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GI Quality Improvement Consortium Catching on Across the Country

Program a Win-Win-Win for Physicians, Patients, Payers

by Monica J. Smith

In an effort to facilitate the pursuit of quality in the evolving context of American health care, the American College of Gastroenterology (ACG) and the American Society for Gastrointestinal Endoscopy (ASGE) launched the GI Quality Improvement Consortium (GIQuIC), a database of quality measures in endoscopy that will allow participants to measure themselves against national benchmarks, satisfy demands for transparency, and possibly reap some financial rewards.

"I think there is more and more emphasis from payers and CMS [the Centers for Medicare & Medicaid Services] for us to document that we are complying with quality measures," said Karen L. Woods, MD, a gastroenterologist in Houston. "This is going to become the type of data they will want to see from us, so we feel as though we spearheaded it, took the initiative and are telling them, 'This is what you should look at in gastroenterology.' "

Since the initiative was launched, 60 sites with more than 500 physicians have signed contracts, registered hardware and software and implemented the program, estimated Thomas M. Deas Jr., MD, medical director, Fort Worth Endoscopy Center, Texas, and a member of the GIQuIC advisory board.

"We've already exceeded my expectations," Dr. Deas said. "Any type of IT [information technology] program will be slow to catch on. There is typically some physician resistance and pushback to change. But there are incentives for physicians to get involved."

One incentive is to demonstrate to public and private regulatory bodies that a practice is actively involved in tracking quality measures. Indianapolis Gastroenterology and Hepatology,

in Indiana, a single-specialty, private practice group with 14 gastroenterologists, joined GIQuIC about a year-and-a-half ago in order to have a full year of data collected by 2012.

“We’re seeking accreditation this year and I’m trying to get ready for that, to make sure we’re in good shape,” said Laura Allen, RN, a clinical director for the group. “A lot of accrediting agencies look for practices to do some sort of benchmarking, and this is a great way to do it.”

Another incentive is to streamline the process by which physicians report data to Medicare’s Physician Quality Reporting System (PQRS).

“Right now, to report that information, you have to click on a certain code with your EMR [electronic medical record], which is tedious and not very reliable—you tend to forget or don’t report often enough, and then you fail to qualify for the incentive. GIQuIC users will be able to report some of these measures via the registry, and Medicare has a small percentage fee increase for that,” Dr. Deas said.

With an ever-increasing emphasis on quality and outcomes in health care, participation in GIQuIC may make participants more attractive to commercial payers as well.

“We’ve had conversations with some payers about using participation in the quality registry to identify preferred providers,” Dr. Deas said.

Currently, GIQuIC participants are able to report data relative to colonoscopy procedures, focusing on well-established quality indicators including adenoma detection rate, cecal intubation rate, quality of bowel preparation, indications for procedure and screening surveillance intervals. Soon they will be able to report on a broader array of endoscopic procedures and in other clinical areas as well.

The Pilot

The concept of GIQuIC was tested over the course of two years in a pilot program involving more than 20 sites, including about 60 physicians, from around the country. Those participants reflected the endoscopists who would be involved down the road, “some in academic practice, some in private practice, some in big group practices, and some in small practices like myself,” said Dr. Woods.

The goals of the pilot were to validate the collection of quality data as a computerized report, to determine if the data could be collated and examined in a large group sample across all participants, and to see if this type of benchmarking effort could suggest trends in the real-world performance of endoscopists. How long are colonoscopies taking? How many polyps are endoscopists detecting? What surveillance intervals are they recommending? Are patients adequately prepped? Are procedures matching up with indications?

Throughout the course of the pilot, participants submitted data through manual data entry or endoscopy report writers (endowriters) to the data registry. They had periodic meetings and received reports on how each compared to one another and how well they met the standards of care for colonoscopy as established by an ASGE and ACG task force (Bjorkman DJ, Popp

JW Jr. *Am J Gastroenterol* 2006;101:864-865; Faigel DO et al. *Gastrointest Endosc* 2006;63[4 suppl]:S3-S9).

“We were trying to meet those standards and see if this data report collecting system would work; could people get it done? Could they give 100% of their data? Did the data look useful once it was collated and reports given?” Dr. Woods said. “We found that it was very successful. We validated the ability to do it.”

GIQuIC was rolled out nationally in mid-2010 and is now available to any site where endoscopy procedures are performed, including offices, ambulatory surgery centers (ASC) and hospitals. Fees for participation in the service are based on the number of physicians in the practice.

Getting Set Up

When Dr. Woods first approached her institution, The Methodist Hospital System in Houston, with the idea of installing a quality data collection system, they approved of the idea, but not of GIQuIC.

“They said, ‘This doesn’t look like it would be that hard to do: We have our own IT people, so we can set this up, but we don’t want to share our data outside the hospital system, so we’ll set up a data collecting system on our own,’ ” she said.

After a year-and-a-half trying to do so, The Methodist System changed its mind. “They finally said, ‘We simply can’t get this done; GIQuIC looks like a good, low-cost investment to get back a lot of quality data in return.’ That’s when they allowed me to bring GIQuIC to the table.”

During the pilot project, Dr. Woods’ husband, who works in her office as a researcher, uploaded all of her data manually. But the GIQuIC system The Methodist System has purchased for all hospitals in its system will link to the endowriter they use. “We’ll all do the same type of report so that it’s standardized, and we’ll upload our data whenever it requires us to do so, then get our reports back—so no more manual data entry,” she said.

GIQuIC may seem a natural direction for groups that already have been investigating ways to capture quality indicators or actually have implemented ways to do so. Indianapolis Gastroenterology and Hepatology started tracking quality measures long before GIQuIC was available, said Michael S. Morelli, MD, president of the group.

“One of the endeavors we’ve embarked on over the past few years is to stay at the forefront of the movement in medicine toward demonstrating quality,” he said, noting that his group published a paper on colonoscopy performance and benchmarking around the time the ACG and ASGE were rolling out GIQuIC (Morelli MS et al. *J Clin Gastroenterol* 2010;44:152-153). “This system really worked well with what we were trying to accomplish, which was to start measuring how well we were performing endoscopy services, specifically our colonoscopy quality outcomes.”

Prior to adopting GIQuIC, Dr. Morelli's group had extracted a lot of their data manually. "With this program, we're able to do it electronically. We can get almost any type of information we need with the touch of a button through the GIQuIC program," he said. "It is helping us accomplish what we want to do—to measure our quality—and it's helping us support the professional societies we belong to."

David Greenwald, MD, gastroenterology fellowship training director and associate division director, Montefiore Medical Center, New York City, has been enthusiastic about benchmarking, registries and GIQuIC for years through his leadership in the ASGE Endoscopic Unit Recognition Program.

"We've been promoting the use of databases and benchmarking for many years now, because we think quality is critical," he said. "It's not enough to just do a colonoscopy for cancer screening—it has to be high quality each and every time."

The Advanced Endoscopy Center in the Bronx, N.Y., of which Dr. Greenwald is the medical director, implemented the program about six months ago. So far it's running smoothly. "It's been going great because the required data collection is truly behind the scenes," Dr. Greenwald said. "It's seamless. You don't actually know it's happening."

Dr. Greenwald's center already was using an endowriter to create endoscopy reports after procedures, and as such, involvement in GIQuIC does not require an extra step.

"The quality measures being gathered by the GIQuIC registry are the same as those being collected for the endoscopy reports, so when we enter information for the endoscopy reports, we're entering information for the benchmarking registry program as well," he said.

That information is then uploaded electronically at regular intervals to the registry, which is run by a CMS-qualified vendor. The data are stripped of all identifiable information, encrypted and batched for use in reporting and benchmarking. Participants can generate reports on anything in the registry to benchmark themselves against local, regional or national groups.

Dr. Greenwald's group found the program relatively easy to establish. "We needed some assistance from the software manufacturer of our endoscopic report, but they are familiar with GIQuIC, helped us set it up and customized it for our needs," Dr. Greenwald said.

Indianapolis Gastroenterology and Hepatology spent a few months setting up GIQuIC, making sure the interface worked with their endowriter and that they were entering the data they needed to be entering and doing so in the right way. "We did find some bugs, but that's what it's all about," Ms. Allen said. "I think we were one of the first practices to do this with CORI

[Clinical Outcomes Research Initiative], and it's been working really well."

Identifying Gaps

It took a little time to implement and fine-tune GIQuIC, to identify individuals in the endoscopy center to manage it and to get everyone on board using it, but at this point Indianapolis Gastroenterology and Hepatology has accumulated enough information to put it to use. "We now have six to nine months, enough data to be meaningful," Dr. Morelli said.

With the reports from GIQuIC, the group has been able to pinpoint stronger and weaker areas of performance. "This program has really helped identify certain gaps we've had in services we're providing," Dr. Morelli said. "In some areas, it's really been a surprise to some of the physicians how well they are or are not doing compared with what they thought."

Just as most drivers consider themselves at least as good if not better than others behind the wheel, most physicians think they're doing an above-average job. "But when you look and see that you're actually performing below the standard benchmark for polyp detection, then you can go back and try to figure out why that is," Dr. Morelli said. "Is your prep inadequate? Are you withdrawing the scope too fast? You try to look at variations in what you're doing and how you could improve."

The group has now established a committee to identify gaps and think about ways to close them; the next step is to set up quality improvement programs for the practice.

"Thus far, we've been giving information to individual physicians and it's up to them to devise their own strategies for improvement, but we want to standardize that a little bit," Dr. Morelli said.

Selling Points

Of course, most physicians want to do a good job, and it seems many are open to using a tool that will help them identify areas of weakness if it helps them toward the goal of improving in order to provide the best service they can for their patients. But a little financial incentive doesn't hurt.

"We've been able to use this data not only to start to devise ways to improve, but we've also started marketing to our patients—showing them that we're doing better than the national benchmarks," Dr. Morelli said. "We want to prove our quality to them and make them comfortable coming to us, to differentiate us from others who do colonoscopy."

Indianapolis Gastroenterology and Hepatology also has started talking with insurance companies about how they can use this information to get paid according more to how well they're doing rather than how much they are doing.

"The current status of medicine is fee for services, but the future of medicine will be based on cost-effectiveness—doing the right thing, demonstrating high quality with good outcomes," Dr. Morelli said.

Ms. Allen found participation in GIQuIC worked to the group's advantage during recent contract negotiations with an insurance payer. "I think they were very impressed with the results and with the fact that we had the data, which shows them we are committed to quality," she said. "They appreciate the fact that we have statistics like that, so I think that's very helpful."

Programs like GIQuIC may help all parties win, said Dr. Morelli.

"[They are] good for the patient because they're cost-effective, demonstrate high quality and help doctors to improve; good for the physician because it helps them practice high-quality medicine and, hopefully, get reimbursed for quality rather than volume; and good for insurance companies to not pay for needless procedures or procedures that are not done effectively," Dr. Morelli said.

"They're going to be paying for quality, which is what everyone wants. I think these types of programs really help propel medicine, in particular our specialty, toward that type of future."