

ACS QVP Focused Pre-Review Questionnaire

INSTITUTIONAL ADMINISTRATIVE COMMITMENT (IAC)

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

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- 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**

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8. Are hospital staff encouraged to report “near miss” events?

9. Are “near miss” events shared for educational purposes?

If yes, describe how.

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

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

5. Who is responsible for administering safety culture education?

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

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

PROGRAM SCOPE & GOVERNANCE (PSG)

PSG.1: Surgical Quality Officer (SQO)

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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.

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.

PROGRAM SCOPE & GOVERNANCE (PSG)

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

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

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

Committee Responsibilities

4. 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.)	<input type="checkbox"/> SQSC <input type="checkbox"/> Not reviewed by Committee <input type="checkbox"/> Other Committee, provider name: <input type="checkbox"/> Describe how information flows to the SQO:
Cost Reduction & Utilization	<input type="checkbox"/> SQSC <input type="checkbox"/> Not reviewed by Committee <input type="checkbox"/> Other Committee, provider name: <input type="checkbox"/> Describe how information flows to the SQO:

Peer/Case Reviews	<input type="checkbox"/> SQSC <input type="checkbox"/> Not reviewed by Committee <input type="checkbox"/> Other Committee, provider name: <input type="checkbox"/> 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.)	<input type="checkbox"/> SQSC <input type="checkbox"/> Not reviewed by Committee <input type="checkbox"/> Other Committee, provider name: <input type="checkbox"/> Describe how information flows to the SQO:
Safety Culture & Disruptive Behavior	<input type="checkbox"/> SQSC <input type="checkbox"/> Not reviewed by Committee <input type="checkbox"/> Other Committee, provider name: <input type="checkbox"/> Describe how information flows to the SQO:
Standardization Across the 5 Phases of Care and Pathway Development	<input type="checkbox"/> SQSC <input type="checkbox"/> Not reviewed by Committee <input type="checkbox"/> Other Committee, provider name: <input type="checkbox"/> Describe how information flows to the SQO:
Access and Distribution of Data	<input type="checkbox"/> SQSC <input type="checkbox"/> Not reviewed by Committee <input type="checkbox"/> Other Committee, provider name: <input type="checkbox"/> Describe how information flows to the SQO:
QI Activities	<input type="checkbox"/> SQSC <input type="checkbox"/> Not reviewed by Committee <input type="checkbox"/> Other Committee, provider name: <input type="checkbox"/> Describe how information flows to the SQO:

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

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

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

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

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

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

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

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

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

14. *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):*

PATIENT CARE: EXPECTATIONS & PROTOCOLS (PC)

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

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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	<input type="checkbox"/> Hospital-wide evaluation processes/readiness clinic/protocols, pre-op clearance, etc. (attach copy) <input type="checkbox"/> Processes/protocols either don't exist or exist at the individual specialty level only	<input type="checkbox"/> Compliance with hospital-wide processes/protocols are measured regularly <input type="checkbox"/> Compliance to 2/3 of standardized protocol elements is >70%
PHASE II: Immediate Pre-operative Phase (day of surgery)	<input type="checkbox"/> Hospital-wide processes/protocols, i.e., check-ins, med rec, consent, etc. (attach copy) <input type="checkbox"/> Processes/protocols either don't exist or exist at the individual specialty level only	<input type="checkbox"/> Compliance with hospital-wide processes/protocols are measured regularly <input type="checkbox"/> Compliance to 2/3 of standardized protocol elements is >70%
Phase III: Intra-operative Phase	<input type="checkbox"/> Hospital-wide operating room processes/protocols i.e., universal protocol, debriefing, etc. (attach copy) <input type="checkbox"/> Processes/protocols either don't exist or exist at the individual specialty level only	<input type="checkbox"/> Compliance with hospital-wide processes/protocols are measured regularly <input type="checkbox"/> Compliance to 2/3 of standardized protocol elements is >70%
PHASE IV: Post-operative phase process/protocol	<input type="checkbox"/> Hospital-wide processes/protocols, i.e., hand-offs, ICU, PACU, floor/unit, rescue team activation, discharge process, etc. (attach copy)	<input type="checkbox"/> Compliance with hospital-wide processes/protocols are measured regularly <input type="checkbox"/> Compliance to 2/3 of standardized

	<input type="checkbox"/> Processes/protocols either don't exist or exist at the individual specialty level only	protocol elements is >70%
Phase V: Post-discharge process/protocol to bridge gap between discharge and follow-up	<input type="checkbox"/> 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) <input type="checkbox"/> Processes/protocols either don't exist or exist at the individual specialty level only	<input type="checkbox"/> Compliance with hospital-wide processes/protocols are measured regularly <input type="checkbox"/> 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

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

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

- Dashboards
- Daily safety huddles
- Reported to department leadership

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

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:

QUALITY IMPROVEMENT (QI)

QI.2: Surgeon Review

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

If yes, describe:

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

If yes, describe:

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

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

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

If other, describe:

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

6. 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)

7. 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)

QUALITY IMPROVEMENT (QI)

QI.3: Credentialing, Privileging, and Onboarding

[View Standard](#)

1. 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?
<i>New Surgeons (includes new hires, entering practice following training, or following a break in practice)</i>	How Long is the FPPE/onboarding process? (e.g., 3 months)	(e.g., 5)	Yes/No <input type="checkbox"/> Procedure Specific	Yes/No <input type="checkbox"/> Procedure Specific	Yes/No <input type="checkbox"/> Procedure Specific
<i>Established Surgeons Renewing Existing Privileges</i>	How often are privileges renewed/OPPE process? (e.g., Annually)	(e.g., 5)	Yes/No <input type="checkbox"/> Procedure Specific	Yes/No <input type="checkbox"/> Procedure Specific	Yes/No <input type="checkbox"/> Procedure Specific
<i>Established Surgeons Requesting New Privileges</i>	How long is the FPPE process? (e.g., 3 months)	(e.g., 5)	Yes/No <input type="checkbox"/> Procedure Specific	Yes/No <input type="checkbox"/> Procedure Specific	Yes/No <input type="checkbox"/> Procedure Specific

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

4. 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:

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

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

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

8. 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:

9. 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	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High
Data Quality	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High
QI/PI Expertise	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High
FTE Support for QI/PI	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High
Competing Priorities	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High

List any additional barriers:

10. 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.)?

11. 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:*