

## ***Leapfrog Responses to Public Comments on the 2010 Leapfrog Hospital Survey***

<b>Number</b>	<b>Category</b>	<b>Theme of Public Comment</b>	<b>Leapfrog Response</b>
1	General	We appreciate that The Leapfrog Group has listened to recent hospital feedback and is not making substantial changes to the 2010 survey.	Leapfrog actively encourages hospitals to provide feedback on the survey at various points throughout the survey cycle, including debriefing calls, the public comment period, and pilot testing the new survey. Through these opportunities to provide feedback, hospitals have indicated the importance of having a year to focus on existing survey standards; Leapfrog also recognizes that many hospitals participate in reward programs which also require at least two years of measures. .
2	CPOE Evaluation Tool	Imposing a potential \$5,000 fee for hospitals to use the CPOE Evaluation Tool might be budget prohibitive to hospitals in 2010. 2010 budgets are already developed and approved. Leapfrog would need to wait until the 2011 Survey cycle to move forward with this initiative.	For the initial 2010 survey reporting period, Leapfrog has decided to hold-off on implementing a fee for hospital use of the CPOE Evaluation Tool. Leapfrog will continue to assess the need for a fee as the CPOE Evaluation Tool is further developed.
3	CPOE Evaluation Tool	How would a \$5,000 fee to use the CPOE Evaluation Tool be beneficial to hospitals? In this time of cost containment, additional costs could deter hospitals for completing the survey.	<p>Charging a fee for use of the CPOE Evaluation Tool would provide Leapfrog the means to ensure the Tool remains a current and valuable experience for hospitals. Potential enhancements include expansion of the Help Desk support and creating additional order sets.</p> <p>Leapfrog is very sensitive to the economic pressures that every organization faces. Hence, this is why Leapfrog has not rushed into the decision to charge a fee and why Leapfrog is actively seeking feedback from hospitals on this proposed change.</p>

## ***Leapfrog Responses to Public Comments on the 2010 Leapfrog Hospital Survey***

<b>Number</b>	<b>Category</b>	<b>Theme of Public Comment</b>	<b>Leapfrog Response</b>
4	CPOE Evaluation Tool	If a fee for using the CPOE Evaluation Tool goes through, would the fee be voluntary? Would paying the fee be a requisite to complete the CPOE Leap?	<p>For the initial 2010 survey reporting period, Leapfrog has decided to hold-off on implementing a fee for hospital use of the CPOE Evaluation Tool. Leapfrog will continue to assess the need for a fee as the CPOE Evaluation Tool is further developed.</p> <p>If a fee is implemented for accessing the CPOE Evaluation Tool, the fee would likely apply to all hospitals. Paying the fee would not be a requisite to a hospital completing the CPOE Leap, per se, but given that an assessment with the Tool is an integral part of the CPOE Leap, achieving high performance on the CPOE Leap will not be possible without conducting an assessment with the Tool.</p>
5	CPOE Evaluation Tool	If a fee is charged, could hospitals choose not to assess their system with the CPOE Evaluation Tool and have their final results on the CPOE Leap not be negatively impacted?	<p>For the initial 2010 survey reporting period, Leapfrog has decided to hold-off on implementing a fee for hospital use of the CPOE Evaluation Tool. Leapfrog will continue to assess the need for a fee as the CPOE Evaluation Tool is further developed.</p> <p>Given the current scoring algorithm for the CPOE Leap, a hospital's failure to assess their CPOE system with the CPOE Evaluation Tool would have a negative impact on their overall CPOE Leap score.</p>
6	CPOE Evaluation Tool	Why would Leapfrog want to "penalize" hospitals for implementing a costly CPOE system, by then charging them to evaluate their system?	<p>Since its inception, Leapfrog has encouraged hospital adoption of CPOE systems. But given the substantial cost of those systems, both Leapfrog and hospitals want to ensure those systems are implemented effectively. The CPOE Evaluation Tool provides hospitals the opportunity to conduct a post-implementation assessment. To ensure the Tool remains an effective assessment, Leapfrog does need to have the means to fund necessary enhancements.</p>

## ***Leapfrog Responses to Public Comments on the 2010 Leapfrog Hospital Survey***

<b>Number</b>	<b>Category</b>	<b>Theme of Public Comment</b>	<b>Leapfrog Response</b>
7	CPOE Evaluation Tool	With hospitals being so cash-strapped, it is hard to see how many hospitals would be in favor of a fee. That being said, our hospital's administration is prepared to pay a reasonable amount for use of the CPOE Evaluation Tool.	<p>For the initial 2010 survey reporting period, Leapfrog has decided to hold-off on implementing a fee for hospital use of the CPOE Evaluation Tool. Leapfrog will continue to assess the need for a fee as the CPOE Evaluation Tool is further developed.</p> <p>Leapfrog will continue to reflect on needed Tool enhancements, and continue to solicit hospital feedback, to determine an appropriate fee amount that would allow Leapfrog to keep the CPOE Evaluation Tool a current and valuable experience for hospitals.</p>
8	CPOE Evaluation Tool	Our hospital is one hospital in a six hospital system. For hospital systems, how would fees be assessed for use of the CPOE Evaluation Tool? Will each hospital have to pay the fee?	<p>For the initial 2010 survey reporting period, Leapfrog has decided to hold-off on implementing a fee for hospital use of the CPOE Evaluation Tool. Leapfrog will continue to assess the need for a fee as the CPOE Evaluation Tool is further developed.</p> <p>As the Leapfrog Hospital Survey asks each individual hospital to assess their CPOE system with the CPOE Evaluation Tool, that policy would likely extend to having each hospital pay the fee. Leapfrog is committed to creating a fee structure that is fair to all hospitals, regardless of size or affiliation.</p>
9	CPOE Evaluation Tool	Would the fee to use the CPOE Evaluation Tool be charged for each survey cycle?	At this point, hospitals are asked to assess their CPOE system at least once during each survey cycle. A fee, if implemented, would most likely be charged for each use. Leapfrog will be assessing the issue of frequency of test taking for high performing hospitals.
10	CPOE Evaluation Tool	Small and not-for-profit hospitals have to pay premium dollars for our EMRs because we don't have the purchase leverage that large facilities and networks have. Would Leapfrog consider a prorated fee structure based on average daily census or annual discharges?	If a fee is implemented for accessing the CPOE Evaluation Tool, Leapfrog is committed to creating a fee structure that is fair to hospitals of all sizes.

## ***Leapfrog Responses to Public Comments on the 2010 Leapfrog Hospital Survey***

<b>Number</b>	<b>Category</b>	<b>Theme of Public Comment</b>	<b>Leapfrog Response</b>
11	CPOE Evaluation Tool	Once our hospital has tested their CPOE system using the CPOE Evaluation Tool, and the result is a successfully completed test, we see no need for the organization to keep retesting for each annual survey. Unless of course, content of the CPOE Evaluation Tool is changed.	Leapfrog's experts have found that hospital CPOE systems frequently change over time. Between assessments, alerts may be turned on and/or off and software may be updated. It is important to both consumers and purchasers of health care that hospitals periodically demonstrate that their implemented CPOE system continues to provide appropriate decision support to prescribers. Leapfrog will be working with the national experts to assess frequency for consistently high performing facilities. However, at this point the thresholds for successfully completing the test are quite low and it has been anticipated that those thresholds for success would increase over time.
12	CPOE Evaluation Tool	Currently, the CPOE Evaluation Tool provides the user with a score (percentage) for each order checking category and an overall result. But users don't know the number of questions per order checking category or the number of missed questions per category. From a continuous improvement standpoint, it would be useful if hospitals received more information on the specific questions that were answered incorrectly. It would give hospitals an opportunity to address the areas of concern for future evaluations.	Given that the CPOE Evaluation Tool currently has a limited number of test orders in the database, and the integrity of the test needs to be maintained, Leapfrog is unable to share back the details of specific orders with hospitals. While Leapfrog hopes to be able to enlarge the test order database, it is unlikely that we will identify individual orders, except for those which would result in severe harm, in our feedback to hospitals. It is our hope that hospitals work with their clinicians and vendor to determine appropriate alerting levels. Currently, if a hospital's CPOE system did not produce an alert for a test order that could have caused the patient "severe harm", that information is shared back with the hospital at the conclusion of the test.
13	CPOE Evaluation Tool	How is it valuable for hospitals that are currently in the process of implementing CPOE to have access to the CPOE Evaluation Tool? There is much learning that occurs post-implementation.	Leapfrog would agree with the assessment that much of the learning about CPOE goes on post-implementation, however, hospitals implementing CPOE systems would benefit from being able to access the CPOE Evaluation Tool to test issues of connectivity across different information sources, as well as to provide feedback to clinicians/prescribers on where to focus their attention for protocols and alerting. .

## ***Leapfrog Responses to Public Comments on the 2010 Leapfrog Hospital Survey***

<b>Number</b>	<b>Category</b>	<b>Theme of Public Comment</b>	<b>Leapfrog Response</b>
14	CPOE Evaluation Tool	Paying a fee to use the CPOE Evaluation Tool would be okay, but only if it would help to provide a method of validating test answers to increase the worth of test. We would not be in favor of a fee to increase Help Desk support or to have hospitals that are implementing CPOE systems participate.	Leapfrog continues to look at opportunities to ensure the accuracy of hospital responses to the main part of the Leapfrog Hospital Survey and the CPOE Evaluation Tool. As we continue to evaluate assessing a fee for use of the CPOE Evaluation Tool, we will keep this potential use of funds in mind.
15	CPOE Evaluation Tool	The literature and references for drug-drug interactions vary greatly. Drug reference databases that are utilized for commercial clinical decision support also vary greatly. Therefore, the CPOE Evaluation Tool should use only drug interactions that are rated at the highest level (severe) by most or all CDS databases.	The developers of the CPOE Evaluation Tool are currently working on creating new order sets. The new order sets will only test hospitals on those drug-drug interactions that have been categorized as the highest level by major formulary databases.
16	CPOE Evaluation Tool	It takes considerable time and effort to respond to the survey, so hospitals are already bearing a cost of providing information to Leapfrog. To charge a fee on top of this creates a disincentive to comply.	Leapfrog and its purchaser members appreciate the efforts hospitals put forth to complete the Leapfrog survey. If Leapfrog does decide to charge a fee for use of the CPOE Evaluation Tool, the funds collected would be reinvested into the CPOE Evaluation Tool, to keep it a current and valuable experience for hospitals.

## ***Leapfrog Responses to Public Comments on the 2010 Leapfrog Hospital Survey***

<b>Number</b>	<b>Category</b>	<b>Theme of Public Comment</b>	<b>Leapfrog Response</b>
17	CPOE Evaluation Tool	Leapfrog has structured the CPOE evaluation and overall process so that hospitals are left to elucidate the CPOE safety criteria. A more proactive approach would be similar to The Joint Commission and NCQA through making the new/revised standards, criteria and specifications available to hospitals prior to formal Survey evaluations. Hospitals can then evaluate their current practices and systems in order to implement the recommended systems and policies & procedures. Leapfrog could do more to promote safe medication practice by providing specific information upfront on what decision support content authenticates safe medication practice. This would provide hospitals the opportunity to have dialog with drug database vendors to evaluate and possibly implement the Leapfrog recommendations. This would create a more collegial relationship focused on safe medication practices for patients.	The CPOE Evaluation Tool is a high-level sample of how effectively a hospital's implemented CPOE system alerts prescribers to common, serious prescribing errors. The intent of the Tool is not to test hospital systems on all decision support capabilities, nor should the test scenarios be construed as the only decision support hospitals need to have in place. Each test contains a small number of orders and is intended to be a sample of the performance of the system. Leapfrog focuses its efforts on transparency of performance as the lever to improve quality, and relies on its national experts for measure development to assess how best to measure performance. As an organization Leapfrog does not intend to certify or accredit facilities, but rather to provide valuable information on hospitals' current performance. Leapfrog does encourage hospitals to continue to engage their vendors in discussions about CPOE and medication safety.
18	CPOE Evaluation Tool	In our experience, hospitals still see the CPOE Evaluation Tool as a "work in progress" that still has much progress to make before it's truly reliable. Adding a charge to use it would probably not be well received and perhaps may increase opposition to the CPOE Leap.	The CPOE Evaluation Tool developers are working on updates to the Tool orders; updates that will help address the validity and reliability concerns that hospitals have raised over the last 18 months. The updated orders are slated to be introduced in Fall 2010.

## ***Leapfrog Responses to Public Comments on the 2010 Leapfrog Hospital Survey***

<b>Number</b>	<b>Category</b>	<b>Theme of Public Comment</b>	<b>Leapfrog Response</b>
19	CPOE Evaluation Tool	Charging hospitals a fee of \$5,000 may preclude some organizations from participating in the survey. Leapfrog should consider applying for federal stimulus funding to support the ongoing research and development of this tool.	<p>For the initial 2010 survey reporting period, Leapfrog has decided to hold-off on implementing a fee for hospital use of the CPOE Evaluation Tool. Leapfrog will continue to assess the need for a fee as the CPOE Evaluation Tool is further developed.</p> <p>Leapfrog has had two meetings with the Office of the National Coordinator for Health Information Technology (ONCHIT) and presented to him and his staff details about the CPOE Evaluation Tool and hospital performance on the Tool. Leapfrog urges hospitals that have successfully implemented CPOE systems to send letters to the National Coordinator to share your experiences on system implementation.</p> <p>Leapfrog has been actively pursuing funding for the CPOE Tool from both government sources and private foundations.</p>
20	CPOE Evaluation Tool	Leapfrog noted that additional test orders might be added to the CPOE Evaluation Tool. We want to ensure hospitals are given enough time to complete a test if these additional order sets are added.	While the additional test orders will be added to the master test database, the number of orders each hospital will receive for their evaluation is not expected to change. The additional orders should not increase the time it takes hospitals to complete an assessment.
21	CPOE Evaluation Tool	While the enhancements related to expanding the Help Desk Support to include a telephonic option for communication could prove to be invaluable to hospitals, it would be helpful if it could include having rankings for priority requests. For example, in some situations, hospitals may have general questions, but in other situations, hospitals may have questions or need help the day that the hospital is scheduled to take the CPOE Evaluation Test and need a more immediate response.	The current web-based form for hospitals to contact the Help Desk does include the option for hospitals to indicate either that a test is underway and immediate help is needed, or they have a general question about the Tool. If a telephonic option for the Help Desk does become available, we would continue to provide hospitals a way to indicate the urgency of their question.

## ***Leapfrog Responses to Public Comments on the 2010 Leapfrog Hospital Survey***

<b>Number</b>	<b>Category</b>	<b>Theme of Public Comment</b>	<b>Leapfrog Response</b>
22	CPOE Evaluation Tool	Does Leapfrog have any intent of changing the scoring algorithm for the CPOE Evaluation Tool? Currently, if a hospital does not score a minimum of 50% in the drug-drug and drug-allergy categories, scores in the other categories do not matter.	<p>Leapfrog does not have plans to change the scoring algorithm for the CPOE Evaluation Tool in the 2010 survey cycle. Leapfrog's CPOE expert panel felt performance in the drug-drug and drug-allergy order checking categories was essential to hospitals demonstrating basic medication safety.</p> <p>Future changes to the scoring algorithm could include raising the 50% threshold within an order category for hospitals to receive credit for that order checking category.</p>
23	CPOE Evaluation Tool	Does a score of 100% on an individual order checking category reflect a CPOE system that is safer and one that results in better outcomes? Research has found that too many alerts result in alert fatigue and make the meaningful alerts less effective.	CPOE systems that do have adequate clinical decision support in place to alert prescribers to common, serious prescribing errors would be considered safer than systems that do not adequately alert prescribers. But to ensure a hospital's CPOE system is not over-alerting prescribers, the CPOE Evaluation Tool includes a handful of "nuisance" orders within each test. These "nuisance orders" are orders for which a prescriber should not be receiving an alert.
24	IPS (ICU Physician Staffing)	Providing rural hospitals partial credit for 24 hour, 7 day a week teleintensivist coverage is a fair add. This is a positive change and one that addresses the challenge of attracting intensivists to rural areas.	The intent in providing additional partial credit to rural hospitals for 24 hour, 7 day a week teleintensivist coverage was in recognition of the challenges rural hospitals face in attracting on-site intensivists. Thank you for recognizing the intent.
25	IPS (ICU Physician Staffing)	Our hospital's e-ICU coverage includes 19 hour/7 day-a-week intensivist coverage and 24 hour/7-day-a-week ICU nurse coverage. Our experience has been that this coverage has demonstrated very positive improvement in both length of stay and mortality rates. We would recommend that intensivist coverage of e-ICU should be reviewed with those who have experience with this modality to determine what their recommendations are for "clinically effective" intensivist coverage.	Leapfrog's IPS expert panel indicated, that in their experience, the 24 hour, 7 day a week teleintensivist staffing model is one best suited for achieving significant changes in outcomes.

## ***Leapfrog Responses to Public Comments on the 2010 Leapfrog Hospital Survey***

<b>Number</b>	<b>Category</b>	<b>Theme of Public Comment</b>	<b>Leapfrog Response</b>
26	EBHR-AAA	What was the rationale for removing the "beta-blocker prescribed at discharge" process measure for AAA patients (AAA-2)?	The recent evidence of this safety practice conflicts with the original guidelines.
27	EBHR – All Surgeries/Conditions	The public comment materials stated that the model parameters used in calculating and scoring the Survival Predictors would be assessed by the model developers for appropriateness of use in the 2010 Survey. Is there any documentation about this process? Who are the model developers?	<p>A link to a white paper that explains the research, methodology, and calculations behind the Survival Predictor models can be found on the survey home page.</p> <p>The model developers are Drs. John Birkmeyer, MD and Justin Dimick, MD from the University of Michigan and Dr. Doug Staiger, Ph.D., from Dartmouth.</p>
28	Safe Surgical Scheduling	Other than outpatient surgery centers, how could a hospital not have interruptions in elective cases by emergencies?	As was indicated in the Safe Surgical Scheduling Leap guidelines, patient flow through the hospital is improved by dedicating a number of operating rooms to 'unscheduled' cases and reserving the rest of the operating rooms for 'scheduled' or elective cases.
29	Safe Surgical Scheduling	The draft language for this Leap is quite vague. The "admission smoothing" process and outcome need to be better defined, among other things.	Thank you for that feedback. We will review our current documentation to identify how the language explaining the Leap can be better defined.
30	Safe Surgical Scheduling	It is important that Leapfrog stick to evidence-based interventions. Do all the interventions outlined in the Leap criteria really have evidence behind them?	These approaches have been implemented by numerous hospitals across the U.S., resulting in substantial improvements in both patient flow and patient throughput.

## ***Leapfrog Responses to Public Comments on the 2010 Leapfrog Hospital Survey***

<b>Number</b>	<b>Category</b>	<b>Theme of Public Comment</b>	<b>Leapfrog Response</b>
31	Safe Surgical Scheduling	While linking the scheduling of operating rooms to patient safety has an intuitive appeal, there is little, to no, evidence proving this connection. The suboptimal delivery of safe care may possibly be related to scheduling, but there are several other factors that could lead to the same outcomes, such as staffing and physical capacity. It is acknowledged that the methods suggested can in fact improve the utilization and efficiency of operating room, but implying that this leads to improved patient safety does not appear to be based in any data. Conversely, it is evident that certain patient safety measures have actually led to less efficient use of OR resources such as the timeout and the use of checklists.	<p>There is indirect evidence that these approaches can reduce errors in providing care. These approaches have produced both reductions in staff overtime and staff stress, both of which have been linked to lower quality and less safe care. Another indirect safety effect is there should be fewer patients being held in the ED, as full ICUs should be less common. Finally, given the national shortages in both doctor and nurse staffing, any efforts to reduce waste will benefit the level of care that patients receive.</p> <p>The focus of this Leap is not on reducing the length of time a patient and their surgeon spend in the operating room, but on ensuring the operating rooms, the OR staff, and downstream units are being used efficiently.</p>
32	Safe Surgical Scheduling	The use of "operations management" and "variability methods" is weakly defined, and many hospitals could argue they are doing this. If the intent of the survey requirement is to expect a certain level of scientific rigor is used in scheduling practices, then the standard needs to specify what that is very clearly.	Thank you for that feedback. The methods for implementation do require scientific rigor and expert advice. We will review our current documentation to identify how the language explaining the Leap can be better defined.
33	Safe Surgical Scheduling	The expectation that a hospital experiences a 15% increase in operating room (OR) throughput over three years assumes that the volume exists to grow at this rate. Fifteen percent growth averages to about 5% per year, which in the current healthcare environment is an entirely unrealistic expectation. At our hospital, our OR volume has been static, which has to do more with external factors, than anything we are doing internally to grow business and capacity.	Given the expected growth in Medicare beneficiaries and the addition of insured patients resulting from health care reform legislation, the demand for health services is expected to grow substantially over the next five years. Leapfrog wants to ensure hospitals are using their current physical resource in an efficient manner, before undertaking expensive expansions. In addition, hospitals always do have the option of reducing the number of OR suites they are operating.
34	Safe Surgical Scheduling	The methods suggested in the references are relatively new concepts. To our knowledge, very few hospitals in the country have successfully implemented this scheduling approach. To adopt	While small in number, those hospitals that have adopted these approaches to-date have seen a substantial improvement in both patient flow and patient throughput. Leapfrog believes wide-spread

## ***Leapfrog Responses to Public Comments on the 2010 Leapfrog Hospital Survey***

<b>Number</b>	<b>Category</b>	<b>Theme of Public Comment</b>	<b>Leapfrog Response</b>
		this as a mainstream best practice is premature and, at this point, unfounded.	implementation of these ideas would have a transformative effect on the delivery of health care in the U.S.
35	Safe Surgical Scheduling	To require a hospital budget for such efforts is unnecessary. Much of this work can be done within the available resources at more progressive hospitals.	Process improvement programs, even those at progressive hospitals, are often most successful when supported with dedicated staff time. The budget could reflect the internal and/or external resources needed to implement the Leap.
36	Safe Surgical Scheduling	Without more discussion and significant refinement, our hospital cannot support the proposed Safe Surgical Scheduling standard.	Leapfrog will continue to explore opportunities to better define the Leap criteria and definitions.
37	Safe Surgical Scheduling	Our hospital's understanding is that Leapfrog proposes to use a measure of improvement in a hospital's overall patient throughput to assess the hospital's efforts and success in managing their surgical schedules. In our experience, patient throughput is mostly affected by the volume of medicine patients, not surgical patients. The Leapfrog proposal for this new section of the survey seems to be too narrow and does not reflect real circumstances.	The proposed standard for the Leap is a 15% improvement in all surgical/procedural units over three years. The standard does not speak to overall patient throughput, although a side-benefit is that emergency rooms will not be overcrowded due to back-ups in surgical suites or ICU's.
38	Safe Surgical Scheduling	The proposed Leapfrog Safe Surgery Scheduling measures appear to be a reasonable approach and directionally correct.	Thank you for that input.
39	Safe Surgical Scheduling	The proposed three year timeline for progression seems appropriate based on our own experience focusing on this area for the past three years.	Thank you for that input.

## ***Leapfrog Responses to Public Comments on the 2010 Leapfrog Hospital Survey***

<b>Number</b>	<b>Category</b>	<b>Theme of Public Comment</b>	<b>Leapfrog Response</b>
40	Safe Surgical Scheduling	In the event a hospital has been focusing on safe surgery scheduling practices for a period of time, and has already achieved a significant increase in throughput over the past three years, the opportunity to further increase throughput by 15% may be a challenge to achieve. We would recommend an option to go back for a period of years to provide documentation of the starting baseline and the increase in volume achieved to date.	When this Leap is introduced to the survey, Leapfrog will provide hospitals a method for indicating past efforts in improving patient throughput. Hospitals will need to be able to document both their growth in throughput and their current unit utilization, as to demonstrate that additional growth opportunities are unfeasible.
41	Safe Surgical Scheduling	As the aim of this Leap is to increase OR throughput, and not to increase the number of staffed beds, we would recommend the inclusion of Ambulatory ORs in the overall equation. Safe surgery scheduling practices should include measures related to performing the right procedure in the right venue. Inpatient ORs should be utilized for those patients/ and surgical procedures that require the level of support provided in an inpatient environment. Our hospital has made significant progress in moving outpatient surgical procedures to the ambulatory surgery setting. We would not want the proposed measures to result in moving outpatient procedures back into the inpatient setting in order to show increased throughput/volume.	Thank you for bringing to our attention the need to counteract any perverse incentives hospitals may have in shifting patients from the outpatient setting back to the inpatient setting. Prior to roll-out, Leapfrog will work with its expert panel to determine the most appropriate measurement strategies to ensure this practice is not encouraged.
42	Safe Surgical Scheduling	It would be helpful if Leapfrog were to release specifics related to this new section to hospitals several months prior to the survey period. It is currently unclear as to how this area will be measured.	When Leapfrog moves forward with implementing this Leap, the actual survey questions and scoring algorithms that will be associated with this section of the survey will be released as soon as they are ready.

## ***Leapfrog Responses to Public Comments on the 2010 Leapfrog Hospital Survey***

<b>Number</b>	<b>Category</b>	<b>Theme of Public Comment</b>	<b>Leapfrog Response</b>
43	Hospital-Acquired Conditions - CLASBI (Central Line-Associated Bloodstream Infections)	In regards to using a standardized infection ratio (SIR) for scoring hospitals on their CLABSI performance, will the benchmark data come from the most recent NHSN report? As CLABSIs have been decreasing in general over last few years, comparing current data to past data will bias the results towards improvement.	<p>The benchmark data will come from the most recent NHSN report, which reflects data from calendar year 2008. Comparing more recent data to older national benchmarks could make hospitals appear to have lower infection rates, but the relative rankings of hospitals should remain somewhat consistent.</p> <p>Leapfrog remains committed to the point that comparisons to national average are only helpful in that they allow comparisons across hospitals standardized for the types of ICUs they report. But being better than national average is not enough. The goal for all hospitals should <i>not</i> be just to attain a certain score relative to national benchmarks, but to attain zero bloodstream infections. A rate of zero infections is not affected at all by the standardization—zero is zero.</p>
44	Hospital-Acquired Conditions - CLASBI (Central Line-Associated Bloodstream Infections)	In calculating the standardized infection ratio (SIR), will each hospital's calculation be based on the different types of ICUs they operate within their facility?	The SIR does standardize for the type of ICU, so that each hospital-reported ICU is compared to nationally reported CLABSI rates for that ICU location.
45	Hospital-Acquired Conditions - CLASBI (Central Line-Associated Bloodstream Infections)	One criticism of the standardized infection ratio (SIR) is that it is intended to remove potential patterns or temporal changes, which in Infection Control is exactly what we would want to follow and track.	<p>While the SIR is not <i>intended</i> to remove patterns or temporal changes, this is one potential outcome of its use. Patterns and trends in time are important considerations and for this reason, infection control specialists need to consider a range of other measures.</p> <p>The SIR's strength is that it provides a common basis on which to compare hospitals to one another.</p>

## ***Leapfrog Responses to Public Comments on the 2010 Leapfrog Hospital Survey***

<b>Number</b>	<b>Category</b>	<b>Theme of Public Comment</b>	<b>Leapfrog Response</b>
46	Hospital-Acquired Conditions - CLASBI (Central Line-Associated Bloodstream Infections)	Can children's hospitals participation in other collaborative efforts aimed at reducing CLASBI fulfill the expectation of participating in the "STOP BSI: ON THE CUSP" prevention program"?	Children's hospitals' participation in NACHRI's CLASBI prevention program can be substituted for participation in the "STOP BSI: ON THE CUSP" prevention program.
47	Survey Documentation Format	Our hospital agrees with Leapfrog's plans to reorganize the survey documentation.	Thank you for the comment. Hospitals have shared with us over the last couple of years the challenges of having so many reference documents.
48	Other	Hospitals would appreciate more transparency from Leapfrog on how survey results are scored. Specifically, which survey responses make up the quality, safety, and efficiency scores? Many of the scores are composite measures, and details about the composite methodology would be much appreciated.	Leapfrog makes all of its scoring algorithms publicly available on the survey home page. Hospitals are urged to contact the survey Help Desk if they are struggling to find a specific scoring algorithm or if they have questions on interpretation.
49	Other	After a hospital has submitted its survey, it is able to print off the responses that were submitted. There is some confusion with the current printing format, as the printed responses do not consistently align with the survey section numbers.	The printout is intended to emphasize responses, as it was prohibitive to replicate the entire survey tool. The numbering on the printout is generally section.question with the question text repeated. In the EBHR and CAC sections, the numbering is different, as the numbering switches to subsections, however, the question text and question sequence are correct. Leapfrog does encourage hospitals to submit feedback on display and printing features through the survey Help Desk.
50	Other	In previous survey cycles, our hospital did not always receive e-mail updates about revisions that were being made mid-cycle to the Leapfrog survey.	Leapfrog has typically e-mailed hospitals about mid-cycle survey revisions only when the changes made to the survey are considered substantial. In addition, Leapfrog only has the e-mail address for the survey contact named in the latest submitted survey, which may be the previous cycle's survey contact. If employees leave or are reassigned it is important to update the contact person on the survey.

## ***Leapfrog Responses to Public Comments on the 2010 Leapfrog Hospital Survey***

<b>Number</b>	<b>Category</b>	<b>Theme of Public Comment</b>	<b>Leapfrog Response</b>
51	Other	<p>Why is survey correspondence only sent to the person whose name was identified in the previous year's Leapfrog Hospital Survey? This can be a problem, as that person may no longer be involved with completing the Leapfrog Hospital Survey. Could a different system be developed that allows for flexibility in who receives updates about the survey?</p>	<p>Leapfrog sends survey communications to the survey contact listed in the hospital's latest submitted survey. Early in a survey cycle, a hospital's latest submitted survey is often the survey submitted in the previous survey cycle.</p> <p>Over the last two years, Leapfrog has made a concerted effort to expand opportunities for survey communications. Leapfrog has created a special Twitter account for updates on the Leapfrog Hospital Survey, which can be accessed through Twitter or from the survey home page. In addition, in the demographics section of the survey, hospitals can identify a system contact and e-mail address, in addition to their primary survey contact.</p>
52	Other	<p>When Leapfrog has to make revisions to the measure specifications mid-survey cycle, we would recommend that the survey submission deadline be pushed back to accommodate the revisions.</p>	<p>Leapfrog typically tries not to make many revisions to measures or measure specifications during the survey cycle. The June 30<sup>th</sup> reporting deadline is important for many of our purchaser members, as many of them have their open enrollment periods in early Fall. Where possible, Leapfrog tries to adhere to the June 30<sup>th</sup> deadline.</p>