Quality Assessment and Performance Improvement in the Ophthalmic ASC

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Regulatory Requirements

- QAPI Program required by:
  - Medicare
  - Most states ASC licensing regulations
  - Accrediting bodies
- Governing Body has oversight of QAPI Program

Quality Assessment and Performance Improvement

- The ASC must develop, implement and maintain an ongoing, data-driven quality assessment and performance improvement (QAPI) program.
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<td>- Interpretive Guidelines: §416.43</td>
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<td>- The QAPI CfC requires an ASC to take a proactive, comprehensive and ongoing approach to improving the quality and safety of the surgical services it delivers. The QAPI CfC presumes that ASCs employ a systems approach to evaluating their systems and processes, identifying problems that have occurred or that potentially might result from the ASC’s practices and getting to root causes of problems rather than just superficially addressing one problem at a time.</td>
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<td>- CMS does not prescribe a particular QAPI program; it provides each ASC with the flexibility to develop its own program. Each program must, however, satisfy the regulatory criteria:</td>
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<td>- Ongoing – i.e., the program is a continuing one, not just a one-time effort. Evidence of this would include, but is not limited to, things like collection by the ASC of quality data at regular intervals; analysis of the updated data at regular intervals; and updated records of actions taken to address quality problems identified in the analyses, as well as new data collection to determine if the corrective actions were effective.</td>
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<td>- Data-driven – i.e., the program must identify in a systematic manner what data it will collect to measure various aspects of quality of care; the frequency of data collection; how the data will be collected and analyzed; and evidence that the program uses the data collected to assess quality and stimulate performance improvement.</td>
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Quality Assessment and Performance Improvement

- §416.43(a) Standard: Program Scope

  (1) 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.

- §416.43(c) Standard: Program Activities

  (1) 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.

  (i) Focus on high risk, high volume, and problem-prone areas.

  (ii) Consider incidence, prevalence and severity of problems in those areas.

  (iii) Affect health outcomes, patient safety and quality of care.
Quality Assessment and Performance Improvement

- Indicators can be broken down into several types:
  - Outcomes Indicators measure results of care; typical outcomes measures include risk-adjusted mortality rates, complication rates, healthcare-associated infection rates, length of stay, readmission rates, etc. In the ASC setting, outcomes measures might focus on things like complication rates, healthcare-associated infection rates, cases exceeding 24 hours, transfers to hospitals, wrong site surgeries, etc.
  - Process of Care Indicators measure how often the standard of care was met for patients with a diagnosis related to that standard. For example, in the ASC setting, measures might focus on the administration and time of prophylactic antibiotics.
  - Patient Perception Indicators measure a patient’s experience of the care he/she received in the ASC. AHRQ sponsored development of one patient experience of care instrument, H-CAHPS, that CMS now uses in reporting on hospital quality. There may be similar patient survey instruments that could be used in the ASC setting.

Quality Assessment and Performance Improvement

- The regulation at §416.43(a) requires that an ASC’s QAPI program must improve both patient health outcomes and patient safety in the ASC. In order to achieve these goals, the ASC’s QAPI program must:

  1. Be ongoing – i.e., the program is a continuing one, not just a one-time effort or occasional effort. Evidence that the ASC’s program is ongoing would include, for example, collection by the ASC of quality data at regular intervals; analysis of the updated data at regular intervals; and updated records of actions taken to address quality problems identified in the analyses, as well as new data collection to determine if the corrective actions were effective.
2. Use quality indicators or performance measures associated with improved health outcomes in a surgical setting. The quality and safety indicators available differ in terms of the weight and type of evidence for their effectiveness in measuring quality.

For some indicators there is compelling peer-reviewed research of an association with improved health outcomes. For others, typically process of care indicators, consensus among experts in the field suggests a strong association with improved quality of care.

Indicators also differ in terms of how the data is collected, and how frequently the data should be collected.

The ASC is required to focus on high risk, high volume, and problem-prone areas. It is required to consider, when selecting the measures/indicators that will shape its improvement activities in these areas, the following:

- The incidence rate, i.e., the rate or frequency at which problems occur in the ASC related to area measured by the indicator. “Incidence” is a technical term used in epidemiology, referring to the frequency with which something, such as a disease, appears in a particular population or area. In disease epidemiology, the incidence is the number of newly diagnosed cases during a specific time period.
Incidence Rate

- Applying this concept in the ASC setting, as an example, the annual incidence of surgical site infections in an ASC would be the rate that results when dividing the number of such infections that occurred in a calendar year by the total number of surgical cases in the ASC during that same year. Likewise, the annual incidence of emergency transfers to a hospital would be the rate that results when dividing the number of such transfers by the total number of surgical cases during the same year.

Prevalence

- The prevalence, i.e., how widespread something is in an ASC at a given point in time. “Prevalence” is also a technical term used in epidemiology, and is a statistical concept referring to the number of cases of a disease that are present in a particular population at a given time. In an ASC setting, for example, it would make little sense to employ measures related to prevalence of pressure ulcers among ASC patients, since the limited amount of time a patient typically spends in an ASC makes it unlikely that the ASC’s care processes contributes to pressure ulcers.

- On the other hand a more appropriate measure might be periodic observation of the hand hygiene practices of all staff providing direct patient care, in order to assess the prevalence of good versus deficient practices

Severity of Problems

- The severity of problems. For example, any single instance of a transfer of a patient to a hospital represents a serious adverse, unplanned outcome of the surgical procedure, and it would be appropriate for an ASC to track and evaluate all such cases, due to their severity, even if they are low volume incidents.
3. Identify and reduce medical errors/adverse patient events. Although there is no single, standard definition of a medical error or adverse event, the Institute of Medicine created a series of definitions related to patient safety that are helpful in understanding the regulatory requirement:

- **An error is defined as the failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning).**
- **An adverse event is an injury caused by medical management rather than the underlying condition of the patient.**
- **An adverse event attributable to error is a preventable adverse event.**

### Implementation of QAPI

- Documentation required for implementation of QAPI program by the QAPI coordinator
- Delegation of authority from the governing body
- QAPI coordinator reports activities of the QAPI program and committee to the medical staff committee, governing board and staff.
Goals of the QAPI Program

- Monitor effectiveness of service and quality of care in the ASC
- Identify areas of improvement
- Identify problematic events, policies and practices.

In order to achieve the goals of the QAPI Program, the ASC must:

- Implement ongoing evaluation of current services
- Identify and measure thresholds of key indicators
- Complete internal and external benchmarking
- Complete QAPI studies

Evaluation of Current Services

- Ongoing peer review
- Track and trend incident reports
- Safety trends
- Annual evaluation of the QAPI Program
Quality Indicators

- QAPI program must include ongoing assessment and review – accomplished by monitoring quality indicators

- Examples of quality indicators
  - Transfer rate
  - Infection Rate
  - Complication rate
  - Patient satisfaction
  - Patient burns
  - Patient falls
  - Antibiotic Timing
  - Wrong site, wrong side, wrong patient, wrong procedure, wrong patient, wrong implant.

Elements of a QAPI Study

1. Purpose:
   - A statement of the purpose of the QAPI activity that includes a description of the process or situation being reviewed, or a known or suspected problem, and explains why it is significant to the organization.
   - Briefly state the problem
   - Note why it is important to address this problem in your organization.

QAPI Study – Performance Goal

2. Performance Goal:
   - Identification of the performance goal against which the organization will compare its current performance in the area of the study.
   - Describe the level of performance your organization would like to achieve.
   - It is important to note that 0% or 100% may not be realistic targets when setting performance goals.
QAPI Study – Data Collection Plan

3. Description of the data that will be collected in order to determine the organization’s current performance in the area of the study:
   - Determine what data will be needed to verify:
     - Whether the problem actually exists
     - The frequency and severity of the problem
     - The source of the problem
     - How the data will be collected

QAPI Study – Data Collection

4. Show evidence of data collection
   - May use tables, graphs, pie charts, etc.
   - Describe the data that was actually collected.
   - How was the data recorded?
   - This is not the area for analysis or conclusion – Describe only what was done to gather data.
QAPI Study – Data Analysis

5. Data analysis describes findings about the frequency, severity and source(s) of the problem(s).
   - Examine the data that was collected and analyze to address the problem studied.
   - Does the data actually describe that the suspected problem exists, if there is not a problem there cannot be a QAPI study (you must have a problem before you can design a solution).
   - If there is a problem, what does the data state about the frequency, severity and source of the problem.
   - Describe how the data was analyzed and how findings/conclusions were derived.

QAPI Study – Performance Goal Comparison

6. Compare the organization’s current performance in the area of the study against the previously identified performance goal.
   - Use the data collected to measure current performance to threshold that the organization should achieve.

QAPI Study - Implementation

7. Implementation of corrective action to resolve identified problem(s)
   - Utilizing information obtained during data collection and analysis regarding frequency, severity and source of the problem, identify corrective action(s) that must be taken to improve performance and achieve performance goal.
   - Implement the selected corrective action and determine appropriate length of time to measure effectiveness of corrective action (restudy).
8. Re-measurement (a second round of data collection and analysis) to objectively determine whether the corrective actions achieved and sustained demonstrable improvement.

- At the previously determined restudy time, repeat the steps for data collection and analysis.
- Measure identical items as those measured during original data collection and analysis

9. If the initial corrective action did not achieve and/or sustain the desired improved performance goal, implementation of additional corrective action(s) and continued re-measurement will be necessary until the problem is resolved.

QAPI Study - Communication

10. Communication of the findings of the quality improvement activities to the governing board and throughout the organization, as appropriate and incorporation of such findings into the organization’s educational activities (“closing the loop”)

"Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution; it represents the wise choice of many alternatives."

-WILLIAM A FOSTER