








How to improve your Endoscopy Practice through Performance Feedback

January 18, 2020
10th Annual Endoscopy Skills Day for Practising Endoscopists and their Teams

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 Physician Learning Program

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 CALGARY DIVISION OF
GASTROENTEROLOGY & HEPATOLOGY

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Faculty/Presenter Disclosure

- **Presenter:** Kelly Warren Burak
- **Relationships that may introduce potential bias and/or conflict of interest:**
 - **Grants/Research Support:** PLP is funded by a grant from Alberta Health / Alberta Medical Association
 - **Speakers Bureau/Honoraria:** none
 - **Consulting Fees:** none
 - **Other:** Employee of University of Calgary (AMHSP)

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Disclosure of Commercial Support

- **This program has received financial support from the Rural Health Professions Action Plan (RhPAP), Pendopharm, Ferring, Olympus, Vantage, Cook, EMPRSS, Pentax, Boston Scientific, MD Management in the form of unrestricted educational grants.**

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Managing Sources of Potential Conflict and/or Bias

- Consideration was given by the Planning Committee to identify when a speaker's personal or professional interest(s) may compete with or have actual, potential, or apparent influence over their presentation.
- Learning objectives and/or session descriptions were developed and reviewed by the Planning Committee, composed of health professionals/experts, responsible for overseeing the program's needs assessment and subsequent content development to ensure accuracy and fair balance.
- Information and/or recommendations in the program are evidence- and/or guidelines-based, and the opinions of the independent speakers will be identified as such.

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Learning Objectives

At the end of the session, participants will be equipped to:

- **Define** audit & feedback and **recognize** how it may improve individual and programmatic practice
- **Describe** quality initiatives currently underway in the province
- Become familiar with audit & feedback opportunities in **Alberta**

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Image Source: Bitmoji

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1) Knowledge to Action Gap



Image Source: @kwburak

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2) Patient Safety

“Health care harms patients too frequently and routinely fails to deliver its potential benefits.”

- **Equitable**
- **Effective**
- **Efficient**
- **Safe**
- **Timely**
- **Patient-centred**



Institute of Medicine Report (2001)

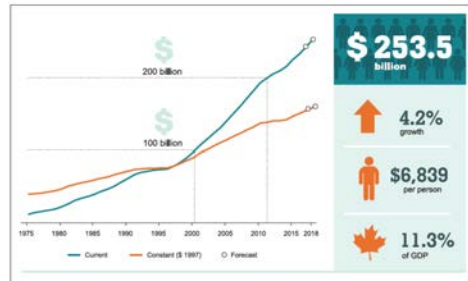


<http://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf>

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3) Sustainability

Figure 1 How much will we spend on health in 2018?

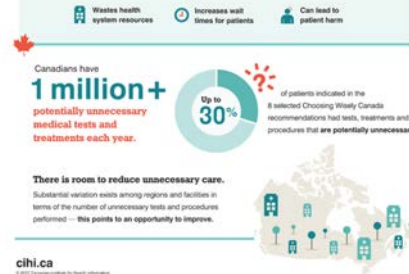


Source: National Health Expenditure Database, Canadian Institute for Health Information.

<https://www.cihi.ca/sites/default/files/document/nhex-trends-narrative-report-2018-en-web.pdf>



Unnecessary care in Canada



cihi.ca

<https://www.cihi.ca/en/unnecessary-care-in-canada-infographic>

What is in a name?

Characteristics	CME
Driver	Teacher
Focus	Medical Expert
Delivery	Lectures
Outcome	Improved patient care

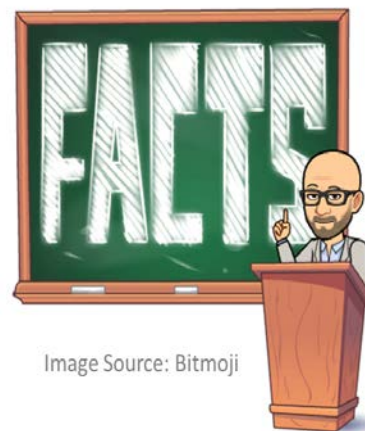


Image Source: Bitmoji



Adapted from Filipe HP, et al. Ann Eye Sci 2017; 2 (46): 1-10.

What is Audit and Feedback?

Definition:

- A summary of clinical performance provided over a specified period of time, which aims to improve healthcare quality

Synonyms:

- Physician report cards
- Physician performance reports
- Physician practice improvement (PPI)



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Effectiveness of CME

(Formal meta-analysis or other systematic reviews N=26)

Interactive techniques:

- **audit with feedback**
- academic detailing
- outreach reminders

Clinical practice guidelines
& key opinion leaders

Didactic presentations &
printed information only

Effectiveness

Little to no effect
on changing physician
practice patterns


Most effective
at simultaneously
changing physician care
and patient outcomes



Adapted from: Bloom B. Intl J Tech Assess Health Care 2005; 21(3): 380–385.

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Does Audit & Feedback Work?




THE COCHRANE
COLLABORATION®

- **140 Clinical Trials**
 - A&F improves compliance with desired professional behavior by 4% (IQR 0.5-16%)

- **A&F is more effective when . . .**
 - The source is a respected colleague
 - It is delivered both verbally and written form
 - It is provided more than once
 - It includes explicit targets and an action plan



SCAN ME



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Source: Ivers N, et al. Cochrane Database of Systematic Reviews 2012; 6: CD000259.

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Annals of Internal Medicine

ACADEMIA AND THE PROFESSION

Practice Feedback Interventions: 15 Suggestions for Optimizing Effectiveness


Jamie C. Brehaut, PhD; Heather L. Colquhoun, PhD; Kevin W. Eva, PhD; Kelly Carroll, MA; Anne Sales, PhD; Susan Michie, PhD; Noah Ivers, MD, PhD; and Jeremy M. Grimshaw, MD, PhD

Ann Intern Med. 2016;164:435-441. doi:10.7326/M15-2248 www.annals.org


The Calgary Audit and Feedback Framework: a practical, evidence-informed approach for the design and implementation of socially constructed learning interventions using audit and group feedback

Lara J. Cooke^{1*}, Diane Duncan², Laura Rivera³, Shawn K. Dowling³, Christopher Symonds⁴ and Heather Amson⁵

Implement Sci 2018; 13(1):136.



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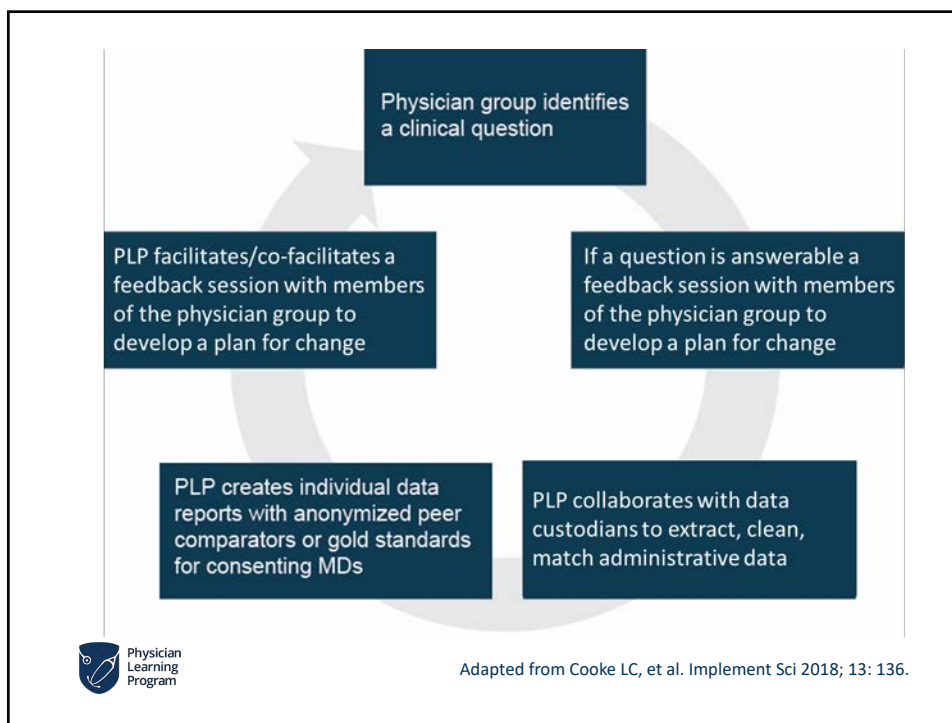
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What makes PLP unique?

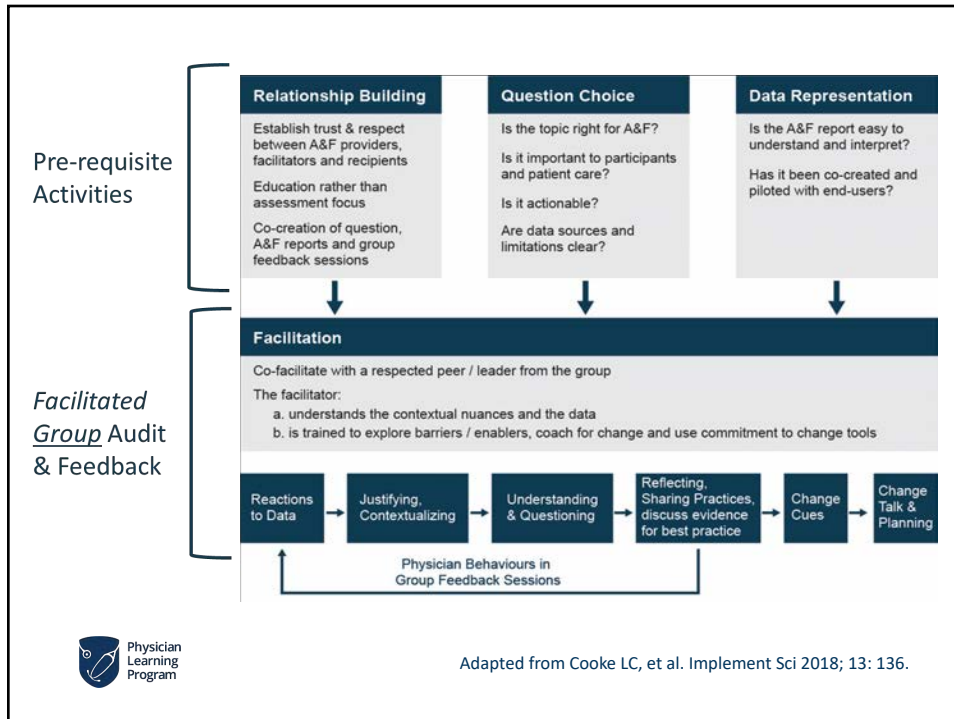
- **The Data**
- **The Approach**
 - Driven by physicians, supported by PLP resources
 - Confidential and non-judgmental
 - Facilitated A&F *in groups*
 - Commitment to change with defined action plans
 - Eligible for self-directed CPD credits



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Future of Medical Education in Canada

THE FUTURE OF MEDICAL EDUCATION IN CANADA
L'AVENIR DE L'ÉDUCATION MÉDICALE AU CANADA

SUPPORTING LEARNING AND CONTINUOUS PRACTICE IMPROVEMENT FOR PHYSICIANS IN CANADA: A NEW WAY FORWARD

PHYSICIAN LEARNING AND PRACTICE IMPROVEMENT

A Collective Vision for CPD in Canada

SCAN ME

Source: www.fmec-cpd.ca

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FMEC-CPD Recommendation

9. All physicians will be expected to participate in a continuous cycle of practice improvement that is supported by understandable, relevant, and trusted individual or aggregate practice data with facilitated feedback for the benefit of patients.



Adapted from http://fmrac.ca/wp-content/uploads/2016/04/PPI-System_ENG.pdf

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“For Alberta, we will most likely have a standard of practice mandating the requirement to participate in an ongoing quality improvement program by 2022.”

– Scott McLeod, Registrar, CPSA
The Messenger, February 2019



<http://www.cpsa.ca/practice-improvement-and-professional-development/>

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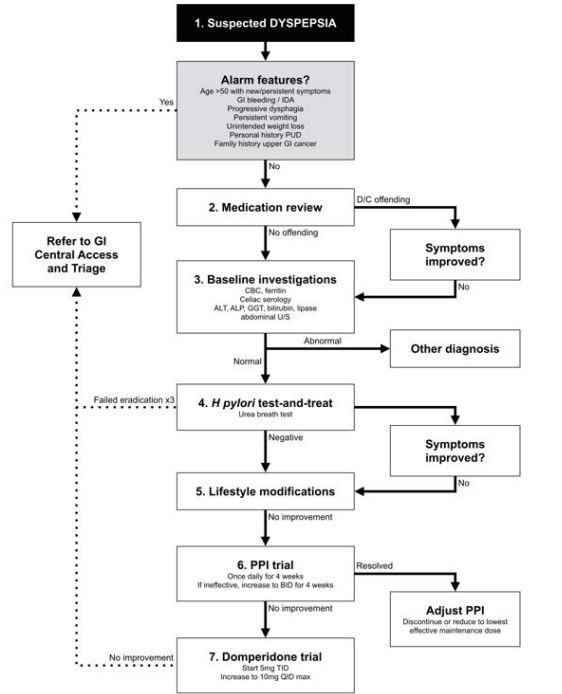
Why Dyspepsia?

- **Dyspepsia is common - 20% of the population**
 - Patients have a normal life expectancy
 - Symptoms negatively impact on QoL
 - CPGs = EGD is not recommended unless red flags
- **Limited endoscopic resources**
 - Improve utilization = improve access
 - Opportunity to optimize the use of EGD




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AHS Enhanced Primary Care Pathway



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QUALITY INDICATORS FOR
GI ENDOSCOPIC PROCEDURES

Quality indicators for EGD

www.giejournal.org

Background


- In 2009, 6.9 million EGDs performed in USA (cost \$12.3B)
- 50% ↑ in EGD utilization in Medicare from 2000 to 2010

Indications for EGD

- 23 recognized indications
- EGD is generally NOT indicated for evaluating functional symptoms

Quality indicators


- Pre-procedure (1–9)
- Intra-procedural (10–14)
- Post-procedure (15–23)





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ASGE and ACG. *Gastrointestinal Endoscopy* 2015; 81(1): 17-30.

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QUALITY INDICATORS FOR
GI ENDOSCOPIC PROCEDURES

Quality indicators for EGD

www.giejournal.org


Quality indicator
Pre-procedure

1. Frequency with which endoscopy is performed for an indication that is included in a published standard list of appropriate indications, and the indication is documented (priority indicator)

Grade of Recommendation = 1C+

Measurement Type = Process

Performance Target = 80%



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ASGE and ACG. *Gastrointestinal Endoscopy* 2015; 81(1): 17-30.

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Avoid performing endoscopy for patients with dyspepsia under the age of 55 without alarm symptoms

<https://choosingwiselycanada.org/gastroenterology/>

- First line approach for managing dyspepsia:
 - proton pump inhibitor therapy
 - non-invasive test for *Helicobacter pylori* and then offering therapy if the patient is positive
- If the patient has alarm features such as progressive dysphagia, anemia or weight loss, endoscopy may be appropriate



Talley NJ, et al. American gastroenterological association technical review on the evaluation of dyspepsia. *Gastroenterology* **2005**;129(5):1756-80.

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2017 Updated Guidelines



CLINICAL GUIDELINES 1

ACG and CAG Clinical Guideline: Management of Dyspepsia

Paul M. Moayyedi, MB, ChB, PhD, MPH, FACP, Brian E. Lacy, MD, PhD, FACP, Christopher N. Andrews, MD¹, Robert A. Enns, MD², Colin W. Howden, MD, FACP³ and Nimish Vakil, MD, FACP⁴

We have updated both the American College of Gastroenterology (ACG) and the Canadian Association of Gastroenterology (CAG) guidelines on dyspepsia in a joint ACG/CAG dyspepsia guideline. We suggest that patients ≥ 60 years of age presenting with dyspepsia are investigated with upper gastrointestinal endoscopy to exclude organic pathology. This is a conditional recommendation and patients at higher risk of malignancy (such as spending their childhood in a high risk gastric cancer country or having a positive family history) could be offered an endoscopy at a younger age. Alarm features should not automatically precipitate endoscopy in younger patients but this should be considered on a case-by-case basis. We recommend patients < 60 years of age have a non-invasive test *Helicobacter pylori* and treatment if positive. Those that are negative or do not respond to this approach should be given a trial of proton pump inhibitor (PPI) therapy. If these are ineffective tricyclic antidepressants (TCA) or prokinetic therapies can be tried. Patients that have an endoscopy where no pathology is found are defined as having functional dyspepsia (FD). *H. pylori* eradication should be offered in these patients if they are infected. We recommend PPI, TCA and prokinetic therapy (in that order) in those that fail therapy or are *H. pylori* negative. We do not recommend routine upper gastrointestinal (GI) motility testing but it may be useful in selected patients.

Am J Gastroenterol advance online publication, 20 June 2017, doi:10.1038/ajg.2017.154



Moayyedi P, et al. *Am J Gastroenterol* 2017;112(7):988-1013.

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Recommendations



- 1. We suggest dyspepsia patients aged 60 or over have an endoscopy to exclude upper gastrointestinal neoplasia.**

Conditional recommendation

Very low quality evidence

- Raised threshold to >60 as the 55 year old threshold for endoscopy was borderline in economic analyses
- Age-specific incidence of gastric cancer has fallen further in the US and Canada



Moayyedi P, et al. Am J Gastroenterol 2017;112(7):988-1013.

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Recommendations



- 2. We do not suggest endoscopy to investigate alarm features for dyspepsia patients under the age of 60 to exclude upper GI neoplasia.**

Conditional recommendation

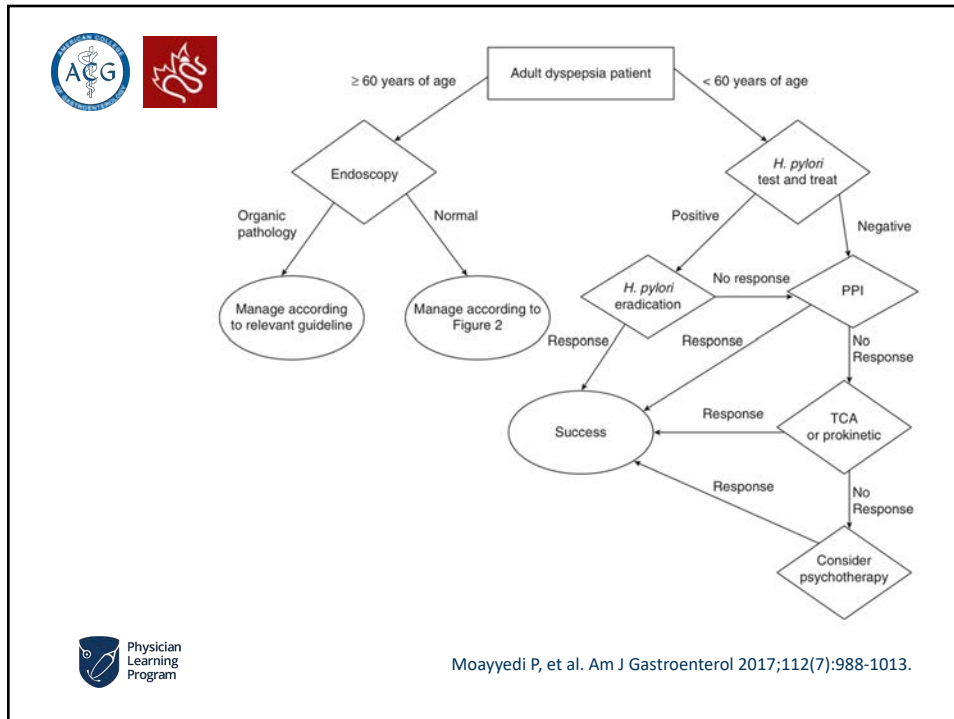
Moderate quality evidence

- Systematic review of 7 studies (46,000 patients) undergoing endoscopy → alarm features limited value
 - Sn 67%, Sp 66%, LR+ 2.74, prevalence 0.3%
 - **Even with alarm symptoms the risk is <1%**

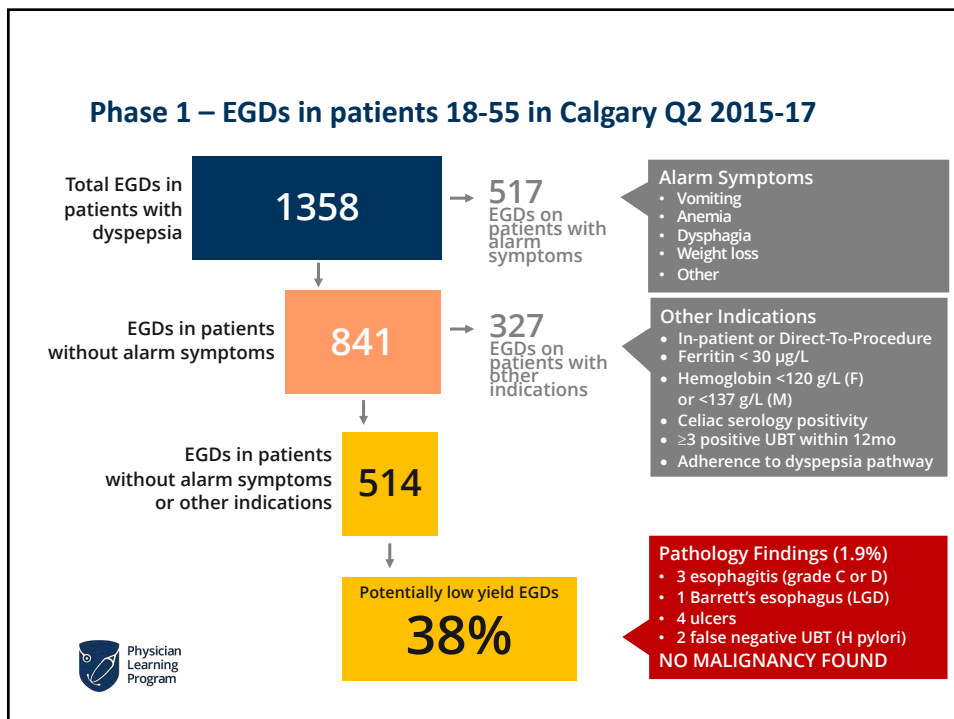


Moayyedi P, et al. Am J Gastroenterol 2017;112(7):988-1013.

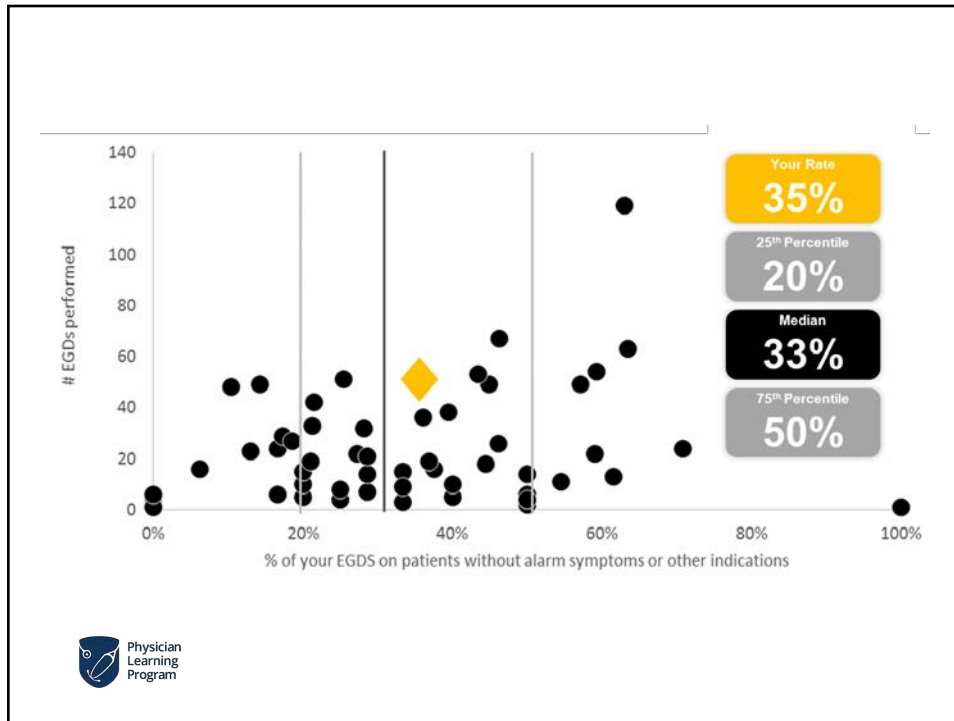
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Phase 2 Initiatives

- Design a support tool to assist clinicians
- Design an infographic for patients explaining the best practices for diagnosing and treating dyspepsia
- Complete a second data pull and provide reports in March 2020
- Scale project provincially
 - Digestive Health SCN
 - CWA grant

**Just Say
"Nope to the Scope"**

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Designing Patient & Clinician Resources

Key findings

Gastroenterologists

- perform an EGD to provide relief
- some patients want re-assurance that they don't have cancer
- patients wait a long time to see specialists

Family physicians

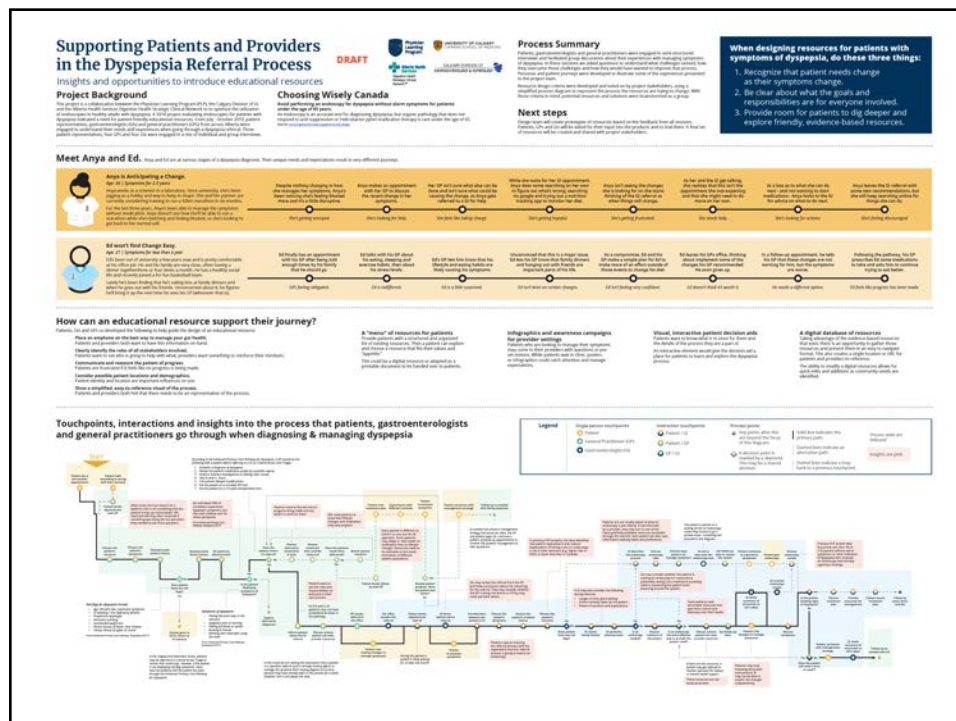
- patient consults are too short to diagnosis dyspepsia & review pathway
- patients want something to treat their symptoms right away

Patients

- require multiple visits to GP with lengthy time to diagnosis
- pathway not explained or mentioned, seems like a "scattershot" approach to treatment, in some cases



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Do you need a scope?

A GI specialist may order a scope to investigate dyspepsia symptoms, but a scope will not cure dyspepsia.

It is rare for dyspepsia to be caused by a more serious underlying health condition, and symptoms are often fully managed with your family doctor.

Patient

What can I do?

Lifestyle factors play a large role in managing dyspepsia. You can help to manage your dyspepsia symptoms by considering the following lifestyle modifications:

- Diet
- Weight management
- Smoking
- Stress management

What questions should I ask my doctor?

- How can I mitigate my dyspepsia symptoms?
- What are the risks associated with a scope?
- Which treatment options should I be focusing on?
- How long will each take?

Doctor

Tests that might be done:

- H. pylori testing
- Imaging

Medications that might be prescribed:

- Short-Acting Proton Pump Inhibitors (PPIs)
- Dampers/stone
- Low-dose anti-depressants

What symptoms should I watch for?


- Black stool
- Difficulty / pain swallowing
- Persistent vomiting
- Vomiting with blood
- Unintended weight loss

Navigating Dyspepsia


Patient

What can I do?


How you eat, sleep and manage your stress can have a big impact on your gut health. Consider the following lifestyle modifications:




Maintain a healthy diet




Get moving



Get lots of sleep



Avoid cigarettes and alcohol



Manage your stress

Doctor

What might my doctor do?

It is rare for dyspepsia to be caused by a more serious underlying health condition, and symptoms are often fully managed with your family doctor.

Tests that might be ordered:

- Test for Helicobacter pylori (H. pylori) bacteria which causes inflammation and ulcers.

Medications that might be prescribed:

- Proton Pump Inhibitors (PPIs) to control stomach acid and heal ulcers

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Phase 2 – EGDs in patients 18-55 in Calgary Q2 2018-19

Total EGDs in patients with dyspepsia

738

→

393 EGDs on patients with alarm symptoms

EGDs in patients without alarm symptoms

345

→

179 EGDs on patients with other indications

EGDs in patients without alarm symptoms or other indications

166

↓

Potentially low yield EGDs

22%

Alarm Symptoms

- Vomiting
- Anemia
- Dysphagia
- Weight loss
- Other


Other Indications

- In-patient or Direct-To-Procedure
- Ferritin < 30 µg/L
- Hemoglobin <120 g/L (F) or <137 g/L (M)
- Celiac serology positivity
- Adherence to dyspepsia pathway

Pathology Findings (6%)

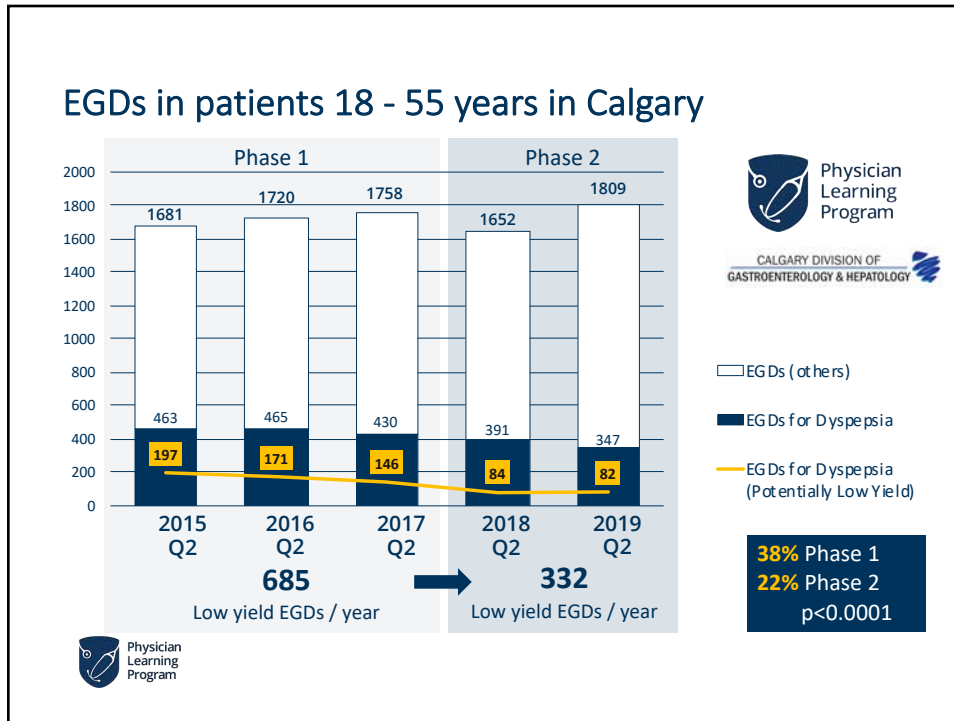
- 1 esophagitis (grade D)
- 1 esophageal candidiasis
- 2 eosinophilic esophagitis
- 1 pill induced esophagitis
- 1 gastric dysplasia
- 3 ulcers
- 1 Celiac disease

NO MALIGNANCY FOUND



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Take Home Points

1. CPD is evolving -> Physician Practice Improvement is coming!
2. Audit & Feedback is effective at changing physician behaviours
3. Provincial QI projects in endoscopy in AB
 - Endoscopy → Dyspepsia
 - Colonoscopy → C-GRS

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Acknowledgements

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Charlene Feuffel


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QUESTIONS

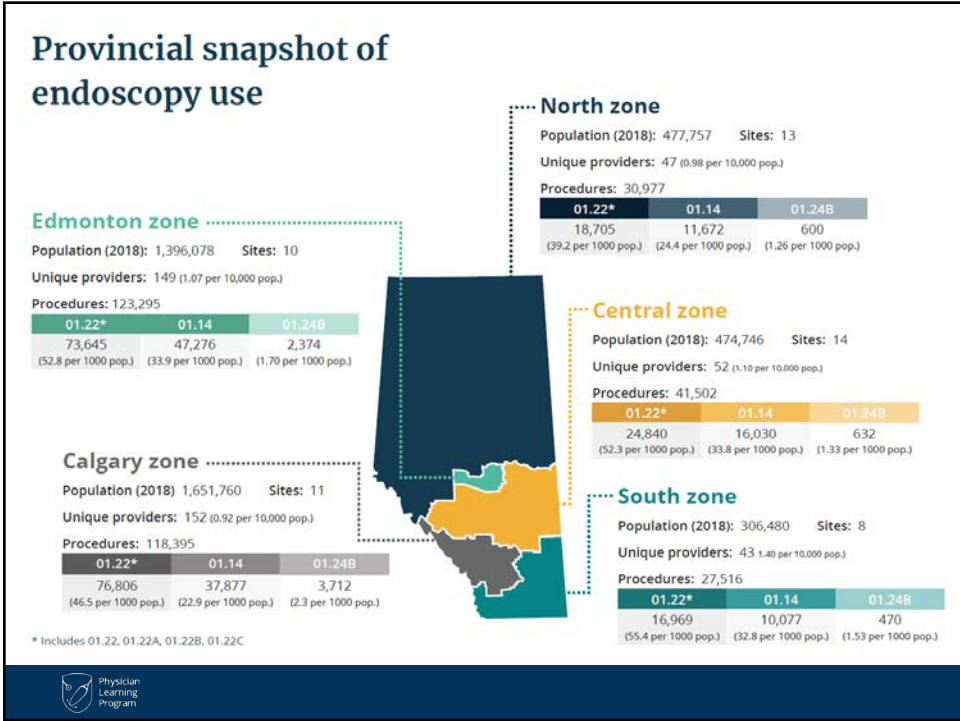
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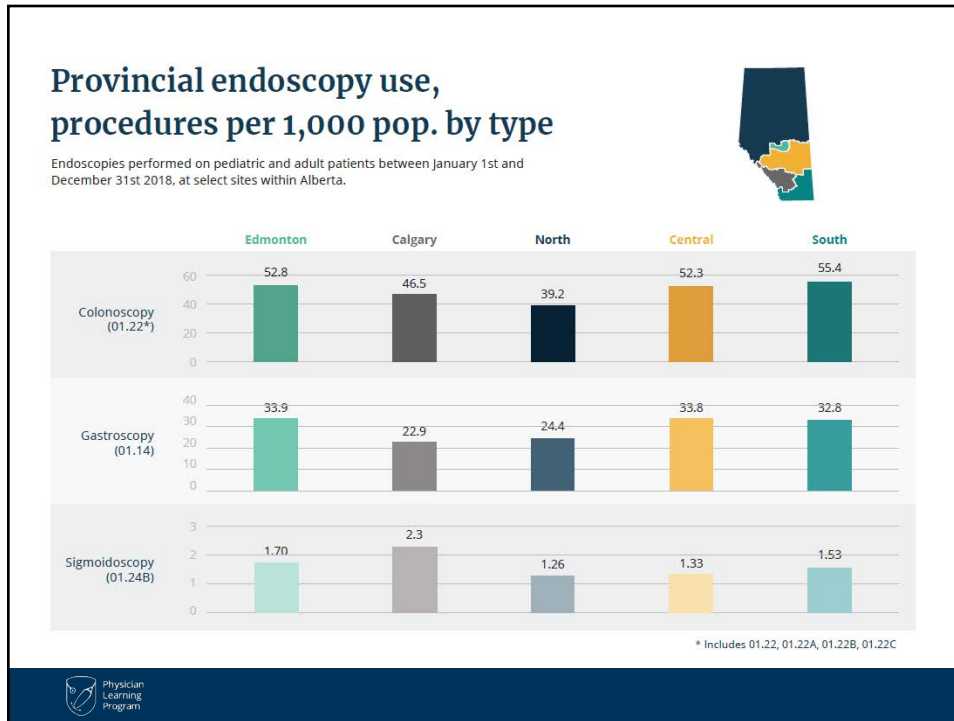
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