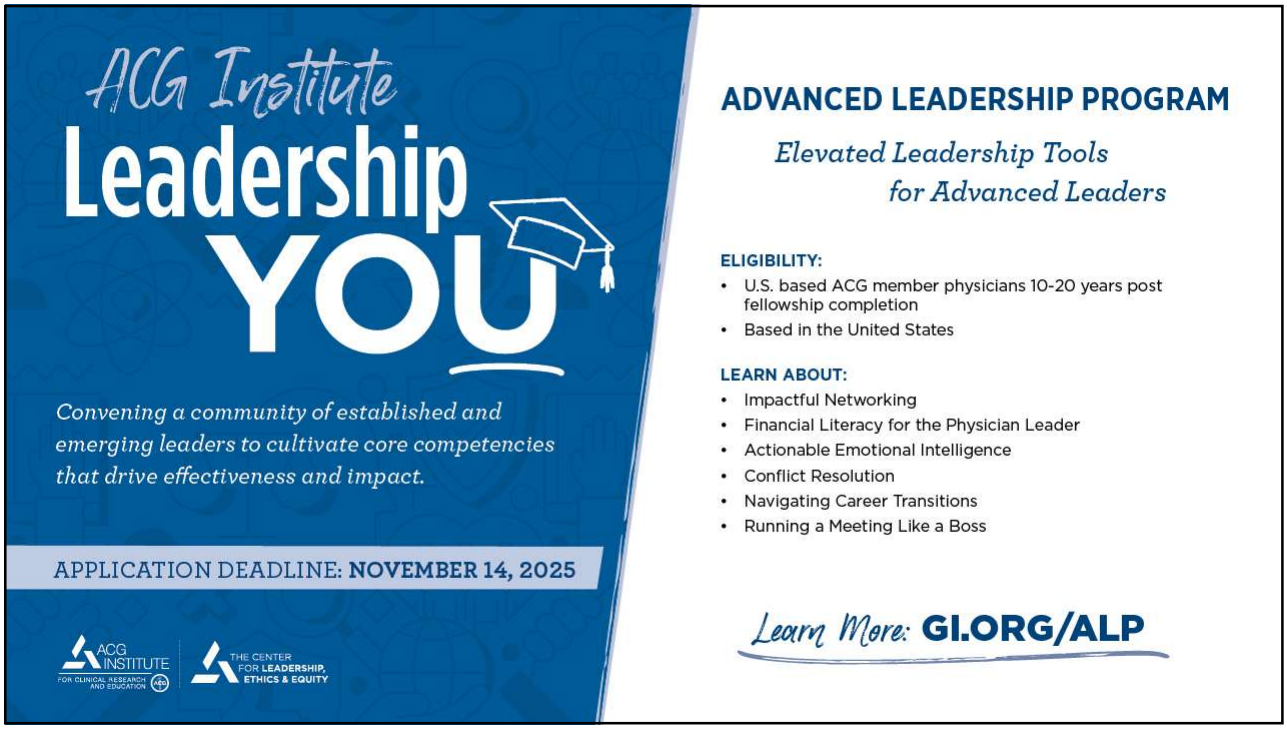
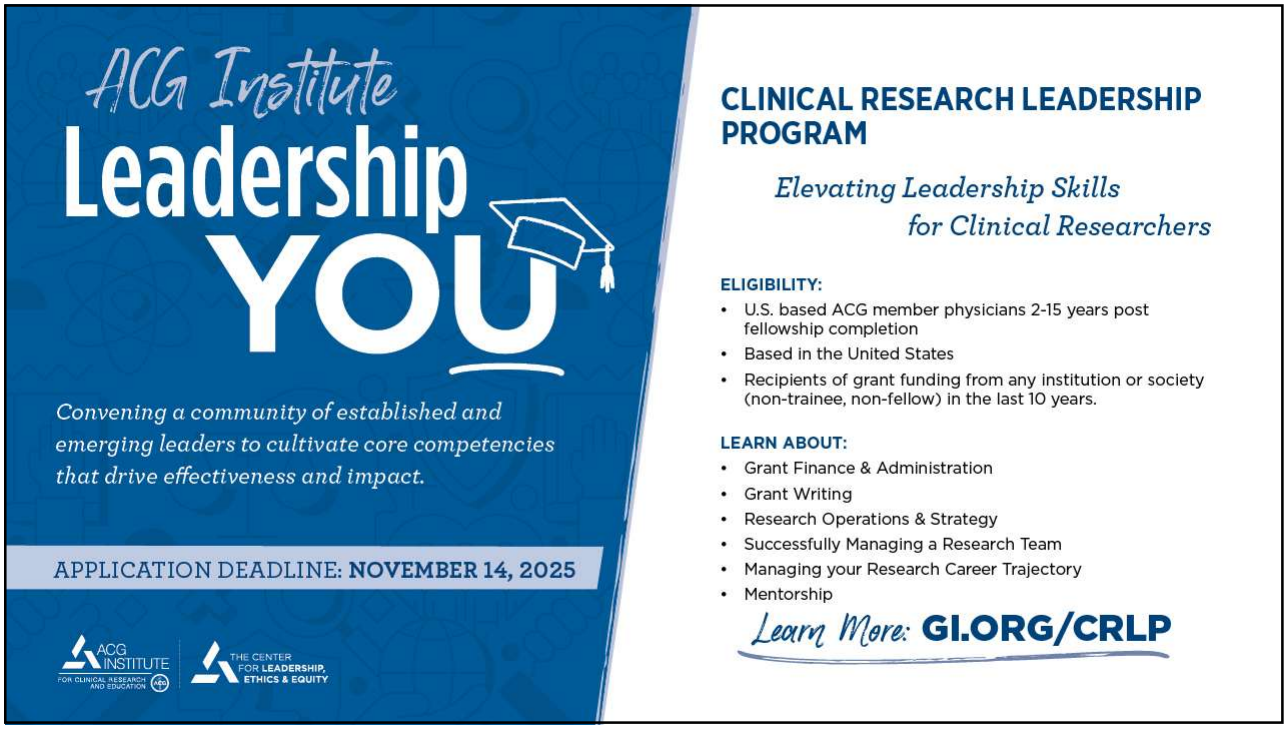
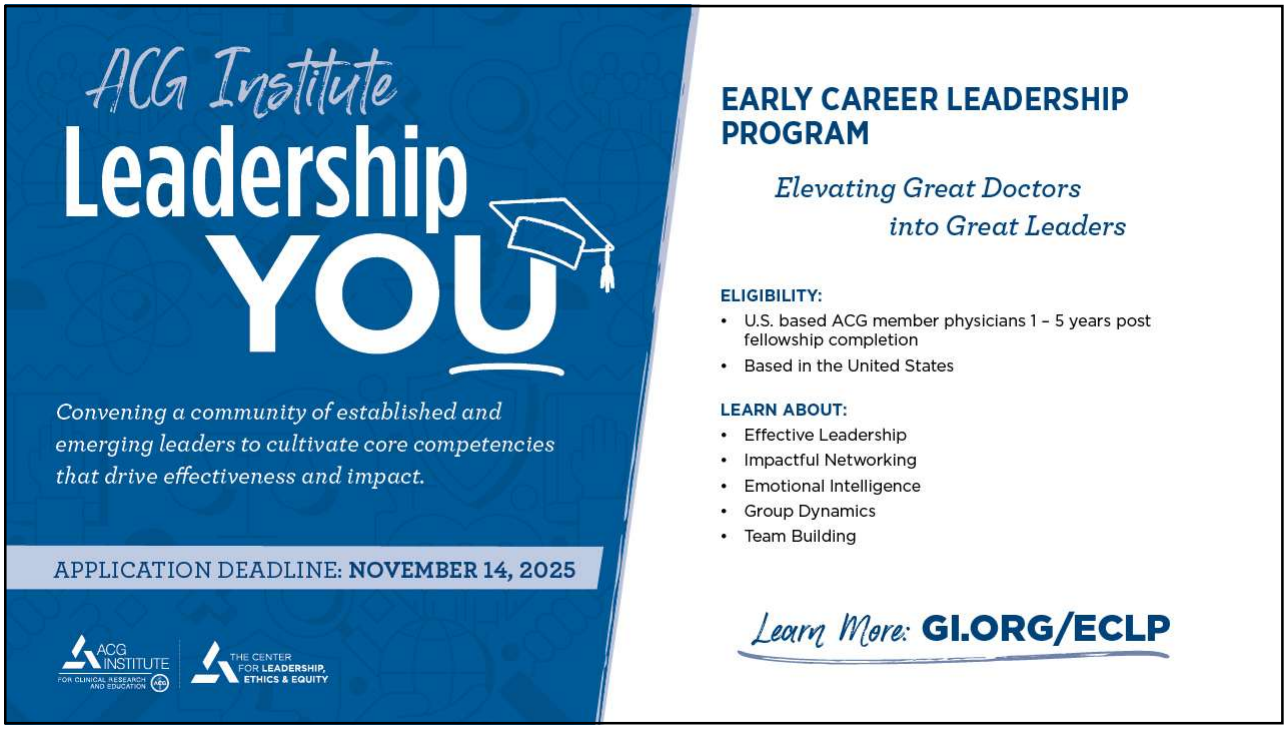

ACG Institute
Leadership
YOU
Convening a community of established and emerging leaders to cultivate core competencies that drive effectiveness and impact.
APPLICATION DEADLINE: NOVEMBER 14, 2025
ACG INSTITUTE FOR CLINICAL RESEARCH AND EDUCATION
THE CENTER FOR LEADERSHIP, ETHICS & EQUITY
ADVANCED LEADERSHIP PROGRAM
Elevated Leadership Tools for Advanced Leaders
ELIGIBILITY:
• U.S. based ACG member physicians 10-20 years post fellowship completion
• Based in the United States
LEARN ABOUT:
• Impactful Networking
• Financial Literacy for the Physician Leader
• Actionable Emotional Intelligence
• Conflict Resolution
• Navigating Career Transitions
• Running a Meeting Like a Boss
Learn More: GI.ORG/ALP

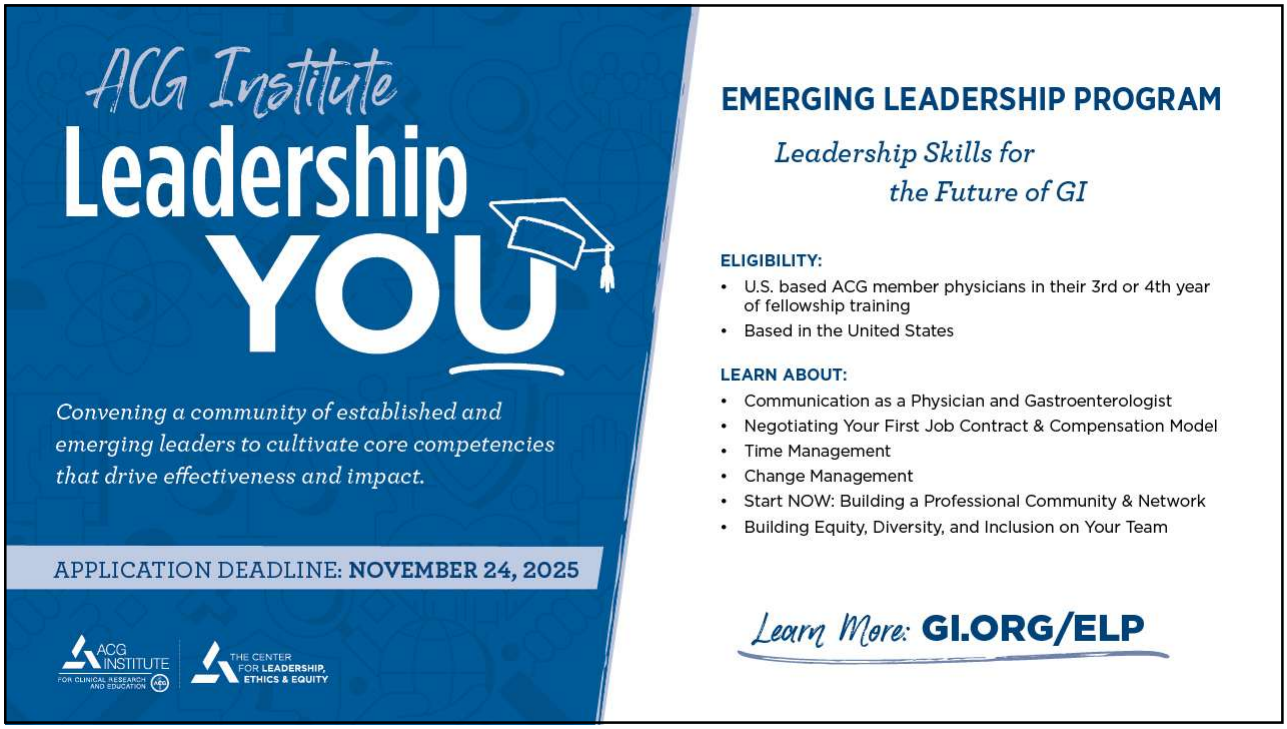
1


ACG Institute
Leadership
YOU
Convening a community of established and emerging leaders to cultivate core competencies that drive effectiveness and impact.
APPLICATION DEADLINE: NOVEMBER 14, 2025
ACG INSTITUTE FOR CLINICAL RESEARCH AND EDUCATION
THE CENTER FOR LEADERSHIP, ETHICS & EQUITY
CLINICAL RESEARCH LEADERSHIP PROGRAM
Elevating Leadership Skills for Clinical Researchers
ELIGIBILITY:
• U.S. based ACG member physicians 2-15 years post fellowship completion
• Based in the United States
• Recipients of grant funding from any institution or society (non-trainee, non-fellow) in the last 10 years.
LEARN ABOUT:
• Grant Finance & Administration
• Grant Writing
• Research Operations & Strategy
• Successfully Managing a Research Team
• Managing your Research Career Trajectory
• Mentorship
Learn More: GI.ORG/CRLP

2


ACG Institute
Leadership
YOU
Convening a community of established and emerging leaders to cultivate core competencies that drive effectiveness and impact.
APPLICATION DEADLINE: NOVEMBER 14, 2025
ACG INSTITUTE FOR CLINICAL RESEARCH AND EDUCATION
THE CENTER FOR LEADERSHIP, ETHICS & EQUITY
EARLY CAREER LEADERSHIP PROGRAM
Elevating Great Doctors into Great Leaders
ELIGIBILITY:
• U.S. based ACG member physicians 1 – 5 years post fellowship completion
• Based in the United States
LEARN ABOUT:
• Effective Leadership
• Impactful Networking
• Emotional Intelligence
• Group Dynamics
• Team Building
Learn More: GI.ORG/ECLP

3


ACG Institute
Leadership
YOU
Convening a community of established and emerging leaders to cultivate core competencies that drive effectiveness and impact.
APPLICATION DEADLINE: NOVEMBER 24, 2025
ACG INSTITUTE FOR CLINICAL RESEARCH AND EDUCATION
THE CENTER FOR LEADERSHIP, ETHICS & EQUITY
EMERGING LEADERSHIP PROGRAM
Leadership Skills for the Future of GI
ELIGIBILITY:
• U.S. based ACG member physicians in their 3rd or 4th year of fellowship training
• Based in the United States
LEARN ABOUT:
• Communication as a Physician and Gastroenterologist
• Negotiating Your First Job Contract & Compensation Model
• Time Management
• Change Management
• Start NOW: Building a Professional Community & Network
• Building Equity, Diversity, and Inclusion on Your Team
Learn More: GI.ORG/ELP

4

5

NOTE: Must complete Prequalification Form (bit.ly/33guW6k) by November 3rd

6


ACG/ASGE Epidemiologic Research Award in Gastrointestinal Endoscopy
$50k/ 1- or 2-year award
To fund research using the GIQuIC registry
•Request a Letter of Support from GIQuIC by November 3
•Email: research@giquic.org
ACG
ACG INSTITUTE
FOR CLINICAL RESEARCH AND EDUCATION
ASGE

7


ACG Institute
Leadership YOU
Convening a community of established and emerging leaders to cultivate core competencies that drive effectiveness and impact.
ACG INSTITUTE FOR CLINICAL RESEARCH AND EDUCATION
THE CENTER FOR LEADERSHIP, ETHICS & EQUITY
Apply for the program that matches your experience!
The LE&E Center Early Career Leadership Program
U.S. based ACG member physicians 1 – 5 years post fellowship completion
The LE&E Center Advanced Leadership Program
U.S. based ACG member physicians 10-20 years post fellowship completion
The LE&E Center Clinical Research Leadership Program
U.S. based ACG member physicians 2-15 years post fellowship completion
Recipients of grant funding from any institution or society (non-trainee, non-fellow) in the last 10 years
APPLICATION DEADLINE: NOVEMBER 14, 2025
The LE&E Center Emerging Leadership Program
U.S. based ACG member physicians in their 3rd or 4th year of fellowship training
APPLICATION DEADLINE: NOVEMBER 24, 2025
Learn More:
GI.ORG/LEADERSHIP-YOU

8

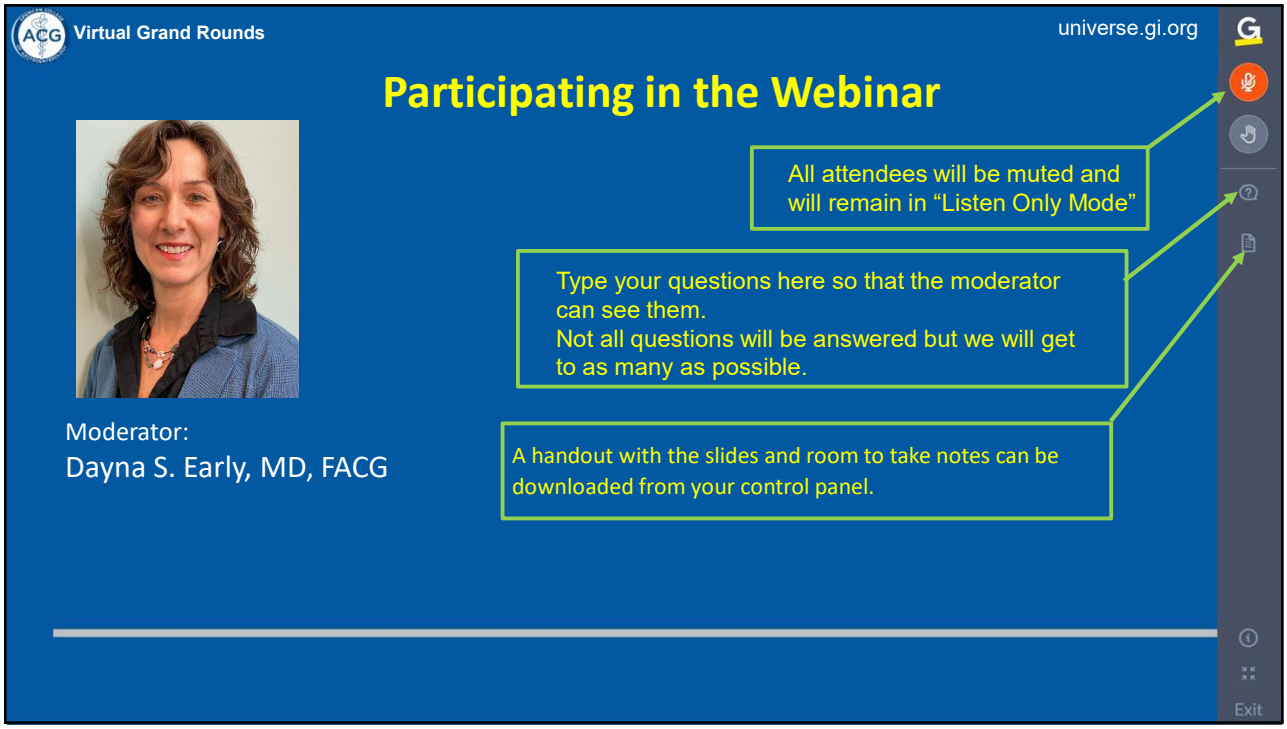
- **Visit gi.org/research-awards** to learn more about the 8 grant categories & apply
- **New! Grant Writing Resources -** gi.org/grant-writing-resources
  - for grant tips, videos, and written resources

9

10


2025
ACG'S HEPATOLOGY SCHOOL & SOUTHERN
REGIONAL POSTGRADUATE COURSE
DECEMBER 5-7, 2025 | RENAISSANCE HOTEL, NASHVILLE, TN
Register online: meetings.gi.org

11


Virtual Grand Rounds
universe.gi.org
Participating in the Webinar
All attendees will be muted and will remain in "Listen Only Mode"
Type your questions here so that the moderator can see them.
Not all questions will be answered but we will get to as many as possible.
A handout with the slides and room to take notes can be downloaded from your control panel.
Moderator:
Dayna S. Early, MD, FACG
Exit

12

Virtual Grand Rounds

universe.gi.org

ACG Virtual Grand Rounds

Join us for upcoming Virtual Grand Rounds!

Week 46 – Thursday, November 13, 2025
Short Bowel Syndrome: Cases of Non-Short Bowel/Intestinal Failure: Pearls for Recognition and Management
Faculty: George Ou, MD
Moderator: Omar Jamil, MD
At Noon and 8pm Eastern

Week 47 – Thursday, November 20, 2025
Vaccine Update for Gastroenterologist- IBD and Beyond
Faculty: Freddy Caldera, DO, MS, PhD, FACG
Moderator: Francis A. Farraye, MD, MSc, MACG
At Noon and 8pm Eastern

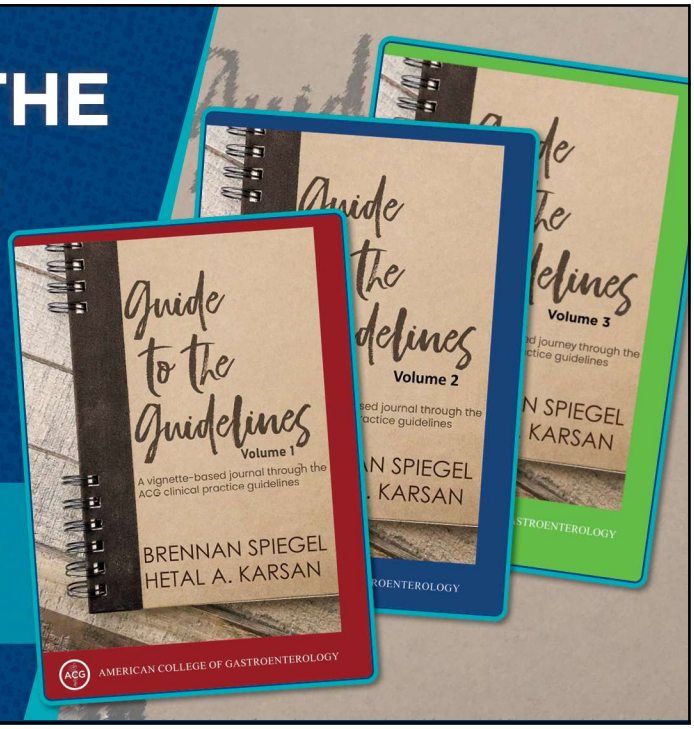
Visit **gi.org/ACGVGR** to Register

13

GUIDE TO THE GUIDELINES

Book Series with New Volume

Visit
https://members.gi.org/store/
to purchase your copies!



14

Virtual Grand Rounds

universe.gi.org

Disclosures

Rena H. Yadlapati, MD, MSHS, FACG

Braintree Pharmaceuticals: Consultant; Medtronic: Consultant; Phathom Pharmaceuticals: Consultant; Reckitt Benckiser Healthcare Ltd: Consultant; RJS Mediagnostix: Advisory Board; StatLinkMD: Consultant

Dayna S. Early, MD, FACG

Guardant Health: Advisory Board; Olympus: Consultant

**All of the relevant financial relationships listed for these individuals have been mitigated*

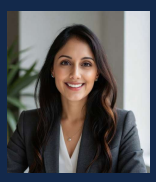
15

Virtual Grand Rounds

universe.gi.org

Quality Indicators for Upper Endoscopy

Rena Yadlapati MD, MSHS, FACG
Professor of Clinical Medicine
Director, Center for Esophageal Diseases
Medical Director, GI Motility Lab
University of California San Diego



UC San Diego School of Medicine

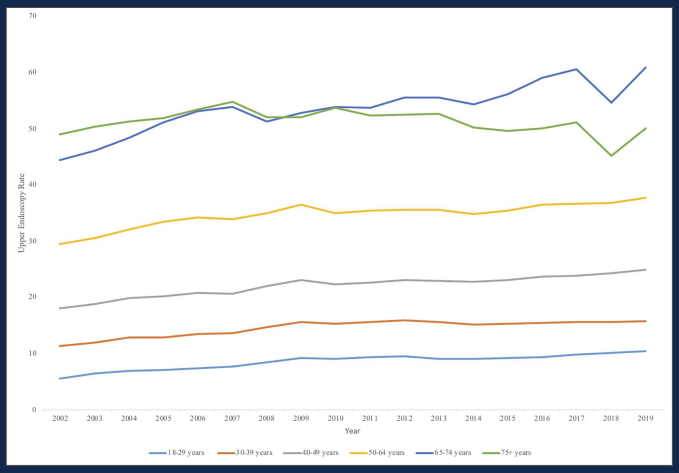
16

Virtual Grand Rounds

universe.gi.org

Upper GI Endoscopy

- Rate of EGDs rising
  - 2019: 7.5 million in US
- Expanding list of accepted indications for EGD
- High utilization without an appropriate indication
  - 5 to 49% cases
- Delivery of high-quality care in EGD is essential



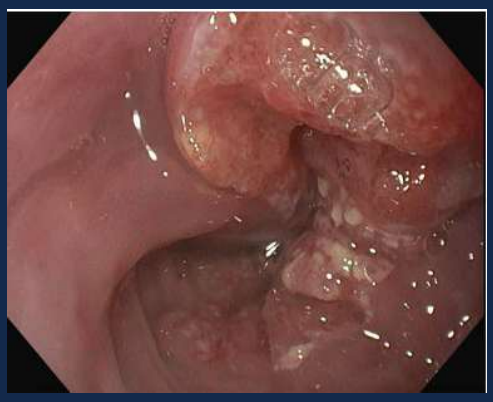
Peery AF, et al. *Gastroenterology.* 2022; Zullo A, et al. *Dig Liver Dis.* 2019; Chassin MR, eta l. *JAMA.* 1998

17

Virtual Grand Rounds

universe.gi.org

Woman with prior history of fundoplication complaining of > 1 year of dysphagia and other esophageal symptoms. Underwent an endoscopy 3 months ago with an outside endoscopist. **No images** taken. Report noted a **"mild stricture status post dilation**. **Otherwise normal"**

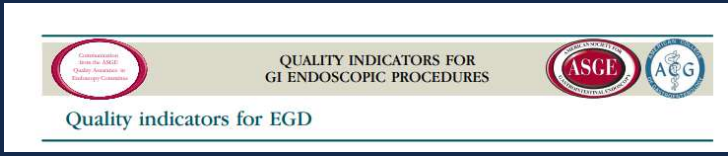


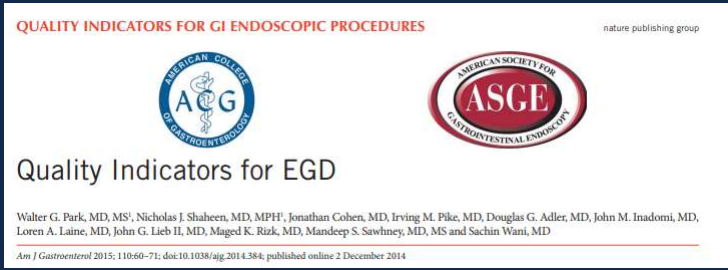
18

Virtual Grand Rounds

universe.gi.org

History of QI for Upper Endoscopy in US





Practice makes perfect – but only if you're measuring what 'perfect' looks like

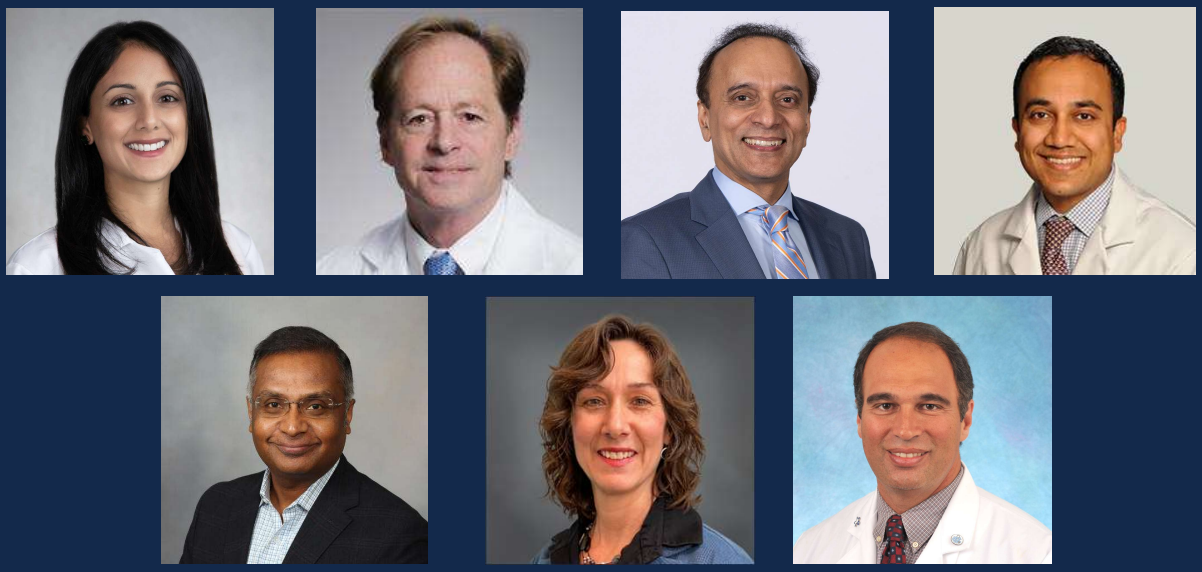
Cohen J, et al. *Am J Gastroenterol.* 2006; Park WG/Shaheen NJ, et al. *Gastrointestinal Endoscopy/American Journal of Gastroenterology,* 2015

19

Virtual Grand Rounds

universe.gi.org

Updated Quality Indicators for Upper GI Endoscopy Team



20

Virtual Grand Rounds

universe.gi.org

Quality Indicators for Upper GI Endoscopy: Task

Present quality indicators with performance targets relevant to current day upper GI endoscopy

- Update existing QIs and present relevant data
- Introduce new QIs based on interval progress in the field
- Remove prior QIs that are outdated or for which compliance is already high
- Indicators common to all GI endoscopic procedures detailed by *Elmunzer BJ et al.*

21

Virtual Grand Rounds

universe.gi.org

Methodology

- QIs divided into 3 time-periods: Pre-, Intra-, and Post-procedure
- Qis classified as outcome or process measure

- Systematic search strategy performed for each indicator (Jan 2014 to May 2023)
- Strength of recommendation evaluated
- Performance targets established for each QI
  - Never event expressed as performance target >98%

Grade of recommendation	Clarity of benefit	Methodologic strength supporting evidence	Implications
1A	Clear	Randomized trials without important limitations	Strong recommendation; can be applied to most clinical settings
1B	Clear	Randomized trials with important limitations (inconsistent results, nonfatal methodologic flaws)	Strong recommendation; likely to apply to most practice settings
1C+	Clear	Overwhelming evidence from observational studies	Strong recommendation, can apply to most practice settings in most situations
1C	Clear	Observational studies	Intermediate-strength recommendation, may change when stronger evidence is available
2A	Unclear	Randomized trials without important limitations	Intermediate-strength recommendation; best action may differ depending on circumstances or patients' or societal values
2B	Unclear	Randomized trials with important limitations (inconsistent results, nonfatal methodologic flaws)	Weak recommendation; alternative approaches may be better under some circumstances
2C	Unclear	Observational studies	Very weak recommendation; alternative approaches are likely to be better under some circumstances
3	Unclear	Expert opinion only	Weak recommendation, likely to change as data becomes available

22

Quality Indicators for Upper GI Endoscopy

Pre-Procedure

23

Quality Indicators for Upper GI Endoscopy: Pre-Procedure

Pre-Procedure		Performance Target	Type of Measure
1	**Frequency with which endoscopy is performed for an indication that is included in a published standard list of appropriate indications, and the indication is documented**	>95%	Process
2	**Frequency of EGD performed within 24 hours for patients admitted to or under observation in hospital for upper GI bleeding**	>80%	Process

*QI 2 excludes patients low risk for hospital based intervention (Glasgow Blatchford score <1)

24

Pre-Procedure QIs Common to all Endoscopy

Preprocedure
1. Frequency with which endoscopy is performed for an indication that is included in a published standard list of appropriate indications and the indication is documented (priority indicator)
2. Frequency with which informed consent is obtained and documented
3. Frequency with which preprocedure history and directed physical examination are performed and documented
4. Frequency with which a sedation plan that includes risk for sedation-related adverse events is developed and documented before sedation is initiated
5. Frequency with which prophylactic antibiotics are administered for appropriate indications (priority indicator)
6. Frequency with which management of antithrombotic therapy is formulated and documented before the procedure (priority indicator)
7. Frequency with which a team pause is performed and documented
8. Frequency with which endoscopy is performed or supervised by an individual who is fully trained and appropriately credentialed to perform that particular procedure

25

Virtual Grand Rounds
universe.gi.org

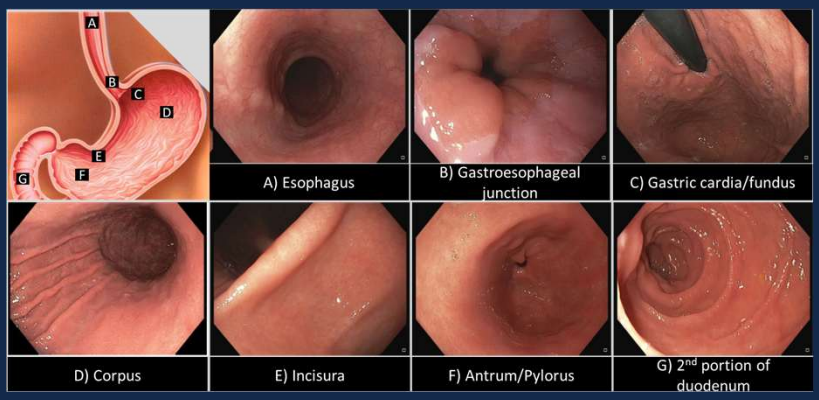
Quality Indicators for Upper GI Endoscopy

Intra-Procedure

26

Photodocumentation!!

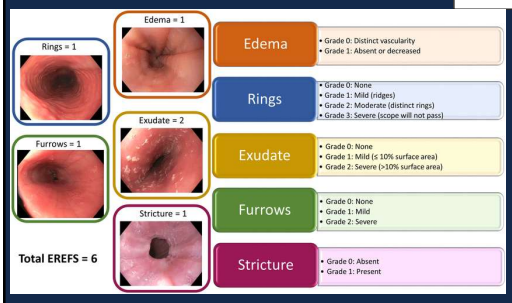
Intra-Procedure		Performance Target	Type of Measure
3*	**Frequency of photodocumentation of the esophagus, gastro-esophageal junction, gastric cardia/fundus, corpus, incisura, antrum/pylorus, 2nd portion of duodenum, and detected lesions in patients undergoing EGD**	>90%	Process



27

Intra-Procedure QI: Eosinophilic Esophagitis

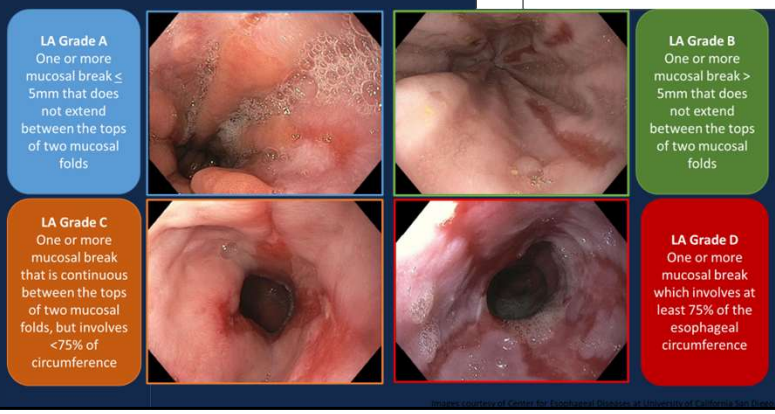
Intra-Procedure		Performance Target	Type of Measure
4	**Frequency of obtaining a total of 6 biopsies (or more) obtained from at least two levels (proximal/mid and distal) of the esophagus in the absence of an endoscopically evident etiology for dysphagia in patients reporting dysphagia**	>90%	Process
5	**Frequency of endoscopic reference score documentation when eosinophilic esophagitis is suspected or established.**	>95%	Process



28

Intra-Procedure QI: Erosive Esophagitis

	Intra-Procedure	Performance Target	Type of Measure
6*	Frequency of Los Angeles Classification documentation when erosive esophagitis is present	>98%	Process



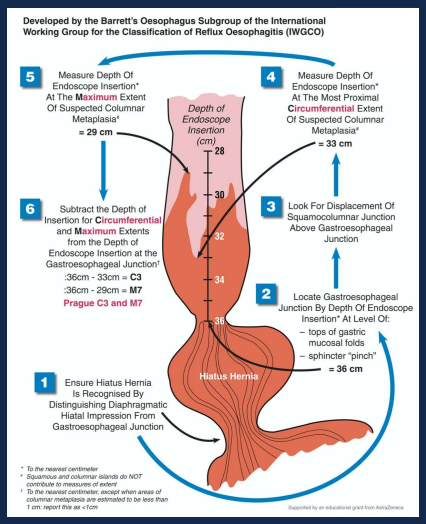
29

Intra-Procedure QI: Barrett's Esophagus

	Intra-Procedure	Performance Target	Type of Measure
7	Frequency with which the locations of the squamo-columnar junction, the gastroesophageal junction, and the diaphragmatic hiatus (if there is a hiatal hernia present) are recorded for patients with endoscopically suspected columnar metaplasia in the tubular esophagus	>95%	Process
8*	Frequency with which the presence of at least 1 cm of endoscopically evident columnar mucosa is documented while obtaining biopsies to evaluate for Barrett's esophagus	>95%	Process
9*	Frequency with which the extent of suspected or confirmed BE is documented using the Prague criteria, in cases of suspected or confirmed BE.	>95%	Process

Suspected/Confirmed BE

- *Document* landmarks (SCJ, GEJ, diaphragmatic hiatus)
- *Document* Prague criteria
- *Document* ≥1cm of columnar mucosa if biopsies obtained for BE evaluation



30

Intra-Procedure QI: Barrett's Esophagus continued

	Intra-Procedure	Performance Target	Type of Measure
10	Frequency with which high definition white light endoscopy (with dye based or virtual chromoendoscopy) is utilized for performing surveillance endoscopy in patients with BE	>90%	Process
11	Frequency of systematic four quadrant biopsies every 2cm taken throughout the extent of the endoscopically involved segment of BE in patients with known BE undergoing surveillance endoscopy	>90%	Process
12	Frequency with which biopsies/endoscopic resection are obtained from visible lesions, and processed separately from the systematic biopsies in a patient with known BE with a visible lesion identified on surveillance endoscopy	>90%	Process

Surveillance BE
- Utilize HDWLE/ Chromoendoscopy
- Utilize systematic biopsy protocol
- Visible lesion →Process biopsies/ endoscopic resection separate

31

Intra-Procedure QI: Ulcer Disease & GI Bleeding

	Intra-Procedure	Performance Target	Type of Measure
13*	Frequency with which, during EGD examination revealing peptic ulcers, at least one of the following stigmata is noted: active bleeding, nonbleeding visible vessels (pigmented protuberance), adherent clot, flat spot, or clean based	>98%	Process
14*	Frequency of endoscopic treatment delivered to ulcers with active spurting or oozing or with nonbleeding visible vessels	>90%	Process
15	Frequency of a second treatment modality delivered (eg, coagulation, clips, argon plasma) when epinephrine injection is used to treat actively bleeding or nonbleeding visible vessels in patients with bleeding peptic ulcers	>98%	Process
16*	Frequency with which achievement of primary hemostasis in cases of attempted hemostasis of non-variceal upper GI bleeding lesion is documented	>90%	Outcome

Forrest class	Evidence /stigmata of recent bleeding
IA	Arterial or spurting haemorrhage
IB	Oozing haemorrhage
IIA	Visible vessel
IIB	Adherent clot
IIC	Dark base/ haematin covered lesion
III	Lesions without active bleeding

Peptic Ulcer Disease/UGIB
- Document stigmata (Forrest classification)
- Deliver endoscopic treatment to actively bleeding or nonbleeding visible vessel
  - If epinephrine injection used for hemostasis, deliver 2nd treatment modality
  - Document achievement of primary hemostasis

32

Virtual Grand Rounds

universe.gi.org

Intra-Procedure QI: Gastric Biopsies & Polyps

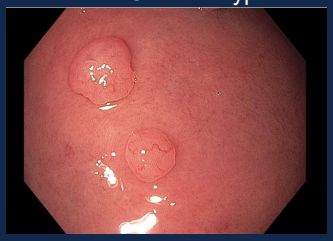
	Intra-Procedure	Performance Target	Type of Measure
17	**Frequency with which gastric biopsies are done, or follow up endoscopy is planned, to exclude malignancy in patients with gastric ulcers**	>80%	Process
20	**Frequency with which gastric polyps (without the typical appearance of a fundic gland polyp) >10mm in size are biopsied or resected**	>80%	Process

Gastric Lesions:

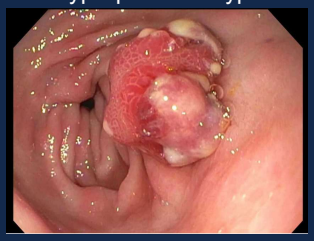
Gastric ulcer → *biopsy* to exclude malignancy

Gastric polyp >10mm → *biopsy*/resect

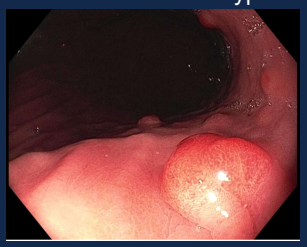
Fundic Gland Polyp



Hyperplastic Polyp



Adenomatous Polyp

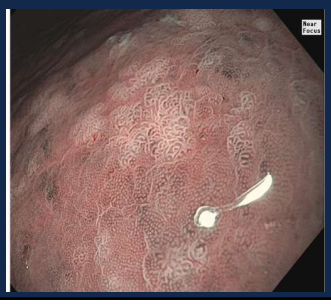


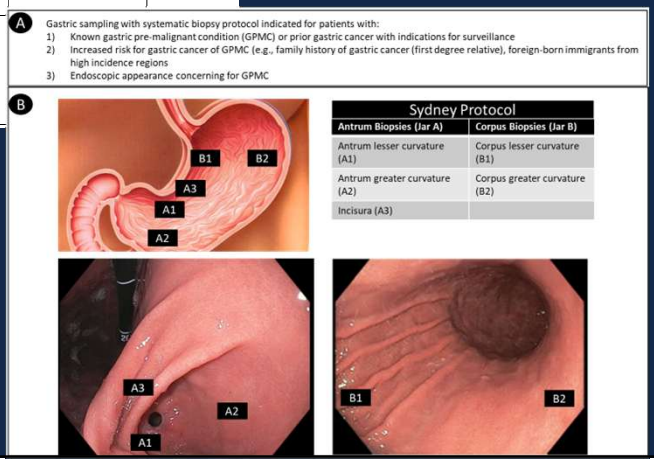
33

Intra-Procedure QI: Gastric Pre-malignant Conditions

	Intra-Procedure	Performance Target	Type of Measure
18*	**Frequency of systematic biopsies of the gastric corpus, antrum and incisura in patients with known gastric premalignant conditions (GPMC), patients at high-risk for gastric cancer or patients with an endoscopic appearance concerning for GPMC**	>90%	Process
19	**Frequency with which high definition white-light endoscopy and virtual chromoendoscopy is utilized in patients with known GPMC, patients at high-risk for gastric cancer or patients with an endoscopic appearance concerning for GPMC**		

Patchy gastric intestinal metaplasia with near focus imaging and NBI.



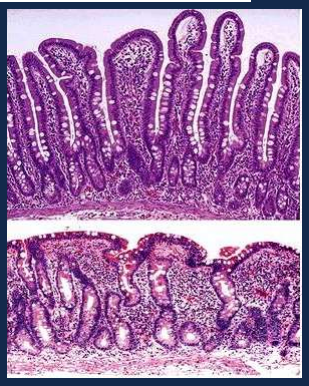


34

Intra-Procedure QI: Duodenal Biopsies

	Intra-Procedure	Performance Target	Type of Measure
21	Frequency with which ≥4 duodenal biopsies (including 1 from the bulb) are obtained in patients with suspected celiac disease	>98%	Process

Optimal biopsy protocol for suspected celiac disease:
- **4 biopsies distal to the bulb**
- **2 biopsies in the bulb at 9 and 12 o'clock position**



35

Quality Indicators for Upper GI Endoscopy

Post-Procedure

Let's close the loop – because quality without follow-up is like a biopsy without pathology.

36

Post-Procedure QI: Erosive Esophageal Disease

Post-Procedure		Perf Targ
22	Frequency of repeat endoscopy recommendation following a course of acid suppression in cases of Los Angeles C or D erosive esophagitis	>90
23	Frequency of acid suppression therapy recommendation for patients who underwent dilation for peptic esophageal strictures and do not have allergy or other contraindication to these medications	>98

Potent Acid Suppressive Agents	FDA Approved Indications and Dosages
Pantoprazole	Healing of EE; 40mg daily for up to 8 weeks Maintenance of healed EE; 40mg daily Pathological hypersecretory conditions; 40mg daily
Omeprazole*	Healing of EE; 20mg daily for 4 to 8 weeks Maintenance of healed EE; 20mg daily GERD, symptomatic (nonerosive); 20mg daily for up to 4 weeks Gastric ulcer, short term treatment of benign; 40mg daily for 4 to 8 weeks Duodenal ulcer (short-term treatment); 20mg daily Pathological hypersecretory conditions; 60mg twice daily Frequent heartburn; OTC treatment; 20mg daily for 14 days
Lansoprazole*	Healing of EE; 30mg daily for up to 8 weeks Maintenance of healed EE; 15mg daily GERD, symptomatic (nonerosive); 15mg daily for up to 8 weeks Gastric ulcer, short term treatment of benign; 30mg daily for up to 8 weeks Gastric ulcer, healing of NSAID-associated; 30mg daily for up to 8 weeks Gastric ulcer, risk reduction of NSAID associated; 15mg daily for up to 12 weeks Duodenal ulcer (short-term treatment); 15mg daily for 4 weeks Duodenal ulcer (maintenance of healed); 15mg daily Pathological hypersecretory conditions; 60mg twice daily Frequent heartburn; OTC treatment; 15mg daily for 14 days
Esomeprazole*	Healing of EE; 20mg or 40mg daily 4 to 8 weeks Maintenance of healed EE; 20mg daily GERD, symptomatic (nonerosive); 20mg daily for 4 weeks Gastric ulcer, risk reduction of NSAID associated; 20mg or 40mg daily for up to 6 months Pathological hypersecretory conditions; 40mg twice daily Frequent heartburn; OTC treatment; 22.3 mg daily for 14 days
Rabeprazole*	Duodenal ulcer (short-term treatment); 20mg daily for 4 weeks GERD, healing of erosive or ulcerative; 20mg daily for 4 to 8 weeks GERD, maintenance of healing of erosive or ulcerative; 20mg daily GERD, symptomatic (nonerosive); 20mg daily for 4 weeks Pathological hypersecretory conditions; 60mg daily
Dexlansoprazole	Healing of EE; 60mg daily up to 8 weeks Maintenance of healed EE; 30mg daily GERD, symptomatic (nonerosive); 30mg daily for 4 weeks
Vonoprazan*	Healing of EE; 20mg daily Maintenance of healed EE; 10mg daily

37

Post-Procedure QI: Barrett's Esophagus

Post-Procedure		Performance Target	Type of Measure
24	Frequency with which follow-up surveillance endoscopy is recommended no sooner than 3 years if systematic surveillance biopsies were performed in a patient known to have non-dysplastic BE without prior history of dysplasia	>80%	Process
25	Frequency of achieving complete eradication of intestinal metaplasia within 18 months of initial endoscopic treatment in patients with Barrett's esophagus and dysplasia or IMC undergoing endoscopic eradication therapy.	>75%	Outcome

38

Post-Procedure QI: Post-hemostasis

	Post-Procedure	Performance Target	Type of Measure
26*	**Frequency of administering high-dose PPI therapy (continuous or intermittently for 3 days) after successful endoscopic hemostatic therapy of a bleeding ulcer in patients without allergy or contraindication to the medication.**	>95%	Process

39

Post-Procedure QI: H. pylori & GPMC

	Post-Procedure	Performance Target	Type of Measure
27	**Frequency with which plans to test for *H. pylori* infection are documented in patients with GPMC, PUD, and other *H. pylori*-associated conditions**	>95%	Process
28	**Frequency with which plans to treat and assess eradication of *H pylori* infection are documented in patients with endoscopically diagnosed *H pylori***	>95%	Outcome
29	**Frequency that the GPMC surveillance plan is documented in patients with known GPMC.**	>90%	Process

40

Summary

- **Key updates in QIs for Upper GI Endoscopy**
  - New QI# 1: photo documentation
  - Multiple new QIs focused on quality inspection and follow-up of pre-malignant conditions (BE, GPMC) and evaluation for EoE
- **All prior QIs were not retained as compliance to indicators is high in endoscopic practice**
  - Prophylactic antibiotics prior to PEG tube
  - Variceal ligation as first modality of endoscopic treatment for esophageal varices
  - Acid suppression following endoscopic diagnosis of PUD
- **Beyond scope of this document**
  - Antibiotics in portal hypertension/cirrhosis presenting with UGIB
  - Vasoactive drugs for suspected variceal bleeding

41

Future Directions

- Documentation of procedure time or inspection time
- Neoplasia detection rate
- Endo-bariatrics
- Third space endoscopy
- Deep learning/artificial intelligence

42

Quality Isn't Just a Checkbox – it's the difference between a procedure and a profession

43

Virtual Grand Rounds

Questions

universe.gi.org

Rena H. Yadlapati, MD, MSHS, FACG

Dayna S. Early, MD, FACG

44


GI Innovation Through Collaboration
Let's talk... ACG invites you to join the conversation in the GI Circles.
ACG's Online Professional Networking Communities
Login or sign-up now at: acg-gi-circle.within3.com
GI
ACG GI Circle
Connect and collaborate within GI
IBD Circle
A Partnership of the American College of Gastroenterology and the Crohn's & Colitis Foundation

45