Cancer Registry Quality Control
Geisinger’s Plan

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Geisinger Service Area
Geisinger Health System Cancer Registry

Three CoC-accredited Cancer Programs

- Geisinger Medical Center - ACAD Program
  2,700 New Analytics Cases/Year

- Geisinger Wyoming Valley Medical Center - CCCP Program
  1,500 New Analytic Cases/Year

- Geisinger Lewistown Hospital - CCP Program
  275 New Analytic Cases/Year

- All facilities separately licensed and CoC-accredited
- One centralized cancer registry database
- Standardized Policies and Procedures
- 10 CTRs, 1 Follow-up Clerk, Mgr Cancer Registry
- Cancer Registry Subcommittee
CoC STANDARD 1.6

Cancer Registry Quality Control Plan

Each calendar year, the cancer committee establishes and implements a plan to annually evaluate the quality of cancer registry data and activity. The plan includes procedures to monitor and evaluate each required control plan component.

Definition and Requirements

- Multiple areas of cancer registry activity
- Accuracy and completeness of abstracted data
- Cancer Registry Quality Control Coordinator
  Monitors each area of activity
  Recommends corrective action if needed
  Reports results, recommendations and results of recommendations at least annually
Minimum Requirements for Quality Control Plan

1) Sets the review criteria
   - Which data elements will be reviewed?

2) Sets the quality control timetable
   - Will the activity be performed monthly, bi-annually, or on an annual basis?

3) Specifies the quality control methods, sources, and individuals involved
   How will the activity be carried out, who will be included, where will the information come from, how will findings be documented?
   a) Required activities:
      » Random sampling of annual analytic caseload
      » Physician review (reviewers may include residents & other physicians not necessarily on the cancer committee)
   b) External audits (such as state or central cancer registry case-finding audits) may be used to fulfill part of this requirement
Minimum Requirements for Quality Control Plan

4) Identifies the activities to be evaluated.

**Required activities:**

a) Casefinding
b) Abstracting timeliness
c) Accuracy of abstracted data
   - Class of Case
   - Primary Site
   - Histology
   - AJCC Stage or other appropriate staging system
   - First course of treatment
   - Follow-up information
d) The percentage of information coded as unknown
e) NCDB data submission, correction of data errors, and resubmission of corrected data
Minimum Requirements for Quality Control Plan

5) Defines the scope of the evaluation.
   Required scope:
   a) Minimum: 10 percent of annual analytic caseload
   b) Maximum: 300 cases annually

6) Establishes the minimum quality benchmarks and required accuracy. Cancer registry data submitted to the NCDB meet the established quality and timeliness criteria included in the annual NCDB Call For Data.

7) Maintains documentation of the quality control activity.
   a) Required documentation
   b) Review criteria
   c) Cases reviewed
   d) Identified data errors and resolutions
   e) Reports findings to the cancer committee annually
Revisions & Updates to Quality Control Plan

- Annual Process – part of the HIM Department Manual & available system-wide via Geisinger's Infoweb.
- Additional approvers assigned within the plan are cancer committees for all 3 facilities and Associate VP, HIM.
- Current CoC Standards Manual is reviewed for any changes. Cancer Registry Mgr/Cancer Registry Quality Control Coordinator updates QC plan as needed.
- Cancer Registry Quality Control Plan presented & discussed at Cancer Registry Subcommittee meeting, changes incorporated if needed, and approved by physicians.
- Approval date is added to the plan, Asst VP, HIM reviews and approves. Plan is published in online HIM Dept Manual.
- Reported to Cancer Committee.

Geisinger QC Plan Purpose Statement

To ensure high quality cancer registry data for accurate assessment of treatment outcomes and patient survival. To provide a means to evaluate and monitor multiple areas of cancer registry activity including data collection and dissemination in compliance with Commission on Cancer, Cancer Program Standards: Ensuring Patient-Centered Care, 2016 Edition, Standards 1.6, 5.1, 5.2, 5.5, 5.6. To monitor compliance with the College of American Pathologists (CAP) protocols, Standard 2.1.
Responsibilities

**Cancer Registry Quality Coordinator:** Works in collaboration with the Manager, Cancer Registry (if not same individual) to monitor each area of cancer registry activity, recommends corrective action if needed, and reports findings at least annually to the cancer committee.

**Cancer Committee:** Annually establishes and implements the quality control plan to evaluate and monitor cancer registry activity; implements corrective action for areas that do not meet CoC standards and/or cancer committee requirements.

**Responsibilities**

**Cancer Committee:** ensures the following:

1) The accuracy and completeness of abstracted data.
2) Casefinding is reviewed annually & 100% reporting compliance is achieved.
3) Annually, complete data for the NCDB Call For Data is submitted in compliance with established criteria. (Std 5.5)
4) Annually, cases submitted to NCDB that were diagnosed on or after 1/1/03 meet the established quality criteria & resubmission deadline specified in the annual Call For Data. (Std 5.6)
5) From initial enrollment & throughout the 3 year accreditation period, the program actively participates in RQRS & all eligible cases for all performance measures are submitted. (Std 5.2)
Responsibilities

Cancer Committee: ensures the following:

6) Case abstracting is performed by, or under supervision of a CTR. (Std 5.1)
7) Compliance with CAP protocols using synoptic format for 95% of eligible path reports containing a cancer diagnosis is achieved. (Std 2.1)

How is This Accomplished at Geisinger?

- Physician quality reviews of cancer registry abstracting with a minimum 10% random sample of annual analytic cases, 300 case maximum.
- CTR staff peer reviews to include: abstracting, casefinding, and follow-up.
- PCR annual case reconciliation.
- Pathologist review of a minimum, random sample of 10% of cases eligible for CAP protocols, 300 case maximum.
- Cancer registry report of NCDB submissions and results to Registry Subcommittee and Cancer Committee.
- CLP semi-annual reporting of RQRS data and performance at cancer committee meetings. Abstracting timeliness reporting at bi-monthly Cancer Registry Subcommittee meetings and at least semi-annually at Cancer Committee meetings by registry.
How is This Accomplished at Geisinger?

- Annual Quality Control Review – Percentage of information coded to unknown.

Policy: The NCDB Data Completeness and Default Overuse Report is reviewed annually with a focus on areas that do not meet the NCDB benchmark. A minimum of one area with a high percentage coded to unknown is chosen for study. The review will be completed and presented to Cancer Committee within 11 months.

How is This Accomplished at Geisinger?

- Cancer Registry Plan for CTR supervision of non-credentialed staff that perform cancer registry abstracting.

Policy: All non-CTR staff who are in the 3 yr grace period and considered fully trained in case abstraction are supervised by a CTR and are quality reviewed quarterly by the same methods used to evaluate CTR abstracting accuracy. Accuracy must be 95%. All non-CTR staff who are in training for case abstraction are supervised by a CTR and undergo quality reviews for 100% of their cases.
Quality Control Plan Layout

• Quality Control Plan lists each activity accompanied by the policy, criteria, timetable, individuals involved and their responsibilities, minimum quality benchmark and quality control methods & sources including details for registry staff to carry out their task.

Required Activities To Be Evaluated - Example
Accuracy of abstracted data

- Physician Quality Control Review Cancer Registry Abstracting
- Case abstraction Peer Review
- Follow-up Peer Review
- Quality Control Review – Percentage of information coded as unknown
Physician QC Review – Cancer Registry Abstracting

- **Policy:** Cancer Committee will review a minimum 10% random sample of annual analytic cases, to a max of 300, to ensure the accuracy and completeness of abstracted data.
- **Frequency:** Biannually
- **Required accuracy rate for each area of review:** 90%

- **Items reviewed:** Class of case, primary site, histology, AJCC Path Stage, CS, First course of treatment

- **Participants:** Physician members of Cancer Committee (exception – Radiologist & Pathologist), minimum two CTRs. A non-committee physician can also be involved depending on need. Cancer Registry Quality Coordinator/Manager, Cancer Registry

**Responsibilities:**

- **CTR –** selects random analytic cases based on top 5-6 sites, (minimum 10% of analytic caseload), prepares & distributes audit packets, assists reviewers as needed, reviews potential errors identified by physicians, corrects errors in cancer registry database if needed.
- **Cancer Program Physician –** reviews cancer registry data for accuracy comparing abstract to EPIC EHR, documents findings on cancer registry quality control form.
- **Cancer Committee Chair –** resolves abstracting issues between registrars and physician reviewers if needed.
- **Cancer Registry Quality Coordinator/Mgr, Cancer Registry –** communicates with physician reviewers to explain CTR documentation if CTR does not agree with identified potential error & follows to resolution, collates & summarizes findings reports findings to Cancer Committee monitors the quality of registry data, recommends corrective action if the activity falls below the annual goal or requirements, directs re-education if needed, maintains documentation of the activity.
Physician Review EMR Guide

C:\Users\ceisenhower\Desktop\S 25 PHYSICIAN CHART AUDIT EMR GUIDE.docx

Physician Review QC Form

C:\Users\ceisenhower\Desktop\S 26 PHYSICIAN CHART AUDIT FORM_revision 090712.xls
Geisinger Cancer Registry Quality Control Plan

- C:\Users\ceisenhower\Desktop\S 29 Geisinger Quality Control Plan.pdf

Issues Encountered - Process

- Staff buy-in for Peer Review process
- Finding enough time to complete reviews or prepare packets for physician reviews
- Physicians not completing reviews in a timely manner
- Physicians not understanding abstracting guidelines
Issues Identified - Data

- **Casefinding Review**
  a) Melanocytic proliferation
  b) Cicatrix

- **Abstracting Review**
  a) Class of case
     Multiple clinics, some hospital based & covered under facility license, some operating under different corporate entity
  b) Clinical T – Tis
  c) Bx if removes all tissue

- **Data Completeness Review**
  a) LVI
  b) Medical Oncologist NPI

- **Follow-up Peer Review**
  a) Expired patient – marked as not followed but vital status not changed
  b) Disease status change, recurrence field not updated
QUESTIONS?