Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:
https://reachmd.com/programs/cme/quality-indicators-how-do-you-compare-part-1/17861/

Released: 03/20/2024
Valid until: 03/20/2025
Time needed to complete: 53m

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Quality Indicators: How Do You Compare? Part 1

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Shaukat:
Hello. This is CME on ReachMD, and I'm Dr. Aasma Shaukat. Here with me today is Dr. Doug Rex.

Thanks for coming on, Doug. We have a lot of questions for you, but I'll start with a very important one. Do clinicians know the quality indicators and whether they're meeting them, and how important is this?

Dr. Rex:
So, Aasma, this is an incredibly important movement that's been happening in colonoscopy in the United States and around the world for the past 2 decades, the quality movement. We have a lot of so-called quality indicators, but the key ones, first of all, with regard to detection, the adenoma detection rate [ADR]. The percentage of patients undergoing screening colonoscopy who have one or more conventional adenomas detected, currently for age 50 and above, but we expect this will be changed to age 45 and above because of the recommendation to now screen at age 45. There are what we call priority indicators, and the first one is the adenoma detection rate. We're likely to see some expansion of the recommendations for detection because we've learned that detection of sessile serrated lesions, and even something about adenomas per colonoscopy, as opposed to just how many people have one or more adenomas, gives some additional information about who's doing well with detection.

Secondly, the cecal intubation rate. The frequency of that should be at least 95%, and screening colonoscopies likely to soon be made 95% for all. Third, another one is withdrawal time. This is probably not a priority indicator, but we've learned that rather than the original 6 minutes of minimum withdrawal time during colonoscopy, it probably needs to be 8 to 9 minutes. And I think another now becoming a priority indicator is the quality of bowel preparation, because as we've been discussing, when the bowel preparation is inadequate, it has so many negative consequences for the patient and for the cost to the healthcare system and society of delivering colonoscopy services. We don't have, really, a mandate, a legal mandate to measure quality, but as part of the quality movement, more and more gastroenterologists and other colonoscopists around the country are starting to engage in this process.

We know that the adenoma detection rate, the higher it is, it predicts improved protection against colorectal cancer. We know that when physicians improve their adenoma detection rates, that their patients start to have a lower risk of developing colorectal cancer. Let's face it: This is the reason why we're doing colonoscopy most of the time is to keep people from getting colorectal cancer. So the quality measurement is critical. More and more people all the time are doing it. I really think that if you're not measuring at least the adenoma detection rate, you're really not demonstrating enough seriousness about the primary purpose of doing colonoscopy. So I think, more and more, and I hope everyone is getting on board with quality measurement and reporting and improving those who have lower performance for these measurements.

Dr. Shaukat:
All right. Thank you so much for those excellent points, Doug, and thank you for your leadership in writing these guidelines.

So what we've learned is ADR is a very important quality indicator, one that we should be getting feedback on, report cards, and trying to improve constantly. Withdrawal time of minimum 6 minutes, but likely 8 to 9, and it's not really the time that's crucial; it's what we do in that time is truly what we are after. That time should be spent in good withdrawal technique, and the hallmarks of a good withdrawal technique are washing and suctioning, looking behind folds, and then segmental inspection and timed withdrawal.

In that aspect, taking a second look at the right colon is extremely important, because we know that we see a lot of things on that second look, so that's another way to enhance our yield of detection. And then finally, ensuring that we have cecal intubation rate and prep adequacy rate that exceed 95% is extremely important for us.

Thank you for this excellent discussion. Thank you for tuning in, and be sure to check out our part 2.

Announcer:
You have been listening to CME on ReachMD. This activity is provided by Prova Education and is part of our MinuteCE curriculum.

To receive your free CME credit, or to download this activity, go to ReachMD.com/Prova. Thank you for listening.