QUALITY AND INNOVATION PROGRAM
INTERNAL MEDICINE
UNIVERSITY OF MICHIGAN HEALTH SYSTEM

Gastroenterology - Clinical Quality Overview

Division Clinical Units and Leads	Quality Committees and Roles
Division Chief: Chung Owyang Quality Council Representatives: John Allen, Mike Rice Division Administrator: Jeff Holden ACU Medical Director Pod D Taubman: Grace Elta MPU Medical Director: Grace Elta MPC/NHC MPU Medical Director: Leslie Aldrich M-Plan 5B Unit Lead: Mike Rice	*BCBS Collaborative Quality Initiatives* • None *Quality Groups and Committees* • GI Peer Review Committee (meets two times per year) • MPU QA meets monthly • MPC and NMPU: Dr. Aldrich reviews • Medication Safety committee (Mike Rice) *Institutional Quality Roles with Division Lead* OCA Peer Review committee (Grace Elta)
Highest Volume Conditions	**Division Specific Specialty Conditions**
1. Functional bowel disease 2. IBD 3. Hepatology 4. Pancreatic biliary 5. Endoscopy	1. Good quality measures for endoscopy: ADR, cecal intubation, and screening / surveillance intervals (the last are mandatory CMS measures) 2. Flouroscopy time for advanced endoscopists 3. New quality measure on HCC surveillance in cirrhotic patients 4. IBD group developing three measures: steroid sparing therapy, bone loss, VTE
Choosing Wisely – Selected Measures	**Quality Improvement Priorities**
1. For pharmacological treatment of patients with gastroesophageal reflux disease (GERD), long-term acid suppression therapy (proton pump inhibitors or histamine2 receptor antagonists) should be titrated to the lowest effective dose needed to achieve therapeutic goals. 2. Do not repeat colorectal cancer screening (by any method) for 10 years after a high-quality colonoscopy is negative in average-risk individuals. 3. Do not repeat colonoscopy for at least five years for patients who have one or two small (< 1 cm) adenomatous polyps, without high-grade dysplasia, completely removed via a high-quality colonoscopy. 4. For a patient who is diagnosed with Barrett's esophagus, who has undergone a second endoscopy that confirms the absence of dysplasia on biopsy, a follow-up surveillance examination should not be performed in less than three years as per published guidelines. 5. For a patient with functional abdominal pain syndrome (as per ROME III criteria) computed tomography (CT) scans should not be repeated unless there is a major change in clinical findings or symptoms. **Status:** Active work is being done in each area; #2 and #3 are mandatory CMS measures.	• Develop queries of MiChart to capture measures on outpatient visit quality in hepatology and IBD

Last Update: 2-28-18

Measurement – Peer Review Metrics	Measurement – Registries and Other Data
Peer Review Rate-Based Indicators • Resident evaluations • Cecal intubation rate • Failure to notify patient of biopsy results • Procedure complication rates • Adenoma detection rates in CRC screening colonoscopies • Fluoroscopy time for interventional endoscopists Case-Based Indicators • Complications reported on Riskpro	*Registries* • Inflammatory Bowel Disease (in process) *Regularly Reviewed Data* PACE • ALOS, discharges • Mandatory CMS measures (#2 and #3 of Choosing Wisely) QMP • Dashboards • Inflammatory Bowel Disease (in process – once IBD registry is established)