2017 QCDR Measures

Following is an overview of the clinical quality measures in GIQuIC that can be reported to CMS for the Quality performance category of the Merit-Based Incentive Payment System (MIPS) via the GIQuIC Qualified Clinical Data Registry (QCDR) for the 2017 program year. Additional detail on GIQuIC's "homegrown" (aka non-MIPS) measures available for public reporting follows on the subsequent pages.

The GIQuIC 2017 QCDR has been approved to report to the Quality, Improvement Activities, and Advancing Care Information performance categories.

Measure #	Title	Outcome/ High-Priority
QPP 343	Screening Colonoscopy Adenoma Detection Rate	Outcome
QPP 425	Photodocumentation of Cecal Intubation	N/A
QPP 320	Appropriate follow-up interval for normal colonoscopy in average risk patients	High-Priority
GIQIC 15	Appropriate follow-up interval of 3 years recommended based on pathology findings from screening colonoscopy in average-risk patients	High-Priority
NHCR 4	Repeat screening colonoscopy recommended within one year due to inadequate/poor bowel preparation	Outcome
GIQIC 12	Appropriate indication for colonoscopy	N/A
GIQIC 10	Appropriate management of anticoagulation in the peri-procedural period rate – EGD	High-Priority

GIQIC 15: Appropriate follow-up interval of 3 years recommended based on pathology findings from screening colonoscopy in average-risk patients

Description: Percentage of average-risk patients aged 50 years and older receiving a screening colonoscopy with biopsy or polypectomy and pathology findings of 3-10 adenomas, Advanced Neoplasm (≥ 10 mm, high grade dysplasia, villous component), Sessile serrated polyp ≥ 10 mm OR sessile serrate polyp with dysplasia OR traditional serrated adenoma who had a recommended follow-up interval of 3 years for repeat colonoscopy

Denominator: All complete and adequately prepped screening colonoscopies of average-risk patients aged 50 years and older with biopsy or polypectomy and pathology findings of 3-10 adenomas, OR Advanced Neoplasm (≥ 10 mm, high grade dysplasia, villous component) OR Sessile serrated polyp ≥ 10 mm OR sessile serrated polyp with dysplasia OR traditional serrated adenoma

Denominator Exceptions/Exclusions: None

Numerator: Number of average-risk patients aged 50 years and older receiving a complete and adequately prepped screening colonoscopy with biopsy or polypectomy and pathology findings of 3-10 adenomas OR Advanced Neoplasm (≥ 10 mm, high grade dysplasia, villous component) OR Sessile serrated polyp ≥ 10 mm OR sessile serrated polyp with dysplasia OR traditional serrated adenoma who had a recommended follow-up interval of 3 years for repeat colonoscopy

Rationale and Supported Evidence:

The *Guidelines for Colonoscopy Surveillance After Screening and Polypectomy: Consensus Update by the US Multi-society Task Force on Colorectal Cancer* [18] presents recommendations for surveillance intervals in individuals with baseline average risk. Colonoscopies should follow recommended post-polypectomy surveillance intervals to be clinically effective and to minimize risk and further to be cost-effective. Average-risk patients aged 50 years and older receiving a screening colonoscopy with biopsy or polypectomy and pathology findings of 3-10 adenomas, advanced neoplasm (≥ 10 mm, high grade dysplasia, villous component), sessile serrated polyp ≥ 10 mm OR sessile serrate polyp with dysplasia or traditional serrated adenoma should receive a recommended follow-up interval of 3 years for repeat colonoscopy.

NHCR 4: Repeat screening or surveillance colonoscopy recommended within one year due to inadequate/poor bowel preparation

Description: Percentage of patients recommended for repeat screening or surveillance colonoscopy within one year or less due to inadequate/poor bowel preparation quality

Denominator: Number of screening and surveillance colonoscopies with bowel preparation documented as inadequate/poor

Denominator Exceptions/Exclusions: None

Numerator: Number of screening and surveillance colonoscopies with bowel preparation documented as inadequate/poor and whose recommended follow-up was ≤ 1 year

Rationale and Supported Evidence:
The economic burden of repeating examinations because of inadequate bowel preparation is substantial. The Clinical Outcomes Research Initiative (CORI) on Colonoscopy Quality Indicators Study of 53 gastroenterology practice sites in 24 states looked at all patients undergoing colonoscopy (n=438,521); in this study, quality of bowel prep recorded was assessed. Findings indicated that 13.9% of reports did not have bowel prep quality reported and in 14 of 53 practices, over 20% did not have bowel prep quality.[1] A study conducted in a public hospital and university hospital setting concluded that inadequate bowel preparation increased costs by 12% in the university hospital and 22% in the public hospital.[2] The percentage of outpatient examinations with inadequate bowel preparation that require repeat colonoscopy in 1 year should not exceed 15%.[3] All patients for whom bowel preparation was assessed and documented as inadequate should receive a recommended follow up interval of one year or less.

[1] Lieberman, D. et al. Standardized colonoscopy reporting and data system: report of the Quality Assurance Task Group of the National Colorectal Cancer Roundtable. Gastrointestinal Endoscopy 2007; 65(6): 757-766.
[2] Rex DK, Bond JH, Winawer S , et al. Quality in the technical performance of colonoscopy and the continuous quality improvement process for colonoscopy: recommendations of the U.S. Multi-Society Task Force on Colorectal Cancer. Am J Gastroenterol. 2002 Jun;97(6):1296-308.
[3] Froehlich F, Wietlisbach V, Gonvers JJ, et al. Impact of colonic cleansing on quality and diagnostic yield of colonoscopy: the European Panel of Appropriateness of Gastrointestinal Endoscopy European multicenter study. Gastrointest Endosc 2005;61:378-84.

GIQIC 12: Appropriate indication for colonoscopy

Description: Percentage of colonoscopy procedures performed for an indication that is included in a published standard list of appropriate indications and the indication is documented

Denominator: All colonoscopies

Denominator Exceptions/Exclusions: None

Numerator: Number of colonoscopies performed for an indication that is included in a published standard list of appropriate indications

Measure Type: Process, standard measure **Measure Domain:** Effective Clinical Care

PQRS Status of Measure Concept: N/A **NQF Endorsement Status:** N/A

Rationale and Supporting Evidence:

In 2012, ASGE updated its indications for endoscopic procedures, Appropriate Use of Gastrointestinal Endoscopy.[4] This list was determined by a review of published literature and expert consensus. Studies have shown that when colonoscopy is done for appropriate reasons, significantly more clinically relevant diagnoses are made.[5, 6, 7]

Based on the evidence GIQuIC's supporting societies agree the performance target for an appropriate indication measure should be > 80%.

[4] ASGE Standards of Practice Committee, Early DS, Ben-Menachem T *et al.* Appropriate use of GI endoscopy. Gastrointest Endosc 2012;75:1127-31.
[5] Balaguer F, Llach J, Castells A, et al. The European panel on the appropriateness of gastrointestinal endoscopy guidelines colonoscopy in an open-access endoscopy unit: a prospective study. Aliment Pharmacol Ther 2005;21:609-13.
[6] Vader JP, Pache I, Froehlich F, et al. Overuse and underuse of colonoscopy in a European primary care setting. Gastrointest Endosc 2000;52:593-99.
[7] de Bosset V, Froehlich F, Rey JP, et al. Do explicit appropriateness criteria enhance the diagnostic yield of colonoscopy? Endoscopy 2002;34:360-8.

GIQIC 10: Appropriate management of anticoagulation in the peri-procedural period rate – EGD

Description: Percentage of patients undergoing an EGD on an anti-platelet agent or an anticoagulant who leave the endoscopy unit with instructions for management of this medication

Denominator: All patients undergoing an EGD on an anti-platelet agent or an anticoagulant

Denominator Exceptions/Exclusions: None

Numerator: Number of patients on an anti-platelet agent or an anticoagulant who leave the endoscopy unit with instructions for management of this medication

Measure Type: Process, standard measure **Measure Domain:** Communication and Care Coordination

Rationale and Supported Evidence:

Given bleeding is an adverse event associated with EGD,[8, 9, 10] adherence to this quality measure is supported by GIQuIC for this population of patients.

[8] Ginzburg L, Greenwald D, Cohen J. Complications of endoscopy. Gastrointest Endosc Clin N Am 2007;17:405-32.
[9] Ben-Menachem T, Decker GA, Early DS, et al. Adverse events of upper GI endoscopy. Gastrointest Endosc 2012;76:707-18.
[10] Eisen GM, Baron TH, Dominitz JA, et al. Complications of upper GI endoscopy. Gastrointest Endosc 2002;55:784-93.