FACT – CIBMTR Collaborative Data Audit Process An Update

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FACT Chief Medical Officer
FACT – CIBMTR Collaborative Data Audit Process
Using Data Audit Results to Improve Data Management

- History and Rationale
- FACT-CIBMTR Data Audit Committee
  - Processes
  - Updated Results
- Items to be determined
FACT – CIBMTR Data Audits

- FACT and CIBMTR have been performing independent primary on-site data audits for >20 years, with corrective action required for deficiencies

- Processes are different & have changed, yet:
  - FACT Clinical Inspectors cite programs for significant data accuracy problems
  - CIBMTR continues to find Programs with >3% critical field error rates:
    - Some programs improve with next audit; others do not

- Approximately 72% concordance:
  - Programs with >3% CER; FACT citation for data management deficiency
  - Programs with FACT citations; CIBMTR >3% CER
CIBMTR – FACT Comparative Results 2012 – 2015
N=175 Programs

<table>
<thead>
<tr>
<th></th>
<th>FACT CITATION</th>
<th>NO FACT CITATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIBMTR &gt; 3.0% CER</td>
<td>13 (7%)</td>
<td>30 (17%)</td>
</tr>
<tr>
<td>CIBMTR ≤ 3.0% CER</td>
<td>18 (10%)</td>
<td>114 (65%)</td>
</tr>
</tbody>
</table>

Audits Concordant = 7% + 65% = 72%
Discordant = 17% + 10% = 27%
FACT-CIBMTR Data Audit Project Background

• FACT – CIBMTR Data Audit Task Force formed (2013) assess the state of Data Auditing and to develop new, collaborative approach:
  • Facilitate improvements in data management and quality of data
  • Increase attention and potentially resources to data management through risk of more severe consequences for non-compliance
  • Reduce burden of duplicative audits for Transplant Centers
  • Allow clinical inspectors more time on-site to address other issues [e.g., clinical outcomes]

• Chair: Dr. Daniel Couriel
  • Representatives from FACT and CIBMTR
Task Force Conclusions

• Despite apparent differences, overall mission of the two organizations is the same: to improve quality patient care and outcomes in cellular therapy and transplantation

• There are strengths and weaknesses to both FACT and CIBMTR processes

• No audit system is perfect; no audit detects every error

• No Audit System can guarantee zero error rate (...to err is human...)

• No audit system can MAKE a program improve
  • Incentives and consequences matter
  • Resources matter and may be out of program control

• Collaboration has potential benefits to
  • Transplant / Cellular Therapy Programs
  • FACT
  • CIBMTR
  • Patients and public
Data Audit Task Force Conclusions

• Recommendations of Task Force:
  • Try a collaborative approach incorporating the strengths of each process and minimizes duplication
  • Add elements that increase value

• Proposal approved by both Boards: February 2015

• Data Audit Committee established

• A work in progress ...
  • Continuous study and education
  • Observation of each other’s processes
  • “Soft launch” – few programs; few inspectors
  • Building trust

• Collaboration fully launched: April 2017
B 4.000 DATA MANAGEMENT

B4.100 Each Program shall keep complete and accurate patient records.

B4.200 The records **should** include data of the type required and published by the International Bone Marrow Transplant Registry (IBMTR) or Autologous Bone Marrow Transplant Registry (ABMTR).

How to assess???
Assessment of Data Accuracy and Completeness

• Pick some data points
• Verify accuracy against source data at the Program
• Limitations:
  • It is only one Standard – must not require whole day
  • Data points must seem important to applicant & inspector
  • Should be the same data as IBMTR collects
  • Programs must know in advance which charts to prepare
Clinical on-site inspector compared data to source data
Errors noted, reported to program, presumably corrected
Systemic errors or many errors → B4.100 citation on inspection report
Deficiency requires documented corrective action prior to accreditation
FACT Data Audit Process – Version 2.0

- Standard changed to “...shall...”
- Eliminated unique FACT data sheets
- Verified accuracy using copy of TED forms
- Reduced number of data points audited
- Combination of data points audited:
  - Five specified; five randomly chosen by inspector
  - Same or different for each patient, each Program; each inspector
FACT Data Audit Process – Current Version 3.0

- Clinical inspector audits items from TED or MED-A forms
- Audit a minimum of 30 data points for each type of transplant
  - Five data points for each patient identified by FACT or JACIE; remainder random choice of inspector
    - Primary Disease; stem cell source; Donor type, engraftment date; survival
- Variability noted among inspectors
  - Choice of random fields, same or different for each record
  - Amount of detail recorded for FACT coordinators
  - Likelihood of citation
- Consequences of deficiency to Standard B9.1
  - Submit plan to correct data management
  - Often required follow up internal audit at interim report
  - Potential loss of accreditation
CIBMTR Audit Program Goals

• Ensure the quality and accuracy of the research database / Center-specific Outcomes Analysis
• Identify and **correct** errors
  • Critical field errors, random field errors
  • Systemic or non-systemic errors
• Implement systems / processes to help prevent errors
• Provide additional training for transplant centers
CIBMTR Audit Program - Logistics

• Generally 3-4 day audit; 2 auditors
• Four year audit cycle
• Auditors with specific initial and ongoing training and oversight of competency
• Minimum of 20 eligible recipients to qualify for audit
  • 16 recipients selected for audit, regardless of transplant center volume or reporting volume
• Recipients eligible for audit: pre-transplant and 100-day data completed
• TED forms and CRF forms (~6,500 data points)
FACT – CIBMTR Audit Processes

FACT

- > 60 data points
- ~ 2 hours; one inspector
- 3 year cycle
- Consequences: potential loss of accreditation and loss of insurance coverage
- Inspectors:
  - BMT physicians (Peer to peer)
  - Trained in inspecting/Standards
  - Many diverse individuals
- Goal: verify “complete and accurate data”; educate Programs / personnel
  - May define “accuracy” according to their own knowledge in the field

CIBMTR

- ~6,500 data points
- 3-4 days; 2-3 auditors
- 4 year cycle
- Consequences: data not included; scientists not allowed participation/leadership roles; possible NMDP would deny unrelated donors
- Auditors:
  - Minimum: bachelor’s-prepared
  - Trained and experienced in auditing
  - Consistent; limited number of auditors
- Goals: ensure quality and accuracy of research database and SCTOD; identify & correct errors, identify preventive action; educate centers
  - Manual of Instructions to define potential answers
The Collaboration
• All verification of data accuracy against source data will be performed by the CIBMTR audit teams according to current procedures and schedules.
  • CAP submitted and assessed by CIBMTR; closed or further action required per CIBMTR policies and procedures
• FACT Clinical inspectors will not perform a data audit on-site.
  • Transplant programs will not prepare data sheets specifically for FACT.
  • Transplant patient logs will be required to verify transplant numbers, types of transplants, age groups, transplant sites.
• Clinical inspectors will have access to all CIBMTR results
  • Will review data management with clinical team
  • Will focus on implementation / adequacy of corrective action plans, internal data audits, and quality improvement.
  • May have specific elements to assess at the direction of the Data Audit Committee.

*STANDARDIZED FORM TO INSTRUCT*
• FACT will assess Program’s data completeness and accuracy annually at the time annual report or renewal compliance application

• Each Program will submit
  • Dates of last three CIBMTR audits and results for
    • Overall Error Rate
    • Critical Field Error Rate
    • Systemic Errors
    • Random Error Rate
  • Summary report from CIBMTR
  • Any Corrective Action Plan required from most recent CIBMTR audit
  • Progress report on the implementation of the CAP, including internal data audit of effectiveness of CAP
• FACT and CIBMTR will use the same criteria for “acceptable performance” or assignment of consequences:
  • > 8% CER X 1 audit
  • > 5% CER X 2 consecutive audits
  • > 3% CER X 3 consecutive audits  [3% of 6,500 = 195 errors]

• FACT consequences will be phased in, allowing programs already not performing well to improve
  • Consequences may include loss of accreditation

• FACT will assess timeliness and completeness of data by CPI reports from CIBMTR indicating “in good standing”.
  • Consequences will follow designation of “not in good standing”
VALUE – ADDED ELEMENTS:

- FACT-CIBMTR Data Audit Committee will review ALL data management information submitted to FACT

- Committee will independently assess adequacy of CAP, timely implementation and documentation of CAP, adequacy and results of internal audits, and effectiveness of CAP.
  - Standardized data collection tools have been developed
  - These data will automatically be required with each submission of a compliance or renewal application or annual report in portal.

- Continuous process rather than every 3-4 years – more opportunity to educate, make adjustments

- Increased scrutiny over adequacy of CAP and of implementation, timeliness, follow up audits

- Additional tools to assist programs struggling with making improvements. Webpage: resources, examples, tips

- Increased pressure on institutions to provide needed resources

- Hope to publish commendable practices
**Programs Not Audited by CIBMTR**

- CIBMTR does not audit Centers that are too small [< 20 transplants per cycle] or non-reporting programs
- Standard B9.1 is not going away
- Until there is a better plan, there will be an on-site data audit by Clinical Inspector similar to, but more comprehensive than what has been done in the past
  - Alternatives being considered:
    - Larger data set
    - Additional inspector (Quality Manager) to perform more comprehensive data audit
    - Require submission to CIBMTR
    - Other
Progress
FACT-CIBMTR Data Audit Committee

Co-Chairs: Phyllis I. Warkentin, MD
          Bronwen Shaw, MD, PhD

- Debra Christianson
- Daniel Couriel, MD
- Shakila Khan, MD
- Roberta King
- Carlos Ramos, MD
- Vandana Rangnekar
- Sharon Robison

- Patricia Steinert
- William Tse, MD
- David Vesole, MD
- John Wagner, MD
- Victoria Whalen
- Heather Conway
- Linda Miller
Data Audit Accomplishments

April 2017-January 2018, Committee reviewed CIBMTR results of 94 Programs

<table>
<thead>
<tr>
<th>Group</th>
<th>Critical Field Error Rates</th>
<th>CPI status</th>
<th>Systemic issue identified</th>
<th>Corrective Action Plan required (CAP)</th>
<th>Number of programs reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>≤3.0%</td>
<td>Passed</td>
<td>No</td>
<td>No</td>
<td>50</td>
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<tr>
<td>B</td>
<td>≤3.0%</td>
<td>Passed</td>
<td>Yes</td>
<td>Yes</td>
<td>24</td>
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<tr>
<td>C</td>
<td>≤3.0%</td>
<td>Failed</td>
<td>No</td>
<td>Yes</td>
<td>2</td>
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<tr>
<td>D</td>
<td>&gt;3.0%</td>
<td>Passed</td>
<td>Yes</td>
<td>Yes</td>
<td>12</td>
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<tr>
<td>E</td>
<td>No CIBMTR Audits</td>
<td>Passed</td>
<td>NA</td>
<td>NA</td>
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<td></td>
<td>TOTAL</td>
<td></td>
<td></td>
<td></td>
<td>94</td>
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</table>
Data Audit Committee Reviews

- A. No action required
- B. CAP review, systemic issues
- C. CAP reviewed, CPI status
- D. CAP reviewed, error rates >3.0%
- E. Internal audit reviewed, program not audited by CIBMTR
Systemic Errors

**Definition**: Critical field error rate >3% OR ≤ 3%, systemic error exists when >10% of total CER occur in a single data reporting field.

- 36 programs had systemic errors identified
  - 24 with CER ≤ 3%; 12 with CER >3%
  - Corrective Action Plans required and reviewed
  - Most common Data Areas cited for systemic errors:
    - **DISEASE STATUS AND LATEST DISEASE ASSESSMENT** – 77%
      [e.g.,: disease status at TX; best response; relapse indicators; method of disease assessment [molecular, flow, cytogenetics]]
    - **HCT Product and Infusion** – 22%
      [e.g.,: type of product; cell counts; thaw and infusion times]
    - **GVHD** – 14%
      [e.g.,: GVHD indicator, organ involvement; maximum grade, diagnosis date, prophylaxis, treatment]
Common Corrective Action Plans

CAP Implemented in Response to Errors Identified during Most Recent CIBMTR Data Audit

- Staff: 9
- Audit Process: 25
- Meetings: 13
- CIBMTR Resources: 42
- Documents: 23
- Review Process: 12
- Training: 59
Program Audits Effectiveness

- Not required to submit an audit
- Programs submitted audits: issues noted
- Programs were recently audited by CIBMTR; therefore, CAP cannot be assessed at this point
- Programs submitted acceptable audits
- Program's audit is to be assessed

Audits Submitted = 44
Committee assessed audits to be appropriate = 5
Audits submitted had problems = 30
Audit Issues in 30 Submissions

• Audit Design Deficiencies
  • Data audited was not in the reporting area with systemic errors 14
  • Audit acceptance error rate higher than 3% CIBMTR expected accuracy rate 5
  • Small sample size 6
  • Old data / Follow up not timely 4
  • Scope unclear 4
  • Audit fields not defined 13

• Audit Performance Deficiencies
  • No evidence cause of error was investigated 11
  • No summation or evaluation of data 22
  • Only summary submitted 3
  • No data submitted
  • Only data table submitted 6

• Report Deficiencies
  • Various documentation practices, no signatures, date
Audit Report: Minimal Requirements

• Audit Plan
• Date audit performed
• Audit Scope
• Fields audited: number of fields, which fields. May attach a table of raw data to the report
• Findings and recommendations, including explanation of any deviations from expected scope or method and of any data not included in the analysis
• Summary:
  • Assessment/evaluation of results
  • Identify underlying cause(s) of errors
  • Define corrective and preventive action
• Follow up, including timeline. Verify correction
• Signatures and comments
• Documentation of where results were reviewed
• Quality meeting presentation, if applicable. Include meeting minutes and attendance.
Audit Tips

• Choose data points in area of reporting in which problems have been encountered
  • When audits demonstrate 100% accuracy over time, rotate to other data points.
• Read and follow the data management instruction manual
• Take advantage of training opportunities
• If program is passing all CIBMTR data audit requirements, perform internal audits of new or revised forms when issued, data points where instructions for completion have changed, or choose data points from areas where most programs struggle.
• Set acceptance criteria higher than CIBMTR
• Be certain to audit work by all personnel
<table>
<thead>
<tr>
<th>Program</th>
<th>[Insert date here]</th>
<th>[Insert date here]</th>
<th>[Insert date here]</th>
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</thead>
<tbody>
<tr>
<td>Error rates for the last three (3) CIBMTR Data Audits</td>
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<tr>
<td>Critical Field Error Rate (CER)</td>
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<td></td>
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<tr>
<td>Random Field Error Rate</td>
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</tr>
<tr>
<td>Overall Field Error Rate</td>
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<td></td>
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</tr>
<tr>
<td>Systemic CAP identified?</td>
<td>Yes ☐</td>
<td>No ☐</td>
<td>Yes ☐</td>
</tr>
<tr>
<td>Systemic CAP identified?</td>
<td>No ☐</td>
<td>Yes ☐</td>
<td>No ☐</td>
</tr>
<tr>
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<td>Yes ☐</td>
<td>No ☐</td>
<td>Yes ☐</td>
</tr>
<tr>
<td>Systemic CAP identified?</td>
<td>No ☐</td>
<td>Yes ☐</td>
<td>No ☐</td>
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<tr>
<td>CIBMTR auditor comments</td>
<td>[Enter auditor comments]</td>
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<tr>
<td>CPI</td>
<td>[Enter date here]</td>
<td>[Enter date here]</td>
<td>[Enter date here]</td>
</tr>
<tr>
<td>In Good Standing:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Current IRB documents on file with CIBMTR</td>
<td>Good Standing ☐</td>
<td>No ☐</td>
<td>Good Standing ☐</td>
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<tr>
<td>2. Met consecutive reporting requirements for HCT transplants</td>
<td>Not in Good Standing ☐</td>
<td>☐</td>
<td>Not in Good Standing ☐</td>
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<tr>
<td>3. Completed 90% of the required forms</td>
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<tr>
<td>Comments</td>
<td></td>
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<tr>
<td>Corrective actions</td>
<td>[From Corrective Action Plan]</td>
<td></td>
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</tr>
<tr>
<td>FACT-CIBMTR Data Audit Committee determination of adequacy of CAP and implementation progress</td>
<td>[Enter committee comments]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal audit on data accuracy required?</td>
<td>Yes ☐</td>
<td>No ☐</td>
<td></td>
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<tr>
<td>Additional information, recommendations, and comments by FACT-CIBMTR Data Audit Committee</td>
<td>[Enter committee comments]</td>
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<tr>
<td>Description of program’s progress on CAP implementation</td>
<td>[Enter inspector comments]</td>
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<tr>
<td>Additional information provided to inspector as requested by FACT-CIBMTR Data Audit Committee</td>
<td>[Enter inspector comments]</td>
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<tr>
<td>Commendable practices</td>
<td>[Enter inspector comments regarding commendable practices here for those programs showing improved scores or consistently scoring at a commendable level, if applicable]</td>
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## Program Status

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>Number of Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three audits in a row with &gt;3.0% CER</td>
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</tr>
<tr>
<td>Two audits in a row with &gt;5.0% CER</td>
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</tr>
<tr>
<td>Two audits in a row with &gt;3.0% CER</td>
<td>5</td>
</tr>
</tbody>
</table>

Nature and timing of FACT consequences to be determined
A Work in Progress...

• Remaining issues:
  • Programs that do not report to or are not audited by CIBMTR – need a process to address data (International Programs with FACT accreditation; small Programs)
    • Small number of accredited programs
    • Several alternatives – report to CIBMTR; additional on-site audit with accreditation ...
  • Criteria for improvement
  • Define measurements of Process success
  • Timeline to suspend accreditation
  • Other details...
Questions?
Thank you.