

ADVANCES IN IBD

Current Developments in the Treatment of Inflammatory Bowel Diseases

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Creating Quality Measures in IBD

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G&H What are some of the concerns pertaining to the quality of medical care for inflammatory bowel disease?

CS It has been 20 years since the Institute of Medicine (IOM) first issued its “Measuring the Quality of Health Care” report. Another report from the IOM, “Crossing the Quality Chasm,” published in 2001, brought this issue even further onto the radar of healthcare practitioners. Thus, quality of care is not uniquely important for inflammatory bowel disease (IBD); it is essential for all healthcare. Many areas of medicine are currently catching up in terms of defining quality and determining how to address it in practice. Some of these concerns are uniform across all fields of medicine.

G&H How is quality defined?

CS The main approach we use to think about quality in medical care is from the perspective of underuse, overuse, and misuse. For underuse, we ask the question: are patients being undertreated, or are appropriate therapies or screening mechanisms not being utilized? For overuse, are too many procedures being performed? Are physicians using expensive, powerful medications when they may not be needed? For misuse, are medications being used in the wrong way, for example at the wrong time or in the wrong doses?

For IBD specifically, a 2006 publication by Reddy and colleagues describes a study conducted at Brigham and Women’s Hospital. The group looked at prior treatments and procedures among IBD patients referred to

their hospital to see how the care of these patients compared to treatment guidelines. A fairly small proportion had received care that adhered to the treatment guidelines. Were these patients being referred to Brigham and Women’s Hospital because they were not responding to standard therapy, or were the standard therapies not being used in the optimal way? The answer was not clear, but these findings point to a central issue at the heart of quality care research, which is to allow all patients equal access to high-quality care.

In another study, Kappelman and colleagues at the University of North Carolina looked at immunomodulator use, one of the most commonly used medications in IBD, across 10 healthcare centers. The researchers found great variation in the use of this therapy.

Variation is a key word in discussions about quality because widely varying care is a sign of poor quality. When everyone is doing something differently, then we know that some patients are not receiving the highest quality care.

A 2006 study by Nguyen and colleagues reinforces the point about variation. This study evaluated the colectomy rate among patients with ulcerative colitis based on race and geography. There was a wide variation in the rates at which patients were having their colons removed. One could make the argument that different races have different phenotypes of the disease, which could account for variation along racial lines. However, that argument could not be made for geography. People on the West Coast do not have a phenotypically distinct disease from people in the Northeast. Nevertheless, such variation is exactly what Nguyen and colleagues identified. This finding is a clue that there may be a gap in knowledge or application of our current skills.

In IBD, we are in desperate need of defining quality measures. Once these measures, or quality indicators, as they are often called, are defined, we need to determine how to best apply them in clinical practice.

G&H Do physicians who treat IBD patients recognize the need to define quality indicators?

CS I think that this need is becoming increasingly recognized in all of medicine. Quality of care is a new concept

that few of us learned in medical school, but now it is becoming part of our everyday culture. Defining quality indicators will be an essential component to our practice because it will likely lead to better care for our patients. A second reason to define quality measures is that reimbursement will probably eventually depend upon them. In other words, physicians will eventually be paid not for doing a job, but for doing a job well.

In IBD, this discussion is still very new. Other areas of medicine have paved the way very effectively. Cystic fibrosis and cardiology stand out as two great examples of how to integrate quality measures into practice. The Cystic Fibrosis Foundation and the Northern New England Cardiovascular Disease Study Group have been looking at quality measures for several years now, and have shown how patient outcomes can be improved by focusing on quality. The experience of these two groups confirms that integrating quality measures into care can improve patient outcomes.

G&H How are measures of quality defined for IBD?

CS This work is in progress. Two groups are currently working on this issue for adult IBD care. The Crohn's and Colitis Foundation of America (CCFA) has a Quality of Care Committee (part of the Professional Education Committee), chaired by Gil Melmed, MD, of Cedars-Sinai. This committee is working together with a group of national experts to develop quality indicators that all physicians who treat patients with IBD can use as a guide.

A similar effort is underway at the American Gastroenterological Association (AGA), in collaboration with John Allen, MD, who is based in Minnesota. The CCFA is working together with Dr. Allen in a collaborative effort to define good outcomes and good care in IBD.

A pediatric IBD collaborative called "Improve Care Now" is already measuring adherence to quality indicators and measuring outcomes for children with Crohn's and colitis. There are some differences in what to measure in pediatric versus adult IBD care, but the overall definitions of quality and goals are similar.

G&H Is it possible to define these measures?

CS Because IBD is such a heterogeneous disease, defining these measures is difficult, but it is possible. Using the medical literature already available, we know that there are some aspects of diagnosis, treatment, and outcomes that are better than others. The groups working on defining these measures started with an extensive literature search and then focused on what makes logical and practical sense as an indicator of quality care for patients.

G&H Is it also important to define factors that contribute to uneven quality of care?

CS Yes, this is very important. How do we know what causes variation? There may be several reasons. It could be that no one knows the optimal treatment approach, which means that we need to focus on defining it better. Variation could be a function of physician availability and access to care—an overstaffed or understaffed hospital, for example. Care may also be supply-sensitive. As an example, in a region with 20 colorectal surgeons, the rate of colon surgeries will tend to be higher than in a region with 5 colorectal surgeons, perhaps not because more surgeries are necessary, but because surgeons are more widely available. The first step is showing that variation exists. Then, we need to figure out why.

One of my hopes for this work is that IBD data can be displayed in a manner similar to that of the Dartmouth Atlas. The Atlas is a very useful tool that maps out healthcare utilization nationally for Medicare patients. An approach such as this would allow us to see how care is distributed across the country for IBD patients and where there might be overuse or underuse of resources.

G&H This process could take a long time. Is there any way to shorten it?

CS There are different types of quality measures that we can look at. Outcome measures take the longest to define because we have to wait and see how patients fare after any particular treatment approach. However, there are also process and structural measures. Process measures are easier to gauge. For example, we can develop a process to try to keep patients off of corticosteroids. We can then measure in our individual practices over a time period of months or a year to determine whether the process put into place works. With this approach, we are not directly measuring if patients have better outcomes, but we are determining whether our process was effective.

Structural measures look at the setting in which care is delivered. Are the correct specialists available? Is the infrastructure effective? Have electronic medical records been incorporated into the healthcare center to ensure that patient care is tracked efficiently? Similar to process measures, it is not possible to say for sure whether these measures result in better outcomes, but we infer that this would be the case. These measures can be defined and integrated into practice very quickly.

It will take years to know whether outcomes are improved—whether patients are undergoing fewer surgeries, whether they are experiencing less disability, whether quality of life is improved. However, we have to take a leap of faith that if incorporating these quality

indicators into care worked for other medical fields, it will also work for IBD.

Another important topic for gastroenterology, although not specifically relevant for IBD, is the polyp detection rate during colonoscopy. Specifically, the rate of polyp detection is highly correlated with withdrawal times for colonoscopy. A study has shown that fewer polyps are found with colonoscopies that take less than 6 minutes compared to those that take more than 6 minutes. If our goal is to find and remove polyps, then a quality measure would be that colonoscopies should take longer than 6 minutes. Many centers are now measuring colonoscopy withdrawal times in order to ensure that patients are receiving optimal care.

G&H Is it possible that longer colonoscopies will lead to the removal of polyps that do not necessarily require removal?

CS Yes, and this would be an example of overuse. This question illustrates the connection between process measures and outcome. Are we removing polyps that do not need to be removed? Finding 5 polyps seems better than finding 2 polyps, but is that ultimately saving lives?

G&H What kind of end result do you envision? Will there be a set of guidelines issued to physicians treating patients with IBD?

CS The plan of the committees working on quality of care in adult IBD is to have measures/indicators available very soon. The AGA physician performance measures will be available in the second half of 2010, with the CCFA quality indicators to follow shortly. The pediatric IBD collaborative “Improve Care Now” already has a network established to implement strategies to improve quality and measure outcomes.

An ultimate goal will be to have a set of quality measures that help us guide how we care for patients. We can measure our performance and improve our care in areas where it is suboptimal. If we follow the lead of the Cystic Fibrosis Foundation and others who have been successful, a possible goal could be to develop some form of accreditation process by which a healthcare center could be certified and incorporated as a “center of excellence.”

Experts in quality have found it important to allow complete transparency in the process. For example, patients with cystic fibrosis and their parents can look online and see the adherence to quality indicators and outcomes for the center at which they are being cared for, and compare this to other centers nationally. The idea is not to punish or embarrass centers with worse outcomes, but to allow the centers to help each other in globally improving quality.

G&H Do you expect to meet resistance among physicians?

CS Some degree of resistance is part of any process of change. However, I think that in the coming years, we will be asked by many different sources to prove that we are providing good quality of care to our patients. I would expect that once there is widespread acceptance of this, any guidance for how to adhere to quality measures will be welcomed. I think all physicians would prefer to follow guidelines issued by their colleagues rather than guidelines issued by insurers or politicians, which could be the alternative.

The process of improving the quality of care is something that we want to do to ensure that the best new research and ideas are not left behind in journals, but become incorporated into our practice and applied equally to all patients with IBD. Our overall goal is to make patients’ lives better. I think that we can all agree with that motive.

Suggested Reading

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