U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

COST AND RESOURCE UTILIZATION (CRU) DATA COLLECTION FOR THE MEDICARE Hospital Leadership Quality Assessment Tool (HLQAT)

OFFICE OF MANAGEMENT AND BUDGET
CLEARANCE PACKAGE SUPPORTING STATEMENT-PART A

February 4, 2021

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CONTENTS

A. BACKGROUND

Hospital excellence and leadership

In recent years, several sets of activities at the national level have created momentum for greater engagement of hospital leadership in quality improvement. Beginning in 1999, the Institute of Medicine published the landmark series, To Err is Human (Kohn, 2000), Crossing the Quality Chasm (Richardson, Institute of Medicine, 2001), and Leadership by Example (Corrigan, Institute of Medicine, 2002). In 2004, the Centers for Medicare & Medicaid Services (CMS) initiated the Hospital Quality Alliance, which publicly posted clinical quality measures on a range of conditions, thereby giving governing boards and other senior leaders material they needed to review hospital quality and push for system-level improvements. In 2005, numerous national organizations such as the Governance Institute, the American Hospital Association and the Institute for Healthcare Improvement demonstrated a heightened level of interest in leadership engagement in quality by pursuing initiatives related to transformational change in hospitals and quality oversight.

Recent empirical studies document the relationship between organizational performance and leadership factors that include the influence of governing boards, CEOs and senior executives. (Kroch, Duan et al. 2007; Alexander, Fennell et al. 1993; Berwick 1996; Weiner, Alexander et al. 1996; Parker, Wubbenhorst et al. 1999; Shortell, Rundall et al. 2007).

The Health Resources and Services Administration (HRSA, 2007) reported on a study that examined high performing transplant centers and identified strategies, drivers, and change concepts for achieving excellence. The most important among them is an institutional vision and commitment evidenced by established goals, sufficient institutional resources to achieve them and monitoring progress. Additional key components of excellence are commitment to a comprehensive multidisciplinary approach, a committed team built around experienced, high-performing physicians, recruitment and training of specialized staff, a collegial, non-hierarchical team approach to care, evidence-based care, and aggressive management of performance outcomes. The most useful finding in this study is the conceptualization of strategic drivers of change, which is a concept that is central to the porject.

In a study involving interviews with key informants at four hospitals that were among the top improvers over a two-year period, Silow-Carroll et al. (2007) found certain common features. Specifically, they found trigger mechanisms led to organizational or structural changes that facilitated new ways of identifying and solving problems. In turn, these mechanisms resulted in the creation of new protocols and practices, producing improved outcomes.

Common themes of the studies cited above are the importance of board and executive leadership commitment to quality improvement, the role of established quality improvement goals, and the necessity of building capacity through dedicated structures and resources for pursuing quality improvement. In 2006, the Hospital Leadership Collaborative (HLC)[1]

[1]The Hospital Leadership Collaborative (HLC) is a multi-disciplinary group of health services researchers and executives from the Department of Health Management and Policy (HMP) at the University of Iowa College of Public Health, The Iowa Foundation for Medical Care (IFMC), the Oklahoma Foundation for Medical Quality (OFMQ), the Health Services Advisory Group (HSAG),

launched a public-private partnership to develop a CMS-endorsed self-assessment tool, “The Hospital Leadership and Quality Assessment Tool” (HLQAT) to assist hospitals in the improvement of quality through enhanced hospital governance, executive, physician, and clinical engagement.

B. JUSTIFICATION

1. Need and legal

The CMS Quality Improvement Organization (QIO) Program

The statutory mission of the QIO Program, as set forth in section 1862(g) of the Social Security Act, is to promote the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries and to ensure that those services are reasonable and necessary. The quality strategies of the Medicare QIO Program are carried out by state and territory specific QIO contractors working with health care providers in their state, territory, and the District of Columbia.

Based on statutory language and the experience of the Centers for Medicare & Medicaid Services (CMS) in administering the Program, CMS has identified the improvement of quality of care for beneficiaries as one of three goals of the program.

This QIO contract contains a number of quality improvement initiatives that are authorized by various provisions in the Act. As a general matter, Section 1862(g) of the Act mandates that the Secretary enter into contracts with QIOs for the purpose of determining that Medicare services are reasonable and medically necessary, and for the purposes of promoting the effective, efficient, and economical delivery of health care services, and of promoting the quality of services of the type for which payment may be made under Medicare. CMS interprets the term “promoting the quality of services” to involve more than QIOs reviewing care on a case- by-case basis, but as covering a broad range of proactive initiatives that will promote higher quality. CMS has, for example, included in the Scope of Work (SOW) Tasks in which the QIO will provide technical assistance to Medicare-participating providers and practitioners in order to help them improve the quality of the care they furnish to Medicare beneficiaries. Additional authority for these activities appears in Section 1154(a)(8) of the Act, which requires that QIOs perform such duties and functions and assume such responsibilities and comply with such other requirements as may be required by the Medicare statute.

CMS regards survey activities as appropriate if they will directly benefit Medicare beneficiaries.
In addition, Section 1154(a)(10) of the Act specifically requires that the QIOs “coordinate activities, including information exchanges, which are consistent with economical and efficient operation of programs among appropriate public and private agencies or organizations, including other public or private review organizations as may be appropriate.” CMS regards this as specific authority for QIOs to coordinate and operate a broad range of collaboratives and community activities among private and public entities, as long as the predicted outcome will directly benefit the Medicare program. In addition,

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Premier CareScience and the Centers for Medicare & Medicaid Services (CMS).

Section 1156(c) of the Act states that it is the duty of each QIO to use such authority or influence as it may possess as a professional organization, and to enlist the support of any other professional or governmental organization having influence or authority over healthcare practitioners or entities furnishing services in its area, in assuring that each practitioner or entity shall comply with all obligations imposed on them under Section 1156(a). Under these obligations, providers and practitioners must assure that they will provide services of a quality that meets professionally recognized standards of care.

Ninth Scope of Work QIO Contract
The 9th SOW, beginning in August 2008, aims to improve the quality of care and protect Medicare beneficiaries through a number of Themes and Requirements. One of four themes is Patient Safety.
The requirements of the Patient Safety Theme are designed to address areas of patient harm where there is evidence the harm can be mitigated. Harm mitigation and safety improvement are addressed by measures of process and system change. For each topic within the Patient Safety Theme the goal is to have providers working with the QIO to reach performance benchmarks on specific clinical measures. One of the ways the QIO will do this is to obtain agreement from the executive leadership of specific providers (hospitals) to participate in Patient Safety quality improvement efforts. CMS expects QIOs to work with executive leadership to initiate additional and new commitments to Quality Improvement (QI) in their facilities. The QIOs must identify the executives who have agreed to work with the QIOs and notify the support contractor.

In the 9th SOW theme 6.2 Patient Safety, on page 39 item 3, says that the QIO should, “Administer and collect results of the … Hospital Leadership and Quality Assessment Tool (HLQAT). “

In the context of the contract the data that must be collected by the QIO is whether or not a hospital takes the survey. The QIOs will encourage hospitals to release their scores back to the state QIO in order to achieve a deeper analysis of the relationship between leadership and quality and to receive technical assistance for improvement. The QIO will neither forward the data nor aggregate it with other hospitals.

2. Information Users

Hospitals leaders will take the HLQAT instrument via web-based technology. This function will be carried out in conjunction with CMS and the QIO 9th SOW, to convey the importance of this effort in relation to Medicare and other public priorities. The American Hospital Association (AHA) and Institute for Healthcare Improvement (IHI) have expressed support as part of their global interest in hospital quality improvement.

This administration of the HLQAT seeks responses from approximately a dozen leaders in each hospital, including physicians (e.g., CEO, CMO), board members, director-level, and mid-level clinical managers – these responses can provide a multi-level representation of hospital leadership showing its commitment to institutional change.

One premise of this project is that purchasers and public policies are going to challenge the hospital industry to undergo transformational changes. The salient metrics of hospital quality are “outcomes,” including clinical quality, patient experiences, and efficiency. Hospital structures and leadership are means to the ends; hence, there is not a strong incentive to inflate or otherwise “game” HLQAT scores. The HLQAT and technical assistance that may be requested by the hospital, will be marketed to hospitals as timely, valuable resources, not simply burdens. Because self-administering of the HLQAT is not mandatory, there is no reason to expect a 100% response rate.

To facilitate the role of the QIO program, CMS will sponsor several training conferences, organized under the banner of Patient Safety and the 9th SOW, to train the QIO improvement leaders on the implementation of quality improvement. Representatives from the HLC will participate in each conference. The HLC will, at the direction of CMS, provide training on the use of the HLQAT to support the goals of these conferences.

3. Use of Information Technology

HLQAT will be administered via web-based technology to as many medical/surgical hospitals in the country working with QIOs as possible. The main vehicle for sharing the HLQAT is the web. Websites provide quick and ready access to such simple but profound change tools. For example, over the years, the CMS MedQIC website has steadily evolved from a library of information into a significant compendium of support and tools for the QIO community. MedQIC is a dynamic site that provides QIOs and providers with the resources they need to improve the quality of health care. (www.qualitynet.org/MedQIC) Hospitals concerned about the cost of quality will find the “Quality Makes Good Business Sense Handbook” and other such tools on the MedQIC website.

The HLQAT for QIO use will be maintained on a non-government associated private website.

4. Duplication of effort

The HLQAT does not duplicate any other known instrument, and will provide unique information to the hospital unavailable from any other source.

5. Small business

It is not anticipated that the use of the HLQAT instrument will impose any larger burden on small hospitals than on larger sized hospitals. Participation is voluntary, and a decision not to participate will not affect hospital status with Medicare/Medicaid programs. Also, if requested by the hospital, HLQAT scores will be used to assist small hospitals as well as larger hospitals.

6. Less frequest collection

The use of the HLQAT is completely voluntary on the part of the hospital. CMS anticipates that it would be used at least twice by any hospital which chooses to do so.

7. Special Circumstances

There are no special circumstances for the use of this quality tool.

8. Federal Register/Outside Consultation

The 60-day Federal Register notice for this collection published on xxxxxxxxx. Since August 2002, CMS has consulted with various industry associations such as the American Hospital Association (AHA), the Institute for Healthcare Improvement (IHI), the University of Iowa, and the Oklahoma Foundation for Medical Quality, the Iowa Foundation for Medical Care, among others.

9. Payments/Gifts to Respondents

Hosptials participating in the use of the HLQAT quality tool will receive no compensation for their time.

10. Confidentiality

The HLQAT data shall adhere to the privacy, confidentiality and disclosure requirements set forth in Section 1160 of the Act, and in Section 42 of the Code of Federal Regulation (CFR) Part 480; Section H of this contract, which limits uses and disclosures when the QIO is acting as a business associate of CMS and contains the business associate agreement required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules; the *QIO Manual*; and other applicable federal laws, regulations and administrative directives. The business associate agreement requirement applies if the QIO conducts any activities on behalf of CMS' Medicare fee-for-service health plan function involving the use or disclosure of protected health information or electronic protected health information such as for payment or health care operations. The business associate agreement in Section H applies only where the QIO is serving as a HIPAA business associate of CMS' Medicare FFS health plan function, which includes conducting payment or health care operations activities. The business associate agreement does not apply when the QIO is not serving as a HIPAA business associate of CMS' Medicare FFS health plan function such as when the QIO is providing health oversight activities as defined by the Act, based on the grant of authority provided to it by CMS to conduct authorized health oversight activities.

11. Sensitive Questions

There are no sensitive questions.

12. Burden Estimates (Hours & Wages)

CMS interest in the use of the HLQAT by hospitals for this project is contractually confined to the 9th SOW with two periods of voluntary use by the hospital. However, hospitals may choose to use the tool as they see fit.

Hosptial burden is restricted to the time requried to prepare for the HLQAT and taking the survey online. Estimated time burden for participating hospitals for this activity is 30 minutes preparation time and 22 minutes to

take the survey for a total of 0.87 hour per respondent. In addition there is a five hour preparation time for the hospital as a whole. This five hours is added to the Operations Director time in Table1 below.

CMS anticipates approximately 1,500 hospitals will participate in this quality exercise two times each.

Individual respondents will include twelve persons associated with the hospital in some way including: board members, staff, and physicians such as: Hospital CEO, Medical Director, Clinical Quality Director, Operations Director, Board Member, nursing and physician staff. Table 1 below shows the number expected to take the survey, the average per hour wage, the total cost per institution, and the cost to the total number of hospitals participating for one time.

The total cost for taking the survey one time and repeating it a second time is 44,820 hours and $3,076,170.00 dollars.

Table 1. Burden Estimates to take the survey. The survey will be repeated one time and therefore taken twice.

Respondent	Number	Hours to prepare	Hours to take	Hours per person	Total Hours	Cost per hour	Cost per person	Cost per institution
Medical Director	1	0.5	0.37	0.87	0.87	$98.00	$85.26	$85.26
CEO	1	0.5	0.37	0.87	0.87	$300.54	$261.47	$261.47
Board member	2	0.5	0.37	0.87	1.74	$0.00	$0.00	$0.00
Head Nurse	1	0.5	0.37	0.87	0.87	$40.60	$35.32	$35.32
Operations Dirctor	1	5	0.37	5.37	5.37	$58.00	$311.46	$311.46
Nurse	3	0.5	0.37	0.87	2.61	$29.20	$25.40	$76.21
Doctor	2	0.5	0.37	0.87	1.74	$77.90	$67.77	$135.55
Surgeon	1	0.5	0.37	0.87	0.87	$138.07	$120.12	$120.12
Total	12	8.5	2.96	11.46	14.94			$1,025.39
Total Burden for 1,500 hospitals to take the survey one time.					22,410			$1,538,085.00
Total Burden for 1,500 hospitals to take the survey twice.					44,820			$3,076,170.00

13. Capital Costs

This is a twice repeated quality exercise for Medicare Quality Improvement Program 9th SOW purposes. No capital costs will accrue to respondents related to the collection of information for this exercise.

14. Cost to Federal Government

The cost of this data collection activity will be partially funded by the Centers for Medicare and Medicaid Services through the contract “9th SOW Quality Improvement Contracts”
Solicitation Number: CMS-2007-QIO9thSOW-NAHC
Agency: Department of Health and Human Services
Office: Centers for Medicare & Medicaid Services

It is included under Theme 6.2, “Patient Safety”

Table 2 calculates the cost to the federal government per QIO for assisting hospitals with the HLQAT quality instrument. The QIO Director will spend one-half hour familiarizing themselves with the instrument and directing staff to move forward with the exercise. This is the total time that the Director will spend. QIO staff, Hospital Qualilty Advisors, will spend one hour familiarizing themselves with the instrument and approximately one hour per hospital suggesting that using the tool would be helpful.

Preparation cost is the number of QIOs (53) multiplied by the cost per QIO to prepare ($165). The cost to assist one hospital is one hour multiplied by the cost per hour of the Hospital Quality Advisor ($58). The cost to assist 1,500 hospitals is the sum of the prepartion time cost ($8,745) plus the cost per hospital assist time ($58) multiplied by 1,500 ($87,000). The total cost to the government for one iteration of the HLQAT is $95,745. The second round we anticipate no preparation time and only 15 minutes per hospital for a total of $21,750.00.

The total cost to the government will be $117,495.00

Table 2. Government Burden Estimates

QIO Staff	Number	Hours to prepare	Hours per hospital	Hours per person	Total Hours	Cost per hour	Cost per person	Cost per QIO to prepare	Cost per QIO to assist one hospital
Director	1	0.5	0	0.5	0.5	$98.00	$49.00	$49.00	0
Hospital Quality Advisor	2	1	1	2	4	$58.00	$116.00	$116.00	$58.00
Total	3	1.5	1	2.5	4.5	$78.00	$82.50	$165.00	$58.00
Total Number of Hospital	1500								
Preparation Time = 53 * preparation cost								$8,745.00	
Quality Advisor time = 1,500* assist cost									$87,000.00
Total Cost to Government									$95,745.00

15. Changes to Burden

This is a new information collection request.

16. Publication/Tabulation Dates

The survey contract RFP for the 9th Scope of Work is currently being prepared by CMS. CMS expect yes/no results from the survey to be tabulated through July of 2011, or the end of the 9th SOW or when directed by CMS. The tabulated results will be reported to CMS by the survey contractor as a part of their regular reporting mechanisms. The results will be a part of the survey contractor final report to CMS. CMS does not anticipate the survey contractor

reports will be published.

17. Expiration Date

This is a 9th SOW survey. The 9th SOW ends July 31, 2011. Data collection for the 9th SOW evaluation will end October of 2010 and data analysis will begin immediately thereafter. These dates are, and have been from August of 2008, contained in the CMS contracts with each QIO.

18. Certification Statement

There are no exceptions to the certification statement.

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Hospital Leadership and Quality Assessment Tool©
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This document includes the draft Hospital Leadership and Quality Assessment Tool©. This draft survey is designed to assess the perceptions of Board members and hospital leadership about important areas of clinical quality improvement in their hospitals.

The survey was developed by the University of Iowa, Department of Health Management and Policy, and the Oklahoma Foundation for Medical Quality. The survey has been pretested with participants representing various levels of hospital leadership.

This questionnaire should not be used or cited by any individual or organization for any purpose without written permission. If you have any questions about the document, please contact either of the following:

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Hospital Leadership and Quality Assessment Tool©

SURVEY INSTRUCTIONS

In this survey, the term **hospital leadership** refers to the Chief Executive Officer/top executive, the Chief Medical Officer/top physician leader, the Chief Financial Officer/top finance executive, the Chief Nursing Officer/top nursing leader, and other senior executive leaders and directors.

Hospitals differ in their organizational structure. Please answer the survey questions from your individual perspective, given your position in your hospital organization.

SECTION A: Your Board

1. The term Board refers to your hospital's Governing Board or Board of Trustees. If your hospital operates under only a systemwide Board, or if you are more familiar with the systemwide Board, please answer about your systemwide Board. For questions that specifically refer to Board activities, indicate which Board you will be thinking about in the survey. (Mark only one)

☐ a. Hospital Board

☐ b. Systemwide Board

SECTION B: Knowledge Seeking

1. During the past 12 months, how often did hospital leadership seek input about quality and patient safety issues by doing the following activities?

	Not in the past 12 months	Once or twice in the past 12 months	Several times in the past 12 months	Monthly	More than once a month	Does Not Apply or Don't Know
a. Conducting community focus groups	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
b. Reviewing patient satisfaction data/complaints	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
c. Inviting patients/family members to attend Board meetings	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
d. Encouraging the sharing of patients' stories about their experiences in the hospital (in-person stories, letters, or both)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
e. Surveying employees about clinical quality improvement and/or patient safety	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
f. Other (Please specify):	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9

SECTION B: Knowledge Seeking (continued)

2. During the past 12 months, how often did hospital leadership review the following items?

	Not in the past 12 months	Once or twice in the past 12 months	Several times in the past 12 months	Monthly	More than once a month	Does Not Apply or Don't Know
a. Updates on major clinical quality improvement initiatives	☐1	☐2	☐3	☐4	☐5	☐9
b. Progress toward clinical quality goals	☐1	☐2	☐3	☐4	☐5	☐9
c. Clinical quality indicators/data	☐1	☐2	☐3	☐4	☐5	☐9
d. Patient safety data	☐1	☐2	☐3	☐4	☐5	☐9
e. Risk management issues	☐1	☐2	☐3	☐4	☐5	☐9
f. Budget information	☐1	☐2	☐3	☐4	☐5	☐9
g. Employee satisfaction data (e.g., staff turnover)	☐1	☐2	☐3	☐4	☐5	☐9
h. Physician profiling data (i.e., comparative physician-level data on quality)	☐1	☐2	☐3	☐4	☐5	☐9

3a. During the past 12 months, did any senior executive leaders in this hospital participate in executive walk rounds to discuss quality and safety of care with staff, patients, or families?

☐1. Yes (Go to Question 3b)

☐2. No (Go to Section C)

☐3. Don't know (Go to Section C)

3b. During the past 12 months, how often did the following persons participate in executive walk rounds to discuss quality and safety of care with staff, patients, or families?

	Not in the past 12 months	Once or twice in the past 12 months	Several times in the past 12 months	Monthly	More than once a month	Does Not Apply or Don't Know
a. A member of the Board	☐1	☐2	☐3	☐4	☐5	☐9
b. The Chief Executive Officer (CEO)/top executive	☐1	☐2	☐3	☐4	☐5	☐9
c. Chief Medical Officer/top physician leader	☐1	☐2	☐3	☐4	☐5	☐9
d. Chief Nursing Officer/top nursing leader	☐1	☐2	☐3	☐4	☐5	☐9
e. Other senior executive leaders	☐1	☐2	☐3	☐4	☐5	☐9

SECTION C: Goals and Priorities

To what extent do the following statements apply in this hospital?

	Not at All	A little	Some-what	A moderate amount	A lot	Does Not Apply or Don't Know
1. This hospital's mission or vision statement contains language that clearly supports a commitment to achieving excellence in:						
a. Clinical quality	☐1	☐2	☐3	☐4	☐5	☐9
b. Patient safety	☐1	☐2	☐3	☐4	☐5	☐9
2. Hospital leadership actively solicits input from key departments, individuals, or experts when planning the hospital's clinical quality improvement goals	☐1	☐2	☐3	☐4	☐5	☐9
3. Hospital leadership uses clinical quality information to establish clinical quality improvement goals for the hospital	☐1	☐2	☐3	☐4	☐5	☐9
4. Hospital leadership has an effective mechanism for establishing priorities among potential clinical quality improvement goals	☐1	☐2	☐3	☐4	☐5	☐9
5. Hospital leadership promotes clinical quality as a top priority	☐1	☐2	☐3	☐4	☐5	☐9
6. Hospital leadership promotes patient safety as a top priority	☐1	☐2	☐3	☐4	☐5	☐9
7. This hospital has implemented effective policies and procedures to help achieve its clinical quality improvement goals	☐1	☐2	☐3	☐4	☐5	☐9
8. This hospital has established measures to evaluate progress toward clinical quality improvement goals	☐1	☐2	☐3	☐4	☐5	☐9
9. Medical staff have an effective process for incorporating evidence-based medicine into practice standards	☐1	☐2	☐3	☐4	☐5	☐9
10. The by-laws and/or policies of medical staff support the use of evidence-based medicine protocols	☐1	☐2	☐3	☐4	☐5	☐9
11. The Board supports public reporting of this hospital's clinical quality data	☐1	☐2	☐3	☐4	☐5	☐9

SECTION D: Communication about Clinical Quality Improvement

During the past 12 months, how often did the following discussions or communications occur in this hospital?

	Not in the past 12 months	Once or twice in the past 12 months	Several times in the past 12 months	Monthly	More than once a month	Does not Apply or Don't Know
1. Senior executive leaders discussed hospital quality data with staff reporting to them	☐1	☐2	☐3	☐4	☐5	☐9
2. Physician leaders, both administrative and clinical, discussed hospital-level quality data with medical staff	☐1	☐2	☐3	☐4	☐5	☐9
3. Physician leaders, both administrative and clinical, discussed external clinical benchmarking (comparative) data with medical staff	☐1	☐2	☐3	☐4	☐5	☐9
4. Clinical leaders at the department level discussed hospital quality data with staff reporting to them	☐1	☐2	☐3	☐4	☐5	☐9
5. Clinical leaders at the department level discussed external benchmarking (comparative) data with staff reporting to them	☐1	☐2	☐3	☐4	☐5	☐9
6. Clinical leaders at the department level communicated clinical quality improvement goals to staff reporting to them	☐1	☐2	☐3	☐4	☐5	☐9

SECTION E: Collaboration

To what extent do the following statements apply in this hospital?

	Not at All	A little	Some-what	A moderate amount	A lot	Does Not Apply or Don't Know
1. The Board and the Chief Medical Officer/top physician leader collaborate on clinical quality improvement	☐1	☐2	☐3	☐4	☐5	☐9
2. The Board and medical staff (other than the top physician leader) collaborate on clinical quality improvement	☐1	☐2	☐3	☐4	☐5	☐9
3. The Chief Medical Officer/top physician leader in this hospital collaborates with:	☐1	☐2	☐3	☐4	☐5	☐9
a. The Board, to address clinical quality issues concerning physician practice	☐1	☐2	☐3	☐4	☐5	☐9
b. Other senior executive leaders, to address clinical quality issues in this hospital	☐1	☐2	☐3	☐4	☐5	☐9
c. The top nursing leader, to address clinical quality issues in this hospital	☐1	☐2	☐3	☐4	☐5	☐9

SECTION F: Roles and Responsibilities

How much do you agree or disagree with the following statements?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. Senior executive leaders are assigned responsibility for major clinical quality improvement initiatives.....	☐1	☐2	☐3	☐4	☐5	☐9
2. Senior executive leaders assigned responsibility to work on quality improvement initiatives have the authority to initiate actions to address gaps in clinical quality.....	☐1	☐2	☐3	☐4	☐5	☐9
3. The responsibilities of individual Board members, as these relate to hospital clinical quality, are clearly defined.....	☐1	☐2	☐3	☐4	☐5	☐9
4. New Board members are given adequate orientation regarding their clinical quality improvement responsibilities.....	☐1	☐2	☐3	☐4	☐5	☐9
5. Physician champions are identified to promote and lead new clinical quality improvement initiatives.....	☐1	☐2	☐3	☐4	☐5	☐9
6. Physician champions are supported in their role by the Chief Medical Officer/top physician leader.....	☐1	☐2	☐3	☐4	☐5	☐9
7. Clinical leaders in this hospital initiate actions to deal with quality issues in clinical practice.....	☐1	☐2	☐3	☐4	☐5	☐9
8. The following persons are effective champions for clinical quality improvement initiatives in this hospital:						
a. Chief Executive Officer/top executive leader	☐1	☐2	☐3	☐4	☐5	☐9
b. Chief Medical Officer/top physician leader	☐1	☐2	☐3	☐4	☐5	☐9
c. Chief Financial Officer/top finance executive	☐1	☐2	☐3	☐4	☐5	☐9
d. Chief Nursing Officer/top nursing leader	☐1	☐2	☐3	☐4	☐5	☐9

SECTION G: Monitoring/Evaluation

During the past 12 months, how often did the following occur in this hospital?

		Not in the past 12 months	Once or twice in the past 12 months	Several times in the past 12 months	Monthly	More than once a month	Does Not Apply or Don't Know
1.	Clinical quality improvement initiatives in this hospital were evaluated to assess their effectiveness.....	☐1	☐2	☐3	☐4	☐5	☐9
2.	Clinical quality improvement initiatives in this hospital were evaluated to assess their sustainability.....	☐1	☐2	☐3	☐4	☐5	☐9
3.	This hospital provided medical staff with feedback on their individual performance on clinical quality indicators.....	☐1	☐2	☐3	☐4	☐5	☐9
4.	This hospital provided medical staff with reports comparing their individual performance on clinical quality indicators with their peers' performance.....	☐1	☐2	☐3	☐4	☐5	☐9
5.	Hospital leadership followed up on opportunities and concerns raised during their executive walk rounds.....	☐1	☐2	☐3	☐4	☐5	☐9
6.	Hospital leadership performed a cost/benefit analysis of the impact of this hospital's clinical quality improvement initiatives.....	☐1	☐2	☐3	☐4	☐5	☐9
7.	Hospital leadership evaluated improvement by comparing its clinical quality data with data from other hospitals.....	☐1	☐2	☐3	☐4	☐5	☐9
8.	The Board completed a self-evaluation regarding effectiveness of Board actions to improve clinical quality.....	☐1	☐2	☐3	☐4	☐5	☐9
9.	The Board has had an external evaluation of effectiveness of its actions with regard to clinical quality.....	☐1	☐2	☐3	☐4	☐5	☐9

How much do you agree or disagree with the following statements?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. This hospital recognizes clinical staff who demonstrate a strong commitment to clinical quality	☐1	☐2	☐3	☐4	☐5	☐9
2. This hospital rewards clinical staff who demonstrate a strong commitment to clinical quality	☐1	☐2	☐3	☐4	☐5	☐9
3. Physician performance on specific clinical quality indicators is used to make decisions regarding privileging and recredentialing	☐1	☐2	☐3	☐4	☐5	☐9
4. Performance expectations that support the hospital's clinical quality goals are built into performance evaluation criteria for the following persons						
a. Hospital leadership	☐1	☐2	☐3	☐4	☐5	☐9
b. Front-line clinical staff	☐1	☐2	☐3	☐4	☐5	☐9

SECTION I: Resource Support for Clinical Quality Improvement

How much do you agree or disagree with the following statements?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. Sufficient staff are available to provide care that meets the organization's expectations for quality	☐1	☐2	☐3	☐4	☐5	☐9
2. This hospital's annual operating budget includes specific funding for clinical quality improvement activities	☐1	☐2	☐3	☐4	☐5	☐9
3. Leaders of clinical quality improvement initiatives are able to receive sufficient funds for their improvement activities	☐1	☐2	☐3	☐4	☐5	☐9
4. Adequate time is dedicated/allocated to quality improvement activities in this hospital	☐1	☐2	☐3	☐4	☐5	☐9
5. This hospital has all the experts it needs to support clinical quality improvement	☐1	☐2	☐3	☐4	☐5	☐9

SECTION J: Education and Training

1. To what extent are the following persons provided with formal education and training in clinical quality improvement?

	Not at All	A little	Some-what	A moderate amount	A lot	Does Not Apply or Don't Know
a. Board members	☐1	☐2	☐3	☐4	☐5	☐9
b. Chief Executive Officer/top executive	☐1	☐2	☐3	☐4	☐5	☐9
c. Chief Medical Officer/top physician leader	☐1	☐2	☐3	☐4	☐5	☐9
d. Chief Nursing Officer/top nursing leader	☐1	☐2	☐3	☐4	☐5	☐9
e. Other senior executive leaders	☐1	☐2	☐3	☐4	☐5	☐9
f. Other physician leaders (administrative or clinical)	☐1	☐2	☐3	☐4	☐5	☐9

SECTION K: Nonpunitive Culture

How much do you agree or disagree with the following statements?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. In this hospital, patient care errors made by staff are dealt with in a just (fair and reasonable) manner	☐1	☐2	☐3	☐4	☐5	☐9
2. This hospital supports a nonpunitive response to staff errors in the following ways:						
a. Policies outline how staff errors are investigated and handled	☐1	☐2	☐3	☐4	☐5	☐9
b. Patient care errors are disclosed to patients and families	☐1	☐2	☐3	☐4	☐5	☐9
c. Errors (not due to outright negligence or criminal intent) are viewed as opportunities for staff education and performance improvement	☐1	☐2	☐3	☐4	☐5	☐9

SECTION L: Public Reporting/Transparency

1. This hospital shares its clinical performance data in the following ways (e.g., data for quality of care provided to patients with heart attack, heart failure, pneumonia):

	Yes	No	Does Not Apply or Don't Know
a. Submits data for the CMS Hospital Compare web site	☐1	☐2	☐9
b. Participates in State hospital public reporting activities	☐1	☐2	☐9
c. Posts the data on the hospital's public web site (Internet).....	☐1	☐2	☐9
d. Posts the data on the hospital's intranet (internal web site).....	☐1	☐2	☐9
e. Includes the data in Board reports.....	☐1	☐2	☐9
f. Presents the data at hospital department meetings	☐1	☐2	☐9
g. Makes the data available to hospital staff.....	☐1	☐2	☐9

SECTION M: Clinical Management Tools and Techniques and Processes

To facilitate and/or coordinate the safety and quality of patient care between caregivers, this hospital uses:

	Not at All	A little	Some-what	A moderate amount	A lot	Does Not Apply or Don't Know
1. Clinical tools						
a. Clinical guidelines (protocols)	☐1	☐2	☐3	☐4	☐5	☐9
b. Clinical pathways	☐1	☐2	☐3	☐4	☐5	☐9
c. Standing orders	☐1	☐2	☐3	☐4	☐5	☐9
d. Preprinted or computer-generated order sets	☐1	☐2	☐3	☐4	☐5	☐9
e. Preprinted or computer-generated diagnosis specific discharge instructions	☐1	☐2	☐3	☐4	☐5	☐9
f. Benchmarking (comparative analysis on clinical performance)	☐1	☐2	☐3	☐4	☐5	☐9
g. Other (Please specify): _____	☐1	☐2	☐3	☐4	☐5	☐9
2. Clinical techniques and processes						
a. Team clinical rounds at the bedside	☐1	☐2	☐3	☐4	☐5	☐9
b. Multidisciplinary integrated progress notes	☐1	☐2	☐3	☐4	☐5	☐9
c. Concurrent review of quality indicators by case managers	☐1	☐2	☐3	☐4	☐5	☐9
d. Rapid response teams	☐1	☐2	☐3	☐4	☐5	☐9
e. Other (Please specify): _____	☐1	☐2	☐3	☐4	☐5	☐9

SECTION N: Overall Quality Ratings

1. **How much do you agree or disagree that this hospital devotes adequate resources to quality improvement? (Mark one)**
   - ☐a. Strongly disagree
   - ☐b. Disagree
   - ☐c. Neither Agree Nor Disagree
   - ☐d. Agree
   - ☐e. Strongly agree

2. **To what extent do you think there is a commitment to quality throughout the organization? (Mark one)**

☐a. Not at all

☐b. A little

☐c. Somewhat

☐d. A moderate amount

☐e. A lot

3. To what extent do you think that quality improvement in your hospital is a success? (Mark one)

☐a. Not at all

☐b. A little

☐c. Somewhat

☐d. A moderate amount

☐e. A lot

Section O: Your Comments

Please feel free to write any comments you may have about clinical quality improvement in your hospital.

Thank you for your participation!