Clinical Integration: The Silver Lining on the Approaching Storm Clouds

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Chief Quality Officer, Beth Israel Ambulatory Endoscopy Services

Medical Director, Eastside Endoscopy, LLC

Objectives

- Define types of quality and the who and what of measuring it.
- Discuss the definitions, history, and potential of clinical integration to enhance value and quality in the practice of endoscopy.
- Summarize the development, implementation, and maintenance of a successful model for endoscopic clinical integration spanning academic medical centers and hospital partnered ASCs.

Clinical Integration

Definitions of Quality & Benchmarking

- Measurable Quality – Compliance with or adherence to standards (i.e., practice guidelines/protocols)
- Appreciative Quality – Comprehension and appraisal of excellence beyond minimal standards and criteria
- Perceptive Quality – degree of excellence perceived and judged by the recipient or observer of care
- Benchmarking – The continual process of measuring practices against the performance of recognized leaders at a particular function, regardless of "industry standard"

Adapted from Janet Brown, The Healthcare Quality Handbook, 2011

Statement of Purpose

- The Quality Management Strategy shall be a coordinated, comprehensive, and continued effort to monitor and improve patient safety and the performance of all care and procedures. Its goal and purpose shall be to strive for optimal outcomes with continuous improvements that are consistently representative of a high standard of practice in the community, minimize risks to patients and organization, and are cost-effective.

Adapted from Janet Brown, The Healthcare Quality Handbook, 2011

Clinical Integration

Why Are We Doing This ?

- Standardization across centers and hospital-based units will improve quality and efficiency.
- Sharing data and benchmarking among stakeholders can only drive continued improvements in quality, safety, and efficiency.
- Demonstration of successful clinical integration through tangible improvements in quality and efficiency has and will continue to be recognized by health insurance carriers.

Clinical Integration

- "An active and ongoing program to evaluate and modify the clinical practice patterns of the physician participants so as to create a high degree of interdependence and collaboration among the physicians to control costs and ensure quality."

FTC/DOJ Statements of Antitrust Enforcement Policy in Health Care, #8.B.1 (1996) http://www.ftc.gov/bc/healthcare/industryguide/policy/statement8.html

Clinical Integration

- Clinical Integration is the extent to which patient care services are coordinated across people, functions, activities, and sites over time so as to maximize the value of services delivered to patients.

Stephen M Shortell, Robin Gillies, David Anderson, *Remaking Healthcare in America, 2000*

Ambulatory Endoscopy Program

- Four academic ambulatory endoscopy hospital units
- Four joint venture ambulatory endoscopy centers

Ambulatory Endoscopy Clinical Integration Program

Components

- Clinical Integration Committee
- Joint Quality Endoscopy Committee
- Clinical Integration Website
- GIQuIC
- Endoscopy Unit Recognition Program
- Health Information Exchange

Clinical Integration Committee

- Chaired by the chiefs of gastroenterology at two academic medical centers
- Committee includes the medical directors of all affiliated ambulatory endoscopy centers attend meetings
- Topics discussed:
  - Center operations
  - Credentialing
  - Practice guidelines/Standards of care
  - Utilization
  - Benchmarking and quality review

Ambulatory Endoscopy Clinical Integration Program
Joint Quality Endoscopy Committee

- Chaired by the director of endoscopy at one of the academic ambulatory endoscopy hospital units
- Attended by nurse managers from all hospitals and affiliated ambulatory endoscopy units
- Agenda:
  - Monthly statistics
    - Center/Hospital volumes
    - Complications, Hospital Transfers
  - Chart reviews (monthly)
  - Infection control
- Outliers are noted, and there is discussion regarding development of systems to improve performance which is reviewed at the next meeting

Joint Quality Committee

Data Collection Elements

- **Medical Record Review:**
  - 25 charts per month monitoring the following elements
    - Withdrawal Time (avg. minutes)
    - Cecal Intubation Rate %
    - Documentation of Pre-Procedure H&P %
    - Procedure Consent Signed Dated & Timed %
    - Anesthesia Consent Signed Dated & Timed %
    - Observed Compliance Time Out Procedure %
    - Medication Reconciliation Documented %
    - Discharge Orders Dated & Timed %
    - Post-Procedure Documentation Dated & Timed %
    - PACU Arrival Time Coincide with Anesthesia Record %
    - Documentation of Hand-off to Recovery Room RN %

Joint Quality Committee

Data Collection Elements

- Peer Review
  - Peer Review: 2 charts per GI physician per month (1 EGD & 1 Colon)
  - Peer Review: 2 charts per Anesthesiologist per month
- Infection Control:
  - Direct observation of hand-washing and PPE compliance: 10 observations of each per month
  - 3M Clean Trace: 2 scopes per day
- Hospital Transfers (ASCs only)
- The New York Patient Occurrence and Tracking System (NYPORTS)
- Satisfaction Surveys (to be discussed)

Ambulatory Endoscopy Clinical Integration Program
Joint Quality Committee

Endoscopy Quality Committee Report

Jul-12

Indicator	Goal	Site A	Site B	Site C	Site D	Site 1	Site 2	Site 3	Site 4	Average
Average Withdrawl Time (minutes)	6	12.80	10.00	10.10	10.10	8.30	8.10	5.50	6.00	8.54
Cecal Intubation Rate (%)	95	98.30	99.30	95.00	100.00	97.00	98.00	97.00	99.50	97.68
Documentation of Pre-Procedure H&P (%)	100	88.00	56.00	100.00	96.00	100.00	92.00	100.00	95.00	91.89
Procedure Consent: Signed/Dated/Timed (%)	100	92.00	98.00	100.00	100.00	100.00	92.00	100.00	99.00	97.89
Anesthesia Consent: Signed/Dated/Timed (%)	100	96.00	95.00	100.00	100.00	100.00	NA	100.00	99.00	98.75
Observed Compliance Time Out Procedure (%)	100	94.00	98.00	100.00	100.00	100.00	100.00	92.00	100.00	98.22
Medication Reconciliation Documented (%)	100	88.00	100.00	50.00	100.00	100.00	100.00	100.00	100.00	93.11
Discharge Orders: Dated/Timed (%)	100	68.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	96.44
Post-Procedure Documentation: Dated/Timed (%)	100	96.00	100.00	100.00	100.00	100.00	100.00	100.00		99.50
PACU Arrival Time Coincide with Anesthesia Record (%)	100	84.00	100.00	100.00	100.00	100.00	NA	NA	NA	97.33
Documentation of Hand-off to recovery Room RN (%)	100	96.00	55.00	100.00	100.00	NA	100.00	100.00	NA	93.00
INFECTION CONTROL										
-3M Clean Trace										
-Hand Washing (%)	100	92.00	96.00	100.00	100.00	94.00	100.00	100.00		97.75
-PPE (%)	100	88.00	98.00	100.00	100.00	92.00	100.00	100.00		97.25
Hospital Transfers/Admissions-ASCs only (#)	0		0.00		0.00	0.00				0.00
NYPORTS (#)	0		0.00		0.00	0.00				0.00

Volume Statistics

Affiliated Endoscopy Center Volume (2012)

Site A

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
Colonoscopy	373	419	476	414	454	446	380	454	390	407			4,213
Upper Endoscopy	290	311	329	307	301	290	272	316	296	289			3,001
Flexible Sigmoidoscopy	10	3	6	4	10	7	6	7	8	9			70
Upper EUS	63	67	80	71	90	69	75	87	57	84			743
Lower EUS	3	3	3	5	6	5	2	2	3	6			38
ERCP	56	62	69	64	63	58	67	73	64	65			641
Small Bowel Enteroscopy		2	3	4	4	4	1	3	1	1			24
EGD/PEG	8	4	5	8	8	7	7	8	5	4			64
Totals	804	871	971	877	936	886	810	950	824	865	-	-	8,794

Site B

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
Colonoscopy	470	499	507	507	559	503	457	426	364	416			4,708
Upper Endoscopy	259	322	347	304	326	302	267	280	217	271			2,895
Flexible Sigmoidoscopy	31	21	14	18	26	38	22	28	32	20			250
Upper EUS	20	15	38	12	27	17	17	16	20	19			201
Lower EUS	1	3	2		4	2	2	2	2	4			22
ERCP													-
Small Bowel Enteroscopy													-
EGD/PEG													-
Totals	781	860	908	841	942	862	765	752	635	730	-	-	8,076

Site C

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
Colonoscopy	97	112	114	95	119	104	110	99	102	114			1,066
Upper Endoscopy	104	115	121	119	111	118	112	115	113	124			1,152
Flexible Sigmoidoscopy		5	2	6	1	3	2	4	10	5			38
Upper EUS													-
Lower EUS													-
ERCP	10	11	5	13	9	10	13	6	4	14			95
Small Bowel Enteroscopy				1			1						2
EGD/PEG										1			1
Totals	211	243	242	234	240	235	238	224	229	258	-	-	2,354

Site D

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
Colonoscopy	[redacted]			608	660	612	537	537	490	601			4,045
Upper Endoscopy				277	293	284	273	261	213	295			1,896
Flexible Sigmoidoscopy				9	26	20	14	15	26	20			130
Upper EUS													-
Lower EUS													-
ERCP													-
Small Bowel Enteroscopy								12	15	12			39
EGD/PEG													-
Totals				894	979	916	824	825	744	928	-	-	6,110

Site 1

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
Colonoscopy	115	162	179	152	173	156	163	144	119	142			1,505
Upper Endoscopy	138	131	182	129	127	113	144	120	120	134			1,338
Flexible Sigmoidoscopy	1	2		4	3	1	1		1	2			15
Upper EUS													-
Lower EUS													-
ERCP													-
Small Bowel Enteroscopy				1		1		1					3
EGD/PEG													-
Totals	254	295	361	286	303	271	308	265	240	278	-	-	2,861

Site 2

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
Colonoscopy	264	281	275	257	306	298	222	257	185	216			2,561
Upper Endoscopy	200	211	201	176	189	204	152	135	148	145			1,761
Flexible Sigmoidoscopy	8	9	3	4	5	7	1	3	1	5			46
Upper EUS													-
Lower EUS													-
ERCP	7	8	4	8	7	6	5	3	5	6			59
Small Bowel Enteroscopy													-
EGD/PEG													-
Totals	479	509	483	445	507	515	380	398	339	372	-	-	4,427

Site 3

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
Colonoscopy	211	220	234	195	213	202	160	183	161	185			1,964
Upper Endoscopy	145	133	162	141	152	117	124	109	82	106			1,271
Flexible Sigmoidoscopy		7	10	15	9	19	14	16	15	18			123
Upper EUS						10	4		9	6			29
Lower EUS													-
ERCP	10	4	5	6	9	11	11	-	8	6			70
Small Bowel Enteroscopy	1	1				2							4
EGD/PEG					2	1				2			5
Totals	367	365	411	357	385	362	313	308	275	323	-	-	3,466

Site 4

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
Colonoscopy	[redacted]					98	258	466	490	569			1,881
Upper Endoscopy						62	154	256	324	321			1,117
Flexible Sigmoidoscopy							1		3	3			7
Upper EUS													-
Lower EUS													-
ERCP													-
Small Bowel Enteroscopy													-
EGD/PEG													-
Totals						160	413	722	817	893	-	-	3,005

Totals	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
Colonoscopy	1,530	1,693	1,785	2,228	2,484	2,419	2,287	2,566	2,301	2,650	-	-	21,943
Upper Endoscopy	1,136	1,223	1,342	1,453	1,499	1,490	1,498	1,592	1,513	1,685	-	-	14,431
Flexible Sigmoidoscopy	50	47	35	60	80	95	61	73	96	82	-	-	679
Upper EUS	83	82	118	83	117	96	96	103	86	109	-	-	973
Lower EUS	4	6	5	5	10	7	4	4	5	10	-	-	60
ERCP	83	85	83	91	88	85	96	82	81	91	-	-	865
Small Bowel Enteroscopy	2	3	3	6	4	7	2	16	16	13	-	-	72
EGD/PEG	8	4	5	8	10	8	7	8	5	7	-	-	70
Totals	2,896	3,143	3,376	3,934	4,292	4,207	4,051	4,444	4,103	4,647	-	-	39,093

Ambulatory Endoscopy Clinical Integration Program
Clinical Integration Website

- Purpose
  - Update and educate physician participants on clinical and quality issues including:
    - Credentialing
    - Practice guidelines
    - Center policies
- Content
  - Reference articles
  - Credentialing Policies
  - Direct links to practice guidelines utilized by all affiliated centers and hospitals
  - Center and Hospital Volume/Quality Statistics
- Future Content
  - Patient Satisfaction Surveys
  - Patient Education

Endoscopy Integration

Endoscopy Integration

Practice Guideline

- American Society for Gastrointestinal Endoscopy Guidelines
- Cleveland Clinic ASA Physical Classification System
- Guidelines for Colonoscopy Surveillance After Screening and Polypectomy: A Consensus Update
- Screening and Surveillance For Early Detection of Colorectal Cancer and Adenomatous Polyps: Joint Guideline from the American Cancer Society, USMSTF, and American College of Radiology

Credentialing

- Affiliated Ambulatory Endoscopy Centers Credentialing Policy

ASC/Hospital Endoscopy Quality References

- CMS Patient Safety List
- AGA ASC 2012 Final Rule Summary
- ASC Quality Collaboration Implementation Guide
- ASGE Quality Reporting 2012
- Measuring the Quality of Endoscopy
- Quality Indicators for Gastrointestinal Endoscopic Procedures
- Quality Indicators for Colonoscopy
- Quality Indicators for Esophagogastroduodenoscopy
- Quality Measures for Colonoscopy
- Standardization of Endoscopy Reporting
- ACG-Competencies in Endoscopy

Supporting Documents

- Clinical Integration - Responding to Market Place
- Clinical Integration - Ambulatory Surgery Centers
- Clinical Integration - IPA
- Teaching the Competencies: Using Observed Structured Clinical Examinations for Faculty Development
- Principles of Privileging and Credentialing for Endoscopy and Colonoscopy

Links to Clinical and Practice Guidelines

- American College of Gastroenterology Clinical Guidelines
- American Gastroenterological Association Guidelines
- American Society for Gastrointestinal Endoscopy Standards of Practice

Ambulatory Endoscopy Clinical Integration Program
GIQuIC (GI Quality Improvement Consortium, Ltd.)

- All affiliated endoscopy centers and hospitals enrolled as of August 2012
- National data repository developed by the American Society for Gastrointestinal Endoscopy and the American College of Gastroenterology
- Program gauges and evaluates overall performance of gastroenterologists and endoscopists based upon measures developed and/or endorsed by ASGE and ACG
- The program allows comparison of facilities and physician performance to peers

Ambulatory Endoscopy Clinical Integration Program

- The longest operating ambulatory endoscopy center in the clinical integration program exemplifies the dedication to the principles of clinical integration.
  - Health record exchange
  - Clinical Services
  - Clinical Leadership and Coordination
    - **Medical Director**
    - **Clinical Nurse Liaison**
    - **Practice Guidelines**
    - **Credentialing**
    - **Utilization and Quality Review**
    - **Physician Report Cards**
    - **GIQuIC**
    - **New York Colonoscopy Quality Benchmarking Group (NYCCQBG) Participation**
    - **Patient Satisfaction**

Ambulatory Endoscopy Clinical Integration Program

- Health record exchange
  - Currently medical records of hospital patients are accessible electronically at the ASC. Within six months clinical information will be available between hospitals and ASCs through Health Information Exchange (HIE)
  - Clinical labs, radiology, pathology, and endoscopy reports are available at all times eliminating the need for duplicative pre- or post- operative testing

Ambulatory Endoscopy Clinical Integration Program

- Clinical Services
  - The ASC has a transfer and affiliation agreement with the hospital
  - Ancillary services provided by the hospital:
    - Surgical pathology
    - Labs
    - Radiology

Ambulatory Endoscopy Clinical Integration Program

- **Practice Guidelines**
  - Uniform guidelines set forth by the ASGE
  - Guidelines are readily available for all participating physicians on the clinical integration website
  - Modifications or amendments to clinical practice guidelines are subject to review and approval by the clinical integration committee

Ambulatory Endoscopy Clinical Integration Program

- Credentialing
  - Performed in accordance with a uniform policy that applies to all physicians providing gastroenterology services at a hospital and/or affiliated ambulatory endoscopy center
  - Criteria available on website

Ambulatory Endoscopy Clinical Integration Program

Utilization and Quality Review

- Random charts are reviewed monthly for each member physician.
- Charts are analyzed for compliance with well established quality measures.
- Results are tabulated and reviewed at quarterly CQI and peer review committee meetings.
- Committee meetings are attended by the medical director and member physicians on a rotational basis.

Ambulatory Endoscopy Clinical Integration Program

Utilization and Quality Review (continued)

- Physician outliers identified.
- Data is shared internally as well as more widely with members of the endoscopy clinical integration committee to obtain a unified data set for each particular physician.
- Outlier physicians are required to participate in quality improvement efforts and enhanced monitoring.

Ambulatory Endoscopy Clinical Integration Program

Physician Quality Achievement Report

- Designed to inform physicians about their performance with respect to established quality measures and patient satisfaction
- Benchmarking to be performed within and between centers and hospitals
- Measures included uniform across all affiliated hospitals and ambulatory centers

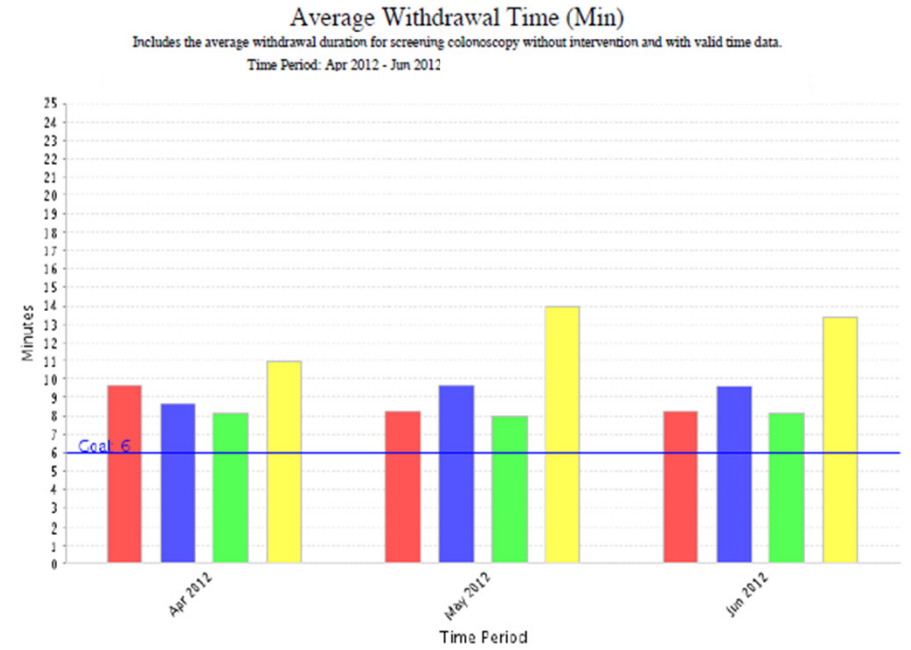
Physician Quality Report

Quality Measure	Quarter average	Peer average	Variance
Cecal Intubation			
Preparation Quality			
ASA Classification			
Preprocedure Assessment			
Patient Satisfaction			
Appropriate Surveillance Interval			
Withdrawal Time			

The data presented in the table above is derived from the following sources:

1. Cecal intubation rate is derived as the average percentage of colonoscopies performed during which the physician successfully intubated the cecum. This includes screening and diagnostic procedures. The benchmark for this measure is >90 %. Data for this measure is extracted from the EMR database
2. Preparation quality is the percentage of colonoscopies that were reported as having a "good" or "excellent" preparation. Good is defined as sufficient to identify polyps 5mm or greater. The benchmark for this measure is >90%. Data for this measure is extracted from the electronic medical record database
3. ASA classification is based on the average number of procedures which had an ASA classification documented in the respective endoscopy report. The benchmark for this measure is 100%. Data for this measure is extracted from EMR database
4. The pre-procedure assessment consists of a brief history, physical exam and documentation indicating the physician has determined the patient is an adequate candidate for the planned procedure. Data for this measure is extracted from the EMR database for all patients seen at the center by the respective physician.
5. Patient satisfaction is derived from an average of the aggregate results extracted from the subset of questions contained in returned patient surveys pertaining to an individual physician's interaction with patients
6. Appropriate surveillance interval is based on the PQRS 185 measure which refers to the percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp in previous colonoscopy findings who had a follow-up interval of 3 or more years since their last colonoscopy documented in the colonoscopy report .
7. Withdrawal time is based on the average number of minutes a physician took to withdraw the scope from the cecum during screening colonoscopy when no maneuvers were performed. Data for this measure is derived from the reporting module contained in the Provation EMR. The benchmark for this measure is 6 minutes or greater.

Ambulatory Endoscopy Clinical Integration Program GIQuIC

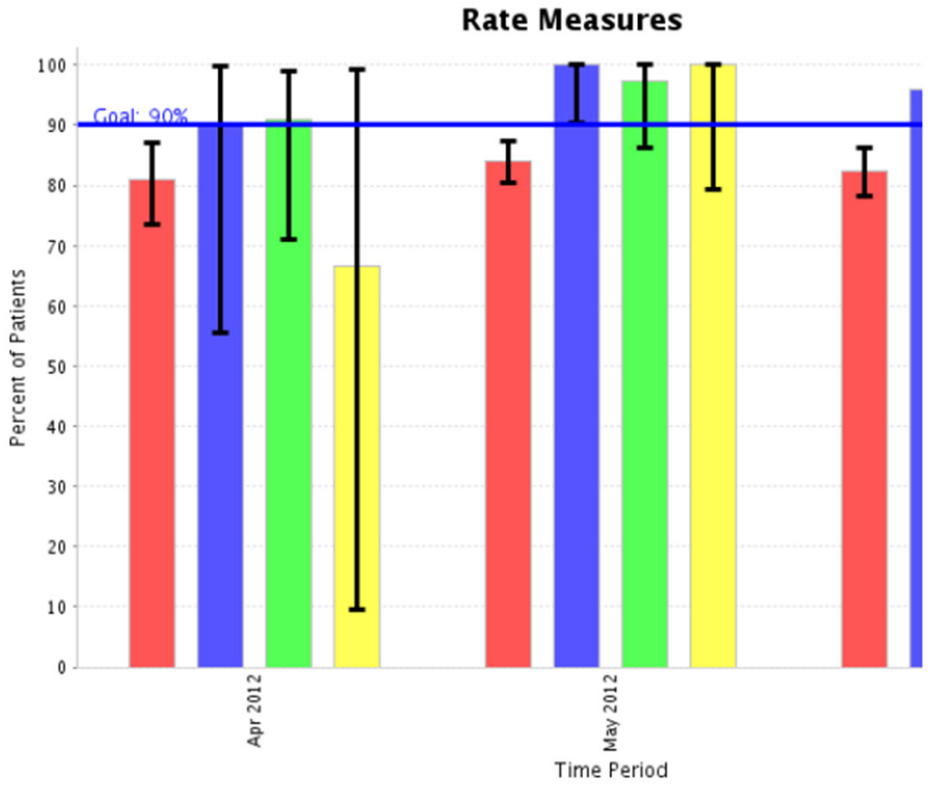


Data For: Average Withdrawal Time (Min)

Goal: 6%

Benchmark Group	Time Period	Average
	Apr 2012	9.6
	May 2012	8.3
	Jun 2012	8.2
	Apr 2012	8.7
	May 2012	9.7
	Jun 2012	9.6
	Apr 2012	8.1
	May 2012	8.0
	Jun 2012	8.1
	Apr 2012	10.9

Ambulatory Endoscopy Clinical Integration Program GIQuIC



Photodocumentation of the Cecum- All Colonoscopies

Percentage of colonoscopies into the cecum including photodocumentation of one or more of the ileocecal valve, appendiceal orifice, or terminal ileum.

Time Period: Apr 2012 - Jun 2012; S

Data For: Photodocumentation of the Cecum- All Colonoscopies						
Goal: 90%						
Benchmark Group	Time Period	Numerator	Denominator	% of Patients	95% C.I. Low	95% C.I. High
My Sites	Apr 2012	114	141	80.9%	73.4%	87.0%
My Sites	May 2012	396	471	84.1%	80.5%	87.3%
My Sites	Jun 2012	301	365	82.5%	78.2%	86.3%

NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE
Thomas Farley, M.D., M.P.H.
Commissioner

August 16, 2012

Brett Bernstein, MD
Director of Endoscopy

New York, NY 10010

Dear Dr. Bernstein:

As you know, the NYC Colonoscopy Quality Benchmarking Group (NYCCQBG) is a collaboration among the NYC Department of Health and Mental Hygiene (DOHMH), the Citywide Colon Cancer Control Coalition (C5), and the New York Society for Gastrointestinal Endoscopists (NYSGE). NYCCQBG's goal is to improve the effectiveness of colonoscopy screening in NYC through benchmarking colonoscopy quality indicators.

Thank you for participation in NYCCQBG. The NYC DOHMH applauds your efforts to ensure and improve the quality of colonoscopy screening. And we look forward to a productive and instructive partnership.

Sincerely,

Mari Carlesimo, JD
Director, Cancer Prevention Program
Primary Care Information Project
NYC Department of Health and Mental Hygiene

The NYC Colonoscopy Quality Benchmarking Group

A Focus on Quality to Improve Colonoscopy Screening in New York City

Dates: Screening colonoscopies performed 4/23/12-6/9/12

NYC Colonoscopy Quality Indicators Summary[1]	GOAL	YOUR SITE, N= 364[2]
Adenoma Detection Rate[3]		
Females ≥ 50 years old	≥ 15%	14%
Males ≥ 50 years old	≥ 25%	24%
Pre-procedure		
Informed consent documentation	100%	100%
ASA category assessment	100%	100%
Intra-procedure		
Cecal intubation with photo documentation	95%	84%
Average withdrawal time (in minutes)[4]	≥ 6	8.4 minutes
Bowel preparation quality documentation[5]	100%	100%
Intra- and post-procedure complications documentation[6]	100%	100%
Post-procedure		
Discharge instruction provided	100%	100%

Notes:

1) *Additional benchmarking reports broken down by demographic variables are available upon request.*
2) N refers to the total number of unique patients who undergo a screening colonoscopy.
3) 120 cases were dropped due to incomplete pathology results.
4) *Cases with polypectomies or biopsies taken are excluded*
5) *Bowel preparation quality options are 'adequate' or 'inadequate', thus the rate is based on the percentage of procedures deemed 'adequate'.*
6) *A breakdown of specific complications (e.g., perforation rates, bleeding rates) is available upon request.*

"This (publication, project, etc) was supported by Grant/Cooperative Agreement IU58DP000783 from the Centers for Disease Control and Prevention (CDC) and the New York State Department of Health (NYSDOH). Its contents are solely the responsibility of the New York City Department of Health and Mental Hygiene and do not necessarily represent the official views of CDC or NYSDOH."

Ambulatory Endoscopy Clinical Integration Program
Patient Satisfaction

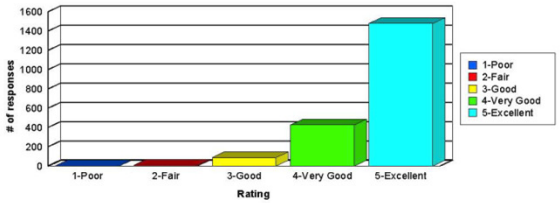
Patient Satisfaction – Patient satisfaction is measured at the initial site using a standardized questionnaire which is taken home by the patients and mailed to an independent third party vendor that tabulates results. The physicians and staff take these results very seriously and are proud to see that the center consistently demonstrates that over 90% of patients rank the center as very good or excellent in all areas.

For Year Of 2012

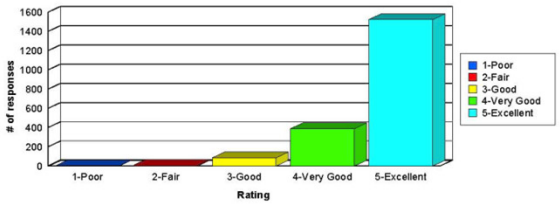
Total Surveys Returned = 2,019 Total Cases = 6,243 % Surveys Returned = 32.0%

Dr: All Doctors

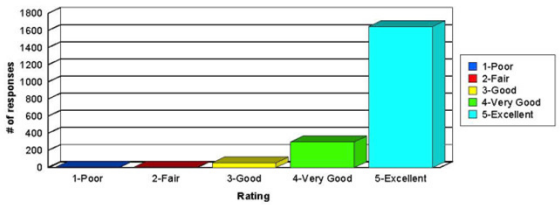
4. The experience in terms of how safe and secure you felt



5. Your confidence in the skills of OUR nursing staff



6. Doctor(s) ability and willingness to address questions about your care



For Year Of 2012

Total Surveys Returned = 57

Dr: BBB

	Poor	Fair	Good	Very Good	Excellent	Total	Avg Score
1. The availability, helpfulness, sincerity of our endoscopy center staff by phone.	0 0%	0 0%	6 11%	18 32%	33 58%	57	4.47
2. The knowledge, helpfulness and attitude of our reception/registration staff	0 0%	0 0%	6 11%	18 32%	33 58%	57	4.47
3. Overall comfort, amenities, cleanliness and accessibility of our facility	0 0%	0 0%	2 4%	18 32%	37 65%	57	4.61
4. The experience in terms of how safe and secure you felt	0 0%	1 2%	4 7%	10 18%	42 74%	57	4.63
5. Your confidence in the skills of OUR nursing staff	0 0%	0 0%	3 5%	8 14%	45 80%	56	4.75
6. Doctor(s) ability and willingness to address questions about your care	0 0%	0 0%	1 2%	11 20%	44 79%	56	4.77
7. Your confidence in the skill of your physician	0 0%	0 0%	0 0%	9 17%	45 83%	54	4.83
8. Were you kept informed of any delays in your procedure start time	1 2%	1 2%	3 6%	15 28%	33 62%	53	4.47
9. Effectiveness in meeting your overall time expectations	1 2%	1 2%	3 5%	12 21%	39 70%	56	4.55
10. The clarity, explanation, and completeness of your discharge instructions	0 0%	0 0%	3 5%	12 21%	42 74%	57	4.68
11. The helpfulness of the Center in answering questions during your post-op call	0 0%	0 0%	5 10%	11 22%	34 68%	50	4.58
12. All Center staff worked as team, and respected your privacy and dignity	0 0%	0 0%	5 9%	9 16%	43 75%	57	4.67
13. Probability you will return to our facility for future endoscopic needs	0 0%	0 0%	4 7%	9 16%	44 77%	57	4.70

14. Would you like us to contact you about any of your answers to the survey?

Ambulatory Endoscopy Clinical Integration Program
Cost-Effectiveness and Quality

- 30% of procedures performed at the initial site were derived from the hospital and are now performed in a more cost-effective setting.

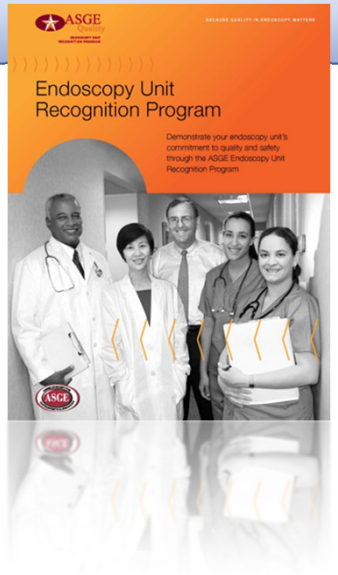
- 70% of procedures were previously performed in private offices with no clinical oversight or quality measurement.

Ambulatory Endoscopy Clinical Integration Program
Future Opportunities

- Expansion of ‘direct access’ colonoscopy program
- More rigorous oversight of surveillance intervals
- Expansion of interventional endoscopic capabilities in this more cost-effective venue
- Utilizing IT driven quality metrics to modify physician behavior

ASGE Endoscopy Unit Recognition Program (EURP)

Get recognized for promoting quality and safety in your endoscopy unit!



ASGE Quality
ENDOSCOPY UNIT
RECOGNITION PROGRAM

See "Clinical Practice" at ASGE online.

GIQuIC: An ASGE-ACG benchmarking program

Improve outcomes through better documentation.

Set the stage for improved reimbursements.

Metrics from participating physicians, ASCs, offices and hospitals will be shared to:

...identify gaps in care

...develop quality indicators

...provide benchmarking reports

Click "Practice Management" at ASGE online.

Questions

Additional Questions

- **ASGE Quality Improvement/GIQuIC**
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