From Findings to Action: Applying your QAPI Findings

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Patients First. *Always.*

LEARNING OBJECTIVES

- Define meaningful quality indicators tied to ASC operations
- Select, Design, and execute performance improvement projects (PIPs) that are effective and helpful
- Use PIP findings to prompt and initiate additional follow up PIPs

QUAD A STANDARD 10-B-1

SUB-SECTION B: Quality Improvement Program		
10-B-1	The ASC must develop, implement and maintain an ongoing, data-driven quality assessment and performance improvement (QAPI) program.	416.43 Condition A B C

QUAD A STANDARD 10-B-2

10-B-2	The facility has a written quality improvement program implemented which includes surveys or projects to: - Monitor and evaluate patient care - Evaluate methods to improve patient care - Identify and correct deficiencies within the facility - Alert the facility's Quality Improvement Program to identify, track, trend, evaluate and resolve problems.

QUAD A STANDARD 10-B-7

10-B-7	The program must include, but not be limited to, an ongoing program that demonstrates measurable improvement in patient health outcomes and improves patient safety by using quality indicators or performance measures associated with improved health outcomes and by the identification and reduction of medical errors.

QUAD A STANDARD 10-B-10

10-B-10	The ASC must use the data collected to monitor the effectiveness and safety of its services, and quality of its care.

10-B-11	The ASC must use the data collected to identify opportunities that could lead to improvements and changes in its patient care.

QUAD A STANDARD 10-B-15/16

10-B-15	Performance improvement activities must track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time.
10-B-16	The ASC must implement preventive strategies throughout the facility targeting adverse patient events and ensure that all staff are familiar with these strategies.

QUAD A STANDARD 10-B-17/18

10-B-17	The number and scope of distinct improvement projects conducted annually must reflect the scope and complexity of the ASC's services and operations.	
10-B-18	The ASC must document the projects that are being conducted. The documentation, at a minimum, must include the reason(s) for implementing the project, and a description of the project's results.	

QUAD A STANDARD 10-B-19/20

ID	Standard
10-B-19	The governing body must ensure that the QAPI program is defined, implemented, and maintained by the ASC.
10-B-20	The governing body must ensure that the QAPI program addresses the ASC's priorities and that all improvements are evaluated for effectiveness.

WHAT QAPI IS

- Quality Assurance (QA): Is an organization meeting defined standards
- Performance Improvement (PI): How do we design and redesign processes to do better?
- QA+PI=QAPI : Continuous, data-driven, organization wide
- ***Goals: Safer care, better outcomes, regulatory readiness***

QAPI PROGRAM VS ANNUAL QAPI PLAN

- QAPI Program
  - Big picture, ongoing, data-driven approach across an ASC
  - Required for CMS coverage and accreditation
- Annual QAPI Plan
  - Year-specific roadmap of activities and metrics
  - Reviewed/approved annually by leadership
  - Drives priorities, indicators, and PIPs for the year

WHAT ARE SURVEYORS LOOKING FOR?

- Defined indicators & data:
  - Clinical (e.g., infections, transfers, unplanned admissions, patient satisfaction)
  - Operational (e.g., case delays, cancellations, supply issues)
  - Contracted services included
- Data collection methods & frequency: clearly specified
- **Benchmarks & thresholds: internal and/or external**
- **Prioritized corrective actions & re-measurement timelines**
- **Oversight & accountability: individual or committee with authority**

COMMON QAPI PITFALLS IN THE ASC

- Missing indicators for contracted services
- Indicators that don't match actual ASC services
- No clear data collection plan (source, method, frequency)
- QAPI focused only on clinical care; no operational metrics
- **QAPI meetings that review data but don't document actions or follow-up**

REGULATORY FOUNDATIONS FOR ASCs (KEY QAPI REQUIREMENTS)

- **Ongoing, data-driven program** (not episodic)
- Scope:
  - Measurable improvement in health outcomes
  - Focus is always on patient safety, medical errors, & infection control
- **Data:**
  - **Collect, analyze, and use quality indicators and adverse event data**
- Priorities:
  - High-risk, high-volume, problem-prone areas
  - Implementation of sustainable improvements
- Governing body
  - Defines program, allocates resources, sets expectations

SUSTAINING GAINS: BEYOND "ONE & DONE"

- Integrate successful changes into:
  - Policies/procedures
  - Staff orientation and annual competencies
  - Checklists and EMR workflows
- Continue **re-measurement** at a reduced frequency
- Use **dashboards** to keep priorities visible to leaders and staff
- Periodically **revisit past PIPs** – new risks can emerge

SIMPLE PERFORANCE IMPROVEMENT MODEL: PDCA IN THE ASC

- **Plan:** Define problem, baseline data, goal, team, interventions
- **Do:** Pilot changes (e.g., change pre-op checklist, new timeout process)
- **Check:** Re-measure, compare to baseline and benchmarks
- **Act:**
  - Standardize successful change in policy/education
  - Or revise and repeat cycle

EXAMPLE PIP 1: REDUCING UNPLANNED HOME OXYGEN

- **Indicator:** Unplanned orders for home oxygen
- **Baseline:** Approximately 5% last year (above internal goal of <1%, above ASCQC benchmark)
- **Plan:**
  - Review 12 months of cases for patterns
  - Root cause analysis on highest-risk procedures
- **Interventions:**
  - Anesthetic Technique Modification
  - Staff Education with Standardized post-op monitoring protocol
- **Check/Act:**
  - Quarterly review; if sustained ≤1% for 2 quarters, hardwire into policy

EXAMPLE PIP 1: REDUCING UNPLANNED HOME OXYGEN

- **Indicator:** Unplanned orders for home oxygen after placing restrictions
- **Baseline:** Approximately 5% last year (above internal goal of <1%, above ASCQC benchmark)
- **Plan:**
  - Review 6 weeks of cases for patterns
  - Root cause analysis on cases requiring home oxygen
- **Interventions:**
  - Anesthetic Technique Modification
  - Restriction of certain medications, Encouraging early arousal and movement
- **Check/Act:**
  - Weekly review; if sustained ≤1% for 2 quarters, hardwire into policy

EXAMPLE PIP 2: INCREASED POSTOPERATIVE INFECTION RATE

- **Indicator:** Increase in Q4 Infection Rate
- **Baseline:** 700% increase in Q4 over the year over year infection rates
- **Plan:**
  - Review Q4 Infections for commonalities.
  - Root cause analysis on cases with infection
- **Interventions:**
  - Reviewed infection control practices with staff
  - One staff member removed from service
- **Check/Act:**
  - Quarterly review; Additional infection control education upon hire and annually

EXAMPLE PIP 2: INCREASED POSTOPERATIVE INFECTION RATE

- **Indicator:** Change in Infection Rate Compared to Q4
- **Baseline:** 100% decrease in Q1 vs. Q4 infection rates
- **Plan:**
  - Review Q1 Infections for commonalities.
  - Root cause analysis on cases with infection in other room
- **Interventions:**
  - Reviewed infection control practices with staff, established new policies
  - One staff member removed from service
- **Check/Act:**
  - Quarterly review; Additional infection control education upon hire and annually

EXAMPLE PIP 3: ON-TIME FIRST CASE STARTS

- **Indicator:** Late first case starts
- **Baseline:** Varies by surgeon between <5% to >50%
- **Plan:**
  - Track 3 months of case start times
  - Identify repeat offenders
  - Root cause analysis on common offenders
- **Interventions:**
  - Educated Staff and Recorded start times and reasons for late start
  - Changed Physician Block Time
- **Check/Act:**
  - Quarterly review; if additional block restriction, additional staff benchmarks enacted.

EXAMPLE PIP 3: ON-TIME FIRST CASE STARTS

- **Indicator:** Continued late first case starts
- **Baseline:** Varies by surgeon between <5% to >50%, One recurrent offender
- **Plan:**
  - Track 3 months of case start times
  - Identify repeat offenders
  - Root cause analysis on common offender
- **Interventions:**
  - Educated Staff and Recorded start times and reasons for late start
  - Changed Physician Block Time Again
- **Check/Act:**
  - Quarterly review; instigated additional block restriction, additional staff benchmarks enacted.

INDICATOR GRID

INDICATOR	TYPE	DATA SOURCE	FREQUENCY	BENCHMARK / GOAL	OWNER
Unplanned Home Oxygen	Outcome	Chart Review, Home O2 Log	Monthly	≤ 1% of cases	Clinical Dir/ Medical Dir
Post-op infection rate	Outcome	Infection log	Monthly	≤ 0.5% (internal)	IC Nurse
On-time first case starts	Process	OR schedule reports	Monthly	≥ 95% (internal benchmark)	OR Manager

INDICATOR GRID

INDICATOR	TYPE	DATA SOURCE	FREQUENCY	BENCHMARK / GOAL	OWNER
Unplanned Home Oxygen	Outcome	Chart Review, Home O2 Log	Monthly	≤ 1% of cases, Not met, Additional follow up	Clinical Dir/ Medical Dir
Post-op infection rate	Outcome	Infection log	Quarterly/ Annually	≤ 0.5% (internal), Goal Met, Permanent Policies Implemented	IC Nurse
On-time first case starts	Process	OR schedule reports	Monthly/ Quarterly	≥ 95% (internal benchmark), Not met, additional block time modification.	OR Manager

KEY RESOURCES

- **CMS ASC Conditions for Coverage & QAPI:**
  - 42 CFR §416.43 – Quality Assessment and Performance Improvement
- **ASC Quality Reporting (ASCQR) Program:**
  - CMS ASCQR overview: https://www.cms.gov/medicare/quality/initiatives/asc-quality-reporting
  - QualityNet ASC section & Specifications Manuals: https://qualitynet.cms.gov/asc/specifications-manuals
  - Quality Reporting Center – ASCQR resources: https://www.qualityreportingcenter.com/en/ascqr-program
- **ASCA Resources:**
  - Quality Reporting & Patient Safety: https://www.ascassociation.org/asc-operations/quality
  - ASC Quality Reporting overview: https://www.ascassociation.org/asca/medicare/quality-reporting

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