PROPOSED CHANGES TO THE 2017 LEAPFROG HOSPITAL SURVEY

OPEN FOR PUBLIC COMMENT

Each year, The Leapfrog Group’s team of researchers reviews the literature and convenes expert panels to ensure the Leapfrog Hospital Survey aligns with the latest science as well the public reporting needs of purchasers and consumers. Once a list of proposed changes is assembled for the next year’s survey, Leapfrog releases those changes for public comment. Comments are reviewed by Leapfrog’s team of researchers and used to further refine the survey before it is finalized.

The proposed changes to the 2017 Leapfrog Hospital Survey are outlined below. To provide public comment, please respond by completing the public comment form here. Comments will be accepted until COB on December 21, 2016.

We are grateful to those who take the time to submit comments each year. These comments bring enormous value to Leapfrog’s team and help ensure the survey is valuable to hospitals, purchasers, and consumers.

For information on the 2016 Leapfrog Hospital Survey, visit www.leapfroggroup.org/survey.

PROPOSED CONTENT CHANGES

SECTION 1: BASIC HOSPITAL INFORMATION

Leapfrog will ask hospitals to divide total acute care admissions into total adult and total pediatric admissions for the reporting period. This update will allow Leapfrog to identify hospitals that are eligible to complete the new Pediatric Care section of the survey. We will also ask hospitals to identify whether or not they have any specialty ICUs and/or NICUs. This will enhance our automated Data Review Warnings in the Online Survey Tool and help hospitals avoid time-consuming reporting errors.

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

There are no proposed changes to the questions in Section 2 Medication Safety – CPOE. However, Leapfrog will be launching an updated version of the CPOE Evaluation Tool with the 2017 Leapfrog Hospital Survey on April 1st.

The CPOE Evaluation Tool development team, led by Drs. David Bates and David Classen, received a grant from the Agency for Healthcare Research and Quality (AHRQ) to update the Adult Inpatient CPOE Evaluation Tool. Version 3.0 of the CPOE Evaluation Tool incorporates feedback we have received from hospitals regarding formulary issues, lab value issues, and outdated alerts. The new Tool will include updated patient profiles, updated medication orders, and an updated user interface, as well as other enhancements such as a display timer.
In addition, the CPOE Evaluation Tool will be scored based on an updated scoring algorithm. The algorithm for the Tool is currently being finalized by the developers. We plan to release additional details during Town Hall Calls in January and February. Hospitals can register for the Town Hall Calls now.

The principles behind the scoring algorithm for Leapfrog’s CPOE Standard will not change. Hospitals will still be scored based on their implementation status (i.e., percentage of inpatient medication orders entered through CPOE system) and their score from the CPOE Tool. Find the 2016 Leapfrog Hospital Survey Scoring Algorithms at http://www.leapfroggroup.org/survey-materials/scoring-and-results.

SECTION 3: INPATIENT SURGERY

Last year, Leapfrog announced that the survival predictor measures would be retired following the close of the 2016 Leapfrog Hospital Survey. The original survival predictor measures were developed and validated using several years of ICD-9 administrative data which is no longer applicable due to the national conversion to ICD-10 administrative coding. As a result, Leapfrog’s experts have recommended that we retire the survival predictor measures. Over the past year, Leapfrog has convened a national expert panel to develop new structural measures of surgical safety.

In 2017, Leapfrog is proposing to roll out two new structural measures. The first assesses whether hospitals and surgeons perform a minimum volume of procedures needed to meet basic safety standards. The second assesses whether hospitals have processes in place to ensure surgery is only being done when medically necessary. Both measures are described below.

STRUCTURAL MEASURE 1: MINIMUM VOLUME STANDARDS FOR SAFETY

The body of research supporting a strong relationship between surgical volume and outcomes continues to grow; the latest of which reinforces the early findings of Birkmeyer, Dimick, and others in the early 2000s. Leapfrog’s new measure builds on that research, along with the pioneering work of physician leaders and researchers from Dartmouth-Hitchcock, Johns Hopkins, and the University of Michigan, to advocate for minimum hospital and surgeon volume standards for the ten procedures listed below. Leapfrog is not proposing to collect data that identifies specific surgeons at this time, but instead will report whether surgeries were performed by surgeons who met the minimum volume standard.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Hospital (minimum per 12-months or 24-month average)</th>
<th>Surgeon (minimum per 12-months or 24-month average)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bariatric surgery for weight loss</td>
<td>40</td>
<td>20</td>
</tr>
<tr>
<td>Esophagus resections</td>
<td>20</td>
<td>TBD</td>
</tr>
<tr>
<td>Lung resections</td>
<td>40</td>
<td>20</td>
</tr>
<tr>
<td>Pancreas resections</td>
<td>20</td>
<td>TBD</td>
</tr>
<tr>
<td>Rectal cancer surgery</td>
<td>15</td>
<td>TBD</td>
</tr>
<tr>
<td>Carotid artery stenting</td>
<td>10</td>
<td>TBD</td>
</tr>
<tr>
<td>Complex abdominal aortic aneurysm repair</td>
<td>20</td>
<td>TBD</td>
</tr>
<tr>
<td>Mitral valve repair</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Hip replacement</td>
<td>50</td>
<td>25</td>
</tr>
<tr>
<td>Knee replacement</td>
<td>50</td>
<td>25</td>
</tr>
</tbody>
</table>
Hospitals will be asked:

- if they perform any of the 10 procedures
- whether they fall below the minimum hospital volume standards outlined above for any of the 10 procedures they do perform (procedures will be specified using ICD-10 codes),
- how many, if any, of the surgeries at their hospital were performed by surgeons who meet the minimum volume standards outlined above for any of the 10 procedures they do perform (procedures will be specified using ICD-10 codes), and
- whether they will commit over the next 12-24 months to updating the hospital’s credentialing and privileging standards to ensure compliance with minimum hospital and surgeon volume standards outlined above.

**Background Minimum Volume Standards**

Early versions of the Leapfrog Hospital Survey evaluated hospitals on their volume of high-risk surgeries. Since Leapfrog launched its Evidence-Based Hospital Referral standard in 2001, the evidence to support the volume-outcome relationship has only increased. Last year, U.S. News conducted an analysis looking at the volume-outcome relationship and found that:

- Large numbers of hospitals continue to do small numbers of procedures
- Knee replacement patients who had their surgery in the lowest-volume centers were nearly 70% more likely to die than patients treated at centers in the top quintile.
- As many as 11,000 deaths might have been prevented from 2010 through 2012 if patients who went to the lowest-volume fifth of the hospitals had gone to the highest-volume fifth.

A recent study of cancer surgeries by the California Health Care Foundation further points to the relationship between very low volumes of cancer surgeries and poor patient outcomes. The study concluded that there is an association between low hospital surgery volume and higher mortality and complication rates for the following 11 cancers: bladder, brain, breast, colon, esophagus, liver, lung, pancreas, prostate, rectum, and stomach. The study also found that the majority of California's hospitals performed surgery for one or more of these 11 cancers only once or twice in 2014, and of cancer patients who had surgery at a hospital that did a small number of those surgeries in 2014, more than 70% were within 50 miles of a hospital performing higher volumes.

An analysis of Leapfrog’s own 2016 Leapfrog Hospital Survey Results (as of June 30, 2016), further illustrated this issue as we found that:

- More than half of hospitals that only perform Pancreatic Resections on cancer patients performed 0 to 2 procedures (217 out of 515 hospitals).
- More than half of the hospitals that only perform Esophageal Resections on cancer patients performed 0 to 2 procedures (347 out of the 595 hospitals).
- A third of the hospitals that electively perform both types of cancer procedures performed 0 to 2 procedures (138 out of 445 hospitals).

The proposed new structural measure challenges hospitals and health systems across the country to hold themselves accountable for minimum hospital and surgeon volume standards known to improve the odds of a safer surgery for their patients. Leapfrog is also exploring opportunities to publicly credit hospitals that have deliberately chosen not to perform these surgeries because they are unable to meet the minimum hospital or surgeon volume standards, and we welcome suggestions on this through public comment.
## Proposed Scoring Algorithm for the Minimum Hospital and Surgeon Volume Structural Measure

<table>
<thead>
<tr>
<th>Minimum Volume Standard Score (Performance Category)</th>
<th>Meaning that…</th>
</tr>
</thead>
</table>
| **Fully Meets the Standard**                         | • The hospital met the minimum hospital volume standard for each of the 10 surgeries they perform (from the table above),  
• 100% of those surgeries were performed by surgeons who met the minimum volume standard (from the table above), and  
• The hospital has committed to updating the hospital’s credentialing and privileging standards within 24 months to ensure compliance with **minimum** hospital and surgeon volume standards (from the table above) |
| **Substantial Progress**                             | • The hospital met the minimum hospital volume standard for each of the 10 surgeries they perform (from the table above),  
• At least 75% of the surgeries were performed by surgeons who met the minimum volume standard (from the table above), and  
• The hospital has committed to updating the hospital’s credentialing and privileging standards within 24 months to ensure compliance with **minimum** hospital and surgeon volume standards |
| **Some Progress**                                    | • The hospital met the minimum hospital volume standard for at least 50% of the 10 surgeries they perform (from the table above)  
• At least 50%, but fewer than 75%, of the surgeries were performed by surgeons who met the minimum volume standard (from the table above), or  
• The hospital has committed to updating the hospital’s credentialing and privileging standards within 24 months to ensure compliance with **minimum** hospital and surgeon volume standards |
| **Willing to Report**                                | • The hospital met the minimum hospital volume standard for fewer than 50% of the 10 surgeries they perform (from the table above)  
• Fewer than 50% of the surgeries were performed by surgeons who met the minimum volume standard (from the table above), or  
• The hospital has **not** committed to updating the hospital’s credentialing and privileging standards within 24 months to ensure compliance with the **minimum** hospital and surgeon volume standards |
| **Does Not Apply**                                   | Means the hospital does not perform any of the 10 volume-sensitive surgeries. |
| **Declined to Respond**                             | Means the hospital did not respond to the questions in this section of the survey or did not submit a survey. |

### STRUCTURAL MEASURE 2: HOSPITAL-WIDE SURGICAL NECESSITY MONITORING POLICY

In 2017, in addition to reporting on new minimum volume standard, hospitals will be asked to report on their implementation of a hospital-wide policy which includes processes aimed at monitoring surgical necessity and preventing overuse of surgical procedures. The policy includes the following key elements:

- We engage patients in a shared decision making* around the harms and benefits of surgery and ensure the patient is informed about the range of treatment alternatives to surgery.
We require our surgeons to be aware of specialty society’s clinical practice guidelines, including relevant Choosing Wisely lists, and employ them in their clinical decision-making.

We monitor the necessity of surgery at our hospital and periodically report results to the hospital Board alongside other quality and safety reports. Strategies used to monitor surgical necessity may include the following:

- Surgeries are reviewed monthly by the Chief Medical Officer and/or the clinical department head
- The hospital reviews surgeon volume and patient indications for surgery on a monthly basis, prioritizing the review of outlier surgeons whose volume is unusually high
- The hospital performs a quarterly chart audit
- Other monitoring strategies used in the hospital’s QI program

We have a pre-defined, formal plan of action that includes accountability for surgeons, surgical leadership, as well as administrative leadership when an inappropriate surgery is identified.

Proposed Scoring Algorithm for the Hospital-Wide Surgical Necessity Monitoring Policy

<table>
<thead>
<tr>
<th>Surgical Necessity Monitoring Policy</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fully Meets the Standard</strong></td>
<td>Means the hospital has implemented a policy that includes all of the 4 elements of the policy</td>
</tr>
<tr>
<td><strong>Substantial Progress</strong></td>
<td>Means the hospital has implemented a policy that includes 3 of the 4 elements of the policy</td>
</tr>
<tr>
<td><strong>Some Progress</strong></td>
<td>Means that hospital has implemented a policy that includes 2 of the 4 elements of the policy</td>
</tr>
<tr>
<td><strong>Willing to Report</strong></td>
<td>Means the hospital has implemented one or none of the 4 elements of the policy</td>
</tr>
<tr>
<td><strong>Does Not Apply</strong></td>
<td>Means the hospital does not perform inpatient surgery</td>
</tr>
<tr>
<td><strong>Declined to Respond</strong></td>
<td>Means the hospital did not respond to the questions in this section of the survey or did not submit a survey</td>
</tr>
</tbody>
</table>

Leapfrog is proposing to publicly report results from this section in 2017 for both new structural measures.

For 2018 and beyond, Leapfrog is working with its national expert panel to develop additional measures of surgical outcomes. This will include measures that consider patient outcomes, complications, and patient experience ratings, harmonized to the extent feasible with data already collected by CMS, national accrediting organizations, clinical registries, and electronic medical records. In addition, we intend to consider measures that are endorsed by the National Quality Forum whenever possible.

**SECTION 4: MATERNITY CARE**

Proposed Scoring Algorithm for Section 4E Maternity Care Process Measures

We are proposing two changes to the scoring algorithm for Section 4E Maternity Care Process Measures which includes Newborn Bilirubin Screening Prior to Discharge and Appropriate DVT Prophylaxis in Women Undergoing Cesarean Section.

First, we are proposing to increase the target rate for both measures from 80% to 90%. The increase in the rate of compliance for the two process measures is based on the recommendation from Leapfrog’s Maternity Care Expert Panel. Following a review of the preliminary 2016 survey results, which showed that over 90% of hospitals met the 80%
target rate for each of these measures, the expert panel felt that a target rate of 90% or higher was both appropriate and attainable given that these measures have minimum exclusions/exceptions and the vast majority of reporting hospitals are already meeting that standard.

Next, hospitals that met the target for one of the two measures, but do not meet the minimum sample size for the other have been scored as “Some Progress,” which did not distinguish them from hospitals that did not measure their compliance with one of the two processes. We are proposing to update the scoring algorithm in 2017 so that hospitals that met the target for one of the two measures, but did not meet the minimum sample size for the other measure will be scored as “Substantial Progress.” The table outlining the proposed scoring algorithm is below.

<table>
<thead>
<tr>
<th>Maternity Care Process Measures Score (Performance Category)</th>
<th>Meaning that:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully Meets the Standard</td>
<td>The hospital met the 90% target for both Newborn Bilirubin Screening Prior to Discharge and Appropriate DVT Prophylaxis in Women Undergoing Cesarean Section</td>
</tr>
<tr>
<td>Substantial Progress</td>
<td>The hospital met the 90% target for one of the process measures and did not meet the minimum reporting requirement for the other process measure (n&lt;10)</td>
</tr>
<tr>
<td>Some Progress</td>
<td>The hospital met the 90% target for one of the process measures and did not perform a medical record audit of all cases or did not meet the 90% target for the other process measure</td>
</tr>
<tr>
<td>Willing to Report</td>
<td>The hospital did not meet the 90% target on either process measure or the hospital did not measure</td>
</tr>
<tr>
<td>Unable to Calculate Score</td>
<td>The hospital did not meet the minimum reporting requirements for either process measure (n &lt; 10)</td>
</tr>
<tr>
<td>Does Not Apply</td>
<td>The hospital did not deliver newborns during the reporting period</td>
</tr>
<tr>
<td>Declined to Respond</td>
<td>The hospital did not respond to the questions in this section of the survey</td>
</tr>
</tbody>
</table>

**Proposed Scoring Algorithm for Section 4F High-Risk Deliveries Process Measure**
Similar to the two maternity care process measures in Section 4E, the expert panel has recommended that Leapfrog increase the target rate for the Antenatal Steroid process measure in Section 4F High Risk Deliveries from 80% to 90% in 2017. No other updates to the scoring algorithm for this section are proposed. Find the 2016 Leapfrog Hospital Survey Scoring Algorithms at [http://www.leapfroggroup.org/survey-materials/scoring-and-results](http://www.leapfroggroup.org/survey-materials/scoring-and-results).

**SECTION 5: ICU PHYSICIAN STAFFING (IPS)**

We are proposing the removal of question #11, which asks whether hospitals have a board approved budget to fully meet Leapfrog’s standard in the next survey cycle. Based on an analysis of hospital responses over the past several years, it does not appear that the majority of hospitals that answer “yes” to this question subsequently meet Leapfrog’s standard in the following year.

**Proposed Scoring Algorithm for ICU Physician Staffing**
Based on the removal of question #11, we are proposing the following changes to the ICU Physician Staffing scoring algorithm in regards to earning “Substantial Progress” or “Some Progress.” There is no change to the scoring algorithm in regards to earning “Fully Meets Standard” or “Willing to Report.”
<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Meaning that…</th>
</tr>
</thead>
</table>
| **Fully Meets Standards**            | - All patients in adult and pediatric general medical and surgical ICU(s) and neuro ICUs are managed or co-managed by one or more physicians who are certified in critical care medicine; and  
  - One or more intensivist(s) is/are present in each ICU during daytime hours onsite for at least 8 hours per day, 7 days per week OR via telemedicine 24 hours per day, 7 days per week, with some on-site intensivist time AND provide(s) clinical care exclusively in this ICU during these hours; and  
  - When intensivists are not present (on-site or via telemedicine) in these ICUs, one of them returns more than 95% of pages from these units within five minutes; and  
  - When an intensivist is not present (on-site or via telemedicine) in the ICU, another physician, physician assistant, nurse practitioner or FCCS-certified nurse “effector” is on-site at the hospital and able to reach ICU patients within five minutes in more than 95% of the cases |
| **Substantial Progress**             | - All patients in adult/pediatric medical ICU(s) and neuro ICUs are managed or co-managed by one or more physicians who are certified in critical care medicine, whether on-site or via telemedicine; and  
  - The hospital has implemented any one or more of the following practices: a. Intensivists are present and manage or co-manage all patients in all ICUs on-site at least 8 hours per day, 4 days per week or 4 hours per day, 7 days per week;  
  b. Intensivists are present and manage or co-manage all patients in all ICUs via telemedicine 24 hours per day, 7 days per week, with on-site daily care planning at least 4 days per week  
  c. Clinical pharmacists make daily rounds on adult medical/surgical and neuro ICU patients, and  
  - An intensivist:  
    a. leads daily, multi-disciplinary team rounds on-site, or  
    b. makes admission and discharge decisions when on-site. |
| **Substantial Progress (alternative for hospitals)** | - All patients in adult/pediatric medical ICU(s) and neuro ICUs are managed or co-managed by one or more physicians who are certified in critical care medicine (intensivists), whether on-site or via telemedicine; and  
  - Intensivists are present and manage or co-manage all patients in all ICUs via telemedicine that is functional 24 hours per day, 7 days per week with onsite care planning done by an intensivist, hospitalist, anesthesiologist, or a physician trained in emergency medicine; use of telemedicine requires that additional Leapfrog telemedicine specifications are met. |
| **Some Progress**                    | - Some patients in the ICU(s) are managed or co-managed by an intensivist when present on-site or via telemedicine, and  
  - An intensivist:  
    a. leads daily, multi-disciplinary team rounds on-site, or  
    b. makes admission and discharge decisions when on-site. |
| **Willing to Report**                | The hospital responded to all the Leapfrog survey questions, but it does not yet meet the criteria for Some Progress. |
| **Does Not Apply**                   | Means the hospital does not operate an adult or pediatric medical and/or surgical, or neuro ICU |
| **Declined to Respond**              | The hospital did not respond to the questions in this section of the survey |

SECTION 6: NQF SAFE PRACTICES SCORE

Leapfrog is proposing to reduce the number of safe practices on the survey from eight to five, as a result of the recommendations of our panel of experts who evaluated the evidence this year. The experts identified one safe practice that no longer reflected the latest evidence (Safe Practice 23 Healthcare-Associated Complications in Ventilated Patients), one safe practice where hospital performance has ‘topped out’ (Safe Practice 3 Teamwork Training and Skill Building), and an additional safe practice that could be replaced with another measure that more clearly measures the quality of the medication reconciliation process (Safe Practice 17 Medication Reconciliation, which is now better reported through the new medication reconciliation measure described in Section 8 of this document).

Proposed Scoring Algorithm for NQF Safe Practices Score
Due to the reduction in the number of practices, Leapfrog is proposing to update the weights for three of the remaining five practices to better reflect their impact on patient safety. The updates to the practice weights will also result in an update to the number of total possible points earned for this section of the survey (see Table 1 below). Hospitals that indicate in Safe Practice #9 that they have current Magnet status designation, as determined by the American Nurses Credentialing Center (ANCC), will continue to receive full points for this Safe Practice.

<table>
<thead>
<tr>
<th>NQF Safe Practice</th>
<th>2016 Survey Weight</th>
<th>2017 Survey Proposed Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Culture of Safety Leadership Structures and Systems</td>
<td>120</td>
<td>120</td>
</tr>
<tr>
<td>2 Culture Measurement, Feedback, and Intervention</td>
<td>20</td>
<td>120</td>
</tr>
<tr>
<td>3 Teamwork Training and Skill Building</td>
<td>40</td>
<td>N/A</td>
</tr>
<tr>
<td>4 Risks and Hazards</td>
<td>120</td>
<td>100</td>
</tr>
<tr>
<td>9 Nursing Workforce</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>17 Medication Reconciliation</td>
<td>35</td>
<td>N/A</td>
</tr>
<tr>
<td>19 Hand Hygiene</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>23 Healthcare-Associated Complications in Ventilated Patients</td>
<td>20</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Total Possible Points</strong></td>
<td><strong>485</strong></td>
<td><strong>500</strong></td>
</tr>
</tbody>
</table>

Specific numerical cut-points for each performance category will be established based on surveys submitted by June 30, 2016. Leapfrog intends to freeze these cut-points for a minimum of three years, but will evaluate their appropriateness each year. Find the 2016 Leapfrog Hospital Survey Scoring Algorithms at [http://www.leapfroggroup.org/survey-materials/scoring-and-results](http://www.leapfroggroup.org/survey-materials/scoring-and-results).

SECTION 7: MANAGING SERIOUS ERRORS

SECTION 7A NEVER EVENTS POLICY STATEMENT

Since 2008, Leapfrog has asked hospitals to agree to all of the following principles if a never event occurs within their facility:

- We will apologize to the patient and/or family affected by the never event
• We will report the event to at least one of the following external agencies within 10 days of becoming aware that the never event has occurred:
  o Joint Commission, as part of its Sentinel Events policy
  o State reporting program for medical errors
  o Patient Safety Organization (as defined in The Patient Safety and Quality Improvement Act of 2005)
• We agree to perform a root cause analysis, 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

Since Leapfrog declared these principles as our standard, new research and experience have further informed evidence on best practices for addressing never events. In particular, AHRQ developed, tested, and launched the CANDOR Toolkit, and the National Patient Safety Foundation gathered stakeholders to propose new approaches to performing root cause analysis. After reviewing the latest hospital resources and national report, Leapfrog is proposing to add four additional principles to its policy statement beginning in 2017, to further ensure that patients and families, as well as caregivers, receive appropriate follow-up if a never event occurs:

• We will advise the patient and/or family that an adverse event may have occurred within 60 minutes after the event is identified.
• We will have a protocol in place to provide support for caregivers involved in never events, and make that protocol known to all employees and affiliated clinicians.
• We will meet with the patient and/or family, if willing and able, to (a) gather evidence for the root cause analysis, (b) review conclusions from the root cause analysis, and (c) share the actions we will take to prevent future recurrences of similar events.
• We will perform an annual review to ensure compliance with each element of Leapfrog’s Never Events Policy for each never event that occurred.

There are no proposed changes to the scoring algorithm. To find the Never Events Policy scoring algorithm from the 2016 Leapfrog Hospital Survey, visit http://www.leapfroggroup.org/survey-materials/scoring-and-results.

SECTION 7B AND 7C HEALTHCARE-ASSOCIATED INFECTIONS

Currently, in Section 7B and 7C, Leapfrog asks hospitals to report infection data for five healthcare associated infections: CLABSI (ICU only), CAUTI (ICU only), SSI:colon, MRSA, and C.difficile. In 2017, there will be several changes to this section.

First, Leapfrog will combine Sections 7B and 7C into a single section: 7B Healthcare-Associated Infections. Next, Leapfrog will remove the NHSN ICU-only CLABSI and CAUTI measures and adding the NHSN facility-wide inpatient measures for CLABSI and CAUTI.

Lastly, Leapfrog plans to remove the burden of data entry for hospitals reporting on any of the five applicable infection measures. In 2017, Leapfrog will require reporting hospitals to join The Leapfrog Group’s NHSN Group in order to be scored and publicly reported on the measures. By joining Leapfrog’s NHSN group (at no cost to the hospital), Leapfrog will be able to obtain the hospital’s standardized infection ratios for each of the five applicable infection measures, as well as individual ICU and ward rates for CLABSI and CAUTI, directly from NHSN.
Reporting Periods for Section 7B Healthcare-Associated Infections
As we have done in previous years, Leapfrog will use two reporting periods for this section of the survey. Prior to September 1st, Leapfrog will use the NHSN SIR for CY2016. Beginning on and after September 1st, Leapfrog will use the NHSN SIR for 2016Q3 to 2017Q2.

Hospitals must join Leapfrog’s NHSN Group by the end of the month in which they are submitting the section. For example, hospitals submitting by the June 30th deadline, must join Leapfrog’s NHSN Group by June 30th or they will be publicly reported as ‘declined to respond’ for each of the 5 infections.

Hospitals will be able to review their NHSN data by accessing their Hospital Details Page prior to the first publication of 2017 Leapfrog Hospital Survey Results.

Proposed Scoring Algorithm for Section 7B Healthcare-Associated Infections
In December 2016, NHSN launched updated baselines and an updated methodology to calculate standardized infection ratios (SIRs) for each of the five infection measures. Therefore, Leapfrog will recalculate the quartile cut-points used to assign performance categories for these five measures based on the national distribution of SIRs using the CMS national dataset released in December.

In the 2016 Leapfrog Hospital Survey, pediatric hospitals that did not report on MRSA or C. Difficile were scored as “Does Not Apply” for both measures. In 2017, pediatric hospitals will be required to perform surveillance on all applicable infection measures, including MRSA and C. Difficile, and report this information to NHSN. In addition, pediatric hospitals will be required to join Leapfrog’s NHSN group in order to be scored on the section.

Public Reporting for Section 7B Healthcare-Associated Infections
Hospitals will be able to review their NHSN data by accessing their Hospital Details Page prior to the first publication of 2017 Leapfrog Hospital Survey Results.

Join Leapfrog’s NHSN Group
In order for Leapfrog to obtain a hospital’s data, hospitals will need to join Leapfrog’s NHSN Group. Joining the NHSN group allows Leapfrog to view and download selected shared data, but it does not allow other members of the group (i.e. other hospitals) to view data. Only Leapfrog will be granted access to view and download data when you join Leapfrog’s NHSN group. Please see Appendix I for joining instructions and Appendix II for answers to some FAQs.

Leapfrog recommends that hospitals join the group as soon as possible and contact the Help Desk if there are any issues. To join the Leapfrog group, the NHSN administrator will need to follow the instructions outlined in Appendix I. In addition, hospitals within a system will need to ensure that they are reporting individually within NHSN. Leapfrog will be holding a webinar to provide more information on joining the group. Register now.

SECTION 8: MEDICATION SAFETY

Section 8 Bar Code Medication Administration will be renamed “Section 8 Medication Safety” for the 2017 Leapfrog Hospital Survey. The section will include two subsections: 8A Bar Code Medication Administration and 8B Medication Reconciliation.
PROPOSED CHANGES TO SECTION 8A BAR CODE MEDICATION ADMINISTRATION

Leapfrog is proposing to update the definition of Medical and/or Surgical Units to include Telemetry Units in Questions #6-8. Additionally, based on the recommendation of Leapfrog’s Maternity Care Expert Panel and BCMA Expert Panel, Leapfrog is proposing to add Labor and Delivery Units to the types of units hospitals will be asked to report on in 2017.

We are not proposing any changes to the scoring algorithm. Find the 2016 Leapfrog Hospital Survey Scoring Algorithms at http://www.leapfroggroup.org/survey-materials/scoring-and-results.

PROPOSED CHANGES TO SECTION 8B MEDICATION RECONCILIATION

Leapfrog is proposing the addition of an NQF-endorsed medication reconciliation measure: Number of Unintentional Medication Discrepancies per Patient (NQF 2456). The measure, in use in over a dozen hospitals across the country, focuses on the quality and accuracy of the hospital’s medication reconciliation process. The measure is applicable to adult patients only.

Hospitals will be asked to sample 25 adult inpatients per quarter and have a licensed pharmacist create a ‘gold standard’ preadmission medication list (PAML), which will be compared to the medication list from admission and to the medication list on discharge. Hospitals will report on the number of unintentional medication discrepancies identified between the PAML and the admission and discharge orders, and Leapfrog will calculate the number of unintentional medication discrepancies per medication per patient.

In 2017, the Medication Reconciliation measure will not be scored or publicly reported. This measure will be scored and publicly reported in 2018.

SECTION 9: PEDIATRIC CARE

Leapfrog plans to remove the Readmissions for Common Acute Conditions and Procedures Section from the 2017 Survey as these data are already publicly reported by CMS. However, the readmission rates for all 6 conditions and procedures included in the CMS Readmissions Reduction Program and published by CMS will continue to be incorporated into Leapfrog’s Value-Based Purchasing Platform, as resource use is a core component of value.

Section 9 of the 2017 Leapfrog Hospital Survey will consist of two new, NQF-endorsed pediatric measures: CAHPS Child Hospital Survey and Pediatric Computed Tomography (CT) Radiation Dose.

9A CAHPS Child Hospital Survey
The CAHPS Child Hospital Survey instrument has been endorsed by the National Quality Forum (NQF 2548) for use in accountability programs such as public reporting and pay for performance. It is used to assess the experiences of pediatric patients (17 and younger) and their parents or guardians with inpatient care. The survey covers most of the topics addressed by the Adult version, as well as topics that are particularly relevant to pediatric care.

Hospitals that have administered the CAHPS Child Hospital Survey during the full 12-month reporting period will be asked to report their Top Box score for each of the 18 measures of patient experience, which include 10 composite measures and 8 single-item measures.
9B Pediatric Computed Tomography (CT) Radiation Dose

The Pediatric CT Radiation Dose measure has also been endorsed by the National Quality Forum (NQF 2820). Hospitals will be asked to provide radiation dose metrics among consecutive pediatric patients, who have undergone a CT of the head, chest, abdomen/pelvis, or chest/abdomen/pelvis. These dose metrics include the mean dose as measured using DLP, CTDIvol, and SSDE within age strata. The goal of the measure is to provide a framework where facilities can easily assess their doses, compare them to benchmarks, and take corrective action to lower their doses if they exceed threshold values.

In 2017, neither of new sections will be scored or publicly reported. Both sections will be scored and publicly reported in 2018.

To provide public comment, please respond by completing the public comment form located [here](#). Comments will be accepted until COB December 21, 2016. Thank you for your interest in the Leapfrog Hospital Survey.
APPENDIX I

Instructions for Joining Leapfrog’s NHSN Group

1. Log into NHSN (needs to be someone with Administrator rights): https://sams.cdc.gov/
2. Select “Group” → “Join”

![Image of NHSN Group Memberships]

3. Enter the following:
   a. Group ID: 44303
   b. Group Joining Password: LeapfrogHospitalSurvey
4. Select “Join Group” button
5. After agreeing to the message, you will be brought to the “Confer Rights-Patient Safety” screen where you will see the data our Group is requesting access to.
6. You will need to review the requested information and select “Accept” at the bottom of the screen in order to share your data.

More detailed instructions on joining the group and accepting the data requested are available here: http://www.cdc.gov/nhsn/pdfs/groups-startup/joingroup-current.pdf

Note on Multi-Campus Reporting

In alignment with other sections of the survey, Leapfrog requires that hospitals within a system report individually to the Leapfrog Hospital Survey. This policy also applies to hospitals that share a Medicare Provider Number, tax payer ID, hospital license, etc. that are not within a contiguous geographic location. This policy also requires that hospitals report separately to NHSN. NHSN’s policy aligns with Leapfrog and is stated as follows: “If free-standing facilities are located in physically separate buildings, whether on the same property or over multiple campuses, each individual facility should be enrolled separately in NHSN. This applies even if physically separate facilities share a single CMS Certification Number (CCN).” If your facility or system is currently incorrectly enrolled and reporting data from multiple facilities with a single NHSN ID then you will need to follow these NHSN instructions to address this situation prior to the opening of the 2017 Leapfrog Hospital Survey in April (by the end of 2017 Quarter 2):
1. Continue reporting into one NHSN OrgID for the remainder of the current quarter. For example, if you realize in February 2015 that your healthcare system is incorrectly enrolled, continue reporting this way until all data for 2015 quarter 1 (through March 2015) have been entered.

2. Once all data for the current quarter have been entered, continue to use the established NHSN OrgID for the reporting of data from the largest hospital in the healthcare system. You will need to enroll each of the additional hospitals as separate facilities in NHSN. The process of enrolling separate facilities may begin at any time, however we recommend that facilities wait to enter data into the “new” NHSN facilities until the start of the next quarter. To enroll facilities, you will need to have “NHSN Enrollment” listed as an activity on your SAMS profile. Email the NHSN Helpdesk (NHSN@cdc.gov) if you need to have “NHSN Enrollment” added to your SAMS profile.

3. Once all data for the current quarter have been entered, inactivate all NHSN locations in the established OrgID that represent units in a physically separate facility. For detailed instructions on inactivating a location, please see page 11 from the 2013 NHSN Newsletter: http://www.cdc.gov/nhsn/PDFs/Newsletters/Newsletter-Dec2013.pdf.

4. Complete enrollment and facility set-up for the new NHSN facilities, including proper location mapping. If the facility was using CDA to upload data into NHSN, each new NHSN facility will need a separate OID. The OIDs for the new facilities can be requested using this process: http://www.cdc.gov/nhsn/PDFs/CDA/OID_Assignment_Procedure.pdf. Once the OIDs are obtained, they should be entered into the new NHSN facilities and shared with your vendor.

APPENDIX II

FAQs Regarding Joining Leapfrog’s NHSN Group

Q: Will the data be shared with other members of the group?

A: No, a facility that joins a group does not have access to any data from other facilities in the group. Data will only be shared with Leapfrog.

Q: How will the data be used?

A: The data will be used to pre-populate Sections 7B and 7C of Section 7 Managing Serious Errors in the 2017 Leapfrog Hospital Survey.

Q: What data is being requested?

A: The data being requested by Leapfrog is used to generate individual rates and standardized infection ratios for CLABSI, CAUTI, MRSA, CDI, and SSI: colon within NHSN. Immediately after joining the Group, the facility will be taken to a screen listing the data that the Group is requesting access to, referred to as the Data Rights Template. An “X” in the box indicates that a particular piece of data is being requested by the Group. For events and denominators, the facility can indicate “N/A” if an item is not applicable and can use the drop-down boxes on the

template to include or exclude non-applicable locations. Other fields on the template are not editable. The facility must select the “Accept” button at the bottom of the screen in order to accept the template of data rights and share data with the Group.

Q: Who from our facility needs to complete the “join group” process within NHSN?

A: An administrative-level NHSN user is needed to join a Group within NHSN and complete the “Confer Rights” process.

Q: After joining the NHSN group, what else is required?

A: When a hospital first joins the group they are asked to “confer rights” to the Leapfrog Group, which specifies the data that would be shared with Leapfrog. Leapfrog has set up a data rights template, which specifies the data we are requesting. Once a facility joins and accepts the data sharing, there is nothing else that is required. If Leapfrog updates the data rights we are requesting, then the NHSN administrator would be notified when they next log into NHSN. They have the option to accept the updated data sharing request or leave the group. Hospitals will be able to view the data that is being pulled into the Leapfrog Hospital Survey by accessing their Hospital Details Page from their survey dashboard after June 30th.

Q: Will joining the Leapfrog group prohibit us from joining other NHSN Groups?

A: No, facilities may join multiple groups.