NORTH MEMORIAL AMBULATORY SURGERY CENTER AT MAPLE GROVE
2025 ANNUAL QUALITY IMPROVEMENT WORK PLAN

						Timeline			
Activity	**Owner**	**Purpose**	**Measures/Actions**	**Goal/Std/benchmark**	**Data Source**	**Q1**	**Q2**	**Q3**	**Q4**
Mandatory Requirements									
Compliance with MDH ASC regulations and CMS CfC's	NMASCMG	Remain compliant with all state and federal regulations, specifically the ASC CfC's and MN ASC Regulations.	All leadership will be knowledgeable and kept abreast of current and any revisions of standards. Education provided to staff as needed	Regulatory Compliance – Maintain compliance with CMS CFC's and MN Regulations.	CMS CfC's MN Regulations Survey Outcomes	X	X	X	X
Compliance with CDC Infection Control Guidelines	NMASCMG	Remain compliant with CDC infection control guidelines in an effort to prevent or stop the spread of infections in our ASC.	▪CDC infection control guidelines will be reviewed periodically to ensure adherence. ▪AAMI, AORN, MDH, ASPAN, SGNA and APIC guidelines will be reviewed and followed as well. ▪The peer review process will be initiated and followed for any reported SSI.	▪Maintain Regulatory Compliance ▪Infection Rates will be less than 1:1000 patients.	▪Track and trend using a 30 and 90 day SSI query for surgeons for surgery and impants. ▪Infection preventionist from other facilities will notify the Executive Director of any SSI that is associated with our ASC. ▪Any other means of being notified of an SSI will be investigated by the Executive DIrector	X	X	X	X

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Compliance with AAAHC standards and provisions of care.	ALL Team Members	Remain compliant with AAAHC standard in order to continue with our accreditation status.	▪Remain knowledgeable of current standards and stay abreast of any changes and/or recommendations. ▪On-going evaluation of compliance by Executive Director. Provide team education as needed for any deviations.	Successful re-accreditation every 3 years.	Survey every 3 years, next survey 2026.	X	X	X	X
Compliance with all mandated reporting requirements.	Executive Director	Ensure ongoing reimbursement increases from Medicare and seek to improve scores where appropriate.	Claims-based submission for Medicare requirements. Annual submission of remaining measures for both CMS and MN Community Measurement.	Submission for all measures by deadlines and on every claim.	EPIC and Provation. Measures to be reported through Quality Net, NHSN or are claim based reported via SMP	X	X	X	X
Annual Evaluation	Executive Director, QAPI Committee	Review the effectiveness of the annual plan for the previous year; determine new goals to ensure compliance and relevance.	Completed evaluation.	BOG reviews and approves evaluation.	Various sources; audit results, education effectiveness, QAPI meeting minutes, etc. will be used to evaluate the effectiveness of the QAPI program annually.	X			

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Quality/Risk Program Description	QI	Annual review of the program incorporating changes identified in evaluation.	Review and revise program and structure to reflect improvements.	BOG reviews and approves program description.	Various	X			
Annual Work Plan	Executive Director, QAPI committee	Outline the planning, monitoring and improvement activities for the ASC for each year.	Work plan is completed by the Executive Director, presented for approval to the QAPI committee. Any revisions suggested by the QAPI team will be made to the plan.	Work plan is reviewed and approved by BOG.	Various	X			
Biannual Review of Policies and Procedures	Senior Leadership, Managers, and designee's.	Assure P&P's are updated to reflect current regulations and standard of care. Next comprehensive review is due in June 2025 and on going as needed.	▪Policies and procedures reviewed and revised as needed. ▪Staff will review policies per mandatory requirements and/or with changes.	Policies and procedures updated.	AORN, AAMI, AAAHC, CMS, ASPAN, SGNA to name a few.	X	X	X	X

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Employee Education	Executive Director, Managers, HR Director	Comprehensive training and education will be provided upon hire, annually and as needed to facilitate and promote the commitment to quality of care and service.	▪Health Stream Online learning upon hire and annually there after. ▪New Hire required learning (QAPI/IC plan, emergency policies, POC - determined by role in the ASC). ▪ Mandatory Emergency Drills and Fire Drills ▪Additional education as needed to promote the highest quality of care by each team member.	▪100% staff completion of Health Stream learning annually with 80% score. ▪100% attendance/participation in emergency drills as required by team member role in the ASC. ▪Attendance/participation by team members at in-services, classes, on-going required education for certifications and licensure.	▪Health Stream Reporting ▪Rosters for drills and in-services ▪Proof of required certifications for team members i.e. current BLS/ACLS/PALs as needed by role definition.	X	X	X	X

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Quality Indicator Monitoring									
Infections/SSI, Implants and HAI	Executive Director/Managers and assigned committee members	Track/trend and analyze infection in order to prevent/minimize them. Monitor adherence to infection control practices and policies.	▪Follow-up on all patients sustaining post-op infection; 30-days and 90-days for implants. ▪ Initiate peer review on patients who develop infections. ▪Ongoing environmental audits. Analyze and report any deviations from established norms an correct any action items. •Audit endoscopy cleaning competency on annual basis to ensure compliance due to complexity of process. •Random environment of care audits to ensure cleaning is per AORN, CDC, and other regulatory standards.	▪ASCA mean 1.1:1000. Benchmark with SMP and ASC Quality Collaboration	▪EPIC Reporting ▪SSI and Implant 30 and 90 day query for all surgeons ▪Endoscope Processing Competency ▪Environment of Cleaning audit form	X	X	X	X

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Transfers/ Hospital Admissions	Executive Director and Managers	ASC's provide surgical services to patients not requiring hospitalization. The frequency of a transfer and/or admission does not result directly in the care received at an ASC nor can underlying medical conditions requiring a transfer/admission be anticipated in advance 100% of the time. When a transfer and/or admission does occur it is the best interets of the ASC to analyze the patient criteria and reason for transfer/admission to determine if the ASC could have prevented this from occuring and how to improve in the future.	▪ASCA rate of transfer/admission is 0.944:1000 patients. ▪Track all hospital transfers and admissions within 72 hours of surgery ▪Analyze and report any trends and recommendations to the QAPI committee and the BOG. ▪Initiate triggered peer review process per policy. ▪Educate providers and staff as needed on trends and how to reduce/eliminate those.	▪ASCA mean is 0.944 per 1000 admissions. ▪ ASC Quality Collaboration mean is 0.889 per 1000 admissions. ▪Our goal is to be less than the ASCA and ASC Quality Collaboration mean. We will be at or below 0.005 per 1000 admissions.	▪Post Op phone calls •Occurrence Reports •Monthly surgeron query reports •Individual Patient Satisfaction Responses •Misc.	X	X	X	X

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Patient/Visitor and Employee Occurrences	Executive Director	Occurrence investigation is crucial to help prevent a similar one in the future, prepare for staffing shortages, and provide medical care as needed to affected individuals.	▪Occurences for both employees and visitors will be tracked. ▪An investigation will occur to determine the cause of the occurrence, what steps could've been taken to prevent the occurrence, and how to prevent this from occuring in the future.	Our goal is to keep our visitors and team members safe and free from injury. All occurences will be investigated and appropriate actions will be taken to correct issues identified. These will be reported to the QAPI committee and to the BOG quarterly and an annual summary will be provided to the respective committees.	Occurrence Reports	X	X	X	X
Patient Satisfaction OAS CAHPS	*ALL* NMASCMG Team Members	Measuring patient satisfaction is vital for growth, it provides insights into what works well and where opportunities for improvement are. Patient satisfction is essential for promoting loyalty, retaining customers and reducing cost.	It is now a CMS requirement to utilize the OAS CAHPS for our surveys. Our 4 main areas of focus continue to be 1.Overall Communication 2. Discharge insturctions helpful 3.Facility/Personal treatment 4.Recommend the facility	Our goal for 2025 is to achieve the 200 surveys to meet our CMS requirement.	Press Ganey monthly and quarterly patient satisfaction reports	X	X	X	X

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Maintain Normothermia	Executive Director and Managers	Hypothermia, even when mild, is associated, with consequences such as increased succeptibility to infection, impaired coagulation, cardiovascular stress and cardiac complications, as well post-anesthesic shivering and thermal discomfort.	Track and trend patient temperatures within first 15 minutes post op for general and neuraxial patients whose anesthesia has been greater than 60 minutes. Annual reporting through HQAR.	Temperature within first 15 minutes of arrival in phase 1 will be at or >96.8 degrees F 97 % of time per ASCA benchmark.	EPIC Report	X	X	X	X
Contracted Services	Administrative Support Manager	To assure that all contracted services are maintaining quality standards and following appropriate guidelines.	Documented evidence of quality measures will be kept on file for all contracted services. It will be updated annually.	Documented evidence of quality will be kept on file for 100% of vendors.	QI Contract Manual	X	X	X	X

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High-Volume, High-Risk, or Problem-Prone Processes – Improvement Activities									
Infection Control Hand Hygiene SPD audits Normothermia Prophylactic IV antibiotics	Executive Director, Managers and designee's	To decrease the risk of a HCA infection from the hands of health care workers and/or instrument processed incorrectly. Comply with current CDC and WHO Hand Hygiene Guidelines. Comply with current APIC, AAMI, AORN and CMS standards for IUSS and SPD monitoring.	▪Monitor HH, complete random audits rates and provide feedback of rates to staff and committees. ▪Completion of required SPD audits. Address any deviations noted.	▪Achieve 93% pre and post-hand hygiene compliance. ▪No SPD audit deviation from standard of practice. ▪<1% IUSS annually	▪Hand washing Audits ▪IUSS Monitoring ▪SPD audits	X	X	X	X
Patient and Post-Op care giver finds discharge instructions helpful.	Perioperative Manager, Perioperative Team, *ALL* members of the team	Increase patient satisfaction by providing quality discharge instructions to help the patient and their post-op care giver manage care after surgery while at home safely and confidently.	Monitor rates of this measure monthly/quarterly based on patient satisfaction scores. Continue to educate staff on the importance.	Nat'l average is 93%, Corp average is 93%. Our goal is to be equal to or greater than the Nat'l and Corp average of 93%.	Monthly and quarterly Press Ganey reports	X	X	X	X

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Process History/Physical and Consents	Managers, Surgery Scheduling, PAN, Senior Leadership as needed.	▪To ensure completion of H&P's and consents to be compliant state and federal regulations, and to avoid adverse events.	20 Random audits for H&P's (to include "day of H&P's") to ensure adherence to our consent policy 4011. ▪Initiate peer review process for any non compliance with our policy. ▪Address any consent issues/concerns as needed.	100% complaince	▪Designated team members to complete audits for consents and H&P's. EPIC and paper documentation will be used to complete the audit process.	x	x	x	x
Allergy Audits	*ALL* OR team members, ALL PeriOp team members, ALL PAN members	To assure all allergies are addressed and have a reaction listed	▪20 random chart audits per month to achieve 100% compliance. ▪Appropriate actions will be initiated based on results of the above actions.	100% compliance with all indicators on observational audits.	Allergy Audit Tool will be used.	X	X	X	X

APPROVALS:

QAPI Committee Approval: Signature: _____ Date: _____

Board of Governor Approval: Signature: _____ Date: _____

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