**EXAMPLE POLICIES AND PROCEDURES**

**Title/Description: Case Ascertainment** 
**Policy Number: 1**
**Departments Affected:** Hospital / Provider-Wide (Health Information Management)
**Topic:** Case-finding/Suspense

| **Effective Date:** | **Reviewed/Revised**: **Date:** 5/2005 | **Approved by**: CANCER COMMITTEE | **Prepared by**: |
|---|---|---|---|

**PURPOSE**

A. Describe the goals of a hospital-based case-finding and suspense system.
B. List the hospital departments that provide case-finding information.
C. Describe the preferred methods for identifying new cancer cases.
D. Describe methods for monitoring case-finding.

**DEFINITIONS**

Case ascertainment is the systematic process used to identify all cases eligible to be included in the cancer registry database. Reportable is defined as what must be included in the case-finding process according to the screening list of ICD-9 cases for case-finding. (See Attachment #1 Screening List of ICD-9 Codes for Case-finding.)

**GOAL:**

To identify "all" reportable cancer cases diagnosed, treated and/or evaluated at XXXX Hospital. The cancer registrar is responsible for identifying all cancer cases according to the requirements of XXXX Hospital, the American College of Surgeons and the Illinois State Cancer Registry. Localized squamous and basal cell carcinomas of the skin are reportable by agreement, meaning they are to be accessioned and abstracted, but not transmitted to the state. The cancer registrar is responsible for monitoring the completeness of case-finding through various quality control procedures.
The Reportable List is maintained in the cancer registry with copies available in the Department of Pathology.

**IDENTIFYING SOURCE DOCUMENTS:**

•Pathology and Cytology documents
•Disease Index of ICD-9 Cancer Coded Cases (Inpatient and Outpatient)
•Inpatient and Outpatient Medical Records
•Radiation Oncology treatment summaries
•Hematology/Oncology Center documents

**CASEFINDING METHODS:**

The following sources are to be used to identify potential new cancer cases.

Disease Index: The cancer registrar shall obtain a computerized list from the hospital Information Systems department that contains the disease index for the cancer registry. The Director or Assistant Director of the Health Information Department generates this list.

Inpatient and Outpatient Chart Review: Charts pulled from the disease index to review for inclusion in registry.

Pathology and Cytology Reports: The Department of Pathology sends to the cancer registry on a daily basis all pathology and cytology reports. The registry reviews all cases, filtering for cases that show a malignant disease and those that are possibly malignant.

Oncology Reports: The registry performs manual review of Radiation Oncology treatment summaries and Hematology/Oncology Center reports to determine those cases that may be diagnosed clinically. Radiology reports are filed separately in date order in the Health Information Management Department.

**SUSPENSE FILE:**
Once a case has been identified from any one of the listed sources above, the registrar needs to determine if: this is a new **suspense case**, a case already abstracted or a case already entered as a suspense case. If this is a new case and is not in suspense the case needs to be entered into the ERS Suspense System (follow the ERS manual for entering a new case into the suspense system). If this case is already abstracted, the registrar needs to investigate whether patient is having a recurrence or a new primary diagnosed or if this is just a routine follow-up visit. Follow the policy on documenting the proper follow-up information.
The paper case-finding sources are keep manually until the case is abstracted at which time they are filed in the registry by accession year and patient name (alphabetical).

**COMPLETENESS MONITORING:**
Monitoring completeness of case-finding shall be done to ensure complete reporting of all reportable cases. The Illinois State Cancer Registry monitors case-finding on an annual basis reviewing 3-4 months of case-finding documents.

**References:**

American College of Surgeons, *Commission on Cancer, Cancer Program Standards,* 2004, Chapter 2.
"Cancer Registry Management Principles and Practice", second ed., NCRA, 2004.
International Classification of Diseases, Third Edition, ICD-O-3, World Health Organization

**Date Revised:** _____
**Date Reviewed:** _____
**Date Initiated:** _____

**Title/Description: TNM Staging** 
**Policy Number: 2A**
**Departments Affected:** Hospital / Provider-Wide (Health Information Management)
**Topic:** Procedure for staging

| **Effective Date:** | **Reviewed/Revised Date:** | **Approved by:** | **Prepared by:** |
|---|---|---|---|
| | 5/2005 | Cancer Committee | |

## PURPOSE

To define proper procedure for TNM Staging, which is a required component for all reportable and eligible cases in an approved cancer program.

## POLICY

Every analytic case eligible for TNM staging, with a staging scheme in the AJCC TNM Staging, 6th edition Manual must have a staging form on the hospital or oncology chart. For cases diagnosed before 2005, the registry is responsible for placing a pre-printed site appropriate form on the hospital chart at time of abstracting. The demographics section must be filled out, and physician name (see staging assignment hierarchy below) with diagnosis date written above patient name section. The form is then attached to front of chart and returned to medical records department where a deficiency is to be added to the physician's work queue to be completed and then returned to registry for review. In the event a stage is questioned, the registrar will resubmit to the physician with additional documentation or information and review again. If there is still an issue, the Cancer Program Director or Cancer Committee Chair will review the case.For cases diagnosed as of January 01, 2005, the coding department in Medical Records will be placing TNM forms on every chart with a new reportable diagnosis and assign to appropriate physician. Registry will then review completed stage and enter it into the electronic abstract following the above instructions as before.

## STAGING RESPONSIBILITY HIERARCHY

1. Surgeon, if patient has cancer-directed surgery.
2. Oncologist, if patient has cancer-directed treatment.
3. Physician who performed biopsy or diagnosis if no treatment performed at this institution.
4. Managing physician, if a clinical diagnosis only made.
5. Cancer Committee designee if none of the above is able to stage the case.

**Date Initiated: _____**
**Date Revised: _____ Date Reviewed: _____**

**Title/Description: TNM Staging Procedure** 
**Policy Number: 2B**
**Departments Affected:** Hospital / Provider-Wide (Health Information Management)
**Topic:** Procedure for staging

| **Effective Date:** | **Reviewed/Revised Date:** | **Approved by**: | **Prepared by**: |
|---|---|---|---|
| | 5/2005 | Cancer Committee | |

**Staging Procedure –** XXXX Hospital for cases beginning January 1, 2007
In order to accommodate electronic medical record implementation at XXXX Hospital, staging forms will be sent to physicians for completion and then provided to Health Information Management for scanning into the electronic record.

**Procedure**
Approximately mid-month, run a suspense list following procedure below:
In ERS, select **Reporting,** then **Adhoc**
In Adhoc, select **Rpt_file**
From Label drop down, select **Reporter Staging Forms**
From Filename drop down, select **SUNA**
In **Selection Attr**, change Admit date to date of suspense month prior to current month, i.e. in February, select cases from January.
Select **Transfer to Excel**
Save excel sheet to C: and name of month - staging, i.e. January Staging.
In **C:** open the **January Staging** spreadsheet and adjust columns to accommodate text in the columns.
Highlight columns with text – Name, MR#, Admit Date and Site and using right mouse key, select **Copy.**
From **My Documents**, select and open **STAGE TRACKER**
In cell below last patient in TRACKER, place cursor and using right mouse key, select **Paste.**
Pull path reports from suspense file for the month you are working with prepare mailing.
Copy path report and prepare staging from for each case with patient name, MR#, Managing physician name and XXXX Hospital.

**Policy Number: 2B**
**Departments Affected:** Hospital / Provider-Wide (Health Information Management)
**Topic:** Procedure for staging

| **Effective Date:** | **Reviewed/Revised Date:** | **Approved by**: | **Prepared by**: |
|---|---|---|---|
| | 5/2005 | Cancer Committee | |

**Procedure**: (continued)
Place cover letter, staging form, copy of path report and business reply envelope in mailing envelope. Use 9 x 12 envelopes for multiple forms when needed. Update STAGE TRACKER with the following:
Physician staging form being sent to – *see Staging Responsibility Hierarchy.
Date sent.
In cases for which there is no AJCC staging schema or another reason staging is not required, enter **NA** in **Date Sent** column and reason in **Comments.**
When information completed for each patient, **Sort** cases so that entire list is in alphabetical order and **Save** STAGE TRACKER. (To sort, place cursor in first cell of spreadsheet with patient name and select **AZ↓** from toolbar.)
Enter date received as each staging form is returned and take completed staging form to Health Information Management.
Prior to sending next month's forms, make follow-up calls to check on form completion of cases sent out during previous month.
At end of the next month, i.e. end of March for January cases, compile list of outstanding forms with patient name, MR#, physician name and date sent and provide to HIM for so that they can contact physicians.

**Date Initiated: _____**
**Date Revised: _____** **Date Reviewed: _____**

**Title/Description: Registry and Confidentiality Policy/HIPAA Policy** 

**Policy Number: 3**

**Departments Affected:** Hospital / Provider-Wide (Health Information Management)

**Topic:** Registry compliance with confidentiality guidelines

| **Effective Date:** | **Reviewed/Revised Date:** 5/2005 | **Approved by**: Cancer Committee | **Prepared by**: |
|---|---|---|---|

**CONFIDENTIALITY:**

Federal laws pertaining to cancer registry are designed to protect patient privacy. The National Cancer Registry Act of 1971 mandates the collection, analysis and dissemination of data for use in prevention, diagnosis and treatment of cancer. The National Program of Cancer Registries (NPCR) Public Law 102-515, The Cancer Registries Amendment Act of 1992, grants the Centers for Disease Control and Prevention authority to implement, monitor and assist population-based cancer registries in the collection and maintenance of cancer data. The Illinois State Cancer Registry mandates that all health care facilities report newly diagnosed cancer cases. Each of these laws has the intent of protecting patient privacy while also allowing data to be used forresearch and surveillance purposes. See also the included Hospital's HIPAA policy for further information.

**Departments Affected:** Hospital / Provider-Wide (Health Information Management)

**Topic:** Registry compliance with confidentiality guidelines

| **Effective Date:** | **Reviewed/Revised**: **Date:** 5/2005 | **Approved by**: Cancer Committee | **Prepared by**: |
|---|---|---|---|

XXXX Hospital is committed to maintaining the confidentially of cancer patient information. All data obtained by the Cancer Registry on malignant diseases shall be considered confidential and shall be used only for statistical, scientific and medical research and for reducing the morbidity or mortality of malignant diseases to the extent possible. This includes data collected from physician offices and other health care facilities. The cancer registry staff shall sign a confidentiality pledge statement annually indicating their commitment to patient confidentiality.

**Title/Description: Clinical Management/Cancer Conference** 
**Policy Number: 4**
**Departments Affected:** Cancer Registry (Health Information Management)
**Topic:** Cancer Conference Management

| **Effective Date:** | **Reviewed/Revised**: | **Approved by**: | **Prepared by**: |
|---|---|---|---|
| | **Date:** 5/2005 | Cancer Committee | |

**GOAL:**

1. 1.Multi-modality and interdisciplinary cancer case reviews are conducted on a regular basis to ensure patients' access to consultative services by all disciplines. Interdisciplinary cancer conferences provide prospective patient case review and assures quality of care evaluation related to diagnosis, treatment, follow-up, rehabilitation, and supportive care. Prospective is defined as prior to treatment or at any time a clinical treatment plan is reviewed for further evaluation.
2. The cancer conferences contribute to the education of all health care providers.
3. 4.Cancer Conferences are held on a weekly basis in accordance with the requirements of the American College of Surgeons for Approved Cancer Programs for a Teaching Hospital Cancer Program.Category I credits are given for the conference. The CME credit sheets are printed out by the medical education staff and distributed at the meetings.

**Policy Number: 4**
**Departments Affected:** Cancer Registry (Health Information Management)
**Topic:** Cancer Conference Management

| **Effective Date:** | **Reviewed/Revised**: **Date:** 5/2005 | **Approved by**: Cancer Committee | **Prepared by**: |
|---|---|---|---|

**CANCER REGISTRY'S ROLE:**
Distribute cancer conference notices in various posting locations on campus. Seven days before the conference, the registrar makes calls to the office of the physician scheduled to present, to obtain the information about the case they are to present. The registrar will ask the Cancer Program Director to select and present cases for discussion as a last resort and only if none are submitted by scheduled physicians.Coordinate cancer conference schedules/notices with patient information to Pathology, Radiology, Surgery, Internal Medicine (including patient's primary care physician, Radiation Oncology and Medical Oncology.Maintain attendance records including names and specialties of the attendees, whether the case is prospective or retrospective.

**References:**
American College of Surgeons, *Commission on Cancer, Cancer Program Standards, 2004*
"Cancer Registry Management Principles and Practice", second edition, NCRA, 2004.

**Date Initiated: _____ Date Revised: _____**
**Date Reviewed: _____**