LEARNING OBJECTIVES

- Define meaningful quality indicators tied to ASC operations
- Select, Design, and execute performance improvement projects (PIPs) that are effective and helpful

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-8/9/10

ID	Standard
10-B-8	The ASC must measure, analyze, and track quality indicators, adverse patient events, infection control and other aspects of performance that includes care and services furnished in the ASC.
10-B-9	The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC.
10-B-10	The ASC must use the data collected to monitor the effectiveness and safety of its services, and quality of its care.

QUAD A STANDARD 10-B-11/12

10-B-11	The ASC must use the data collected to identify opportunities that could lead to improvements and changes in its patient care.
10-B-12	The ASC must set priorities for its performance improvement activities that focus on high risk, high volume, and problem-prone areas.

QUAD A STANDARD 10-B-13/14

10-B-13	The ASC must set priorities for its performance improvement activities that consider incidence, prevalence, and severity of problems in those areas.
10-B-14	The ASC must set priorities for its performance improvement activities that affect health outcomes, patient safety, and quality of care.

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.

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*

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

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 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 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 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.

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

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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