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| Leapfrog Hospital Survey  Hard Copy |

**QUESTIONS & REPORTING PERIODS**

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Welcome to the 2017 Leapfrog Hospital Survey

[**http://leapfroggroup.org/survey**](http://leapfroggroup.org/survey)

## Important Notes about the 2017 Survey

1. The Leapfrog Hospital Survey webpages are located at <http://leapfroggroup.org/survey>. Please bookmark this URL. You can also download a site map [here](http://www.leapfroggroup.org/survey-materials/get-started).
2. Note the word “hospital” used throughout this survey refers to an individual hospital. If your hospital is part of a multi-hospital healthcare system or a multi-campus hospital, you will need to complete the survey for each individual hospital. Please refer to [Leapfrog’s Multi-Campus Hospital Reporting Policy](http://leapfroggroup.org/survey-materials/multi-campus-reporting-policy).
3. **Due to the update to the CPOE Evaluation Tool, the Tool will not be accessible from the Survey Dashboard until April 15.** Adult hospitals that indicate they have a CPOE system in at least one inpatient unit are asked to demonstrate, via a test, that the inpatient CPOE system can alert physicians to at least 50% of common serious prescribing errors. Hospitals cannot access the CPOE Evaluation Tool until they have submitted Sections 1 Basic Hospital Information and 2 Medication Safety - CPOE of the online survey. More information about the CPOE Evaluation Tool, including instructions, scoring, and FAQs are available on the survey website. In addition, the CPOE Evaluation Tool was updated in 2017 to include new patient profiles and medication orders, as well as a redesigned user interface and updated time limits. All hospitals are urged to take a Sample Test prior to beginning an Adult Inpatient Test.
4. Adult and pediatric hospitals reporting on Section 7B Healthcare-Associated Infections are required to join Leapfrog’s NHSN Group. More information, including important deadlines, is available on the [Join NHSN Group webpage](http://www.leapfroggroup.org/survey-materials/join-nhsn).
5. Leapfrog Hospital Survey Results will be available for hospitals to view on July 12 via the Hospital Details Page link on the Survey Dashboard. Survey Results will be posted to the [public website](http://leapfroggroup.org/compare-hospitals) on July 25 and then updated within the first 5 business days of each month to reflect surveys submitted or re-submitted between June 30and December 31, and previously submitted surveys that were corrected before January 31. Survey Results are frozen from February to July 25.
6. All questions regarding the Leapfrog Hospital Survey should be submitted to the Help Desk at <https://leapfroghospitalsurvey.zendesk.com>. Questions submitted to the Help Desk will receive a response within 24-48 hours.
7. For hospitals that would like Leapfrog Hospital Survey Results included in their **Leapfrog Hospital Safety Grade** please visit the “For Hospitals” section of the Hospital Safety Grade [website](http://www.hospitalsafetygrade.org/for-hospitals/updates-and-timelines-for-hospitals) for important information on Data Snapshot Dates. A Leapfrog Hospital Survey must be submitted by the Data Snapshot Date in order for survey data to be used in the Hospital Safety Grade.
8. Leapfrog is committed to ensuring the accuracy of Leapfrog Hospital Survey results. Please review the information on the [Data Accuracy webpage](http://www.leapfroggroup.org/survey-materials/data-accuracy).
9. The 2017 Leapfrog Hospital Survey will close on **December 31, 2017**. Hospitals that do not submit a survey or CPOE Evaluation Tool (adult hospitals only) by **December 31, 2017 at midnight Eastern Time** will have to wait until the launch of the 2018 survey on April 1, 2018.

## Overview of the 2017 Leapfrog Hospital Survey

The Leapfrog Hospital Survey is divided into nine sections:

|  |  |  |
| --- | --- | --- |
| **Section #** | **Section Title** | **Brief Description** |
|  | [**Profile**](#Sect1) | The profile section asks you to provide certain demographic and contact information. The profile section can be accessed and updated anytime throughout the year by logging into the Survey Dashboard with your hospital’s security code. |
| **1** | [**Basic Hospital Information**](#_Basic_Hospital_Information) | The first section asks you to provide information about your hospital’s bed size, admissions, teaching status, and ICUs operated. |
| **2** | [**Medication Safety - Computerized Physician Order Entry (CPOE)**](#Sect2) | The second section is one of The Leapfrog Group’s original quality and safety standards, and is designed to determine your hospital’s use of CPOE to prevent medication errors. |
| **3** | **[Inpatient Surgery](#InpatientSurg)** | The third section is new in 2017. It is designed to collect information on hospital and surgeon volume for 10 high-risk procedures and information on your hospital’s development of appropriateness criteria to prevent unnecessary procedures. (This section will not be publicly reported in 2017.) |
| **4** | [**Maternity Care**](#Sect4) | The fourth section is designed to demonstrate your hospital’s performance on nationally endorsed maternity measures of care for normal and high-risk deliveries. |
| **5** | [**ICU Physician Staffing (IPS)**](#Sect5) | The fifth section is one of The Leapfrog Group’s original quality and safety standards, and is designed to determine whether or not patients in ICUs are cared for by physicians certified in critical care. |
| **6** | [**Safe Practices Score**](#Sect6) **(SPS)** | The sixth section is one of The Leapfrog Group’s original quality and safety standards, and is designed to determine a hospital’s adherence to five National Quality Forum-endorsed safe practices. |
| **7** | [**Managing Serious Errors**](#Sec7) | The seventh section is designed to assess your hospital’s antibiotic stewardship efforts, as well as your performance on five NHSN infection measures and two hospital-acquired condition measures. In addition, the section evaluates your hospital’s response to Never Events.  New in 2017: Hospitals reporting on Section 7B Healthcare-Associated Infections are required to join Leapfrog’s NHSN Group. Important information and deadlines available on the [Join NHSN Group webpage](http://www.leapfroggroup.org/survey-materials/join-nhsn). |
| **8** | [**Medication Safety**](#MedSafety) | The eighth section is designed to assess additional processes your hospital has in place to prevent medication errors including bar code medication administration, and new in 2017, medication reconciliation. (The medication reconciliation subsection will not be publicly reported in 2017.) |
| **9** | [**Pediatric Care**](#PedCare) | The ninth section is new in 2017. It is designed to assess two dimensions of pediatric care: patient experience and Computed Tomography (CT) radiation dose. (This section will not be publicly reported in 2017.) |

**Section one, as well as section two, four, five, or six are required in order to submit a Leapfrog Hospital Survey.** Hospitals are strongly urged to submit all sections of the Leapfrog Hospital Survey that are applicable to their facility. For a more detailed overview of the 2017 Leapfrog Hospital Survey, including a crosswalk of nationally endorsed measures and a description of how measures are publicly reported, visit the [Get Started webpages](http://leapfroggroup.org/survey-materials/get-started).

Background information about the Leapfrog Hospital Survey, including Fact Sheets, Bibliographies, and White Papers, are available on the [Survey Content webpages](http://leapfroggroup.org/ratings-reports/survey-content).

Each of the nine survey sections is organized in the same format in the hard copy of the survey and the online survey tool:

* **General information** about The Leapfrog Group standard (included in the hard copy only).
* **Reporting periods** to provide hospitals with specific periods of time for each set of questions.
* **Survey questions** which may include references to endnotes. The survey questions and endnotes match the online survey tool exactly.
* **Affirmation of accuracy** by your hospital’s CEO/Chief Administrative Officer or by an individual that has been designated by the hospital CEO. These statements affirm the accuracy of your hospital’s responses.
* **Reference information** which includes ‘What’s New’ and ‘Change Summaries,’ important measure specifications, answers to frequently asked questions, and other notes that must be carefully reviewed before providing responses to any of the survey questions (included in the hard copy only).

In addition to the survey questions, adult hospitals that indicate they have a CPOE system in at least one inpatient unit are asked to demonstrate, via a test, that the inpatient CPOE system can alert physicians to at least 50% of common serious prescribing errors. Adult hospitals cannot access the CPOE Evaluation Tool until they have submitted Sections 1 Basic Hospital Information and 2 Medication Safety - CPOE of the online survey. Carefully review the information on the [Prepare for a CPOE Tool webpage](http://leapfroggroup.org/survey-materials/prepare-cpoe-tool). **Due to the update to the CPOE Evaluation Tool, the Tool will not be accessible from the Survey Dashboard until April 15.**

Any changes made to the measure specifications after April 1will be reflected in the hard copy of the survey in the Reference Information sections under the “Change Summary” header (see [Table of Contents](#TOC)). In addition, the updates to the specifications will be highlighted in yellow. If the changes are substantial, we will email the primary survey contact your hospital indicated in the profile section of the survey. If the notification is sent before your hospital submits a 2017 Leapfrog Hospital Survey, the email will go to the primary survey contact provided in the last survey submitted in the 2016 survey cycle.

The Leapfrog Group and its participating members are committed to presenting information that is as current as possible, and therefore allow hospitals to update and re-submit their survey up until December 31. Please carefully review the reporting periods in each section before updating your survey. Leapfrog Hospital Survey Results are updated monthly beginning on July 25at Leapfrog’s [public website](http://leapfroggroup.org/compare-hospitals). Hospitals are required to update the information in their survey within 30 days of any change in status. We reserve the right to decertify information that is not current.

For a list of measures from the Leapfrog Hospital Survey that are included in the Leapfrog Hospital Safety Grade in the “For Hospitals” section of the Hospital Safety Grade [website](http://www.hospitalsafetygrade.org/for-hospitals/updates-and-timelines-for-hospitals).

## Pre-Submission Checklist

Before you complete and submit the survey via the online survey tool, there are a number of steps every hospital should complete:

* **Visit the survey website pages at** <http://leapfroggroup.org/survey>**.**
* **Make sure you have a 16-digit security code**. If you don’t, download a [Security Code Request Form](http://leapfroggroup.org/survey-materials/security-code). If your hospital is part of a multi-hospital healthcare system, you will need a separate security code for each individual hospital within the system. Please refer to [Leapfrog’s Multi-Campus Hospital Reporting Policy](http://www.leapfroggroup.org/survey-materials/multi-campus-reporting-policy).
* **Download a hard copy of the survey** on the [Survey and CPOE Materials webpage](http://leapfroggroup.org/survey-materials/survey-and-cpoe-materials.). Read through the entire survey document to ensure that you understand what information is required.
* **Review the reference information** in each section of the survey document and download other [supporting materials](http://leapfroggroup.org/survey-materials/survey-and-cpoe-materials.). These documents and tools contain information that you will need to accurately respond to the survey questions.
* **Join Leapfrog’s NHSN Group**. Adult and pediatric hospitals reporting on Section 7B Healthcare-Associated Infections are required to join Leapfrog’s NHSN Group. More information, including important deadlines, is available on the [Join NHSN Group webpage](http://www.leapfroggroup.org/survey-materials/join-nhsn).
* **Identify individuals from your hospital to help you** gather the data you will need to complete the various sections of the survey.
* **Complete a hard copy of the survey before you log into the online survey tool**. This will expedite the online completion and help to avoid the online survey tool "timing out" after 20 minutes of idle time (a security precaution). Once all of the information has been collected and recorded in the hard copy of the survey, the CEO or his/her designee can typically complete the survey online in less than 60 minutes from the hardcopy record. Please note, responses can only be submitted using the online survey tool.
* **Download and review a copy of the Quick Start Guide** on the [Get Started webpage](http://leapfroggroup.org/survey-materials/get-started). This document includes important instructions on how to navigate the online survey tool.
* **Check survey deadlines.** Carefully review survey [deadlines](http://leapfroggroup.org/survey-materials/deadlines) before you begin. Ensure that you have enough time to collect the data, complete a hard copy of the survey, and complete and submit the online survey. In addition, for hospitals that have CPOE in at least one inpatient unit, make sure you have enough time to take a [CPOE Evaluation Tool](http://www.leapfroggroup.org/survey-materials/prepare-cpoe-tool). For hospitals reporting on Section 7B Healthcare-Associated Infections make sure you have joined Leapfrog’s NHSN Group by the appropriate [deadline](http://www.leapfroggroup.org/survey-materials/join-nhsn).
* **Review Leapfrog’s policies and procedures regarding data accuracy**. Detailed information can be found on the [Data Accuracy webpage](http://www.leapfroggroup.org/survey-materials/data-accuracy).

**Leapfrog Hospital Survey Binder**The Leapfrog Hospital Survey Binder was developed to assist hospitals that have been selected for On-Site Data Verification.

However, all hospitals can utilize the binder to assist in organizing the documentation used to complete the survey. Download a copy of the binder on the [Survey and CPOE Materials webpage](http://leapfroggroup.org/survey-materials/survey-and-cpoe-materials.).

## Instructions for Submitting a Leapfrog Hospital Survey

**Important Notes:**

Note 1: Please carefully review these instructions and the [Quick Start Guide](http://leapfroggroup.org/survey-materials/get-started) before you begin.

Note 2: Each section of the survey must be completed before it can be affirmed in the online survey tool. Only sections that are affirmed can be submitted. Hospitals are responsible for ensuring that each submitted section is accurate.

1. Log into the [Survey Dashboard](https://survey.leapfroggroup.org) using your 16-digit security code.
2. The first time you log into the 2017 Leapfrog Hospital Survey, you will need to complete and save your hospital’s Profile. The Profile includes demographic and contact information. The Profile should be updated throughout the year if any information changes. **Failure to maintain current contact information could result in important, time-sensitive information being sent to the wrong person.**
3. Once the Profile has been completed and saved, you will be taken to the Survey Dashboard.
4. You can navigate to sections of the online survey tool using the links on the Survey Dashboard. More information about navigating within the online survey tool is available in the [Quick Start Guide](http://leapfroggroup.org/survey-materials/get-started).
5. Answer questions in the applicable sections or update responses to previously submitted sections. The online survey tool will automatically save your responses as you enter them. There is no ‘save’ button.
6. Once you have completed each section of the online survey tool, you will need to return to the Survey Dashboard to affirm each section of the survey. Please remember that if you are making updates, all updated sections must be re-affirmed.
7. Before you are able to select the “*submit affirmed sections*” button on the Survey Dashboard, you will need to “*check for data review warnings*.” When you select the “*check for data review warnings*” button, the sections of your survey that have been affirmed will be scanned for potential reporting errors. If any errors are identified, a data review warning message will be generated and will appear on the Survey Dashboard.
8. If any [data review warnings](http://www.leapfroggroup.org/survey-materials/data-accuracy) are generated, you will still be able to submit your survey. However, you will need to address the potential reporting errors identified during the scan or risk having related sections of your survey decertified.
9. Once you have checked for data review warnings, you can select the “*submit affirmed sections*” button.
10. Use the “*Print Last Submitted Survey”* button on the Survey Dashboard to print a copy of your submitted survey, and review it for accuracy and completeness. Remember, sections that are not affirmed will not be submitted.
11. Review your results on the Hospital Details Page via the link on the Survey Dashboard beginning July 12and review your [publicly reported results](http://leapfroggroup.org/compare-hospitals) after the first 5 business days of the month following your (re)submission starting on July 25.
12. Hospitals submitting a CPOE Evaluation Tool should carefully review the instructions, scoring information, and FAQs available on the [Survey and CPOE Materials webpage](http://leapfroggroup.org/survey-materials/prepare-cpoe-tool). The CPOE Evaluation Tool was updated and redesigned in 2017.
13. Leapfrog is committed to ensuring the accuracy of Leapfrog Hospital Survey results. Please review our data accuracy protocols on the [Data Accuracy webpage](http://www.leapfroggroup.org/survey-materials/data-accuracy).

### Helpful Tips for Verifying Submission

Use the following tips to help verify that your submission was completed and that the appropriate sections were submitted:

* **Check the Survey Dashboard:** Refer to the “Section Status” column on the Survey Dashboard. All submitted sections will be marked as “Submitted.”
* **Check your email:** You will receive a survey submission confirmation email within five minutes of submitting a survey. Please Note: This email will not specify what sections were submitted – you will need to use the other tips to determine which of the sections were submitted.
* **Print Last Submitted Survey:** The survey submission date will be listed at the top of the page under the heading “Submitted Survey.” Be sure to check the submission date, review each section for accuracy and completeness, and check that each affirmation is complete (Sections 1-9).
* **Review the Hospital Details Page:** Your survey results will be available on July 12th via the Hospital Details Page link on the Survey Dashboard. Carefully review your results, in particular your NHSN information for applicable healthcare-associated infections.
* **Check your publicly reported results:** Always check your Leapfrog Hospital Survey Results on the public [website](http://leapfroggroup.org/compare-hospitals). Results are posted by the first 5 business days of the month following your submission starting on July 25.

### Tips for updating or correcting a previously submitted Leapfrog Hospital Survey

Hospitals have the opportunity to update or correct previously submitted survey responses at any point during the survey cycle. Most updates or corrections are made:

* At the request of Leapfrog:
  + Following Leapfrog’s monthly data review, the hospital and/or system contact received an email from the Help Desk detailing potential reporting errors
* Following on-site data verification:
  + Hospitals selected for on-site data verification will receive a finding report at the end of the scheduled visit which will indicate any responses that need to be updated or corrected.
* At the discretion of the hospital:
  + To correct a data entry error identified by the hospital
  + To reflect a change in status or performance on a measure (i.e. closed a unit or stopped performing a procedure)
  + To provide more current responses for those measures with two reporting periods

Updates after Receiving a Help Desk Email or Following On-Site Data Verification

Leapfrog conducts monthly data reviews of responses submitted to the Leapfrog Hospital Survey starting with surveys submitted on or before June 30th and monthly thereafter until the survey closes on December 31st. (See the [Data Accuracy](http://www.leapfroggroup.org/survey-materials/data-accuracy) section of the website for detailed information.) Following the monthly data review, the Primary Survey Contact and the System Contact are notified by email of any survey responses that need to be reviewed and/or updated by the hospital.

If you receive a data review notification by email, you are required to update/correct your previously submitted Leapfrog Hospital Survey by the end of the month using:

* The **ORIGINAL** reporting period that was used for that section of the survey for the original submission. For example, if a hospital submitted a survey for the first time on August 20, 2017 and then received a data review notification email at the beginning of September, they would update their responses based on the reporting period used in the August 20, 2017 submission.

Following a scheduled on-site data verification visit, hospitals will receive a findings report. If the finding report details any responses that need to be updated or corrected, please contact the [Help Desk](https://leapfroghospitalsurvey.zendesk.com).

General Updates (for hospitals that have not received a Help Desk Email)

Leapfrog has always offered hospitals two reporting periods so that hospitals have the opportunity to report the most current data. With the exception of Section 7B – Healthcare-Associated Infections, updating a survey is optional, though we do recommend that if your performance or if a structure has changed significantly, you update your survey within 30 days. In addition, hospitals should update their surveys if they become aware of any reporting errors or data inaccuracies in their previous submission. Hospitals may update one or more sections of the survey, without updating the entire survey.

Hospitals that are submitting general updates should use:

* The stated[reporting period](#_Reporting_Periods) at the top of each section selected based on the date of your re-submission.
* When updating a section, hospitals must update responses to ALL questions within that section using the same reporting period. For example, if a hospital submitted a survey for the first time in June and then wanted to update the responses for the Early Elective Deliveries questions in sub-section 4B in December, they would update the entire Section 4 Maternity Care based on updated reporting period for December.

For information on Leapfrog’s automatic updates to Section 7B – Healthcare-Associated Infection, please review the [Join NHSN Group webpage](http://www.leapfroggroup.org/survey-materials/join-nhsn).

**Quick Tip**: Remember to re-affirm any section of the survey that has been updated, and then resubmit the survey. Print a copy of your Last Submitted Survey and review it for accuracy and completeness. Check your updated survey results within the first 5 business days of the month following your resubmission on the [public website](http://leapfroggroup.org/compare-hospitals).

## Deadlines

### Deadlines for the 2017 Leapfrog Hospital Survey

The 2017 Leapfrog Hospital Survey opens on April 1 and closes on December 31 at 12 midnight ET. The CPOE Evaluation Tool will open on April 15and cannot be accessed after December 31. Corrections to surveys submitted by December 31 must be submitted by January 31, 2018 at 12 midnight ET. Hospitals will not be able to log into their 2017 Surveys after this date. For more detailed information about 2017 Leapfrog Hospital Survey Deadlines, including deadlines for receiving free Competitive Benchmarking Summary Reports and Top Hospital Awards are posted on the [Deadlines webpage](http://leapfroggroup.org/survey-materials/deadlines).

### Deadlines to Join Leapfrog’s NHSN Group

Hospitals reporting on Section 7B Healthcare-Associated Infections are required to join Leapfrog’s NHSN Group. Please visit our [webpage](http://www.leapfroggroup.org/survey-materials/join-nhsn) for instructions on how to join the group as well as information about important deadlines.

### Deadlines Related to the Hospital Safety Grade

Hospitals that would like Leapfrog Hospital Survey Results used in their Hospital Safety Grade must submit a survey by the “[Data Snapshot Dates](http://www.hospitalsafetygrade.org/for-hospitals/updates-and-timelines-for-hospitals.).” The Leapfrog Hospital Survey and the Hospital Safety Grade are distinct programs administered by The Leapfrog Group. Though some measures from the Leapfrog Hospital Survey are used in the Hospital Safety Grade, the grade also utilizes publicly available data from other data sources. Find FAQs in the “For Hospitals” section of the Hospital Safety Grade [website](http://www.hospitalsafetygrade.org/for-hospitals/HospitalFAQ).

## Technical Assistance

### Help Desk

Leapfrog operates an online Survey Help Desk to provide hospitals with technical assistance and answers to content-related survey questions. The Help Desk is staffed Monday-Friday from 9:00 am to 5:00 pm ET. Help Desk support staff typically respond to inquiries within 24-48 hours, but we do ask that hospitals plan ahead and allow ample time to fulfill security code requests and other urgent tickets before survey deadlines.

Tickets can be submitted electronically at <https://leapfroghospitalsurvey.zendesk.com>. You will receive a confirmation email and response from [helpdesk@leapfroggroup.org](mailto:helpdesk@leapfroggroup.org). **To ensure that you receive our emails, please work with your IT Team to add the @leapfroggroup.org domain to your email’s safe sender list and whitelist the following IP address: 67.212.170.242.**

### Leapfrog Survey Users Group

In response to many requests from hospitals, Leapfrog launched a Hospital Survey Users Group. For an annual fee of $225 per user, hospitals will have access to all User Group benefits for one Survey Cycle (March – December). Hospitals that join the Users Group will have access to:

* Topical monthly technical assistance calls
  + Topics will include: changes to Leapfrog’s online survey platform, changes to scoring algorithms, overview of new measures, utilizing Leapfrog results in your market, etc.
  + Every call will include 20 minutes for Q and A
* Special webinars and presentations regarding Leapfrog standards
* Presentations by Leapfrog’s Expert Panel Members

For more information and to register, please visit the [Users Group webpage](http://www.leapfroggroup.org/survey-materials/users-group).

Hospitals that choose not to join the Users Group will still have access to the Help Desk for free. The Users Group is designed for hospitals that need additional support in understanding the survey and the scored results.

## Reporting Periods

**Important Note:** Reporting periods should be updated based on the date of survey/section submission.

|  | **Survey Submitted Prior to September 1** | **Survey (Re)Submitted On or After September 1** |
| --- | --- | --- |
| **Survey Section/**  **Measure** | **Reporting Period** | **Reporting Period** |
| **1** Basic Hospital Information | 12-months ending 12/31/2016 | 12-months ending 06/30/2017 |
| **2** Medication Safety - Computerized Physician Order Entry (CPOE) | Latest 3-months prior to survey submission | Latest 3-months prior to survey submission |
| **3A** Hospital and Surgeon Volume | 12-months ending 12/31/2016 | 12-months ending 06/30/2017 |
| **3B** Surgical Appropriateness | Latest 12-months prior to survey submission | Latest 12-months prior to survey submission |
| **4A** Maternity Care | 12-months ending 12/31/2016 | 12-months ending 06/30/2017 |
| **4B** Elective Delivery | 12-months ending 12/31/2016 | 12-months ending 06/30/2017 |
| **4C** Cesarean Birth | 12-months ending 12/31/2016 | 12-months ending 06/30/2017 |
| **4D** Episiotomy | 12-months ending 12/31/2016 | 12-months ending 06/30/2017 |
| **4E** Bilirubin Screening & DVT Prophylaxis | 12-months ending 12/31/2016 | 12-months ending 06/30/2017 |
| **4F** High-Risk Deliveries | Volume: 12-months ending 12/31/2016 | Volume: 12-months ending 06/30/2017 |
| VON: Latest 12-month report | VON: Latest 12-month report |
| Antenatal Steroids:  12-months ending 12/31/2016 | Antenatal Steroids:  12-months ending 06/30/2017 |
| **5** ICU Physician Staffing | Latest 3-months prior to survey submission | Latest 3-months prior to survey submission |
| **6** National Quality Forum (NQF) Safe Practices | Latest 12- or 24-months prior to survey submission (see individual safe practice for specific reporting period) | Latest 12- or 24-months prior to survey submission (see individual safe practice for specific reporting period) |
| **7A** Never Events Policy | N/A | N/A |
| **7B** CLABSI and CAUTI (ICU and select wards), MRSA, C. Diff., SSI: Colon\* | 12-months ending 12/31/2016 | 12-months ending 06/30/2017 |
| **7C** Hospital-Acquired Injuries and Pressure Ulcers | 12-months ending 12/31/2016 | 12-months ending 06/30/2017 |
| **7D** Antibiotic Stewardship Practices | 2016 NHSN Annual Survey or current structure at time of submission | 2016 NHSN Annual Survey or current structure at time of submission |
| **8A** Bar Code Medication Administration (BCMA) | Latest 3-months prior to survey submission | Latest 3-months prior to survey submission |
| **8B** Medication Reconciliation | Latest 3-months prior to survey submission | Latest 3-months prior to survey submission |
| **9A** CAHPS Child Hospital Survey | 12-months ending 12/31/2016 | 12-months ending 06/30/2017 |
| **9B** Pediatric Computed Tomography (CT) Radiation Dose | 12-months ending 12/31/2016 | 12-months ending 06/30/2017 |

\*In order Adult and pediatric hospitals reporting on Section 7B Healthcare-Associated Infections are required to join Leapfrog’s NHSN Group. More information, including important deadlines, is available on the [Join NHSN Group webpage](http://www.leapfroggroup.org/survey-materials/join-nhsn).

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PROFILE

Hospitals must first complete and submit a Profile on the Survey Dashboard before accessing the online survey tool for the first time. The Profile is available year round and should be updated as necessary.

Profile

### 

The Profile must be completed and submitted before you can access the online survey tool. The profile is available year round and should be updated as necessary.

|  |
| --- |
| Profile |

**Specifications:** Hospitals that share a Medicare Provider Number are required to report by facility. Please carefully review [Leapfrog’s Multi-Campus Reporting Policy](http://leapfroggroup.org/survey-materials/multi-campus-reporting-policy).

**Important Notes:**

Note 1: Leapfrog uses an administration system that links contacts shared by hospitals (i.e. CEOs, survey contacts, system contacts, and PR contacts). Only one phone number and email address will be maintained for each contact, meaning that if this shared contact’s information is updated in one hospital’s Profile, it will be updated for all hospitals associated with the contact.

Note 2: The primary contact (i.e. Survey Contact 1) and system contact will be notified at the beginning of each month if Leapfrog finds any error in your survey that needs to be corrected.

### Facility Information

|  |  |
| --- | --- |
| **Organization Name** | **Medicare Provider Number** [**(MPN)**](#Endnote1)**[[1]](#endnote-2)**  If the MPN displayed in the online survey tool is not correct, contact the Help Desk immediately. |
|  |  |
|  | **Does your facility share this MPN with another facility?** |
|  | 🞏 Yes  🞏 No |
|  | [**NHSN ID**](#Endnote2)**[[2]](#endnote-3)** |
|  |  |
|  | **Federal Tax Identification Number** [**(TIN)**](#Endnote3)**[[3]](#endnote-4)** |
|  |  |
|  | **National Provider Identifier** [**(NPI)**](#Endnote4)**[[4]](#endnote-5)** |
|  |  |

### Demographic Information

|  |  |
| --- | --- |
| **Physical Address**  (used for public reporting) | **Mailing Address**  (used to send important communications) |
| **Street Address** | **Street Address or P.O. Box** |
|  |  |
| **City** | **City** |
|  |  |
| [**State**](#Endnote5)**[[5]](#endnote-6)** | **State** |
|  |  |
| **Zip Code** | **Zip Code** |
|  |  |
| **Zip Code Suffix** | **Zip Code Suffix** |
|  |  |
| **Main Phone Number** |  |
|  |  |
| [**Hospital Website Address**](#Endnote6)**[[6]](#endnote-7)**  (So consumers can learn more about your hospital’s efforts in the area of patient safety and quality improvement) |  |
|  |  |

### Contact Information

|  |  |
| --- | --- |
| **Chief Executive Officer (CEO)** | **Chairman of the Board** |
| **First Name** | **First Name** |
|  |  |
| **Last Name** | **Last Name** |
|  |  |
| **Email Address**  (required for emailing of security codes and Top Hospital notification) |  |
|  |  |

|  |  |
| --- | --- |
| **Primary Contact** | **Secondary Contact** |
| **First Name** | **First Name** |
|  |  |
| **Last Name** | **Last Name** |
|  |  |
| **Title** | **Title** |
|  |  |
| **Phone Number** | **Phone Number** |
|  |  |
| **Phone Number Extension** | **Phone Number Extension** |
|  |  |
| **Email Address** | **Email Address** |
|  |  |

|  |  |
| --- | --- |
| **Hospital PR Contact**  (required so that Leapfrog may provide information on Leapfrog accolades, such as Top Hospital notification, and announcements) |  |
| **First Name** |  |
|  |  |
| **Last Name** |  |
|  |  |
| **Phone Number** |  |
|  |  |
| **Phone Number Extension** |  |
|  |  |
| **Email Address** |  |
|  |  |

|  |  |
| --- | --- |
| **Health System Information** | |
| **Is this hospital part of a healthcare system or Integrated Delivery Network?** | **System PR Contact First Name** |
| 🞏 Yes  🞏 No  If yes, provide contact information. |  |
| **Name of the healthcare system or Integrated Delivery Network** | **System PR Contact Last Name** |
|  |  |
| **System Contact First Name** | **System PR Contact Phone Number** |
|  |  |
| **System Contact Last Name** | **System PR Contact Phone Number Extension** |
|  |  |
| **System Contact Email Address** | **System PR Contact Email Address** |
|  |  |
| **Additional Contact Information**  Please provide the email address for your hospital’s general inbox (e.g., [info@hospital.com](mailto:info@hospital.com)). This will be used on the Leapfrog Hospital Results website for patients and consumers to provide feedback directly to your hospitals. | |
|  | |

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SECTION 1: BASIC HOSPITAL INFORMATION

This section includes questions and reference information for Section 1 Basic Hospital Information. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 1: 2017 Basic Hospital Information

Section 1 must be completed before you can submit a Leapfrog Hospital Survey. This section asks for demographic information that is used by researchers and displayed on the Leapfrog Hospital Survey Results [website](http://www.leapfroggroup.org/compare-hospitals). This information is not used in scoring.

|  |
| --- |
| 1: Basic Hospital Information |

**Specifications:** Hospitals that share a Medicare Provider Number are required to report by facility. Please carefully review [Leapfrog’s Multi-Campus Reporting Policy](http://leapfroggroup.org/survey-materials/multi-campus-reporting-policy).

|  |
| --- |
| **Reporting Time Period: 12 months**   * Surveys submitted prior to September 1: 01/01/2016 – 12/31/2016 * Surveys (re)submitted on or after September 1: 07/01/2016 – 06/30/2017 |

|  |  |
| --- | --- |
| 1. Reporting time period used: | 🞎 01/01/2016 – 12/31/2016  🞎 07/01/2016 – 06/30/2017 |
| 1. Number of [licensed](#Endnote7)[[7]](#endnote-8) medical, surgical, and obstetric beds. | *\_\_\_\_\_* |
| 1. Number of [staffed](#Endnote8)[[8]](#endnote-9) medical, surgical, and obstetric beds. | *\_\_\_\_\_* |
| 1. Number of [total adult acute-care admissions](#Endnote9)[[9]](#endnote-10) to your hospital during the reporting period. | *\_\_\_\_\_* |
| 1. Number of [total pediatric acute-care admissions](#Endnote10)[[10]](#endnote-11) to your hospital during the reporting period. | *\_\_\_\_\_* |
| 1. Does your hospital operate any adult or pediatric general medical and/or surgical or neuro ICUs? | *Yes*  *No* |
| If yes to question #6: |  |
| 1. Number of [licensed ICU](#Endnote11)[[11]](#endnote-12) beds. | *\_\_\_\_\_* |
| 1. Number of [staffed ICU](#Endnote12)[[12]](#endnote-13) beds. | *\_\_\_\_\_* |
| 1. Number of [admissions to adult and pediatric general medical/surgical ICU(s) and neuro ICUs](#Endnote13)[[13]](#endnote-14) during the reporting period. | *\_\_\_\_\_* |
| 1. Does your hospital operate any of the following specialty ICUs: medical cardiac, respiratory, surgical cardiothoracic, burn, trauma, pediatric cardiothoracic, oncology, or any level NICU? | *Yes*  *No* |
| 1. Is your hospital a member of the Council of Teaching Hospitals and Health Systems [(COTH)](#Endnote14)?[[14]](#endnote-15) | *Yes*  *No* |
| 1. If no, is your hospital considered a [teaching hospital](#Endnote15)?[[15]](#endnote-16) | *Yes*  *No* |

**Affirmation of Accuracy**

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Basic Hospital Information Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract with Leapfrog are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the survey results public reporting website, The Leapfrog Group’s Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group. This information does not infringe any third party’s intellectual property rights. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract with Leapfrog reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the hospital’s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(name) (title)

on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

*(date)*

Section 1: 2017 Basic Hospital Reference Information

### What’s New in the 2017 Survey

Instead of asking for total acute care admissions, Leapfrog has added questions asking for [adult](#Endnote9)9 and [pediatric](#Endnote10)10 admissions separately. Leapfrog has also added questions asking whether your facility operates any specialty ICUs or NICUs. This will allow for additional [data review](http://www.leapfroggroup.org/survey-materials/data-accuracy) warnings within the online survey and reduce potential reporting errors. None of the information in Section 1 is used for scoring, nor is admissions data publicly reported.

### Change Summary since Release

None. If substantive changes are made to this section of the survey after release on April 1, 2017 they will be documented in this Change Summary section.

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SECTION 2: MEDICATION SAFETY - COMPUTERIZED PHYSICIAN ORDER ENTRY (CPOE)

This section includes questions and reference information for Section 2 Medication Safety - Computerized Physician Order Entry. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 2: 2017 Medication Safety - Computerized Physician Order Entry (CPOE)

**CPOE Fact Sheet:** <http://leapfroggroup.org/ratings-reports/survey-content>

**The Pediatric Inpatient CPOE Evaluation Tool is not available. Pediatric Hospitals should complete questions #1-4 only.**

**Each hospital fully meeting this standard:**

1. Assures that prescribers\* enter at least 75% of inpatient medication orders via a computer system that includes decision support software to reduce prescribing errors; and,
2. For adult and general hospitals, demonstrates, via a test\*\*, that its inpatient CPOE system can alert physicians to at least 50% of common serious prescribing errors.

\* “Prescribers” used throughout this section refers to all licensed clinicians authorized by the state in which the hospital is located to order pharmaceuticals for patients.

\*\* For the 2017 Survey, scored results on the Adult Inpatient Test of the CPOE Evaluation Tool will be used to assess if an adult or general hospital’s CPOE system is alerting prescribers to at least 50% of common serious prescribing errors. A hospital may access the CPOE Evaluation Tool (Sample and Adult Inpatient Test) only after the following:

1. Responding ‘yes’ to question #2, indicating that your hospital has a functioning CPOE system in at least one inpatient unit
2. Responding to questions #3-4
3. Submitting Sections 1 Basic Hospital Information and 2 Medication Safety - CPOE from the Survey Dashboard

**Important Notes:**

Note 1: Due to the updates to the CPOE Evaluation Tool, the Tool will not be accessible from the Survey Dashboard until April 15. All hospitals are urged to complete a Sample Test prior to starting an Adult Inpatient Test and to review the updated [instructions](http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials) and [scoring criteria](http://www.leapfroggroup.org/survey-materials/scoring-and-results).

Note 3: Hospitals must complete an Adult Inpatient Test at least once per survey cycle (April to December). Hospitals are only able to re-take a CPOE Evaluation Tool after 120 days have passed since they last completed the CPOE Evaluation Tool.

**Download the 2017 Leapfrog Hospital Survey Scoring Algorithm on the** [**Scoring and Results webpage**](http://www.leapfroggroup.org/survey-materials/scoring-and-results)**.**

|  |
| --- |
| 2: Medication Safety - Computerized Physician Order Entry (CPOE) |

**Specifications:** Hospitals that share a Medicare Provider Number are required to report by facility. Please carefully review [Leapfrog’s Multi-Campus Reporting Policy](http://leapfroggroup.org/survey-materials/multi-campus-reporting-policy).

|  |
| --- |
| **Reporting Time Period: 3 months**  Answer questions #1-4 for the latest 3-month period prior to the submission of this section of the survey. |

|  |  |  |
| --- | --- | --- |
| 1. What is the latest 3-month reporting period for which your hospital is submitting responses to this section? 3-month reporting time period ending: | | *\_\_\_\_\_\_*  *Format: MM/YYYY* |
| 1. Does your hospital have a functioning CPOE system in one or more inpatient units of the hospital that:  * includes decision support software to reduce prescribing errors; and, * is [linked](#Endnote16)[[16]](#endnote-17) to pharmacy, laboratory, and admitting-discharge-transfer (ADT) information in your hospital | | *Yes*  *No* |
| *If “yes” to question #2, continue with questions #3 and #4; otherwise, skip to Affirmation of Accuracy* | | |
| 1. Total number of **inpatient medication orders**, including orders made in units which do NOT have a functioning CPOE system. | | *\_\_\_\_\_*  *Format: Whole numbers only* |
| 1. The number of **orders** in question #3 that licensed prescribers entered via a CPOE system that meets the criteria outlined in question #2. | | *\_\_\_\_\_*  *Format: Whole numbers only* |
| *If “yes” to question #2 and you are an* ***adult or general hospital****, you will be able to access the* ***CPOE Evaluation Tool*** *from the Survey Dashboard after submitting Sections 1 Basic Hospital Information and 2 Medication Safety – CPOE starting on April 15.*  *Question #5 does not apply to pediatric hospitals.* | | |
| 1. What was your hospital’s score when it tested its CPOE system using the Leapfrog CPOE Evaluation Tool?   ***Adult Inpatient Test must be completed between***  ***April 15 – December 31, 2017*** | *No response required here. Determined automatically based on* ***separately completing*** *a test using the*  *Leapfrog CPOE Evaluation Tool* | |

**Affirmation of Accuracy**

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Medication Safety - Computerized Physician Order Entry Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract with Leapfrog are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the survey results public reporting website, The Leapfrog Group’s Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group. This information does not infringe any third party’s intellectual property rights. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract with Leapfrog reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the hospital’s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(name) (title)

on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

*(date)*

Section 2: 2017 Medication Safety - Computerized Physician Order Entry Reference Information

**The Pediatric Inpatient CPOE Evaluation Tool is not available. Pediatric Hospitals should complete questions #1-4 only.**

### What’s New in the 2017 Survey

There are no substantive changes to the questions in this section. However, the CPOE Evaluation Tool has been updated for 2017. Version 3.0 of the CPOE Evaluation Tool incorporates feedback we have received from hospitals regarding formulary issues, lab value issues, and outdated alerts. The new Tool will include updated patient profiles, updated medication orders, and an updated user interface, as well as other enhancements such as a display timer.

The new CPOE Evaluation Tool also includes updated time limits. Hospitals will now have 3 hours to complete Steps 1 and 2 (Print Test Patients and Set-up Test Patients) and 3 hours to complete Steps 3-6 (Print Test Orders, Enter Test Orders, Enter Responses, and Submit Affirmation). Lastly, the wait time between Adult Inpatient Tests has been shortened from 6 months to 120 days. Please carefully review the updated instructions on the [Survey and CPOE Materials webpage](http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials).

Due to the updates to the CPOE Evaluation Tool, the Tool will not be accessible on the Survey Dashboard until April 15.

In addition, the CPOE Evaluation Tool will be scored based on an updated [scoring algorithm](http://www.leapfroggroup.org/survey-materials/scoring-and-results).

### 

### Change Summary since Release

None. If substantive changes are made to this section of the survey after release on April 1, 2017 they will be documented in this Change Summary section.

## CPOE Frequently Asked Questions (FAQs)

1. **What 3-month reporting period should be used when reporting on this section?**

Hospitals should use the most recent three month reporting period available prior to submission. For example, if your hospital is submitting a survey in June, you would use March 1, 2017 to May 30, 2017.

1. **Does a pharmacy system that catches prescribing errors like potential interactions, dosing errors, etc. qualify as CPOE?**

No. This does not qualify as CPOE. In fact, the very large favorable impact documented at the Brigham and Women’s hospital was achieved when CPOE replaced a prior electronic prescribing system identical to the pharmacy order entry systems which the inquirer is describing. While it is very important to eliminate hand-written prescriptions, it is also important to have in place decision-support.

1. **What orders should we count for the CPOE denominator? The numerator?**

For the denominator, hospitals should only include **initial** inpatient medication orders. For example, orders that are modified from an initial order that maintain the original intent of the original order would not be counted.

For the numerator, hospitals should count those orders in the denominator that were entered through a CPOE system by a licensed prescriber. Per protocol orders and standard order sets approved by a medical committee can also be included in the numerator if they are initiated by a nurse or licensed prescriber.

1. **Could we count an order that a prescriber calls in via telephone, but is entered by a nurse (or ward secretary) into the CPOE system in our numerator?**

No, orders that are verbally given to a non-licensed prescriber (i.e. nurse) to enter into the CPOE system would not be included in the numerator. This ensures that the prescriber sees all decision support.

1. **Could we count an order that a resident or intern enters into the CPOE system in our numerator?**

Yes, residents and interns can prescribe medications under their own authority. Hospitals should include all resident/intern-ordered medications when responding to questions #3 and #4.

1. **Can we report the numerator and denominator from our Stage 2 Meaningful Use Reports?**

Yes. Hospitals may report on Meaningful Use Measure 1: Medication for POS 21 (inpatient) only. If hospitals are not able to separate out orders from POS 23 (emergency department) the report cannot be used. More information about Measure 1: Medication can be found at: <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EH_3CPOEObjective.pdf>

1. **How often should a hospital take a CPOE Evaluation Tool?**

In order to be included in a hospital’s scoring for the CPOE standard, the CPOE Evaluation Tool needs to be taken at least once per survey cycle (April 15 – December 31). Within a survey cycle, a hospital cannot retake a CPOE Evaluation Tool until at least 120 days have passed since their last test was taken.

1. **How do hospitals access the CPOE Evaluation Tool?** Log into the online survey tool with your 16-digit security code. Submit Sections 1 Basic Hospital Information and 2 Medication Safety - CPOE. The CPOE Tool button will appear on the Survey Dashboard. Once the Adult Inpatient Test is complete, hospitals will need to come back into the survey and submit any uncompleted sections of the survey, or they will receive a score of “Declined to Respond” for those sections.

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SECTION 3: INPATIENT SURGERY

This section includes questions and reference information for Section 3 Inpatient Surgery. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 3: 2017 Inpatient Surgery

**This section is not applicable to Pediatric hospitals.**

This section of the survey is new in 2017 and assesses surgical volume at the hospital and individual surgeon level. The ten procedures included in this section have been selected due to the strong, evidence-based relationship between volume and outcomes. Responses provided for this section will be used to inform the minimum hospital and surgeon volume standards for safety recommended by Leapfrog’s national expert panel. In addition, the section assesses whether hospitals have processes in place to ensure surgery is only being performed on patients that meet evidence-based, hospital-defined criteria, thereby decreasing the opportunities for inappropriate surgeries and balancing Leapfrog’s volume standard.

This section will not be scored and results for this section of the survey will not be publicly reported in 2017. This section will be scored and results will be publicly reported in 2018.

|  |  |
| --- | --- |
| 3A: Hospital and Surgeon Volume **Specifications:** See [***Hospital and Surgeon Volume***](#MinVolSpecs) in the Inpatient Surgery Reference Information on page 49.   |  | | --- | | **Reporting Time Period:** **12-months**   * Surveys submitted prior to September 1: 01/01/2016 - 12/31/2016 (12-month count) * Surveys (re)submitted on or after September 1: 07/01/2016 - 06/30/2017 (12-month count) | |

|  |  |
| --- | --- |
| 1. 12-month reporting time period used: | * 01/01/2016 – 12/31/2016 (12 month count) * 07/01/2016 – 06/30/2017 (12 month count) |
| 1. Check all procedures that your hospital performs as defined in Inpatient Surgery Reference Information.   *If your hospital does not perform the procedure or ONLY does so when a patient is too unstable for safe transfer, do not check the box next to that procedure.*  *If “None of the above,” please skip remaining questions in Section 3A and 3B, and go to the Affirmation of Accuracy.* | * Carotid endarterectomy * Mitral valve repair and replacement * Open aortic aneurysm repair * Lung resection * Esophageal resection * Pancreatic resection * Rectal cancer surgery * Hip replacement * Knee replacement * Bariatric surgery for weight loss * None of the above |

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| 1. Total **hospital** volume for each selected procedure during the reporting period:   *Volume should represent a 12-month count consistent with the reporting period selected in question #1.* | |
| *Procedure* | *Number of Procedures Performed*  *(12-month count)*  *Format: Whole numbers only* |
| Carotid endarterectomy |  |
| Mitral valve repair and replacement |  |
| Open abdominal aortic aneurysm repair |  |
| Lung resection |  |
| Esophageal resection |  |
| Pancreatic resection |  |
| Rectal cancer surgery |  |
| Hip replacement |  |
| Knee replacement |  |
| Bariatric surgery for weight loss |  |

|  |  |
| --- | --- |
| 1. For the surgeons who performed **carotid endarterectomy** at your hospital during the reporting period, how many surgeons performed at each volume strata?   *Report on the total surgeon volume using the reporting period selected in question #1. If you do not have any surgeons to report in a particular volume strata, enter “0.” Do not leave any blanks.* | |
| 1. 1 surgery | \_\_\_\_\_\_\_\_ surgeons |
| 1. 2 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 3 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 4 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 5 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 6-10 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 11-15 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 16-20 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 21-25 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. More than 25 surgeries | \_\_\_\_\_\_\_\_ surgeons |

|  |  |
| --- | --- |
| 1. For the surgeons who performed **mitral valve repair and replacement** at your hospital during the reporting period, how many surgeons performed at each volume strata?   *Report on the total surgeon volume using the reporting period selected in question #1. If you do not have any surgeons to report in a particular volume strata, enter “0.” Do not leave any blanks.* | |
| 1. 1 surgery | \_\_\_\_\_\_\_\_ surgeons |
| 1. 2 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 3 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 4 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 5 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 6-10 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 11-15 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 16-20 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 21-25 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. More than 25 surgeries | \_\_\_\_\_\_\_\_ surgeons |

|  |  |
| --- | --- |
| 1. For the surgeons who performed **open abdominal aortic aneurysm repair** at your hospital during the reporting period, how many surgeons performed at each volume strata?   *Report on the total surgeon volume using the reporting period selected in question #1. If you do not have any surgeons to report in a particular volume strata, enter “0.” Do not leave any blanks.* | |
| 1. 1 surgery | \_\_\_\_\_\_\_\_ surgeons |
| 1. 2 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 3 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 4 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 5 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 6-10 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 11-15 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 16-20 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 21-25 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. More than 25 surgeries | \_\_\_\_\_\_\_\_ surgeons |

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| --- | --- |
| 1. For the surgeons who performed **lung resection** at your hospital during the reporting period, how many surgeons performed at each volume strata?   *Report on the total surgeon volume using the reporting period selected in question #1. If you do not have any surgeons to report in a particular volume strata, enter “0.” Do not leave any blanks.* | |
| 1. 1surgery | \_\_\_\_\_\_\_\_ surgeons |
| 1. 2 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 3 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 4 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 5 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 6-10 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 11-15 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 16-20 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 21-25 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. More than 25 surgeries | \_\_\_\_\_\_\_\_ surgeons |

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| --- | --- |
| 1. For the surgeons who performed **esophageal resection** at your hospital during the reporting period, how many surgeons performed at each volume strata?   *Report on the total surgeon volume using the reporting period selected in question #1. If you do not have any surgeons to report in a particular volume strata, enter “0.” Do not leave any blanks.* | |
| 1. 1 surgery | \_\_\_\_\_\_\_\_ surgeons |
| 1. 2 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 3 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 4 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 5 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 6 -10 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 11-15 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 16-20 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 21-25 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. More than 25 surgeries | \_\_\_\_\_\_\_\_ surgeons |

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| --- | --- |
| 1. For the surgeons who performed **pancreatic resection** at your hospital during the reporting period, how many surgeons performed at each volume strata?   *Report on the total surgeon volume using the reporting period selected in question #1. If you do not have any surgeons to report in a particular volume strata, enter “0.” Do not leave any blanks.* | |
| 1. 1 surgery | \_\_\_\_\_\_\_\_ surgeons |
| 1. 2 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 3 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 4 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 5 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 6-10 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 11-15 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 16-20 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 21-25 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. More than 25 surgeries | \_\_\_\_\_\_\_\_ surgeons |

|  |  |
| --- | --- |
| 1. For the surgeons who performed **rectal cancer surgery** at your hospital during the reporting period, how many surgeons performed at each volume strata?   *Report on the total surgeon volume using the reporting period selected in question #1. If you do not have any surgeons to report in a particular volume strata, enter “0.” Do not leave any blanks.* | |
| 1. 1 surgery | \_\_\_\_\_\_\_\_ surgeons |
| 1. 2 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 3 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 4 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 5 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 6-10 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 11-15 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 16-20 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 21-25 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. More than 25 surgeries | \_\_\_\_\_\_\_\_ surgeons |

|  |  |
| --- | --- |
| 1. For the surgeons who performed **hip replacement** at your hospital during the reporting period, how many surgeons performed at each volume strata?   *Report on the total surgeon volume using the reporting period selected in question #1. If you do not have any surgeons to report in a particular volume strata, enter “0.” Do not leave any blanks.* | |
| 1. 1 surgery | \_\_\_\_\_\_\_\_ surgeons |
| 1. 2 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 3 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 4 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 5 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 6-10 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 11-15 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 16-20 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 21-25 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. More than 25 surgeries | \_\_\_\_\_\_\_\_ surgeons |

|  |  |
| --- | --- |
| 1. For the surgeons who performed **knee replacement** at your hospital during the reporting period, how many surgeons performed at each volume strata?   *Report on the total surgeon volume using the reporting period selected in question #1. If you do not have any surgeons to report in a particular volume strata, enter “0.” Do not leave any blanks.* | |
| 1. 1 surgery | \_\_\_\_\_\_\_\_ surgeons |
| 1. 2 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 3 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 4 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 5 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 6-10 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 11-15 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 16-20 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 21-25 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. More than 25 surgeries | \_\_\_\_\_\_\_\_ surgeons |
|  |  |
| 1. For the surgeons who performed **bariatric surgery for weight loss** at your hospital during the reporting period, how many surgeons performed at each volume strata?   *Report on the total surgeon volume using the reporting period selected in question #1. If you do not have any surgeons to report in a particular volume strata, enter “0.” Do not leave any blanks.* | |
| 1. 1 surgery | \_\_\_\_\_\_\_\_ surgeons |
| 1. 2 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 3 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 4 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 5 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 6-10 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 11-15 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 16-20 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. 21-25 surgeries | \_\_\_\_\_\_\_\_ surgeons |
| 1. More than 25 surgeries | \_\_\_\_\_\_\_\_ surgeons |

|  |  |
| --- | --- |
| 14) Has your hospital or health system established and implemented minimum **hospital** volume standards for any of the following procedures:  *Check all that apply.* | * Carotid endarterectomy * Mitral valve repair and replacement * Open aortic aneurysm repair * Lung resection * Esophageal resection * Pancreatic resection * Rectal cancer surgery * Hip replacement * Knee replacement * Bariatric surgery for weight loss * None of the above |
| 15) Has your hospital or health system established and implemented minimum **surgeon** volume standards for any of the following procedures:  *Check all that apply.* | * Carotid endarterectomy * Mitral valve repair and replacement * Open aortic aneurysm repair * Lung resection * Esophageal resection * Pancreatic resection * Rectal cancer surgery * Hip replacement * Knee replacement * Bariatric surgery for weight loss   None of the above |

|  |  |
| --- | --- |
| 3B: Surgical Appropriateness  |  | | --- | | **Reporting Time Period:**  Answer questions #1-10 for the latest 12-month period prior to the submission of this section of the survey. | |

|  |  |
| --- | --- |
| 1. Does your hospital have appropriateness criteria for any of the following 10 surgeries:   *If “None of the above,” skip the remainder of the questions in Section 3B, and go to the Affirmation of Accuracy.* | * Carotid endarterectomy * Mitral valve repair and replacement * Open aortic aneurysm repair * Lung resection * Esophageal resection * Pancreatic resection * Rectal cancer surgery * Hip replacement * Knee replacement * Bariatric surgery for weight loss * None of the above |
| 1. If “yes” to question #1, did your hospital do any of the following in developing the appropriateness criteria: | * Use the latest evidence and clinical guidelines * Solicit input from employed surgeons, and if applicable, non-employed surgeons * Incorporate relevant [Choosing Wisely lists](http://www.choosingwisely.org/clinician-lists/) * Review, and if appropriate, update the criteria on an annual basis * None of the above |
| 1. Does your hospital have processes or structures in place to promote ongoing adherence to the appropriateness criteria? | *Yes*  *No* |
| 1. If “yes” to question #3, for which of the following 10 surgeries: | * Carotid endarterectomy * Mitral valve repair and replacement * Open aortic aneurysm repair * Lung resection * Esophageal resection * Pancreatic resection * Rectal cancer surgery * Hip replacement * Knee replacement * Bariatric surgery for weight loss |
| 1. Does your hospital conduct regular retrospective reviews of surgical cases to evaluate the extent to which your appropriateness criteria are met or not met by each surgeon? | *Yes*  *No* |
| 1. If “yes” to question #5, for which of the following 10 surgeries | * Carotid endarterectomy * Mitral valve repair and replacement * Open aortic aneurysm repair * Lung resection * Esophageal resection * Pancreatic resection * Rectal cancer surgery * Hip replacement * Knee replacement * Bariatric surgery for weight loss |
| 1. Does your hospital have a process in place for communicating with surgeons, surgical leadership, and administrative leadership when a surgeon’s trend or pattern suggests challenges to adhering to your appropriateness criteria and work to understand potential barriers to meeting the criteria? | *Yes*  *No* |
| 1. If “yes” to question #7, for which of the following 10 surgeries: | * Carotid endarterectomy * Mitral valve repair and replacement * Open aortic aneurysm repair * Lung resection * Esophageal resection * Pancreatic resection * Rectal cancer surgery * Hip replacement * Knee replacement * Bariatric surgery for weight loss |
| 1. Does your hospital report annually to its Board the finding from the retrospective reviews and plans to improve adherence to the appropriateness criteria? | *Yes*  *No* |
| 1. If “yes” to question #9, for which of the following 10 surgeries: | * Carotid endarterectomy * Mitral valve repair and replacement * Open aortic aneurysm repair * Lung resection * Esophageal resection * Pancreatic resection * Rectal cancer surgery * Hip replacement * Knee replacement * Bariatric surgery for weight loss |

**Affirmation of Accuracy**

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Inpatient Surgery Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract with Leapfrog are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the survey results public reporting website, The Leapfrog Group’s Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group. This information does not infringe any third party’s intellectual property rights. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract with Leapfrog reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the hospital’s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(name) (title)

on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

*(date)*

Section 3: 2017 Inpatient Surgery Reference Information

**This section is not applicable to Pediatric hospitals.**

### What’s New in the 2017 Survey

Leapfrog removed the survival predictor measures and renamed Section 3 as Inpatient Surgery. This section of the survey is new in 2017 and assesses surgical volume at the hospital and individual surgeon level. The ten procedures included in this section have been selected due to the strong, evidence-based relationship between volume and outcomes. Responses provided for this section will be used to inform the minimum hospital and surgeon volume standards for safety recommended by Leapfrog’s national expert panel. In addition, the section assesses whether hospitals have processes in place to ensure surgery is only being performed on patients that meet evidence-based, hospital-defined criteria, thereby decreasing the opportunities for inappropriate surgeries and balancing Leapfrog’s volume standard.

This section will not be scored and results for this section of the survey will not be publicly reported in 2017. This section will be scored and results will be publicly reported in 2018.

### Change Summary since Release

If substantive changes are made to this section of the survey after release on April 1, 2017 they will be documented in this Change Summary section.

Issued on April 5, 2017 - Leapfrog has removed the 24-month annual average reporting time period from Section 3A Hospital and Surgeon Volume as the measure is specified in ICD-10 and ICD-10 coded data are not available for the entire 24 months due to the national transition to ICD-10 going into effect on October 1, 2015. Hospitals will only have the option of reporting on a 12-month count and must use the ICD-10 diagnosis and procedure codes provided by Leapfrog in this section of the survey.

Issued on April 5, 2017 – Leapfrog has updated the list of ICD-10 diagnosis codes for **Occlusion and Stenosis and Cerebral Infarction**. We have replaced I65.2 (a “parent” code) with I65.21, I65.22, 165.23, and I65.29.

## Inpatient Surgery Measure Specifications – Hospital and Surgeon Volume

For each of the 10 surgical procedures included in Section 3A Hospital and Surgeon Volume, Leapfrog has provided a set of ICD-10 procedure codes, and in some cases an additional set of ICD-10 diagnosis codes, for counting patients. While it is expected that most procedures would be indicated as a principle procedure given their severity, if the procedure code is found in any position, the patient can be counted if the code qualifies according to the definition. Similarly, if the diagnosis code is found in any position, the patient can be counted.

Only the ICD-10 procedure and diagnosis codes provided by Leapfrog should be used to report on the hospital volume and the surgeon volume questions.

If your hospital does not perform the procedure or ONLY does so when a patient is too unstable for safe transfer, do not check the box for that procedure in question #2.

When calculating **hospital volume**: count the number of **patients** discharged from your facility within the reporting period with any one or more of the codes specified for each procedure, subject to the other inclusion/exclusion criteria below. Age restrictions apply to all 10 procedures.

When calculating **surgeon volume**: count the number of patients discharged within the reporting period with any one of more of the specified procedure codes for each procedure performed by the individual surgeon. If the surgeon performed the procedure at more than one facility during the reporting period, hospitals should attempt to obtain total surgeon volume across all facilities for the individual surgeon during the reporting period using the list of ICD-10 codes provided by Leapfrog. Volume cannot be obtained using CPT or other codes.

When identifying **surgeons** who performed each procedure: only include those surgeons who were privileged and credentialed to perform the procedure at your facility throughout the entire reporting period. Surgeons who were only privileged and credentialed to perform the procedure for a portion of the reporting period (e.g. new surgeons, visiting fellows, retiring surgeons, etc.), should not be included. See FAQs for additional information about reporting on new service lines and new surgeons.

### Carotid Endarterectomy Measure References

For Carotid Endarterectomy, there are two sets of ICD-10 codes for counting patients. The first set of codes is to identify patients who have had the procedure. The second set of codes is to identify patient with a specific diagnosis.

**Source**: The Leapfrog Group

Number of patients, age 18 years and older, discharged with the following ICD-10 codes in any procedure field AND any of the following ICD-10 codes in any diagnosis field.

**ICD-10 Carotid Endarterectomy Procedure Codes**

| **ICD10 Procedure Code** | **Code Description** |
| --- | --- |
| 03CH0ZZ | Extirpation of Matter from Right Common Carotid Artery, Open Approach |
| 03CJ0ZZ | Extirpation of Matter from Left Common Carotid Artery, Open Approach |
| 03CK0ZZ | Extirpation of Matter from Right Internal Carotid Artery, Open Approach |
| 03CL0ZZ | Extirpation of Matter from Left Internal Carotid Artery, Open Approach |
| 03CM0ZZ | Extirpation of Matter from Right External Carotid Artery, Open Approach |
| 03CN0ZZ | Extirpation of Matter from Left External Carotid Artery, Open Approach |

**ICD-10 Occlusion and Stenosis and Cerebral Infarction Diagnosis Codes**

| **ICD10 Diagnosis Code** | **Code Description** |
| --- | --- |
| I65.21 | Occlusion and stenosis of right carotid artery |
| I65.22 | Occlusion and stenosis of left carotid artery |
| I65.23 | Occlusion and stenosis of bilateral carotid arteries |
| I65.29 | Occlusion and stenosis of unspecified carotid artery |
| I65.21 | Occlusion and stenosis of right carotid artery |
| I65.22 | Occlusion and stenosis of left carotid artery |
| I65.23 | Occlusion and stenosis of bilateral carotid arteries |
| I65.29 | Occlusion and stenosis of unspecified carotid artery |
| I65.8 | Occlusion and stenosis of other precerebral arteries |
| I65.9 | Occlusion and stenosis of unspecified precerebral artery |
| I63.23 | Cerebral infarction due to unspecified occlusion or stenosis of carotid arteries |
| I63.231 | Cerebral infarction due to unspecified occlusion or stenosis of right carotid arteries |
| I63.232 | Cerebral infarction due to unspecified occlusion or stenosis of left carotid arteries |
| I63.233 | Cerebral infarction due to unspecified occlusion or stenosis of bilateral carotid arteries |
| I63.239 | Cerebral infarction due to unspecified occlusion or stenosis of unspecified carotid arteries |

### Mitral Valve Repair and Replacement Measure References

For Mitral Valve Repair and Replacement, there is only one set of ICD-10 codes for counting patients. The set of codes is to identify patients who have had the procedure.

**Source**: The Leapfrog Group

Number of patients, age 18 years and older, discharged with the following ICD-10 codes in any procedure field.

**ICD-10 Mitral Valve Repair and Replacement Procedure Codes**

|  |  |
| --- | --- |
| **ICD10 Procedure Code** | **Code Description** |
| 02QG0ZZ | Repair Mitral Valve, Open Approach |
| 02RG07Z | Replacement of Mitral Valve with Autologous Tissue Substitute, Open Approach |
| 02RG08Z | Replacement of Mitral Valve with Zooplastic Tissue, Open Approach |
| 02RG0JZ | Replacement of Mitral Valve with Synthetic Substitute, Open Approach |
| 02RG0KZ | Replacement of Mitral Valve with Nonautologous Tissue Substitute, Open Approach |
| 02RG47Z | Replacement of Mitral Valve with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 02RG48Z | Replacement of Mitral Valve with Zooplastic Tissue, Percutaneous Endoscopic Approach |
| 02RG4JZ | Replacement of Mitral Valve with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 02RG4KZ | Replacement of Mitral Valve with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 02UG0JZ | Supplement Mitral Valve with Synthetic Substitute, Open Approach |

### Open Aortic Aneurysm Repair Measure References

For Open Aortic Aneurysm Repair, there are two sets of ICD-10 codes for counting patients. The first set of codes is to identify patients who have had the procedure. The second set of codes is to identify patient with a specific diagnosis.

**Source**: The Leapfrog Group

Number of patients, age 18 years and older, discharged with the following ICD-10 codes in any procedure field AND any of the following ICD-10 codes in any diagnosis field.

**ICD-10 Open Aortic Aneurysm Repair Procedure Codes**

|  |  |
| --- | --- |
| **ICD10 Procedure Code** | **Code Description** |
| 04100J8 | Bypass Abdominal Aorta to Bilateral Common Iliac Arteries with Synthetic Substitute, Open Approach |
| 04R00JZ | Replacement of Abdominal Aorta with Synthetic Substitute, Open Approach |
| 04Q00ZZ | Repair Abdominal Aorta, Open Approach |
| 04QC0ZZ | Repair Right Common Iliac Artery, Open Approach |
| 04QD0ZZ | Repair Left Common Iliac Artery, Open Approach |

**ICD-10 Unruptured Aortic Aneurysm Diagnosis Codes**

|  |  |
| --- | --- |
| **ICD10 Diagnosis Code** | **Code Description** |
| I71.4 | Abdominal aortic aneurysm, without rupture |
| I71.6 | Thoracoabdominal aortic aneurysm, without rupture |
| I71.9 | Aortic aneurysm of unspecified site, without rupture |

### Lung Resection Measure References

For Lung Resection, there are two sets of ICD-10 codes for counting patients. The first set of codes is to identify patients who have had the procedure. The second set of codes is to identify patient with a specific diagnosis.

**Source**: The Leapfrog Group

Number of patients, age 18 years and older, discharged with the following ICD-10 codes in any procedure field AND any of the following ICD-10 codes in any diagnosis field.

**ICD-10 Lung Resection Procedure Codes**

|  |  |
| --- | --- |
| **ICD10 Procedure Code** | **Code Description** |
| 0BBC0ZZ | Excision of Right Upper Lung Lobe, Open Approach |
| 0BBC3ZZ | Excision of Right Upper Lung Lobe, Percutaneous Approach |
| 0BBC4ZZ | Excision of Right Upper Lung Lobe, Percutaneous Endoscopic Approach |
| 0BBD0ZZ | Excision of Right Middle Lung Lobe, Open Approach |
| 0BBD3ZZ | Excision of Right Middle Lung Lobe, Percutaneous Approach |
| 0BBD4ZZ | Excision of Right Middle Lung Lobe, Percutaneous Endoscopic Approach |
| 0BBF0ZZ | Excision of Right Lower Lung Lobe, Open Approach |
| 0BBF3ZZ | Excision of Right Lower Lung Lobe, Percutaneous Approach |
| 0BBF4ZZ | Excision of Right Lower Lung Lobe, Percutaneous Endoscopic Approach |
| 0BBG0ZZ | Excision of Left Upper Lung Lobe, Open Approach |
| 0BBG3ZZ | Excision of Left Upper Lung Lobe, Percutaneous Approach |
| 0BBG4ZZ | Excision of Left Upper Lung Lobe, Percutaneous Endoscopic Approach |
| 0BBH0ZZ | Excision of Lung Lingula, Open Approach |
| 0BBH3ZZ | Excision of Lung Lingula, Percutaneous Approach |
| 0BBH4ZZ | Excision of Lung Lingula, Percutaneous Endoscopic Approach |
| 0BBJ0ZZ | Excision of Left Lower Lung Lobe, Open Approach |
| 0BBJ3ZZ | Excision of Left Lower Lung Lobe, Percutaneous Approach |
| 0BBJ4ZZ | Excision of Left Lower Lung Lobe, Percutaneous Endoscopic Approach |
| 0BBK0ZZ | Excision of Right Lung, Open Approach |
| 0BBK3ZZ | Excision of Right Lung, Percutaneous Approach |
| 0BBK4ZZ | Excision of Right Lung, Percutaneous Endoscopic Approach |
| 0BBL0ZZ | Excision of Left Lung, Open Approach |
| 0BBL3ZZ | Excision of Left Lung, Percutaneous Approach |
| 0BBL4ZZ | Excision of Left Lung, Percutaneous Endoscopic Approach |
| 0BBL7ZZ | Excision of Left Lung, Via Natural or Artificial Opening |
| 0BTC0ZZ | Resection of Right Upper Lung Lobe, Open Approach |
| 0BTC4ZZ | Resection of Right Upper Lung Lobe, Percutaneous Endoscopic Approach |
| 0BTD0ZZ | Resection of Right Middle Lung Lobe, Open Approach |
| 0BTD4ZZ | Resection of Right Middle Lung Lobe, Percutaneous Endoscopic Approach |
| 0BTF0ZZ | Resection of Right Lower Lung Lobe, Open Approach |
| 0BTF4ZZ | Resection of Right Lower Lung Lobe, Percutaneous Endoscopic Approach |
| 0BTG0ZZ | Resection of Left Upper Lung Lobe, Open Approach |
| 0BTG4ZZ | Resection of Left Upper Lung Lobe, Percutaneous Endoscopic Approach |
| 0BTH0ZZ | Resection of Lung Lingula, Open Approach |
| 0BTH4ZZ | Resection of Lung Lingula, Percutaneous Endoscopic Approach |
| 0BTJ0ZZ | Resection of Left Lower Lung Lobe, Open Approach |
| 0BTJ4ZZ | Resection of Left Lower Lung Lobe, Percutaneous Endoscopic Approach |
| 0BTK0ZZ | Resection of Right Lung, Open Approach |
| 0BTK4ZZ | Resection of Right Lung, Percutaneous Endoscopic Approach |
| 0BTL0ZZ | Resection of Left Lung, Open Approach |
| 0BTL4ZZ | Resection of Left Lung, Percutaneous Endoscopic Approach |

**ICD-10 Malignant Tumor Diagnosis Codes**

|  |  |
| --- | --- |
| **ICD10 Diagnosis Code** | **Code Description** |
| C34.00 | Malignant neoplasm of main bronchus |
| C34.01 | Malignant neoplasm of right main bronchus |
| C34.02 | Malignant neoplasm of left main bronchus |
| C34.10 | Malignant neoplasm of upper lobe, unspecified bronchus or lung |
| C34.11 | Malignant neoplasm of upper lobe, right bronchus or lung |
| C34.12 | Malignant neoplasm of upper lobe, left bronchus or lung |
| C34.2 | Malignant neoplasm of middle lobe, bronchus or lung |
| C34.30 | Malignant neoplasm of lower lobe, unspecified bronchus or lung |
| C34.31 | Malignant neoplasm of lower lobe, right bronchus or lung |
| C34.32 | Malignant neoplasm of lower lobe, left bronchus or lung |
| C34.80 | Malignant neoplasm of overlapping sites of unspecified bronchus and lung |
| C34.81 | Malignant neoplasm of overlapping sites of right bronchus and lung |
| C34.82 | Malignant neoplasm of overlapping sites of left bronchus and lung |
| C34.90 | Malignant neoplasm of unspecified part of unspecified bronchus or lung |
| C34.91 | Malignant neoplasm of unspecified part of right bronchus or lung |
| C34.92 | Malignant neoplasm of unspecified part of left bronchus or lung |

### Esophageal Resection Measure References

For Esophageal Resection, there are two sets of ICD-10 codes for counting patients. The first set of codes is to identify patients who have had the procedure. The second set of codes is to identify patient with a specific diagnosis.

**Source**: The Leapfrog Group

Number of patients, age 18 years and older, discharged with the following ICD-10 codes in any procedure field AND any of the following ICD-10 codes in any diagnosis field.

**ICD-10 Esophageal Resection Procedure Codes**

|  |  |
| --- | --- |
| **ICD10 Procedure Code** | **Code Description** |
| 0DB10ZZ | Excision of Upper Esophagus, Open Approach |
| 0DB13ZZ | Excision of Upper Esophagus, Percutaneous Approach |
| 0DB20ZZ | Excision of Middle Esophagus, Open Approach |
| 0DB23ZZ | Excision of Middle Esophagus, Percutaneous Approach |
| 0DB30ZZ | Excision of Lower Esophagus, Open Approach |
| 0DB33ZZ | Excision of Lower Esophagus, Percutaneous Approach |
| 0DB50ZZ | Excision of Esophagus, Open Approach |
| 0DB53ZZ | Excision of Esophagus, Percutaneous Approach |
| 0DT10ZZ | Resection of Upper Esophagus, Open Approach |
| 0DT14ZZ | Resection of Upper Esophagus, Percutaneous Endoscopic Approach |
| 0DT20ZZ | Resection of Middle Esophagus, Open Approach |
| 0DT24ZZ | Resection of Middle Esophagus, Percutaneous Endoscopic Approach |
| 0DT30ZZ | Resection of Lower Esophagus, Open Approach |
| 0DT34ZZ | Resection of Lower Esophagus, Percutaneous Endoscopic Approach |
| 0DT50ZZ | Resection of Esophagus, Open Approach |
| 0DT54ZZ | Resection of Esophagus, Percutaneous Endoscopic Approach |
| 0DT60ZZ | Resection of Stomach, Open Approach |
| 0DT64ZZ | Resection of Stomach, Percutaneous Endoscopic Approach |

**ICD-10 Malignant Tumor Diagnosis Codes**

|  |  |
| --- | --- |
| **ICD10 Diagnosis Code** | **Code Description** |
| C15.3 | Malignant neoplasm of upper third of esophagus |
| C15.4 | Malignant neoplasm of middle third of esophagus |
| C15.5 | Malignant neoplasm of lower third of esophagus |
| C15.8 | Malignant neoplasm of overlapping sites of esophagus |
| C15.9 | Malignant neoplasm of esophagus, unspecified |
| C16.0 | Malignancy of the cardio-esophageal junction |

### Pancreatic Resection Measure References

For Pancreatic Resection, there are two sets of ICD-10 codes for counting patients. The first set of codes is to identify patients who have had the procedure. The second set of codes is to identify patient with a specific diagnosis.

**Source**: The Leapfrog Group

Number of patients, age 18 years and older, discharged with the following ICD-10 codes in any procedure field AND any of the following ICD-10 codes in any diagnosis field.

**ICD-10 Pancreatic Resection Procedure Codes**

|  |  |
| --- | --- |
| **ICD10 Procedure Code** | **Code Description** |
| 0DB90ZZ | Excision of Duodenum, Open Approach |
| 0DB93ZZ | Excision of Duodenum, Percutaneous Approach |
| 0DB94ZZ | Excision of Duodenum, Percutaneous Endoscopic Approach |
| 0DT90ZZ | Resection of Duodenum, Open Approach |
| 0DT94ZZ | Resection of Duodenum, Percutaneous Endoscopic Approach |
| 0FBG0ZZ | Excision of Pancreas, Open Approach |
| 0FBG3ZZ | Excision of Pancreas, Percutaneous Approach |
| 0FBG4ZZ | Excision of Pancreas, Percutaneous Endoscopic Approach |
| 0FTG0ZZ | Resection of Pancreas, Open Approach |
| 0FTG4ZZ | Resection of Pancreas, Percutaneous Endoscopic Approach |

**ICD-10 Malignant Tumor Diagnosis Codes**

|  |  |
| --- | --- |
| **ICD10 Diagnosis Code** | **Code Description** |
| C17.0 | Malignant neoplasm of duodenum |
| C24.0 | Malignant neoplasm of extrahepatic bile duct |
| C24.1 | Malignant neoplasm of ampulla of Vater |
| C24.8 | Malignant neoplasm of overlapping sites of biliary tract |
| C24.9 | Malignant neoplasm of biliary tract, unspecified |
| C25.0 | Malignant neoplasm of head of pancreas |
| C25.1 | Malignant neoplasm of body of pancreas |
| C25.3 | Malignant neoplasm of pancreatic duct |
| C25.4 | Malignant neoplasm of endocrine pancreas |
| C25.7 | Malignant neoplasm of other parts of pancreas |
| C25.8 | Malignant neoplasm of overlapping sites of pancreas |
| C25.9 | Malignant neoplasm of pancreas, unspecified |

### Rectal Cancer Surgery Measure References

For Rectal Cancer Surgery, there are two sets of ICD-10 codes for counting patients. The first set of codes is to identify patients who have had the procedure. The second set of codes is to identify patient with a specific diagnosis.

**Source**: The Leapfrog Group

Number of patients, age 18 years and older, discharged with the following ICD-10 codes in any procedure field AND any of the following ICD-10 codes in any diagnosis field

**ICD-10 Rectal Cancer Surgery Procedure Codes**

|  |  |
| --- | --- |
| **ICD10 Procedure Code** | **Code Description** |
| 0DBP0ZZ | Excision of Rectum, Open Approach |
| 0DBP4ZZ | Excision of Rectum, Percutaneous Endoscopic Approach |
| 0DTP0ZZ | Resection of Rectum, Open Approach |
| 0DTP4ZZ | Resection of Rectum, Percutaneous Endoscopic Approach |

**ICD-10 Malignant Tumor Diagnosis Codes**

|  |  |
| --- | --- |
| **ICD10 Diagnosis Code** | **Code Description** |
| C20 | Malignant neoplasm of rectum |
| C21.8 | Malignant neoplasm of overlapping sites of rectum, anus and anal canal |

### Hip Replacement Measure References

For Hip Replacement, there is only one set of ICD-10 codes for counting patients. The set of codes is to identify patients who have had the procedure.

**Source**: The Leapfrog Group

Number of patients, age 18 years and older, discharged with the following ICD-10 codes in any procedure field.

**ICD-10 Hip Replacement Procedure Codes**

|  |  |
| --- | --- |
| **ICD10 Procedure Code** | **Code Description** |
| 0SR9049 | Replacement of Right Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Cemented, Open Approach |
| 0SR904A | Replacement of Right Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Uncemented, Open Approach |
| 0SR904Z | Replacement of Right Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Open Approach |
| 0SRB049 | Replacement of Left Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Cemented, Open Approach |
| 0SRB04A | Replacement of Left Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Uncemented, Open Approach |
| 0SRB04Z | Replacement of Left Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Open Approach |

### Knee Replacement Measure References

For Knee Replacement, there is only one set of ICD-10 codes for counting patients. The set of codes is to identify patients who have had the procedure.

**Source**: The Leapfrog Group

Number of patients, age 18 years and older, discharged with the following ICD-10 codes in any procedure field.

**ICD-10 Knee Replacement Procedure Codes**

|  |  |
| --- | --- |
| **ICD10 Procedure Code** | **Code Description** |
| 0SRC0J9 | Replacement of Right Knee Joint with Synthetic Substitute, Cemented, Open Approach |
| 0SRC0JA | Replacement of Right Knee Joint with Synthetic Substitute, Uncemented, Open Approach |
| 0SRC0JZ | Replacement of Right Knee Joint with Synthetic Substitute, Open Approach |
| 0SRD0J9 | Replacement of Left Knee Joint with Synthetic Substitute, Cemented, Open Approach |
| 0SRD0JA | Replacement of Left Knee Joint with Synthetic Substitute, Uncemented, Open Approach |
| 0SRD0JZ | Replacement of Left Knee Joint with Synthetic Substitute, Open Approach |
| 0SRT0J9 | Replacement of Right Knee Joint, Femoral Surface with Synthetic Substitute, Cemented, Open Approach |
| 0SRT0JA | Replacement of Right Knee Joint, Femoral Surface with Synthetic Substitute, Uncemented, Open Approach |
| 0SRT0JZ | Replacement of Right Knee Joint, Femoral Surface with Synthetic Substitute, Open Approach |
| 0SRU0J9 | Replacement of Left Knee Joint, Femoral Surface with Synthetic Substitute, Cemented, Open Approach |
| 0SRU0JA | Replacement of Left Knee Joint, Femoral Surface with Synthetic Substitute, Uncemented, Open Approach |
| 0SRU0JZ | Replacement of Left Knee Joint, Femoral Surface with Synthetic Substitute, Open Approach |
| 0SRV0J9 | Replacement of Right Knee Joint, Tibial Surface with Synthetic Substitute, Cemented, Open Approach |
| 0SRV0JA | Replacement of Right Knee Joint, Tibial Surface with Synthetic Substitute, Uncemented, Open Approach |
| 0SRV0JZ | Replacement of Right Knee Joint, Tibial Surface with Synthetic Substitute, Open Approach |
| 0SRW0J9 | Replacement of Left Knee Joint, Tibial Surface with Synthetic Substitute, Cemented, Open Approach |
| 0SRW0JA | Replacement of Left Knee Joint, Tibial Surface with Synthetic Substitute, Uncemented, Open Approach |
| 0SRW0JZ | Replacement of Left Knee Joint, Tibial Surface with Synthetic Substitute, Open Approach |

### Bariatric Surgery for Weight Loss Measure References

For Bariatric Surgery, there are two sets of ICD-10 codes for counting patients. The first set of codes is to identify patients who have had the procedure. The second set of codes is to identify patient with a specific diagnosis.

**Source**: The Leapfrog Group

Number of patients, age 18 years and older, discharged with the following ICD-10 codes in any procedure field AND any of the following ICD-10 codes in any diagnosis field.

**ICD-10 Bariatric Surgery Procedure Codes**

|  |  |
| --- | --- |
| **ICD10 Procedure Code** | **Code Description** |
| 0D16079 | Bypass Stomach to Duodenum with Autologous Tissue Substitute, Open Approach |
| 0D1607A | Bypass Stomach to Jejunum with Autologous Tissue Substitute, Open Approach |
| 0D1607B | Bypass Stomach to Ileum with Autologous Tissue Substitute, Open Approach |
| 0D160Z9 | Bypass Stomach to Duodenum, Open Approach |
| 0D160ZA | Bypass Stomach to Jejunum, Open Approach |
| 0D160ZB | Bypass Stomach to Ileum, Open Approach |
| 0D16479 | Bypass Stomach to Duodenum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D1647A | Bypass Stomach to Jejunum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D1647B | Bypass Stomach to Ileum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D164Z9 | Bypass Stomach to Duodenum, Percutaneous Endoscopic Approach |
| 0D164ZA | Bypass Stomach to Jejunum, Percutaneous Endoscopic Approach |
| 0D164ZB | Bypass Stomach to Ileum, Percutaneous Endoscopic Approach |
| 0DB60Z3 | Excision of Stomach, Open Approach, Vertical |
| 0DB60ZZ | Excision of Stomach, Open Approach |
| 0DB63Z3 | Excision of Stomach, Percutaneous Approach, Vertical |
| 0DB63ZZ | Excision of Stomach, Percutaneous Approach |
| 0DB64Z3 | Excision of Stomach, Percutaneous Endoscopic Approach, Vertical |

**ICD-10 Morbid Obesity Diagnosis Codes**

|  |  |
| --- | --- |
| **ICD10 Procedure Code** | **Code Description** |
| E66.01 | Morbid (severe) obesity due to excess calories |
| E66.09 | Other obesity due to excess calories |
| E66.8 | Other obesity |
| Z68.35 | Body mass index (BMI) 35.0-35.9, adult |
| Z68.36 | Body mass index (BMI) 36.0-36.9, adult |
| Z68.37 | Body mass index (BMI) 37.0-37.9, adult |
| Z68.38 | Body mass index (BMI) 38.0-38.9, adult |
| Z68.39 | Body mass index (BMI) 39.0-39.9, adult |
| Z68.41 | Body mass index (BMI) 40.0-44.9, adult |
| Z68.42 | Body mass index (BMI) 45.0-49.9, adult |
| Z68.43 | Body mass index (BMI) 50-59.9 , adult |
| Z68.44 | Body mass index (BMI) 60.0-69.9, adult |
| Z68.45 | Body mass index (BMI) 70 or greater, adult |

## Inpatient Surgery Frequently Asked Questions (FAQs)

1. **When counting patients, should we only include those who had the procedure performed electively? Can we also include those patients who had the procedure performed urgently?**

Hospitals should count all patients with the relevant procedure or diagnosis.

1. **If a hospital elects to begin a new service line of procedures, how should the hospital report its volume and surgeon volumes while establishing the new line?**

To not penalize hospitals that start new service lines, hospitals will receive an 18-month grace period before having to report on the hospital and surgeon volume for a new procedure. From the day that the hospital performs the procedure for the first time, the hospital and its surgeons will have 18 months to reach the annual volume standard. During this period, the hospital does not have to report its procedure volumes for the hospital or surgeons. However, once the hospital reaches the end of the 18-month grace period, it must report its hospital and surgeon procedure volume.

1. **How should we deal with a temporarily drop in volume due to losing a surgeon’s service?**

To accommodate fluctuations in hospital volumes, Leapfrog intends to offer hospitals the opportunity to report on their average case volumes over a 24 month period in 2018 when responses are scored and publicly reported. But no temporary pass is explicitly provided if a productive surgeon leaves the hospital.

1. **For determining surgeon volume, if a surgeon assists another surgeon during a procedure, which surgeon should receive credit for performing the procedure?**

The procedure should count for both surgeons’ procedure totals. This would apply when both surgeons are experienced, practicing surgeons. Please see below for determining credit for residents, fellows, or those being proctored.

1. **For determining surgeon volume, how should we count procedures that involve residents, fellows, or those being proctored and an experienced surgeon who is mentoring her/him?**

Residents, fellows, or those being proctored should be excluded from surgeon volume reporting. The experienced surgeon should receive the credit toward her/his procedure total.

1. **For determining surgeon volume, how should we count procedures that involve surgeons who have just finished training and are building up their experience?**

Surgeons who have just finished his/her training should receive a 24-month grace period to build up their experience. After that point, his/her volume should be tracked for the surgeon volume. The procedures performed by this surgeon during the reporting period should still be counted towards the hospital’s volume total, as the broader staff still had the experience with the surgery.

1. **If a surgeon was not ‘active’ during the entire reporting period (e.g., just hired, sabbatical, illness, etc.), how should this surgeon’s procedures be reported?**

If a surgeon is unable to meet the surgeon volume standards due to an extended absence during the reporting period, he/she should be excluded from the surgeon volume reporting. The procedures performed by this surgeon during the reporting period should still be counted towards the hospital’s procedure total, as the broader staff still had the experience with the surgery.

1. **Does this section apply to critical access hospitals?**

Leapfrog recognizes the important role that critical access hospitals play in serving their communities. In general, critical access hospitals do not perform the types of procedures that are included in this section, but if the critical access hospital does perform the procedure, the standards still apply.

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SECTION 4: MATERNITY CARE

This section includes questions and reference information for Section 4 Maternity Care. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 4: 2017 Maternity Care

**Maternity Care Fact Sheet:** <http://leapfroggroup.org/ratings-reports/survey-content>

**Adult and Pediatric Hospitals that did not deliver newborns during the reporting period should respond “No” to question #2, and then skip the remainder of the section. The hospital will be shown as “Does Not Apply.”**

This section of the survey addresses the care provided by a hospital for newborn deliveries.

Hospital performance in this section is measured by evidence-based outcome and process measures.

**Each hospital fully meeting the standards for Maternity Care:**

1. Meets or is better than the 5.0% target for performance on the nationally-endorsed “Elective Deliveries Before 39 Weeks Gestation” outcome measure
2. Meets or is better than the 23.9% target for performance on the nationally-endorsed “NTSV Cesarean Section” outcome measure
3. Meets or is better than the 5.0% target for performance on the nationally-endorsed “Incidence of Episiotomy” outcome measure
4. Meets or exceeds a 90% target for both process measures of care: Newborn Bilirubin Screening Prior to Discharge and Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery

**Each hospital fully meeting the High-Risk Deliveries standard:**

1. Achieves favorable hospital volume characteristics for high-risk deliveries by admitting 50 or more very-low birth-weight newborns/year to its NICU or achieves favorable outcomes for high-risk deliveries as measured by the Vermont Oxford Network  
   **and**
2. Meets or exceeds a 90% target for the antenatal steroids process measure

**Download the 2017 Leapfrog Hospital Survey Scoring Algorithm on the** [**Scoring and Results webpage**](http://www.leapfroggroup.org/survey-materials/scoring-and-results)**.**

|  |
| --- |
| 4A Maternity Care Volume |

|  |  |  |
| --- | --- | --- |
| **Specifications:** See [***Maternity Care Volume***](#_Maternity_Care_Volume_1) in the Maternity Care Reference Information on page 76.   |  | | --- | | **Reporting Time Period: 12 months**   * Surveys submitted prior to September 1: 01/01/2016 - 12/31/2016 * Surveys (re)submitted on or after September 1: 07/01/2016 - 06/30/2017 | | |
| 1. 12-month reporting time period used: | * 01/01/2016 - 12/31/2016 * 07/01/2016 - 06/30/2017 |
| 1. Did the hospital deliver newborn babies during the reporting time period?   *If “no,” please skip remaining questions for Section 4 including all subsections, and go on to the Affirmation of Accuracy. The hospital will be scored as “Does not apply.”*  *Otherwise, continue on to question #3.* | *Yes*  *No* |
| 1. Total number of live births at this hospital location for the reporting time period.   *If fewer than 10 cases, skip remaining questions for Section 4 including all subsections, and go on to the Affirmation of Accuracy. The hospital will be scored as “Unable to Calculate Score.”*  *Otherwise, continue to Section 4B.* | *\_\_\_\_\_\_* |

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| --- | --- | --- |
| 4B: Elective Deliveries **Specifications:** See [***Elective Deliveries***](#_Early_Elective_Deliveries) in the Maternity Care Reference Information on pages 77-78.   |  | | --- | | **Reporting Time Period: 12 months**  Answer questions #1-5 based on all cases (or a sufficient sample of them)   * Surveys submitted prior to September 1: 01/01/2016 - 12/31/2016 * Surveys (re)submitted on or after September 1: 07/01/2016 - 06/30/2017 |   ***Sufficient Sample***: See [***Elective Deliveries***](#_Early_Elective_Deliveries) for instructions for identifying a sufficient sample to answer questions #1-5. | |
| 1. 12-month reporting time period used: | * 01/01/2016 - 12/31/2016 * 07/01/2016 - 06/30/2017 |
| 1. Total number of mothers (or sufficient sample of them) that delivered newborns with >=37 weeks of gestation completed and <39 weeks of gestation completed, with **Excluded Populations** removed.   *If fewer than 10 cases met the criteria for the denominator, skip questions #3-5, and move on to the next subsection.* | *\_\_\_\_\_\_* |
| 1. Total number of mothers indicated in question #2 that had their newborn delivered electively (not spontaneously). | *\_\_\_\_\_\_* |
| 1. Do the responses in questions #2 and #3 above represent a sample of cases? | *Yes*  *No* |
| 1. If “yes” to question #4, did your hospital sample using The Joint Commission’s sampling algorithm or Leapfrog’s sampling instructions, as provided in the Maternity Care Reference Information? | *The Joint Commission*  *The Leapfrog Group* |

|  |  |  |
| --- | --- | --- |
| 4C: Cesarean Birth **Specifications:** See ***[Cesarean Birth](#CsectSpecs)*** in the Maternity Care Reference Information on pages 79-80.   |  | | --- | | **Reporting Time Period: 12 months**  Answer questions #1-5 based on all cases (or a sufficient sample of them)   * Surveys submitted prior to September 1: 01/01/2016 - 12/31/2016 * Surveys (re)submitted on or after September 1: 07/01/2016 - 06/30/2017 |   ***Sufficient Sample***: See [***Cesarean Birth***](#CsectSpecs) for instructions for identifying a sufficient sample to answer questions #2 and #3. | |
| 1. 12-month reporting time period used: | * 01/01/2016 - 12/31/2016 * 07/01/2016 - 06/30/2017 |
| 1. Total number of nulliparous mothers (or sufficient sample of them) that delivered a live term singleton newborn in the vertex presentation with >=37 weeks of gestation completed, with **Excluded Populations** removed.   *If fewer than 10 cases met the criteria for the denominator, skip questions #3-5, and move on to the next subsection.* | *\_\_\_\_\_\_* |
| 1. Total number of mothers indicated in question #2 that had their newborn delivered via cesarean section. | *\_\_\_\_\_\_* |
| 1. Do the responses in questions #2 and #3 above represent a sample of cases? | *Yes*  *No* |
| 1. If “yes” to question #4, did your hospital sample using The Joint Commission’s sampling algorithm or Leapfrog’s sampling instructions, as provided in the Maternity Care Reference Information? | *The Joint Commission*  *The Leapfrog Group* |

|  |  |  |
| --- | --- | --- |
| 4D: Episiotomy **Specifications:** See [***Episiotomy***](#_Episiotomy) in the Maternity Care Reference Information on page 81.   |  | | --- | | **Reporting Time Period:** **12 months**  Answer questions #1-3 based on all cases   * Surveys submitted prior to September 1: 01/01/2016 - 12/31/2016 * Surveys (re)submitted on or after September 1: 07/01/2016 - 06/30/2017 | | |
| 1. 12-month reporting time period used: | * 01/01/2016 - 12/31/2016 * 07/01/2016 - 06/30/2017 |
| 1. Total number of vaginal deliveries, with **Excluded Populations** removed. | **\_\_\_\_\_\_** |
| 1. Total number of mothers indicated in question #2 that had an episiotomy procedure performed. | **\_\_\_\_\_\_** |

|  |  |
| --- | --- |
| 4E: Process Measures of Quality **Specifications:** See [***Maternity Care Process Measure Specifications***](#MatProcessSpecs) in the Maternity Care Reference Information on pages 82-83.   |  | | --- | | **Reporting Time Period:** **12 months**  Answer questions #1-10 based on all cases (or a sufficient sample of them)   * Surveys submitted prior to September 1: 01/01/2016 - 12/31/2016 * Surveys (re)submitted on or after September 1: 07/01/2016 - 06/30/2017 | |

***Sufficient Sample***: See [***Maternity Care Process Measure Specifications***](#MatProcessSpecs) for instructions for identifying a sufficient sample to answer questions #3-4 and #8-9.

|  |  |
| --- | --- |
| **Newborn Bilirubin Screening Prior to Discharge** | |
| 1. 12-month reporting time period used: | * 01/01/2016 - 12/31/2016 * 07/01/2016 - 06/30/2017 |
| 1. Did your hospital perform a medical record audit on all cases (or a sufficient sample of them) **and** measure adherence to the newborn bilirubin screening prior to discharge clinical guideline?   *If “yes,” but fewer than 10 cases met the inclusion criteria for the denominator, skip questions #3-5.* | *Yes*  *No*  *Yes, but fewer than 10 cases met the inclusion criteria for the denominator* |
| 1. Number of cases measured against the guideline, either all cases or a sufficient sample of them (**denominator**). | **\_\_\_\_\_\_** |
| 1. Number of cases in question #3 that adhere to the clinical process guideline (**numerator**). | **\_\_\_\_\_\_** |
| 1. Do the responses in questions #3 and #4 represent a sample of cases? | *Yes*  *No* |

|  |  |
| --- | --- |
| **Appropriate DVT Prophylaxis in Women Undergoing Cesarean Section** | |
| 1. 12-month reporting time period used: | * 01/01/2016 - 12/31/2016 * 07/01/2016 - 06/30/2017 |
| 1. Did your hospital perform a medical record audit on all cases (or a sufficient sample of them) **and** measure adherence to the appropriate DVT prophylaxis in women undergoing cesarean section clinical guideline?   *If “yes,” but fewer than 10 cases met the inclusion criteria for the denominator, skip questions #8-10.* | *Yes*  *No*  *Yes, but fewer than 10 cases met the inclusion criteria for the denominator* |
| 1. Number of cases measured against the guideline, either all cases or a sufficient sample of them (**denominator**). | **\_\_\_\_\_\_** |
| 1. Number of cases in question #8 that adhere to the clinical process guideline (**numerator**). | **\_\_\_\_\_\_** |
| 1. Do the responses in questions #8 and #9 represent a sample of cases? | *Yes*  *No* |

|  |  |
| --- | --- |
| 4F:High-Risk DeliveriesHigh-Risk Deliveries | |
| 1. Does your hospital [electively admit high-risk deliveries](#Endnote17)[[17]](#endnote-18)?   *If “no,” skip questions #2-17, and go to the Affirmation of Accuracy.* | *Yes*  *No* |
| 1. Does your hospital operate a neonatal ICU, or is it [co-located](#Endnote18)[[18]](#endnote-19) with a hospital that operates a NICU, that admits or accepts transfers of [very-low birth weight babies](#Endnote19)[[19]](#endnote-20)?   *If “no,” skip questions #3-11, and move on to questions #12-17.*  *If the NICU is co-located in another hospital and your hospital immediately transfers all complicated newborns there, answer question #3 and either questions #4-5 or #6-11 based on information pertaining to the co-located hospital’s NICU.* | *Yes*  *No* |
| 1. Hospitals that participate in the Vermont Oxford Network (VON) and have a recent 12-month report available may elect to report your facility’s Volume (questions #4-5)  **OR**   the [VON’s Death or Morbidity Measure](#Endnote20)[[20]](#endnote-21) (questions #6-11).  Hospitals that do not participate in the Vermont Oxford Network, should report your facility’s Volume (questions #4-5).  Please indicate which measure the hospital will report on*:*  *If you elect to report on Volume, answer questions #4-5, and skip questions #6-11.*  *If you elect to report on the VON National Performance Measure, skip questions #4-5, and report on questions #6-11.* | Volume  VON National Performance Measure |

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| --- | --- | --- |
| Neonatal Intensive Care Unit(s) – Volume **Specifications:** See [***High-Risk Deliveries Volume Standard***](#HighRiskVol) in the Maternity Care Reference Information on page 84.     |  | | --- | | **Reporting Time Period: 12 months**   * Surveys submitted prior to September 1: 01/01/2016 - 12/31/2016 * Surveys (re)submitted on or after September 1: 07/01/2016 - 06/30/2017 | | |
| 1. 12-month reporting time period used: | * 01/01/2016 - 12/31/2016 * 07/01/2016 - 06/30/2017 |
| 1. For the reporting time period, how many very-low birth-weight babies were admitted to your hospital’s neonatal intensive care unit(s)? | \_\_\_\_\_\_\_ |

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| Neonatal Intensive Care Unit(s) – National Performance Measurement **Specifications:** See [***VON National Performance Measure Specifications***](#_VON_National_Performance)in the Maternity Care Reference Information on page 85.   |  | | --- | | **Reporting Time Period:**  Base your responses on the latest 12-month report received from the Vermont Oxford Network (VON) **for the Death or Morbidity Measure.**   * Surveys submitted prior to September 1: 2015 VON data * Surveys (re)submitted on or after September 1: 2016 VON data | | |
| 1. Does your hospital participate in the Vermont Oxford Network performance reporting system for high-risk deliveries and did your hospital submit data for all such deliveries during the most recent 12-month period for which performance reports have been released? | *Yes*  *No* |
| 1. What is the most recent 12-month reporting time period for which VON performance results are available? | \_\_\_\_\_\_\_\_\_\_  *YYYY Format: 2015* |
| 1. From the report, what is your hospital’s volume? | \_\_\_\_\_\_\_ |
| 1. From the same report, what was your hospital’s **SMR 95% lowe**r **bound**? | *\_\_\_\_\_\_\_*  *Format: 0.8* |
| 1. From the same report, what was your hospital’s observed to expected ratio of morbidity or mortality (**SMR shrunken**)? | *\_\_\_\_\_\_\_*  *Format: 1.0* |
| 1. From the same report, what was your hospital’s **SMR 95% upper bound**? | *\_\_\_\_\_\_\_*  *Format: 1.2* |

|  |  |
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| Process Measure of Quality – Antenatal Steroids | |
| **Specifications:** See [***Antenatal Steroids Process Measure Specifications***](#_Antenatal_Steroids_Process) in the Maternity Care Reference Information on pages 86-87.   |  | | --- | | **Reporting Time Period:**  For hospitals reporting on the **VON** measure, answer questions #12-17 based on a 12-month reporting time period:   * Surveys submitted prior to September 1: 2015 VON data * Surveys (re)submitted on or after September 1: 2016 VON data   For hospitals reporting on **The Joint Commission’s PC-03** measure, answer questions #12-17 based on a 12-month reporting time period:   * Surveys submitted prior to September 1: 01/01/2016 - 12/31/2016 * Surveys (re)submitted on or after September 1: 07/01/2016 - 06/30/2017 | | |
| 1. Do the responses for questions #15-17 below represent data collected using VON or The Joint Commission measure specifications?  *If “VON,” skip question #14. If “The Joint Commission,” skip question #13.* | VON  The Joint Commission |
| 1. If VON, what is the most recent 12-month reporting time period for which VON performance results are available? | *\_\_\_\_\_\_*  *YYYY Format: 2015* |
| 1. If The Joint Commission, 12-month reporting time period used: | * 01/01/2016 - 12/31/2016 * 07/01/2016 - 06/30/2017 |
| 1. Did your hospital perform a medical record audit on all cases (or a sufficient sample of them) for certain high-risk deliveries **and** measure adherence to the antenatal steroids clinical process guideline for these high-risk deliveries?   *If “no,” skip questions #16-17, and go to the Affirmation of Accuracy.*  *If “yes, but fewer than 10 cases met the inclusion criteria for the denominator,” skip questions #16-17 and go to the Affirmation of Accuracy.* | *Yes*  *No*  *Yes, but fewer than 10 cases met the inclusion criteria for the denominator* |
| 1. Number of cases measured against the guideline, either all cases or a sufficient sample of them (**denominator**). | \_\_\_\_\_\_\_ |
| 1. Number of cases in question #16 that adhere to the clinical process guideline for this condition (**numerator**). | \_\_\_\_\_\_\_ |

**Affirmation of Accuracy**

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Maternity Care Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract with Leapfrog are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the survey results public reporting website, The Leapfrog Group’s Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group. This information does not infringe any third party’s intellectual property rights. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract with Leapfrog reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the hospital’s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(name) (title)

on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

*(date)*

Section 4: 2017 Maternity Care Reference Information

### What’s New in the 2017 Survey

There are no substantive changes to this section. The three Joint Commission (TJC) measures included in Section 4 (Early Elective Deliveries, NTSV C-sections, and Antenatal Steroids) will use TJC measure specifications v2016A1. This version no longer includes “enrolled in clinical trials” as an exclusion criterion when identifying the denominator for these measures.

The sample size for the maternity care process measures has been updated from 30 cases (in 2016) to 60 cases since the 2017 Leapfrog Hospital Survey uses a 12-month reporting period for these measures. It had been temporarily decreased due to the 9-month reporting period used in the 2016 Leapfrog Hospital Survey.

Leapfrog has increased its target for the three process measures included in this section (Newborn Bilirubin Screening Prior to Discharge, Appropriate DVT Prophylaxis for Women Undergoing Cesarean Section, and Antenatal Steroids) from 80% to 90%. Please see the updated scoring algorithm for this section, which is available at on the [Scoring and Results webpage](http://www.leapfroggroup.org/survey-materials/scoring-and-results).

### Change Summary since Release

If substantive changes are made to this section of the survey after release on April 1, 2017, they will be documented in this Change Summary section.

## Maternity Care Measure Specifications

### Maternity Care Volume

**Important Note:** Hospitals that share a Medicare Provider Number are required to report by facility. Please carefully review [Leapfrog’s Multi-Campus Reporting Policy](http://leapfroggroup.org/survey-materials/multi-campus-reporting-policy).

|  |
| --- |
| **Source:** The Leapfrog Group |
| **Reporting Time Period: 12 months**   * Surveys submitted prior to September 1: 01/01/2016 - 12/31/2016 * Surveys (re)submitted on or after September 1: 07/01/2016 - 06/30/2017 |
| **Question 3:** The number of live births at this hospital location, reported to your state during the reporting time period.  Alternatively, the below list of Z codes can be used to identify live births, with the caution that these codes are coded for the newborn, not the mother; likely to be found in your hospital’s birth CIS/medical record system; but often not in claims data since normal newborn care may be included in the mother’s claim without baby’s diagnosis coding.   * Z38.00 – Z38.01: Single liveborn infant, born in hospital * Z38.30 – Z38.31: Twin liveborn infant, born in hospital * Z38.61 – Z38.69: Other multiple liveborn infant, born in hospital   Note: This data point is simply used to qualify a hospital for further reporting of the normal delivery measures. |

### Elective Deliveries

**Important Notes:**

Note 1: Elective Deliveries can be reported based on all eligible cases OR a sufficient sample of cases as outlined in the denominator specifications.

Note 2: Leapfrog uses the specifications created by The Joint Commission (TJC) for the Elective Deliveries measure. As such, Leapfrog will update its instructions annually, and more frequently if appropriate, to maintain alignment with TJC. Hospitals can access TJC’s measure specifications directly using the links in the table below.

Note 3: Hospitals that share a Medicare Provider Number are required to report by facility. Please carefully review [Leapfrog’s Multi-Campus Reporting Policy](http://leapfroggroup.org/survey-materials/multi-campus-reporting-policy).

|  |
| --- |
| **Source:** Joint Commission PC-01 **(version 2016A1)** |
| **Reporting Time Period: 12 months**   * Surveys submitted prior to September 1: 01/01/2016 - 12/31/2016 * Surveys (re)submitted on or after September 1: 07/01/2016 - 06/30/2017 |
| If you measured this quality indicator, reported the results to TJC, and continue to submit these data to The Joint Commission, **use those data when responding to this subsection of the survey.**  Otherwise, use TJC’s PC-01 Elective Deliveries measure specifications (**version 2016A1**) to retrospectively collect and report data for this measure. The PC-01 measure specifications are outlined below. To access the measure specifications directly on The Joint Commission’s website, visit <https://manual.jointcommission.org/releases/TJC2016A1/MIF0166.html>. |
| **Sampling Cases:** Hospitals that report the Perinatal Care Measure Set to TJC may use the sampling methodology used by the TJC to report on these questions.  Otherwise, hospitals opting to identify a sufficient sample of mothers for this measure, in lieu of full case reporting, should follow these instructions:   * Review your hospital’s first delivery as of **April 15, 2016** (or **July 15, 2016** if (re)submitting a survey on or after September 1, 2017). * Evaluate this case against the inclusion criteria; retain the case for the sample if the delivery was at or after 259 days gestation (37 completed weeks gestation) and before 273 days gestation (39 completed weeks gestation). * Evaluate this case against the exclusion criteria; retain the case for the sample if it does not meet any of the listed exclusions. * Move to the next delivery and evaluate for inclusion/exclusion applicability. * Continue through cases in sequential order until **a sample of at least 100 cases** is reached, or all cases in the reporting period are reviewed, whichever comes first. |
| **Question 2 (denominator):** Patients delivering newborns with >= 37 and < 39 weeks of gestation completed with ***Excluded Populations*** removed.  *Note: The denominator should include both mothers that had their newborn delivered electively and mothers that delivered spontaneously at the specified weeks of gestation.*  **Included Populations**:   * *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for delivery as defined in Appendix A, Table [11.01.1](https://manual.jointcommission.org/releases/TJC2016A1/AppendixATJC.html#Table_Number_11.01.1:_Delivery). * *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for planned cesarean birth in labor as defined in Appendix A, Table [11.06.1](https://manual.jointcommission.org/releases/TJC2016A1/AppendixATJC.html#Table_Number_11.06.1:_Planned_Cesarean_Birth_in_Labor).   **Excluded Populations:**   * *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table [11.07](https://manual.jointcommission.org/releases/TJC2016A1/AppendixATJC.html#Table_Number_11.07:_Conditions_Possibly_Justifying_Elective_Delivery_Prior_to_39_Weeks_Gestation) * Less than 8 years of age * Greater than or equal to 65 years of age * Length of stay > 120 days * [*Gestational Age*](https://manual.jointcommission.org/releases/TJC2016A1/DataElem0265.html) < 37 or >= 39 weeks or UTD   **Data Elements:** Visit <https://manual.jointcommission.org/releases/TJC2016A1/MIF0166.html>.  ***If fewer than 10 cases during the reporting period, skip the next question.*** |
| **Question 3 (numerator):** Patients with elective deliveries included in the denominator.  **Included Populations:**  *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for one or more of the following:   * Medical induction of labor as defined in Appendix A, Table [11.05](https://manual.jointcommission.org/releases/TJC2016A1/AppendixATJC.html#Table_Number_11.05:_Medical_Induction_of_Labor) while not in [*Labor*](https://manual.jointcommission.org/releases/TJC2016A1/DataElem0263.html) prior to the procedure * Cesarean birth as defined in Appendix A, Table [11.06](https://manual.jointcommission.org/releases/TJC2016A1/AppendixATJC.html#Table_Number_11.06:_Cesarean_Birth) and all of the following:   + not in [*Labor*](https://manual.jointcommission.org/releases/TJC2016A1/DataElem0263.html)   + no history of a *[Prior Uterine Surgery](https://manual.jointcommission.org/releases/TJC2016A1/DataElem0520.html)*   **Excluded Populations:** None  **Data Elements: Visit** <https://manual.jointcommission.org/releases/TJC2016A1/MIF0166.html>**.** |

### 

### Cesarean Birth

**Important Notes:**

Note 1: Cesarean Births can be reported based on all eligible cases OR a sufficient sample of cases as outlined in the denominator specifications.

Note 2: Leapfrog uses the specifications created by The Joint Commission (TJC) for the Cesarean Births measure. As such, Leapfrog will update its instructions annually, and more frequently if appropriate, to maintain alignment with TJC. Hospitals can access the TJC’s measure specifications directly using the links in the table below.

Note 3: Hospitals that share a Medicare Provider Number are required to report by facility. Please carefully review [Leapfrog’s Multi-Campus Reporting Policy](http://leapfroggroup.org/survey-materials/multi-campus-reporting-policy).

|  |
| --- |
| **Source:** Joint Commission PC-02 **(version 2016A1)** |
| **Reporting Time Period: 12 months**   * Surveys submitted prior to September 1: 01/01/2016 – 12/31/2016 * Surveys (re)submitted on or after September 1: 07/01/2016 – 06/30/2017 |
| If you measured this quality indicator, reported the results to The Joint Commission, and continue to submit these data to The Joint Commission, **use those data when responding to this subsection of the survey.**  Otherwise, use The Joint Commission’s PC-02 Cesarean Birth measure specifications (**version 2016A1**) to retrospectively collect and report data for this measure. The PC-02 measure specifications are outlined below. To access the measure specifications directly on The Joint Commission’s website, visit <https://manual.jointcommission.org/releases/TJC2016A1/MIF0167.html>. |
| **Sampling Cases:** Hospitals that report the Perinatal Care Measure Set to TJC may use the sampling methodology used by the TJC to report on these questions.  Otherwise, hospitals opting to identify a sufficient sample of mothers for this measure, in lieu of full case reporting, should follow these instructions:   * Review your hospital’s first delivery as of **April 15, 2016** (or **July 15, 2016** if (re)submitting a survey on or after September 1, 2017). * Evaluate this case against the inclusion criteria; retain the case for the sample if the delivery was >=37 weeks gestation. * Evaluate this case against the exclusion criteria; retain the case for the sample if it does not meet any of the listed exclusions. * Move to the next delivery and evaluate for inclusion/exclusion applicability. * Continue through cases in sequential order until **a sample of at least 100 cases** is reached, or all cases in the reporting period are reviewed, whichever comes first. |
| **Question 2 (denominator):** Nulliparous patients delivered of a live term singleton newborn in vertex presentation with ***Excluded populations*** removed.  *Note: The denominator should include both nulliparous mothers with a live term singleton newborn in vertex presentation that had their newborn delivered via cesarean section and nulliparous mothers that delivered vaginally.*  **Included Populations:**   * *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for delivery as defined in Appendix A, Table [11.01.1](https://manual.jointcommission.org/releases/TJC2016A1/AppendixATJC.html#Table_Number_11.01.1:_Delivery). * Nulliparous patients with ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for outcome of delivery as defined in Appendix A, Table [11.08](https://manual.jointcommission.org/releases/TJC2016A1/AppendixATJC.html#Table_Number_11.08:_Outcome_of_Delivery), and with a delivery of a newborn with 37 weeks or more of gestation completed.   **Excluded Populations:**   * ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for multiple gestations and other presentations as defined in Appendix A, Table [11.09](https://manual.jointcommission.org/releases/TJC2016A1/AppendixATJC.html#Table_Number_11.09:_Multiple_Gestations_and_Other_Presentations) * Less than 8 years of age * Greater than or equal to 65 years of age * Length of stay >120 days * [*Gestational Age*](https://manual.jointcommission.org/releases/TJC2016A1/DataElem0265.html)< 37 weeksor UTD   **Data Elements:** Visit <https://manual.jointcommission.org/releases/TJC2016A1/MIF0167.html>.  ***If fewer than 10 cases during the reporting period, skip the next question.*** |
| **Question 3 (numerator):** Patients in the denominator with cesarean births.  **Included Populations:**  ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for cesarean birth as defined in Appendix A, Table [11.06](https://manual.jointcommission.org/releases/TJC2016A1/AppendixATJC.html#Table_Number_11.06:_Cesarean_Birth)  **Excluded Populations:** None  **Data Elements:** Visit[https://manual.jointcommission.org/releases/TJC2016A1/MIF0167.html.](https://manual.jointcommission.org/releases/TJC2016A1/MIF0167.html.%20) |

### Episiotomy

|  |
| --- |
| **Source:** National Quality Forum #0470 |
| **Reporting Time Period: 12 months**   * Surveys submitted prior to September 1: 01/01/2016 - 12/31/2016 * Surveys (re)submitted on or after September 1: 07/01/2016 - 06/30/2017 |
| **Question 2 (denominator):** Total number of vaginal deliveries during the reporting time period, with Excluded Populations removed.  For the purposes of this measure, use the following MS-DRGs to identify a vaginal delivery:   * 767: Vaginal delivery with sterilization and/or D&C * 768: Vaginal delivery with O.R. procedure except sterilization and/or D&C * 774: Vaginal delivery with complicating diagnoses * 775: Vaginal delivery without complicating diagnoses   **Excluded Populations:**  Exclude any cases with the following ICD-10-CM diagnostic code in a primary or secondary field:   * O66.0: Obstructed labor due to shoulder dystocia |
| **Question 3 (numerator):** Total number of mothers included question #2 (the denominator) that had an episiotomy procedure performed.  For the purposes of this measure, the following ICD-10-PCS procedure codes should be used for identifying an episiotomy:   * 0W8NXZZ: Division of female perineum, external approach |

### 

## Maternity Care Process Measure Specifications

**Important Notes:**

Note 1: There is only one set of measure specifications for Maternity Care Process Measures. These measure specifications should be used by all hospitals.

Note 2:For Maternity Care Process Measures, hospitals with a sufficient sample size (as defined below), can randomly sample for the denominator of each indicator, and measure and report adherence based on that sample. Most likely, the numerator criteria for these two measures will require medical chart review if these specific data are not already extracted or coded consistently for other purposes.

### Newborn Bilirubin Screening Prior to Discharge

|  |
| --- |
| **Source:** Providence Health |
| **Reporting Time Period:** **12 months**   * Surveys submitted prior to September 1: 01/01/2016 - 12/312016 * Surveys (re)submitted on or after September 1: 07/01/2016 - 06/30/2017 |
| **Sampling:** If you have fewer than 60 cases that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, include ALL of these cases in measuring adherence to the process guidelines. You need NOT use more than 12 months of historical data to increase the eligible cases beyond 60; just measure and report on ALL eligible cases that you have in that reporting time period.  If you have more than 60 cases that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, you may randomly sample 60 of them for the denominator of each guideline, and measure and report adherence based on that sample. When sampling from a larger population of cases, this is the minimum number of cases needed to make a statistically reliable statement of percentage adherence to the process guideline. |
| **Question 3 (denominator):** Eligible cases include all normal newborns born at or beyond 35 completed weeks gestation that were delivered in the facility during the reporting period (all inborns) with **Excluded Populations** removed.  **Excluded Populations:**   * admitted to a NICU, either at your hospital or another hospital; or * with parental refusal to test; or * prenatal documentation of severe congenital anomalies in the newborn and documentation that the newborn will receive comfort care measures only; or * newborn died prior to discharge |
| **Question 4 (numerator):** Number of eligible cases included in the denominator who have a serum or transcutaneous bilirubin screen prior to discharge to identify risk of hyperbilirubinemia according to the Bhutani Nomogram.  For an example of the Bhutani Nomogram, please see:  *American Academy of Pediatrics Clinical Practice Guidelines: Management of Hyperbilirubinemia in the Newborn Infant 35 or More Weeks of Gestation.*  <http://pediatrics.aappublications.org/content/114/1/297.full>  **Tip**: To view any Figure in the reference, click on it to open, then again to enlarge. |

### Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery

|  |
| --- |
| **Source:** National Quality Forum #0473 |
| **Reporting Time Period:** **12 months**   * Surveys submitted prior to September 1: 01/01/2016 - 12/31/2016 * Surveys (re)submitted on or after September 1: 07/01/2016 - 06/30/2017 |
| **Sampling:** If you have fewer than 60 cases that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, include ALL of these cases in measuring adherence to the process guidelines. You need NOT use more than 12 months of historical data to increase the eligible cases beyond 60; just measure and report on ALL eligible cases that you have in that reporting time period.  If you have more than 60 cases that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, you may randomly sample 60 of them for the denominator of each guideline, and measure and report adherence based on that sample. When sampling from a larger population of cases, this is the minimum number of cases needed to make a statistically reliable statement of percentage adherence to the process guideline. |
| **Questions 8 (denominator):** Eligible cases include all women undergoing cesarean delivery during the reporting period.    Include cases with one of the following MS-DRG codes:   * 765: Cesarean section w CC/MCC * 766: Cesarean section w/o CC/MCC   **Excluded Populations:** None. |
| **Question 9 (numerator)** Number of eligible cases included in the denominator who received either fractionated or unfractionated heparin or heparinoid, or pneumatic compression devices prior to surgery. |

## High-Risk Deliveries Measure Specifications

### High-Risk Deliveries Volume Standard

**Important Note:** Hospitals should respond to **either** Volume OR the VON National Performance Measure.

Hospitals opting to report on Volume should only use ICD-10-CM codes as indicated in the specifications. When calculating hospital volume, count the number of patients with any one or more of the specified diagnosis codes for high-risk deliveries, subject to the other inclusion/exclusion criteria below. The diagnosis codes may be in either a primary or secondary field. The count can include inborn as well as transfer cases.

Question #5: Instructions for Volume Reporting

**Source:** The Leapfrog Group

**Number of newborns admitted to the NICU with the following ICD-10-CM codes:**

|  |  |
| --- | --- |
| **ICD-10-CM Code** | **Description** |
| P05.02 | Newborn light for gestational age, 500-749 grams |
| P05.03 | Newborn light for gestational age, 750-999 grams |
| P05.04 | Newborn light for gestational age, 1000-1249 grams |
| P05.05 | Newborn light for gestational age, 1250-1499 grams |
| P05.12 | Newborn small for gestational age, 500-749 grams |
| P05.13 | Newborn small for gestational age, 750-999 grams |
| P05.14 | Newborn small for gestational age, 1000-1249 grams |
| P05.15 | Newborn small for gestational age, 1250-1499 grams |
| P05.2 | Newborn affected by fetal malnutrition not light or small for gestational age |
| P05.9 | Newborn affected by slow intrauterine growth, unspecified |
| P07.02 | Extremely low birth weight newborn, 500-749 grams |
| P07.03 | Extremely low birth weight newborn, 750-999 grams |
| P07.14 | Other low birth weight newborn, 1000-1249 grams |
| P07.15 | Other low birth weight newborn, 1250-1499 grams |

### VON National Performance Measure Specifications

**Important Note:** Hospitals should respond to **either** Volume OR the VON National Performance Measure.

Hospitals opting to report on the VON National Performance Measure should use these instructions. There is only one set of instructions for the VON National Performance Measure.

Questions #6-11: Instructions for reporting on Death or Morbidity

Download instructions for using the VON Nightingale online tool on the [Survey and CPOE Materials webpage](http://leapfroggroup.org/survey-materials/survey-and-cpoe-materials).

|  |  |
| --- | --- |
| **Entity:** | **Vermont Oxford Network (SMR Report from Nightingale online tool)** |
| Volume | For the latest 12-month standardized mortality or morbidity ratio (SMR) report for Death or Morbidity, enter your hospital’s “N” for the volume of cases for the reporting period. |
| SMR 95% (lower bound) | From the same report, enter your hospital’s “SMR 95% (lower)” for Death or Morbidity. This represents the lower value of your hospital’s 95% confidence interval. |
| SMR (shrunken) | From the same report, enter your hospital’s “SMR (shrunken)” for Death or Morbidity. This is the weighted average of the hospital value and the population (Vermont Oxford Network) mean value. |
| SMR 95% (upper bound) | From the same report, enter your hospital’s “SMR 95% (upper)” for Death or Morbidity. This represents the upper value of your hospital’s 95% confidence interval. |

### Antenatal Steroids Process Measure

**Important Notes:**

Note 1: The specifications provided below include instructions for hospitals participating in VON, as well as those hospitals participating with The Joint Commission (TJC). Other facilities should use The Joint Commission’s PC-03 Antenatal Steroids measure specifications provided below to retrospectively collect and report data for this measure. Please be sure that you review the appropriate specifications below based on your participation status in VON or TJC.

Note 2: Hospitals that share a Medicare Provider Number are required to report by facility. Please carefully review [Leapfrog’s Multi-Campus Reporting Policy](http://leapfroggroup.org/survey-materials/multi-campus-reporting-policy).

|  |
| --- |
| **For hospitals that participate in the Vermont Oxford Network (VON)** |
| If your hospital participates in the Vermont Oxford Network, and has:   * measured adherence to the antenatal steroids process-of-care quality indicator, * reported the results to VON, and * continues to submit these data to VON, then   your hospital may use those data (numerator and denominator) when responding to this subsection of survey, and ignore The Joint Commission (TJC) specifications listed below for the measure.  Download instructions for using the VON Nightingale online tool on the [Survey and CPOE Materials webpage](http://leapfroggroup.org/survey-materials/survey-and-cpoe-materials). |
| **For hospitals that participate with The Joint Commission** |
| **Source:** Joint Commission PC-03 **(version 2016A1)** |
| **Reporting Time Period:** **12 months**   * Surveys submitted prior to September 1: 01/01/2016 - 12/31/2016 * Surveys (re)submitted on or after September 1: 07/01/2016 - 06/30/2017 |
| If your hospital participates with The Joint Commission, and has:   * measured adherence to this process-of-care quality indicator, * reported the results to The Joint Commission, and * continue to submit these data to The Joint Commission, then   use those data when responding to this subsection of the survey.  Otherwise, use The Joint Commission’s PC-03 Antenatal Steroids measure specifications (version 2016A1) detailed below to retrospectively collect and report data for this measure. To access the measure specifications directly on The Joint Commission’s website, visit <https://manual.jointcommission.org/releases/TJC2016A1/MIF0168.html>. |
| **Sampling Cases:** Hospitals that report the Perinatal Care Measure Set to TJC may use the sampling methodology used by the TJC to report on these questions.  Otherwise, if you have fewer than 60 cases that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, include ALL of these cases in measuring adherence to the process guidelines. You need NOT use more than 12 months of historical data to increase the eligible cases beyond 60; just measure and report on ALL eligible cases that you have in that reporting time period.  If you have more than 60 cases that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, you may randomly sample 60 of them for the denominator of each guideline, and measure and report adherence based on that sample. When sampling from a larger population of cases, this is the minimum number of cases needed to make a statistically reliable statement of percentage adherence to the process guideline. |
| **Question 16 (denominator)** Patients delivering live preterm newborns with >=24 and <34 weeks gestation completed with ***Excluded populations***removed.  **Included Populations:**   * *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for delivery as defined in Appendix A, Table [11.01.1](https://manual.jointcommission.org/releases/TJC2016A1/AppendixATJC.html#Table_Number_11.01.1:_Delivery).   **Excluded Populations:**   * Less than 8 years of age * Greater than or equal to 65 years of age * Length of Stay >120 days * Documented [*Reason for Not Initiating Antenatal Steroids*](https://manual.jointcommission.org/releases/TJC2016A1/DataElem0269.html) * *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for fetal demise as defined in Appendix A, Table [11.09.1](https://manual.jointcommission.org/releases/TJC2016A1/AppendixATJC.html#Table_Number_11.09.1:_Fetal_Demise) * [*Gestational Age*](https://manual.jointcommission.org/releases/TJC2016A1/DataElem0265.html)< 24 or >= 34 weeks or UTD   **Data Elements:** Visit <https://manual.jointcommission.org/releases/TJC2016A1/MIF0168.html>. |
| **Question 17 (numerator):** The number of patients included in the denominator with antenatal steroids initiated prior to delivering preterm newborns.  **Included Populations:**  [Antenatal steroids initiated](https://manual.jointcommission.org/releases/TJC2016A1/DataElem0268.html) (refer to Appendix C, Table [11.0](https://manual.jointcommission.org/releases/TJC2016A1/AppendixCTJC.html#Table_Number_11.0:_Antenatal_Steroid_Medications__40Ver._2016A1_41), antenatal steroid medications)  **Excluded Populations:** None.  **Data Elements:** Visit <https://manual.jointcommission.org/releases/TJC2016A1/MIF0168.html>. |

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SECTION 5: ICU PHYSICIAN STAFFING (IPS)

This section includes questions and reference information for Section 5 ICU Physician Staffing. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 5: 2017 ICU Physician Staffing (IPS) Standard

**IPS Fact Sheet:** <http://leapfroggroup.org/ratings-reports/survey-content>

**A hospital fully meeting this standard assures that**:

[All patients](#Endnote21)[[21]](#endnote-22) in its [adult or pediatric general medical and/or surgical ICUs and neuro ICUs](#Endnote22)[[22]](#endnote-23) are [managed or co-managed](#Endnote23)[[23]](#endnote-24) by physicians [certified in critical care medicine](#Endnote24)[[24]](#endnote-25) who:

* Are [ordinarily present in the ICU](#Endnote25)[[25]](#endnote-26) (on-site, or via [telemedicine](#Endnote28)28 that meets Leapfrog specifications) during daytime hours a minimum of 8 hours per day, 7 days per week, and during this time provide clinical care [exclusively](#Endnote25)25 in the ICU; and
* At other times\* . . . ;
* Return more than 95% of ICU calls within 5 minutes, based on a [quantified analysis](#Endnote26)[[26]](#endnote-27) of notification device response time; and
* Can rely on a physician, physician assistant, nurse practitioner, or a [FCCS-certified nurse “effector”](#Endnote27)[[27]](#endnote-28) who is in the hospital and able to reach ICU patients within 5 minutes in more than 95% of cases, based on a quantified hospital analysis of notification device response time.

\*Not applicable for hospitals with 24/7 intensivist coverage.

If you have no licensed or staffed adult or pediatric general medical and/or surgical ICU beds or neuro ICUs, this section does not apply to your hospital. Answer “No” to the second question and move on to complete the affirmation. Your hospital’s results will be displayed as ‘Does Not Apply’ on the public website.

**Download the 2017 Leapfrog Hospital Survey Scoring Algorithm on the** [**Scoring and Results webpage**](http://www.leapfroggroup.org/survey-materials/scoring-and-results)**.**

|  |
| --- |
| 5: ICU PHYSICIAN STAFFING (IPS) |

Review each of the endnotes referenced in the questions below before responding to each question.

**Important Notes:**

Note 1: Some intensivist “presence” may be accomplished via teleintensivists per Leapfrog’s specifications ([More Information](#Endnote28)[[28]](#endnote-29)). However, at this time hospitals cannot fully meet the standard through the sole use of teleintensivists.

Note 2: On an interim basis, other categories of physicians may be considered by Leapfrog to be “certified in Critical Care Medicine” ([More Information](#Endnote24)24).

|  |
| --- |
| **Reporting Time Period:** Answer questions #1-13 based on the staffing structure currently in place at the time that you submit this section of the survey. The staffing structure should have been in place for at least the past 3 months and reflect the ordinary staffing structure for the ICU. |

|  |  |  |
| --- | --- | --- |
| 1. What is the latest 3-month reporting period for which your hospital is submitting responses to this section? 3 months ending: | | *\_\_\_\_\_\_*  *Format: MM/YYYY* |
| 1. Does your hospital operate any [adult or pediatric general medical and/or surgical ICUs or neuro ICUs](#Endnote22)22? | | *Yes*  *No* |
| *If “no,” please skip the remaining questions and go to the Affirmation of Accuracy. Otherwise, continue to question #3.* | | | |
| 1. Are [all patients](#Endnote21)21 in these ICUs [managed or co-managed](#Endnote23)23 by one or more physicians who are [certified in critical care medicine](#Endnote24)24? | *Yes, all are certified in critical care*  *Yes, based on expanded definition of certified*  *No* | |

*If “no” to question #3; skip questions #4-6 and continue on to questions #7-13.*

|  |  |  |
| --- | --- | --- |
| 4) Is one or more of these physicians (from question #3) [ordinarily present](#Endnote25)25 in each of these ICUs during daytime hours **for at least 8 hours per day, 7 days per week,** and do they provide clinical care [exclusively](#Endnote25)25 in one ICU during these hours? ([More information on the use of telemedicine](#Endnote28)28) | | *Yes*  *No* |
| 5) When these physicians (from question #4) are not present in these ICUs on-site or via telemedicine, do they return more than 95% of calls/pages/texts from these units within five minutes, based on a [quantified analysis](#Endnote26)26 of notification device response time? | *Yes*  *No*  *Not applicable, Intensivists are present 24/7* | |
| 6) When these physicians (from question #4) are not present on-site in the ICU or not able to reach an ICU patient within 5 minutes, can they rely on a physician, physician assistant, nurse practitioner, or [FCCS-certified nurse “effector”](#Endnote27)27 who is in the hospital and able to reach these ICU patients within five minutes in more than 95% of the cases, based on a [quantified analysis](#Endnote26)26 of notification device response time? | *Yes*  *No*  *Not applicable, Intensivists are present 24/7* | |

*If “no” to any of questions #4-6 in this section, please answer the following questions #7-13.*

|  |  |
| --- | --- |
| 7) Are [all patients](#Endnote21)21 in these ICUs [managed or co-managed](#Endnote23)23 by one or more physicians [certified in critical care medicine](#Endnote24)24 who meet **all** of the following criteria:   * [ordinarily present](#Endnote25)25 on-site in these units; * for at least **8 hours per day, 4 days per week or 4 hours per day, 7 days per week**, and * providing clinical care [exclusively](#Endnote25)25 in one ICU during these hours? | *Yes*  *No* |
| 1. Are [all patients](#Endnote21)21 in these ICUs [managed or co-managed](#Endnote23)23 by one or more physicians [certified in critical care medicine](#Endnote24)24 who meet **all** three of the following criteria:  * present via telemedicine for **24 hours per day, 7 days per week** * meet modified Leapfrog ICU requirements for intensivist presence in the ICU via telemedicine ([More Information](#Endnote29)[[29]](#endnote-30)) * supported in the establishment and revision of daily care planning for each ICU patient by an on-site intensivist, hospitalist, anesthesiologist, or physician trained in emergency medicine | *Yes*  *No* |
| 1. Are [all patients](#Endnote21)21 in these ICUs [managed or co-managed](#Endnote23)23 by one or more physicians [certified in critical care medicine](#Endnote24)24 who are:  * on-site at least **4 days per week** to establish or revise daily care plans for each ICU patient?   *If yes, skip question #10.* | *Yes*  *No* |
| 1. If not [all patients](#Endnote21)21 are [managed or co-managed](#Endnote23)23 by physicians [certified in critical care medicine](#Endnote24)24, either on-site or via [telemedicine](#Endnote29)29, are some patients managed by these physicians? | *Yes*  *No* |
| 1. Does an on-site clinical pharmacist make daily rounds on patients in these ICUs 7 days per week? | *Yes*  *No* |
| 1. Does a physician [certified in critical care medicine](#Endnote24)24 lead daily multi-disciplinary rounds on-site on [all patients](#Endnote21)21 in these ICUs 7 days per week? | *Yes*  *No* |
| 1. When certified physicians are on-site in these ICUs, do they have responsibility for all ICU admission and discharge decisions? | *Yes*  *No* |

**Affirmation of Accuracy:**

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the ICU Physician Staffing Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract with Leapfrog are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the survey results public reporting website, The Leapfrog Group’s Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group. This information does not infringe any third party’s intellectual property rights. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract with Leapfrog reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the hospital’s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(name) (title)

on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(date)

Section 5: 2017 ICU Physician Staffing (IPS) Reference Information

### What’s New in the 2017 Survey

Leapfrog removed question #11, which asked hospitals about having a budget to support Leapfrog’s ICU Staffing policy. Please see the updated scoring algorithm for this section, which is available at on the [Scoring and Results webpage](http://www.leapfroggroup.org/survey-materials/scoring-and-results).

### Change Summary since Release

None. If substantive changes are made to this section of the survey after release on April 1, 2017, they will be documented in this Change Summary section.

## IPS Frequently Asked Questions (FAQs)

### General Questions

1. **What is the reporting period for this measure?**

Hospitals should report on Section 5 based on their staffing structure at the time they submit the survey. The staffing structure should have been in place for at least the past 3 months and should reflect the ordinary staffing structure for the ICU.

1. **How should hospitals report if they have more than one type of qualifying ICU?**

Hospitals with more than one ICU type are instructed to report on questions in Section 5 based on the minimum staffing levels, not the maximum staffing levels.

1. **Does Leapfrog’s IPS standard apply to mixed acuity units? A multi-organizational service unit (MOSU) unit?**Coverage is dictated by the patient’s status, not the physical bed. The standard applies to those patients considered to be ICU patients.
2. **Our ICU contains beds for general medical-surgical patients and beds for cardiac care patients. The cardiac care patients are cared for by a cardiologist. Do the cardiac care patients also need to be managed or co-managed by an intensivist?**Leapfrog’s standard of intensivist staffing applies to all general medical-surgical ICU patients and neuro ICU patients in the ICU. Patients that are being cared for a single organ system (e.g., cardiac) are not included in the standard. If a general medical-surgical ICU or neuro ICU patient occupies a cardiac care bed, then the patient does need to be managed or co-managed by an intensivist. The focus of Leapfrog’s standard is on the type of patient, not the type of bed they occupy.
3. **Are the standards applicable only to tertiary-care hospitals?**

No. The standards apply to all hospitals operating adult or pediatric general medical and/or surgical ICUs and neuro ICUs.

1. **For questions #7-9, do all bullets need to be met in order to select “yes”?**

Yes, all bulleted criteria must be met within each question in Section 5 in order to be eligible to select “yes” for a particular question.

1. **Can you clarify how to handle situations where the ICU standard is met some but not all of the time?**

If the ICU standard is not met at least 8 hours a day, 7 days a week, hospitals have the opportunity to get partial credit for having intensivists on-site at least some time during the week, or having telemedicine in place that meets the specified criteria for telemedicine. If the number of hours varies from week to week, hospitals should respond with the number of hours per week that the ICU standard is usually met.

1. **What roles should be included in multidisciplinary rounds?**For rounds to be considered multidisciplinary, the team should include 3 or more persons. Typical personnel that would be part of the rounding team include: physician, nurse, pharmacist, physical and/or occupational therapist, and nutritionist.

### Certification Questions

1. **Is there any empirical basis for specifying a minimum annual number of days of ICU experience for each Board-eligible physician providing ICU care?**

No. Accordingly, if it is added to the Leapfrog standard in the future, it will be based on newly published research and expert advice.

1. **Can hospitalists be counted as intensivists?**

No.

1. **Do all intensivists serving as tele-intensivists need to meet Leapfrog’s definition of “certified in critical care medicine”?**

Yes. All intensivists who serve as tele-intensivists do need to meet Leapfrog’s definition of “certified in critical care medicine”. Leapfrog will provide a three year grace period (until the 2019 survey) for tele-intensivist providers to be compliant with this requirement.

1. **How should intensivists trained in critical medicine in a foreign country be treated for purposes of meeting the ICU Physician Staffing (IPS) Leap? While they offer excellent training, many foreign countries do not offer specific critical care board certifications.**

Foreign trained physicians who were certified as intensivists in the country in which they trained, also count as intensivists for the purposes of the ICU Physician staffing (IPS) Leap.

### Response Time Questions

1. **If our hospital requires that ICU calls/pages/texts are answered within five minutes and therefore does not track responses to calls/pages/texts, how should we report our compliance on this part of the standard?**

To meet the Leapfrog standard, hospitals must affirm to the public that they meet it. If your hospital requires that calls/pages/texts be answered within five minutes and has documentation that they are, then you should indicate that your hospital meets the standard. If your hospital requires that calls/pages/texts are answered within five minutes and you don’t know whether they are or are not, then you should not indicate that your hospital meets the standard.

1. **Does Leapfrog specify standards for second tier calls (e.g., the initial call to a physician is not answered within 5 minutes. What is the next step)?**No. We do not intend to reach this level of detail in our specifications, absent a compelling case that the gain would offset its added complexity.
2. **Are we expected to conduct an audit to verify that high-urgency calls/pages/texts are returned within 5 minutes, and are there definitions for what constitutes high and low urgency calls/pages/texts?**You should have some quantitative basis for saying that calls/pages/texts are returned within 5 minutes at least 95% of the time. You could study a sample, or could use the tracking mechanism built in to the notification device system, if one exists. The basis for responding affirmatively should be more than just peoples’ perceptions of response time.  
     
   You don’t have to focus only on high urgency calls/pages/texts – but some notification device systems can make this differentiation and, in these instances, low urgency calls/pages/texts can be carved out of the analysis of response times.  
     
   Providers can monitor notification device response times in multiple ways, as long as the data collection process is non-biased and scientific.  
     
   As an example:  
   Providers could maintain an exception log in the ICU(s) on six randomly sampled days per year. On those days, ICU nurses could record:

* the number of urgent calls/pages/texts made to intensivists when they are not present in the unit (whether on-site or via telemedicine);
* the number of urgent calls/pages/texts made to other physicians or FCCS-certified effectors when no physician or FCCS-certified effector is physically present in the unit; and
* the number of times that responses exceed 5 minutes for those respective calls/pages/texts.

Hospitals can then cost-effectively estimate whether they meet the 95% timely response standards by dividing the average number of log exceptions per day by the average number of calls/pages/texts per day.

1. **If my hospital has little to no instances where there is no intensivist coverage, how should we conduct the response-time audit? Can we perform mock pages to satisfy the intent?**

Unannounced, mock pages would meet the intent. In order for the audit to be reliable, 20 unannounced, mock pages over 90 days should be evaluated.

1. **If I have a closed ICU or 24/7 intensivist coverage, do I still have to perform a quantitative analysis of pager response times?**

If the unit has 24/7 intensivist coverage, than an analysis of response times is not required. If the unit does not have 24/7 intensivist coverage, than yes, closed ICUs must still perform a quantitative analysis of pager response times.

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SECTION 6: NQF Safe Practices

This section includes questions and reference information for Section 6 Safe Practices Score. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 6: 2017 NQF Safe Practices

**NQF Safe Practices Fact Sheet:** <http://leapfroggroup.org/ratings-reports/survey-content>

In May 2003, the National Quality Forum (NQF) published *Safe Practices for Better Healthcare: A Consensus Report*, which listed 30 practices that, if adopted, would have major positive impact on the safety of patients in healthcare settings. In 2009, NQF modified these Safe Practices and added six new practices. This section focuses on five of the 34 practices in the *Safe Practices for Better Healthcare: A Consensus Report 2010 update.*

Before completing this section of the survey, please review the supporting documents, including the National Quality Forum’s **Safe Practices for Better Healthcare - 2010 Update** on the [Survey and CPOE Materials webpage](http://leapfroggroup.org/survey-materials/survey-and-cpoe-materials.).

**Download the 2017 Leapfrog Hospital Survey Scoring Algorithm on the** [**Scoring and Results webpage**](http://www.leapfroggroup.org/survey-materials/scoring-and-results)**.**

|  |  |  |  |
| --- | --- | --- | --- |
| ***Section*** | ***NQF Safe Practice*** | ***Results Shown On Leapfrog’s Consumer Site As:*** | ***Weighting (pts)*** |
| **6A** | [Culture of Safety Leadership Structures and Systems](#SP1) | *Effective leadership to prevent errors* | 120 |
| **6B** | [Culture Measurement, Feedback, and Intervention](#SP2) | *Staff work together to prevent errors* | 120 |
| **6C** | [Risks and Hazards](#SP4) | *Track and reduce risks to patients* | 100 |
| **6D** | [Nursing Workforce](#SP9) | *Enough qualified nurses* | 100 |
| **6E** | [Hand Hygiene](#SP19) | *Handwashing* | 60 |
|  | **GRAND TOTAL** |  | 500 |

**Important Note:** In the online survey tool, make sure to click the **“Review of this Practice Complete” checkbox at the bottom of each safe practice** even if no items are checked, to mark the Safe Practice as complete. This checkbox must be checked for all five Safe Practices in order to affirm Section 6 in the online survey tool.

## 6A: Practice #1 - Culture of Safety Leadership Structures and Systems

*(Page numbers reference NQF Safe Practices for Better Healthcare – 2010 Update report)*

***Check all boxes that apply.***

|  |  |  |
| --- | --- | --- |
| 1.1 | **In regard to raising the awareness of key stakeholders to our organization’s efforts to improve patient safety, the following actions related to identification and mitigation of risk and hazards have been taken:** | |
| AWARENESS | a **🞏** | board (governance) minutes for the past 12 months reflect regular communication regarding **all** three of the following:   * risks and hazards (as defined by *Safe Practice #4, Identification and Mitigation of Risks and Hazards)*; * culture measurement (as defined by *Safe Practice #2,* *Culture Measurement*, *Feedback, and Intervention*); and, * progress towards resolution of safety and quality problems. (p.75) |
| b **🞏** | patients (who are not employed by the organization) and family of patients are active participants in safety and quality committees that meet on a regularly scheduled basis (e.g. biannually or quarterly). (p.75) |
| c **🞏** | steps have been taken to [report to the community](#Endnote30)[[30]](#endnote-31) in the last 12 months of ongoing efforts to improve safety and quality in the organization and the results of these efforts. (p.75) |
| d **🞏** | all staff and independent practitioners were made aware in the past 12 months of ongoing efforts to reduce risks and hazards and to improve patient safety and quality in the organization. (p.75) |
| 1.2 | **In regard to holding the Board, senior management, mid-level management, physician leadership, and frontline caregivers directly accountable for results related to identifying and reducing unsafe practices, the organization has done the following:** | |
| ACCOUNTABILITY | a **🞏** | an integrated, patient safety program has been in place for at least the past 12 months providing oversight and alignment of safe practice activities. (p.76) |
| b **🞏** | a patient safety officer (PSO) has been appointed and communicates regularly with the Board (governance) and senior administrative leadership; the PSO is the primary point of contact of the integrated, patient safety program. (p.76) |
| c **🞏** | performance has been documented in performance reviews and/or compensation incentives for all levels of hospital management and hospital-employed caregivers noted above. (p.76) |
| d **🞏** | the interdisciplinary patient safety team communicated regularly with management regarding **all** three of the following:   * root cause analyses (as defined by *Safe Practice #4 Risks and Hazards*); * progress in meeting safety goals; * provide team training to caregivers; and   documented these communications in meeting minutes. (pp.76-77) |
| e **🞏** | the facility reported adverse events to external mandatory or voluntary programs. (p.77) |

|  |  |  |
| --- | --- | --- |
| 1.3 | **In regard to implementation of the patient safety program, the Board (governance) and senior administrative leaders have provided resources to cover the implementation during the last 12 months, and:** | |
| ABILITY | a **🞏** | dedicated patient safety program budgets support the program, staffing, and technology investment. (p.77) |
|  |  |
| 1.4 | **Structures and systems for assuring that leadership is taking direct and specific actions have been in place for the past 12 months, as evidenced by:** | |
| ACTION | a **🞏** | CEO and senior administrative leaders are personally engaged in reinforcing patient safety improvements, e.g., “walk-arounds”, holding patient safety meetings, reporting to the Board (governance). Calendars reflect allocated time. (p.78) |
| b **🞏** | CEO has actively engaged unit, service-line, departmental and mid-level management leaders in patient safety improvement actions. (p.79) |
| c **🞏** | hospital has established a structure for input into the patient safety program by licensed independent practitioners and the organized medical staff and medical leadership. Input documented in meeting minutes or materials. (p.79) |
| 1.5 | **🞏** | Review of this safe practice is complete.  *This check box is in the online survey tool to ensure that your hospital has reviewed data entry for the above questions. This question must be marked, even if no items are checked.* |

## 6B: Practice #2 - Culture Measurement, Feedback, and Intervention

*(Page numbers reference NQF Safe Practices for Better Healthcare – 2010 Update report)*

***Check all boxes that apply.***

|  |  |  |
| --- | --- | --- |
| 2.1 | **In regard to Culture Measurement, our organization has done the following within the last 24 months:** | |
| AWARENESS | a **🞏** | conducted a culture of safety survey of our employees using a [nationally recognized tool that has demonstrated validity, consistency and reliability.](#Endnote31)[[31]](#endnote-32) The units surveyed account for at least 50% of the aggregated care delivered to patients within the facility, and includes the high patient safety risk units or departments*.*(p.88)  ***If item ‘a’ is not checked, no other items in this Practice #2 may be checked.*** |
| b **🞏** | portrayed the results of the culture survey in a report, which reflects both hospital-wide and individual unit level results, as applicable. (p.88) |
| c **🞏** | benchmarked results of the culture survey against external organizations, such as “like” hospitals or other hospitals within the same health system. |
| d **🞏** | compared results of the culture surveys across internal work groups, roles, and staff levels. |
| e **🞏** | used results of the culture survey to debrief at the relevant unit level, using semi-structured approaches for the debriefings and presenting results in aggregate form to ensure the anonymity of survey respondents. |
| 2.2 | **In regard to accountability for improvements in the measurement of the culture of safety, our organization has done the following within the last 24 months:** | |
| ACCOUNTABILITY | a **🞏** | involved senior administrative leadership in the identification and selection of sampled units; and, in the selection of an appropriate tool for measuring the culture of safety. (p.88) |
| b **🞏** | shared the results of the culture measurement survey with the Board (governance) and senior administrative leadership in a formal report and discussion. (p.88) |
| c **🞏** | included in performance evaluation criteria for senior administrative leaders both the response rates to the survey and the use of the survey results in the improvement efforts. |
| 2.3 | **In regard to the culture of safety measurement, the organization has done the following (or has had the following in place) within the last 12 months:** | |
| ABILITY | a **🞏** | conducted staff education program(s) on methods to improve the culture of safety, tailored to the organization’s survey results. (p.89) |
| b **🞏** | included the costs of annual culture measurement/follow-up activities in the patient safety program budget. (p.88) |
| 2.4 | **In regard to culture measurement, feedback, and interventions, our organization has done the following or has had the following in place within the last 12 months:** | |
| ACTION | a **🞏** | developed or implemented explicit, hospital-wide organizational policies and procedures for regular culture measurement (p.88)  **OR**  implemented strategies for improving culture based on survey results. (p.88) |
| b **🞏** | disseminated the results of the survey widely across the institution, with follow-up meetings held by senior administrative leadership with the sampled units. (p.88) |
| c **🞏** | identified performance improvement interventions based on the survey results, which were shared with senior administrative leadership and subsequently measured and monitored. (p.88) |
| 2.5 | **🞏** | Review of this safe practice is complete.  *This check box is in the online survey tool to ensure that your hospital has reviewed data entry for the above questions. This question must be marked, even if no items are checked.* |

## 6C: Practice #4 - Risks and Hazards

*(Page numbers reference NQF Safe Practices for Better Healthcare – 2010 Update report)*

*Check all boxes that apply.*

|  |  |  |
| --- | --- | --- |
| 4.1 | **Within the last 12 months our organization has done the following:** | |
| AWARENESS | a **🞏** | assessed risks and hazards to patients by reviewing multiple retrospective sources, such as:   * serious and sentinel event reporting; * root cause analyses for adverse events; * independent comparative mortality and morbidity information with the hospital’s performance; * patient safety indicators; * trigger tools; * hospital accreditation surveys; * risk management and filed litigation; * anonymous internal complaints, including complaints of abusive and disruptive caregiver behavior; and * complaints filed with state/federal authorities;   and based on those findings, documented recommendations for improvement. (p.105) |
| b **🞏** | assessed risks and hazards to patients using prospective identification methods: Failure Modes and Effects Analysis (FMEA) and/or Probabilistic Risk Assessment, and has documented recommendations for improvement. (p.106) |
| c **🞏** | combined results of (a) and (b) above to develop their risk profile, and used that profile to identify priorities and develop risk mitigation plans. (p.107) |
| d **🞏** | shared results from the two assessments, noted in (a), (b), and the risk mitigation plan noted in (c) above widely across the organization, from the Board (governance) to front-line caregivers. (p.107)  ***This item may not be checked unless all items 4.1a, b, c are checked.*** |
| 4.2 | **Leadership is accountable for identification of risks and hazards to patients, and mitigation efforts in the past year, as evidenced by:** | |
| ACCOUNTABILITY | a **🞏** | approval of an action plan by the CEO and the Board (governance) for undertaking the assessments of risk, hazards and for the mitigation of risk for patients. (p.106) |
| b **🞏** | incorporation of the identification and mitigation of risks into performance reviews  **OR**  outlined financial incentives for leadership and the Patient Safety Officer for identifying and mitigating risks to patients as identified in the approved action plan. |
| 4.3 | **In regard to developing the ability to appropriately assess risk and hazards to patients, the organization has done the following or had in place during the last 12 months:** | |
| ABILITY | a **🞏** | resourced patient safety program budgets sufficiently to support ongoing risk and hazard assessments and programs for reduction of risk. |
| b **🞏** | provided managers at all levels with training on the prospective identification tools for monitoring risk in their areas. Training was documented. (pp.107-108) |
| c **🞏** | senior managers have received training in the integration of risk and hazard information across the organization. Training was documented. (pp. 107-108) |
| 4.4 | **Structures and systems for assuring that direct and specific actions have taken place to mitigate risks to patients for the past 12 months, include:** | |
| ACTION | a **🞏** | provided risk identification training to the management and staff in high risk patient safety units such as: emergency department, labor and delivery, ICUs, and operating rooms. (p.106) |
| b **🞏** | established or already had in place a structure, developed by the CEO and senior leadership, for gathering all information related to risks, hazards and mitigation efforts within the organization with input from all levels of staff within the organization and from patients and their families. (p.110) |
| c **🞏** | evidence of high-performance or actions taken for the following four patient safety risk areas: falls, malnutrition, aspiration, and workforce fatigue (p.108) |
| 4.5 | **🞏** | Review of this safe practice is complete.  *This check box is in the online survey tool to ensure that your hospital has reviewed data entry for the above questions. This question must be marked, even if no items are checked.* |

## 6D: Practice #9 - Nursing Workforce

*(Page numbers reference NQF Safe Practices for Better Healthcare – 2010 Update report)*

|  |  |  |
| --- | --- | --- |
| 9 | Is your hospital currently recognized as an [American Nurses Credentialing Center (ANCC) Magnet® organization](#Endnote32)[[32]](#endnote-33)?  **🞏** Yes  **🞏** No  *If “yes,” your hospital will receive full credit for this Safe Practice and no additional boxes need to be checked. If “no,” please check all of the boxes that apply.* | |
| 9.1 | **In regard to ensuring adequate and competent nursing staff service and nursing leadership at all levels, our organization has done the following or has had the following in place within the last 12 months:** | |
| AWARENESS | a **🞏** | held at least one educational meeting for clinicians, senior management, mid-level management, and line management specifically related to the areas of patient safety and adequate nurse staffing effectiveness. (p.155) |
| b **🞏** | performed a risk assessment that includes an evaluation of the frequency and severity of adverse events that can be related to nurse staffing. (p.155) |
| c **🞏** | submitted a report to the Board (governance) with recommendations for measurable improvement targets. (p.155) |
| d **🞏** | collected and analyzed data of actual unit-specific nurse staffing levels on a quarterly basis to identify and address potential patient safety-related staffing issues. (p.155) |
| e **🞏** | provided unit-specific reports of potential patient safety-related staffing issues to senior administrative leadership and the Board (governance) at least quarterly. (p.155) |
| 9.2 | **In regard to ensuring adequate and competent nursing staff service and nursing leadership at all levels, our organization has done the following or has had the following in place within the last 12 months:** | |
| ACCOUNTABILITY | a **🞏** | held departmental/clinical leadership directly accountable for improvements in performance through performance reviews or compensation. (p.155) |
| b **🞏** | included senior nursing leadership as part of the hospital senior management team. (p.155) |
| c **🞏** | reported performance metrics related to this Safe Practice to the Board (governance). (p.155) |
| d **🞏** | held the Board (governance) and senior administrative leadership accountable for the provision of financial resources to ensure adequate nurse staffing levels. (p.155) |
| 9.3 | **In regard to ensuring adequate and competent nursing staff service and nursing leadership at all levels, our organization has done the following or has had the following in place within the last 12 months:** | |
| ABILITY | a **🞏** | conducted staff education on maintaining and improving competencies specific to assigned job duties related to the safety of the patient, with attendance documented. (p.155) |
| b **🞏** | allocated protected time for direct care staff and managers to reduce adverse events related to staffing levels or competency issues. |
| c **🞏** | documented expenses incurred during the past year tied to quality improvement efforts around this Safe Practice. |
| d **🞏** | budgeted financial resources for balancing staffing levels and skill levels to improve performance. (p.155) |
| e **🞏** | governance has approved a budget for reaching optimal nurse staffing. (p.155) |
| 9.4 | **In regard to ensuring adequate and competent nursing staff service and nursing leadership at all levels, our organization has done the following within the last 12 months or has had the following in place during the last 12 months and updates are made regularly:** | |
| ACTION | a **🞏** | implemented a staffing plan, with input from nurses, to ensure that adequate nursing staff-to-patient ratios are achieved. (p.154) |
| b **🞏** | developed policies and procedures for effective staffing targets that specify number, competency and skill mix of nursing staff. (p.155) |
| c **🞏** | implemented a performance improvement project that minimizes the risk to patients from less than optimal staffing levels. (p.155)  **OR**  monitored a previously implemented hospital-wide performance improvement program that measures, and demonstrates full achievement of, the impact of this specific Safe Practice. (p.155) |
| 9.5 | **🞏** | Review of this safe practice is complete.  *This check box is in the online survey tool to ensure that your hospital has reviewed data entry for the above questions. This question must be marked, even if no items are checked.* |

## 6E: Practice #19 - Hand Hygiene

*(Page numbers reference NQF Safe Practices for Better Healthcare – 2010 Update report)*

***Check all boxes that apply.***

|  |  |  |
| --- | --- | --- |
| 19.1 | **In regard to preventing hospital-acquired infections related to inadequate hand hygiene, our organization has done the following or has had the following in place within the last 12 months:** | |
| AWARENESS | a **🞏** | conducted a [hospital-wide evaluation](#Endnote33)[[33]](#endnote-34) of the potential impact of improvements in hand hygiene on the frequency of hospital-acquired infections in our patient population. (p.250) |
| b **🞏** | submitted a report to the Board (governance) with recommendations for measurable improvement targets. |
| 19.2 | **In regard to preventing hospital-acquired infections related to inadequate hand hygiene, our organization has done the following or has had the following in place within the last 12 months:** | |
| ACCOUNTABILITY | a **🞏** | held clinical leadership directly accountable for this patient safety area through performance reviews or compensation. |
| b **🞏** | held senior administrative leadership directly accountable for performance in this patient safety area through performance reviews or compensation. |
| c **🞏** | held the patient safety officer directly accountable for improvements in performance through performance reviews or compensation. |
| d **🞏** | reported to the Board (governance) the results of the measurable improvement targets. |
| 19.3 | **In regard to preventing hospital-acquired infections related to inadequate hand hygiene, our organization has done the following or has had the following in place within the last 12 months:** | |
| ABILITY | a **🞏** | conducted staff education/knowledge transfer and skill development programs, with attendance documented. (p.251) |
| b **🞏** | documented expenditures on staff education related to this Safe Practice in the previous year. |
| 19.4 | **In regard to preventing hospital-acquired infections related to inadequate hand hygiene, our organization has done the following within the last 12 months or has had the following in place during the last 12 months and updates are made regularly:** | |
| ACTION | a **🞏** | developed and implemented explicit policies and procedures across the entire organization to prevent hospital-acquired infections due to inadequate hand hygiene including CDC guidelines with category IA, IB, or IC evidence. (p.250) |
| b **🞏** | implemented a formal performance improvement program addressing hospital-acquired infections focused on hand hygiene compliance, with regular performance measurement and tracking improvement (pp.250-251)  **OR**  monitored a previously implemented hospital-wide performance improvement program that measures, and demonstrates full achievement of, the impact of this specific Safe Practice. (pp.250-251) |
| 19.5 | **🞏** | Review of this safe practice is complete.  *This check box is in the online survey tool to ensure that your hospital has reviewed data entry for the above questions. This question must be marked, even if no items are checked.* |

**Affirmation of Accuracy**

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the NQF Safe Practices Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract with Leapfrog are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the survey results public reporting website, The Leapfrog Group’s Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group. This information does not infringe any third party’s intellectual property rights. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract with Leapfrog reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the hospital’s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(name) (title)

on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(date)

Section 6: 2017 NQF Safe Practices Reference Information

### What’s New in the 2017 Survey

Leapfrog removed three Safe Practices: Safe Practice #3 Teamwork Training and Skill Building, Safe Practice #17 Medication Reconciliation, and Safe Practice #23 Health Care Associated Complications in Ventilated Patients. Please see the updated scoring algorithm for this section, which is available at on the [Scoring and Results webpage](http://www.leapfroggroup.org/survey-materials/scoring-and-results).

### Change Summary since Release

None. If substantive changes are made to this section of the survey after release on April 1, 2017, they will be documented in this Change Summary section.

## Tips for Reporting on Section 6 Safe Practices

* **Prepare**
  + Download and review a copy of the National Quality Forum’s *Safe Practices for Better Healthcare – 2010 Update* report (see link on <http://leapfroggroup.org/survey-materials/survey-and-cpoe-materials>)
  + Print and review a hard copy of (1) the survey questions, (2) practice-specific FAQs, and (3) the scoring algorithm
* **Identify Individuals to Assist** 
  + Decide who should participate on your team to assist in collection of the documentation for assessment.
* **Plan:** We suggest that a team be formed that might just be a couple of individuals in some hospitals or a much larger group for larger organizations. That team should be briefed and assigned duties to help capture the key information necessary for submission.
* **Collect:** Key documentation should be collected to support answering the survey. It will be helpful to archive it for future reference as Leapfrog does a random review of safe practices documentation every year. In addition, the documentation can be helpful when the survey is updated or re-submitted by the hospital.
* **Assess:** When all of the supporting documents are assembled, it is recommended that hospitals review their final responses to Section 6 with the CEO and/or responsible leadership. Hospitals should update their answers online as they adopt additional practices.
* **Submit:** Section 6 must be completed and affirmed before it can be submitted with the survey.

## Safe Practices Frequently Asked Questions (FAQs)

### General FAQs for the Safe Practices:

AWARENESS:

1. **Why is it necessary to continue to review a safe practice once it has been implemented?**All too often in the hectic pace of providing patient care in a hospital, with frequent staff turnover and lots of part-time employees, it is difficult to get a change in practice well established. Annual review with monitoring and tracking of the safe practices will ensure that they are embedded in the operations of the hospital and not lost in the transition of new staff coming in or part-time employees coming and going.
2. **The phrase “frequency and severity of …” is used throughout the survey within many Aware responses. What is the intent and how can a hospital satisfy this requirement?**In order for a hospital to be fully aware of the extent that any patient safety issue exists within the organization, a hospital needs to review all adverse events to determine how often they occur and to establish an impact severity scale on the patient (e.g., the NCC MERP Index or other severity indexing tool).

ACCOUNTABILITY:

1. **What constitutes “direct accountability”?**Direct accountability refers to a senior executive or department level manager who has oversight responsibility for the area of the hospital that implementation of any particular safe practice may impact.
2. **What constitutes direct and regular reporting to Board (governance) by “the person responsible for patient safety”?**A senior executive (who may or may not have the title “Patient Safety Officer”) satisfies the reporting requirement if he has responsibility for multiple and integrated areas of patient safety. Multiple executives who may be responsible for one area of safety each, however, who do not assess the integrated safety issues, would not qualify. Individual department safety reports may be submitted to a

* Patient Safety Officer or senior executive, responsible for patient safety, who provides a comprehensive report to the Board.
* Direct means personal reporting to a safety or quality sub-committee of a board of trustees/directors or direct reporting to the Board.

1. **The phrase “performance reviews or compensation” is used throughout the survey within many *Accountable* responses. Do such reviews and incentives need to have specific language about a safe practice, or can a set of patient safety goals be attached?**A performance review or incentive plan should include specific language about a safe practice. A list of safe practices and related goals may be incorporated into the performance review and/or incentive plan orformalized programs whereby a measure of success of those activities or programs is tied to individual performance reviews or compensation incentive plans of executives.
2. **The terms “senior administrative leadership” and “clinical leadership” are used throughout the survey. What employee categories qualify for these labels?**For the purposes of the survey, these labels refer to administrators who are responsible for hospital-wide departments or services.

ABILITY:

1. **What is meant by “dedicated budget resources” related to a specific Safe Practice?**The intent of statements within the ABILITY questions is to verify that any additional specifications or example implementations can be identified in the budget, within a department budget that rolls up into the hospital budget or, if during the course of a current budget year, a department or hospital has a clear paper trail of any outlay of expenses specific to the safe practices.
2. **Can the dedicated budget requirement be met if the budget includes categories which address the Safe Practice, but do not specifically name the Safe Practice?**Yes, if it can be verified that any of the additional specifications or example implementations can be identified within a department budget that rolls up into the hospital budget; or, if during the course of a current budget year, a department or hospital has a clear paper trail of any outlay of expenses specific to the safe practices, the intent of this question will be met.
3. **If a staff educator’s role and function includes education specific to the Safe Practices, does this meet the dedicated budget resources requirement, or does the budget need to allocate a specific amount of time to the Safe Practices?**If the staff educator’s job description identifies the specific safe practices he addresses in his educational role, the intent of this item is met. Any documentation of training or education time spent on a safe practice or expenditures on educational supplies or meeting preparation materials that address any of the safe practices will meet the intent of the dedicated budget resources requirements. Specific time allocations per safe practice are not required as long as there is documentation of staff participation through meeting minutes or educational materials presented and attendance records.
4. **If education policies and procedures for a Safe Practice are already in place and compliance is monitored, are annual staff education and skill development programs still required?**Even if policies and procedures for a Safe Practice are already in place and compliance can be monitored, annual education sessions or skills fairs are required to address frequent high staff turnover, use of agency/traveler staff, and updated changes in policies and practices. Implementation of a process change more than a year ago without monitoring for performance compliance or updated education sessions will not meet the expectations of this safe practice.
5. **Education is a frequent requirement for credit throughout the survey. How should employee education be measured?**To qualify for credit, educational meetings should clearly address the subject matter pertinent to adverse events and performance improvement targeted by the Safe Practice being surveyed. Hospitals should track meeting or presentation dates, frequency of employee training sessions provided, attendance records or completion records, and the percentage of the total employee population who received the information.
6. **How should employee education be measured?**Hospitals should track meeting or presentation dates, frequency of employee training sessions provided, attendance records, and the percent of the total employee population attending the educational programs.

ACTION:

1. **The term “hospital-wide” is used throughout the survey. Does this mean throughout the hospital, or throughout a health system?**Since individual hospitals are required to complete the survey, “hospital-wide” refers to all departments within a hospital. For hospitals which are part of a larger health system, a desired patient safety goal would be to roll out best practices in a coordinated program across the entire system**.**
2. **Numerous survey questions relate to developing or implementing Performance Improvement Programs. What are the minimum requirements to qualify as such a program?**Performance improvement programs should include **all** of the following five elements:

* **Education** regarding the pertinent adverse event frequency, severity, and/or impact of best practices
* **Skill building** in use of performance improvement tools
* **Measurement** of process measures or outcomes measures
* **Process improvement** and interventions
* **Reporting** of performance outcomes

1. **What about organizations that have already implemented a particular Safe Practice more than 12 months prior to submitting the survey? How is this addressed?**Those organizations that have already implemented all elements of a Safe Practice more than 12 months prior to submitting the survey, should have the following in place as part of their “ongoing” programs, including:

* Identified leader who is accountable to assure improvements are sustained and regular updates are made
* Defined and approved policies, procedures, or protocols that are being monitored
* Specific metrics with defined targets that are trended and trigger action where appropriate

### FAQs Specific to Safe Practices

6A: Safe Practice # 1 Leadership Structures and Systems

**1.1a: In our hospital, our board minutes are very vague. Reports that may have been submitted during a board meeting and discussed are not clearly indicated in the minutes. Any suggestions on how hospitals could better reflect communication on the three requested topics?**

We would urge hospitals to improve the detail of their board minutes. The discussion of risks and hazards, culture measurement, and progress towards resolution of safety and quality programs can be a general note in the minutes, without specific details, but hospitals should maintain copies of presentations and reports related to these agenda items as documentation of adherence to this practice.

**1.1a: What is Leapfrog’s definition of “regular” communication?**

The time period for Safe Practice 1 is the within the past 12 months. Regular communication would therefore refer to communication regarding all three of these items listed within the practice that occurs more than once a year during your Board meetings. Some hospitals may communicate regarding these items quarterly and others may communicate regarding these items monthly.

**1.1b: What is meant by “patients and family of patients are active participants in safety and quality committees?”**

Patients and/or family of patients should participate in safety and quality committee meetings in-person, via conference call, or via video conference. If the participant is invited, but does not regularly attend, this would not be an active participant. Patients and family should be able to provide their perspective to the committee members during meetings. Quality and Safety Committees should have influence over quality and safety related issues throughout the hospital, not just within a particular department or service line. Meetings should be formal and minutes should be taken.

**1.1b: For purposes of serving on quality and safety committees, can a board member who was a patient at the hospital count for this question?**  
The preference would be to find a non-Board member, non-employee to serve on the committee. Board members have a fiduciary responsibility for the organization, and therefore may have a potential conflict representing the views of patients and/or families.

1. **1.1b: How can a hospital document that patients and/or family of patients are active participants in safety and quality committees that meet on a regular scheduled basis and what are some examples of types of committees that would meet the intent of this practice element?**Examples of documentation that demonstrates patient and/or family of patients are active participants in safety and quality committees include committee rosters or meeting meetings with attendance and participation noted. Examples of active participation: presenting or co-presenting a topic; leading or co-leading a discussion; having the patient or family member as co-chair of the committee. Quality and Safety Committees should provide input to leadership on the management of quality and safety related issues throughout the hospital, not just within a particular department or specialty.
2. **1.1d: Does the information shared with the community in 1.1c need to match the information shared with staff and independent practitioners in 1.1.d?**

No. The two audiences are different and therefore it may be appropriate to share different information. Also, you may also choose to use different language to communicate with the different audiences.

1. **1.2: What roles are included in “frontline caregivers”?**Anyone who has direct care with the patient. Examples include nurses, environmental services staff, and allied health professionals.
2. **1.2a: What is Leapfrog’s definition of a “patient safety program”?**

According to page 76 of the NQF Safe Practices for Better Healthcare 2010 Update, a Patient Safety Program is defined as the following: "An integrated patient safety program should be implemented throughout the healthcare organization. This program should provide oversight, ensure the alignment of patient safety activities, and provide opportunities for all individuals who work in the organization to be educated and participate in safety and quality initiatives. Leaders should create an environment in which safety and quality issues are openly discussed. A just culture should be fostered in which frontline personnel feel comfortable disclosing errors—including their own— while maintaining professional accountability. [Botwinick, 2006]"

1. **1.2b: Does the hospital need to have a full-time Patient Safety Officer to receive full credit for question 1.2b?**  
   The organization may appoint an officer who may have other assigned duties or may specifically employ a patient safety officer designated with this accountability. A senior executive satisfies the reporting requirement if he has responsibility for multiple and integrated areas of patient safety as outlined in FAQ #4.
2. **1.2c: It can be challenging to document that all of the roles in hospital are held accountable for reducing unsafe practices. Suggestions on how hospitals can ensure accountability?**

Every employee should have a patient safety component to their annual review. Another option is to include in the employee’s competency review (OPPE, FPPE).

1. **1.2e: Our hospital did not have any adverse events. Can we still check the box?**

We would urge your hospital to first reassess its conclusion that no adverse events occurred at your hospital; that would be highly unusual. After that reassessment, if no adverse events were identified, it would be appropriate to check the box if your hospital has policies reporting such events, when they do occur, to a mandatory or voluntary program.

1. **1.2d: What is an interdisciplinary patient safety committee?**  
   An interdisciplinary patient safety committee is an internal hospital committee that oversees the activities defined in the NQF Safe Practice 1 Practice Element Specifications and develops action plans to create solutions and changes in performance.
2. **1.3a: Does the budget presented to the Board have to describe each line item included in the patient safety program?**

No. The budget presented to the Board may be broad. However, the elements that make-up the patient safety program should be identified in a line item manner within a department budget that rolls up into the overall hospital budget.

1. **1.4a and b: What if our hospital does not have a position with the title “CEO” or the CEO position is over the larger health system?**

Equivalent functions to CEO at the individual hospital-level would be Hospital Administrator or Chief Administrative Officer.

1. **1.4a: What is meant by executive “walk-arounds” and how often should they take place?**The executive walk-arounds provide visibility and access to senior management by front-line clinical staff. Management has the opportunity to address issues and concerns in various departments while they are on site. The process also provides an opportunity for feedback on implementation of improvement strategies and tactics. Monthly meetings with staff in a centralized location do not meet the intent of this Safe Practice.
2. **1.4a: How can progress on the implementation of executive “walk-arounds” be measured?**

* The number of walk-rounds performed per unit or clinical area may be measured for designated time periods as shown in the executive’s calendar. Some progressive hospitals have tied incentives to regular executive walk-rounds and to reliable exchange of information on clinical unit performance.
* Some hospitals have established a feedback loop between senior executives and front-line staff to measure the implementation of performance improvement ideas that were generated by executive walk-arounds.

1. **1.4b: What are some examples of how the CEO has actively engaged leaders in patient safety improvement actions?**Examples may include:

* Senior leadership appoints a clinical staff member as leader of a specific strategic safety initiative, allocates 20% of his regular work hours to this effort, budgets team training for the leader and initiative participants, signs off on a sanctioned charter, sends an invitation to other disciplines to join this initiative, and adds an update on progress to the senior leadership regular operational meetings.
* The department manager assures that there is clinical coverage for the staff member’s time allotted for this effort.
* Refer to the following American College of Healthcare Executives professional policy statement, which outcomes how leaders should be engaged in patient safety and quality: <https://www.ache.org/policy/exec-ensure-patsafe.cfm>.

1. **1.4c:** **What are some examples of how the board and leadership might engage the medical staff as direct contributors to my organization’s patient safety program?**Examples may include:

* Senior leadership requests time on Medical Staff Department standing agendas to provide patient safety updates and elicit direct feedback on specific areas as well as ”what keeps the medical staff up at night.”
* Medical staff are invited and encouraged to be active participants on clinical unit meetings where patient safety is addressed.
* The board appoints a community-based active medical staff member to represent the organization on a regional patient safety initiative.

1. **1.4c: In an organization where all medical staff is employed, there are no “licensed independent practitioners.” How do we answer this question?**The spirit of the issue question is to gain input from ***informal medical leaders*** who everyone respects in an organization either for great competence or for significant volume of patients they see and care for or both. Often they do not have a significant position in the hierarchal structure of an organization; however carry a great deal of influence over how the organization is run. Thus, they are informal leaders who can be change agents and “accelerators or barriers for improvement.” If the organization's governance and administrative leaders seek and document input from informal medical leaders regarding patient safety programs, then that organization may affirm that such actions have been taken. If a formal mechanism is established to seek such information, the organization should reply in the affirmative.

6B: Safe Practice # 2 Culture Measurement, Feedback, and Intervention

1. **2.1a: What qualifies as a cultural survey? Does an employee satisfaction survey qualify?**A number of surveys are readily available that specifically address culture, safety climate, and teamwork. These surveys incorporate all of the additional specifications as outlined in NQF Safe Practice 2 (see 2010 NQF Safe Practice Report). A general employee satisfaction survey that has a small component of the survey addressing organizational culture does not qualify. [See endnote 31 for Leapfrog’s Guidelines for a Culture of Safety Survey.](#Endnote31)
2. **2.1b: For reporting individual unit level results, what is the minimum number of responses we should have?**

Major vendors use a threshold of 5 or more responses and 40% response rate. For larger units, a lower response rate may be acceptable. If a unit does not meet these thresholds, your hospital could aggregate the results of “like” units together (e.g., med/surg units, ICUs, ORs). Hospitals should not combine results across “dislike” units.

1. **2.1c: What is meant by “like” hospitals? Can we benchmark against other hospitals in our system? How would a pediatric hospital benchmark against other pediatric hospitals?**

* Hospitals should benchmark against hospitals with similar demographics, such as type, number of beds, number of admissions, urban/rural designation, etc.
* Hospitals in systems should benchmark throughout the health system, but not within the same region.
* The intent would be for pediatric hospitals to compare their results with other pediatric hospitals. Please refer to instructions starting on page 29 of AHRQ’s Hospital Survey on Patient Safety Culture: 2016 User Comparative Database Report: <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/2016/2016_hospitalsops_report_pt1.pdf>

1. **2.2a:** **Senior administrative leadership requires that all departments participate in the culture of safety survey. Does this requirement meet the intent of Safe Practice?**

If senior leadership requires that ALL departments participate in the survey, then the intent of this safe practice is met.

1. **2.3a: Which employees should be included in the staff education program? Employees in all units or just those in low-performing units?**

Staff education needs to include education for senior executives and leadership. As all units have opportunities for improvement, the staff education should be given to every employee, focusing on the deficiencies of that specific unit.

6C: Safe Practice #4 Identification & Mitigation of Risks and Hazards

1. **4.1a: Can data collection from use of Trigger Tools be used for this Safe Practice Element?**Yes. To document your hospital’s use of trigger tools, you might include the number of charts reviewed using a Trigger Tool performed manually or on an automated basis in a report.
2. **4.1a: What is meant by “reviewing retrospective sources?”**As addressed in the NQF Safe Practice Report, organizations should employ various tools that assist them in identification of risks and hazards as close to or at the time that they may occur. Some of these may include Trigger Tools that send “flags” or messaging electronically that something could or already has transpired that needs immediate attention, direct observations of potential or real safety-related instances during the walk-rounds process, as well as immediate identification through “stop the line” actions that are further evaluated.   
     
   Other tools may include analysis of existing documentation of problems with safety—such as: complaints, litigation, problems with accreditation, etc. These events should trigger action at the time of occurrence and can be analyzed with other important indicators, such as mortality and morbidity related to care delivery.
3. **4.1a: Does our hospital need to have a list of recommendations for improvement based on the analysis from using multiple retrospective sources?**

Yes, that is a fair expectation of hospitals that they generate a list of recommendations for improvement. Hospitals may find using a severity/frequency/risk assessment grid to identify which risks and hazards the hospital needs to focus on.

1. **4.1b: What is meant by “prospective identification methods?”**Proactive identification of risks and hazards involves use of methods in areas identified as being high-risk, such as Failure Modes and Effects Analysis (FMEA) and Probabilistic Risk Assessment (PRA). Organizations are most likely most familiar and have some experience with the FMEA process in conjunction with current Joint Commission standards requirements.   
     
   The NQF Report includes several references that further illustrate how to employ use of these tools as a means to systematically identify possible failure areas before these events occur.
2. **4.3b: What would be an example of training that can be provided to managers on tools for monitoring risk?**

One example of training provided to managers on a tool that monitors risk is the Tinetti Balance Assessment. Training on the use of risk monitoring tools, such as the Tinetti Balance Assessment, may be performed by external educators or may utilize internal resources.

1. **4.4a: Is it acceptable for a hospital to provide risk identification training on one specific risk?**

No. Training would need to be on a broader set of risks. Ideally, hospitals would stress in the training a generalizable set of skills that could help with the mitigation of all risks.

6D: Safe Practice # 9 Nursing Workforce

1. **9.2d: If the state has set minimum nurse to patient staffing ratios, does our hospital automatically earn credit?**

No. Minimum ratios do not necessarily address the “adequacy” issue, as they make-up of your hospital’s patient population may require more intensive staffing than are prescribed by the state’s minimum.

1. **9.3: How does a hospital receive credit for staffing performance improvement activities not planned in the budget?**If a hospital has not allocated budget dollars for a performance improvement project tied to this safe practice but can demonstrate expenses tied to a project to improve nurse staffing targets in their organization they can receive credit for this question. In addition, plans to allocate specific budget dollars to this safe practice should be incorporated into the next upcoming budget year as an ongoing process to maintain appropriate staffing patterns.
2. **9.4a: What constitutes “a staffing plan” related to nurse staffing targets?**“A staffing plan” refers to nursing policies and procedures or a specific process used by the organization to pre-determine appropriate staffing patterns based on usual patient mix and nursing qualifications. A hospital must demonstrate full achievement of their targets.
3. **9.4: What staffing processes address the expectations of the Action answer of this Safe Practice?**Recognizing that there is no galvanized number that represents “the correct” nurse staffing pattern, organizations must integrate a number of data sets into a staffing system that pre-defines and quantifies appropriate staffing targets. These data sets include:

* Historical Data (e.g., patient volumes, acuity levels, and staff volumes of direct caregivers)
* Comparative Data (e.g., comparisons between similar units internally and comparative external data from hospitals of like size and geographic location)
* Clinical Outcomes
* Skill Mix of Staff (e.g., licensing levels and educational training, years of experience, and volume of new graduates on a unit)
* Physical environment (distance staff have to travel to access support equipment, visibility of patients, locations of nursing stations to patient rooms, etc.)
* Type of patient care needs
* Support services available

At least daily monitoring should take place to determine variances between pre-determined staffing patterns and actual staffing patterns. If necessary, corrective action should be taken. Regular monitoring should take place to determine accuracy of targets established and determine adjustments as needed.

1. **9.4: Are there other examples of Performance Improvement activities that would help provide credit towards this safe practice?**Yes, an example of a performance improvement project that would help provide Action credit for this safe practice would be for a hospital to commit to achieve the American Association of Critical Care Nurses (AACN) Beacon award for Critical Care Excellence. The criteria to be met include:

* Recognized excellence in the intensive care environments in which nurses work and critically ill patients live
* Recognized excellence of the highest quality measures, processes, structures and outcomes based upon evidence
* Recognized excellence in collaboration, communication, and partnerships that support the value of healing and humane environments
* Developed a program that contributes to actualization of AACN’s mission, vision and values.

6E: Safe Practice # 19 Hand Hygiene

1. **19.1, 19.4: How will institutions measure or monitor progress with this Safe Practice?**The following elements may be monitored as part of a performance improvement project:

* Implementation of the nationally-approved hand hygiene guidelines as established by the Centers for Disease Control (CDC)
* Hospital-acquired infection rates as a pre- and post-test after the implementation of interventions, such as bedside dispensers or other equipment for hand decontamination made available to staff

1. **19.4: Will use of the CDC guidelines for hand hygiene meet this Safe Practice?**Yes. Please visit <http://www.cdc.gov/handhygiene/Guidelines.html>.
2. **19.4b: Would a general hand hygiene “campaign” be enough to count as a formal performance improvement program?**No. To meet this element, hospitals should be employing one or more of the following: technology systems to monitor hand hygiene compliance, use of secret observers, and measuring use of hand hygiene product.

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SECTION 7: MANAGING SERIOUS ERRORS

This section includes questions and reference information for Section 7 Managing Serious Errors. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 7: 2017 Managing Serious Errors

**Never Events Fact Sheet:** <http://leapfroggroup.org/ratings-reports/survey-content>

This section of the survey addresses the occurrence of serious errors in hospitals.

Hospitals are asked to implement the nine principles of Leapfrog’s Never Events policy when a serious error or “never event” occurs within their facility. Please note that in 2017, hospitals will only be scored on their responses to Leapfrog’s original five principles. Responses to the four new principles will not be used in scoring until 2018.

In addition to the management of serious errors, hospitals are asked to report data on five healthcare-associated infections– Central line-associated bloodstream infections (CLABSI) in ICUs and select wards, Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards, Facility-wide inpatient Methicillin-resistant Staphylococcus Aureus (MRSA) Blood Laboratory-identified Events, Facility-wide inpatient Clostridium difficile (C. Diff.) Laboratory-identified Events*,* and Surgical Site Infections from colon surgery (SSI: Colon) – as well as, two hospital-acquired conditions – stage III or IV pressure ulcers and injuries.

Lastly, hospitals are asked to report on their adoption and implementation of the CDC’s Core Elements of Antibiotic Stewardship Programs.

**Each hospital fully meeting the standards for this section of the survey:**

1. Has a policy that includes the five original principles of Leapfrog’s Never Events policy and will implement this policy if a “never event” occurs within their facility.
2. Has a CLABSI standardized infection ratio of less than or equal to 0.250 for ICU and select ward inpatients.

1. Has a CAUTI standardized infection ratio of less than or equal to 0.250 for ICU and select ward inpatients.
2. Has a MRSA standardized infection ratio of less than or equal to 0.250 for facility-wide inpatients.
3. Has a C. Diff. standardized infection ratio of less than or equal to 0.250 for facility-wide inpatients.
4. Has a SSI: Colon standardized infection ratio of less than or equal to 0.250 for inpatients following eligible colon procedures.
5. Has implemented all 7 of the CDC’s Core Elements of Antibiotic Stewardship Programs.

Due to the national transition from ICD-9 to ICD-10, Leapfrog is re-setting the cut-points for the hospital-acquired pressure ulcer and injuries measures. The cut-points will be established based on surveys submitted by June 30, 2017. This document will be updated to include the new cut-points on July 25.

**Download the 2017 Leapfrog Hospital Survey Scoring Algorithm on the** [**Scoring and Results webpage**](http://www.leapfroggroup.org/survey-materials/scoring-and-results)**.**

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| 7A: The Leapfrog Group “Never Events” Policy Statement  |  |  | | --- | --- | | Below are the nine elements which make up The Leapfrog Group’s Policy Statement regarding [never event](#Endnote35)s.[[34]](#endnote-35) Indicate which of the following principles are included in your hospital’s never events policy.  **As a reminder, in 2017, hospitals will only be scored on their responses to questions #1-5 which represent the original five elements of Leapfrog’s Policy Statement. Responses to questions #6-9 will not be used in scoring until 2018.** | | | 1. We will [apologize to the patient](#Endnote36)[[35]](#endnote-36) and/or family affected by the never event. | *Yes*  *No* | | 1. We will report the event to at least one of the following [external agencies](#Endnote37)[[36]](#endnote-37) within 10 days of becoming aware that the never event has occurred:  * Joint Commission, as part of its Sentinel Events policy * State reporting program for medical errors * Patient Safety Organization (as defined in The Patient Safety and Quality Improvement Act of 2005) | *Yes*  *No* | | 1. We agree to perform a [root cause analysis](#Endnote38),[[37]](#endnote-38) which at a minimum, includes the elements required by the chosen external reporting agency. | *Yes*  *No* | | 1. We will waive all costs directly related to the never event. | *Yes*  *No* | | 1. We will make a copy of this policy available to patients, patients’ family members, and payers upon request. | *Yes*  *No* | | 1. We will interview patients and/or families who are willing and able, to gather evidence for the root cause analysis. | *Yes*  *No* | | 1. We will inform the patient and/or his/her family of the action(s) that our hospital will take to prevent future recurrences of similar events based on the findings from the root cause analysis. | *Yes*  *No* | | 1. We will have a protocol in place to provide support for caregivers involved in never events, and make that protocol known to all caregivers and affiliated clinicians. | *Yes*  *No* | | 1. We will perform an annual review to ensure compliance with each element of Leapfrog’s Never Events Policy for each never event that occurred. | *Yes*  *No* |   **Important Note:** To earn credit for this question, hospitals must have a policy in place that addresses the National Quality Forum’s list of Serious Reportable Events. All references to “never event” or “serious reportable event” are specific to the National Quality Forum list available at <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=69573>.   |  | | --- | |  | |

|  |  |
| --- | --- |
| 7B: Healthcare-Associated Infections  |  | | --- | | **Reporting Time Period: 12 months**   * Surveys submitted prior to September: 01/01/2016 - 12/31/2016 * Surveys (re)submitted on or after September 1: 07/01/2016 - 06/30/2017   *Leapfrog will update data 4 times per survey cycle for all current members of our NHSN group that have provided an accurate NHSN ID in the Profile and submitted Section 7 Managing Serious Errors. Before September 1st, Leapfrog will use calendar year 2016 data. On or after September 1st, Leapfrog will use 2016 Quarter 3 data through 2017 Quarter 2 data.*  *Visit the* [*Join NHSN Group webpage*](http://www.leapfroggroup.org/survey-materials/join-nhsn) *for important information on deadlines for joining Leapfrog’s NHSN Group.* |   Beginning in 2017, hospitals will no longer be able to enter their infection data into the online survey tool. Instead, Leapfrog will obtain standardized infection ratios (SIRs) for each of the five applicable infection measures (CLABSI in ICUs and select wards, CAUTI in ICUs and select wards, Facility-wide inpatient MRSA Blood Laboratory-identified Events, Facility-wide inpatient C. Diff. Laboratory-identified Events, and SSI: Colon) directly from the CDC’s National Healthcare Safety Network (NHSN) application. Please be sure you have followed the instructions provided [online](http://www.leapfroggroup.org/survey-materials/join-nhsn) and have joined Leapfrog’s NHSN group by the specified deadlines.  In addition to joining Leapfrog’s NHSN group, hospitals must provide an accurate NHSN ID in the Profile section of the online survey tool and submit Section 7 Managing Serious Errors. Hospitals that join Leapfrog’s NHSN group, but do not provide an accurate NHSN ID in their Profile or do not submit Section 7 Managing Serious Errors, will be scored and publicly reported as “Declined to Respond” for each of the five infection measures.  Please refer to the “Deadlines and Reporting Periods” table provided [online](http://www.leapfroggroup.org/survey-materials/join-nhsn) for information on when you can preview your SIRs on your Hospital Details Page. Hospitals that join Leapfrog’s NHSN Group by June 22nd and submit Section 7 of their Leapfrog Hospital Survey by June 30th will be able to view the SIRs obtained directly from NHSN for the reporting period listed above by logging into their Hospital Details Page on July 12th. For all other deadlines, please refer to the instructions provided [online](http://www.leapfroggroup.org/survey-materials/join-nhsn). |

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| 7C: Hospital-Acquired Conditions – Pressure Ulcers and Injuries **Pediatric hospitals skip questions #1-5.**  **Critical access hospitals (CAH) that do not collect Present-on-Admission (POA) indicators should answer “no” to question #2 and will be scored as “Does Not Apply.**  **Specifications:** Hospitals should refer to the [***Pressure Ulcers and Injuries Measure Specifications***](#PUInjSpecs) in the Managing Serious Errors Reference Information on pages 137-138 for counting patient discharges and events.   |  | | --- | | **Reporting Time Period: 12 months**   * Surveys submitted prior to September 1: 01/01/2016 - 12/31/2016 * Surveys (re)submitted on or after September 1: 07/01/2016 - 06/30/2017 | | |
| 1. 12-month reporting time period used: | * 01/01/2016 - 12/31/2016 * 07/01/2016 - 06/30/2017 |
| 1. Has your hospital collected Present-on-Admission (POA) indicators for the Reporting Time Period, tabulated HAC measures as specified here for that time period, and chosen to report this information to the survey?   *If “no,” skip questions #3-5 and proceed to the next subsection. Score will show as “Declined to Respond.”   If hospital is a critical access hospital, and selects “no,” score will show as “Does Not Apply.”* | *Yes*  *No* |
| 1. Total number of adult inpatient discharges (including deaths) during the reporting period. | \_\_\_\_\_\_\_\_ |
| **Pressure Ulcers** | |
| 1. Number of discharges **in question #3** with a hospital-acquired stage III or IV Pressure Ulcer. | \_\_\_\_\_\_\_\_ |
| **Injuries** | |
| 1. Number of discharges **in question #3** with a hospital-acquired injury. | \_\_\_\_\_\_\_\_ |

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| 7D: Antibiotic Stewardship Practices |

The following questions have been taken directly from the NHSN’s 2016 Patient Safety Component – Annual Hospital Survey questions #23 – 33. More information about these questions can be found at <http://www.cdc.gov/nhsn/forms/instr/57_103-TOI.pdf>

|  |
| --- |
| **Reporting Time Period:** Answer questions #1-11 based on your hospital’s 2016 NHSN Annual Hospital Survey or based on your hospital’s current structure. |

|  |  |
| --- | --- |
| 1. Does your facility have a written statement of support from leadership that supports efforts to improve antibiotic use (antibiotic stewardship)? | *Yes*  *No* |
| 1. Is there a leader responsible for stewardship activities at your facility?   *If “no,” skip 2a and move on to question #3.* | *Yes*  *No* |
| 2a) If yes, what is the position of this leader? (check one) | * *Physician* * *Pharmacist* * *Co-led by both Pharmacist and Physician* * *Other (please specify):* |
| 1. Is there at least one pharmacist responsible for improving antibiotic use at your facility? | *Yes*  *No* |
| 1. Does your facility provide any salary support for dedicated time for antibiotic stewardship leadership activities? | *Yes*  *No* |
| 1. Does your facility have a policy that requires prescribers to document an indication for all antibiotics in the medical record or during order entry?   *If “no,” skip 5a and move on to question #6.* | *Yes*  *No* |
| 5a) If Yes, has adherence to the policy to document an indication been monitored? | *Yes*  *No* |
| 1. Does your facility have facility-specific treatment recommendations, based on national guidelines and local susceptibility, to assist with antibiotic selection for common clinical conditions?   *If “no,” skip 6a and move on to question #7.* | *Yes*  *No* |
| 6a) If Yes, has adherence to facility-specific treatment recommendations been monitored? | *Yes*  *No* |
| 1. Is there a formal procedure for all clinicians to review the appropriateness of all antibiotics at or after 48 hours from the initial orders (e.g., antibiotic time out)? | *Yes*  *No* |
| 1. Do any specified antibiotic agents need to be approved by a physician or pharmacist prior to dispensing at your facility? | *Yes*  *No* |
| 1. Does a physician or pharmacist review courses of therapy for specified antibiotic agents and communicate results with prescribers at your facility?   *If “no,” skip 9a and move on to question #10.* | *Yes*  *No* |
| 9a) If Yes, what type of feedback is provided to prescribers? (Check all that apply) | * *Feedback on antimicrobial route and/or dosage* * *Feedback on the selection of antimicrobial therapy and/or duration of therapy* * *Other (please specify):* |
| 1. Does your facility monitor antibiotic use (consumption) at the unit, service, and/or facility wide?   *If “no,” skip 10a and 10b and move on to question #11.* | *Yes*  *No* |
| |  | | --- | | 10a) If Yes, by which metrics? (Check all that apply) | | * *Days of Therapy (DOT)* * *Defined Daily Dose (DDD)* * *Purchasing Data* * *Other (please specify):* |
| |  | | --- | | 10b) If Yes, are facility- and/or unit- or service-specific reports on antibiotic use shared with prescribers? | | *Yes*  *No* |
| 1. Has your facility provided education to clinicians and other relevant staff on improving antibiotic use? | *Yes*  *No* |

**Affirmation of Accuracy**

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Managing Serious Errors Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract with Leapfrog are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the survey results public reporting website, The Leapfrog Group’s Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group. This information does not infringe any third party’s intellectual property rights. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract with Leapfrog reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the hospital’s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(name) (title)

on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(date)

Section 7: 2017 Managing Serious Errors Reference Information

### What’s New in the 2017 Survey

Leapfrog has added four new elements to its Never Events Policy Statement. In 2017, hospitals will only be scored on their responses to Leapfrog’s five original elements. Please see the 2017 Scoring Algorithm document on the [Scoring and Results webpage](http://www.leapfroggroup.org/survey-materials/scoring-and-resultsleapfroggroup.org/survey-materials/scoring-results).

Leapfrog has replaced the ICU-only CLABSI and CAUTI measures with the CLABSI and CAUTI in ICUs and select wards measures to be consistent with NHSN and CMS. We have also removed reporting on CLABSI, CAUTI, MRSA, C. Diff., and SSI: Colon from the online survey. Instead, hospitals must join Leapfrog’s NHSN Group which will allow Leapfrog to obtain the data directly from CDC’s National Healthcare Safety Network (NHSN). Hospitals will be able to review their data by accessing their Hospital Details Page beginning on July 12and then by the 5th of each month thereafter. In order for Leapfrog to access hospital data, hospitals will need to elect to join Leapfrog’s NHSN Group by the specified [deadlines](http://www.leapfroggroup.org/survey-materials/join-nhsn).

Due to the updated NHSN baselines and SIR methodology, Leapfrog has established updated cut-points used to assign performance categories (e.g., Fully Meets the Standard, Substantial Progress, etc.) for these five measures based on the national distribution of SIRs using the CMS national dataset released in December. The updated cut-points are reflected on page 128 of this document and in the 2017 Scoring Algorithm document.

Due to the national transition from ICD-9 to ICD-10, Leapfrog is re-setting the cut-points for the hospital-acquired pressure ulcer and injuries measures. The cut-points will be established based on surveys submitted by June 30, 2017. This document will be updated to include the new cut-points on July 25th and the updated cut-points will be added to the 2017 Scoring Algorithm document.

Lastly, the questions in Section 7D Antibiotic Stewardship Practices have been updated to align with the 2016 NHSN Patient Safety Survey. The scoring algorithm has been updated accordingly as well. Please see the 2017 Scoring Algorithm document.

### Change Summary since Release

None. If substantive changes are made to this section of the survey after release on April 1, 2017, they will be documented in this Change Summary section.

## Never Events Frequently Asked Questions (FAQs)

1. **What are never events?**

The National Quality Forum, a nonprofit national coalition of physicians, hospitals, businesses and policy-makers, has identified 29 events as occurrences that should never happen in a hospital and can be prevented. They termed them “serious reportable events”, or never events. They include surgical events, such as performing the wrong surgical procedure, product or device events, such as contaminated drugs or devices, and criminal events, such as abduction of a patient.   
  
To earn credit for this question, hospitals must have a policy in place that addresses the National Quality Forum’s list of Serious Reportable Events. All references to “never event” or “serious reportable event” are specific to the National Quality Forum list available at <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=69573>. Hospitals may not earn credit for this question if they have only implemented a policy that includes the Centers for Medicare and Medicaid Services (CMS) Never Events.

1. **When reporting Never Events, what “state reporting program for medical errors” applies in my state?**Congress has passed legislation requiring all states to develop a reporting program for medical errors. At this time, many states have already enacted or adopted some requirement that hospitals report serious medical errors or similar adverse events to a state agency. Others are still implementing legislation or regulations that define that requirement. States that have developed programs may also define reportable events differently.
2. **What if there is no “state reporting program for medical errors” in my state? Do we still have to report Never Events to meet Leapfrog principles for this policy? To whom?**Hospitals in states that do not have a state reporting program or requirement in effect can meet the reporting requirement of Leapfrog’s principles for implementation of a Never Events policy by reporting all Never Events voluntarily to either The Joint Commission or a Patient Safety Organization.   
     
   If there is no state-required reporting program in effect, no available Patient Safety Organization to which your hospital can report, and your hospital is not Joint Commission accredited, the Leapfrog requirement for reporting to an external agency is amended. Hospitals must report the Never-Event to their governance board. And, hospitals must still perform a root-cause analysis internally of each Never Event to meet Leapfrog’s principle for full implementation of its Never Events policy.
3. **The reportable adverse events defined by our state’s reporting program don’t include all 29 Never Events endorsed by the National Quality Forum (NQF) and adopted in the Leapfrog policy. Will reporting only the state-required reportable events to the state agency suffice for meeting Leapfrog’s requirement for reporting Never Events to an external agency? Does our hospital have to report other Never Events, as defined by NQF/Leapfrog, to that state agency even though not required by our state’s reporting program?**Hospitalsshould report all of their state-required reportable events to the state agency. All other Never Events, as defined by NQF’s list of Serious Reportable Events, that cannot be reported to the state agency, should be reported to another external agency (e.g., accreditor, Patient Safety Organization), if possible. If reporting those events to another external agency is not possible, the final option is to report those events to the hospital’s governance board.
4. **Won’t Leapfrog’s request to have hospitals apologize to the patient put the hospital at risk for liability?**Not necessarily. Research indicates that malpractice suits are often the result of a failure on the hospital’s part to communicate openly with the patient and apologize for its error. Patients feel the most anger when they perceive that no one is willing to take responsibility for the adverse event that has occurred. A sincere apology from the responsible hospital staff can help to heal the breach of trust between doctor/hospital and patient. (When Things Go Wrong: Responding to Adverse Events. Boston, 2006. Mass Coalition for the Prevention of Medical Errors)
5. **How does Leapfrog define “waive cost”?**At its core, Leapfrog’s approach to never events is about improving patient care. While the policy asks hospitals to refrain from billing either the patient or a third party payer, such as a health plan or employer company, for any costs directly related to a serious reportable adverse event, Leapfrog understands that, due to the wide array of circumstances surrounding never events, specific details of what constitutes “waiving cost” should be handled on a case-by-case basis by the parties involved.
6. **Does Leapfrog recommend any resources for hospitals looking to adhere to Leapfrog’s Never Events principles?**

Yes, the Agency for Healthcare Research and Quality (AHRQ) has developed and tested the [Communication and Optimal Resolution (CANDOR) Toolkit](http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/candor/introduction.html), which outlines a process for hospitals and practitioners to respond to unexpected events in a timely, thorough, and just way. The National Patient Safety Foundation (NPSF) has issued a report titled [RCA2: Improving Root Cause Analyses and Actions to Prevent Harm](http://www.npsf.org/?page=RCA2), which examines best practices and provides guidelines to help standardize and improve Root Cause Analysis. In addition, hospitals can download tips and tools for interviewing patients and families for the Root Cause Analysis on the [Survey and CPOE Materials webpage](http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials).

## Healthcare-Associated Infections Specifications

**Important Notes:**

Note 1: Hospitals that share a Medicare Provider Number are required to report by facility. Please carefully review [Leapfrog’s Multi-Campus Reporting Policy](http://leapfroggroup.org/survey-materials/multi-campus-reporting-policy).

Note 2: Hospitals must provide an accurate NHSN ID in the Profile section of their survey.

Data is obtained directly from CDC’s National Healthcare Safety Network (NHSN). Hospitals that join Leapfrog’s NHSN Group by June 22and submit Section 7 of their Leapfrog Hospital Survey by June 30will be able to view the SIRs obtained directly from NHSN by logging into their Hospital Details Page on July 12. For instructions and all other deadlines and release dates, please refer to the “Instructions for Joining Leapfrog’s NHSN Group” and the “Deadlines and Reporting Periods” table provided on the [Join NHSN Group webpage](http://www.leapfroggroup.org/survey-materials/join-nhsn).

Reports can also be pulled directly from NHSN for the purposes of verifying your data by following these instructions:

The following reports are accessible under Reports > CMS Reports > Acute Care Hospitals (Hospital IQR):

* CLABSI in ICUs and select wards: “SIR – CLAB Data for Hospital IQR”
* CAUTI in ICUs and select wards: “SIR – CAU Data for Hospital IQR”
* Facility-wide inpatient MRSA Blood Laboratory-identified Events: “SIR – MRSA Blood FacwideIN LabID Data for Hospital IQR”
* Facility-wide inpatient C. Diff Laboratory-identified Events: “SIR – CDI FacwideIN LabID Data for Hospital IQR”
* SSI: Colon: “SIR – Complex 30-Day SSI Data for Hospital IQR”

These reports were created in order to allow facilities to review the infection data that would be submitted to CMS on their behalf. However, these same output options can be used to verify the data that Leapfrog is obtaining directly from NHSN for your facility.

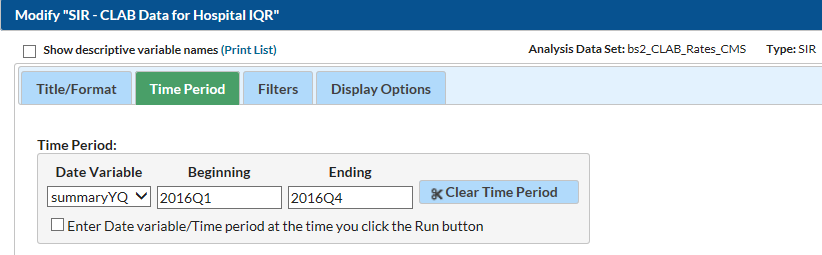
*Before running these output options, remember to generate your datasets for the most up-to-date data reported to NHSN by your facility. Generating datasets is required to have the new 2015 baselines used appropriately. To generate datasets, go to Analysis > Generate Data Sets, then click “Generate New”.*

The CLABSI/CAUTI reports will include in-plan CLABSI or CAUTI data for each adult and pediatric ICU and in-plan CLABSI or CAUTI data for each adult and pediatric medical, surgical, and medical/surgical ward, as well as the SIR for your hospital. The other reports will include in-plan MRSA blood laboratory-identified events data or C. Diff. laboratory-identified events data or SSI: Colon procedure data. Be sure you are using the correct date range when generating your report:

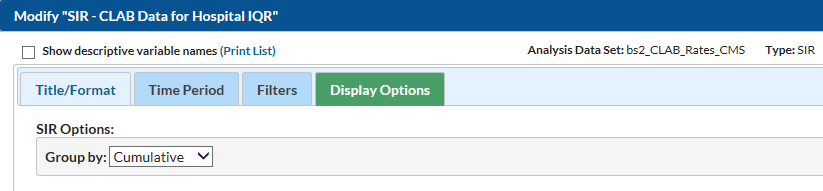
* Prior to September 1, 2017, use **summaryYQ 2016Q1 to 2016Q4.**
* On or after September 1, 2017, use **summaryYQ 2016Q3 to 2017Q2.**

You will need to modify your reports in order to get the appropriate SIR for the reporting period. To update your report, follow these instructions before running:

1. Select the report you would like to run and hit “Modify Report”.
2. Select the “Time Period” tab. Then select **summaryYQ** as the Date Variable and enter the Beginning and Ending Quarter.
   1. Prior to September 1, 2017, use **summaryYQ 2016Q1 to 2016Q4.**
   2. On or after September 1, 2017, use **summaryYQ 2016Q2 to 2017Q2.**



1. Select the “Display Options” tab and change the value of the dropdown menu from SummaryYQ to **Cumulative** to get a cumulative SIR for the time period specified.



**Important Note:** Do not make any other modifications to the report options. Other options specified are the default CMS IQR report options and should be left as is to ensure that you are pulling the correct data.

1. After updating the time period and the group by options, select “Run”.

You are not required nor are you able to enter data for these measures directly into the survey. Reports should be used for verification purposes only.

## Pressure Ulcers and Injuries Measure Specifications

**Important Notes**

Note 1: This section does not apply to pediatric hospitals.

Note 2: This section does not apply to critical access hospitals (CAH) that do not collect Present-on-Admission (POA) indicators.

Note 3: Hospitals that share a Medicare Provider Number are required to report by facility. Please carefully review [Leapfrog’s Multi-Campus Reporting Policy](http://leapfroggroup.org/survey-materials/multi-campus-reporting-policy).

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| Hospital-Acquired Pressure Ulcers |
| **Source:** The Leapfrog Group  **Reporting Time Period: 12 months**   * Surveys submitted prior to September 1: 01/01/2016 - 12/31/2016 * Surveys (re)submitted on or after September 1: 07/01/2016 - 06/30/2017 |
| **Q.3**  **Denominator:** Total adult (ages 18 and older) inpatient discharges (including deaths) during the reporting time period. [Note: Hospitals should include in the denominator any patient for which they code present-on-admission (POA). This would include most short-stay psych and rehab patients.] |
| **Q.4**  **Numerator**: Number of eligible cases included in the denominator with any of the following ICD-10 diagnosis codes for stage III and IV pressure ulcers as a secondary diagnosis (diagnosis 2-9 on a claim), with a Present-on-Admission (POA) indicator of “N” or “U”, as defined in CMS’ Appendix I Hospital Acquired Conditions (HAC) List for HAC 04: Stage III and IV Pressure Ulcers Secondary Diagnosis.    Download a full list of v33 ICD 10 Stage III and IV Pressure Ulcer codes at <http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials> (see **Pressure Ulcers and Injuries CC-MCC Diagnosis Codes** sheet). |

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| Hospital-Acquired Injuries |
| **Source:** The Leapfrog Group  **Reporting Time Period: 12 months**   * Surveys submitted prior to September 1: 01/01/2016 - 12/31/2016 * Surveys (re)submitted on or after September 1: 07/01/2016 - 06/30/2017 |
| **Q.3**  **Denominator:** Total adult (ages 18 and older) inpatient discharges (including deaths) during the reporting time period. [Note: Hospitals should include in the denominator any patient for which they code present-on-admission (POA). This would include most short-stay psych and rehab patients.] |
| **Q.5**  **Numerator**: Number of eligible cases included in the denominator with any of the following ICD-10 diagnosis codes for falls and trauma as a secondary diagnosis (diagnosis 2-9 on a claim), with a Present-on-Admission (POA) indicator of “N” or “U”, as defined in CMS’ Appendix I Hospital Acquired Conditions (HAC) List for HAC 05: Falls and Trauma Secondary Diagnosis.  Download a full list of v33 CC/MCC codes at <http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials> (see **Pressure Ulcers and Injuries CC-MCC Diagnosis Codes** sheet). |

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SECTION 8: MEDICATION SAFETY

This section includes questions and reference information for Section 8 Medication Safety. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 8: 2017 Medication Safety

**Bar Code Medication Administration and Medication Reconciliation Fact Sheets:** <http://leapfroggroup.org/ratings-reports/survey-content>

This section of the survey asks hospitals about their use of bar code medication administration (BCMA) systems in administering medications at the bedside to reduce medication errors across inpatient units. It also assesses the quality and accuracy of the hospital’s medication reconciliation process.

**Each hospital fully meeting the BCMA standard:**

1. Has implemented the use of BCMA at the bedside in 100% of applicable units
2. Has achieved at least 95% compliance with scanning patients and medications during administration
3. Has a BMCA system that includes all of the following types of decision support: wrong patient, wrong medication, wrong dose, wrong time, vital sign check, patient-specific allergy check, and second nurse check needed.
4. Has structures in place to monitor and reduce workarounds, which include having a formal committee that meets routinely to review data reports on BCMA system use, having back-up systems for hardware failures, having a help desk that provides timely responses to urgent BCMA issues in real-time, conducting real-time observations of users using the BCMA system, and engaging nursing leadership at the unit level on BCMA use.

The Medication Reconciliation measure will not be scored or publicly reported in 2017. The measure will be scored and publicly reported in 2018.

**Download the 2017 Leapfrog Hospital Survey Scoring Algorithm on the** [**Scoring and Results webpage**](http://www.leapfroggroup.org/survey-materials/scoring-and-results)**.**

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| 8A Bar Code Medication Administration |

**Specifications:** Hospitals that share a Medicare Provider Number are required to report by facility. Please carefully review [Leapfrog’s Multi-Campus Reporting Policy](http://leapfroggroup.org/survey-materials/multi-campus-reporting-policy).

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| **Reporting Time Period: 3 months**  Answer questions #1-15 for the latest 3-month period prior to the submission of this section of the survey. |

|  |  |
| --- | --- |
| 1. What is the latest 3-month reporting period for which your hospital is submitting responses to this section? 3-month reporting time period ending: | *\_\_\_\_\_\_*  *Format: MM/YYYY* |
| 1. Does your hospital use a Bar Code Medication Administration (BCMA) system that is linked to the electronic medication administration record (eMAR) when administering medications at the bedside in at least one inpatient unit?   *If “yes,” complete questions #3-15.*  *If “no,” skip the remaining questions in 8A and move on to the next subsection.* | *Yes*  *No* |
| 1. Does your hospital operate Intensive Care Units (adult, pediatric, and/or neonatal)?   *If “no,” skip questions #4 and #5.* | *Yes*  *No* |
| 1. If “yes,” how many of this type of unit are open and staffed in the hospital? | *\_\_\_\_\_* |
| 1. How many of the units in question #4 utilized the BCMA/eMAR system when administering medications at the bedside? | *\_\_\_\_\_* |
| 1. Does your hospital operate [Medical and/or Surgical Units (including telemetry units)](#Endnote42)[[38]](#endnote-39)?   *If “no,” skip questions #7 and #8.* | *Yes*  *No* |
| 1. If “yes,” how many of this type of unit were open and staffed in the hospital? | *\_\_\_\_\_* |
| 1. How many of the units in question #7 utilized the BCMA/eMAR system when administering medications at the bedside? | *\_\_\_\_\_* |
| 1. Does your hospital operate a Labor and Delivery Unit?   *If “no”, skip questions #10 and #11.* | *\_\_\_\_\_* |
| 1. If “yes,” how many of this type of unit were open and staffed in the hospital? | *\_\_\_\_\_* |
| 1. How many of the units in Question #10 utilized the BCMA/eMAR system when administering medications at the bedside? | *\_\_\_\_\_* |

*If “no,” to questions #3, #6, and #9 above, skip the remainder of the questions and go to the Affirmation of Accuracy. Your hospital will be scored as “Does Not Apply.” Otherwise, move on to questions #12-15.*

|  |  |
| --- | --- |
| 1. The number of inpatient medication administrations ordered and scannable during the reporting period in those units indicated in questions #3-11 above? | \_\_\_\_\_ |
| 1. The number of medication administrations from question #12 that had both the patient and the medication scanned during administration with a BCMA system that is linked to the electronic medication administration record (eMAR)? | \_\_\_\_\_ |

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| --- | --- | --- |
| 1. What types of decision support does your hospital’s BCMA system provide to users of the system?   (*Do not leave any questions blank*) | | |
| a) | Wrong patient | *Yes*  *No* |
| b) | Wrong medication | *Yes*  *No* |
| c) | Wrong dose | *Yes*  *No* |
| d) | Wrong time (e.g., early/late warning; warning that medication cannot be administered twice within a given window of time) | *Yes*  *No* |
| e) | Vital sign check | *Yes*  *No* |
| f) | Patient-specific allergy check | *Yes*  *No* |
| g) | Second nurse check needed | *Yes*  *No* |

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| 1. Which of the following mechanisms does your hospital use to reduce and understand potential BCMA system “workarounds”? (*Do not leave any questions blank)* | | |
| a) | Has a formal committee that meets routinely to review data reports on BCMA system use | *Yes*  *No* |
| b) | Has back-up systems for BCMA hardware failures | *Yes*  *No* |
| c) | Has a Help Desk that provides timely responses to urgent BCMA issues in real-time | *Yes*  *No* |
| d) | Conducts real-time observations of users using the BCMA system | *Yes*  *No* |
| e) | Engages nursing leadership at the unit level on BCMA use | *Yes*  *No* |

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| 8B: Medication Reconciliation |

**This section is not applicable to Pediatric hospitals.**

**Specifications:** See [***Medication Reconciliation Measure Specifications***](#MedRecSpecs) in the Medication Safety Reference Information on page 146.

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| |  | | --- | | **Reporting Time Period: 3 months**  Answer questions #1-6 for the latest 3-month period prior to the submission of this section of the survey. |  |  |  | | --- | --- | | 1. During the reporting period, did your hospital conduct a random sample of its adult patients to collect the total number of unintentional medication discrepancies identified between the [gold standard medication history](#Endnote43)[[39]](#endnote-40) and the admission and discharge orders?   *If “yes,” complete questions #2-6.*  *If “no,” go to the Affirmation of Accuracy.* | *Yes*  *No* |  |  |  | | --- | --- | | *For questions #2-6, report on a sample of at least 10 patients.* | | | 1. Number of patients that your hospital [sampled](#Endnote44)[[40]](#endnote-41). | *\_\_\_\_\_* | | 1. Total number of medications obtained from the gold standard medication history for each patient included in the sample ([gold standard pre-admission medications](#Endnote45)[[41]](#endnote-42)). | *\_\_\_\_\_* | | 1. Total number of [unintentional discrepancies among the gold standard medications](#Endnote42)[[42]](#endnote-43) in question #3 at admission and/or discharge. | *\_\_\_\_\_* | | 1. Total number of additional medications that were [ordered unintentionally](#Endnote43)[[43]](#endnote-44) for the patients sampled on admission and/or discharge. | *­­\_\_\_\_\_* | | 1. Total number of [discrepancies due to unintentionally ordered additional medications](#Endnote44)[[44]](#endnote-45) in question #5 on admission and/or discharge. | *\_\_\_\_\_* | |

**Affirmation of Accuracy:**

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Bar Code Medication Administration Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract with Leapfrog are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the survey results public reporting website, The Leapfrog Group’s Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group. This information does not infringe any third party’s intellectual property rights. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract with Leapfrog reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the hospital’s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(name) (title)

on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Section 8: 2017 Medication Safety Reference Information

### What’s New in the 2017 Survey

Leapfrog has added a new Medication Reconciliation measure to Section 8 and has therefore renamed the section “Medication Safety.” This section will not be scored and results for this section of the survey will not be publicly reported in 2017. This section will be scored and results will be publicly reported in 2018.

Leapfrog has added labor and delivery unit questions to Section 8A BCMA, and included telemetry units in its definition of medical and surgical units for questions #6-8.

### Change Summary since Release

None. If substantive changes are made to this section of the survey after release on April 1, 2017, they will be documented in this Change Summary section.

## BCMA Frequently Asked Questions (FAQs)

1. **Why does the Bar Code Medication Administration system have to be connected to an electronic medication administration record (eMAR)?**

An eMAR serves as the communication interphase that automatically documents the administration of medication into certified Electronic Health Record (EHR) technology. By linking BCMA with the eMAR, information on medication administration is captured in a much timelier manner than a manual documentation process can accomplish.

1. **Which intensive care, medical/surgical, and labor/delivery units should be included?**

Only include those units that have been opened and staffed for the entire 3-month reporting period. For example, if you open a new unit that has only been open and staffed for 1-month out of the 3-month reporting period, you would not include that unit when responding to the questions in this section.

1. **Why aren’t hospitals being asked about their use of Bar Code Medication Administration systems in the pharmacy?**

For its first year of including BCMA in the Hospital Survey and publicly reporting results, Leapfrog is focusing on BCMA implementation at the bedside. Leapfrog may expand its BCMA standard to include implementation in the pharmacy in future surveys.

1. **Is manual scanning (for example, in lieu of scanning the patient’s wristband, we type in the patient’s number) something we can count in our BCMA scans*?***

No. The problem is that the user may type in the wrong patient number, negating the safety benefits. The best practice is to scan the wristband that is on the wrist of the patient.

1. **In our hospital some medications are ordered and scheduled, but not administered. Should medications that are ordered and scheduled, but not administered be included when responding to Questions #12 and #13?**

No, medications that are not administered should not be included in Questions #12 and #13.

1. **If an alert is part of the eMAR, but not the Bar Code Medication Administration system, should we respond “yes” to the decision support elements in Question #14a - g?**

If the provider and pharmacist are notified or alerted (i.e., patient-specific allergy, vital sign check or second nurse check), but the nurse or provider administering the medication does not receive an alert at the point of administration, then your hospital should answer “no” to these questions about decision support.

1. **My hospital’s EHR workflow for medication administration is designed in such a way that our system will never generate a “wrong patient” alert. How should we answer the question in the survey about whether we have that type of decision support?**

If your hospital’s EHR workflow is designed so that the nurse scans the patient first, and then the medications, such that the nurse would never receive a ‘wrong patient’ alert, for purposes of the survey, your hospital should indicate that it has ‘wrong patient’ decision support. The goal of including ‘wrong patient’ is to acknowledge that as a safe practice and to drive organizations to validate the ‘right patient’ in the medication administration process. The workflow described helps ensure that that ‘wrong patient’ is not encountered.

1. **What is the definition of a vital sign check? Is it to alert the user to check the vital signs before administering the medication, or is it an alert if the vital signs are not within the parameters of the medication?**

If the BCMA system does not alert the user to perform a vital sign check when scanning a medication that would require this check before administration of the medication, then the hospital should answer “no” to Question #14e. The user does not need to receive an alert if vital signs are not within the parameters, but the user should be required to enter the vital signs into the system before moving forward with administering the medication.

1. **Ideally our hospital’s CPOE system would catch a potential allergy alert at the point of medication ordering. If so, why would we need to receive an allergy alert from our BCMA system?**

Some hospitals choose to use a BCMA system without using a CPOE system so this type of decision support is very important for patient safety.

1. **Must a hospital establish a separate committee to meet solely to review data reports on BCMA system use?**

While establishing a committee that has the sole purpose of reviewing data reports on BCMA system use is encouraged, it is not required to meet Leapfrog’s standard. At a minimum, a pre-existing standing committee that meets on a regular basis could be given the responsibility of reviewing these reports. The committee chosen to review the reports must include individuals whose roles reflect each part of the BCMA process (e.g., pharmacists, nurses, IT personnel, etc.).

1. **What are some examples of “back-up systems” for hardware failures?**

Examples of “back-up systems” include extra BCMA scanners, portable computers, batteries, and mice that are easily accessible to nurses experiencing equipment malfunctions. Quickly replacing malfunctioning equipment is essential to preventing workarounds.

1. **What are some examples of “engaging nursing leadership at the unit level on BCMA use?”**

Engaging nursing leadership on BCMA use should be an active, ongoing process. An engaged leader would actively use BCMA data to coach staff towards safe or desired behaviors. Examples of activities in which nursing leadership could be engaged include, but are not limited to:

* + Education sessions in units
  + Review of policies regarding use and non-use of BCMA
  + Investigating problems with BCMA specific to the unit
  + Providing a forum for users to report BCMA problems and reasons for workarounds
  + Providing suggestions for improvements to both technology and process

## Medication Reconciliation Measure Specifications

**Important Notes:**

Note 1: This section does not apply to pediatric hospitals.

Note 2: A hospital pharmacist plays two important roles in data collection for this measure. First, the pharmacist is responsible for obtaining the gold standard medication history from each sampled patient. Second, the pharmacist is responsible for identifying the unintentional discrepancies by comparing the gold standard medication history to admission orders and discharge orders.

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| --- |
| **Source:** Brigham and Women’s Hospital (NQF #2456) |
| **Reporting Period:** The latest 3-month period prior to submission of this section of the survey. |
| **Medication Reconciliation Excel Workbook and Medication Reconciliation Worksheet**  To assist hospitals in responding to questions #2-6, Leapfrog has developed two important tools for hospitals. The Medication Reconciliation Excel Workbook includes 4 tabs: Instructions, Sampling, MedHistory Checklist, and Data Entry. The Medication Reconciliation Worksheet is a Word Document that can be used by the pharmacists to identify the number of unintentional discrepancies at admission and/or discharge for each sampled patient (question #4). The Medication Reconciliation Worksheet can also be used to track additional medications that were ordered unintentionally at admission and/or discharge (questions #5-6).  Both tools are available on the Survey and CPOE Materials [webpage](http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials) and should be used when reporting on this measure. |
| **Q.2**  **Number of patients that your hospital sampled:** Hospitals are asked to sample at least 10 patients during the 3 months prior to submitting this section of the survey. Patients that were discharged or expired before the gold standard medication history could be obtained should be excluded from the sample.  For assistance in obtaining a sample of 10 patients, see the [Medication Reconciliation Excel Workbook](http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials). Review the Instructions tab and then use the Sampling tab to select patients for review. |
| **Q.3**  **Total # of medications obtained from the gold standard medication history for each patient included in the sample:** Enter the total number of gold standard medications for each sampled patient into the Data Entry tab of the Excel Workbook. The workbook will automatically sum the total number of gold standard medications across all sampled patients and that number should be entered in the survey.  To collect the Gold Standard Medication History for each sampled patient, the pharmacist should use the MedHistory Checklist provided in the [Medication Reconciliation Excel Workbook](http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials).  **Exclusions:**  Exclude the following medications from the gold standard pre-admission medications **unless** the medication is clinically relevant:  a) as needed (PRN) medications, except inhalers, nitroglycerin, opioids, muscle relaxants, sedatives, and non-opioid analgesics  b) topical lotions/creams  c) saline nasal spray and artificial tear eye drops  d) herbals and supplements  e) vitamins  Two examples of clinically relevant medications that should not be excluded from the gold standard pre-admission medication list would be iron for a patient with anemia, or calcium/vitamin D for a patient with osteoporosis.  Medications that a patient is completely non-adherent to (i.e. patient has not been taking at all) should also be excluded from the Gold Standard Medication List. |
| **Q.4**  **Total # of unintentional discrepancies among the gold standard medications in question #3 at admission and/or discharge:** Enter the total number of unintentional discrepancies among gold standard medications for each sampled patient into the Data Entry tab of the Excel Workbook. The workbook will automatically sum the total number of unintentional discrepancies among the gold standard medications across all sampled patients and that number should be entered in the survey.  To identify the number of unintentional discrepancies among gold standard medications (from question #3) at admission and/or discharge for each sampled patient, the pharmacists can use the [Medication Reconciliation Worksheet (Word document)](http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials). Page 1 of this worksheet should be completed for each sampled patient, and includes a table where the pharmacist can record any additional, unintentionally ordered medications. Page 2 should be completed for **each** gold standard medication per patient, and allows the pharmacist to record and count the discrepancies between the gold standard medication history and the admission and/or discharge order. The worksheet includes very specific instructions on how to record and count unintentional discrepancies.  For each gold standard medication, there may be up to two unintentional discrepancies: a discrepancy in admission orders and a discrepancy in discharge orders. For example, if a medication on the gold standard list is ordered for a patient on admission with the incorrect dose, this counts as one discrepancy. If this medication is ordered on discharge for the same incorrect dose, this counts as a second discrepancy. The number of unintentional discrepancies is a count of medication orders where an unintentional discrepancy occurred. Pharmacists should not count the number of errors associated with the same medication order (e.g., a discrepancy in the dose and frequency in the same medication in admission orders counts as one discrepancy). |
| **Q.5**  **Total # of additional medications that were ordered unintentionally for the patients sampled on admission and/or discharge:** Enter the total number of additional medications that were ordered unintentionally for each sampled patient into the Data Entry tab of the Excel Workbook. The workbook will automatically sum the total number of additional medications that were ordered unintentionally across all sampled patients and that number should be entered in the survey.  Pharmacists can record and track the additional medications that were ordered unintentionally for each sampled patient in the first page of the [Medication Reconciliation Worksheet (Word document)](http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials). Include medications that the patient was not taking (and was not supposed to be taking) prior to admission, but the medical team incorrectly thought the patient was taking the medication and therefore ordered it on admission and/or discharge. Count each additional medication ordered unintentionally only once, regardless of whether it was ordered on admission, discharge, or both. |
| **Q.6**  **Total # of discrepancies due to unintentionally ordered additional medications in question #5 on admission and/or discharge:** Enter the total number of discrepancies due to additional medications that were ordered unintentionally for each sampled patient into the Data Entry tab of the Excel Workbook. The workbook will automatically sum the total number of discrepancies due to additional medications that were ordered unintentionally across all sampled patients and that number should be entered in the survey.  For each additional medication that was ordered unintentionally (question #5), there may be up to two discrepancies: unintentionally ordered at admission, unintentionally ordered at discharge, or both. For example, if a medication is unintentionally ordered at admission, then this counts as one discrepancy. If the same medication is also ordered at discharge, then this counts as a second discrepancy for this medication. |

## Medication Reconciliation Frequently Asked Questions (FAQs)

1. **A pharmacist creates the Pre-admission Medical List as part of normal care. Can this be used as the Gold Standard Medication List?**

No, a different trained pharmacist should collect the Gold Standard Medication List when collecting data for this measure.

1. **Does the same pharmacist need to obtain the Gold Standard Medication List and perform the review to identify unintentional medication discrepancies?**
2. **When should the gold standard medication history be obtained by the pharmacist?**

The pharmacist should obtain the gold standard medication history within 24 hours of admission, typically the morning after admission.

1. **Can a pharmacy tech or student obtain the Gold Standard Medication List?**

No. In accordance with the research and testing by measure developers as well as compliance with the NQF measure endorsement, only licensed pharmacists will be allowed to obtain the gold standard medication list and identify unintentional discrepancies. Pharmacy residents who have been trained and have experience (at least several months) obtaining medication histories from patients could fill this role.

1. **What orders are considered admission orders?**

All orders written from the time of admission until 8:00 a.m. the following morning or until 8 hours after the time of admission, whichever comes first.

1. **Are there any types of admission orders that can or should be excluded?**

Yes, (a) Medication orders that are clearly related to the chief complaint (e.g., levofloxacin for pneumonia when pneumonia is the admitting diagnosis), (b) Medication orders that clearly documented (e.g., lovenox for DVT prophylaxis), and (c) Standard PRN orders at your hospital (e.g., Tylenol PM if that is in the standard order set at your hospital).

1. **Should admission orders that are discontinued prior to discharge be included?**

Yes. Some of these orders may end up being counted in question #5 (additional medications that were unintentionally ordered).

1. **If a dose and a route discrepancy are found for the same medication, does it count as one or two in the number of unintentional discrepancies?**

The number of unintentional discrepancies is a count of medication orders where an unintentional discrepancy occurred. A medication order may have several errors associated with it (e.g., dose, route, timing, etc.). You should not count the number of errors associated with the same medication order. However, discrepancies with admission orders and discharge orders are counted separately. For example, if a medication on the gold standard list is ordered for a patient on admission with the incorrect dose, this counts as one discrepancy. If this medication is ordered on discharge with the same incorrect dose, this would count as a second discrepancy. But a medication with a dose and frequency discrepancy in admission orders counts as one discrepancy.

1. **Do all of the additional medications that were ordered unintentionally in question #5 count as unintentional discrepancies in #6**?

Yes. If a medication is unintentionally ordered at admission, then this counts as one discrepancy. If the same medication is unintentionally ordered at discharge, then this counts as a second discrepancy. If an unintentionally ordered medication in Question #5 was ordered on both admission and discharge, then this would count as **two** discrepancies in Question #6, (but counts as one medication in Question #5).

1. **Are there any resources available for implementing a medication reconciliation program?**

The developer of this measure has two toolkits available for hospitals that wish to implement a medication reconciliation program:

* [Medication Reconciliation Implementation Toolkit](http://www.hospitalmedicine.org/Web/Quality___Innovation/Implementation_Toolkit/MARQUIS/Overview_Medication_Reconciliation.aspx) (free)
* [The MARQUIS Collaborative](http://www.hospitalmedicine.org/Web/Quality___Innovation/Implementation_Toolkit/MARQUIS/MARQUIS_Collaborative_Program_Recruitment.aspx) (charge)

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SECTION 9: PEDIATRIC CARE

This section includes questions and reference information for Section 9 Pediatric Care. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 9: 2017 Pediatric Care

**This section is only applicable to general, acute-care hospitals and free-standing pediatric hospitals that care for patients 17 years of age or younger.**

This section of the survey asks hospitals about their care of pediatric patients in the areas of radiation exposure and patient experience. This section will not be scored and results for this section of the survey will not be publicly reported in 2017. This section will be scored and results will be publicly reported in 2018.

**Please note that throughout the year, Leapfrog will be adding to the list of FAQS for Section 9.**

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| 9A Patient Experience (CAHPS Child Hospital Survey) |

**This section is only applicable to general, acute-care hospitals and free-standing pediatric hospitals that care for patients 17 years of age or younger.**

This section of the survey asks hospitals who care for pediatric patients about their results from the Child Hospital CAHPS Survey. The first several questions are designed to learn more about the current administration of the survey. The next 18 questions are designed to capture the “[Top Box](#Endnote45)”[[45]](#endnote-46) score for each of the 18 measures of patient experience, which include 10 composite measures and 8 single-item measures.

This section will not be scored and results for this section of the survey will not be publicly reported in 2017. This section will be scored and results will be publicly reported in 2018.

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| **Reporting Time Period: 12 months**   * Surveys submitted prior to September 1: 01/01/2016 - 12/31/2016 * Surveys (re)submitted on or after September 1: 07/01/2016 - 06/30/2017 |

|  |  |
| --- | --- |
| 1. 12-month reporting time period used: | 🞎 01/01/2016 - 12/31/2016  🞎 07/01/2016 - 06/30/2017 |
| Did your hospital have at least 1,000 pediatric acute-care admissions during the reporting time period?  *Refer to your response to question #5 in* [*Section 1 Basic Hospital Information*](#_1:_Basic_Hospital)*.*  *If “no,” skip the remaining questions in Section 9A and move on to the next subsection.* | *Yes*  *No* |
| 1. Has your hospital administered the CAHPS Child Hospital Survey during the full 12-month reporting period?   *If “yes,” continue to questions #4-25.*  *If “no,” skip the remaining questions in Section 9A. Responses to questions #4-25 must reflect a full 12-month reporting period.* | *Yes*  *No* |
|  | | |
| 1. What vendor was used to administer your hospital’s Child Hospital Survey? | \_\_\_\_\_\_  *Format: Free text* |
| 1. How many surveys were administered during the reporting period? (i.e. the number of surveys that were sent out) | \_\_\_\_\_\_  *Format: Whole numbers only* |
| 1. Which of the following modes were used to administer the survey?   *Select all that apply.* | * Mail * Phone * Email * Tablet * Other (please specify): |
| 1. Which of the following times were surveys administered during the reporting period?   *Select all that apply.* | * Day of discharge * After discharge |

**In questions #8 – 25, report your hospital’s “Top Box Score” from each patient experience measure from your 12-month vendor report that matches the reporting period that you selected in question #1.**

|  |  |
| --- | --- |
| 1. Communication with Parents – Communication between you and your child’s nurses | *N/A (sample size too small)*  \_\_\_\_\_\_  *Format: Whole numbers only* |
| 1. Communication with Parents – Communication between you and your child’s doctors | *N/A (sample size too small)*  \_\_\_\_\_\_  *Format: Whole numbers only* |
| 1. Communication with Parents – Communication about your child’s medicines | *N/A (sample size too small)*  \_\_\_\_\_\_  *Format: Whole numbers only* |
| 1. Communication with Parents – Keeping you informed about your child’s care | *N/A (sample size too small)*  \_\_\_\_\_\_  *Format: Whole numbers only* |
| 1. Communication with Parents – Privacy when talking with doctors, nurses, and other providers | *N/A (sample size too small)*  \_\_\_\_\_\_  *Format: Whole numbers only* |
| 1. Communication with Parents – Preparing you and your child to leave the hospital | *N/A (sample size too small)*  \_\_\_\_\_\_  *Format: Whole numbers only* |
| 1. Communication with Parents – Keeping you informed about your child’s care in the Emergency Room | *N/A (sample size too small)*  \_\_\_\_\_\_  *Format: Whole numbers only* |
| 1. Communication with Children – How well nurses communicate with your child | *N/A (sample size too small)*  \_\_\_\_\_\_  *Format: Whole numbers only* |
| 1. Communication with Children – How well doctors communicate with your child | *N/A (sample size too small)*  \_\_\_\_\_\_  *Format: Whole numbers only* |
| 1. Communication with Children – Involving teens in their care | *N/A (sample size too small)*  \_\_\_\_\_\_  *Format: Whole numbers only* |
| 1. Attention to Safety and Comfort – Preventing mistakes and helping you report concerns | *N/A (sample size too small)*  \_\_\_\_\_\_  *Format: Whole numbers only* |
| 1. Attention to Safety and Comfort – Responsiveness to the call button | *N/A (sample size too small)*  \_\_\_\_\_\_  *Format: Whole numbers only* |
| 1. Attention to Safety and Comfort – Helping your child feel comfortable | *N/A (sample size too small)*  \_\_\_\_\_\_  *Format: Whole numbers only* |
| 1. Attention to Safety and Comfort – Paying attention to your child’s pain | *N/A (sample size too small)*  \_\_\_\_\_\_  *Format: Whole numbers only* |
| 1. Hospital Environment – Cleanliness of hospital room | *N/A (sample size too small)*  \_\_\_\_\_\_  *Format: Whole numbers only* |
| 1. Hospital Environment – Quietness of hospital room | *N/A (sample size too small)*  \_\_\_\_\_\_  *Format: Whole numbers only* |
| 1. Hospital Environment – Overall rating | *N/A (sample size too small)*  \_\_\_\_\_\_  *Format: Whole numbers only* |
| 1. Global Rating – Recommend hospital | *N/A (sample size too small)*  \_\_\_\_\_\_  *Format: Whole numbers only* |

|  |
| --- |
| 9B Pediatric Computed Tomography (CT) Radiation Dose |

**This section is only applicable to general, acute-care hospitals and free-standing pediatric hospitals that care for patients 17 years of age or younger.**

This section of the survey asks hospitals about radiation dose metrics among pediatric patients who have undergone CT of the head, chest, abdomen/pelvis, or chest/abdomen/pelvis.

This section will not be scored and results for this section of the survey will not be publicly reported in 2017. This section will be scored and results will be publicly reported in 2018.

**Specifications:** See [***Pediatric Computed Tomography (CT) Radiation Dose***](#PedCTSpecs)in the Pediatric Care Reference Information on page 162.

|  |
| --- |
| **Reporting Time Period: 12 months**  Answer questions #1-8 based on all cases (or a [sufficient sample of them](#PedCTSpecs))   * Surveys submitted prior to September 1: 01/01/2016 - 12/31/2016 * Surveys (re)submitted on or after September 1: 07/01/2016 - 06/30/2017 |

|  |  |
| --- | --- |
| 1. 12-month reporting time period used: | 🞎 01/01/2016 - 12/31/2016  🞎 07/01/2016 - 06/30/2017 |
| 1. Does your hospital perform CT scans on pediatric patients?   *If “yes,” continue to question #3.*  *If “no,” skip remaining questions in Section 9B, and go to the Affirmation of Accuracy.* | *Yes*  *No* |
| 1. Can your hospital calculate its distribution of CT radiation doses for pediatric patients over the reporting period, and do you choose to report those data to this survey?   *If “yes,” complete questions #4-7.*  *If “no,” skip remaining questions in Section 9B, and go to the Affirmation of Accuracy.* | *Yes*  *No* | |

|  |
| --- |
|  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. Enter your facility’s 25th, 50th, and 75th percentiles for CT radiation dose length product (DLP) in **head** scans for pediatric patients for each age stratum. If available, please calculate data using a 16 cm phantom.   *If the number of encounters for an age stratum is less than 10 (in column a), skip columns b, c, and d and then move to the next age stratum. If zero, enter “0” in column a.* | | | | | | |
| **Age Group** | **HEAD** | | | | | |
| **(a)**  **Number of encounters** | **(b)**  **25th Percentile** | | **(c)**  **50th Percentile** | | **(d)**  **75th Percentile** |
| < 1 year |  |  | |  | |  |
| 1 - 4 |  |  | |  | |  |
| 5 - 9 |  |  | |  | |  |
| 10 - 14 |  |  | |  | |  |
| 15 - 17 |  |  | |  | |  |
|  |  | |  | |  | |
| 1. Enter your facility’s 25th, 50th, and 75th percentiles for CT radiation dose length product (DLP) in **chest** scans for pediatric patients for each age stratum. If available, please calculate data using a 32 cm phantom.   *If the number of encounters for an age stratum is less than 10 (in column a), skip columns b, c, and d and then move to the next age stratum. If zero, enter “0” in column a.* | | | | | | |
| **Age Group** | **CHEST** | | | | | |
| **(a)**  **Number of encounters** | **(b)**  **25th Percentile** | | **(c)**  **50th Percentile** | | **(d)**  **75th Percentile** |
| < 1 year |  |  | |  | |  |
| 1 - 4 |  |  | |  | |  |
| 5 - 9 |  |  | |  | |  |
| 10 - 14 |  |  | |  | |  |
| 15 - 17 |  |  | |  | |  |
|  |  | |  | |  | |
| 1. Enter your facility’s 25th, 50th, and 75th percentiles for CT radiation dose length product (DLP) in **abdomen/pelvis** scans for pediatric patients for each age stratum. If available, please calculate data using a 32 cm phantom.   *If the number of encounters for an age stratum is less than 10 (in column a), skip columns b, c, and d and then move to the next age stratum. If zero, enter “0” in column a.* | | | | | | |
| **Age Group** | **ABDOMEN/PELVIS** | | | | | |
| **(a)**  **Number of encounters** | **(b)**  **25th Percentile** | | **(c)**  **50th Percentile** | | **(d)**  **75th Percentile** |
| < 1 year |  |  | |  | |  |
| 1 - 4 |  |  | |  | |  |
| 5 - 9 |  |  | |  | |  |
| 10 - 14 |  |  | |  | |  |
| 15 - 17 |  |  | |  | |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Enter your facility’s 25th, 50th, and 75th percentiles for CT radiation dose length product (DLP) in **chest/abdomen/pelvis** scans for pediatric patients for each age stratum. If available, please calculate data using a 32 cm phantom.   *If the number of encounters for an age stratum is less than 10 (in column a), skip columns b, c, and d and then move to the next age stratum. If zero, enter “0” in column a.* | | | | |
| **Age Group** | **CHEST/ABDOMEN/PELVIS** | | | |
| **(a)**  **Number of encounters** | **(b)**  **25th Percentile** | **(c)**  **50th Percentile** | **(d)**  **75th Percentile** |
| < 1 year |  |  |  |  |
| 1 - 4 |  |  |  |  |
| 5 - 9 |  |  |  |  |
| 10 - 14 |  |  |  |  |
| 15 - 17 |  |  |  |  |

|  |  |
| --- | --- |
| 1. What is the manufacturer of the CT scanner used to answer questions #1-7?   *Check all that apply.* | * GE * Toshiba * Phillips * Siemens * Other (please specify): |

**Affirmation of Accuracy**

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Readmissions for Common Acute Conditions and Procedures Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract with Leapfrog are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the survey results public reporting website, The Leapfrog Group’s Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group. This information does not infringe any third party’s intellectual property rights. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract with Leapfrog reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the hospital’s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(name) (title)

on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(date)

Section 9: 2017 Pediatric Care Reference Information

### What’s New in the 2017 Survey

This section will not be scored and results for this section of the survey will not be publicly reported in 2017. This section will be scored and results will be publicly reported in 2018.

### Change Summary since Release

None. If substantive changes are made to this section of the survey after release on April 1, 2017, they will be documented in this Change Summary section.

## Pediatric Computed Tomography (CT) Radiation Dose Specifications

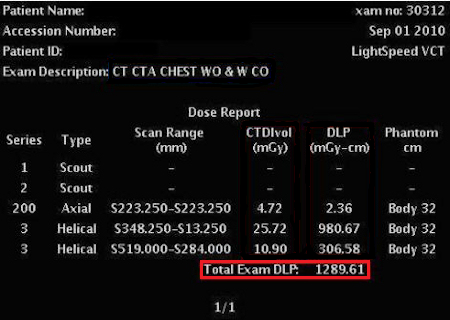
**Important Notes:**

Note 1: For purposes of this measure, an “encounter” consists of a full examination and any CT scans performed within one hour of each other involving the designated anatomic area (i.e. head, chest, abdomen/pelvis, or chest/abdomen/pelvis). For example, a CT scan is conducted on a patient’s head. Thirty minutes later, another CT scan is conducted on the same patient’s head. Together, these two scans are considered one “encounter.” Scans of two different anatomic areas would not be considered to be the same “encounter.” Scans of the same anatomic area performed greater than 60 minutes apart would also not be consider the same “encounter”.

Note 2: This measure includes two sets of instructions in the table below: one for hospitals using dose monitoring software and one for hospitals that are not using dose monitoring software. Please be sure to use the correct set of instructions.

|  |
| --- |
| **Source:** University of California, San Francisco (NQF #2820) |
| **Reporting Time Period: 12 months**   * Surveys submitted prior to September 1: 01/01/2016 - 12/31/2016 * Surveys (re)submitted on or after September 1: 07/01/2016 - 06/30/2017 |
| **Hospitals using dose monitoring software:**  Data for this measure can be obtained using dose monitoring software. See instructions below. |
| **Q.4, column a Total Number of Encounters**  Using your dose monitoring software, obtain the total number of encounters in **head scans** for each age stratum (<1, 1-4, 5-9, 10-14, 15-17). Enter these values into the survey.  **Exclusions:**  Encounters that cross multiple anatomic areas should be excluded. For example, encounters involving both the head and neck are excluded from the “head” anatomic region.  **Sampling Cases:**  Hospitals using dose monitoring software should not report on a sample of cases. They should report on all encounters in the 12-month reporting period. |
| **Q.4, columns b, c, and d 25th, 50th, and 75th Percentiles**  Based on the encounters identified for each age stratum (column a), use your dose monitoring software to calculate the 25th percentile (column b), the 50th percentile (column c), and the 75th percentile (column d) for CT radiation dose length product (DLP) in **head scans**. Enter these values into the survey rounded to the nearest whole number.  If the number of encounters for an age stratum (i.e. <1 or 1-4, etc.) is less than 10 (column a), skip columns b, c, and d. If the number of encounters for an age stratum is zero, enter “0” in column a, and skip columns b, c, and d. You cannot leave any rows in column a blank.  For hospitals using dose monitoring software, if possible, generate the DLP using the following Phantom Dose Specifications.  **Phantom Dose Specifications:**  For head scans, use a 16 cm phantom dose value. For patients older than 1 year, use a 32 cm phantom dose value for chest, abdomen, and pelvis scans. For patients less than a year old, you may use either a 16 cm or 32 cm phantom dose value, as dictated by your CT scanner’s manufacturer. The orange box in the screenshot below the table is an example of a Dose Report which shows the phantom dose value used. The phantom dose value is used to estimate the radiation dose to the patient. |
| **Q. 5-7**  Repeat the instructions from question #4 to respond to questions #5 (chest scans), #6 (abdomen/pelvis scans) and #7 (chest/abdomen/pelvis scans). |
| **Q. 8**  Select the manufacturer(s) of your CT machine(s). |
| **Hospitals not using dose monitoring software:**  Data for this measure can be obtained from Dose Reports that come directly from the CT Machine and are sent along with the images to the Picture Archiving and Communications (PACS) used to review the images. See instructions below. |
| **CT Dose Excel Workbook**  To assist hospitals who do not use dose monitoring software in calculating the responses to questions #4-7, Leapfrog has developed a CT Dose Workbook. The workbook includes five tabs: Instructions, Head, Chest, Abdomen/Pelvis, Chest/Abdomen/Pelvis. Once you enter your hospital’s CT radiation dose length product (DLP) data into the appropriate tab, the workbook will automatically calculate your responses to questions #4-7 and those values should be entered in the survey.  The tool is available on the Survey and CPOE Materials [webpage](http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials) and should be used when reporting on this measure. |
| **Q.4-7, column a Total Number of Encounters**  To determine the total number of encounters for each anatomical area and age stratum, you will need to obtain dose reports. See sampling instructions below.  **Exclusions:**  Encounters that cross multiple anatomic areas should be excluded. For example, encounters involving both the head and neck are excluded from the “head” anatomic region.  **Sampling Cases:** Hospitals that are using information stored in the CT Machine have the option of reporting on all encounters or a sample of encounters. Hospitals opting to identify a sample of encounters for this measure should follow these instructions:   * Review your hospital’s scan on January 15, 2016 (or July 15, 2016 if (re)submitting a survey on or after September 1, 2017). * Work sequentially until **a sample of at least 30 encounters per anatomic area and age strata combination** (i.e. head, <1; head 1-4, etc.) is reached, or all cases in the reporting period are reviewed, whichever comes first. |
| **Q.4-7, columns b, c, and d 25th, 50th, and 75th Percentiles**  Using your dose reports, enter the **Total DLP (mGY-cm)** for each encounter into appropriate tab of the [CT Dose Workbook](http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials). Be sure to review the instructions tab carefully before you begin entering data. Each tab is dedicated to an anatomical area, and each marked column within each tab is dedicated to an age stratum. The worksheet will automatically calculate the total number of encounters, as well as the 25th, 50th, and 75th percentiles for each anatomical area and age stratum. See the example CT Dose Report from a CT scanner below this table. The red box highlighted the Total DLP. Note that your CT scanner may have a differently formatted Dose Report. |
| **Q.8**  Select the manufacturer(s) of your CT machine(s). |

**Example of Dose Report**



## Pediatric CT Radiation Dose Frequently Asked Questions (FAQs)

1. **Is this measure only applicable to pediatric inpatients, or should all pediatric scans be included?**

All pediatric patient (17 years old or younger) scans should be included when reporting on this measure, including cases that were never admitted to an inpatient ward.

1. **Should multiple phase scans be included in the reporting?**

Yes, the intent of this measure is to capture the entire dose a patient receives, even if this radiation is received over multiple phase scans.

1. **Are any procedures excluded from this measure?**

No, all scans of the anatomic area must be included. This includes all procedures and contrasts. However, examinations that cross multiple anatomic areas should be excluded. For example, encounters involving both the head and neck are excluded from the “head” anatomic region.

1. **Should any CT encounters involving anatomic areas not listed in the survey questions (i.e. head, chest, abdomen/pelvis, or chest/abdomen/pelvis) be included in the reporting?**

No. When reporting CT encounters in the survey, only encounters involving the head, chest, abdomen/pelvis, or chest/abdomen/pelvis should be included. Encounters involving any other anatomic area should not be reported. For example, encounters involving both the head and neck are excluded from the “head” anatomic region.

1. **Are the CT doses adjusted for any factors other than age, such as height and weight?**

No, CT doses are only stratified by age and anatomical region. Currently other patient information such as height and weight are not captured at the time of scanning, nor held in the CT machine. Therefore, much of that data is unavailable to some hospitals at this time.

Endnotes and “More Information”

1. ***Medicare Provider Number (MPN)***

   A Medicare Provider Number (MPN) is issued by the Centers for Medicare and Medicaid Services (CMS) to financial reporting entities, which may be individual hospitals or a group of hospitals, for purposes of reimbursement. While Leapfrog does ask each campus of a multi-hospital system to submit an individual survey, hospitals within the system may be assigned the same Medicare Provider Number and therefore should have the same MPN reported in this field. MPNs are six digits; with the first two digits representing the state in which the hospital is located. Hospitals that do not receive Medicare reimbursement may not have a Medicare Provider Number and should not have a MPN reported in this field. Leapfrog pre-populates this field in the online survey. If the hospital MPN is different from the one shown online, please contact the Help Desk. [↑](#endnote-ref-2)
2. ***National Health Safety Network (NHSN) ID***

   A NHSN ID is issued by the Centers for Disease Control and Prevention and is used as a unique identifier for facilities participating in NHSN surveillance activities. Each hospital within a system, even if they share a MPN, should report separately to NHSN and should have their own NHSN ID if they are located separately. Please see the NHSN instructions available at <http://www.leapfroggroup.org/survey-materials/join-nhsn>. NHSN IDs are five digits.

   In order to be scored and publicly reported for any of the five applicable infection measures, hospitals must: (1) provide an accurate NHSN ID in the Profile (2) join Leapfrog NHSN Group by the appropriate [deadline](http://www.leapfroggroup.org/survey-materials/join-nhsn), and (3) submit Section 7 of the online survey by the appropriate [deadline](http://www.leapfroggroup.org/survey-materials/join-nhsn). [↑](#endnote-ref-3)
3. ***Federal Tax Identification Number (TIN)***

   Enter the TIN that your hospital uses for billing purposes. *The number is a nine-digit number, e.g., 098765432 and must conform precisely to this format – be sure to enter any leading 0.* If your hospital has more than one TIN, use the one that would most typically be used for UB-92 claims filed with commercial health insurance plans for inpatient hospital stays. [↑](#endnote-ref-4)
4. ***National Provider Identifier (NPI)***

   The NPI is a Health Insurance Portability and Accountability Act (HIPPA) Administrative Simplification Standard. The NPI is a unique identification number of covered health care providers. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or medical specialty. [↑](#endnote-ref-5)
5. ***State***  
   Your hospital is assigned to a state based on the Medicare Provider Number assigned (or identifier specially issued by the Leapfrog Survey Help Desk) to your hospital. If your hospital is incorrectly assigned to a state, contact the [Help Desk](https://leapfroghospitalsurvey.zendesk.com) to resolve the discrepancy. [↑](#endnote-ref-6)
6. ***Tips for entering Web addresses***

   This address becomes the link attached to your hospital’s name in public release of survey results. Enter it exactly as you wish it to be and test it.

   Do not exit out of the survey to go to the Web page of interest while you are entering data into the survey or some of your survey entries may be lost.

   Instead, minimize (but don’t close) the survey window, and any other windows that are open, then open your internet browser in a separate window. Find the Web page whose address you wish to enter and Copy/Paste the entire address into the survey entry. **The http:// prefix needs to be included.**

   If entering the Web page address manually, be careful to type it correctly, without embedded spaces. Forward (/) or backward (\) slashes may be used. Don’t forget the “www.” if that is part of the address. **The http:// prefix needs to be included.**

   Make sure to use .org, rather than .com, if that’s the domain for your hospital’s Website.

   Although many hospitals elect to enter the address for the home page of their hospital Website, consider pointing it to a page specific to patient safety, the Leapfrog safety practices, or other quality improvement activities about which you want to communicate to your community. [↑](#endnote-ref-7)
7. ***Licensed Beds***

   If your state does not designate and license bed types, enter the number of staffed beds from question #3. Include short-term, acute-care medical, surgical, and obstetrical beds as licensed by your state. Exclude beds licensed or used for long-term rehabilitation or psychiatric care, or sub-acute care, (e.g., skilled nursing facility, hospice extended care, sub-acute eating disorder treatment, extended care facility, or residential substance abuse treatment). If the number of licensed beds has changed in the last year, indicate the most recent number for which it is licensed. [↑](#endnote-ref-8)
8. ***Staffed Beds***

   Include licensed beds regularly in operation, whether currently occupied by a patient or not. If the number has changed over the last year, indicate the average or other number most representative of your operating bed capacity over the last year. [↑](#endnote-ref-9)
9. ***Total Adult Acute-Care Admissions***

   Include acute-care medical, surgical and obstetrical adult (aged 18 years and older) admissions to your hospital. Include transfers from other hospitals as admissions to your hospital. Include any admissions directly to an ICU in your hospital, even if counted in question #9. Exclude long-term, rehabilitation, short and long-term psychiatric, sub-acute care (e.g., skilled nursing facility, hospice extended care, sub-acute eating disorder treatment, extended care facility, or residential substance abuse treatment) admissions. Exclude normal newborn admissions to the nursery. [↑](#endnote-ref-10)
10. ***Total Pediatric Acute-Care Admissions***

    Include acute-care medical and surgical pediatric (aged 17 years or younger) admissions to your hospital. Include transfers from other hospitals as admissions to your hospital. Include any admissions directly to a pediatric ICU or NICU in your hospital, even if counted in question #9. Exclude normal newborn admissions to the nursery. Exclude admissions to adult medical and/or surgical wards or adult ICUs (e.g., if your hospital does not have any pediatric units, but does occasionally admit pediatric patients for emergency surgery or care, these admissions would not be included). [↑](#endnote-ref-11)
11. ***Licensed ICU Beds***

    If your state separately designates ICU beds, indicate the number of licensed beds in adult or pediatric general medical and/or surgical ICUs and neuro ICUs (medical and surgical). If your state does not designate and license ICU beds, enter the number of staffed beds from question #8. See endnote #22 for more information. [↑](#endnote-ref-12)
12. ***Staffed ICU Beds***

    Indicate the number of ICU beds from question #7 that are regularly in operation, whether currently occupied by a patient or not. If the number has changed over the last year, indicate the average or other number most representative of your operating ICU capacity over the last year. See endnote #22 for more information.   
     [↑](#endnote-ref-13)
13. ***ICU Admissions to Adult and Pediatric General Medical and/or Surgical or Neuro ICUs***

    Include admissions to adult and pediatric general medical and/or surgical ICUs and Neuro ICUs (medical and surgical) from question #8, whether directly admitted to the unit or transferred to the unit from another area of your hospital, e.g., post-operatively. Count the number of hospitalizations that include an ICU stay, not the number of patient trips to the ICU.

    Ignore admissions to units “dedicated exclusively” to patients with specialized conditions (e.g. cardiac, burn, trauma, neonatal, etc.) that are distinct and separate from other adult or pediatric general medical and/or surgical ICUs or neuro ICUs unless the same ICU is used for both specialized intensive care patients as well as general medical and/or surgical or neuro intensive care patients. “Dedicated exclusively” means that general medical and/or surgical or neuro patients are not also cared for in these specialized units (except in rare overflow situations). Ignore admissions or transfers to intermediate care or step-down units for this question. [↑](#endnote-ref-14)
14. ***Council of Teaching Hospitals and Health Systems (COTH)***

    COTH is made up of teaching hospitals and health systems. More information about COTH is available at <https://www.aamc.org/members/coth/>. If the hospital selects "yes" to this question, and the hospital is selected for Top Hospital, the hospital's designation will be listed as "Top Teaching Hospital.” [↑](#endnote-ref-15)
15. ***Teaching Hospital***

    Hospitals self-identified as a “teaching hospital” may have the following in place: a documented affiliation agreement with a medical school; sponsor or participate in at least four approved, active residency programs; and have at least two of the approved residency programs in medicine, surgery, obstetrics/gynecology, pediatrics, family practice, or psychiatry. If the hospital selects "yes" to this question, and the hospital is selected for Top Hospital, the hospital's designation will be listed as "Top Teaching Hospital.” [↑](#endnote-ref-16)
16. ***CPOE Linked to Pharmacy, Laboratory, ADT Information***

    The ability of a CPOE system to catch the majority of common, serious prescribing errors depends on proper identification of patients (ADT information), current and recent pharmacy orders and drug dispensing history, and access and integration of key laboratory results for the patient. CPOE systems that are not linked to those other systems or do not reflect that current information accurately about the patient are not likely to catch serious prescribing errors. [↑](#endnote-ref-17)
17. ***High-Risk Deliveries Electively Admitted***

    Includes deliveries with:

    * *expected* birth weight <1500 grams; or
    * gestational age at least 22 weeks but <32 weeks.

    Not all women at risk for delivery of babies with these conditions are known beforehand to be at risk. Therefore, deliveries in which these high-risk conditions were unknown prior to admission are not considered electively admitted high-risk deliveries.

    If your hospital admits deliveries where these conditions are known prior to admission, then your hospital electively admits high-risk deliveries and you should answer “yes” to question #1; otherwise, answer “no.” [↑](#endnote-ref-18)
18. ***Co-located with a Hospital Having a NICU***

    A hospital without a neonatal ICU but in immediate physical proximity to another hospital that has a neonatal ICU, e.g., a children’s hospital next door to which your hospital immediately transfers all complicated newborns, is considered as sharing a co-located NICU. "Immediate physical proximity” means the two facilities must be physically connected, either by a tunnel, an enclosed bridge, or the hospitals should abut each other so that the hallways readily connect. Based on available research evidence, the pivotal factor is that the neonatal team be able to attend the high-risk deliveries whenever a neonatal resuscitation might be necessary. If the hospitals are not immediately adjacent to each other, this isn't possible. [↑](#endnote-ref-19)
19. ***Very-low birth weight babies***

    Complicated newborns are those infants with a birth weight <1500 grams. If your hospital has a neonatal ICU (or is co-located with a hospital that has a neonatal ICU) that admits or accepts transfers of neonates with these conditions, you should answer “yes” to question #2. [↑](#endnote-ref-20)
20. ***VON’s Death or Morbidity Measure***

    This measure is collected and calculated by the Vermont Oxford Network and includes patients who have died or known to have one or more of the following: severe intraventricular hemorrhage (SIVH); chronic lung disease (CLD); necrotizing enterocolitis (NEC); pneumothorax any late infection (bacterial, fungal, or coagulase negative staph); or cystic periventricular leukomalacia (PVL). [↑](#endnote-ref-21)
21. ***All Patients***

    **“All patients”** means all general medical and/or surgical ICU patients and neuro ICU patients in the ICU. [↑](#endnote-ref-22)
22. ***Adult or Pediatric General Medical and/or Surgical ICUs or Neuro ICUs***

    The IPS standard applies only to adult and pediatric general medical and/or surgical ICUs and neuro ICUs (medical and surgical). When responding to this section, ignore units “dedicated exclusively” to patients with specialized conditions (e.g. cardiac, burn, trauma, neonatal, etc.) that are distinct and separate from other adult or pediatric general medical and/or surgical ICUs or neuro ICUs unless the same ICU is used for both specialized intensive care patients as well as general medical and/or surgical or neuro intensive care patients. “Dedicated exclusively” means that general medical and/or surgical or neuro patients are not also cared for in these specialized units (except in rare overflow situations). Ignore admissions or transfers to intermediate care or step-down units for this question.

    For hospitals that have more than one type of ICU included in this standard, where the ICU physician staffing structure may differ among ICU types, hospitals are instructed to report on the least restrictive ICU when responding to questions #1-13 in Section 5 ICU Physician Staffing. For example, if the pediatric medical ICU is staffed by intensivists at least 8 hours/day, 7 days/week, but the adult medical ICU is not, the hospital would respond to questions #1-13 based on the adult medical ICU. [↑](#endnote-ref-23)
23. ***Managed or Co-Managed***

    The intensivist, when present (whether on-site or via telemedicine), is authorized to diagnose, treat, and write orders for a patient in the ICU on his/her own authority. Mandatory consults or daily rounds by an intensivist are not sufficient to meet the managed/co-managed requirement. However, an ICU need not be closed to meet this requirement. [↑](#endnote-ref-24)
24. **Certified in Critical Care Medicine**

    A physician who is “certified in Critical Care Medicine” is a board-certified physician who is additionally certified in the subspecialty of Critical Care Medicine. Certification in Critical Care Medicine is awarded by the American Boards of Internal Medicine, Surgery, Anesthesiology, Pediatrics, and Emergency Medicine.

    On an interim basis, three other categories of physicians are considered by Leapfrog to be equivalent to a physician “certified in Critical Care Medicine” for the purpose of meeting the standard:

    * Physicians who completed training prior to availability of subspecialty certification in critical care in their specialty (1987 for Internal Medicine, Surgery, Anesthesiology, Pediatrics and 2013 for Emergency Medicine), who are board- certified in their specialty, and who have provided at least six weeks of full-time ICU care annually. (The weeks need not be consecutive weeks.)
    * Physicians who have finished their fellowship in Critical Care Medicine, but have not yet passed an existing board-certifying exam, are considered to be equivalent to a physician “Certified in Critical Care Medicine” for up to three years after completion of the fellowship. This provides the physician an adequate window to take her/his boards and re-take if necessary.
    * Physicians who are board-certified in their primary specialty and have completed a critical care fellowship at an ACGME-accredited program, but are ineligible to sit for a board-certifying exam in Critical Care in either their primary specialty or subspecialty because their training occurred under two separate certifying boards, are considered to be equivalent to a physician “Certified in Critical Care Medicine” if they are board-certified in their primary specialty and have provided at least six weeks of full-time ICU care annually. (The weeks need not be consecutive weeks.)

    Physicians who have let their board certification lapse are not considered to be “Certified in Critical Care Medicine”.

    “Neurointensivists” are classified as physicians who are board-certified in their primary specialty and who are additionally certified in the subspecialty of Neurocritical Care Medicine. Certification in Neurocritical Care Medicine is awarded by the United Council for Neurologic Subspecialties (UCNS) or through completion of the Society of Neurological Surgeon’s CAST fellowship, with subsequent passage of the associated ABNS exam. On an interim basis, physicians are considered by Leapfrog to be equivalent to a physician “certified in Neurocritical Care Medicine” if they completed the CAST fellowship prior to the availability of the associated ABNS exam, are board- certified in their specialty, and have provided at least six weeks of full-time ICU care annually. (The weeks need not be consecutive weeks.) [↑](#endnote-ref-25)
25. ***Ordinarily and Exclusively Present in the ICU***

    **“Ordinarily present in the ICU”** refers to direct presence in the ICU (or presence via telemedicine – see endnote #28) of an intensivist during the 4-hour or 8-hour period. While it need not be the same intensivist for the entire 4-hour or 8-hour period, it is expected that the ICU(s) are primarily staffed by dedicated ICU intensivists who are ordinarily and exclusively present in the ICU(s). "Presence" does *not* mean staffed part-time by multiple physicians who are not ordinarily and exclusively dedicated to the ICU, *nor* does it mean the cumulative time that one or more intensivists spend in the unit visiting, rounding, consulting, or responding to pages.

    **Note:** To meet the Leapfrog ICU requirement for intensivist presence in the ICU via telemonitoring, a hospital must affirm that its telemonitoring intensivist presence fulfills all 10 key features found in endnote #28, including daily care planning by an on-site intensivist.

    The standard allows for normally expected intensivist activities outside of the ICU related to their responsibilities in the ICU (e.g., evaluating patients proposed for ICU admission), as long as intensivists are ordinarily present in the ICU and return immediately when paged. An intensivist present in one ICU immediately adjacent to another can be considered present in both units as long as s/he can respond to demands in both units as if s/he would if both units were one larger unit. For the purposes of this survey, “adjacent” units are those units that can be reached within 5 minutes. While tele-intensivists can be used to meet the presence requirement, some on-site intensivist presence is still necessary to meet the Leapfrog specifications.

    **“Exclusively”** means that when the physician is in the ICU, s/he has no concurrent clinical responsibilities to non-ICU patients. [↑](#endnote-ref-26)
26. ***Quantified Analysis of Response Times***

    Providers can monitor call/pager/text response times from notification devices in multiple ways, as long as the data collection process is non-biased and scientific.

    As an example . . .

    Providers could maintain an exception log in the ICU(s) on six randomly sampled days per year. On those days, ICU nurses could record:

    the number of urgent calls/pages/texts made to intensivists when they are not present in the unit (whether on-site or via telemedicine);

    the number of urgent calls/pages/texts made to other physicians or FCCS-certified effectors when no physician or FCCS-certified effector is physically present in the unit; and

    the number of times that responses exceed 5 minutes for those respective calls/pages/texts.

    Hospitals can then cost-effectively estimate whether they meet the 95% timely response standards by dividing the average number of log exceptions per day by the average number of calls/pages/texts per day.

    This may exclude low-urgency calls/pages/texts, if the notification device system can designate low-urgency calls/pages/texts or if the hospital has an alternative scientific method for documenting high-urgency calls/pages/texts that are not returned within 5 minutes.

    If a unit has 24/7 intensivist coverage, then an analysis of response times is not required. [↑](#endnote-ref-27)
27. **FCCS-Certified Nurse “Effector”**

    FCCS certificates are awarded to nurses and doctors upon their successful completion of a brief course developed by the Society for Critical Care Medicine to improve/confirm critical care knowledge and skills. For more information visit <http://www.sccm.org/Fundamentals/FCCS/Pages/SponsoredCourse.aspx>. At present, this is the only such course recommended by The Leapfrog Group’s expert advisory panel. Intensivists and any other physicians who are certified in critical care medicine (or eligible based on residency training or fellowship) need not also be FCCS certified. Physician assistants and nurse practitioners also are not required to be FCCS certified. [↑](#endnote-ref-28)
28. ***Intensivist Presence via Telemedicine***

    To meet the Leapfrog ICU requirement for intensivist presence in the ICU via telemonitoring, a hospital must affirm that its telemonitoring intensivist presence fulfills all of the following 10 key features based on a modification of the approach reported in Critical Care Medicine (Rosenfeld, B. et al. “Intensive care unit telemedicine: Alternate paradigm for providing continuous intensivist care,” *Critical Care Medicine*, Vol. 28, No. 1, pp. 3925-3931). Note that, as with other Leapfrog specifications, these features must be met under ordinary circumstances.

    A physician certified in critical care medicine (see endnote 24) who is physically present in the ICU (“on-site intensivist) performs a comprehensive review of each ICU patient each day and establishes and/or revises the care plan. The tele-intensivist, who must all be a physician certified in critical care medicine (see endnote 24) has immediate access to information regarding the on-site intensivist’s care plan at the time monitoring responsibility is transferred to him or her by the on-site intensivist. When care is transferred back to the on-site intensivist, the tele-intensivist communicates (rounds) with the on-site intensivist to review the patient’s progress and set direction.

    When an intensivist is not on-site in the ICU managing or co-managing all ICU patients, a tele-intensivist is monitoring and able to manage all ICU patients for the remaining 24 hours per day,   
    7 days per week. “Monitoring” means the tele-intensivist has no other concurrent responsibilities, is immediately available to communicate with ICU staff, and is in the physical presence of the tele-ICU’s patient monitoring and communications equipment. "Manage" means authorized to diagnose, treat, and write orders for a patient in the ICU on his/her own authority.

    A tele-intensivist has immediate access to key patient data, including:

    physiologic bedside monitor data (in real-time);

    laboratory orders and results;

    medications ordered and administered; and,

    notes, radiographs, ECGs, etc. on demand.

    Data links between the ICU and the tele-intensivist are reliable (>98% up-time) and secure (HIPAA compliant).

    Via A-V support, tele-intensivists are able to visualize patients with sufficient clarity to assess breathing pattern, and communicate with on-site personnel at the bedside in real time.

    Written standards for remote care are established and include, at a minimum:

    tele-intensivists are certified by a national medical specialty board in critical care medicine;

    tele-intensivists are licensed to practice in the legal jurisdiction in which the ICU is located;

    tele-intensivists are credentialed in each hospital to which he/she provides remote care (can be special telemedicine credentialing);

    activities of the tele-intensivist are reviewed within the hospital’s quality assurance committee structure;

    there are explicit policies regarding roles and responsibilities of both the on-site intensivist and the tele-intensivist; and,

    there is a process for educating staff regarding the function, roles, and responsibilities of the tele-intensivist.

    Tele-ICU care is proactive, with routine review of all patients at a frequency appropriate to their severity of illness.

    A tele-intensivist’s patient workload ordinarily permits him or her to complete a comprehensive assessment of any patient within five minutes of the request for assistance being initiated by hospital staff.

    There is an established written process to ensure effective communication between the on-site care team and the tele-intensivist.

    The tele-intensivist documents patient care activities and this documentation is incorporated into the patient record. [↑](#endnote-ref-29)
29. ***Modified Intensivist Presence via Telemedicine***

    To earn reduced credit on the Leapfrog ICU standard for intensivist presence in the ICU via telemonitoring, a hospital must affirm that its telemonitoring intensivist presence fulfills the following nine key features based on a modification of the approach reported in Critical Care Medicine (Rosenfeld, B. et al. “Intensive care unit telemedicine: Alternate paradigm for providing continuous intensivist care,” *Critical Care Medicine*, Vol. 28, No. 1, pp. 3925-3931). Note that, as with other Leapfrog specifications, these features must be met under ordinary circumstances.

    When an intensivist is not on-site in the ICU managing or co-managing all ICU patients, a tele-intensivist is monitoring and able to manage all ICU patients for the remaining 24 hours per day,   
    7 days per week. “Monitoring” means the tele-intensivist has no other concurrent responsibilities, is immediately available to communicate with ICU staff, and is in the physical presence of the tele-ICU’s patient monitoring and communications equipment. "Manage" means authorized to diagnose, treat, and write orders for a patient in the ICU on his/her own authority.

    A tele-intensivist has immediate access to key patient data, including:

    physiologic bedside monitor data (in real-time);

    laboratory orders and results;

    medications ordered and administered; and,

    notes, radiographs, ECGs, etc. on demand.

    Data links between the ICU and the tele-intensivist are reliable (>98% up-time) and secure (HIPAA compliant).

    Via A-V support, tele-intensivists are able to visualize patients with sufficient clarity to assess breathing pattern, and communicate with on-site personnel at the bedside in real time.

    Written standards for remote care are established and include, at a minimum:

    tele-intensivists are certified by a national medical specialty board in critical care medicine;

    tele-intensivists are licensed to practice in the legal jurisdiction in which the ICU is located;

    tele-intensivists are credentialed in each hospital to which he/she provides remote care (can be special telemedicine credentialing);

    activities of the tele-intensivist are reviewed within the hospital’s quality assurance committee structure;

    there are explicit policies regarding roles and responsibilities of both the on-site intensivist and the tele-intensivist; and,

    there is a process for educating staff regarding the function, roles, and responsibilities of the tele-intensivist.

    Tele-ICU care is proactive, with routine review of all patients at a frequency appropriate to their severity of illness.

    A tele-intensivist’s patient workload ordinarily permits him or her to complete a comprehensive assessment of any patient within five minutes of the request for assistance being initiated by hospital staff.

    There is an established written process to ensure effective communication between the on-site care team and the tele-intensivist.

    The tele-intensivist documents patient care activities and this documentation is incorporated into the patient record. [↑](#endnote-ref-30)
30. ***Report to the community***

    The goal is for your hospital to take active steps to communicate with your community, explaining what your organization has done in the last 12 months to improve safety and quality and the results of those efforts. Communication vehicles could include: a webpage for consumers/patients, an e-newsletter that is emailed out, a paper newsletter or report that is mailed out, or an ad in the local paper. The reason for this communication is that hospitals need to be held accountable by their communities for the care being delivered. [↑](#endnote-ref-31)
31. ***Guidelines for a Culture of Safety Survey that Demonstrates Validity, Consistency, and Reliability***

    Hospitals that do not use a nationally recognized culture of safety tool must ensure that their culture survey meets Leapfrog’s guidelines for what constitutes a valid, consistent, and reliable survey tool. These guidelines were developed in consultation with Leapfrog’s Culture of Safety Expert Panel. The guidelines can be found at <http://leapfroggroup.org/survey-materials/survey-and-cpoe-materials>. [↑](#endnote-ref-32)
32. ***American Nurses Credentialing Center (ANCC) Magnet ® Organizations***

    For a list of hospitals that are currently recognized as Magnet organizations, please see ANCC’s website at <http://www.nursecredentialing.org/Magnet/FindaMagnetFacility.aspx> [↑](#endnote-ref-33)
33. ***Hospital-Wide Evaluation***

    The goal of this element is to understand how hospital hand hygiene compliance tracks with rates of hospital-acquired infections. One way of evaluating this relationship is to create a scatter plot with hand hygiene performance on one axis and HAI rates on the other axis. Best practice would be to create a separate plot for each type of infection and it is likely most meaningful to look at compliance rates and infection rates by unit or unit type (i.e. ICUs, medical wards, etc.). [↑](#endnote-ref-34)
34. ***Never Event***

    In 2011, the National Quality Forum released a list of 29 events that they termed “serious reportable events,” extremely rare medical errors that should never happen to a patient. Often termed “never events,” these include errors such as surgery performed on the wrong body part or on the wrong patient, leaving a foreign object inside a patient after surgery, or discharging an infant to the wrong person. This is an update of NQF’s original 2002 and 2006 reports. Please see NQF’s “Never Events” list at <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=69573>. Hospitals may not earn credit for this question if they have only implemented a policy that includes the Center for Medicare and Medicaid (CMS) Never Events. [↑](#endnote-ref-35)
35. ***Apology to the Patient***

    While Leapfrog recognizes that on very rare occasions “never events” can occur that are not the fault of care systems or clinical care staff, given the high level of trust patients place in health care providers, Leapfrog feels it is appropriate for caregivers to apologize when a patient within their care setting suffers a serious event.

    As the National Quality Forum identified in their 2002, 2006, and 2011 Serious Reportable Events Report, given the serious nature of these events, it is reasonable for hospitals to initially assume that the adverse event was due to the referenced course of care.  And while further investigation and/or root cause analysis of the unplanned event may be needed to confirm or refute the presumed relationship, delaying an apology to the patient is not treating the patient with compassion and sympathy. [↑](#endnote-ref-36)
36. ***Reporting Never Events to External Agencies***  
    If your hospital is not accredited by The Joint Commission, is located in a state without a state-wide reporting program for medical errors, AND there is no available Patient Safety Organization to which your hospital can report medical errors, the hospital should report the event to the Board of Trustees. Full implementation of the Never Events policy still requires the hospital to conduct a root cause analysis of the event. [↑](#endnote-ref-37)
37. ***Root Cause Analysis***

    The National Patient Safety Foundation published a set of best practices and guidelines in its report “RCA2 Improving Root Cause Analysis and Action to Prevent Harm.” The report can be found at <http://www.npsf.org/?page=RCA2>. [↑](#endnote-ref-38)
38. **Medical and/or Surgical Units**

    An exact definition on which units would be included in general medical, surgical, or medical/surgical cannot be provided because each hospital is laid out differently. For information about what is considered a general medical, surgical, or medical/surgical unit, please refer to the CDC’s definitions of Medical Ward, Medical/Surgical Ward, and Surgical Ward on p. 15-18 to 15- 20 of the following link: <http://www.cdc.gov/nhsn/PDFs/pscManual/15LocationsDescriptions_current.pdf>.

    The flowchart on p. 15-3 can also be used to help define units in your hospital.

    Telemetry units are considered medical/surgical units and must be included in this question. Units for patients from a specific service type (e.g., burn, cardiac) should not be included. [↑](#endnote-ref-39)
39. ***Gold Standard Medication History***

    Shortly after admission (e.g., the next morning), a gold standard medication history should be captured by a trained pharmacist. This should be in addition to the pre-admission medication list (PAML) compiled by the team as a part of usual care. A checklist is available in the 3rd tab of the [Medication Reconciliation Workbook](http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials) to be used by pharmacists to obtain the Gold Standard Medication list. See the [measure specifications](#MedRecSpecs) for more information on the workbook.

    [↑](#endnote-ref-40)
40. ***Sampling for Medication Reconciliation***

    The sample should contain at least 10 patients per quarter. Patients that were discharged or expired before the gold standard history could be obtained should be excluded from the sample. A sampling worksheet is available in the [Medication Reconciliation Workbook](http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials) for those who would like assistance in obtaining a random sample of patients. See the [measure specifications](#MedRecSpecs) for more information on the workbook. [↑](#endnote-ref-41)
41. ***Gold Standard Pre-admission Medications***

    Exclude the following from the gold standard pre-admission medications **unless** the medication is clinically relevant: a) as needed (PRN) medications, except inhalers, nitroglycerin, opioids, muscle relaxants, sedatives, and non-opioid analgesics; b) topical lotions/creams; c) saline nasal spray and artificial tear eye drops; d) herbals and supplements; and e) vitamins. Medications that a patient is completely non-adherent to (i.e. has not been taking at all) should be excluded from the Gold Standard Medication List. Two examples of clinically relevant medications that should not be excluded from the gold standard pre-admission medication list would be iron for a patient with anemia, or calcium/vitamin D for a patient with osteoporosis. [↑](#endnote-ref-42)
42. ***Discrepancies in Gold Standard Medications***

    For each gold standard medication, there may be up to two unintentional discrepancies: a discrepancy in admission orders and a discrepancy in discharge orders. For example, if a medication on the gold standard list is ordered for a patient on admission with the incorrect dose, this counts as one discrepancy. If this medication is ordered on discharge for the same incorrect dose, this counts as a second discrepancy. The number of unintentional discrepancies is a count of medication orders where an unintentional discrepancy occurred. You should not count the number of errors associated with the same medication order (e.g., a discrepancy in the dose and frequency in the same medication in admission orders counts as one discrepancy). [↑](#endnote-ref-43)
43. ***Ordered Unintentionally***

    Include cases where a patient was not taking (and was not supposed to be taking) a certain medication, but the medical team incorrectly thought the patient was taking the medication and therefore ordered it on admission and/or discharge. Count one per medication, regardless of whether it was ordered on admission, discharge, or both.

    [↑](#endnote-ref-44)
44. ***Discrepancies due to Unintentionally Ordered Additional Medications***

    For each unintentionally ordered additional medication, there may be up to two discrepancies: unintentionally ordered at admission, unintentionally ordered at discharge, or both. For example, if a medication is unintentionally ordered at admission, then this counts as one discrepancy. If the same medication is also ordered at discharge, then this counts as a second discrepancy. [↑](#endnote-ref-45)
45. ***Top Box Score***

    The percent of survey respondents who chose the most positive score for a given item. So in a scale “never,” “sometimes,” “usually,” and “always”, the **top box** **score** would be the percent of survey respondents choosing “always.” Looking at the **top box** is an approach to understand the number of responses with a strong sentiment. For the Child CAHPS Survey overall ratings, responses of 9 and 10 are included in the top box score. [↑](#endnote-ref-46)