Hello,
We would like to thank you for your participation in this survey. Its purpose is to collect information regarding the implementation of the Partnership for Patients (PfP) initiative and, if any, your relationship and work with the Hospital Engagement Networks (HENs) and/or Hospital Improvement Innovation Networks (HIINs). We also ask about the patient safety outcomes your hospital has achieved as a result of your interactions with the PfP (whether or not your hospital was aligned with a HEN/HIIN). Your input will be invaluable for us to complete an unbiased and robust evaluation of the PfP.

With the approval of the Centers for Medicare & Medicaid Services (CMS), we will provide you with the general results of this survey. This information could be of help to you and your hospital by providing critical information regarding processes, behaviors, and cultural changes that affect and improve patient safety practices in hospitals nationwide.

We estimate that it will take approximately 30 minutes to complete the six sections of this survey. These sections include: 1. General background information about you and your role in the hospital. 2. General background information about your hospital. 3. Hospital processes, procedures, and outcomes. 4. Hospital culture. 5. Hospital engagement with the PfP. 6. Opinions about the PfP. Please answer each question to the best of your knowledge or ability. Please feel free to recruit the help of others in your hospital if you need further information to respond to some of the questions. Lastly, note that your identity and that of the hospital will remain confidential. We will only provide the aggregate findings obtained from the analysis of all survey responses we receive to CMS. Likewise, we will only publish overall aggregated findings, where no individual hospital will be identified.

To begin the survey, please select CONTINUE
❍ CONTINUE (1)

Tell Us About Yourself
This section asks about your current role in the hospital.

1. From the list below, please select all that apply to your current role in the hospital.
- ❑ Care service provider (1)
- ❑ Care coordinator (2)
- ❑ Unit supervisor (3)
- ❑ Hospital administrator (e.g., billing, accounting, medical records) (4)
- ❑ IT (5)
- ❑ Patient and caregiver advocate (6)
- ❑ Executive (e.g., CEO, CFO) (7)
- ❑ Compliance officer (8)
- ❑ Director of nursing (9)
- ❑ Hospital inpatient quality reporting (10)
- ❑ Infection control (11)
- ❑ Medical director (12)
- ❑ Medical records (13)
- ❑ Patient safety (14)
- ❑ Quality improvement (15)
- ❑ Risk management (16)
- ❑ Safety officer (17)
- ❑ Other (18) _____

2. How long have you served in your current role?
- ❍ Less than 1 year (1)
- ❍ 1–2 years (2)
- ❍ 2–5 years (3)
- ❍ 6–10 years (4)
- ❍ 11–15 years (5)
- ❍ 16–20 years (6)
- ❍ More than 20 years (7)

3. How long have you worked for this hospital?
- ❍ Less than 1 year (1)
- ❍ 1–2 years (2)
- ❍ 2–5 years (3)
- ❍ 6–10 years (4)
- ❍ 11–15 years (5)
- ❍ 16–20 years (6)
- ❍ More than 20 years (7)

General Information About Your Hospital

This section asks questions about your hospital's participation in different programs aimed at improving patient safety and reducing readmission rates.

Below is a list of terms and definitions we are using in this section of the survey.

Acronym or Topic	Definition
HEN	Hospital Engagement Network
HIIN	Hospital Improvement Innovation Network
PfP	Partnership for Patients
HAC	Hospital-acquired condition
ADE	Adverse drug event
CAUTI	Catheter-associated urinary tract infection
CLABSI	Central line-associated bloodstream infection
VTE	Venous thromboembolism
Adverse Event	Any type of error, mistake, incident, accident, or deviation, regardless of whether it results in patient harm.
Patient Safety	The avoidance and prevention of patient injuries or adverse events resulting from the processes of healthcare delivery.

4. Was your hospital aligned with a HEN for PfP 1.0 (December 2011/April 2012–December 2014)?

- ❍ Yes, the entire period (1)
- ❍ Yes, but not for the entire period (2)
- ❍ No (3)

5. Was your hospital aligned with a HEN for PfP 2.0 (September 2015–September 2016)?

- ❍ Yes, the entire period (1)
- ❍ Yes, but not for the entire period (2)
- ❍ No (3)

6. Is your hospital currently aligned with a HIIN?

- ❍ Yes (1)
- ❍ No (2)

7. Below is a list of programs, agencies, and sources of information that hospitals have used to improve patient safety and prevent readmissions between September 2015 and September 2016 (the period of PfP 2.0). From this list, please select all items that applied to your hospital.

- ❑ HENs or the PfP (1)
- ❑ Reporting to the National Healthcare Safety Network (NHSN) (2)
- ❑ Accountable Care Organizations (ACOs) (3)
- ❑ Payment policies – Medicare (4)
- ❑ Payment policies – Medicaid (5)
- ❑ Payment policies – private-sector insurance (6)
- ❑ Joint Commission (7)
- ❑ Quality Improvement Organizations' (QIOs) work (8)
- ❑ Institute for Healthcare Improvement (IHI) (9)
- ❑ Community-based Care Transitions Program (CCTP) (10)
- ❑ State hospital association-sponsored effort (11)
- ❑ Agency for Healthcare Research and Quality's (AHRQ) Comprehensive Unit-based Safety Program (CUSP) (12)
- ❑ Bundled Payments for Care Improvement (BPCI) (13)
- ❑ Meaningful use of electronic health records (EHRs) (14)
- ❑ Other reporting requirement (please list) (15) _____
- ❑ Other national, regional, state, or local initiative (please list) (16) _____
- ❑ Hospital system-level initiative (please list) (17) _____
- ❑ Other (please list) (18) _____

Please assign a ranking to each of the programs, agencies, and sources of information you identified above regarding their level of helpfulness to your hospital's efforts in improving the incidence of the following targeted HACs and readmissions. Use values from 1 to 5 for this ranking, with 5 being the most helpful and 1 being not helpful at all. You can use the same ranking for two or more items if you deem them being equally useful regarding a particular HAC or readmissions.

	ADEs (1)	CAUTI (2)	CLABSI (3)	Pressure Ulcers (4)	VTE (5)
HENs or PfP (1)					
Reporting to the NHSN (2)					
ACOs (3)					
Payment policies - Medicare (4)					
Payment policies - Medicaid (5)					
Payment policies – private-sector insurance (6)					
Joint Commission (7)					
QIOs work (8)					
IHI (9)					
CCTP (10)					
State hospital association-sponsored effort (11)					
AHRQ CUSP (12)					
BPCI (13)					
Meaningful use of EHR (14)					
Other reporting requirement					

(15) Other national, regional, state, or local initiative (16) Hospital system-level initiative (17)					

Your Hospital's Processes and Procedures

This section asks questions about your hospital's processes and procedures related to patient safety. Below is a list of terms and definitions we are using in this survey.

Acronym or Topic	Definition
PfP	Partnership for Patients
Adverse Event	Any type of error, mistake, incident, accident, or deviation, regardless of whether it results in patient harm.
Patient Safety	The avoidance and prevention of patient injuries or adverse events resulting from the processes of healthcare delivery.
Process	Any actions taken during the course of care to improve patient safety during the hospital stay and care transitions.
Organization of Patient Care	Any changes to the number and type of staff, staff roles, and staff coordination to improve patient safety during the hospital stay and care transitions.

9. In the following table, we provide a list of activities that hospitals have established to enhance the process of patient care with the purpose of improving patient safety. For each activity: a) Please indicate whether your hospital is currently implementing this activity, has previously implemented this activity (during the timeframes provided), or whether this is not applicable to your hospital. Please note that multiple timeframes can be selected. b) If there are activities not included in this list that your hospital is currently implementing or has implemented in the past to enhance patient safety, please add them to the blank spaces below the list.

	Currently Implementing (1)	Implemented Prior to August 2015 (2)	Implemented Between September 2015 & September 2016 (3)	Implemented After September 2016 (4)	Not Applicable (5)
1.Using behavioral/procedural checklists (1)	❑	❑	❑	❑	❑
2. Standardizing communication strategies among providers (e.g., Situation-Background-Assessment-Recommendation) (2)	❑	❑	❑	❑	❑
3. Standardizing patient handoff communication protocols (3)	❑	❑	❑	❑	❑
4. Establishing chain of responsibility (or command) among providers and administrators (4)	❑	❑	❑	❑	❑
5. Performing unit/hospital walk rounds (5)	❑	❑	❑	❑	❑
6. Using a situation evaluation and monitoring system (6)	❑	❑	❑	❑	❑
7. Formalizing a staff-wide reporting system (7)	❑	❑	❑	❑	❑
8. Establishing patient safety goals at each level of the hospital organization	❑	❑	❑	❑	❑

(8) 9. Delegating patient safety oversight to junior staff (9)	❑	❑	❑	❑	❑
10. Establishing regular focus groups, training, and capacity-building events regarding patient safety practices for all levels of hospital staff (10)	❑	❑	❑	❑	❑
11. Recording measures of patient harm not previously tracked (11)	❑	❑	❑	❑	❑
12. Changing the definition or the manner in which a harm is measured or recorded (12)	❑	❑	❑	❑	❑
13. Other Item 1 (please list) (13)	❑	❑	❑	❑	❑
14. Other Item 2 (please list) (14)	❑	❑	❑	❑	❑
15. Other Item 3 (please list) (15)	❑	❑	❑	❑	❑
16. Other Item 4 (please list) (16)	❑	❑	❑	❑	❑

10. In the following table, we provide a list of activities related to the organization of patient care that hospitals have done to enhance patient safety and patient safety culture at the hospital level. For each activity:
a) Please indicate whether your hospital is currently implementing this activity, has previously implemented this activity (during the timeframes provided), or whether this is not applicable to your hospital. Please note that multiple timeframes can be selected.
b) If there are activities not included in this list that your hospital is currently implementing or has implemented in the past to enhance patient safety, please add them to the blank spaces below the list.

	Currently Implementing (1)	Implemented Prior to August 2015 (2)	Implemented Between September 2015 & September 2016 (3)	Implemented After September 2016 (4)	Not Applicable (5)
1. Hiring care coordinators (e.g., social workers, nurses with coordinating role) to address patient safety (1)	❑	❑	❑	❑	❑
2. Assigning new coordinator roles to existing staff (e.g., nurse, pharmacist) to address patient safety (2)	❑	❑	❑	❑	❑
3. Hiring additional nurses for care provision to increase the nurse-to-physician ratio (3)	❑	❑	❑	❑	❑
4. Hiring physicians, physician assistants, pharmacists,	❑	❑	❑	❑	❑

and other non-nursing staff to address gaps in patient safety (4)					
5. Adjusting provider work shifts to ensure service coverage (5)	❑	❑	❑	❑	❑
6. Creating systems of care coordination among different providers (e.g., nurses, physicians – the patient care team) within a unit (6)	❑	❑	❑	❑	❑
7. Creating systems of provider coordination between different care units (7)	❑	❑	❑	❑	❑
8. Creating systems of care coordination between hospital administration and the patient care team (8)	❑	❑	❑	❑	❑
9. Creating systems of care that include patient, family, and caregiver	❑	❑	❑	❑	❑

input (9)					
10. Creating forums in which all hospital staff levels can discuss and design strategies to improve patient safety (10)	❑	❑	❑	❑	❑
11. Other Item 1 (please list) (11)	❑	❑	❑	❑	❑
12. Other Item 2 (please list) (12)	❑	❑	❑	❑	❑
13. Other Item 3 (please list) (13)	❑	❑	❑	❑	❑
14. Other Item 4 (please list) (14)	❑	❑	❑	❑	❑

11. In the following table, we provide a list of focus areas for hospital patient safety initiatives. Hospitals have chosen to focus on and implement policies and processes to enhance all of these areas, some of them, or none of them. For each initiative area:
a) Please indicate whether your hospital is currently focusing on this area, has previously focused on this area (during the timeframes provided), or whether this is not applicable to your hospital. Please note that multiple timeframes can be selected.
b) If there are initiative areas not included in this list that your hospital is currently focusing on or has focused on in the past to enhance patient safety, please add them to the blank spaces below the list.

	Currently Focusing on (1)	Focused on Prior to August 2015 (2)	Focused on Between September 2015 & September 2016 (3)	Focused on After September 2016 (4)	Not Applicable (5)
1. ADE (1)	❑	❑	❑	❑	❑
2. CAUTI (2)	❑	❑	❑	❑	❑
3. CLABSI (3)	❑	❑	❑	❑	❑
4. Injuries from falls and immobility (4)	❑	❑	❑	❑	❑
5. Clostridium difficile (C. difficile) (5)	❑	❑	❑	❑	❑
6. Sepsis (6)	❑	❑	❑	❑	❑
7. Pressure ulcers (7)	❑	❑	❑	❑	❑
8. Surgical site infections (SSIs) (8)	❑	❑	❑	❑	❑
9. VTE (9)	❑	❑	❑	❑	❑
10. VAE (10)	❑	❑	❑	❑	❑
11. All-cause harm (11)	❑	❑	❑	❑	❑
12. Readmissions (12)	❑	❑	❑	❑	❑
13. Disparities (13)	❑	❑	❑	❑	❑
14. Hospital-acquired pressure ulcers (HAPUs) (14)	❑	❑	❑	❑	❑
15. Obstetrical	❑	❑	❑	❑	❑

adverse events (such as postpartum hemorrhage or preeclampsia) (15)					
16. Early elective delivery (EED) (16)	❑	❑	❑	❑	❑
17. Airway safety (17)	❑	❑	❑	❑	❑
18. Procedural harm (18)	❑	❑	❑	❑	❑
19. Iatrogenic delerium (19)	❑	❑	❑	❑	❑
20. Failure to rescue (20)	❑	❑	❑	❑	❑
21. Costs savings (21)	❑	❑	❑	❑	❑
22. Culture of safety (22)	❑	❑	❑	❑	❑
23. Antibiotic stewardship (23)	❑	❑	❑	❑	❑
24. Malnutrition (24)	❑	❑	❑	❑	❑
25. Diagnostic errors (25)	❑	❑	❑	❑	❑
26. Overexposure to radiation (26)	❑	❑	❑	❑	❑
27. Methicillin-resistant Staphylococcus aureus (MRSA) (27)	❑	❑	❑	❑	❑
28. Other item (please list) (28)	❑	❑	❑	❑	❑

Q26 12. What tools and resources is your hospital lacking that would be helpful in pursuing reductions in adverse events and readmissions? (Please list up to three)

- ❑ 1. (1) _____
- ❑ 2. (2) _____
- ❑ 3. (3) _____

Your Hospital's Level of Engagement With the HENs/HIINs and the PfP

This section asks questions about experiences with working with the HEN (September 2016 and earlier)/HIIN (after September 2016) as either part of the PfP or as a non HEN/HIIN-aligned hospital. Below is a list of terms and definitions we are using in this section of the survey

Acronym or Topic	Definition
HEN	Hospital Engagement Network
HIN	Hospital Improvement Innovation Network
PfP	Partnership for Patients
Adverse event	Any type of error, mistake, incident, accident, or deviation, regardless of whether it results in patient harm.
Patient Safety	The avoidance and prevention of patient injuries or adverse events resulting from the processes of healthcare delivery.

13.. This set of questions refers to a potential list of HEN/HIIN activities in which your hospital may have participated. Please indicate the frequency of this participation, if any.

Regular engagement	Attended all or most of the activities.
Occasional engagement	Attended some of the activities.
Minimal engagement	Attended a few of the activities (sporadic involvement).
One time	Attended this activity once.

a. The following table presents a list of HEN activities associated with the PfP 2.0. Please indicate the frequency with which your hospital engaged in these activities during the period of September 2015 to September 2016. If your hospital engaged in an activity with a HEN that is not on the list, please add it in the blank spaces below.

	Regular Engagement (1)	Occasional Engagement (2)	Minimal Engagement (3)	One TIme (4)	Not Applicable (5)
1. In-person meetings between hospitals and HENs to share progress or lessons learned. (1)	❍	❍	❍	❍	❍
2. Virtual meetings between hospitals and HENs to share progress or lessons learned. (2)	❍	❍	❍	❍	❍
3. Formal information sessions about effective measurement approaches, tools, or processes to improve patient safety. (3)	❍	❍	❍	❍	❍
4. Working with a HEN improvement advisor to plan or implement patient safety processes (general). (4)	❍	❍	❍	❍	❍

5. Working with a HEN improvement advisor to address a patient safety issue specific to your hospital. (5)	❍	❍	❍	❍	❍
6. Receiving advice or lessons learned on a safety process from another hospital. (6)	❍	❍	❍	❍	❍
7. Providing advice or lessons learned on a safety process to another hospital. (7)	❍	❍	❍	❍	❍
8. Receiving feedback from someone at the HEN on processes, measurements, or tools related to patient safety. (8)	❍	❍	❍	❍	❍
9. Receiving training and tools on how to support and build a culture of cooperation focused on patient safety in your hospital. (9)	❍	❍	❍	❍	❍
10. Receiving training and tools on how to engage and enhance involvement of patients,	❍	❍	❍	❍	❍

families, and caregivers in their own care. (10)					
11. Other Item 1 (please list) (11)	❍	❍	❍	❍	❍
12. Other Item 2 (please list) (12)	❍	❍	❍	❍	❍
13. Other Item 3 (please list) (13)	❍	❍	❍	❍	❍
14. Other Item 4 (please list) (14)	❍	❍	❍	❍	❍

b. The following table provides a list of HIIN activities associated with the PfP. Please indicate the frequency with which your hospital engaged with your HIIN since September 2016. If you engaged in an activity with a HIIN not listed, please add it in the blank spaces below.

Regular engagement	Attended all or most of the activities.
Occasional engagement	Attended some of the activities.
Minimal engagement	Attended a few of the activities (sporadic involvement).
One time	Attended this activity once.

	Regular Engagement (1)	Occasional Engagement (2)	Minimal Engagement (3)	One TIme (4)	Not Applicable (5)
1. In-person meetings between hospitals and HIINs to share progress or lessons learned. (1)	❍	❍	❍	❍	❍
2. Virtual meetings between hospitals and HIINs to share progress or lessons learned. (2)	❍	❍	❍	❍	❍
3. Formal information sessions about effective measurement approaches, tools, or processes to improve patient safety. (3)	❍	❍	❍	❍	❍
4. Working with a HIIN improvement advisor to plan or implement patient safety processes (general). (4)	❍	❍	❍	❍	❍
5. Working with a HIIN improvement advisor to	❍	❍	❍	❍	❍

address a patient safety issue specific to your hospital. (5)					
6. Receiving advice or lessons learned on a safety process from another hospital. (6)	❍	❍	❍	❍	❍
7. Providing advice or lessons learned on a safety process to another hospital. (7)	❍	❍	❍	❍	❍
8. Receiving feedback from someone at the HIIN on processes, measurements, or tools related to patient safety. (8)	❍	❍	❍	❍	❍
9. Receiving training and tools on how to support and build a culture of cooperation focused on patient safety in your hospital. (9)	❍	❍	❍	❍	❍
10. Receiving training and tools on how to engage and enhance involvement of patients, families, and caregivers in their own care. (10)	❍	❍	❍	❍	❍

11. Other Item 1 (please list) (11)	❍	❍	❍	❍	❍
12. Other Item 2 (please list) (12)	❍	❍	❍	❍	❍
13. Other Item 3 (please list) (13)	❍	❍	❍	❍	❍
14. Other Item 4 (please list) (14)	❍	❍	❍	❍	❍

14. The following set of questions refers to your hospital level of engagement with HEN/HIIN activities related to particular areas of focus.
a. In each of the following areas, please mark the response that best describes your hospital's level of engagement in patient safety activities sponsored or led by a HEN during PfP 2.0 (from September 2015 to September 2016) that were related to the following areas.

	Fully Engaged (1)	Moderate Engagement (2)	Minimal Engagement (3)	None (4)
1. ADEs (1)	❍	❍	❍	❍
2. CAUTIs (2)	❍	❍	❍	❍
3. CLABSIs (3)	❍	❍	❍	❍
4. C. difficile (4)	❍	❍	❍	❍
5. Sepsis (5)	❍	❍	❍	❍
6. Injuries from falls and immobility (6)	❍	❍	❍	❍
7. Pressure ulcers (7)	❍	❍	❍	❍
8. SSIs (8)	❍	❍	❍	❍
9. VTE (9)	❍	❍	❍	❍
10. VAEs (10)	❍	❍	❍	❍
11. All-cause harm (11)	❍	❍	❍	❍
12. Readmission (12)	❍	❍	❍	❍
13. Disparities (13)	❍	❍	❍	❍
14. HAPUs (14)	❍	❍	❍	❍
15. Obstetrical adverse events (such as postpartum hemorrhage or preeclampsia) (15)	❍	❍	❍	❍
16. EED (16)	❍	❍	❍	❍
17. Airway safety (17)	❍	❍	❍	❍
18. Procedural harm (18)	❍	❍	❍	❍
19. Iatrogenic delirium (19)	❍	❍	❍	❍
20. Failure to rescue (20)	❍	❍	❍	❍

21. Cost savings (21)	❍	❍	❍	❍
22. Culture of safety (22)	❍	❍	❍	❍
23. Antibiotic stewardship (23)	❍	❍	❍	❍
24. Malnutrition (24)	❍	❍	❍	❍
25. Diagnostic errors (25)	❍	❍	❍	❍
26. Overexposure to radiation (26)	❍	❍	❍	❍
27. MRSA (27)	❍	❍	❍	❍
28 Other Item (please list) (28)	❍	❍	❍	❍

b. In each of the following areas, please mark the response that best describes your hospital's level of engagement in patient safety activities sponsored or led by a HIIN (since September 2016) that are related to the following areas.

	Fully Engaged (1)	Moderate Engagement (2)	Minimal Engagement (3)	None (4)
1. ADEs (1)	❍	❍	❍	❍
2. CAUTIs (2)	❍	❍	❍	❍
3. CLABSIs (3)	❍	❍	❍	❍
4. C. difficile (4)	❍	❍	❍	❍
5. Sepsis (5)	❍	❍	❍	❍
6. Injuries from falls and immobility (6)	❍	❍	❍	❍
7. Pressure ulcers (7)	❍	❍	❍	❍
8. SSIs (8)	❍	❍	❍	❍
9. VTE (9)	❍	❍	❍	❍
10. VAEs (10)	❍	❍	❍	❍
11. All-cause harm (11)	❍	❍	❍	❍
12. Readmissions (12)	❍	❍	❍	❍
13. Disparities (13)	❍	❍	❍	❍
14. HAPUs (14)	❍	❍	❍	❍
15. Obstetrical adverse events (such as postpartum hemorrhage or preeclampsia) (15)	❍	❍	❍	❍
16. EED (16)	❍	❍	❍	❍
17. Airway safety (17)	❍	❍	❍	❍
18. Procedural harm (18)	❍	❍	❍	❍
19. Iatrogenic delirium (19)	❍	❍	❍	❍
20. Failure to rescue (20)	❍	❍	❍	❍
21. Costs	❍	❍	❍	❍

savings (21)				
22. Culture of safety (22)	❍	❍	❍	❍
23. Antibiotic stewardship (23)	❍	❍	❍	❍
24. Malnutrition (24)	❍	❍	❍	❍
25. Diagnostic errors (25)	❍	❍	❍	❍
26. Overexposure to radiation (26)	❍	❍	❍	❍
27. MRSA (27)	❍	❍	❍	❍
28. Other Item (please list) (28)	❍	❍	❍	❍

15. For those items for which you selected “minimally engaged” or “not engaged at all,” which of the following best describes the reason(s) why this hospital was not fully engaged in the patient safety work with a HEN or HIIN? Check all that apply.

- ❑ The hospital did not need the support of the HEN or HIIN. (1)
- ❑ The areas are not applicable to this hospital. (2)
- ❑ We preferred to work with another organization outside the hospital. (3)
- ❑ Management placed a low priority on participation. (4)
- ❑ Suboptimal quality of resources or programming by the HEN or HIIN. (5)
- ❑ Inconvenient scheduling of learning events by HEN or HIIN. (6)
- ❑ Other reason (please specify) (7) _____

16. Because of assistance received from the HEN, did your hospital make any changes to care processes aimed at reducing the rate of preventable adverse events in any of the following areas? Check all that apply.

- ❑ ADEs (1)
- ❑ CAUTIs (2)
- ❑ CLABSIs (3)
- ❑ Injuries from falls and immobility (4)
- ❑ C. difficile (5)
- ❑ Sepsis (6)
- ❑ HAPUs (7)
- ❑ SSIs (8)
- ❑ VTE (9)
- ❑ VAEs (10)
- ❑ All-cause harm (11)
- ❑ Readmissions (12)
- ❑ Disparities (13)
- ❑ Obstetrical adverse events (such as postpartum hemorrhage or preeclampsia) (14)
- ❑ EED (15)
- ❑ Airway safety (16)
- ❑ Procedural harm (17)
- ❑ Iatrogenic Delirium (18)
- ❑ Failure to rescue (19)
- ❑ Cost savings (20)
- ❑ Acute renal failure (21)
- ❑ Culture of safety (22)
- ❑ Antibiotic stewardship (23)
- ❑ Malnutrition (24)
- ❑ Diagnostic errors (25)
- ❑ Overexposure to radiation (26)
- ❑ MRSA (27)
- ❑ Other adverse events or harm areas not mentioned above (please list) (28)

  _____

17. The following questions ask about your perceptions about working/interacting with the HEN during PfP 2.0. In answering these questions, please refer to your activities during the period September 2015 to September 2016, marking the extent to which you agree or disagree with each item.

	Strongly disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly agree (5)
1. The HEN effectively engaged hospital leadership (1)	❍	❍	❍	❍	❍
2. The HEN was effective in addressing your hospital's specific patient safety and care needs (2)	❍	❍	❍	❍	❍
3. The HEN helped my hospital improve patient safety practices and reduce adverse events. (3)	❍	❍	❍	❍	❍
4. The HEN helped the hospital staff to coordinate care better and to approach patient safety and prevention of adverse events more effectively (4)	❍	❍	❍	❍	❍
5. The HEN facilitated engagement with community organizations that support and advocate	❍	❍	❍	❍	❍

for patients and patient safety (5)					
6. The HEN facilitated engagement with State-level organizations that engage and support patient care and patient safety practices (6)	❍	❍	❍	❍	❍
7. The HEN facilitated engagement with Federal agencies that support patient care and safety, such as AHRQ, Health Resources and Services Administration, CMS, Center for Medicare & Medicaid Innovation, U.S. Department of Health & Human Services, U.S. Department of Veterans Affairs, and others (7)	❍	❍	❍	❍	❍
8. The HEN facilitated engagement with patients, their families and caregivers, and/or patient	❍	❍	❍	❍	❍

advocates (8)					
9. Working with the HEN complimented other patient-safety initiatives at the hospital (9)	❍	❍	❍	❍	❍
10. The HEN staff sought my hospital's input on solving the problems faced by other hospitals (10)	❍	❍	❍	❍	❍
11. The HEN facilitated a relationship with other hospital(s) that would not have happened otherwise (11)	❍	❍	❍	❍	❍

Your Opinions About the PfP
The questions in this section ask about your opnions and beliefs about PfP participation.

18. These questions ask about your opinions regarding any learning and capacity-building resources provided by the HENs/HIINs. Taken together, how useful have the resources been in?

	Not at All Useful (1)	Not Very Useful (2)	Somewhat Useful (3)	Very Useful (4)
1. Increasing staff and leadership knowledge of how to prevent and reduce harms in this hospital? (1)	❍	❍	❍	❍
2. Creating, reinforcing, or enhancing commitment to reduce harms in this hospital at all staff levels? (2)	❍	❍	❍	❍
3. Enabling this hospital to identify and take new or different strategies to reduce adverse events? (3)	❍	❍	❍	❍
4. Training in quality improvement concepts and methods? (4)	❍	❍	❍	❍
5. Effective communication strategies? (5)	❍	❍	❍	❍
6. Determining specific data needs for quality of care measuring and monitoring? (6)	❍	❍	❍	❍

19. The following questions ask about staff experiences with HEN engagement/PfP 2.0 participation (from September 2015 until September 2016). For each item, please indicate the degree to which you perceived it occurring in your hospital.

	Never (1)	Rarely (2)	Sometimes (3)	Most of the Time (4)	Always (5)
1.Staff/leadership cited PfP/HEN engagement as a reason for interacting with other units within the hospital (1)	❍	❍	❍	❍	❍
2. Staff at several levels cited PfP/HEN engagement as a reason for interacting with other hospitals (2)	❍	❍	❍	❍	❍
3. Staff at several levels participated in HEN meetings (3)	❍	❍	❍	❍	❍
4. Staff at all levels felt empowered to raise concerns related to patient safety (4)	❍	❍	❍	❍	❍
5. Staff at all levels felt empowered to propose practices and procedures that enhance patient safety (5)	❍	❍	❍	❍	❍
6. Staff at several levels engaged with HEN-sponsored activities (6)	❍	❍	❍	❍	❍
7. Staff at several levels readily participated in	❍	❍	❍	❍	❍

focus groups to better understand patient safety (7)					
8. Direct patient and family input was engaged and incorporated (8)	❍	❍	❍	❍	❍

the space below, please provide any comments you would like to add regarding your hospital's patient safety culture and practices, and your hospital's participation in the PfP.

This marks the end of the survey. Thank you for your participation.
Should you have any questions or comments or would like to provide further information to complement your answers today, please do not hesitate in contacting us at:

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❍ Click to continue to submit responses (1)