ASGE Endoscopy Unit Recognition Program Application

Demographics

The application must be reviewed and signed by the medical director of the endoscopy unit.

- Recognition, and as such application, is based on a facility's physical address.
- If applying for more than one unit, an application must be completed for each unit.
- Questions? Contact EURP@asge.org.

Please indicate if your application is a Renewal, New, or Reinstatement (lapsed more than a year) _____

Name of Medical Director _____

Medical Director's Specialty _____

Medical Director Signature _____ Date _____

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

Main Contact for Application _____

Main Contact Email _____

Physical Address of Unit/Facility _____

_____

_____

Award certificates are mailed to the main contact at the physical address of unit/facility, unless arranged otherwise with ASGE staff.

The endoscopy unit is in a Hospital, Ambulatory Surgery Center (ASC), or Office? _____

If the endoscopy unit is affiliated with another unit recognized by or applying to the program, please provide the name(s).

_____

Accreditation Organization _____ Expiration Date _____

ASGE Quality Course Requirement

At least one unit representative must register and attend an offering of the ASGE course Im*proving Quality and Safety in Your Endoscopy Unit* (Quality Course). This course is periodically offered live and is always available on-demand via ASGE's online learning platform GI Leap. **Renewing units have the option** to take the Quality Course or the *GI Unit Leadership* course (Unit Leader), also offered live periodically and always available on-demand.

Name of Course Participant _____

If more than one unit representative participated in a course, please list at least two registrants for verification.

Which course was taken (Quality Course or Unit Leader)? _____

Date of Course Taken or On-demand _____

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Membership Requirement and Verification

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, performing endoscopic procedures in the unit.

If the unit has endoscopists performing less than 50 endoscopic procedures in the unit annually, the medical director of the unit must be a member of ASGE. Performance data on low volume endoscopists is still **required** to be submitted as part of the application's Quality Policy Assessment for all relevant procedures.

Physicians performing endoscopic procedures in the unit

Name	ASGE Member (Y/N)	Performs >50 procedures in the unit annually (Y/N)	Email

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Attestation of Guideline Adoption

The Medical Director of the endoscopy unit must attest to having adopted the following ASGE clinical guidelines and the CDC guideline on infection control as unit policy. By signing this form, you attest that you understand the guidelines and have adopted the principles within them into your unit policies.

The following guidance documents are based on a critical, systematic review of the available data and expert consensus. They represent best practices around maintaining and ensuring that quality and safety are upheld in endoscopy units. The ASGE guidelines are published online at https://www.asge.org/home/resources/publications/guidelines.

- Antibiotic prophylaxis for GI endoscopy
- ASGE Guideline for Infection control during GI endoscopy
- Guidelines for privileging, credentialing, and proctoring to perform GI endoscopy
- Guidelines for safety in the gastrointestinal endoscopy unit
- Guidelines for sedation and anesthesia in GI endoscopy
- Management of antithrombotic agents for patients undergoing GI endoscopy
- Multisociety guideline on reprocessing flexible gastrointestinal endoscopes

I certify that I understand the above ASGE guidance documents and that our unit has adopted the principles within them into unit policies and will adopt any revised versions of them.

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" 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 the unit has adopted the CDC guideline as unit policy and will adopt any updates and revised versions of this guideline.

Medical Director Signature _____ Date _____

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Attestation of Competency

Please attest that all pertinent staff members have completed training and competency assessments for endoscope reprocessing, sterile medication administration, and infection prevention in the endoscopy unit within the prior year. (Please duplicate this form, as needed, to list additional staff or include on a separate page labeled *Attestation of Competency*.)

Assessment for Endoscope Reprocessing

Staff Member Names

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Sterile Medication Administration (Safe Injection Practices)

Staff Member Names

_____ _____

_____ _____

_____ _____

_____ _____

Infection Prevention

Staff Member Names

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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Quality Policy Assessment

Part A

Submit, as supplements to this application form, unit policies that the unit has developed and adopted for continuous or intermittent assessment of the following quality measures, with associated performance targets for selected measures. **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. **Quality of preparation** during colonoscopy, employing standardized criteria **(labeled as Attachment A.1.)**
2. **Cecal Intubation Rate** by endoscopists, during colonoscopy **(labeled as Attachment A.2.)**
3. **Adenoma detection rates** by endoscopist, during colonoscopy **(labeled as Attachment A.3.)**
4. **Adverse event tracking**, by major classes and severity, for the unit as a whole **(labeled as Attachment A.4.)**
5. **Administration of Patient Satisfaction surveys** by the unit as a whole **(labeled as Attachment A.5.)**

Part B

Submit physician performance results pertaining to the measures listed on page 6 of the application: (a) quality of bowel preparation documented; (b) cecal intubation rate; and (c) adenoma detection rate. You will be reporting performance in aggregate (unit level) and by individual endoscopist (physician level).

- **In aggregate:** Report unit-level performance on page 6.
- **By individual endoscopist:** Report physician-level performance on Page 8 or in a supplemental document representing physician level performance in a similar way (e.g., GIQuIC report). *You may de-identify the physicians using unique identifiers (e.g., MD1).*
- In cases of suboptimal performance on any quality measure (i.e., performance targets listed in the application have not been met), a detailed remediation plan must be formulated and submitted as a supplement to this application. Remediation plans should 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 performance results provided in this application and its supplements are confidential, considered Quality Assurance data and inadmissible. Please retain underlying data for possible future use/audit.

The endoscopy unit is in a Hospital, Ambulatory Surgery Center (ASC), or Office? _____

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

ERCP _____ procedures, performed by _____ endoscopists

EUS _____ procedures, performed by _____ endoscopists

Please help us understand the unit's workflow relative to data collection (e.g., manual chart review, EHR-supported, GIQuIC/registry-supported). _____

If other, please provide a supplement labeled Attachment B.3. explaining the unit's data collection workflow.

1. Enter aggregate performance results below for the unit (all endoscopists) in the past year based on annual numbers or other sequential or random data and on Page 8 (or similar) performance results on each measure by endoscopist. At least 50 cases per provider must be reviewed. If a provider is low volume (i.e., less than 50 colonoscopies in the year), the performance results must still be included with a note explaining the volume below the requirement (e.g., ERCPist).

   Describe the duration of data collection on which the performance results are based (e.g., year, 50 consecutive cases).

   _____

   a. Quality of bowel preparation

   Please state which colonoscopies are included in the denominator – screening, surveillance, or all colonoscopies.

   _____

   Rate of documentation of prep quality (number with prep quality / number reviewed)

   ____ / _____ (_____%)

   Adequacy of bowel prep rate (number Adequate or better / number reviewed

   ____ / _____ (_____%)

   Performance Threshold: If the preparation quality is not documented as adequate or better (e.g., good/excellent, Boston Bowel Prep Score ≥ 6) in ≥ 90% of cases for the entire unit, then a remediation plan labeled **Attachment B.3.a.** must be submitted. Note that bowel prep adequacy is often a unit rather than physician performance issue.

   b. Cecal intubation rate

   Please state which colonoscopies are included in the denominator – screening, surveillance, or all colonoscopies.

   _____

   Cecal intubation indicates photodocumentation of at least one cecal landmark (e.g., appendiceal orifice, ileocecal valve). Does the unit monitor performance for cecal intubation rate based on photodocumentation of at least two cecal landmarks (best practice)? Y/N _____

   (number Yes / number reviewed)

   ____ / _____ (_____%)

   Performance Threshold: If the cecal intubation rate is not ≥ 95% for the entire unit and for each individual endoscopist, then a remediation plan labeled **Attachment B.3.b.** must be submitted.

c. Adenoma detection rate (ADR)

Adenoma detection rate (ADR), or how often the endoscopist finds an adenoma, which is a precancerous growth in the colon

In August 2024, ASGE and the American College of Gastroenterology issued latest recommendations on quality indicators for colonoscopy, which advance our ability to evaluate a physician's performance to reduce post-colonoscopy colorectal cancer. ASGE recognizes it will take units time to evolve their quality improvement programs to align with the updated recommendations so currently allows for a range of options monitoring ADR. Through this application, ASGE seeks to understand how you are monitoring ADR and remediating endoscopists not meeting an appropriate performance threshold.

Continue to monitor colonoscopy quality metrics as you have been while reviewing the updated recommendations and making a plan for alignment with the updates. ASGE is with you on this journey.

ADR numerator = Number of patients with adenomas detected

ADR denominator: Please state which colonoscopies were used for the denominator (e.g., screens, all)

_____

Exceptions or Exclusions: Please state any denominator exclusions (e.g., indication positive stool-based test)

_____

_____

ADR (number of patients with adenomas detected / number of patients)

____ / _____ (_____%)

OR

ADR Male (number of male patients with adenomas detected / number of male patients)

____ / _____ (_____%)

ADR Female (number of female patients with adenomas detected / number of female patients)

____ / _____ (_____%)

OR

Adenomas per colonoscopy

_____ (unit average)

Performance Threshold: The performance threshold varies based on which colonoscopies are included in the denominator. If the adenoma detection rate for the entire unit and for each endoscopist does not meet the appropriate performance threshold noted below, a detailed remediation plan labeled **Attachment B.3.c.** must be submitted.

Screening colonoscopies only in the denominator: ≥ 25% or ≥ 30% for male and ≥ 20% for female

Screening colonoscopies plus in the denominator: ≥ 35% or ≥ 40% for male and ≥ 30% for female

Adenomas per colonoscopy: ≥ .6

The unit should use the following format for submitting individual physician performance results. Results may be submitted in other formats, such as GIQuIC reports. T**he performance rate for each physician on each quality metric should be reflected as a percentage (%).**

MD ID	Adequacy of Bowel Prep	Cecal Intubation Rate	ADR	ADR Male	ADR Female	APC
MD 1	_____	_____	_____	_____	_____	_____
MD 2	_____	_____	_____	_____	_____	_____
MD 3	_____	_____	_____	_____	_____	_____
MD 4	_____	_____	_____	_____	_____	_____
MD 5	_____	_____	_____	_____	_____	_____
MD 6	_____	_____	_____	_____	_____	_____
MD 7	_____	_____	_____	_____	_____	_____
MD 8	_____	_____	_____	_____	_____	_____
MD 9	_____	_____	_____	_____	_____	_____
MD 10	_____	_____	_____	_____	_____	_____
MD 11	_____	_____	_____	_____	_____	_____
MD 12	_____	_____	_____	_____	_____	_____
MD 13	_____	_____	_____	_____	_____	_____
MD 14	_____	_____	_____	_____	_____	_____
MD 15	_____	_____	_____	_____	_____	_____
MD 16	_____	_____	_____	_____	_____	_____
MD 17	_____	_____	_____	_____	_____	_____
MD 18	_____	_____	_____	_____	_____	_____
MD 19	_____	_____	_____	_____	_____	_____
MD 20	_____	_____	_____	_____	_____	_____

Adverse events (AEs) for unit as a whole for all procedures and types

(number of AEs / overall procedure number)

____ / _____ (_____%)

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

Deaths attributable to a procedure _____

Unplanned admissions within 14 days _____

Unplanned anesthesia calls to intubate or use of reversal agents (during moderate sedation) _____

Perforations _____

Bleeds requiring transfusion _____

Cardiopulmonary events attributable to a procedure _____

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:

_____

ASGE Endoscopy Unit Recognition Program Application

Quality Improvement Project Summary

Submit as an attachment [labeled **Attachment QI**] to this application a summary (minimum 200-300 words, maximum 2 pages) of a **clinical** quality improvement project completed in your unit. This should be a project with an issue addressed by the unit for which there was a demonstrated change in performance based on an intervention. It should ***not*** be a quality assurance activity but a quality improvement project.

You may 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.

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?

The summary provided is confidential, considered Quality Assurance data and inadmissible.

ASGE Endoscopy Unit Recognition Program Application

Application Fees and Payment Information

Application Fees

- The application fee is processed once the unit is confirmed to have met the ASGE Membership Requirement. The application fee is nonrefundable. Units have one year from the time the application fee is paid to meet all requirements.
- Once the application fee has been processed, the review and approval process begins. The process typically takes 1-3 months and is contingent upon all application materials being received and determined to meet program requirements. The contact listed on Page 1 of the application should be attentive to questions from ASGE Quality staff.

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.

What percentage of unit endoscopists are members of ASGE? _____

B. The unit participates in the GIQuIC registry. (To learn more about GIQuIC visit the GIQuIC web site.)

Does your unit participate in the GIQuIC registry? _____

Standard Application Rates

Primary or Single Unit Rates	Additional Unit Rates
$950 (meets 50% membership, less than 100%)	$475 (meets 50% membership, less than 100%)
$700 (100% ASGE membership)	$350 (100% ASGE membership)

Application Rates with GIQuIC Discount

Primary or Single Unit Rates	Additional Unit Rates
$800 (meets 50% membership, less than 100%)	$400 (meets 50% membership, less than 100%)
$550 (100% ASGE membership)	$275 (100% ASGE membership)

Payment Information

Rate $_____

Unit Name _____

Address _____

City/State/Zip _____

Phone _____

Email _____

Method of Payment (credit card or check payable to ASGE) _____

Credit Card Type (MasterCard/Visa/AMEX) _____

Credit Card Number _____

Name on Credit Card _____

Cardholder's Signature _____

Phone _____

Email _____

Mail, email, or fax completed application with payment to:
American Society for Gastrointestinal Endoscopy
ATTN: Endoscopy Unit Recognition Program
3300 Woodcreek Drive
Downers Grove, IL 60515
EURP@asge.org Fax: 630.963.8332