Leapfrog Hospital Survey
Hard Copy

QUESTIONS & REPORTING PERIODS
ENDNOTES
MEASURE SPECIFICATIONS
FAQS

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Welcome to the 2016 Leapfrog Hospital Survey

http://leapfroggroup.org/survey

Important Notes about the 2016 Survey

1. The Leapfrog Hospital Survey webpages have moved from https://leapfroghospitalsurvey.org to https://leapfroggroup.org/survey. Please bookmark this new URL.

2. The online survey platform has been updated and redesigned to improve the user experience. The new survey platform, which includes a redesigned survey dashboard, redesigned online survey tool, and the link to the CPOE Evaluation Tool, will not be available to hospitals until **April 15, 2016**. Hospitals can download the hard copy of the survey on April 1st and use it to gather data and information so they are ready to input survey responses on or after April 15th, when the new online survey platform is launched.

3. Note the word "hospital" used throughout this survey refers to an individual hospital. If your hospital is part of a multi-hospital healthcare system, you will need to complete the survey for each individual hospital within the system. Please refer to Leapfrog's Multi-Campus Hospital Reporting Policy at http://leapfroggroup.org/survey-materials/multi-campus-reporting-policy.

4. 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 in a majority of medication checking categories. Hospitals cannot access the CPOE Evaluation Tool until they have completed, affirmed, and submitted Section 2 CPOE of the online survey. More information about the CPOE Evaluation Tool, including instructions, scoring, and FAQs are available at http://leapfroggroup.org/survey-materials/survey-and-cpoe-materials.

5. Leapfrog Hospital Survey Results will be posted at http://leapfroggroup.org/compare-hospitals on July 25, 2016 and then updated within the first 5 business days of each month to reflect surveys submitted or re-submitted between June 30th and December 31st, and previously submitted surveys that were corrected before January 31st. Survey Results are frozen from February to July 25th.

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 **Hospital Safety Score**, please visit http://www.hospitalsafetyscore.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 Score.

8. Leapfrog is committed to ensuring the accuracy of Leapfrog Hospital Survey results. Please review our protocols at: http://www.leapfroggroup.org/survey-materials/data-accuracy.

9. The 2016 Leapfrog Hospital Survey will close on **December 31, 2016**. Hospitals that do not submit a survey or CPOE Evaluation Tool (adult hospitals only) by **December 31, 2016 at midnight Eastern Time** will have to wait until the launch of the 2017 survey on April 1, 2017.

Overview of the 2016 Leapfrog Hospital Survey

The Leapfrog Hospital Survey is divided into nine sections:

Section #	Section Title	Brief Description
	Profile	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	The first section asks you to provide information about your hospital's bed size and teaching status.
2	Computerized Physician Order Entry (CPOE)	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	Evidence-Based Hospital Referral (EBHR)	The third section is one of The Leapfrog Group's original quality and safety standards, and is designed to determine your hospital's performance on nationally endorsed quality of care measures for four high-risk surgical procedures. This section is not applicable to pediatric hospitals.
4	Maternity Care	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)	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 (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 eight of the thirty-four National Quality Forum's safe practices.
7	Managing Serious Errors	The seventh section is designed to demonstrate your hospital's performance in preventing hospital-acquired infections and other conditions, as well as to evaluate your hospital's Never Events policy.
8	Bar Code Medication Administration	The eighth section was new in 2015 and is designed to demonstrate your hospital's use of bar code medication administration to prevent medication errors.
9	Readmission for Common Acute Conditions	The ninth section is designed to demonstrate your hospital's performance on six readmission measures collected and reported by the Centers for Medicare and Medicaid Services. Responses for this section are pre-populated in the online survey tool. This section is not applicable to pediatric hospitals.

Section one, as well as sections two, three, 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 2016 Leapfrog Hospital Survey, including a crosswalk of nationally endorsed measures and a description of how measures are publicly reported on the Leapfrog Hospital Survey Results Website, visit http://leapfroggroup.org/survey-materials/get-started.

For background information about the Leapfrog Hospital Survey, including Fact Sheets, Bibliographies, and White Papers, visit 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:

- **General information** about The Leapfrog Group standard [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 [hard copy only].

The online survey tool will only include the reporting periods, survey questions, endnotes, and the affirmation of accuracy following each section. General information and reference information are not included in the online survey tool.

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 in a majority of medication order checking categories. Adult hospitals cannot access the CPOE Evaluation Tool until they have completed, affirmed, and submitted Section 2 CPOE of the online survey. More information about the CPOE Evaluation Tool, including instructions, scoring, and FAQs are available at http://leapfroggroup.org/survey-materials/prepare-cpoe-tool.

Any changes made to the measure specifications in the middle of the survey cycle will be reflected in the hard copy of the survey in the Reference Information sections under the 'Change Summary' header (see Table of Contents). In addition, the updates to the specifications will be highlighted in yellow. If the changes are substantial, we will email the survey contact your hospital indicated in the profile section of the survey. If the notification is sent before your hospital submits a 2016 Leapfrog Hospital Survey, the email will go to the survey contact provided in the last survey submitted in the 2015 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 31st. Please carefully review the reporting periods in each section before updating your survey. Leapfrog Hospital Survey Results are updated monthly beginning on July 25th at Leapfrog's public reporting 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.

Leapfrog is committed to ensuring the accuracy of Leapfrog Hospital Survey results. Please review our protocols at: http://www.leapfroggroup.org/survey-materials/data-accuracy.

Pre-Submission Checklist

Before you complete and submit 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 which can be found at http://leapfroggroup.org/survey-materials/security-code. If your hospital is part of a multi-hospital healthcare system, you will need to a separate security code for each individual hospital within the system. Please refer to Leapfrog's Multi-Campus Hospital Reporting Policy at http://leapfroggroup.org/survey-materials/get-started.

- ☐ **Download a hard copy of the survey** at 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** provided in each section of the survey document and also download other supporting materials from 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.

- ☐ **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** at http://leapfroggroup.org/survey-materials/get-started. This document includes important instructions on how to navigate the new online survey tool. (Will not be available until April 15th)

- ☐ **Check survey deadlines.** Always be sure to check survey deadlines before you begin, which are posted at http://leapfroggroup.org/survey-materials/deadlines. 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 Sample and Adult Inpatient CPOE Evaluation Tool. Visit http://leapfroggroup.org/survey-materials/prepare-cpoe-tool for more information.

    - ☐ **Review Leapfrog's policies and procedures regarding data accuracy**. Detailed information can be found at http://www.leapfroggroup.org/survey-materials/data-accuracy.

New in 2016!
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. A copy of the binder materials can be found at http://leapfroggroup.org/survey-materials/survey-and-cpoe-materials.

Instructions for Submitting a Leapfrog Hospital Survey

Important Notes:

Note 1: Leapfrog has moved to a new survey platform. Please carefully review these instructions and the **Quick Start Guide** 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 using your 16-digit security code at survey.leapfroggroup.org.
2. The first time you log into the 2016 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**.
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 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. For more information visit http://www.leapfroggroup.org/survey-materials/data-accuracy.
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 publicly reported results after the first 5 business days of the month following your (re)submission at http://leapfroggroup.org/compare-hospitals starting on July 25, 2016.
12. Hospitals submitting a CPOE Evaluation Tool should carefully review the instructions, scoring information, and FAQs available at http://leapfroggroup.org/survey-materials/prepare-cpoe-tool.
13. Leapfrog is committed to ensuring the accuracy of Leapfrog Hospital Survey results. Please review our protocols at: 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).
- **Check your publicly reported results:** Always check your Leapfrog Hospital Survey Results at http://leapfroggroup.org/compare-hospitals. Results are posted by the first 5 business days of the month following your submission.

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** 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, 2016 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, 2016 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 at 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. Updating a survey is optional, though we do recommend that if your performance or 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 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.

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 at http://leapfroggroup.org/compare-hospitals.

Deadlines

Deadlines for the 2016 Leapfrog Hospital Survey

The 2016 Leapfrog Hospital Survey opens on April 1, 2016 and closes on December 31, 2016 at 12 midnight ET. Corrections to surveys submitted by December 31, 2016 must be submitted by January 31, 2017 at 12 midnight ET. Hospitals will not be able to log into their 2016 Surveys after this date. For more detailed information about 2016 Leapfrog Hospital Survey Deadlines, including deadlines for receiving free Competitive Benchmarking Summary Reports and Top Hospital Awards, visit http://leapfroggroup.org/survey-materials/deadlines.

Deadlines Related to the Hospital Safety Score

Please visit http://www.hospitalsafetyscore.org/for-hospitals/updates-and-timelines-for-hospitals for a timeline of the Hospital Safety Score, which includes "Data Snapshot Dates" and other important dates associated with Spring and Fall updates to the Hospital Safety Score. The Leapfrog Hospital Survey and the Hospital Safety Score are distinct programs administered by The Leapfrog Group. Though some measures from the Leapfrog Hospital Survey are used in the Hospital Safety Score, the score also utilizes publicly available data from other data sources.

Hospitals that would like Leapfrog Hospital Survey Results used in their Hospital Safety Score must submit a survey by the Data Snapshot Dates published at http://www.hospitalsafetyscore.org/for-hospitals/updates-and-timelines-for-hospitals.

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 am to 5 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. **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.**

Leapfrog Survey Users Group

In response to many requests from hospitals, Leapfrog launched a Hospital Survey Users Group. For an annual fee of $150 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 http://leapfroggroup.org/survey-materials/get-help.

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: Due to the nation-wide transition from the use of ICD-9 administrative codes to ICD-10 administrative codes, Leapfrog has updated the reporting periods and measure specifications based on a hospital's survey submission date. Please carefully review the information below and contact the Help Desk if you have any questions.

	Survey (Re)Submitted Prior to September 1, 2016		**Survey (Re)Submitted On or After September 1, 2016**	
Survey Section/ Measure	**Reporting Period**	**Use of ICD 9 or ICD 10 codes**	**Reporting Period**	**Use of ICD 9 or ICD 10 codes**
Section 1 Basic Hospital Information	12-months ending 12/31/2015	N/A	12-months ending 06/30/2016	N/A
Section 2 Computerized Prescriber Order Entry (CPOE)	Latest 3-months prior to survey submission	N/A	Latest 3-months prior to survey submission	N/A
Section 3 Evidence-Based Hospital Referral (AVR, AAA, Pancreatectomy, Esophagetcomy)	12-months or 24-months ending 09/30/2015	ICD-9	12-months or 24-months ending 09/30/2015	ICD-9
4A Maternity Care	9-months ending 09/30/2015	N/A	9-months ending 06/30/2016	N/A
4B Early Elective Deliveries	9-months ending 09/30/2015	ICD-9	9-months ending 06/30/2016	ICD-10
4C NTSV Cesarean Section	9-months ending 09/30/2015	ICD-9	9-months ending 06/30/2016	ICD-10
4D Incidence of Episiotomy	9-months ending 09/30/2015	ICD-9	9-months ending 06/30/2016	ICD-10
4E Bilirubin Screening & DVT Prophylaxis	9-months ending 09/30/2015	N/A	9-months ending 06/30/2016	N/A
4F High-Risk Newborn Deliveries	Volume: 12-months ending 09/30/2015	ICD-9	Volume: 12-months ending 09/30/2015	ICD-9
	VON: Latest 12- or 36-month report	N/A	VON: Latest 12- or 36-month report	N/A
	Antenatal Steroids: 9-months ending 09/30/2015	ICD-9	Antenatal Steroids: 9-months ending 06/30/2016	ICD-10
5 ICU Physician Staffing	Latest 3-months prior to survey submission	N/A	Latest 3-months prior to survey submission	N/A

	Survey (Re)Submitted Prior to September 1, 2016		Survey (Re)Submitted On or After September 1, 2016	
Survey Section/ Measure	**Reporting Period**	**Use of ICD 9 or ICD 10 codes**	**Reporting Period**	**Use of ICD 9 or ICD 10 codes**
6 National Quality Forum's Safe Practices	Latest 12- or 24-months prior to submission (see individual safe practice for specific reporting period)	N/A	Latest 12- or 24-months prior to submission (see individual safe practice for specific reporting period)	N/A
7A Never Events Policy	N/A	N/A	N/A	N/A
7B CLABSI and CAUTI (ICU only)	12-months ending 12/31/2015	N/A	12-months ending 06/30/2016	N/A
7C Surgical Site Infection: Major Colon Surgery, MRSA, and C. Diff.	12-months ending 12/31/2015	N/A	12-months ending 06/30/2016	N/A
7D Hospital-acquired Injuries and Pressure Ulcers	9-months ending 09/30/2015	ICD-9	9-months ending 06/30/2016	ICD-10
7E Antibiotic Stewardship Programs	N/A	N/A	N/A	N/A
8 Bar Code Medication Administration	Latest 3-months prior to survey submission	N/A	Latest 3-months prior to survey submission	N/A
9 Readmission for Common Acute Conditions & Procedures	N/A	N/A	N/A	N/A

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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.

Specifications: Hospitals that share a Medicare Provider Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Important Notes:

Note 1: Leapfrog is implementing a new 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)**[1] If the MPN displayed in the online survey tool is not correct, contact the Help Desk immediately.
	Federal Tax Identification Number (TIN)[2]
	National Provider Identifier (NPI)[3]

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[4]	**State**
Zip Code	**Zip Code**
Zip Code Suffix	**Zip Code Suffix**
Main Phone Number	
Hospital Website Address[5] (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**

PR Contact (required for Top Hospital notification)	**Health System Information**
First Name	**Is this hospital part of a healthcare system or Integrated Delivery Network?**
	☐ Yes ☐ No If yes, provide contact information.
Last Name	**Name of the healthcare system or Integrated Delivery Network**
Phone Number	**System Contact First Name**
Phone Number Extension	**System Contact Last Name**
Email Address	**System Contact Email Address**
Additional Contact Information Please provide the email address for your hospital's general inbox (e.g. 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: 2016 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.

Reporting Time Period: 12 months

- For surveys submitted prior to September 1, 2016: 01/01/2015 – 12/31/2015
- For surveys (re)submitted on or after September 1, 2016: 07/01/2015 – 06/30/2016

1)	Reporting time period used:	☐ 01/01/2015 – 12/31/2015 ☐ 07/01/2015 – 06/30/2016
2)	Number of licensed[6] medical, surgical, and obstetric beds.	
3)	Number of staffed[7] medical, surgical, and obstetric beds.	
4)	Number of total acute-care admissions[8] to your hospital.	
5)	Number of licensed ICU[9] beds.	
6)	Number of staffed ICU[10] beds.	
7)	Number of admissions to adult and pediatric general medical/surgical ICU(s)[11].	
8)	Is your hospital a member of the Council of Teaching Hospitals and Health Systems (COTH)?[12]	*Yes* *No*
9)	If no, is your hospital considered a teaching hospital?[13]	*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 reflect 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 Score, 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 person 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: 2016 Basic Hospital Reference Information

What's New in the 2016 Survey

Section 1 must be affirmed and submitted.

Change Summary since Release

None. If substantive changes are made to this section of the survey after release on April 1, 2016 they will be documented in this Change Summary section.

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SECTION 2: COMPUTERIZED PHYSICIAN ORDER ENTRY (CPOE)

This section includes questions and reference information for Section 2 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: 2016 Computerized Physician Order Entry (CPOE) Standard

Link to 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 in a majority of medication checking categories, including the drug: drug and drug: allergy checking categories.

* "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 2016 Survey, scored results on the Adult Inpatient CPOE Evaluation Tool will be used to assess if an adult or general hospital's CPOE system is alerting physicians to at least 50% of common serious prescribing errors in a majority of medication checking categories, including the drug: drug and drug: allergy checking categories. A hospital may access the CPOE Evaluation Tool only after the following:

a) Responding 'yes' to question #2, indicating that your hospital has a functioning CPOE system in at least one inpatient unit
b) Responding to questions #3-4
c) Affirming and submitting Section 2 from the survey dashboard

More information about the 2016 Leapfrog Hospital Survey Scoring Algorithms and CPOE Evaluation Tool Scoring Criteria is available at: http://leapfroggroup.org/survey-materials/scoring-and-results**.**

Important Note: The CPOE Evaluation Tool must be taken at least once per survey cycle to be included in your overall CPOE score (see Scoring Algorithms in the 'Scoring and Results' section of the website). Hospitals are only able to re-take a CPOE Evaluation Tool after 6 months have passed since they last completed the CPOE Evaluation Tool.

Specifications: Hospitals that share a Medicare Provider Number are required to report by facility. Please carefully review Leapfrog's 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*
2) 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[14] 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

3) Total number of **inpatient medication orders**, including orders made in units which do NOT have a functioning CPOE system.	_____ *Format: Whole numbers only*
4) 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 Section 2.*

Question #5 does not apply to pediatric hospitals.

5) What was your hospital's score when it tested its CPOE system using the Leapfrog CPOE Evaluation Tool? ***Test must be completed on or after April 15, 2016***	*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 Computerized Physician Order Entry Section at our hospital, and I hereby certify that this information is true, accurate, and reflect 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 Score, 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 person 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: Computerized Physician Order Entry (CPOE) Reference Information

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

What's New in the 2016 Survey

No substantive changes to this section.

Change Summary since Release

None. If substantive changes are made to this section of the survey after release on April 1, 2016 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, 2016 to May 30, 2016.

2. **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.

3. **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.

4. **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.

5. **Can we report the numerator and denominator from our Stage 2 Meaningful Use Reports?**
   Yes. Hospitals may report on 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: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Stage2_HospitalCore_1_CPOE_MedicationOrders.pdf.

6. **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.

7. **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 1 – December 31). Within a survey cycle, a hospital cannot retake a CPOE Evaluation Tool until at least 6 months have passed since their last test was taken.

8. **How do hospitals access the CPOE Evaluation Tool?**
   Log into the online survey tool with your 16-digit security code. Complete, affirm, and submit Section 2. The CPOE Tool button will appear on the Survey Dashboard. Once the evaluation 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: EVIDENCE-BASED HOSPITAL REFERRAL (EBHR)

This section includes questions and reference information for Section 3 Evidence-Based Hospital Referral. 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: 2016 Evidence-Based Hospital Referral

Link to EBHR Fact Sheet: http://leapfroggroup.org/ratings-reports/survey-content

This section is not applicable to Pediatric hospitals.

Each hospital fully meeting one or more of the high-risk surgical standards:

1. For aortic valve replacement (AVR), participates in and scores better than the group average for participating hospitals in its ratio of observed-to-expected mortality in a national performance measurement system (Society of Thoracic Surgeons), or in a regional performance measurement system (Northern New England Cardiovascular Disease Study Group), and achieves the favorable volume characteristic: 120 or more AVR patients/year for the hospital.

   or

2. For AVR, abdominal aortic aneurysm repair (AAA), pancreatic resection, and esophagectomy, places in the best quartile for the predicted mortality composite measure for the procedure, as compared to a national sample of hospitals.

For hospitals that do not perform these procedures, or refer/transfer all safe and legally transferable patients for such high-risk procedures or conditions, the standard does not apply for that procedure or condition. If you answer 'No' to any of the procedures listed in Subsection 3A, questions #1-4 below, the notation 'Does Not Apply' will be displayed for that procedure on the public reporting website.

More information about the 2016 Leapfrog Hospital Survey Scoring Algorithms is available at:
http://leapfroggroup.org/survey-materials/scoring-and-results

3A High-Risk Surgical Procedures Provided

Does your hospital perform these procedures **on an elective basis**?

If your hospital does not perform the procedure or ONLY does so when a patient is too unstable for safe transfer, answer 'No.'

1) Aortic valve replacement	*Yes* *No*
2) Abdominal aortic aneurysm repair	*Yes* *No*
3) Pancreatic resection	*Yes* *No*
4) Esophagectomy	*Yes* *No*

See ***Volume Standards*** in the EBHR Reference Information on pages 45-50 for ICD-9 coding specifications and other criteria to identify and count patients with these procedures.

3B: Aortic Valve Replacement

If you answered "yes" to question #1 in Section 3A, indicating that you perform AVR, complete these questions pertaining to this high-risk surgery.

Aortic Valve Replacement (AVR) – Volume

Specifications: See ***AVR Volume Standard*** in the EBHR Reference Information on page 45.

Reporting Time Period: 12 months or *optionally* the 24 months (annual average)
- 10/01/2014 – 09/30/2015 (12 months)
- 10/01/2013 – 09/30/2015 (24 months annual average)

1) Reporting time period used was 12- or 24-months:	☐ 10/01/2014 – 09/30/2015 ☐ 10/01/2013 – 09/30/2015
2) Total number of patients (including those that expired) with an AVR procedure at this hospital location. *Annual number of patients for the volume Reporting Time Period (or annual average if reporting on 24 months of data)*	_____
3) Total number of patients (including those that expired) with a Transcatheter Aortic Valve Replacement (TAVR) procedure at this hospital location. *Annual number of patients for the volume Reporting Time Period (or annual average if reporting on 24 months of data)*	_____
4) How many patients included in question #2 and question #3 died in the hospital following this procedure? (More information[15]) *(Annual average if reporting on 24 months of data)*	_____

Aortic Valve Replacement (AVR) – National Performance Measurement

Indicate your hospital's participation in and results from the following national performance measurement system.

Reporting Time Period: Base your responses on the latest 12-month report received from the Society of Thoracic Surgeons (STS).

5) Has your hospital participated in the Society of Thoracic Surgeons (STS) performance reporting system for aortic valve replacement surgery and submitted data for all such procedures in the most recent 12-month period for which performance reports have been released, and would you like to share those results? More Information[16] *If "yes," continue with questions #6-8. Otherwise, skip questions #6-8.*	*Yes* *No*
6) What is the most recent 12-month reporting period for which STS performance results are available? 12 months ending:	_____ *Format: MM/YYYY*
7) From the report for that time period, what was the Operative Mortality, Risk-adjusted rate[17] reported for your hospital (observed rate) as a percentage for aortic valve replacement surgery?	_____% *Format: 3.1*
8) From the same report, what was the Operative Mortality, Risk-adjusted rate[18] reported for the All STS cohort (expected rate) as a percentage for aortic valve replacement surgery?	_____% *Format: 4.2*

Aortic Valve Replacement (AVR) – Regional Registries

Hospitals in Maine, New Hampshire, and Vermont ONLY. If you answered "no" question #5, please complete questions #9-13.

Reporting Time Period: Base your responses on the latest 12-month report received from your regional registry [Northern New England Cardiovascular Disease Study Group (NNECDSG)].

9) Are AVR mortality outcomes for your hospital included in the regional registry (NNECDSG) report for the most recently reported period[19]? *If "no," skip questions #10-13.*	*Yes* *No*
10) What is the most recent 12-month reporting period for which your hospital's results are included in your regional registry report? 12 months ending:	_____ *MM/YYYY*
11) If AVR mortality outcome results for your hospital are included with another hospital and/or reported under a **different hospital name** from that indicated in the Organization Information section of this survey, indicate the reported name of the hospital:	_____
12) From the report for that time period, what was the observed mortality rate[20] as a percentage for aortic valve replacement surgery?	_____*%* *Format: 3.1*
13) From the same report, what was the expected mortality rate[21] as a percentage for aortic valve replacement surgery?	_____*%* *Format: 3.1*

3C: Abdominal Aortic Aneurysm (AAA) Repair

If you answered "yes" to question #2 in Section 3A, indicating that you perform AAA, complete these questions pertaining to this high-risk surgery.

Abdominal Aortic Aneurysm (AAA) Repair – Volume

Specifications: See ***AAA Volume Standard*** in the EBHR Reference Information on page 47.

Reporting Time Period: 12 months or *optionally* the 24 months (annual average)
- 10/01/2014 – 09/30/2015 (12 months)
- 10/01/2013 – 09/30/2015 (24 months annual average)

1) Reporting time period used was 12- or 24-months:	☐ 10/01/2014 – 09/30/2015 ☐ 10/01/2013 – 09/30/2015
2) Total number of patients (including those that expired) with an AAA Repair procedure at this hospital location. *Annual number of patients for the volume Reporting Time Period (or annual average if reporting on 24 months of data)*	_____
3) Total number of patients (including those that expired) with an unruptured AAA Repair procedure at this hospital location *Annual number of patients for the volume Reporting Time Period (or annual average if reporting on 24 months of data)*	_____
4) How many patients included in question #3 died in the hospital following this procedure? (More information)[15] *(Annual average if reporting on 24 months of data)*	_____

3D: Pancreatic Resections

If you answered 'yes' to question #3 in Section 3A, indicating that you perform Pancreatic Resection, complete these questions pertaining to this high-risk surgery.

Pancreatic Resections – Volume

Specifications: See ***Pancreatectomy Volume Standard*** in the EBHR Reference Information on pages 48-49.

Reporting Time Period: 12 months or *optionally* the 24 months (annual average)
- 10/01/2014 – 09/30/2015 (12 months)
- 10/01/2013 – 09/30/2015 (24 months annual average)

1) Reporting time period used was 12- or 24-months:	☐ 10/01/2014 – 09/30/2015 ☐ 10/01/2013 – 09/30/2015
2) Total number of patients (including those that expired) with a Pancreatic Resection procedure at this hospital location. *Annual number of patients for the volume Reporting Time Period (or annual average if reporting on 24 months of data)*	_____
3) Total number of patients (including those that expired) in question #2 with a diagnosis of duodenal, biliary, or pancreatic cancer *Annual number of patients for the volume Reporting Time Period (or annual average if reporting on 24 months of data)*	_____
4) How many patients included in question #3 died in the hospital following this procedure? (More information)[15] *(Annual average if reporting on 24 months of data)*	_____

3E: Esophagectomy

If you answered "Yes" to question #4 in Section 3A, indicating that you perform Esophagectomy, complete these questions pertaining to this high-risk surgery.

Esophagectomy – Volume

Specifications: See ***Esophagectomy Volume Standard*** in the EBHR Reference Information on page 50.

Reporting Time Period: 12 months or *optionally* the 24 months (annual average)
- 10/01/2014 – 09/30/2015 (12 months)
- 10/01/2013 – 09/30/2015 (24 months annual average)

1) Reporting time period used was 12- or 24-months:	☐ 10/01/2014 – 09/30/2015 ☐ 10/01/2013 – 09/30/2015
2) Total number of patients (including those that expired) with an Esophagectomy procedure at this hospital location. *Annual number of patients for the volume Reporting Time Period (or annual average if reporting on 24 months of data)*	_____
3) Total number of patients (including those that expired) in question #2 with a diagnosis of esophageal cancer *Annual number of patients for the volume Reporting Time Period (or annual average if reporting on 24 months of data)*	_____
4) How many patients included in question #3 died in the hospital following this procedure? (More information)[15] *(Annual average if reporting on 24 months of data)*	_____

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 Evidence-Based Hospital Referral Section at our hospital, and I hereby certify that this information is true, accurate, and reflect 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 Score, 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 person 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: 2015 Evidence-Based Hospital Referral (EBHR) Reference Information

This section is not applicable to Pediatric hospitals.

What's New in the 2016 Survey

No substantive changes were made to this section.

Please note that the reporting period for this section of the survey is the 12-months ending September 30, 2015. Therefore, only ICD-9 procedure codes are included.

Change Summary since Release

None. If substantive changes are made to this section of the survey after release on April 1, 2016 they will be documented in this Change Summary section.

EBHR Frequently Asked Questions (FAQs)

1. **How are the procedure codes used to define the high-risk procedures; do they refer to primary procedure codes, or primary and secondary codes?**
   When counting patient volume for the procedure, the procedure code may be in either a primary or secondary field.

2. **What criteria were used to identify the codes? Sometimes it appears that an entire code group was selected and at other times just a subset of a code group was selected.**
   Codes were determined by the measure developer; Leapfrog is using endorsed or national performance measures in the survey where possible. Thus, we use the codes identified by the specific measure developer.

   All exclusions are intentional. They are based on a combination of the actual mortality risk of the condition, clinical judgment, and consistency with data and measure sources in the evidence used to establish volume cut points. Additionally, codes may be retired and new codes added by the coding developers.

3. **We are developing a volume report for our hospital. Our counts include all coded procedures that match the ICD-9 codes for each of the four high-risk surgeries of the Leapfrog EBHR standard. The volume numbers in our report are higher than the number of discharges. Should we count procedures or discharges?**
   Count discharges that have one or more of the procedure codes for that respective high-risk surgery. A patient discharge should never be counted more than once for the high-risk procedure. (The same patient discharge may be counted once each for different high-risk surgeries if the patient stay included different high-risk procedures.)

4. **Should I use the admission or discharge date when determining whether or not a case falls within the Reporting Period?**
   The discharge date should be used to determine whether or not a case falls within the Reporting Period.

5. **Why is Leapfrog asking for the number of deaths in our hospital for specific procedures? How will this information be used?**
   The Leapfrog Group collects this information for use in a composite measure of survival developed by experts in the measurement of quality and safety. This measure utilizes information on hospital volume and mortality. More information about the composite surgical survival measure is available at http://leapfroggroup.org/survey-materials/scoring-and-results. Leapfrog does not publish the specific number of deaths occurring for the procedure; it instead publishes the results of the composite measure.

6. **How should we count the following procedures when a patient has a procedure done multiple times during an admission?**
   Count the patient only once for that high-risk procedure. If the procedure is repeated during a subsequent hospital stay, count that one as well.

7. **How will The Leapfrog Group account for hospitals that do not perform all of the high-risk surgeries?**
   A hospital's responses are evaluated separately by high-risk procedure or condition. For a hospital not performing a high-risk procedure on an elective basis, or that does not admit high-risk deliveries, the standard for that procedure or condition does not apply and this will be indicated in Leapfrog public results.

AVR Measure References

AVR Volume Standard

For AVR, there is only one set of codes for counting all patients who have had the procedure. While it is expected that most procedures would be indicated as a principal 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.

*Use only ICD-9-CM codes as indicated in each specification. When calculating hospital volume: count the number of **patients** with any one or more of the specified procedure codes for that EBHR procedure, subject to the other inclusion/exclusion criteria below. Patient age restrictions apply to all procedures.*

Question #2: Total number of patients undergoing procedure

Source: The Leapfrog Group

Number of patients discharged with ICD-9-CM PROCEDURE CODES: 35.21 or 35.22 in any procedure field.

Age 18 years and older

ICD-9-CM AVR procedure codes:

35.21	Replacement of aortic valve with tissue graft
35.22	Other replacement of aortic valve

Question #3: Total number of patients undergoing a transcatheter aortic repair procedure

Source: The Leapfrog Group

Number of patients discharged with ICD-9-CM PROCEDURE CODES: 35.05 or 35.06 in any procedure field.

Age 18 years and older

ICD-9-CM TAVR procedure codes:

35.05	Endovascular replacement of aortic valve
35.06	Transapical replacement of aortic valve

AVR Outcomes Specifications

Questions #5-8 Instructions for National Performance Measurement Reporting

Entity:	**STS (Isolated AVR Report)**
Operative mortality, Risk-adjusted Rate for Your Hospital (Observed):	For the latest year reported, enter your hospital's "Risk-adjusted Operative Mortality rate" for AVR (report p. AV Replace-62 or a page nearby) in AVR Question 7, respectively. These are your hospital's actual operative mortality rates, standardized (risk-adjusted) to the STS all-hospital risk. Operative mortality includes in-hospital and 30-day post-operative mortality out-of-hospital.
Operative mortality, Risk-adjusted Rate for All STS Cohort (Expected):	Enter the all-hospital STS "Risk-adjusted Operative Mortality rate" for AVR operative mortality (report p. AV Replace-62 or a page nearby) in AVR Question 8, respectively. These are the national expected operative mortality rates to which you hospital's actual standardized rate in AVR Question 7 will be compared. Operative mortality includes in-hospital and 30-day post-operative mortality out-of-hospital.

Questions #9-13 Instructions for Regional Registries

Entity:	**NNECDSG (ME, NH, VT only)**
Observed mortality rate:	In-hospital mortality rate includes any post-operative death during their admission for the procedure. Report this as a percentage, with one decimal-place precision.
Risk-Adjusted expected mortality rate:	In-hospital mortality rate includes any post-operative death during their admission for the procedure. This is the expected mortality rate based on all-hospital average mortality, but risk-adjusted for the severity of the hospital's patient severity for the hospital's reported cases. Report this as a percentage, with one decimal-place precision. In no event should statistical confidence intervals be used or reported.

AAA Repair Measure References

AAA Volume Standard

For AAA, there are two sets of ICD-9-CM codes for counting patients for each of these procedures. The first set of codes is for counting all patients who have had the procedure (Question #2). The second set of codes for AAA is for counting patients who have had a non-emergent or non-ruptured repair (AAA Question #3). While it is expected that most procedures would be indicated as a principal 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.

*Use only ICD-9-CM codes as indicated in each specification. When calculating hospital volume: count the number of **patients** with any one or more of the specified procedure codes for that EBHR procedure, subject to the other inclusion/exclusion criteria below. Patient age restrictions apply to all procedures.*

Question #2: All patients undergoing procedure

Source: The Leapfrog Group

Number of patients, age 18 years and older, discharged with the following ICD-9-CM codes in any procedure field:

ICD-9-CM AAA procedure codes:

38.34	Resection of aorta with anastomosis
38.44	Resection of abdominal aorta with replacement
38.64	Other excision of abdominal aorta
39.25	Aorta-iliac-femoral bypass
39.71	Endovascular implementation of graft in abdominal aorta

Exclude cases:
MDC 14 (pregnancy, childbirth, and puerperium)
MDC 15 (newborns and other neonates)

Question #3: Patients with an unruptured AAA procedure

Source: The Leapfrog Group

Number of patients, age 18 years and older, discharged with the following ICD-9-CM codes in any procedure field:

ICD-9-CM AAA procedure codes:

38.34	Resection of aorta with anastomosis
38.44	Resection of abdominal aorta with replacement
38.64	Other excision of abdominal aorta
39.25	Aorta-iliac-femoral bypass
39.71	Endovascular implementation of graft in abdominal aorta

AND

ICD-9-CM Diagnosis Codes

441.4	Abdominal aneurysm without mention of rupture
441.9	Aortic aneurysm of unspecified site without rupture

Exclude cases:
MDC 14 (pregnancy, childbirth, and puerperium)
MDC 15 (newborns and other neonates)

Pancreatectomy Measure References

Pancreatectomy Volume Standard

For Pancreatectomy, there are two sets of ICD-9-CM codes for counting patients for each of these procedures. The first set of codes is for counting all patients who have had the procedure (Question #2). The second set of codes for Pancreatectomy is for counting patients who have had the procedure and also had a diagnosis of cancer (Question #3). While it is expected that most procedures would be indicated as a principal 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.

*Use only ICD-9-CM codes as indicated in each specification. When calculating hospital volume: count the number of **patients** with any one or more of the specified procedure codes for that EBHR procedure, subject to the other inclusion/exclusion criteria below. Patient age restrictions apply to all procedures.*

The count for the volume measures can include emergent cases as well as "elective" scheduled cases.

Question #2: All patients undergoing procedure

Source: The Leapfrog Group

Number of patients, age 18 years and older, discharged with the following ICD-9-CM codes in any procedure field:

ICD-9-CM pancreatic resection procedure codes:

52.51	Proximal pancreatectomy
52.53	Radical subtotal pancreatectomy
52.6	Total Pancreatectomy
52.7	Radical Pancreaticoduodenectomy

Question #3: Select patients in Question #2 with a diagnosis of duodenal, biliary, or pancreatic cancer

Source: The Leapfrog Group

Number of patients identified in Question #2 that also had an ICD-9-CM diagnosis code of:

ICD-9-CM duodenal, biliary, and pancreatic cancer diagnosis codes:

152.0	Malignant neoplasm of duodenum
152.1	Malignant neoplasm of jejunum
152.2	Malignant neoplasm of ileum
152.3	Malignant neoplasm of meckel's diverticulum
152.8	Malignant neoplasm of other specified sites of small intestine
152.9	Malignant neoplasm of small intestine unspecified site
156.0	Malignant neoplasm of gallbladder
156.1	Malignant neoplasm of extrahepatic bile ducts
156.2	Malignant neoplasm of ampulla of vater
156.8	Malignant neoplasm of other specified sites of gallbladder and extrahepatic bile ducts
156.9	Malignant neoplasm of biliary tract part unspecified site
157.0	Malignant neoplasm of head of pancreas
157.1	Malignant neoplasm of body of pancreas
157.2	Malignant neoplasm of tail of pancreas
157.3	Malignant neoplasm of pancreatic duct
157.4	Malignant neoplasm of islets of langerhans
157.8	Malignant neoplasm of other specified sites of pancreas
157.9	Malignant neoplasm of pancreas part unspecified

Esophagectomy Measure References

Esophagectomy Volume Standard

For Esophagectomy, there are two sets of ICD-9-CM codes for counting patients for each of these procedures. The first set of codes is for counting all patients who have had the procedure (Question #2). The second set of codes for Esophagectomy are for counting patients who have had the procedure and also had a diagnosis of cancer (Question #3). While it is expected that most procedures would be indicated as a principal 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.

*Use only ICD-9-CM codes as indicated in the each specification. When calculating hospital volumes, count the number of **patients** with any one or more of the specified procedure codes for that EBHR procedure, subject to the other inclusion/exclusion criteria below. Patient age restrictions apply to all procedures. Additionally, presence or absence of certain diagnosis codes may further determine whether the patient qualifies to be counted.*

The count for the volume measures can include emergent cases as well as "elective" scheduled cases.

Question #2: All patients undergoing procedure

Source: The Leapfrog Group

Number of patients, age 18 years and older, discharged with the following ICD-9-CM codes in any procedure field:

ICD-9-CM esophageal resection procedure codes:

42.4 42.40	Excision of esophagus Esophagectomy, not otherwise specified
42.41	Partial esophagectomy
42.42	Total esophagectomy
43.99	Other total gastrectomy

Question #3: Select patients in Question #2 with a diagnosis of esophageal cancer

Source: The Leapfrog Group

Number of patients identified in Question #2 that also had an ICD-9-CM diagnosis code of:

ICD-9-CM esophageal cancer diagnosis codes:

150.0	Malignant neoplasm of cervical esophagus
150.1	Malignant neoplasm of thoracic esophagus
150.2	Malignant neoplasm of abdominal esophagus
150.3	Malignant neoplasm of upper third of esophagus
150.4	Malignant neoplasm of middle third of esophagus
150.5	Malignant neoplasm of lower third of esophagus
150.8	Malignant neoplasm of other specified part of esophagus
150.9	Malignant neoplasm of esophagus unspecified site
151.0	Malignant neoplasm of cardio-esophageal junction

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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: 2016 Maternity Care

Link to 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 an 80% target for both process measures of care

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. Achieves 80% or higher adherence to nationally endorsed process measures of quality.

More information about the 2016 Leapfrog Hospital Survey Scoring Algorithms is available at:
http://leapfroggroup.org/survey-materials/scoring-and-results

4A Maternity Care

Specifications: See ***Maternity Care Volume*** in the Maternity Care Reference Information on page 64.

Reporting Time Period: 9 months
- Surveys submitted prior to September 1, 2016: 01/01/2015 – 09/30/2015
- Surveys (re)submitted on or after September 1, 2016: 10/01/2015 – 06/30/2016

1) 9-month reporting time period used:	☐ 01/01/2015 - 09/30/2015 ☐ 10/01/2015 – 06/30/2016
2) Did the hospital deliver newborn babies during the reporting period? *If "no," please skip remaining questions for Section 4 including all subsections; hospital will be scored as "Does not apply." Otherwise, continue on to question #3.*	*Yes* *No*
3) 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. Otherwise, continue to Section 4B.*	_____

4B: Early Elective Deliveries

Specifications: See ***Early Elective Deliveries*** in the Maternity Care Reference Information on pages 65-67.

Reporting Time Period: 9 months
Answer questions #1-5 based on all cases (or a sufficient sample of them)
- Surveys submitted prior to September 1, 2016: 01/01/2015 - 09/30/2015
- Surveys (re)submitted on or after September 1, 2016: 10/01/2015 – 06/30/2016

Sufficient Sample: See ***Early Elective Deliveries*** for instructions for identifying a sufficient sample to answer questions #1-5.

Elective Delivery Prior To 39 Completed Weeks of Gestation	
1) 9-month reporting time period used:	☐ 01/01/2015 - 09/30/2015 ☐ 10/01/2015 – 06/30/2016
2) Total number of mothers (or sufficient sample of them) that delivered newborns with >=37 weeks of gestation completed and <39 weeks of gestation completed during the reporting period, 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.*	_____
3) Total number of mothers indicated in question #2 which had their newborn delivered electively (not spontaneously).	_____
4) Do the responses in questions #2 and #3 above represent a sample of cases?	*Yes* *No*
5) 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 Section

Specifications: See ***NTSV Cesarean Sections*** in the Maternity Care Reference Information on pages 67-69.

Reporting Time Period: 9 months
Answer questions #1-5 based on all cases (or a sufficient sample of them)
- Surveys submitted prior to September 1, 2016: 01/01/2015 - 09/30/2015
- Surveys (re)submitted on or after September 1, 2016: 10/01/2015 – 06/30/2016

Sufficient Sample: See ***NTSV Cesarean Sections*** for instructions for identifying a sufficient sample to answer questions #2 and #3.

NTSV Cesarean Sections	
1) 9-month reporting period used:	☐ 01/01/2015 – 09/30/2015 ☐ 10/01/2015 - 06/30/2016
2) Total number of nulliparous mothers (or sufficient sample of them) that delivered a live term singleton newborn in the vertex presentation and 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.*	_____
3) Total number of mothers indicated in question #2 which had their newborn delivered via cesarean section.	_____
4) Do the responses in questions #2 and #3 above represent a sample of cases?	*Yes* *No*
5) 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*** in the Maternity Care Reference Information on pages 69-70.

Reporting Time Period: 9 months
Answer questions #1-3 based on all cases

- Surveys submitted prior to September 1, 2016: 01/01/2015 - 09/30/2015
- Surveys (re)submitted on or after September 1, 2016: 10/01/2015 – 06/30/2016

Incidence of Episiotomy in Vaginal Deliveries	
1) 9-month reporting time period used:	☐ 01/01/2015 - 09/30/2015 ☐ 10/01/2015 - 06/30/2016
2) Total number of vaginal deliveries during the reporting period with **Excluded Populations** removed.	_____
3) 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*** in the Maternity Care Reference Information on pages 70-71.

Reporting Time Period: 9 months
Answer questions #1-10 based on all cases (or a sufficient sample of them)
- Surveys submitted prior to September 1, 2016: 01/01/2015 - 09/30/2015
- Surveys (re)submitted on or after September 1, 2016: 10/01/2015 – 06/30/2016

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

Newborn Bilirubin Screening Prior to Discharge	
1) 9-month reporting time period used:	☐ 01/01/2015 - 09/30/2015 ☐ 10/01/2015 - 06/30/2016
2) Has your hospital performed a medical record audit on all cases (or a sufficient sample of them) for the Reporting Time Period **and** measured 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*
3) Number of cases measured against the guideline, either all cases or a sufficient sample of them (**denominator**)	_____
4) Number of cases in question #3 that adhere to the clinical process guideline (**numerator**)	_____
5) Do the responses in questions #3 and #4 represent a sample of cases?	*Yes* *No*

Appropriate DVT Prophylaxis in Women Undergoing Cesarean Section	
6) 9-month reporting time period used:	☐ 01/01/2015 - 09/30/2015 ☐ 10/01/2015 - 06/30/2016
7) Has your hospital performed a medical record audit on all cases (or a sufficient sample of them) for the Reporting Time Period **and** measured 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*
8) Number of cases measured against the guideline, either all cases or a sufficient sample of them (**denominator**)	_____
9) Number of cases in question #8 that adhere to the clinical process guideline (**numerator**)	_____
10) Do the responses in questions #8 and #9 represent a sample of cases?	*Yes* *No*

4F:High-Risk Deliveries

High-Risk Deliveries

1) Does your hospital electively admit high-risk deliveries[22]? *If "no," skip questions #2-17, and move on to the next section.*	*Yes* *No*
2) Does your hospital operate a neonatal ICU, or is it co-located[23] with a hospital that operates a NICU, that admits or accepts transfers of very-low birth weight babies[24]? *If "no," answer questions #12-17, and skip questions #3-11.* *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*
3) Hospitals that participate in the Vermont Oxford Network (VON), and have a recent 12-month or 36-month report available, may elect to report your facility's Volume (questions #4-5) **OR** the VON's Death or Morbidity Measure[25] (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

Neonatal Intensive Care Unit(s) – Volume

Specifications: See ***High-Risk Deliveries Volume Standard*** in the Maternity Care Reference Information on page 72.

Reporting Time Period: 12 months
Answer questions #4-5 based on the 12-month reporting time period:
10/01/2014 – 09/30/2015

4) 12-month reporting time period used:	☐ 10/01/2014 - 09/30/2015
5) For the Reporting Time Period, how many very-low birth-weight babies were admitted to your hospital's neonatal intensive care unit(s)?	_____

Neonatal Intensive Care Unit(s) – National Performance Measurement

Specifications: See ***VON National Performance Measure Specifications*** in the Maternity Care Reference Information on page 73.

Reporting Time Period:
Base your responses on the latest 12-month or 36-month report received from the Vermont Oxford Network (VON) **for the Death or Morbidity Measure.**

6) 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? *If "no," please return to question #3 and select "Volume," then complete questions #4 and #5.*	*Yes* *No*
7) What is the most recent 12-month or 36-month reporting period for which VON performance results are available? Time period ending:	_____ *YYYY* *Format: 2015*
8) From the report for that time period, what is your hospital's volume?	_____
9) From the same report, what was your hospital's **SMR 95% lower bound**?	_____ *Format: 0.8*
10) From the report for that time period, what was your hospital's observed to expected ratio of morbidity or mortality (**SMR shrunken**)?	_____ *Format: 1.0*
11) From the same report, what was your hospital's **SMR 95% upper bound**?	_____ *Format: 1.2*

Process Measure of Quality – Antenatal Steroids

Specifications: See ***Antenatal Steroids Process Measure Specifications*** in the Maternity Care Reference Information on pages 74-75.

Reporting Time Period:
For hospitals reporting on the **VON** measure, answer questions #12-17 for the most recent **12-month** period available, ending within the last 12-months.

For hospitals reporting on **The Joint Commission's PC-03** measure, answer questions #12-17 based on a **9-month** reporting time period:

- Surveys submitted prior to September 1, 2016: 01/01/2015 - 09/30/2015
- Surveys (re)submitted on or after September 1, 2016: 10/01/2015 – 06/30/2016

12) 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
13) If VON, what is the most recent 12-month reporting period for which VON performance results are available? Time period ending:	_____ *YYYY* *Format: 2015*
14) If The Joint Commission, 9-month reporting time period used:	☐ 01/01/2015 - 09/30/2015 ☐ 10/01/2015 - 06/30/2016
15) Has your hospital performed a medical record audit on all cases (or a sufficient sample of them) for certain high-risk deliveries for the Reporting Time Period, **and** measured adherence to the antenatal steroids clinical process guideline for these high-risk deliveries. *If "no," skip questions #16-17.* *If "yes, but fewer than 10 cases met the inclusion criteria for the denominator," skip questions #16-17.*	*Yes* *No* *Yes, but fewer than 10 cases met the inclusion criteria for the denominator*
16) Number of cases measured against the guideline, either all cases or a sufficient sample of them, for these deliveries (i.e. number of cases audited and meeting the criteria for inclusion in the **denominator** of the measure)	_____
17) 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 reflect 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 Score, 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 person 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: 2016 Maternity Care Reference Information

What's New in the 2016 Survey

Most of the measures in Section 4 have two sets of measure specifications:

- The first set should be used by hospitals that submit a survey prior to September 1, 2016 and will only use **ICD-9 administrative codes**
- The second set should be used by hospitals that (re)submit a survey on or after September 1, 2016 and will only use **ICD-10 administrative codes**
- The high-risk deliveries volume standard only has one set of measure specifications which use **ICD-9 administrative codes**

In addition, most of the measures in Section 4 have a 9-month reporting period to accommodate the transition from ICD-9 administrative codes to ICD-10 administrative codes, with the following exceptions:

- Hospitals reporting on the high-risk deliveries volume standard will report on a 12-month period
- Hospitals reporting on the high-risk deliveries outcome and process measures using a Vermont Oxford Network report, will use the most recent 12- or 36-month report.

Change Summary since Release

If substantive changes are made to this section of the survey after release on April 1, 2016, they will be documented in this Change Summary section.

Issued May 6, 2016

1. The sample size for the Maternity Care Process Measures – Newborn Bilirubin Screening Prior to Discharge and DVT Prophylaxis in Women Undergoing Cesarean Section – has been reduced from 60 cases to 45 cases to reflect the change in the reporting period from 12-months in 2015 to 9-months in 2016. This change is reflected on pages 70-71 of this document, and highlighted in yellow.

In addition, the sample size for the High-Risk Delivery Process Measure – Antenatal Steroids – has been reduced from 60 cases to 45 cases to reflect the change in the reporting period from 12-months in 2015 to 9-months in 2016. This change is reflected on pages 74-75 of this document, and highlighted in yellow.

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.

Total Live Births	
Source: The Leapfrog Group	
Use the following measure specifications for surveys submitted **prior to September 1, 2016**. **Reporting Time Period: 9 months** January 1, 2015 – September 30, 2015	Use the following measure specifications for surveys (re)submitted **on or after September 1, 2016**. **Reporting Time Period: 9 months** October 1, 2015 – June 30, 2016
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 V 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. V30 - Single liveborn V31 - Twin, mate liveborn V32 - Twin, mate stillborn V33 - Twin, unspecified V34 - Other multiple, mates all liveborn V36 - Other multiple, mates live- and stillborn V37 - Other multiple, unspecified V39 - Unspecified Note: This data point is simply used to qualify a hospital for further reporting of the normal delivery measures.	**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.

Early Elective Deliveries

Important Notes:

Note 1: Early 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 Delivery Prior to 39 Weeks 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.

Notes on Changes between PC-01 version 2015A1 and 2015B2: In version 2015B2, the measure specification for identifying the numerator for early elective deliveries no longer includes the inclusion criterion for cesarean births where the patient is "not experiencing spontaneous rupture of membranes."

Use the following measure specifications for surveys submitted **prior to September 1, 2016**.	Use the following measure specifications for surveys (re)submitted **on or after September 1, 2016**.
Elective Delivery At or After 37 Completed Weeks or Prior to 39 Completed Weeks of Gestation	
Source: Joint Commission PC-01 **(version 2015A1)** **Reporting Time Period: 9 months** January 1, 2015 – September 30, 2015	**Source:** Joint Commission PC-01 **(version 2015B2)** **Reporting Time Period: 9 months** October 1, 2015 – June 30, 2016
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 Delivery measure specifications (**version 2015A1**) to retrospectively collect and report data for this measure. The PC-01 measure specifications are outlined below. To access the measure specifications directly on TJC's website, visit https://manual.jointcommission.org/releases/TJC2015A1/MIF0166.html.	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 Delivery measure specifications (**version 2015B2**) 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/TJC2015B2/MIF0166.html.
Sampling Cases: Hospitals that report the Perinatal Care Measure Set to the TJC may use the sampling methodology used by 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 **January 15, 2015**. • 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	**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 **October 15, 2015**. • 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.	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. **Included Populations:** • *ICD-9-CM Principal or ICD-9-CM Other Diagnosis Codes* for pregnancy as defined in Appendix A, Table 11.01, 11.02, 11.03 or 11.04 • *ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes* for planned cesarean section in labor as defined in Appendix A, Table 11.06.1 **Excluded Populations:** • *ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes* for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07 • Less than 8 years of age • Greater than or equal to 65 years of age • Length of stay > 120 days • Enrolled in clinical trials • *Gestational Age* < 37 or >= 39 weeks or UTD **Data Elements:** Visit https://manual.jointcommission.org/releases/TJC2015A1/MIF0166.html**.** ***If fewer than 10 cases during the reporting period, skip the next question.***	**Question 2 (denominator):** Patients delivering newborns with >= 37 and < 39 weeks of 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. • *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. **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 • Less than 8 years of age • Greater than or equal to 65 years of age • Length of stay > 120 days • Enrolled in clinical trials • *Gestational Age* < 37 or >= 39 weeks or UTD **Data Elements:** Visit https://manual.jointcommission.org/releases/TJC2015B2/MIF0166.html. ***If fewer than 10 cases during the reporting period, skip the next question.***

Question 3 (numerator): Patients with elective deliveries that were included in the denominator
 	
Included Populations:
ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes for one or more of the following:
• Medical induction of labor as defined in Appendix A, Table 11.05
• Cesarean section as defined in Appendix A, Table 11.06 and all of the following:
  ○ not in *Labor*
  ○ no history of a *Prior Uterine Surgery*
 	
Excluded Populations: None
 	
Data Elements: Visit https://manual.jointcommission.org/releases/TJC2015A1/MIF0166.html.
	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 while not in *Labor* prior to the procedure
	• Cesarean birth as defined in Appendix A, Table 11.06 and all of the following:
	  ○ not in *Labor*
	  ○ no history of a *Prior Uterine Surgery*
	
	Excluded Populations: None
	
	Data Elements: Visit https://manual.jointcommission.org/releases/TJC2015B2/MIF0166.html**.**

NTSV Cesarean Sections

Important Notes:

Note 1: NTSV Cesarean Sections 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 NTSV Cesarean Sections 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.

Notes on Changes between PC-02 version 2015A1 and 2015B2: Measure specifications for identifying the denominator for NTSV Cesarean Sections in version 2015B2 use ICD 10 **procedure** codes that indicate delivery, whereas the denominator specifications in version 2015A1 use ICD 9 **diagnostic** codes that indicate pregnancy.

Use the following measure specifications for surveys submitted **prior to September 1, 2016**.	Use the following measure specifications for surveys (re)submitted **on or after September 1, 2016**.
Cesarean Sections	
Source: Joint Commission PC-02 **(version 2015A1)** **Reporting Time Period: 9 months** January 1, 2015 – September 30, 2015	**Source:** Joint Commission PC-02 **(version 2015B2)** **Reporting Time Period: 9 months** October 1, 2015 – June 30, 2016
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.**	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 Commissions PC-02 Cesarean Section measure specifications (**version 2015A1**) 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/TJC2015A1/MIF0167.html.	Otherwise, use The Joint Commission's PC-02 Cesarean Section measure specifications (**version 2015B2**) 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/TJC2015B2/MIF0167.html.
Sampling: 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 **January 15, 2015**. • 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.	**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 **October 15, 2015**. • 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. **Included Populations:** • *ICD-9-CM Principal or ICD-9-CM Other Diagnosis Codes* for pregnancy as defined in Appendix A, Table 11.01, 11.02, 11.03 or 11.04 • Nulliparous patients with *ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes* for outcome of delivery as defined in Appendix A, Table 11.08 and with a delivery of a newborn with 37 weeks or more of gestation completed **Excluded Populations:** • *ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes* for multiple gestations and other presentations as defined in Appendix A, Table 11.09 • Less than 8 years of age • Greater than or equal to 65 years of age • Length of Stay >120 days	**Question 2 (denominator):** Nulliparous patients delivered of a live term singleton newborn in vertex presentation. **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. • 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, 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 • Less than 8 years of age • Greater than or equal to 65 years of age • Length of stay >120 days

• Enrolled in clinical trials • *Gestational Age* < 37 weeks or UTD **Data Elements:** Visit https://manual.jointcommission.org/releases/TJC2015A1/MIF0167.html. ***If fewer than 10 cases during the reporting period, skip the next question.***	• Enrolled in clinical trials • *Gestational Age* < 37 weeks or UTD **Data Elements:** Visit https://manual.jointcommission.org/releases/TJC2015B2/MIF0167.html. ***If fewer than 10 cases during the reporting period, skip the next question.***
Question 3 (numerator): Patients in the denominator with cesarean sections. **Included Populations:** *ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes* for cesarean section as defined in Appendix A, Table 11.06 **Excluded Populations:** None **Data Elements:** Visit https://manual.jointcommission.org/releases/TJC2015A1/MIF0167.html.	**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 **Excluded Populations:** None **Data Elements:** Visit https://manual.jointcommission.org/releases/TJC2015B2/MIF0167.html.

Episiotomy

Use the following measure specifications for surveys submitted **prior to September 1, 2016**.	Use the following measure specifications for surveys (re)submitted **on or after September 1, 2016**.
Incidence of Episiotomy in Vaginal Deliveries	
Source: National Quality Forum #0470 **Reporting Time Period: 9 months** January 1, 2015 – September 30, 2015	**Source:** National Quality Forum #0470 **Reporting Time Period: 9 months** October 1, 2015 – June 30, 2016
Question 2 (denominator): Total number of vaginal deliveries during the reporting 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-9-CM diagnostic code in a primary or secondary field: • 660.41: Shoulder (girdle) dystocia, delivered, with or without mention of antepartum condition	**Question 2 (denominator):** Total number of vaginal deliveries during the reporting 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): Number of cases included in the denominator that had an episiotomy procedure performed. For the purposes of this measure, the following ICD-9-CM procedure codes should be used for identifying an episiotomy: • 72.1: Low forceps operation with episiotomy • 72.21: Mid forceps operation with episiotomy • 72.31: High forceps operation with episiotomy • 72.71: Vacuum extraction with episiotomy • 73.6: Episiotomy	**Question 3 (numerator):** Number of cases included in 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: 9 months** • Surveys submitted prior to September 1, 2016: 01/01/2015 - 09/30/2015 • Surveys (re)submitted on or after September 1, 2016: 10/01/2015 – 06/30/2016
Sampling: If you have fewer than 45 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 9 months of historical data to increase the eligible cases beyond 45; just measure and report on ALL eligible cases that you have in that reporting time period. If you have more than 45 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 45 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: 9 months

- Surveys submitted prior to September 1, 2016: 01/01/2015 - 09/30/2015
- Surveys (re)submitted on or after September 1, 2016: 10/01/2015 – 06/30/2016

Sampling: If you have fewer than 45 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 9 months of historical data to increase the eligible cases beyond 45; just measure and report on ALL eligible cases that you have in that reporting time period.

If you have more than 45 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 45 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 will only use ICD-9-CM codes for the 2016 Leapfrog Hospital Survey. There is only one reporting period for this measure: October 1, 2014 – September 30, 2015.

Use only ICD-9-CM codes as indicated in the specifications. When calculating hospital volume: count the number of **patients** with any one or more of the specified procedure codes for high-risk deliveries, subject to the other inclusion/exclusion criteria below.

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-9-CM codes:

764.02-764.05	Light for dates without mention of malnutrition—500 gms.-1499 gms.
764.12-764.15	Light for dates with signs of fetal malnutrition -- 500 gms. - 1499 gms.
764.22-764.25	Fetal malnutrition without mention of “light for dates” -- 500 gms. -1499 gms.
764.92-764.95	Fetal growth retardation, unspecified -- 500gms. - 1499 gms.
765.02-765.05	Extreme immaturity -- 500 gms – 1499 gms
765.12-765.15	Other preterm infants -- 500 gms-1499 gms

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 at 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 or 36-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: Hospitals reporting on the VON Antenatal Steroids Process Measure should use these instructions. There is only one set of instructions for the VON Antenatal Steroid Process Measure.

Note 2: Hospitals that share a Medicare Provider Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Notes on Changes between PC-03 version 2015A1 and 2015B2: Measure specifications for identifying the denominator for antenatal steroids in version 2015B2 use ICD 10 **procedure** codes that indicate delivery, whereas the denominator specifications in version 2015A1 use ICD 9 **diagnostic** codes that indicate pregnancy.

<table>
<tr><td>Use the following measure specifications for surveys submitted <u>prior to September 1, 2016</u>.</td><td>Use the following measure specifications for surveys (re)submitted <u>on or after September 1, 2016</u>.</td></tr>
<tr><td colspan="2">Antenatal Steroids Process Measure</td></tr>
<tr><td colspan="2"><u>If you participate in the Vermont Oxford Network</u>, measured adherence to the antenatal steroids process-of-care quality indicator, reported the results to VON, and continue to submit these data to VON, then 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.</td></tr>
<tr><td>Source: Joint Commission PC-03 (version 2015A1)

Reporting Time Period: 9 months
January 1, 2015 – September 30, 2015</td><td>Source: Joint Commission PC-03 (version 2015B2)

Reporting Time Period: 9 months
October 1, 2015 – June 30, 2016</td></tr>
<tr><td><u>If you participate with The Joint Commission</u>, 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, use those data when responding to this subsection of the survey.

<u>Otherwise, use The Joint Commission's PC-03 Antenatal Steroids measure specifications (version 2015A1) detailed below</u> 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/TJC2015A1/MIF0168.html.</td><td><u>If you participate with The Joint Commission</u>, 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, use those data when responding to this subsection of the survey.

<u>Otherwise, use The Joint Commission's PC-03 Antenatal Steroids measure specifications (version 2015B2) detailed below</u> 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/TJC2015B2/MIF0168.html.</td></tr>
<tr><td colspan="2">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 <u>fewer than 45 cases</u> 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 9 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 <u>more than 45 cases</u> that meet the criteria for inclusion in the denominator of the process measure</td></tr>
</table>

during the time period of the medical record audit, you may randomly sample 45 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. **Included Populations:** • *ICD-9-CM Principal or ICD-9-CM Other Diagnosis Codes* for pregnancy as defined in Appendix A, Tables 11.01, 11.02, 11.03 or 11.04 **Excluded Populations:** • Less than 8 years of age • Greater than or equal to 65 years of age • Length of Stay >120 days • Enrolled in clinical trials • Documented *Reason for Not Initiating Antenatal Steroid Therapy* • *ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes* for fetal demise as defined in Appendix A, Table 11.09.1 • *Gestational Age* < 24 or >= 34 weeks or UTD **Data Elements:** Visit https://manual.jointcommission.org/releases/TJC2015A1/MIF0168.html.	**Question 16 (denominator)** Patients delivering live preterm newborns with >=24 and <34 weeks gestation completed. **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. **Excluded Populations:** • Less than 8 years of age • Greater than or equal to 65 years of age • Length of Stay >120 days • Enrolled in clinical trials • Documented *Reason for Not Initiating Antenatal Steroids* • *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 • *Gestational Age* < 24 or >= 34 weeks or UTD **Data Elements:** Visit https://manual.jointcommission.org/releases/TJC2015B2/MIF0168.html.
Question 17 (numerator): The number of patients included in the denominator with antenatal steroid therapy initiated prior to delivering preterm newborns. **Included Populations:** Antenatal steroid therapy initiated (refer to Appendix C, Table 11.0, antenatal steroid medications) **Excluded Populations:** None **Data Elements:** Visit https://manual.jointcommission.org/releases/TJC2015A1/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 (refer to Appendix C, Table 11.0, antenatal steroid medications) **Excluded Populations:** None. **Data Elements:** Visit https://manual.jointcommission.org/releases/TJC2015B2/MIF0168.html.

Maternity Care Frequently Asked Questions (FAQs)

General Questions Regarding High-Risk Deliveries

1. **How are the procedure codes used to define the high-risk procedures; do they refer to primary procedure codes, or primary and secondary codes?**
   When counting patient volume for the procedure, the procedure code may be in either a primary or secondary field. The High Risk Delivery volume measure also utilizes diagnosis codes to determine volume of very low birth weight babies. The diagnosis can be either primary or secondary for determining the elective status of the high risk delivery.

2. **Do the codes related to Leapfrog's High-Risk Deliveries apply only to neonates?**
   Yes. Older patients should not be included. These codes are used to determine whether your hospital admits or accepts transfers to your NICU of newborns whose weight or gestation period creates higher risk. The codes are also used to count patient volume to compute the number of very low birth weight babies treated in the NICU. This recent change is based on new evidence in the literature.

High-Risk Deliveries Process Measure Questions

1. **How do we count a patient transferred here from another facility where they received the steroids at the other facility? Is this patient excluded from our data since we did not administer the steroids?**
   Refer to The Joint Commission's definition of "antenatal steroid therapy initiated" at https://manual.jointcommission.org/releases/TJC2015A1/DataElem0269.html.

2. **We cannot count moms using the Vermont Oxford Network (VON) data; they only count infants. How do we report the process measure for use of antenatal steroids?**
   If using the VON data, use the number of infants, but ONLY for those who are inborn, i.e., where the status of the mothers is known and the mothers were delivered at your hospital. The denominator is the number of low birth weight infants. The numerator includes those infants in the denominator whose moms received antenatal steroids for that delivery.

3. **When using VON reports, what time period should we use?**
   If using VON data to report your hospital's adherence to this process measure, use the most recent 12 months available. If relying on a report from VON, use the most recently available report, so long as it is based on a 12-month period that ends within 12 months prior to your submitting a survey AND your hospital continues to participate in and submit these data to VON. Instructions for accessing your reports via the VON Nightingale Tool are available at: http://leapfroggroup.org/survey-materials/survey-and-cpoe-materials.

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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: 2016 ICU Physician Staffing (IPS) Standard

Link to IPS Fact Sheet: http://leapfroggroup.org/ratings-reports/survey-content

A hospital fully meeting this standard assures that:
All patients[26] in its adult or pediatric general medical and/or surgical ICUs and neuro ICUs[27] are managed or co-managed[28] by physicians certified in critical care medicine[29] who:

- Are ordinarily present in the ICU[30] (on-site, or via telemedicine[33] 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[30] in the ICU; and
- At other times** . . . ;
  - Return more than 95% of ICU calls/pages within 5 minutes, based on a quantified analysis[31] of notification device response time;* and
  - Can rely on a physician, physician assistant, nurse practitioner, or a FCCS-certified nurse "effector"[32] 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.*

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

**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.

More information about the 2016 Leapfrog Hospital Survey Scoring Algorithms is available at:
http://leapfroggroup.org/survey-materials/scoring-and-results

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[33]). 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[29]).

Reporting Time Period: Answer questions #1-14 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*
2) Does your hospital operate any adult or pediatric general medical and/or surgical ICUs or neuro ICUs[27]?	*Yes* *No*

If "yes" to question #2 continue; otherwise, skip remaining questions.

3) Are all patients[26] in these ICUs managed or co-managed[28] by one or more physicians who are certified in critical care medicine[29]?	*Yes, all are certified in critical care* *Yes, based on expanded definition of certified* *No*

4) Is one or more of these physicians ordinarily present[30] 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[30] in one ICU during these hours? (More information on the use of telemedicine[33])	*Yes* *No*
5) When these physicians are not present in these ICUs on-site or via telemedicine, do they return more than 95% of calls/pages from these units within five minutes, based on a quantified analysis[31] of notification device response time? *(This percentage may exclude low-urgency calls/pages, if the notification device system can designate low-urgency calls/pages or if the hospital has an alternative scientific method for documenting high-urgency calls/pages that are not returned within 5 minutes.)*	*Yes* *No* *Not applicable, Intensivists are present 24/7*
6) When these physicians 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"[32] 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[31] of notification device response time? *(This percentage may exclude low-urgency calls/pages, if the notification device system can designate low-urgency calls/pages or if the hospital has an alternative scientific method for documenting high-urgency calls/pages that are not returned within 5 minutes.)*	*Yes* *No* *Not applicable, Intensivists are present 24/7*

If you answered "No" to any of questions #3-6 in this section, please answer the following questions for adult and pediatric, general medical and/or surgical ICUs and neuro ICUs.

7) Are all patients[26] in these ICUs managed or co-managed[28] by one or more physicians certified in critical care medicine[29] who meet **all** of the following criteria: • ordinarily present[30] 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[30] in one ICU during these hours?	*Yes* *No*
8) Are all patients in these ICUs managed or co-managed by one or more physicians certified in critical care medicine 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[34]) • 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*
9) Are all patients in these ICUs managed or co-managed by one or more physicians certified in critical care medicine 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*
10) If not all patients are managed or co-managed by physicians certified in critical care medicine, either on-site or via telemedicine, are some patients managed by these physicians?	*Yes* *No*
11) Does your hospital have a board-approved budget that is adequate to fully meet Leapfrog's ICU Physician Staffing standard?	*Yes* *No*
12) Does an on-site clinical pharmacist make daily rounds on patients in these ICUs 7 days per week?	*Yes* *No*
13) Does a physician certified in critical care medicine lead daily multi-disciplinary rounds on-site on all patients in these ICUs 7 days per week?	*Yes* *No*
14) 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 reflect 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 Score, 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 person 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: 2016 ICU Physician Staffing (IPS) Reference Information

What's New in the 2016 Survey

Leapfrog has added an additional response type for questions #5 and #6 in Section 5: ICU Physician Staffing (IPS). The new response type will give hospitals the opportunity to report 24/7 intensivist coverage in an applicable ICU.

Change Summary since Release

None. If substantive changes are made to this section of the survey after release on April 1, 2016, 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.

2. **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.

3. **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.

4. **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.

5. **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.

6. **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.

7. **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.

8. **On weekends and slower days in the ICU, do intensivists need to be present in the ICU for the full eight hours, or just scheduled for the eight hours?**
   On weekends and slower days in the ICU, as long as the intensivist does not have concurrent responsibilities, they just need to be scheduled for the 8 hours. They can leave the hospital early if it's slow, but need to be available to respond to pages/calls.

9. **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.

10. **How would a hospital document that it has a board-approved budget to fully meet Leapfrog's IPS standard?**
    Hospitals must have a board approved budget adequate to provide coverage in applicable ICUs 8 hours/day, 7 days/week exclusively in that ICU. At a minimum the board approved budget should include1.5 FTE per ICU.

Certification Questions

11. **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.

12. **Can hospitalists be counted as intensivists?**
    No.

13. **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.

14. **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

15. **If our hospital <u>requires</u> that ICU calls/pages are answered within five minutes and therefore does not track responses to calls/pages, 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 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 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.

16. **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.

17. **Are we expected to conduct an audit to verify that high-urgency calls/pages are returned within 5 minutes, and are there definitions for what constitutes high and low urgency calls/pages?**
    You should have some quantitative basis for saying that calls/pages 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 – but some notification device systems can make this differentiation and, in these instances, low urgency calls/pages 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 made to intensivists when they are not present in the unit (whether on-site or via telemedicine);
- the number of urgent calls/pages 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.

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 per day.

18. **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: SAFE PRACTICES SCORE (SPS)

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: 2016 NQF Safe Practices

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 eight 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**, at http://leapfroggroup.org/survey-materials/survey-and-cpoe-materials.

For each of the eight NQF-endorsed Safe Practices listed on the next page, please review and check items, as appropriate. Safe Practice #23 may not apply to your hospital and you can indicate so at the beginning of that practice.

More information about the 2016 Leapfrog Hospital Survey Scoring Algorithms is available at:
http://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	*Effective leadership to prevent errors*	120
6B	Culture Measurement, Feedback, and Intervention	*Staff work together to prevent errors*	20
6C	Teamwork Training and Skill Building	*Training to improve safety*	40
6D	Risks and Hazards	*Track and reduce risks to patients*	120
6E	Nursing Workforce	*Enough qualified nurses*	100
6F	Medication Reconciliation	*Correct medication information is communicated*	35
6G	Hand Hygiene	*Handwashing*	30
6H	Healthcare-Associated Complications in Ventilated Patients [a]	*Take steps to prevent ventilator problems*	20
	GRAND TOTAL		485

[a] If this Safe Practice does not apply at your hospital, you can indicate so at the beginning of this Safe-Practice section. To submit this section of the survey, this Safe Practice needs to be completed, even if only to indicate not applicable to your hospital.

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 eight 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 AWARENESS	**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:** 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 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 ACCOUNTABILITY	**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:** 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, Culture Measurement, Feedback, and Intervention*); • progress in meeting safety goals; and, • providing team training to caregivers (as defined by *Safe Practice #3, Teamwork Training and Skill Building*); 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 ABILITY	**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:** a ☐ dedicated patient safety program budgets support the program, staffing, and technology investment. (p.77)
1.4 ACTION	**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:** 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 AWARENESS	**In regard to Culture Measurement, our organization has done the following within the last 24 months:** a ☐ conducted a culture of safety survey of our employees using a nationally recognized tool that has demonstrated validity, consistency and reliability.[35] 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 in a report, which reflects both hospital-wide and individual unit level results, as applicable. 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 ACCOUNTABILITY	**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:** 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 ABILITY	**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:** 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 ACTION	**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:** 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 #3 - Teamwork Training and Skill Building

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

Check all boxes that apply.

3.1 AWARENESS	**In regard to teamwork training and skill building, our organization has done the following within the last 12 months:** a ☐ conducted a literature review of teamwork training in healthcare or other settings and have identified best practices. (p.101) **OR** conducted a review of available teamwork training programs in progressive organizations to identify best practices. (p.99) b ☐ conducted an assessment of high-risk areas, in terms of patient safety, by an interdisciplinary patient safety team to determine specific processes (e.g. communication, collaboration, etc.) and those involved in those processes in need of teamwork improvement. The results of the assessment were shared to senior administrative leadership. (p.97) c ☐ shared results of the assessment (from 3.1b) that determined specific processes and those involved in those processes in need of teamwork improvement with senior management, mid-level management and physician leadership. (pp.97-98) d ☐ informed senior management, mid-level management and physician leadership that to meet the need, internal resources and possible resources from progressive organizations have been identified. e ☐ assessed the organizational need for rapid response systems and any associated training. (p.97)
3.2 ACCOUNTABILITY	**In regard to leadership being held accountable for the demonstration of teamwork skills in the organization, our organization has done the following within the last 12 months:** a ☐ determined, through a literature review or an assessment, a set of targeted units or service lines for detailed teamwork training and effective teamwork skill building. These units/lines were identified by the CEO to the Board (governance), senior managers, and medical staff. (p.97) b ☐ provided basic teamwork training[36] to the Board (governance), senior managers, medical staff, mid-level management, and frontline nurses on communication hand-offs and team failures leading to patient harm. Training was documented in personnel or administrative records. (p.96)
3.3 ABILITY	**In regard to effective teamwork training and skill building, our organization has done the following within the last 12 months:** a ☐ resourced patient safety program budgets to support the assessment of need and team training activities. b ☐ provided clinical staff and licensed independent practitioners in the hospital-targeted units detailed teamwork training and skill building. Participation was documented. (p.96)

3.4 ACTION	**Effective team-centered interventions were either in place or were initiated in the past 12 months, as evidenced by:** a ☐ notation in board minutes documenting that the performance improvement targets in identified units were being addressed. (p.97) b ☐ evaluation or documentation of unit or service line results for teams that had received the detailed team training intervention during the past 12 months. (pp.97-98)
3.5	☐ 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 #4 - Risks and Hazards

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

Check all boxes that apply.

4.1	AWARENESS	**Within the last 12 months our organization has done the following:** 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	ACCOUNTABILITY	**Leadership is accountable for identification of risks and hazards to patients, and mitigation efforts in the past year, as evidenced by:** 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	ABILITY	**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:** 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 ACTION	**Structures and systems for assuring that direct and specific actions have taken place to mitigate risks to patients for the past 12 months, include:** 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.*

6E: 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[37]? ☐ 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 AWARENESS	**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:** 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 ACCOUNTABILITY	**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:** 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 ABILITY	**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:** 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 ACTION	**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:** 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.*

6F: Practice #17 - Medication Reconciliation

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

Check all boxes that apply.

17.1 AWARENESS	**In regard to adverse drug events and the medication reconciliation process, our organization has done the following or has had the following in place within the last 12 months:** a ☐ completed a review of the literature and identified specific, evidence-based best practices for process redesign. (pp.225-228) b ☐ conducted a hospital-wide evaluation of the frequency and severity of adverse drug events associated with medication reconciliation in our patient population. c ☐ submitted a report to the Board (governance) with recommendations for measurable improvement targets. (p.224)
17.2 ACCOUNTABILITY	**In regard to adverse drug events and the medication reconciliation process, our organization has done the following or has had the following in place within the last 12 months:** a ☐ held senior administrative leadership directly accountable for performance in this patient safety area through performance reviews or compensation. b ☐ held the patient safety officer directly accountable for improvements in performance through performance reviews or compensation. c ☐ reported to the Board (governance) the results of the measurable improvement targets. (p.224)
17.3 ABILITY	**In regard to adverse drug events and the medication reconciliation process, our organization has done the following or has had the following in place within the last 12 months:** a ☐ conducted staff education/knowledge transfer and skill development programs, with attendance documented. (p.221) b ☐ conducted an education program for all newly hired clinicians on the importance of medication reconciliation, with attendance documented. (p.219) c ☐ allocated protected time for direct care staff and managers, and dedicated budget resources for best practices development for the organization's medication reconciliation system. (p.222)

17.4 ACTION	**In regard to the medication reconciliation process, 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:** a ☐ developed and implemented explicit policies and procedures across the entire organization regarding medication reconciliation. b ☐ implemented a formal performance improvement program addressing the impact of this specific Safe Practice **OR** monitored a previously implemented hospital-wide performance improvement program that measures, and demonstrates full achievement of, the impact of this specific Safe Practice. c ☐ implemented standardized processes to obtain and document a complete list of each patient's current medications at the beginning of each episode of care. (p.219) d ☐ implemented standardized processes to ensure that a complete list of the patient's medications is communicated to the next provider of service, including the documentation of communication between providers. (p.220) e ☐ implemented standardized processes to provide the patient, and family/caregiver as needed, a current list and explanation of the patient's reconciled medications upon the patient leaving the organization's care. (p.220) f ☐ have reconciled medications for patients whose care setting, or level of care has changed, or has had a change in health status. (p.220)
17.5	☐ 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.*

6G: Practice #19 - Hand Hygiene

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

Check all boxes that apply.

19.1 AWARENESS	**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:** a ☐ conducted a hospital-wide evaluation of the potential impact of improvements in hand hygiene on the frequency and severity 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 ACCOUNTABILITY	**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:** 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 ABILITY	**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:** 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 ACTION	**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:** 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.*

6H: Practice #23 - Prevention of Healthcare-Associated Complications in Ventilated Patients

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

Important Note: For purposes of this Safe Practice, ventilator-associated complications include; ventilator associated pneumonia, venous thromboembolism, peptic ulcer disease, dental complications, and pressure ulcers.

Check all boxes that apply.

23	Does your facility care for patients on ventilators? ☐ Yes ☐ No *If "yes," continue with the remainder of this Safe Practice. If, "no," move on; hospital will be scored as "Does Not Apply."*
23.1 AWARENESS	**In regard to complications associated with ventilator use, our organization has done the following or has had the following in place within the last 12 months:** a ☐ conducted an evaluation of the frequency and severity of ventilator-associated complications, specifically ventilator associated pneumonia, venous thromboembolism, peptic ulcer disease, dental complications, and pressure ulcers in our patient population and communicated findings to senior administrative and clinical leadership. (p.290) b ☐ submitted a report to the Board (governance) with recommendations for measurable improvement targets.
23.2 ACCOUNTABILITY	**In regard to complications associated with ventilator use, our organization has done the following or has had the following in place within the last 12 months:** a ☐ held senior administrative leadership and clinical leadership directly accountable for improvements in performance through performance reviews or compensation. b ☐ held the patient safety officer directly accountable for improvements in performance through performance reviews or compensation. c ☐ reported to the Board (governance) the results of the measurable improvement targets.
23.3 ABILITY	**In regard to complications associated with ventilator use, our organization has done the following or has had the following in place within the last 12 months:** a ☐ conducted a staff education/ knowledge transfer and skill development programs on best practices and strategies to reduce complications with attendance documented. The organization: b ☐ documented or can document expenses incurred during the past year tied to this Safe Practice. (p.293) c ☐ allocated compensated caregiver staff time and dedicated line item budget resources for best practices development for the organization's prevention of ventilator associated complications.

23.4 ACTION	**In regard to complications associated with ventilator use, 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:** a ☐ documented evidence that all ventilated patients are included in an appropriate adult or pediatric specific bundle or prevention plan that is clearly documented in the medical record. (p.293) b ☐ implemented explicit organizational policies for the disinfection, sterilization, and maintenance of respiratory equipment that are aligned with evidenced based guidelines. (p.290) c ☐ documented evidence that all ventilated patients and/or their families have been educated on prevention measures involved in the care of the ventilated patient. (p.292) d ☐ implemented a formal performance improvement program with regular performance measurement and tracking improvement addressing ventilator associated complication prevention and compliance with prevention strategies (p.293) **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.293)
23.5	☐ 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 reflect 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 Score, 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 person 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: 2016 Leapfrog Safe Practices Score (SPS) Reference Information

What's New in the 2016 Survey

Earlier this year, Leapfrog convened a national expert panel to update the wording of the safe practice elements included in Section 6 NQF Safe Practices Score to provide greater clarity to hospitals, and ensure accurate, standard responses across all hospitals. In addition to wording updates, the panel also recommended changes to be consistent with the NQF Safe Practices for Better Healthcare – 2010 Update and the 2010 Safe Practices Audit completed by NQF in 2014.

In addition, the Culture of Safety national expert panel performed a comprehensive review of Safe Practice 2 Culture Measurement, Feedback, and Intervention and identified gaps in this practice. The panel recommended the addition of four (4) safe practice elements. In response to questions about which safety culture surveys meet the intent of Safe Practice 2, the panel has also developed a set of Guidelines for a Culture of Safety Survey that Demonstrates Validity, Consistency, and Reliability (see end note 35).

Change Summary since Release

None. If substantive changes are made to this section of the survey after release on April 1, 2016, they will be documented in this Change Summary section.

Tips for Reporting on Section 6 Safe Practices

Through the experience of hospitals that participate in Leapfrog's Pilot Test program, Leapfrog recommends the following steps:

- ☐ **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:

3) 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.

4) 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.

5) 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 or formalized programs whereby a measure of success of those activities or programs is tied to individual performance reviews or compensation incentive plans of executives.

6) The terms "senior administrative leadership", "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:

7) 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.

8) 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.

9) 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.

10) 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.

11) 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.

12) 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:

13) 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**.**

14) Numerous survey questions provide opportunities to generate credit for having undertaken 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**, interventions, and **reporting** of performance outcomes.

15) 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, including Additional Specifications, 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

16) SP1: The term "CEO" is used throughout this Safe Practice. 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.

17) 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 can be a general note in the minutes, without specific detail on those risks and hazards.

18) 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 specialty. Meetings should be formal and minutes should be taken.

19) 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? As a small hospital, it can be challenging to find patients to join committees.
The preference would be to find a non-Board member, non-employee to serve on the committee. As Board members have a fiduciary responsibility for the organization, they may have a potential conflict.

20) 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.

21) 1.1c: What steps can a hospital take to report efforts to the community?
Examples of efforts a hospital could take to report ongoing efforts to improve safety and quality in the organization and the results of these efforts might include: an annual report, a webpage on the hospitals website, a community newsletter. The effort should be aimed to reach the community at large.

22) 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.

23) 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.

24) 1.2c: It can be challenging to document that all of the roles in the 'stem' are held accountable for 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).

25) 1.2e: Our hospital did not have any adverse events. Can we still check to 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.

26) 1.4a: What is meant by Executive Walk-Rounds and how often should they take place?
The Executive Walk-Rounds 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.

27) 1.4a: How can progress on the implementation of Executive Walk Rounds 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-Rounds.

28) 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 NQF Safe Practice 1, Additional Specifications. Multiple executives who may be responsible for one area of safety each, and who do not assess the overall integrated safety

issues, would not qualify.

29) 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.

30) 1.1c, 1.2e: What would qualify to fulfill the additional specification "the community was made aware of ongoing efforts to improve safety and quality in the organization" (Also refer to "Facility reports adverse events to external mandatory or voluntary programs"

- The Leapfrog Group will be publishing the results of this survey on its Web site which will be open to the public. However, each organization must determine how to publicize its compliance with the safe practices in its individual market area.
- Public disclosure may include reporting the results of this survey on a hospital Web site if available, placing notices or posters throughout the organization, including information in newsletters and annual reports that are sent to the public with other marketing materials.
- If a hospital has a mechanism in place (e.g., an annual report) to annually report quality and safety performance outcomes to the public, that includes a subset of the NQF Safe Practices, the expectations of this question have been met.
- The requirements of this question have been met if a hospital has a mechanism in place to report publicly, at least yearly, quality and safety performance outcomes that includes a subset of the NQF Safe Practices.
- If a hospital has indicated in Section 7 of the Leapfrog Survey that they agree to uphold the Serious Reportable Events Policy Statement.

31) 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.

32) 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.

33) 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.

34) 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 governance and administrative leaders ensure that input regarding patient safety programs is sought from such informal medical leaders in a routine manner and is documented, then an organization may affirmatively acknowledge that such actions have been taken and if a mechanism is established to seek such information then an organization may affirmatively acknowledge so in their answer.

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

35) 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 35.

36) 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.

37) 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.

38) 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 #3 Teamwork Training and Skill Building

39) 3.1b: Any suggestions of resources we can use to determine processes in need of teamwork improvement?
One helpful resource may be the Team Training Needs Analysis.

40) 3.1e: What is the conceptual link between teamwork and rapid response systems?
Rapid response systems are ideally multidisciplinary, which requires a particular focus on teamwork. For more information, please see *AHRQ's TEAMSTEEPPS Training* and *AHA's Team-Based Health Care Delivery: Lessons from the Field.*

41) 3.2b: How should teamwork training be provided to the stakeholder groups listed?
For front-line staff, the most valuable way of teaching teamwork are practice-based methods (e.g., simulation) followed by a discussion. For senior leaders and the Board, it would be appropriate for them to watch a taped simulation and to have case-based discussions around sentinel events, causes of failure, and how teamwork could be improved to help prevent those from happening again.

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

42) 4.1a: Can data collection from use of Trigger Tools be used for this Safe Practice Element?
Yes. As outlined in the Additional Specifications Retrospective as well as Real Time or Near Real Time Trigger Tools are an important component. Supporting source data may include the number of charts reviewed using a Trigger Tool performed manually or on an automated basis.

43) 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.

44) 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.

45) 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.

46) 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.

47) 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.

6E: Safe Practice # 9 Nursing Workforce

48) 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.

49) 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.

50) 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.

51) 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.

6F: Safe Practice # 17 Medication Reconciliation

52) 17.1b: What is the definition of adverse drug event?
An adverse drug event has been defined by the Institute of Medicine as "an injury resulting from medical intervention related to a drug". This broad term encompasses harms that occur during medical care that are directly caused by the drug including but are not limited to medication errors, adverse drug reactions, allergic reactions, and overdoses.

53) 17.1b: If our hospital puts in ADEs through our hospital's error reporting system, does that count as a hospital-wide evaluation?
No. In addition to reviewing the error reporting system, hospitals should also look at the following sources for errors: pharmacy reviews, CPOE, P&T committee review, review of hospital-approved protocols, hospital readmissions, claims data, pharmacy system data, and risk management systems.

54) 17.2a: Which leadership roles should be included in 'senior administrative leadership' to meet this element?
Examples include: CMO/VPMA, CNO, CEO, COO, Director of Pharmacy and those folks report to

up the chain of command (recognizing that these may be variable). These are examples and titles may be different.

55) 17.3a: Which staff roles should receive education/knowledge transfer and skill development programs on medication reconciliation?
Physicians, nursing staff, pharmacists, pharmacy techs, allied health staff, medical assistants, patients, and families of patients.

6G: Safe Practice # 19 Hand Hygiene

56) 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

57) 19.4: Will use of the CDC guidelines for hand hygiene meet this Safe Practice?
Yes. Please see: http://www.cdc.gov/handhygiene/Guidelines.html.

58) 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.

6H: Safe Practice # 23 Prevention of Healthcare-Associated Complications in Ventilated Patients

59) 23.1a and 23.2a: Which roles are included in senior administrative and clinical leadership?
COO, CEO, CNO, CMO, Head of Pharmacy, and respiratory therapists.

60) 23.3a: Which staff roles should receive education/knowledge transfer and skill development programs on ventilator use and its complications?
Physicians, nurses, pharmacists, and respiratory therapists.

61) 23.4c: Do ALL ventilated patients and/or their families need to be educated on prevention measures involved in the care of the ventilated patient? What if the patient is unconscious and has no family members?
In that situation, it would be appropriate to document that the patient is unresponsive, has no family members, and therefore no opportunity for education. When the patient does not have family members, it would be appropriate to adopt a broader definition of "family" to include loved ones and those who will be caring for the patient.

62) 23.4: How can pediatric hospitals address the expectations of the Action answer of this Safe Practice?
The action expectations of this survey question may be satisfied by implementation and adoption of the Pediatric elements for those patients 18 years and younger as outlined in this NQF Safe Practice Additional Specifications.

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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: 2016 Managing Serious Errors

Link to 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 five principles of Leapfrog's Never Events policy when a serious error or "never event" occurs within their facility. More information on the five principles of the policy is available at: http://leapfroggroup.org/ratings-reports/inpatient-care-management.

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), catheter-associated urinary tract infections (CAUTI), Methicillin-resistant *Staphylococcus aureus* (MRSA), *Clostridium difficile* (CDI), and surgical site infections after major 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 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 0.000 for patients in the ICU.
3. Has a CAUTI standardized infection ratio of less than or equal to 0.443 for patients in the ICU.
4. Has a MRSA standardized infection ratio of less than or equal to 0.373 for facility-wide inpatients.
5. Has a CDI standardized infection ratio of less than or equal to 0.450 for facility-wide inpatients.
6. Has a SSI Colon standardized infection ratio of less than or equal to 0.386 for inpatients following eligible colon procedures.
7. Has a rate of 0.000 per 1,000 patient discharges for hospital-acquired stage III or IV pressure ulcers.
8. Has a rate less than or equal to 0.16 per 1,000 patient discharges for hospital-acquired injuries.
9. Has implemented all 7 of the CDC's Core Elements of Antibiotic Stewardship Programs.

More information about the 2016 Leapfrog Hospital Survey Scoring Algorithms is available at: http://leapfroggroup.org/survey-materials/scoring-and-results.

7A: The Leapfrog Group "Never Events" Policy Statement

The Leapfrog Group asks hospitals to agree to all of the following principles if a never event[38] occurs within their facility:

- We will apologize to the patient[39] and/or family affected by the never event
- We will report the event to at least one of the following external agencies[40] 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)
- We agree to perform a root cause analysis[41], consistent with instructions from the chosen reporting agency
- We will waive all costs directly related to a serious reportable adverse event
- We will make a copy of this policy available to patients, patients' family members, and payers upon request

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.

Indicate below your hospital's efforts in relation to The Leapfrog Group policy statement on "Never Events."

1) Has your hospital implemented a policy that adheres to **all** of the principles of The Leapfrog Group policy statement, above?	*Yes* *No*

7B: Hospital-Acquired Infections – CLABSI and CAUTI

Specifications: See ***CLABSI and CAUTI Specifications*** in the Managing Serious Errors Reference Information on pages 133-135 for reporting on infections, device days, and for appropriate inclusion and exclusion criteria as defined by the CDC/NHSN**.**

Reporting Time Period: 12 months

- Surveys submitted prior to September 1, 2016: 01/01/2015 – 12/31/2015
- Surveys (re)submitted on or after September 1, 2016: 07/01/2015 – 06/30/2016

1) 12-month reporting time period used:	☐ 01/01/2015 – 12/31/2015 ☐ 07/01/2015 – 06/30/2016
2) Does your hospital operate one or more of the intensive care units (ICUs) listed in question #8 below? *If "no", skip questions #3-10 and proceed to the next subsection.*	*Yes* *No*
3) Has your hospital measured its incidence of Central Line-Associated Bloodstream Infections (CLABSI) in an intensive care unit for the Reporting Time Period using definitions and measure specifications developed by the CDC's National Healthcare Safety Network (NHSN) and chosen to report this information to the survey? *If "no," CLABSI score will show as "Declined to Respond." If your hospital did not use the NHSN definitions and measure specifications, you must respond "no" to this question.* *If "yes, but did not have any central line days during the reporting period," CLABSI score will show as "Does Not Apply."*	*Yes* *No* *Yes, but did not have any central line days during the reporting period*
4) Has your hospital measured its incidence of Catheter-Associated Urinary Tract Infections (CAUTI) in an intensive care unit for the Reporting Time Period using definitions and measure specifications developed by the CDC's National Healthcare Safety Network (NHSN) and chosen to report this information to the survey? *If "no," CAUTI score will show as "Declined to Respond." If your hospital did not use the NHSN definitions and measure specifications, you must respond "no" to this question.* *If "yes, but did not have any catheter days during the reporting period," CAUTI score will show as "Does Not Apply."*	*Yes* *No* *Yes, but did not have any catheter days during the reporting period*
5) Has your hospital reported this information (referred to in question #3 and #4) to the CDC/NHSN? *Continue with question #6 regardless.*	*Yes* *No*
6) Is your hospital designated as a "major teaching hospital[42]"? *Continue with questions #7 regardless.*	*Yes* *No*

7) Does your hospital utilize personnel trained in human factors engineering[43]?	*Yes* *No*

8) Check all ICU types that were staffed and open during the reporting period:	☐ Medical ☐ Surgical ☐ Medical/Surgical ☐ Pediatric Medical ☐ Pediatric Medical/Surgical ☐ Pediatric Cardiothoracic ☐ Medical Cardiac ☐ Respiratory ☐ Surgical Cardiothoracic ☐ Neurologic ☐ Neurosurgical ☐ Burn ☐ Trauma ☐ NICU II/III ☐ NICU III

9) Total number of central line days and central line-associated bloodstream infections in each ICU type during the reporting period as reported to the CDC/NHSN:

	9a) Total number of central line days **(denominator)**	9b) Total number of central line-associated bloodstream infections **(numerator)**
Medical		
Surgical		
Medical/Surgical		
Pediatric Medical		
Pediatric Medical/Surgical		
Pediatric Cardiothoracic		
Medical Cardiac		
Respiratory		
Surgical Cardiothoracic		
Neurologic		
Neurosurgical		
Burn		
Trauma		
NICU II/III		
<= 750 g		
751 – 1,000 g		
1,001 – 1,500 g		
1,501 – 2,500 g		
>2,500 g		
NICU III		
<= 750 g		
751 – 1,000 g		
1,001 – 1,500 g		
1,501 – 2,500 g		
>2,500 g		

10) Total number of urinary catheter days and catheter-associated urinary tract infections in each ICU type during the reporting period as reported to the CDC/NHSN:

	10a) Total number of catheter days: (**denominator)**	10b) Total number of catheter-associated urinary tract infections: (**numerator)**
Medical		
Surgical		
Medical/Surgical		
Pediatric Medical		
Pediatric Medical/Surgical		
Pediatric Cardiothoracic		
Medical Cardiac		
Respiratory		
Surgical Cardiothoracic		
Neurologic		
Neurosurgical		
Burn		
Trauma		

7C: Other Healthcare-Associated Infections

Specifications: See ***Other Healthcare-Associated Infections Specifications*** in the Managing Serious Errors Reference Information on pages 135-137 for reporting on the standardized infection ratio as calculated for the reporting period by the CDC's National Healthcare Safety Network (NHSN)**.**

Reporting Time Period: 12 months

- Surveys submitted prior to September 1, 2016: 01/01/2015 – 12/31/2015
- Surveys (re)submitted on or after September 1, 2016: 07/01/2015 – 06/30/2016

1) 12-month reporting time period used:	☐ 01/01/2015 – 12/31/2015 ☐ 07/01/2015 – 06/30/2016
2) Has your hospital measured its incidence of MRSA in the facility-wide inpatient population as defined by the NHSN for the Reporting Time Period, reported this information to the NHSN using definitions and measure specifications developed by the NHSN, and chosen to report this information to the survey? *If "no," MRSA score will show as "Declined to Respond."* *If hospital is a pediatric hospital and selects "no," score will show as "Does Not Apply."*	*Yes* *No* *Yes, but displayed on NHSN report as 'Not Available'*
3) If 'yes' to questions #2, what was your hospital's standardized infection ratio for MRSA as shown on your NHSN report for the Reporting Time Period selected in question #1?	_____ *Format: 1.234*
4) Has your hospital measured its incidence of C. Difficile in the facility-wide inpatient population as defined by the NHSN for the Reporting Time Period, reported this information to the NHSN using definitions and measure specifications developed by NHSN, and chosen to report this information to the survey? *If "no," C. Difficile score will show as "Declined to Respond."* *If hospital is a pediatric hospital and selects "no," score will show as "Does Not Apply."*	*Yes* *No* *Yes, but displayed on NHSN report as 'Not Available'*
5) If 'yes' to question #4, what was your hospital's standardized infection ratio for C. Difficile as shown on your NHSN report for the Reporting Time Period selected in question #1?	_____ *Format: 1.234*
6) Has your hospital measured its incidence of Surgical Site Infections after Colon Surgery (SSI Colon) for those procedures defined by the NHSN for the Reporting Time Period, reported this information to the NHSN using definitions and measure specifications developed by the NHSN, and chosen to report this information to the survey? *Hospitals that do not perform colon surgeries should select "Does Not Apply" and move on to the next subsection.* *If "no," SSI Colon score will show as "Declined to Respond."*	*Yes* *No* *Does not apply* *Yes, but displayed on NHSN report as 'Not Available'*

7) If 'yes' to question #6, what was your hospital's standardized infection ratio for SSI Colon as shown on your NHSN report for the Reporting Time Period selected in question #1?	_____ *Format: 1.234*

7D: Hospital-Acquired Conditions – Pressure Ulcer 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*** in the Managing Serious Errors Reference Information on pages 138-139 for counting patient discharges and events.

Reporting Time Period: 9 months
- Surveys submitted prior to September 1, 2016: 01/01/2015 – 09/30/2015
- Surveys (re)submitted on or after September 1, 2016: 10/01/2015 – 06/30/2016

1) 9-month reporting time period used:	☐ 01/01/2015 – 09/30/2015 ☐ 10/01/2015 – 06/30/2016
2) 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*
3) Total number of adult inpatient discharges (including deaths) during the reporting period.	_____

Pressure Ulcers

4) Number of discharges **in question #3** with a hospital-acquired stage III or IV Pressure Ulcer.	_____

Injuries

5) Number of discharges **in question #3** with a hospital-acquired injury.	_____

7E: Antibiotic Stewardship Practices

The following questions have been taken directly from the NHSN's 2015 Patient Safety Component – Annual Hospital Survey questions #23 – 34. 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 #1-12 based your hospital's most current NHSN Annual Hospital Survey (must be 2015 or 2016 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*
2) Is there a leader responsible for outcomes of 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* ☐ *Other (please specify):*
3) Is there at least one pharmacist responsible for improving antibiotic use at your facility?	*Yes* *No*
4) Does your facility provide any salary support for dedicated time for antibiotic stewardship activities?	*Yes* *No*
5) 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*
6) 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*
7) 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*
8) Do any specified antibiotic agents need to be approved by a physician or pharmacist prior to dispensing at your facility?	*Yes* *No*
9) Does a physician or pharmacist review courses of therapy for specified antibiotic agents and communicate results with prescribers (i.e., audit with	*Yes* *No*

feedback) at your facility?	
10) 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* ☐ *Defined Daily Dose* ☐ *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*
11) Do prescribers ever receive feedback by the stewardship program about how they can improve their antibiotic prescribing?	*Yes* *No*
12) Has your stewardship program 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 reflect 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 Score, 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 person 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: 2016 Managing Serious Errors Reference Information

What's New in the 2016 Survey

In response to requests from hospitals, Leapfrog included three additional hospital-acquired infection measures on the survey: MRSA, CDI, and SSI after Major Colon Surgery. These measures come directly from the NHSN and are in use in one or more CMS inpatient reporting programs. Unlike the central line-associated bloodstream infection and catheter-associated urinary tract infection measures, these measures do not require hospitals to report by specific unit or ward, as they are hospital-wide inpatient or surgery specific measures. Therefore, Leapfrog will not ask hospitals to report a numerator and denominator. Instead, hospitals will report the standardized infection ratio (SIR) as calculated by NHSN for a specified 12-month reporting period.

In order to support national efforts around the responsible use of antibiotics in hospitals, Leapfrog will be publicly reporting hospital compliance with the CDC's standards for Antibiotic Stewardship Programs. The CDC has published seven Core Elements of Antibiotic Stewardship Programs:

- Leadership Commitment
- Accountability
- Drug Expertise
- Action
- Tracking
- Reporting
- Education

To collect this information regarding hospital adoption of these seven Core Elements, Leapfrog will use a set of 12 questions from the NHSN Annual Hospital Survey on antibiotic stewardship programs (questions #23-34 from the NHSN Annual Hospital Survey).

Change Summary since Release

None. If substantive changes are made to this section of the survey after release on April 1, 2016, they will be documented in this Change Summary section.

Issued May 31, 2016:

1. Pediatric hospitals that respond "no," to questions #2 and #4 in Section 7C Other Healthcare-Associated Infections will be scored as "Does Not Apply."

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.

2. **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.

3. **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.

4. **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?**
   Hospitals should 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.

5. **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)

6. **Is Leapfrog's belief that hospitals should not bill for "never events" just a cost savings measure for employers or health plans?**
   No. These events are rare and most likely do not represent a significant savings for employers or health plans. However, for a patient, it could relieve a significant financial burden. We believe that any patient who suffers from a "never event" should never have to pay for it.

7. **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.

CLABSI and CAUTI Specifications

Important Note: Hospitals that share a Medicare Provider Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Incidence Rate of Central Line-Associated Bloodstream Infections

Source: National Quality Forum (NQF) #0139

Rates will be stratified by ICU type – medical, surgical, medical/surgical, pediatric medical, pediatric medical/surgical, pediatric cardiothoracic, medical cardiac, respiratory, surgical cardiothoracic, neurologic, neurosurgical, burn, trauma, Level II/III NICU, and Level III NICU, (see below for a table of ICU types).

Reporting Time Period: 12 months

- Surveys submitted prior to September 1, 2016: 01/01/2015 – 12/30/2015
- Surveys (re)submitted on or after September 1, 2016: 07/01/2015 – 06/30/2016

Definition of ICU Types

Below is a list of those ICU types for which hospitals should report their central line-associated bloodstream infection (CLABSI) data to the survey.

Hospitals should only report on applicable ICU types listed above. If an ICU type is not listed (i.e. Level II NICU), do not include those line days or infections in your survey responses. The ICU types that you report on the survey should be the same as those you report to the NHSN using the NHSN descriptions and location mapping instructions: http://www.cdc.gov/nhsn/PDFs/pscManual/15LocationsDescriptions_current.pdf

Survey ICU Name	*CDC ICU Name*
Medical	*Medical Critical Care*
Surgical	*Surgical Critical Care*
Medical/Surgical	*Medical/Surgical Critical Care*
Pediatric Medical	*Pediatric Medical Critical Care*
Pediatric Medical/Surgical	*Pediatric Medical/Surgical Critical Care*
Pediatric Cardiothoracic	*Pediatric Cardiothoracic Critical Care*
Medical Cardiac	*Medical Cardiac Critical Care*
Respiratory	*Respiratory Critical Care*
Surgical Cardiothoracic	*Surgical Cardiothoracic Critical Care*
Neurologic	*Neurologic Critical Care*
Neurosurgical	*Neurosurgical Critical Care*
Burn	*Burn Critical Care*
Trauma	*Trauma Critical Care*
NICU II/III	*Neonatal Critical Care (Level II/III)*

NICU III	*Neonatal Critical Care (Level III)*

Directions for using central line-associated bloodstream infection (CLABSI) data reported to the Centers for Disease Control and Prevention/National Healthcare Safety Network (CDC/NHSN) for completing question #9:

Hospitals should use the central line-associated bloodstream infection (CLABSI) data they report to the Centers for Disease Control and Prevention/National Healthcare Safety Network (CDC/NHSN) in completing columns (a) and (b) for question #9.

Hospitals using CDC/NHSN data should report their denominators in column (a) and numerators in column (b). Actual rates and standardized infection ratios (SIRs) will be calculated by Leapfrog.

Hospitals that do not report CLABSI data to CDC/NHSN should follow the protocols and specifications outlined by the CDC/NHSN here: http://www.cdc.gov/nhsn/acute-care-hospital/clabsi/index.html. Hospitals that do not use the CDC/NHSN measure specifications should report "no" to question #3, and move on to question #4.

Incidence Rate of Catheter-associated Urinary Tract Infections

Source: National Quality Forum (NQF) #0138

Rates will be stratified by ICU type – medical, surgical, medical/surgical, pediatric medical, pediatric medical/surgical, pediatric cardiothoracic, medical cardiac, respiratory, surgical cardiothoracic, neurologic, neurosurgical, burn, and trauma (see below for a table of ICU types).

Reporting Time Period: 12 months

- Surveys submitted prior to September 1, 2016: 01/01/2015 – 12/30/2015
- Surveys (re)submitted on or after September 1, 2016: 07/01/2015 – 06/30/2016

Definition of ICU Types

Below is a list of those ICU types for which hospitals should report their catheter-associated urinary tract infection (CAUTI) data to the survey.

Hospitals should only report on applicable ICU types listed above. If an ICU type is not listed (i.e. Level II NICU), do not include those line days or infections in your survey responses. The ICU types that you report on the survey should be the same as those you report to the NHSN using the NHSN descriptions and location mapping instructions: http://www.cdc.gov/nhsn/PDFs/pscManual/15LocationsDescriptions_current.pdf

Survey ICU Name	*CDC ICU Name*
Medical	*Medical Critical Care*
Surgical	*Surgical Critical Care*
Medical/Surgical	*Medical/Surgical Critical Care*
Pediatric Medical	*Pediatric Medical Critical Care*
Pediatric Medical/Surgical	*Pediatric Medical/Surgical Critical Care*
Pediatric Cardiothoracic	*Pediatric Cardiothoracic Critical Care*
Medical Cardiac	*Medical Cardiac Critical Care*

Respiratory	*Respiratory Critical Care*
Surgical Cardiothoracic	*Surgical Cardiothoracic Critical Care*
Neurologic	*Neurologic Critical Care*
Neurosurgical	*Neurosurgical Critical Care*
Burn	*Burn Critical Care*
Trauma	*Trauma Critical Care*

Directions for using catheter-associated urinary tract infection (CAUTI) data reported to the Centers for Disease Control and Prevention/National Healthcare Safety Network (CDC/NHSN) for completing question #10.

Hospitals are able to use the CAUTI data they report to the Centers for Disease Control and Prevention/National Healthcare Safety Network (CDC/NHSN) in completing columns (a) and (b) for question #10.

Hospitals using CDC/NHSN data should report their denominators in column (a) and numerators in column (b). Actual rates will be calculated by Leapfrog.

Hospitals that do not report CAUTI data to CDC/NHSN should follow the protocols and specifications outlined by the CDC/NHSN here: http://www.cdc.gov/nhsn/acute-care-hospital/CAUTI/index.html. Hospitals that do not use the CDC/NHSN measure specifications should report "no" to question #4, and move on.

Other Healthcare-Associated Infections Specifications

Important Note: Hospitals that share a Medicare Provider Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia

Source: National Quality Forum (NQF) #1716

Reporting Time Period: 12 months

- Surveys submitted prior to September 1, 2016: 01/01/2015 – 12/30/2015
- Surveys (re)submitted on or after September 1, 2016: 07/01/2015 – 06/30/2016

Directions for using the NHSN Analysis Output Option, "SIR – MRSA Blood FacwideIn LabID Data for CMS IPPS" for completing question #3:

The NHSN Analysis Output Option, "SIR - MRSA Blood FacwideIn LabID Data for CMS IPPS**"** was created in order to allow facilities to review those MRSA Blood LabID data that would be submitted to CMS on their behalf. However, this same output option can be used to report to the survey using the reporting periods listed above.

This report will include in-plan FacWideIn MRSA blood LabID data by quarter as well as the SIR for the hospital. Be sure you are using the correct date range when generating your report:

- For hospitals submitting the survey prior to September 1, 2016, use **summaryYQ 2015Q1 to 2015Q4.**
- For hospitals submitting the survey on or after September 1, 2016, use **summaryYQ 2015Q2 to 2016Q2.**

Once you have generated the report, enter the SIR exactly as it appears (see screenshot below) in question #3.

location	MRSA_bldIncCount	numExpMRSA	numpatdays	SIR	SIR_pval	sir95ci
FACWIDEIN	2	1.699	45489	1.177	0.7489	0.197, 3.889

If you have specific questions about the data appearing on your dashboard, please contact the CDC.

To learn more about the standardized infection ratio (SIR) as it pertains to MRSA data, please see: http://www.cdc.gov/nhsn/PDFs/mrsa-cdi/RiskAdjustment-MRSA-CDI.pdf.

Facility-wide Inpatient Hospital-onset Clostridium difficile Infection

Source: National Quality Forum (NQF) #1717

Reporting Time Period: 12 months

- Surveys submitted prior to September 1, 2016: 01/01/2015 – 12/30/2015
- Surveys (re)submitted on or after September 1, 2016: 07/01/2015 – 06/30/2016

Directions for using the NHSN Analysis Output Option, "SIR – FacWideIn CDI LabID Data for CMS IPPS" for completing question #5:

The NHSN Analysis Output Option, "SIR – FacWidIn CDI LabID Data for CMS IPPS" was created in order to allow facilities to review those CDI LabID data that would be submitted to CMS on their behalf. However, this same output option can be used to report to the survey using the reporting periods listed above.

This report will include in-plan FacWideIn CDI LabID data by quarter as well as the SIR for the hospital. Be sure you are using the correct date range when generating your report:

- For hospitals submitting the survey prior to September 1, 2016, use **summaryYQ 2015Q1 to 2015Q4.**
- For hospitals submitting the survey on or after September 1, 2016, use **summaryYQ 2015Q2 to 2016Q2.**

Once you have generated the report, enter the SIR exactly as it appears (see screenshot below) in question #5.

Location	CDIF Facility Incident HO LabID Event Count	CDIF Facility Incident HO LabID Number Expected	Patient Days	SIR	SIR p-value	95% Confidence Interval
FACWIDEIN	21	27.364	42466	0.767	0.2190	0.488, 1.153

If you have specific questions about the data appearing on your dashboard, please contact the CDC.

To learn more about the standardized infection ratio (SIR) as it pertains to CDI data, please see: http://www.cdc.gov/nhsn/PDFs/mrsa-cdi/RiskAdjustment-MRSA-CDI.pdf.

Surgical Site Infection: Major Colon Surgery

Source: National Quality Forum (NQF) #0753

Reporting Time Period: 12 months

- Surveys submitted prior to September 1, 2016: 01/01/2015 – 12/30/2015
- Surveys (re)submitted on or after September 1, 2016: 07/01/2015 – 06/30/2016

Directions for using the NHSN Analysis Output Option, "SIR – Complex 30-Day SSI Data for CMS IPPS" for completing question #7:

The NHSN Analysis Output Option, "SIR – Complex 30-Day SSI Data for CMS IPPS" was created in order to allow facilities to review those **SSI COLO** data that would be submitted to CMS on their behalf. However, this same output option can be used to report to the survey using the reporting periods listed above.

This report will include in-plan, inpatient **COLO** procedures in adult patients (i.e., ≥ 18 years of age at the time of the procedure data by quarter as well as the SIR for the hospital. Be sure you are using the correct date range when generating your report:

- For hospitals submitting the survey prior to September 1, 2016, use **summaryYQ 2015Q1 to 2015Q4.**
- For hospitals submitting the survey on or after September 1, 2016, use **summaryYQ 2015Q2 to 2016Q2.**

Once you have generated the report, enter the SIR exactly as it appears (see screenshot below) in question #5.

Procedure Code	Procedure Count	infCountComplex30d	numExpComplex30d	SIRComplex30d	SIRComplex30d_pval	SIRComplex30d95CI
COLO	80	2	2.741	0.73	0.725	0.122, 2.410
HYST	64	0	0.58	.	.	

If you have specific questions about the data appearing on your dashboard, please contact the CDC.

To learn more about the standardized infection ratio (SIR), including how it is calculated for SSI data, please see the SIR Newsletter at: http://www.cdc.gov/nhsn/PDFs/Newsletters/NHSN_NL_OCT_2010SE_final.pdf

Hospital-Acquired Pressure Ulcers and Injuries References

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.

Use the following measure specifications for surveys submitted **prior to September 1, 2016**.	Use the following measure specifications for surveys submitted **on or after September 1, 2016**.
Pressure Ulcers	
Source: The Leapfrog Group **Reporting Time Period: 9 months** • January 1, 2015 – September 30, 2015	**Source:** The Leapfrog Group **Reporting Time Period: 9 months** • October 1, 2015 – June 30, 2016
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.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 denominator with any ICD-9 diagnosis code in a secondary diagnosis field (diagnosis 2-9 on a claim) of 707.23 or 707.24 AND the diagnosis has a Present-on-Admission (POA) indicator of "N" or "U".	**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 ICD 10 Stage III and IV Pressure Ulcer codes at http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials.

Use the following measure specifications for surveys submitted **prior to September 1, 2016**.	Use the following measure specifications for surveys submitted **on or after September 1, 2016**.
Injuries	
Source: The Leapfrog Group **Reporting Time Period: 9 months** • January 1, 2015 – September 30, 2015	**Source:** The Leapfrog Group **Reporting Time Period: 9 months** • October 1, 2015 – June 30, 2016
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.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 diagnosis codes as a secondary diagnosis (diagnoses 2-9 on a claim), with a POA code of 'N' or 'U', **and designated as a 2015 Complication or Comorbidity (CC) or Major Complication or Comorbidity (MCC):** • Fracture ..... 800–829 (CC/MCC) • Dislocation ..... 830–839 (CC/MCC) • Intracranial injury ..... 850–854 (CC/MCC) • Crushing injury ..... 925–929 (CC/MCC) • Burn .....940–949 (CC/MCC) • Other injuries .....991–994 (CC/MCC) Download a full list of CC/MCC codes at http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials (see **ICD-9 CC-MCC Diagnosis Codes** sheet).	**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 CC/MCC codes at http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials (see **ICD-10 CC-MCC Diagnosis Codes** sheet).

Antibiotic Stewardship Practices Frequently Asked Questions (FAQs)

1. **Where can hospitals find more information about the questions in this section?**
   The survey itself is available on-line at http://www.cdc.gov/nhsn/forms/57.103_pshospsurv_blank.pdf as are the instructions for filling it out http://www.cdc.gov/nhsn/forms/instr/57_103-TOI.pdf.

2. **Where can hospitals find more information about the CDC's Core Elements?**
   The CDC has several resources for hospitals on its website. Please visit: http://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html.

3. **Where can hospitals find more information about improving antibiotic practices?**
   The CDC's Vital Signs provides hospitals and others with information on what hospitals can do to prevent inappropriate use of antibiotics: http://www.cdc.gov/vitalsigns/antibiotic-prescribing-practices/index.html.

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SECTION 8: BAR CODE MEDICATION ADMINISTRATION

This section includes questions and reference information for Section 8 Bar Code Medication Administration. 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: 2016 Bar Code Medication Administration

Link to Bar Code Medication Administration Fact Sheet: 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.

Each hospital fully meeting this 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.

More information about the 2016 Leapfrog Hospital Survey Scoring Algorithms is available at: http://leapfroggroup.org/survey-materials/survey-and-cpoe-materials

Specifications: Hospitals that share a Medicare Provider Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Reporting Time Period: Answer questions #1-12 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*
2) 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 #3-12.* *If "no," skip to the affirmation.*	*Yes* *No*
3) Does your hospital operate Intensive Care Units (adult, pediatric, and/or neonatal)? *If "no," skip questions #4 and #5.*	*Yes* *No*
4) If "yes," how many of this type of unit are open and staffed in the hospital?	_____
5) How many of the units in question #4 utilized the BCMA/eMAR system when administering medications at the bedside?	_____
6) Does your hospital operate Medical and/or Surgical Units? *If "no," skip questions #7 and #8.*	*Yes* *No*
7) If "yes," how many of this type of unit were open and staffed in the hospital?	_____
8) How many of the units in question #7 utilized the BCMA/eMAR system when administering medications at the bedside?	_____

If "no," to questions #3 AND #6, skip the remainder of the questions and go to the affirmation. Your hospital will be scored as "Does Not Apply." Otherwise, move on to questions #9-12.

9) The number of inpatient medication administrations ordered and scannable during the reporting period in those units indicated in questions #3-8 above?	_____
10) The number of medication administrations from question #9 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)?	_____

11) 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*

12) 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 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*

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 reflect 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 Score, 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 person 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: 2016 Bar Code Medication Administration Reference Information

What's New in the 2016 Survey

In 2015, Leapfrog introduced this as a new standard focused on hospital use of BCMA systems in administering medications at the bedside to better recognize hospitals for effective efforts to prevent medication errors. Results for this section of the survey will now be publicly reported in 2016.

Change Summary since Release

None. If substantive changes are made to this section of the survey after release on April 1, 2016, they will be documented in this Change Summary section.

BCMA Frequently Asked Questions (FAQs)

1. **Why is Leapfrog asking hospitals about their use of Bar Code Medication Administration systems at the bedside?**
   Research indicates that bar code medication administration systems (BCMAs) are one of the proposed solutions to medication administration errors and may reduce reported medication errors by as much as 86%.

2. **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.

3. **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 #11 a - 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.

4. **My hospital's EHR only allows a user to have one patient record open at the time. Therefore, our system will never generate a 'wrong patient' alert. How should we answer the question about that type of decision support?**
   Hospitals that do not receive a 'wrong patient' alert due to their EHR only opening one patient record at a time should answer 'yes' to having that type of decision support.

5. **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 #11e. 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.

6. **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.

7. **Which intensive care and medical/surgical 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.

8. **What is considered a medical unit and what is considered a surgical unit?**
   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.

Units for patients from a specific service type (e.g., burn, cardiac) should not be included.

9. **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.).

10. **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.

11. **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

12. **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 #9 and #10?**
    No, medications that are not administered should not be included in Questions #9 and #10.

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SECTION 9: READMISSION FOR COMMON ACUTE CONDITIONS AND PROCEDURES

This section includes questions and reference information for Section 9 Resource Use for Common Acute Conditions. 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: 2016 Readmission for Common Acute Conditions and Procedures

This section does not apply to Pediatric Hospitals.

Critical Access Hospitals that voluntarily report to CMS are required to complete and submit this section or the hospital will be shown as 'Declined to Respond." Critical Access Hospitals that do not voluntarily report to CMS should respond "No" to question #1, and then skip the remainder of the section. The hospital will be shown as "Does Not Apply."

In Section 9, Leapfrog asks hospitals to report their 30-day readmission rates for Medicare patients that are collected and calculated by CMS for six common acute conditions and procedures: heart attack (acute myocardial infarction), heart failure, pneumonia, chronic obstructive pulmonary disease, coronary artery bypass graft, and total hip/total knee arthroplasty.

Leapfrog will calculate a composite readmission score using the readmission rates for those conditions where more than 25 cases were reported. The number of cases reported for each condition will be used for weighting in the composite score.

Each hospital fully meeting the standard:

1. Is in the best performance category (lowest readmission rates) for the overall Readmission composite.

More information about the 2016 Leapfrog Hospital Survey Scoring Algorithms is available at:
http://leapfroggroup.org/survey-materials/survey-and-cpoe-materials

Important Notes:

Note 1: Responses to Section 9B are pre-populated in the online survey tool based on information published by CMS on the Hospital Compare Website for your hospital's Medicare Provider Number. If the Medicare Provider Number displayed in the Hospital Profile has changed or is not correct, please contact the Help Desk immediately at https://leapfroghospitalsurvey.zendesk.com.

Note 2: Even though the responses to Section 9B are pre-populated, Section 9 must still be affirmed and submitted on the Survey Dashboard in order for your hospital to earn credit for this section of the survey. If you do not affirm and submit Section 9, you will be publicly reported as "Declined to Respond."

Note 3: Responses to this section will be automatically updated in July or August, if and when CMS updates the Hospital Compare Website. Leapfrog will notify hospitals via email when the update occurs. **Hospitals will not need to log back into their survey to re-affirm this section or re-submit their survey if they have submitted a survey prior to the CMS update. (Updated on August 3, 2016)**

9A CMS Participation

1) Does your hospital participate in the CMS Hospital Inpatient Quality Reporting Program or voluntarily participate in the CMS Readmissions Reduction Program? *If 'no,' skip remaining questions in Section 9; the hospital will be shown as "Does Not Apply."* *Otherwise continue with question #2.*		*Yes* *No*
2) Does your hospital share a Medicare Provider Number (MPN) with another facility, and therefore the data submitted and reported by CMS represents combined results for more than one facility? *If "yes," continue to question #3. If "no," continue to the next section.*		*Yes* *No*
3) If you answered "yes," to question #2 above to indicate that you share a Medicare Provider Number with another hospital, please indicate which conditions your hospital cares for and which procedures your hospital performs:		
a)	Acute Myocardial Infarction (AMI)	*Yes* *No*
b)	Heart Failure	*Yes* *No*
c)	Pneumonia	*Yes* *No*
d)	Chronic Obstructive Pulmonary Disease (COPD)	*Yes* *No*
e)	Hip/Knee Arthroplasty	*Yes* *No*
f)	Coronary Artery Bypass Graft (CABG)	*Yes* *No*

9B Readmission for Common Acute Conditions and Procedures

Important Notes:

Note 1: Responses to Section 9B are pre-populated in the online survey tool based on information published by CMS on the Hospital Compare Website for your hospital's Medicare Provider Number. If the Medicare Provider Number displayed in the Hospital Profile has changed or is not correct, please contact the Help Desk immediately.

Note 2: Even though the responses to Section 9B are pre-populated, Section 9 must still be affirmed and submitted on the Survey Dashboard in order for your hospital to earn credit for this section of the survey. If you do not affirm and submit Section 9, you will be publicly reported as "Declined to Respond."

Note 3: Responses to this section will be automatically updated in July or August, if and when CMS updates the Hospital Compare Website. Leapfrog will notify hospitals via email when the update occurs. **Hospitals will not need to log back into their survey to re-affirm this section or re-submit their survey if they have submitted a survey prior to the CMS update. (Updated on August 3, 2016)**

1) The latest 36-month reporting period for CMS ending: *(Reporting periods for measures published on Hospital Compare can be found at: http://www.medicare.gov/hospitalcompare/Data/Data-Updated.html).*	_ _/_ _/_ _ _ _ *Format: MM/DD/YYYY* *(Will be populated in online survey tool)*
Acute Myocardial Infarction (AMI)	
2) Number of AMI cases reported by CMS for your hospital. *If the number of cases reported by CMS is less than 25, this condition will not be used to calculate the readmission composite score.*	*Will be populated in online survey tool*
3) 30-day Risk Standardized Readmission Rate for AMI reported by CMS for your hospital.	*Will be populated in online survey tool*
Heart Failure	
4) Number of heart failure cases reported by CMS for your hospital. *If the number of cases reported by CMS is less than 25, this condition will not be used to calculate the readmission composite score.*	*Will be populated in online survey tool*
5) 30-day Risk Standardized Readmission Rate for heart failure reported by CMS for your hospital.	*Will be populated in online survey tool*
Pneumonia	
6) Number of pneumonia cases reported by CMS for your hospital. *If the number of cases reported by CMS is less than 25, this condition will not be used to calculate the readmission composite score.*	*Will be populated in online survey tool*
7) 30-day Risk Standardized Readmission Rate for pneumonia reported by CMS for your hospital.	*Will be populated in online survey tool*

Chronic Obstructive Pulmonary Disease (COPD)	
8) Number of COPD cases reported by CMS for your hospital. *If the number of cases reported by CMS is less than 25, this condition will not be used to calculate the readmission composite score.*	*Will be populated in online survey tool*
9) 30-day Risk Standardized Readmission Rate for COPD reported by CMS for your hospital.	*Will be populated in online survey tool*
Total Hip Arthroplasty/Total Knee Arthroplasty (THA/TKA)	
10) Number of THA/TKA cases reported by CMS for your hospital. *If the number of cases reported by CMS is less than 25, this condition will not be used to calculate the readmission composite score.*	*Will be populated in online survey tool*
11) 30-day Risk Standardized Readmission Rate for THA/TKA reported by CMS for your hospital.	*Will be populated in online survey tool*
Coronary Artery Bypass Graft (CABG)	
12) Number of CABG cases reported by CMS for your hospital *If the number of cases reported by CMS is less than 25, this condition will not be used to calculate the readmission composite score.*	*Will be populated in online survey tool*
13) 30-day Risk Standardized Readmission Rate for CABG reported by CMS for your hospital.	*Will be populated in online survey 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 Readmissions for Common Acute Conditions and Procedures Section at our hospital, and I hereby certify that this information is true, accurate, and reflect 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 Score, 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 person 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: 2016 Resource Use for Common Acute Conditions Reference Information

This section does not apply to Pediatric Hospitals.

Critical Access Hospitals that voluntarily report to CMS are required to complete and submit this section or the hospital will be shown as 'Declined to Respond." Critical Access Hospitals that do not voluntarily report to CMS should respond "No" to question #1, and then skip the remainder of the section. The hospital will be shown as "Does Not Apply."

What's New in the 2016 Survey

In 2015, Leapfrog asked hospital to report on both risk-adjusted lengths of stay and readmission rates for three common acute conditions (AMI, Heart Failure, and Pneumonia). In 2016, due to the national transition to ICD-10 administrative coding and the challenges of updating the risk adjustment model given the scarcity of published ICD-10 administrative data sets, Leapfrog removed the length of stay measures from this section of the survey.

We added three additional readmission measures to this section to better align with the CMS Readmission Reduction Program: CABG, COPD, and THA/TKA. Leapfrog will continue to calculate a volume-weighted composite score for hospital readmissions. The composite will be made up of six, rather than three measures. Hospitals no longer need to look up the volume and readmission rate for each measure on the CMS Hospital Compare Website. This information will be pre-populated in each survey based on the hospital's Medicare Provider Number.

Important Notes:

Note 1: Responses to Section 9B are pre-populated in the online survey tool based on information published by CMS on the Hospital Compare Website for your hospital's Medicare Provider Number. If the Medicare Provider Number displayed in the Hospital Profile has changed or is not correct, please contact the Help Desk immediately.

Note 2: Even though the responses to Section 9B are pre-populated, Section 9 must still be affirmed and submitted on the Survey Dashboard in order for your hospital to earn credit for this section of the survey. If you do not affirm and submit Section 9, you will be publicly reported as "Declined to Respond."

Note 3: Responses to this section will be automatically updated in July or August, if and when CMS updates the Hospital Compare Website. Leapfrog will notify hospitals via email when the update occurs. **Hospitals will not need to log back into their survey to re-affirm this section or re-submit their survey if they have submitted a survey prior to the CMS update. (Updated on August 3, 2016)**

Change Summary since Release

None. If substantive changes are made to this section of the survey after release on April 1, 2016, they will be documented in this Change Summary section.

Issued August 3, 2016

On July 27, 2016 CMS updated information on Hospital Compare, including the volume and readmission rates for acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN), chronic obstructive pulmonary disease (COPD), coronary artery bypass graft (CABG), and total hip/total knee arthroplasty (THA/TKA). On August 3, 2016, Leapfrog updated Section 9B of the online survey tool with this new information which reflects data collected from **07/01/2012 to 06/30/2015**. Hospitals are encouraged to log into their surveys to review the updated information in Section 9B. You do **not** need to re-affirm or re-submit Section 9. Your hospital's survey results will be automatically updated to reflect this new information within the first 5 days of September.

Readmission Measures References

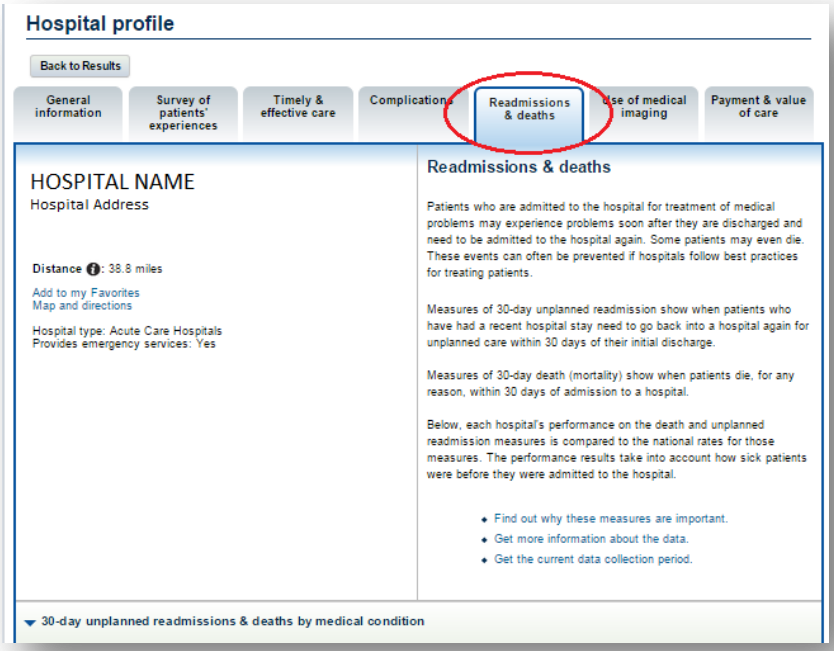
Responses to Section 9B are pre-populated based on information published by CMS on the Hospital Compare Website (https://www.medicare.gov/hospitalcompare/search.html). These responses need to be reviewed, affirmed, and submitted. If you identify a discrepancy, please contact the Help Desk at https://leapfroghospitalsurvey.zendesk.com.

30-day risk standardized readmission rates are collected and calculated by CMS. To verify the values that Leapfrog has pre-populated into your online survey tool in this section of the survey, you will need to access your hospital's publicly reported results on CMS Hospital Compare. Please use the following instructions:

1. Search for your facility at https://www.medicare.gov/hospitalcompare/search.html.

2. After you have found your hospital in the list of results, click on your hospital name to be brought to your "Hospital Profile."

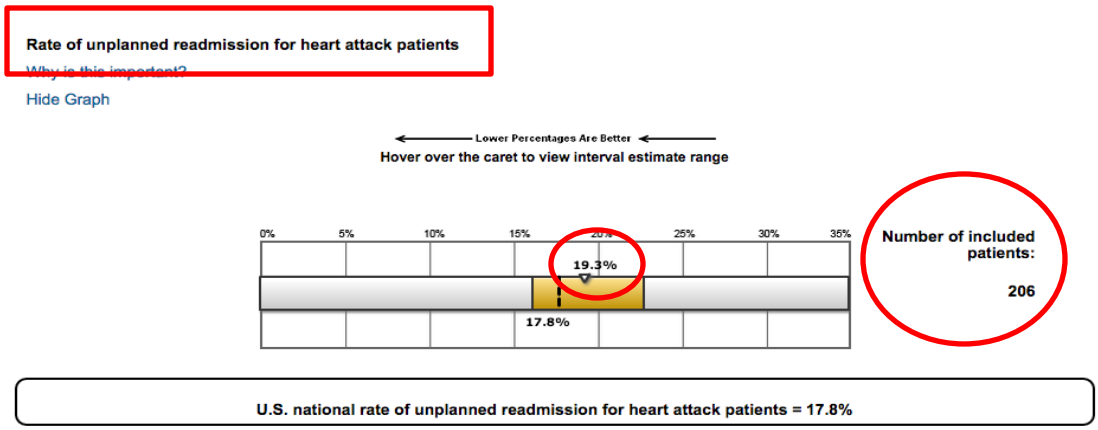
3. Once on your "Hospital Profile" page, select the tab titled "Readmissions & deaths":



4. Under the sub-heading titled "30-day unplanned readmissions & deaths by medical condition", expand one the four conditions (Chronic obstructive pulmonary disease (COPD), Heart attack, Heart failure, and Pneumonia) and select the "Show Graphs" button.

   Under the sub-heading titled "30-day unplanned readmissions & deaths by surgical procedure", expand one of the two conditions (Coronary artery bypass graft (CABG) and hip/knee surgery) and select the "Show Graphs" button.

5. For each condition applicable to your hospital, locate the **number of included patients** and the **readmission rate** (listed above the bar in the graph). These are the values pre-populated in Questions #2-3 (AMI), Questions #4-5 (heart failure),Questions #6-7 (pneumonia), Questions #8-9 (COPD), Questions #10-11 (THA/TKA), and Questions #12-13 (CABG). Refer to screenshot below:



If you identify a discrepancy, please contact the Help Desk at https://leapfroghospitalsurvey.zendesk.com.

Important Note: Responses to this section will be automatically updated in July or August, if and when CMS updates the Hospital Compare Website. Leapfrog will notify hospitals via email when the update occurs. **Hospitals will not need to log back into their survey to re-affirm this section or re-submit their survey if they have submitted a survey prior to the CMS update. (Updated on August 3, 2016)**

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.

[2] ***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.

[3] ***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.

[4] ***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 to resolve the discrepancy.

[5] ***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.

[6] ***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 (SNF), 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.

[7] ***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.

[8] ***Total Acute-Care Admissions***
Include acute-care medical, surgical and obstetrical admissions to your hospital. Exclude long-term, rehabilitation, short and long-term psychiatric, sub-acute care (e.g., skilled nursing facility (SNF), hospice extended care, sub-acute eating disorder treatment, extended care facility, or residential substance abuse treatment) admissions. Exclude normal newborn admissions to the nursery. 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 #7.

[9] ***Licensed ICU Beds***
If your state separately designates ICU beds in its licensure, indicate the number of such beds currently licensed this way. If your state does not designate and license ICU beds, enter the number of staffed beds from question #6.

Include adult and pediatric general medical and surgical ICU beds as well as beds in neurology/ neurosurgery ICUs, but exclude Coronary Care Unit (CCU) beds if they are separately licensed and operated. Do not include Neonatal Intensive Care Units, separate Trauma or Burn units, or beds in intermediate care or step-down units. (If the same licensed ICU beds are used for both coronary intensive care and other medical-surgical conditions, include them.) If the number licensed has changed over the last year, indicate the most recent number for which it is licensed.

[10] ***Staffed ICU Beds***
Include ICU 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 ICU capacity over the last year.

Include adult and pediatric general medical and surgical ICU beds as well as beds in neurology/ neurosurgery ICUs, but exclude Coronary Care Unit (CCU) beds if they are separately licensed and operated. Do not include Neonatal Intensive Care Units, separate Trauma or Burn units, or beds in intermediate care or step-down units. (If the same licensed ICU beds are used for both coronary intensive care as well as other medical-surgical conditions, include them.) If the number has changed over the last year, indicate the average or other number most representative of your operating bed capacity in these units over the last year.

[11] ***ICU Admissions***
Include admissions to adult or pediatric general medical and surgical ICU beds as well as beds in neurology/ neurosurgery ICUs, 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 highly specialized conditions -- e.g., ignore admissions to any Coronary Care Unit (CCU) that is distinct and separate from other adult/pediatric general medical/surgical ICUs. (If the same ICU is used for both coronary intensive care as well as other general medical-surgical conditions, include admissions to these units in your responses.) Other examples of highly specialized units to ignore when responding are neonatal intensive care units, separate trauma, burn, cardiovascular, or cardio-thoracic units. “Dedicated exclusively” means that general med/surg patients are not also cared for in these specialized units (except in rare overflow situations). Also ignore admissions or transfers to intermediate care or step-down units for this question.

[12] ***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/.

[13] ***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.

[14] ***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.

[15] ***Post-Procedure Inpatient Deaths***
Include in-hospital deaths for the patients included in the previous question, i.e., where the patient died during the hospital stay that included that procedure. Count deaths following the specific surgery, whether the death can be directly related to that procedure or not. Do not count deaths where the patient was discharged alive following the surgery but died during a subsequent re-admission (unless the procedure was repeated during that re-admission and the patient subsequently died during that stay).

For participants in STS or NNECDSG national or regional performance measurement systems, this definition differs from "Operative Mortality" as used in those reporting systems, which include both in-hospital and 30-day post-operative mortality out-of-hospital. (See endnotes #16, #17, and #18 below for STS Report information.)

[16] ***Participation in STS or Performance Measurement Systems***
If your hospital currently participates and has begun submitting data for all such procedures but has not yet received any reports, you should indicate "no". Return to the survey and update answers to the remaining questions when you receive your hospital's first reported results.

[17] ***Your Hospitals (Observed) Operative Mortality, Risk-adjusted Rate from STS Reports***
For your hospitals most recent 12-month report, enter your hospital's "Operative Mortality, Risk-adjusted rate" for AVR (found in STS report on page "AV Replace--62") in AVR Question #7. This is your hospital's actual operative mortality rate, standardized (risk-adjusted) to the STS all-hospital risk. Operative Mortality, Risk-adjusted rate includes in-hospital and 30-day post-operative mortality out-of-hospital.

[18] ***All STS Cohort (Expected) Operative Mortality, Risk-adjusted Rate from STS Reports***
Enter the all-hospital STS cohort's "Operative Mortality, Risk-adjusted rate" for AVR (found in STS report on page "AV Replace--62") in AVR Question #8. This is the national expected operative mortality rate to which your hospital's observed rate in AVR Question #7 will be compared. Operative mortality includes in-hospital and 30-day post-operative mortality out-of-hospital.

[19] ***Mortality Results in Publicly Reporting States and Regional Registries***
Hospitals located in a state with publicly reported outcomes should refer to the ***Outcome Specifications*** in the **EBHR Reference Information** on page 47 to determine how they should report based on those reports. If you are aware of publicly-reported results in these states for a more recent period, please contact the Leapfrog Help Desk. Hospitals that participate in a regional registry should report their results from the most recent report provided by the registry.

[20] ***Observed Mortality Rates from Publicly Reported Outcomes and Regional Registries***
Publicly Reported Outcomes: Follow the instructions in the ***Outcome Specifications*** in the **EBHR Reference Information** on page 47 to determine the value to report for this question for your hospital.

NNECDSG reports: Please refer to the document titled *"Leapfrog Hospital Survey Data"* provided to you as an addendum to your most recent NNECDSG Cardiac Surgery or PCI report.

[21] ***Expected Mortality Rates from Publicly Reported Outcomes and Regional Registries***
Publicly Reported Outcomes: Follow the instructions in the ***Outcome Specifications*** in *Section 3* of the **EBHR Reference Information** on page 47 to determine the value to report for this question for your hospital.

NNECDSG Reports: Please refer to the document titled *"Leapfrog Hospital Survey Data"* provided to you as an addendum to your most recent NNECDSG Cardiac Surgery or PCI report.

[22] ***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'.

[23] ***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.

[24] ***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.

[25] ***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).

[26] ***All Patients***
"All patients" means all general medical-surgical ICU patients and neuro ICU patients in the ICU.

[27] ***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 other highly specialized conditions. E.g., ignore any Coronary Care Unit (CCU) that is distinct and separate from other adult/pediatric general medical/surgical ICUs. (If the same ICU is used for both coronary intensive care as well as other general medical-surgical conditions, include this unit in your responses.) Other examples of highly specialized units to ignore when responding are: neonatal intensive care units, separate trauma, burn, cardiovascular, or cardio-thoracic. "Dedicated exclusively" means that general med/surg patients are not also cared for in these specialized units (except in rare overflow situations). If they are, then the IPS standard applies to those units as well. Also ignore intermediate care or step-down units when responding to this section.

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 #1-14 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 #1-14 based on the adult medical ICU.

[28] ***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 close-staffed to meet this requirement.

[29] ***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 are annually. (The weeks need not be consecutive weeks.)

Due to the recent availability of subspecialty certification in critical care, Emergency Medicine physicians who completed their training after 2013 will have until 2016 to complete their subspecialty certification in critical care in order to be considered by Leapfrog as "certified in Critical Care Medicine."

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.)

[30] ***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 #33) 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 #33, 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.

[31] ***Quantified Analysis of Call/Pager Response Times***
Providers can monitor call/pager 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 made to intensivists when they are not present in the unit (whether on-site or via telemedicine);
- the number of urgent calls/pages 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.

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 per day.

If a unit has 24/7 intensivist coverage, than an analysis of response times is not required.

[32] ***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/SCCM/FCCS+and+Training+Courses/. 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.

[33] ***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.

1. A physician certified in critical care medicine (see endnote 29) 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 29) 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.

2. 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.

3. A tele-intensivist has immediate access to key patient data, including:
   a) physiologic bedside monitor data (in real-time);
   b) laboratory orders and results;
   c) medications ordered and administered; and,
   d) notes, radiographs, ECGs, etc. on demand.

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

5. 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.

6. Written standards for remote care are established and include, at a minimum:
   a) tele-intensivists are certified by a national medical specialty board in critical care medicine;
   b) tele-intensivists are licensed to practice in the legal jurisdiction in which the ICU is located;
   c) tele-intensivists are credentialed in each hospital to which he/she provides remote care (can be special telemedicine credentialing);
   d) activities of the tele-intensivist are reviewed within the hospital's quality assurance committee structure;
   e) there are explicit policies regarding roles and responsibilities of both the on-site intensivist and the tele-intensivist; and,
   f) there is a process for educating staff regarding the function, roles, and responsibilities of the tele-intensivist.

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

8. 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.

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

10. The tele-intensivist documents patient care activities and this documentation is incorporated into the patient record.

[34] ***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.

1. 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.

2. A tele-intensivist has immediate access to key patient data, including:
   a) physiologic bedside monitor data (in real-time);
   b) laboratory orders and results;
   c) medications ordered and administered; and,
   d) notes, radiographs, ECGs, etc. on demand.

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

4. 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.

5. Written standards for remote care are established and include, at a minimum:
   a) tele-intensivists are certified by a national medical specialty board in critical care medicine;
   b) tele-intensivists are licensed to practice in the legal jurisdiction in which the ICU is located;
   c) tele-intensivists are credentialed in each hospital to which he/she provides remote care (can be special telemedicine credentialing);
   d) activities of the tele-intensivist are reviewed within the hospital's quality assurance committee structure;
   e) there are explicit policies regarding roles and responsibilities of both the on-site intensivist and the tele-intensivist; and,
   f) there is a process for educating staff regarding the function, roles, and responsibilities of the tele-intensivist.

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

7. 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.

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

9. The tele-intensivist documents patient care activities and this documentation is incorporated into the patient record.

[35] ***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.

[36] ***Teamwork Training***
Teamwork training subject matter includes: sources of communication failures, hand-offs, and team failures that lead to patient harm. Participation should be documented.

[37] ***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

[38] ***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.

[39] ***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.

[40] ***Reporting Never Events to External Agencies***
If your hospital is not a Joint Commission accredited hospital, 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.

[41] ***Root Cause Analysis***

The state of Minnesota has developed an online RCA toolkit designed to be a resource for any hospital that would like to establish or improve their RCA process. The toolkit can be found at: http://www.health.state.mn.us/patientsafety/toolkit/index.html

[42] ***Major Teaching Hospital***
A hospital is identified as a major teaching hospital if it achieves a minimum ratio of one resident (i.e. physician in training) per four staffed inpatient beds; or, the hospital has self-designated as a major teaching hospital to the CDC NHSN.

[43] ***Human Factors Engineering***
Personnel trained in human factors engineering include those persons with formal training in human factors engineering, human factors, ergonomics, or human engineering. Their training includes a focus on the interaction between the human and the system, including the work environment, tools, and computer systems. A hospital employee with formal training in human factors engineering, human factors, ergonomics, or human engineering, would have a degree (e.g. a BS, MS, etc.) or would have completed 4-5 courses on the topic. A single course would not be sufficient.