

In the News

ISSUE: OCTOBER 2009 | VOLUME: 60:10

Nationwide Benchmarking Pilot Program Drives Participants To Improve Quality

by Monica J. Smith

New York—The impetus to measure quality stems from many different sources. Partly, it comes from the inherent desire of most physicians to improve the quality of each performance every time they do it.

“Why are we measuring quality—aren’t all procedures the same?” Irving Pike, MD, asked attendees of the Sixth Annual Citywide Colon Cancer Control Coalition (C5) Summit, held in New York City in June. Answering his own question, he said, “This is not Lake Wobegon, and we’re not all above average.”

It seems lately that *everyone* wants to know exactly how well physicians are doing. Before 2001 and the white paper calling for transparency in quality, what the public knew about a physician’s practice was whatever that physician chose to reveal. Quality was self-reported and reputations self-built. But the climate has changed.

“Following the publishing of that paper, we now have requests by the government, insurance companies and patients about specific quality measures,” said Dr. Pike, who is assistant professor of clinical internal medicine at Eastern Virginia Medical School, in Norfolk, and president of Gastroenterology Consultants, a division of Gastrointestinal and Liver Specialists of Tidewater, PLLC, in Virginia Beach. “Our reputation is based on the answers we can give them to specific questions.”

From this point on, it seems likely that the quality of all practices will be available to all stakeholders, and reputations will be linked to evidence of high-quality performance in



medicine. But how do you measure, capture and demonstrate quality?

“The bottom line is that we need some scoring system. Peter Cotton calls them ‘report cards,’ we’re calling them benchmarks now. We need an infrastructure to analyze that,” said Jonathan Cohen, MD, clinical professor of medicine, New York University Medical Center, New York City.

Benchmarking Becoming Worldwide Trend

“This whole idea of benchmarking is really coming on now; the idea that you’re measuring yourself against a standard, as well as against others,” said David Greenwald, MD, gastroenterology fellowship training director and associate division director, Montefiore Medical Center, New York City. “You can see how you’re doing, and hopefully you will improve your performance based on that benchmarking data.

“We’re not alone in this effort, it has actually been going on worldwide,” added Dr. Greenwald, who presented an example of the effort made in the United Kingdom to capture quality.

The U.K. program called for reporting outcomes in two basic dimensions: quality, and safety and customer care. “Each of those two dimensions has six items, each item has four descriptors and each descriptor is underpinned by one of four measures,” Dr. Greenwald said. “While it appears to be a complicated scheme, it’s actually very simple because it gets down to specific questions you can ask, look at the outcomes, and then, essentially, benchmark.”

At the outset of this initiative, the United Kingdom wasn’t doing very well. There was “very poor performance in the quality measures they were looking at when they started,” Dr. Greenwald said. But once they started measuring outcomes and reporting the results, things got a lot better.

From 2004 to 2008, “everything they were measuring started to improve. The minute they started measuring any area of performance, it improved dramatically,” Dr. Greenwald said. “So just measuring performance and reporting data seems to be a good way of improving performance.”

Compelled to find a way to use the 14 quality indicators for gastroenterology developed by the joint task force of the American College of Gastroenterology (ACG) and the American Society for Gastrointestinal Endoscopy (ASGE) (Rex DK et al. *Gastrointest Endosc* 2006;63:S16-S28), Dr. Pike and a group of experts from around the country collaborated to develop a method of benchmarking that would measure their own quality against that of their peers.

“While they were working on the development of the quality indicators, a number of task force members recognized that the indicators would only be worthwhile if they were put to use,” Dr. Pike said.

He turned to his local health care system, Sentara Health Care, to ask for help in setting up a benchmarking pilot. Sentara offered the services of its experts and allowed the use of its own hardware to collect data. “They actually built the tool for us,” Dr. Pike said. The ACG and the ASGE also gave their endorsement and lent support to the project.

ACG and ASGE Initiate Nationwide Quality Indicator Pilot Program

What evolved from the National GI Endoscopic Quality Indicator Benchmarking Pilot is now a Web-based program operated and overseen by GI Quality Consortium, Ltd., a nonprofit company established by the ACG and the ASGE. At this point, representatives from more than 20 different medical groups nationwide—between 60 and 70 physicians—are participating in the pilot project.

Physicians can document data one of two ways. Those who use electronic medical record (EMR) systems specifically designed to generate endoscopy/colonoscopy reports can select specific options that result in a description of the procedure they performed. “As a physician does his or her colonoscopy, that data is captured—it does not require a separate action,” Dr. Pike said. “Every time they do a report, the quality of the procedure can be established.”

For those who do not use EMR systems, “we’ve developed a paper data-collection tool, which is the front and back of one piece of paper that has all the data fields that are being collected electronically [with an EMR system] displayed on the paper,” Dr. Pike explained.

Those using the paper data-collection tool can enter that information into an access database similar to a spreadsheet. “Now it’s in an electronic format that can be sent to the central database,” Dr. Pike said. Physicians he has interviewed say that the paper data-collection tool is surprisingly efficient and adds little time to a case.

Whether via an EMR system or the paper data-collection tool, participants do experience an initial learning curve. “People developed techniques over the years for filling out their reports, and now they have to populate a data field by clicking the parameters,” Dr. Pike said.

But once participants breached that learning curve, something interesting happened. “Every one of them said that it changed their focus to quality. They were no longer concentrating on whether they did 15 or 20 colonoscopies in a day, but on the quality of each exam,” Dr. Pike said. “It totally changed their perspective.”

He presented a mockup of a quality report at the C5 Summit in which performance was represented by the color of the cell in a given field: Green indicated reaching a goal, yellow meant being within 10% of the goal and red indicated falling more than 10% short of the goal. Cells in the spreadsheet change color as the data changes.

“In very quick fashion, you can look at the benchmarking report and see where you stand,” Dr. Pike said. “Over time you move from predominantly red and yellow ... to more and more green.”

Only three to five measures are taken on any procedure. “If you try to measure all of them, you’re not going to have any focus. As you move to all green [in an area], you may stop measuring one thing and measure something else, but check back now and then,” Dr. Pike said.

Preliminary results from the first 15,000 cases in the database are encouraging.

“We have a 100% report of measures in [American Society of Anesthesiologists] risk stratification,” Dr. Pike said. “Adenoma detection rate is above average and [has] improved over time. The one measure that’s increasing most is the average withdrawal time from the cecum. The focus has come to quality as a result of this project.”

At this point, a vendor is being selected to build a larger data repository that will accept many more physicians, and the ASGE and ACG offices are collecting a list of interested parties who will sign on to participate once that database is available.

“In the interim, most of the software vendors that have been involved in this project have developed methodologies that allow gastroenterologists to locally download their data from their own endowriter,” Dr. Pike said. “They can collect their data in that fashion or use our paper data-collection tool and put it into a spreadsheet.”

Ultimately, the final measure of quality in screening colonoscopy is a zero incidence of colorectal cancer between the screening and the surveillance interval. “Will we ever get there? Probably not,” Dr. Pike said. “But it’s my opinion that the quality indicators will help us get closer.

“If we improve the quality of the exams we do, patients will get better results and we will ultimately improve the outcome,” he said. “I think it’s a total win situation all the way through.”

For more information on participating in a benchmarking program, visit www.giquic.org or contact the GI Quality Consortium at giquic@acg.gi.org
