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Quality Initiatives, Benchmarking in Gastroenterology: Is It Worth It?

One Expert Says ‘Yes,’ Explains Why

By Caroline Helwick

San Diego—Gastroenterologists who are procrastinating about participating in quality initiatives need to get on board now, according to Irving M. Pike, MD, who laid out his reasons in a lecture at the 2012 Digestive Disease Week meeting.



Although there may be reimbursement advantages associated with quality reporting, that should not be the incentive, Dr. Pike said. “We should be doing it anyway,” he told colleagues at the meeting.

Participation in quality initiatives “could positively impact your practice reputation if you do it, and negatively if you don’t,” said Dr. Pike, chief medical officer of John Muir Health in Walnut Creek, Calif.

“Initially, it may cost you money *not* to,” he added.

Incentives and Penalties

During 2012, physicians have their last chance to receive the full \$44,000 per physician for attesting to “meaningful use” grants. Penalties for not meeting the meaningful use definition come into play after 2016 and escalate over time. Quality reporting is one of the criteria for attesting to “meaningful use.”

“But more specifically, what about your reputation?” Dr. Pike offered.

By 2013, the Centers for Medicare & Medicaid Services will publish quality measures on a Web site, including a listing of physicians who participate in the Physician Quality Reporting System (PQRS).

“This will be transparent for all, and one quality measure is whether you are participating in

the PQRS program, which raises the question to the public: If you are not, why aren't you?"

By 2015, Medicare reimbursement will be reduced by 1.5% for providers not participating in PQRS. After that, a 2% cut looms in 2016 and 2017. Together with penalties for not attesting to meaningful use, reimbursements to practices could fall by 10%.

"And 10% of millions of dollars in a gastroenterology practice gets to be a real number," Dr. Pike quipped.

Another reason to "bother" to participate, Dr. Pike said, is to retain patients.

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For example, in 2013, gastroenterologists participating in Blue Cross Blue Shield of North Carolina (BCBSNC) will be required to submit quality data from a gastroenterology specialty registry in order to be included in the network. BCBSNC represents approximately 70% of the state's commercial health insurance market. Should the company decide to expand its program in the future, gastroenterologists will have little choice about participating. For the current program, participation in at least some of the measures will be sufficient in order to allow a one-year "ramp-up to readiness," but eventually more will be required. This could be

the beginning of a trend.

The best reason for participating in quality initiatives, however, may be that measuring and reporting quality does improve patient care, he said. This was eloquently shown by Douglas Rex, MD, and colleagues who secretly videotaped endoscopists performing colonoscopies, then later informed the endoscopists that they were *going to be* videotaped to assess the attainment of five quality measures. Compared with the stealth baseline videos, measurable improvements were demonstrated for all endoscopists on all parameters. The investigators attributed the improvements to the endoscopists' anticipation of being observed and measured.

"The fact of measuring quality moves the quality curve to the right," Dr. Pike pointed out.

Because of the trend toward benchmarking, he added, it is not uncommon today for the lowest performer in an endoscopy practice to have an adenoma detection rate of 40% and the highest to reach 60%.

GI Registries for Reporting Quality

Currently, two gastroenterology registries are available for measuring quality: the American Gastroenterological Association's (AGA) Digestive Health Outcomes Registry and the GI Quality Improvement Consortium (GIQuIC), available through a partnership of the American College of Gastroenterology and the American Society for Gastrointestinal Endoscopy.

The AGA registry allows data to be entered electronically for users of gMed version 4 or others via interfacing with FIGMD at an additional cost. The FIGMD registry includes quality measures for colorectal cancer (CRC) screening, hepatitis C and inflammatory bowel disease, among other things. For example, to demonstrate quality in CRC prevention, providers need to show the following:

- Percentage of patients aged 18 years and older with documented CRC risk assessment prior to the CRC screening procedure
- Percentage of patients aged 18 years and older receiving colonoscopy with the appropriate follow-up interval based on postprocedure CRC risk assessment
- Percentage of patients aged 18 years and older receiving a colonoscopy with American Society of Anesthesiology (ASA) class 1 or 2 status when an anesthesia professional was used
- Percentage of colonoscopy patients experiencing an adverse event (AE) within two days of the procedure
- Percentage of patients who received a complete colonoscopy
- Adenoma detection rate

The GIQuIC registry offers a direct "endowriter-to-database" upload system. Currently, nine endowriter software vendors are certified to submit data to the registry and several other vendors are in the process of becoming certified; therefore, with this system, a third-party vendor interface is not required. Manual data entry also is available for facilities not using an

electronic report writer; these practices can submit data via an electronic data collection form.

Providers using the GIQuIC registry receive an immediate report and can benchmark their performance on a daily, weekly, monthly, quarterly or annual basis. Benchmarking reports are generated in a standard format and can be customized by data managers at each participating facility, greatly increasing the number of measures that can be analyzed. The tool also offers separate evaluation of trainees in order to follow their endoscopic skill development.

Still evolving, at press time the GIQuIC tool had 84 data points and 11 measures, including medical history and physical documentation, informed consent documentation (including potential AEs), adequacy of bowel preparation, written discharge instructions for outpatients, ASA risk stratification, withdrawal time, documentation of indication, cecal intubation with photo documentation, adenoma detection rate and immediate AEs. Other quality measures are in development.

“GIQuIC will keep abreast of all third party–developed measures and be prepared to include them in the registry,” Dr. Pike said.

Dr. Pike concluded by urging physicians to get more involved in quality initiatives and to take advantage of these registries to their fullest extent.

“Maintaining autonomy as a specialty is very important,” he said. “If we don’t decide on these measures ourselves, most assuredly third-party payers will be handing us measures—and they may not be the measures we find important.”

Dr. Pike serves on the advisory committee/review panel for Validare and is a consultant for Olympus.
