



# THE **LEAPFROG** GROUP

Informing Choices. Rewarding Excellence.  
**Getting Health Care Right.**

## **Town Hall Call-2007 Survey**

### **Rural Hospitals**

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The Leapfrog 2007 Hospital Quality and Safety Survey  
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# Town Hall Call Overview

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  - Leapfrog and the Hospital Quality and Safety Survey
- Survey Submission Logistics/Timeline/Website Resources
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- Detailed review of survey questions
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  - Intensive Care Physician Staffing (IPS)
  - Evidence-based Hospital Referral (EBHR)
  - Never Events
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- Approach to the Survey
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# Leapfrog Survey: Unique in the Milieu

- Represent employers/purchasers/consumers interests
- Seeks public accountability
- Rewards high performance
- Performance measures that are “not the low hanging fruit” (e.g., Safe Practices)
- Regional and national in scope
- Free from external political pressure
- Not out to “sell” a product—but rather change behavior through products
- Harmonized with other major national performance measurement programs

# Survey Submission Logistics, Timeline, Website Resources

# Submission Issues

- Security Codes and CEO Delegation
- Maintaining survey records of answers
- Helpdesk services
- Website resources

# Survey Security and Integrity

- Core principle: hospital self-certification
- Executive authority . . .and accountability
- Survey security and integrity are critical:
  - 16-digit security code
- Authorization to access granted only to:
  - CEO . . . can provide code directly to any delegate(s)
  - CEO-authorized delegate . . . Help Desk can email security codes

# Regional Rollout Contacts

- RRO contacts:
  - Identified on survey home page
  - Help Desk refers RRO hospitals to contact for 16-digit code
  - Hospitals should consider getting CEO Delegation authorizations for alternative hospital contact person; fax authorizations to the Help Desk

# Survey Helpdesk Available

- Survey Helpdesk—designed to respond within 48 hours of question (unless it requires an expert panel member to respond)
- Link on survey homepage

[Leapfrog.medstat@thomson.com](mailto:Leapfrog.medstat@thomson.com)

# 2007 Timeline

- March 5, 2007—Leapfrog Launches 2007 Survey
- May 31, 2007- RRO targeted rural hospitals report or be listed on Leapfrog's Web site as Did Not Disclose
- June 7<sup>th</sup>, 2007 Website lists new results

# Website Resources

To assist hospitals in completing the Survey, Leapfrog makes the following tools available:

- Frequently Asked Questions
- Overview of “What’s New in 2007?”
- Fact sheets on Each Leap (including bibliography information)
- Scoring Algorithms
- End Notes
- Link to purchase NQF Safe Practices Revised Handbook

# What's New for 2007

# What's New for 2007—First 3 Leaps

- CPOE—change in commitment time period for initial response to CPOE section
- EBHR changes
  - New procedures (Aortic Valve Replacement; Bariatric)
  - Surgeon volume added for composite volume measure
  - Mortality question for all procedures
  - Hospital volume based on specifications from AHRQ QIs (denominators differ from process measures)
  - Process question specifications are from endorsed measure sets (JCAHO/CMS/STS) (Exclusions differ across measure developers)

# What's New for 2007

- “Never Events” Policy added
- Transparency Indicator added
- Safe Practices revised

# Overview of Leaps

# Computerized Physician Order Entry (CPOE)

- Up to 8 in 10 serious drug errors prevented
- Criteria to fully implement Leap—Prescribers enter 75% of orders via CPOE meeting requirements
- CPOE systems must be linked to other hospital IT; must contain decision-support and require documented overrides for alerts
- NEW in 2007 - 1<sup>st</sup> Commitment timeframe has changed from 1 to 2 years.
- Change is in response to research indicating that successful planning and implementation of a comprehensive CPOE system takes a significant time investment (Bates)

# Intensive Care Physician Staffing (IPS)

- ICU Daytime Staffing with Critical Care Medicine (CCM) Trained M.D. live or via tele-monitoring (eICU)
- To fully meet must manage or co-manage all cases—and be present in ICU 8 hrs/7 days week; partial credit for fewer days
- Standard shown to reduce mortality by 29% ( JAMA, 11/02)
- JCAHO mortality measure still under review. Leapfrog will align with JCAHO measures when data are available

# Evidence-based Hospital Referral (EBHR) *or* risk-adjusted outcomes comparison

- Establishes thresholds for hospital and surgeon volume
- Utilizes mortality; provides additional credit for participation in national performance measurement systems and adherence to process measures
- Measures together provide evidence of where to send patients

# High Risk Procedures/Condition

- CABG
- PCI
- AAA
- Esophagectomy
- Pancreatectomy
- High Risk Deliveries
- Aortic Valve Replacements (NEW in 2007)
- Bariatric Surgeries (NEW IN 2007)

# EBHR Measures Vary by Procedure

- CABG includes hospital volume, surgical volume, risk-adjusted mortality, raw mortality, and 8 process measures
- PCI includes hospital volume, surgical volume, risk-adjusted mortality, raw mortality, and 3 process measures
- AAA includes hospital volume, surgical volume and 2 process measures, and raw mortality
- Aortic Valve Replacement includes hospital volume, surgical volume, risk-adjusted mortality, and raw mortality
- Bariatric Surgery includes hospital volume, surgical volume, and raw mortality
- High Risk Deliveries include NICU census, and 1 process measure (antenatal steroids)

# Addition of Surgeon Volume

## Purpose of Change:

To incorporate accumulated new scientific evidence of surgeon volume effects on outcomes

## Approach:

- Leapfrog will request hospitals provide the total number of surgeons electively performing the specific procedure for the same period of time used for hospital volume
- Leapfrog will ask how many of the surgeons who electively perform the procedure, perform the recommended number of procedures/ year based on either in-hospital counts or incorporating all procedures by a surgeons
- Thresholds for scoring were set based on research evidence related to reductions in mortality at a specific number of procedures—experience counts! This will be incorporated into overall score for each relevant EHR procedure or treatment
- See p. 107 of survey for tool to assist with the surgeon volume questions

# To Meet EBHR Volume Standard

High Risk Procedure	Hospital Volume	Surgeon Volume
CABG	450 or more	100
PCI	400 or more	75
AVR	120 or more	22
AAA	50 or more	8
Pancreatectomy	11 or more	2
Esophagectomy	13 or more	2
Bariatric	100 or more	20

NICU average daily census > 15

# Addition of “raw mortality question”

- Hospitals will be asked to report the number of deaths occurring in the inpatient setting for the cases reported in the volume count
- A composite methodology under development by Drs. Birkmeyer and Dimmick will take into account hospital volume and number of deaths to create a composite mortality predictor
- Data received will be analyzed and may be reported later in this survey cycle. We will not publicly report the number of raw deaths reported by a hospital
- Raw mortality = count of deaths occurring following high risk procedure in the inpatient setting

# New Transparency Indicator

**The survey will now recognize other reporting initiatives that:**

- are provided to the public beyond just a hospital/health system web site
- are listed in the AHRQ compendium
- are available at no cost and without use of a password
- require unique data submissions
- provide comparisons across hospitals

# *New* “Never Events” Policy

- In the 2007 survey hospitals will be asked if they comply with the Leapfrog Policy Statement on “Never Events” or if they intend to comply
- Hospitals reporting intent to comply must return to the survey and indicate compliance within 60 days or their names will be removed from the compliance report at the next month’s update

# Safe Practices 2007

- Rationale for Updates, Changes
  - Harmonization of Measure Sets
- Basic design of survey ( 4 A's) remains the same
  - Awareness
  - Accountability
  - Ability
  - Action
- Changes to the content
  - New measures and revisions to existing measures
  - Revised weighting

# Safe Practices 2007

- Safe Practices grouped into chapters
- 3 practices eliminated through merger
- 3 new practices added
  - #4 Disclosure
  - #6 Direct Caregivers
  - #14 Medication Reconciliation (see Q & A)
- More specific implementation requirements
- No credit for commitments

EXECUTIVE SUMMARY OVERVIEW	2004 Weight	2007 Weight
<b>CHAPTER 2: Creating and Sustaining A Culture of Patient Safety</b>		
<b>Practice Element 1:</b> Leadership Structures and Systems	263 (Prior SP 1)*	120
<b>Practice Element 2:</b> Culture Survey Measurement and Feedback	300 SME	20
<b>Practice Element 3:</b> Teamwork & Team interventions		40
<b>Practice Element 4:</b> Identification & Mitigation of Risks and Hazards		120
<b>CHAPTER 3: Informed Consent, and Disclosure</b>		
<b>Safe Practice 2:</b> Informed Consent (Prior SP 10)	9	4
<b>Safe Practice 3:</b> Life-Sustaining Treatment. (Prior SP 11)	12	4
<b>Safe Practice 4:</b> Disclosure	NA	25
<b>CHAPTER 4: Matching Healthcare Needs With Service Delivery Capacity</b>		
<b>Safe Practice 5:</b> Nursing Workforce (Prior SP 3)	119	100
<b>Safe Practice 6:</b> Direct Caregivers	NA New	20
<b>Safe Practice 7:</b> ICU Care	Leap 2	
<b>CHAPTER 5: Facilitating Information Transfer and Clear Communication</b>		
<b>Safe Practice 8:</b> Critical Care Information (Prior SP 9)	84	84
<b>Safe Practice 9:</b> Order Read-Back (Prior SP 6)	36	25
<b>Safe Practice 10:</b> Labeling Studies (Prior SP 13)	16	15
<b>Safe Practice 11:</b> Discharge Systems (Prior SP 8)	17	25
<b>Safe Practice 12:</b> Safe Adoption of CPOE	Leap 1	
<b>Safe Practice 13:</b> Abbreviations (Prior SP 7)	17	15
<b>CHAPTER 6: Improving Patient Safety Through Medication Management</b>		
<b>Safe Practice 14:</b> Medication Reconciliation	NA New	35
<b>Safe Practice 15:</b> Pharmacist Role (Prior SP 5)	32	32
<b>Safe Practice 16:</b> Standardizing Medication Labeling and Packaging (Prior SP 28)	22	20
<b>Safe Practice 17:</b> High Alert Medications (Prior SP 29)	21	20
<b>Safe Practice 18:</b> Unit Dose Medications (Prior SP 30)	29	25

## What went up or is new?

- ✓ Culture – 263 to 300
- ✓ Disclosure – 25
- ✓ Direct Care Giver - 20
- ✓ Medication Reconciliation - 35

EXECUTIVE SUMMARY OVERVIEW	2004 Weight	2007 Weight
<b>CHAPTER 7: Prevention of Healthcare-Associated Infections</b>		
<b>Safe Practice 19:</b> Prevention of Aspiration and VAP (Prior SP 19)	24	20
<b>Safe Practice 20:</b> CVC BSI Prevention (Prior SP 20)	33	30
<b>Safe Practice 21:</b> Surgical Site Prevention (Prior SP 21)	37	30
<b>Safe Practice 22:</b> Hand Hygiene (Prior SP 25)	33	30
<b>Safe Practice 23:</b> Influenza Prevention (Prior SP 26)	11	10
<b>Chapter 8: Condition and Site-Specific Practices</b>		
<b>Safe Practice 24:</b> Evidence Based Referrals	Leap 3	
<b>Safe Practice 25:</b> Wrong Site, Wrong Procedure, Wrong Person Surgery Prevention (Prior SP 14)	30	20
<b>Safe Practice 26:</b> Perioperative Myocardial Infarct/Ischemia Prevention (Prior SP 15)	23	20
<b>Safe Practice 27:</b> Pressure Ulcer Prevention (Prior SP 16)	28	25
<b>Safe Practice 28:</b> DVT/VTE Prevention (Prior SP 17)	27	25
<b>Safe Practice 29:</b> Anticoagulation Therapy (Prior SP 18)	39	35
<b>Safe Practice 30:</b> Contrast Media Induced Renal Failure Prevention (Prior SP 22)	12	10

# Scoring for SPS

# Safe Practices Score (SPS)

- Hospitals that respond will be relatively ranked by score
- Final score is assigned (1/4 to full circle)
- If some practices don't apply, hospitals may indicate so, and point scoring will be re-indexed accordingly
- Website will show summary score and drill down for completion “bars” for individual Safe Practices

# Improving Your Safe Practices Score (SPS)

- Gather team/identify lead for data gathering/meet weekly to share information
- Purchase online PDF of NQF Report
- Download all documents—be sure each team member has access to FAQs/End Notes—about 75% of calls to help desk can be answered through FAQs or End Notes
- Identify gaps for highly weighted items (Culture—now 300 points out of 1000)
- Determine possible priorities for improvement—very possible score will go down—no credit for commitments
- Meet with C-suite to articulate areas where rapid improvements can be made...

# Q and A

# WHY are the first three leaps called out from the remaining NQF Safe Practices that are in the 4<sup>th</sup> Leap's rolled up score?

- Continuity of measurement across time to allow purchasers and consumers to assess progress
- EBHR utilizes endorsed measures other than the Safe Practices (e.g., CABG, PCI and valve surgeries endorsed in the NQF Cardiac Measure Set)
- CABG, PCI, and High Risk Deliveries and Bariatric surgery of import to purchasers, but not listed in the EBHR Safe Practice
- Process measures are harmonized with other national performance measures from JCAHO, STS, and VON

# What is “measure harmonization?”

- Measures within the survey that have been developed by other national measure developers are used in place of homegrown measures
- Cross-credit for activities done for harmonized measures for specific questions within the survey—not the survey as a whole.

# Example of New Safe Practice #14

Preventing Adverse Drug Events via  
Medication Reconciliation

# Safe Practice #14: Implementation

## Approaches Applicable to All Hospitals

- Develop and use template medication reconciliation to gather information about current medications and allergies, standardize care and prevent errors
- Identify internal champions to lead implementation of practice
- Use solutions provided by others including IHI
- Progressive organizations have active physician and nursing engagement, effective improvement team, actively engaged administrator, and collaborative initiatives

# Leapfrog Survey Questions for SP #14

**In regard to adverse drug events and the medication reconciliation process, our organization is:**

- **Aware** of OUR performance improvement opportunity in this area in that...
  - within the last 12 months prior to submitting this survey, the organization has undertaken an evaluation of the frequency and severity of adverse drug events in our patient population, that includes an assessment of the potential impact of transitions from one care setting to another.
  - the organization has completed a review of the literature and performed an enterprise-wide evaluation of the frequency and severity of adverse events in our organization, including how to more effectively accurately reconcile and communicate an individual patient's medication profile within the facility as well as to their next care provider; and we have submitted a summary report to administration and governance with recommendations for measurable improvement targets and further action.
- **Accountable** to the issue of adverse drug events as evidenced by...
  - our CEO, senior executives, pharmacy director, and departmental/clinical service line managers being directly accountable through documented personal performance reviews or personal compensation incentives.
  - the Patient Safety Officer or an Administrator who oversees organizational patient safety regularly reports performance metrics related to this area of the medication use process to the CEO and board of trustees and is directly accountable for this area through documented performance reviews or compensation.

# Survey Questions for SP#14

- Invested in our ability to deal with this issue of adverse drug events by...
  - conducting staff education/knowledge transfer and/or skill development in the area of reducing adverse drug events related to all aspects of the medication reconciliation process as outlined by this Safe Practice and additional specifications in alignment with the Joint Commission (JCAHO) Medication Management (MM) Standards and IHI 100,000 Lives Campaign bundle.
  - formally allocating dedicated multidisciplinary human resources to focus on adverse drug events including dedicated staff time and budget allocation to address identification, mitigation, and prevention strategies.
- Taking action to address this area as evidenced by...
  - already having actively implemented explicit organizational policies and procedures addressing all elements of this Safe Practice including Additional Specifications.
  - having completed a formal enterprise-wide performance improvement program (with regular performance measurement and tracking improvement having been done within the last 12 months) that addresses all elements of this Safe Practice, including Additional Specifications.

# Survey Questions SP #14

- Assure, at a minimum, the following elements of this Safe Practice, including Additional Specifications, have already been adopted into practice...
  - A standardized process that includes involvement of the patient and their family or caregiver, where appropriate, to obtain and document a complete list of each patient's current medications at the beginning of each episode of care
  - A complete list of medications prescribed as outlined in this Safe Practice, including the Additional Specifications, in alignment with JCAHO Medication Management and IHI bundle requirements.
  - A complete list of the patient's medications which are communicated to the next provider of service, the patient and, as appropriate, family/caregiver when a patient is referred or transferred to another setting, service, practitioner, or level of care within or outside the facility.
  - A list that includes a full range of medications defined in this Safe Practice and Additional Specifications, including JCAHO requirements.
  - The medication reconciliation which occurs any time the organization requires that orders be rewritten, any time the patient changes services, setting, provider, or level of care, and when new medications orders are written.