Implementation Tips

Background

In August 2024, The American College of Gastroenterology (ACG) and the American Society for Gastrointestinal Endoscopy (ASGE) issued latest recommendations on quality indicators for colonoscopy, the gold standard for colorectal cancer screening (CRC). This marks the latest update of efforts that began two decades ago to ensure consistently high-quality standards for colonoscopy.

This latest set of guidelines, published online and in the September print issues of *The American Journal of Gastroenterology* (AJG) and *GIE Gastrointestinal Endoscopy,* emphasize the importance of determining, and measuring, priority quality indicators. While quality measurements related to all indicators may not always be feasible given time, cost and staffing constraints, a set of extremely important measures, called priority indicators, have been developed to guide practices in where to focus. Based on clinical relevance, evidence of variable performance, and ease with which the information can be collected , the priority indicators for colonoscopy outlined are:

- Adenoma detection rate (ADR), or how often the endoscopist finds an adenoma, which is a precancerous growth in the colon
- Sessile serrated lesion detection rate, or how often the endoscopist finds a sessile serrated lesion (also called sessile serrated adenoma or sessile serrated polyp), which is another precancerous growth in the colon
- Rate of using recommended screening and surveillance intervals
- Bowel preparation adequacy rate
- Cecal intubation rate, or what proportion of the time the endoscopist is able to view the entire colon

Frequently Asked Questions (FAQ)

The purpose of this document is to provide implementation tips with the issuance of updated recommendations. This document is not all inclusive and should not replace a careful review of the updated recommendations for *quality indicators for colonoscopy* as issued by ASGE and ACG.

FAQ1: Why have ASGE and ACG released updated recommendations for quality indicators for colonoscopy?

The updated recommendations advance our ability to evaluate a physician's performance in order to reduce post-colonoscopy colorectal cancer. As always, the goal is to provide the best care to patients by setting high-quality standards for colonoscopy performance, which makes it effective at cancer prevention

FAQ2: By when will colonoscopists be held accountable to these new recommendations?

There are no set deadlines yet. Colonoscopists and their teams should plan to update their quality improvement programs, as feasible, with the updated recommendations.

Next steps for endoscopy teams include the following:

- Share the 2024 *quality indicators for colonoscopy* with members of your unit's Quality Committee or otherwise convened team, which may include IT staff in addition to clinical staff including pathologists, and plan to review and discuss the updated guidance, in particular the priority indicators.

- Continue to monitor colonoscopy quality metrics as you have been while reviewing the updated recommendations and making a plan for alignment with the updates.
- Determine a project plan with timeline for implementingthe updated recommendations.
    - Timelines will differ across units based on data collection and measure calculation resources (e.g., manual chart review, IT-supported, GIQuIC).
    - Alignment with some updated recommendations may occur more readily than others.
- Note in your quality improvement program when the calculation of a quality metric has changed (e.g., from screening colonoscopy ADR to all outpatient colonoscopy ADR) or adoption of a new performance target is in effect and communicate the change to all endoscopists and other stakeholders.
    - Further, keep in mind, performance targets represent the floor at which remediation is triggered. For example, colonoscopists should continue to strive to improve their ADRs, even when a high performer. As Corley et al. demonstrated, for each 1% increase in ADR, there is a 3% decrease in risk of interval cancer and 5% decrease in risk of fatal interval cancer. (Corley, D.A. et al.; Adenoma detection rate and risk of colorectal cancer and death; *N Engl J Med*. 2014; 370:1298-1306)

Honoree units in the ASGE Endoscopy Unit Recognition Program (EURP)
An updated application will be posted by year-end 2024 and will reflect options for reporting colonoscopy quality metrics for units renewing in 2025 and 2026. We recognize, for example, that a 2025 application will likely report out performance measurement from calendar year 2024 during which screening colonoscopy ADR was monitored and that would be reflected in the application.

Keep in mind, the goal of EURP is to recognize GI endoscopy units and healthcare teams demonstrating their commitment to continuous quality improvement. The program is designed to support your team in developing, maintaining, and growing your quality improvement efforts and is not seeking to be punitive. ASGE aims to support and empower your team in strengthening the unit's quality improvement program.

GIQuIC Registry Participants Reporting to MIPS via the GIQuIC 2024 QCDR
GIQuIC is in the process of implementing new measure reports aligning with the updated recommendations, as needed, while retaining, for a period, existing measure reports (e.g. screening colonoscopy ADR).

From a quality improvement standpoint, registry participants can begin monitoring physician performance in alignment with the updated recommendations as the new measure reports become available. Again, some colonoscopy quality indicators have remained the same in terms of calculations but have new performance target so require no updates to measure logic (e.g., adequacy of bowel preparation).

From an accountability standpoint, the priority indicators have provided and will continue to provide a foundation for discussion with third parties (e.g., payors) evaluating physician and endoscopy unit performance on colonoscopy in value-based payment models. CMS already includes quality measures for ADR and adherence to recommended screening and surveillance intervals in public reporting programs (i.e., Merit-based Incentive Payment System [MIPS], ASC Quality Reporting Program, Hospital Outpatient Quality Reporting Program).

For those registry participants reporting to MIPS for the 2024 performance year via the GIQuIC 2024 qualified clinical data registry (QCDR), the measure logic for ADR remains based on screening colonoscopy only. Should GIQuIC be approved to serve as a QCDR for the 2025 performance year (CMS approval is an annual process), ADR would still be based on screening colonoscopy only.

FAQ3: Where should our team begin to implement the updated recommendations?
Priority indicators were identified to guide practices on indicators to focus on. Based on clinical relevance, evidence of variable performance, and feasibility of measurement, the priority indicators for colonoscopy outlined are as follows with the updates noted. They are ordered based on ease of implementation – from no change to change in performance targets to change in measure specifications to a new measure.

Rate of using recommended screening and surveillance intervals
Frequency with which colonoscopies follow recommended post-polypectomy and post–cancer resection surveillance intervals and frequency of 10-y intervals between screening colonoscopies in average risk patients who have negative examination results and adequate bowel cleansing.

- Measures assessing use of appropriate screening and surveillance intervals remain unchanged.

Cecal intubation rate
Percentage of patients undergoing colonoscopy with intact colons who have full intubation of the cecum with photo documentation of cecal landmarks.

- The performance target for all colonoscopies has been increased from ≥90% to ≥95%.

Bowel preparation adequacy rate
Percentage of patients undergoing colonoscopy with adequate bowel preparation, preferably defined as Boston Bowel Preparation Scale score ≥2 in each of 3 colon segments or by description of the preparation as excellent, good, or adequate.

- This measure remains the same with encouragement to move to adoption of the Boston Bowel Preparation Scale for evaluation of bowel prep adequacy.
- The performance target has been increased from ≥85% to ≥90%. For EURP honorees, the goal was already 90%.

Withdrawal time
Average withdrawal time in normal colonoscopies without biopsy sampling or polypectomies in persons aged ≥45 y undergoing screening, surveillance, or diagnostic colonoscopy. Patients with positive noncolonoscopy screening tests, genetic cancer syndromes (eg, polyposis), IBD, or undergoing colonoscopy for therapy of known neoplasms are excluded from the calculation.

- While **not a priority indicator**, expanding the denominator for withdrawal time measurement from screenings only to all colonoscopies should be easy to implement.
- The performance target has increased from ≥6 to ≥8 minutes.
- Withdrawal time = careful and detailed inspection of the colon, from the appendiceal orifice to completion of retroflexion in the rectum.

- The updated performance target applies to all colonscopists – from high- to low-level performers. A colonoscopist with a high ADR should not be exempt from adhering to the updated performance target for withdrawal time.

Adenoma detection rate (ADR)
Percentage of patients aged ≥45 yr undergoing colonoscopy for screening, surveillance, or diagnostic indications other than positive noncolonoscopy screening tests (e.g., fecal tests or CT colonography) who have ≥1 conventional adenomas detected and verified by pathology. Patients with positive noncolonoscopy screening tests, genetic cancer syndromes (e.g., polyposis), IBD, or undergoing colonoscopy for therapy of known neoplasms are excluded from the calculation.

- The denominator has expanded for this measure to include all outpatient colonoscopies.
- The performance target has been increased from ≥25% to ≥35% and can still be looked at by sex with the target for male ADR moving from ≥30% to ≥40% and female ADR ≥20% to ≥30%. If measuring male ADR and female ADR, a simple average of the two performance rates is the best approach to determine overall ADR.
- For a case to count towards the numerator, the patient had ≥1 conventional adenomas detected and verified by pathology. If the only findings were sessile serrated lesion, the case should be removed from the calculation, as an exception. While this does not represent a change, not all unit have recognized this and should take this into account, particularly with the addition of the new outcome measure sessile serrated lesion detection rate.
- The exclusions, specifically patients with positive noncolonoscopy screening tests (such as FIT, Cologuard, blood test or CT colonography, genetic cancer syndromes, IBD, or undergoing colonoscopy for therapy of known neoplasms, remain the same and your team should ensure the exclusions are factored into ADR calculation.
- Since publication of the last *quality indicators for colonoscopy* paper, stool-based colorectal cancer screening has become more widely adopted with adoption increasing. As noted above, patients with an indication of positive noncolonoscopy screening test coming in for a follow-up screening colonoscopy should be excluded from the ADR calculation.

Sessile serrated lesion detection rate (SSLDR)
Percentage of patients aged ≥45 yr undergoing screening, surveillance, or diagnostic colonoscopy for symptoms with ≥1 sessile serrated lesions removed and documented by pathology. Patients with positive noncolonoscopy screening tests, genetic cancer syndromes (e.g., polyposis), IBD, or undergoing colonoscopy for therapy of known neoplasms are excluded from the calculation.

- This is a new quality indicator and, like ADR, has been identified as an outcome measure because of SSL association with post colonoscopy colorectal cancer in recent studies.
- It is important to note the appropriate term to accompany “sessile serrated” is “lesion.” Pathology referring to findings as “sessile serrated adenomas” or “sessile serrated polyps” should be included in this measure calculation with agreement the appropriate term moving forward is “sessile serrated lesion.”
- The performance target has been set at ≥6%. Again, keeping in mind, performance targets are the floor. Colonoscopists falling below a performance target should be remediated.
- This measure should be assessed at an overall rate and not stratified by patient sex, at this time.