We understand the many demands you face.

ONLY THE CAP can provide the comprehensive programs and services to help you consistently deliver accurate test results, monitor overall laboratory performance, and increase and sharpen your staff’s skills.

We can help you discover new ways to achieve your goals.

You always put accurate patient results first.
It is our common mission.
Benchmark the accuracy of your procedures.

Changes in health care require a new standard of quality.

Elevate the quality of your management decisions with CAP Quality Management Tools (QMT).

Improve your confidence in the accuracy of your test results with CAP Calibration Verification/Linearity (CVL) programs.

Ensure standardization of your patient results regardless of testing platforms with the CAP accuracy-based programs.

Demonstrate consistent quality with CAP proficiency testing (PT).
# Table of Contents

2015 Quality Management Tools

- Q-PROBES™ .......................................................... 4
- Q-TRACKS® .......................................................... 9
- Q-TRACKS® Clinical Pathology Monitors ................. 11
- Q-TRACKS® Anatomic Pathology Monitors .............. 17
- Q-MONITORS® .................................................... 19
- Quality Management Tools Pricing Overview .......... 21
Quality Management Tools

Use the CAP’s Quality Management Tools (QMT) to improve the Total Testing Process by identifying quality improvement opportunities of selected key processes in the clinical and anatomic pathology laboratories, examining preanalytical, analytical and postanalytical phases:

- **Establish realistic goals** by comparing performance against similar institutions with comparable demographics
- **Monitor progress through** unique and robust quality indicators on a periodical basis
- **Make effective quality management decisions** based on practical and in-depth individual reports provided to participants
- **Improve efficiencies** to allow time for more patient-centric activities
- **Easily integrate quality management into your daily work processes** with predesigned monitoring tools developed by laboratory professionals and scientists

**Q-PROBES™** A One-Time Opportunity to Perform In-Depth Quality Assessment

**Q-TRACKS®** A Program for Continuous Quality Monitoring

**Q-MONITORS®** Customized Quality Monitors Program

Q-PROBES, Q-TRACKS, and Q-MONITORS activities meet the American Board of Pathology MOC Part IV Practice Performance Assessment requirements.
# Quality Management Tools

## Q-PROBES, Q-TRACKS, and Q-MONITORS

offer a comprehensive collection of tools to complement your quality management program needs.*

<table>
<thead>
<tr>
<th>Q-PROBES</th>
<th>Preanalytic</th>
<th>Analytic</th>
<th>Postanalytic</th>
<th>Anatomic Pathology</th>
<th>Clinical Pathology</th>
<th>Turnaround Time</th>
<th>Patient Safety</th>
<th>Microbiology</th>
<th>Transfusion Medicine</th>
<th>Chemistry/Hematology</th>
<th>Customer Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Bank Safety Practices (QP151)</td>
<td>NEW</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Clinical Test Utilization: Unnecessary Testing (QP152)</td>
<td>NEW</td>
<td></td>
<td></td>
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<tr>
<td>Physician Satisfaction with Anatomic Pathology Services (QP153)</td>
<td>NEW</td>
<td></td>
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<tr>
<td>Identification Errors (QP154)</td>
<td>NEW</td>
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<td>Q-TRACKS</td>
<td>Preanalytic</td>
<td>Analytic</td>
<td>Postanalytic</td>
<td>Anatomic Pathology</td>
<td>Clinical Pathology</td>
<td>Turnaround Time</td>
<td>Patient Safety</td>
<td>Microbiology</td>
<td>Transfusion Medicine</td>
<td>Chemistry/Hematology</td>
<td>Customer Satisfaction</td>
</tr>
<tr>
<td>Patient Identification Accuracy (QT1)</td>
<td></td>
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<td>Blood Culture Contamination (QT2)</td>
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<tr>
<td>Laboratory Specimen Acceptability (QT3)</td>
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<tr>
<td>In-Date Blood Product Wastage (QT4)</td>
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<tr>
<td>Gynecologic Cytology Outcomes: Biopsy Correlation Performance (QT5)</td>
<td></td>
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<td>Satisfaction With Outpatient Specimen Collection (QT7)</td>
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<tr>
<td>Stat Test Turnaround Time Outliers (QT8)</td>
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<td>Critical Values Reporting (QT10)</td>
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<td>Turnaround Time of Troponin (QT15)</td>
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<tr>
<td>Corrected Results (QT16)</td>
<td></td>
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<tr>
<td>Outpatient Order Entry Errors (QT17)</td>
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<tr>
<td>Mislabeled Cases, Specimens, Blocks, and Slides in Surgical Pathology (QT19)</td>
<td></td>
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<tr>
<td>Q-MONITORS</td>
<td>Preanalytic</td>
<td>Analytic</td>
<td>Postanalytic</td>
<td>Anatomic Pathology</td>
<td>Clinical Pathology</td>
<td>Turnaround Time</td>
<td>Patient Safety</td>
<td>Microbiology</td>
<td>Transfusion Medicine</td>
<td>Chemistry/Hematology</td>
<td>Customer Satisfaction</td>
</tr>
<tr>
<td>Monitoring of Troponin Metrics for Suspected MI (QM1)</td>
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*The CAP requires accredited laboratories to have a quality management plan that covers all areas of the laboratory and includes benchmarking key measures of laboratory performance (GEN.13806, GEN.20316, COM.04000). The Joint Commission requires accredited hospitals to regularly collect and analyze performance data (PI.01.01.01, PI.02.01.01). CLIA requires laboratories to monitor, assess, and correct problems identified in preanalytic, analytic, and postanalytic systems (§493.1249, §493.1289, §493.1299).
A One-Time Opportunity to Perform In-Depth Quality Assessment

Pilot quality monitoring—Use Q-PROBES short-term comprehensive quality studies to learn how to start monitoring and measuring key processes that you may not have followed in the past or that are not commonly monitored in most laboratories. Q-PROBES studies analyze hot topics and industry trends to keep the laboratory current.

Gain experience in data collection and analysis—Participants will collect data during predetermined dates. Based on submitted data, the CAP provides personalized reports with the individual participant’s performance compared against other participants.

Strengthen your quality assessment expertise—CAP’s pathologist experts provide in-depth discussion and identify best practices for laboratories to strive for. In addition, consolidated results of the studies are carefully reviewed and analyzed to be published in the form of scientific articles. Such articles give participants an extra layer of information to be utilized for further analysis.

Participants in the Q-PROBES program receive:

- Users guide
- Templates and instructions for data collection
- Individual report, how to interpret the results guide, overall aggregated data
- Data Analysis and Critique that includes data distributions and analysis of laboratory practices and commentaries from pathologist experts on improvement opportunities
- Access to the scientific articles that are published with the results of the studies

Q-PROBES activities meet the American Board of Pathology MOC Part IV Practice Performance Assessment requirements.

1 Q-PROBES studies are available only one time annually and may not be repeated in the future.
Blood Bank Safety Practices  QP151

Transfusion of ABO incompatible red blood cells can be a lethal error and is most commonly due to patient or specimen misidentification. Since the rate of incompatible ABO transfusions at any single institution is very low, this study will focus on the frequency of specimen identification errors that can lead to incompatible ABO transfusion.

Objectives
Determine the rates of mislabeled specimens submitted for ABO typing and of ABO result discrepancies (wrong-blood-in-tube); compare rates between laboratories.

Data Collection
From a 30-day review of all specimens submitted for ABO typing, participants will record the number of mislabeled specimens, the number of ABO typing results with a historical type on record, the number of current specimen results that are discrepant from the historical results, and the total number of RBC transfusions.

A mislabeled specimen will be defined as any specimen that does not meet the requirements of the institution’s labeling policy.

For the most recent calendar or fiscal year, the number of RBC units transfused, the total number of specimens submitted for ABO typing, and the number of ABO results that were discrepant from the historical results will also be recorded.

Performance Indicators
• Primary:
  o Percent of mislabeled ABO specimens
• Secondary:
  o Percent of ABO typing result discrepancies
  o Percent of correct historical ABO types
  o Percent of mislabeled ABO specimens that are rejected

This is a one-time study conducted in the first quarter.
In spite of well-known concerns and costs associated with inappropriate laboratory testing, implementation of effective solutions is challenging. Educational interventions tend to be transient while use of automated testing algorithms, menu restrictions, feedback or other strategies that may effectively diminish inappropriate laboratory testing are not in widespread use. Collecting information about testing patterns is vital for evaluating inappropriate utilization and developing policies and procedures to improve testing practices.

Objectives
Assess laboratory testing utilization by evaluating results from previous tests that indicate additional testing may be unnecessary.

Data Collection
Participants will retrospectively collect data from the most recent 30 to 40 patients with completed orders for free PSA, factor V Leiden and positive anti-HAV testing. Current testing date and previous testing date and results (as applicable) will be recorded. Participants will also complete a questionnaire about their test utilization practices, policies, and procedures.

Performance Indicators
- Percent of inappropriate tests performed
- Percent of free PSA tests performed when recently tested total PSA is outside of the range for accurately interpreting free PSA results
- Percent of anti-HAV tests performed when previous test results were positive
- Percent of factor V Leiden mutation tests performed when the patient had already been tested

This is a one-time study conducted in the second quarter.
**Physician Satisfaction with Anatomic Pathology Services**  
**QP153**

Although patients are the principle end-users of anatomic pathology services, clinicians enjoy a preferred customer status and their opinions are an essential component in developing a customer-oriented pathology department. Surveying clinicians will provide valuable information for anatomic pathology quality improvement activities.

**Objectives**
Assess clinician satisfaction with anatomic pathology services and correlate it with the laboratory workload, performance improvement activities, and customer support services.

**Data Collection**
Clinicians will be asked to complete a standardized questionnaire regarding their perception of anatomic pathology services. Questions on services will include timeliness of reporting, diagnostic accuracy, communication, educational activities, accessibility, responsiveness to problems, and courtesy of staff. Clinical questionnaires will be available by two modes of access: electronic distribution with direct return to the CAP, or by use of hard copy response forms. Data from the first 50 returned questionnaires will be submitted for analysis.

**Performance Indicators**
- **Primary:**
  - Overall mean satisfaction score
- **Secondary:**
  - Mean satisfaction score for anatomic pathology service categories

---

This is a one-time study conducted in the third quarter.
Identification errors in the laboratory have the potential to cause serious patient adverse events. These errors may involve misidentification of a patient or of a specimen. The laboratory’s ability to recognize these errors before results are released contributes to a culture of patient safety and minimizes the adverse consequences of identification errors.

Objectives
Examine how well your laboratory prevents identification errors by detecting them before results are released to caregivers. Participants will receive their overall identification error rate and their rates of error detection before and after results are released to primary caregivers. These rates will be compared to the error rates from all participating institutions. This study will also seek to identify institutional processes and factors more likely to be found in laboratories that detect a high proportion of identification errors before results are released.

Data Collection
Over five weeks, participants will collect data on all patient and specimen identification errors detected by their laboratory before results were released, and also on identification errors that come to their attention after results were released. Participants will record whether they know of any patient harm that resulted from any of the identification errors. In addition, laboratories will have the option of tracking the reason for the identification errors.

This study includes all types of testing, both clinical and anatomic pathology, and tests from all patient locations (eg, inpatient, outpatient, outreach).

Performance Indicators
• Primary:
  ○ Overall identification error rate
  ○ Rate of identification errors detected before release of results
  ○ Rate of identification errors detected after release of results

• Secondary:
  ○ Breakdown of identification error detection time (before or after release of results)
  ○ Breakdown of reasons for identification error

This is a one-time study conducted in the fourth quarter.
Q-TRACKS
A Program for Continuous Quality Monitoring

Identify and monitor opportunities for quality improvement over time
Use established Q-TRACKS programs to identify opportunities to quantitate your quality improvement measures.

Evaluate quality improvements
Measure the effectiveness and impact of implemented changes in key processes. The individual reports include performance of quality indicators over time, benchmarking information, trends, and suggested areas for improvement.

Step 1:
Establish realistic benchmarks by comparing your laboratory to others like yours.

Step 2:
Identify improvement opportunities.

Step 3:
Monitor improvement over time to ensure accurate results, patient safety, and quality patient care.
Participants in the Q-TRACKS program receive:

- Users guide
- Templates and instructions for data collection
- Quarterly reports that include: fingerprint clusters, customer-defined groups, and all institution comparisons
- Peer directory
- Annual summary report

Q-TRACKS activities meet the American Board of Pathology MOC Part IV Practice Performance Assessment requirements.

Quality Management Resources from CAP Experts

Laboratory Administration for Pathologists
Elizabeth A. Wagar, MD, FCAP
Richard E. Horowitz, MD, FCAP, and
Gene P. Siegal, MD, PhD, FCAP, editors
Item number: PUB312
Hardcover; 300 pages; 100+ figures, tables, and photographs; 2011

Quality Management in Anatomic Pathology: Promoting Patient Safety through Systems Improvement and Error Reduction
Raouf E. Nakhleh, MD, FCAP, and
Patrick L. Fitzgibbons, MD, FCAP, editors
Item number: PUB118
Softcover; 198 pages; 70+ exhibits and tables; 2005

Quality Management in Clinical Laboratories: Promoting Patient Safety through Risk Reduction and Continuous Improvement
Paul Valenstein, MD, FCAP, editor
Item number: PUB214
Softcover; 265 pages; 80+ exhibits and tables; 2005

To order
Visit cap.org and choose the Shop tab or call the CAP Customer Contact Center at 800-323-4040 or 847-832-7000 option 1.
Q-TRACKS Clinical Pathology Monitors

Patient Identification Accuracy  QT1

In order to report accurate laboratory results and meet The Joint Commission National Patient Safety Goal #1: “Identify patients correctly,” institutions must properly identify patients. Since most laboratories perform testing away from the patient, patient identification, and labeling of specimens and coordination with test requisitions must be performed accurately and completely. By continuously monitoring for wristband errors, participants can promptly identify and correct problems that may interfere with patient care services.

Objectives
Assess the incidence of wristband errors within individual institutions, compare performance between participating institutions, and identify improvement opportunities.

Data Collection
On six predetermined days per month, participants will monitor patient wristband identification for all phlebotomies performed at their institution. Phlebotomists will tally the total number of wristbands checked, the number of errors found, and the types of wristband error. This monitor includes all routinely wristbanded patients. Include emergency department patients only if the emergency department routinely applies wristbands to these patients.

Performance Indicator
• Wristband error rate (%)

Performance Breakdown
• Breakdown of wristband error types (%)

Blood Culture Contamination  QT2

Despite advances in blood culture practices and technology, false-positive blood culture results due to contaminants continue to be a critical problem. Blood culture contamination rate, the primary indicator of preanalytic performance in microbiology, is associated with increased length of hospital stay, additional expense, and the administration of unnecessary antibiotics. The CAP and other accrediting organizations require you to monitor and evaluate key indicators of quality for improvement opportunities. Use this monitor to help meet this requirement.

Objective
Determine the rate of blood culture contamination using standardized criteria for classifying contaminants.

Data Collection
On a monthly basis, participants will tabulate the total number of blood cultures processed and the total number of contaminated blood cultures. Blood cultures from neonatal patients are tabulated separately. For the purposes of this study, participants will consider a blood culture to be contaminated if they find one or more of the following organisms in only one of a series of blood culture specimens: Coagulase-negative Staphylococcus; Micrococcus; Alpha-hemolytic viridans group streptococci; Propionibacterium acnes; Corynebacterium sp. (diptheroids); or Bacillus sp. Participants have the option to monitor institution-specific subgroups, for example, a specific department or patient population.

Performance Indicators
• Neonatal contamination rate (%)
• Other contamination rate (%)
• Overall contamination rate (%)

Look for your input forms approximately three weeks prior to the quarter.
## Laboratory Specimen Acceptability  QT3

A substantial amount of rework, diagnostic and therapeutic delay, and patient inconvenience can result from specimen rejection. Patient redraws may result from unlabeled, mislabeled, and incompletely labeled specimens; clotted and/or hemolyzed specimens; or insufficient specimen quantity. By continuously monitoring specimen acceptability, collection, and transport, laboratories can promptly identify and correct problems.

**Objective**
Identify and characterize unacceptable blood specimens that are submitted to the chemistry and hematology/coagulation sections of the clinical laboratory for testing.

**Data Collection**
This monitor includes all blood specimens submitted for testing to the chemistry and hematology departments of the clinical laboratory. On a weekly basis, participants will record the total number of specimens received, the number of rejected specimens, and the primary reason each specimen was rejected.

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Performance Breakdown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specimen rejection rate (%)</td>
<td>Breakdown of reasons for rejection (%)</td>
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## In-Date Blood Product Wastage  QT4

Blood for transfusion is a precious resource. At a minimum, wastage of blood that is not out-of-date represents a financial loss to the health care system. More ominously, systemic wastage of blood may reflect an environment of care that is out of control and could pose risks to patient safety.

**Objective**
Compare the rates of blood product wastage (ie, units discarded in-date) in participating hospitals and track rates of improvement over time.

**Data Collection**
On a monthly basis, participants will use blood bank records to obtain information on the total number of units transfused for each type of blood component. Participants will track the number and type of blood units that are wasted in-date and the circumstances of wastage. This monitor includes the following types of blood components: red blood cells (allogeneic), frozen plasma, platelet concentrates, single donor platelets, and cryoprecipitate.

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<thead>
<tr>
<th>Performance Indicators</th>
<th>Performance Breakdown</th>
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</thead>
<tbody>
<tr>
<td>Overall blood wastage rate (%)</td>
<td>Breakdown of circumstances of wastage (%)</td>
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<td>Wastage rates by blood component type (%)</td>
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</tbody>
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Look for your input forms approximately three weeks prior to the quarter.
## Satisfaction With Outpatient Specimen Collection  QT7

Specimen collection is one of the few areas of laboratory medicine that involves direct outpatient contact. As a result, patient satisfaction with this service is a vital indicator of quality laboratory performance. The CAP’s Laboratory Accreditation Program requires measurement of patient satisfaction with laboratory services (GEN.20335). Use this monitor to help meet this requirement.

### Objective
Assess patient satisfaction with outpatient phlebotomy services by measuring patients’ assessment of waiting time, discomfort level, courteous treatment, and overall satisfaction.

### Data Collection
On a monthly basis, participants will provide copies of a standardized questionnaire to a minimum of 25 outpatients (maximum of 99 outpatients) using predetermined data collection criteria. This monitor includes any outpatient undergoing venipuncture. This monitor excludes patients seen in the emergency department, ambulatory surgery area, urgent care facility, chest pain center, 23-hour short-stay facility, employee health department, outpatient health screening fair/promotion, dialysis center, nursing home, or extended care facility.

### Performance Indicators
- Overall patient satisfaction score
- Patients “more than satisfied” (%)

---

## Stat Test Turnaround Time Outliers  QT8

The stat test turnaround time (TAT) outlier rate, expressed as a percentage of tests missing target reporting times, is a measure of outcomes that evaluates how well the laboratory meets patient and clinician needs. This monitor helps meet CAP Checklist requirement GEN.20316, “The QM program includes monitoring key indicators of quality in the preanalytic, analytic, and postanalytic phases.”

### Objective
Monitor the frequency that stat test TAT intervals exceed institutional stat test TAT expectations.

### Data Collection
Before beginning data collection, participants will establish a specimen receipt-to-report deadline for emergency department (ED) stat potassium tests. On six predetermined days per month, participants will monitor the TAT of up to 10 randomly selected ED stat potassium tests on each of three, eight-hour shifts (up to 180 tests per month) and track the number of ED stat potassium results reported later than the established reporting deadline. This monitor includes stat potassium tests ordered as part of a panel and excludes stat potassium levels that are requested on body fluids other than blood, as part of timed or protocol studies, or after the specimen arrives in the laboratory.

### Performance Indicator
- Stat test TAT outlier rate (%)

### Performance Breakdowns
- Breakdown of outliers by shift (%)
- Breakdown of outliers by day of week (%)

---

Look for your input forms approximately three weeks prior to the quarter.
## Critical Values Reporting  QT10

Laboratories commonly refer to critical values as results requiring immediate notification to the physician or caregiver for necessary patient evaluation or treatment. Regulations from agencies and accreditors such as the CMS, The Joint Commission, and the CAP (GEN.20316, COM.30000) mandate that laboratories develop and implement an alert system for critical values. Use this monitor to document compliance with your laboratory’s alert plan.

### Objective
Evaluate the documentation of successful critical values reporting in the general laboratory for inpatients (including discharged inpatients) and outpatients.

### Data Collection
On a monthly basis, participants will evaluate 120 inpatient, 20 discharged inpatient, and 120 outpatient critical values. Data collection will include general chemistry, hematology, and coagulation analytes on the critical values list. Retrospectively, participants will record the total number of critical values monitored and the number with documentation of successful notification. In addition, participants will provide the number of critical values that were not communicated within three hours, the number of failed notifications due to laboratory oversight, and the number of successful notifications to licensed caregivers. This monitor will exclude critical values for cardiac markers, drugs of abuse, therapeutic drug levels, urinalysis, blood gases, point-of-care tests, and tests performed at reference laboratories.

### Performance Indicators
- Total critical values reporting rate (%)
- Inpatient critical values reporting rate (%)
- Discharged inpatient critical values reporting rate (%)
- Outpatient critical values reporting rate (%)
- Failed notification (<3 hours) rate (%)

---

Look for your input forms approximately three weeks prior to the quarter.
Turnaround Time of Troponin  QT15

The swiftness with which physicians establish diagnoses of acute myocardial infarction (AMI) in patients presenting to the emergency department (ED) with chest pain may determine the type and predict the outcome of therapy those patients will receive. Included in the total time consumed in establishing diagnoses of AMI are the component intervals required to measure biochemical markers of myocardial injury. One of the most critical biochemical markers is troponin. Use this monitor to help meet CAP Checklist requirement GEN.20316 QM Indicators of Quality.

**Objective**
Determine the median order-to-report turnaround time (TAT) of troponin (I or T) ordered to rule out myocardial infarction and the percent of troponin results reported by each institution’s established deadline.

**Data Collection**
On six predetermined days per month, participants will record TATs (in minutes) for three randomly selected troponin specimens obtained from ED patients on each of three traditional shifts, a total of nine measurements. Participants will measure TATs from the time of test order to the time results are available to ED personnel.

**Performance Indicators**
- Median troponin order-to-report TAT (minutes)
- Troponin TAT compliance rate (%)

Corrected Results  QT16

The CAP developed this Q-TRACKS monitor in recognition of the importance of timely detection and correction of erroneous laboratory results. Accuracy in laboratory results is critical to the effectiveness of a physician’s plan of care for a patient. An erroneous result can delay or alter patient treatment; therefore, detection of erroneous results should be a priority in every laboratory and should be monitored as a key quality indicator. Help measure your compliance with CLIA 493.1299, Postanalytic Systems Quality Assessment, with this monitor.

**Objective**
Monitor the number of corrected test results within individual institutions and compare performance with that of all institutions and those institutions similar to yours.

**Data Collection**
On a monthly basis, participants will monitor the number of corrected test results and the total number of billable tests for that month. Include test results for all patients in all care settings with the following exclusions: anatomic pathology tests, narrative physician-interpreted tests (eg, bone marrow biopsies and peripheral smear reports), and point-of-care tests.

**Performance Indicator**
- Test result correction rate (per 10,000 billable tests)

Look for your input forms approximately three weeks prior to the quarter.
### Outpatient Order Entry Errors  QT17

Order accuracy bears an obvious relationship to the quality of laboratory testing. When the laboratory fails to complete a requested test, it delays the diagnostic evaluation, potentially extending a patient’s hospital stay and prolonging therapy. When the laboratory completes a test that was not requested, the cost of care increases, patients may be subjected to unnecessary phlebotomy, and laboratory efficiency declines.

**Objective**
Measure the incidence of incorrectly interpreted and entered outpatient physician test orders into the laboratory information system, compare performance across institutions, and track performance over time.

**Data Collection**
On six preselected weekdays per month, participants will compare eight outpatient requisitions or order sheets to the orders entered into the laboratory’s information system to determine if any order entry errors occurred. Order entry error categories include requesting physician errors; incorrect, missing, and extra test errors; test priority errors; and copy or fax result errors. This monitor excludes tests performed in transfusion medicine or anatomic pathology. This monitor also excludes tests from the following patient care settings: inpatient, emergency department, ambulatory surgery, urgent care, chest pain center, 23-hour short-stay facility, employee health department, outpatient screening fair/promotion, and dialysis center.

**Performance Indicators**
- Overall outpatient order entry error rate (%)
- Order entry error rates by type (%)

**Performance Breakdown**
- Breakdown of error types (%)

---

Look for your input forms approximately three weeks prior to the quarter.
Gynecologic Cytology Outcomes: Biopsy Correlation Performance  QT5

The correlation of cervicovaginal cytology (Pap test) findings with cervical biopsy results is a significant part of the cytopathology laboratory’s quality assurance program. By monitoring this correlation, the laboratory can identify and address potential problems requiring improvement, thereby ensuring better patient results.

Objective
Quantify the correlation between the findings of cervicovaginal cytology and corresponding histologic material.

Data Collection
On a monthly basis, participants will record the number of true-positive, false-positive, and false-negative cytology-biopsy correlations. The false-negative correlations will be classified into four error categories: screening errors, interpretive errors, screening and interpretive errors, and adequacy determination errors. Participants will also record the biopsy diagnoses for Pap tests with an interpretation of atypical squamous cells (ASC-US and ASC-H) or atypical glandular cells (AGC). This monitor includes cervical biopsy specimens submitted to the laboratory that have a corresponding satisfactory or satisfactory but limited Pap test within three months of the biopsy.

Performance Indicators
- Predictive value of positive cytology (%)
- Sensitivity (%)
- Screening/interpretation sensitivity (%)
- Sampling sensitivity (%)
- Percent positive for ASC-US interpretations
- Percent positive for ASC-H interpretations
- Percent positive for AGC interpretations

Look for your input forms approximately three weeks prior to the quarter.
Mislabeled Cases, Specimens, Blocks, and Slides in Surgical Pathology  QT19

Mislabeling of surgical pathology specimens has potential catastrophic consequences for patient care. By continuously monitoring the rate of mislabeled specimens, participants will be able to identify problems and variables associated with mislabeled specimens, blocks, and slides. This Q-TRACKS monitor will also help participating laboratories fulfill The Joint Commission National Patient Safety Goal #1: “Identify patients correctly” in the discipline of surgical pathology.

Objectives
Determine the rates of mislabeled cases, specimens, blocks, and slides and the rate at which mislabeling errors led to a corrected report and compare performance to other institutions.

Data Collection
Prospectively track each time a specimen container, block or slide is relabeled or renumbered due to an identification error; and if, as a result, a corrected report is issued. Participants will also report the number of cases processed each month and the number of blocks and slides (including special stains) that are processed during the same time period. Data will be collected monthly.

This Q-TRACKS monitor is limited to routine histology processing.

Performance Indicators
• Rate of mislabeled events (mislabeled cases, specimens, blocks, and slides) per case
• Percent of errors that resulted in a corrected report
• Rate of mislabeled cases
• Rate of mislabeled specimens
• Rate of mislabeled blocks
• Rate of mislabeled slides

Look for your input forms approximately three weeks prior to the quarter.
Q-MONITORS

A Program for a Customized Comprehensive Assessment

Evaluate quality improvements in your laboratory

With today’s focus on reducing medical errors, achieving and maintaining excellence is key to success. Using continuous monitoring, Q-MONITORS provide a comprehensive assessment of key processes in your institution.

Structure your data collection and analysis for success

Use Q-MONITORS to help build and improve data collection and analyze processes that contribute to quality of care, patient safety, and outcomes. Observe performance trends over time to identify and monitor opportunities for quality improvement through quantitative quality measures.

Establish realistic laboratory benchmarks and performance goals

Q-MONITORS are customized programs that address process-, outcome-, and structure-oriented quality assurance issues. Establish benchmarks through external database comparisons and compare your performance to establish goals for performance improvement.
Monitoring of Troponin Metrics for Suspected MI  QM1

Patients presenting to the emergency department (ED) with chest pain must be evaluated quickly. Rapid serum troponin measurement is an important part of ED practice that can provide decisive information for patient management. Reducing delays in troponin testing has been reported to result in shorter length of stay in the ED and more rapid initiation of anti-ischemic treatment. Emergency departments and chest pain centers should, therefore, have effective procedures for ensuring optimal turnaround time (TAT) for troponin and a process for ongoing monitoring to ensure that performance meets expectations.

Objective
Determine and monitor troponin TATs for patient arrival to result availability and/or up to six time intervals within the total testing process for patients presenting to the ED with chest pain.

Data Collection
Six days per month, collect data from nine patients presenting to the ED with chest pain and tested for troponin level. Data includes time of patient arrival, troponin test order, specimen collection, laboratory receipt, and result availability. It is not necessary to provide data from each TAT component. Participants select which TAT metrics to monitor, with the option to monitor all metrics.

Participants will also complete a questionnaire about clinical and laboratory practices related to troponin testing.

Metrics
Depending on the data submitted, the following metrics will be provided. In addition, TAT benchmarking, as compared to all institutions, will be provided for both point-of-care and clinical laboratory testing for patient arrival to result availability and specimen collection to result availability.

- Patient arrival to result availability
- Specimen collection to result availability
- Test order to result availability
- Patient arrival to test order
- Test order to specimen collection
- Specimen collection to laboratory receipt
- Laboratory receipt to result availability

Performance indicators
- Median TAT for troponin testing intervals (monthly)
- Test order to result availability compliance rate (if applicable)
- Specimen collection to result availability compliance rate (if applicable)

Look for your input forms approximately three weeks prior to the quarter.
## Quality Management Tools Pricing Overview

### 2015 Q-PROBES

<table>
<thead>
<tr>
<th>Modules/Packages</th>
<th>Program Codes</th>
<th>Price</th>
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<tbody>
<tr>
<td>Individual QP Studies</td>
<td>QP151, QP152, QP153, QP154</td>
<td>$420 each</td>
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<tr>
<td>All Four QP Studies</td>
<td>PRO</td>
<td>$1,516</td>
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### 2015 Q-TRACKS

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<tr>
<td>Individual Clinical Pathology (CP) Monitors</td>
<td>QT1, QT2, QT3, QT4, QT7, QT8, QT10, QT15, QT16, QT17</td>
<td>$940 each</td>
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<tr>
<td>Individual Anatomic Pathology (AP) Monitors</td>
<td>QT5, QT19</td>
<td>$940 each</td>
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<td>Combined CP/AP Module – Includes all 12 QT Monitors</td>
<td>QTP</td>
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<tr>
<td>Clinical Pathology Module – Includes all 10 CP Monitors</td>
<td>QTC</td>
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### 2015 Q-MONITORS

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<tr>
<th>Module</th>
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</thead>
<tbody>
<tr>
<td>Individual QM Study</td>
<td>QM1</td>
<td>$780</td>
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</table>
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