

AHRQ Safety Program for Long-Term Care: HAIs/CAUTI Registration Form

Please take a moment to gather the following information for the registration:

1. Medicare Federal Provider Number (if applicable)
2. Number of staff working at least 8 hours per week (whether contracted or employed)
3. Total number of Medicare and/or Medicaid Federally Certified beds
4. Essential team members for the program (e.g. Team Lead, Survey Coordinator, Data Coordinator, Administrative Champion)
5. All fields are **required**

Team Lead Contact Information

Team Lead Name: _____

Team Lead E-mail: _____

Team Lead Phone Number: _____

Facility information

1. Select your Lead Organization:

- Advancing Excellence
- Alabama Quality Assurance Foundation
- Arizona Health and Hospital Association
- CAHF (California Association of Health Facilities)
- Foundation for Healthy Communities (NH)
- Genesis HealthCare
- Grace Living Centers (OK)
- Healthcare Association of New York State
- Healthcentric Advisors (RI)
- HealthInsight (NV, NM, UT)
- Information & Quality Healthcare (MS)
- The Joint Commission
- Louisiana eQHealth Solutions, Inc.
- Massachusetts Senior Care Association
- Minnesota Hospital Association

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- Missouri Hospital Association
- New Jersey Hospital Association
- North Dakota Quality Health Care Association
- Oregon Patient Safety Commission
- Pennsylvania Patient Safety Authority
- Presbyterian Manors of Mid-America (KS & MO)
- Professional Nursing Solutions, LLC (AR)
- Qualidigm (CT)
- Quality Health Associates of North Dakota
- South Carolina Hospital Association
- South Dakota Association of Healthcare Organizations
- South Florida Hospital & Healthcare Association
- Spectrum Health (MI)
- Telligen (IL & IA)
- Tennessee Healthcare Association
- Veteran's Health Administration
- Other (Please Specify) _____

2. State: _____

3. Facility name: _____

4. Medicare Federal Provider Number (if applicable): _____

5. Facility Contact information

Address: _____

City: _____

Zip: _____

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6. Enter the number of staff in your facility regularly working at least 8 hours per week (whether employed or contracted):

7. Enter the number of Medicare and/or Medicaid Federally Certified beds in your facility:

Total Certified Beds: _____

8. Do all staff members have access to computers with internet access during work hours for project use?

Yes

No

- 8.1. If No, comment on staff computer and internet access:

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AHRQ Program Essential Team Members

9. Will the Team Lead have any additional roles in the program? (Select all that apply)

- Administrative Champion (If selected skip question 16)
- Survey Coordinator (If selected, skip questions 11 – 13)
- Data Coordinator (If selected, skip questions 14 and 15)
- No Other Team Roles

10. What is the Team Lead's title in the facility? (Select all that apply)

- | | |
|---------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Medical Director | <input type="checkbox"/> Director of Nursing (DON) |
| <input type="checkbox"/> Infection Control Practitioner | <input type="checkbox"/> Administrator |
| <input type="checkbox"/> Licensed Nurse | <input type="checkbox"/> Certified Nursing Assistant |
| <input type="checkbox"/> Social Worker | <input type="checkbox"/> Other (Please specify) |
- _____

11. Survey Coordinator Contact Information

Name: _____

E-mail: _____

Phone Number: _____

12. What is the Survey Coordinator's title in the facility? (Select all that apply)

- | | |
|---------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Medical Director | <input type="checkbox"/> Director of Nursing (DON) |
| <input type="checkbox"/> Infection Control Practitioner | <input type="checkbox"/> Administrator |
| <input type="checkbox"/> Licensed Nurse | <input type="checkbox"/> Certified Nursing Assistant |
| <input type="checkbox"/> Social Worker | <input type="checkbox"/> Other (Please specify) |
- _____

13. Will the Survey Coordinator also be your Data Coordinator?

- Yes No
(Skip questions 14 and 15)

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14. Data Coordinator Contact Information

Name: _____

E-mail: _____

Phone Number: _____

15. What is the Data Coordinator's title in the facility? (Select all that apply)

Medical Director

Director of Nursing (DON)

Infection Control Practitioner

Administrator

Licensed Nurse

Certified Nursing Assistant

Social Worker

Other (Please specify)

16. Administrative Champion Contact Information

Name: _____

E-mail: _____

Phone Number: _____

Thank you for your time in completing registration for the AHRQ Safety Program for Long-Term Care: CAUTI.

Please contact your Organizational Lead for any additional information about the program