Maximizing Quality in Your Practice and Making it Pay Off

David A. Johnson, MD, FACG
Professor of Medicine/Chief of Gastroenterology
Eastern VA Medical School
Norfolk, VA
The changing landscape of healthcare will not only force the typical GI practice into a more formative participation in benchmarking activities, but will force a change of focus from an internal to external audience. Traditional benchmarking has focused on cost and efficiency. Downward pricing pressure will drive continuation of such activities, but there will be an intense and ever increasing focus on quality direction for value-based purchasing. Furthermore, the rising consumerism related to healthcare consumption, will force defensive benchmarking with an eye to how the data will be perceived by an external audience.

Defensive benchmarking will evaluate the confluence of quality measures, patient satisfaction and price, in light of how these will be evaluated by the patient as well as the insurers. Traditional benchmarking can provide cost data to support pricing decisions, but well-defined and broadly accepted quality measures that can transcend single episodes of care and are applicable to complex patient care across specialties have yet to be developed. The gastrointestinal professional organizations have increasingly embraced the quality improvement paradigm that is advancing through medicine.

**Recognition and measure excellence of endoscopists**

The proof of quality comes from documentation of performance and outcome. There is no substitute for collecting relevant data. Trainees are now expected to maintain logbooks of their procedural activity during training, and many authorities have recommended that endoscopists should continue to collect data prospectively on their endoscopic practice and performance. This translates into “endoscopy report cards.”

The performance measures listed below are my best prediction of those measures that will important in the near-term application for your GI practice. Many of the early quality measures have targeted colonoscopy given the volumes represented in GI practice.

1. Colonoscopy appropriateness for use in surveillance of polyp follow-up. Recognizably this is already a PQRS measure for 2012.
2. Adenoma detection rate – Although an intermediate endpoint in the final goal of colon cancer prevention/reduction, this measure has now been validated as predictive for reduction of interval CRC following colonoscopy.
3. Cecal intubation rate – simple, easily defined by landmarks (and photo documentation).

**Comment**: In present day practice, based on the scientific evidence, these three indicators offer perhaps the best and most immediate validation for quality colonoscopy. These measures have been suggested as the best option for performance based reimbursement.
Coming soon?

4. Interval recommendations for follow-up colonoscopy? Compliance to colonoscopy screening/surveillance guidelines is suboptimal and reflects both overuse and underuse.

5. Adequacy of colon preps? Consistently in large studies, approximately 20% of preps are inadequate. These lead to rescheduled procedures and/or the significant potential for missed lesions.

6. A “culture of safety” – recognizably, many in large academic centers have heard this term already. Those with ASCs should already be preparing. CMS announced details of the new ambulatory surgery center (ASC) quality reporting program in the ASC prospective payment system 2012 final rule. Beginning Oct. 1, 2012, ASCs will be required to submit quality data on measures to avoid a 2 percent reduction in 2014 Medicare payments.

7. Endoscopic sedation/anesthesia – this is a hot button for insurance.

8. Overutilization of endoscopy in Barrett’s esophagus. The current practice of surveillance is, however, not close to the current guideline recommendations for 3-5 yr interval surveillance for BE without dysplasia.

What should you do?

The idea that you are not already being measured is naïve! Gastroenterologists need to be proactively collecting data that are accurate and reflective of your practice. The GI Quality Improvement Consortium (GIQuIC) registry (http://giquic.gi.org) is a national registry and is the recognized process for defining quality and has received considerable favorable comments from both CMS and private insurers.

There is no doubt that this will be the future for defining quality of endoscopic procedures. The sooner GIs recognize the importance, the more prepared they will be for short term and rapid adjustments required by payers and patients alike!

References


