

Measuring the Quality of Endoscopy

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(Am J Gastroenterol 2006;101:864–865)

The practice of gastrointestinal endoscopy is facing a crisis. There is decreasing reimbursement for endoscopic procedures in the face of increasing demand. We are challenged to assess the quality of the services we provide. Although providing the best possible patient care is our most important goal, we are poorly equipped to measure our ability to achieve that goal.

Our financial future is in jeopardy. Government payments, mainly in the form of Medicare and Medicaid, account for approximately 50% of all health care costs in the United States. In 2003, U.S. health care expenditures were \$1.7 trillion, representing 15.3% of the gross domestic product (GDP) and \$5670 per person (1). These costs are projected to more than double to \$3.6 trillion in 2014, or 18.7% of the GDP. This is an average annual increase of 7.1%, 1.9% greater than the growth of the GDP. In the face of growing expenditures, Medicare physician payments have remained relatively flat. At the time of this writing, the physician fee schedule for Medicare has decreased 4.4% from 2005. Legislation to hold fees constant for 1 year has passed and is waiting for the President's signature. The recent addition of a Medicare prescription drug benefit will cost \$1.2 trillion over 10 years (2). Payment trends in the private sector have followed those of Medicare. There are increasing efforts to shift both the cost and responsibility for health care spending to patients from both public and private payers.

During this time of financial stress there has also been increasing demand to track and improve patient outcomes. The Institute of Medicine (IOM) released its report, "To Err is Human: Building a Safer Health System" in 1999 (3). This report raised national awareness of medical complications, claiming that 44,000 to 98,000 people die each year as a result of medical errors. This was followed by the 2001 IOM report, "Crossing the Quality Chasm: A New Health System for the 21st Century," advocating widespread changes in health care to improve quality (4). Some states have begun reporting provider-specific crude outcomes data, such as surgical mortality, to the public. In 1990 the nonprofit National Committee on Quality Assurance (NCQA) was established to evaluate the quality of health care plans. The NCQA also administers the Health Plan Employer Data and Information Set (HEDIS) to provide health care plan performance information to consumers (5). This has developed into a national database on provider performance that consists of more than 60 measures of performance of specific

services in identified patient populations (6). The rate of colorectal cancer screening is the only gastroenterology-related HEDIS measure. In response to public and legislative pressure, the Centers for Medicare and Medicaid Services (CMS) has announced its intent to link provider payment to performance, in a "pay for performance" (P4P) program. Hospitals are already required to report 10 performance indicators to CMS to receive full payment for their services. Demonstration projects for physician performance are underway, and the agency has begun to identify specific quality indicators (7). Sixteen initial performance measures for physicians have been announced (none relating to endoscopy). In the near future, physicians will be required to track and report their performance in these areas to receive full Medicare payment. We can anticipate that reimbursement for endoscopy will also soon be linked to reporting and performance on quality measures.

When we address the issue of performance measures for endoscopy, it becomes clear that we have no reliable way to distinguish a high-quality endoscopic procedure done by a trained endoscopist from a procedure performed by an inadequately trained provider. Fortunately, adverse events are too rare to track as a meaningful indicator of quality. Direct observation of each procedure by an evaluator with formal training in endoscopy is impractical. We need objective, practical ways to grade our performance.

The ASGE and ACG recognize that if we do not develop evidence-based quality measures, an administrative or governmental agency without experience or insight into the practice of endoscopy will define these measures for us. We collaborated through a joint task force that reviewed data on quality measures for all major endoscopic procedures. After a year of intense effort they have developed the specific measures outlined in this report. It is clear from their efforts that we have limited data on endoscopic quality. The measures they propose are not perfect, or even applicable in all cases. Many areas for future study are identified. In the end, however, they have presented us with a series of practical quality measures that all endoscopists can use to assess and improve their performance. By adopting these recommendations we can begin to distinguish appropriate, high-quality endoscopy from inappropriate and poorly performed procedures. This will improve patient care, provide comparative information for consumers, and prepare us for the future, reporting requirements that will surely come.

We sincerely thank the task force chairs, Dr Douglas Faigel and Dr Irving Pike, for their hard work and leadership. We also thank the members of the task force who critically evaluated the literature and our endoscopic practice to provide these insightful reports. Their important contribution has provided us with the critical tools required to face a challenging future.

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