

AGA CENTER FOR QUALITY IN PRACTICE

Best Practices: Community-Based Gastroenterology Practices

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The Practice

This is 1 of 2 articles produced by the AGA Center for Quality in Practice (CQIP) that will describe best practices related to quality improvement, implementation of quality measurement, enhancing high-quality care, and developing patient safety initiatives. This article focuses on a community-based practice, and the second article will focus on clinical academic practices. These articles fulfill the goal and intent of the CQIP, to identify and disseminate best practices of physicians/groups with respect to quality initiatives to foster the examination and improvement of quality and safety in all gastrointestinal practices. This article outlines various management strategies to enhance quality including those used in a large Midwest community-based practice.

The objectives of this article are as follows: (1) to increase the reader's understanding of quality-improvement mechanisms and activities to evaluate, measure, and enhance care delivered in a large community-based gastroenterology practice, and (2) to identify the best clinical, safety, and quality in practices within a community-based practice setting.

This practice was established in 1996 with the merger of 3 independent gastroenterology practices. The practice provides a full range of gastroenterology and hepatology ambulatory and inpatient care and treatments and procedures for adult and pediatric patients. Outpatient clinics are operated in 6 locations with adjacent endoscopy centers and 2 infusions centers. One office is designed and dedicated especially to pediatric gastroenterology services. This practice adopted quality measurement and quality improvement as its number one business strategy in 2004. This effort was promoted internally as a key strategic move in anticipation of expanding consumer-driven health care and the perception that various pay-for-performance initiatives would be forthcoming from various national and regional payers. Two fundamental steps in quality improvement were believed to be needed: (1) the development of measurement tools within an electronic medical record (EMR) and (2) internal changes in the culture of practice from production based to quality based.

The Minnesota Gastroenterology practice began converting to an EMR in late 2003, and the effort continues. The initial conversion process focused on practice management, and the second phase focused on the development of endoscopy reporting, which supports and allows for the collection and analysis of information related to quality of care. The EMR has been a collaborative effort of the clinicians and administration. The system network allows referring providers to send referrals and access information on the status of their patients cared for by members of the practice.

Quality data collection and measurement are supported by the EMR. It has been designed to search data that are recorded in a menu-driven format, which allows for the combination of clinical and financial data and reporting on the value of a service. In this system, value is defined as incremental quality improvement divided by cost—an equation that reflects the stakeholder value of a service. Others have defined the value of care as quality/price.¹ The focus on value has been essential to maintain an emphasis on both quality and cost.

Opportunities to design the clinical centers incorporate input from multiple disciplines and levels of the organization. Physicians, midlevel providers, nurses, administrative staff, and patients, through patient-satisfaction surveys, participate in design processes.

Quality Improvement Culture and Structure

Measurement and the use of data are a necessary component of any quality program. Therefore, a practice must accept the concept that aspects of care provided will be measured. The main driver in efforts to build a quality measurement and improvement effort is the recognition that enhancing value (see earlier) will be the single most important business strategy for a practice to succeed in an environment of diminishing resources and conversion to a consumer-driven health care market. In this practice the adoption of quality as part of its culture began initially as a business strategy. That is, the practice knew, and accepted, that quality needed to be measured to ensure long-term financial success. However, as they began to explore measurement it became clear that first education about quality, its value to care, and the bottom-line was needed. That education led to a shift of quality from a management idea to a true part of the practice culture.

A formal governance structure that aligns with incentives gives authority to the culture of quality. This, of course, requires a willingness to invest in quality and decrease production.² The development of such governance grew quickly for this practice as the culture shifted. For example, leadership agreed to fund a quality department, including a designated physician medical director for quality, the inclusion of service and clinical quality measurement, and reporting of quality data.

The quality department is composed of the Medical Director, physician committee chairs, chief operating officer, senior

director of operations, director of quality, and 3 full-time nurse quality advisors. The work of the department is directed by the Quality Steering Committee and is overseen by the administration. The Steering Committee is made up of representatives from other key committees.

Three ideals that have driven the practice's quality culture are its passion for customer-focused care, the incorporation of the Institute of Medicine's 6 aims for improving health care (safety, effectiveness, equity, efficiency, timeliness, and patient-centered care),³ and a commitment to create a positive work environment for physicians and staff with accountability.

Physician accountability within the context of quality measurement required a compromise by individual physicians with regard to their personal autonomy. This fundamental shift in outlook was discussed thoroughly and required agreement by all providers. This buy-in and shift in culture is critical as a practice moves from a collection of providers to an integrated quality-driven organization.^{2,3}

Best Practices Regarding Quality-Improvement/Management Programs

There are a number of organizational behaviors that both reflect and support the culture of quality. These concepts and the resulting initiatives can be applied to most community-based practices, although the scope may vary depending on the size and focus of the practice. The reader should consider his or her own practice and how these overarching best practices may be transferred.

Mission Statement

Every practice needs a clear understanding of where the practice is going and how the leadership wants to get there. For example, did the practice form to support each individual physician's practice or is there an overriding corporate goal that supersedes a single individual's prerogatives? At a provider level, this is addressed in one's contract or employment agreement, defining the accountability to mission, vision, and type of care to be provided. The mission statement of the practice should address and speak to quality of care. In this practice the quality program works to provide a reporting system that sends a message that is supportive of the mission statement.

Physician Leadership for Quality

The size and resources of the practice will certainly impact the structure of a quality program. At a minimum, there needs to be a designated physician lead or champion for quality who is accountable for implementing quality initiatives and oversight for compliance. Recently, many payers have included language in their contracts to support and provide quality directives that also should be considered in structuring the program and accountabilities.

Physician and Staff Orientation

All practices should provide physician and staff orientation that addresses the accountability for quality, related policies and procedures, and performance expectations. In the practice reported here, all new employees and physicians are provided with a thorough orientation, including discussions about the quality program, its principles, and their accountabil-

ities. The learning includes defining acceptable and unacceptable behavior standards and addressing how the quality culture impacts provider/staff performance of patient care. For those in clinical roles, the orientation process often is customized. Physicians are asked to sign a commitment to a Citizenship Philosophy designed by the physicians for the physicians. This compact outlines *gives* (responsibilities) and *gets* (benefits of the practice). Management and staff have similar pledges that are incorporated into the learning.

Compensation Packages

As public and private payers explore and test various value-based payment options, all practices need to consider how quality/performance will be included in compensation calculations. The recognition that a practice is committed to quality improvement means that physician and staff incentives must be aligned together with this philosophy. In this practice, quality-performance measures are incorporated into staff and physician compensation packages. These goals relate to procedural outcomes, behavioral factors, and patient satisfaction. Staff incentives (bonuses) are tied to production and patient-satisfaction goals.

Customer Service

As patients assume more financial responsibility for their health care practices, physicians and staff need to be sensitive to the patient care experience. Feedback about the care and service provided can be ascertained through patient survey tools administered by a practice or third party. For example, most payers (health plans) routinely survey their beneficiaries about their satisfaction with provider care and services. In this practice the customer service department captures complaints and compliments about staff and providers, regardless of whether it is in the business or clinical area. Offering patients/families an opportunity to complete satisfaction surveys is routine and an ongoing process with regular, specific, physician-level feedback reports. Service data are shared with physicians and staff as an opportunity for system learning. It also drives process evaluation and changes and includes internal customers (other staff/physicians). Open dialogue and local problem solving is encouraged. The use of written, telephone, and internet-based surveys has allowed this practice to collect more than 20,000 surveys per year ($\approx 35\%$ of patient contacts).

Collaboration

Collaboration in quality and safety initiatives is key to support, and minimize gaps, in knowledge.⁴ Collaboration is a value integrated into the practice and is supported by the board to the frontline staff. Although difficult to measure, collaboration can be experienced through the respectful exchange of ideas and inclusion of all disciplines and levels of the organization as various initiatives are developed and implemented.

Association With Regional Stakeholder Groups

Linkage to and involvement with regional stakeholder groups looking at quality improvement such as the nationally recognized Institute for Clinical Systems Improvement and local business groups can be a source of information and, more importantly, an epicenter for synergies for improvement initiatives across organizations.

Practice Guidelines

Adoption of clinical practice guidelines can prompt care and provide a common point of reference for the physician regarding the management of a particular condition. Guidelines are not intended to replace professional judgment, nor are they a recipe to be applied to all patients with a particular condition. However, when based on evidence, they can be used to guide care and educate patients regarding various aspects of care such as ongoing monitoring required for their condition or related to treatment, such as immunosuppressants.⁵ This practice has adopted/developed internal clinical practice guidelines and policies for major treatments, procedures, and conditions handled by the group. Such policies/guidelines also should address areas of safety, such as universal precautions and latex sensitivity. Guidelines are reviewed and updated as needed, but at least every 2 years.

Individual Physician Quality Data/Feedback

Whatever quality initiatives a practice undertakes, whether process (appointment wait time) or clinical (cecum intubation rates), the members of the practice need feedback in a timely manner. The entire team should have access to aggregate data so all can be involved in identifying barriers to success, problem solving, and supporting improvement activities. Disseminating physician-level reports is likely to result in mixed reactions. In this case, this practice initially experienced a defensive reaction at the time of the first disclosure of data. However, as physicians began to understand what is behind the numbers, they have become more comfortable with the process and the data, shortening the bell curve. The initial focus has been on colonoscopy-quality indicators (based on current national consensus recommendations), for which the data are shared individually and in aggregate form every 6 months.

Administrator Communications

Communication and open dialogue is essential for a culture of safety² and quality.⁶ Communication tools include team meetings, staff newsletters, and educational materials (electronic or paper). In this practice the chief executive officer regularly addresses questions and concerns related to the practice, quality, or any other matters in a dedicated section of the practice intranet.

Best Practices Regarding Safety

Although many of the best practices identified later speak to safety and quality in relation to colonoscopy, we have attempted to broaden their application to other areas of practice as well. Therefore, the reader should consider his or her own practice and how these overarching best practices may be transferred.

Credentialing

Establishing credentialing criteria allows a practice to set a bar for competency. This practice requires that all endoscopists are board eligible or certified in gastroenterology or colorectal surgery, in accordance with national gastrointestinal standards set out by the American Society for Gastrointestinal Endoscopy. Similarly, each endoscopy center's basic cardiac life support-certified registered nurses is supported and encouraged to certify in gastroenterology. All endoscopy center staff

are required to participate in an extensive training and orientation program to ensure compliance to basic practice standards.

Facility credentials and accreditation also must be considered. These include any state licensure requirements, Medicare requirements, and quality standards of accrediting entities such as the Accreditation Association for Ambulatory Health Care and the Joint Commission on Accreditation of Healthcare Organizations defined by the center governing board as requirements.

Endoscope Disinfection and Cleaning

National standards (American Society for Gastrointestinal Endoscopy, Society of Gastroenterology Nurses and Associates, Association of Practitioners in Infection Control, American Society for Testing and Materials) should be applied to endoscope disinfection and cleaning processes and procedures. Compliance with such standards should be audited routinely and may be required by local law and accreditation bodies. This practice evaluates staff competencies related to these processes quarterly in a formal manner, based on written tests and direct observation by trained educators.

Accuracy of Biopsy Specimen Labeling and Follow-Up Evaluation

This practice uses a multiple-check process for labeling biopsy specimens, including an examination room check and 2 independent checks before leaving the facility. Incorporation of such redundancies is known to reduce errors.⁶ A monthly near-miss report is discussed at the staff and management levels to facilitate systems learning. This initiative has been extremely valuable in reducing errors from double digits to -0.5 percent since implementation.

Preprocedure Physical and Informed Consent

Policies and procedures for a brief physical examination and informed consent before the administration of conscious sedation should be established.⁷ Regulatory agencies, accreditation bodies, and malpractice insurance requirements also should be explored to ascertain that such policies and procedures are comprehensive. This practice has established such policies and procedures and monitors compliance.

Compliance With Anticoagulation and Antibiotic Guidelines

Guidelines regarding the management of patients using anticoagulants during endoscopy and those for preprocedure antibiotics should be used and compliance should be monitored.⁷

Monitor and Measure Unplanned Reversal of Sedation Medication

In this practice ongoing monitoring of reversal agent use is standard operating procedure at all endoscopy centers. These data are reported quarterly to the Quality Steering Committee. Rex et al⁷ have written about monitoring these particular indicators.

Measure and Monitor Serious Postoperative Complications

This practice monitors serious complications including death within 30 days, perforation, bleeding with transfusion, and cardiac arrest. Ongoing monitoring and reporting is standard practice. Rex et al⁷ have written about monitoring these particular indicators.

Reviewing Adverse Events

Reviewing and reporting of adverse events and near misses against those required by regulators and accrediting bodies is another monitor of safety.⁶ A safe environment needs to exist if the expectation is for the self-reporting of errors. This practice experienced significant resistance when the process was first implemented but, after a brief hiatus, the process has been revamped to ensure educational, not punitive, opportunities for the review.

Best Clinical Practices

Multidisciplinary Collaborative Approach to Care

It has been documented in the literature that a multidisciplinary collaborative approach supports safety and quality care.²⁻⁴ All levels and all committees and work groups addressing quality in the practice include representation from across functions—nurses, physicians, midlevel staff, and nonclinical staff engage in joint problem solving.

Use of Clinical Measures and Monitoring

Identifying and defining quality indicators are core functions of a quality program. For endoscopy this practice has included effectiveness of bowel preparation, cecum intubation rates, and adenoma removal rates for patients older than 50 years (effectiveness).⁷

Closing

It is our hope that this discussion of best practices in a large community-based gastroenterology practice will help to energize and stimulate gastroenterology practices of all types and sizes to examine quality and safety within their own setting. Depending on the particular practice environment, the structure and activities of the quality program may vary. However,

the key concepts that a practice must accept for a successful quality program are as follows:

- Performance measurement is a part of the practice environment and operation.
- Accountability at all levels of the practice directed toward excellence, service, and increased stakeholder value (internal and external).
- Sacrifice individual physician autonomy for the sake of quality.
- Willingness to invest in quality knowing it will impact and potentially decrease individual production.

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