In this manuscript, the authors described the performances of the endoscopists in the Northern Alberta region. Overall, I think this work provides valuable information on the performance of the endoscopists, which may facilitate the future implementation studies aiming to improve the key performance indicators of the endoscopists in the region and beyond. However, the statistical methods the authors applied may be improved. I have some comments for the authors to consider.

1. It would be great to provide the aggregate comparison in the characteristics (age, sex, specialty, year of experience etc.) of the 16 participating endoscopists vs. the entire 25 endoscopists, if data are available. This will provide us some clues on the selection bias. **We do not have data on those endoscopists (and their patients) who did not participate in the study.**

2. Overall, the purpose of the study is to describe the performance of the endoscopists. Indeed, the authors presented the proportion of endoscopists who achieved the benchmark at each individual KPI, but it would be great to describe the variations in the patients characteristics (e.g. proportions of females, median age, FIT) treated by each endoscopists. This will provide the readers information on whether the comparison in the KPIs among endoscopists is based on a relatively level field. **Please see response to Q 29d.**

3. In the result section, page 7 line 1-24, the authors described the excessive likelihood of normal colonoscopy, adenomatous polyps and CRC cancers in FIT (+) patients compared to all 'indications' (this might be a typo? all 'individuals'?), but the risk ratio (i.e. the ratio of the proportion of CRC cancer in FIT (+) patients to the proportion of CRC cancer in the entire cohort) is more relevant. **CLARIFIED: We compared the outcomes of patients having a colonoscopy for FIT+ to the entire cohort.**

4. Page 7, line 45-48: Only 'extremal quotient' was presented for variation assessment which seems a bit too simple. Please consider other statistical measures for variations assessment such as the weighted coefficient of variation, $\chi^2$ statistic, systematic component of variation (SCV), and empirical Bayes (EB) variance estimate. **Please see response to Q 39. We do not feel expanding on the variability would provide any further clarity.**

5. Please add standard deviation or 95% CI for all the means and percentages in the tables and result section if applicable. **ADDED**
6. Future studies may include the investigation on the factors associated with the suboptimal performance in order to inform mitigating strategies. **Agreed, could be considered by other future studies. Not currently a goal of the current study team.**

**Reviewer 2: Dr. Clarence Wong**
**Institution:** University of Alberta

**General comments (author response in bold)**

The authors should be commended on completing such an important study. There is a gap in the literature regarding colonoscopy quality in the community. In most provinces, colonoscopy is provided in rural communities by a similar group of endoscopists as outlined in this paper. Thus, any assessments looking at the quality and outcomes of such procedures are greatly needed, and could be compared to those done in large urban centres.

This study used an online, secure web database to allow for real time data entry. The use of tablets or computers was innovative and likely eased participation.

Some questions:

1-What were the sizes of the communities in the 4 participating centres? Were there any differences between rural and small urban endoscopists.
**Due to the small sample size of participants, we decided not to analyze the regional facility to the rural facilities. In addition, some endoscopists participated at both primary (regional) and secondary (rural) locations. An analysis of whether the same endoscopists outcomes differ in different communities is beyond the scope of our initial study, but could be explored in future studies.**

2-Were colonoscopies entered consecutive/serial entry from the start of the study in 2018 to completion?
**Yes, clarified by adding “consecutive colonoscopies”**

3-How were the major KPI benchmarks assessed? Were they all self reported or was secondary agreement (eg cecal intubation confirmed by endoscopist and nurse in room) required?
**Please see Q15, 16 responses. Visualization of cecal landmarks (appendiceal orifice, tri-folds, IC value +/- terminal ileum intubation) was captured in the database. Cecal intubation was determined by secondary agreement – collaboration between the nurse and the endoscopist. This was discussed in the manuscript in “data sources” and “limitations.”**

4-For cecal intubation, what criteria was used to ensure that the cecal cap was fully inspected?
**Photodocumentation? Identification of cecal strap or appendiceal orifice? Intubation of terminal ileum?**
**Please see response to above question. Q3.**
**Landmarks identified (but not reported in manuscript): could add this if desired by the editors.**
**Appendiceal orifice: identified 96.4%, trifolds: 95.4%, IC valve 96.5%. Intubation of terminal ileum: 27.1%.**
Due to some communities’ inability to provide photograph storage, photo documentation was not required for confirming cecal intubation.

5-For bowel prep cleanliness and patient comfort, was this also endoscopist self-reported? 
**Please see Q15 response.**

6-Were there any adverse events? There are quality indicator intra- and post-procedure adverse events that would be important to highlight. Did this rural group have an ability to record adverse events? 
**We did not have the ability to adjudicate AEs and therefore we did not collect / report on adverse events. This will be a goal of a future study. Happy to put in limitations or future studies.**

7-Regarding variability, some sub group analysis may help. For example, analyze first time colonoscopy FIT+ patients. Using that criteria, were the endoscopists similar in their PDR? Another analysis could be separating those using conscious sedation vs anesthesia (propofol). In this setting, were the levels of consciousness similar or different? 
**Please see response Q29d.**
**FOR FUTURE STUDY: We feel a future study using our data set could be exploring the variability of patient outcomes by endoscopist performing conscious sedation or anaesthetist performing propofol assisted sedation.**

I cannot see the images on page 20 and page 21 under Cancer Incidence. 
**REVISED: No images, just formatting issues.**

Overall, I think this is an important study that could highlight the quality of colonoscopy in rural and small urban settings. Some further sub-analysis could strengthen this paper.