



# Is Quality

## Your Trump Card?

BY TOM DEAS, MD

The raging health care reform debate has intensified the focus on increasing the value of health care services through improved quality and concurrent cost reduction. While maximizing quality of care often leads to lower total health care costs, the resources which are needed to measure and improve quality in the Ambulatory Endoscopy Center (AEC) will often increase the overhead cost structure of the AEC. Depending on the level of resources committed to quality assurance, an AEC may expend as much as \$10 per case in support of quality initiatives. When the AEC mission is to create a patient-centric care environment, the resources committed to quality yield a substantial positive return on investment:

- Better clinical outcomes for patients
- A safer patient environment and protection from bad press
- Improved patient service and satisfaction
- Fewer adverse events
- AEC accreditation and/or ASGE Endoscopic Unit Recognition\*\*\*
- Improved marketing

\*\*\*The **ASGE Endoscopy Unit Recognition Program** recognizes endoscopy units that follow the ASGE guidelines on privileging, quality assurance, endoscopy reprocessing and CDC infection control guidelines. The program also requires attendance by a representative of the unit to an ASGE course designed to thoroughly review concepts in the guidelines. The course agenda includes improving patient satisfaction, endoscopy-related infections, endoscope reprocessing, understanding quality metrics, designing and implementing a quality improvement program, training and credentialing, strategies for accreditation and re-accreditation, quality in sedation and monitoring, and more. ASGE members may go to [www.asge.com](http://www.asge.com) for more information on the Endoscopic Unit Recognition Award.

- Increased adenoma detection and CRC prevention
- Fewer missed lesions

Development of a program to maximize the quality and safety of gastrointestinal endoscopy begins with the mindset of the endoscopy team and facility governance who are fully committed to the principle of measuring and improving the quality and safety of care delivery. This way of thinking acknowledges that cognitive abilities, technical skills and behavioral patterns

may vary widely among endoscopists and other care providers. While some variations are expected, desirable and tolerable, others may exceed benchmarks of quality and safety that are established as the facility's bottom-line expectation of its endoscopy team. All members of the team must establish quality and safety as a #1 priority.

It is important that the physician staff take the lead in creating and sustaining a continuing focus on quality of care and safety, assuring that quality performance takes priority and trumps production pressure, case volume, economic interests or other efficiency measures. The endoscopist staff must be receptive to findings of evidence-based medicine and guidelines, and be amenable to facility studies which may highlight the need



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for performance improvement, behavioral change, additional training or other interventions.

To fulfill this commitment, the money has to follow the mindset. Endoscopy unit leadership must allocate resources to accomplish quality objectives. A quality program of excellence will not evolve if it is an extracurricular activity or one that is accomplished when "spare time" is available to complete the work.

Resources should be budgeted for some, if not all, of the following:

- Facility quality nurse who may share other duties
- Medical Director
- Endoscopy report software
- Practice management software
- Education & training
- Facility quality committee that reports to the governing body

Quality initiatives may be accomplished without all these resources, but a more robust quality program cannot be easily sustained without significant resource allocation. The cost and time commitment to achieve unit accreditation should also be considered. In addition to the quality leadership infrastructure, other members of both the clinical and administrative staff must be cooperative and fully supportive of quality studies and initiatives.

The quality team should then identify quality and/or service measures that warrant attention, or for which there is clear evidence that improvement is needed. Useful measures may derive from external sources such as ASGE guidelines, medical literature, or other performance standards.

These may include but are not limited to:

- Adenoma detection rate
- Colonoscopy withdrawal times
- Cecal intubation rate
- Endoscopic complications
- Colon preparation quality
- Polyp surveillance intervals

- Cancers found within three years of prior endoscopy
- Clinical indications for endoscopy
- Use of antibiotic prophylaxis
- Anticoagulation management

Some measures may be established to address problems identified within the endoscopy unit:

- Late physicians
- Case turnover efficiency
- Scope maintenance
- Scope disinfection process
- Endoscopic complications
- Patient complaints
- High cancellation rates
- Block scheduling

Having considered these measures and others, the facility quality committee should prioritize their objectives, obtain medical staff support, and commit the resources to study design, data collection and analysis. Care should be taken to assure that data are collected in an objective, unbiased, fair and reliable manner. Make it clear that the objective is to measure and improve performance, and not to accuse or ascribe fault or guilt for poor performance.

Study design should answer the following questions:

- For what period of time or number of patients will study data be collected?
- What data will be recorded? (A tool for consistent data collection will need to be designed.)
- Who will collect the data?
- How will the data be analyzed to obtain the performance measured?
- How will the results be presented to affected endoscopy unit staff?
- What will be used for benchmarks, standards, or guidelines in the analysis?

Benchmarking is an essential element of quality improvement. As an athlete improves performance based on personal bests, qualifying times and record times, a quality program should use

internal and external benchmarks and some absolute benchmarks as goals for improvement. Internal benchmarking references your own past performance for comparison and improvement. *For example, if photo documentation of the cecum occurs 86% of the time in 2008, you may use that as an internal benchmark and set 90% as your goal for 2009.* External benchmarking uses measures derived from medical literature, professional guidelines/standards or accumulated data from other similar entities. *For example, external benchmarks may include, 0.1-0.2% post-polypectomy bleeding rate from published articles, a 95% cecal intubation rate for screening colonoscopy from ASGE Standards and Guidelines, or 95% satisfaction rate which was achieved by all the ASCs who are partnered with a corporate partner.* Absolute benchmarks are the "never" events. *Examples include wrong site procedures or breaches of scope reprocessing protocols.*

When complete, the study finding should be shared with the endoscopy unit staff. In some cases, blinding of the data may be appropriate; however, all persons whose performance is being evaluated should be given their performance assessment compared to the blinded performance of their peers and to validated benchmarks. Depending on the study, sharing of all the findings openly may be acceptable. Study design and data collection methods should be fully reviewed and critiqued, as well as the findings of the study by the physician staff and others involved in the study processes.

Most quality studies identify variations in care and areas of potential improvement. When these findings have been reviewed and accepted as valid measures, performance benchmarks and expectations should be

established for the physicians and endoscopy unit staff. To achieve maximum improvement in quality performance, the study should be repeated at an appropriate time interval to measure progress toward performance improvement.

The commitment to improved quality of care and safety should be embedded in the culture of our endoscopy units. The optimal, sustainable result requires a commitment at all levels from governance leadership to the receptionist—including budgeted financial resources and a physician staff that embrace and encourage the process of peer review and quality improvement. If you have not already begun, now is the time to start your quality initiative or to enhance your current quality initiatives, as the years ahead will require a sharper focus on quality performance.

*A version of this article was originally published in the "Improving Quality and Safety in Your Endoscopy Unit" course syllabus and has been reprinted here with permission from the American Society for Gastrointestinal Endoscopy (ASGE).*

*Additional Reading: Quality Indicators for Gastrointestinal Endoscopic Procedures, Gastrointestinal Endoscopy, Volume 63, No. 4:2006. Supplement ASGE 2007 Guidelines for Gastrointestinal Endoscopy: Practice, Technology, and Training.*

Named one of the **2009 top doctors** in **Becker's ASC Review – 23 Gastroenterologists to Know**

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### STUDY EXAMPLE:

**Quality Issue:** *There has been an increase in over-sedation and prolonged recovery times (>30 min) in our endoscopy unit. What is the root cause of the problem?*

**Study Description:** *The study will include 50 patients for each of 10 staff physicians undergoing moderate sedation with midazolam and fentanyl for routine esophagogastroduodenoscopy, colonoscopy, or both procedures. The following data will be recorded either manually or electronically (EHR) by the sedating nurse and recovery nurse: Patient name, ID, DOB, DOS, procedure type, concurrent sedative/narcotic medication, midazolam dose, fentanyl dose, reversal agent if any, a rival time in recovery, discharge time from recovery, reason for prolonged recovery.*

**Analysis:** *The data will be analyzed to determine if any pattern exists for delayed recovery and reversal agent use for the nurse administering sedation, the physician performing the procedure, or concurrent use of sedative/narcotic medications to include benzodiazepines, hypnotics, narcotics, and daily alcohol intake. A summary of average dosages of versed and fentanyl, average recovery times, and number of delayed recovery (>30 min) will be provided for each staff physician and sedating nurse. All providers will receive their own results along with the blinded results for their peers. Average recovery times and episodes of prolonged recovery will also be analyzed based on the presence or absence of sedative/narcotic medications.*

**Action steps:** *Findings may confirm no trends or patterns that require remediation or altered management. However, findings may warrant further training or guidance of nurses and or physicians in moderate sedation. In addition, some patients' medications and alcohol history may justify future consideration of sedation alternatives to midazolam and fentanyl.*

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