DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
National Institutes of Health

Laboratory of Pathology, NCI, CCR

MEMORANDUM

January 13, 2023

TO: Laboratory of Pathology Clinical Staff

FROM: Frederic G. Barr, MD, PhD (Medical Director)

Armando Filie, MD (Quality Management Chair)

Joseph Chinquee, DHSc, MT(ASCP)DLM (Clinical Manager)

SUBJECT: **2022 Annual Review of Efficacy of the Quality Management Plan for the Laboratory of Pathology, NCI**

In accordance with the College of American Pathologists' (CAP) Laboratory General Checklist GEN.20326, the Quality Management (QM) Plan must be implemented as designed and reviewed annually for effectiveness. As has been the standard practice for past years, the 2022 LP QM Indicators assessed pre-analytic, analytic, and post-analytic criteria, including components to monitor turnaround times, intra-operative correlations, corrected reports, delays in obtaining surgical specimen orders, patient identification events, specimen processing and quality control (QC) errors.

RESIDENTS' QI PROJECTS

The LP QM program also incorporates "projects" that are planned, implemented, and monitored by LP's Clinical Residents and Fellows; these projects address: a) specific CAP checklist requirements; b) areas that need further monitoring and improvement based on the results of indicators; or c) recurring issues in LP's sections that may pose a risk to quality management.

Projects identified for CY2022 included: CAP cancer protocols reporting, accessioning errors for submitted surgical cases, reporting and follow-up of predictive markers, missing slides, clinical notification of unusual findings and compliance with IHC daily control QC. The residents' projects were not consistently reported to the QM Committee. Faculty advisors were not proactive with setting meetings with assigned clinical residents and fellow(s), and there was no accountable QM staff to ensure follow up on QI findings until Q4 when new hired staff was assigned to track and keep the projects on task. A goal in CY2023 is to ensure faculty and clinical residents continue to participate in developing indicators, plans of assessment, and corrective actions for both monthly meetings and resident projects.

CUSTOMER SATISFACTION SURVEY

The LP Customer Satisfaction Survey (CSS) is on a biennial rotation and will next occur in November 2023. One goal for the CY2023 CSS is to surpass prior years' participation. This survey will poll NIH professional and support level staff utilizing LP clinical, research, and academic services. Respondents will include branch chiefs, staff clinicians, clinical and research fellows, physician assistants, nurse practitioners, nursing staff, and clinical and research support customers. The results from the Customer Satisfaction Survey will be reviewed with the Branch Chief, Medical Director, Clinical Laboratory Manager and Quality Management Chair. The survey results will also be presented and discussed at a LP Senior Staff Meeting upon completion. Areas with the most significant decrease in satisfaction from 2021 survey include: availability of staff or staff pathologists and the quality of professional interaction and communication with the staff pathologists. These areas will be a priority focus in the LP Quality Management Committee.

SUMMARY & RECOMMENDATIONS:

The 2022 QM program was all-encompassing and addressed indicators from each clinical service as well as common areas that affect the LP. The QM Committee also oversaw issues affecting staff safety, environment of care, customer satisfaction and performance improvement efforts. The basis of the monthly QM program is to review and address quality indicators and identify areas for improvement. The QM Committee's goal is to maintain at least 12, but no more than 20 indicators; this past year focused on 20 quality indicators.

The QM Committee section participants opted to maintain indicators relevant to their service, and also retained LP-wide indicators that addressed industry best practices (e.g. surgical turnaround times, identification events, and revised reports). Although quality indicators remained consistent with the previous year, several thresholds were lowered to continue to address quality improvement efforts.

SUBMITTED SURGICAL TURNAROUND TIMES:

Submitted Service cases demonstrated consistent compliance with the established 7 day threshold. Following the recommendation of the Medical Director and QM Committee members, TAT was lowered from 7 working days to 5 days and put in place on March 2022. Since March, SS reached the 5-day TAT once within the last nine months; it will be a goal for us to more consistently reach this standard in CY 23.

The NCI-COMPASS Program continues to increase in complexity (test types) and volumes, resulting in an increase in submitted consult cases from clinicians in the CONUS and internationally. Because of the increase, the Medical Director recommended separating different thresholds for the Molecular Diagnostics program involving receipt, processing, extraction, testing, and report sign-out. To accomplish this objective, ST cases were removed from the turnaround time quality indicator for Submitted Surgical Cases, which required more time-dependent reports to determine patient eligibility for admission onto protocols.

SMALL BIOPSY TURNAROUND TIMES:

In June 2022, the new threshold for the Small Biopsy TAT was revised from 7 working days to 5 working days based on QM Committee discussions and with approval of the Medical Director. Since revision of the threshold, there has been 1 month that the 5 day threshold has been met, and 6 months that the previous 7 day threshold was met while the new 5 day threshold was not. As a continued goal, we aim to improve on this TAT in CY23.

COMPLEX CASES TURNAROUND TIMES:

The QM Committee chose to modify TAT in Complex Cases in July. Due to consistent improvement in the 10-day threshold, it was modified to 8 days. Since implementing this change, the QM committee has struggled to reach the new threshold, and has not been successful since the change was made. We will continue to closely monitor Complex Cases and continue with our goal to reach a TAT of 8 working days.

FAD TURNAROUND TIMES:

In the December 2022 meeting, the Medical Director and Chief of PostMortem Services agreed with the residents' request that, while 45 days should be the goal, the 60-day mandated turnaround will be the expected threshold. The plan was updated that any resident with an outstanding autopsy over 60 days will meet with the Branch Chief, Chief Resident, and the Residency Director.

CONCLUSION:

Overall, there were more positive than negative outcomes for the CY2022 QM Program. The QM Committee will determine if any indicators may be removed and/or other relevant indicators evaluated and/or added. During the CY2022 QM period, the Laboratory of Pathology's clinical services had consistently good participation in performance improvement efforts from all clinical sections. This past year, all sections were routinely represented, and residents and fellows attending QM meetings participated in the biennial CAP accreditation self-inspection as inspectors. Residents provided important feedback on issues associated with: pre-analytical issues, such as reasons

and solutions with missing IHC quality control reviews; analytic delays for in- house and submitted service, such as cases that required additional outside material or multiple consults; and post-analytic variables. The LP QM program is robust and has demonstrated success with process improvement in multiple aspects of LP's services.

Reviewed and discussed in January 25, 2023 QM Committee meeting

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