## Appendix A – Organizational Characteristics Survey

**Diagnostic Safety Capacity Building – Measure Dx Resource**

Form Approved  
OMB No. xxxx-xxxx  
Exp. Date xx/xx/20xx

Please complete the following information about your organization:

**General Information About Your Organization**

|  |  |  |
| --- | --- | --- |
| **Organization name** |  | |
| **Mailing address (city, state, ZIP code)** |  | |
| **Contact person and title** |  | |
| **Organization type** |  Academic medical center   Other not-for-profit   For-profit | |
| **Types of facilities within organization (check all that apply and indicate number of facilities)** |  Hospital(s): \_\_\_ (total number of beds: \_\_\_)  Annual # of admissions: \_\_\_   Emergency department(s): \_\_\_  Annual # of ED visits: \_\_\_\_   Ambulatory clinic site(s): \_\_\_  Annual # of ambulatory clinic visits: \_\_\_\_ | |
| **Approximate number of active staff clinicians** | Physicians | \_\_\_\_\_\_\_\_\_\_ |
|  | Advance Practice Practitioners (NP, PA) | \_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |
| **Total number of patients served by organization** | Number of hospital admissions per year: \_\_\_\_\_\_\_\_\_\_  Number of ambulatory clinic visits per year: \_\_\_\_\_\_\_\_\_\_ | |
| **Race (indicate % of patients)** | White  Black or African American  American Indian or Alaska Native  Asian  Native Hawaiian or Other Pacific Islander  Multiple racial categories | \_\_\_\_\_\_\_\_\_%  \_\_\_\_\_\_\_\_\_%  \_\_\_\_\_\_\_\_\_%  \_\_\_\_\_\_\_\_\_%  \_\_\_\_\_\_\_\_\_%  \_\_\_\_\_\_\_\_\_% |
| **Ethnicity (indicate % of patients)** | Hispanic or Latino  Not Hispanic or Latino | \_\_\_\_\_\_\_\_\_%  \_\_\_\_\_\_\_\_\_% |

**Information about Patient Safety and Quality Improvement Activities of the Organization**

|  |  |
| --- | --- |
| **What role(s) and/or department in your organization is responsible for patient safety?** |  |
| **Does your organization routinely conduct a patient safety culture survey?** |  No   Yes 🡪  Please specify which survey you use:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of the last survey: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Which of the following activities are held regularly in your organization?** | Peer reviews  Morbidity and mortality conferences  Death reviews  Root cause analysis  Healthcare failure mode and effects analysis  Other methods: |
| **Does your organization have a patient safety hotline or incident reporting system for providers?** | Yes  No |
| **Does your organization have a patient safety hotline or incident reporting system for patients?** | Yes  No |
| **Which electronic health record platform does your organization use?** |  |
| **Do you use electronic health record data for patient safety analysis or improvement?** | Yes  No |

This survey is authorized under 42 U.S.C. 299a. The confidentiality of your responses to this survey is protected by Sections 944(c) and 308(d) of the Public Health Service Act [42 U.S.C. 299c-3(c) and 42 U.S.C. 242m(d)].  Information that could identify you will not be disclosed unless you have consented to that disclosure. Public reporting burden for this collection of information is estimated to average 60 minutes per response, the estimated time required to complete the survey. 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-XXXX) AHRQ, 5600 Fishers Lane, Room #07W42, Rockville, MD 20857.