



SUMMARY OF CHANGES TO THE 2019 LEAPFROG HOSPITAL SURVEY & RESPONSES TO PUBLIC COMMENTS

PUBLISHED MARCH 25, 2019

Each year, The Leapfrog Group's team of researchers, in conjunction with the Armstrong Institute for Patient Safety and Quality at Johns Hopkins Medicine, review literature and convene national expert panels to ensure the Leapfrog Hospital Survey aligns with the latest science as well the public reporting needs of purchasers and consumers. We assemble a list of proposed changes for the next year's Survey and release those changes for a 30-day public comment period. Comments are reviewed carefully and used to further refine the Survey. The Survey is then pilot tested with a diverse group of hospitals across the country. Following the pilot test, Survey content and scoring are finalized for launch on April 1.

Leapfrog received over 100 public comments in response to its proposed changes for the 2019 Leapfrog Hospital Survey. Those comments, as well as the results from the pilot test, were incorporated into the final content and scoring algorithms for the Survey. We have summarized the changes in this document, and included summaries and responses to public comments in [Appendix I](#).

We offer our sincere gratitude to all commenters for the time and thought they gave to the 2019 Leapfrog Hospital Survey. The submitted comments were invaluable to the development of a high-quality Survey that serves our many constituents, including purchasers and payors, as well as hospitals and the public at large.

The 2019 Leapfrog Hospital Survey will open on April 1, 2019 and a hard copy of the Survey will be available for download [here](#). Leapfrog has already scheduled a number of informative Town Hall Calls. Hospitals and other stakeholders can register on the Town Hall Calls [webpage](#).



STRUCTURAL CHANGES

LEAPFROG HOSPITAL SURVEY DEADLINES

Beginning with the 2019 Leapfrog Hospital Survey, the Late Submission Deadline for the Leapfrog Hospital Survey will be **November 30**, rather than December 31 as in previous years. No new Surveys or CPOE Evaluation Tool tests can be submitted after November 30. The months of December and January will be reserved for corrections to previously submitted Surveys only; the CPOE Evaluation Tool will not be available for use.

As always, hospitals should plan to meet the June 30 Submission Deadline for the Survey. Hospitals submitting a Leapfrog Hospital Survey by June 30 will have results publicly reported at www.leapfroggroup.org/compare-hospitals starting on July 25.

Participating hospitals that would like the opportunity to take two CPOE Tests during the Survey Cycle will need to plan accordingly as there will continue to be a 120-day waiting period between tests. As in previous years, the Online Survey Tool will not be accessible to hospitals after midnight ET on January 31.

Please refer to Leapfrog's website for a full list of all deadlines related to the 2019 Leapfrog Hospital Survey: <http://www.leapfroggroup.org/survey-materials/deadlines>.

PENDING LEAPFROG VERIFICATION

To further Leapfrog's commitment to publicly reporting accurate Survey Results, Leapfrog will make the following change to its [Monthly Data Review](#) process in 2019. Hospitals that receive a Category A Data Review message at the beginning of the month for any measure will have until the end of that same month to either (1) document that the original response was correct or (2) correct the data entry or reporting error, or they will be publicly reported as "Pending Leapfrog Verification" for that measure. This term is used to indicate that the hospital has self-reported survey responses that are under further review by Leapfrog.

Category A Data Review messages are reserved for responses that are considered implausible or responses that appear to have been provided with the intent to mislead. As in past Surveys, the primary Survey Contact and System Contact will receive an email within the first 5 business days of the month AFTER they submit a Leapfrog Hospital Survey if their Survey has been flagged for any Category A Data Review messages. Hospitals will need to respond to that email immediately to indicate that they will either (1) document that the original response was correct or (2) correct the data entry or reporting error.

If any Category A Data Review messages are not resolved by January 31 (when the Online Hospital Survey Tool is taken offline), the entire section in which the flagged responses were included will be decertified and all measures within the section will be publicly reported as "Declined to Respond."



CONTENT AND SCORING CHANGES

PROFILE

To align with the terminology used by the Centers for Medicare and Medicaid Services (CMS), Leapfrog updated the terminology used for the Medicare Provider Number (MPN) to the CMS Certification Number (CCN). This information will continue to be pre-populated in the Profile Section of the Online Hospital Survey Tool, and hospitals will need to contact the [Help Desk](#) if updates are required.

SECTION 1: BASIC HOSPITAL INFORMATION

Based on feedback received during the public comment period and pilot testing, Leapfrog has updated several endnotes within Section 1 to clarify what types of beds and admissions should be included when reporting on this section of the Survey. All endnotes should be carefully reviewed prior to responding to the questions in Section 1.

To more accurately identify hospitals that are eligible to report on Section 9A Patient Experience (CAHPS Child Hospital Survey), Leapfrog added a new question regarding the total number of admissions to any level neonatal ICU (NICU) to Section 1. Hospitals with fewer than 100 non-NICU pediatric admissions are not required to administer the CAHPS Child Hospital Survey and this question, as well as question #11 which asks for the total number of pediatric acute-care admissions, will be used in Leapfrog's [Monthly Data Review](#) to help ensure that hospitals are responding accurately to Section 9A.

Leapfrog will continue to obtain teaching status data directly from the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) Patient Safety Component – Annual Hospital Survey. Find instructions on how to join Leapfrog's NHSN Group and deadlines for the 2019 Survey at <http://www.leapfroggroup.org/survey-materials/join-nhsn>.

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

Based on questions received during the 2018 Survey Cycle, Leapfrog has further refined the measure specifications for both questions #3 (total number of inpatient medication orders across all inpatient units, including those without CPOE) and question #4 (total number of those inpatient medication orders included in question #3 that were entered by a licensed prescriber via a qualified CPOE system).

In 2019, Leapfrog has added new exclusion criteria to the denominator (question #3) which indicates that medications ordered verbally during a "code" (i.e., urgent medication orders) should **not** be included in the denominator.

Additional refinements have been made to the measure specifications to further clarify which orders to include when responding to questions #3 and #4. Hospitals should review the measure specifications carefully when they are available on April 1 in the hard copy of the 2019 Leapfrog Hospital Survey.

There are no changes to the Scoring Algorithm for Section 2 Medication Safety – Computerized Physician Order Entry (CPOE).



SECTION 2: CPOE EVALUATION TOOL (FOR ADULT HOSPITALS ONLY)

Leapfrog has updated the CPOE Evaluation Tool to incorporate feedback that was received from participating hospitals. First, Test Patients and Test Orders will render on the webpage in HTML, but hospitals will then download them as a PDF, eliminating any formatting issues. Previously, the Test Patients and Test Orders were rendered on the webpage in an Adobe Acrobat viewer, causing print issues for many hospitals. Secondly, the Test Order library has been updated to resolve commonly reported formulary issues. Lastly, the Orders and Observation Sheet has been updated to resolve the confusion between the Drug-Lab and Drug Monitoring order checking categories and the Online Answer Form has been updated to incorporate feedback received from hospitals regarding how Drug-Age and Drug-Lab alerts are displayed to licensed prescribers.

Please see [Appendix II](#) for a complete description of each Order Checking Category.

As a reminder, the CPOE Evaluation Tool is only available to adult/general hospitals and will be taken offline on November 30. Leapfrog recommends that all adult/general hospitals complete their CPOE Test and submit their 2019 Leapfrog Hospital Survey by the June 30 Submission Deadline.

There are no changes to the Scoring Algorithm for the CPOE Evaluation Tool.

SECTION 3: INPATIENT SURGERY (APPLICABLE TO ADULT/GENERAL HOSPITALS ONLY)

SECTION 3A: HOSPITAL AND SURGEON VOLUME

Leapfrog will continue to ask hospitals to report on Leapfrog’s minimum hospital volume standards for eight high-risk surgical procedures and whether or not their process for privileging surgeons includes the surgeons meeting or exceeding Leapfrog’s minimum surgeon volume standards.

In 2019, Leapfrog has aligned with the [Society for Vascular Surgery’s \(SVS\)](#) definition of open aortic procedures and has adopted their hospital volume standard. The new definition includes additional ICD-10 procedure codes for hospitals to use in counting open aortic procedures of any type. Given the change from open abdominal aortic aneurysm repair (AAA) to open aortic procedures, Leapfrog has removed the diagnosis codes previously associated with open AAA. Hospitals will only use the provided procedure codes when determining hospital volume for open aortic procedures. In addition, the minimum hospital volume standard for open aortic procedures was updated to ten cases and the minimum surgeon volume standard was updated to seven cases. See the complete list of minimum hospital and surgeon volume standards for 2019 in [Appendix III](#).

In addition, the measure specifications have been updated to include ‘carcinoma in situ’ diagnosis codes that should be used in identifying hospital volume for the following procedures:

Lung Resection for Cancer (Additional ICD-10 Diagnosis Codes for 2019)

ICD 10 CM	Description
D0220	Carcinoma in situ of unspecified bronchus and lung
D0221	Carcinoma in situ of right bronchus and lung
D0222	Carcinoma in situ of left bronchus and lung



Esophageal Resection for Cancer (Additional ICD-10 Diagnosis Codes for 2019)

ICD 10 CM	Description
D001	Carcinoma in situ of esophagus

Rectal Cancer Surgery (Additional ICD-10 Diagnosis Codes for 2019)

ICD 10 CM	Description
D011	Carcinoma in situ of rectosigmoid junction
D012	Carcinoma in situ of rectum
D013	Carcinoma in situ of anus and anal canal

As is the case for all procedures, the diagnosis codes should be ignored when determining surgeon volume for the purposes of surgeon privileging. Hospitals should carefully review the updated measure specifications and FAQs when they are published in the hard copy of the 2019 Leapfrog Hospital Survey on April 1.

As stated above, the minimum hospital volume standard and minimum surgeon volume standard for open aortic procedures was updated and can be reviewed in [Appendix III](#). There are no other changes to the Scoring Algorithm for Section 3A Hospital and Surgeon Volume.

SECTION 3B: SURGICAL APPROPRIATENESS

In 2019, Leapfrog will continue to ask hospitals to report on the steps they have taken to ensure surgical appropriateness for the following four high-risk procedures: carotid endarterectomy, mitral valve repair and replacement, open aortic procedures, and bariatric surgery for weight loss. However, for the four cancer surgeries, lung resection for cancer, pancreatic resection for cancer, esophageal resection for cancer, and rectal cancer surgery, Leapfrog is asking a single question regarding national accreditation status from the [American College of Surgeons](#) (applies to rectal cancer surgery only) OR regarding whether or not the hospital has a multidisciplinary tumor board that prospectively reviews cancer cases to ensure surgical appropriateness.

See a copy of the updated questions for Section 3B in [Appendix IV](#).

In 2019, responses to Section 3B Surgical Appropriateness will not be scored, but they will continue to be used in public reporting. As in prior years, when visitors to Leapfrog's public reporting website click into the score icon (i.e., four filled bars, three filled bars, etc.), they will see a statement indicating whether the hospital has the processes and/or protocols described above for each applicable procedure.

SECTION 4: MATERNITY CARE

Leapfrog has provided updated measure specifications from The Joint Commission (TJC) for PC-01 Elective Deliveries (Section 4B), PC-02 Cesarean Birth (Section 4C), and PC-03 Antenatal Steroids (Section 4F) for those hospitals that do not already submit data to TJC and therefore need to retrospectively collect data. Hospitals measuring these quality indicators and reporting results to The Joint Commission should continue to use the data reported to TJC when responding to these subsections of the Survey.



In addition, hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in their CMQCC reports when responding to subsections 4B Elective Deliveries, 4C Cesarean Birth, 4D Episiotomy, and 4E Process Measures of Quality.

There are no changes to the Scoring Algorithms for any measures in Section 4 Maternity Care.

SECTION 4A: MATERNITY CARE VOLUME

Leapfrog has added a response option to Question #2 in Section 4A Maternity Care Volume so that hospitals can indicate if they delivered newborn babies during the reporting period, but now have a closed labor and delivery unit or had/have a labor and delivery unit that was not open for the entire reporting period. The question and response options are as follows:

<p>2) Did the hospital deliver newborn babies during the reporting time period?</p> <p><i>If “no” or “yes, but unit is now closed or wasn’t open for the entire reporting period,” skip the remaining questions in Section 4, including all subsections, and go to the Affirmation of Accuracy. The hospital will be scored as “Does Not Apply.”</i></p>	<p>Yes No Yes, but unit is now closed or wasn’t open for the entire reporting period</p>
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Hospitals selecting “No” or “Yes, but unit is now closed or wasn’t open for the entire reporting period” will skip the remaining questions in Section 4 and will be scored as “Does Not Apply” for all maternity care measures. Historically, Leapfrog has advised hospitals to report “No” if they do not currently deliver newborn babies or do not have a labor and delivery unit that was open for the entire 12-month reporting period, and scored these facilities as “Does Not Apply.” There is no change to how this is publicly reported. Results are publicly reported at www.leapfroggroup.org/compare-hospitals and Leapfrog does not want to misdirect consumers to a hospital for delivery if they may no longer provide this service.

SECTION 4B: ELECTIVE DELIVERIES

There are no changes to this subsection.

SECTION 4C: CESAREAN BIRTH

There are no changes to this subsection.

SECTION 4D: EPISIOTOMY

Based on comments received during the public comment period and CMS’ October 2018 update to the national MS-DRG codes, Leapfrog has included additional MS-DRG codes that should be used in identifying vaginal deliveries for the purposes of reporting on the episiotomy denominator (question #2). The episiotomy measure is endorsed by the National Quality Forum (NQF) and the measure steward has included these additional MS-DRGs in their most recent annual update completed on January 9, 2019.

For the purposes of this measure, the following MS-DRGs should be used to identify a vaginal delivery (*indicates new in 2019*):

- 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
- *796*: Vaginal delivery with sterilization/D&C with MCC
- *797*: Vaginal delivery with sterilization/D&C with CC
- *798*: Vaginal delivery with sterilization/D&C without CC/MCC
- *805*: Vaginal delivery without sterilization/D&C with MCC
- *806*: Vaginal delivery without sterilization/D&C with CC
- *807*: Vaginal delivery without sterilization/D&C without CC/MCC

Furthermore, Leapfrog has provided APR-DRG codes that can be used in addition to the MS-DRG codes for identifying vaginal deliveries for those facilities that use APR-DRG coding instead of or in addition to MS-DRG coding.

The following APR-DRGs should also be used to identify a vaginal delivery if your facility uses APR-DRG coding:

- 541: Vaginal delivery with sterilization and/or D&C
- 542: Vaginal delivery with complicating procedures excluding sterilization and/or D&C
- 560: Vaginal delivery

There are no changes to the numerator specifications or the Scoring Algorithm for Section 4D Episiotomy.

SECTION 4E: PROCESS MEASURES OF QUALITY

This section has been updated to only include one question asking for the 12-month reporting time period used. The 12-month reporting time period indicated in question #1 should be used for reporting on both of the maternity care process measures: newborn bilirubin screening prior to discharge and appropriate DVT prophylaxis in women undergoing cesarean section.

SECTION 4F: HIGH-RISK DELIVERIES

Leapfrog has added a question asking hospitals if they used a sample when reporting on their adherence to the antenatal steroids clinical process guideline for high-risk deliveries. Hospitals will still be required to either report on all cases or a random sample of 60 cases.

SECTION 5: ICU PHYSICIAN STAFFING (IPS)

Leapfrog has also made minor updates to the wording of some of the questions and response options in Section 5 ICU Physician Staffing to clarify which criteria must be met in order to answer each question in the affirmative. Hospitals should review the updated questions before responding to this section of the Survey.

In addition, regarding physicians, physician assistants, or nurse practitioners acting as the responder when the intensivist is not present on-site in the ICU or not able to physically reach an ICU patient within 5 minutes (question #7), Leapfrog updated the minimum requirements to ensure that these responders are qualified to carry out the orders of the intensivists. Physicians, physician assistants, or nurse practitioners must:

1. Be a graduate with a training license from an ACGME accredited training program or have an active state license to practice as a physician, nurse practitioner, or physician assistant in the state in which the patient is located.



2. Have privileges to provide medical services in the unit (i.e. ICU) and for patients of the age range approved in advance by the hospital's governing body (e.g., medical staff committee, chief medical officer, chief nursing officer, etc.), as specified by the institution's internal policies (bylaws).
3. Carry out the intensivist's orders and instructions, under the intensivist's guidance, when they are serving in a responder role.

FCCS-certified nurses can continue to act as responders/"effectors" for the purposes of question #7 and Leapfrog has added an FAQ to clarify that FCCS-certified interns can also serve as the responder/"effector."

Leapfrog has updated the criteria regarding the availability of clinical pharmacists (question #12) in adult and pediatric general medical and/or surgical ICUs and neuro ICUs. On previous Surveys, Leapfrog required rounding, on-site, by a clinical pharmacist seven days per week. Beginning in 2019, hospitals will have two options: having clinical pharmacists round on all applicable ICU patients, on-site, seven days per week or five days a week with an additional response time requirement for the remaining two days of the week.

The National Expert Panel continues to believe in the important role that clinical pharmacists play within the ICU care team and, therefore, the scoring for ICU Physician Staffing in regards to the use of clinical pharmacists to round on ICU patients will remain the same (as a component of "Substantial Progress").

SECTION 6: NQF SAFE PRACTICES

Leapfrog has made minor text updates to a few of the NQF Safe Practices included in Section 6 and has added new FAQs to further assist reporting hospitals in 2019.

In addition, Leapfrog has updated the definition of "Board (governance)" used in this section of the Survey to include both the full board of directors or a committee of the board (such as a board-appointed, hospital-wide patient safety and quality committee).

SECTION 6F: NEW HAND HYGIENE PRACTICES (WILL NOT BE SCORED OR PUBLICLY REPORTED IN 2019)

In 2019, Leapfrog has added a new subsection to Section 6 of the Leapfrog Hospital Survey, which focuses on adherence to Hand Hygiene "best practices" identified by a [National Hand Hygiene Expert Panel](#) and adopted in part from the World Health Organization's [Hand Hygiene Self-Assessment Framework](#). As per Leapfrog's standard practice, this new subsection will not be publicly reported for hospitals in the first year it appears on the Survey, 2019, but will be reported in subsequent years.

These practices have been refined based on feedback from pilot hospitals. They will focus on four main topics:

- Training and education
- Infrastructure for supporting hand hygiene
- Monitoring and feedback
- Additional questions (for fact finding only)

Hospitals should continue to report on the existing NQF Hand Hygiene Safe Practice 19 in Subsection 6E, which will continue to be scored, publicly reported, and included in the Fall 2019 and Spring 2020 Leapfrog Hospital Safety Grades. Beginning in



2020, Leapfrog anticipates this new Hand Hygiene Practice measure will be scored and publicly reported, and will replace Safe Practice 19 in the Leapfrog Hospital Survey and the Hospital Safety Grade.

Feedback on these questions should be submitted to Leapfrog's [Help Desk](#) and comments received will be used to further refine the questions and scoring for the 2020 Leapfrog Hospital Survey.

SECTION 7: MANAGING SERIOUS ERRORS

SECTION 7A: NEVER EVENTS POLICY STATEMENT

There are no changes to this subsection.

SECTION 7B: HEALTHCARE-ASSOCIATED INFECTIONS

There are no changes to this subsection. Leapfrog will continue to obtain healthcare-associated infection data directly from the CDC's National Healthcare Safety Network (NHSN). Find instructions on how to join Leapfrog's NHSN Group and deadlines for the 2019 Survey at <http://www.leapfroggroup.org/survey-materials/join-nhsn>.

While the 2019 Leapfrog Hospital Survey closes on November 30, 2019, Leapfrog will continue to obtain the data from NHSN four times. The last NHSN data pull is on December 20, 2019 to incorporate any corrections facilities that joined by the last join date of November 30, 2019 may have made to their NHSN data since the last NHSN data pull and to take into account changes made due to the CMS Reporting Deadline in November for the 2019Q2 data. All data pull dates can be found at <http://www.leapfroggroup.org/survey-materials/join-nhsn>.

SECTION 7C: ANTIBIOTIC STEWARDSHIP PRACTICES

The antibiotic stewardship practices data is based on responses to the "Antibiotic Stewardship Practices" section of the 2018 Patient Safety Component – Annual Hospital Survey within NHSN. The CDC calculates the number of [Core Elements of an Antibiotic Stewardship Program](#) that a hospital has met based on a hospital's responses to questions #31-40 and Leapfrog uses this information to place a hospital in a performance category.

In 2019, the CDC/NHSN has made several updates to the Antibiotic Stewardship Practices section on the 2018 Patient Safety Component – Annual Hospital Survey. While the seven (7) Core Elements remain the same, the CDC/NHSN has revised and added several required questions, as well as a section of optional questions. In general, the updated and added questions increase opportunities for acute care hospitals to meet the Core Elements. The exception to this is the removal of a question regarding salary support for antibiotic stewardship leadership activities; however, there are still several options available for hospitals to meet the Leadership Core Element.

Leapfrog will continue to obtain antibiotic stewardship practices data directly from the CDC's National Healthcare Safety Network (NHSN). Find instructions on how to join Leapfrog's NHSN Group and deadlines for the 2019 Survey at <http://www.leapfroggroup.org/survey-materials/join-nhsn>.

While the 2019 Leapfrog Hospital Survey closes on November 30, 2019, Leapfrog will continue to obtain the data from NHSN four times. The last NHSN data pull is on December 20, 2019 to incorporate any corrections facilities that joined by the last join date of November 30, 2019 may have made to their NHSN data since the last NHSN data pull and to take into



account changes made due to the CMS Reporting Deadline in November for the 2019Q2 data. All data pull dates can be found at <http://www.leapfroggroup.org/survey-materials/join-nhsn>.

SECTION 8: MEDICATION SAFETY

SECTION 8A: BAR CODE MEDICATION ADMINISTRATION

Leapfrog has updated Section 8A question #12 to further understand compliance rates and process adherence in units that are utilizing a BCMA system. In question #12, hospitals will ONLY include the total number of inpatient medication administrations ordered and scannable during the reporting period in those units (intensive care, medical and/or surgical, and labor and delivery) where they are utilizing BCMA. The question has been updated to refer directly to questions #5, #8, and #11 which ask about utilization of a BCMA system in intensive care units (adult, pediatric, and/or neonatal), medical and/or surgical units (adult and/or pediatric), and labor and delivery units.

In addition, based on feedback from hospitals, health systems, and Leapfrog’s National Expert Panel, as well as a review of the current literature, Leapfrog removed the patient-specific allergy check and vital sign check from the list of required types of decision-support. The 2019 BCMA standard requires five types of decision-support: Wrong patient, wrong medication, wrong dose, wrong time, and second nurse check needed.

The 2019 Scoring Algorithm for the BCMA Standard has been updated to reflect this change. See below.

BCMA Score (Performance Category)	% Units	% Compliance	Decision Support	Processes & Structures to Prevent Workarounds
Fully Meets the Standard	100%	95%	5 out of 5	6 out of 8
Substantial Progress	The hospital meets 3 of the 4 standards			
Some Progress	The hospital meets 2 of the 4 standards			
Willing to Report	The hospital meets 1 or 0 of the 4 standards			
Declined to Respond	The hospital did not respond to the questions in this section of the Survey or did not submit a Survey.			
Does Not Apply	The hospital does not operate an ICU, medical/surgical unit, or labor and delivery unit.			

SECTION 8B: MEDICATION RECONCILIATION (APPLICABLE TO ADULT/GENERAL HOSPITALS ONLY)

In an effort to understand what hospitals are doing to ensure the accuracy of their existing medication reconciliation process, Leapfrog is implementing the following changes to the questions and scoring algorithm for this subsection:

- Hospitals will be asked if they have implemented ANY process or protocol to measure the accuracy of their existing medication reconciliation process.
- Hospitals will then be asked if they have implemented the NQF-endorsed protocol of measuring the accuracy of their existing medication reconciliation process (same questions as in previous years).



- The scoring algorithm will be updated to allow hospitals to earn partial credit (“Willing to Report”) if they are at least implementing some process or protocol to measure the accuracy of their existing medication reconciliation process.
- To “Fully Meet the Standard,” hospitals must continue to implement the NQF-endorsed protocol and report the data collected to Leapfrog.

The sample sizes required for reporting the data collected on the NQF-endorsed protocol have been updated for 2019. Hospitals can choose to report on at least 15 patients during a 3-month reporting period or at least 30 patients using a 6-month reporting period:

- Hospitals that started and have continued to sample 15 patients on a quarterly basis using the 2018 Leapfrog Hospital Survey measure specifications can use those data when reporting on this section of the Survey.
- Hospitals that did not start sampling patients in 2018, can sample in real-time (i.e. after April 1) and start data collection any time during the Survey Cycle by sampling 15 patients.

The 2019 Medication Reconciliation Scoring Algorithm has been updated accordingly:

Medication Reconciliation Score (Performance Category)	Meaning that...
Fully Meets the Standard	The hospital uses a nationally endorsed protocol to collect data on the accuracy of its medication reconciliation process and reported the data collected to Leapfrog.
Some Progress	The hospital uses a nationally endorsed protocol to collect data on the accuracy of its medication reconciliation process, but did not report the data collected to Leapfrog.
Willing to Report	The hospital is not yet using the endorsed protocol to collect data on the accuracy of its medication reconciliation process or has not put any protocol in place.
Declined to Respond	The hospital did not respond to the questions in this section of the Survey, or did not submit a Survey.
Does Not Apply	The hospital is a pediatric facility.

Note: Hospitals are scored as “Some Progress” if they sampled and responded to the questions in this section of the Survey, but had their responses flagged in Leapfrog’s [Monthly Data Review](#).

Lastly, Leapfrog has also made the following additional refinements to the measure specifications and data collection tools based on feedback received in 2018:

- Updated the definition of “Admission Orders” to include all orders written from the time of admission until 8am the following morning or until 8-12 hours after the time of admission, whichever comes first.
- The Medication Reconciliation Workbook (Excel) has been updated to visually display alerts resulting from data entry errors (i.e. cells will be displayed as red if a data entry error is present) and includes additional clarification to help hospitals identify and correct errors prior to submission.

In November, Leapfrog proposed including a new electronic REDCap form as an optional resource for reporting hospitals for an annual fee of \$100, which would reduce the time needed by the pharmacist for data collection. However, hospitals commented that the cost of using the form was prohibitive, and therefore Leapfrog has decided not to move forward with



developing the form for 2019. Hospitals can still develop their own electronic forms for use in collecting data on this measure, but they must include the same items as Leapfrog's Medication Reconciliation Worksheet.

SECTION 9: PEDIATRIC CARE

SECTION 9A: PATIENT EXPERIENCE (CAHPS CHILD HOSPITAL SURVEY)

Based on valuable feedback received in 2018, Leapfrog has updated question #2 and its response options to ensure that the Top Box Scores from the CAHPS Child Hospital Survey represent an appropriate sample of patients. Hospitals completing the Child CAHPS Hospital Survey should have at least 100 pediatric acute-care admissions to inpatient units other than a neonatal ICU (NICU) to ensure that the hospital's sample is not overly represented by NICU discharges. Hospitals with fewer than 100 non-NICU admissions out of the total number of acute care pediatric admissions do not have to administer the CAHPS Child Hospital Survey and will be scored as "Does Not Apply."

Hospitals will be asked to refer to questions #5 total acute care pediatric admissions and question #11 total admissions to any level neonatal ICU from Section 1, to determine how to respond this section of the Survey.

Leapfrog has included additional FAQs to assist reporting hospitals in 2019, which should be reviewed before responding to this subsection of the Survey.

There are no changes to the Scoring Algorithm for Section 9A Patient Experience (CAHPS Child Hospital Survey).

SECTION 9B: PEDIATRIC COMPUTED TOMOGRAPHY (CT) RADIATION DOSE

In order to ensure standardized reporting, Leapfrog has added a sampling question in Section 9B of the 2019 Leapfrog Hospital Survey. Hospitals that report using "manual data collection" for CT radiation dose length product (DLP) will be asked whether the responses represent a sample of cases. For those hospitals that did sample, this will help ensure that the minimum number of sampled cases is reported in the Survey: 30 encounters per anatomic area and age stratum combination.

There are no changes to the Scoring Algorithm for Section 9B Pediatric Computed Tomography (CT) Radiation Dose.

SECTION 10: OUTPATIENT PROCEDURES (WILL NOT BE SCORED OR PUBLICLY REPORTED IN 2019)

BACKGROUND

As [announced](#) on October 16, 2018, Leapfrog will be adding a new section to the 2019 Leapfrog Hospital Survey focused on measuring the safety and quality of outpatient procedures performed in hospital outpatient departments (HOPDs). Leapfrog will also launch a new Ambulatory Surgery Center (ASC) Survey. The goal of this new initiative is to give purchasers and consumers the information they need when choosing a place for procedures and surgeries that do not require a hospital stay, so this section of the Leapfrog Hospital Survey as well as the new ASC Survey will obtain parallel and comparable information from target facilities.

Across both surveys, Leapfrog will gather data on several important areas including basic facility information, information on medical, surgical, and clinical staff, volume and safety of procedures performed, patient safety practices, and patient experience. In 2019, responses to this Section of the Survey will not be scored or publicly reported. ASCs and hospital



outpatient departments that participate will receive detailed benchmarking reports they can use with purchasers and payors in their markets. In addition, Leapfrog plans to publish a national, aggregate report based on our findings. In 2020, Leapfrog will score and publicly report Survey Results from this new section of the Leapfrog Hospital Survey and the new ASC Survey.

ELIGIBILITY

In 2019, Section 10 Outpatient Procedures will apply to pediatric and general hospitals that perform common procedures within the following surgical specialties on an outpatient basis either in the hospital or at a separate hospital outpatient location:

- Gastroenterology
- General surgery
- Ophthalmology
- Orthopedic
- Otolaryngology
- Urology
- Dermatology
- Neurological surgery
- Obstetrics and gynecology
- Plastic and reconstructive surgery

A list of procedures within each specialty area is available in [Appendix V](#). In Section 10 Outpatient Procedures, hospitals will only report on outpatient procedures that were performed either in the hospital or at a separate outpatient location that operates under the same CMS certification as their hospital. Hospitals with multiple outpatient locations (i.e. hospitals that perform outpatient procedures both in the hospital and at a separate hospital outpatient location) will be asked to provide information on these locations in the Basic Outpatient Department Information Subsection.

CONTENT

This new section will consist of five subsections outlined below:

- **Section 10A: Basic Outpatient Department Information.** Leapfrog is asking hospitals if they perform specific outpatient (or same-day) procedures in the hospital (i.e. outpatient department) or at a facility co-located with the hospital (i.e. outpatient tower connected to the hospital), at a separate location (separate on/off-campus hospital outpatient location or ambulatory surgery unit), or in multiple locations. Hospitals are able to provide facility information for any hospital outpatient departments that are not co-located with their hospital and they will need to select to report on either their hospital (including all outpatient locations co-located with their hospital) or only one separate hospital outpatient location. Hospitals will report on the remainder of the questions in Section 10 using the selected location. Leapfrog will use information collected in 2019 to make determinations for reporting on multiple outpatient locations in 2020.

This subsection also includes questions regarding written transfer agreements and policies for emergent transfers, urgent transfers, and non-urgent transfers.



- Section 10B: Medical, Surgical, and Clinical Staff. Leapfrog is asking hospitals about the training and education of their medical, surgical, and clinical staff to ensure they are properly trained in resuscitation and have board certification.
- Section 10C: Volume and Safety of Procedures. Hospitals are asked to report information on the procedures performed in their outpatient locations including:
 - Volume of outpatient procedures within the specialties listed [above](#)
 - Processes to ensure facility staff follow-up with patients and physicians after a procedure is performed and that patients know whom to contact after hours
 - Processes to ensure that patients are selected appropriately for the outpatient setting and that patients and their families have adequate time to review consent materials
 - Structures to ensure that procedures are performed safely
- Section 10D: Medication Safety in Outpatient Departments. Leapfrog is asking hospitals to report on medication safety processes specific to outpatients. This includes questions pertaining to medication and allergy documentation for outpatients.
- Section 10E: Patient Experience. Hospitals are asked to report on domain scores and selected aggregated responses from the Outpatient and Ambulatory Surgery CAHPS (OAS CAHPS) Survey.

Surgical centers that are a distinct entity and that are operationally and administratively independent from a hospital should report using the new [Ambulatory Surgery Center Survey](#). This would include surgical centers that are separately certified by Medicare and have their own CCN (i.e. nnCnnnnnn). For a list of Ambulatory Surgery Centers certified by Medicare, visit <https://www.medicare.gov/hospitalcompare/asc-ascqr.html>.



APPENDIX I: RESPONSES TO PUBLIC COMMENTS

Leapfrog received over 100 public comments in response to the proposed changes to the 2019 Leapfrog Hospital Survey. Comments were submitted from health care organizations, as well as health care experts, patient advocates, and purchasers.

Responses to the public comments are organized by survey section below. If you submitted a comment, and do not see a response, or if you have additional questions, please contact the Help Desk at <https://leapfroghelpdesk.zendesk.com>.

LEAPFROG HOSPITAL SURVEY DEADLINE

A commenter expressed agreement with changing the Late Submission Deadline to November 30.

This change will give hospitals a two-month Verification and Correction Period to resolve any data entry and reporting errors identified during the [Monthly Data Review or Monthly Documentation Requests](#) before the Survey Results are finalized for the year. Leapfrog continues to expect all hospitals to submit a Leapfrog Hospital Survey and CPOE Evaluation Tool by the Submission Deadline of June 30. As always, hospitals that miss the June 30 Submission Deadline will be publicly reported as “Declined to Respond” when Leapfrog publishes its first set of 2019 Leapfrog Hospital Survey Results in July.

Several commenters expressed concern regarding their ability to take multiple CPOE Tests given the new Late Submission Deadline of November 30.

The CPOE Evaluation Tool is not designed to be taken more than twice per Survey Cycle. The waiting period between CPOE Tests will not be updated and will remain 120 days. Hospitals should schedule their first test in order to meet all applicable deadlines. Hospitals that submit their Survey and first CPOE Evaluation Tool by June 30 will have no problem scheduling a second test prior to November 30.

Some commenters expressed concern about updating their Leapfrog Hospital Survey in December with more recent data given the new Late Submission Deadline of November 30.

Hospitals that meet the June 30 Submission Deadline will still have many opportunities to update their Leapfrog Hospital Survey with more recent data. Most sections of the Leapfrog Hospital Survey allow hospitals to update their responses either 1) based on the most recent three-months at the time of submission; OR 2) using an updated reporting period for Surveys submitted on or after September 1. In the first scenario, hospitals will be able to update their Surveys with more recent data any time prior to November 30. In the second scenario, hospitals will still have three months (September-November) to update the applicable sections with more recent data.

One commenter felt that a one-month Verification and Correction Period was sufficient and opposed updating the deadline to November 30 to allow for a two-month Verification and Correction Period.

Based on Leapfrog’s experience over the past several years, hospitals require more than one month to investigate and respond to Leapfrog’s Monthly Data Review messages and Monthly Requests for Documentation. In order to give them the time they need to respond to these requests appropriately, we must extend the Correction Period to two months (December and January).



SECTION 1 BASIC HOSPITAL INFORMATION

A few commenters disagreed with Leapfrog’s proposal to update the endnote describing the criteria for “licensed acute-care beds” to include short-term, inpatient rehabilitation beds since other measures on the Leapfrog Hospital Survey do not include inpatient rehabilitation. These beds are also often separately licensed and reflect a different patient population.

Leapfrog has updated the endnote specifications for both “licensed acute-care beds” and “adult/pediatric acute-care admissions” to exclude both short-term and long-term rehabilitation beds and admissions. These questions will now closely align with the data collected in other sections of the Leapfrog Hospital Survey.

SECTION 2 COMPUTERIZED PHYSICIAN ORDER ENTRY (CPOE)

One commenter requested that Leapfrog allow hospitals to use their Meaningful Use Reports when reporting on Section 2 CPOE.

Leapfrog's understanding is that the CMS Meaningful Use program has transitioned to the Promoting Interoperability Program. The new program has four objectives, and inpatient use of CPOE is not one of them (https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents_EH_Medicare_2019.pdf). The prescribing focus appears to have shifted to discharged orders. Therefore, Leapfrog has decided to maintain the CPOE measure specifications, which have been updated to provide more clarity on the data that should be pulled from your hospital's CPOE system.

SECTION 3 INPATIENT SURGERY

In addition to comments regarding the proposed changes, some commenters expressed concerns about the ability of rural and smaller community hospitals and physicians to meet the hospital and surgeon volume standards. Some felt that these standards put an undue burden on lower income patients who are not able to afford to go to a larger hospital system or urban area where hospitals and surgeons may be doing a higher volume of cases.

Leapfrog’s goal with this section of the Survey is to ensure that patients are aware of the hospital’s experience with specific surgical procedures, as a significant body of research now exists to suggest a strong relationship between the number of times a hospital or a surgeon performs a specific surgical procedure and the outcomes for those patients, including death and complication rates. The eight procedures included in the Survey are those that have compelling evidence linking hospital volume and patient mortality. Leapfrog’s standard is agnostic to the size or location of the hospital. Leapfrog’s goal with this section is to ensure the best care for patients, whether they live in rural or urban communities.

Leapfrog does recognize there is a possible tension between experience and access, but believes transparency of these data is ultimately what is most important to patients so they can make the best decisions for themselves, which may be a decision between staying local and choosing to drive to a hospital with more experience. It is Leapfrog’s longstanding policy that hospitals that do not achieve adequate volume for identified procedures should refer patients to safer alternative facilities.



One commenter stated that they do not support minimum hospital and/or surgeon volume standards because outcomes measures are more important in measuring safety and higher volume does not guarantee safety or quality.

While Leapfrog recognizes that volume is not a perfect substitute for outcomes, for the eight surgeries being measured in the 2019 Leapfrog Survey, there is a strong body of [evidence](#) linking hospital and surgeon experience and patient outcomes. Leapfrog continues to explore opportunities to incorporate evidence-based, endorsed outcome measures (e.g., mortality, morbidity) into the Survey.

SECTION 4 MATERNITY CARE

Some commenters indicated that Leapfrog needed to include additional MS-DRG codes for identifying vaginal deliveries for the purposes of reporting on the denominator in Section 4D Episiotomy due to the October 2018 CMS update to the MS-DRG codes.

Leapfrog has added the additional MS-DRG codes based on the October 2018 CMS update. Please find a list of the additional codes included in the [Section 4D Change Summary](#) above.

SECTION 5 ICU PHYSICIAN STAFFING

Two commenters suggested that Leapfrog update the minimum requirements of the physician, physician assistant (PA), or nurse practitioner (NP) who is serving as a responder to allow for the inclusion of residents and fellows.

Leapfrog has updated the criteria. Please see the [Section 5 Change Summary](#) published above for more information.

In addition to the changes proposed, one hospital commented that the ICU Physician Staffing measure is not fair for small and rural hospitals who may not have the same resources as a larger or urban hospital and whose patients may be unable to travel elsewhere.

Decades of literature pertaining to ICU outcomes suggest that ICU mortality is significantly reduced when physicians who are certified in critical care manage or co-manage all ICU patients and are supported by the appropriate staffing structures. In recent years, Leapfrog has expanded its standard to include the use of supplemental tele-intensivists for the purposes of allowing rural hospitals to earn substantial credit for investing in this evidence-based service. Leapfrog realizes that hospitals with small units may lack the economies of scale necessary to support full-time intensivists for their ICUs, and would encourage them to explore tele-intensivist services. ICU coverage is highly significant for patients and thus an important factor for public reporting.

More information on the evidence behind Leapfrog's ICU Physician Staffing for all hospitals may be reviewed at <http://www.leapfroggroup.org/ratings-reports/icu-physician-staffing>.

SECTION 6 NQF SAFE PRACTICES

Several commenters requested clarification on the elements and the questions included in the new hand hygiene section and how this section will be scored.

The new hand hygiene questions will be available when the 2019 Leapfrog Hospital Survey launches on April 1. They will be included in the hard copy of the Survey, which will be published April 1, 2019, at <http://www.leapfroggroup.org/survey->



[materials/survey-and-cpoe-materials](#). This section will not be publicly reported until 2020 and Leapfrog encourages hospitals to submit comments to the [Help Desk](#) throughout the 2019 Survey Cycle. Feedback received will be used to further refine the questions before publicly reporting results in 2020.

Two commenters expressed concerns with Leapfrog using the WHO's Hand Hygiene Self-Assessment Framework when developing the new hand hygiene questions in Section 6F and felt that this framework might be too prescriptive and excessive.

Leapfrog modeled the questions in Section 6F after the World Health Organization's [Hand Hygiene Self-Assessment Framework](#), but the elements included have been adapted for use in U.S. hospitals and not all elements of the framework are included. In addition, Leapfrog researchers and the [Hand Hygiene Expert Panel](#) identified other elements (not included in the WHO Framework) to include based on existing evidence and models from the Joint Commission, CDC, and other sources. Many of the concerns raised, e.g., the need to audit towels, monitor soap levels, display and audit posters, use WHO documents, have a WHO Hand Hygiene Technical Reference Manual available to all healthcare workers etc., are items that are not included in Leapfrog's new Hand Hygiene Practices. The questions will be available for hospitals to view on April 1 at <http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials> and Leapfrog asks that hospital submit any feedback to the [Help Desk](#).

Two commenters were concerned that the new Hand Hygiene questions would not align with guidelines they are using from The Joint Commission's Solutions for Transforming Healthcare Hand Hygiene Targeted Solutions Tool or the CDC's Hand Hygiene Guidelines.

Leapfrog has reviewed these other guidelines and the elements included in Section 6F do not conflict with these other tools/guidelines.

One commenter expressed support of the new hand hygiene practices since it aligns with their organizational goal of 100% compliance.

Leapfrog agrees with the goal of 100% compliance. However, in this first year of reporting on the new hand hygiene section, Leapfrog will not be asking hospitals to report on their rates of compliance, but we will ask how hospitals are monitoring compliance. We hope hospitals will use the questions in Section 6F to strengthen their hand hygiene training, education, and monitoring programs, and make any needed changes to their infrastructure.

One commenter expressed concerns regarding the requirements Leapfrog will include regarding "monitoring and feedback" due to the challenges of getting consistent and accurate data and the investment required for implementing an electronic compliance monitoring system.

The questions in Section 6F Hand Hygiene ask about a variety of strategies that can be used to improve hand hygiene and while responses will not be scored or publicly reported in 2019, Leapfrog is encouraging hospitals to take a multimodal approach, which includes observations, training/education, and electronic compliance monitoring. With regard to monitoring hand hygiene compliance, Leapfrog's standard highlights electronic compliance monitoring, which early but compelling evidence suggests offers results superior to observation for many types of hand hygiene compliance (such as hand washing and the use of alcohol-based hand sanitizer). As with Computerized Physician Order Entry (CPOE) systems and Bar Code Medication Administration Systems (BCMA), Leapfrog expects hospitals to incorporate the best possible solutions to safety problems that endanger patients, and recognizes and reports when hospitals demonstrate that investment.



SECTION 7 MANAGING SERIOUS ERRORS

No comments were submitted.

SECTION 8 MEDICATION SAFETY

Two commenters supported Leapfrog’s decision to remove patient-specific allergy checks and vital sign checks from the decision support elements required for the Bar Code Medication Administration (BCMA) standard, but some commenters disagreed with their removals.

Leapfrog is committed to ensuring that elements of its standards are grounded in the latest scientific evidence, and the evidence as reviewed by the Expert Panel does not support inclusion of these two elements. As the evidence and technology evolves in the coming years, we will consider adding these decision-support elements back to the BCMA Standard.

A few commenters felt that the cost of the proposed medication reconciliation REDCap form was prohibitive.

This form was proposed as an optional resource for hospitals reporting on the medication reconciliation measure. The measure developer would charge an annual fee of \$100 to cover the costs of developing and maintaining the form on their server. Leapfrog will not move forward with developing this form for 2019 due to hospitals’ concerns about the cost and general lack of interest. Hospitals can still develop their own electronic forms for use in collecting data on this measure, but they must include the same items as Leapfrog’s Medication Reconciliation Worksheet.

A few commenters expressed concerns regarding the continued requirement of using pharmacists for performing the audits for the medication reconciliation measure due to limited pharmacy resources etc., and asked that Leapfrog reconsider allowing pharmacy techs to capture the Gold Standard Medication Reconciliation History.

In accordance with the research and testing by measure developers as well as compliance with the NQF-endorsed measure, only licensed pharmacists can obtain the Gold Standard Medication List and identify unintentional discrepancies for those patients selected to be included in the sample (i.e. 15 patients over 3 months or 30 patients over 6 months). This does not preclude involvement from other clinicians in the medication reconciliation process.

One commenter stated that it is difficult for critical access hospitals to meet the minimum sample sizes required for the medication reconciliation measure.

Leapfrog believes that it is achievable for a CAH to sample 15 patients in a 3-month period. Medication errors, including medication reconciliation errors, remain one of the most common errors in hospitals. The reductions in medication reconciliation errors that result from using the data collected from the sample for quality improvement are well-documented.



SECTION 9 PEDIATRIC CARE

One commenter asked if the expectation was that the Child CAHPS Survey be administered to families/caregivers of NICU patients as many of the questions do not necessarily apply to this patient population.

Yes, the Child CAHPS Hospital Survey was designed to be administered to pediatric discharges including NICU discharges. Additional details on fielding the CAHPS Child Hospital Survey can be found [here](#). However, hospitals should have at least 100 pediatric acute-care admissions to inpatient units other than a neonatal ICU (NICU) to ensure that the hospital's sample is not overly represented by NICU discharges. Hospitals with fewer than 100 non-NICU admissions out of the total number of acute care pediatric admissions do not have to administer the CAHPS Child Hospital Survey. Leapfrog has updated the questions and notes within the subsection to make this more clear.

In 2019, hospitals that have been administering the CAHPS survey without including NICU discharges in their sample can report those results to Leapfrog, provided they meet the minimum sample size and timing requirements in the Leapfrog Hospital Survey. However, Leapfrog is urging hospitals to begin including NICU discharges-- per the manual guidelines-- immediately, as CAHPS is designed to include those patients. Hospitals that are just starting to administer the survey in 2019 should include NICU discharges in their sample per the sampling framework detailed in the manual.

One commenter disagreed with requiring non-pediatric facilities to administer and report on the CAHPS Child Hospital Survey because of low sample sizes (even if the facility had at least 500 pediatric admissions) and increased financial cost.

Leapfrog continues to ask all participating hospitals (pediatric and non-pediatric) with at least 500 pediatric acute-care admissions to administer and report on the CAHPS Child Hospital Survey. Hospitals with fewer than 500 pediatric admissions or at least 500 pediatric admissions but fewer than 100 were for non-NICU patients are reported as "Does Not Apply." While the cost of administering the survey can be a concern for some hospitals, the CAHPS Child Hospital Survey instrument includes metrics that are of top priority to consumers, purchasers, and payors, and thus should be considered a priority by hospitals.

One commenter asked Leapfrog to reconsider how hospitals are scored in Section 9B Pediatric CT Dose, suggesting consideration of metrics for dosing based on the diagnostic task instead of simply awarding hospitals with lower radiation doses the highest point value.

Leapfrog understands that there is variability in a child's size and/or diagnostic task that may lead to different dosing levels. This is one reason why hospitals are asked to report doses at the 25th, 50th and 75th percentiles so that Leapfrog can continue to carefully monitor dosing levels across hospitals. The measure developer has found in a large randomized trial that routine review and sharing of dosage by hospitals leads to dose reductions without compromise to clinical efficacy. As noted earlier, Leapfrog continues to monitor dosing levels to see if hospitals are reporting inappropriately low doses. Leapfrog will continue to work with the measure developer and National Expert Panel to review the data collected and recommend updates to the specifications as appropriate.



SECTION 10 OUTPATIENT PROCEDURES

One commenter expressed concerns about an increased reporting burden on facilities with the addition of Section 10 Outpatient Procedures.

More than 60% of surgical procedures are now performed either by hospital outpatient departments or ambulatory surgery centers. As a result, employers and other purchasers urged Leapfrog to begin reporting on the safety and quality of those settings in addition to our Survey focused on inpatient care; it is simply no longer adequate to report exclusively on inpatient care. In this first year, the national Expert Panel, along with research partners at Johns Hopkins Medicine, recommended focusing on process and structural measures relevant to all hospitals and ASCs performing outpatient procedures. Leapfrog is also focusing on high volume procedures that are performed in both settings, typically require sedation or general anesthesia, and are common among privately insured patients (i.e. as opposed to common only among Medicare patients).

Leapfrog welcomes feedback on the time required to gather documentation and report to the questions in Section 10 Outpatient Procedures in 2019 and will make further refinements for 2020.

One commenter asked how they would respond on Section 10B Medical, Surgical and Clinical Staff given that one of their outpatient surgery centers is set up in a partnership and the staff are employed by a management company.

The questions in Section 10B specifically ask about required certifications for clinicians who are present while patients are recovering from outpatient procedures, and about board certification/eligibility for surgeons, anesthesiologists, nurse anesthetists involved in the procedures. The responses are not dependent on whether the hospital or a management company employs these individuals.

One commenter suggested that Leapfrog risk-adjust the data collected on procedures in Section 10 Outpatient Procedures.

In Section 10, Leapfrog will be collecting volume information for select procedures and will also be including questions on patient follow-up, the provision of consent materials, and the use of a safe surgery checklist. Rates will not be provided, nor will any other calculation of outcomes, and therefore risk-adjustment is not needed on the 2019 Leapfrog ASC Survey.

Some commenters disagreed with Leapfrog asking hospitals to administer the OAS CAHPS Survey since it is not currently required by CMS and felt that it might be difficult to manage.

While Leapfrog understands that the OAS CAHPS Survey is still a voluntary component of the CMS ASC Quality Reporting Program, this survey is the only nationally standardized instrument designed to compare patient experience in both HOPDs and ASCs. No other survey has been tested and validated for this purpose. All measures included in Leapfrog's programs are predicated on the latest evidence and recommended by Leapfrog's panels of experts. Most of all, they are a high priority to consumers, employers, and other purchasers.

Leapfrog will continue to include these questions on the Leapfrog Hospital Survey and the Leapfrog ASC Survey and would welcome additional feedback from participating facilities.

APPENDIX II: ORDER CHECKING CATEGORIES INCLUDED IN THE CPOE EVALUATION TOOL (V3.6)

Each category included in the CPOE Evaluation Tool represents an area where a serious adverse drug event (ADE) could occur if the CPOE system’s clinical decision support fails to alert the prescriber. The intent of the test is to measure and improve hospitals’ use of clinical decision support to reduce ADEs and improve medication safety. The CPOE Evaluation Tool is designed to test for two types of clinical decision support:

1. **Scenario-Specific Advice/Information:** Information related to the Test Order, which may include the medication’s specific dose, route, and frequency, and the Test Patient, which includes specific patient demographics (e.g., age, gender) and clinical information such as problems/diagnoses, lab values, and allergies, as applicable. The scenario-specific advice/information may also involve the *combination* of two specific medication orders.
2. **Medication-Specific Advice/Information:** General information that might appear any time the medication is ordered for any patient and is not specifically related to the Test Patient (see the Drug Monitoring Order Checking Category).

The table below details the type of clinical decision support (i.e. advice/information) expected in each Order Checking Category.

Order Checking Category	Description	Type of Information to Record	Example
Therapeutic Duplication	Medication combinations overlap therapeutically (same agent or same class)	Scenario-specific advice/information	Using clonazepam and lorazepam together
Drug Dose (Single)	Specified dose of medication exceeds safe range for single dose	Scenario-specific advice/information	Tenfold overdose of digoxin
Drug Dose (Daily)	Specified frequency of administration results in daily dose that exceeds safe range for daily dose	Scenario-specific advice/information	Ordering ibuprofen regular dose every three hours
Drug Allergy	Medication (or medication class) is one for which patient allergy has been documented	Scenario-specific advice/information	Penicillin prescribed for patient with documented penicillin allergy
Drug-Route	Specified route of administration is inappropriate and potentially harmful	Scenario-specific advice/information	Use of hydroxyzine intravenously
Drug-Drug Interaction	Medications in pair of orders result in known harmful interaction when used in combination	Scenario-specific advice/information	Concurrent phenelzine and sumatriptan
Drug Diagnosis	Medication dose inappropriate/contraindicated based on documented problem/diagnosis	Scenario-specific advice/information	Nonspecific beta-blocker in patient with asthma
Drug- Age	Medication dose inappropriate/contraindicated based on patient age	Scenario-specific advice/information	Prescribing diazepam for a patient over 65 years old
Drug Laboratory	Medication dose inappropriate/contraindicated based on documented laboratory test results (includes renal status)	Scenario-specific advice/information	Use of nitrofurantoin in patient with severe renal failure
Drug Monitoring	Medication for which the standard of care includes subsequent monitoring of the drug level or lab value to avoid harm	Medication-specific advice/information	Prompt to monitor drug levels when ordering aminoglycosides or INR/PT when ordering warfarin



The Tool also includes an “Alert Fatigue” test category, which checks if prescribers are receiving alerts or information for inconsequential medication interactions that clinicians typically ignore. An example would be alerting on the concurrent use of hydrochlorothiazide and captopril. This test category is not included in scoring.

The Tool also includes a “Deception Analysis” test category, which checks for “false positives” (e.g., orders that should not have generated any warning in the hospital’s CPOE system). Hospital’s that “fail” the Deception Analysis are scored as “incomplete evaluation” and will not be able to retake an Adult Inpatient Test for 120 days.



APPENDIX III: 2019 MINIMUM HOSPITAL AND SURGEON VOLUME STANDARDS

Procedure	Hospital Volume (minimum per 12- months or 24- month average)	Surgeon Volume (minimum per 12- months or 24- month average)
Carotid endarterectomy	20	10
Mitral valve repair and replacement	40	20
<i>Open aortic procedures*</i>	10*	7*
Lung resection for cancer	40	15
Esophageal resection for cancer	20	7
Pancreatic resection for cancer	20	10
Rectal cancer surgery	16	6
Bariatric surgery for weight loss	50	20

*Updated for 2019

APPENDIX IV: 2019 SURGICAL APPROPRIATENESS QUESTIONS

<p>1) Does your hospital have appropriateness criteria for <u>any</u> of the following procedures:</p> <p><i>If "None of the above," skip questions #1b-5 and continue on to question #6.</i></p>	<p><input type="checkbox"/> Carotid endarterectomy</p> <p><input type="checkbox"/> Mitral valve repair and replacement</p> <p><input type="checkbox"/> Open aortic procedures</p> <p><input type="checkbox"/> Bariatric surgery for weight loss</p> <p><input type="checkbox"/> None of the above</p>
<p>1b) Did your hospital do <u>any</u> of the following in developing the appropriateness criteria:</p>	<p><input type="checkbox"/> Use the latest evidence and clinical guidelines</p> <p><input type="checkbox"/> Solicit input from employed surgeons, and if applicable, non-employed surgeons</p> <p><input type="checkbox"/> Incorporate relevant Choosing Wisely lists</p> <p><input type="checkbox"/> Review, and if appropriate, update the criteria on an annual basis</p> <p><input type="checkbox"/> None of the above</p>
<p>2) Does your hospital have processes or structures in place to promote ongoing adherence to the appropriateness criteria for <u>any</u> of the following procedures:</p>	<p><input type="checkbox"/> Carotid endarterectomy</p> <p><input type="checkbox"/> Mitral valve repair and replacement</p> <p><input type="checkbox"/> Open aortic procedures</p> <p><input type="checkbox"/> Bariatric surgery for weight loss</p> <p><input type="checkbox"/> None of the above</p>
<p>3) Does your hospital conduct regular retrospective reviews of surgical cases to evaluate the extent to which your appropriateness criteria are met or not met by each surgeon for <u>any</u> of the following procedures:</p>	<p><input type="checkbox"/> Carotid endarterectomy</p> <p><input type="checkbox"/> Mitral valve repair and replacement</p> <p><input type="checkbox"/> Open aortic procedures</p> <p><input type="checkbox"/> Bariatric surgery for weight loss</p> <p><input type="checkbox"/> None of the above</p>
<p>4) Does your hospital have a process in place for communicating with surgeons, surgical leadership, and administrative leadership when a surgeon's trend or pattern suggests challenges to adhering to your appropriateness criteria and work to understand potential barriers to meeting the criteria for <u>any</u> of the following procedures:</p>	<p><input type="checkbox"/> Carotid endarterectomy</p> <p><input type="checkbox"/> Mitral valve repair and replacement</p> <p><input type="checkbox"/> Open aortic procedures</p> <p><input type="checkbox"/> Bariatric surgery for weight loss</p> <p><input type="checkbox"/> None of the above</p>
<p>5) Does your hospital report annually to its Board the findings from the retrospective reviews and plans to improve adherence to the appropriateness criteria for <u>any</u> of the following procedures:</p>	<p><input type="checkbox"/> Carotid endarterectomy</p> <p><input type="checkbox"/> Mitral valve repair and replacement</p> <p><input type="checkbox"/> Open aortic procedures</p> <p><input type="checkbox"/> Bariatric surgery for weight loss</p> <p><input type="checkbox"/> None of the above</p>
<p>6) Does your hospital have national accreditation from the American College of Surgeons (applies to rectal cancer surgery only)</p> <p>OR</p> <p>Does your hospital have a multidisciplinary tumor board that prospectively reviews cancer cases to ensure surgical appropriateness for <u>any</u> of the following procedures:</p>	<p><input type="checkbox"/> Lung resection for cancer</p> <p><input type="checkbox"/> Esophageal resection for cancer</p> <p><input type="checkbox"/> Pancreatic resection for cancer</p> <p><input type="checkbox"/> Rectal cancer surgery</p> <p><input type="checkbox"/> None of the above</p>

APPENDIX V: LIST OF 2019 OUTPATIENT PROCEDURES

ADULT PROCEDURES

Gastroenterology procedures: upper GI endoscopy; other upper GI procedures; small intestine and stomal endoscopy; and lower GI endoscopy

General surgery procedures: cholecystectomy and common duct exploration; excision of skin lesion; hemorrhoid procedures; inguinal and femoral hernia repairs; other hernia repairs; laparoscopy; lumpectomy or quadrantectomy of breast; mastectomy; and skin grafts

Ophthalmology procedures: anterior segment eye procedures; and posterior segment eye procedures

Orthopedic procedures: finger, hand, wrist, forearm, and elbow procedures; shoulder procedures; spine procedures; hip procedures; knee procedures; toe, foot, ankle, and leg procedures; and general orthopedic procedures

Otolaryngology procedures: ear procedures; mouth procedures; nasal/ sinus procedures; pharynx/ adenoid/ tonsil procedures

Urology procedures: circumcision; cystourethroscopy; male genital procedures; male sterilization procedures; urethra procedures; and vaginal repair procedures

Dermatology procedures: complex skin repairs

Neurological surgery procedures: spinal fusions

Obstetrics and gynecology procedures: cervix procedures; hysteroscopy; and uterus and adnexa laparoscopies

Plastic and reconstructive surgery procedures: breast repair or reconstructive procedures; musculoskeletal graft or implant procedures

PEDIATRIC PROCEDURES

Gastroenterology procedures: upper GI endoscopy; other upper GI procedures; small intestine and stomal endoscopy; and lower GI endoscopy

General surgery procedures: inguinal and femoral hernia repair; and other hernia repair

Ophthalmology procedures: anterior segment eye procedures

Orthopedic procedures: finger, hand, wrist, forearm, and elbow procedures; shoulder procedures; spine procedures; hip procedures; knee procedures; toe, foot, ankle, and leg procedures; and general orthopedic procedures

Otolaryngology procedures: ear procedures; mouth procedures; nasal/ sinus procedures; pharynx/ adenoid/ tonsil procedures



Urology procedures: circumcision; cystourethroscopy; male genital procedures; urethra procedures; and vaginal repair procedures