

Benchmarking To Excellence: Using Quality Indicators To Improve Performance

BY IRVING M. PIKE, MD, FACG

To err is Human: Building a Safer Health System” is the title of a report released by the Institute of Medicine (IOM) in 1999. The report raised awareness of medical complications. The claim of the report is that as many as 98,000 people die each year due to medical errors.¹ A later report, “Crossing the Quality Chasm: A New Health System for the 21st Century,” issued by the IOM advocated a full revamping of health care to improve quality.² These reports have stimulated the development of local and national efforts by hospitals, health care systems, and medical-specialty organizations and, to a lesser extent, group practices to produce measurement tools for reporting performance. The public in general and individual patients are looking and asking for evidence that their physician is a good physician. It is quickly becoming evident that as gastroenterologists, we should be prepared to answer their questions. Beyond assuring our patients, is there additional benefit derived from gastroenterologists measuring our own performance?

In 2006, David J. Bjorkman, MD, MSPH, ASGE President 2004-2005, and John W. Popp, Jr., MD, FACG, ACG President 2004-2005, in an introductory message to five endoscopy quality indicator articles, cautioned that if we do not develop evidence-based quality measures, an administrative or government agency without experience or insight into the practice of endoscopy will define these measures for us. They urged gastroenterologists to use measurement tools to distinguish appropriate, high-quality endoscopy from inappropriate, poorly performed procedures.³ In referring to the articles concerning gastrointestinal endoscopic quality indicators that followed in the same journal, they conclude, “By adopting these recommendations, we can

begin to distinguish appropriate, high-quality endoscopy from inappropriate, poorly performed procedures. This will improve patient care, provide comparative information for consumers, and prepare us for the future reporting requirements that will surely come.”

Following the publication of Barclay, Vicari, et al’s article linking colonoscopic withdrawal time and adenoma detection rate during screening colonoscopy in the New England Journal of Medicine (NEJM),⁴ and its subsequent coverage in numerous media articles, the author has experienced several patients who have inquired about his withdrawal time when performing screening colonoscopy. Happily, he has been able to answer, with evidence based on measurements in his practice’s endoscopy suite, that his withdrawal times are greater than those recommended as minimum times in the NEJM article they had read. This is likely the beginning of additional requests for more information. It would be a wise thing to begin measuring now and finding out how your practice performs with respect to some of the currently published quality indicators. It is a well-accepted adage that “one improves only what one measures.” Knowing how you currently score with respect to indicators, will allow you to look into the reason for any apparent areas that need improvement before the call for transparency in medical practice comes to be. You’ll have time to improve your performance before you decide to provide this information about your practice to the public, or a request for this information comes from CMS or private insurance companies.

As physicians, we have an inherent tendency to compete. Knowing we are being compared to others in our practice or individuals in practices in our region or across the country, invokes attention to

detail and a predictable improvement in performance. Benchmarking invariably “moves the performance curve to the right.” The author had the opportunity, while being employed as a Vice President of Medical Affairs

part-time for a number of years, to participate in a health system-wide, clinical-effectiveness benchmarking project. The seven-hospital system measured more than twenty clinical performance measures in each hospital and benchmarked with each other. Each year performance in all facilities improved. Whereas an incidence of 4.5 ventilator associated pneumonias per 1000 ventilator days may have been a good score when the program started, having 1.5 ventilator associated pneumonias per 1000 ventilator days three years later would have been a very poor performance among the seven-hospital benchmarking group. In the interim, each hospital’s medical staff and critical care unit staff spent time and effort understanding what steps needed to be taken to reduce the incidence. The top score continuously moved to the right. No doubt, Gastroenterology practices measuring adenoma find rates on colonoscopy and comparing themselves to other practices will increase the find rate and presumably decrease the colon cancer rate over time. Of course, only by measuring will we know this.

Beyond improving scores, and likely, quality, how can clinical benchmarking benefit Gastroenterology practices? It is not difficult to envision being able to present a practice’s performance record to insurance companies at time of contract negotiation for leverage in these discussions. As pay-for-performance



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programs (P4P) are developed by insurance companies across the country, it is becoming evident that many of these programs are more about rewarding cost containment than about improving quality. Having a benchmarking tool with standardized quality indicators will enable gastroenterologists to argue effectively for P4P programs based on recognized indicators, rather than the cost containment project of the year for each and every insurance company. Should we not receive a bonus for high percentage of screening colonoscopies with successful cecal intubations and a high adenoma find rates rather than for writing prescriptions for generic omeprazole instead of a brand name PPI, as at least one insurance company has decided? The author envisions Gastroenterology practices and our national societies urging, if not insisting, that insurance companies choose to develop their P4P programs around accepted quality indicators rather than economic indicators. As health savings accounts become the vehicle for more and more individuals to pay for their health care, it is predicted that health care shoppers are going to be more selective about what services they receive and where they receive them. Those able to demonstrate quality care are more likely to attract these patients. The inability to demonstrate that the care you are providing is of high quality may be no better to the consumer than providing poor care.

Having a benchmarking tool to help improve the quality of care provided by gastroenterologists will also serve to help manage risk. True risk management is about limiting the likelihood of injury or poor outcome to a patient and, incidentally, the risk of legal claims against the physician. Following quality guidelines, improving one's performance and having documentation of that performance, overall, is a proactive method of risk management. Too often medical liability companies consider risk management to be negotiating as low a settlement as possible and passing on the cost of settlements in the form of higher premiums to their insured physicians.

A benchmarking group of gastroenterologists composed of 12 groups from many different areas of the country have come together, with the assistance of

corporate support, to pilot a tool that will allow gastroenterologists nationally to submit data. This can be done either manually or directly from their electronic endowriters, via a protected web-based site, in order to regularly produce reports to the physicians about their quality performance compared to other participants in the program. The tool is based on the articles pertaining to quality in endoscopy published simultaneously in the *American Journal of Gastroenterology* and *Gastrointestinal Endoscopy* in April 2006.^{5,6,7,8,9} If successful, this tool should provide participants with the information needed to improve the care of their patients, participate in quality focused P4P programs, and manage risk within their practice. A sample of quality measurements can be seen in the table below.

Colonoscopy Indicators	Physician A	Physician B	Physician C	Physician D
Appropriate Indication (AUGE)	78%	72%	84%	79%
Screening Cecal Intubation Rate with Photographic Evidence of Landmarks	94%	96%	89%	96%
Withdrawal Time During Screening Colonoscopy (avg)	6.5 min.	9 min	4.8 min	7.6 min
Adenoma Find Rate in Screening	27%	36%	18%	34%
Incidence of Perforation	.0002	.0001	.0008	.0001
Incidence of Post Polypectomy Bleed	.002	.0004	.0004	.0001

As gastroenterologists, we maintain that we receive the training and acquire and maintain the skills to provide the highest quality of cognitive digestive system medicine and gastrointestinal endoscopic care available from physicians today. The time has arrived for us to be able to demonstrate what we maintain to be true. Benchmarking will be a powerful tool to do this.

Special Comment:

The author acknowledges the accomplishment of the joint task force for endoscopic quality, created by the American College of Gastroenterology and American Society for Gastrointestinal Endoscopy, in creating the articles referenced. The articles provide the framework for the benchmarking of quality indicators in gastroenterology. Current participants and sponsors are listed as follows. Other physicians and corporate sponsors are in the process of joining this effort.

- Medical University of South Carolina
- Rockford Gastroenterology Associates, Ltd.
- Asheville Gastroenterology Associates
- Riverdale Gastroenterology and Liver Physicians Endoscopy
- NYU Gastroenterology Department
- Digestive Health Specialists, Tacoma
- Cincinnati Gastroenterology
- Carolina Digestive Health Associates, Charlotte, N. C.
- GI Associates, Knoxville
- Oregon Health Science University
- Gastroenterology Associates of North Texas, Fort Worth
- Gastrointestinal and Liver Specialists of Tidewater, PLLC, Southeast Virginia
- GI Pathology
- gMED
- Olympus of America
- ProVation Medical
- Sentara Healthcare

Dr. Irving Pike joined Gastroenterology Consultants in Virginia Beach, Virginia in 1983, which is now a division of Gastrointestinal and Liver Specialists of Tidewater, a 28-physician group where he served as President and as a member of its Board of Managers. Dr. Pike recently retired from a part-time executive position with Sentara Healthcare, an integrated delivery system in Southeastern Virginia. He had served in various positions from 1994-2006. While at Sentara he developed a two year curriculum for business education for practicing physicians. His last position with Sentara before returning to full-time gastroenterology practice was as Vice President of Medical Affairs at Sentara Bayside Hospital. He currently serves as the Chairman of the American College of Gastroenterology's Practice Management Committee and Chairman of the American Society for Gastrointestinal Endoscopy's Ambulatory Endoscopy Center Special Interest Group.

¹ Institute of Medicine. (1999). To err is human: Building a safer health system. Washington D. C. National Academy Press.
² Institute of Medicine (2001). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington D. C. National Academy Press.
³ Bjorkman, David J., Popp, John W. Jr., Measuring the Quality of Endoscopy. American Journal of Gastroenterology 101(4): 864-865, 2006.
⁴ Barclay Robert L., Vicari Joseph J., Colonoscopic Withdrawal Times and Adenoma Detection during Screening Colonoscopy. New England Journal of Medicine 355(24): 2533-2541, 2006.
^{5,6,7,8,9} Faigel Douglas O., Pike Irving M., et. al., Quality Indicators for Gastrointestinal Endoscopic Procedures: An Introduction. Gastrointestinal Endoscopy 63(4):S3-S9, 2006. Cohen Jonathan, Safdi Michael A., et. al., Quality Indicators for Esophagogastro-duodenoscopy. Gastrointestinal Endoscopy 63(4):S10-S15, 2006.
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