

PATIENT SAFETY ORGANIZATION INFORMATION FORM

The Agency for Healthcare Research and Quality (AHRQ), of the Department of Health and Human Services (HHS), administers the provisions of the Patient Safety Act dealing with Patient Safety Organizations (PSO operations). This form is intended for PSOs listed by AHRQ. Completion of this form provides information to HHS on the types of health care providers, settings, and reports for which PSOs conduct patient safety activities. This form is designed to collect data that will be used to generate aggregate statistics necessary to administer the Patient Safety Act and to report on the Act's impact.

Please submit this information by February 28th each year for the prior calendar year. For example, data from calendar year 2011 should be submitted by February 28, 2012. *This information should be entered electronically at AHRQ's PSO Privacy Protection Center Web site www.psoppc.org. Please contact support@psoppc.org for more information about registering for an account. To submit a hard copy, please send to: PSO PPC, IFMC, 1776 West Lakes Parkway, West Des Moines, IA 50266.*

PSO Name		AHRQ-assigned PSO Number
Reporting Year	Form Completed By	Today's Date

PART A: PSO INFORMATION

Please note that the information requested in Part A is to be completed only once per year for the PSO. Responses should reflect PSO information for the prior calendar year.

1	How many agreements/contracts with providers did the PSO have for services pursuant to the Patient Safety Act? · If none, enter "0".	_____
2	From how many of these agreements/contracts were reports submitted to the PSO? If none, enter "0". ·	_____
3	How many individual patient safety reports using AHRQ's Common Formats did the PSO receive? If none, enter "0". ·	_____
4	Did the PSO receive patient safety work product (PSWP) from any provider with which the PSO did not have an agreement/contract? ·	<input type="checkbox"/> YES <input type="checkbox"/> NO
5	Which of the following categories best describes your PSO (or, if a component PSO, the parent)? Select all that apply: · <ul style="list-style-type: none"> <input type="checkbox"/> Association; includes medical society and any other type of professional association or trade association <input type="checkbox"/> Consulting firm; includes research institute (except if part of an educational establishment), data analysis firm, etc. <input type="checkbox"/> Consumer (advocacy) organization <input type="checkbox"/> Financial services organization <input type="checkbox"/> Healthcare provider organization; includes hospital, physician group, and any other type of provider, laboratory, tissue bank, and any other type of auxiliary service <input type="checkbox"/> Insurer (other than health insurance provider) <input type="checkbox"/> Software development organization <input type="checkbox"/> University or other educational establishment <input type="checkbox"/> Wholesaler/retailer; includes general purchasing organization, wholesaler or similar entity; Durable Medical Equipment (DME) supplier, retail pharmacy, other retailer or similar entity <input type="checkbox"/> Other, please specify: _____ 	
6	Does your PSO concern itself with all aspects of patient safety or does your PSO focus on a specific area of concern (e.g., site/setting, medical specialty, care delivery process, etc.)? Select One: · <ul style="list-style-type: none"> <input type="checkbox"/> No specific focus; solicits all types of patient safety concerns 	

Specific focus

PART A: PSO INFORMATION – continued

7. Only if your PSO has a specific focus, In which particular category or categories does the PSO solicit reports? **Select All That Apply:**

- | | | |
|---|--|---|
| <input type="checkbox"/> Blood or Blood Products | <input type="checkbox"/> Devices and/or Medical/Surgical Supplies, including HIT | <input type="checkbox"/> Falls |
| <input type="checkbox"/> Healthcare-associated Infections | <input type="checkbox"/> Medication and/or Other Substances | <input type="checkbox"/> Perinatal |
| <input type="checkbox"/> Pressure Ulcers | <input type="checkbox"/> Surgery and Anesthesia | <input type="checkbox"/> Venous Thromboembolism |
| <input type="checkbox"/> Other, please specify: _____ | | |

8. Is your PSO a component PSO? **Select One:**

- Yes, it is a component and a separate legal entity
- Yes, it is a component, but it is not a separate legal entity
- No, it is not a component PSO.

9. Which of the following best describes your PSO (or if the component PSO is not a separate legal entity, please describe its parent)? **Select One:**

- | | |
|--|--|
| <input type="checkbox"/> Federal, State, local, or tribal government agency | <input type="checkbox"/> For-profit entity |
| <input type="checkbox"/> Nonprofit entity; includes foundation, university, etc. | <input type="checkbox"/> Other |

10. Does your PSO offer any service other than patient safety activities (as defined in the Patient Safety Act and Rule)? **Select One:**

- Yes
- No

11. What geographic area does the PSO intend to serve? **Select One:**

- National
- State
- Regional (can include more than one state)
- Local

PART B: PROVIDER(S) INFORMATION

Part B requests further information about each of the institutional or individual providers with which the PSO has an agreement/ contract pursuant to the Patient Safety Act (e.g., if your PSO has a separate contract with five institutional or individual providers, complete Part B for each of the five providers). When the contract is with an institutional provider, provide information in Part B only on the facility or office-based practice with which your PSO has a contract; do not report on the individual healthcare providers (e.g., physicians, nurses, etc.) who work in a facility or office-based practice unless your PSO has separate contracts with those individuals.

If a PSO has a contract with a health system that includes multiple hospitals or other facilities, please complete Part B for each provider/facility in the system that currently submits, or intends to submit information to your PSO. Likewise, if a your PSO has a contract with a hospital that includes other facilities owned/operated by the hospital (e.g., free standing ambulatory surgery center or long term care facility, your PSO should complete part B for each facility owned/operated by the hospital that currently submits, or intends to submit, information to the PSO.

PSOs that do not have any agreements/contracts with providers need not complete Part B.

First three digits of provider's zip code: _____

PSO-assigned Provider ID Code: _____
The PSO-Assigned Provider ID Code is a surrogate provider ID that the PSO assigns to each of its contracted healthcare provider(s) to protect the anonymity of the healthcare provider(s).

1. Type of provider. **Select One:**

- General (acute care) hospital
- Specialty or other hospital
- Skilled nursing or long term care facility
- Office of licensed/state-certified practitioner(s) (such as doctor, dentist, psychologist, physiotherapist, etc.) with **five or fewer** such practitioners
- Office of licensed/state-certified practitioners (such as doctor, dentist, psychologist, physiotherapist, etc.) with **six or more** such practitioners; includes community health center, group practice, clinic, etc. with six or more practitioners
- Ambulatory surgery center
- Independent laboratory, freestanding diagnostic or imaging center, tissue bank, etc.
- Specialized treatment facility; includes renal dialysis center, chemotherapy center, etc.
- Ambulance, emergency medical technician, paramedic services, etc.
- Home health care; includes in-home treatment services, hospice care, etc.
- Retail pharmacy
- Other, please specify: _____

2. Size of metropolitan area in which provider is located. **Select One of the National Center for Health Statistics Urban-Rural Classifications** http://www.cdc.gov/nchs/data_access/urban_rural.htm:

- Large metropolitan area (1,000,000 or more population)
- Medium metropolitan area (250,000 to 999,999 population)
- Small metropolitan area (50,000 to 249,999 population)
- Micropolitan area (Less than 20,000 to 49,999 population)
- Noncore area (Neither metropolitan nor micropolitan)

3. Is the PSO aware of this provider reporting to another PSO? **Select One:**

- Yes
- No

4. **To be completed for each hospital and skilled nursing facility/long term care facility (if any):**

Provider size (for hospitals and/or skilled nursing facilities/long term care only)

What was the number of licensed beds at the end of the most recent calendar year for which data are available? Enter number of beds rounded to the nearest 100 (NOTE: For hospitals with fewer than 100 beds, please enter the whole number without rounding [e.g., for a hospital with 75 beds, please enter "75"]): _____

5.	What is the provider's ownership status? Select One:
	<input type="checkbox"/> Government (Federal, State, or local)
	<input type="checkbox"/> Private, nonprofit
	<input type="checkbox"/> Private, for-profit
	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Other, please specify: _____
6.	<p><i>To be completed for hospitals only (general or specialty):</i></p> <p>Academic Affiliation</p> <p>Is this provider part of an academic medical center or is this provider affiliated with a teaching program? Select One:</p> <p><input type="checkbox"/> Yes, this provider is part of an academic medical center</p> <p><input type="checkbox"/> Yes, this provider has a teaching affiliation, but is not part of an academic medical center; includes teaching facility through which students, interns, residents, etc. rotate</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p>
<p style="text-align: center;">Burden Statement</p> <p>Public reporting burden for the collection of information is estimated to average 3 hours per response. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer, Attention: PRA, Paperwork Reduction Project (0935-0143), AHRQ, 540 Gaither Road, Room #5036, Rockville, MD 20850.</p>	