Program Application – ASC/HOPD/Office

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)
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  □ HOPD only

Unit/Group Name:
Please list your unit/group name exactly as you wish it to appear on your recognition certificate. If your name has changed since your unit’s last application, please provide former name.

Practice Manager:
Primary Contact for this application

Practice Manager’s Email:

Physical Address:

Mailing Address:
if different from physical address

City: ___________________________ State: ___________ Zip: ___________
Phone: _______________________ Fax: ___________________

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.

Accrediting Organization:
Completion of the ASGE Quality Course, Improving Quality and Safety in Your Endoscopy Unit
To meet this program criterion, at least one unit representative must participate in the course within a year prior to a new application. Reapplicants should participate in the course prior to their renewal application due date. Participation can be via live event, streaming a live event, or taking an on-demand course.

Renewing Units Only: Renewing units can fulfill this criterion by attending either the course listed above or a GI Endoscopy Unit Leadership course.

Name of Course Participant(s)

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<tr>
<th>Last</th>
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<th>Date Attended</th>
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American Society for Gastrointestinal Endoscopy  ·  3300 Woodcreek Drive  ·  Downers Grove, IL 60515  ·  Phone 630.573.0600  ·  Fax 630.963.8332
Application and criteria effective July 29, 2019
### 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.

<table>
<thead>
<tr>
<th>Name</th>
<th>ASGE member?</th>
<th>Annual Colonoscopy Procedures</th>
<th>Physician Specialty</th>
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<tr>
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<td>GI (gastroenterologist), IM (Internal Medicine), FP (Family Practice) Surgeon or Other</td>
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Attestation of Guideline Adoption

The Medical Director of the endoscopy unit must attest to adopting the following seven 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 them as unit policy. The ASGE guidelines are linked below and published online at www.asge.org.

Unit/Group Name: __________________________

ADOPTION OF ASGE GUIDELINES

The following guidelines 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 following guidelines can be found at https://www.asge.org/home/guidelines.

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

I certify that I understand the above seven ASGE guidelines and that our unit has adopted these seven guidelines as unit policies and will adopt any revised versions of them.

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” 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 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**

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**Sterile Medication Administration** (Safe Injection Practices)

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<th>Staff Name</th>
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**Infection Prevention**

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**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 the EURP web page. 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. 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. Use of Patient Satisfaction surveys by the unit as a whole (labeled as Attachment A.5.)
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.

Part B
Submit one cycle of data 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 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 form or suggested format. Please de-identify the physicians, using unique identifiers (e.g., MD1).
- 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
   - [ ] 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
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 50 or more screening/surveillance colonoscopies per endoscopist. Attach a supplemental document listing the performance by endoscopist. (See Appendix A for a form or recommended format for submitting individual physician data.)

**First-time applicants only:** While all applying units are encouraged to submit as large a sample size per endoscopist as feasible, newly applying units may submit a minimum review of the last 25 screening/surveillance colonoscopies per endoscopist.

Is the data per endoscopist being submitted for the whole year, 50 consecutive cases, or otherwise?

- [ ] Year
- [ ] 50 cases
- [ ] Other, please specify (e.g., one quarter) ________________

Please help us understand the unit’s workflow relative to data collection.

- [ ] Manual Chart Review
- [ ] EHR-supported performance monitoring
- [ ] Registry-supported monitoring (e.g., GIQuIC)
- [ ] Other, please provide a supplement labeled **Attachment B.3.** explaining the unit’s data collection workflow.

### a. Quality of bowel preparation documented

(Number yes / Number reviewed; % Yes): ____ / ____ (___%)

Percent Adequate or better: ___%

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 please provide brief rationale and improvement/remediation plan labeled **Attachment B.3.a.**

### b. Cecal Intubation Rate for entire unit

(Number yes / Number reviewed; % Yes): ____ / ____ (___%)

If the cecal intubation rate is not > 95% in screening and surveillance procedures for the entire unit and for each individual endoscopist, then please provide brief rationale and improvement/remediation plan labeled **Attachment B.3.b.**

**Note:** Cecal intubation indicates photodocumentation of at least one cecal landmark (i.e., appendiceal orifice, ileocecal valve, or terminal ileum). If the unit monitors performance based on photodocumentation of at least two cecal landmarks, please indicate Yes. [Circle or highlight one] Yes or No

### c. Adenoma detection rate for unit in Screened patients > 50 Years Old

- Numerator = Number of patients with adenomas detected = _____
- Denominator = Number of patients screened = _____ (___%)

OR

- Numerator = Number of male patients with adenomas detected = _____
- Denominator = Number of male patients screened = _____ (___%)
- Numerator = Number of female patients with adenomas detected = _____
- Denominator = Number of female patients screened = _____ (___%)

If the adenoma detection rate for the entire unit and for each endoscopist is not > 25% or > 30% for male and > 20% for female, then 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.c.***
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?

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Count</th>
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<tbody>
<tr>
<td>Deaths attributable to a procedure</td>
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<tr>
<td>Unplanned admissions within 14 days</td>
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<tr>
<td>Unplanned anesthesia calls to intubate or use of reversal agents (during planned moderate sedation)</td>
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<tr>
<td>Perforations</td>
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<tr>
<td>Bleeds requiring transfusion</td>
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<tr>
<td>Cardiopulmonary events attributable to a procedure</td>
<td></td>
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</tbody>
</table>

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 the GIQuIC web site.)

<table>
<thead>
<tr>
<th>EURP Only</th>
<th>EURP + GIQuIC</th>
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<tbody>
<tr>
<td>Primary or Single Unit</td>
<td>Additional Units</td>
</tr>
<tr>
<td>≥ 50% Membership</td>
<td>$950</td>
</tr>
<tr>
<td></td>
<td>$475</td>
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<tr>
<td>100% Membership</td>
<td>$700</td>
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<td>$350</td>
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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
ATTN: Endoscopy Unit Recognition Program
3300 Woodcreek Drive
Downers Grove, IL 60515
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 (3 pages) along with attachments
  Please note all attachments must be labeled as instructed.

☐ 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.*

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<thead>
<tr>
<th>MD</th>
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<th>Quality of Bowel Prep documented as Adequate or better</th>
<th>Cecal Intubation Rate</th>
<th>Adenoma Detection Rate (comingled male/female)</th>
<th>Adenoma Detection Rate (male)</th>
<th>Adenoma Detection Rate (female)</th>
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