



***ABIM Colonoscopy PIM™
Practice Improvement Module
Measures Catalogue***

**Colonoscopy PIM
Measures Catalogue
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TABLE OF CONTENTS

Introduction 3

Outcomes of Care 5

Processes of Care..... 6

Introduction

This catalogue provides information related to the American Board of Internal Medicine's Colonoscopy Practice Improvement Module®. It is written in language that addresses the physician who might choose to complete this module, and it details the specifics of the module. Included is information regarding:

- **Purpose and structuring of the module**
- **Patient inclusion criteria**
- **Detailed description of the measures**

This PIM examines the care you provide to your patients by addressing key processes and outcomes related to colonoscopy. These are based primarily on guidelines from the American Cancer Society, the American College of Gastroenterology, and the American Society of Gastrointestinal Endoscopy.

The PIM is divided into three parts, with multiple sections in each part.

Part 1 -Performance Data

Provide baseline data about your practice's current performance by...

- Reviewing your charts
- Assessing your practice systems

The 16 chart review measures are listed below. **ABIM requires a minimum of 25 chart reviews.** The practice systems assessment comprises questions covering various aspects of practice structure and protocols.

Patients can be **included** in this module if **all** of the following are true:

1. They are between the ages of 15 and 90 (inclusive) *AND*
2. They underwent any portion of a colonoscopy either performed directly by you or under your direct supervision. This could include patients who received sedation but did not complete a full colonoscopy as a result of adverse reactions, technical difficulties, etc.

Patients should be **excluded** from this module if they did not undergo any portion of a colonoscopy (including sedation for the procedure if sedation was planned).

Part 2 - Quality Improvement (QI) Plan

Develop a plan for improving one aspect of your practice after reviewing the analysis of your current performance data. The analysis will include many aspects of care you provide to your patients. Ultimately, you will target only one of these to use in this quality improvement (QI) cycle.

Part 3 - Remeasurement

Remeasure your performance data after you have implemented your QI plan to see if you achieved your goal. Then, you will reflect on the process of developing and implementing a QI plan.

You may claim CME credit for completing this activity. The University of Pennsylvania School of Medicine designates this educational activity for a maximum of 20 *AMA PRA Category 1 Credit(s)*TM.

COLONOSCOPY - OUTCOMES OF CARE

Clinical Outcomes				
Measure Title	Description	Numerator	Denominator	Rationale
Adverse procedural event during colonoscopy	Patients in the sample who were reported as having had an adverse procedural event during colonoscopy	Number of patients in the sample who were reported as having had an adverse procedural event during colonoscopy	Number of patients in the sample	Potential adverse events during colonoscopy include bowel perforation and hemorrhage. These events, however, are rare (less than 0.35%) but occur more often with therapeutic procedures than diagnostic. Preprocedure evaluation can identify patients who may be at greater risk for complications, particularly hemorrhage.
Adverse event or complication after colonoscopy	Patients in the sample with whom follow-up communications were done within 24 hours of the procedure and who were reported as having had an adverse event or complication after colonoscopy	Number of patients in the sample with whom follow-up communications were done within 24 hours of the procedure and who were reported as having had an adverse event or complication after colonoscopy	Number of patients in the sample with whom follow-up communications were done within 24 hours of the procedure	Complications from colonoscopy include perforation, hemorrhage, postpolypectomy coagulation syndrome, myocardial infarction, cerebrovascular accident, splenic rupture, and acute appendicitis. Complications related to bowel preparation and sedation also can occur. All of these events, however, are rare (less than 0.35%) but occur more often with therapeutic procedures than diagnostic. Preprocedure evaluation can identify patients who may be at greater risk for complications, particularly hemorrhage. Early recognition and treatment of complications decreases morbidity.

COLONOSCOPY - PROCESSES OF CARE

Documentation & Communication				
Measure Title	Description	Numerator	Denominator	Rationale
Informed consent documented prior to procedure	Patients in the sample for whom informed consent was documented prior to the procedure	Number of patients in the sample for whom informed consent was documented prior to the procedure	Number of patients in the sample	Informed consent must be obtained before the procedure, from either the patient or guardian. Discussion must include the risks, benefits, and alternatives to the procedure. Four specific adverse events should be explained: colon perforation, missing a significant neoplastic lesion, hemorrhage, and complications of sedation.
Informed consent listed all four possible adverse events	Patients in the sample from whom informed consent was obtained and whose charts specifically documented all four possible adverse events: perforation, missing significant neoplasm, hemorrhage, and adverse sedative complications	Number of patients in the sample from whom informed consent was obtained and whose charts specifically documented all four possible adverse events: perforation, missing significant neoplasm, hemorrhage, and adverse sedative complications	Number of patients in the sample from whom informed consent was obtained	Informed consent must be obtained before the procedure, from either the patient or guardian. Discussion must include the risks, benefits, and alternatives to the procedure. Four specific adverse events should be explained: colon perforation, missing a significant neoplastic lesion, hemorrhage, and complications of sedation.
ASA risk status determined and documented prior to procedure	Patients in the sample for whom ASA risk status was determined and documented prior to the procedure	Number of patients in the sample for whom ASA risk status was determined and documented prior to the procedure	Number of patients in the sample	The American Society of Anesthesiologists (ASA) approved a classification scheme for physical status. The original 1941 scheme has been updated slightly but continues to be used for risk stratification of patients who will receive sedation.
Clinical indication for colonoscopy documented	Patients in the sample for whom the clinical indication for colonoscopy was documented	Number of patients in the sample for whom the clinical indication for colonoscopy was documented	Number of patients in the sample	The American Society for Gastrointestinal Endoscopy (ASGE) and the U.S. Multi-Society Task Force on Colon Cancer have published appropriate indications for colonoscopy. The indication should be documented for each procedure; justification should be provided for

Documentation & Communication				
Measure Title	Description	Numerator	Denominator	Rationale
				any nonstandard indication.
Recovery of all resected polyps or neoplasms	Patients in the sample who were reported as having all resected polyps successfully recovered and sent for pathologic examination	Number of patients in the sample who were reported as having all resected polyps successfully recovered and sent for pathologic examination	Number of patients in the sample for whom colonoscopy revealed any resectable polyps or other neoplasms	An accurate description of all resected polyps or neoplasms is an essential component in management. Timing of follow-up colonoscopy is based on the number, size, and pathology of adenomatous polyps. All three of these elements should be documented.
Notification of pathology results within one week	Patients in the sample who were reported as having all resected polyps successfully recovered and sent for pathologic examination and who were notified of the results of the pathologic examination within one week	Number of patients in the sample who were reported as having all resected polyps successfully recovered and sent for pathologic examination and who were notified of the results of the pathologic examination within one week	Number of patients in the sample who were reported as having all resected polyps successfully recovered and sent for pathologic examination	An accurate description of all resected polyps or neoplasms is an essential component in management. Timing of follow-up colonoscopy is based on the number, size, and pathology of adenomatous polyps. All three of these elements should be documented.
Follow-up communication within 24 hours of the procedure	Patients in the sample with whom follow-up communication occurred within 24 hours of the procedure	Number of patients in the sample with whom follow-up communication occurred within 24 hours of the procedure	Number of patients in the sample	Complications of colonoscopy are rare; some, particularly bleeding, some can be noted during or immediately after the procedure. Others may not become apparent for some time. Patients should be contacted within 24 hours to determine whether any delayed complications have occurred.

Clinical Indications				
Measure Title	Description	Numerator	Denominator	Rationale
Screening colonoscopy indicated	Patients in the sample for whom screening colonoscopy was indicated	Number of patients in the sample for whom screening colonoscopy was indicated	Number of patients in the sample for whom the clinical indication for colonoscopy was documented	The American Society for Gastrointestinal Endoscopy (ASGE) and the U.S. Multi-Society Task Force on Colon Cancer have published appropriate indications for colonoscopy. The indication should be documented for each procedure; justification should be provided for any nonstandard indication. Screening colonoscopy is appropriate for asymptomatic patients age 50 and older who are at average risk for colorectal cancer.
Diagnostic colonoscopy indicated	Patients in the sample for whom diagnostic colonoscopy was indicated	Number of patients in the sample for whom diagnostic colonoscopy was indicated	Number of patients in the sample for whom the clinical indication for colonoscopy was documented	The American Society for Gastrointestinal Endoscopy (ASGE) and the U.S. Multi-Society Task Force on Colon Cancer have published appropriate indications for colonoscopy. The indication should be documented for each procedure; justification should be provided for any nonstandard indication.
Surveillance colonoscopy indicated	Patients in the sample for whom surveillance colonoscopy was indicated	Number of patients in the sample for whom surveillance colonoscopy was indicated	Number of patients in the sample for whom the clinical indication for colonoscopy was documented	The American Society for Gastrointestinal Endoscopy (ASGE) and the U.S. Multi-Society Task Force on Colon Cancer have published appropriate indications for colonoscopy. The indication should be documented for each procedure; justification should be provided for any nonstandard indication.
Other clinical indication	Patients in the sample for whom the clinical indication for colonoscopy was "other"	Number of patients in the sample for whom the clinical indication for colonoscopy was "other"	Number of patients in the sample for whom the clinical indication for colonoscopy was documented	The American Society for Gastrointestinal Endoscopy (ASGE) and the U.S. Multi-Society Task Force on Colon Cancer have published appropriate indications for colonoscopy. The indication should be documented for each procedure; justification should be provided for any nonstandard indication.

Cecal Intubation				
Measure Title	Description	Numerator	Denominator	Rationale
Successful cecal intubation	Patients in the sample who were reported as having had the cecum successfully intubated	Number of patients in the sample who were reported as having had the cecum successfully intubated	Number of patients in the sample, excluding those who have no cecum	Cecal intubation is an important quality indicator for colonoscopy. It increases the sensitivity of the test and eliminates the need for additional or repeat procedures to view the entire colon. Among skilled colonoscopists, Marshall and Barthel (Gastrointest Endosc 1993;39:518-520) found cecal intubation rates of 90% for all patients and more than 95% for healthy adults undergoing screening colonoscopy.

Withdrawal Time				
Measure Title	Description	Numerator	Denominator	Rationale
Systematic measurement of colonoscopy withdrawal time	Patients in the sample for whom cecal intubation was successful and colonoscopy withdrawal time was measured systematically	Number of patients in the sample for whom cecal intubation was successful and colonoscopy withdrawal time was measured systematically	Number of patients in the sample for whom cecal intubation was successful	Experts recommend that scope withdrawal time for a colonoscopy without biopsy or polypectomy should be at least six minutes. Withdrawal time, however, is a proxy measure for adenoma detection rate. Studies suggest that rapid withdrawal allows insufficient time for inspection of the mucosa.
Colonoscopy withdrawal time \geq 6 minutes	Patients in the sample for whom cecal intubation was successful and colonoscopy withdrawal time was recorded as greater than or equal to 6 minutes	Number of patients in the sample for whom cecal intubation was successful and colonoscopy withdrawal time was recorded as greater than or equal to 6 minutes	Number of patients in the sample for whom cecal intubation was successful	Experts recommend that scope withdrawal time for a colonoscopy without biopsy or polypectomy should be at least six minutes. Withdrawal time, however, is a proxy measure for adenoma detection rate. Studies suggest that rapid withdrawal allows insufficient time for inspection of the mucosa.

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