Program Application

The application must be reviewed and signed by the medical director of the endoscopy unit.
If applying for more than one unit, please provide this information for each unit on a duplicate form. This form is available for download at www.asge.org/quality/EURP.

Please check one: ☐ New Application ☐ Renewal ☐ Reinstatement Expiration date, if applicable_____

Name of Medical Director: _____

(Please print clearly) Last First MI

As the medical director of this unit I hereby attest to the accuracy of all information submitted via this application with my signature.

_____

Medical Director Signature Specialty Date

Type of endoscopy unit: ☐ Office-based ☐ Ambulatory Surgical Center ☐ Hospital-based unit ☐ HOPD only

Unit/Group Name: _____
If your name has changed since your unit's last application, please provide former name _____

Practice Manager: _____

Practice Manager's Email: _____

Physical Address: _____

Mailing Address:
if different from physical address _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Contact Information (Important! Please list your unit/group name exactly as you wish it to appear on your recognition certificate, if awarded.)

Indicate any institutional affiliation of your endoscopy office/unit(s), if applicable.

_____

***If applying for multiple units regardless of affiliation*, total number of endoscopy units under your supervision** _____

For the purposes of the EUR Program **units at separate physical addresses are considered separate units**, regardless of institutional affiliation or ownership. Please complete an application for each individual unit seeking recognition and note the additional unit names below or on a separate page.

_____

_____

Indicate the organization from which the unit received accreditation. Proof of current accreditation is required.

Accrediting Organization: _____ **Expiration Date:** _____

Completion of the ASGE Quality Course, *Improving Quality and Safety in Your Endoscopy Unit*
Units applying to the program are encouraged to send a physician and non-physician manager to the course. To meet the program eligibility criterion, at least one unit representative must attend the course within a year prior to a new application. Reapplicants should attend the course prior to their renewal application due date. (Visit **www.asge.org/quality/qualitycourse** for a list of upcoming courses.)

Name of Course Participant(s)

Last	First	Date Attended
Last	First	Date Attended

Membership Verification

Name and membership status of endoscopists working in the unit

At least 50% of all endoscopists working in the unit must be ASGE members, with an "endoscopist working in the unit" defined as any physician, regardless of specialty, who performs 50 or more endoscopic procedures per year in the unit.

If the unit has endoscopists performing less than 50 endoscopic procedures in the unit annually, please note the following:

- The medical director of the unit must be a member of ASGE.
- While these endoscopists do not need to be listed immediately below, performance data on these endoscopists is still required to be submitted as part of the application's Quality Policy Assessment.

(Please duplicate this form to list additional endoscopists in the same unit.)

For questions regarding membership status, please contact ASGE Customer Care at 630.573.0600.

Name	ASGE member?	Annual Colonoscopy Procedures	Physician Specialty GI (gastroenterologist), IM (Internal Medicine), FP (Family Practice) Surgeon or Other	E-mail address
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			

Attestation of Guideline Adoption

The Medical Director of the endoscopy unit must attest to adopting two ASGE clinical guidelines and the CDC guideline on infection control as unit policy for all units listed on the application. By signing this form, you attest that you understand the guidelines and have adopted them as unit policy. The ASGE guidelines are linked below and published online at www.asge.org.

Unit/Group Name: _____

Main Practice Address: _____

ADOPTION OF ASGE CREDENTIALING GUIDELINE

The "Methods of Granting Hospital Privileges to Perform Gastrointestinal Endoscopy" (http://www.asge.org/WorkArea/showcontent.aspx?id=3004) was prepared by the Standards of Practice Committee of the American Society for Gastrointestinal Endoscopy. It represents guidelines for appropriate utilization of endoscopy and is based on a critical review of the available data and expert consensus.

This document is intended to provide the principles by which credentialing organizations may create policy and practical guidelines for granting gastrointestinal endoscopic privileges. Additionally, guidelines for defining continued competence, quality improvement, and the granting of privileges for newly developed or evolving endoscopic procedures are provided. The principles set out in this document are intended to apply universally to all those who perform endoscopic procedures.

I certify that I understand the ASGE credentialing guideline and that our unit has adopted this guideline as unit policy and will adopt any revised versions of this guideline.

Name of Medical Director	Medical Director Signature	Date

ADOPTION OF ASGE REPROCESSING GUIDELINE

The "Multisociety guideline on reprocessing flexible GI endoscopes: 2016 update" (http://www.asge.org/uploadedFiles/Publications_(public)/Practice_guidelines/MS_guideline_reprocessing_GI_endoscopes.pdf) is a position statement that was published following a multi-stakeholder consensus panel convened by the American Society for Gastrointestinal Endoscopy and the Society for Healthcare Epidemiology of America.

Professional organizations vary in recommended practices. This document is not intended to replace these guidelines, but to complement them, emphasizing those areas in which a broad range of professionals have reached consensus based on the available evidence.

I certify that I understand the ASGE reprocessing guideline and that our unit has adopted this guideline as unit policy and will adopt any revised versions of this guideline.

Name of Medical Director	Medical Director Signature	Date

ADOPTION OF CDC GUIDELINE FOR ISOLATION PRECAUTIONS

The CDC "Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007" (http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf) is intended for use by healthcare providers responsible for developing, implementing and evaluating infection control programs for healthcare settings across the continuum of care.

I certify that I understand the CDC "Guideline for Isolation Precautions of 2007" and that unit has adopted the CDC guideline as unit policy and will adopt any revised versions of this guideline.

Name of Medical Director	Medical Director Signature	Date

Attestation of Competency

Please attest that all pertinent staff members have completed competency assessments for endoscope reprocessing, sterile medication administration (for those staff to whom it is applicable), and infection prevention in the endoscopy unit within the prior year. (Please duplicate this form, as needed, to list additional staff.)

Assessment for Endoscope Reprocessing

Staff Name: _____ Date of Completion: _____

Staff Name: _____ Date of Completion: _____

Staff Name: _____ Date of Completion: _____

Staff Name: _____ Date of Completion: _____

Staff Name: _____ Date of Completion: _____

Name of Medical Director **Medical Director Signature** **Date**

Sterile Medication Administration (Safe Injection Practices)

Staff Name: _____ Date of Completion: _____

Staff Name: _____ Date of Completion: _____

Staff Name: _____ Date of Completion: _____

Staff Name: _____ Date of Completion: _____

Staff Name: _____ Date of Completion: _____

Name of Medical Director **Medical Director Signature** **Date**

Infection Prevention

Staff Name: _____ Date of Completion: _____

Staff Name: _____ Date of Completion: _____

Staff Name: _____ Date of Completion: _____

Staff Name: _____ Date of Completion: _____

Staff Name: _____ Date of Completion: _____

Name of Medical Director **Medical Director Signature** **Date**

Quality Policy Assessment

For sample materials to assist you in completing the Quality Policy Assessment components of the application, please visit www.asge.org/quality/eurp. Your materials do not need to mirror these samples. However, many have found them useful.

Part A
Demonstrate that unit policies have been developed and adopted for continuous or intermittent assessment of the following Quality Measures, with associated performance targets for selected measures, by attaching copies of policies with dates of approval/adoption to this application. **Please submit only the policies related to the following, labeling documents submitted along with this application as indicated below. Please do not staple application materials.**

1. **Patient assessment** for procedural risk before sedated procedures – employing ASA score, Mallampati Score or another standardized assessment **(labeled as Attachment A.1.)**
2. **Quality of preparation** during colonoscopy, employing standardized criteria **(labeled as Attachment A.2.)**
3. **Cecal Intubation Rate** by endoscopists, during colonoscopy **(labeled as Attachment A.3.)**
4. **Adenoma detection rates** by endoscopist, during colonoscopy **(labeled as Attachment A.4.)**
5. **Adverse event tracking**, by major classes and severity, for the unit as a whole **(labeled as Attachment A.5.)**
6. **Use of Patient Satisfaction surveys** by the unit as a whole **(labeled as Attachment A.6.)**
   All EURP recognized units must administer a patient satisfaction survey. The policy should note the method by which your unit's patient satisfaction survey is administered. Please submit a blank copy of the survey tool currently in use.
   (ASGE's recommended survey tool can be accessed online at www.asge.org/quality, http://www.asge.org/WorkArea/showcontent.aspx?id=14112.)

Part B
Submit one cycle of data pertaining to the measures listed on page 6 of the application: (a) patient risk assessment documented; (b) quality of bowel preparation documented; (c) cecal intubation rate; and (d) adenoma detection rate. You will be reporting the data in aggregate and by individual endoscopist.

- **In aggregate:** Report the aggregate data on page 6.
- **By individual endoscopist:** Attach a supplemental document listing the performance by endoscopist. Appendix A of this application includes a suggested format. *Please de-identify the physicians, using unique identifiers (e.g., MD1, MD2).*
- In cases of suboptimal performance, if applicable, demonstrate that improvement/remediation plans have been formulated.
  Remediation plans ideally include educational plan, time period anticipated for physician/staff education, details of other interventions, goal sample size, estimated time period to reach sample size, and estimated date of completion.

The data provided is confidential, considered Quality Assurance data and inadmissible. Please retain underlying data for possible future use/audit.

1. For what type of endoscopy unit is the award being sought? (Please select one.)

   ☐ Office-based ☐ Ambulatory Surgical Center ☐ Hospital-based unit ☐ HOPD only

2. How many of the following procedures did your unit do in the last year, and how many physicians perform each procedure type?

   Colonoscopy _____ procedures, performed by _____ endoscopists

   EGD: _____ procedures, performed by _____ endoscopists

   EUS: _____ procedures, performed by _____ endoscopists

   ERCP: _____ procedures, performed by _____ endoscopists

   For ERCP, do all physicians perform > 50/year? ☐ Yes ☐ No ☐ N/A

Quality Policy Assessment *continued*

3. Enter aggregate results below for the unit in the past year based on annual numbers or other sequential or random data – at a minimum review of the last 25 or more screening/surveillance colonoscopies per endoscopist. Attach a supplemental document listing the performance by endoscopist. (See Appendix A for a recommended format for submitting individual physician data.)

   Is the data per endoscopist being submitted for the whole year, 25 consecutive cases, or otherwise?

   ☐ Year ☐ 25 cases ☐ Other, please specify (e.g., one quarter) _____

   a. Patient risk assessment documented (Number yes / Number reviewed; % Yes): ___ / ___ (___%)

   Percent ASA I: ____

   Percent ASA II: ____

   Percent ASA III: ____

   Percent ASA IV: ____

   If the assessment is not documented in ≥ 95% of cases, please provide brief rationale and improvement/remediation plan.

   Data demonstrating that performance by each individual endoscopist along with an improvement/remediation plan, if applicable, should be labeled **Attachment B.3.a.**

   b. Quality of bowel preparation documented (Number yes / Number reviewed; % Yes): ___ / ___ (___%)

   Percent Adequate or better: ___%)

   If the preparation quality is not documented or not recorded as adequate or better in ≥ 90% of cases for the entire unit, please provide brief rationale and improvement/remediation plan.

   Data demonstrating performance by each individual endoscopist along with an improvement/remediation plan, if applicable, should be labeled **Attachment B.3.b.**

   c. Cecal Intubation Rate for entire unit (Number yes / Number reviewed; % Yes): ____/ ____ (____%)

   Range of Cecal Intubation Rate among endoscopists: _____% (low) to _____% (high)

   If the cecal intubation rate is not ≥ 95% in screening and surveillance procedures for the entire unit and for each individual endoscopist, please provide brief rationale and improvement/remediation plan.

   Data demonstrating performance by each individual endoscopist along with an improvement/remediation plan, if applicable, should be labeled **Attachment B.3.c.**

   d. Adenoma detection rates for unit in Screened patients ≥ 50 Years Old

   Numerator = Number of male patients with adenomas detected = _____

   Denominator = Number of male patients screened = _____ (_____%)

   Range of Adenoma Detection Rate for men among endoscopists: _____% (low) to _____% (high)

   Numerator = Number of female patients with adenomas detected = _____

   Denominator = Number of female patients screened = _____ (_____%)

   Range of Adenoma Detection Rate for women among endoscopists: _____% (low) to _____% (high)

   If the adenoma detection rate for the entire unit and for each endoscopist is not ≥ 30% for men and ≥ 20% for women, please provide a brief discussion and improvement/remediation plan.

   Data demonstrating performance by each individual endoscopist along with an improvement/remediation plan, if applicable, should be labeled **Attachment B.3.d.**

Quality Policy Assessment *continued*

Adverse events for unit as a whole (All procedures and types

(Number / overall procedure Number): _____ / _____ (___ %)

How many adverse events of each variety were experienced within the past year?

	Outpatient Procedure	In-patient Procedure
Deaths attributable to a procedure		
Unplanned admissions within 48 hours		
Unplanned anesthesia calls to intubate (during planned moderate sedation)		
Perforations		
Bleeds requiring transfusion		
Post ERCP Pancreatitis		

What practices does your unit use to identify adverse events? (Please check all that apply.)

- ☐ Intra-procedure and post-procedure complications recorded during visit
- ☐ Change in-patient status - requirement for hospital admission
- ☐ 24-48 hour call back
- ☐ Delayed callback (> one week) post procedure
- ☐ Other, explain:

Quality Improvement Project Summary

Submit as an attachment [labeled **Attachment QI**] to this application a summary (200-300 words) of a **clinical** quality improvement project completed in your unit. Please use the ***Define-Measure-Analyze-Improve-Control*** format to present your project, the related outcomes and future goals. The following questions are provided as guidance; they do not need to be answered individually. **The summary provided is confidential, considered Quality Assurance data and inadmissible.**

Define your project
- What is/was the gap in quality of care?
- What were the project goals or anticipated changes you sought to achieve?

Measure your project
- What were the performance measures of interest?
- How was the data acquired? Was it easily accessible?
- What was the baseline performance? (measurement before intervention)
- What were the targets for performance?

Analyze your project
- What local or higher-level factors contribute to defects, gaps, or variance?
- Which factors does the project address?
- What quality improvement methods and tools were utilized? (e.g., run charts, control charts, reports showing changes over time, PDSA, Lean Six Sigma)

Improve your performance
- What intervention did you pilot or implement?
- What did repeat measurement of performance measures show?

Control summary
- What were the outcomes of the project?
- Did you achieve the project goals? If not, what did you learn? What barriers did you encounter?
- Are there any limitations to the findings? Are there additional benefits?
- Were financial benefits or cost savings realized? If so, explain.
- How will the findings be communicated?
- Are the improvements sustainable?
- Can the intervention be disseminated to the other sites as a best practice?

Application Fees and Payment Information

Application Fees

Discounts to the program apply for units meeting either or both of the following conditions. Please see the fee table below.

A. All endoscopists in the unit are members of ASGE.
At least 50% of unit endoscopists must be ASGE members to apply to the program.

B. The unit participates in the GIQuIC registry. (To learn more about GIQuIC visit www.asge.org/quality/GIQuIC.)

	EURP Only		EURP + GIQuIC	
	Primary or Single Unit	**Additional Units**	**Primary or Single Unit**	**Additional Units**
≥ 50% Membership	$950	$475	$800	$400
100% Membership	$700	$350	$550	$275

Your program application will not be processed until the application fee is received. Units will have one year from the time the application fee is paid to meet all requirements. The application fee is nonrefundable.

Payment Information

Date: .....

Unit/Group Name: .....

Address 1: .....

Address 2: .....

City: ..... **State:** ..... **Zip:** .....

Phone: ..... **Fax:** .....

Email: .....

Method of Payment (Please check one.) ☐ Credit Card (please complete below) ☐ Check payable to ASGE

Credit Card Type: ☐ Master Card ☐ Visa ☐ American Express

Card Number: ..... **Expiration Date:** .....

Authorized Name on Card (please print) .....

Cardholder's Signature .....

Mail or fax completed application with payment to:

American Society for Gastrointestinal Endoscopy
P.O. Box 809055
Chicago, IL 60680-9055

Fax: 630.963.8332

Application Checklist

Be sure to submit these completed materials!
Please do not staple or bind materials.

- ☐ Program application form
- ☐ Proof of successful and current accreditation by a recognized accrediting body (e.g., AAAHC, AAAASF, The Joint Commission, or DNV)
- ☐ Membership Verification form
- ☐ Attestation of Guideline Adoption form
- ☐ Attestation of Competency form
- ☐ Quality Policy Assessment forms (4 pages) along with attachments
  Please note all attachments must be labeled as instructed. Applications will be returned for labeling.
- ☐ Quality Improvement Project Summary [labeled Attachment QI]
  Please note only a summary is required for submission. Complete project documentation will be returned for summarization.
- ☐ New member application(s) (Visit **www.asge.org** to apply today and save.)
- ☐ Application fees

Questions regarding your application, the program or group membership?

Please contact ASGE by phone at 630.573.0600
or via email at eurp@asge.org.

Appendix A

It is suggested the unit use the following format for submitting individual physician data. Data may be submitted in other formats, such as GIQuIC reports. *Please de-identify the physicians, using unique identifiers such as MD1, MD2, etc.*

MD	# of patients w/colonoscopy	Patient Risk Assessment Documented	Cecal Intubation Rate	Quality of Bowel Prep documented as Adequate or better	Women adenoma rates	Men adenoma detection rates
MD1						
MD2						
MD3						
MD4						
MD5						
MD6						
MD7						
MD8						
MD9						
MD10						