Northside Hospital Cancer Institute (NHCI) Organizational Overview

- Three not-for-profit hospitals, located in metro-Atlanta, with total of 838 licensed beds.
- NHCI affiliated outpatient centers and medical office buildings throughout Georgia, including recent partnership with two large oncology practices.
- More than 2,200 physicians on staff and 8,200 employees.
- Approximately 700,000 patient encounters annually.

Program Highlights

- Blood & Marrow Transplant Program at NHCI ranked among the best in the U.S. for fifth consecutive year for having the excellent survival rates for matched & unrelated donors (MUD)/allogeneic transplants.
- More cases of breast and GYN cancer diagnosed and treated than any other comprehensive community cancer hospital in the Southeast.
- Fully accredited by American College of Surgeons Commission on Cancer (CoC) & National Accreditation Program for Breast Centers (NAPBC).
- Our program also consists of screenings, genetics, research, support, survivorship, and palliative care
Then...

**Impacting Patient Care through RQRS**

- RQRS model innovative
  - Data used in real-time and central software to keep track of compliance.
- Data utilized in an impactful way to prevent patients from ‘falling through the cracks’
  - Appealed to physicians and energized registry staff
- Administration also interested, especially in light of the national discussions on pay-for-performance.

**NHCI RQRS Start: Beta Site**

- In 2009, all CoC hospitals in the State of Georgia were invited to participate in the Beta Testing of RQRS.
- Dr. Joseph Lipscomb, member of the CoC Quality Integration Committee, acted as a knowledgeable and supportive liaison with our facility.
- NHCI Administration strongly considered participation.
Shared Experiences

• Registry learned from alpha sites how they had implemented their processes and what pitfalls they had addressed.
  • Most programs were very pleased with the system but had not anticipated additional, necessary start up time
  • Smaller programs were able to incorporate RQRS into their day to day functions
  • One program had started but been unable to maintain the RQRS functions and their registry work and opted out.

NHCI Considerations

• Our Case Volume
  • 1200 breast and nearly 200 colorectal patients in 2009

• Cost
  • The staff were already highly efficient. It was likely additional staff would need to be hired.
  • Equipment to support new staff would need to be purchased.

• Process Change
  • Although concurrent abstracting was not required for participation, in order for RQRS to be most meaningful, concurrent abstracting was deemed essential.

• CoC Survey Scheduled for May 2010
  • Consider that participation might disrupt the existing processes and possibly lead to a deficiency, i.e. abstracting timeliness.

Tasks Associated with RQRS

• Collect adjuvant therapy data
• Address alerts in real time
• Find missing prognostic factors
• Submit quarterly error-free RQRS data
• Locate treatment and referral facilities for Class 00 cases
• Concurrent abstracting
• Include breast and colorectal patients from non-CoC facility into RQRS process.
Staffing Needs

- Difficult to assess how much more staff needed for RQRS functions; however, based on the number of tasks and volume of cases, 1 FTE was recommended.

Concurrent Abstracting

Time Study
- 40 data fields required for RQRS data submittal
- Internal study focused on time spent abstracting these data fields.
- Average of 13 minutes per case with a minimum of 275 hours overall per year
- Conclusion: Concurrent Abstracting deferred until RQRS up & running

Moving Forward

- Administration approved participation and NHCI became a Beta Site in Fall 2009
- Based on the number of functions and volume of patients, 1 FTE was approved
- Desktop computer was ordered
- Space allocated in registry office
Recruitment

- At that time, registry recruitment presented difficulties due to a competitive market & lack of telecommuting option.
- Hired a non-CTR with a Bachelors in Science and oncology transcription experience.
- Oriented to breast and colorectal treatment management, physician referral patterns, registry software, and hospital oncology program.

Backlog: How Far Back?

- Non-concordant case review occurred annually after NCDB released CP3R data. Proactive process not in place.
- Only the adjuvant treatment provided at the facility was captured at time of abstracting.
- Because 2008 adjuvant therapy had not been collected, the registry would go back and capture that data.

Initial RQRS Dashboard
One Case at a Time

- Networking with other registries and use of physician records fundamental to success
- Contacting physician practices, including free standing radiation centers critical
- Patients contacted as last resort
- Backlog eliminated nearly 18 months later and cases completely caught up.

Challenges

- Difficult to keep to quarterly data submittal schedule.
- Concurrent abstracting implementation was delayed until RQRS backlog was eliminated.
  - Since concurrent abstracting was not required and cases were submitted after the six month abstracting mark, some patient treatment could not be impacted.
  - Deferred working on alerts until backlog eliminated

...and Now
RQRS Today

- All CoC accredited programs invited to participate in RQRS during Summer 2011.
- Effective July 2013, abstracting timeliness was replaced by participation in RQRS (Commendation Standard only)
- With more hospitals participating, the ability to benchmark improves on a national and state level.

Website Navigation

Website Elements:
- Dashboard
- Color Alerts
  - Treatment Summary
- Case List
- Comparison/Benchmarking
- My Account –
  - Who has access?
  - Who should have access?

Rapid Quality Reporting

- System is stable & rarely down
- Data submissions can be done at any time
- Submissions are processed quickly
- Case updates are available within 2-3 business days
- RQRS Staff is responsive to e-mails with good turn around time.
Lessons Learned

• Create a tickler system to keep up with the cases & utilize notes feature
• Bundle cases for research – two measures at a time
• Review the outliers on a regular basis
• Review Class 00’s at one time.
• Collaborate with Navigation to ensure patients do not “fall through the cracks”
• Keep your physicians and administrators in the loop

Navigation Referrals

Consider referring to Navigator:

• Patient seeing an oncologist but treatment plan not documented
• Patients given prescription for hormone therapy but follow up appointment is after 1 year mark
• Lack of insurance or underinsured
• Rural patients
• Patients with language barriers
• Financial concerns stated in chart
• Psychosocial issues stated in chart
• Registry cannot locate patient

CoC Liaison

• Liaison required to present 4 times per year
• Present breast & the colorectal CP3R measures separately.
• Vary presentations. Physicians and committee members tend to get “burned out” by hearing the same story over & over.
• If rates are improving, especially based on some action, ensure Liaison is sharing the success with Cancer Committee. Document in the minutes.
• If additional action is necessary, Liaison should act as champion for improvement. Document in the minutes.
Non-Concordance/Outliers

• Don’t expect 100% compliance
• Keep careful log or narrative on why the case is an outlier. Physicians will want to know what happened with these patients. Examples:
  • ER/PR Weakly Positive → Oncotype Triple Negative
  • Delays due to wound healing
• If possible, keep track of the number of patients impacted because of registry intervention.

Concurrent Abstracting

• Implemented concurrent abstracting for breast cases only in 2011 and added 1 FTE to support this process.
• Staff prepared to accept this change.
  • The case is “touched” 3 to 4 times before full abstraction takes place.
  • Detailed notes in the registry database tells who added which information on the case and when.
• Everyone responsible for clearing edits.
  • RQRS submitted monthly
• Folded in colorectal concurrent abstracting six months later.

Dashboard
Benchmarking

• CoC Liaison – should be physician champion – work to produce these presentations to your Cancer Committee
• Choose appropriate comparison: national, regional, and/or state.
• Use the data to drive improvements in care

RQRS Treatment Summary

Takeaways

• Plan & implement for YOUR program and YOUR patients
• Work the case list, work the alerts, submit the cases, work more cases, resubmit, etc.
• Share the information and the story with your physicians, administrators, and Cancer Committee
• Ask for Guidance
Questions?