Continuous Quality Improvement: Retroactive application of death clearance best practices

Jeannette Jackson-Thompson, MSPH, PhD

Operations Director, Missouri Cancer Registry

Research Assistant Professor, Health Management & Informatics

Jacksonthompsonj@health.missouri.edu

Acknowledgments

MCR Staff:

N. Cole, CTR, Non-hospital Coordinator

S. Vest, CTR, Project Manager

C. Anderson, CTR, T&DC Coordinator

A copy of this presentation will be posted at:
http://mcr.umh.edu

Supported by CDC/NPCR Cooperative Agreement #U55/CCU721904-01 and a contract between the University of Missouri and the Missouri Department of Health and Senior Services

Background

- Prior to publication of NAACCR's *Resolving Death Clearance Issues, 2003,* clear guidelines for what constitutes a death certificate only (DCO) case did not exist.

Background (cont'd)

- Result:
  - Differing interpretations of DCO
  - Negative impact on:
    - quality control within central registries; and
    - comparability across registries.

What should we do?

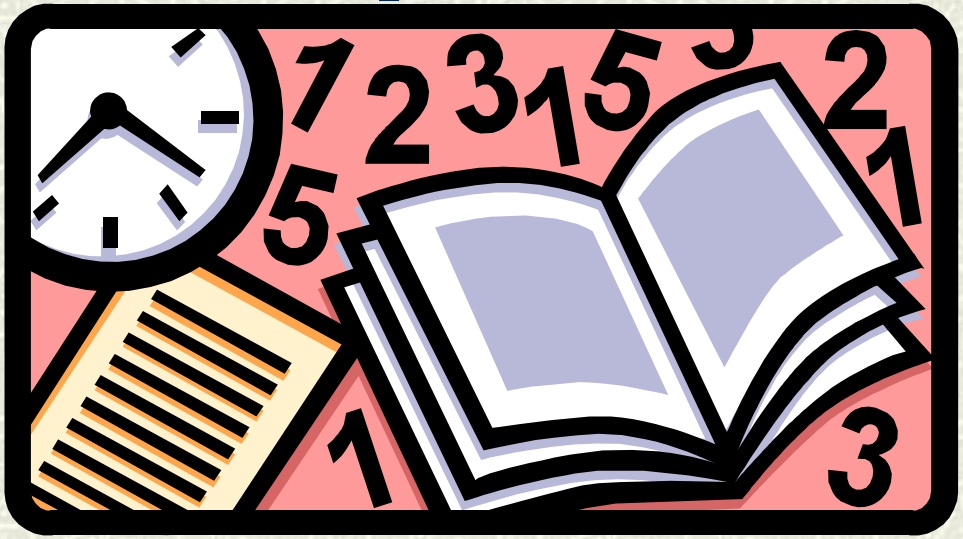
- MCR staff decided to apply retroactively "best practice" procedures to 1996 death records entered as DCO cases without review of death certificates.

Why no review?

- 1996 DCO cases = 2,956
  - 11% of total cases
- Lack of:
  - Time;
  - Resources; or
  - Legal authority.

Challenges: 1996 = Reference Yr

- Accuracy of data reported – primary focus.
- Completeness – hospital & data exchange cases.
- Timeliness – need to educate hospitals.



Legal authority

- Hospital – inpatient only 1996-99 cases
- Statute 28 Aug 99 – hospital outpt. 1/1/2000
- Non-hospital – regulations pub. 12/2000
  - LTCFs
  - Path labs
  - Ambulatory surgical centers
  - Cancer treatment centers
  - Physicians

Follow-back to hospitals

- 1996 – first year death clearance & follow-back conducted
  - Procedures had to be developed.
  - Time-consuming – multiple contacts w/ hospitals needed.

Our Objective

- Improve quality of the MCR database

Why would DCO review improve database?

- DC follow-back from hospitals - only 13% missed cases for year.
- Estimated 50% of DCs had interval for ca.
- Most signed by MD.
- Best practice – convert to MDO 1996 or earlier.

Methods

- Selected five sites/types
  - Brain
  - Leukemias
  - Lymphomas
  - Lung
  - Prostate

Why these sites?

- Strong possibility that prostate cancers and chronic leukemias & lymphomas dx < 1996.
- Brain tumor v. brain cancer – some deaths might be miscoded.
- Large number of lung cancers – interval more likely to be noted.
- Five sites = 36.1% (N=1,067) of all DCOs.

Methods

- MCR staff reviewed 1,067 certificates.
- We applied guidelines:
  - Site must be specified;
  - Interval must be noted; and
  - Certificate must be signed by MD/DO.
- Each certificate classified as:
  - MDO, DCO or Non-reportable.

Results

- Less than half (44.8%) were still DCO cases.
- Over 50% (51.9%) became MDO cases.
- Remainder (3.7%) were non-reportable.

Results (cont'd)

- Of the MDO cases:
  - Slightly less than 1/3 (32.4%) were 1996 cases;
  - Over 40% (43.8%) were 1995 cases; and
  - More than 20% (23.9%) were earlier than 1995.

Conclusions

- Data quality and case completeness have been improved by applying these guidelines:
  - Information (e.g., length of time condition present) that was lost as DCO is now in database.
  - Cases have been assigned to specific years, not just current year.

Conclusions (cont'd)

- These procedures should be used on the remaining 1996 cases.
- Same procedures should be applied to 1997 cases (action taken, not reported here).

Recommendations

- Procedures contained in NAACCR's *Resolving Death Clearance Issues 2003* are a vast improvement but some ambiguities (e.g, how should "years" be interpreted?) remain.
- Additional work is needed.
  - When abstract submitted, it seemed that only a few 'tweaks' were needed.

Vision – happy trails

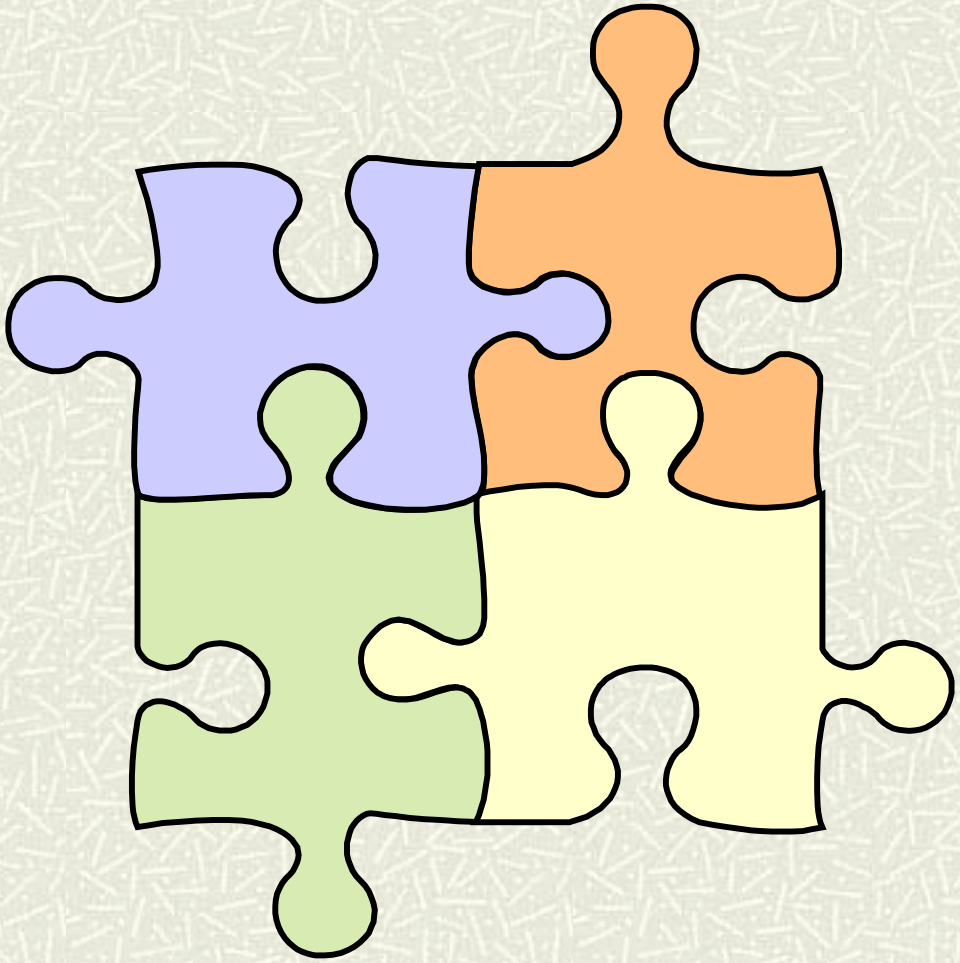
We were ready to ride off into the sunset.

Surprise!!!!

There was a joker in the pack!

- Not everyone agrees that MDOs are a good thing.

Central Registries

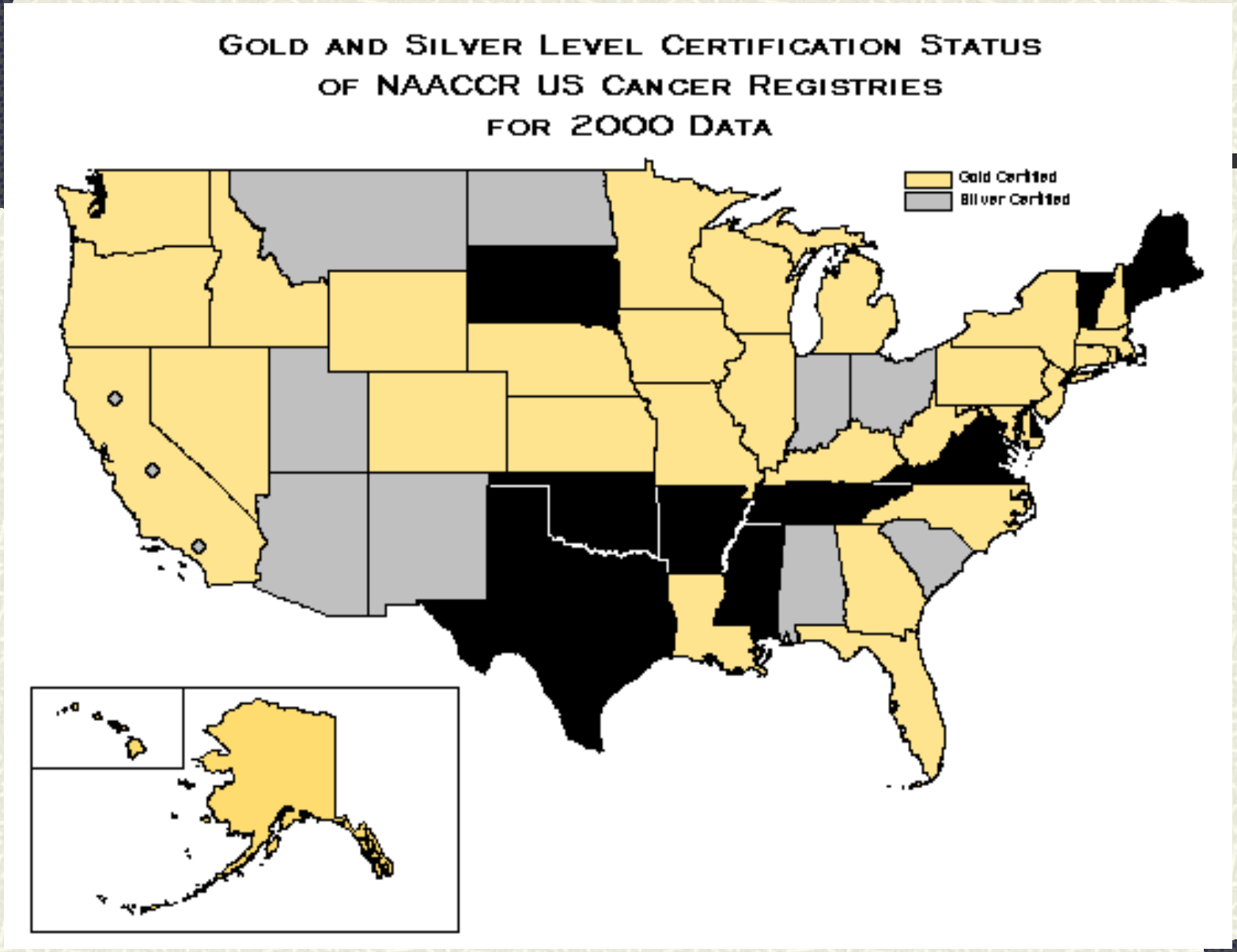


Certification

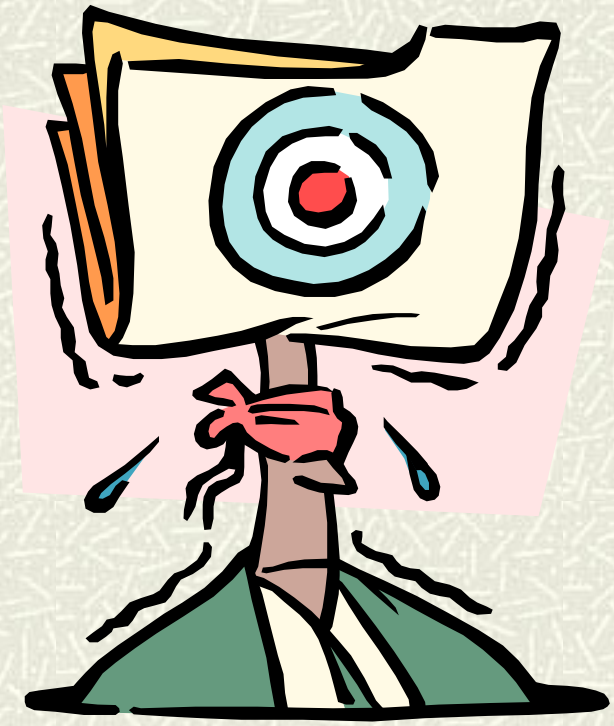
Registry Elements	Gold Std	Silver Std	Measure
Completeness of Case Ascertainment	≥ 95%	≥ 90%	SEER Incidence to U.S. Mortality Ratio (*CINA*)
Completeness of Information:			
Missing "age at diagnosis"	≤ 2%	≤ 3%	Actual Data
Missing "sex"	≤ 2%	≤ 3%	Actual Data
Missing "race"	≤ 3%	≤ 5%	Actual Data
Missing "state/province and county"	≤ 2%	≤ 3%	Actual Data

Certification (con't)

Registry Elements	Gold Std	Silver Std	Measure
DCO Cases	≤ 3%	≤ 5%	Must do complete death clearance
Duplicate Cases	≤ 1 per 1000	≤ 2 per 1000	*CINA* Protocol
Passing EDITS	≥ 99%	≥ 97%	*CINA* EDITS
Timeliness	1998 data submitted by 12/1/00	1999 data submitted by 12/1/01	Data submitted for review 23 months from the close of the diagnosis year.


Gold and Silver Level Certification Status
of NAACCR US Cancer Registries
for 2000 Data
Gold Certified
Silver Certified

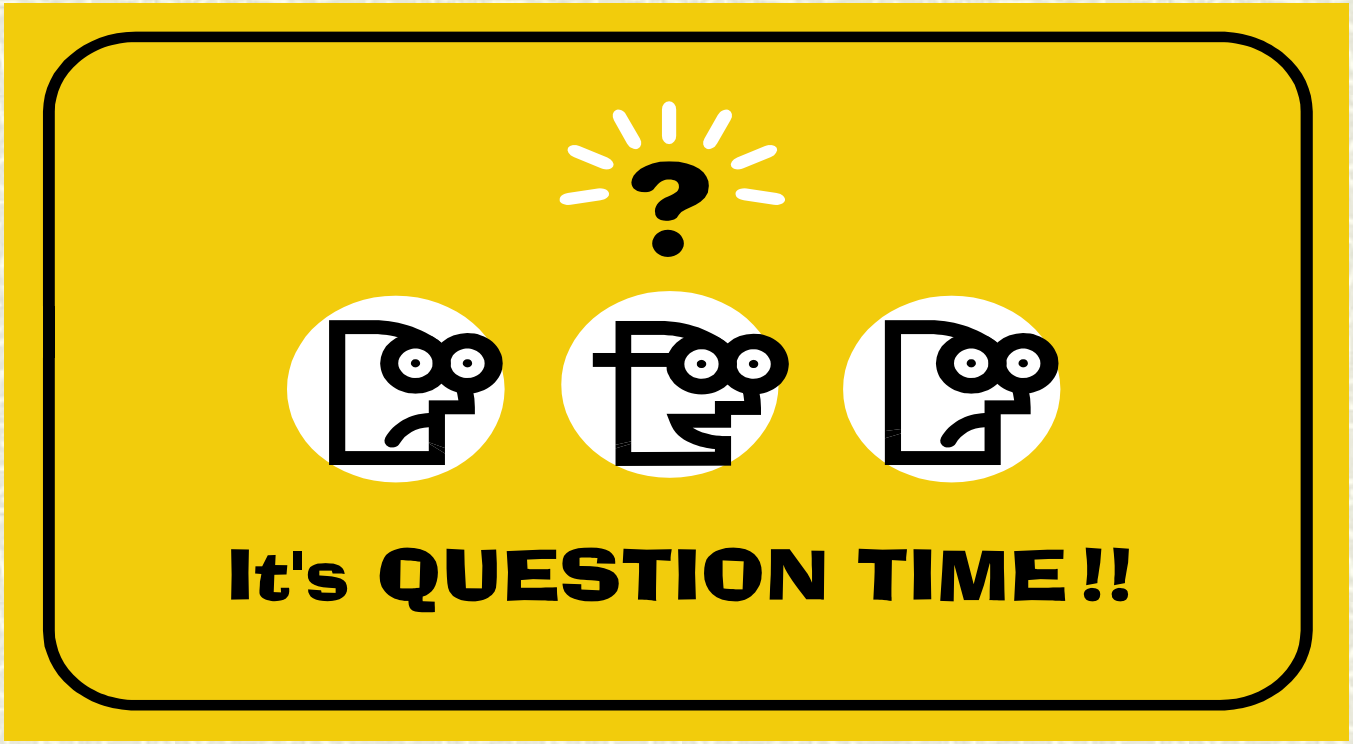
MDO v. DCO



Give us your opinion

- Jacksonthompsonj@health.missouri.edu

  (573) 882-7775

Thank you!!!

Questions/Discussion