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:

- **Identify** quality improvement opportunities and monitor progress over time
- **Establish** realistic goals for your laboratory using a set of customized external benchmarks
- **Demonstrate** the ability to meet accreditation requirements

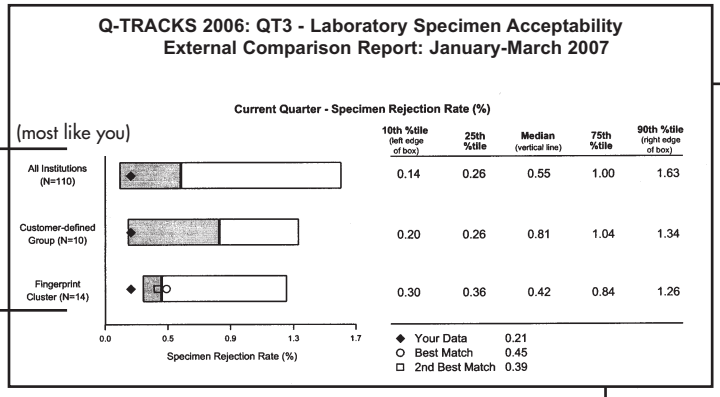
Integrate QMT into your daily activities to support your quality improvement initiatives!

Q-TRACKS

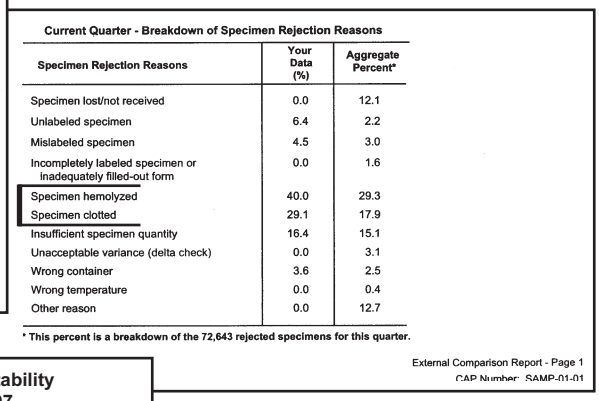
A Program of Continuous Quality Measurement

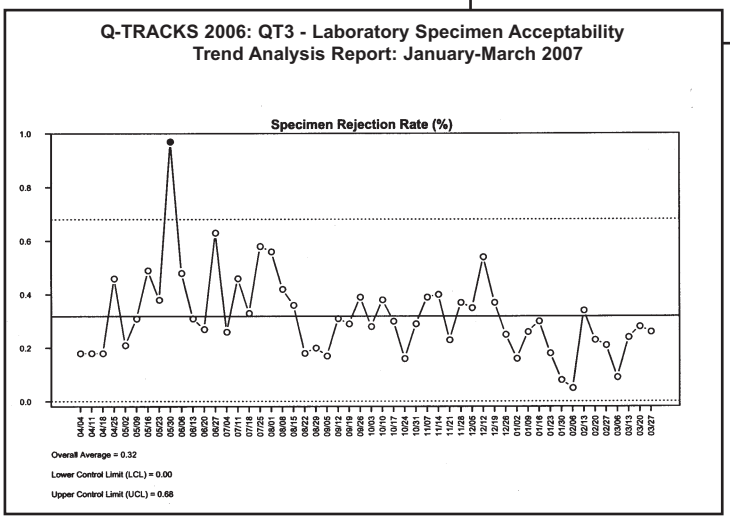
Observe performance trends over time to identify and monitor opportunities for quality improvement through quantitative quality measures. Q-TRACKS offers continuous quality monitoring with longitudinal tracking of performance and key indicators for clinical and anatomic pathology.

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



Step 2:
Identify and refine improvement opportunities.





Step 3:
Monitor improvement over time to ensure accurate diagnosis, patient safety, and patient care.

Q-TRACKS offers CME/CE credit for all laboratory staff each quarter to help you build a solid foundation of education and knowledge within your organization.

College of American Pathologists

Q-TRACKS Clinical Pathology Monitors

Patient Identification Accuracy QT1

The proper identification of a patient is vital to reporting accurate laboratory results and meeting the Joint Commission 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 types 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 (%)

Performance Breakdown

- 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 was rejected will be recorded.

Performance Indicators

- Specimen Rejection Rate (%)

Performance Breakdown

- 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 (%)
- Wastage Rates by Blood Component Type(%)

Performance Breakdown

- Breakdown of Wastage Reasons (%)

Input forms for quarterly data collection will be sent to participants 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. 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 Joint Commission and CAP (GEN.20316, 20348).

Monitor 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 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" (%)

Stat Test Turnaround Time Outliers QT8

Measuring laboratory stat test turnaround time (TAT) is useful to the laboratory in evaluating the service delivery process. The stat test TAT outlier rate, expressed as a percent 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 question GEN.20316, "Are key indicators of quality monitored and evaluated to detect problems and opportunities for improvement?"

Monitor Objective

Monitor the frequency with which 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 determinations 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 Indicators

- Stat TAT Outlier Rate (%)

Performance Breakdown

- Breakdown of Outliers by Shift (%)
- Breakdown of Outliers by Day of Week (%)

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

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, the Joint Commission, and CAP (GEN.20365, 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 a monthly basis, participants will evaluate 120 inpatient and 120 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.

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 outcomes 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 of which is troponin. Help meet CAP checklist question GEN.20364 with this monitor.

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 Troponin Order-to-Report TAT (minutes)
- Troponin TAT Compliance Rate (%)

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: 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)

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

Outpatient Order Entry Errors QT17

Patient Safety Monitor

Category 1 CME

CE

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 (%)

Performance Breakdown

- Breakdown of Error Types (%)

Q-TRACKS Anatomic Pathology Monitors

Category 1 CME

CE

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

On a monthly basis, participants are asked to record information on true-positive, false-positive, and false-negative cytology-biopsy correlations. False-negative correlations will be separated into four error categories. 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.

Q-PROBES offers CME/CE credit to all laboratory staff to help you build a solid foundation of education and knowledge within your organization.

Examine the effectiveness of key processes with Q-PROBES.

Document Control Practices QP081

Accrediting organizations such as CAP and the Joint Commission require that laboratories employ proper document control practices, but deficient document control practices are one of the most frequently cited deficiencies during laboratory inspections. This Q-PROBES study can assist your organization in meeting document control requirements by identifying any gaps in current practices.

Study Objective

Assess compliance with standards by examining a sample of documents in use and compare them against accepted document control standards.

Data Collection

Participants will identify documents used in the laboratory (policies, procedures, work aids, etc.) by tracking orders and specimens as they move through the laboratory. This process will be repeated until 75 documents are collected. Each document will be examined and assessed for compliance with six document control standards.

Performance Indicators

- Percent of sampled documents that fulfill all six document control requirements
- Percent of sampled documents that do not fulfill an individual document control requirement

***Shipping Begins** December 10, 2007 **Order Deadline** February 8, 2008

Point of Care Testing Documentation QP082

A complete point of care (POC) program includes a defined organization, supervision, written procedures, training, competency assessment, instrument evaluation, quality control, proficiency testing and appropriate result recording and notification. Auditing your POC testing program can provide valuable information about program performance and help your institution meet external inspection requirements.

Study Objective

Assess POC program documentation related to training, competency assessment, and quality control.

Data Collection

Participants will retrospectively review testing records for 25 operators who perform POC glucose testing and 25 operators who perform urine reagent strip (dipstick) testing (operators may overlap). Training, competency assessment, and quality control records will be assessed for 50 operators (25 POC glucose testing and 25 urine reagent strip testing).

Performance Indicators

- Percent testing events performed by personnel with up-to-date documentation of training and competency
- Percent testing events with documentation of the individual who performed the test
- Percent required quality control events performed in accordance with institution policy
- Percent of out of control results that have documentation of appropriate action taken

***Shipping Begins** March 24, 2008 **Order Deadline** April 17, 2008

*Orders must be received by the order deadline.

Utilization of Red Blood Cell Transfusions QP083

New

Category 1 CME

CE

Transfusions can be life saving for patients, but they are expensive and entail a number of risks, including transfusion-transmitted disease, hemolytic and non-hemolytic transfusion reactions, volume overload, and immunomodulation. In some circumstances, liberal transfusion of red blood cells (RBCs) has been associated with adverse patient outcomes. Therefore, accrediting agencies require transfusion utilization review to ensure that transfusion practice at an institution is consistent with good medical practice.

Study Objective

Determine conformance of red blood cell transfusion practice with institutional guidelines and benchmark transfusion guidelines against other institutions.

Data Collection

Participants will retrospectively identify 50 consecutive RBC transfusion events. Information will be collected about: (1) the number of RBC units released; (2) the time of issue of the RBC unit(s); (3) the pre-transfusion hemoglobin (Hgb) level; (4) the post-transfusion Hgb level if available; (5) the pre-transfusion Hgb level from your institutional RBC transfusion guidelines that would be applied to each of the 50 RBC transfusion events; (6) Hgb level used by your institution to evaluate intra-operative transfusion, as applicable; and (7) the clinical indication for the transfusion.

Performance Indicators

- Percent of reviewed RBC transfusions meeting criteria
- Average pre-RBC transfusion hemoglobin value
- Hemoglobin cutoff values for acceptable RBC transfusions by clinical indication

***Shipping Begins** June 23, 2008 **Order Deadline** July 17, 2008

Contemporaneous Surgical Pathology Case Review QP084

New

Category 1 CME

CE

Several studies have demonstrated that contemporaneous case review (review before sign-out) by a second pathologist on selected organ systems or diseases reduces the number of amended reports. This study will help you understand the frequency with which different practices review cases, as well as categorize the organ systems and diseases that trigger review, and can help your practice further refine review policies.

Study Objective

Determine the frequency of contemporaneous surgical pathology case reviews, the number and types of cases being reviewed, and the reason for routine reviews.

Data Collection

Participants will retrospectively review 400 consecutively accessioned cases. For those cases with review before sign-out, the following information will be collected: (1) organ system involved; (2) disease type; (3) number of pathologists that reviewed the case; and (4) reason for review.

Performance Indicators

- Percent of surgical pathology cases that received a secondary review
- Percent of cases with a secondary review by organ system, disease type, and reason for review

***Shipping Begins** September 22, 2008 **Order Deadline** October 16, 2008

*Orders must be received by the order deadline.

LMIP

Laboratory Management Index Program

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.

LMIP

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:

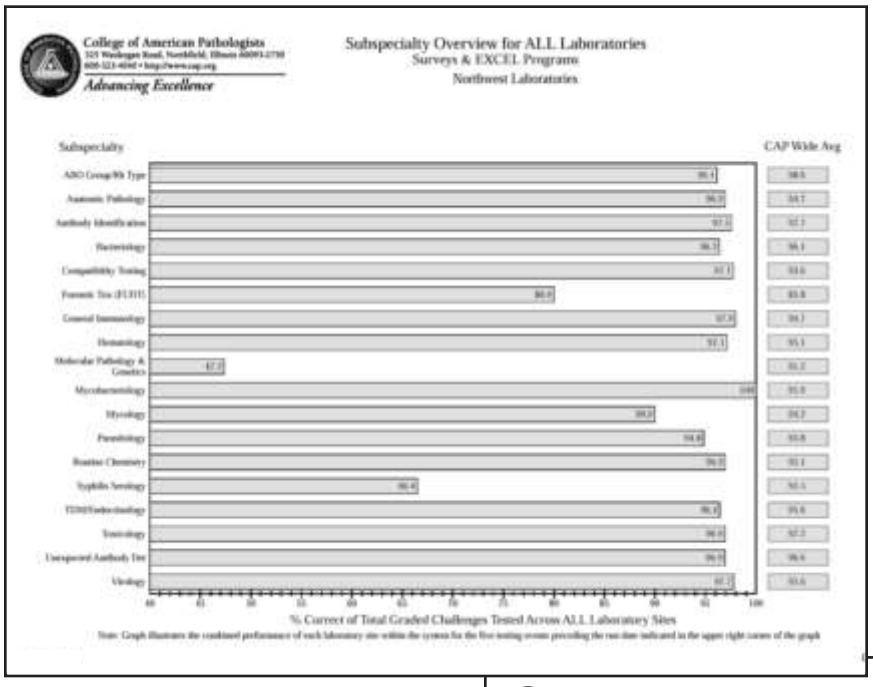
- Surveys & Anatomic Pathology Education Programs and EXCEL®
- Laboratory Accreditation Program
- Q-TRACKS Program
- LMIP - Laboratory Management Index Program

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

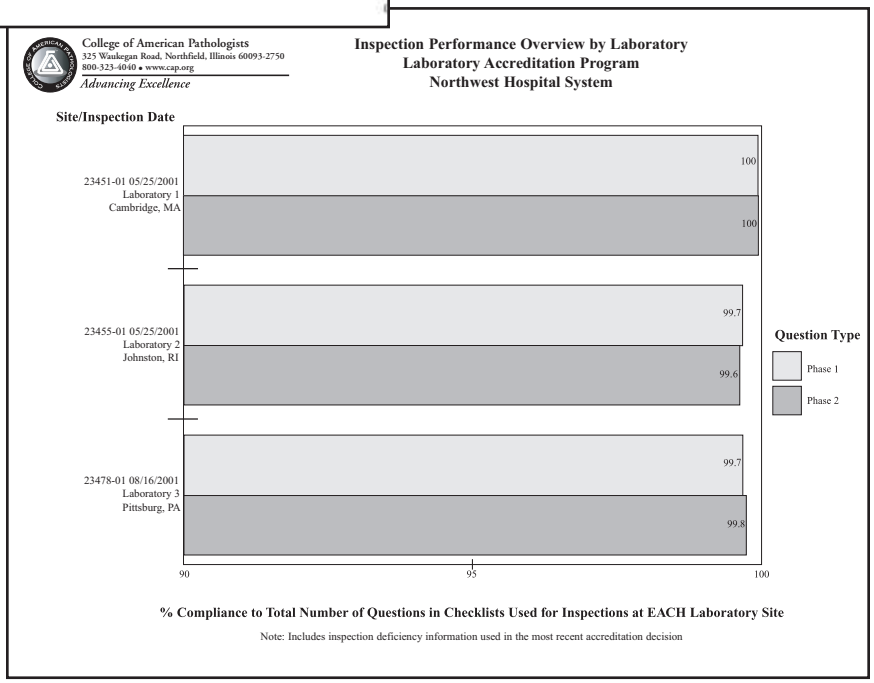
- Download data and manipulate reports to accommodate your specific institution's needs
- Use e-mail to forward one or all reports to appropriate individuals for viewing
- Designate viewing options to select individuals via the CAP Web site directly
- Receive CAP LINKS reports more promptly via the Web—your 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.



Accreditation reports recap inspection findings for each laboratory.

QUALITY MANAGEMENT TOOLS PRICING

2008 Q-TRACKS Pricing

Modules/Package	Product Codes	Price
Individual Clinical Pathology (CP) Monitors	QT1, QT2, QT3, QT4, QT7, QT8, QT9, QT10, QT15, QT16, QT17	$928 each
Individual Anatomic Pathology (AP) Monitor	QT5	$928 each
Combined CP/AP Module– Includes all 12 QT Monitors	QTP	$9,680
Clinical Pathology Module– Includes all 11 CP Monitors	QTC	$9,360
Patient Safety Module Includes QT1, QT2, QT10, QT15, QT16, QT17	QTS	$4,940

2008 Q-PROBES Pricing

Modules/Package	Product Codes	Price
Individual QP Studies	QP081, QP082, QP083, QP084	$380 each
All Four QP Studies	PRO	$1,368

2008 LMIP Pricing

Module	Product Code	Price
LMIP	LMB	$796

2008 CAP LINKS Pricing

Combination Program Options	Product Code	Surveys/ EXCEL®	LAP	Q-TRACKS	LMIP	Price
Option 1	IMR1	▮	▮	▮	▮	$2,800
Option 2	IMR2	▮	▮			$2,000
Option 3	IMR3	▮		▮	▮	$2,200
Option 4	IMR4		▮	▮	▮	$1,500
Individual Program Options						
Surveys/EXCEL Program	IMRPT	▮				$1,500
Laboratory Accreditation Program	IMRLP		▮			$800
Q-TRACKS	IMRQT			▮		$500
LMIP	IMRLM				▮	$500