The Path to Quality Improvement in Endoscopy

Benchmarking

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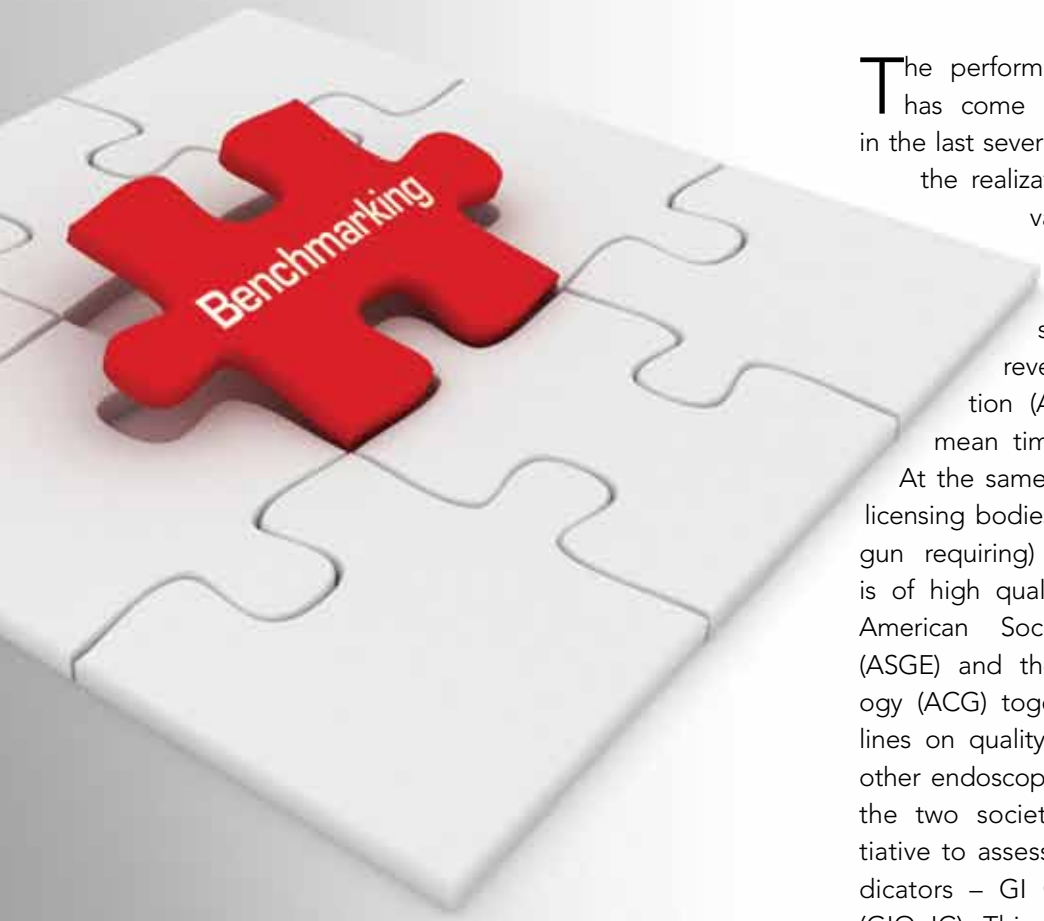


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The performance of colonoscopy has come under closer scrutiny in the last several years in part due to the realization of the significant variation in endoscopists' findings. A community-based study by Barclay et al revealed greater rates of adenoma detection (ADR) in endoscopists who had longer mean times of withdrawal of the colonoscope[1]. At the same time, payers, accrediting organizations, licensing bodies and patients have been asking (or begun requiring) evidence that physician performance is of high quality. Professional societies such as the American Society for Gastrointestinal Endoscopy (ASGE) and the American College of Gastroenterology (ACG) together published evidence-based guidelines on quality indicators for colonoscopy (as well as other endoscopic procedures) in 2006. Building on this, the two societies together launched a registry initiative to assess and track the use of these quality indicators – GI Quality Improvement Consortium Ltd. (GIQuIC). This national registry has fostered the ability for endoscopists to benchmark themselves and provide impetus for quality improvement.

Benchmarking can be defined as the process of comparison with a standard to develop best practices.

For colonoscopy that would include quality indicators such as rate of cecal intubation, prep assessment, appropriate indications for procedure, pathology collection and ADR, amongst others.

Ultimately, ADR and other markers are surrogate measures for what we truly care about—the prevention of colorectal cancer. A recent seminal study has solidified the link between ADR and risk of interval colon cancer (those diagnosed before a subsequent exam). Kaminski et al found a significant association between individual endoscopist's rate of detection of adenomas and the risk of subsequent colon cancer[2]. Data like this has resulted in intensive research studies to improve polyp detection in many ways whether it be inspection technique, withdrawal times, improvement in device optics and training.

GIQuIC underwent a two year pilot program that included significant auditing and upgrades to develop a benchmarking tool that can be helpful to your practice. Both hand tallied and electronic forms were utilized to collect data on over 25,000 colonoscopies. After successful completion of the pilot program, a vendor was chosen to develop this benchmarking registry on a much greater scale. The data registry is now maintained by Outcome Sciences, which is PQRI certified and has been one of the pioneers in developing electronic patient registries. All of the major endowriters including Olympus, Provation, CORI, gMed, Endosoft, EmergeEndo and MD-reports were involved in the pilot phase, so that physicians using any of these programs in their daily practice could seamlessly become part of GIQuIC and data collection. Furthermore, by including all the major endowriters, recommendations can be made for the development of standard reporting metrics so all endoscopists collect the same necessary data and report it in a comparable fashion.

The goals of the GIQuIC data repository include ease of use, integration into your daily practice and providing the necessary information to understand your own practices data as well as be able to compare and benchmark against others. In addition, the pilot project has shown that the mere collection of data in individual practices has improved both reporting of quality indicators, as well as performance, as rates of cecal intubation and ADRs have improved at local sites. Not surprisingly, endoscopists who are shown their data all wish to improve—an endoscopic Hawthorne effect. The strength of this registry data is that those endoscopists who may fall below established benchmarks have the opportunity to improve over time. Participation in this data registry will also foster validation of proposed benchmark metrics by the gastrointestinal societies. The GIQuIC repository will permit large scale evaluation of our daily practices. In addition, we will be able to assess compliance with surveillance interval recommendations for patients.

So why should you get involved? 1) Current regulatory agencies have begun and will expand the mandatory reporting of quality measures. 2) Subsequent payment may be directly linked to both reporting and performance on quality measures. 3) Patients are now asking and will likely ask more often about these measures. There have been numerous articles in the medical and lay press about the variability in quality of colonoscopy performance. Patients have asked me "what is my polyp finding rate, my complication rate and how often I achieve a complete exam." 4) All of us want to provide the best care possible. It's the right thing to do.

Currently, GIQuIC can be linked to seven endo report writers for direct data collection. Data entry is performed in real-time but there is manual data entry for those who prefer this or don't utilize one of the endowriters that is linked to GIQuIC. All of the data is audited for completeness and accuracy. A local data manager generates reports. Several PQRS measures are being developed and the data registry is updated frequently. In addition, our staff is working on developing measures for both EGD and ERCP.

GIQuIC continues to accept applications from endoscopists to be part of this consortium. By being part of this registry, your group will be able to collect local endoscopic data and receive regional and national benchmarking and contribute to this important process. Please register today at www.giquic.org.

[1] Barclay RL, Vicari JJ, Doughty AS et al. Colonoscopic withdrawal times and adenoma detection during screening colonoscopy. N Engl J Med 2006 Dec ;355(24):2533-41.

[2] Kaminski MF, Regula J, Kraszewska E et al. Quality indicators for colonoscopy and the risk of interval colon cancer. N Eng J Med 2010 May;362(19):1795-1803.

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