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) 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 ☐ 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.

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*
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 Unit Leadership* course.

Name of Course Participant(s)

Last	First	Date of Course
Last	First	Date of Course

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 Screening Colonoscopy Procedure Volume**	**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 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/resources/key-resources/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 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 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 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 including 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.)**
   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:** Include in the application submission a listing the performance by endoscopist, as seen on Page 7 of the application. A separate page(s) with individual endoscopist performance results may be submitted and should follow this format. Submission of GIQuIC reports is acceptable, if the unit participates in the registry. *Please de-identify the physicians, using unique identifiers (e.g., MD1).*
- In cases of suboptimal performance, demonstrate that remediation plans have been formulated. If the performance targets noted on Page 6 of the application have not been met, submission of detailed remediation plans is required.

  Remediation plans ideally 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 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

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 screening/surveillance colonoscopies per endoscopist**. Include a supplemental document listing the performance by endoscopist (i.e., Page 7 or similarly formatted page).

   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): ___ / ___ (___%)
   (rate of documentation)

   Percent Adequate or better: (___%) **(rate of adequacy of bowel prep)**

   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.

   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 a remediation plan labeled **Attachment B.3.b.** must be submitted.

   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 ≥ 45 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, a detailed remediation plan labeled **Attachment B.3.c.** must be submitted.

Quality Policy Assessment *continued*

The unit should use the following format for submitting individual physician performance results. Results may be submitted in other formats, such as GIQuIC reports.

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

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 (minimum 200-300 words, maximum 2 pages) of a **clinical** quality improvement project completed in your unit. This should be a project with a issue addressed by the unit for which there was a demonstrated change in performance based on an intervention. It should ***not*** be a quality 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.

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.)

	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. The application fee is nonrefundable.

Units have one year from the time the application fee is paid to meet all requirements. Applications are reviewed for completeness and then a physician reviewer from the ASGE Quality Assurance in Endoscopy Committee performs a clinical review. Once the application meets *Recommended* status from the physician reviewer, the application advances to the ASGE Governing Board for final approval. The Practice Manager listed on Page 1 of the application should be attentive to questions from ASGE Quality staff.

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. Applications with credit card payment may be submitted via email to EURP@asge.org or via fax.

- ☐ 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 along with labeled attachments
  Please note all attachments must be labeled as instructed.
- ☐ Quality Improvement Project Summary [labeled Attachment QI]
  Please note only a summary of a completed QI project is required for submission.
- ☐ 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.