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How Can We Ensure Quality in Endoscopy Units?

Dr. Buch:
This Dr. Peter Buch, your host for *GI Insights* on ReachMD. As we all know, the ultimate goal of quality in medicine is to improve outcomes and to reduce costs. And here to discuss quality in gastroenterology is Dr. Hamita Sachar, an Assistant Professor of Medicine in Digestive Diseases and the Director of Ambulatory Services and Digestive Diseases at Yale School of Medicine. Welcome to the program, Dr. Sachar.

Dr. Sachar:
Thank you for having me.

Dr. Buch:
It's a delight. So Dr. Sachar, what are the top quality issues in an endoscopy unit?

Dr. Sachar:
So Peter, over the years, there has been an immense focus on defining what really constitutes a high-quality endoscopy. Now the core idea behind doing this is to bridge the gap between what is current clinical practice and what is optimal patient care, or the ideal. So far procedure-associated quality indicators have taken center stage, especially since they have been very well studied and can directly be related to patient outcomes. There's been significant efforts that have been made to translate these quality concepts into everyday practice with a focus on making them easier to measure and become more actionable. However, a critical component of high-quality endoscopy services relates to the site of the procedure, that is the endoscopy unit itself. So there are several reasons why this is important, including more satisfied patients and providers. There's greater case volume to be had. There are more efficiencies, and there could be avoidance of poor quality and safety problems, which honestly could be very catastrophic.

Lastly, as healthcare reimbursement in the United States becomes more dependent upon demonstration of performance and quality, stakeholders such as patients payers, endoscopists, governing organizations, they all will be looking for guidance on endoscopy unit-wide performance. Now unlike many procedure-associated quality indicators, evidence-based indicators used to measure the quality of endoscopy units are really lacking.

To address this further, the ASGE did convene a task force, and really the primary objectives was to look at the literature and come up with evidence-based quality metrics and really to drive consensus amongst stakeholders.

So they came up with five key areas that they wanted to focus on. And they were patient experience, employee experience, efficiency and operations, procedure related and safety, and infection control. And through this process, they came up with 155 quality indicators, which is a lot, and it really got consensus on 29, but highlighted five that really were thought to be priority quality indicators and probably the most meaningful.

So of those five, I just want to say that the first one focuses on the define leadership structure. So as you can tell, a good leadership structure that's in place can really show organizational commitment, and it really magnifies efficiency and operations in the endoscopy unit and also really advances staff experience.

The second one is endoscopy unit has a regular education training program and continually invests in improving this for all the staff especially when it comes to new equipment and devices and endoscopic techniques.

The third is the endoscopy unit records, tracks, and monitors procedure quality indicators for the endoscopists at the level of the endoscopist and the endoscopy unit. So this is something that we're more familiar with in general.

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The fourth one is the procedure reports are communicated to referring providers and a process in place for patients to receive a copy of their endoscopy report.

The last one is the process that's in place to track each specific endoscope from storage use to reprocessing, and back. As we know, this is a marker of high standard for infection control and really has been very central to the news in the recent years because of those outbreaks that have happened in relationship with infection control.

Dr. Buch:
Thank you. And Dr. Sachar, how would you approach a physician who has a substandard adenoma detection rate?

Dr. Sachar:
Yeah, that's a good question, Peter. It comes up every so often, but really the way to think about endoscopists who have lower than what the benchmark for adenoma detection rate is to first be transparent about the data and to show them their data. So if you have a system in place within your endoscopy unit that measures this benchmark and is readily available to them for review, say every quarter or every half year or whatever it is, it can be very meaningful.

There's been several studies that have looked at endoscopists just being told what their adenoma detection rate is. And in turn, that has really increased the rate without any other intervention. In other studies, they've suggested that you need some sort of educational tool as well in order to make that happen. But I think that's fairly powerful on its own.

I like to also think about an algorithmic approach to this. So we know that adenoma detection rate is affected by several different factors. So the first thing I really go over with the endoscopist if I do notice that this is a consistent problem is something like a bowel prep and to see whether they're consistently giving their patients adequate or high quality bowel preps because we all know the better the quality of the prep, the more adenomas you will detect. So really to make sure that the patients are getting appropriate instructions, they're using correct language, and it's targeted to the right literacy levels. Whether they're using split-dose preps, they're decreasing the time, from the prep to the endoscopy, they're all are important factors and making sure that patients get high-quality preps.

I also encourage the use of using standardized bowel prep scores within the endoscopy unit, because it really helps define what the bowel prep is like. And it's standard across everybody, so there's less variation within that. So things like Boston bowel prep scores, Aronchick scale, whatever it just has to be a standard across the board.

Now if the bowel prep is adequate, then I move on to talking a little bit more about whether folks are spending enough time in the colon. So really the goal here is to increase the colonic examination time. Now while withdrawal time has fallen a little bit out of favor in terms of a quality metric over ADR, I still think it's very useful, especially for people who have low adenoma detection rates. If you look harder, you're probably going to find more. So that's really the idea behind this concept of spending enough time in the colon and looking as carefully as you can.

Then if that doesn't seem to be doing too much, we move on to improving the technique. So we do know that certain techniques like retroflexion within the cecum, or a second look in the right colon has been shown to increase adenoma detection rates.

There's also this idea of dynamic positioning of the patient and when water exchange techniques work; I think that there's a little bit of variation on literature on that, but they can be helpful. I think this idea of like a teamwork approach to detect adenomas, which is whether your nurse or tech who's working with you is also looking at the screen, can be very helpful in identifying adenomas and making it sort of a team-based approach overall.

And then there's this last factor of technology. So really, the goal here is to improve contrast between the background and the polyp. And you know, there's been many, many techniques like image enhancement technologies that have been helpful in this regard. Although the literature is not consistently shown improvement, people could learn to use this. So this would be like narrow-band imaging, I-Scan, chromoendoscopy, things like that.

And then the other thing that the technology really focuses on is really improving visualization behind the folds. So there have been devices at the end of the scope that usually help, things like Endocuffs, EndoRings. And then there's other technology like the Third-Eye Panoramic Device, or the GI system, which really tries to look behind the folds, or give you this wide view of the colon that can really help with all these things. I do think that the order in which I go is again, bowel prep first, then spending more time in the colon, then improving technique, and then technology.

Dr. Buch:
Thanks for sharing that. For those just joining us. This is *GI Insights* on ReachMD. I'm Dr. Peter Buch. And joining me today to talk about quality in GI care is Dr. Hamita Sachar.

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Now Dr. Sachar, if we zero in on the peer review process, can you describe the benefits of joining a peer review process like GIQuIC?

Dr. Sachar:
I think the bottom line here is that if you have quality data that you're able to collect, measure, and share, that really supports the idea that we're able to provide with quality metrics that are actionable, ultimately, so I think if your endo unit is not already doing this on their own, things like GIQuIC can be very helpful because there's sort of these c national level registries that help with storing this kind of quality indicator data. It can help you on an endoscopy level, look at what is happening in real time or over long periods of times. And if you do make any workflow changes, or any sort of changes at all within the endo unit, you can really measure that along the way. It also promotes transparency to your endoscopists and staff alike. So I find it to be very helpful. And it's been very helpful for academic centers and community-based practices or ASCs across the country.

Dr. Buch:
Before we wrap up, Dr. Sachar, is there anything else you would like to share with our listeners?

Dr. Sachar:
I'd like to emphasize the need for endoscopy unit-based quality metrics, as we know that they're probably going to have great impact on the quality of care that we provide for our patients and the value that we demonstrate for the procedures that we do on a daily basis. I think that more research into providing evidence behind most of these metrics would be the future, and I look forward to seeing more from our national societies about this.

Dr. Buch:
Well, you've certainly given us a great look at how we can help ensure quality in gastroenterology. And I want to thank you, Dr. Sachar, for joining me today.

Dr. Sachar:
Thank you for having me, Peter.

Dr. Buch:
For ReachMD, this is Dr. Peter Buch. To access this episode as well as others from the series, please access reachmd.com/giinsights, where you can Be Part of the Knowledge. Thanks for listening and see you next time.

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