

**Appendix A – Organization Characteristics Survey**

## Diagnostic Safety Capacity Building – Diagnostic Safety Measurement Resource

Please complete the following information about your organization:

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

### General Information About Your Organization

<b>Organization name</b>					
<b>Mailing address (city, state, ZIP code)</b>					
<b>Contact person and title</b>					
<b>Organization type</b>	<input type="checkbox"/> Academic medical center <input type="checkbox"/> Other not-for-profit <input type="checkbox"/> For-profit				
<b>Types of facilities within organization (check all that apply and indicate number of facilities)</b>	<input type="checkbox"/> Hospital(s): ____ (total number of beds: ____) Annual # of admissions: ____ <input type="checkbox"/> Emergency department(s): ____ Annual # of ED visits: ____ <input type="checkbox"/> Ambulatory clinic site(s): ____ Annual # of ambulatory clinic visits: ____				
<b>Approximate number of active staff clinicians</b>	<table border="0"> <tr> <td>Physicians</td> <td>_____</td> </tr> <tr> <td>Advance Practice Practitioners (NP, PA)</td> <td>_____</td> </tr> </table>	Physicians	_____	Advance Practice Practitioners (NP, PA)	_____
Physicians	_____				
Advance Practice Practitioners (NP, PA)	_____				
<b>Total number of patients served by organization</b>	Number of hospital admissions per year: _____ Number of ambulatory clinic visits per year: _____				
<b>Race (indicate % of patients)</b>	White _____% Black or African American _____% American Indian or Alaska Native _____% Asian _____% Native Hawaiian or Other Pacific Islander _____% Multiple racial categories _____%				
<b>Ethnicity (indicate % of patients)</b>	Hispanic or Latino _____% Not Hispanic or Latino _____%				

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

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