QAPI ESSENTIALS: BUILDING A STRONG FOUNDATION FOR YOUR FACILITY

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Patients First. *Always.*

LEARNING OBJECTIVES

- Describe CMS and QAPI expectations for ASCs
- Define meaningful quality indicators tied to ASC operations
- Examine QAPI and ASCQR and other reporting requirements
- Select, Design, and execute performance improvement projects (PIPs) that are effective and helpful

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

WHAT QAPI IS (AND IS NOT)

- 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 (not pointless paperwork)

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

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

CONNECTING QAPI TO ASCQR & EXTERNAL REPORTING

- ASCQR Program: CMS pay-for-reporting program
  - Non-compliance => 2.0 percentage point reduction in ASC fee schedule
- Measures address:
  - Outcomes, processes, patient safety, care coordination, patient experience (OAS CAHPS)
- Opportunity: Use ASCQR measures as routine QAPI indicators and benchmarking tools

DEFINING MEANINGFUL QUALITY INDICATORS

- Start from CMS/ASCQR & accreditor expectations:
  - Infection rates (SSI, post-op infections)
  - Unplanned transfers/admissions
  - Patient falls, burns, wrong site events
  - Medication errors, blood transfusions
  - OAS CAHPS/patient satisfaction results
- Add ASC-specific indicators:
  - On-time starts, turnover time, same-day cancellations
  - Supply waste, implant or medication stockouts
- For each indicator, define: numerator, denominator, data source, frequency, owner

BUILDING YOUR INDICATOR GRID (TEMPLATE)

INDICATOR	TYPE	DATA SOURCE	FREQUENCY	BENCHMARK / GOAL	OWNER
Unplanned Hospital Transfer	Outcome	Transfer log, EMR	Monthly	≤ 1% of cases	Clinical Dir
Post-op infection rate	Outcome	Infection log	Monthly	≤ 0.5% (internal)	IPC Nurse
On-time first case starts	Process	OR schedule reports	Monthly	≥ 90% (internal benchmark)	OR Manager
Patient satisfaction (OAS)	Experience	OAS CAHPS/vendor	Quarterly	≥ 95% “top box” on key Qs	Admin

MANDATORY REPORTING TO CMS

- ASC-1: Patient Burns
- ASC-2: Patient Falls
- ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant
- ASC-4: All-Cause Hospital Transfer/Admission
- ASC-9: Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
- ASC-12: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

MANDATORY REPORTING TO CMS (CONTINUED)

- ASC-13: Normothermia Outcome
- ASC-14: Unplanned Anterior Vitrectomy
- ASC-15 a–e: Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey
- ASC-17: Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures
- ASC-18: Hospital Visits after Urology Ambulatory Surgical Center Procedures
- ASC-19: Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers

VOLUNTARY REPORTING TO CMS

- ASC-11: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
- ASC-21: Risk-Standardized Patient Reported Outcome-Based Performance Measure (PRO-PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the ASC Setting (THA/TKA PRO-PM)

PRIORITIZING WHAT TO IMPROVE

- Use CMS priority criteria:
  - High-risk
  - High-volume
  - Problem-prone
  - High severity if something goes wrong
- Consider:
  - Gaps vs internal/external benchmarks (ASCQR, ASC Quality Collaboration reports)
  - Frequency of events, staff concerns, patient complaints
  - Regulatory “hot spots” from recent survey findings

SELECTING PERFORMANCE IMPROVEMENT PROJECTS (PIPs)

- PIPs must reflect scope and complexity of the ASC (42 CFR §416.43(d))
- Aim for at least:
  - 1–2 clinical safety PIPs (e.g., infection prevention, transfers)
  - 1 operational PIP (e.g., on-time starts, turnover time)
- Good PIP candidates:
  - Persistent under-performance vs benchmark
  - Sentinel or near-miss events
  - ASCQR measures with room for improvement
  - Issues raised repeatedly in staff/patient feedback

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: REDUCING UNPLANNED HOSPITAL TRANSFERS

- **Indicator:** Unplanned transfer to hospital within 24 hours of discharge
- **Baseline:** 1.8% 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:**
  - Tighter patient selection criteria for high-risk procedures
  - Standardized post-op monitoring protocol
- **Check/Act:**
  - Quarterly review; if sustained ≤1% for 2 quarters, hardwire into policy

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

BUILDING A CULTURE THAT SUPPORTS QAPI

- Leadership behaviors:
  - Regular review of QAPI reports at governing body meetings
  - Visible support for safety reporting and non-punitive response to error
- Frontline engagement:
  - Encourage staff to bring issues/ideas – convert to QAPI topics
  - Share results (e.g., “We reduced infections by X%”)
- Education:
  - Ongoing training on **why** data and indicators matter
  - Tie QAPI to staff recognition and professional growth

30-DAY ACTION CHECKLIST

- Confirm your **QAPI Program description** and **current-year plan** are updated and approved
- Build or refresh your **indicator grid** (clinical + operational + contracted services)
- Map where ASCQR and other required measures fit in your QAPI plan
- Identify **1–2 PIPs** for the coming year using recent data and survey findings
- Schedule a standing **QAPI meeting cadence** with clear minutes and follow-up tracking

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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