Quality Management Tools

The CAP’s comprehensive collection of Quality Management Tools (QMT) strengthens your knowledge of key laboratory processes, identifies quality improvement opportunities, and provides the information you need for effective laboratory management:

- **Q-TRACKS®** Continuous Quality Monitors Program
- **Q-PROBES™** In-Depth Quality Assurance Program
- **LMIP®** Laboratory Management Index Program
- **CAP LINKS™** The Laboratory Integrated Knowledge Source

The CAP’s Quality Management Tools help you:

- **Deliver** quality patient care throughout your organization
- **Satisfy** accreditation requirements and JCAHO National Patient Safety Goals
- **Establish** realistic benchmarks for your laboratory

*Integrate QMT into your daily activities to support your quality improvement initiatives!*
Q-TRACKS

A Program of Continuous Quality Measurement

Observe performance trends over time to identify and monitor opportunities for quality improvement through quantitative quality measures. Q-TRACKS offers continuous quality monitoring with longitudinal tracking of performance and key indicators for clinical and anatomic pathology.

Help ensure accurate diagnosis, patient safety, and appropriate care –
Q-TRACKS monitors reach beyond the testing phase to evaluate the quality of processes both within and beyond the laboratory that can impact test results and patient outcomes.

Identify and monitor improvement opportunities – Each Q-TRACKS monitor provides a quarterly Performance Management Report package that helps identify improvement opportunities and monitor the effectiveness of changes implemented over time.

Establish realistic laboratory benchmarks – Measure your lab’s performance against that of participating labs to help you set performance goals. Q-TRACKS helps you identify those labs with the greatest similarities using a field-tested tool. Fingerprint clusters* identify the most appropriate peer groups based on test volume/complexity, demographics, and operational characteristics. Customer-defined groups allow you to customize peer groups by having you decide which characteristics are most important for comparison.

<table>
<thead>
<tr>
<th>Module/Package</th>
<th>Product Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Clinical Pathology Monitors</td>
<td>QT1, QT2, QT3, QT4, QT7, QT8, QT9, QT10, QT15, QT16, QT17</td>
</tr>
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<td>Individual Anatomic Pathology Monitors</td>
<td>QT5</td>
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<td>Combined CP/AP Module—</td>
<td>QTP</td>
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<td>Clinical Pathology Module—</td>
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*Fingerprint clusters are provided when 50 or more labs return data.

Q-TRACKS offers CME/CE credit each quarter to help you build a solid foundation of education and knowledge within your organization.
Q-TRACKS Clinical Pathology Monitors

**Patient Identification Accuracy QT1**

The proper identification of a patient is vital to reporting accurate laboratory results and meeting JCAHO National Patient Safety Goal #1: “Improve the accuracy of patient identification.” Since the majority of testing is performed away from the patient, patient identification, labeling of specimens, and coordination with test requisitions must be conducted accurately and completely. By continuously monitoring for wristband errors, participants can promptly identify and correct problems that may interfere with patient care services.

**Monitor Objective**
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 type of wristband error. This monitor includes all routinely wristbanded patients. (Emergency department patients are included only if the emergency department routinely applies wristbands to these patients.)

**Performance Indicators**
- Wristband Error Rate (%)  
- Breakdown of Wristband Error Types (%)

**Blood Culture Contamination QT2**

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

**Monitor 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. For the purposes of this study, participants will consider a blood culture to be contaminated if one or more of the following organisms are found in only one of a series of blood culture specimens: Coagulase-negative *Staphylococcus*; *Micrococcus*; Alpha-hemolytic (*viridans*) *Streptococci*; *Propionibacterium acnes*; *Corynebacterium* sp. (diptheroids); or *Bacillus* sp. Optional institution-specific subgroups may be used to track parameters that may affect contamination rates. Additionally, neonatal totals can be tabulated separately from other blood cultures.

**Performance Indicators**
- Total Contamination Rate (%)  
- Neonatal Contamination Rate (%)  
- Other Contamination Rate (%)

Input forms for quarterly data collection will be sent to participants 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 be due to issues including unlabeled, mislabeled, and incompletely labeled specimens; clotted and/or hemolyzed specimens; and insufficient specimen quantity. By continuously monitoring specimen acceptability, collection, and transport, problems can be promptly identified and corrected, leading to improved patient care. Participation in this monitor can help satisfy the CAP’s checklist question, “Are preanalytic variables monitored?”

Monitor Objective
Identify and characterize unacceptable blood specimens that are submitted to the chemistry and hematology 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. Weekly tallies of the total number of specimens received, the number of rejected specimens, and the primary reason each specimen is rejected will be recorded.

Performance Indicators
- Specimen Rejection Rate (%)  
- Breakdown of Rejection Reasons (%)

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.

Monitor Objective
Compare the rates of blood product wastage (i.e., 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. The following types of blood components will be included: whole blood (allogeneic); red blood cells (allogeneic); fresh frozen plasma; platelet concentrates; single donor platelets; and cryoprecipitate.

Performance Indicators
- Overall Wastage Rate (%)  
- Other Blood Components Wastage Rates (%)  
- Breakdown of Wastage Reasons (%)

Input forms for quarterly data collection will be sent to participants approximately three weeks prior to the quarter.
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. By participating in this monitor, you can help ensure that patient satisfaction with laboratory services is being measured as required by accrediting agencies such as the JCAHO and CAP (GEN.20316, 20348).

**Monitor Objective**

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

**Data Collection**

On a monthly basis, participants will distribute copies of a questionnaire to a minimum of 25 outpatients (maximum of 99 outpatients), using predetermined data collection criteria. This monitor includes any outpatient undergoing venipuncture or for whom assistance was required in specimen collection by your laboratory staff. 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**

- Patient Satisfaction Score
- Patients “More Than Satisfied” (%)
Inpatient Test Availability  QT9

When laboratory results are not available for a physician’s morning rounds, there may be a delay in the treatment, diagnosis, and discharge of a patient. In turn, this delay may prolong a patient’s hospital stay and cause physicians to repeat patient visits. By monitoring the frequency of test reporting times that exceed expectations, you can determine areas that require improvement, implement changes, and increase physician and patient satisfaction. Monitor this post-analytic performance indicator to measure and address your long-term performance.

Monitor Objective
Establish the compliance rate at which laboratories meet morning test reporting deadlines.

Data Collection
Participants will choose one or more nonintensive patient care areas and/or laboratory sections to monitor. They will select one morning reporting deadline in conjunction with health care staff who use the laboratory. On six predetermined days per month, participants will record the total number of tests monitored and the total number of specific tests reported by the designated deadline. Tests originating from intensive care units and the emergency department, as well as stat requests, are excluded from this monitor.

Performance Indicator
• Reporting Compliance Rate (%)

Critical Values Reporting  QT10

Critical values in the laboratory are defined as results requiring immediate notification to the physician or caregiver for necessary patient evaluation or treatment. While critical value notification has been a routine practice in laboratory medicine for many years, recent regulations from agencies and accreditors such as CMS, JCAHO, and CAP (GEN.20364, 20316, 41320) have mandated that laboratories develop and implement an alert system for critical values. Use this monitor to document compliance with your laboratory’s alert plan.

Monitor Objective
Evaluate the documentation of successful critical values reporting in the general laboratory for both inpatients and outpatients according to the laboratory’s policy.

Data Collection
On six predetermined days per month, participants will evaluate inpatient and outpatient critical values for the designated sections. 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 if there was documentation of notification. This monitor will exclude critical values for microbiology, cardiac markers, drugs of abuse, therapeutic drug levels, urinalysis, blood gases, point-of-care tests, tests performed at reference laboratories, and critical values on discharged patients.

Performance Indicators
• Total Critical Values Reporting Rate (%)
• Inpatient Critical Values Reporting Rate (%)
• Outpatient Critical Values Reporting Rate (%)

Input forms for quarterly data collection will be sent to participants approximately three weeks prior to the quarter.
Monitor Objective

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

Data Collection

Participants will record the TATs (in minutes) for three randomly selected troponin specimens obtained from patients seen in EDs on each of three traditional shifts (total of nine measurements) on six pre-determined days per month. TATs will be measured from the times the tests are ordered to the times that results are made available to ED personnel. Participants will also have the option of monitoring collection-to-receipt intervals.

Performance Indicators

• Median TAT of Troponin Measured from the Time Troponin Is Ordered to the Time the Result Is Made Available to ED Personnel
• Percentage of Troponin Results Reported by your Institution’s Established Reporting Deadline

Corrected Results QT16

This Q-TRACKS monitor was developed 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 Assessment, with this monitor.

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. Test results for all patients in all care settings will be included, with the following exclusions: tests performed by reference laboratories, anatomic pathology tests, and narrative physician-interpreted tests (i.e., bone marrow biopsies and peripheral smear reports).

Performance Indicator

• Test Result Correction Rate (per 10,000 billable tests)
### 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 the diagnostic evaluation is delayed, 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.

**Monitor Objective**

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

**Data Collection**

On six pre-selected weekdays per month, eight outpatient requisitions or order sheets will be compared to the orders entered into the laboratory's information system to determine if any order entry errors occurred. Order entry error categories include incorrect physician information, and incorrect, extra, or missed tests. Tests performed in transfusion medicine/blood bank or anatomic pathology are excluded.

**Performance Indicators**

- Outpatient Order Entry Error Rate (%)
- Order Entry Error Rates by Type (%)

### Q-TRACKS Anatomic Pathology Monitors

**Gynecologic Cytology Outcomes: Biopsy Correlation Performance QT5**

The correlation of cervicovaginal cytology (Pap test) findings with cervical biopsy results has been a staple in the cytopathology laboratory's quality assurance program. By monitoring this correlation, the laboratory can identify potential problems requiring improvement, thereby ensuring better patient results.

**Monitor Objective**

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

**Data Collection**

Participants are asked to record information on true-positive, false-positive, and false-negative cytology-biopsy correlations on a monthly basis. False-negative correlations will be separated into four error categories on a monthly basis. Participants will 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 patients for whom a cervical biopsy specimen is submitted to the laboratory and for whom a satisfactory or satisfactory but limited Pap test has been submitted within three months previous to the biopsy or at the time of the biopsy.

**Performance Indicators**

- Predictive Value of Positive Cytology (%)
- Screening/Interpretation Sensitivity (%)
- Percent Positive for ASC-US Interpretations
- Percent Positive for ASC-H Interpretations
- Sensitivity (%)
- Sampling Sensitivity (%)
- Percent Positive for AGC Interpretations

Input forms for quarterly data collection will be sent to participants approximately three weeks prior to the quarter.
Q-PROBES

A Program for an In-depth Comprehensive Assessment

Evaluate quality improvements in your lab – With today’s focus on reducing medical errors, achieving and maintaining excellence is key to success. Using short-term studies, Q-PROBES provides a one-time comprehensive assessment of key processes in your laboratory.

Structure your data collection and analysis for success – Use Q-PROBES to help build and improve data collection and analysis processes that contribute to quality of care, patient safety, and outcomes.

Establish realistic laboratory benchmarks and performance goals – Q-PROBES is an external peer-comparison program that addresses process-, outcome-, and structure-oriented quality assurance issues. Establish benchmarks through external database comparisons and compare your performance to that of peer organizations to establish laboratory goals and improve performance.

<table>
<thead>
<tr>
<th>2007 Q-PROBES</th>
<th>Product Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modules/Package</td>
<td></td>
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<td>Individual QP Studies</td>
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<tr>
<td>All Four QP Studies</td>
<td>PRO</td>
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Q-PROBES offers CME/CE credit to help you build a solid foundation of education and knowledge within your organization.

Examine the effectiveness of key processes with Q-PROBES.
Physician Satisfaction with Clinical Laboratory Services  QP071

Accrediting organizations, including the CAP and JCAHO, require that institutions measure physician satisfaction with laboratory services through ongoing monitors. This Q-PROBES study can assist your organization in meeting this requirement while helping to identify improvement areas and to ensure physician satisfaction with your services.

**Study Objective**
Evaluating physician satisfaction with laboratory services and correlate it with the percentage of outpatient laboratory work, performance improvement activities, and customer support services.

**Data Collection**
Participants will distribute a standardized questionnaire addressing 15 laboratory service categories, including test turnaround time and critical value notification, to a maximum of 300 physician customers. Data from the first 50 returned questionnaires will be submitted for analysis.

**Performance Indicators**
- Overall Mean Satisfaction Score
- Percentage of Excellent/Good and Below/Average Ratings for Each Service Category (%)

*Shipping Begins* December 11, 2006  *Order Deadline* February 8, 2007

Specimen Labeling Errors  QP072

Adverse clinical events can often be traced to improper specimen labeling or to specimen rejection related to improper labeling. Efficient, accurate laboratory services support the best patient care. Help your institution maintain compliance with JCAHO National Patient Safety Goal #1: “improve the accuracy of patient identification,” by enrolling in this Q-PROBES study.

**Study Objective**
Assess the frequency and potential impact of mislabeled specimens. Determine the percent of specimens with labeling errors, the breakdown by error type, and compare your performance with other institutions.

**Data Collection**
Participants will collect data prospectively on all mislabeled inpatient and outpatient blood specimens for up to four weeks to determine the type of labeling error. Labeling error types will include: (1) missing or unreadable required information, (2) missing label, (3) mismatched specimen label and requisition, and (4) misalignment of label for automated barcode readers. In addition, the number of specimens that were relabeled due to label misalignment will be determined. The total number of specimens received during the study time period will also be recorded.

**Performance Indicators**
- Specimens with a Labeling Error for One or More Reasons (%)
- Relabeled Specimens due to Label Misalignment (%)
- Breakdown of Labeling Errors by Type (%)

*Shipping Begins* March 27, 2007  *Order Deadline* April 19, 2007

*Orders must be received by the order deadline.*
Critical Values: Physician Notification Processes QP073

Timely notification of critical results can impact patient outcomes, often decisively. Partner with your hospital to help meet JCAHO’s National Patient Safety Goal #2: “Improve the effectiveness of communication among caregivers.”

Study Objective
Determine the length of time it takes non-physician caregivers who are called about critical results to notify physicians, collect detailed information about notification practices, and identify practices that make critical result notification more reliable and timely.

Data Collection
Participants will record the following detailed information on a total of 50 consecutive critical value notifications for outpatients, inpatients, and emergency department patients: (1) laboratory result verification time, (2) number of calls required to contact a caregiver who accepted the result, (3) time laboratory contacted a caregiver who accepted the result, and the type of caregiver contacted, (4) presence/absence of read-back verification, (5) length of time non-physician caregiver who received the result took to notify a physician, the number of calls required, and the use of read-back verification. Note: participation requires laboratory staff to follow-up with non-physician caregivers to determine when the physician was notified.

Performance Indicators
• Calls with Read-backs (%)
• Occurrences Where Only One Call Was Needed to Notify a Caregiver of the Critical Result (%)
• Turnaround Time (TAT) from Result Verification to Non-physician Caregiver Notification; from Non-physician Caregiver Notification to Physician Notification; and from Result Verification to Physician Notification

*Shipping Begins  June 25, 2007  Order Deadline  July 19, 2007

Blood Bank Safety Practices QP074

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.

Study Objective
Determine the rates of (1) labeling errors on specimens submitted for ABO typing, and (2) specimen misidentification errors in which the current ABO typing result does not match the historical ABO type.

Data Collection
From a retrospective review of the most recent calendar or fiscal year, participants will record all incorrectly labeled specimens submitted for ABO typing, as well as the number of ABO typing errors secondary to patient or specimen misidentification, as determined from a discrepancy with the historical ABO typing result. Incorrect labeling will be defined as: incomplete or missing required information, mismatched information between requisition and specimen label, and unlabeled specimens. The number of RBC units transfused and the total number of specimens processed for ABO typing for the fiscal or calendar year will be recorded.

Performance Indicators
• Rate of ABO Specimen Labeling Errors  • Rate of ABO Typing Result Discrepancies

*Shipping Begins  September 24, 2007  Order Deadline  October 18, 2007

*Orders must be received by the order deadline.
Manage your laboratory more effectively with LMIP — The Laboratory Management Index Program (LMIP) is an effective fiscal management tool that provides you with a valuable peer comparison of your laboratory’s performance. LMIP can assist you with the annual budget process, contract negotiations, and daily operations management while you earn valuable CME and CE credits.

With over 10 years of experience and the largest laboratory participant database, LMIP is the best management resource for health care professionals charged with decision-making responsibilities. Using management ratios as performance indicators, LMIP extends beyond traditional analysis of productivity and staffing to focus on the most important factors affecting laboratory performance:

- **Productivity** – How effectively are you using your laboratory personnel?
- **Utilization** – How do your test-ordering patterns compare to those of your peers?
- **Cost-effectiveness** – How efficiently are you using your supplies, equipment, and labor?

With LMIP’s statistically valid method of peer grouping (fingerprint clustering), you receive the most meaningful comparisons. These comparisons allow you, your colleagues, and your administration to make informed and realistic decisions about staffing, budgets, and other performance targets.

Achieving quality test results involves more than just ensuring that tests are conducted properly. Understanding financial factors that drive laboratory processes enhances your confidence in the management decisions you make. Ultimately, these decisions will guide your organization to deliver superior patient care.

<table>
<thead>
<tr>
<th>2007 LMIP</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Module</strong></td>
<td><strong>Product Code</strong></td>
</tr>
<tr>
<td>LMIP</td>
<td>LMB</td>
</tr>
</tbody>
</table>
LMIP input items are collected and analyzed quarterly to provide a report of your laboratory’s overall operations. The data collected is used to generate relevant management ratios that provide analysis of the productivity of personnel, laboratory policies and procedures, salary and other expenses, physician test utilization, and organizational benefits. The input items you will collect include:

- Blood Expense
- Consumable Expense
- Equipment Depreciation Expense
- Equipment Maintenance and Repair Expense
- Hospital Inpatient Days
- Hospital Inpatient Discharges
- Inpatient SBTs
- Nonpatient SBTs
- On-Site SBTs
- Outpatient SBTs
- Outpatient Visits
- Referred SBTs
- Referred SBT Expense
- Testing Labor Expense
- Testing Paid Hours
- Total Labor Expense
- Total Laboratory Paid Hours
- Total Laboratory Worked Hours
- Total SBTs

The Standardized Billable Test (SBT) is the primary unit of measure for LMIP. The SBT is a method of standardizing test counts and eliminates billing, accounting, and interpretation variations to ensure valid comparisons are created.

**LMIP offers CME/CE credit to one individual each quarter to help you build a solid foundation of education and knowledge within your organization.**

**Upon completing the program and education activity, you will have learned how to:**

- Consistently and accurately calculate Standardized Billable Tests
- Categorize and calculate laboratory expenses to be used in establishing laboratory specific LMIP performance ratios
- Apply LMIP definitions for consistent reporting between institutions and articulate the procedure for interpreting or evaluating laboratory performance
- Categorize and calculate laboratory staffing levels and types as they relate to the LMIP program
CAP LINKS

The Integrated Knowledge Source

Consolidate proficiency testing, accreditation, and QI data for your entire organization into concise and actionable reports.

CAP LINKS is designed for multihospital systems, academic medical centers with numerous testing locations, and national commercial reference laboratories. CAP LINKS provides a high level overview useful in identifying improvement opportunities and demonstrating good QI performance. CAP LINKS data are accessed directly from the CAP Laboratory Improvement Database. Therefore, no additional data submission is required. CAP LINKS is available for all of your CAP laboratory improvement programs, including:

- Surveys & Anatomic Pathology Education Programs and EXCEL®
- Laboratory Accreditation Program
- Q-TRACKS Program
- LMIP - Laboratory Management Index Program

CAP LINKS has been enhanced to provide you the ability to:

- Download data and manipulate reports to accommodate your specific institution’s needs
- Use e-mail to forward one or all reports to appropriate individuals for viewing
- Designate viewing options to select individuals via the CAP Web site directly
- Receive CAP LINKS reports more promptly via the Web—your printed reports will continue to be forwarded via regular mail
- Respond to exceptions in a more timely manner

The report package allows you to quickly see good performance and identify sites that may require special attention, both at the laboratory level and at the system or corporate level.

Reports are generated on a quarterly basis and distributed by mail and via the Internet to an individual whom you designate as your system’s primary contact. Annually, your primary contact will receive an overview of the system’s full-year performance for proficiency testing. Online reports are secure and viewable by those individuals with granted viewing privileges.
Quarterly reports summarize PT system-wide average results by discipline to allow for interlaboratory comparisons.

To gain maximum management power, CAP LINKS is available in convenient and cost-effective combination packages. Individual program options are also available.

### 2007 CAP LINKS Pricing

<table>
<thead>
<tr>
<th>Combination Program Options</th>
<th>Product Code</th>
<th>Surveys/EXCEL®</th>
<th>LAP</th>
<th>Q-TRACKS</th>
<th>LMIP</th>
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To participate in CAP LINKS, you must first enroll in the corresponding Surveys & Anatomic Pathology Education, EXCEL, Q-TRACKS, and/or LMIP program. To order CAP LINKS, please call 800-323-4040 option 1 #.
Quality Management Tools: A Continuing Education Opportunity

Continuing education credit is available with select Quality Management Tools. For LMIP, each quarter one individual at each participating institution can earn education credit upon completion of the paper-based education activity. New for Q-PROBES and Q-TRACKS, multiple laboratory staff can earn continuing education credit (CME/CE) by reading the Final Critique and answering the online learning assessment questions. For more information, visit www.cap.org, click on the Accreditation and Laboratory Improvement tab, and then click About Q-TRACKS, About Q-PROBES, or About LMIP under Quality Assurance Programs.

<table>
<thead>
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<td>QT1-5, QT7-10, QT15-17</td>
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</tr>
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</table>

Look for this icon to identify products that include an opportunity to earn CME/CE.

Look for this icon to identify products that help you monitor patient safety.

Accreditation
The College of American Pathologists (CAP) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing education for physicians.

CME Category 1
The College of American Pathologists designates Q-TRACKS for a maximum of 48 (1 credit per quarter, per monitor) AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

The College of American Pathologists designates Q-PROBES for a maximum of 4 (1 credit per quarter, per monitor) AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

The College of American Pathologists designates LMIP for a maximum of 12 (3 credits per quarter) AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

CE (Continuing Education for non-physicians)
The CAP designates Q-TRACKS for a maximum of 48 credits/hours (1 credit/hour per quarter, per monitor) of continuing education. Each participant should only claim those credits/hours he/she actually spent in the activity.

The CAP designates Q-PROBES for a maximum of 4 credits/hours (1 credit/hour per study) of continuing education. Each participant should only claim those credits/hours he/she actually spent in the activity.

The CAP designates LMIP for a maximum of 12 credits/hours (3 credits/hours per quarter) of continuing education. Each participant should only claim those credits/hours he/she actually spent in the activity.

Q-TRACKS, Q-PROBES, and LMIP are acceptable to meet the continuing education requirements for the ASCP Board of Registry Certification Maintenance Program.

Q-TRACKS, Q-PROBES and LMIP are approved for continuing education credit in the states of California and Florida.