ASGE International Endoscopy Unit Recognition Program (iEURP)

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.

Please check one: ☐ New Application

Name of Medical Director: _____
(Please print clearly) Last/Family Name First Name Middle Name

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 ☐ Other

Unit/Group Name:
Please list your unit/group name exactly as you wish it to appear on your recognition certificate. _____

_____

Practice Manager Name:
Primary Contact for this application _____

Practice Manager's Email: _____

Address: _____

City: _____ **State:** _____ **Postal Code:** _____

Country: _____ **Phone:** _____

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 iEUR 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 International Regional Quality Course.
To meet this program criterion, at least one unit representative must participate in the course prior to receiving the recognition from ASGE.

Name of Course Participant(s)

Last	First	Date Attended

Membership Verification

Name and membership status of endoscopists working in the unit

To be eligible for the ASGE International EURP (iEURP), the following conditions must be met:

At least 30% 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's Membership office at membership@asge.org.

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			

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**

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 the iEURP 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.**

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. **Poyp 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 iEURP 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 document; (b) cecal intubation rate; and (c) polyp 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 that your endoscopic unit has not yet applied any of the quality measures, kindly demonstrate that implementation plans have been formulated.
- 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 (Hospital Outpatient Department) 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

   Other _____ procedures, performed by _____ endoscopists

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 50 or more 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 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

   ☐ 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 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 photo documentation 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. Polyp detection rate for unit in Screened patients ≥ 50 Years Old

   Numerator = Number of patients with polyps detected = _____

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

   OR

   Numerator = Number of male patients with polyps detected = _____

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

   Numerator = Number of female patients with polyps detected = _____

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

   If the polyp detection rate for the entire unit and for each endoscopist is not yet established, then please provide a brief discussion on how a plan for recording PDR will be implemented.

   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?

Deaths attributable to a procedure	
Unplanned admissions within 14 days	
Unplanned anesthesia calls to intubate or use of reversal agents (during planned 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:

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

	ASGE iEURP Fees	
	Primary or Single Unit	**Additional Units**
USD	$950	$475

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:** ..... **Postal Code:** .....

Country: ..... **Phone:** .....

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 (local accreditation will be considered or international such as ACREDITAS Global (AAAHC), Joint Commission International, 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)
- ☐ 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.*
*In the case that the quality measures listed below are not documented, please include a discussion describing how the endoscopy unit will begin reporting these measures. *Please note that providing ASGE with this data will be required prior to renewal.*

				Report PDR as comingled sex or M/F		
MD	**# of patients in Adenoma Detection Rate denominator**	**Quality of Bowel Prep documented as Adequate or better**	**Cecal Intubation Rate**	**Polyp Detection Rate (comingled male/female)**	**Polyp Detection Rate (male)**	**Polyp Detection Rate (female)**
MD1						
MD2						
MD3						
MD4						
MD5						
MD6						
MD7						
MD8						
MD9						
MD10						