Abstracted By: DGW

RX Summ--Treatment Status (FCDS) [FL1452]  
**E: 0860: <BLANK> is not a valid value for RX Summ--Treatment Status**  
 RX Summ--Treatment Status #1285 (Start Pos: 2224) Value: --blank--

Text--Dx Proc--Scopes (FCDS) [FL1521]  
**E: 0930: Text--Dx Proc--Scopes cannot be blank**  
 Text--Dx Proc--Scopes #2540 (Start Pos: 8035) Value: --blank--

\_SYS Schema ID, Date of Diagnosis (NAACCR) [N2823]  
**E: 1883: Schema ID must not be blank for cases diagnosed 2018 and later**  
 Schema ID #3800 (Start Pos: 1726) Value: --blank--  
 Date of Diagnosis #390 (Start Pos: 544) Value: [20180829]

Total Edits for this Record: 3

---

**Record: 4** Accession Number/Seq: 201800789/00 ♦ Topography: C342 ♦ Histology: 80103 ♦ Diagnosis Year: 2018 ♦ Abstracted By: SWL

Total Edits for this Record: 0

---

**Record: 5** Accession Number/Seq: 199400543/02 ♦ Topography: C504 ♦ Histology: 85202 ♦ Diagnosis Year: 2018 ♦ Abstracted By: CSA

\_SYS Schema ID, Date of Diagnosis (NAACCR) [N2823]

Download Exit

- The edit display shows the edit set and date the report was run.
- Each case is listed as Record 1, Record 2, etc. Separated by the blue bar and patient information.
- The display lists the number of errors per case.
- Errors are displayed in red font and the value entered in the abstract is displayed in green font.
- Edit tag numbers and NAACCR position numbers are displayed in light blue.
- The edit summary report is displayed at the bottom of the report.
- The exit icon exits the screen. The Download icon downloads the edit report to Word, where it can be saved as an attachment or printed.

The print icon will print without going to Word.

## System Configuration- Edit Display Report

**Edit Summary Report**
Wednesday, March 27, 2019 3:36:50 PM

Edit Set: FCDS - Incoming Abstracts  
 Edits Metafile: FL\_v18C.smf  
 Input Data File: State Export.txt  
 Output Report File: CRStar\_GenEdits\_56204.rtf

Type	Edit Name	Edit Tag	Error Count
E	_SYS Schema ID, Date of Diagnosis (NAACCR)	N2823	570
E	Abstracted By (NAACCR)	N0201	21
E	Accession Number--Hosp (COC)	N0034	1
E	Addr at DX--City (NAACCR)	N0799	17
E	Addr at Dx--City, County, Postal Code (FCDS)	FL1410	1
E	Addr at DX--No/Street (FCDS)	FL1378	28
E	Addr at DX--Postal Code (NAACCR)	N0123	17
E	Addr at DX--State (NAACCR)	N0122	17
E	Addr at DX--Supplementl (FCDS)	FL1386	1
E	Addr Current--City (NAACCR)	N0350	17
E	Addr Current--City, County, Postal Code (FCDS)	FL1497	1
E	Addr Current--No/Street (FCDS)	FL1379	29
E	Addr Current--Postal Code (NAACCR)	N0170	17
E	Addr Current--State (FCDS)	FL1490	17
E	Age, Primary Site, Morph ICDO3--Adult (FCDS)	FL1391	1
E	Behavior Code ICDO3, Sequence Number--Hosp (FCDS)	FL1358	1
E	Weight (FCDS)	FL1545	33
W	RX Summ--Other (FCDS)	FL1364	7

Total Edits: 1425  
 Total Warnings: 7  
 Records Processed: 585  
 Processing Time: 3:36:45 PM - 3:36:50 PM

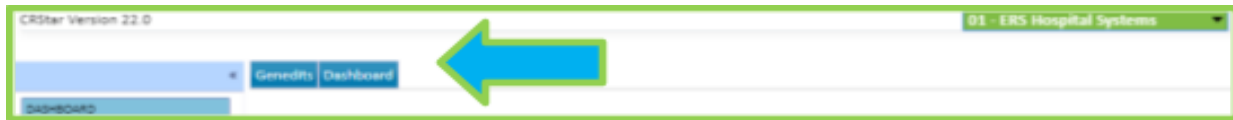
Download
Exit

- The edit summary report displays the type of edits set.
- The edit metafile displays the version of edits being run.
- The input data file displays the name the user gave the file.
- The Output report file is the name given when a user uses the Download option once the edit is displayed.
- Each Error or Warning is listed with the name of the edit, the Edit Tag number and the number of errors or warnings for each. In addition to errors and warnings, additional messages associated with the errors may also be listed. Messages do not require corrections. They simply accompany the error message and provide additional information.

The total number of edits and warnings are displayed at the bottom of the report as well as how many cases were processed in the file.

## System Configuration- Dashboard- (Dashboard Configuration)

This function requires the user to have System Admin rights attached to their log-in to view and set up this screen.



1. Go to Preferences tab, then System Configuration, then click on the Dashboard tab.
2. The Dashboard Configuration window will appear and enables MANY customizable options to be set for each of the dashboard reports.
3. The hospital for which you are setting parameters displays at the top of the dashboard window. Example: Hospital 01 – ERS Hospital Systems. To change display for a different hospital, simply exit this window and select the hospital from the GREEN drop-down menu at the TOP of your screen. (See the blue arrow below). Then select the Dashboard tab again for the parameter window to open.
4. Fill in the reference year of the facility if it is newer than the ACoS default year for dashboard reports to utilize when calculating follow-up.
5. If setting for a pediatric facility, check the box. This excludes patients greater than 26 years of age for the Lost to Follow-up report calculations.
6. For each report, set the customized date range that is most appropriate for your needs: ranges must be valid dates, but can be days, weeks, months, quarters, etc. Follow the format as seen below: MM/DD/YYYY. If End Date is left blank, the system will refresh to current date.
7. In a Multi-Hospital setting the user may choose the facilities to include in each graph or to isolate a single facility. Enter the facility followed by a comma and no space.
8. By checking the Admin Only box listed to the right of each report, prevents all users EXCEPT the users with admin logins from seeing that report on their dashboard screen. Keep in mind that users with system admin rights can view this configuration screen to make changes.
9. Once dates are filled in for each report and selections made in the checkboxes, select SAVE, then EXIT.

Return to this screen to make any changes at any time. The dashboard reports will continue to show the data within the date range set until it is changed to reflect other dates.

Hospital: 01 ERS Hospital Systems  
 Reference Year: 2006

Pediatric Facility

	Begin Date	End Date	Hosp List	Admin Only		Begin Date	End Date	Hosp List	Admin Only
Cases Abstracted:	12/01/2017		01	<input type="checkbox"/>	Stage by Physician:	01/01/2015		01,02,03	<input type="checkbox"/>
Cases Completed:	11/12/2017		01	<input type="checkbox"/>	Suspense by Site:	01/01/2021		01	<input type="checkbox"/>
Class by Site:	01/01/2016		01	<input type="checkbox"/>	Timeliness:	01/01/2017		01	<input type="checkbox"/>
County by Site:	01/01/2016		01	<input type="checkbox"/>	Top 5 Sites:	01/01/2018		01	<input type="checkbox"/>
In/Out Migration:	01/01/2016		01	<input type="checkbox"/>					
Follow Up Calcs:	N/A	N/A	01	<input type="checkbox"/>					
Follow-Up Entered:			01	<input type="checkbox"/>					
Last Follow-Up Entered:			01	<input type="checkbox"/>					
Quality Measures:	01/01/2021		N/A	<input type="checkbox"/>					
Referred From:	01/01/2016		01	<input type="checkbox"/>					
Referred To:	01/01/2016		01	<input type="checkbox"/>					

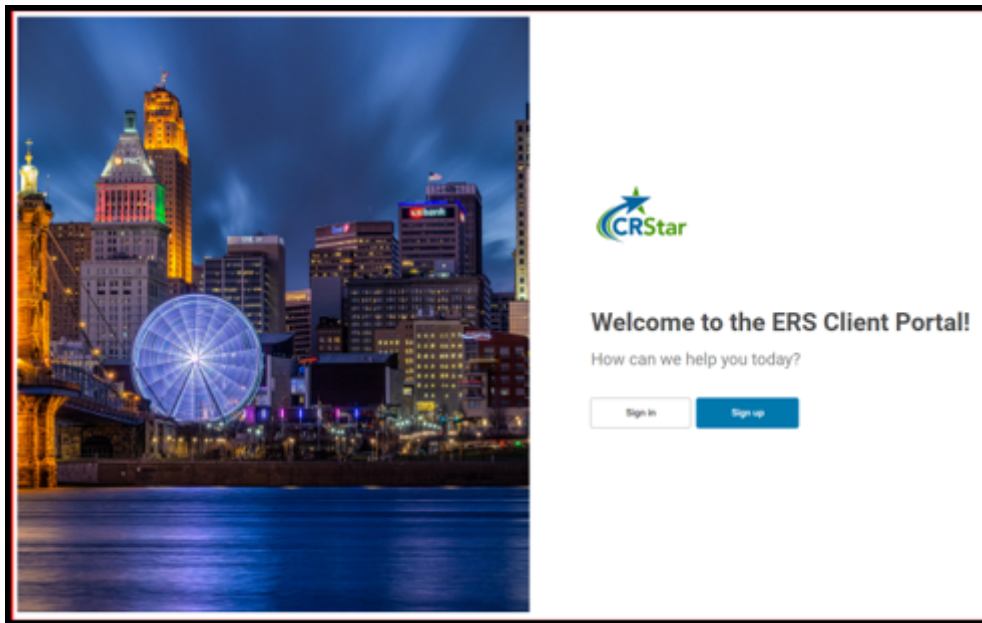
REFERENCE\_YEAR - 2006

Save

## Chapter 9 HELP

### Support Portal Bookmark the Portal

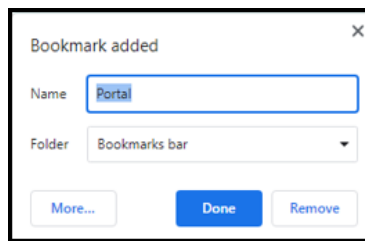
Link to the new Client Portal: <https://ers.myportallogin.com/>.



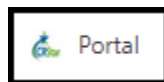
The new Client Portal only supports the Google Chrome™ web browser, though the portal may work in other browsers. To bookmark the page in Chrome, click the Star icon in the upper right corner:



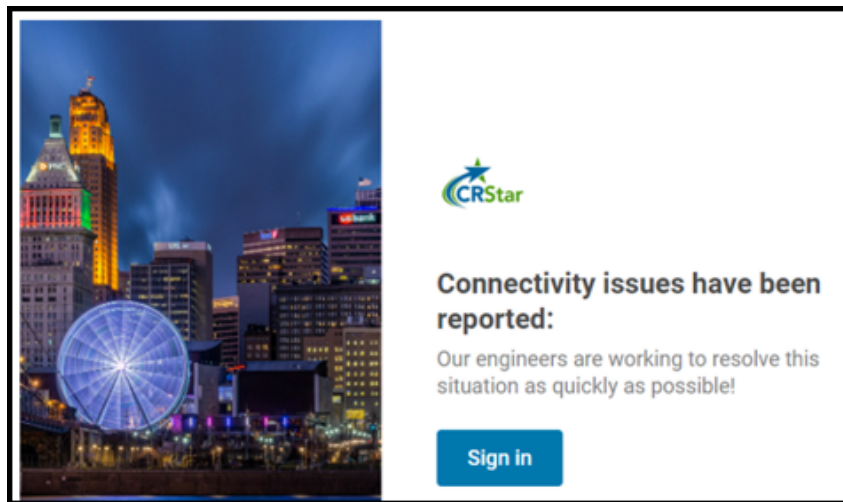
You can enter any name that you'd like (or just leave it Portal"). Select "Bookmarks bar" for the Folder location and click "Done":



You should now see the Portal Icon in your Bookmarks Bar:



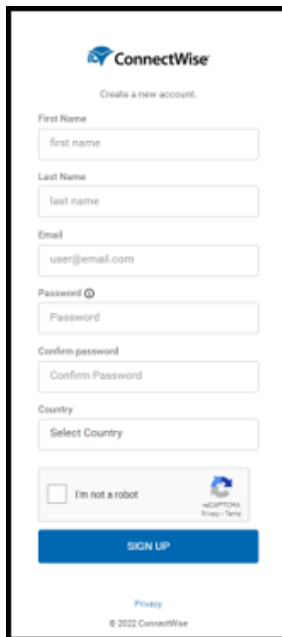
In the event of CRStar connectivity issues, the following screen will be displayed:



In these circumstances it is not necessary to enter a ticket as we are already aware of the problem and are working on it. We will send updates as often as deemed necessary by our crisis team. Most connectivity issues are resolved rather quickly, so we recommend you check the page often.

## Sign Up for Portal Access

The first time you access the Portal, you must create an account using the email address that you are registered with in the current portal. Click the "Sign Up" button on the homepage. You will be asked to provide some basic information and set your password:




ConnectWise  
Create a new account.

First Name  
first name


Last Name  
last name

Email  
user@email.com

Password   
Password

Confirm password  
Confirm Password

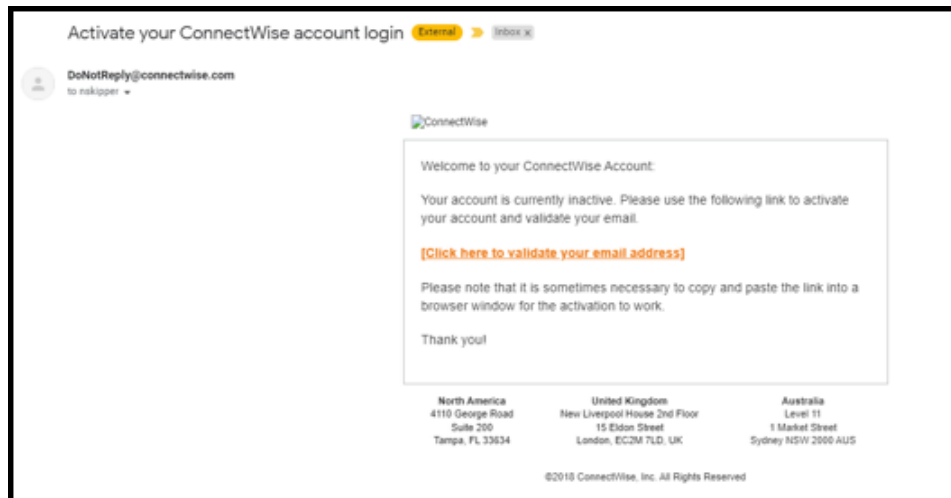
Country  
Select Country

I'm not a robot   
reCAPTCHA  
Privacy - Terms

**SIGN UP**

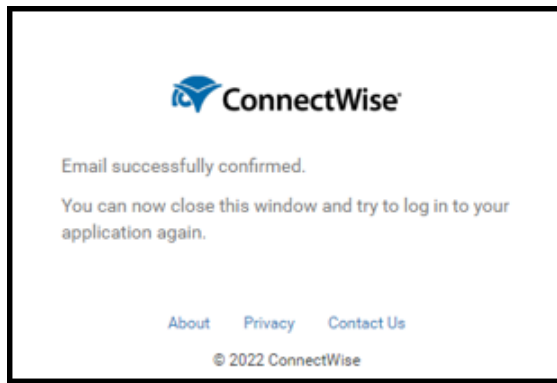
[Privacy](#)  
© 2022 ConnectWise

Complete the form. Check the “I’m not a robot” box and click “Sign Up”.  
You will receive an email with a link to validate your email address:

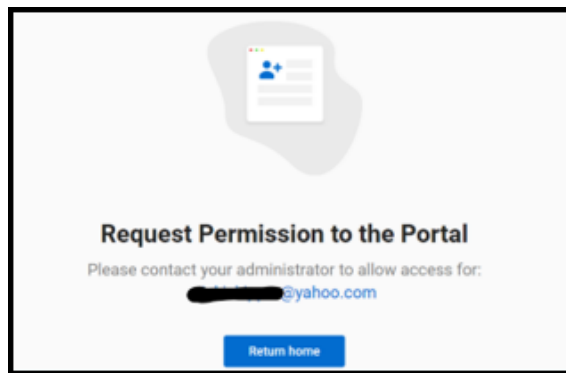


Click on the link and you should see this confirmation:





If your email is not recognized, you will get a message telling you to request permission to the portal from your system administrator:

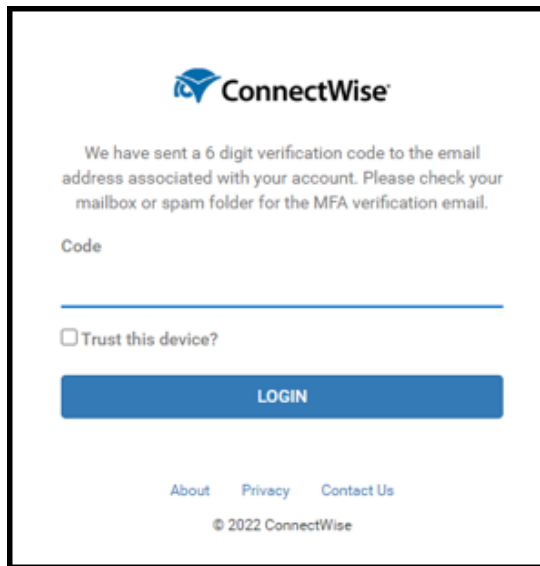


**PLEASE NOTE**

- Portal accounts are managed by the System Admin at each facility.
- If you do not have access, this must be reported to your System Admin, not Health Catalyst staff.
- We may be able to help in an emergency, but members of the Health Catalyst support teams do not have access to client account settings.

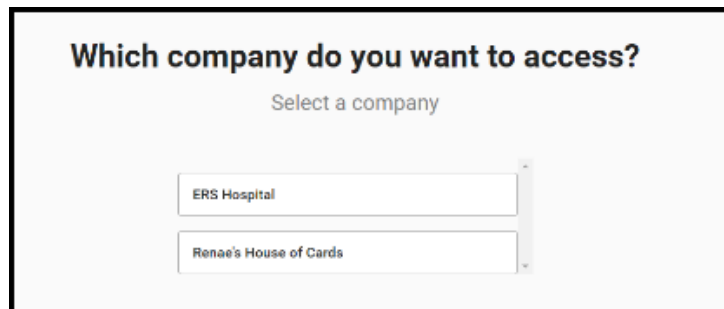
If

your login is successful, you will receive a verification code:



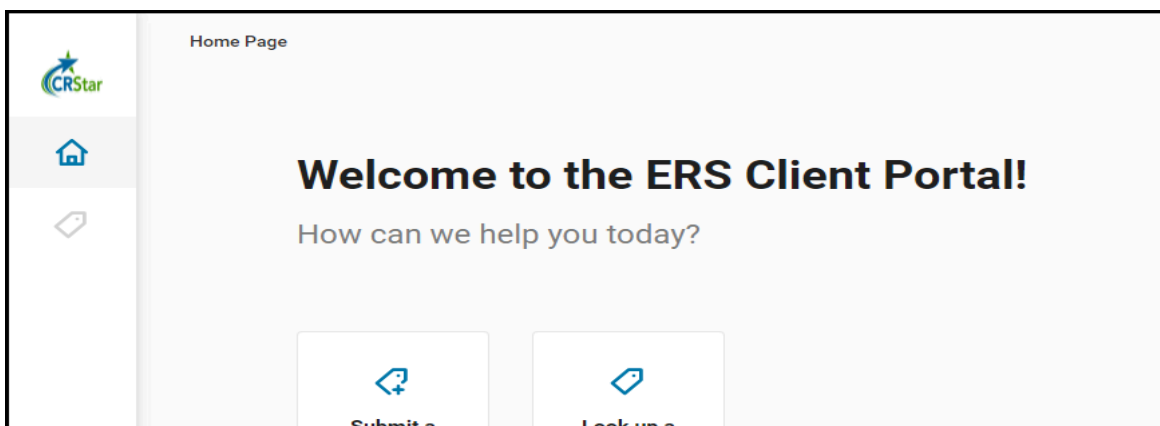
Enter the code to complete the login.

- If you work with a single facility, you will be taken directly to the Home Page.
- If you use CRStar at multiple facilities, you will be prompted to select the company for which you need support:

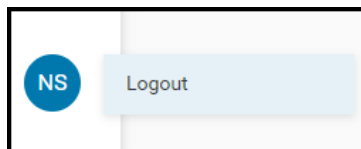


After selecting a company, you will be taken to the Home Page.

## Navigate the Home Page

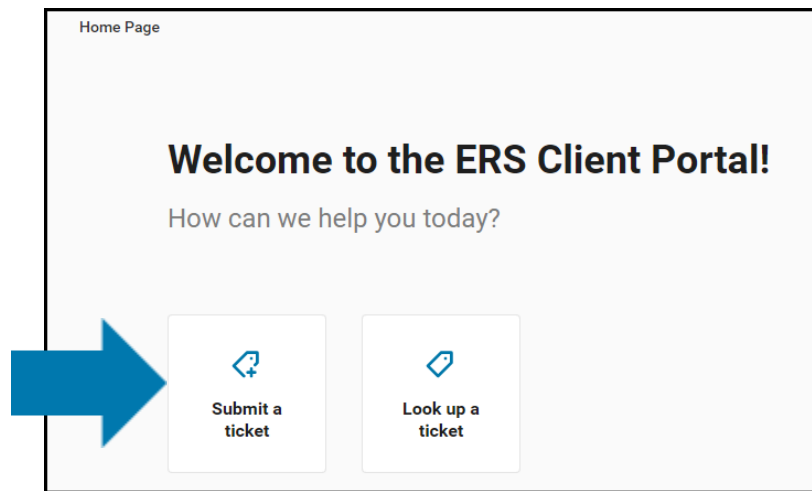


Navigating the Home Page is very simple. There are two main tabs, "Submit a ticket" and "Look up a ticket". On the left side, there is a "Home" icon (clicking this will take you to the Home Page) and a "Ticket" icon (clicking this will take you to the "Look up a ticket" page). You will see your initials in the lower left corner of the Home Page. Click on your initials and a "Logout" button will appear. Click on the "Logout" button to exit the Portal:

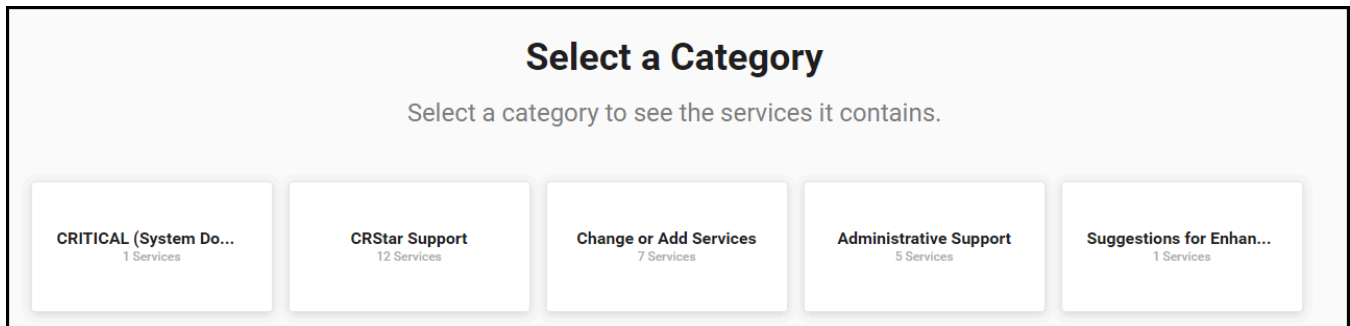


## **Submit a Ticket**

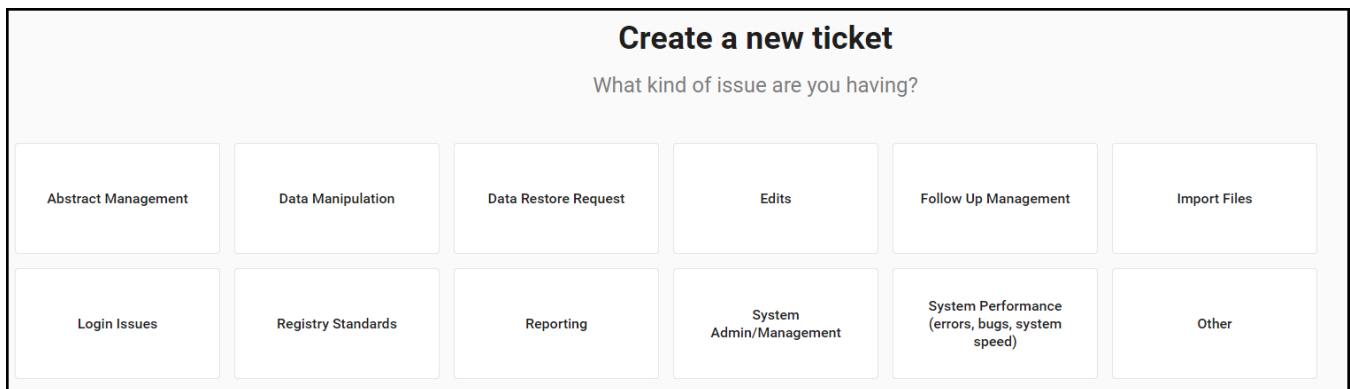
From the Home Page, click the "Submit a Ticket" button:



This will take you to the category selection page. There are five categories to choose from: Critical, CRStar Support, Change or Add Services, Administrative Support, and Suggestions for Enhancements:



The CRITICAL category is to be used ONLY when users cannot work in CRStar. CRStar Support, Change or Add Services, and Administrative Support contain multiple services. Once you have clicked on a category, the services page will open (see example below):



Select the service that best describes your support needs and click on that service to submit a ticket. Below is a screenshot of the Edits service page. Click on any active (blue) link located in the upper left corner of the screen to return to any of the previous pages.

Home Page / Look up a ticket / Categories / Services / Ticket details

Step 1 of 1

## Edits

What are the Accession and Sequence numbers for the case(s) you need assistance with? ⓘ

0 / 500

If the case does not have an Accession #, please provide the best phone # to reach you at:

0 / 20

Please provide additional details here (optional):

0 / 1000

Feel free to add attachments here (please do not include any PHI in any attachment)

Attach

To submit a ticket, simply fill in the appropriate fields and click the "Submit" button. None of the fields are required but providing as much information as possible will enable our support staff to resolve your issue more efficiently.

I need assistance with (please select from the dropdown below):

Please tell us how we can help you:

Most service tickets are configured using the following three components:

1. A dropdown menu from which you can select the most appropriate response.
2. A free text field where you can provide any details that are relevant.
3. An area to upload attachments.

As stated before, none of the fields are required to enter a ticket but providing as much detail as possible will ensure that the ticket gets assigned to the appropriate staff and gets handled as quickly and efficiently as possible.

Avoid using the "Other" service selection whenever possible.

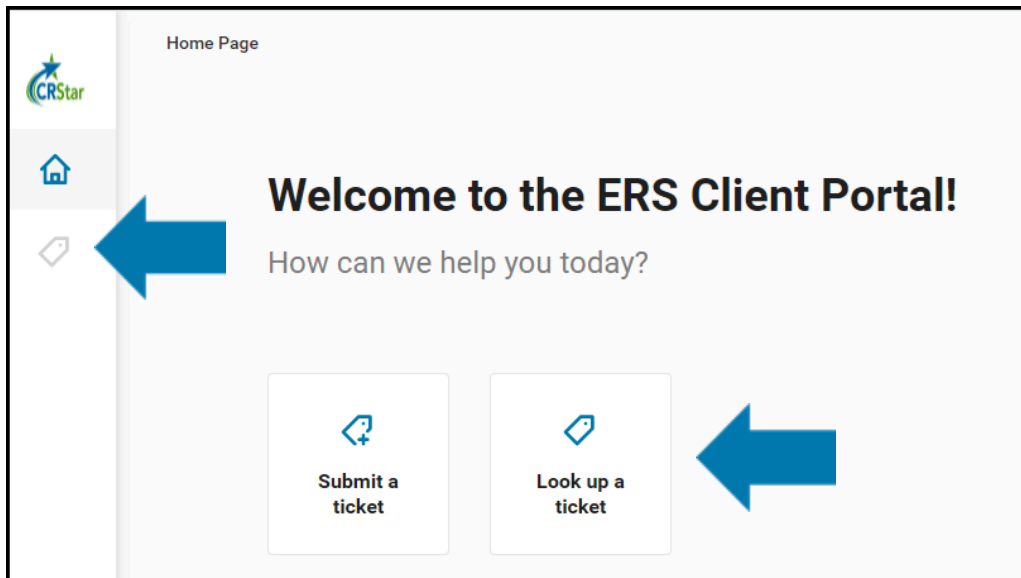
**IMPORTANT**

Do NOT include PHI or attach a document that includes PHI.

Health Catalyst staff deletes all PHI immediately.

## Look Up a Ticket

From the homepage, click the "Look up a ticket" box, or click the ticket icon on the left:



This will open a list of all your open tickets. There is also a "Create Ticket" button on this page which can be used to submit a ticket. Ticket status will change as the ticket is handled (from "New" to "Assigned" to "In Progress", etc.):

Home Page / Look up a ticket

### Tickets

Create Ticket

Search summary, contact or ticket #

TICKET #	SUMMARY	STATUS	TECHNICIAN	CONTACT
#44646	Data Manipulation - Global change	New	Unassigned	Jul 1, 2022 12:11 PM Nicki Skipper Standard
#44645	Edits - 01202200001/00	Assigned	Nicki Skipper	Jul 1, 2022 12:07 PM Nicki Skipper Standard

Create Ticket

Search summary, contact or ticket #

TICKET #	SUMMARY	STATUS	TECHNICIAN	CONTACT
#44648	System Performance - Error message	In Progress	Bonnie Nelson	Jul 1, 2022 12:15 PM Nicki Skipper Standard
#44646	Data Manipulation - Global change	In Progress	Nicki Skipper	Jul 1, 2022 12:11 PM Nicki Skipper Standard
#44645	Edits - 01202200001/00	In Progress	Nicki Skipper	Jul 1, 2022 12:07 PM Nicki Skipper Standard

Click on any ticket to open it.

Home Page / Look up a ticket

## Tickets

Create Ticket

TICKET #	SUMMARY	STATUS
#44648	System Performance - Error message	In Progress
#44646	Data Manipulation - Global change	In Progress
#44645	Edits - 01202200001/00	In Progress

1 - 3 of 3 items

X

< **Ticket #44646** >

### Data Manipulation - Global change

Submitted 12:11 PM - 7/1/2022 Status: **In Progress**  
 Contact Nicki Skipper Standard Technician: Nicki Skipper

Write a message

---

**Attachment** 30 seconds ago  
[Ticket#44646/123456/Data Manipulation - Global change -- has been updated.eml](#)

---

**NS Nicki Skipper** 31 seconds ago  
 Nicki Skipper Fri 07/01/2022 4:33 PM UTC-05  
 The global change has been applied. Please check the cases and make sure all is well.

---

**NS Nicki Skipper Standard** 4 hours ago  
 I need assistance with (please select from the dropdown below):  
 Global change  
 Please tell us how we can help you:  
 Several cases have the incorrect CS Version Original coded

You can view all of the communication in the ticket here, including any attachments. To send a message to the technician, use the "Write a message" box.

X

< **Ticket #44646** >

### Data Manipulation - Global change

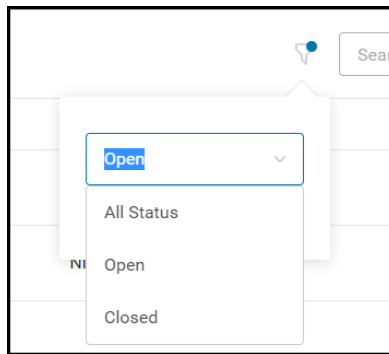
Submitted 12:11 PM - 7/1/2022 Status: **In Progress**  
 Contact Nicki Skipper Standard Technician: Nicki Skipper

Everything looks good now, thank you|

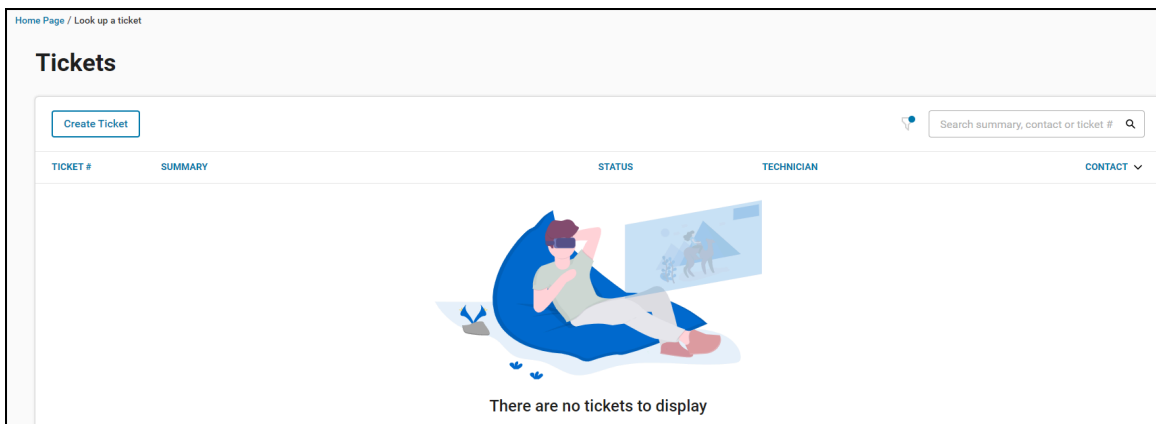
Click the black "X" in the upper left corner to close the ticket.

The default view shows only open tickets. Use the filter icon to view only open tickets or only closed tickets:

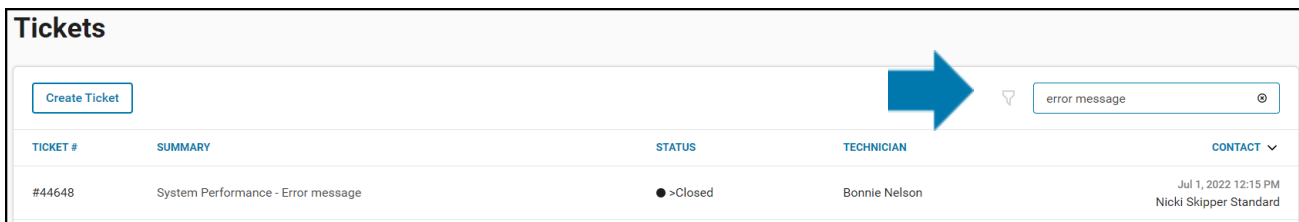




The filter icon displays a blue dot when showing only open tickets. If there are no open tickets, this view will appear:

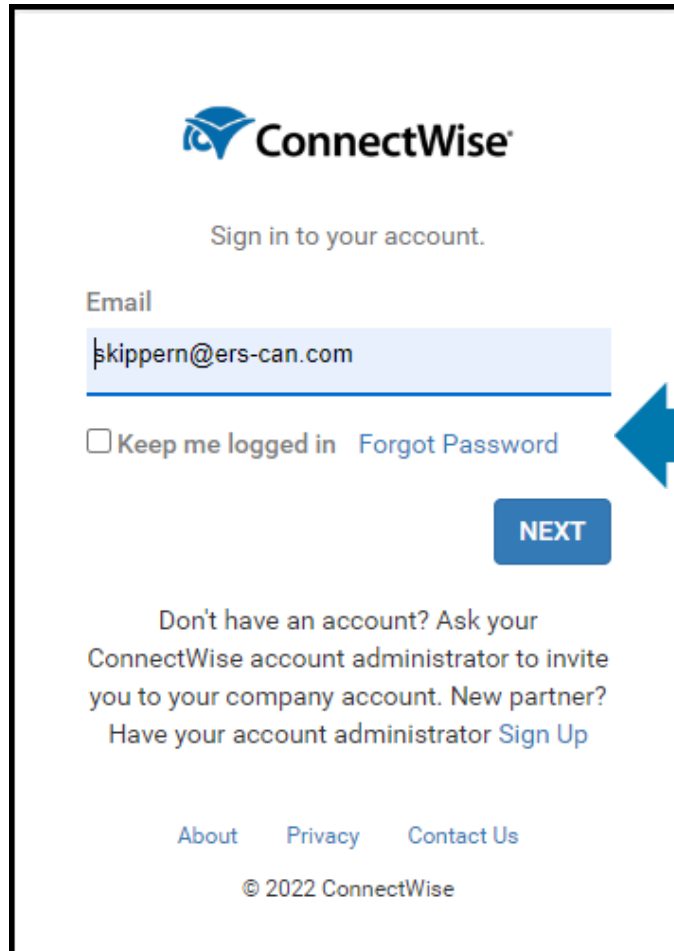


There is also a search window, where you can search by key words (from the summary), contact info or ticket #:



## Forgotten Passwords

Passwords can only be reset by each individual user. Do not report password issues to your system admin or to Health Catalyst staff. To reset your password, enter your email address on the login screen and click the "Forgot Password" link. An email will be sent with a link to reset your password.



The image shows a screenshot of the ConnectWise login interface. At the top is the ConnectWise logo. Below it is the text "Sign in to your account." followed by an "Email" label and a text input field containing "skippern@ers-can.com". Below the input field is a checkbox labeled "Keep me logged in" and a link labeled "Forgot Password". A blue arrow points to the "Forgot Password" link. To the right of the "Forgot Password" link is a blue "NEXT" button. Below the login fields is a section for new users: "Don't have an account? Ask your ConnectWise account administrator to invite you to your company account. New partner? Have your account administrator Sign Up". At the bottom are links for "About", "Privacy", and "Contact Us", and a copyright notice "© 2022 ConnectWise".

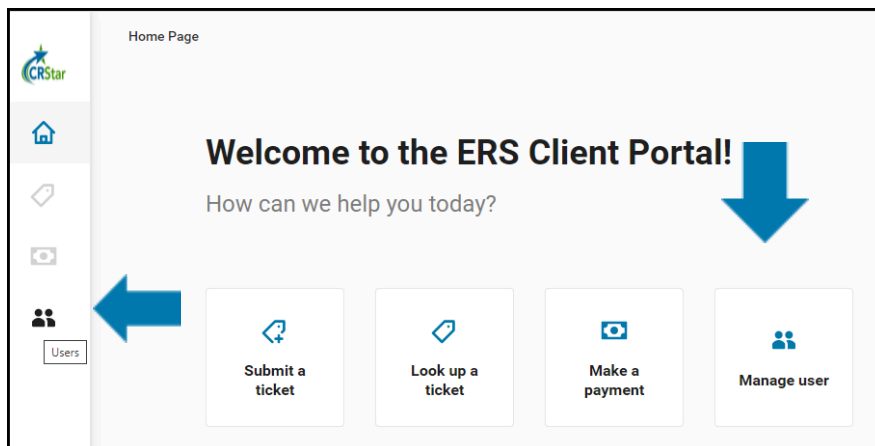
## User Management (for System Administrators)

In addition to the "Submit a ticket" and "Lookup a ticket" functions, system admins have access to "Manage user" functions.

### PLEASE NOTE:

Although you will see a "Make a payment" button, this function is not in use at this time.

To get to the user management screen, you can click the "Users" icon from the left toolbar, or click the "Manage user" box on the main screen:



The User Management screen lists all users, their emails, company name and roles (level of permissions in the Portal):

### User Management

Add User 

Search by name Q

<input type="checkbox"/>	NAME	EMAIL	COMPANY	ROLE
<input type="checkbox"/>	Jonathan Test	jrakestrawtest@mycrstar.com	ERS Hospital	Full Admin
<input type="checkbox"/>	Katelyn Test	katelyntest@ers-can.com	ERS Hospital	Full Admin
<input type="checkbox"/>	Laura Test	lauratest@mycrstar.com	ERS Hospital	Full Admin

To search for a user, use the search box in the upper right corner.

To add a user, click the "Add User" box in the upper left corner. The "Add a new contact" dialog will open. Enter the name, email and phone information, then select a user role from the dropdown and click "Save":

#### Add a new contact

**First name**

**Last name**

**Email address**  
Select type

**Phone number**  
Select type

**User role**  
Standard User

Back
Save

"Standard User" is the default role selected. Available roles are listed below:

	Log in to the portal	Submit a ticket	Look up own tickets	Look up all user tickets	View Invoices	Make a payment	View a project	Manage a user
Full Admin	✓	✓	✓	✓	✓	✓	✓	✓
Ticket Manager	✓	✓	✓	✓			✓	
Billing Admin	✓	✓	✓		✓	✓	✓	
Ticket Read-Only	✓		✓					
Standard User	✓	✓	✓					
No Access								

**PLEASE NOTE:**

Invoices, payments and projects are not available through the Portal at this time.

User roles can be edited one at a time or in groups. To select users, check the box next to the users names:

The screenshot shows a user management interface. At the top left is a blue button labeled "Add User" with a pencil icon to its right. Below this is a table with three rows. The first row has a header with a checkbox and the text "NAME". The second row has a checked checkbox, the name "Jonathan Test", and a pencil icon. The third row has an unchecked checkbox and the name "Katelyn Test". The fourth row has a checked checkbox and the name "Laura Test".

Checking any box will activate the edit icon (the pencil icon). Click on the icon to open the edit dialog:

This is a close-up of the edit icon (pencil) from the previous screenshot. A blue arrow points from the right towards the pencil icon. Below the pencil icon is a small button labeled "Edit".

Select the role you wish to assign the user(s) and click "Save".

### Permission Role

Change the permission role for 2 selected users

**Full Admin**  
 This role has full functionality for all administrative features

**Ticket Manager**  
 This user can create tickets for other users and comment on existing tickets and view projects

**Billing Admin**  
 This user can pay invoices as well as submit their own tickets and view projects

**Standard User**  
 This user can create their own tickets and can comment on existing tickets

**Ticket Read-Only**  
 This user can only read their own tickets and cannot create them

**No Access**  
 This user is prohibited from accessing the portal and can no longer log in

Cancel
Save

To update a user's contact information, click on the user (each user will turn grey as you hover your mouse over it):

<span style="border: 1px solid #0070c0; padding: 2px 5px; margin-right: 5px;">Add User</span> <span style="font-size: 1em;">✎</span>		
<input type="checkbox"/>	<b>NAME</b>	<b>EMAIL</b>
<input type="checkbox"/>	Jonathan Test	jrakestrawtest@mycrstar.com

This will open the "Update contact" dialog:

### Update contact

First name

Last name

Email address

Phone number

User role

Click "Save" to save your changes.

The Health Catalyst Registry and Technical Support Staff frequently work with clients assisting with routine support issues that occasionally require the Health Catalyst representative to see screen shots of abstracts, reports or to know the identity of a particular case to identify possible software related issues. The confidentiality of these records is of utmost importance. Health Catalyst has strict internal policies in dealing with PHI and we ask that our clients adhere to the guidelines listed below to assure that we comply and do not breach patient confidentiality.

1. All data exported via Internet or e-mailed containing patient identifiers must be encrypted.
2. In the event hard copies containing patient identifiers are received in any Health Catalyst office, they will immediately be shredded.
3. Faxes containing PHI must be redacted prior to transmission. Any faxed information not redacted is shredded.
4. Please do not email or leave a voice mail for the Health Catalyst representative with any PHI data.
5. Please do not enter PHI in the "Issue" when submitting a support request through the Support Portal. If this is done, the Health Catalyst representative that picks up the support call will delete the PHI from the portal call. This information can be obtained by the Health Catalyst representative via phone call.
6. Do not send attachments via the support portal containing screen shots or reports with patient information.
7. Accession number should be used as a patient identifier. It is acceptable to include such information as site, sequence, and hospital code.
8. Information that is not acceptable to include are: Name, Address, Social Security Number, Phone Number, Date of Birth and Medical Record Number. If such information is required by an Health Catalyst employee, a phone call to the client, a GTM session or an encrypted attachment is acceptable.
9. It is the responsibility of the Cancer Registry Manager/Supervisor to share this information with all new employees and or contract employees.
10. This policy does not replace any BAA agreement between Health Catalyst and the facility.

We appreciate your cooperation with this policy to keep your data safe!

## Chapter 10 CRSTAR SHORTCUTS

Additional shortcuts have been added for convenience: Patient Lookup, Select A Pop, Print Abstract, Print Tx Summary, Delete an Abstract, Copy Abstract, Print a Demand Letter, Print SCP, and Registry



Resources (weblinks). These shortcuts are located on the bottom of the left-hand navigation panel once logged into CRStar. These shortcuts take users directly to the task menu to perform that selected function.

The screenshot displays the CRStar Dashboard interface. On the left is a navigation panel with various menu items. The main content area is divided into two sections. The left section, titled 'Suspense By Site', shows a pie chart and a table of site data. The right section, titled 'Quality Measures (v.22)', shows a horizontal bar chart and a legend of quality measure categories.

**Navigation Panel (Left):**

- DASHBOARD
  - Dashboard
- ABSTRACT MANAGEMENT
- FOLLOW UP MANAGEMENT
- REPORTING
- SYSTEM ADMINISTRATION
- SYSTEM MANAGEMENT
- PREFERENCES
- HELP
- CRStar REPORTING
- Logout
- CRStar Shortcuts
  - Patient Lookup
  - Select A Pop
  - Print Abstract
  - Print Tx Summary
  - Delete Abstract
  - Copy Abstract
  - Print Demand Letter
  - Print SCP
  - Registry Resources

**Suspense By Site (Left Panel):**

Report Type: Suspense By Site  
Admit/First Cont Date: 01/01/2021 - 02/03/2023

**Site Data Table:**

Site	Cases	Percent
Breast	7	17.5%
Blood & Bone Marrow	4	10%
Lymph Nodes	3	7.5%
Lung	3	7.5%

**Quality Measures (v.22) (Right Panel):**



Report Type: Quality Measures  
ERS Hospital Systems  
Dx Date: 01/01/2020 - 02/03/2023

**Quality Measure Legend:**

- Breast - Chemo 0/0
- Breast - Hormone 0/0
- Breast - Noodle Bx 5/13
- Breast - Rad/Const 1/2
- Breast - Rad/Mast 0/0
- Breast - Rad/Const 0/0
- Colon - Chemo 0/0
- Colon - Lymph Nodes 0/0
- Gastric - Chemo 0/0
- Gastric - Lymph Nodes 0/1
- Lung - No Surgery 0/1
- NSCLC - Chemo 0/0
- Rectal - Radiation 0/1
- Rectal - Resection 0/1
- Rectal - Radiation 0/1
- Head and Neck - Radiation 0/0
- Melanoma - Adj. Therapy 0/0

## Chapter 11 FAQs

### Frequently Asked Questions

- How do I enter a new patient? While in **Patient Abstract on Lookup Screen**, if the patient ID/Name does not appear, click the **New Patient** Button at the bottom left of the screen.
- How do I add a primary to an existing patient? While on the **Patient Maintenance** screen of the patient, click the **New Primary** Button located under the grid listing the patient primaries.
- How do I move to the next screen while on the **Patient Maintenance Screen**? While on **Patient Maintenance Screen**, click the **Select** button next to the primary to access.
- Where do I enter the contact/next of kin information? On the **Patient Maintenance** page of abstract, there are 2 sections at the top: **Patient** displays the patient info and **Contacts** displays contact/next of kin information. Click the **Contacts** button to enter contact/next of kin information. The button displaying information will appear white while the information under the tab that is not displayed is in **BLUE**.
- Where do I enter text? On most Screens, on the far-right side bottom of the screens notice the **TextPad** button, once clicked, the text screen pops up. All text fields are available here. Be sure to scroll to view all the text fields.
- How do I navigate around the abstract, move from field to field? Use the tab key verses the enter key to move from field to field.
- Are there help screens? While in any field, click on the ? Icon located on the top of each screen.
- Why is the Treatment Information I entered not being saved? Remember when entering treatment, click the treatment modality and enter the treatment. User must click **Save** before exiting.
- How do I enter NO Treatment? When there is no treatment given, on the **Treatment Summary** screen, enter a "0" in the **Rx Summ Status** field located at the top of the page. Then once the **Rx Summ Status** field is filled in, the **Initial Rx Date** field becomes active, then enter the date no treatment was decided.
- Where do I enter Treatment text? Treatment text can either be entered within each treatment window or on the text screen on the far-right side bottom of this screen, notice the **TextPad** button, once clicked, the text screen pops up. Information entered on the treatment section of the **TextPad** transfers to the text boxes located within each treatment window and vice versa.
- Are the CPM, BPM and RPM Screens mandatory to complete? None of the information collected on the CPM, BPM or RPM screens is required by any standard setter and none of the information recorded here is exported. While these fields are very useful to monitor the standards and will be utilized in future reports to generate information for the SAR Application, if a facility does not collect this information, click the **Case Admin Tab** located at the top of the screen to bypass these screens completely.
- How do I run Edits? To run the edits at the end of the abstract, click the >> on the top right side of the screen. Click on the genedits icon from the **Quick Link** selection.
- How do I adjust the screen size? Press **Control and +** to increase size or **Control and -** to decrease size. Another option is to use the zoom feature in Google Chrome. Click on the icon that looks like 3 dark lines  on the right top of the screen and adjust the zoom. (Another tip, make sure the  screen resolution settings are set to the optimal defaults for the monitor you are using.)

## MISCELLANEOUS

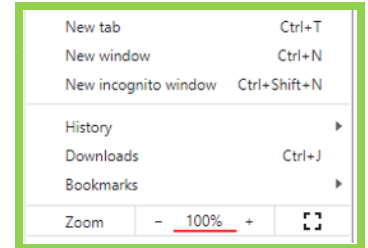
### Screen Distorted

There are several factors that can affect the screen display of text and applications on your computer. You may need to adjust one or more of these settings to allow CRStar to display properly on your screen.

#### 1) Change Zoom Level in Chrome:

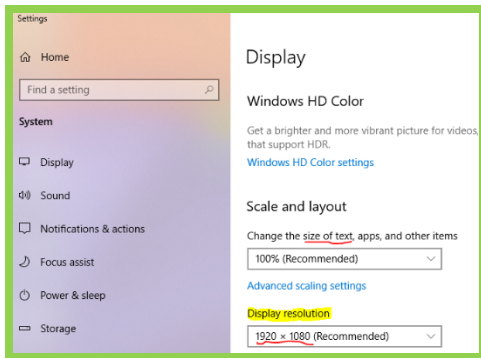
- Hit ctrl and + to zoom in.
- Hit ctrl and - to zoom out.  
or
- Click the menu in the upper-right corner of Chrome and change the zoom level here.

I would recommend starting with a zoom level of 100% until we know that this is not the issue affecting your screen display.



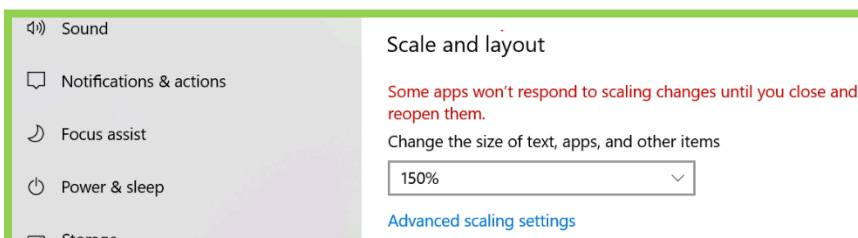
#### 2) Changing Screen Resolution:

- Right-click on desktop.
- Choose "Display Settings".
- From here, choose a screen resolution for the monitor that is high and preferably a "recommended" resolution. In the screenshot below, note it set to 1920 x 1080, but this may vary depending on the computer and monitor.



#### 3) Check and make sure the Text Size settings on your pc are set to 100% and not 125% or 150%.

- From the same screen (above) where the screen resolution is changed, navigate to the option to "Make text and other items larger or smaller". Changing this from 100% can adversely affect how things appear on the screen. If it is set to "Larger - 150%" a warning may appear regarding this, so make sure it is set to 100%, until this is ruled out as the cause of the issue.



## Control, Shift, Alt Keys

### Keyboard Shortcuts

Function	Shortcut
Select All	Control-A
Deselect All	Control-Shift-A
Copy	Control-C
Get Text or Image	Control-D
Item Duplicate	Control-Alt-Shift-D
Search and Replace	Control-F
Lock Item	Control-L
Lock Item Size	Control-Shift-L
Group Items	Control-G

Document Information	Control-I
Delete Item	Control-K
New File	Control-N
Open File	Control-O
Print	Control-P
Quit	Control-Q
Save	Control-S
Save As	Control-Shift-S
Ungroup Item	Control-Shift-G
Paste	Control-V
Close File	Control-W
Cut	Control-X
Edit with Story Editor	Control-Y
Undo	Control-Z
Redo	Control-Shift-Z
Select All	Control-A
DeSelect All	Control-Shift-A
Zoom to fit	Control-0
Zoom to 100%	Control-1
Zoom In	Control-Plus
Zoom Out	Control-Minus
Zoom In/Out	Control-Mousewheel
Smart Hyphen	Control-Shift-Minus
Non Breaking Space	Control-Space
Insert Page Number	Control-Alt-Shift-P
Raise	Control-Home
Lower	Control-End
Raise to top	Home
Lower to bottom	End
Frame Break	Control-Return
Column Break	Control-Shift-Return
Stacked Objects, next in Z-order	Control-Shift-LMouse
Resizing object when other object on top	Control-drag
Resize proportionally	Control-drag
Move image in image frame without entering frame edit mode	Control-Alt-drag
Move frame/group with X/Y constrained	Control-drag
Rotate a line or when creating a line, constrain the angle of rotation	Control-drag and rotate
Rotate an existing item on the page other than a line and constrain the angle of rotation	Control-drag and rotate
Resize to a square	Shift-drag
New Line	Shift-Return
Scale text	Alt-Shift-drag

Scale text proportionally	Alt-Control-drag
Move item 1 unit (current: pt,mm,in,c,p,cm)	Arrow keys
Move item 0.1 units (current: pt,mm,in,c,p,cm)	Shift+Arrow keys
Move item 10 units (current: pt,mm,in,c,p,cm)	Control+Arrow keys
Move item 0.01 units (current: pt,mm,in,c,p,cm)	Control+Shift+Arrow keys
Resize item 1 unit outwards (current: pt,mm,in,c,p,cm)	Alt+Arrow keys
Resize item 1 unit inwards(current: pt,mm,in,c,p,cm)	Shift+Alt+Arrow keys
Move to start of paragraph in text edit mode on canvas	Control Up Arrow
Move to end of paragraph in text edit mode on canvas	Control Down Arrow
Move to start of frame in text edit mode on canvas	Control Page Up
Move to end of frame in text edit mode on canvas	Control Page Down
Resize image while in image frame edit mode on canvas	Alt+Arrow keys

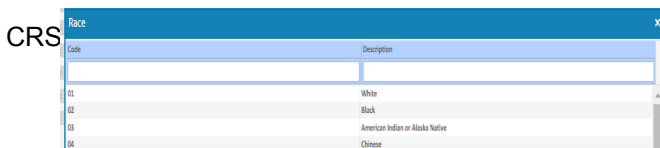
## Mouseless Navigation

A new feature has been added to the abstract called "Mouseless Navigation". This feature is available in both the full abstract, as well as in the rapid abstract. As the feature implies, the user can move through the abstract, access drop downs, and make selections, move between tabs on a screen and use the navigation buttons without using the mouse.

### Summary of Key Functions:

- Tab key: Moves from one field to the next field and moves through the navigation buttons at the bottom of the screen.
- Shift Tab: Moves from a field back to the previous field.
- Down Arrow key: Launches drop down window.
- Enter key: Makes a selection in a drop down.

### Drop downs:



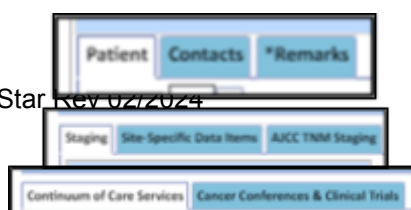
- Down arrow - launches drop down window to open.
- To search - start typing in the code or description field.

## Patient Primary Grid:

SOC\_SEC\_NBR - 999-99-9999

- When the user tabs through all fields and tabs on the patient screen, the cursor will go to the Delete button first and then through all fields of the first row until it reaches Select.
- If the cursor lands in any field that has a drop down option, the down arrow key can be used to launch the look up window and the instructions on page 1 may be followed.
- If the user continues to use the tab key, the cursor will move through all three rows until it reaches the New Primary button.
- If the user is on a row and wishes to select that case to move to the Diagnosis screen, tab through until Select is highlighted, then hit Enter.
- If changes have been made, from the New Primary button the cursor will move to the Save button. Hitting Enter will engage the save.
- The cursor will move from Save to Exit and hitting enter here will exit the screen. To go back up to select a primary, use the mouse.

Moving to Other Tabs on the Same Screen:



Accessing the Navigation Buttons:

- Screens with multiple tabs, such as the patient, staging, Surgery Maintenance, etc., advancing through all fields on the screen activates the new tab. Or simply clicking on the screen label at the top.

Accessing the Navigation Buttons:

- On each screen, when the user is in the last field, using the tab key will move to the navigation buttons at the bottom of the screen.
- As the user tabs through each button, they will become highlighted.
- Hitting Enter will engage the button, i.e., Save, Next, Previous, etc.
- Screen tabs populate at the top once the diagnosis screen is activated. To change screens, click the screen tab of choice at the top of CRStar. There are also the Previous and Next Command buttons at the bottom of the screen to work screen to screen. Using the down arrow key will engage the choice options.
- When on the Text Pad button, hitting enter will display the text fields.
- After tabbing through the last text field on the text pad, the next tabs will highlight the Cancel and Save & Exit command button. Clicking enter will perform the command.

Treatment Summary Screen:

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