ACS QVP Hospital Pre-Review Questionnaire

INSTITUTIONAL ADMINISTRATIVE COMMITMENT (IAC)

IAC.1: Leadership Commitment and Engagement to Surgical Quality and Safety

View Standard

1. Upload a letter from hospital leadership (e.g., CEO) demonstrating the commitment to the "Surgical Quality and Safety Program". This letter should include:
a) A high-level description of the "Surgical Quality and Safety Program".
b) Hospital-wide quality improvement initiatives in the past 12 months in surgery or surgery-related disciplines.
c) Hospital leadership's involvement in surgical quality and safety efforts.
d) Current and future financial investment in surgical quality and safety.
e) Commitment to team-based and evidence-based care. (IAC.1.1)

2. Upload an organizational chart (e.g. wiring diagram) that illustrates your hospital's infrastructure, including all departments and their relationship to each other and hospital administration (IAC.1.2).

3. Upload an organizational chart including the different committees/governing bodies throughout the organization that support surgical quality and safety functions/initiatives, their leaders, and the connections between them and hospital administrative leadership (IAC.1.3).

4. Is there an a priori mechanism or forum for requesting quality and safety resources (e.g. registry participation, external quality program participation, FTE support, educational opportunities, etc.)?

5. If yes, describe the mechanism and process (e.g. requests can be submitted at anytime using a budget support request form, there is a meeting semi-annually where requests can be presented for approval, etc.):

6. Describe how quality and safety resource requests are reviewed and prioritized.

7. Upload a completed roster of ALL surgeons privileged at the hospital using the provided template.

INSTITUTIONAL ADMINISTRATIVE COMMITMENT (IAC)

IAC.2: Culture of Patient Safety and High Reliability

View Standard

1. Does your hospital use a quality dashboard?

If yes, **upload** your quality dashboard (IAC.2.1).

2. List in the table all safety culture surveys conducted at the hospital over the past 3 years using the **template**.

3. Upload reports/results from safety culture assessments conducted either at the hospital or department-level over the past 3 years (e.g. SAQ, HSOPS, etc.) (IAC.2.2).

4. How often do you plan to conduct safety culture surveys going forward?

5. What are the top 3 areas identified in your safety culture results for needing improvement?

6. Who is responsible for administering safety culture education?

7. Is formal safety culture education (e.g., TeamSTEPPS) provided to hospital staff at the time of initial onboarding?

8. How often is ongoing formal safety culture education provided to hospital staff?

9. Upload a listing of recent training/education initiatives for the surgical team on safety culture/ safety attitudes, including dates of training and participant list using the template below.

10. Are hospital staff encouraged to report "near miss" events?

11. Are "near miss" events shared for educational purposes?

If yes, describe how.

PROGRAM SCOPE & GOVERNANCE (PSG)

PSG.1: Surgical Quality Officer (SQO)

View Standard

1. List the name of the individual performing the majority of the SQO responsibilities:

2. What is the FTE amount dedicated to the SQO role? (e.g., enter 0.5 if the individual is halftime) (do not include a percent sign in your response):

3. Indicate the following responsibilities that fall under the SQO (select all that apply):

☐Adverse Event Review
☐Clinical Practice Variation
☐Quality & Safety Guidelines
☐Identify Cross-cutting Issues
❒QI Initiatives Across Surgery

4. List any other responsibilities related to this role.

5. List departments/areas within surgery this individual is responsible for (e.g., general surgery only vs. Neuro, Gyn, ENT, et al).

6. If there are other individuals performing certain aspects of the SQO role, provide their names and describe their functions and areas of responsibility.

7. If more than one person is serving in an SQO role, describe how often they meet and how communication, coordination, and accountability are maintained across all responsibilities and departments of surgery. departments of surgery.

8. Upload a formal job description that details the responsibilities, reporting relationships, programmatic authority, and experience required of the individual(s) serving as the SQO (PSG.1.1).

9. Upload the curriculum vitae for individual(s) serving as the SQO (PSG.1.2).

10. Upload the SQO reporting structure through a wiring diagram (PSG.1.3).

PROGRAM SCOPE & GOVERNANCE (PSG)

PSG.2: Surgical Quality and Safety Committee (SQSC)

View Standard

1. Is there an overarching committee(s) that oversees quality and safety specific to surgery across all departments of surgery?

If yes, provide the name of the overarching committee that best meets the definition of the SQSC.

2. Upload the formal SQSC charter and or mission statement (PSG.2.1).

3. Upload a committee roster for the SQSC that names all members and the specialties/disciplines they represent (PSG.2.2).

4. Upload an organizational diagram representing the SQSC's position as well as other governance committees within the organizational framework of the hospital (PSG.2.3).

5. Upload annual SQSC goals and progress tracker (PSG.2.4).

6. Upload agendas and meeting minutes (including attendance record) from most recent SQSC committee meeting over the last 12 months (PSG.2.5).

7. If there is no overarching committee, explain and provide brief description of governance structure.

8. Is there a mechanism, process, or structure to align, coordinate, and communicate amongst all committees?

If yes, describe.

Committee Responsibilities

9. Indicate the committee responsible for overseeing each of the following functions:

OR Operations (i.e., on-time starts, meaningful implementation of time outs, sterilization issues, etc.)	☐SQSC ☐Not reviewed by Committee ☐Other Committee, provide name: ☐Describe how information flows to the SQO:
Cost Reduction & Utilization	☐SQSC ☐Not reviewed by Committee ☐Other Committee, provide name: ☐Describe how information flows to the SQO:
Peer/Case Reviews	☐SQSC ☐Not reviewed by Committee ☐Other Committee, provide name: ☐Describe how information flows to the SQO:
Surgery Program Communication (i.e., cross-cutting surgery protocols, pre-anesthesia clinic use/referrals, Covid-19-related protocol changes, etc.)	☐SQSC ☐Not reviewed by Committee ☐Other Committee, provide name: ☐Describe how information flows to the SQO:

Safety Culture & Disruptive Behavior	☐SQSC ☐Not reviewed by Committee ☐Other Committee, provide name: ☐Describe how information flows to the SQO:
Standardization Across the 5 Phases of Care and Pathway Development	☐SQSC ☐Not reviewed by Committee ☐Other Committee, provide name: ☐Describe how information flows to the SQO:
Access and Distribution of Data	☐SQSC ☐Not reviewed by Committee ☐Other Committee, provide name: ☐Describe how information flows to the SQO:
QI Activities	☐SQSC ☐Not reviewed by Committee ☐Other Committee, provide name: ☐Describe how information flows to the SQO:

10. What level of administrative/project management resources are available to the SQSC/SQO(s) to support their job functions?

11. What is the FTE amount of administrative/ project management support dedicated to the SQO (e.g. enter 0.5 if the individual is halftime)?

12. Enter the name(s) of the individual(s) in the administrative/project management support role(s):

13. What level of data analyst resources are available to the SQSC/SQO(s) to support their job functions?

14. What is the FTE amount of data analyst support dedicated to the SQO (e.g. enter 0.5 if the individual is halftime)?

15. Enter the name(s) of the individual(s) in the data analyst role(s):

16. What level of quality/process improvement resources are available to the SQSC/SQO(s) to support their job functions?

17. What is the FTE amount of quality/process improvement resources dedicated to the SQO (e.g. enter 0.5 if the individual is halftime)?

18. Enter the name(s) of the individual(s) in the quality/process improvement role(s):

19. Describe other resources available to the SQO. Include whether the resource is dedicated or shared, the FTE amount dedicated to the role(s) and the name(s) of the individuals in the role(s):

20. Upload job descriptions for QI/PI practitioner(s), data analyst(s), and administrative/project management personnel (PSG.2.6).

PATIENT CARE: EXPECTATIONS & PROTOCOLS (PC)

PC.1: Standardized and Team-Based Processes in the Five Phases of Care

View Standard

1. For the following phases of care, indicate if there are **HOSPITAL-WIDE** standard processes/protocols that exist across all surgical specialties. Check ALL that apply:

PHASE 1: Pre-operative evaluation process/protocol	☐Hospital-wide evaluation processes/ readiness clinic/ protocols, pre-op clearance, etc. (attach copy) ☐Processes/ protocols either don't exist or exist at the individual specialty level only	☐Compliance with hospital-wide processes/ protocols are measured regularly ☐Compliance to 2/3 of standardized protocol elements is >70%
PHASE II: Immediate Pre-operative Phase (day of surgery)	☐Hospital-wide processes/protocols, i.e., check-ins, med rec, consent, etc. (attach copy) ☐Processes/ protocols either don't exist or exist at the individual specialty level only	☐ Compliance with hospital-wide processes/ protocols are measured regularly ☐ Compliance to 2/3 of standardized protocol elements is >70%
Phase III: Intra-operative Phase	☐Hospital-wide operating room processes/protocols i.e., universal protocol, debriefing, etc. (attach copy) ☐Processes/protocols either don't exist or exist at the individual specialty level only	☐ Compliance with hospital-wide processes/ protocols are measured regularly ☐ Compliance to 2/3 of standardized protocol elements is >70%
PHASE IV: Post-operative phase process/protocol	☐Hospital-wide processes/ protocols, i.e., hand-offs, ICU, PACU, floor/unit, rescue team activation, discharge process, etc. (attach copy)	☐ Compliance with hospital-wide processes/ protocols are measured regularly ☐ Compliance to 2/3 of standardized protocol elements is >70%
	☐Processes/protocols either don't exist or exist at the individual specialty level only	
Phase V: Post-discharge process/protocol to bridge gap between discharge and follow-up	☐Hospital-wide processes/protocols, i.e. transfers & hand-offs to SNF/long-term rehab, patient navigation, follow-up, education and support for wound/ port management, signs and symptoms of a complication (attach copy) ☐Processes/ protocols either don't exist or exist at the individual specialty level only	☐ Compliance with hospital-wide processes/ protocols are measured regularly ☐ Compliance to 2/3 of standardized protocol elements is >70%

2. Upload Phase I-V hospital-wide processes and protocols.

PATIENT CARE: EXPECTATIONS & PROTOCOLS (PC)

PC.2: Disease-Based Management Programs and Integrated Practice Units

View Standard

All information collected to verify PC.2 is captured within the Specialty Pre-Review Questionnaires.

DATA SURVEILLANCE & SYSTEMS (DSS)

DSS.1: Data Collection and Surveillance

View Standard

1. Indicate the sources of **HOSPITAL-WIDE** data (other than disease-specific registries) that your hospital uses to monitor surgical quality and safety:

Data Source	Data Type	Who Inputs Data	Data Shared Routinely
(.e.g., NSQIP, VQI, STS, etc.)	☐ Incident/Serious Safety Event Reporting System ☐Other reporting mechanism to track (near misses and good catches) ☐Administrative claims data (e.g. billing, EHR data, Vizient, Premier) ☐ Local, clinically relevant data capture (e.g. Redcap, homegrown registry) ☐ External, multi-hospital clinical data registry (e.g. ACS NSQIP, SVS VQI, STS National Database, etc.) ☐Electronic health record associated data (e.g. EPIC SlicerDicer) ☐Risk Adjusted ☐Regional Benchmark Data ☐National Benchmark Data ☐Other	☐Hospital Staff ☐ Patients/Caregivers Surgeon ☐ Data Abstractor ☐ Automated from EHR	☐Hospital Leadership (i.e. CMO, quality dept leadership) ☐ Surgeon Leadership (i.e. chair, SQO) ☐Specialty Leadership (i.e. thoracic surgery chief) ☐ Frontline Surgeons ☐ Frontline Care Providers

2. For **HOSPITAL-WIDE** data describe who analyzes the data, creates reports, does measure development? Include number of FTEs and qualifications:

3. How often are hospital-wide data on surgical quality and safety reported out?

If other, explain:

4. How are the data reported out? (select all that apply)

☐ Dashboards
☐ Daily safety huddles
☐ Reported to department leadership
☐ Reported to nursing leadership

If other, explain:

5. Upload the most recent (patient de-identified) data reports from each registry or data source you monitor for quality improvement purposes including patient experience data, HOSPITAL-WIDE event reporting and surgical outcomes data, and surgical specialty-specific data (DSS.1.1).

6. Upload the hospital policy/training on reporting quality and safety events (DSS.1.2).

QUALITY IMPROVEMENT (QI)

QI.1: Case Review

View Standard

1. Is there a formal process for surgical case review, separate from specialty-level case review processes, that identifies and reviews cases across departments/surgical specialties at the hospital level?

If yes, describe the frequency of meetings (case review vs. ad-hoc) and name/titles of who performs reviews (individual, team, multidisciplinary team):

Questions #2-12 pertain only to a SURGERY-WIDE case review process. Do not respond regarding specialty-level case review processes here, as those responses should be included on the corresponding Specialty PRQs. If you only conduct case review at the specialty-level you can skip the following questions. Examples of case review documentation will also be assessed during the site visit during the Chart Review session (see Chart/Documentation Preparation Guide for details).

2. Check all **HOSPITAL-LEVEL** case review types that apply:

☐ Surgery-wide M&M conference; cases reviewed primarily for educational purposes
☐ Surgery-wide case review process by hospital quality staff and/or surgeon leader; primarily for identifying sentinel events for referral to RCA process or Hospital Peer Review committee
☐ Surgery-wide multi-disciplinary case review conference with representatives across disciplines and surgical specialties; primarily for the purpose of identifying cross-cutting process or quality improvement opportunities

If Other, describe:

3. How many surgery-related cases, including sentinel events, were reviewed as part of a formal surgery-wide case review process over the last 12 months (include cases that have begun review and are still in process)?

4. How many surgery-related cases led to a Root Cause Analysis (RCA) over the past 3 years?

5. Describe the criteria used for case selection as part of the **surgery-wide** case review process:

Randomized Case Review (select all that apply)
☐Random case selection for educational review purposes as part of M&M
☐Random case selection for adherence to protocols or resource utilization
☐No randomized case review

For-Cause Case Review (select all that apply)
☐For-Cause Case Review of selected mortalities
☐For-Cause Case Review of all mortalities
☐Select sentinel/serious safety events (i.e. retained foreign bodies, wrong site surgery, etc.)
☐All sentinel/serious safety events
☐Select reoperations
☐All reoperations
☐There are set criteria for specific complications (i.e. readmissions, intra-op complications or procedure time, post-op complications, etc.) that are reviewed

6. If there are set criteria for specific complications, list the types of complications reviewed:

7. If cases are selected at random for adherence to protocols or for resource utilization, describe the process:

8. Who selects cases for review (check all that apply)?

☐Surgeon leader
☐Quality staff person
☐Surgeons select their own cases
If committee or other, describe:

9. What are the data or sources used for case identification (check all that apply)?

☐Hospital serious safety event reporting system
☐Referral from hospital-level peer review, risk management, or other hospital-level committee
☐EMR or Administrative Data Report
☐Clinical registry reports
☐Individual Referrals or by word of mouth

If other source, describe:

10. Is there an event classification system (i.e. numeric rating based on severity, non-preventable/preventable, etc.)?

If yes, describe:

11. Is there a standardized way for documenting review findings?

If yes, **describe or attach** form.

12. Is there a routine, formal process for loop closure?

If yes, **describe or attach** process flow:

13. Provide an example of a recent sentinel event (e.g., wrong site surgery, retained foreign body, etc.) and describe the process for review (do not include any patient identifiers):

14. Upload diagram/process flow map(s) for case review process that includes surgery-wide criteria for case review selection, data source(s) used to identify cases, institutional bodies that review cases and feedback loop for case review findings (QI.1.1).

15. Upload the form/template(s) used for case review write-ups (QI.1.2).

16. Upload (patient de-identified) case review conference agendas, meeting minutes, and attendance records from the 3 most recent case review conferences (QI.1.3).

QUALITY IMPROVEMENT (QI)

QI.2: Surgeon Review

View Standard

1. Upload the surgeon/peer review committee roster, include title and specialty.

2. Does the make up of the surgeon/peer review committee shift depending on the type of case being reviewed?

If yes, describe:

3. Are there circumstances when cases sent to an external group for surgeon/peer review?

If yes, describe:

4. How does your hospital capture and track surgeon/peer review documentation?

5. How are surgeons requiring peer review identified (check all that apply)?

☐Case Review
☐Tracking Outliers
☐Referral from Department Chair
☐Word of Mouth
☐Other

6. How many surgeons have been evaluated as part of a formal Surgeon Review (i.e. Individual Peer Review) process over the past 3 years?

7. Of these surgeons how many…

	# of Surgeons
The review revealed there was not a surgeon-level performance issue	(e.g., 5)
No longer practicing at the hospital	(e.g., 5)
Issues were successfully addressed through proctoring or other remediation process and issues have not recurred	(e.g., 5)
Surgeon(s) continues to be monitored for performance issues or it is unclear if performance issue was resolved	(e.g., 5)

8. Upload all policies and procedures pertaining to the peer review processes (QI.2.1).

9. Indicate if you have any of the following programs/policies (check all that apply).

☐Disruptive Behavior Policy
☐Aging Surgeon Policy
☐Surgeon Wellness Program (i.e. second victim or burnout prevention program)

10. Upload hospital policies/process for addressing disruptive behavior, aging surgeons, surgeon wellness programs, etc. (QI.2.2).

QUALITY IMPROVEMENT (QI)

QI.3: Credentialing, Privileging, and Onboarding

View Standard

1. Upload all policies and procedures pertaining to the credentialing, privileging, and onboarding (QI.3.1).

2. Upload privileging documentation that outlines "core privileges" and "special privileges" (QI.3.2).

3. Please complete the following with details regarding privileging process:

	Length FPPE/OPPE Process	*# of Cases Reviewed*	*Volume Requirements*	*Education/Training Requirements*	*Direct Observation of Surgeon Required?*
New Surgeons (includes new hires, entering practice following training, or following a break in practice)	How Long is the FPPE/onboarding process? *(e.g., 3 months)*	*(e.g., 5)*	Yes/No ☐Procedure Specific	Yes/No ☐Procedure Specific	Yes/No ☐Procedure Specific
Established Surgeons Renewing Existing Privileges	How often are privileges renewed/OPPE process? *(e.g., Annually)*	*(e.g., 5)*	Yes/No ☐Procedure Specific	Yes/No ☐Procedure Specific	Yes/No ☐Procedure Specific
Established Surgeons Requesting New Privileges	How long is the FPPE process? *(e.g., 3 months)*	*(e.g., 5)*	Yes/No ☐Procedure Specific	Yes/No ☐Procedure Specific	Yes/No ☐Procedure Specific

4. Describe the process for safe introduction of new surgical procedures or technology. Provide the most recent example and provide details regarding requirements for training, proctoring, and ongoing monitoring of outcomes:

QUALITY IMPROVEMENT (QI)

QI.4: Continuous Quality Improvement Using Data

View Standard

1. Does the hospital conduct data-driven quality improvement (QI) initiatives across specialties specific to surgery?

2. If yes, **complete and upload** the template to provide examples of all **CROSS-SPECIALTY** surgery-specific QI initiatives from the last past 12 months. (e.g., project addressing day-of surgery cancellations, project addressing geriatric patient care across specialties, etc.):

3. Upload 1-5 examples (i.e., power point slides or completed PI tool that provides project details) of recent **CROSS-SPECIALTY** quality improvement initiatives within the last 12 months. (QI.4.1)

4. Who is responsible for leading and supporting quality improvement initiatives across surgery and what is the SQO's involvement?

5. Do you have dedicated QI staff trained in quality improvement methodologies (e.g., LEAN, Six Sigma) within surgery or from the hospital's quality department to support surgery-specific quality improvement initiatives?

If yes, describe:

6. Who is responsible for identifying cross-specialty quality improvement initiatives?

7. What are the data sources most often used to identify quality improvement initiatives?

8. Who, and by what mechanism, are quality improvement initiatives prioritized and chosen?

9. Do you have adequate FTE support to conduct all of the QI initiatives you believe are central to ensuring safe and high-quality surgical care?

Provide explanation:

10. Rate the following potential barriers to conducting quality improvement initiatives as high, medium, or low:

HIGH: We don't have this resource or this is a significant barrier
MEDIUM: We have limited resources or this is sometimes a barrier
LOW: We have sufficient resources or this is not a barrier

Access to Data	☐Low ☐Medium ☐High
Data Quality	☐Low ☐Medium ☐High
QI/PI Expertise	☐Low ☐Medium ☐High
FTE Support for QI/PI	☐Low ☐Medium ☐High
Competing Priorities	☐Low ☐Medium ☐High

List any additional barriers:

11. What are your top **HOSPITAL-WIDE** surgical quality goals for this year (e.g. standardized pre-op evaluation process, standardized protocols for geriatric surgery patients, opioid stewardship, etc.)?

12. What were the goals for the 2 years prior?

QUALITY IMPROVEMENT (QI)

QI.5: Compliance with Hospital-Level Regulatory Performance Metrics

View Standard

1. Indicate the name and title of the individual(s) who oversees external regulatory metrics and performance.

2. Indicate the name and title of the individual(s) who decide prioritization of regulatory metrics.

3. Indicate the name and title of the individual who oversees alignment and coordination of performance of surgery-related regulatory metrics (e.g. SSI, readmissions of surgery patients, other).

4. Indicate which of the following external regulatory bodies have provided your hospital with a report/ratings in the last 3 years (check all that apply):

☐CMS Star Rating
☐Vizient Hospital Benchmarking
☐Premier Hospital Benchmarking
Healthgrades
☐U.S. News and World Report Hospital Ranking
☐Joint Commission, DNV, other equivalent hospital certification/ranking

If other, list here:

***5. Upload** all report summaries/ratings received from these agencies (QI.5.1).*