# Leapfrog Hospital Survey
# Hard Copy

**QUESTIONS & REPORTING PERIODS**
**ENDNOTES**
**MEASURE SPECIFICATIONS**
**FAQS**

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# *Welcome to the 2026 Leapfrog Hospital Survey*

**https://leapfroggroup.org/hospital**

## Important Notes About the 2026 Survey

1. The Leapfrog Hospital Survey webpages are located at https://leapfroggroup.org/hospital. Please bookmark this URL.

2. Note the word "hospital" used throughout this Survey refers to an individual hospital. If your hospital is part of a multi-hospital health care system or a multi-campus hospital, you will need to complete the Survey for each individual hospital. Please refer to Leapfrog's Multi-Campus Hospital Reporting Policy.

3. To submit a Survey via the Online Hospital Survey Tool, hospitals are required to complete and affirm the following sections: Section 1: Patient Rights and Ethics, Section 2: Medication Safety, Section 4: Maternity Care, Section 5: Physician and Nurse Staffing, Section 6: Patient Safety Practices, Section 7: Managing Serious Errors, and Section 8: Pediatric Care (for pediatric hospitals only). However, hospitals are urged to submit all sections of the Survey and can indicate within a section if a measure does not apply. Hospitals that would like to be eligible for Top Hospital must submit all sections of the Survey.

4. Adult and general hospitals that indicate they have a Computerized Physician Order Entry (CPOE) system in at least one inpatient unit are asked to demonstrate, via a test, that the inpatient CPOE system can alert prescribers to at least 60% of frequent serious medication errors known to cause harm to patients. Hospitals will have access to the CPOE Evaluation Tool immediately after completing the Hospital Profile in the Online Hospital Survey Tool. Adult and general hospitals cannot submit the Survey, including results from the Adult Inpatient CPOE Test, until all the following Survey sections have been completed and affirmed: Section 1: Patient Rights and Ethics, Section 2: Medication Safety, Section 4: Maternity Care, Section 5: Physician and Nurse Staffing, Section 6: Patient Safety Practices, and Section 7: Managing Serious Errors. Hospitals are urged to ensure that the Adult Inpatient CPOE Test is submitted along with the Survey (i.e., in the same month) to meet the deadlines for the Leapfrog Hospital Survey and Leapfrog's other programs such as Top Hospital and the Leapfrog Hospital Safety Grade.

5. Adult and pediatric hospitals reporting on Section 7B: Healthcare-Associated Infections are required to join Leapfrog's NHSN Group. Information about teaching status will also be pulled directly from NHSN. More information, including important deadlines, is available on the Review NHSN Instructions webpage.

6. Leapfrog Hospital Survey Results will be available on the Hospital Details Page beginning July 12 and publicly reported on the public reporting website on July 25 for hospitals that submit a Survey by the June 30 Submission Deadline. After July, the Hospital Details Page and public reporting website will be refreshed monthly within the first seven (7) business days of each month to reflect Surveys submitted or resubmitted between July 1 and November 30 and previously submitted Surveys that were corrected between December 1 and January 31. Survey Results are frozen from February to July 25.

7. All questions regarding the Leapfrog Hospital Survey should be submitted to the Help Desk at https://leapfroghelpdesk.zendesk.com. Questions submitted to the Help Desk will receive a response within 1-2 business days (see Help Desk Holiday Schedule for planned closures).

8. For hospitals that would like Leapfrog Hospital Survey Results included in their **Leapfrog Hospital Safety Grade,** please visit the "For Hospitals" section of the Hospital Safety Grade website for important information on Data Snapshot Dates. A Leapfrog Hospital Survey must be submitted by the Data Snapshot Date for Survey data to be used in the Hospital Safety Grade.


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**9.** Leapfrog is committed to verifying the accuracy of Leapfrog Hospital Survey Results. Please review the information on the Data Accuracy webpage.

**10.** The Submission Deadline for the 2026 Leapfrog Hospital Survey is **June 30, 2026,** and the Late Submission and Performance Update Deadline is **November 30, 2026**. Hospitals that do not submit a Survey or CPOE Evaluation Tool (adult and general hospitals only) before 11:59 pm Eastern Time on **November 30, 2026,** will have to wait until the launch of the 2027 Leapfrog Hospital Survey on April 1, 2027 to submit a Survey.


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# Overview of the 2026 Leapfrog Hospital Survey

The Leapfrog Hospital Survey is divided into nine sections and the Hospital Profile. A description of each section is listed below. For a more detailed overview of the 2026 Leapfrog Hospital Survey, including a crosswalk of nationally endorsed measures and a description of how measures are publicly reported, visit the Survey Overview webpage.

| Section Number | Section Title | Brief Description |
|---|---|---|
| | **Hospital Profile** | The Hospital Profile includes questions about demographic and contact information. The Profile can be accessed and updated anytime throughout the year after logging into the Online Hospital Survey Tool. The Hospital Profile must be completed and submitted before you can access Sections 1-9 and the CPOE Evaluation Tool on the Survey Dashboard. |
| **1** | **Patient Rights and Ethics** | Section 1 includes questions about your hospital's billing ethics, health care equity, and informed consent processes. This section also includes questions on your hospital bed size, admissions, ICUs, and teaching status. |
| **2** | **Medication Safety** | Section 2 includes questions about your hospital's use of CPOE and BCMA, and (for adult and general hospitals) questions about your hospital's medication reconciliation process. The EHR application subsection (2B) is only applicable to adult and general hospitals and will not be scored or publicly reported. In 2026, four questions about Artificial Intelligence (AI) applications were added to subsection 2B – these questions are required but will not be scored or publicly reported. |
| **3** | **Adult and Pediatric Complex Surgery** | Section 3 includes questions about your hospital's volume and process for privileging surgeons for eleven high-risk procedures, outcomes for mitral valve repair and replacement, and participation in The Society of Thoracic Surgeon's Congenital Heart Surgery Database for hospitals that perform the Norwood procedure. This section also includes questions about the implementation of a safe surgery checklist. |
| **4** | **Maternity Care** | Section 4 includes questions about maternity care volume and services, cesarean birth, episiotomy, newborn bilirubin screening, and DVT prophylaxis for women undergoing cesarean delivery. The section also includes questions about high-risk deliveries, including volume and outcomes. The subsection on cesarean birth (4B) includes questions about cesarean births stratified by race/ethnicity that will not be scored or publicly reported, however, responses will be used for confidential reporting on the Hospital Details Page in 2026. |
| **5** | **Physician and Nurse Staffing** | Section 5 includes questions about the management of critical care patients and the staffing structure of your hospital's adult and pediatric general medical, surgical, medical/surgical, and neuro ICUs, and questions about your hospital's nursing staffing. |
| **6** | **Patient Safety Practices** | Section 6 includes questions about your hospital's adherence to two National Quality Forum-endorsed Safe Practices, and questions about your hospital's hand hygiene practices. It also includes a subsection on diagnostic excellence (6D) and a new subsection on Hospital Boarding in the Emergency Department (ED) (6E). Section 6D is required while Section 6E is optional. These subsections will not be scored or publicly reported. |


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| Section Number | Section Title | Brief Description |
|---|---|---|
| **7** | **Managing Serious Errors** | Section 7 includes questions about your hospital's response to Never Events. In addition, Leapfrog collects information via its NHSN Group about five healthcare-associated infections (CLABSI, CAUTI, MRSA, *C. diff.*, and SSI: Colon). Hospitals reporting on Section 7B: Healthcare-Associated Infections are required to join Leapfrog's NHSN Group. Important information and deadlines are available on the Review NHSN Instructions webpage. |
| **8** | **Pediatric Care** | Section 8 includes questions about patient experience (CAHPS Child Hospital Survey) and Computed Tomography (CT) radiation dose for pediatric patients. For 2026, pediatric hospital are required to complete this section. |
| **9** | **Outpatient Procedures** | Section 9 includes questions about the volume and safety of same-day procedures performed in hospital outpatient departments. Additionally, Leapfrog downloads CMS data on unplanned hospital visits after an outpatient colonoscopy (OP-32) and the experience of patients who had a same-day surgery performed (OAS CAHPS). For 2026, reporting on Section 9C: Volume of Procedures is optional. |

Section 1: Patient Rights and Ethics, Section 2: Medication Safety, Section 4: Maternity Care, Section 5: Physician and Nurse Staffing, Section 6: Patient Safety Practices, Section 7: Managing Serious Errors, and Section 8: Pediatric Care (for pediatric hospitals only) are required to submit a Survey via the Online Hospital Survey Tool. Hospitals are strongly urged to submit all sections of the Leapfrog Hospital Survey and can indicate within a section if a measure does not apply.

The hard copy of the Survey and the Online Hospital Survey Tool are organized in the same format for all nine sections:

- **General information** about The Leapfrog Group's standard (included in the hard copy only).
- **Reporting periods** to provide hospitals with specific periods of time for each set of questions.
- **Survey questions** which may include references to endnotes or FAQs. The Survey questions and endnotes match the Online Hospital Survey Tool exactly.
- **Affirmation of accuracy** by your hospital's CEO/Chief Administrative Officer or by an individual that has been designated by the hospital CEO. These statements affirm the accuracy of your hospital's responses and must be completed in the Online Hospital Survey Tool to submit a Survey.
- **Reference information** which includes "What's New" and "Change Summaries," important measure specifications, answers to frequently asked questions, and other notes that must be carefully reviewed before responding to any of the Survey questions (included in the hard copy only).

In addition to the Survey questions, adult and general hospitals that indicate they have a CPOE system in at least one inpatient unit are asked to demonstrate, via a test, that the inpatient CPOE system can alert physicians to at least 60% of frequent serious medication errors known to cause harm to patients. Adult and general hospitals can access the CPOE Evaluation Tool immediately after completing the Hospital Profile in the Online Hospital Survey Tool. Carefully review the information on the Prepare for a CPOE Tool webpage.

Any changes made to the measure specifications after April 1 will be reflected in the hard copy of the Survey in the Reference Information sections under the "Change Summary" header (see Table of Contents). In addition, the updates to the specifications will be highlighted in yellow. If the changes are substantial, we will email the Primary Survey Contact your hospital provided in the Hospital Profile of the Online Hospital Survey Tool. If the notification is sent before your hospital submits a 2026 Leapfrog Hospital Survey, the email will go to the Primary Survey Contact provided in the previous year's Survey.


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The Leapfrog Group and its participating members are committed to presenting information that is as current as possible, therefore we allow hospitals to update and resubmit their Survey until the **November 30** Late Submission and Performance Update Deadline. Please carefully review the reporting periods in each section before updating your Survey. Leapfrog Hospital Survey Results are updated monthly beginning in July on Leapfrog's public reporting website. Hospitals are required to update the information in their Survey within 30 days of any change in status. We reserve the right to decertify information that is not current. More information on updating your Survey is available on the Updating Your Hospital Survey webpage.


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# Pre-Submission Checklist

Before you complete and submit the Survey via the Online Hospital Survey Tool, there are several steps you should complete:

- ☐ **Visit the Hospital Survey webpages at** https://leapfroggroup.org/hospital**.**
- ☐ **Make sure you have a 16-digit security code**. If you don't, download a Security Code Request form. If your hospital is part of a multi-hospital healthcare system, you will need a separate security code for each individual hospital within the system. Please refer to Leapfrog's Multi-Campus Hospital Reporting Policy.
- ☐ **Download a hard copy of the Survey** (PDF or Word document) on the Survey and CPOE Materials webpage. Read through the entire document to ensure that you understand what information is required.
- ☐ **Review the reference information** in each section of the Survey document and **download other supporting materials**. These documents and tools contain information that you will need to accurately respond to the Survey questions.
- ☐ **Join Leapfrog's NHSN Group**. Hospitals reporting on Section 7B: Healthcare-Associated Infections are required to join Leapfrog's NHSN Group. More information, including important deadlines, is available on the Review NHSN Instructions webpage.
- ☐ **Accept the American Medical Association's Terms of Use and Download the CPT Code Workbook**. Hospitals reporting on Section 3 Adult and Pediatric Complex Procedures (that perform bariatric surgery for weight loss, total hip replacement surgery, or total knee replacement surgery) and reporting on Section 9 Outpatient Procedures (that perform outpatient procedures) and are optionally reporting on select outpatient procedures must accept the American Medical Association's Terms of Use and download the CPT Code Workbook via the button on the Survey Dashboard in Section 9.
- ☐ **Identify individuals from your hospital to help you** gather the data you will need to complete the various sections of the Survey.
- ☐ **Complete a hard copy of the Survey before you log in to the Online Survey Tool**. This will expedite the data entry into the Online Survey Tool and help to avoid the Tool "timing out" after 20 minutes of idle time (a security precaution). Once all the information has been collected and recorded in the hard copy of the Survey, the CEO or the CEO's designee can typically complete the online data entry in less than an hour. Please note, responses must be entered into the Online Survey Tool to be submitted.
- ☐ **Download and review a copy of the Online Survey Tool Guide** on the Get Started webpage. It includes important instructions on how to navigate the Online Hospital Survey Tool, including instructions on how to verify that your hospital has successfully submitted the Survey.
- ☐ **Check Survey deadlines.** Carefully review Survey deadlines before you begin. Ensure that you have enough time to collect the data, complete a hard copy of the Survey, and complete and submit the Survey via the Online Hospital Survey Tool. In addition, for adult and general hospitals that have implemented CPOE in at least one inpatient unit, make sure you have enough time to take a CPOE Evaluation Tool test.
- ☐ **Download and review the 2026 Leapfrog Hospital Survey Scoring Algorithms.**
- ☐ **Review Leapfrog's policies and procedures regarding data accuracy**. Detailed information can be found on the Data Accuracy webpage.

> **Leapfrog Hospital Survey Binder:** Hospitals should utilize the Leapfrog Hospital Survey Binder to assist in organizing the documentation used to complete the Survey. Download a copy of the binder on the Survey and CPOE Materials webpage.


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# Instructions for Submitting a Leapfrog Hospital Survey

**Important Notes:**

Note 1: Please carefully review these instructions and the Online Survey Tool Guide before you begin.

Note 2: Each section of the Survey must be completed before it can be affirmed in the Online Hospital Survey Tool. Only sections that are affirmed can be submitted. Hospitals are responsible for ensuring that each submitted section is accurate.

1. Log into the Online Hospital Survey Tool using your 16-digit security code.
2. The first time you log into the 2026 Leapfrog Hospital Survey, you will need to complete and submit the Hospital Profile. The Hospital Profile includes demographic and contact information. The Hospital Profile should be updated throughout the year if any information changes and can be accessed at any time. **Failure to maintain current contact information could result in important, time-sensitive information being missed or sent to the wrong person.**
3. Once the Hospital Profile is submitted, you will be taken to the Hospital Survey Dashboard.
4. You can navigate into sections of the Online Hospital Survey Tool using the linked section names on the Hospital Survey Dashboard. You can also access the CPOE Evaluation Tool immediately after completing the Hospital Profile using the Take CPOE Tool button on the Hospital Survey Dashboard. More information about navigating within the Online Hospital Survey Tool is available in the Online Survey Tool Guide.
5. Within sections, you can enter responses to questions and/or update responses to previously submitted sections. The Online Hospital Survey Tool will automatically save your responses as you enter them. There is no “save” button.
6. Once you have completed each section, you will need to return to the Hospital Survey Dashboard to affirm each section of the Survey. Please remember that if you are making updates, all updated sections must be re-affirmed. Please note that affirmed sections are not yet submitted, please review Step 7 below to ensure successful submission.
7. Before you can submit the Survey (select the “*submit affirmed sections*” button on the Hospital Survey Dashboard), you will need to “*check for data review warnings*.” When you select the “*check for data review warnings*” button, the sections of your Survey that are affirmed will be scanned for potential reporting errors. If any errors are identified, a data review warning message will be generated and will appear on the Hospital Survey Dashboard.
8. If any data review warnings are generated, you will still be able to submit your Survey. However, you will need to address the potential reporting errors identified during the scan or risk having the related sections of your Survey decertified (publicly reported as “Declined to Report”). Please note this may not be a comprehensive list – you may still receive additional data verification messages via email.
9. Once you have checked for data review warnings, you can select the “*submit affirmed sections*” button to submit the Survey. Please review the Section Status column on the Hospital Survey Dashboard to verify which sections have been submitted.
10. Use the “*Print Last Submitted Survey”* button on the Hospital Survey Dashboard to print a copy of your Last Submitted Survey and review it for accuracy and completeness. Remember, sections that are not affirmed will not be submitted.
11. Review the 2026 Leapfrog Hospital Survey Scoring Algorithms to see how your Survey responses will be scored and publicly reported by Leapfrog.
12. Review your Survey Results on the Hospital Details Page or public reporting website. Hospitals that submit by June 30 can preview their Survey Results on the Hospital Details Page beginning on July 12, before Leapfrog publicly reports Survey Results beginning on July 25. After July, the Hospital Details Page and public reporting website will be refreshed monthly within the first seven (7) business days of each month following your (re)submission.


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13. Adult and general hospitals submitting a CPOE Evaluation Tool should carefully review the instructions, scoring information, and FAQs available on the Survey and CPOE Materials webpage (see CPOE Tool Instructions under Other Supporting Materials).
14. Leapfrog is committed to verifying the accuracy of Leapfrog Hospital Survey Results. Please review our data accuracy protocols on the Data Accuracy webpage.
15. Responses can be updated or corrected, and the Survey can be resubmitted at any point during the Survey Cycle (April 1 – November 30). Please remember that if you are making updates, all updated sections must be re-affirmed. More information on updating your Survey is available on the Updating Your Hospital Survey webpage.

### *Reporting Policy Following Cybersecurity Events and Natural Disasters or CMS Extraordinary Circumstances Exception*

Hospitals that have experienced a cybersecurity event, natural disaster, EHR transition or have an Extraordinary Circumstances Exception approved by the Centers for Medicare and Medicaid Services (CMS) (i.e., CMS Footnote 28) that impacts data availability during one or more Survey reporting periods can complete and submit a request form in order to participate in the 2026 Leapfrog Hospital Survey. If approved, hospitals will report on the impacted measures using the data available and exclude data from the month(s) impacted by the cybersecurity event, natural disaster, EHR transition or CMS Extraordinary Circumstance. Results will still be calculated if minimum reporting requirements are met and will be displayed on the Survey Results website with the following footnote: "Results are based on limited data due to a reported cybersecurity event, natural disaster, or a CMS Extraordinary Circumstance exception."

For the purposes of the Hospital Safety Grade, a letter grade will still be calculated based on the data available, but any underlying measures impacted by the event will have results reported along with the following footnote: "Results are based on limited data due to a reported cybersecurity event, natural disaster, or a CMS Extraordinary Circumstance exception." For the purposes of Leapfrog Top Hospital, hospitals will still be eligible for Top Hospital pending committee review and subject to meeting all criteria.

### *Verifying Submission*

Use the following steps to verify that your submission was completed and that the appropriate sections were submitted:

- **Check the Hospital Survey Dashboard:** Refer to the “Section Status” column on the Hospital Survey Dashboard. All submitted sections will be marked as “Submitted.”
- **Check your email:** You will receive a Survey submission confirmation email within five minutes of submitting a Survey. Please Note: This email will not specify which sections were submitted – you will need to use the other steps to determine which sections were submitted.
- **Print Last Submitted Survey:** The Survey submission date will be listed at the top of the page under the heading “Submitted Survey.” Be sure to check the submission date, review each section for accuracy and completeness, and check that each affirmation is complete (Sections 1-9).
- **Review the Hospital Details Page:** Your Survey Results will be available beginning July 12 via the Hospital Details Page link on the Hospital Survey Dashboard. Carefully review your results, including data from VON for high-risk deliveries, and your NHSN information for applicable healthcare-associated infections.
- **Check your publicly reported results:** Always check your Leapfrog Hospital Survey Results on the public reporting website. Results are posted on July 25 and are updated within the first 7 (seven) business days of the month following your submission starting in August.


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### *Updating or Correcting a Previously Submitted Leapfrog Hospital Survey*

Hospitals can update or correct previously submitted Survey responses at any point during the Survey Cycle (April 1 to November 30). Please review the Survey Deadlines webpage. Most updates or corrections are made:

- At the request of Leapfrog:
  - Following Leapfrog's Extensive Monthly Data Verification, the Primary Survey Contact, Secondary Survey Contact, and System Survey Contact will receive an email from the Help Desk detailing potential reporting errors.
- Following On-Site Data Verification:
  - Hospitals selected for On-Site Data Verification will receive a report which will indicate any responses that need to be updated or corrected.
- At the discretion of the hospital:
  - To correct a data entry or reporting error.
  - To reflect a change in status or performance on a measure (e.g., closed a unit, stopped performing a procedure, implemented a new policy, etc.).
  - To provide more current responses based on the reporting periods outlined in the hard copy of the Survey.

***Following any updates, hospitals should always use the steps for verifying submission provided above.***

### *Updating a Survey After Receiving a Help Desk Email*

Leapfrog conducts Extensive Monthly Data Verification of responses submitted to the Leapfrog Hospital Survey starting with Surveys submitted by the June 30 Submission Deadline and monthly thereafter until the Online Survey Tool is taken offline on January 31. Following the Extensive Monthly Data Verification, the **Primary Survey Contact, Secondary Survey Contact, and System Contact** are notified by email of any Survey responses that need to be reviewed and/or updated by the hospital.

If you receive a Data Verification email, you are required to document that your original responses were correct or update/correct your previously submitted Leapfrog Hospital Survey by the end of the same month using the **original** reporting period that was used for that section of the Survey in the original submission. For example, if a hospital submitted a Survey for the first time on August 20, then received a Data Verification email at the beginning of September, they would update their responses based on the reporting period used in the August 20 submission.

Hospitals that receive a Category A Data Verification message at the beginning of the month for any measure will have until the end of that same month to contact the Help Desk 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.

If any Category A Data Verification messages are not resolved by January 31 (when the Online Hospital Survey Tool is taken offline), the entire Survey will be decertified, and the hospital will be publicly reported as "Declined to Report" for the entire Leapfrog Hospital Survey.

### *Updating a Survey Following On-Site Data Verification*

Hospitals that are selected for On-Site Data Verification will receive a findings report. If the findings report details any responses that need to be updated or corrected, please contact the Help Desk.


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### *Making General Updates (for hospitals that have not received a Help Desk email)*

Leapfrog offers hospitals multiple reporting periods so that they can report the most current data. Except for Section 4E: High-Risk Deliveries (VON data only), Section 7B: Healthcare-Associated Infections, and Section 9F: CMS Measures, updating a Survey is optional. However, we do recommend that if your performance or if a structure has changed significantly, you update your Survey within 30 days. In addition, hospitals should update their Surveys if they become aware of any reporting errors or data inaccuracies in their previous submission.

Hospitals may update one or more sections of the Survey without updating the entire Survey. In addition, hospitals are not required to retake the CPOE Evaluation Tool if making updates to Section 2A: CPOE questions #3 and #4.

General updates and corrections are allowed at any point during the Survey Cycle (April 1 – November 30). The months of December and January are reserved for correcting data entry errors or reporting errors (i.e., in response to Leapfrog's Extensive Monthly Data Verification) to previously submitted sections of the Survey. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. **Updates made to reflect a change in performance after November 30 will not be scored or publicly reported. New sections of the Survey submitted after November 30 will not be scored or publicly reported.**

Hospitals that are submitting general updates should:

- Use the stated reporting period at the top of each section selected based on the date of your resubmission.
- For Section 4: Maternity Care and Section 6A-6B: NQF Safe Practice #1 and #2, update responses to ALL questions within the section they wish to update using the same reporting period. For example, if a hospital submitted a Survey for the first time in June and then wanted to update the responses for the Cesarean Birth questions in subsection 4B in November, they would update the entire Section 4: Maternity Care based on the updated reporting period for November.

For information on Leapfrog's automatic updates to the VON data in Section 4E: High-Risk Deliveries, the NHSN data in Section 7B: Healthcare-Associated Infections, or the CMS data in Section 9F: CMS Measures, please review the Section 4E: High-Risk Deliveries Measure Specifications, the Review NHSN Instructions webpage, and the Section 9F: CMS Measures Measure Specifications.

**Quick Tip**: Remember to re-affirm any section of the Survey that is updated, check for data review warnings, and then resubmit the entire Survey. Always print a copy of your Last Submitted Survey and review it for accuracy and completeness. Check your updated Survey Results within the first 7 (seven) business days of the month following your resubmission on the public reporting website and the Hospital Details Page.

# Deadlines

### *Deadlines for the 2026 Leapfrog Hospital Survey*

The 2026 Leapfrog Hospital Survey, including the CPOE Evaluation Tool (if applicable), opens on April 1 and has a Submission Deadline of **June 30, 2026**. The Late Submission and Performance Update Deadline is **November 30, 2026**. Surveys and Adult Inpatient CPOE Tests must be submitted before 11:59 pm Eastern Time on **November 30**. The CPOE Evaluation Tool will not be available after **November 30**. The View CPOE Evaluation Tool results link on the Survey Dashboard can only be accessed between April 1 and November 30, so test results must be printed by November 30.

Corrections to Surveys submitted by **November 30** must be submitted by the **January 31, 2027** Corrections Deadline. The Online Hospital Survey Tool will not be available after **January 31, 2027**. Find detailed information about the 2026 Leapfrog Hospital Survey Deadlines, including deadlines for receiving free Competitive Benchmarking Summary Reports and consideration for Top Hospital Awards on the Deadlines webpage.

### *Deadlines for Vermont Oxford Network Data*

Hospitals participating in the Vermont Oxford Network (VON) may opt to report on the VON National Performance Measure in Section 4E: High-Risk Deliveries. Instructions, deadlines, and reporting periods can be reviewed in the VON National Performance Measure Specifications.

### *Deadlines to Join Leapfrog's NHSN Group*

Hospitals reporting on Section 7B: Healthcare-Associated Infections are required to join Leapfrog's NHSN Group. Please visit our webpage for instructions on how to join the group as well as information about important deadlines.

### *Deadlines Related to the Hospital Safety Grade*

Hospitals that would like Leapfrog Hospital Survey Results used in their Leapfrog Hospital Safety Grade must submit a Survey and an Adult Inpatient CPOE Test by the Data Snapshot Dates. The Leapfrog Hospital Survey and the Hospital Safety Grade are distinct programs administered by The Leapfrog Group. Though some measures from the Leapfrog Hospital Survey are used in the Hospital Safety Grade, the grade also utilizes publicly available data from other data sources. Find answers to Frequently Asked Questions in the "For Hospitals" section of the Hospital Safety Grade website.


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# Technical Assistance

## *Leapfrog's Help Desk*

Connect with Leapfrog's in-house subject matter experts via our dedicated Help Desk to get timely support for:

- Survey content and scoring questions,
- Data verification messages and requests for documentation, and
- Technical issues related to the Online Survey Tool, CPOE Evaluation Tool, or the Hospital and Surgery Center Ratings website,

You can also schedule a 1:1 Hospital Survey Orientation and submit feedback on any of Leapfrog's ratings programs, including Top Hospitals and Top ASCs, the Hospital Safety Grade, the Recognized Leader in Caring for People with Diabetes Program and Leapfrog's Value-Based Purchasing Program.

To quickly get you to the right in-house expert for the right level of support, submit your inquiry in writing through the Zendesk ticketing portal at https://leapfroghelpdesk.zendesk.com. You'll receive a reply within 1-2 business days, if not sooner. Tickets submitted during a CPOE Test receive a reply within 10 minutes during normal business hours. More information on submitting and managing Help Desk tickets can be found in the Help Desk Guide.

The Help Desk is staffed Monday through Friday from 9:00 a.m. to 5:00 p.m. ET, except on select holidays. Please review the Help Desk Holiday Schedule for closures and allow ample time for staff to respond to time sensitive requests before any program deadlines.

You can manage your open tickets through email and/or create an account with Zendesk to manage open and archived tickets.

To ensure that you receive our emails, please work with your IT department to add the following to your safe sender list:

- @leapfrog-group.org
- @leapfroghelpdesk.zendesk.com
- @em8434.leapfrog-group.org
- IP address: 159.183.167.150

## *Leapfrog Hospital Survey Webinar Series*

The Leapfrog Hospital Survey Webinar Series is designed for Survey coordinators, hospital leaders, and others who would benefit from a more interactive presentation of Survey materials and information.

The Webinar Series is held monthly from March to December and includes monthly office hours in addition to monthly webinars. The one-hour webinars focus on specific topics related to the Survey, including new measures. Throughout each webinar, participants can ask questions live or via the Zoom Q&A function.

The monthly 30-minute office hours are designed to give participants another regular, interactive touch point with Leapfrog's Help Desk, so Survey coordinators always have the information they need, when they need it.


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Join now and start benefiting from:

- **Monthly Office Hours with the Leapfrog Help Desk:** 30 minutes to get real-time technical assistance, answers to your questions, and help staying on top of upcoming deadlines. Staffed by Leapfrog's expert Help Desk.
- **Monthly Webinars:** Timely and focused presentations on Survey and CPOE Evaluation Tool measures and specifications, scoring information, frequently asked questions, technical assistance, and public reporting. Each webinar concludes with a 20-minute open Q & A session.
- **Archive Library:** Slides and recordings from each webinar are archived in an online portal that participants can access from March to January.

The annual registration fee is $500 per individual.

For a schedule of events and to register, please visit the Leapfrog Hospital Survey Webinar Series webpage.

### *Support for Health Systems*

Are you responsible for coordinating Leapfrog Hospital Survey submissions for more than one hospital? Leapfrog's Health System Support subscription for multi-hospital health systems is designed to help Survey coordinators and health system leaders become in-house experts on the Leapfrog Hospital Survey and the Hospital Safety Grade and make it easy to monitor, compare, and analyze your hospitals' Leapfrog Hospital Survey Results, Hospital Safety Grades, and Custom Benchmarking scores.
The subscription gives you timely data for all your hospitals in a series of easy-to-use Excel workbooks, so you can quickly perform analysis, benchmark performance, build performance dashboards, and identify areas for improvement. Subscribers have access to The Hopper, a custom landing page where each file is stored for easy access throughout the year. Also new API access so you don't have to retrieve files each month (New as of 2025!).

The subscription also includes a seat at Leapfrog's monthly Hospital Webinar Series, so you can become an in-house expert on all aspects of the Leapfrog Hospital Survey and Hospital Safety Grade.

The support package includes the following:

- Hospital Webinar Series (one registration per health system)
- Leapfrog Hospital Survey Responses and Results
- Leapfrog Hospital Safety Grades
- Custom Benchmarking Scores
- Top Hospital Analysis (New as of 2025!)

More information is available on the Support for Health Systems webpage. Please contact the Help Desk for more information.


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# Reporting Periods

**Important Note:** Reporting periods should be selected based on the date of Survey or section submission. However, hospitals do not need to use the same reporting period throughout the Survey.

| | **Survey Submitted Prior to September 1** | **Survey (Re)Submitted on or After September 1** |
|---|---|---|
| **Survey Section/ Measure** | **Reporting Period** | **Reporting Period** |
| **1A** Basic Hospital Information | 12 months ending 12/31/2025 | 12 months ending 06/30/2026 |
| **1B** Billing Ethics | Based on the practices currently in place at the time of Survey Submission | Based on the practices currently in place at the time of Survey Submission |
| **1C** Health Care Equity | Based on the practices currently in place at the time of Survey Submission | Based on the practices currently in place at the time of Survey Submission |
| **1D** Informed Consent | Based on the practices currently in place at the time of Survey Submission | Based on the practices currently in place at the time of Survey Submission |
| **2A** Computerized Physician Order Entry (CPOE) | Latest 3 months prior to Survey submission | Latest 3 months prior to Survey submission |
| **2B** EHR Application Information | Based on the EHR application currently in place at the time of Survey Submission | Based on the EHR application currently in place at the time of Survey Submission |
| **2C** Bar Code Medication Administration (BCMA) | Latest 3 months prior to Survey submission | Latest 3 months prior to Survey submission |
| **2D** Medication Reconciliation | Latest 6 months prior to Survey submission | Latest 6 months prior to Survey submission |
| **3A** Hospital and Surgeon Volume | Volume:<br>12 months or 24-month annual average ending 12/31/2025 | Volume:<br>12 months or 24-month annual average ending 06/30/2026 |
| | STS MVRR Composite Score:<br>Latest 36-month report | STS MVRR Composite Score:<br>Latest 36-month report |
| **3B** Safe Surgery Checklist for Adult and Pediatric Complex Surgery | Latest 12 months prior to Survey submission | Latest 12 months prior to Survey submission |
| **4A** Maternity Care Volume and Services | Volume:<br>12 months ending 12/31/2025 | Volume:<br>12 months ending 06/30/2026 |
| | Services:<br>Based on the practices currently in place at the time of Survey Submission | Services:<br>Based on the practices currently in place at the time of Survey Submission |
| **4B** Cesarean Birth | 12 months ending 12/31/2025 | 12 months ending 06/30/2026 |
| | Cesarean Birth Stratified by Race/Ethnicity:<br>24 months ending 12/31/2025 | Cesarean Birth Stratified by Race/Ethnicity:<br>24 months ending 06/30/2026 |

| | **Survey Submitted Prior to September 1** | **Survey (Re)Submitted on or After September 1** |
|---|---|---|
| **Survey Section/ Measure** | **Reporting Period** | **Reporting Period** |
| **4C** Episiotomy | 12 months ending 12/31/2025 | 12 months ending 06/30/2026 |
| **4D** Process Measures of Quality | 12 months ending 12/31/2025 | 12 months ending 06/30/2026 |
| **4E** High-Risk Deliveries* | Volume:<br>12 months ending 12/31/2025 | Volume:<br>12 months ending 06/30/2026 |
| | VON:<br>2024 report | VON:<br>2025 report |
| **5A** Adult ICU Physician Staffing | Latest 3 months prior to Survey submission | Latest 3 months prior to Survey submission |
| **5B** Pediatric ICU Physician Staffing | Latest 3 months prior to Survey submission | Latest 3 months prior to Survey submission |
| **5C** Nursing Workforce | Nurse Staffing:<br>12 months ending 12/31/2025 | Nurse Staffing:<br>12 months ending 06/30/2026 |
| | NQF Safe Practice #9:<br>Latest 12 months prior to Survey submission | NQF Safe Practice #9:<br>Latest 12 months prior to Survey submission |
| | Percentage of RNs who are BSN-Prepared:<br>Based on the most recent day within the last 12 months for which you have complete data | Percentage of RNs who are BSN-Prepared:<br>Based on the most recent day within the last 12 months for which you have complete data |
| **6A** NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems | Latest 12 months prior to Survey submission | Latest 12 months prior to Survey submission |
| **6B** NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention | Latest 12 or 24 months prior to Survey submission (see individual safe practice for specific reporting period) | Latest 12 or 24 months prior to Survey submission (see individual safe practice for specific reporting period) |
| **6C** Hand Hygiene | Based on the practices currently in place at the time of Survey Submission | Based on the practices currently in place at the time of Survey Submission |
| **6D** Diagnostic Excellence | Latest 24 or 36 months prior to Survey submission (see individual question for specific reporting period) | Latest 24 or 36 months prior to Survey submission (see individual question for specific reporting period) |
| **6E** Hospital Boarding in the Emergency Department (ED) | 12 months ending 12/31/2025 | 12 months ending 06/30/2026 |
| **7A** Never Events | Based on the principles currently included in your hospital's never events policy at the time of Survey submission | Based on the principles currently included in your hospital's never events policy at the time of Survey submission |


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| | **Survey Submitted Prior to September 1** | **Survey (Re)Submitted on or After September 1** |
|---|---|---|
| **Survey Section/ Measure** | **Reporting Period** | **Reporting Period** |
| **7B** Healthcare-Associated Infections** | June and August Data Downloads: 01/01/2025 – 12/31/2025 | October and December Data Downloads: 07/01/2025 – 06/30/2026 or 07/01/2025-06/30/2026 (for hospitals that reported <=50 beds) |
| **8A** Patient Experience (CAHPS Child Hospital Survey) | Latest 12 months prior to Survey submission | Latest 12 months prior to Survey submission |
| **8B** Pediatric Computed Tomography (CT) Radiation Dose | 12 months ending 12/31/2025 | 12 months ending 06/30/2026 |
| **9A** Basic Outpatient Department Information | 12 months ending 12/31/2025 | 12 months ending 06/30/2026 |
| **9B** Medical, Surgical, and Clinical Staff | Latest 3 months prior to Survey submission | Latest 3 months prior to Survey submission |
| **9C** Volume of Procedures | 12 months ending 12/31/2025 | |
| **9D** Safety of Procedures | Latest 12 months prior to Survey submission | Latest 12 months prior to Survey submission |
| **9E** Medication Safety for Outpatient Procedures | 12 months ending 12/31/2025 | 12 months ending 06/30/2026 |
| **9F** CMS Measures*** | June CMS Data Download:<br><br>OP-32: 1/1/2022 - 12/31/2024<br>OAS CAHPS: 7/1/2024 - 6/30/2025<br><br>August CMS Download:<br><br>OP-32: 1/1/2022 - 12/31/2024<br>OAS CAHPS: 10/1/2024 - 9/30/2025 | November CMS Data Download:<br><br>OP-32: 1/1/2022 - 12/31/2024<br>OAS CAHPS: 1/1/2025 - 12/31/2025 |

*Leapfrog will update VON data 3 times per Survey Cycle for all hospitals that provide an accurate VON Transfer Code in the Hospital Profile, submit a Data Sharing Authorization letter to VON, select "VON National Performance Measure" in Section 4E, and submit the 2026 Leapfrog Hospital Survey.

**Adult and pediatric hospitals reporting on Section 7B: Healthcare-Associated Infections are required to join Leapfrog's NHSN Group. More information, including important deadlines, is available on the Review NHSN Instructions webpage. Leapfrog will update data 4 times for all members of our NHSN group that provide an accurate NHSN ID in the Hospital Profile and submit the 2026 Leapfrog Hospital Survey.

*** Leapfrog will update data 3 times per Survey Cycle for all adult hospitals that provide an accurate CCN in the Hospital Profile and report performing outpatient procedures in Section 9A: Basic Outpatient Department Information.


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# Included Units by Survey Section

Note: Only include units that were open for the entire reporting period and that remain currently open.

| Survey Section/ Measure | Units |
|---|---|
| **1A** Basic Hospital Information | • Acute-Care Units [1] (adult and/or pediatric)<br>• General Medical, Surgical, Medical/Surgical and Neuro ICUs[14] (adult and/or pediatric)<br>• Specialty ICUs (adult and/or pediatric)<br>• Level II/III, Level III, and Level IV Neonatal ICUs[17] |
| **1B** Billing Ethics | N/A |
| **1C** Health Care Equity | N/A |
| **1D** Informed Consent | N/A |
| **2A** Computerized Physician Order Entry (CPOE) | N/A |
| **2B** EHR Application Information | N/A |
| **2C** Bar Code Medication Administration (BCMA) | • General Medical, Surgical, Medical/Surgical, and Neuro ICUs[14] (adult and/or pediatric)<br>• Level II/III, Level III, and Level IV Neonatal ICUs[17]<br>• Specialty ICUs (adult and/or pediatric)<br>• Medical, Surgical, and Medical/Surgical Units (including telemetry units)[19](adult and/or pediatric)<br>• Step-down/Progressive Units[20] (adult and/or pediatric)<br>• Labor and Delivery Units[21]<br>• Pre-operative and Post-anesthesia Care Units[22] (adult and/or pediatric) |
| **2D** Medication Reconciliation | • Medical and Medical/Surgical Units (including telemetry units) (adult only)<br>• Step-down/Progressive Units[20] (adult only) |
| **3A** Hospital and Surgeon Volume | N/A |
| **3B** Safe Surgery Checklist for Adult and Pediatric Complex Surgery | N/A |
| **4A** Maternity Care Volume and Services | N/A |
| **4B** Cesarean Birth | N/A |
| **4C** Episiotomy | N/A |
| **4D** Process Measures of Quality | N/A |
| **4E** High-Risk Deliveries | • Level II/III, Level III, and Level IV Neonatal ICUs[17] |


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| Survey Section/ Measure | Units |
|---|---|
| **5A** Adult ICU Physician Staffing | • General Medical, Surgical, Medical/Surgical, and Neuro ICUs[14] (adult) |
| **5B** Pediatric ICU Physician Staffing | • General Medical, Surgical, Medical/Surgical, and Neuro ICUs[14] (pediatric) |
| **5C** Nursing Workforce | Nurse Staffing:<br>• Single Acuity Medical Units (adult and/or pediatric)<br>• Single Acuity Surgical Units (adult and/or pediatric)<br>• Single Acuity Med-Surg Combined Units (adult and/or pediatric)<br>• Mixed Acuity Medical, Surgical and Med-Surg Units (adult and/or pediatric)<br><br>Percentage of RNs who are BSN-Prepared:<br>• N/A<br><br>For more information, refer to the Section 5C: Nursing Workforce Measure Specifications. |
| **6A** NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems | N/A |
| **6B** NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention | N/A |
| **6C** Hand Hygiene | • Medical, Surgical, and Medical/Surgical Units (including telemetry units)[19] (adult and/or pediatric)<br>• Step-down/Progressive Units[20] (adult and/or pediatric)<br>• Obstetrical Units (Labor and Delivery Units[21], nursery, etc., excluding procedural areas)<br>• General Medical, Surgical, Medical/Surgical, and Neuro ICUs[14] (adult and/or pediatric)<br>• Level II/III, Level III, and Level IV Neonatal ICUs[17]<br>• Specialty ICUs (adult and/or pediatric)<br>• Pre-operative and Post-anesthesia Care Units[22] (adult and/or pediatric)<br>• Observation units (adult and/or pediatric)<br>• Dedicated Emergency Departments[47] (adult and/or pediatric) |
| **6D** Diagnostic Excellence | N/A |
| **6E** Hospital Boarding in the Emergency Department (ED) | • Dedicated Emergency Departments[47] (adult and/or pediatric) |
| **7A** Never Events | N/A |
| **7B** Healthcare-Associated Infections | N/A |

| Survey Section/ Measure | Units |
|---|---|
| **8A** Patient Experience (CAHPS Child Hospital Survey) | N/A |
| **8B** Pediatric Computed Tomography (CT) Radiation Dose | N/A |
| **9A** Basic Outpatient Department Information | N/A |
| **9B** Medical, Surgical, and Clinical Staff | N/A |
| **9C** Volume of Procedures | N/A |
| **9D** Safety of Procedures | N/A |
| **9E** Medication Safety for Outpatient Procedures | N/A |
| **9F** CMS Measures | N/A |


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# *HOSPITAL PROFILE*

Hospitals must complete and submit a Hospital Profile via the Online Hospital Survey Tool before accessing the Hospital Survey Dashboard for the first time. The Profile is available year-round and should be updated as needed.


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# Hospital Profile

The Hospital Profile includes questions about demographic and contact information. The Profile can be accessed and updated anytime throughout the year after logging into the Online Hospital Survey Tool.

The Hospital Profile must be completed and submitted before you can access Sections 1-9 and the CPOE Evaluation Tool on the Survey Dashboard.


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# Hospital Profile

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Notes:**

Note 1: Leapfrog uses an administration system that links contacts shared by hospitals (i.e., CEOs, Survey Contacts, System Contacts, and Public Relations Contacts). Only one phone number and email address will be maintained for each contact, meaning that if this shared contact's information is updated in one hospital's Profile, it will be updated for all hospitals associated with the contact.

Note 2: Following Leapfrog's Extensive Monthly Data Verification, the Primary Survey Contact, Secondary Survey Contact, and System Survey Contact will receive an email from the Help Desk detailing potential reporting errors.

### *Hospital Information*

| **Organization Name**<br>This is the name that will appear on Leapfrog's public reporting website. | **CMS Certification Number (CCN)** [2]<br>If the CCN displayed in the Online Hospital Survey Tool is not correct, contact the Leapfrog Help Desk immediately. |
|---|---|
| | |
| | **Does your hospital share this CCN with another facility?** |
| | ○ Yes<br>○ No |
| | **NHSN ID** [3] |
| | |
| | **Vermont Oxford Network (VON) Transfer Code** [4] |
| | |
| | **Federal Tax Identification Number (TIN)** [5] |
| | |
| | **National Provider Identifier (NPI)** [6]<br>If the NPI displayed in the Online Hospital Survey Tool is not correct, contact the Leapfrog Help Desk immediately. |
| | |
| | **Does your hospital share this NPI with another facility?** |
| | ○ Yes<br>○ No |

### *Demographic Information*

| **Physical Address**<br>(used for public reporting) | **Mailing Address**<br>(used to send important communications) |
|---|---|
| **Street Address** | **Street Address or P.O. Box** |
| | |
| **City** | **City** |
| | |
| **State** [7] | **Country** |
| | |
| **Zip Code** | **State** |


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| | |
|---|---|
| | |
| **Zip Code Suffix** | **Zip Code** |
| | |
| **Main Phone Number** | **Zip Code Suffix** |
| | |
| **Hospital Website Address** [8]<br>(so consumers can learn more about your hospital's efforts in the area of patient safety and quality improvement) | |
| | |

### *Contact Information*

| **Chief Executive Officer (CEO)** | **Chairperson of the Board** |
|---|---|
| **Prefix**<br>(e.g., Mr., Ms., Mrs., Dr., etc.) | **First Name** |
| | |
| **First Name** | **Last Name** |
| | |
| **Last Name** | |
| | |
| **Title**<br>(e.g. CEO, President, etc.) | |
| | |
| **E-mail Address**<br>(required for emailing of security codes and Top Hospital notification) | |
| | |

| **Primary Survey Contact** | **Secondary Survey Contact** |
|---|---|
| **First Name** | **First Name** |
| | |
| **Last Name** | **Last Name** |
| | |
| **Title** | **Title** |
| | |
| **Phone Number** | **Phone Number** |
| | |
| **Phone Number Extension** | **Phone Number Extension** |
| | |
| **E-mail Address** | **E-mail Address** |
| | |

| **Hospital Public Relations Contact**<br>(required so that Leapfrog may provide information on Leapfrog accolades, such as Top Hospital notification, and announcements) |
|---|
| **First Name** |
| |
| **Last Name** |
| |
| **Phone Number** |

| |
|---|
| **Phone Number Extension** |
| |
| **E-mail Address** |
| |

| | |
|---|---|
| **Opt-Out**<br>Opt-out of having information in the "Contact Information" subsection shared with third parties. | ☐ Opt-out |

| **Healthcare System Information** |
|---|
| **Name of Healthcare System or Integrated Delivery Network** [9]<br>If the name displayed in the Online Hospital Survey Tool is not correct, contact the Leapfrog Help Desk immediately. |
| |
| **System Contact First Name**<br>Provide a System Contact for the IDN displayed. If no System Contact for the IDN displayed, enter a Contact for a larger parent system or re-enter your Primary or Secondary Survey Contact information. |
| |
| **System Contact Last Name** |
| |
| **System Contact E-mail Address** |
| |

| |
|---|
| **System Public Relations Contact First Name**<br>(required so that Leapfrog may provide information on Leapfrog accolades, such as Top Hospital notification, and announcements) |
| |
| **System Public Relations Contact Last Name** |
| |
| **System Public Relations Contact Phone Number** |
| |
| **System Public Relations Contact Phone Number Extension** |
| |
| **System Public Relations Contact E-mail Address** |
| |

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# *SECTION 1: PATIENT RIGHTS AND ETHICS*

This section includes questions and reference information for Section 1: Patient Rights and Ethics. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.


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# Section 1: Patient Rights and Ethics

**Billing Ethics Bibliography and Fact Sheet:**
https://ratings.leapfroggroup.org/measure/hospital/2026/billing-ethics

**Health Care Equity Bibliography and Fact Sheet:**
https://ratings.leapfroggroup.org/measure/hospital/2026/health-care-equity

**Informed Consent Bibliography and Fact Sheet:**
https://ratings.leapfroggroup.org/measure/hospital/2026/informed-consent

Section 1 includes questions about your hospital's billing ethics, health care equity, and informed consent processes. This section also includes questions on your hospital bed size, admissions, ICUs, and teaching status.

**Each hospital achieving the standard for Billing Ethics:**

1) Provides every patient with a billing statement within 30 days after final claims adjudication that includes all 10 required elements listed in question #1, **and**
2) Gives patients instructions for contacting a billing representative with access to an interpretation service to communicate in the patient's preferred language and has the authority to do all three required elements in question #2 within ten business days, **and**
3) Does NOT take legal action against patients for late or insufficient payment.

**Each hospital achieving the standard for Health Care Equity:**

1) Collects patient self-identified race, ethnicity, and preferred written and/or spoken language data, **and**
2) Trains staff responsible for collecting self-identified demographic data from patients, **and**
3) Uses the patient self-identified demographic data to stratify at least one quality measure, **and**
4) If disparities were identified, has an updated or revised policy or procedure to address the disparity or has developed a written action plan, **and**
5) Shares information about efforts to identify and reduce health care disparities on its public website, **and**
6) Reports out and discusses efforts to identify and address health care disparities with the board.

**Each hospital achieving the standard for Informed Consent:**

1) Has a training program on informed consent that tailors different training topics to different staff roles and has made the training required for newly hired staff and existing staff who were not trained, **and**
2) Ensures that as part of the process for obtaining informed consent, clinicians explain expected difficulties, recovery time, pain management, and restrictions after a procedure, and give the patient an opportunity to ask questions, **and**
3) Ensures every applicable consent form used by the hospital includes the name of the clinician performing the procedure, whether the clinician is expected to be absent, and whether any assistants or trainees will be involved, **and**
4) Ensures every applicable consent form is written at a 6$^{th}$-grade reading level or lower, **and**
5) Prior to conducting the informed consent discussion, identifies the patient/legal guardian's preferred language and provides a medical interpreter, and has a place in the consent form that indicates whether an interpreter was used, **and**
6) Requires clinicians at the hospital to use the "teach back method" with patients/legal guardians.

**Download the 2026 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.**


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# 1A: Basic Hospital Information

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Note:** Only include units that were open for the entire reporting period and that remain currently open.

**Specifications:** See ***Basic Hospital Information Measure Specifications*** in the Reference Information beginning on page 48.

**Reporting Period: 12 months**

- Surveys submitted prior to September 1:
  - 01/01/2025 – 12/31/2025
- Surveys (re)submitted on or after September 1:
  - 07/01/2025 – 06/30/2026

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

### *General Information*

| | | |
|---|---|---|
| 1) | Reporting period used: | ○ 01/01/2025 – 12/31/2025<br>○ 07/01/2025 – 06/30/2026 |
| 2) | Total number of licensed acute-care [10] beds. | _____ |
| 3) | Total number of staffed acute-care [11] beds. | _____ |
| 4) | Total number of adult acute-care admissions [12] to your hospital during the reporting period. | _____ |
| 5) | Total number of pediatric acute-care admissions [13] to your hospital during the reporting period. | _____ |
| 6) | Does your hospital operate any adult and/or pediatric general medical, surgical, medical/surgical, or neuro ICUs [14]?<br><br>*If "yes, adult only" to question #6, skip questions #10-13 below.*<br><br>*If "yes, pediatric only" to question #6, skip questions #7-9 and #13 below.*<br><br>*If "yes, adult and pediatric" to question #6, skip question #13 below.*<br><br>*If "no" to question #6, skip questions #7-12 and continue to question #13.* | ○ Yes, adult only<br>○ Yes, pediatric only<br>○ Yes, adult and pediatric<br>○ No |
| 7) | Total number of licensed [15] adult general medical, surgical, medical/surgical, and neuro ICU beds. | _____ |
| 8) | Total number of staffed [16] adult general medical, surgical, medical/surgical, and neuro ICU beds. | _____ |
| 9) | Total number of adult general medical, surgical, medical/surgical, and neuro ICU[14] admissions during the reporting period. | _____ |
| 10) | Total number of licensed[15] pediatric general medical, surgical, medical/surgical, and neuro ICU beds. | |
| 11) | Total number of staffed[16] pediatric general medical, surgical, medical/surgical, and neuro ICU beds. | |

| | |
|---|---|
| 12) Total number of pediatric general medical, surgical, medical/surgical, and neuro ICU[14] admissions during the reporting period. | |
| 13) If your hospital does not operate dedicated adult or pediatric general medical, surgical, medical/surgical, or neuro ICUs, does your hospital admit adult and/or pediatric general medical, surgical, medical/surgical or neuro ICU patients to mixed acuity units? | ○ Yes<br>○ No |
| 14) Does your hospital operate any of the following specialty ICUs: medical cardiac, respiratory, surgical cardiothoracic, burn, trauma, pediatric cardiothoracic, oncology, Level II/III neonatal ICU, Level III neonatal ICU, or Level IV neonatal ICU[17]?<br><br>*If "no" to question #14, skip question #15 and continue to question #16.* | ○ Yes<br>○ No |
| 15) Total number of admissions to a Level II/III, Level III, or Level IV neonatal ICU [17] during the reporting period. | _____ |
| 16) Is your hospital a Major or Graduate teaching hospital (based on NHSN's definitions) for physicians and/or physicians-in-training or nursing students? | *No response required here. Determined automatically based on NHSN 2025 Patient Safety Component – Annual Hospital Survey.* |

**Reporting Period:** Answer questions #17-19 based on the practices currently in place at the time you submit this section of the Survey.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

### *General Hospital Policies*

| | |
|---|---|
| 17) To help ensure that patients are cared for by well-trained physicians and other providers (e.g., certified registered nurse anesthetists, certified midwives, or certified nurse-midwives, etc.), do your medical staff by-laws or hospital-wide policies require all physicians and providers who have privileges to provide care at your hospital to be board certified or board eligible? | ○ Yes<br>○ No |
| 18) Does your hospital include performance on the Leapfrog Hospital Survey, Leapfrog Hospital Safety Grade, or Leapfrog Top Hospital in performance reviews and/or compensation incentives for senior administrative leadership? | ○ Yes<br>○ No |
| 19) Does your hospital have a policy and protocol that empowers patients, or their family caregivers, to activate a rapid response team (RRT) to evaluate the patient for possible escalation of care, that includes **all** the following elements:<br>• A process to notify patients and family caregivers, verbally or in writing, about how to activate the rapid response team;<br>• A process to ensure clinicians are trained to recognize when a patient or family caregiver is asking for an evaluation by a rapid response team; and<br>• A process to ensure clinicians are trained on how to conduct the evaluation if they are part of the rapid response team? | ○ Yes<br>○ No |

# 1B: Billing Ethics

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Notes:**

Note 1: Questions #4-7 will not be scored or publicly reported.

Note 2: Hyperlinks throughout this subsection refer to the Billing Ethics FAQs beginning on page 499, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

**Reporting Period:** Answer questions #1-3 based on the practices currently in place at the time you submit this section of the Survey.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

| | |
|---|---|
| 1) Within 30 days of the final claims adjudication (or within 30 days from date of service for patients without insurance), does your hospital provide every patient with a billing statement and/or master itemized bill for facility services, either by mail or electronically (via email or the patient portal), that includes ALL the following:<br>a. Name and address of the facility where billed services occurred;<br>b. Date(s) of service;<br>c. An individual line item for each service or bundle of services performed;<br>d. Description of services billed that accompanies each line item or bundle of services performed;<br>e. Amount of any principal, interest, or fees (e.g., late or processing fees), if applicable;<br>f. Amount of any adjustments to the bill (e.g., health plan payment or discounts), if applicable;<br>g. Amount of any payments already received (from the patient or any other party), if applicable;<br>h. Instructions on how to apply for financial assistance, if applicable;<br>i. Instructions in the patient's preferred language on how to obtain a written translation or oral interpretation of the bill; and<br>j. Notification that physician services will be billed separately, if applicable?<br><br>*If any one of the elements above is only provided upon request, select "only upon request." If any one of the elements above is not ever provided, select "no."* | ○ Yes<br>○ No<br>○ Only upon request |
| 2) Does your hospital give patients instructions for contacting a billing representative:<br>• Who has access to an interpretation service to communicate in the patient's preferred language, **and**<br>• Who has the authority to do all the following within 10 business days of being contacted by the patient or patient representative:<br>i. initiate an investigation into errors on the bill, | ○ Yes<br>○ No |

| | |
|---|---|
| ii. offer a price adjustment or debt forgiveness based on hospital policy, and<br>iii. offer a payment plan? | |
| 3) Does your hospital take legal action against patients for late payment or insufficient payment of a medical bill?<br><br>*This question does not include patients with whom your hospital has entered into a written agreement specifying a good faith estimate for a medical service.* | ○ Yes<br>○ No<br>○ No, but required by state or federal law to transfer delinquent payments to a state or federal agency (e.g., Department of Treasury, Attorney General, etc.) for action |
| 4) Does your hospital screen ALL patients to determine if they are eligible for your hospital's financial assistance program, regardless of whether they apply for financial assistance?<br><br>*If "no, we only screen uninsured patients for financial assistance eligibility" or "no, we only screen patients who have applied for financial assistance," skip question #5 and continue to question #6.*<br><br>*If "no, our hospital does not have a financial assistance program," skip questions #5-7 and continue to the next subsection.* | ○ Yes, using a presumptive eligibility tool licensed from a third-party<br>○ Yes, using our hospital's own approach to assessing financial assistance eligibility<br>○ No, we only screen uninsured patients for financial assistance eligibility<br>○ No, we only screen patients who have applied for financial assistance<br>○ No, our hospital does not have a financial assistance program |
| 5) Does your hospital notify ALL patients who were determined to be eligible for your hospital's financial assistance program that they have qualified for the program within 30 days of the determination? | ○ Yes<br>○ No |
| 6) Does your hospital's financial assistance program apply to ALL clinician fees, in addition to facility fees, for clinicians with privileges at your hospital? | ○ Yes<br>○ No<br>○ No, but we include a list of covered clinicians and services in our financial assistance application |
| 7) Does your hospital's financial assistance application include notification that some services, including physician services, may be billed separately? | ○ Yes<br>○ No |


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# 1C: Health Care Equity

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Notes:**

Note 1: Question #5 will not be used in scoring for hospitals that do not identify disparities or if there is inadequate data to determine if disparities exist in question #4. All other questions will be used in scoring and public reporting.

Note 2: Hyperlinks throughout this subsection refer to the Health Care Equity FAQs beginning on page 51, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

**Reporting Period:** Answer questions #1-7 based on the practices currently in place at the time you submit this section of the Survey.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

| | |
|---|---|
| 1) Which of the following **patient self-identified** demographic data does your hospital collect **directly from its patients (or patient's legal guardian)** prior to or while registering a patient for a hospital visit?<br><br>*Select all that apply.*<br><br>*If "none of the above," skip the remaining questions in Section 1C and continue to the next subsection. The hospital will be scored as "Limited Achievement."* | ☐ Race<br>☐ Ethnicity<br>☐ Spoken language preferred for health care (patient or legal guardian)<br>☐ Written language preferred for health care (patient or legal guardian)<br>☐ Sexual orientation<br>☐ Gender identity<br>☐ Ability status<br>☐ None of the above |
| 2) Does your hospital train staff responsible for collecting the self-identified demographic data either in-person or over the phone from patients (or patient's legal guardian) in question #1 at both:<br>• the time of onboarding, and<br>• annually thereafter? | ○ Yes<br>○ No |
| 3) Does your hospital use the patient self-identified demographic data it collects directly from patients (or patient's legal guardian) in question #1 to stratify any quality measure(s) with the aim of identifying health care disparities?<br><br>*If "no" to question #3, skip questions #4-5 and continue to question #6.* | ○ Yes<br>○ No |
| 4) By stratifying the quality measure(s) from question #3, has your hospital identified any health care disparities among its patients?<br><br>*If "no, disparities were not identified" or "inadequate data available to determine if disparities exist" to question #4, skip question #5 and continue to question #6.* | ○ Yes, disparities were identified<br>○ No, disparities were not identified<br>○ Inadequate data available to determine if disparities exist |

| | |
|---|---|
| 5) In the past 12 months, has your hospital used the data and information obtained through question #4 to update or revise its policies or procedures<br><br>OR<br><br>In the past 12 months, has your hospital developed a written action plan that describes how it will address at least one of the health care disparities identified through question #4? | ○ Yes<br>○ No |
| 6) Does your hospital share information on its efforts to identify and reduce health care disparities and the impact of those efforts on its public website based on *race, ethnicity, spoken language preferred for health care (patient or legal guardian), written language preferred for health care (patient or legal guardian), sexual orientation, gender identity, or ability status*? | ○ Yes<br>○ No |
| 7) Does your hospital report out and discuss efforts related to identifying and addressing disparities with the Board at least annually? | ○ Yes<br>○ No |


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# 1D: Informed Consent

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Notes:**

Note 1: In this subsection, questions regarding the informed consent process and consent forms ONLY apply to those procedures where general anesthesia, regional anesthesia, or monitored anesthesia care is used. The questions do NOT apply to anesthesia care; they only apply to the consent process and consent forms for applicable procedures.

Note 2: Hyperlinks throughout this subsection refer to the Informed Consent FAQs beginning on page 52, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

**Reporting Period:** Answer questions #1-6 based on the practices currently in place at the time you submit this section of the Survey.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

### *Training on Informed Consent*

| | |
|---|---|
| 1) Does your hospital train employed staff on informed consent and tailor different training topics to different staff roles, including hospital leaders, MD/NP/PA, nurses and other clinical staff, administrative staff, and interpreters, and has your hospital made the training:<br>• a required component of onboarding for the appropriate newly hired staff, and<br>• required for the appropriate existing staff who were not previously trained? | ○ Yes<br>○ No |

### *Content of Informed Consent Forms*

| | |
|---|---|
| 2) As part of your hospital's process for obtaining informed consent, does:<br>• the clinician explain expected difficulties, recovery time, pain management, and restrictions after a procedure that may be experienced by the patient either in the hospital or post-discharge, if applicable;<br>• the patient have the opportunity to ask questions; and<br>• the consent form document that these two elements of the process have taken place? | ○ Yes<br>○ No |
| 3) Do ALL applicable consent forms used by your hospital include:<br>• the name(s) of the clinician(s) performing the procedure;<br>• whether the clinician is expected to be absent from portions of the procedure (e.g., opening, closing), if applicable; and<br>• whether any assistants or trainees will be involved in the procedure, if applicable? | ○ Yes<br>○ No |

| | |
|---|---|
| 4) Are ALL applicable consent forms used by your hospital written at a 6th-grade reading level or lower?<br><br>*The procedure name and description, and any words accompanied by a plain language definition can be excluded from the reading level assessment.* | ○ Yes, all applicable forms are written at a 6th-grade reading level or lower<br>○ No, but at least one form is written at a 6th-grade reading level or lower<br>○ No forms are written at a 6th-grade reading level or lower<br>○ No, all applicable forms are written at a 9th-grade reading level or lower |

### *Process for Gaining Informed Consent*

| | |
|---|---|
| 5) Prior to the informed consent discussion, does your hospital:<br>• ask what the patient/legal guardian's preferred language for medical decision-making is;<br>• where needed, provide the patient/legal guardian access to a qualified medical interpreter, **NOT a family caregiver;**<br>• use a consent form or notation in the medical record to document whether a qualified medical interpreter was used to conduct the informed consent process; and<br>• have the medical interpreter sign the consent form (either in-person, electronically, or by documenting the use of an interpreter in the medical record)? | ○ Yes<br>○ No |
| 6) As part of the informed consent discussion, do clinicians at your hospital use the "teach back method" with patients/legal guardians where patients/legal guardians are asked to describe in their own words what they understand will be performed, why it will be performed, and what are the primary risks? | ○ Yes<br>○ No |


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**Affirmation of Accuracy**

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Patient Rights and Ethics Section at our hospital, and I hereby affirm that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this affirmation on behalf of our hospital.

The hospital and I acknowledge that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also acknowledge that analyses and ratings The Leapfrog Group derives from this information will be made public on the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade website, and/or other Leapfrog Group published works, products and services. The hospital and I acknowledge that analyses and ratings derived from this information and all intellectual property rights related to those analyses and ratings shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. I hereby affirm that this information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may license analyses and ratings derived from this information to other entities including researchers, not-for-profit entities, and for-profit entities, and the revenue from such licensure will be used solely to support The Leapfrog Group's not-for-profit mission. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
*(first name and last name)* *(title)*
on _____.
*(date)*

# Section 1: Patient Rights and Ethics Reference Information

### *What's New in the 2026 Survey*

### Section 1A: Basic Hospital Information

Leapfrog is updating and adding two new questions in Section 1A: Basic Hospital Information asking hospitals to report on adult and pediatric licensed and staffed ICU beds separately. The purpose of these adjusted questions is to identify hospitals that are eligible to report on adult and/or pediatric ICU Physician Staffing in Section 5A: Adult ICU Physician Staffing and Section 5B: Pediatric ICU Physician Staffing.

Leapfrog is also updating the questions regarding the operations of and admissions to neonatal ICUs to clarify that only level II/III, level III, and level IV neonatal ICUs should be included in responses. This was previously clarified in the associated endnotes and does not reflect a change in how hospitals should report on these questions.

In addition, Leapfrog is removing question #18 which asks if hospitals have a protocol to follow up on patient reported concerns, as performance has improved over time, with more than 99% of hospitals responding "yes" in 2025.

Finally, Leapfrog is persuaded by evidence that attainment of certifications related to improving quality and patient safety can lead to improved patient outcomes. Given the compelling public comments, it is clear that a number of such certifications are available to professionals, and more work is needed to study the evidence on impact to patient care. As a result, Leapfrog will form an advisory committee to explore the evidence on quality and patient safety certifications and delay for one year planned fact-finding questions about the National Association for Healthcare Quality's (NAHQ) Certified Professional in Healthcare Quality (CPHQ) certification.

### Section 1B: Billing Ethics

In response to feedback and responses from hospitals participating in the 2025 Leapfrog Hospital Survey, Leapfrog will make several updates to Section 1B: Billing Ethics.

First, Leapfrog is updating the response options in question #3, which asks if hospitals take legal action against patients for late or insufficient payments, to include an option for public hospitals that are required by state law to transfer unpaid medical bills to a state agency, similar to federal law requirements for Military Treatment Facilities. We anticipate that this updated response option will only apply to public hospitals in limited states (e.g., Illinois or New York). Leapfrog is also adding a FAQ with further information.

Hospitals eligible for this exception should maintain a copy of the state or federal legislation requiring the transfer of medical bills. As part of Leapfrog's Data Accuracy protocol, hospitals may be randomly selected for Leapfrog's monthly documentation requirement and will need to provide documentation supporting their Survey responses.

Second, we are retaining the four fact-finding questions regarding presumptive eligibility and financial assistance programs for patients for another year with plans to incorporate them into the Billing Ethics Standard in 2027. These fact-finding questions will now be required but will not be used in scoring or public reporting in 2026.

Finally, Leapfrog is adding two new FAQs to provide hospitals with additional clarification regarding screening methods and financial assistance application disclosures.

There are no changes to the scoring algorithm for Section 1B: Billing Ethics.

### Section 1C: Health Care Equity

There are no changes to this subsection.


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## Section 1D: Informed Consent

Leapfrog is removing question #2, which asks if hospitals solicit feedback from patients/legal guardians about their hospital's informed consent process. As this question was neither scored nor publicly reported, there are no changes to the scoring algorithm for Section 1D: Informed Consent.

After additional research and consideration of public comments, Leapfrog is adding a new FAQ with guidance on how hospitals can assess the reading level of their Spanish-language consent forms. The reading level of consent forms in languages other than English is an important consideration for improving the accessibility of the informed consent process to all patients, so Leapfrog created an online calculator (available at: https://readability.leapfroggroup.org/) to assist hospitals in evaluating the reading level of their Spanish-language consent forms. In 2026, Leapfrog's standard will continue to focus on consent forms written in the English language, but we expect to extend the standard to Spanish as early as 2027.

In addition, Leapfrog is updating FAQ #28 in Section 1D to add additional information regarding strategies for optimizing the readability of consent forms using Large Language Models.

### *Change Summary Since Release*

None. If substantive changes are made to this section of the Survey after release on April 1, 2026, they will be documented in this Change Summary section.


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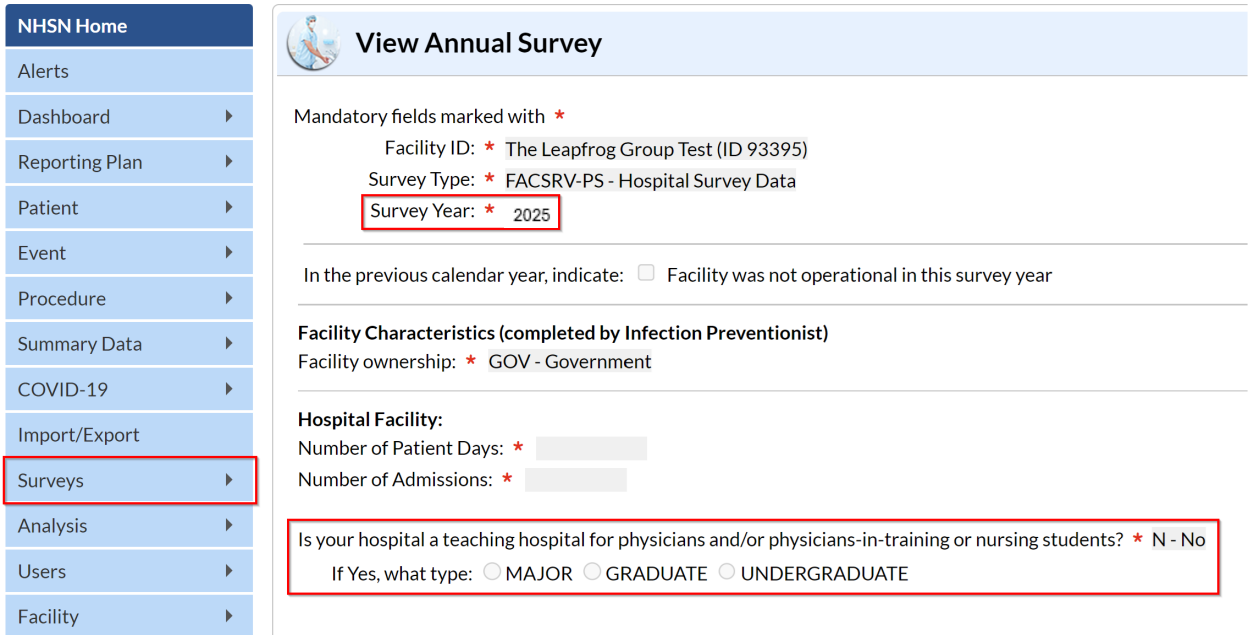
# Section 1A: Basic Hospital Information Measure Specifications

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

Teaching Status is obtained directly from CDC's National Healthcare Safety Network (NHSN) using a hospital's response to the following questions within the "Hospital Facility" section of the 2025 Patient Safety Component – Annual Hospital Survey:

Is your hospital a teaching hospital for physicians and/or physicians-in-training or nursing students? [*Yes, No*]
If Yes, what type: [*Major, Graduate, Undergraduate*]




For the purposes of the 2026 Leapfrog Hospital Survey and Leapfrog's Top Hospital program, Leapfrog will consider the following types a "teaching hospital:" Major and Graduate. NHSN's definitions for types of teaching hospitals may be reviewed here. This designation will also be used for the purposes of assigning hospitals to a teaching or non-teaching hospital cohort for the purposes of scoring the Total Nursing Care Hours per Patient Day and RN Hours per Patient Day measures in Section 5C: Nursing Workforce.

In order for Leapfrog to obtain teaching status from NHSN, hospitals must complete the following steps:

1) Join Leapfrog's NHSN Group and review/accept Leapfrog's Data Rights Template by the published deadlines*,
2) Enter a valid NHSN ID in the Profile of their 2026 Leapfrog Hospital Survey,
3) Answer "yes" to question #1 in Section 7B, and
4) Submit a 2026 Leapfrog Hospital Survey by the published deadlines.

*Hospitals are not required to "re-join" Leapfrog's NHSN Group if they joined and conferred rights in previous Leapfrog Hospital Survey Cycles. However, all hospitals in Leapfrog's NHSN Group must review their Data Rights Template at least annually by the published join-by deadlines.

Instructions for joining or verifying that you are in Leapfrog's NHSN Group are available here (See "NHSN Guidance: Join the Group, Data Rights Template, and Downloading Reports"). These instructions also include information for verifying the teaching status response to the 2025 Patient Safety Component – Annual Hospital Survey.

# Section 1: Patient Rights and Ethics Frequently Asked Questions (FAQs)

## *Basic Hospital Information FAQs*

1. **How does Leapfrog define board certified and board eligible?**
   For physicians:
   - Board certified means that the physician has been awarded certification from the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).
   - Board eligible indicates that the physician has completed their initial training/fellowship but has not yet passed an existing board-certifying exam in a specialty. Leapfrog adheres to the ABMS and AOA Board Eligibility Policy for all specialties, which may be reviewed here: https://www.abms.org/board-certification/board-certification-requirements/board-eligibility/ and https://certification.osteopathic.org/about/, respectively. These eligibility periods provide the physician with an adequate window to take their boards and re-take if necessary.

   For CRNAs, board certified means that the RN has been awarded certification from The National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA).

2. **Regarding clinicians' role in the rapid response team, can we require that activation of the rapid response team be mediated by a clinical professional, such as a nurse? What training do clinicians need to have to respond to a request for a rapid response team?**
   The rapid response team should be able to be directly activated by the patient themselves, as opposed to through a clinical staff intermediary. Regarding the training program, Leapfrog only requires that clinicians be trained to recognize when a patient or family caregiver is asking for an evaluation by a rapid response team and be trained on how to conduct the evaluation if they are part of the rapid response team. Program examples include Condition Help at the University of Pittsburgh Medical Center and a program at MonHealth Medical Center.

## *Billing Ethics FAQs*

3. **Can we consider information provided to patients at admission, or as part of the "conditions of admission" packet of material, as information that meets one or more of the elements of the billing statement in question #1?**
   No. Only information provided directly to the patient by mail or electronically (via email or the patient portal) can be considered.

4. **To meet the criteria for item "i" in question #1, does our hospital have to translate the billing statement and/or master itemized bill to every language spoken by our patients?**
   Hospitals must provide instructions, in the patient's preferred language, on how to obtain a written translation or oral interpretation of the bill if the language constitutes 5% (and at least 50 patients) or 1,000 patients (whichever is less) of the population eligible to be served or likely to receive care at the hospital.

5. **As a SafetyNet hospital, our funding comes from taxpayers, grants, and government funding. A large portion of our patients are deemed indigent and do not receive a bill for any services. Only a small portion with insurance will receive a bill. Therefore, we do not send a bill to every patient. Can we respond "yes" to question #1?**
   Yes. Hospitals do not need to provide billing statements to patients with no balance due in order to respond "yes" to question #1. However, for those patients who are receiving a bill, all the criteria listed in the question must be included to respond "yes."

6. **What does Leapfrog mean by "legal action" in question #3?**
   Legal action can include, but is not limited to, a lawsuit, wage garnishment, filing to take a patient's money out of their tax return, seizing or placing a lien on a patient's personal property, and selling or transferring a patient's debt to a debt collection agency that will take legal action against the patient. If, through their contract with the hospital, the debt collection agency is prevented from taking legal action against patients, selling or transferring a patient's debt to that debt collection agency would not be considered legal action.

   Patients with whom your hospital has entered into a written agreement specifying a good faith estimate for a medical service are not included in this question. A patient's insurance being accepted by the hospital, or publicly available prices for a procedure, do NOT constitute a written agreement specifying a set price for a procedure.

   In addition, other legal proceedings where patients may be named as defendants for causes other than late or non-payment of a medical bill are not included in this standard (e.g., filing a lien after an auto accident, or misappropriation of an insurance reimbursement).

7. **What are alternatives to legal action against patients?**
   To ensure that patients are not being pursued when they no longer have the means to pay, some healthcare providers partner with organizations such as Undue Medical Debt, a nonprofit that uses philanthropically raised funds to acquire bad debt from health systems solely for the purpose of debt relief. They use credit analytics to locate patients with financial hardship and help notify the patient that the debt is abolished. Hospitals can contact Undue Medical Debt here: https://unduemedicaldebt.org/contact/.

8. **What is a "good faith estimate" as referred to in question #3?**
   A good faith estimate includes an itemized list of expected charges for the primary item or service the patient will receive and any other items or services provided as part of the same scheduled episode of care. The final bill must be no more than $400 over the amount of the good faith estimate. The Centers for Medicare and Medicaid Services have published an example template for providing good faith estimates: https://www.cms.gov/files/document/nsa-sample-good-faith-estimate.pdf.

9. **How do I know if a state or federal law requires my hospital to transfer delinquent payments to a state or federal agency (e.g., Department of Treasury, Attorney General, etc.)?**
   These requirements generally apply to public or state-owned hospitals, including hospitals operated by public universities or state health systems, in certain states (e.g., Illinois or New York). The obligation is tied to the hospital's public ownership or operation, rather than hospital status alone.

   Private hospitals are generally not required to transfer delinquent patient accounts to a state or federal agency for collection.

10. **How and when should hospitals initiate the screening process for their financial assistance program?**
    Hospitals should initiate the eligibility screening process on all patients at the time of registration. Hospitals can do so by using presumptive eligibility software used to determine Medicaid eligibility to help determine if patients are eligible for the hospital's own financial assistance programs (e.g., Waystar, FinThrive, RevCo, etc.). Hospitals can use tools such as Experian or paper applications to assess a patient's ability to pay.

    A recent report from Healthcare Financial Management Association (HFMA) highlights the importance of promoting responsible financial assistance, billing, and collection practices. HFMA's report, *Advancing Healthcare Access*, is available at: https://www.hfma.org/finance-and-business-strategy/advancing-healthcare-access/.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11. **Our organization uses more than one method for screening patients for financial assistance eligibility, how should we respond to question #4?**
    When more than one option is applicable, hospitals should select the option that is primarily used for screening patients.

12. **What does Leapfrog mean when asking if the hospital's financial assistance program includes ALL clinicians with privileges at the hospital?**
    Hospitals that offer a financial assistance program (FAP) or "charity care" should provide a list of any clinicians delivering emergency or other medically necessary care in the hospital, that specifies which clinicians and services are covered by the FAP and which are not to ensure that the patient is aware that they may receive a separate bill that they will be responsible for from any clinician who is not covered. More information about what should be included in your financial assistance policy is available here: https://www.irs.gov/charities-non-profits/financial-assistance-policy-and-emergency-medical-care-policy-section-501r4.

13. **Our organization currently lists the notification regarding some services being billed separately in the Frequently Asked Questions on our medical bills. Does this still need to be added to the financial assistance application?**
    Yes, the disclosure should still be included in the financial assistance application itself. The intent of this question is to ensure patients are notified at the point of applying for financial assistance, not just somewhere else in the billing materials.

### *Health Care Equity FAQs*

14. **Our hospital is just starting to explore the collection and use of demographic data. What are some resources or tools we can use to collect demographic data?**
    Hospitals can refer to the Toronto Measuring Health Equity website which includes training videos, manuals, and presentations on how to collect demographic data from patients, including the modeling of interactions between health care staff and patients. Additionally, CMS also has some free tools available on their website at: https://www.cms.gov/priorities/health-equity/minority-health/research-data/research-data/tools.

15. **What types of demographic data should hospitals be collecting?**
    At minimum, hospitals should collect ethnicity and race data from patients. While the Office of Management and Budget (OMB) has revised their Standards for maintaining, collecting, and presenting federal data on race and ethnicity, hospitals may not have implemented those updates. However, the following minimum categories should be used: American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Pacific Islander, and White.

16. **To select any of the patient self-identified demographic data in question #1, does a hospital need to collect the data in a particular way?**
    Hospitals should be regularly collecting the information via registration or a nurse admission assessment directly from the patient or, for pediatric and other patients who cannot communicate the information themselves, the patient's legal guardian. Patients or their legal guardians should have the opportunity to provide the information either verbally (in-person or over the phone) or via a paper form or online patient portal. Information should NOT be collected through observation or other documents (e.g., state-issued ID). This information should be collected from inpatients and outpatients.

17. **Does Leapfrog have an example of how to collect patient self-identified "sexual orientation" or "gender identity" in question #1?**
    The Centers for Disease Control and Prevention (CDC) has issued helpful guidance for providers and facilities on their website at https://www.cdc.gov/sti/hcp/clinical-guidance/taking-a-sexual-history.html. This webpage includes guidance for discussing sexual health, sexual orientation, and gender identity. Additionally, they provide some helpful tips on what questions to ask to collect the data.

    Another great resource is The Nuts and Bolts of SOGI Data Implementation: *A Troubleshooting Toolkit* created by The Fenway Institute: https://fenwayhealth.org/wp-content/uploads/TFI-54_SOGI-Data-Collection-Series-of-3-Tip-Sheets-for-pride-month_NutsAndBolts.pdf.


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18. **What does Leapfrog mean by "ability status"?**
    As described by the CDC, a disability is any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions). More information is available on the CDC website at https://www.cdc.gov/disability-and-health/about/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/disabilityandhealth/disability.html. Examples of questions and ways to determine one's ability status can be found here:
    - https://www.cdc.gov/dhds/datasets/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/disabilityandhealth/datasets.html
    - https://torontohealthequity.ca/wp-content/uploads/2018/03/Measuring-Health-Equity-Participant-Manual-2018.pdf
    - Short Set of questions on Disability: Data Collection - Washington Group
    - Video 2 - Collecting Disability Data

19. **How does Leapfrog define "health care disparities?"**
    Leapfrog defines health care disparities as differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention. More information is available at https://www.ihi.org/insights/words-matter-making-sense-health-equity-terminology.

20. **In question #4, what does Leapfrog mean by "inadequate data available to determine if disparities exist?"**
    Hospitals may find that they cannot determine if a health care disparity exists due to small sample sizes (e.g., fewer than 25 patients able to be measured).

21. **Can we report on health system level data in question #4 if we do not have adequate data to determine if disparities exist?**
    Yes, individual hospitals that do not have enough data to identify disparities among their patients based on the demographic data selected in question #1 can respond "yes" to question #4 if they are aggregating their data for the purposes of analysis with other facilities that are part of their system.

22. **In question #6, is Leapfrog asking whether our hospital is publicly reporting the measures we stratify from question #3 on our website?**
    No. We are trying to assess the extent to which hospitals are sharing any information on their efforts to identify and reduce health care disparities based on the self-identified demographic data collected directly from the patient or legal guardian present and the impact of those efforts. This may take the form of sharing quantitative or qualitative data. It may also include a description of the types of demographic data collected and the analyses performed, which in some cases demonstrated no apparent health care disparities. Please note that the information on your webpage should be easily accessible. If your hospital is part of a health system, you must provide a link to the system webpage from your hospital's individual website. Below are examples that meet the criteria for question #6.
    - Henry Ford Health: https://www.henryford.com/hcp/research/public-population-research/hdrc/resources/demo-data
    - NewYork-Presbyterian: https://www.nyp.org/daliocenter/data-and-infrastructure

### *Informed Consent FAQs*

23. **In cases where hospitals do not have information about informed consent processes that take place at a clinician's (e.g., surgeon's) office, or if informed consent processes are conducted by clinicians that are not employed by the hospital, or in other cases where the hospital does not have visibility into the informed consent process, how should hospitals respond to questions in this section?**
    Hospitals that do not have input over the consent form or visibility into the informed consent process for procedures performed at a hospital, should select "No" for the questions in this section.

If the hospital does have input over the consent form and visibility into the informed consent process for procedures performed at the hospital, such as through the privileging process to allow clinicians to practice at their facility, but the consent forms and the consent process are being completed at the clinician(s)'s office, the hospital can work with those offices to implement the requirements outlined in the questions and, via an annual audit, verify that the forms and process meet the criteria to respond "Yes" to the questions in this section. All documentation should be maintained throughout the Survey Cycle.

24. **Are there any examples of patients for whom the informed consent questions would not apply?**
When responding to the questions in this subsection, you can exclude patients who are unable to communicate and for whom no legal guardian or medical proxy has been identified at least one week prior to the procedure being performed.

25. **Should we consider the term "legal guardian" to be equivalent to the term "legal surrogate decision-maker"?**
Yes, for the purposes of the Leapfrog Hospital Survey, these terms are equivalent.

26. **What roles and staff levels need to be included in the training program on informed consent included in question #1? What types of training can we use?**
As described on page 98 of the AHRQ's Making Informed Consent an Informed Choice – Training for Health Care Leaders, the appropriate roles for training include all the following: hospital leaders, physicians/independent nurse practitioners/independent physician assistants, nurses or other clinical staff, administrative staff in a patient-facing role, and interpreters. The training may be tailored to only include relevant materials based on the staff role. The goal is for each responsible staff person to be trained in their applicable domains. For example:
    - For hospital leaders, training on the definition and principles of informed consent and specifics on the hospital's informed consent policy is appropriate.
    - Clinical staff such as physicians and nurses should also be trained in strategies for clear communication, for presenting choices, and for documentation, if they are responsible for directly conducting the informed consent process.
    - Administrative staff in a patient-facing role and interpreters should also be trained in reviewing and completing documentation if participating in the informed consent process.

    Staff that are not directly employed by the hospital (e.g., medical interpreters who are employed by a contractor) do not need to be trained by the hospital.

    Training does not need to be exclusive to informed consent and can be included as a component or module in other trainings. Examples of trainings include computer-based training, one-on-one precepting, webinars, and staff meeting presentations, as well as other modalities where learning can be assessed after the content is delivered to the trainee.

27. **Should each consent form be customized to include patient- and procedure-specific details to explain expected difficulties and recovery time (question #2)?**
No. Instead, the consent form must document that the conversation between the patient and the clinician took place, and that the patient had the opportunity to ask questions. For example, such language might read: "I confirm that the choices for my treatment were explained to me. I understand the risks I may face and the benefits that may happen. I also know about the issues I might face from having the procedure. I understand how long I will take to recover, how I can manage my pain, and any rules to follow while I am in the hospital and after I leave. I also understand why the procedure is being done."

28. **Does the consent form need to specifically name the assistants and trainees who will be involved in the procedure, the same way the consent form needs to name the clinician performing the procedure?**
No. The consent form only needs to indicate that assistants or trainees may be involved, if this applies to the specific procedure the patient is signing the consent form for.


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**29. Why has Leapfrog selected a 6th-grade reading level target for consent forms, and what are some strategies we can use to meet this?**

Just over half of U.S. adults have a reading level that permits them to understand and synthesize information from a complex text. According to a Gallup analysis, 54% of Americans between the ages of 16 and 74 read below the equivalent of a sixth-grade level. A more recent survey by the Organization for Economic Development and Cooperation (OECD) indicates that literacy in the U.S. has gradually declined since that Gallup analysis, suggesting a still-greater proportion of the population reads below a sixth-grade level today.

Leapfrog hosted two Town Hall Calls led by AHRQ describing techniques for reducing the written complexity of consent forms. The slides are available on Leapfrog's Town Hall Calls webpage; please refer to slides 40-47 for more information in the "Informed Consent" slide deck and slides 40-45 in the "Health Literacy" deck. Additional resources include:

- AHRQ Training Module
- The Patient Education Materials Assessment Tool (PEMAT)
- Clear Communication Index (CCI)
- CMS Toolkit for Making Written Material Clear and Effective

In addition, recent research suggests that Large Language Models (e.g. ChatGPT) can be leveraged to optimize the reading level of consent forms, while retaining the accuracy and completeness of the medical terminology and descriptions used.

- Ramanathan, Rahul & Kelly, Ryan & Shaw, Jeremy & Gopakumar, Adway & Shannon, Michael & Gonzalez, Christopher & Weinberg, Jacob & Bonamer, John & Wawrose, Richard & Spitnale, Michael & Lee, Joon & Weddle, John. (2026). Reducing Complexity in Surgical Consents: The Role of AI in Patient Communication. Medical Research Archives. 13. 10.18103/mra.v13i12.7178.

**30. How should the reading level of the consent form be assessed?**

There are software tools available to assess reading level. For example, consent forms can be edited in Microsoft Word 365, where a readability tool can be used to make this assessment by: (1) on the "File" tab, click the "Options" button; (2) on the "Proofing" tab, under "When correcting spelling and grammar in Word," select the "Show readability statistics" check box. Exit the window. Then, under the Review tab in your Word document, click the "Editor" button in the far left corner of the ribbon, then click "Insights – Document Stats" on the "Editor" sidebar: Word displays a message box showing you the Flesch-Kincaid readability grade-level: any value less than or equal to 6.9 is considered a "sixth-grade" reading level. Reading level can also be assessed using online tools, such as those provided at Readable.com, provided those tools use either the Flesch-Kincaid or SMOG readability standard to evaluate the readability of written language.

**31. How should the reading level of consent forms be assessed in languages other than English?**

To date, Leapfrog has only developed readability guidance for Spanish-language consent forms. For the Spanish language, Leapfrog considers a score of 55 or above on the INFLESZ Scale to be written at a sixth-grade reading level or below. The INFLESZ Scale, developed and validated in 2008 by Barrio-Cantalejo et al, is the most widely used in academic research on readability of Spanish-language consent forms (Aponte 2025). The INFLESZ scale is calculated as 206.835 − 62.35 × (total syllables/total words) − (total words/total sentences). A minimum threshold of 55 and above on the INFLESZ scale is considered to be readable by most patients.

To calculate an INFLESZ score, Leapfrog has provided an online calculator (available at: https://readability.leapfroggroup.org/). You may paste in the text of your consent form or upload a Microsoft Word 365 file: the calculator will provide a score, an indication of pass/fail, and details on the calculation.

For languages other than English and Spanish, Leapfrog has not yet established a scoring methodology.


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Barrio-Cantalejo IM, Simón-Lorda P, Melguizo M, Escalona I, Marijuán MI, Hernando P. Validación de la Escala INFLESZ para evaluar la legibilidad de los textos dirigidos a pacientes [Validation of the INFLESZ scale to evaluate readability of texts aimed at the patient]. An Sist Sanit Navar. 2008;31(2):135-152. doi:10.4321/s1137-66272008000300004

Aponte J, Tejada K, Figueroa K. Readability Level of Spanish Language Online Health Information: A Systematic Review. Hisp Health Care Int. 2025;23(2):107-122. doi:10.1177/15404153241286720.

32. **What information on the consent form can be excluded from the reading level assessment?**
The procedure name and description can be excluded from the reading level assessment. In addition, information intended to be read by the provider or administrative staff ONLY, such as instructions for signing and returning the consent form, and information that is written in by an individual provider to give that patient information specific to their condition, can also be excluded. Finally, any words where a sixth-grade reading level definition is included with the term can be excluded from the reading level assessment. For example, in the sentence “anesthesia (putting you to sleep),” only “putting you to sleep” needs to be considered in the reading level assessment.

33. **What is a qualified medical interpreter?**
In the U.S. Department of Health and Human Services 2023 Language Access Plan, a qualified medical interpreter is defined as “A bilingual/multilingual person who has the appropriate training and experience or demonstrated ability to fully understand, analyze, and process and then faithfully render a spoken, written, or signed message in one language into a second language and who abides by a code of professional practice and ethics.” Leapfrog adheres to this definition for the purposes of reporting on the Hospital Survey.

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# *SECTION 2: MEDICATION SAFETY*

This section includes questions and reference information for Section 2: Medication Safety. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.


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# Section 2: Medication Safety

**Computerized Physician Order Entry (CPOE) Fact Sheet and Bibliography:**
https://ratings.leapfroggroup.org/measure/hospital/2026/safe-medication-ordering

**Bar Code Medication Administration (BCMA) Fact Sheet and Bibliography:**
https://ratings.leapfroggroup.org/measure/hospital/2026/safe-medication-administration

**Medication Reconciliation Fact Sheet:**
https://ratings.leapfroggroup.org/measure/hospital/2026/medication-reconciliation

**In Section 2, pediatric hospitals should only respond to questions in Sections 2A and 2C. Sections 2B and 2D do not apply to pediatric hospitals. Additionally, pediatric hospitals are not required to complete the CPOE Evaluation Tool.**

Section 2 includes questions about your hospital's use of CPOE and BCMA, and (for adult and general hospitals) questions about your hospital's medication reconciliation process. The EHR application subsection (2B) is only applicable to adult and general hospitals and will not be scored or publicly reported. In 2026, four questions about Artificial Intelligence (AI) applications were added to subsection 2B – these questions are required but will not be scored or publicly reported.

**Each hospital achieving the standard for Computerized Physician Order Entry (CPOE):**

1. Assures that prescribers enter at least 85% of inpatient medication orders via a computer system that includes decision support software to reduce prescribing errors, **and**
2. For adult and general hospitals, demonstrates, via a test, that its inpatient CPOE system can alert physicians to at least 60% of frequent serious medication errors known to cause harm to patients.

**Each hospital achieving the standard for Bar Code Medication Administration:**

1. Has implemented the use of BCMA at the bedside in 100% of applicable units; **and**
2. Has achieved at least 95% compliance with scanning patients and medications during administration in applicable units where BCMA is implemented; **and**
3. Has a BCMA system that includes all the following types of decision support: wrong patient, wrong medication, wrong dose, wrong time, and second nurse check needed; **and**
4. Has at least six* of the following structures in place to monitor and reduce workarounds: has a formal committee that meets routinely to review data reports on BCMA system use, has back-up equipment for hardware failures, has a help desk that provides timely responses to urgent BCMA issues in real-time, conducting real-time observations of users using the BCMA system, and engages nursing leadership at the unit level on BCMA use. Additionally, information from these structures is used to implement quality improvement projects or monitor previous quality improvement projects focusing on the hospital's BCMA system. Results from the quality improvement projects are evaluated and demonstrate that these projects have resulted in higher adherence to standard medication administration processes. Finally, resolution of system deficiencies and/or problems that may have contributed to the workaround are communicated back to the end user.

* Hospitals responding "Does not apply, hospital has achieved 95% BCMA scanning compliance in all applicable units based on quarterly monitoring" to question #21f (implementation/monitoring of quality improvement projects) earn credit for both question #21f and question #21g (evaluation of results from quality improvement projects).


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**Each hospital achieving the standard for Medication Reconciliation:**

1. Uses a nationally endorsed protocol to collect data on the accuracy of its medication reconciliation process for at least 30 sampled patients and reported the data collected to Leapfrog, **and**
2. Has a rate of unintentional medication discrepancies that is lower than the 50th percentile (where lower performance is better).

**Download the 2026 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.**

# 2A: Computerized Physician Order Entry (CPOE)

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Notes:**

Note 1: "Prescribers" used throughout this subsection refers to all licensed clinicians who are authorized by the state in which the hospital is located to order medications for patients. This includes residents and interns who are authorized to order medications under their own authority.

Note 2: Adult and general hospitals must complete an Adult Inpatient Test at least once per Survey Cycle (April to November). Hospitals are encouraged to ensure that the Adult Inpatient CPOE Test is submitted along with the Survey to meet the deadlines for Leapfrog's Programs such as Top Hospital, Leapfrog Hospital Safety Grade, etc.

Note 3: Hospitals will have access to the CPOE Evaluation Tool immediately after completing the Hospital Profile in the Online Hospital Survey Tool.

**Specifications:** See ***Computerized Physician Order Entry (CPOE) Measure Specifications*** in the Reference Information beginning on page 73.

**Reporting Period: 3 months**
Answer questions #1-5 for the latest 3-month period prior to the submission of this section of the Survey.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

| | |
|---|---|
| 1) What is the latest 3-month reporting period for which your hospital is submitting responses to this section? 3-month reporting period ending: | _____<br>*Format: Month/Year* |
| 2) Does your hospital have a functioning CPOE system in one or more inpatient units of the hospital that:<br>• includes decision support software to reduce prescribing errors; and<br>• is linked [18] to pharmacy, laboratory, and admitting-discharge-transfer (ADT) information in your hospital?<br><br>*If "no" to question #2, skip the remaining questions in Section 2A and Section 2B, and continue to Section 2C. The hospital will be scored as "Limited Achievement."* | ○ Yes<br>○ No |
| 3) Total number of **inpatient medication orders**, including orders made in units that do NOT have a functioning CPOE system. | _____ |
| 4) Total number of **inpatient medication orders** in question #3 that licensed prescribers entered via a CPOE system that meets the criteria outlined in question #2. | _____ |

*If "yes" to question #2 and you are an **adult or general hospital**, use the Take CPOE Tool button on the Survey Dashboard to access the **CPOE Evaluation Tool.** Question #5 does not apply to pediatric hospitals.*

| | |
|---|---|
| 5) Hospital's score when it tested its CPOE system using the Leapfrog CPOE Evaluation Tool:<br><br>***Adult Inpatient Test must be completed between April 1 and November 30, 2026.*** | *No response required here. Determined automatically based on **separately completing** a test using the Leapfrog CPOE Evaluation Tool.* |

## 2B: EHR Application Information

**This section is not applicable to pediatric hospitals.**

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Note:** This subsection will not be scored or publicly reported. The information collected in this subsection is used by the CPOE Evaluation Tool developers for research and CPOE Evaluation Tool improvements.

**Reporting Period:** Answer questions #1-6 based on the EHR application currently in place at the time you submit this section of the Survey.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

| | |
|---|---|
| 1) Which EHR source is your hospital currently using?<br><br>*If your hospital purchased a third-party vendor system and substantially altered it on implementation, select "Homegrown App," skip questions #2-4, and continue to question #5.* | ○ Vendor Application<br>○ Homegrown Application |
| 2) Which EHR vendor is your hospital currently using? | ○ Altera/Allscripts<br>○ Altera/Digital Health<br>○ Allscripts/Eclipsys<br>○ Altera/Paragon<br>○ CareCast<br>○ Cerner<br>○ CPSI<br>○ Epic<br>○ MEDHOST<br>○ MEDITECH<br>○ Quadramed<br>○ Other (please specify): _____ |
| 3) What EHR version is your hospital currently using? | _____ |
| 4) What is the name of the EHR product that your hospital is currently using? | _____ |
| 5) When was the EHR initially installed at the hospital?<br><br>*Enter the month and year the EHR was installed at the hospital.* | _____<br>*Format: Month/Year* |
| 6) Which EHR Medication Reference Database is your hospital currently using? | ○ Homegrown<br>○ First DataBank (FDB)<br>○ Gold Standard / Elsevier<br>○ Lexicomp<br>○ Medi – Span<br>○ Micromedex<br>○ Multum<br>○ Other (please specify): _____ |

| | |
|---|---|
| 7) Does your hospital currently use Artificial Intelligence (AI) applications in its medication management process (including medication-related clinical decision support, medication ordering, BCMA, and medication reconciliation)?<br><br>*If "no" to question #7, skip the remaining questions in Section 2B, and continue to Section 2C.* | ○ Yes<br>○ No |
| 8) In which areas of the medication management process are Artificial Intelligence (AI) applications used?<br><br>*Select all that apply.* | ☐ Medication-related Clinical Decision Support<br>☐ Medication Ordering<br>☐ Bar Code Medication Administration (BCMA)<br>☐ Medication Reconciliation |
| 9) Are the vendors of these AI applications the same as your EHR and medication reference database systems?<br><br>*Select all that apply.*<br><br>*If "Other Vendors" is selected, continue to question #10. Otherwise, skip question #10 and continue to Section 2C.* | ☐ Same as EHR<br>☐ Same as Medication Safety Reference Database<br>☐ Homegrown<br>☐ Other Vendors |
| 10) What are the names of the Other Vendors that your hospital is currently using in its medication management process from question #8?<br><br>*If entering multiple Other Vendors, separate each by a comma.* | _____ |


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# 2C: Bar Code Medication Administration (BCMA)

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Note:** Only include units that were open for the entire reporting period and that remain currently open.

**Specifications:** See ***Bar Code Medication Administration (BCMA) Measure Specifications*** in the Reference Information beginning on page 755.

**Reporting Period: 3 months**
Answer questions #1-21 for the latest 3-month period prior to the submission of this section of the Survey.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

| | |
|---|---|
| 1) What is the latest 3-month reporting period for which your hospital is submitting responses to questions #2-21? 3-month reporting period ending: | _____<br>*Format: Month/Year* |
| 2) Does your hospital use a Bar Code Medication Administration (BCMA) system that is linked to the electronic medication administration record (eMAR) when administering medications at the bedside in at least one of the following adult and/or pediatric units:<br>• General Medical, Surgical, Medical/Surgical, Neuro,[14] Neonatal,[17] or Specialty ICUs;<br>• Medical, Surgical, or Medical/Surgical Units (including telemetry units);[19]<br>• Step-down/Progressive Units;[20]<br>• Labor and Delivery Unit;[21] or<br>• Pre-operative and Post-anesthesia Care Units[22]?<br><br>*If "no" to question #2, skip questions #3-21 and continue to the next subsection. The hospital will be scored as "Limited Achievement."* | ○ Yes<br>○ No |
| 3) Does your hospital operate adult and/or pediatric General Medical, Surgical, Medical/Surgical, Neuro,[14] Neonatal,[17] or Specialty ICUs?<br><br>*If "no" to question #3, skip questions #4-5 and continue to question #6.* | ○ Yes<br>○ No |
| 4) If "yes," how many of this type of unit are open and staffed in the hospital? | _____ |
| 5) How many of the units in question #4 utilized the BCMA/eMAR system when administering medications at the bedside? | _____ |
| 6) Does your hospital operate adult and/or pediatric Medical, Surgical, or Medical/Surgical Units (including telemetry units)? [19]<br><br>*If "no" to question #6, skip questions #7-8 and continue to question #9.* | ○ Yes<br>○ No |
| 7) If "yes," how many of this type of unit were open and staffed in the hospital? | _____ |

| | |
|---|---|
| 8) How many of the units in question #7 utilized the BCMA/eMAR system when administering medications at the bedside? | _____ |
| 9) Does your hospital operate adult and/or pediatric Step-down/Progressive Units [20]?<br><br>*If "no" to question #9, skip questions #10-11 and continue to question #12.* | ○ Yes<br>○ No |
| 10) If "yes," how many of this type of unit were open and staffed in the hospital? | _____ |
| 11) How many of the units in question #10 utilized the BCMA/eMAR system when administering medications at the bedside? | _____ |
| 12) Does your hospital operate a Labor and Delivery Unit [21]?<br><br>*If "no" to question #12, skip questions #13-14 and continue to question #15.* | ○ Yes<br>○ No |
| 13) If "yes," how many of this type of unit were open and staffed in the hospital? | _____ |
| 14) How many of the units in question #13 utilized the BCMA/eMAR system when administering medications at the bedside? | _____ |
| 15) Does your hospital operate adult and/or pediatric Pre-operative and Post-anesthesia Care Units [22]?<br><br>*If "no" to question #15, skip questions #16-17 and continue to question #18.* | ○ Yes<br>○ No |
| 16) If "yes," how many of this type of unit are open and staffed in the hospital? | _____ |
| 17) How many of the units in question #16 utilized the BCMA/eMAR system when administering medications at the bedside? | _____ |

*If "no" to questions #3, #6, #9, #12, and #15 above, update your response to question #2.*

| | |
|---|---|
| 18) The number of scannable medication administrations during the reporting period in those units that utilize BCMA as indicated in questions #5, #8, #11, #14, and #17 above: | _____ |
| 19) The number of medication administrations from question #18 that had both the patient and the medication scanned during administration with a BCMA system that is linked to the electronic medication administration record (eMAR): | _____ |

| 20) What types of decision support does your hospital's BCMA system provide to users of the system? | | |
|---|---|---|
| a) | Wrong patient | ○ Yes<br>○ No |
| b) | Wrong medication | ○ Yes<br>○ No |
| c) | Wrong dose | ○ Yes<br>○ No |

| | | |
|---|---|---|
| d) | Wrong time (e.g., early/late warning; warning that medication cannot be administered twice within a given window of time) | ○ Yes<br>○ No |
| e) | Second nurse check needed | ○ Yes<br>○ No |

| 21) Which of the following mechanisms does your hospital use to reduce and understand potential BCMA system "workarounds?" | | |
|---|---|---|
| a) | Has a formal committee that meets routinely to review data reports on BCMA system use | ○ Yes<br>○ No |
| b) | Has back-up equipment (e.g., extra scanners, portable computers, batteries, and mice) for BCMA hardware failures | ○ Yes<br>○ No |
| c) | Has a Help Desk that provides timely responses to urgent BCMA issues in real-time | ○ Yes<br>○ No |
| d) | Conducts real-time observations of users at the unit level using the BCMA system | ○ Yes<br>○ No |
| e) | Engages nursing leadership at the unit level on BCMA use | ○ Yes<br>○ No |
| f) | In the past 12 months used the data and information obtained through items a-e to implement quality improvement projects that have focused on improving the hospital's BCMA performance<br><br>**OR**<br><br>In the past 12 months used the data and information obtained through items a-e to monitor a previously implemented quality improvement project focused on improving the hospital's BCMA performance<br><br>*Cannot respond "yes" to this question, unless "yes" to either 21a, 21d or 21e.*<br><br>*If "no" or "does not apply, hospital has achieved 95% BCMA scanning compliance in all applicable units* based on quarterly monitoring*," skip question #21g and continue to question #21h.* | ○ Yes<br>○ No<br>○ Does not apply, hospital has achieved 95% BCMA scanning compliance in **all** applicable units based on quarterly monitoring |
| g) | In the past 12 months evaluated the results of the quality improvement projects (from f) and demonstrated that these projects have resulted in higher adherence to your hospital's standard medication administration process<br><br>**OR**<br><br>In the past 12 months evaluated the results of the quality improvement projects (from f) and demonstrated continued adherence to your hospital's standard medication administration process | ○ Yes<br>○ No |

| | | |
|---|---|---|
| h) | Communicated back to end users the resolution of any system deficiencies and/or problems that may have contributed to workarounds<br><br>*Cannot respond "yes" to this question, unless "yes" to either 21a, 21d or 21e.* | ○ Yes<br>○ No |

# 2D: Medication Reconciliation

**This section is not applicable to pediatric hospitals.**

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Specifications:** See ***Medication Reconciliation Measure Specifications*** in the Reference Information beginning on page 77.

**Reporting Period: 6 months**
Answer questions #1-8 for the latest 6-month period prior to the submission of this section of the Survey.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

**Sufficient Sample:** See ***Medication Reconciliation Measure Specifications*** for instructions on identifying a sufficient sample for question #3.

| | |
|---|---|
| 1) What is the latest 6-month reporting period for which your hospital is submitting responses to this section? 6-month reporting period ending: | _____<br>*Format: Month/Year* |
| 2) During the 6-month reporting period, did your hospital conduct a random sample of adult patients and have a pharmacist or certified pharmacy technician [23] complete the following steps for each patient included in the sample:<br>• Interview Patient and Obtain the Gold Standard Medication History (pharmacist or certified pharmacy technician[23]);<br>• Complete a Medication Reconciliation Worksheet for each sampled patient (pharmacist or certified pharmacy technician[23]);<br>• Compare Gold Standard Medication History to Admission Orders (pharmacist only); and<br>• Compare Gold Standard Medication History to Discharge Orders (pharmacist only)?<br><br>*If "no" to question #2, skip the remaining questions in Section 2D and go to the Affirmation of Accuracy. The hospital will be scored as "Did Not Measure."*<br><br>*If "no, had fewer than 30 admissions to medical or med/surg units" to question #2, skip the remaining questions in Section 2D and go to the Affirmation of Accuracy. The hospital will be scored as "Does Not Apply."* | ○ Yes<br>○ No<br>○ No, had fewer than 30 admissions to medical or med/surg units |

*For questions #3-8, if the sample is less than 30 patients from the 6-month period, the hospital will be scored as "Limited Achievement" and the rate of unintentional discrepancies will not be publicly reported.*

| | |
|---|---|
| 3) Number of adult patients that your hospital sampled [24]. | _____<br>*Max value 500* |

| | |
|---|---|
| 4) Number of patients from question #3 who had zero (0) Gold Standard Medications.<br><br>*If more than 10 out of 30 patients (or one-third) included in the sample had zero (0) Gold Standard Medications, the hospital will be scored as "Unable to Calculate Score."* | _____ |
| 5) Total number of medications obtained by the pharmacist or certified pharmacy technician[23] from the Gold Standard Medication History [25] for the adult patients included in the sample. | _____ |
| 6) Total number of unintentional discrepancies in admission and discharge among the gold standard medications [26] in question #5 identified by the pharmacist. | _____ |
| 7) Total number of unintentionally ordered additional medications [27] for the adult patients included in the sample on admission and/or discharge identified by the pharmacist. | _____ |
| 8) Total number of discrepancies due to unintentionally ordered additional medications [28] in question #7 identified by the pharmacist. | _____ |


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**Affirmation of Accuracy**

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Medication Safety Section at our hospital, and I hereby affirm that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this affirmation on behalf of our hospital.

The hospital and I acknowledge that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also acknowledge that analyses and ratings The Leapfrog Group derives from this information will be made public on the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade website, and/or other Leapfrog Group published works, products and services. The hospital and I acknowledge that analyses and ratings derived from this information and all intellectual property rights related to those analyses and ratings shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. I hereby affirm that this information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may license analyses and ratings derived from this information to other entities including researchers, not-for-profit entities, and for-profit entities, and the revenue from such licensure will be used solely to support The Leapfrog Group's not-for-profit mission. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
*(first name and last name)* *(title)*
on _____.
*(date)*


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# Section 2: Medication Safety Reference Information

### *What's New in the 2026 Survey*

### CPOE Evaluation Tool

The developers of the CPOE Evaluation Tool are revising the test medication scenarios to align with updated clinical guidelines and are removing medications that hospitals frequently report as not included in their formularies.

In addition, after reviewing non-interruptive alerts, Leapfrog's CPOE Expert Panel found that these alerts have become less effective in alerting prescribers to important information about dangerous medication orders. To address this issue, Leapfrog will launch a multi-phase project to:

- Gather examples and references to strengthen guidance on non-interruptive alerts,
- Develop educational webinars for hospitals throughout 2026, and
- Prepare hospitals for updated expectations in the 2027 CPOE Tool.

There are no changes to the scoring algorithm for the CPOE Evaluation Tool.

### Section 2A: Computerized Physician Order Entry (CPOE)

There are no changes to this subsection.

### Section 2B: EHR Application Information

Leapfrog is continuing to ask questions about Artificial Intelligence (AI) applications used as part of a hospital's medication management and these questions will be required beginning in 2026. The responses will be used to research AI vendor influence on a hospital's CPOE Test score. Leapfrog is also updating the definition of AI included in the FAQs to provide more clarity.

As a reminder, Section 2B: EHR Application Information is not scored or publicly reported.

### Section 2C: Bar Code Medication Administration (BCMA)

In response to feedback from hospitals participating in the Survey, Leapfrog is updating two of the elements included for Section 2C: BCMA question #21, which asks about mechanisms used to reduce and understand potential BCMA system "workarounds." The implementation, monitoring, and evaluation of quality improvement projects focused on improving BCMA performance is no longer required for hospitals that have met Leapfrog's standard of 95% compliance with scanning the patient and medication prior to medication administration if this standard is met in ALL applicable units based on quarterly monitoring. To reflect this change, the response options for question #21f have been updated as outlined below and hospitals will not report on question #21g if they indicate "no" or "does not apply" to question #21f. The requirement of having 6 out of 8 processes/structures to reduce and understand potential BCMA system "workarounds" will be maintained and hospitals responding "does not apply" to question #21f will earn credit for both #21f and #21g for the purposes of scoring and public reporting.

There are no other changes to the Scoring Algorithm for Section 2C: BCMA.

### Section 2D: Medication Reconciliation

Leapfrog is updating the measure specifications to clarify that if a pharmacist, pharmacy resident, or certified pharmacy technician creates the pre-admission medication list (PAML) then a different (second) pharmacist, pharmacy resident, or certified pharmacy technician must collect the Gold Standard Medication History. This information was previously clarified in a FAQ.

For ease of reporting, we are providing a flow chart outlining the steps required for data collection which will be available on our Survey materials webpage.


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As a reminder, hospitals can continue to use the 2025 Leapfrog Hospital Survey Measure Specifications for Section 2D: Medication Reconciliation to perform data collection in preparation for the 2026 Leapfrog Hospital Survey.

There are no changes to the scoring algorithm for Section 2D: Medication Reconciliation

### *Change Summary Since Release*

None. If substantive changes are made to this section of the Survey after release on April 1, 2026, they will be documented in this Change Summary section.


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# Section 2: Medication Safety Measure Specifications

## *Computerized Physician Order Entry (CPOE) Measure Specifications*

**Important Notes:**

Note 1: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Note 2: "Licensed prescriber" refers to all licensed clinicians who are authorized by the state in which the hospital is located to order medications for patients. This includes residents and interns who are authorized to order medications under their own authority.

**Source:** The Leapfrog Group

**Reporting Period:** The latest 3-month period prior to the submission of this section of the Survey.

**Medications:** For the purposes of this measure, a **medication** is a substance that is taken into, or placed onto, the body of a person for one or more of the following reasons:

- as a placebo
- to prevent a disease (e.g., flu vaccine)
- to make a diagnosis (e.g., contrast dye)
- to test for the possibility of an adverse effect
- to modify a physiological, biochemical, or anatomical function or abnormality (e.g., heparin/heparin flushes, statins, antihypertensives, etc.)
- to replace a missing factor (e.g., blood product)
- to ameliorate a symptom (e.g., aspirin)
- to treat a disease or condition (including topicals, nasal sprays, eye drops, compounds, inhalants, injectables, patches, etc.)
- to induce anesthesia
- to stabilize or hydrate during medical treatment or procedures (e.g., IV fluids, normal saline, lactated ringers, etc.)
- to provide nutrition (e.g., enteral nutrition products, parenteral nutrition products, breast milk [breast milk applies to BCMA measure only])
- as a supplement (e.g., iron for a patient with iron deficiency anemia or calcium/vitamin D for a patient with osteoporosis)

For the purposes of this measure, the following are **not** considered medications:

- Pre-filled saline flushes and pre-filled heparin flushes (i.e., saline and heparin flushes that come from the manufacturer already filled and are not filled by the hospital's pharmacy)
- Chlorhexidine and alcohol preparation pads
- Intra-op irrigation solutions

**Question #3 (denominator):** Total number of inpatient medication orders, including medication orders made in inpatient units that do NOT have a functioning CPOE system.

**Include:**

- Medications ordered for **any patient with an inpatient status**, including those with an inpatient status who may be in an outpatient unit during an overflow situation.
- Medications ordered for any neonatal ICU patient.
- Medications ordered by **any individual**, including nurses and pharmacists.
- Medications ordered electronically, via a secure texting platform, verbally or via paper.
- Medications ordered verbally during a rapid response (prevention of serious injury, cardiac arrest, and respiratory arrest).

**Exclude**:

- Medications ordered for any newborn in a nursery or mother's room.


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- New medication orders that have been modified from the original order but maintain the intent of the original order (e.g., "new" medication orders generated when a dose, route, frequency, or brand are changed).
- Medications ordered verbally during a "code blue" (i.e., medications ordered verbally when a patient requires resuscitation or needs immediate medical attention, most often as the result of a respiratory arrest or cardiac arrest).
- Medications ordered in an operating room or procedural area.

**Question #4 (numerator): Total number of inpatient medication orders in question #3 that licensed prescribers entered via a CPOE system that meets the criteria outlined in question #2.**

**Include:**

- Medication orders entered into the CPOE system by a **licensed prescriber**
- In addition, the following types of medication orders entered in to a CPOE system by a non-licensed prescriber, such as a nurse or pharmacist, can also be included:
  - Per protocol medication orders (i.e., medication orders with detailed guidance on how to administer, dose or adjust a medication) approved by a medical committee where the implementation of the protocol was authorized by a **licensed prescriber** and orders were initiated in the CPOE system.
  - Standing medication orders (i.e., orders which can be initiated based on medical staff approval of a screening criteria and indication for all patients that meet the screening criteria) approved by a medical committee that were initiated in the CPOE system.
  - Medication orders entered into the CPOE system that required either verbal read back of alerts to the licensed prescriber or a co-signature by a licensed prescriber prior to administration to ensure that the licensed prescriber was made aware of all advice/information generated by the CPOE system.

**Exclude:**

- Medications ordered verbally, via a secure texting platform, or via paper.
- Medication orders entered into the CPOE system by a non-licensed prescriber, such as a nurse or pharmacist, that were NOT per protocol medication orders or standing medication orders.
- Medication orders entered into the CPOE system by a non-licensed prescriber, such as a nurse or pharmacist, that DID NOT require either verbal read back of alerts or a co-signature of a licensed prescriber prior to administration.

See FAQs for additional information about responding to the questions in this section.

### *Bar Code Medication Administration (BCMA) Measure Specifications*

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

**Source:** The Leapfrog Group

**Reporting Period:** The latest 3-month period prior to the submission of this section of the Survey.

**Included Adult and/or Pediatric Units:**

- General Medical, Surgical, Medical/Surgical, Neuro[14], Neonatal[17], or Specialty ICUs
- Medical, Surgical, or Medical/Surgical Units (including telemetry units)[19],
- Step-down/Progressive Units[20]
- Labor and Delivery Unit[21]
- Pre-operative and Post-anesthesia Care Units[22]

**Excluded Units:**

- Emergency departments
- Operating rooms
- Procedural and diagnostic areas, such as radiology units, endoscopy units, etc.
  - Note: Pre-operative and post-anesthesia care areas in these units must be included
- Units that were not open for the entire reporting period or that are not currently open

**Important Note:** Hospitals should count units as they do internally (i.e., if units are considered separate units despite sharing a space, report the units as two; if they are considered a single combined unit, report the unit as one).

**Medications:** For the purposes of this measure, a **medication** is a substance that is taken into, or placed onto, the body of a person for one or more of the following reasons:

- as a placebo
- to prevent a disease (e.g., flu vaccine)
- to make a diagnosis (e.g., contrast dye)
- to test for the possibility of an adverse effect
- to modify a physiological, biochemical or anatomical function or abnormality (e.g., heparin/heparin flushes, statins, antihypertensives, etc.)
- to replace a missing factor (e.g., blood product)
- to ameliorate a symptom (e.g., aspirin)
- to treat a disease or condition (including topicals, nasal sprays, eye drops, compounds, inhalants, injectables, patches, etc.)
- to induce anesthesia
- to stabilize or hydrate during medical treatment or procedures (e.g., IV fluids, normal saline, lactated ringers, etc.)
- to provide nutrition (e.g., enteral nutrition products, parenteral nutrition products, breast milk [breast milk applies to BCMA measure only])
- as a supplement (e.g., iron for a patient with iron deficiency anemia or calcium/vitamin D for a patient with osteoporosis)

For the purposes of this measure, the following are **not** considered medications:

- Pre-filled saline flushes and pre-filled heparin flushes (i.e., saline and heparin flushes that come from the manufacturer already filled and are not filled by the hospital's pharmacy)
- Chlorhexidine and alcohol preparation pads
- Intra-op irrigation solutions

**Question #18 (denominator):** Total number of scannable medication administrations during the reporting period in those units that utilize BCMA as indicated in questions #5, #8, #11, #14 and #17.

**Include** all scannable medication administrations (regardless of patient's admission status and administering provider) in adult and/or pediatric general medical, surgical, medical/surgical, neuro, neonatal, and specialty ICUs; medical, surgical, and medical/surgical units (including telemetry units);

step-down/progressive units; labor and delivery units; and pre-operative and post-anesthesia care units that utilize a BCMA system that is linked to the electronic medication administration record (eMAR).

Include medication administrations during a procedure if the hospital combines their procedural areas with their pre-operative or post-anesthesia care units and is **unable** to distinguish between these medication administrations.

**Exclude:**

- Medication administrations in units that are not specified in question #5, #8, #11, #14 or #17
- Medication administrations in units that do not utilize a BCMA system that is linked to the eMAR
- Medication administrations in units that have not been open or staffed for the entire 3-month reporting period or in units that are not open currently
- Medication administrations during a procedure if the hospital combines their procedural areas with their pre-operative or post-anesthesia care units and is able to distinguish between these medication administrations
- Administrations of medications that are not "scannable," i.e., medications that do not have a bar code and could not be scanned if BCMA were in use

**Question #19 (numerator):** Total number of medication administrations from question #18 that had both the patient and the medication scanned during administration with a BCMA system that is linked to the electronic medication administration record (eMAR).

**Include** medication administrations where both the patient and medication were scanned during administration with a BCMA system that is linked to the eMAR.

**Exclude** medication administrations where neither patient nor medication were scanned during administration or only the patient or only the medication were scanned with a BCMA system that is linked to the eMAR.

See FAQs for additional information about responding to the questions in this section.

### *Medication Reconciliation Measure Specifications*

**Important Notes:**

Note 1: This section does not apply to pediatric hospitals.

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

Note 3: A hospital pharmacist or certified pharmacy technician[23] plays two important roles in data collection for this measure. First, the pharmacist or certified pharmacy technician is responsible for obtaining the Gold Standard Medication History from each sampled patient. Second, the pharmacist is responsible for identifying the unintentional discrepancies by comparing the Gold Standard Medication History to admission orders and discharge orders.

| |
|---|
| **Source:** Brigham and Women's Hospital (NQF #2456) |
| **Reporting Period:** The latest 6-month period prior to submission of this section of the Survey. |
| **Materials for Data Collection:**<br>To complete the data collection for this subsection and respond to questions #3-8 hospitals should download four important tools:<br>• The **Medication Reconciliation Workbook** (Excel) includes 3 tabs: Instructions, Sampling, and Data Entry. This can be used to identify patients to sample and collect data from, as well as calculate the responses to enter into the Online Hospital Survey Tool from the completed Worksheets.<br>• The **Medication Reconciliation Worksheet** (Word) can be used by the pharmacist to identify the number of unintentional discrepancies at admission and/or discharge for each sampled patient (question #6). The Medication Reconciliation Worksheet can also be used to track additional medications that were ordered unintentionally at admission and/or discharge (questions #7-8).<br>• The **MARQUIS 2 Best Possible Medication History: Quick Tips** tri-fold (PDF) includes important information on how the pharmacist or certified pharmacy technician[23] should obtain the Gold Standard Medication History<br>• **Identifying Discrepancies Flow Chart** (PDF) includes important information on how the pharmacist should identify discrepancies between the Gold Standard Medication History and admission and discharge orders.<br>• **Data Collection Flow Chart** (PDF) includes important information outlining the steps on how the data should be collected for this measure.<br><br>All of these tools are available on the Survey and CPOE Materials webpage and should be used when reporting on this measure. |

The intent of this measure is to calculate your hospital's rate of unintentional medication discrepancies per medication. Hospitals may perform data collection on a regular basis or just once for the purposes of reporting on this measure to Leapfrog.

1. Hospitals that collect these data on a regular basis and did so using the previous year's measure specifications can use those data when reporting on this section of the Survey. For example, if your hospital samples regularly on a quarterly basis and collected data January through March using the previous year's specifications, you can report those data on the current year's Survey. We do ask that you download and use the most recent measure specifications and materials when they are made available on April 1 each year.
2. Hospitals that do not sample patients on a regular basis (i.e., quarterly) should sample in real-time beginning April 1 and can collect data at any time during the Survey Cycle (April 1 – November 30). Sampling can be spread out over the entire 6-month reporting period (e.g., five patients per month), or within a shorter time period within those 6 months (e.g., 30 patients in a two-week period).

**Follow the steps below to complete data collection for this measure:**

**Step 1: Identify Patients to Include in the Sample (Survey Coordinator)**

a. To be scored on the rate of unintentional medication discrepancies, hospitals are required to sample at least 30 patients from a 6-month reporting period. Hospitals that sample fewer than 30 patients during the reporting period will be scored and publicly reported as "Limited Achievement."
b. All hospitals should exclude patients under 18 years old, patients who were discharged or expired before the Gold Standard Medication History could be obtained, and patients that do not have discharge orders written during the reporting period.
c. Hospitals should sample patients from medical, medical/surgical, and step-down/progressive units (adult only) to reduce the number of sampled patients with zero (0) Gold Standard Medications. However, hospitals may expand their sampling to patients in additional units of the hospitals.
d. Hospitals should sample patients from different days of the week, including patients admitted on the weekend.
e. On the day of data collection, obtain a list of patients that were admitted the day before to medical and/or medical/surgical units, in the order that they were admitted.
f. Follow the instructions in the Medication Reconciliation Workbook to randomly sample admitted patients.
g. Send the list of sampled patients to the pharmacist, pharmacy resident, or pharmacy technician so they can schedule an in-person, video, or phone interview with each patient to obtain their Gold Standard Medication History.

**Step 2: Interview Patients and Obtain the Gold Standard Medication History (Pharmacist or Certified Pharmacy Technician[23])**

a. A trained pharmacist, pharmacy resident, or certified pharmacy technician[23] must interview the patients from Step 1 and obtain the Gold Standard Medication History within 24 hours after admission, typically the morning after admission.
    i. This interview is in addition to, and separate from, any pre-admission medication list that was created as part of normal care (e.g., PAML obtained by the nurse).
    ii. If a pharmacist, pharmacy resident, or certified pharmacy technician[23] normally obtains the pre-admission medication list from patients in medical or med-surg units, a different pharmacist, pharmacy resident, or certified pharmacy technician[23] must collect the Gold Standard Medication History.
b. The pharmacist, pharmacy resident, or certified pharmacy technician[23] can customize the following script to explain to the patient the reason for the interview: "Hi, I'm *(pharmacist's name)*, a pharmacist at *(name of hospital)*. I know *(care team member who may have collected a pre-admission medication list or PAML)* already asked you about the medications you were taking before you were admitted to the hospital. I'm here to ask you about these medications again. Our hospital has asked me to collect this information again so I can use it to measure how well we are doing in gathering medication histories. What we learn will help us improve our processes of care in the future and make sure we manage patients' medications safely when they come into and after they leave the hospital."
c. The Gold Standard Medication History is the list of medications that the patient was taking prior to admission. Best practices for collecting the Gold Standard Medication History can be found in the "Other Supporting Materials" for Section 2 on the Survey and CPOE Materials webpage.
    i. Pharmacists, pharmacy residents, and certified pharmacy technicians[23] should try to use two sources of information (see MARQUIS 2 Best Possible Medication History: Quick Tips and Medication Reconciliation Implementation Toolkit for examples) and explore any discrepancies (e.g., errors related to dose, route, timing, etc.) before finalizing the Gold Standard Medication History. Once the pharmacist, pharmacy resident, or certified pharmacy technician[23] has completed the patient interview, they can utilize support from non-certified pharmacy technicians, medical assistants, or nurses to investigate second or third information sources (e.g., EHR list, pharmacy list, primary or specialty provider information, etc.). However, the pharmacist, pharmacy resident, or certified pharmacy technician[23] must be the one to obtain and finalize the Gold Standard Medication History.

ii. Medications that a patient is completely non-adherent to, meaning the patient has not taken the medication for at least 30 days, should be excluded from the Gold Standard Medication History.
iii. If a patient has been taking a medication differently to how it was prescribed, then the Gold Standard Medication History should list the medication as the patient was taking it.
iv. Exclude OTC/PRN medications unless they are clinically relevant. This includes topical lotions and creams, saline nasal spray and artificial tear eye drops, herbals and supplements, and vitamins. Two examples of clinically relevant medications that should not be excluded from the gold standard pre-admission medication list would be iron for a patient with iron-deficiency anemia or calcium/vitamin D for a patient with osteoporosis.
v. Include OTC/PRN medications that are clinically relevant. This includes inhalers, nitroglycerin, analgesics (opioid and non-opioid), muscle relaxants, and sedatives, including medications where sedation is a common side effect (e.g., sedation occurs in more than 10% of individuals). This also includes topical medications with systemic actions (e.g., lidocaine, triamcinolone, sulfadiazine, etc.).
vi. Clinically relevant is defined as any OTC/PRN medication that treats a medical condition on the patient's problem list and/or condition they are being treated for during the visit (i.e., reason for the hospital stay).

**Step 3: Complete a Medication Reconciliation Worksheet for each sampled patient (Pharmacist or Certified Pharmacy Technician[23])**

a. Once the Gold Standard Medication History is complete, print out the Medication Reconciliation Worksheet for each sampled patient.
b. Page 1 needs to be printed out for each sampled patient. Page 2 needs to be printed for each Gold Standard Medication the patient was taking.
c. Complete the "Gold Standard Medication" column highlighted in yellow for each Gold Standard Medication on the list:

| Gold Standard Medication | |
|---|---|
| Name: | |
| Dose/Route/ Frequency: | |
| Drug Class:<br>☐ PRN<br>☐ OTC | |
| Pt Adherence:<br>☐ Completely non-adherent*<br>☐ Sporadically non-adherent^ | ☐ Systematically non-adherent**<br>☐ Adherent |
| Comments: | |
| All Sources Used:<br>☐ Patient<br>☐ Pill Bottles<br>☐ Outpatient EMR<br>☐ Transfer Records<br>☐ Pharmacy(s)<br>☐ Other: | ☐ Patient's family/Caregiver<br>☐ Patient's Own Med List<br>☐ Outpatient Provider(s)<br>☐ Past DC Summary<br>☐ Pharmacy Database |

d. If possible, wait until after the patient has been discharged to complete the next steps.

**Step 4: Compare Gold Standard Medication History to Admission Orders (Pharmacist Only)**

a. After the patient has been discharged, obtain the admission and discharge orders for the patient (instructions for comparing the discharge orders are in Step 5 below). Admission orders include all orders written from the time of admission until 8:00 a.m. the following morning or up until 12 hours after the time of admission, whichever comes first.

b. Compare the admission orders to each Gold Standard Medication on the Medication Reconciliation Worksheet. Note any differences.

   i. Review the records for the patient to determine if the differences were intentional or unintentional. Use the Identifying Discrepancies Flow Charts to help with this step.

   ii. If the discrepancy was unintentional, then check the box next to "Yes" highlighted in orange. Otherwise, check "No."

| **Admission Comparison** | |
|---|---|
| Note Differences:<br>(select all that apply)<br>☐ Dose<br>☐ Frequency<br>☐ Duplication<br>☐ Duration<br>☐ Omission | ☐ Route<br>☐ Substitution<br>☐ Formulation<br>☐ Other: |
| Reason:<br>☐ Unintentional (History or Reconciliation Error)<br>☐ Intentional (Clinical Reason) | |
| **Were there any unintentional discrepancies between the gold standard and the admission order?**<br>**☐ Yes**<br>**☐ No**<br>*If "yes," count as 1* | |

c. Review the admission orders for any medications that were not listed in the Gold Standard Medication History. If any of the additional medications were ordered **unintentionally**, list it on the first page of the Medication Reconciliation Worksheet in the blue-highlighted column. You may need to contact the Provider to determine if the medication was ordered unintentionally or not.

**Additional Medications that were Ordered Unintentionally:**

| Additional Medication: | Unintentionally Ordered on: | Comments: |
|---|---|---|
| Name:<br>Dose/Route/Frequency: | ☐ Admission (count as 1)<br>☐ Discharge (count as 1)<br>☐ Both (count as 2) | |
| Name:<br>Dose/Route/Frequency: | ☐ Admission (count as 1)<br>☐ Discharge (count as 1)<br>☐ Both (count as 2) | |
| Name:<br>Dose/Route/Frequency: | ☐ Admission (count as 1)<br>☐ Discharge (count as 1)<br>☐ Both (count as 2) | |

d. If the pharmacist identifies an unintentional discrepancy in the admission orders prior to discharge and alerts the physician so that the unintentional discrepancy can be corrected prior to discharge, this should be recorded on the Medication Reconciliation Worksheet as an unintentional discrepancy in the Admission Comparison and Discharge Comparison columns of the worksheet.


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**Step 5: Compare Gold Standard Medication History to Discharge Orders (Pharmacist Only)**

a. Obtain the discharge orders for the patient.
b. Perform the comparison between the Gold Standard Medications and the discharge orders using the same steps as the admission comparison. Remember to use the Identifying Discrepancies Flow Charts to help with this step.
c. Review the discharge orders for any medications that were not listed in the Gold Standard Medication History. If any of the additional medications were ordered **unintentionally**, list them on the first page of the Medication Reconciliation Worksheet in the blue-highlighted column.
    i. If an unintentionally ordered additional medication was only ordered on admission, then check the "Admission" box in the pink-highlighted column.
    ii. If an unintentionally ordered additional medication was only ordered on discharge, then check the "Discharge" box in the pink -highlighted column.
    iii. If the unintentionally ordered additional medication was ordered on both admission and discharge, then check the "Both" box in the pink-highlighted column.

**Step 6: Sum the number of medications and discrepancies (Survey Coordinator)**

a. The top of the first page of the Medication Reconciliation Worksheet contains four spaces for you to list the data for the patient.

**Total # Unintentional Additional Medications: _____**
*(Enter into column F in the Med Rec Excel Workbook)*

**Total # of admission and discharge discrepancies due to Unintentional Additional Meds: _____**
*(Number of medications that were ordered unintentionally at admission (count as 1), discharge (count as 1), or both admission and discharge (count as 2). Enter into column H in the Med Rec Excel Workbook.*

**Total Number of Gold Standard Meds: _____**
*(Enter into column B in the Med Rec Excel Workbook)*

**Total # of admission and discharge discrepancies in Gold Standard Meds: _____**
*(For each Gold Standard Med, count the number of 'yes' responses to the error question. Minimum number of discrepancies per med is zero. Maximum number of discrepancies per med is 2. Enter into column D in the Med Rec Excel Workbook)*

    i. Find the number of unintentionally ordered additional medications from the blue highlighted column on the same page. Enter in the first space, also highlighted in blue.
    ii. Find the number of **discrepancies** due to unintentionally ordered additional medications from the pink highlighted column on the same page.
        1. If a medication was only ordered on admission or only ordered on discharge, then this counts as one discrepancy.
        2. If a medication was ordered on **both** admission and discharge, then this counts as two discrepancies.
        3. Sum the number of discrepancies across all unintentionally ordered additional medications and enter this number in the pink-highlighted space.
    iii. Find the number of Gold Standard Medications and enter this number in the yellow-highlighted space.
    iv. Find the number of discrepancies in the admission and discharge orders for the Gold Standard Medications
        1. Review the Medication Reconciliation Worksheet for each Gold Standard Medication.
        2. Sum the number of times the orange highlighted "Yes" box is checked, indicating an unintentional discrepancy in admission or discharge orders.
        3. Enter this sum into the orange-highlighted space on the first page of the Medication Reconciliation Worksheet.


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**Step 7: Contact providers if necessary (Pharmacist Only)**
If you found any serious discrepancies that could cause the patient harm, you will need to contact the providers. The provider may need to reach out to the patient, PCP, or pharmacies to have the issue corrected.

**Step 8: Enter data into Excel Workbook and Online Hospital Survey Tool (Survey Coordinator)**
a. Collect all the Medication Reconciliation Worksheets from the pharmacists. Open the Data Entry Tab of the Medication Reconciliation Excel Workbook.
    i. Enter the numbers from the top of each Medication Reconciliation Worksheet into the corresponding columns of the Excel Workbook, for the sampled patient, one patient per row.
    ii. As you enter the data, Row 6 (in red) will automatically sum the values entered for each patient. Once you have entered the data for all sampled patients, you will have the final values to enter into the Online Hospital Survey Tool.
    iii. On the right, your hospital's rate of unintentional medication discrepancies per medication will automatically be calculated based on the data entered.

**Step 9: Use your hospital's results in quality improvement (Survey Coordinator and Pharmacist)**
The developer of this measure has two toolkits available for hospitals that wish to implement a medication reconciliation program:
- Medication Reconciliation Implementation Toolkit (free)
- The MARQUIS Collaborative (fee to participate)

See FAQs for additional information about responding to the questions in this section.

# Section 2: Medication Safety Frequently Asked Questions (FAQs)

## *Computerized Physician Order Entry (CPOE) FAQs*

**Information specific to the CPOE Evaluation Tool, including instructions and FAQs, is available on the Survey and CPOE Materials webpage and the Prepare for CPOE Tool webpage.**

1. **What 3-month reporting period should be used when reporting on this section?**
   When responding to the questions in Section 2A, hospitals should use the most recent three months prior to submitting the Survey for which they have complete data. For example, if submitting Section 2A in the month of June, the most recent 3-month reporting period for which you have complete data may be February, March, and April or March, April, and May. Hospitals cannot submit data collected for less than three full months.

2. **My hospital transitioned to a new CPOE system, and we have not been on the new system for a full 3 months. How should we respond to the questions in Section 2A-2B?**
   When responding to questions #3 and #4 in Section 2A, hospitals can combine inpatient medication data from their old CPOE system with their new CPOE system to have three full months of data. However, hospitals should respond to the questions in Section 2B based on the new CPOE system and take the CPOE Evaluation Tool using the new CPOE system. When taking the CPOE Evaluation Tool, hospitals should select a licensed prescriber that is fully trained on the new system. All hospitals are urged to take a Sample Test before starting the Adult Inpatient Test.

3. **Should we include medications ordered verbally or via paper during system downtime when responding to question #3 (denominator)?**
   Yes. Count medication orders entered during system downtime when responding to question #3. Exclude these orders when responding to question #4.

4. **We can't exclude medication orders that originated from an operating room or procedural area from the CPOE report that we are using to respond to questions #3 (denominator) and #4 (numerator). Can we include these medication orders?**
   Yes, if you are unable to exclude medication orders for inpatients that were ordered from an operating room or procedural area, you can count these orders when responding to questions #3 and #4.

5. **What are examples of per protocol orders?**
   Examples of per protocol orders include vancomycin dosing per protocol and heparin drip per protocol. Per protocol orders refer to orders that the medical staff has approved the use of, based on evidence-based guidance, in advance of its use. Per protocol orders are often identified by the Pharmacy and Therapeutics (P&T) committee and then recommended to the Medical Executive Committee (MEC) for approval. Once approved, per protocol orders are initiated by a licensed prescriber, but then acted on by pharmacy, nursing, radiology, respiratory therapy, etc. Count per protocol orders when responding to questions #3 (denominator) and #4 (numerator).

6. **What are examples of standing orders?**
   Examples of standing orders include influenza vaccine, pneumonia vaccine, hepatitis B vaccine, or erythromycin eye ointment. Standing orders are usually rare, limited use situations. Count standing orders when responding to questions #3 (denominator) and #4 (numerator).

7. **My hospital requires readback for all phone orders, but there is no way to document that the readback occurred. How can we include these orders when responding to question #4 (numerator)?**
   If your hospital cannot document that verbal readback on phone orders occurred, you should develop a written policy that outlines training and implementation of this practice and perform a


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random audit at least annually to ensure the policy is being followed. Maintain documentation of the audit that demonstrates compliance with the policy as Leapfrog performs monthly documentation requests starting with June 30 submissions and continuing until the Survey closes on January 31.

8. **When should we take the CPOE Evaluation Tool?**
   The CPOE Evaluation Tool is a core element of Leapfrog's CPOE Standard. Hospitals are urged to ensure that the Adult Inpatient CPOE Test is submitted along with the Survey (i.e., in the same month) in order to meet the deadlines for the Leapfrog Hospital Survey and Leapfrog's other programs such as Top Hospital and the Leapfrog Hospital Safety Grade.

   Hospitals that submit the Survey, but do not submit an Adult Inpatient Test via the CPOE Evaluation Tool, are scored and publicly reported as "Limited Achievement" on the CPOE measure.

   Within a Survey Cycle (April 1 – November 30), a hospital cannot retake a CPOE Evaluation Tool until at least 120 days have passed since their last test.

9. **Should hospitals take the CPOE Test more than once per Survey Cycle?**
   Not necessarily. Hospitals have the option of re-taking a test after 120 days, but if there were no changes made to your CPOE system after the first test there is likely no reason to retake the test. Hospitals that switch vendors, perform major upgrades, or make significant changes to their decision support settings and/or formulary (e.g., expanding from a limited formulary to a large formulary) should re-take the test to ensure the results reflect their current system.

10. **If we update our responses to questions #3 and #4, do we need to re-take the CPOE Test?**
    No. Hospitals don't need to retake the CPOE Evaluation Tool after submitting updates to Section 2 via the Online Survey Tool. Retaking a test is only recommended for hospitals that switched vendors, performed major upgrades, or made significant changes to their decision support settings and/or formulary.

### *EHR Application Information FAQs*

11. **What is the definition of Artificial Intelligence in Health Care?**
    Artificial Intelligence (AI) in healthcare is the use of machine learning, AI Algorithms, large language models, AI Agents, agentic AI, chatbots, and other related technologies to analyze health data and assist clinicians in tasks like diagnosis, treatment (including clinical decision support), patient monitoring, administrative work, and automated workflows. Its goal is to improve patient outcomes, increase efficiency, and personalize care by providing tools that can identify diseases, streamline workflows, and help predict patient needs.

    Examples of AI applications used in medication management processes are as follows:
    - AI algorithms that suggest a new medication order's dosage, frequency, or duration of therapy.
    - AI algorithms that suggest a new medication for a patient based on an analysis of the patient's medical record.
    - AI algorithms that suggest changes to an existing medication the patient is on based on an analysis of the patient's medical records.


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## *Bar Code Medication Administration (BCMA) FAQs*

### General Questions

12. **Why does the Bar Code Medication Administration system have to be connected to an electronic medication administration record (eMAR)?**
    An eMAR serves as the communication interface that automatically documents the administration of medication into certified Electronic Health Record (EHR) technology. By linking BCMA with the eMAR, information on medication administration is captured in a much timelier manner than a manual documentation process can accomplish.

### Units

13. **Should a unit that has only been open for part of the 3-month reporting period be included?**
    No. Only include those units that are currently open and have been opened and staffed for the entire 3-month reporting period. For example, if you open a new unit that has only been open and staffed for 1-month out of the 3-month reporting period, you will not include that unit when responding to the questions in this section.

14. **How should a hospital report if they had BCMA implemented in some units but not all during the reporting period?**
    To answer "yes" to question #2, your hospital must have a Bar Code Medication Administration (BCMA) system that is linked to the electronic medication administration record (eMAR) when administering medications at the bedside in *at least one* of the following adult and/or pediatric units: general medical, surgical, medical/surgical, neuro, neonatal, or specialty ICU; medical, surgical, or medical/surgical unit (including telemetry units); step-down/progressive unit; labor and delivery unit; or pre-operative unit and/or post-anesthesia care unit. You should only report on units that are currently open and have been in operation for the entire 3-month reporting period selected in question #1. For example, if you have 3 surgical units and are only using BCMA in 1 of the 3 units, you will respond 3 in question #7 and 1 in question #8. You should only include medication administrations that were ordered and scannable in the open and staffed units in which a BCMA system was implemented (as indicated in questions #5, #8, #11, and #14, and #17) when reporting on compliance in questions #18-19.

15. **How should hospitals report if they have a combined pre-operative and post-anesthesia care unit (PACU)?**
    As noted in endnote #22, hospitals must include combined pre-operative and post-anesthesia care units when reporting on questions #15-17. Therefore, hospitals should respond "yes" to question #15 and then report on how many of these units are open and staffed in question #16 and how many of the units utilize the BCMA/eMAR system in question #17. Medication administrations that occurred in these combined pre-operative and post-anesthesia care units must be included when reporting on compliance in question #18-19 provided these units utilize a BCMA system that is linked to the eMAR.

16. **Should we include pre-operative and post-anesthesia care units that are located in our surgery centers or free-standing hospital outpatient departments that share our hospital's license or CMS Certification Number (CCN) when reporting on questions #15-17?**
    No, for the purposes of reporting on Section 2C: BCMA, only include pre-operative and post-anesthesia care units (adult and/or pediatric) that are located in or co-located[31] with your hospital.

17. **Certain procedural units in our hospital (e.g., endoscopy, interventional radiology, cath lab, etc.) encompass the pre-op area, procedural area, and post-anesthesia care area – meaning the same area is used for all three aspects of care. As such, our data includes medications administered pre-operatively, post-operatively, and administered during the procedures. Should we include or exclude these procedural units?**
    Please include these units when responding to questions #15-17 regarding pre-op/PACUs. If you can separate out the medications that are being administered pre- and post- from those that are

administered during a procedure, exclude medications administered during a procedure when reporting on compliance in questions #18-19. Otherwise, you can count these medication administrations when responding to questions #18-19.

## Compliance

18. **What is considered a "scannable" medication?**
    Any medication (see measure specifications) that has a bar code and could be scanned if BCMA were in use would be considered "scannable." In question #18, hospitals should only include ordered and "scannable" medications from the units where they indicated a BCMA system was implemented.

19. **Should we only include inpatient medication administrations when reporting on compliance in questions #18-19?**
    No, hospitals must include all scannable medication administrations (regardless of the patient's admission status) from the units in questions #5, #8, #11, #14 and #17 that were utilizing a BCMA system linked to the eMAR during the reporting period. This would include scannable medications administered to inpatients, outpatients, observation status patients, etc.

20. **Should we exclude medications that were administered in units that are not currently implementing BCMA?**
    Yes. Question #18 is asking about medication administrations ordered and scannable in those units that are open and staffed and that have implemented a BCMA system. You should include all scannable medications ordered and administered to patients in the open and staffed units (from questions #5, #8, #11, #14 and #17) in which a BCMA system was implemented. Question #18 is used as the denominator to calculate the rate of compliance and should include administrations whether the medication and/or patient was scanned during the administration. Question #19 is used as the numerator and is where you would report the number of medication administrations from these units where the patient and medication were scanned during the administration. We would not expect these two responses to be the same.

21. **Should we exclude medications that are given during emergencies when responding to questions #18-19?**
    No. If the medications are considered "scannable" e.g., any medication that has a bar code and could be scanned if BCMA were in use, they should be included in question #18 (the denominator) but would not be counted in question #19 (the numerator) if the patient and medication were not scanned during administration, even if due to an emergency. Leapfrog's target rate for compliance is 95% to allow for emergency cases such as these.

22. **Should we exclude medications that are given during a system downtime when responding to questions #18-19?**
    No. Medications administered during a system downtime should be included in question #18 (the denominator) but would not be counted in questions #19 (the numerator) if the patient and medication were not scanned during administration because the hospital's BCMA system was down.

23. **Our vendor report provides medication and patient scanning rates separately. How can we report on our compliance if our reports do not provide the number of administrations that had both the medication and patient scanned?**
    If your vendor's report only provides the percentage of patients scanned and the percentage of medications scanned separately but does not provide the rate of administrations where both the patient and medication were scanned, please report the lower of the two rates (supply the denominator in question #18 and numerator in question #19), as that would be the maximum possible rate of having both scanned.

    Moving forward, we do ask that your hospital work with your vendor to report out the rate of administrations where both the patient and medication are scanned. It is only when both are scanned that safe medication administration can be ensured.


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24. **Is manual scanning (e.g., in lieu of scanning the patient's wristband, typing in the patient's number) something we can count in our BCMA scans*?***
    No. The problem is that the user may type in the wrong patient number, negating the safety benefits. The best practice is to scan the wristband that is on the wrist of the patient.

25. **Our process is to scan the patient once and then scan each medication. Question #19 seems to want each medication and patient scanned with each medication. Can you clarify?**
    Hospitals should report on the number of administrations where both the patient and the medication were scanned during the administration. During administrations where multiple medications are administered sequentially, the patient should be scanned first, but does not need to be rescanned before each medication is administered.

26. **In our hospital some medications are ordered and scheduled, but not administered. Should medications that are ordered and scheduled, but not administered be included when responding to questions #18-19?**
    No, medications that are not administered should not be included in questions #18-19.

## Decision Support

27. **If an alert is part of the eMAR, but not the Bar Code Medication Administration system, should we respond "yes" to the decision support elements in question #20a - e?**
    If the provider and pharmacist are notified or alerted (e.g., second nurse check), but the nurse or provider administering the medication does not receive an alert at the point of administration, then your hospital should answer "no" to these questions about decision support.

28. **My hospital's EHR workflow for medication administration is designed in such a way that our system will never generate a "wrong patient" alert. How should we answer the question in the Survey about whether we have that type of decision support?**
    If your hospital's EHR workflow is designed so that the nurse scans the patient first, and then the medications, such that the nurse would never receive a "wrong patient" alert, for purposes of the Survey, your hospital should indicate that it has 'wrong patient' decision support. The goal of including a "wrong patient" alert is to acknowledge that as a safe practice and to drive organizations to validate the "right patient" in the medication administration process. The workflow described helps ensure that a 'wrong patient' is not encountered.

29. **Is the "second nurse check needed" decision support element required for all medications or just certain medication classes in order to answer "yes" to question #17e?**
    No. An alert for "second nurse check needed" is only required for certain medications and it is up to each hospital to decide which medication classes require this alert during administration.

## Workarounds

30. **Must a hospital establish a separate committee to meet solely to review data reports on BCMA system use?**
    While establishing a committee that has the sole purpose of reviewing data reports on BCMA system use is encouraged, it is not required. At a minimum, a pre-existing standing committee that meets on a regular basis could be given the responsibility of reviewing these reports. The committee chosen to review the reports must include individuals whose roles reflect each part of the BCMA process (e.g., pharmacists, nurses, IT personnel, etc.).

31. **What are some examples of "back-up equipment" for hardware failures?**
    Examples of "back-up equipment" include extra BCMA scanners, portable computers, batteries, and mice that are easily accessible to nurses experiencing equipment malfunctions. Quickly replacing malfunctioning equipment is essential to prevent workarounds.


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32. **What are some examples of "engaging nursing leadership at the unit level on BCMA use?"**
    Engaging nursing leadership on BCMA use should be an active, ongoing process. An engaged leader would actively use BCMA data to coach staff towards safe or desired behaviors. Examples of activities in which nursing leadership could be engaged include, but are not limited to:
    - Education sessions in units
    - Review of policies regarding use and non-use of BCMA
    - Investigating problems with BCMA specific to the unit
    - Providing a forum for users to report BCMA problems and reasons for workarounds
    - Providing suggestions for improvements to both technology and process

33. **How often should hospitals conduct real-time observations and what do 'best practices' look like?**
    At a minimum, the observations should be conducted on each unit at least biannually (2x/year) and should be 30 minutes or 30 medication administrations in length, whichever is shorter. If a central team does observations, they should ensure each type of unit is observed within that 6-month period. More frequent observations are appropriate for hospitals that have recently introduced BCMA and/or when safety reports indicate a problem, where observations can be helpful in understanding the root cause of an incident or near miss.

    The observations should be direct nurse-BCMA observations, watching how the nurse uses the BCMA system as part of the bedside medication administration process. The observer should note if nurses are using any workarounds to compensate for system issues. In addition to observing the nurse-BCMA interaction, the observer should also have conversations with the nurses, as their comments are often a good source for understanding the causes of workarounds. The observations collected from the different units should be aggregated together to understand trends across the hospital and where the hospital should place a priority for addressing BCMA system issues.

34. **If our hospital meets the 95% compliance target, do we still need to implement or monitor a quality improvement project for question #21f and evaluate the results of those projects for #21g?**
    Implementation or monitoring of a quality improvement project and evaluation of that project is only required if one or more applicable units has not achieved 95% BCMA scanning compliance. Otherwise, the hospital does not need to implement or monitor a quality improvement project or evaluate that project if they have achieved 95% BCMA scanning compliance in **all** applicable units based on quarterly monitoring of compliance. In order to respond that this requirement does not apply, all applicable units must meet the 95% BCMA scanning compliance the quarter prior to submission of this section. Hospitals should respond accordingly to question #21f and must maintain quarterly documentation demonstrating their adherence in each unit.

35. **What are some appropriate mechanisms for communicating back to end users for question #21h?**
    Appropriate mechanisms for communicating back to end users would include staff meetings, safety briefings or unit huddles, or sharing in a Nursing Informatics eNewsletter, through a Medication Safety Team, or Quality Committee newsletter/flyer.

### *Medication Reconciliation FAQs*

### Sampling

36. **Are we required to use Leapfrog's random sampling methodology?**
    No. You may use a different sampling methodology from the methodology provided in the Medication Reconciliation Workbook. However, you should be sure to sample from different days of the week, including weekends.

37. **If the first few patients included in the sample have zero gold standard medications, should we sample more than 30 patients?**
    Yes, hospitals can sample more than 30 patients to ensure their rate of unintentional discrepancies per medication is scored and publicly reported. While 30 is the minimum sample size, hospitals are welcome to sample more than this.

## Gold Standard Medication History

38. **A pharmacist, pharmacy resident, or certified pharmacy technician creates the pre-admission Medical List as part of normal care. Can this be used as the Gold Standard Medication List?**
    No, a different trained pharmacist, pharmacy resident, or certified pharmacy technician[23] should collect the Gold Standard Medication List when collecting data for this measure.

39. **Does the same pharmacist, pharmacy resident, or certified pharmacy technician who obtains the Gold Standard Medication List also need to perform the review to identify unintentional medication discrepancies?**
    No, different pharmacists or pharmacy residents can play different roles in the data collection process. Only pharmacists and pharmacy residents can compare the Gold Standard Medication List to admission and discharge orders to identify unintentional medication discrepancies.

40. **We have two differing records of what dose the patient was taking prior to admission, one from the patient and one from the outpatient pharmacy. What do we record as the correct dose for the Gold Standard Medication?**
    In cases where the medication history obtained from interviewing the patient does not match other written records, the pharmacist will need to go back to the patient with the pharmacy records in hand and figure out the source of the discrepancy (e.g., the patient systematically takes it differently than prescribed vs. the patient was just mistaken about the strength of the pill, etc.). If the discrepancy can't be resolved, then another source will be needed (e.g., caregiver, PCP).

## Admission and Discharge Orders

41. **Are there any types of admission orders that can or should be excluded?**
    Yes, (a) Medication orders that are clearly related to the chief complaint (e.g., levofloxacin for pneumonia when pneumonia is the admitting diagnosis), (b) Medication orders that are clearly documented (e.g., Lovenox for DVT prophylaxis), and (c) Standard PRN orders at your hospital (e.g., Tylenol PM if that is in the standard order set at your hospital).

42. **Should admission orders that are discontinued prior to discharge be included?**
    Yes. Some of these orders may end up being counted in question #7 (additional medications that were unintentionally ordered).

## Identifying Discrepancies

43. **If a dose and a route discrepancy are found for the same medication, does it count as one or two in the number of unintentional discrepancies?**
    The number of unintentional discrepancies is a count of medication orders where an unintentional discrepancy occurred. A medication order may have several errors associated with it (e.g., dose, route, timing, etc.). You should not count the number of errors associated with the same medication order. However, discrepancies in admission orders and discharge orders are counted separately. For example, if a medication on the Gold Standard Medication List is ordered for a patient on admission with the incorrect dose, this counts as one discrepancy. If this medication is ordered on discharge with the same incorrect dose, this would count as a second discrepancy. But a medication with a dose and frequency discrepancy in admission orders counts as one discrepancy.

44. **Do all the additional medications that were ordered unintentionally in question #7 count as unintentional discrepancies in #8**?
Yes. If a medication is unintentionally ordered at admission, then this counts as one discrepancy. If the same medication is unintentionally ordered at discharge, then this counts as a second discrepancy. If an unintentionally ordered medication in question #7 was ordered on both admission and discharge, then this would count as **two** discrepancies in question #8 (but counts as one medication in question #7).

45. **If there is no documentation of systematic or sporadic nonadherence, why does the pharmacist have to count unintentional discrepancies on admission and discharge?**
Systematically non-adherent means the patient consistently takes the medication differently than prescribed. Lack of appropriate documentation of systematic non-adherence can lead to an adverse drug event. For example, if a patient is prescribed hydralazine 25mg three times a day, but always takes 25mg two times a day this must be documented in the clinical record so the care team can decide how to order the medication on admission and discharge (i.e., recorded on the Med Rec Worksheet as an intentional discrepancy). If the systematic non-adherence is not documented and the care team is unaware of how the patient has been taking the medication, they could order and administer it as prescribed and cause, in this example, hypotension in the patient.

    Sporadically non-adherent means that the patient takes the medication as prescribed but, on average, misses two or more doses per week. Lack of appropriate documentation of sporadic non-adherence can lead to an adverse drug event. For example, if a patient is prescribed four antihypertensives, but misses two or more doses per week, this must be documented in the clinical record so the care team can decide how to order the medication on admission and discharge (i.e., recorded on the Med Rec Worksheet as an intentional discrepancy). If the sporadic non-adherence is not documented and the care team is unaware of how the patient has been taking the medication, they could order and administer it as prescribed and cause, in this example, hypotension in the patient.

46. **A patient had two medications that were not on our hospital's formulary. They were not substituted. Do these two medications count as errors of omission?**
Yes. If a Gold Standard Medication was not ordered or appropriately substituted on admission and discharge, it would count as two unintentional medication discrepancies for each medication that was omitted.

## Scoring

47. **What questions are used to calculate the numerator and denominator that results in the rate of unintentional medication discrepancies per medication?**
The rate of unintentional medication discrepancies per medication is calculated using the following formula:

$$\frac{\text{(Question \#6 + Question \#8)}}{\text{(Question \#5 + Question \#7)}} = \text{Rate of unintentional medication discrepancies per medication}$$

This rate is calculated for you in the Med Rec Workbook provided on the Survey Materials webpage. This information is also available in the Scoring Algorithms.

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# *SECTION 3: ADULT AND PEDIATRIC COMPLEX SURGERY*

This section includes questions and reference information for Section 3: Adult and Pediatric Complex Surgery. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.


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# Section 3: Adult and Pediatric Complex Surgery

**Adult and Pediatric Complex Surgery Fact Sheet and Bibliography:**
https://ratings.leapfroggroup.org/measure/hospital/2026/complex-adult-and-pediatric-surgery

**Section 3 is applicable to all hospitals. Hospitals that do not perform the high-risk procedures included in Section 3A should select "None of the above" in question #2 and move on to the Affirmation of Accuracy. Your hospital's results will be displayed as "Does Not Apply" on Leapfrog's public reporting website. Pediatric hospitals should only report on the Norwood procedure, if applicable.**

Section 3 includes questions about your hospital's volume and process for privileging surgeons for eleven high-risk procedures, outcomes for mitral valve repair and replacement, and participation in The Society of Thoracic Surgeon's Congenital Heart Surgery Database for hospitals that perform the Norwood procedure. This section also includes questions about the implementation of a safe surgery checklist.

**Each hospital achieving the standard for each of the nine applicable high-risk procedures:**

1. Meets the minimum hospital volume standard for the procedure, **and**
2. Has a process for privileging surgeons that includes the surgeon meeting or exceeding the minimum annual surgeon volume standard for the procedure.

**Each hospital achieving the standard for mitral valve repair and replacement procedures:**

1. Meets the minimum hospital volume standard for the procedure, **and**
2. Has a process for privileging surgeons that includes meeting or exceeding the minimum annual surgeon volume standard for the procedure, **and**
3. Participates in the Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database (ACSD), **and**
4. Has an STS Mitral Valve Repair/Replacement Composite Score of 3 Stars.

**Each hospital achieving the standard for Norwood procedures:**

1. Meets the minimum hospital volume standard for the procedure, **and**
2. Has a process for privileging surgeons that includes meeting or exceeding the minimum annual surgeon volume standard for the procedure, **and**
3. Participates in the Society of Thoracic Surgeons (STS) Congenital Heart Surgery Database (CHSD).

**Each hospital achieving the standard for the safe surgery checklist:**

1. Uses a safe surgery checklist on **all** patients undergoing an applicable procedure (reported on in Section 3A, if applicable) that includes **all** safe surgery checklist elements; **and**
2. Verbalizes **all** safe surgery checklist elements in the presence of the appropriate personnel; **and**
3. Completes an audit on a sufficient sample of patients to document adherence to the checklist; **and**
4. Has documented adherence to the checklist for at least 90% of the patients included in the audit.

**Download the 2026 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.**


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# 3A: Hospital and Surgeon Volume

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Notes:**

Note 1: This subsection is applicable to all hospitals. Hospitals that do not perform the procedures included in this subsection should select "None of the above" in question #2 and move on to the Affirmation of Accuracy. Your hospital's results will be displayed as "Does Not Apply" on Leapfrog's public reporting website.

Note 2: Pediatric hospitals should only respond to questions regarding the Norwood procedure, if applicable. If the Norwood procedure is not applicable, select "None of the above" in question #2 and move on to the Affirmation of Accuracy. Your hospital's results will be displayed as "Does Not Apply" on Leapfrog's public reporting website.

Note 3: Question #12 is optional and will not be used in scoring or public reporting.

**Specifications:** See ***Hospital and Surgeon Volume Measure Specifications*** in the Reference Information beginning on page 1033.

**Reporting Period: 12 months or *optionally* 24 months (annual average)**

- Surveys submitted prior to September 1:
  - 01/01/2025 – 12/31/2025 (12-month count) or 01/01/2024 – 12/31/2025 (24-month annual average)
- Surveys (re)submitted on or after September 1:
  - 07/01/2025 – 06/30/2026 (12-month count) or 07/01/2024 – 06/30/2026 (24-month annual average)

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

| | |
|---|---|
| 1) 12-month or 24-month reporting period used: | ○ 01/01/2025 – 12/31/2025 (12-month count)<br>○ 01/01/2024 – 12/31/2025 (24-month annual average)<br>○ 07/01/2025 – 06/30/2026 (12-month count)<br>○ 07/01/2024 – 06/30/2026 (24-month annual average) |
| 2) Check all procedures that your hospital performs as defined in the Adult and Pediatric Complex Surgery Reference Information.<br>*Select all that apply.*<br>*Do not check the box for a procedure if your hospital ONLY performs the procedure on an emergency basis or when a patient is too unstable for safe transfer.*<br>*If "none of the above," skip the remaining questions in Section 3 and go to the Affirmation of Accuracy. The hospital will be scored as "Does Not Apply."* | ☐ Carotid endarterectomy<br>☐ Mitral valve repair and replacement<br>☐ Open aortic procedures<br>☐ Lung resection for cancer<br>☐ Esophageal resection for cancer<br>☐ Pancreatic resection for cancer<br>☐ Rectal cancer surgery<br>☐ Bariatric surgery for weight loss<br>☐ Total knee replacement<br>☐ Total hip replacement<br>☐ Norwood procedure<br>☐ None of the above |

*Respond to questions #3-11 based on the procedures selected in question #2.*

3) Total **hospital** volume for each selected procedure during the reporting period:

*Volume should represent a 12-month count or 24-month annual average consistent with the reporting period selected in question #1.*

| *Procedure* | *Hospital Volume Standard* | *Total Hospital Volume* *(12-month count or 24-month annual average)* |
|---|---|---|
| Carotid endarterectomy | *20* | |
| Mitral valve repair and replacement | *40* | |
| Open aortic procedures | *10* | |
| Lung resection for cancer | *40* | |
| Esophageal resection for cancer | *20* | |
| Pancreatic resection for cancer | *20* | |
| Rectal cancer surgery | *16* | |
| Bariatric surgery for weight loss | *50* | |
| Total knee replacement | *50* | |
| Total hip replacement | *50* | |
| Norwood procedure | *8* | |

4) Does the total hospital volume for total knee replacement, total hip replacement, and/or bariatric surgery for weight loss reported on in question #3 above include procedures performed on an inpatient basis, outpatient basis, or both?

| | |
|---|---|
| Total knee replacement | ○ Inpatient<br>○ Outpatient<br>○ Both (inpatient and outpatient) |
| Total hip replacement | ○ Inpatient<br>○ Outpatient<br>○ Both (inpatient and outpatient) |
| Bariatric surgery for weight loss | ○ Inpatient<br>○ Outpatient<br>○ Both (inpatient and outpatient) |

5) Does your hospital's privileging process include the surgeon meeting or exceeding the minimum annual surgeon volume standard listed below?

| *Procedure* | *Annual Surgeon Volume Standard* | |
|---|---|---|
| Carotid endarterectomy | *10* | ○ Yes<br>○ No |
| Mitral valve repair and replacement | *20* | ○ Yes<br>○ No |
| Open aortic procedures | *7* | ○ Yes<br>○ No |
| Lung resection for cancer | *15* | ○ Yes<br>○ No |
| Esophageal resection for cancer | *7* | ○ Yes<br>○ No |


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| | | |
|---|---|---|
| Pancreatic resection for cancer | *10* | ○ Yes<br>○ No |
| Rectal cancer surgery | *6* | ○ Yes<br>○ No |
| Bariatric surgery for weight loss | *20* | ○ Yes<br>○ No |
| Total knee replacement | *25* | ○ Yes<br>○ No |
| Total hip replacement | *25* | ○ Yes<br>○ No |
| Norwood procedure | *5* | ○ Yes<br>○ No |

*If your hospital performs mitral valve repair and replacement (selected the checkbox in question #2), continue to question #6. Otherwise, skip questions #6-9 and continue to question #10.*

**Reporting Period:** Base your responses on the latest **36-month** report received from the Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database (ACSD) for the **Mitral Valve Repair/Replacement Composite Score**.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

| | |
|---|---|
| 6) Does your hospital participate in the Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database (ACSD) and submit data for all applicable procedures during the most recent 36-month period for which performance reports are available?<br><br>*If "no" to question #6, skip questions #7-9 and continue to question #10.* | ○ Yes<br>○ No |
| 7) What is the most recent 36-month reporting period for which STS performance reports are available? Reporting period ending: | _____<br>*Format: Month/Year* |
| 8) Does your hospital have a Mitral Valve Repair/Replacement Composite Score publicly reported on the STS website and do you choose to report data from the most recent performance report to this Survey?<br><br>*If "no" or "yes, but did not meet the STS Data Completeness Requirement [29] during the reporting period," skip question #9 and continue to question #10.* | ○ Yes<br>○ No<br>○ Yes, but did not meet the STS Data Completeness Requirement during the reporting period |
| 9) What is your hospital's Mitral Valve Repair/Replacement Composite Score? | ○ 1 star – lower-than-expected performance<br>○ 2 stars – as-expected performance<br>○ 3 stars – higher-than-expected performance |

*If your hospital performs the Norwood procedure (selected the checkbox in question #2), continue to question #10. Otherwise, skip questions #10-11 and continue to the next subsection.*

| | |
|---|---|
| 10) Does your hospital participate in the Society of Thoracic Surgeons (STS) Congenital Heart Surgery Database (CHSD) and did your hospital submit data for the Norwood procedure during the most recent 48-month period for which performance reports are available?<br><br>*If "no" to question #10, skip question #11 and continue to the next subsection.* | ○ Yes<br>○ No |
| 11) What is the most recent 48-month reporting period for which STS performance reports are available? Reporting period ending: | _____<br>*Format: Month/Year* |

### *Additional Question (Optional – Fact-Finding Only)*

| | |
|---|---|
| 12) Does your hospital have surgeons that perform both total knee replacement and total hip replacement procedures?<br><br>*This question only applies to hospitals that perform both total knee replacement and total hip replacement procedures.*<br><br>*Response will not be scored or publicly reported in 2026.* | ○ Yes<br>○ No |


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# 3B: Safe Surgery Checklist for Adult and Pediatric Complex Surgery

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Notes:**

Note 1: The elements required for each stage of the safe surgery checklist are adapted from the WHO Surgical Safety Checklist and the AHRQ Endoscopy Checklist.

Note 2: Question #7 will not be used in scoring or public reporting.

Note 3: Hyperlinks throughout this subsection refer to the Safe Surgery Checklist for Adult and Pediatric Complex Surgery FAQs beginning on page 1455, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

**Specifications:** See ***Safe Surgery Checklist for Adult and Pediatric Complex Surgery Measure Specifications*** in the Reference Information beginning on page 141.

**Reporting Period: 12 months**
Answer questions #1-9 for the latest 12-month period prior to submission of this section of the Survey.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

**Sufficient Sample:** See ***Safe Surgery Checklist for Adult and Pediatric Complex Surgery Measure Specifications*** for instructions on identifying a sufficient sample for questions #6-9.

| | |
|---|---|
| 1) What is the latest 12-month reporting period for which your hospital is submitting responses to questions #2-9? 12-month reporting period ending: | _____<br>*Format: Month/Year* |
| 2) Does your hospital utilize a safe surgery checklist on every patient every time one of the applicable procedures in Section 3A is performed?<br><br>*If "no" to question #2, skip the remaining questions in Section 3B and go to the Affirmation of Accuracy. The hospital will be scored as "Limited Achievement."* | ○ Yes<br>○ No |
| 3) **Before the induction of anesthesia**, is a safe surgery checklist that includes all the following elements read aloud in the presence of the anesthesia professional and nursing personnel:<br>• Patient ID;<br>• Confirmation of procedure;<br>• Patient consent;<br>• Site marked, if applicable;<br>• Anesthesia/medication check;<br>• Allergies assessed;<br>• Difficult airway/aspiration risk;<br>• Risk of blood loss (only applicable if risk of blood loss is >500ml for adults or >7ml/kg for children); and<br>• Availability of devices (applicable to endoscopy procedures only)? | ○ Yes<br>○ No |

| | |
|---|---|
| 4) **Before the skin incision and/or before the procedure begins**, is a safe surgery checklist that includes all the following elements read aloud in the presence of the whole surgical team**:**<br>• Clinical team introduction;<br>• Confirmation of patient name, procedure, and, if applicable, surgical/incision site;<br>• Antibiotic prophylaxis, if applicable;<br>• Anticipated Critical Events (i.e., non-routine steps, length of procedure, blood loss, patient-specific concerns, sterility);<br>• Equipment check/concerns; and<br>• Essential imaging available, if applicable? | ○ Yes<br>○ No |
| 5) **Before the patient leaves the operating room and/or procedure room**, is a safe surgery checklist that includes all the following elements read aloud in the presence of the whole surgical team:<br>• Confirmation of procedure performed;<br>• Instrument/supply counts;<br>• Specimen labeling, if applicable;<br>• Equipment concerns; and<br>• Patient recovery/management concerns? | ○ Yes<br>○ No |

*If "no" to question #3, #4, or #5, skip the remaining questions in Section 3B and go to the Affirmation of Accuracy. The hospital will be scored as "Limited Achievement."*

*Hospitals performing the audit in Section 3B question #6 and the audit in Section 9D question #6 should audit 15 cases who underwent a procedure included in Section 3A and 15 cases who underwent a procedure included in Section 9C. Hospitals only performing the audit in Section 3B question #6 and not in Section 9D question #6 should audit 30 cases who underwent a procedure included in Section 3A.*

| | |
|---|---|
| 6) Did your hospital perform an audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 3A and measure adherence to the safe surgery checklist?<br><br>*Free-standing pediatric hospitals that perform the Norwood Procedure and hospitals that reported a combined total hospital volume of less than the sufficient sample for all the procedures in Section 3A can sample any patients that had a procedure performed under general anesthesia.*<br><br>*If "no" to question #6, skip the remaining questions in Section 3B and go to the Affirmation of Accuracy. The hospital will be scored as "Limited Achievement."*<br><br>*If "no, performed fewer than 30 total inpatient procedures under general anesthesia" to question #6, skip the remaining questions in Section 3B and go to the Affirmation of Accuracy. The hospital will be scored as "Unable to Calculate Score."* | ○ Yes<br>○ No<br>○ No, performed fewer than 30 total inpatient procedures under general anesthesia |
| 7) How many cases were included in the audit from question #6? | _____<br>*Max value 100* |

| | |
|---|---|
| 8) Which method was used to perform the audit on a sufficient sample in question #6? | ○ In-person observational audit<br>○ Retrospective audit of medical records or EHR data<br>○ Both |
| 9) Based on your hospital's audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 3A, what was your hospital's documented rate of adherence to the safe surgery checklist (i.e., what percentage of the sampled cases had all elements in questions #3, #4, and #5 completed)? | ○ 90%-100%<br>○ 75%-89%<br>○ 50%-74%<br>○ Less than 50% |


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**Affirmation of Accuracy**

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Adult and Pediatric Complex Surgery Section at our hospital, and I hereby affirm that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this affirmation on behalf of our hospital.

The hospital and I acknowledge that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also acknowledge that analyses and ratings The Leapfrog Group derives from this information will be made public on the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade website, and/or other Leapfrog Group published works, products and services. The hospital and I acknowledge that analyses and ratings derived from this information and all intellectual property rights related to those analyses and ratings shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. I hereby affirm that this information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may license analyses and ratings derived from this information to other entities including researchers, not-for-profit entities, and for-profit entities, and the revenue from such licensure will be used solely to support The Leapfrog Group's not-for-profit mission. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
*(first name and last name)* *(title)*
on _____.
*(date)*


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# Section 3: Adult and Pediatric Complex Surgery Reference Information

## *What's New in the 2026 Survey*

### Section 3A: Hospital and Surgeon Volume

Leapfrog's experts are reviewing the ICD-10 and CPT codes used for hospitals reporting on this subsection and any updates (i.e., additions and removals) will be published separately as their review is still ongoing.

Leapfrog is also adding an optional, fact-finding question to determine if the hospital has surgeons that perform both total knee replacement and total hip replacement procedures listed in Section 3A. Leapfrog is adding this question to evaluate how common it is to have the same surgeon performing both procedures given requests received from hospitals and ambulatory surgery centers to combine total hip and knee replacements into a single volume standard.

This optional, fact-finding question will not be used in scoring or public reporting in 2026. There are no changes to the scoring algorithm for Section 3A: Hospital and Surgeon Volume.

### Section 3B: Safe Surgery Checklist for Adult and Pediatric Complex Surgery

There are no changes to this subsection.

## *Change Summary Since Release*

None. If substantive changes are made to this section of the Survey after release on April 1, 2026, they will be documented in this Change Summary section.


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# Section 3: Adult and Pediatric Complex Surgery Measure Specifications

## *Hospital and Surgeon Volume Measure Specifications*

**Important Notes:**

Note 1: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Note 2: For each of the eleven high-risk procedures included in Section 3A: Hospital and Surgeon Volume, Leapfrog has provided a set of ICD-10 procedure codes, and in some cases an additional set of CPT codes (for Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss) or ICD-10 diagnosis codes, for counting **patient discharges**. Please carefully review the measure specifications for each individual procedure to ensure you have the complete list of codes needed. ICD-10 codes are provided below and are also available in an Excel document on the Survey Materials webpage. See Note 3 below for instructions on downloading CPT codes.

Note 3: CPT Codes are provided in downloadable Excel files on the Survey Dashboard. To access the files, click the CPT Code Workbook button next to Section 9. You will be required to complete the American Medical Association's Terms of Use before downloading the Excel file and using the individual CPT codes to query your EHR or billing system. You are only required to complete the Terms of Use once per Survey Cycle (April 1 – November 30).

The CPT Code Workbooks (Excel files) are labeled for Section 3A: Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss and Section 9C: Volume of Procedures. Please note, if you are part of a hospital system, each hospital will need to complete the Terms of Use. This is a requirement of the American Medical Association.

**Source:** The Leapfrog Group, American Medical Association

**Reporting Period: 12 months or *optionally* 24 months (annual average)**

- Surveys submitted prior to September 1:
  - 01/01/2025 – 12/31/2025 (12-month count) or 01/01/2024 – 12/31/2025 (24-month annual average)
- Surveys (re)submitted on or after September 1:
  - 07/01/2025 – 06/30/2026 (12-month count) or 07/01/2024 – 06/30/2026 (24-month annual average)

**Question #2:** Check all procedures that your hospital performs as defined in the Adult and Pediatric Complex Surgery Reference Information (listed below):

- Carotid endarterectomy
- Mitral valve repair and replacement
- Open aortic procedures
- Lung resection for cancer
- Esophageal resection for cancer
- Pancreatic resection for cancer
- Rectal cancer surgery
- Bariatric surgery for weight loss
- Total knee replacement
- Total hip replacement
- Norwood procedure

Free-standing pediatric hospitals should only report on the Norwood procedure, if applicable.

Do not check the box for the procedure if:

- Your hospital does not perform the procedure or ONLY performs the procedure on an emergency basis or when a patient is too unstable for safe transfer.


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- Your hospital has started to perform the procedure in the last 18 months. Leapfrog gives hospitals an 18-month grace period before having to report on hospital volume and process for privileging surgeons for new service lines.

Do check the box for the procedure if:

- Your hospital would perform the procedure but had zero cases during the reporting period. Select the procedure and indicate a hospital volume of zero in question #3. Please note that hospitals can elect to report on a 24-month annual average.
- Your hospital has reached the end of the 18-month grace period for a new service line. You will now have to report on both hospital volume and your process for privileging surgeons for this procedure.

**Question #3**: Total **hospital volume** for each selected procedure (from question #2) during the reporting period:

- Carotid endarterectomy (Hospital Volume Standard: 20)
- Mitral valve repair and replacement (Hospital Volume Standard: 40)
- Open aortic procedures (Hospital Volume Standard: 10)
- Lung resection for cancer (Hospital Volume Standard: 40)
- Esophageal resection for cancer (Hospital Volume Standard: 20)
- Pancreatic resection for cancer (Hospital Volume Standard: 20)
- Rectal cancer surgery (Hospital Volume Standard: 16)
- Bariatric surgery for weight loss (Hospital Volume Standard: 50)
- Total knee replacement (Hospital Volume Standard: 50)
- Total hip replacement (Hospital Volume Standard: 50)
- Norwood procedure (Hospital Volume Standard: 8)

When calculating total **hospital volume** count the number of **patients** discharged from your hospital within the reporting period with any one or more of the ICD-10 codes or CPT codes (for Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss) specified for each procedure, subject to the inclusion criteria below:

- Only the ICD-10 procedure, CPT, and diagnosis codes provided by Leapfrog should be used to report on the questions in Section 3A: Hospital and Surgeon Volume. ICD-10 codes are provided below and are also available in an Excel document on the Survey Materials webpage. See Note 3 above for instructions on downloading CPT codes.
- For procedures that include TWO sets of codes (one set of procedure codes and one set of diagnosis codes), both sets of codes must be used for counting patient discharges (e.g., at least one procedure code **AND** one diagnosis code must be present).
- Except for bariatric surgery for weight loss (where the ICD-10 diagnosis code must be the primary diagnosis) and total knee replacement and total hip replacement (where the procedure code must be the primary procedure), ICD-10 codes for the other procedures can appear in ANY procedure field and ANY diagnosis field.
- Age restrictions apply – For the Norwood procedure only include discharges for pediatric patients (ages 17 years and younger). For the remaining ten procedures, only include discharges for adult patients (ages 18 years and older).

**Question #4:** Does the total hospital volume for total knee replacement, total hip replacement, and/or bariatric surgery for weight loss reported on in question #3 above include procedures performed on an inpatient basis, outpatient basis, or both?

- If your hospital only performs total knee replacement, total hip replacement, and/or bariatric surgery for weight loss on an inpatient basis, select inpatient.
- If your hospital only performs total knee replacement, total hip replacement, and/or bariatric surgery for weight loss on an outpatient basis, select outpatient.
- If your hospital performs total knee replacement, total hip replacement, and/or bariatric surgery for weight loss on both an inpatient and outpatient basis, select both (inpatient and outpatient).


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**Question #5:** Does your hospital's privileging process include the surgeon meeting or exceeding the minimum annual surgeon volume standard listed below?

- Carotid endarterectomy: 10
- Mitral valve repair and replacement: 20
- Open aortic procedures: 7
- Lung resection for cancer: 15
- Esophageal resection for cancer: 7
- Pancreatic resection for cancer: 10
- Rectal cancer surgery: 6
- Bariatric surgery for weight loss: 20
- Total knee replacement: 25
- Total hip replacement: 25
- Norwood procedure: 5

When determining whether surgeons have met or exceeded Leapfrog's minimum annual surgeon volume standards for the purposes of privileging, only refer to the ICD-10 procedure codes and CPT codes (for Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss) – **diagnosis** codes can be ignored.

**Source:** The Society of Thoracic Surgeons (STS)

**Reporting Period:** Latest **36-month** report from Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database (ACSD) for the **Mitral Valve Repair/Replacement Composite Score.**

**Question #6:** Does your hospital participate in the Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database (ACSD), and submit data for all applicable procedures during the most recent 36-month period for which performance reports are available?

Select "yes" if your hospital participates in the Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database (ACSD) and has submitted data for all applicable procedures during the most recent 36-month period.

**Question #7:** What is the most recent 36-month reporting period for which STS performance reports are available? Reporting period ending:

Select the most recent 36-month reporting period for which STS performance reports are available. The reporting period is displayed when reviewing your "MVRR Composite Quality Ratings" at https://publicreporting.sts.org/search/acsd. See screenshot provided for question #9 below.

**Question #8:** Does your hospital have a Mitral Valve Repair/Replacement Composite Score publicly reported on the STS website and do you choose to report data from the most recent performance report to this Survey?

Select "yes" if your hospital elects to share the MVRR data from your most recent performance report with Leapfrog.

**Question #9:** What is your hospital's Mitral Valve Repair/Replacement Composite Score?

Report your Mitral Valve Repair/Replacement Overall Composite Score from the STS Public Reporting website: https://publicreporting.sts.org/search/acsd.

Click on "Search All Groups." Then search for your hospital name/surgery group name in the "Participant Surgery Group Name" field and click your hospital name/surgery group name. On the next page find your "MVRR Composite Quality Rating" and your "Overall Composite Score." Report the number of stars displayed for "Overall Composite Score" represented in the screenshot below.


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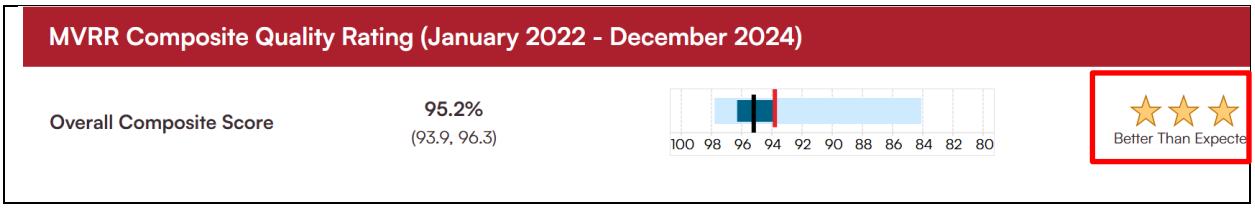


| |
|---|
| **Source:** The Society of Thoracic Surgeons (STS) |
| **Question #10:** Does your hospital participate in the Society of Thoracic Surgeons (STS) Congenital Heart Surgery Database (CHSD) and did your hospital submit data for the Norwood procedure during the most recent 48-month period for which performance reports are available?<br><br>Select "yes" if your hospital participates in the Society of Thoracic Surgeons (STS) Congenital Heart Surgery Database (CHSD) and has submitted data for the Norwood procedure during the most recent 48-month period. |
| **Question #11:** What is the most recent 48-month reporting period for which STS performance reports are available? Reporting period ending:<br><br>Select the most recent 48-month reporting period for which STS performance reports are available. The reporting period should appear at the top of your STS performance report. |

See FAQs for additional information about responding to the questions in this section.

## Carotid Endarterectomy Measure Specifications

For carotid endarterectomy, there are two sets of ICD-10 codes for counting patient discharges. The first set of codes is to identify patients who have had the procedure. The second set of codes is to identify patients with a specific diagnosis.

Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes in any procedure field **AND** any of the following ICD-10 codes in any diagnosis field.

### ICD-10 Carotid Endarterectomy Procedure Codes

| ICD-10 Procedure Code | Code Description |
|---|---|
| 03CH0ZZ | Extirpation of Matter from Right Common Carotid Artery, Open Approach |
| 03CJ0ZZ | Extirpation of Matter from Left Common Carotid Artery, Open Approach |
| 03CK0ZZ | Extirpation of Matter from Right Internal Carotid Artery, Open Approach |
| 03CL0ZZ | Extirpation of Matter from Left Internal Carotid Artery, Open Approach |
| 03CM0ZZ | Extirpation of Matter from Right External Carotid Artery, Open Approach |
| 03CN0ZZ | Extirpation of Matter from Left External Carotid Artery, Open Approach |

### ICD-10 Occlusion and Stenosis and Cerebral Infarction Diagnosis Codes

| ICD-10 Diagnosis Code | Code Description |
|---|---|
| I63.031 | Cerebral infarction due to thrombosis of right carotid artery |
| I63.032 | Cerebral infarction due to thrombosis of left carotid artery |
| I63.033 | Cerebral infarction due to thrombosis of bilateral carotid arteries |
| I63.039 | Cerebral infarction due to thrombosis of unspecified carotid artery |
| I63.131 | Cerebral infarction due to embolism of right carotid artery |
| I63.132 | Cerebral infarction due to embolism of left carotid artery |
| I63.133 | Cerebral infarction due to embolism of bilateral carotid arteries |
| I63.139 | Cerebral infarction due to embolism of unspecified carotid artery |
| I63.231 | Cerebral infarction due to unspecified occlusion or stenosis of right carotid arteries |
| I63.232 | Cerebral infarction due to unspecified occlusion or stenosis of left carotid arteries |
| I63.233 | Cerebral infarction due to unspecified occlusion or stenosis of bilateral carotid arteries |
| I63.239 | Cerebral infarction due to unspecified occlusion or stenosis of unspecified carotid arteries |
| I65.21 | Occlusion and stenosis of right carotid artery |
| I65.22 | Occlusion and stenosis of left carotid artery |
| I65.23 | Occlusion and stenosis of bilateral carotid arteries |
| I65.29 | Occlusion and stenosis of unspecified carotid artery |
| I65.8 | Occlusion and stenosis of other precerebral arteries |
| I65.9 | Occlusion and stenosis of unspecified precerebral artery |


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## Mitral Valve Repair and Replacement Measure Specifications

For mitral valve repair and replacement, there is only one set of ICD-10 codes for counting patient discharges. The set of codes is to identify patients who have had the procedure.

Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes in any procedure field.

**ICD-10 Mitral Valve Repair and Replacement Procedure Codes**

| ICD-10 Procedure Code | Code Description |
|---|---|
| 027G04Z | Dilation of Mitral Valve with Drug-eluting Intraluminal Device, Open Approach |
| 027G0DZ | Dilation of Mitral Valve with Intraluminal Device, Open Approach |
| 027G0ZZ | Dilation of Mitral Valve, Open Approach |
| 02CG0ZZ | Extirpation of Matter from Mitral Valve, Open Approach |
| 02NG0ZZ | Release Mitral Valve, Open Approach |
| 02QG0ZE | Repair Mitral Valve created from Left Atrioventricular Valve, Open Approach |
| 02QG0ZZ | Repair Mitral Valve, Open Approach |
| 02RG07Z | Replacement of Mitral Valve with Autologous Tissue Substitute, Open Approach |
| 02RG08Z | Replacement of Mitral Valve with Zooplastic Tissue, Open Approach |
| 02RG0JZ | Replacement of Mitral Valve with Synthetic Substitute, Open Approach |
| 02RG0KZ | Replacement of Mitral Valve with Nonautologous Tissue Substitute, Open Approach |
| 02UG07E | Supplement Mitral Valve created from Left Atrioventricular Valve with Autologous Tissue Substitute, Open Approach |
| 02UG07Z | Supplement Mitral Valve with Autologous Tissue Substitute, Open Approach |
| 02UG08E | Supplement Mitral Valve created from Left Atrioventricular Valve with Zooplastic Tissue, Open Approach |
| 02UG08Z | Supplement Mitral Valve with Zooplastic Tissue, Open Approach |
| 02UG0JE | Supplement Mitral Valve created from Left Atrioventricular Valve with Synthetic Substitute, Open Approach |
| 02UG0JZ | Supplement Mitral Valve with Synthetic Substitute, Open Approach |
| 02UG0KE | Supplement Mitral Valve created from Left Atrioventricular Valve with Nonautologous Tissue Substitute, Open Approach |
| 02UG0KZ | Supplement Mitral Valve with Nonautologous Tissue Substitute, Open Approach |
| 02VG0ZZ | Restriction of Mitral Valve, Open Approach |


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## Open Aortic Procedures Measure Specifications

For open aortic procedures, there is only one set of ICD-10 codes for counting patient discharges. The set of codes is to identify patients who have had the procedure.

Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes in any procedure field.

**ICD-10 Open Aortic Procedure Codes**

| ICD-10 Procedure Code | Code Description |
|---|---|
| 0410090 | Bypass Abdominal Aorta to Abdominal Aorta with Autologous Venous Tissue, Open Approach |
| 0410091 | Bypass Abdominal Aorta to Celiac Artery with Autologous Venous Tissue, Open Approach |
| 0410092 | Bypass Abdominal Aorta to Mesenteric Artery with Autologous Venous Tissue, Open Approach |
| 0410093 | Bypass Abdominal Aorta to Right Renal Artery with Autologous Venous Tissue, Open Approach |
| 0410094 | Bypass Abdominal Aorta to Left Renal Artery with Autologous Venous Tissue, Open Approach |
| 0410095 | Bypass Abdominal Aorta to Bilateral Renal Artery with Autologous Venous Tissue, Open Approach |
| 0410096 | Bypass Abdominal Aorta to Right Common Iliac Artery with Autologous Venous Tissue, Open Approach |
| 0410097 | Bypass Abdominal Aorta to Left Common Iliac Artery with Autologous Venous Tissue, Open Approach |
| 0410098 | Bypass Abdominal Aorta to Bilateral Common Iliac Arteries with Autologous Venous Tissue, Open Approach |
| 0410099 | Bypass Abdominal Aorta to Right Internal Iliac Artery with Autologous Venous Tissue, Open Approach |
| 021K0ZW | Bypass Right Ventricle to Aorta, Open Approach |
| 021L0ZW | Bypass Left Ventricle to Aorta, Open Approach |
| 021W08A | Bypass Thoracic Aorta, Descending to Innominate Artery with Zooplastic Tissue, Open Approach |
| 021W08B | Bypass Thoracic Aorta, Descending to Subclavian with Zooplastic Tissue, Open Approach |
| 021W08D | Bypass Thoracic Aorta, Descending to Carotid with Zooplastic Tissue, Open Approach |
| 021W08F | Bypass Thoracic Aorta, Descending to Abdominal Artery with Zooplastic Tissue, Open Approach |
| 021W08G | Bypass Thoracic Aorta, Descending to Axillary Artery with Zooplastic Tissue, Open Approach |
| 021W08H | Bypass Thoracic Aorta, Descending to Brachial Artery with Zooplastic Tissue, Open Approach |
| 021W08P | Bypass Thoracic Aorta, Descending to Pulmonary Trunk with Zooplastic Tissue, Open Approach |
| 021W08Q | Bypass Thoracic Aorta, Descending to Right Pulmonary Artery with Zooplastic Tissue, Open Approach |
| 021W08R | Bypass Thoracic Aorta, Descending to Left Pulmonary Artery with Zooplastic Tissue, Open Approach |
| 021W08V | Bypass Thoracic Aorta, Descending to Lower Extremity Artery with Zooplastic Tissue, Open Approach |


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| ICD-10 Procedure Code | Code Description |
|---|---|
| 021W09B | Bypass Thoracic Aorta, Descending to Subclavian with Autologous Venous Tissue, Open Approach |
| 021W09A | Bypass Thoracic Aorta, Descending to Innominate Artery with Autologous Venous Tissue, Open Approach |
| 021W09D | Bypass Thoracic Aorta, Descending to Carotid with Autologous Venous Tissue, Open Approach |
| 021W09F | Bypass Thoracic Aorta, Descending to Abdominal Artery with Autologous Venous Tissue, Open Approach |
| 021W09G | Bypass Thoracic Aorta, Descending to Axillary Artery with Autologous Venous Tissue, Open Approach |
| 021W09H | Bypass Thoracic Aorta, Descending to Brachial Artery with Autologous Venous Tissue, Open Approach |
| 021W09P | Bypass Thoracic Aorta, Descending to Pulmonary Trunk with Autologous Venous Tissue, Open Approach |
| 021W09Q | Bypass Thoracic Aorta, Descending to Right Pulmonary Artery with Autologous Venous Tissue, Open Approach |
| 021W09R | Bypass Thoracic Aorta, Descending to Left Pulmonary Artery with Autologous Venous Tissue, Open Approach |
| 021W09V | Bypass Thoracic Aorta, Descending to Lower Extremity Artery with Autologous Venous Tissue, Open Approach |
| 021W0AA | Bypass Thoracic Aorta, Descending to Innominate Artery with Autologous Arterial Tissue, Open Approach |
| 021W0AB | Bypass Thoracic Aorta, Descending to Subclavian with Autologous Arterial Tissue, Open Approach |
| 021W0AD | Bypass Thoracic Aorta, Descending to Carotid with Autologous Arterial Tissue, Open Approach |
| 021W0AF | Bypass Thoracic Aorta, Descending to Abdominal Artery with Autologous Arterial Tissue, Open Approach |
| 021W0AG | Bypass Thoracic Aorta, Descending to Axillary Artery with Autologous Arterial Tissue, Open Approach |
| 021W0AH | Bypass Thoracic Aorta, Descending to Brachial Artery with Autologous Arterial Tissue, Open Approach |
| 021W0AP | Bypass Thoracic Aorta, Descending to Pulmonary Trunk with Autologous Arterial Tissue, Open Approach |
| 021W0AQ | Bypass Thoracic Aorta, Descending to Right Pulmonary Artery with Autologous Arterial Tissue, Open Approach |
| 021W0AR | Bypass Thoracic Aorta, Descending to Left Pulmonary Artery with Autologous Arterial Tissue, Open Approach |
| 021W0AV | Bypass Thoracic Aorta, Descending to Lower Extremity Artery with Autologous Arterial Tissue, Open Approach |
| 021W0JA | Bypass Thoracic Aorta, Descending to Innominate Artery with Synthetic Substitute, Open Approach |
| 021W0JB | Bypass Thoracic Aorta, Descending to Subclavian with Synthetic Substitute, Open Approach |
| 021W0JD | Bypass Thoracic Aorta, Descending to Carotid with Synthetic Substitute, Open Approach |
| 021W0JF | Bypass Thoracic Aorta, Descending to Abdominal Artery with Synthetic Substitute, Open Approach |
| 021W0JG | Bypass Thoracic Aorta, Descending to Axillary Artery with Synthetic Substitute, Open Approach |
| 021W0JH | Bypass Thoracic Aorta, Descending to Brachial Artery with Synthetic Substitute, Open Approach |
| 021W0JP | Bypass Thoracic Aorta, Descending to Pulmonary Trunk with Synthetic Substitute, Open Approach |


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| ICD-10 Procedure Code | Code Description |
|---|---|
| 021W0JQ | Bypass Thoracic Aorta, Descending to Right Pulmonary Artery with Synthetic Substitute, Open Approach |
| 021W0JR | Bypass Thoracic Aorta, Descending to Left Pulmonary Artery with Synthetic Substitute, Open Approach |
| 021W0JV | Bypass Thoracic Aorta, Descending to Lower Extremity Artery with Synthetic Substitute, Open Approach |
| 021W0KA | Bypass Thoracic Aorta, Descending to Innominate Artery with Nonautologous Tissue Substitute, Open Approach |
| 021W0KB | Bypass Thoracic Aorta, Descending to Subclavian with Nonautologous Tissue Substitute, Open Approach |
| 021W0KD | Bypass Thoracic Aorta, Descending to Carotid with Nonautologous Tissue Substitute, Open Approach |
| 021W0KF | Bypass Thoracic Aorta, Descending to Abdominal Artery with Nonautologous Tissue Substitute, Open Approach |
| 021W0KG | Bypass Thoracic Aorta, Descending to Axillary Artery with Nonautologous Tissue Substitute, Open Approach |
| 021W0KH | Bypass Thoracic Aorta, Descending to Brachial Artery with Nonautologous Tissue Substitute, Open Approach |
| 021W0KP | Bypass Thoracic Aorta, Descending to Pulmonary Trunk with Nonautologous Tissue Substitute, Open Approach |
| 021W0KQ | Bypass Thoracic Aorta, Descending to Right Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach |
| 021W0KR | Bypass Thoracic Aorta, Descending to Left Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach |
| 021W0KV | Bypass Thoracic Aorta, Descending to Lower Extremity Artery with Nonautologous Tissue Substitute, Open Approach |
| 021W0ZA | Bypass Thoracic Aorta, Descending to Innominate Artery, Open Approach |
| 021W0ZB | Bypass Thoracic Aorta, Descending to Subclavian, Open Approach |
| 021W0ZD | Bypass Thoracic Aorta, Descending to Carotid, Open Approach |
| 021W0ZP | Bypass Thoracic Aorta, Descending to Pulmonary Trunk, Open Approach |
| 021W0ZQ | Bypass Thoracic Aorta, Descending to Right Pulmonary Artery, Open Approach |
| 021W0ZR | Bypass Thoracic Aorta, Descending to Left Pulmonary Artery, Open Approach |
| 021X08A | Bypass Thoracic Aorta, Ascending/Arch to Innominate Artery with Zooplastic Tissue, Open Approach |
| 021X08B | Bypass Thoracic Aorta, Ascending/Arch to Subclavian with Zooplastic Tissue, Open Approach |
| 021X08D | Bypass Thoracic Aorta, Ascending/Arch to Carotid with Zooplastic Tissue, Open Approach |
| 021X08P | Bypass Thoracic Aorta, Ascending/Arch to Pulmonary Trunk with Zooplastic Tissue, Open Approach |
| 021X08Q | Bypass Thoracic Aorta, Ascending/Arch to Right Pulmonary Artery with Zooplastic Tissue, Open Approach |
| 021X08R | Bypass Thoracic Aorta, Ascending/Arch to Left Pulmonary Artery with Zooplastic Tissue, Open Approach |
| 021X09A | Bypass Thoracic Aorta, Ascending/Arch to Innominate Artery with Autologous Venous Tissue, Open Approach |
| 021X09B | Bypass Thoracic Aorta, Ascending/Arch to Subclavian with Autologous Venous Tissue, Open Approach |
| 021X09D | Bypass Thoracic Aorta, Ascending/Arch to Carotid with Autologous Venous Tissue, Open Approach |


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| ICD-10 Procedure Code | Code Description |
|---|---|
| 021X09P | Bypass Thoracic Aorta, Ascending/Arch to Pulmonary Trunk with Autologous Venous Tissue, Open Approach |
| 021X09Q | Bypass Thoracic Aorta, Ascending/Arch to Right Pulmonary Artery with Autologous Venous Tissue, Open Approach |
| 021X09R | Bypass Thoracic Aorta, Ascending/Arch to Left Pulmonary Artery with Autologous Venous Tissue, Open Approach |
| 021X0AA | Bypass Thoracic Aorta, Ascending/Arch to Innominate Artery with Autologous Arterial Tissue, Open Approach |
| 021X0AB | Bypass Thoracic Aorta, Ascending/Arch to Subclavian with Autologous Arterial Tissue, Open Approach |
| 021X0AD | Bypass Thoracic Aorta, Ascending/Arch to Carotid with Autologous Arterial Tissue, Open Approach |
| 021X0AP | Bypass Thoracic Aorta, Ascending/Arch to Pulmonary Trunk with Autologous Arterial Tissue, Open Approach |
| 021X0AQ | Bypass Thoracic Aorta, Ascending/Arch to Right Pulmonary Artery with Autologous Arterial Tissue, Open Approach |
| 021X0AR | Bypass Thoracic Aorta, Ascending/Arch to Left Pulmonary Artery with Autologous Arterial Tissue, Open Approach |
| 021X0JA | Bypass Thoracic Aorta, Ascending/Arch to Innominate Artery with Synthetic Substitute, Open Approach |
| 021X0JB | Bypass Thoracic Aorta, Ascending/Arch to Subclavian with Synthetic Substitute, Open Approach |
| 021X0JD | Bypass Thoracic Aorta, Ascending/Arch to Carotid with Synthetic Substitute, Open Approach |
| 021X0JP | Bypass Thoracic Aorta, Ascending/Arch to Pulmonary Trunk with Synthetic Substitute, Open Approach |
| 021X0JQ | Bypass Thoracic Aorta, Ascending/Arch to Right Pulmonary Artery with Synthetic Substitute, Open Approach |
| 021X0JR | Bypass Thoracic Aorta, Ascending/Arch to Left Pulmonary Artery with Synthetic Substitute, Open Approach |
| 021X0KA | Bypass Thoracic Aorta, Ascending/Arch to Innominate Artery with Nonautologous Tissue Substitute, Open Approach |
| 021X0KB | Bypass Thoracic Aorta, Ascending/Arch to Subclavian with Nonautologous Tissue Substitute, Open Approach |
| 021X0KD | Bypass Thoracic Aorta, Ascending/Arch to Carotid with Nonautologous Tissue Substitute, Open Approach |
| 021X0KP | Bypass Thoracic Aorta, Ascending/Arch to Pulmonary Trunk with Nonautologous Tissue Substitute, Open Approach |
| 021X0KQ | Bypass Thoracic Aorta, Ascending/Arch to Right Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach |
| 021X0KR | Bypass Thoracic Aorta, Ascending/Arch to Left Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach |
| 021X0ZA | Bypass Thoracic Aorta, Ascending/Arch to Innominate Artery, Open Approach |
| 021X0ZB | Bypass Thoracic Aorta, Ascending/Arch to Subclavian, Open Approach |
| 021X0ZD | Bypass Thoracic Aorta, Ascending/Arch to Carotid, Open Approach |
| 021X0ZP | Bypass Thoracic Aorta, Ascending/Arch to Pulmonary Trunk, Open Approach |
| 021X0ZQ | Bypass Thoracic Aorta, Ascending/Arch to Right Pulmonary Artery, Open Approach |
| 021X0ZR | Bypass Thoracic Aorta, Ascending/Arch to Left Pulmonary Artery, Open Approach |
| 02BW0ZX | Excision of Thoracic Aorta, Descending, Open Approach, Diagnostic |
| 02BW0ZZ | Excision of Thoracic Aorta, Descending, Open Approach |


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| ICD-10 Procedure Code | Code Description |
|---|---|
| 02BX0ZX | Excision of Thoracic Aorta, Ascending/Arch, Open Approach, Diagnostic |
| 02BX0ZZ | Excision of Thoracic Aorta, Ascending/Arch, Open Approach |
| 02QW0ZZ | Repair Thoracic Aorta, Descending, Open Approach |
| 02QX0ZZ | Repair Thoracic Aorta, Ascending/Arch, Open Approach |
| 02RW07Z | Replacement of Thoracic Aorta, Descending with Autologous Tissue Substitute, Open Approach |
| 02RW08Z | Replacement of Thoracic Aorta, Descending with Zooplastic Tissue, Open Approach |
| 02RW0JZ | Replacement of Thoracic Aorta, Descending with Synthetic Substitute, Open Approach |
| 02RW0KZ | Replacement of Thoracic Aorta, Descending with Nonautologous Tissue Substitute, Open Approach |
| 02RX07Z | Replacement of Thoracic Aorta, Ascending/Arch with Autologous Tissue Substitute, Open Approach |
| 02RX08Z | Replacement of Thoracic Aorta, Ascending/Arch with Zooplastic Tissue, Open Approach |
| 02RX0JZ | Replacement of Thoracic Aorta, Ascending/Arch with Synthetic Substitute, Open Approach |
| 02RX0KZ | Replacement of Thoracic Aorta, Ascending/Arch with Nonautologous Tissue Substitute, Open Approach |
| 02SW0ZZ | Reposition Thoracic Aorta, Descending, Open Approach |
| 02SX0ZZ | Reposition Thoracic Aorta, Ascending/Arch, Open Approach |
| 02UW07Z | Supplement Thoracic Aorta, Descending with Autologous Tissue Substitute, Open Approach |
| 02UW08Z | Supplement Thoracic Aorta, Descending with Zooplastic Tissue, Open Approach |
| 02UW0JZ | Supplement Thoracic Aorta, Descending with Synthetic Substitute, Open Approach |
| 02UW0KZ | Supplement Thoracic Aorta, Descending with Nonautologous Tissue Substitute, Open Approach |
| 02UX08Z | Supplement Thoracic Aorta, Ascending/Arch with Zooplastic Tissue, Open Approach |
| 041009B | Bypass Abdominal Aorta to Left Internal Iliac Artery with Autologous Venous Tissue, Open Approach |
| 041009C | Bypass Abdominal Aorta to Bilateral Internal Iliac Arteries with Autologous Venous Tissue, Open Approach |
| 041009D | Bypass Abdominal Aorta to Right External Iliac Artery with Autologous Venous Tissue, Open Approach |
| 041009F | Bypass Abdominal Aorta to Left External Iliac Artery with Autologous Venous Tissue, Open Approach |
| 041009G | Bypass Abdominal Aorta to Bilateral External Iliac Arteries with Autologous Venous Tissue, Open Approach |
| 041009H | Bypass Abdominal Aorta to Right Femoral Artery with Autologous Venous Tissue, Open Approach |
| 041009J | Bypass Abdominal Aorta to Left Femoral Artery with Autologous Venous Tissue, Open Approach |
| 041009K | Bypass Abdominal Aorta to Bilateral Femoral Arteries with Autologous Venous Tissue, Open Approach |
| 041009Q | Bypass Abdominal Aorta to Lower Extremity Artery with Autologous Venous Tissue, Open Approach |
| 041009R | Bypass Abdominal Aorta to Lower Artery with Autologous Venous Tissue, Open Approach |
| 04100A0 | Bypass Abdominal Aorta to Abdominal Aorta with Autologous Arterial Tissue, Open Approach |


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| ICD-10 Procedure Code | Code Description |
|---|---|
| 04100A1 | Bypass Abdominal Aorta to Celiac Artery with Autologous Arterial Tissue, Open Approach |
| 04100A2 | Bypass Abdominal Aorta to Mesenteric Artery with Autologous Arterial Tissue, Open Approach |
| 04100A3 | Bypass Abdominal Aorta to Right Renal Artery with Autologous Arterial Tissue, Open Approach |
| 04100A4 | Bypass Abdominal Aorta to Left Renal Artery with Autologous Arterial Tissue, Open Approach |
| 04100A5 | Bypass Abdominal Aorta to Bilateral Renal Artery with Autologous Arterial Tissue, Open Approach |
| 04100A6 | Bypass Abdominal Aorta to Right Common Iliac Artery with Autologous Arterial Tissue, Open Approach |
| 04100A7 | Bypass Abdominal Aorta to Left Common Iliac Artery with Autologous Arterial Tissue, Open Approach |
| 04100A8 | Bypass Abdominal Aorta to Bilateral Common Iliac Arteries with Autologous Arterial Tissue, Open Approach |
| 04100A9 | Bypass Abdominal Aorta to Right Internal Iliac Artery with Autologous Arterial Tissue, Open Approach |
| 04100AB | Bypass Abdominal Aorta to Left Internal Iliac Artery with Autologous Arterial Tissue, Open Approach |
| 04100AC | Bypass Abdominal Aorta to Bilateral Internal Iliac Arteries with Autologous Arterial Tissue, Open Approach |
| 04100AD | Bypass Abdominal Aorta to Right External Iliac Artery with Autologous Arterial Tissue, Open Approach |
| 04100AF | Bypass Abdominal Aorta to Left External Iliac Artery with Autologous Arterial Tissue, Open Approach |
| 04100AG | Bypass Abdominal Aorta to Bilateral External Iliac Arteries with Autologous Arterial Tissue, Open Approach |
| 04100AH | Bypass Abdominal Aorta to Right Femoral Artery with Autologous Arterial Tissue, Open Approach |
| 04100AJ | Bypass Abdominal Aorta to Left Femoral Artery with Autologous Arterial Tissue, Open Approach |
| 04100AK | Bypass Abdominal Aorta to Bilateral Femoral Arteries with Autologous Arterial Tissue, Open Approach |
| 04100AQ | Bypass Abdominal Aorta to Lower Extremity Artery with Autologous Arterial Tissue, Open Approach |
| 04100AR | Bypass Abdominal Aorta to Lower Artery with Autologous Arterial Tissue, Open Approach |
| 04100J0 | Bypass Abdominal Aorta to Abdominal Aorta with Synthetic Substitute, Open Approach |
| 04100J1 | Bypass Abdominal Aorta to Celiac Artery with Synthetic Substitute, Open Approach |
| 04100J2 | Bypass Abdominal Aorta to Mesenteric Artery with Synthetic Substitute, Open Approach |
| 04100J3 | Bypass Abdominal Aorta to Right Renal Artery with Synthetic Substitute, Open Approach |
| 04100J4 | Bypass Abdominal Aorta to Left Renal Artery with Synthetic Substitute, Open Approach |
| 04100J5 | Bypass Abdominal Aorta to Bilateral Renal Artery with Synthetic Substitute, Open Approach |
| 04100J6 | Bypass Abdominal Aorta to Right Common Iliac Artery with Synthetic Substitute, Open Approach |
| 04100J7 | Bypass Abdominal Aorta to Left Common Iliac Artery with Synthetic Substitute, Open Approach |
| 04100J8 | Bypass Abdominal Aorta to Bilateral Common Iliac Arteries with Synthetic Substitute, Open Approach |


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| ICD-10 Procedure Code | Code Description |
|---|---|
| 04100J9 | Bypass Abdominal Aorta to Right Internal Iliac Artery with Synthetic Substitute, Open Approach |
| 04100JB | Bypass Abdominal Aorta to Left Internal Iliac Artery with Synthetic Substitute, Open Approach |
| 04100JC | Bypass Abdominal Aorta to Bilateral Internal Iliac Arteries with Synthetic Substitute, Open Approach |
| 04100JD | Bypass Abdominal Aorta to Right External Iliac Artery with Synthetic Substitute, Open Approach |
| 04100JF | Bypass Abdominal Aorta to Left External Iliac Artery with Synthetic Substitute, Open Approach |
| 04100JG | Bypass Abdominal Aorta to Bilateral External Iliac Arteries with Synthetic Substitute, Open Approach |
| 04100JH | Bypass Abdominal Aorta to Right Femoral Artery with Synthetic Substitute, Open Approach |
| 04100JJ | Bypass Abdominal Aorta to Left Femoral Artery with Synthetic Substitute, Open Approach |
| 04100JK | Bypass Abdominal Aorta to Bilateral Femoral Arteries with Synthetic Substitute, Open Approach |
| 04100JQ | Bypass Abdominal Aorta to Lower Extremity Artery with Synthetic Substitute, Open Approach |
| 04100JR | Bypass Abdominal Aorta to Lower Artery with Synthetic Substitute, Open Approach |
| 04100K0 | Bypass Abdominal Aorta to Abdominal Aorta with Nonautologous Tissue Substitute, Open Approach |
| 04100K1 | Bypass Abdominal Aorta to Celiac Artery with Nonautologous Tissue Substitute, Open Approach |
| 04100K2 | Bypass Abdominal Aorta to Mesenteric Artery with Nonautologous Tissue Substitute, Open Approach |
| 04100K3 | Bypass Abdominal Aorta to Right Renal Artery with Nonautologous Tissue Substitute, Open Approach |
| 04100K4 | Bypass Abdominal Aorta to Left Renal Artery with Nonautologous Tissue Substitute, Open Approach |
| 04100K5 | Bypass Abdominal Aorta to Bilateral Renal Artery with Nonautologous Tissue Substitute, Open Approach |
| 04100K6 | Bypass Abdominal Aorta to Right Common Iliac Artery with Nonautologous Tissue Substitute, Open Approach |
| 04100K7 | Bypass Abdominal Aorta to Left Common Iliac Artery with Nonautologous Tissue Substitute, Open Approach |
| 04100K8 | Bypass Abdominal Aorta to Bilateral Common Iliac Arteries with Nonautologous Tissue Substitute, Open Approach |
| 04100K9 | Bypass Abdominal Aorta to Right Internal Iliac Artery with Nonautologous Tissue Substitute, Open Approach |
| 04100KB | Bypass Abdominal Aorta to Left Internal Iliac Artery with Nonautologous Tissue Substitute, Open Approach |
| 04100KC | Bypass Abdominal Aorta to Bilateral Internal Iliac Arteries with Nonautologous Tissue Substitute, Open Approach |
| 04100KD | Bypass Abdominal Aorta to Right External Iliac Artery with Nonautologous Tissue Substitute, Open Approach |
| 04100KF | Bypass Abdominal Aorta to Left External Iliac Artery with Nonautologous Tissue Substitute, Open Approach |
| 04100KG | Bypass Abdominal Aorta to Bilateral External Iliac Arteries with Nonautologous Tissue Substitute, Open Approach |
| 04100KH | Bypass Abdominal Aorta to Right Femoral Artery with Nonautologous Tissue Substitute, Open Approach |


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| ICD-10 Procedure Code | Code Description |
|---|---|
| 04100KJ | Bypass Abdominal Aorta to Left Femoral Artery with Nonautologous Tissue Substitute, Open Approach |
| 04100KK | Bypass Abdominal Aorta to Bilateral Femoral Arteries with Nonautologous Tissue Substitute, Open Approach |
| 04100KQ | Bypass Abdominal Aorta to Lower Extremity Artery with Nonautologous Tissue Substitute, Open Approach |
| 04100KR | Bypass Abdominal Aorta to Lower Artery with Nonautologous Tissue Substitute, Open Approach |
| 04100Z0 | Bypass Abdominal Aorta to Abdominal Aorta, Open Approach |
| 04100Z1 | Bypass Abdominal Aorta to Celiac Artery, Open Approach |
| 04100Z2 | Bypass Abdominal Aorta to Mesenteric Artery, Open Approach |
| 04100Z3 | Bypass Abdominal Aorta to Right Renal Artery, Open Approach |
| 04100Z4 | Bypass Abdominal Aorta to Left Renal Artery, Open Approach |
| 04100Z5 | Bypass Abdominal Aorta to Bilateral Renal Artery, Open Approach |
| 04100Z6 | Bypass Abdominal Aorta to Right Common Iliac Artery, Open Approach |
| 04100Z7 | Bypass Abdominal Aorta to Left Common Iliac Artery, Open Approach |
| 04100Z8 | Bypass Abdominal Aorta to Bilateral Common Iliac Arteries, Open Approach |
| 04100Z9 | Bypass Abdominal Aorta to Right Internal Iliac Artery, Open Approach |
| 04100ZB | Bypass Abdominal Aorta to Left Internal Iliac Artery, Open Approach |
| 04100ZC | Bypass Abdominal Aorta to Bilateral Internal Iliac Arteries, Open Approach |
| 04100ZD | Bypass Abdominal Aorta to Right External Iliac Artery, Open Approach |
| 04100ZF | Bypass Abdominal Aorta to Left External Iliac Artery, Open Approach |
| 04100ZG | Bypass Abdominal Aorta to Bilateral External Iliac Arteries, Open Approach |
| 04100ZH | Bypass Abdominal Aorta to Right Femoral Artery, Open Approach |
| 04100ZJ | Bypass Abdominal Aorta to Left Femoral Artery, Open Approach |
| 04100ZK | Bypass Abdominal Aorta to Bilateral Femoral Arteries, Open Approach |
| 04100ZQ | Bypass Abdominal Aorta to Lower Extremity Artery, Open Approach |
| 04100ZR | Bypass Abdominal Aorta to Lower Artery, Open Approach |
| 041C090 | Bypass Right Common Iliac Artery to Abdominal Aorta with Autologous Venous Tissue, Open Approach |
| 041C0A0 | Bypass Right Common Iliac Artery to Abdominal Aorta with Autologous Arterial Tissue, Open Approach |
| 041C0J0 | Bypass Right Common Iliac Artery to Abdominal Aorta with Synthetic Substitute, Open Approach |
| 041C0K0 | Bypass Right Common Iliac Artery to Abdominal Aorta with Nonautologous Tissue Substitute, Open Approach |
| 041C0Z0 | Bypass Right Common Iliac Artery to Abdominal Aorta, Open Approach |
| 041D090 | Bypass Left Common Iliac Artery to Abdominal Aorta with Autologous Venous Tissue, Open Approach |
| 041D0A0 | Bypass Left Common Iliac Artery to Abdominal Aorta with Autologous Arterial Tissue, Open Approach |
| 041D0J0 | Bypass Left Common Iliac Artery to Abdominal Aorta with Synthetic Substitute, Open Approach |
| 041D0K0 | Bypass Left Common Iliac Artery to Abdominal Aorta with Nonautologous Tissue Substitute, Open Approach |
| 041D0Z0 | Bypass Left Common Iliac Artery to Abdominal Aorta, Open Approach |


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| ICD-10 Procedure Code | Code Description |
|---|---|
| 04B00ZX | Excision of Abdominal Aorta, Open Approach, Diagnostic |
| 04B00ZZ | Excision of Abdominal Aorta, Open Approach |
| 04Q00ZZ | Repair Abdominal Aorta, Open Approach |
| 04R007Z | Replacement of Abdominal Aorta with Autologous Tissue Substitute, Open Approach |
| 04R00JZ | Replacement of Abdominal Aorta with Synthetic Substitute, Open Approach |
| 04R00KZ | Replacement of Abdominal Aorta with Nonautologous Tissue Substitute, Open Approach |
| 04S00ZZ | Reposition Abdominal Aorta, Open Approach |
| 04U007Z | Supplement Abdominal Aorta with Autologous Tissue Substitute, Open Approach |
| 04U00JZ | Supplement Abdominal Aorta with Synthetic Substitute, Open Approach |
| 04U00KZ | Supplement Abdominal Aorta with Nonautologous Tissue Substitute, Open Approach |
| X2RX0N7 | Replacement of Thoracic Aorta, Arch using Branched Synthetic Substitute with Intraluminal Device, Open Approach, New Technology Group 7 |


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## Lung Resection for Cancer Measure Specifications

For lung resection for cancer, there are two sets of ICD-10 codes for counting patient discharges. The first set of codes is to identify patients who have had the procedure. The second set of codes is to identify patients with a specific diagnosis.

Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes in any procedure field **AND** any of the following ICD-10 codes in any diagnosis field.

### ICD-10 Lung Resection for Cancer Procedure Codes

| ICD-10 Procedure Code | Code Description |
|---|---|
| 0BBC0ZZ | Excision of Right Upper Lung Lobe, Open Approach |
| 0BBC3ZZ | Excision of Right Upper Lung Lobe, Percutaneous Approach |
| 0BBC4ZZ | Excision of Right Upper Lung Lobe, Percutaneous Endoscopic Approach |
| 0BBD0ZZ | Excision of Right Middle Lung Lobe, Open Approach |
| 0BBD3ZZ | Excision of Right Middle Lung Lobe, Percutaneous Approach |
| 0BBD4ZZ | Excision of Right Middle Lung Lobe, Percutaneous Endoscopic Approach |
| 0BBF0ZZ | Excision of Right Lower Lung Lobe, Open Approach |
| 0BBF3ZZ | Excision of Right Lower Lung Lobe, Percutaneous Approach |
| 0BBF4ZZ | Excision of Right Lower Lung Lobe, Percutaneous Endoscopic Approach |
| 0BBG0ZZ | Excision of Left Upper Lung Lobe, Open Approach |
| 0BBG3ZZ | Excision of Left Upper Lung Lobe, Percutaneous Approach |
| 0BBG4ZZ | Excision of Left Upper Lung Lobe, Percutaneous Endoscopic Approach |
| 0BBH0ZZ | Excision of Lung Lingula, Open Approach |
| 0BBH3ZZ | Excision of Lung Lingula, Percutaneous Approach |
| 0BBH4ZZ | Excision of Lung Lingula, Percutaneous Endoscopic Approach |
| 0BBJ0ZZ | Excision of Left Lower Lung Lobe, Open Approach |
| 0BBJ3ZZ | Excision of Left Lower Lung Lobe, Percutaneous Approach |
| 0BBJ4ZZ | Excision of Left Lower Lung Lobe, Percutaneous Endoscopic Approach |
| 0BBK0ZZ | Excision of Right Lung, Open Approach |
| 0BBK3ZZ | Excision of Right Lung, Percutaneous Approach |
| 0BBK4ZZ | Excision of Right Lung, Percutaneous Endoscopic Approach |
| 0BBL0ZZ | Excision of Left Lung, Open Approach |
| 0BBL3ZZ | Excision of Left Lung, Percutaneous Approach |
| 0BBL4ZZ | Excision of Left Lung, Percutaneous Endoscopic Approach |
| 0BBL7ZZ | Excision of Left Lung, Via Natural or Artificial Opening |
| 0BTC0ZZ | Resection of Right Upper Lung Lobe, Open Approach |
| 0BTC4ZZ | Resection of Right Upper Lung Lobe, Percutaneous Endoscopic Approach |
| 0BTD0ZZ | Resection of Right Middle Lung Lobe, Open Approach |
| 0BTD4ZZ | Resection of Right Middle Lung Lobe, Percutaneous Endoscopic Approach |
| 0BTF0ZZ | Resection of Right Lower Lung Lobe, Open Approach |
| 0BTF4ZZ | Resection of Right Lower Lung Lobe, Percutaneous Endoscopic Approach |
| 0BTG0ZZ | Resection of Left Upper Lung Lobe, Open Approach |
| 0BTG4ZZ | Resection of Left Upper Lung Lobe, Percutaneous Endoscopic Approach |


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| ICD-10 Procedure Code | Code Description |
|---|---|
| 0BTH0ZZ | Resection of Lung Lingula, Open Approach |
| 0BTH4ZZ | Resection of Lung Lingula, Percutaneous Endoscopic Approach |
| 0BTJ0ZZ | Resection of Left Lower Lung Lobe, Open Approach |
| 0BTJ4ZZ | Resection of Left Lower Lung Lobe, Percutaneous Endoscopic Approach |
| 0BTK0ZZ | Resection of Right Lung, Open Approach |
| 0BTK4ZZ | Resection of Right Lung, Percutaneous Endoscopic Approach |
| 0BTL0ZZ | Resection of Left Lung, Open Approach |
| 0BTL4ZZ | Resection of Left Lung, Percutaneous Endoscopic Approach |

**ICD-10 Malignant Tumor and Cancer in Situ Diagnosis Codes**

| ICD-10 Diagnosis Code | Code Description |
|---|---|
| C7A.090 | Malignant carcinoid tumor of the bronchus and lung |
| C7A.1 | Malignant poorly differentiated neuroendocrine tumors |
| C7A.8 | Other malignant neuroendocrine tumors |
| C34.00 | Malignant neoplasm of main bronchus |
| C34.01 | Malignant neoplasm of right main bronchus |
| C34.02 | Malignant neoplasm of left main bronchus |
| C34.10 | Malignant neoplasm of upper lobe, unspecified bronchus or lung |
| C34.11 | Malignant neoplasm of upper lobe, right bronchus or lung |
| C34.12 | Malignant neoplasm of upper lobe, left bronchus or lung |
| C34.2 | Malignant neoplasm of middle lobe, bronchus or lung |
| C34.30 | Malignant neoplasm of lower lobe, unspecified bronchus or lung |
| C34.31 | Malignant neoplasm of lower lobe, right bronchus or lung |
| C34.32 | Malignant neoplasm of lower lobe, left bronchus or lung |
| C34.80 | Malignant neoplasm of overlapping sites of unspecified bronchus and lung |
| C34.81 | Malignant neoplasm of overlapping sites of right bronchus and lung |
| C34.82 | Malignant neoplasm of overlapping sites of left bronchus and lung |
| C34.90 | Malignant neoplasm of unspecified part of unspecified bronchus or lung |
| C34.91 | Malignant neoplasm of unspecified part of right bronchus or lung |
| C34.92 | Malignant neoplasm of unspecified part of left bronchus or lung |
| D02.20 | Carcinoma in situ of unspecified bronchus and lung |
| D02.21 | Carcinoma in situ of right bronchus and lung |
| D02.22 | Carcinoma in situ of left bronchus and lung |


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## Esophageal Resection for Cancer Measure Specifications

For esophageal resection for cancer, there are two sets of ICD-10 codes for counting patient discharges. The first set of codes is to identify patients who have had the procedure. The second set of codes is to identify patients with a specific diagnosis.

Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes in any procedure field **AND** any of the following ICD-10 codes in any diagnosis field.

### ICD-10 Esophageal Resection for Cancer Procedure Codes

| ICD-10 Procedure Code | Code Description |
|---|---|
| 0D11074 | Bypass Upper Esophagus to Cutaneous with Autologous Tissue Substitute, Open Approach |
| 0D11076 | Bypass Upper Esophagus to Stomach with Autologous Tissue Substitute, Open Approach |
| 0D11079 | Bypass Upper Esophagus to Duodenum with Autologous Tissue Substitute, Open Approach |
| 0D1107A | Bypass Upper Esophagus to Jejunum with Autologous Tissue Substitute, Open Approach |
| 0D1107B | Bypass Upper Esophagus to Ileum with Autologous Tissue Substitute, Open Approach |
| 0D110J4 | Bypass Upper Esophagus to Cutaneous with Synthetic Substitute, Open Approach |
| 0D110J6 | Bypass Upper Esophagus to Stomach with Synthetic Substitute, Open Approach |
| 0D110J9 | Bypass Upper Esophagus to Duodenum with Synthetic Substitute, Open Approach |
| 0D110JA | Bypass Upper Esophagus to Jejunum with Synthetic Substitute, Open Approach |
| 0D110JB | Bypass Upper Esophagus to Ileum with Synthetic Substitute, Open Approach |
| 0D110K4 | Bypass Upper Esophagus to Cutaneous with Nonautologous Tissue Substitute, Open Approach |
| 0D110K6 | Bypass Upper Esophagus to Stomach with Nonautologous Tissue Substitute, Open Approach |
| 0D110K9 | Bypass Upper Esophagus to Duodenum with Nonautologous Tissue Substitute, Open Approach |
| 0D110KA | Bypass Upper Esophagus to Jejunum with Nonautologous Tissue Substitute, Open Approach |
| 0D110KB | Bypass Upper Esophagus to Ileum with Nonautologous Tissue Substitute, Open Approach |
| 0D110Z4 | Bypass Upper Esophagus to Cutaneous, Open Approach |
| 0D110Z6 | Bypass Upper Esophagus to Stomach, Open Approach |
| 0D110Z9 | Bypass Upper Esophagus to Duodenum, Open Approach |
| 0D110ZA | Bypass Upper Esophagus to Jejunum, Open Approach |
| 0D110ZB | Bypass Upper Esophagus to Ileum, Open Approach |
| 0D113J4 | Bypass Upper Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Approach |
| 0D11474 | Bypass Upper Esophagus to Cutaneous with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D11476 | Bypass Upper Esophagus to Stomach with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D11479 | Bypass Upper Esophagus to Duodenum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D1147A | Bypass Upper Esophagus to Jejunum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |


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| ICD-10 Procedure Code | Code Description |
|---|---|
| 0D1147B | Bypass Upper Esophagus to Ileum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D114J4 | Bypass Upper Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 0D114J6 | Bypass Upper Esophagus to Stomach with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 0D114J9 | Bypass Upper Esophagus to Duodenum with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 0D114JA | Bypass Upper Esophagus to Jejunum with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 0D114JB | Bypass Upper Esophagus to Ileum with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 0D114K4 | Bypass Upper Esophagus to Cutaneous with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D114K6 | Bypass Upper Esophagus to Stomach with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D114K9 | Bypass Upper Esophagus to Duodenum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D114KA | Bypass Upper Esophagus to Jejunum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D114KB | Bypass Upper Esophagus to Ileum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D114Z4 | Bypass Upper Esophagus to Cutaneous, Percutaneous Endoscopic Approach |
| 0D114Z6 | Bypass Upper Esophagus to Stomach, Percutaneous Endoscopic Approach |
| 0D114Z9 | Bypass Upper Esophagus to Duodenum, Percutaneous Endoscopic Approach |
| 0D114ZA | Bypass Upper Esophagus to Jejunum, Percutaneous Endoscopic Approach |
| 0D114ZB | Bypass Upper Esophagus to Ileum, Percutaneous Endoscopic Approach |
| 0D11874 | Bypass Upper Esophagus to Cutaneous with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D11876 | Bypass Upper Esophagus to Stomach with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D11879 | Bypass Upper Esophagus to Duodenum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D1187A | Bypass Upper Esophagus to Jejunum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D1187B | Bypass Upper Esophagus to Ileum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D118J4 | Bypass Upper Esophagus to Cutaneous with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D118J6 | Bypass Upper Esophagus to Stomach with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D118J9 | Bypass Upper Esophagus to Duodenum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D118JA | Bypass Upper Esophagus to Jejunum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D118JB | Bypass Upper Esophagus to Ileum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D118K4 | Bypass Upper Esophagus to Cutaneous with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D118K6 | Bypass Upper Esophagus to Stomach with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |


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| ICD-10 Procedure Code | Code Description |
|---|---|
| 0D118K9 | Bypass Upper Esophagus to Duodenum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D118KA | Bypass Upper Esophagus to Jejunum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D118KB | Bypass Upper Esophagus to Ileum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D118Z4 | Bypass Upper Esophagus to Cutaneous, Via Natural or Artificial Opening Endoscopic |
| 0D118Z6 | Bypass Upper Esophagus to Stomach, Via Natural or Artificial Opening Endoscopic |
| 0D118Z9 | Bypass Upper Esophagus to Duodenum, Via Natural or Artificial Opening Endoscopic |
| 0D118ZA | Bypass Upper Esophagus to Jejunum, Via Natural or Artificial Opening Endoscopic |
| 0D118ZB | Bypass Upper Esophagus to Ileum, Via Natural or Artificial Opening Endoscopic |
| 0D12074 | Bypass Middle Esophagus to Cutaneous with Autologous Tissue Substitute, Open Approach |
| 0D12076 | Bypass Middle Esophagus to Stomach with Autologous Tissue Substitute, Open Approach |
| 0D12079 | Bypass Middle Esophagus to Duodenum with Autologous Tissue Substitute, Open Approach |
| 0D1207A | Bypass Middle Esophagus to Jejunum with Autologous Tissue Substitute, Open Approach |
| 0D1207B | Bypass Middle Esophagus to Ileum with Autologous Tissue Substitute, Open Approach |
| 0D120J4 | Bypass Middle Esophagus to Cutaneous with Synthetic Substitute, Open Approach |
| 0D120J6 | Bypass Middle Esophagus to Stomach with Synthetic Substitute, Open Approach |
| 0D120J9 | Bypass Middle Esophagus to Duodenum with Synthetic Substitute, Open Approach |
| 0D120JA | Bypass Middle Esophagus to Jejunum with Synthetic Substitute, Open Approach |
| 0D120JB | Bypass Middle Esophagus to Ileum with Synthetic Substitute, Open Approach |
| 0D120K4 | Bypass Middle Esophagus to Cutaneous with Nonautologous Tissue Substitute, Open Approach |
| 0D120K6 | Bypass Middle Esophagus to Stomach with Nonautologous Tissue Substitute, Open Approach |
| 0D120K9 | Bypass Middle Esophagus to Duodenum with Nonautologous Tissue Substitute, Open Approach |
| 0D120KA | Bypass Middle Esophagus to Jejunum with Nonautologous Tissue Substitute, Open Approach |
| 0D120KB | Bypass Middle Esophagus to Ileum with Nonautologous Tissue Substitute, Open Approach |
| 0D120Z4 | Bypass Middle Esophagus to Cutaneous, Open Approach |
| 0D120Z6 | Bypass Middle Esophagus to Stomach, Open Approach |
| 0D120Z9 | Bypass Middle Esophagus to Duodenum, Open Approach |
| 0D120ZA | Bypass Middle Esophagus to Jejunum, Open Approach |
| 0D120ZB | Bypass Middle Esophagus to Ileum, Open Approach |
| 0D123J4 | Bypass Middle Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Approach |
| 0D12474 | Bypass Middle Esophagus to Cutaneous with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |


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| ICD-10 Procedure Code | Code Description |
|---|---|
| 0D12476 | Bypass Middle Esophagus to Stomach with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D12479 | Bypass Middle Esophagus to Duodenum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D1247A | Bypass Middle Esophagus to Jejunum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D1247B | Bypass Middle Esophagus to Ileum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D124J4 | Bypass Middle Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 0D124J6 | Bypass Middle Esophagus to Stomach with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 0D124J9 | Bypass Middle Esophagus to Duodenum with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 0D124JA | Bypass Middle Esophagus to Jejunum with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 0D124JB | Bypass Middle Esophagus to Ileum with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 0D124K4 | Bypass Middle Esophagus to Cutaneous with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D124K6 | Bypass Middle Esophagus to Stomach with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D124K9 | Bypass Middle Esophagus to Duodenum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D124KA | Bypass Middle Esophagus to Jejunum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D124KB | Bypass Middle Esophagus to Ileum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D124Z4 | Bypass Middle Esophagus to Cutaneous, Percutaneous Endoscopic Approach |
| 0D124Z6 | Bypass Middle Esophagus to Stomach, Percutaneous Endoscopic Approach |
| 0D124Z9 | Bypass Middle Esophagus to Duodenum, Percutaneous Endoscopic Approach |
| 0D124ZA | Bypass Middle Esophagus to Jejunum, Percutaneous Endoscopic Approach |
| 0D124ZB | Bypass Middle Esophagus to Ileum, Percutaneous Endoscopic Approach |
| 0D12874 | Bypass Middle Esophagus to Cutaneous with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D12876 | Bypass Middle Esophagus to Stomach with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D12879 | Bypass Middle Esophagus to Duodenum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D1287A | Bypass Middle Esophagus to Jejunum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D1287B | Bypass Middle Esophagus to Ileum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D128J4 | Bypass Middle Esophagus to Cutaneous with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D128J6 | Bypass Middle Esophagus to Stomach with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D128J9 | Bypass Middle Esophagus to Duodenum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D128JA | Bypass Middle Esophagus to Jejunum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic |


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| ICD-10 Procedure Code | Code Description |
|---|---|
| 0D128JB | Bypass Middle Esophagus to Ileum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D128K4 | Bypass Middle Esophagus to Cutaneous with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D128K6 | Bypass Middle Esophagus to Stomach with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D128K9 | Bypass Middle Esophagus to Duodenum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D128KA | Bypass Middle Esophagus to Jejunum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D128KB | Bypass Middle Esophagus to Ileum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D128Z4 | Bypass Middle Esophagus to Cutaneous, Via Natural or Artificial Opening Endoscopic |
| 0D128Z6 | Bypass Middle Esophagus to Stomach, Via Natural or Artificial Opening Endoscopic |
| 0D128Z9 | Bypass Middle Esophagus to Duodenum, Via Natural or Artificial Opening Endoscopic |
| 0D128ZA | Bypass Middle Esophagus to Jejunum, Via Natural or Artificial Opening Endoscopic |
| 0D128ZB | Bypass Middle Esophagus to Ileum, Via Natural or Artificial Opening Endoscopic |
| 0D13074 | Bypass Lower Esophagus to Cutaneous with Autologous Tissue Substitute, Open Approach |
| 0D13076 | Bypass Lower Esophagus to Stomach with Autologous Tissue Substitute, Open Approach |
| 0D13079 | Bypass Lower Esophagus to Duodenum with Autologous Tissue Substitute, Open Approach |
| 0D1307A | Bypass Lower Esophagus to Jejunum with Autologous Tissue Substitute, Open Approach |
| 0D1307B | Bypass Lower Esophagus to Ileum with Autologous Tissue Substitute, Open Approach |
| 0D130J4 | Bypass Lower Esophagus to Cutaneous with Synthetic Substitute, Open Approach |
| 0D130J6 | Bypass Lower Esophagus to Stomach with Synthetic Substitute, Open Approach |
| 0D130J9 | Bypass Lower Esophagus to Duodenum with Synthetic Substitute, Open Approach |
| 0D130JA | Bypass Lower Esophagus to Jejunum with Synthetic Substitute, Open Approach |
| 0D130JB | Bypass Lower Esophagus to Ileum with Synthetic Substitute, Open Approach |
| 0D130K4 | Bypass Lower Esophagus to Cutaneous with Nonautologous Tissue Substitute, Open Approach |
| 0D130K6 | Bypass Lower Esophagus to Stomach with Nonautologous Tissue Substitute, Open Approach |
| 0D130K9 | Bypass Lower Esophagus to Duodenum with Nonautologous Tissue Substitute, Open Approach |
| 0D130KA | Bypass Lower Esophagus to Jejunum with Nonautologous Tissue Substitute, Open Approach |
| 0D130KB | Bypass Lower Esophagus to Ileum with Nonautologous Tissue Substitute, Open Approach |
| 0D130Z4 | Bypass Lower Esophagus to Cutaneous, Open Approach |
| 0D130Z6 | Bypass Lower Esophagus to Stomach, Open Approach |
| 0D130Z9 | Bypass Lower Esophagus to Duodenum, Open Approach |
| 0D130ZA | Bypass Lower Esophagus to Jejunum, Open Approach |
| 0D130ZB | Bypass Lower Esophagus to Ileum, Open Approach |


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| ICD-10 Procedure Code | Code Description |
|---|---|
| 0D133J4 | Bypass Lower Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Approach |
| 0D13474 | Bypass Lower Esophagus to Cutaneous with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D13476 | Bypass Lower Esophagus to Stomach with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D13479 | Bypass Lower Esophagus to Duodenum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D1347A | Bypass Lower Esophagus to Jejunum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D1347B | Bypass Lower Esophagus to Ileum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D134J4 | Bypass Lower Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 0D134J6 | Bypass Lower Esophagus to Stomach with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 0D134J9 | Bypass Lower Esophagus to Duodenum with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 0D134JA | Bypass Lower Esophagus to Jejunum with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 0D134JB | Bypass Lower Esophagus to Ileum with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 0D134K4 | Bypass Lower Esophagus to Cutaneous with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D134K6 | Bypass Lower Esophagus to Stomach with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D134K9 | Bypass Lower Esophagus to Duodenum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D134KA | Bypass Lower Esophagus to Jejunum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D134KB | Bypass Lower Esophagus to Ileum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D134Z4 | Bypass Lower Esophagus to Cutaneous, Percutaneous Endoscopic Approach |
| 0D134Z6 | Bypass Lower Esophagus to Stomach, Percutaneous Endoscopic Approach |
| 0D134Z9 | Bypass Lower Esophagus to Duodenum, Percutaneous Endoscopic Approach |
| 0D134ZA | Bypass Lower Esophagus to Jejunum, Percutaneous Endoscopic Approach |
| 0D134ZB | Bypass Lower Esophagus to Ileum, Percutaneous Endoscopic Approach |
| 0D13874 | Bypass Lower Esophagus to Cutaneous with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D13876 | Bypass Lower Esophagus to Stomach with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D13879 | Bypass Lower Esophagus to Duodenum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D1387A | Bypass Lower Esophagus to Jejunum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D1387B | Bypass Lower Esophagus to Ileum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D138J4 | Bypass Lower Esophagus to Cutaneous with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D138J6 | Bypass Lower Esophagus to Stomach with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic |


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| ICD-10 Procedure Code | Code Description |
|---|---|
| 0D138J9 | Bypass Lower Esophagus to Duodenum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D138JA | Bypass Lower Esophagus to Jejunum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D138JB | Bypass Lower Esophagus to Ileum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D138K4 | Bypass Lower Esophagus to Cutaneous with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D138K6 | Bypass Lower Esophagus to Stomach with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D138K9 | Bypass Lower Esophagus to Duodenum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D138KA | Bypass Lower Esophagus to Jejunum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D138KB | Bypass Lower Esophagus to Ileum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D138Z4 | Bypass Lower Esophagus to Cutaneous, Via Natural or Artificial Opening Endoscopic |
| 0D138Z6 | Bypass Lower Esophagus to Stomach, Via Natural or Artificial Opening Endoscopic |
| 0D138Z9 | Bypass Lower Esophagus to Duodenum, Via Natural or Artificial Opening Endoscopic |
| 0D138ZA | Bypass Lower Esophagus to Jejunum, Via Natural or Artificial Opening Endoscopic |
| 0D138ZB | Bypass Lower Esophagus to Ileum, Via Natural or Artificial Opening Endoscopic |
| 0D15074 | Bypass Esophagus to Cutaneous with Autologous Tissue Substitute, Open Approach |
| 0D15076 | Bypass Esophagus to Stomach with Autologous Tissue Substitute, Open Approach |
| 0D15079 | Bypass Esophagus to Duodenum with Autologous Tissue Substitute, Open Approach |
| 0D1507A | Bypass Esophagus to Jejunum with Autologous Tissue Substitute, Open Approach |
| 0D1507B | Bypass Esophagus to Ileum with Autologous Tissue Substitute, Open Approach |
| 0D150J4 | Bypass Esophagus to Cutaneous with Synthetic Substitute, Open Approach |
| 0D150J6 | Bypass Esophagus to Stomach with Synthetic Substitute, Open Approach |
| 0D150J9 | Bypass Esophagus to Duodenum with Synthetic Substitute, Open Approach |
| 0D150JA | Bypass Esophagus to Jejunum with Synthetic Substitute, Open Approach |
| 0D150JB | Bypass Esophagus to Ileum with Synthetic Substitute, Open Approach |
| 0D150K4 | Bypass Esophagus to Cutaneous with Nonautologous Tissue Substitute, Open Approach |
| 0D150K6 | Bypass Esophagus to Stomach with Nonautologous Tissue Substitute, Open Approach |
| 0D150K9 | Bypass Esophagus to Duodenum with Nonautologous Tissue Substitute, Open Approach |
| 0D150KA | Bypass Esophagus to Jejunum with Nonautologous Tissue Substitute, Open Approach |
| 0D150KB | Bypass Esophagus to Ileum with Nonautologous Tissue Substitute, Open Approach |
| 0D150Z4 | Bypass Esophagus to Cutaneous, Open Approach |
| 0D150Z6 | Bypass Esophagus to Stomach, Open Approach |
| 0D150Z9 | Bypass Esophagus to Duodenum, Open Approach |


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| ICD-10 Procedure Code | Code Description |
|---|---|
| 0D150ZA | Bypass Esophagus to Jejunum, Open Approach |
| 0D150ZB | Bypass Esophagus to Ileum, Open Approach |
| 0D153J4 | Bypass Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Approach |
| 0D15474 | Bypass Esophagus to Cutaneous with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D15476 | Bypass Esophagus to Stomach with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D15479 | Bypass Esophagus to Duodenum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D1547A | Bypass Esophagus to Jejunum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D1547B | Bypass Esophagus to Ileum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D154J4 | Bypass Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 0D154J6 | Bypass Esophagus to Stomach with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 0D154J9 | Bypass Esophagus to Duodenum with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 0D154JA | Bypass Esophagus to Jejunum with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 0D154JB | Bypass Esophagus to Ileum with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 0D154K4 | Bypass Esophagus to Cutaneous with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D154K6 | Bypass Esophagus to Stomach with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D154K9 | Bypass Esophagus to Duodenum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D154KA | Bypass Esophagus to Jejunum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D154KB | Bypass Esophagus to Ileum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D154Z4 | Bypass Esophagus to Cutaneous, Percutaneous Endoscopic Approach |
| 0D154Z6 | Bypass Esophagus to Stomach, Percutaneous Endoscopic Approach |
| 0D154Z9 | Bypass Esophagus to Duodenum, Percutaneous Endoscopic Approach |
| 0D154ZA | Bypass Esophagus to Jejunum, Percutaneous Endoscopic Approach |
| 0D154ZB | Bypass Esophagus to Ileum, Percutaneous Endoscopic Approach |
| 0D15874 | Bypass Esophagus to Cutaneous with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D15876 | Bypass Esophagus to Stomach with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D15879 | Bypass Esophagus to Duodenum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D1587A | Bypass Esophagus to Jejunum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D1587B | Bypass Esophagus to Ileum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D158J4 | Bypass Esophagus to Cutaneous with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic |


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| ICD-10 Procedure Code | Code Description |
|---|---|
| 0D158J6 | Bypass Esophagus to Stomach with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D158J9 | Bypass Esophagus to Duodenum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D158JA | Bypass Esophagus to Jejunum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D158JB | Bypass Esophagus to Ileum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D158K4 | Bypass Esophagus to Cutaneous with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D158K6 | Bypass Esophagus to Stomach with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D158K9 | Bypass Esophagus to Duodenum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D158KA | Bypass Esophagus to Jejunum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D158KB | Bypass Esophagus to Ileum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D158Z4 | Bypass Esophagus to Cutaneous, Via Natural or Artificial Opening Endoscopic |
| 0D158Z6 | Bypass Esophagus to Stomach, Via Natural or Artificial Opening Endoscopic |
| 0D158Z9 | Bypass Esophagus to Duodenum, Via Natural or Artificial Opening Endoscopic |
| 0D158ZA | Bypass Esophagus to Jejunum, Via Natural or Artificial Opening Endoscopic |
| 0D158ZB | Bypass Esophagus to Ileum, Via Natural or Artificial Opening Endoscopic |
| 0DB10ZZ | Excision of Upper Esophagus, Open Approach |
| 0DB13ZZ | Excision of Upper Esophagus, Percutaneous Approach |
| 0DB14ZZ | Excision of Upper Esophagus, Percutaneous Endoscopic Approach |
| 0DB17ZZ | Excision of Upper Esophagus, Via Natural or Artificial Opening |
| 0DB18ZZ | Excision of Upper Esophagus, Via Natural or Artificial Opening Endoscopic |
| 0DB20ZZ | Excision of Middle Esophagus, Open Approach |
| 0DB23ZZ | Excision of Middle Esophagus, Percutaneous Approach |
| 0DB24ZZ | Excision of Middle Esophagus, Percutaneous Endoscopic Approach |
| 0DB27ZZ | Excision of Middle Esophagus, Via Natural or Artificial Opening |
| 0DB28ZZ | Excision of Middle Esophagus, Via Natural or Artificial Opening Endoscopic |
| 0DB30ZZ | Excision of Lower Esophagus, Open Approach |
| 0DB33ZZ | Excision of Lower Esophagus, Percutaneous Approach |
| 0DB34ZZ | Excision of Lower Esophagus, Percutaneous Endoscopic Approach |
| 0DB37ZZ | Excision of Lower Esophagus, Via Natural or Artificial Opening |
| 0DB38ZZ | Excision of Lower Esophagus, Via Natural or Artificial Opening Endoscopic |
| 0DB50ZZ | Excision of Esophagus, Open Approach |
| 0DB53ZZ | Excision of Esophagus, Percutaneous Approach |
| 0DB54ZZ | Excision of Esophagus, Percutaneous Endoscopic Approach |
| 0DB57ZZ | Excision of Esophagus, Via Natural or Artificial Opening |
| 0DB58ZZ | Excision of Esophagus, Via Natural or Artificial Opening Endoscopic |
| 0DT10ZZ | Resection of Upper Esophagus, Open Approach |
| 0DT14ZZ | Resection of Upper Esophagus, Percutaneous Endoscopic Approach |


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| ICD-10 Procedure Code | Code Description |
|---|---|
| 0DT17ZZ | Resection of Upper Esophagus, Via Natural or Artificial Opening |
| 0DT18ZZ | Resection of Upper Esophagus, Via Natural or Artificial Opening Endoscopic |
| 0DT20ZZ | Resection of Middle Esophagus, Open Approach |
| 0DT24ZZ | Resection of Middle Esophagus, Percutaneous Endoscopic Approach |
| 0DT27ZZ | Resection of Middle Esophagus, Via Natural or Artificial Opening |
| 0DT28ZZ | Resection of Middle Esophagus, Via Natural or Artificial Opening Endoscopic |
| 0DT30ZZ | Resection of Lower Esophagus, Open Approach |
| 0DT34ZZ | Resection of Lower Esophagus, Percutaneous Endoscopic Approach |
| 0DT37ZZ | Resection of Lower Esophagus, Via Natural or Artificial Opening |
| 0DT38ZZ | Resection of Lower Esophagus, Via Natural or Artificial Opening Endoscopic |
| 0DT44ZZ | Resection of Esophagogastric Junction, Percutaneous Endoscopic Approach |
| 0DT50ZZ | Resection of Esophagus, Open Approach |
| 0DT54ZZ | Resection of Esophagus, Percutaneous Endoscopic Approach |
| 0DT57ZZ | Resection of Esophagus, Via Natural or Artificial Opening |
| 0DT58ZZ | Resection of Esophagus, Via Natural or Artificial Opening Endoscopic |
| 0DT60ZZ | Resection of Stomach, Open Approach |
| 0DT64ZZ | Resection of Stomach, Percutaneous Endoscopic Approach |
| 0DT67ZZ | Resection of Stomach, Via Natural or Artificial Opening |
| 0DT68ZZ | Resection of Stomach, Via Natural or Artificial Opening Endoscopic |
| 0DX60Z5 | Transfer Stomach to Esophagus, Open Approach |
| 0DX64Z5 | Transfer Stomach to Esophagus, Percutaneous Endoscopic Approach |
| 0DX80Z5 | Transfer Small Intestine to Esophagus, Open Approach |
| 0DX84Z5 | Transfer Small Intestine to Esophagus, Percutaneous Endoscopic Approach |
| 0DXE0Z5 | Transfer Large Intestine to Esophagus, Open Approach |
| 0DXE4Z5 | Transfer Large Intestine to Esophagus, Percutaneous End |

**ICD-10 Malignant Tumor and Carcinoma in Situ Diagnosis Codes**

| ICD-10 Diagnosis Code | Code Description |
|---|---|
| C15.3 | Malignant neoplasm of upper third of esophagus |
| C15.4 | Malignant neoplasm of middle third of esophagus |
| C15.5 | Malignant neoplasm of lower third of esophagus |
| C15.8 | Malignant neoplasm of overlapping sites of esophagus |
| C15.9 | Malignant neoplasm of esophagus, unspecified |
| C16.0 | Malignancy of the cardio-esophageal junction |
| D00.1 | Carcinoma in situ of esophagus |


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## Pancreatic Resection for Cancer Measure Specifications

For pancreatic resection for cancer, there are two sets of ICD-10 codes for counting patient discharges. The first set of codes is to identify patients who have had the procedure. The second set of codes is to identify patients with a specific diagnosis.

Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes in any procedure field **AND** any of the following ICD-10 codes in any diagnosis field.

### ICD-10 Pancreatic Resection for Cancer Procedure Codes

| ICD-10 Procedure Code | Code Description |
|---|---|
| 0DB90ZZ | Excision of Duodenum, Open Approach |
| 0DB93ZZ | Excision of Duodenum, Percutaneous Approach |
| 0DB94ZZ | Excision of Duodenum, Percutaneous Endoscopic Approach |
| 0DB97ZZ | Excision of Duodenum, Via Natural or Artificial Opening |
| 0DB98ZZ | Excision of Duodenum, Via Natural or Artificial Opening Endoscopic |
| 0DT90ZZ | Resection of Duodenum, Open Approach |
| 0DT94ZZ | Resection of Duodenum, Percutaneous Endoscopic Approach |
| 0DT97ZZ | Resection of Duodenum, Via Natural or Artificial Opening |
| 0DT98ZZ | Resection of Duodenum, Via Natural or Artificial Opening Endoscopic |
| 0FBG0ZZ | Excision of Pancreas, Open Approach |
| 0FBG3ZZ | Excision of Pancreas, Percutaneous Approach |
| 0FBG4ZG | Excision of Pancreas, Percutaneous Endoscopic Approach, Hand-Assisted |
| 0FBG4ZZ | Excision of Pancreas, Percutaneous Endoscopic Approach |
| 0FBG8ZZ | Excision of Pancreas, Via Natural or Artificial Opening Endoscopic |
| 0FTG0ZZ | Resection of Pancreas, Open Approach |
| 0FTG4ZG | Resection of Pancreas, Percutaneous Endoscopic Approach, Hand-Assisted |
| 0FTG4ZZ | Resection of Pancreas, Percutaneous Endoscopic Approach |

### ICD-10 Malignant Tumor Diagnosis Codes

| ICD-10 Diagnosis Code | Code Description |
|---|---|
| C7A.1 | Malignant poorly differentiated neuroendocrine tumors |
| C7A.8 | Other malignant neuroendocrine tumors |
| C17.0 | Malignant neoplasm of duodenum |
| C24.0 | Malignant neoplasm of extrahepatic bile duct |
| C24.1 | Malignant neoplasm of ampulla of Vater |
| C24.8 | Malignant neoplasm of overlapping sites of biliary tract |
| C24.9 | Malignant neoplasm of biliary tract, unspecified |
| C25.0 | Malignant neoplasm of head of pancreas |
| C25.1 | Malignant neoplasm of body of pancreas |
| C25.2 | Malignant neoplasm of tail of pancreas |
| C25.3 | Malignant neoplasm of pancreatic duct |
| C25.4 | Malignant neoplasm of endocrine pancreas |
| C25.7 | Malignant neoplasm of other parts of pancreas |


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| ICD-10 Diagnosis Code | Code Description |
|---|---|
| C25.8 | Malignant neoplasm of overlapping sites of pancreas |
| C25.9 | Malignant neoplasm of pancreas, unspecified |

## Rectal Cancer Surgery Measure Specifications

For rectal cancer surgery, there are two sets of ICD-10 codes for counting patient discharges. The first set of codes is to identify patients who have had the procedure. The second set of codes is to identify patients with a specific diagnosis.

Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes in any procedure field **AND** any of the following ICD-10 codes in any diagnosis field.

### ICD-10 Rectal Cancer Surgery Procedure Codes

| ICD-10 Procedure Code | Code Description |
|---|---|
| 0DBP0ZZ | Excision of Rectum, Open Approach |
| 0DBP3ZZ | Excision of Rectum, Percutaneous Approach |
| 0DBP4ZZ | Excision of Rectum, Percutaneous Endoscopic Approach |
| 0DBP7ZZ | Excision of Rectum, Via Natural or Artificial Opening |
| 0DBP8ZZ | Excision of rectum, via natural or artificial opening endoscopic |
| 0DTP0ZZ | Resection of Rectum, Open Approach |
| 0DTP4ZZ | Resection of Rectum, Percutaneous Endoscopic Approach |
| 0DTP7ZZ | Resection of Rectum, Via Natural or Artificial Opening |
| 0DTP8ZZ | Resection of Rectum, Via Natural or Artificial Opening Endoscopic |

### ICD-10 Malignant Tumor and Carcinoma in Situ Diagnosis Codes

| ICD-10 Diagnosis Code | Code Description |
|---|---|
| C19 | Malignant neoplasm of rectosigmoid junction |
| C20 | Malignant neoplasm of rectum |
| C21.0 | Malignant neoplasm of anus, unspecified |
| C21.1 | Malignant neoplasm of anal canal |
| C21.2 | Malignant neoplasm of cloacogenic zone |
| C21.8 | Malignant neoplasm of overlapping sites of rectum, anus and anal canal |
| C78.5 | Secondary malignant neoplasm of large intestine and rectum |
| D01.1 | Carcinoma in situ of rectosigmoid junction |
| D01.2 | Carcinoma in situ of rectum |
| D01.3 | Carcinoma in situ of anus and anal canal |


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## Bariatric Surgery for Weight Loss Measure Specifications

For bariatric surgery for weight loss, there are three sets of codes. One set of ICD-10 codes for counting inpatient discharges and one set of CPT codes for counting outpatient discharges. The first two sets of codes are to identify patients who have had the procedure. The third set of codes (ICD-10 diagnosis codes) is to identify patients with a specific diagnosis.

To determine the number of patients, ages 18 years and older, discharged for this procedure, hospitals have two options:

1. Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes or the CPT Codes in any procedure field **AND** any of the following ICD-10 codes in the **primary** diagnosis field. This method does not require chart review.
2. Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes or the CPT Codes in any procedure field **AND** any of the following ICD-10 codes in any diagnosis field. In addition, the procedure must have been done **explicitly for weight loss purposes** (i.e., presence of one of the diagnosis codes is necessary, but not sufficient for inclusion). This method requires chart review to ensure the procedure was performed explicitly for weight loss purposes.

### ICD-10 Bariatric Surgery Procedure Codes

| ICD-10 Procedure Code | Code Description |
|---|---|
| 0D16079 | Bypass Stomach to Duodenum with Autologous Tissue Substitute, Open Approach |
| 0D1607A | Bypass Stomach to Jejunum with Autologous Tissue Substitute, Open Approach |
| 0D1607B | Bypass Stomach to Ileum with Autologous Tissue Substitute, Open Approach |
| 0D160J9 | Bypass Stomach to Duodenum with Synthetic Substitute, Open Approach |
| 0D160JA | Bypass Stomach to Jejunum with Synthetic Substitute, Open Approach |
| 0D160JB | Bypass Stomach to Ileum with Synthetic Substitute, Open Approach |
| 0D160K9 | Bypass Stomach to Duodenum with Nonautologous Tissue Substitute, Open Approach |
| 0D160KA | Bypass Stomach to Jejunum with Nonautologous Tissue Substitute, Open Approach |
| 0D160KB | Bypass Stomach to Ileum with Nonautologous Tissue Substitute, Open Approach |
| 0D160Z9 | Bypass Stomach to Duodenum, Open Approach |
| 0D160ZA | Bypass Stomach to Jejunum, Open Approach |
| 0D160ZB | Bypass Stomach to Ileum, Open Approach |
| 0D16479 | Bypass Stomach to Duodenum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D1647A | Bypass Stomach to Jejunum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D1647B | Bypass Stomach to Ileum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D164J9 | Bypass Stomach to Duodenum with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 0D164JA | Bypass Stomach to Jejunum with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 0D164JB | Bypass Stomach to Ileum with Synthetic Substitute, Percutaneous Endoscopic Approach |
| 0D164K9 | Bypass Stomach to Duodenum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D164KA | Bypass Stomach to Jejunum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |


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| | |
|---|---|
| 0D164KB | Bypass Stomach to Ileum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach |
| 0D164Z9 | Bypass Stomach to Duodenum, Percutaneous Endoscopic Approach |
| 0D164ZA | Bypass Stomach to Jejunum, Percutaneous Endoscopic Approach |
| 0D164ZB | Bypass Stomach to Ileum, Percutaneous Endoscopic Approach |
| 0D16879 | Bypass Stomach to Duodenum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D1687A | Bypass Stomach to Jejunum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D1687B | Bypass Stomach to Ileum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D168J9 | Bypass Stomach to Duodenum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D168JA | Bypass Stomach to Jejunum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D168JB | Bypass Stomach to Ileum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D168K9 | Bypass Stomach to Duodenum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D168KA | Bypass Stomach to Jejunum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D168KB | Bypass Stomach to Ileum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic |
| 0D168Z9 | Bypass Stomach to Duodenum, Via Natural or Artificial Opening Endoscopic |
| 0D168ZA | Bypass Stomach to Jejunum, Via Natural or Artificial Opening Endoscopic |
| 0D168ZB | Bypass Stomach to Ileum, Via Natural or Artificial Opening Endoscopic |
| 0DB60Z3 | Excision of Stomach, Open Approach, Vertical |
| 0DB60ZZ | Excision of Stomach, Open Approach |
| 0DB63Z3 | Excision of Stomach, Percutaneous Approach, Vertical |
| 0DB63ZZ | Excision of Stomach, Percutaneous Approach |
| 0DB64Z3 | Excision of Stomach, Percutaneous Endoscopic Approach, Vertical |
| 0DB64ZZ | Excision of Stomach, Percutaneous Endoscopic Approach |

**ICD-10 Morbid Obesity Diagnosis Codes**

| ICD-10 Diagnosis Code | Code Description |
|---|---|
| E66.01 | Morbid (severe) obesity due to excess calories |
| E66.09 | Other obesity due to excess calories |
| E66.1 | Drug induced obesity |
| E66.2 | Morbid (severe) obesity with alveolar hypoventilation |
| E66.3 | Overweight |
| E66.8 | Other obesity |
| E66.811 | Obesity, class 1 |
| E66.812 | Obesity, class 2 |
| E66.813 | Obesity, class 3 |
| E66.89 | Other obesity not elsewhere classified |
| E66.9 | Obesity, unspecified |


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| ICD-10 Diagnosis Code | Code Description |
|---|---|
| E88.82 | Obesity due to disruption of MC4R pathway |
| Z68.35 | Body mass index (BMI) 35.0-35.9, adult |
| Z68.36 | Body mass index (BMI) 36.0-36.9, adult |
| Z68.37 | Body mass index (BMI) 37.0-37.9, adult |
| Z68.38 | Body mass index (BMI) 38.0-38.9, adult |
| Z68.39 | Body mass index (BMI) 39.0-39.9, adult |
| Z68.41 | Body mass index (BMI) 40.0-44.9, adult |
| Z68.42 | Body mass index (BMI) 45.0-49.9, adult |
| Z68.43 | Body mass index (BMI) 50.0-59.9, adult |
| Z68.44 | Body mass index (BMI) 60.0-69.9, adult |
| Z68.45 | Body mass index (BMI) 70 or greater, adult |

**CPT Bariatric Surgery for Weight Loss Procedure Codes**

Leapfrog has provided a set of CPT codes for counting **patients** discharged from your hospital who have undergone the procedure during the reporting period on an outpatient basis.

CPT Codes are provided in downloadable Excel files on the Survey Dashboard. To access the files, click the CPT Code Workbook button next to Section 9. You will be required to complete the American Medical Association's Terms of Use before downloading the Excel file and using the individual CPT codes to query your EHR or billing system. You are only required to complete the Terms of Use once per Survey Cycle (April 1 – November 30).

The CPT Code Workbooks (Excel files) are labeled for Section 3A: Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss and Section 9C: Volume of Procedures. Please note, if you are part of a hospital system, each hospital will need to complete the Terms of Use. This is a requirement of the American Medical Association.

Using the CPT codes found for Bariatric Surgery for Weight Loss in the "Instructions" sheet, count the total number of adult (18 years of age or older) patients discharged for the procedures with the CPT codes listed **AND** any of the above ICD-10 diagnosis codes in the **primary** diagnosis field. The CPT codes can be in any procedure field.

## Total Knee Replacement Measure Specifications

For total knee replacement, there are two sets of codes. One set of ICD-10 codes for counting inpatient discharges and one CPT code for counting outpatient discharges. The two sets of codes are to identify patients who have had the procedure.

To determine the number of patients, ages 18 years and older, discharged for this procedure, hospitals have two options:

- Count the number of patients, ages 18 years and older, discharged with any of the following ICD-10 codes in the **primary** procedure field or the CPT Code in any procedure field. This method does not require chart review. Hospitals should report on total knee replacement procedures performed in the outpatient locations included in Section 9: Outpatient Procedures.
- Count the number of patients, ages 18 years and older, discharged with any of the following ICD-10 codes or CPT Code in any procedure field. **For inpatient cases using ICD-10 codes, exclude any patients where the procedure was done as a revision** (i.e., the presence of one of the procedure codes is necessary, but not sufficient for inclusion). This method requires chart review of inpatient cases to ensure that revisions are not included. Chart review is not required for outpatient cases using the specified CPT Code. Hospitals should report on total knee


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replacement procedures performed in the outpatient locations included in Section 9: Outpatient Procedures.

**ICD-10 Total Knee Replacement Procedure Codes**

| ICD10 Procedure Code | Code Description |
|---|---|
| 0SRC0J9 | Replacement of Right Knee Joint with Synthetic Substitute, Cemented, Open Approach |
| 0SRC0JA | Replacement of Right Knee Joint with Synthetic Substitute, Uncemented, Open Approach |
| 0SRC0JZ | Replacement of Right Knee Joint with Synthetic Substitute, Open Approach |
| 0SRD0J9 | Replacement of Left Knee Joint with Synthetic Substitute, Cemented, Open Approach |
| 0SRD0JA | Replacement of Left Knee Joint with Synthetic Substitute, Uncemented, Open Approach |
| 0SRD0JZ | Replacement of Left Knee Joint with Synthetic Substitute, Open Approach |
| 0SRC069 | Replacement of Right Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Cemented, Open Approach |
| 0SRC06A | Replacement of Right Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Uncemented, Open Approach |
| 0SRC06Z | Replacement of Right Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Open Approach |
| 0SRD069 | Replacement of Left Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Cemented, Open Approach |
| 0SRD06A | Replacement of Left Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Uncemented, Open Approach |
| 0SRD06Z | Replacement of Left Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Open Approach |

**CPT Total Knee Replacement Procedure Code**

Leapfrog has provided a CPT code for counting **patients** discharged from your hospital who have undergone the procedure during the reporting period on an outpatient basis.

CPT Codes are provided in downloadable Excel files on the Survey Dashboard. To access the files, click the CPT Code Workbook button next to Section 9. You will be required to complete the American Medical Association's Terms of Use before downloading the Excel file and using the individual CPT codes to query your EHR or billing system. You are only required to complete the Terms of Use once per Survey Cycle (April 1 – November 30).

The CPT Code Workbooks (Excel files) are labeled for Section 3A: Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss and Section 9C: Volume of Procedures. Please note, if you are part of a hospital system, each hospital will need to complete the Terms of Use. This is a requirement of the American Medical Association.

Using the CPT code found for Total Knee Replacement in the "Instructions" sheet, count the total number of adult (18 years of age or older) patients discharged for the procedure with the CPT code listed. The CPT code can be in any procedure field.


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## Total Hip Replacement Measure Specifications

For total hip replacement, there are two sets of codes. One set of ICD-10 codes for counting inpatient discharges and one CPT code for counting outpatient discharges. The two sets of codes are to identify patients who have had the procedure.

To determine the number of patients, ages 18 years and older, discharged for this procedure, hospitals have two options:

- Count the number of patients, ages 18 years and older, discharged with any of the following ICD-10 codes in the **primary** procedure field or the CPT code in any procedure field. This method does not require chart review. Hospitals should report on total hip replacement procedures performed in the outpatient locations included in Section 9: Outpatient Procedures.
- Count the number of patients, ages 18 years and older, discharged with any of the following ICD-10 codes or the CPT code in any procedure field. **For inpatient cases using ICD-10 codes, exclude any patients where the procedure was done as a revision** (i.e., the presence of one of the procedure codes is necessary, but not sufficient for inclusion). This method requires chart review of inpatient cases to ensure that revisions are not included. Chart review is not required for outpatient cases using the specified CPT Code. Hospitals should report on total hip replacement procedures performed in the outpatient locations included in Section 9: Outpatient Procedures.

### ICD-10 Total Hip Replacement Procedure Codes

| ICD10 Procedure Code | Code Description |
|---|---|
| 0SR9019 | Replacement of Right Hip Joint with Metal Synthetic Substitute, Cemented, Open Approach |
| 0SR901A | Replacement of Right Hip Joint with Metal Synthetic Substitute, Uncemented, Open Approach |
| 0SR901Z | Replacement of Right Hip Joint with Metal Synthetic Substitute, Open Approach |
| 0SR9029 | Replacement of Right Hip Joint with Metal on Polyethylene Synthetic Substitute, Cemented, Open Approach |
| 0SR902A | Replacement of Right Hip Joint with Metal on Polyethylene Synthetic Substitute, Uncemented, Open Approach |
| 0SR902Z | Replacement of Right Hip Joint with Metal on Polyethylene Synthetic Substitute, Open Approach |
| 0SR9039 | Replacement of Right Hip Joint with Ceramic Synthetic Substitute, Cemented, Open Approach |
| 0SR903A | Replacement of Right Hip Joint with Ceramic Synthetic Substitute, Uncemented, Open Approach |
| 0SR903Z | Replacement of Right Hip Joint with Ceramic Synthetic Substitute, Open Approach |
| 0SR9049 | Replacement of Right Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Cemented, Open Approach |
| 0SR904A | Replacement of Right Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Uncemented, Open Approach |
| 0SR904Z | Replacement of Right Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Open Approach |
| 0SR90J9 | Replacement of Right Hip Joint with Synthetic Substitute, Cemented, Open Approach |
| 0SR90JA | Replacement of Right Hip Joint with Synthetic Substitute, Uncemented, Open Approach |
| 0SR90JZ | Replacement of Right Hip Joint with Synthetic Substitute, Open Approach |
| 0SRA009 | Replacement of Right Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Cemented, Open Approach |
| 0SRA00A | Replacement of Right Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Uncemented, Open Approach |


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| | |
|---|---|
| 0SRA00Z | Replacement of Right Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Open Approach |
| 0SRA019 | Replacement of Right Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Cemented, Open Approach |
| 0SRA01A | Replacement of Right Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Uncemented, Open Approach |
| 0SRA01Z | Replacement of Right Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Open Approach |
| 0SRA039 | Replacement of Right Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Cemented, Open Approach |
| 0SRA03A | Replacement of Right Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Uncemented, Open Approach |
| 0SRA03Z | Replacement of Right Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Open Approach |
| 0SRA0J9 | Replacement of Right Hip Joint, Acetabular Surface with Synthetic Substitute, Cemented, Open Approach |
| 0SRA0JA | Replacement of Right Hip Joint, Acetabular Surface with Synthetic Substitute, Uncemented, Open Approach |
| 0SRA0JZ | Replacement of Right Hip Joint, Acetabular Surface with Synthetic Substitute, Open Approach |
| 0SRB019 | Replacement of Left Hip Joint with Metal Synthetic Substitute, Cemented, Open Approach |
| 0SRB01A | Replacement of Left Hip Joint with Metal Synthetic Substitute, Uncemented, Open Approach |
| 0SRB01Z | Replacement of Left Hip Joint with Metal Synthetic Substitute, Open Approach |
| 0SRB029 | Replacement of Left Hip Joint with Metal on Polyethylene Synthetic Substitute, Cemented, Open Approach |
| 0SRB02A | Replacement of Left Hip Joint with Metal on Polyethylene Synthetic Substitute, Uncemented, Open Approach |
| 0SRB02Z | Replacement of Left Hip Joint with Metal on Polyethylene Synthetic Substitute, Open Approach |
| 0SRB039 | Replacement of Left Hip Joint with Ceramic Synthetic Substitute, Cemented, Open Approach |
| 0SRB03A | Replacement of Left Hip Joint with Ceramic Synthetic Substitute, Uncemented, Open Approach |
| 0SRB03Z | Replacement of Left Hip Joint with Ceramic Synthetic Substitute, Open Approach |
| 0SRB049 | Replacement of Left Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Cemented, Open Approach |
| 0SRB04A | Replacement of Left Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Uncemented, Open Approach |
| 0SRB04Z | Replacement of Left Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Open Approach |
| 0SRB0J9 | Replacement of Left Hip Joint with Synthetic Substitute, Cemented, Open Approach |
| 0SRB0JA | Replacement of Left Hip Joint with Synthetic Substitute, Uncemented, Open Approach |
| 0SRB0JZ | Replacement of Left Hip Joint with Synthetic Substitute, Open Approach |
| 0SRE009 | Replacement of Left Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Cemented, Open Approach |
| 0SRE00A | Replacement of Left Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Uncemented, Open Approach |
| 0SRE00Z | Replacement of Left Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Open Approach |
| 0SRE019 | Replacement of Left Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Cemented, Open Approach |


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| | |
|---|---|
| 0SRE01A | Replacement of Left Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Uncemented, Open Approach |
| 0SRE01Z | Replacement of Left Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Open Approach |
| 0SRE039 | Replacement of Left Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Cemented, Open Approach |
| 0SRE03A | Replacement of Left Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Uncemented, Open Approach |
| 0SRE03Z | Replacement of Left Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Open Approach |
| 0SRE0J9 | Replacement of Left Hip Joint, Acetabular Surface with Synthetic Substitute, Cemented, Open Approach |
| 0SRE0JA | Replacement of Left Hip Joint, Acetabular Surface with Synthetic Substitute, Uncemented, Open Approach |
| 0SRE0JZ | Replacement of Left Hip Joint, Acetabular Surface with Synthetic Substitute, Open Approach |
| 0SR9069 | Replacement of Right Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Cemented, Open Approach |
| 0SR906A | Replacement of Right Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Uncemented, Open Approach |
| 0SR906Z | Replacement of Right Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Open Approach |
| 0SRB069 | Replacement of Left Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Cemented, Open Approach |
| 0SRB06A | Replacement of Left Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Uncemented, Open Approach |
| 0SRB06Z | Replacement of Left Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Open Approach |

**CPT Total Hip Replacement Procedure Code**

Leapfrog has provided a CPT code for counting **patients** discharged from your hospital who have undergone the procedure during the reporting period on an outpatient basis.

CPT Codes are provided in downloadable Excel files on the Survey Dashboard. To access the files, click the CPT Code Workbook button next to Section 9. You will be required to complete the American Medical Association's Terms of Use before downloading the Excel file and using the individual CPT codes to query your EHR or billing system. You are only required to complete the Terms of Use once per Survey Cycle (April 1 – November 30).

The CPT Code Workbooks (Excel files) are labeled for Section 3A: Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss and Section 9C: Volume of Procedures. Please note, if you are part of a hospital system, each hospital will need to complete the Terms of Use. This is a requirement of the American Medical Association.

Using the CPT code found for Total Hip Replacement in the "Instructions" sheet, count the total number of adult (18 years of age or older) patients discharged for the procedure with the CPT code listed. The CPT code can be in any procedure field.


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## Norwood Procedure Measure Specifications

For Norwood procedure, there are two sets of ICD-10 procedure codes for counting patient discharges. For a patient to be counted, they must have at least one ICD-10 procedure code from each list.

The first set of codes is to identify patients who have had an arch repair. The second set of codes is to identify patients who have had a shunt.

Count the number of patients, ages 17 years and younger, discharged with at least one of the following ICD-10 procedure codes from each list in any procedure field (i.e., each patient discharge will need to have at least one ICD-10 procedure code from the arch repair set **AND** at least one ICD-10 procedure code from the shunt set). Both procedures would need to be done as part of the same operative session.

### ICD-10 Arch Repair Procedure Codes

| ICD-10 Procedure Code | Code Description |
|---|---|
| 02UX07Z | Supplement Thoracic Aorta, Ascending/Arch with Autologous Tissue Substitute, Open Approach |
| 02UX0JZ | Supplement Thoracic Aorta, Ascending/Arch with Synthetic Substitute, Open Approach |
| 02UX0KZ | Supplement Thoracic Aorta, Ascending/Arch with Nonautologous Tissue Substitute, Open Approach |

### ICD-10 Shunt Procedure Codes

| ICD-10 Procedure Code | Code Description |
|---|---|
| 021K08P | Bypass Right Ventricle to Pulmonary Trunk with Zooplastic Tissue Substitute, Open Approach |
| 021K08Q | Bypass Right Ventricle to Right Pulmonary Artery with Zooplastic Tissue Substitute, Open Approach |
| 021K08R | Bypass Right Ventricle to Left Pulmonary Artery with Zooplastic Tissue Substitute, Open Approach |
| 021K09P | Bypass Right Ventricle to Pulmonary Trunk with Autologous Venous Tissue, Open Approach |
| 021K09Q | Bypass Right Ventricle to Right Pulmonary Artery with Autologous Venous Tissue, Open Approach |
| 021K09R | Bypass Right Ventricle to Right Pulmonary Artery with Autologous Venous Tissue, Open Approach |
| 021K0AP | Bypass Right Ventricle to Pulmonary Trunk with Autologous Arterial Tissue, Open Approach |
| 021K0AQ | Bypass Right Ventricle to Right Pulmonary Artery with Autologous Arterial Tissue, Open Approach |
| 021K0AR | Bypass Right Ventricle to Right Pulmonary Artery with Autologous Arterial Tissue, Open Approach |
| 021K0JP | Bypass Right Ventricle to Pulmonary Trunk with Synthetic Substitute, Open Approach |
| 021K0JQ | Bypass Right Ventricle to Right Pulmonary Artery with Synthetic Substitute, Open Approach |
| 021K0JR | Bypass Right Ventricle to Left Pulmonary Artery with Synthetic Substitute, Open Approach |
| 021K0KP | Bypass Right Ventricle to Pulmonary Trunk with Nonautologous Tissue Substitute, Open Approach |
| 021K0KQ | Bypass Right Ventricle to Right Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach |


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| ICD-10 Procedure Code | Code Description |
|---|---|
| 021K0KR | Bypass Right Ventricle to Right Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach |
| 021Q08A | Bypass Right Pulmonary Artery from Innominate Artery with Zooplastic Tissue, Open Approach |
| 021Q08B | Bypass Right Pulmonary Artery from Subclavian with Zooplastic Tissue, Open Approach |
| 021Q08D | Bypass Right Pulmonary Artery from Carotid with Zooplastic Tissue, Open Approach |
| 021Q09A | Bypass Right Pulmonary Artery from Innominate Artery with Autologous Venous Tissue, Open Approach |
| 021Q09B | Bypass Right Pulmonary Artery from Subclavian with Autologous Venous Tissue, Open Approach |
| 021Q09D | Bypass Right Pulmonary Artery from Carotid with Autologous Venous Tissue, Open Approach |
| 021Q0AA | Bypass Right Pulmonary Artery from Innominate Artery with Autologous Arterial Tissue, Open Approach |
| 021Q0AB | Bypass Right Pulmonary Artery from Subclavian with Autologous Arterial Tissue, Open Approach |
| 021Q0AD | Bypass Right Pulmonary Artery from Carotid with Autologous Arterial Tissue, Open Approach |
| 021Q0JA | Bypass Right Pulmonary Artery from Innominate with Synthetic Substitute, Open Approach |
| 021Q0JB | Bypass Right Pulmonary Artery from Subclavian with Synthetic Substitute, Open Approach |
| 021Q0JD | Bypass Right Pulmonary Artery from Carotid with Synthetic Substitute, Open Approach |
| 021Q0KA | Bypass Right Pulmonary Artery from Innominate Artery with Nonautologous Tissue Substitute, Open Approach |
| 021Q0KB | Bypass Right Pulmonary Artery from Subclavian with Nonautologous Tissue Substitute, Open Approach |
| 021Q0KD | Bypass Right Pulmonary Artery from Carotid with Nonautologous Tissue Substitute, Open Approach |
| 021V0ZP | Bypass Superior Vena Cava to Pulmonary Trunk, Open Approach |
| 021V0ZQ | Bypass Superior Vena Cava to Right Pulmonary Artery, Open Approach |
| 021V0ZR | Bypass Superior Vena Cava to Left Pulmonary Artery, Open Approach |


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## *Safe Surgery Checklist for Adult and Pediatric Complex Surgery Measure Specifications*

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

**Source**: The Leapfrog Group, WHO Surgical Safety Checklist and Implementation Manual, AHRQ Endoscopy Checklist

**Reporting Period**: **12 months**
Latest 12-month period prior to submission of this section of the Survey

**Safe Surgery Checklist Workbook (Excel)**

To complete the data collection and respond to questions #6-9, hospitals should download the Safe Surgery Checklist Workbook (Excel). This workbook includes five tabs: Instructions, Section 3B (Complex Surgery), Section 3B – Data Entry, Section 9D (Outpatient Procedures), Section 9D – Data Entry. The Section 3B tabs can be used to complete the safe surgery checklist audits for this subsection and to calculate the response for question #9.

The workbook is available on the Survey Materials Webpage.

**Sampling:**

Hospitals that perform procedures in both Section 3A and Section 9C, and submit both Section 3 and 9, can randomly sample 15 patients (who had one of the procedures included in Section 3A) and measure and report adherence to the safe surgery checklist based on that sample.

Hospitals that ONLY perform the procedures in Section 3A, or that ONLY submit Section 3, must randomly sample 30 patients (who had one of the procedures included in Section 3A) and measure and report adherence to the safe surgery checklist based on that sample.

When sampling from a larger population of cases, hospitals that perform multiple procedures (e.g., bariatric surgery for weight loss, total hip replacement, total knee replacement, etc.) included in Section 3A and hospitals that perform procedures for both adult and pediatric patients (e.g., the Norwood Procedures) should obtain a representative sample (i.e., include patients who underwent different procedures and include both adult and pediatric patients, if applicable).

*Free-standing pediatric hospitals that perform the Norwood Procedure and hospitals that reported a combined total hospital volume of less than the sufficient sample for all the procedures in Section 3A can sample any patients that had a procedure performed under general anesthesia.*

**Question #6: Did your hospital perform an audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 3A and measure adherence to the safe surgery checklist?**

To respond "yes" to question #6, hospitals must measure and document whether all the elements in questions #3, #4, and #5 were verbalized in the presence of the appropriate personnel for each sampled case. Hospitals that completed the audit should respond "yes" to this question regardless of whether the adherence to the checklist was 100%. Hospitals will report on adherence to the checklist in question #9.

**Question #7: How many cases were included in the audit from question #6?**

Hospitals that perform procedures in both Section 3A and Section 9C, and submit both Section 3 and 9, can randomly sample 15 patients (who had one of the procedures included in Section 3A) and measure and report adherence to the safe surgery checklist based on that sample.

Hospitals that ONLY perform the procedures in Section 3A, or that ONLY submit Section 3, must randomly sample 30 patients (who had one of the procedures included in Section 3A) and measure and report adherence to the safe surgery checklist based on that sample.


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**Question #8: What method was used to perform the audit on a sufficient sample in question #6?**

Hospitals can only perform a retrospective audit by reviewing medical records or EHR data if adherence to the safe surgery checklist is clearly documented in the medical record or EHR and the documentation clearly demonstrates that each element was verbalized in the presence of the appropriate personnel. If hospitals cannot clearly determine whether (a) the checklist element was verbalized and (b) that the appropriate personnel were present via a retrospective audit, an in-person observational audit must be completed.

Hospitals performing in-person observational audits must do so in the latest 12 months prior to Survey submission.

Hospitals performing retrospective audits must audit cases from the latest 12 months prior to Survey submission but can also review any case from Section 3A that was performed in the latest calendar year prior to Survey submission.

**Question #9: Based on your hospital's audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 3A, what was your hospital's documented rate of adherence to the safe surgery checklist (i.e., what percentage of the sampled cases had all elements in questions #3, #4, and #5 completed)?**

Based on the audit completed for question #6, determine the total number of patient audits where **all** elements of the safe surgery checklist (included in questions #3, #4, and #5) were read aloud in the presence of the appropriate personnel 1) before the induction of anesthesia, 2) before the skin incision and/or the procedure began, and 3) before the patient left the operating and/or procedure room.

**Included cases:**

- The patient audit shows that **all** elements of the safe surgery checklist, at **all** three time points, were read aloud in the presence of the appropriate personnel.

**Excluded cases:**

- The patient audit does **not** demonstrate that all elements of the safe surgery checklist were read aloud in the presence of the appropriate personnel (i.e., one or more elements of the checklist were not read aloud or the appropriate personnel were not present during the checklist).
- The patient audit does **not** demonstrate that the safe surgery checklist was read aloud in the presence of the appropriate personnel at all three time points (i.e., before anesthesia, before the skin incision, and before the patient leaves).

**Important Note**: If a Safe Surgery Checklist element includes the qualifier "if applicable," hospitals should determine if that element of the checklist was applicable to the patient and procedure being performed. If the element was determined to be "not applicable" to the patient and procedure, it does not count against the total adherence. For example, if your hospital performed a bariatric surgery for weight loss, the availability of a device on-site would not be applicable. Therefore, when completing the Safe Surgery Checklist Workbook for this patient, indicate N/A for that element (device on-site) and your hospital would be able to count that case as adherent.

See FAQs for additional information about responding to the questions in this section.

# Section 3: Adult and Pediatric Complex Surgery Frequently Asked Questions (FAQs)

## *General Questions*

1. **Does this section apply to critical access hospitals?**
   Yes. In general, critical access hospitals do not perform many of the procedures that are included in this section, but if the critical access hospital does perform the procedure, the standards still apply.

2. **Should we select a procedure from the list in Section 3A question #2 if we only perform that procedure on an outpatient basis?**
   Hospitals that only perform total hip replacements, total knee replacements, and/or bariatric surgery for weight loss on an outpatient basis should select and report on those procedures in Section 3A.

   Otherwise, hospitals should not select and report on the remaining eight procedures if the procedures are always scheduled with the intention of the patient being released on the same day.

   If some of the procedures are scheduled with the intention of the patient being admitted and staying in the hospital overnight, the hospital should report on performing the procedure in question #2 and then ONLY report on the total number of patients discharged following an inpatient stay.

3. **My hospital has a tumor center that only performs total hip replacements and total knee replacements as they come up during a tumor removal surgery, should we select these procedures from the list in Section 3A question #2?**
   If your hospital has a tumor center where orthopedic tumor surgeries are performed and the ONLY total hip replacement and/or total knee replacement procedures ever done at that hospital are for the treatment of the tumor, you should not select and report on total hip replacements or total knee replacements in Section 3A.

## *Hospital Volume FAQs*

4. **How should hospitals calculate volume using a 24-month annual average?**
   To report on a 24-month annual average, calculate the total volume over the past 24 months, and then divide by 2 (i.e., the volume of year one plus the volume of year 2 divided by two equals the 24-month annual average).

5. **Can we count patients who have had one of the procedures listed in Section 3A in combination with another procedure not listed in Section 3A?**
   Yes, hospitals should count all patients that meet the criteria specified in the Hospital and Surgeon Volume Measure Specifications. For example, if a patient has a CABG and a mitral valve repair done at the same time, the hospital should count the patient when calculating total volume for mitral valve repair and replacement.

6. **When counting patients, should we only include those patients who had the procedure performed on a scheduled basis?**
   No. Once a hospital selects a procedure from the list in question #2, they should use the measure specifications for each procedure to count all patients that meet the criteria. This includes patients who had the procedure performed urgently.


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7. **If a hospital elects to begin a new service line of procedures, how should the hospital report its volume and surgeon volumes while establishing the new line?**
   Leapfrog gives hospitals an 18-month grace period before having to report on hospital and surgeon volume for a new procedure. From the day that the hospital performs the procedure for the first time, the hospital and its surgeons will have 18 months to reach the annual volume standard. During this period, the hospital does not have to report its procedure volumes for the hospital or its surgeons. However, once the hospital reaches the end of the 18-month grace period, it must report its hospital and surgeon procedure volume.

8. **How should we deal with a temporary drop in volume due to losing a surgeon's service?**
   To accommodate fluctuations in hospital volumes, hospitals have the option of reporting on their average case volumes over a 24-month period.

9. **Can we count minimally invasive and/or robotic Mitral Valve Repair and Replacement procedures towards our hospital's volume?**
   Yes, the ICD-10 codes Leapfrog has provided for this procedure will capture minimally invasive and/or robotic MVRR procedures in the hospital's count as these are the codes used for those cases.

10. **Our hospital has a free-standing outpatient surgery center that shares our license and/or CMS Certification Number (CCN). Many of our same day total hip replacements, total knee replacements, and bariatric surgery for weight loss procedures are performed there. Can we include these procedures in our total hospital volume when responding to question #3 in Section 3A?**
    Yes, hospitals may count patient discharges with the appropriate CPT procedure code during the reporting period from hospital outpatient departments that share your hospital's license and/or CMS Certification Number (CCN), including, but not limited to free-standing surgery centers and hospital outpatient departments.

### *Surgeon Volume FAQs*

11. **Does the specific procedure and minimum annual surgeon volume standard listed need to be included in our process for privileging surgeons?**
    Yes. Hospitals must ensure that the specific procedure (as defined using the ICD-10 and CPT procedure codes) and minimum annual surgeon volume standard are included in your process for privileging surgeons. Diagnosis codes can be ignored.

12. **Does our privileging process for surgeons have to include the annual surgeon volume standard for initial privileging only or ongoing/renewal of privileging as well?**
    Both. Leapfrog's minimum annual surgeon volume standards should be fully integrated into your hospital's process for privileging surgeons, including both initial and ongoing privileging. There are two exceptions:
    a. Surgeons who have just finished training: see FAQ #14 below.
    b. Surgeons who were not active for the entire reporting period: see FAQ #15 below.

13. **When counting annual surgeon volume for the purposes of privileging, should we consider procedures performed by the surgeon at other hospitals?**
    Yes. When determining whether a surgeon has met or has exceeded Leapfrog's minimum annual surgeon volume standard, we expect that hospitals will consider total experience in the privileging process – this would include procedures performed within the reporting period at different facilities. It is our understanding that through the OPPE process, hospitals have access to total surgeon volume, including the number of procedures performed at other hospitals.

14. **For determining surgeon volume for the purposes of privileging, how should we count procedures that involve surgeons who have just finished training and are building up their experience?**
    Surgeons who have just finished their training should receive a 24-month grace period to build up their experience. After that point, the surgeon's volume should be tracked and included in privileging decisions. The procedures performed by this surgeon during the reporting period should still be counted towards the hospital's volume total, as the broader staff still had the experience with the procedure.

15. **If a surgeon was not "active" during the entire reporting period (e.g., just hired, sabbatical, illness, etc.), should they be included when responding to question #5?**
    If a surgeon was absent for an extended time during the reporting period, the procedures performed by this surgeon during the reporting period should still be counted towards the hospital's procedure total (question #3). However, the surgeon would not need to be considered when responding to question #5 regarding whether your hospital's process for privileging includes the surgeon having to meet Leapfrog's minimum annual surgeon volume standards until they have been active again for an entire reporting period (likely the next year).

16. **When counting surgeon volume for the purposes of privileging, if a procedure is completed by two surgeons (i.e., an assistant or co-surgeon) would they both be able to count the case?**
    If a surgeon assists another surgeon or is a co-surgeon during a procedure, the procedure should NOT count for both surgeons' procedure totals. The case should be applied to a single surgeon.

17. **When determining which surgeons should be required to meet Leapfrog's minimum annual surgeon volume standards for the process of privileging, should surgeons who only ever perform a procedure in emergency circumstances and never perform the procedure on a scheduled basis be included?**
    For the purposes of reporting on question #5 in Section 3A, hospitals can exclude surgeons who will only ever perform a procedure in emergency circumstances if they never perform the procedure on a scheduled basis.

    However, for the purposes of reporting on question #3 in Section 3A, hospitals should count all patients discharged with the relevant procedure or diagnosis for those procedures indicated in question #2 in Section 3A. See FAQ #6.

### *Safe Surgery Checklist for Adult and Pediatric Complex Surgery FAQs*

18. **What 12-month reporting period should be used when reporting on this section?**
    When responding to the questions in Section 3B, hospitals should enter the month in which they complete their observational in-person or retrospective EHR review audits. If your hospital does not perform an audit, enter the month in which you are completing the Survey.

19. **Does the safe surgery checklist referenced in Section 3B apply to all procedures, including endoscopies?**
    Yes, it applies to all procedures in Section 3A. If your hospital does not utilize a safe surgery checklist for all procedures in Section 3A, including endoscopies, respond "no" to question #2.

20. **Can different elements of the "Before the induction of anesthesia" checklist (question #3) be performed in different places?**
    Yes, hospitals may perform some elements of the pre-anesthesia checklist outside of the operating room. Hospitals may read aloud the following elements in a pre-procedure (preop) area: Patient ID, Confirmation of procedure, Patient consent, Site marked, if applicable, and Allergies assessed.

    Hospitals should not remove conversation prompts as it is harmful to the purpose of the checklist and should continue debriefing and requiring participation of the surgical team members in key moments.


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21. **Do we need to perform a "clinical team introduction" if the team already knows each other and/or will be in the operating room together all day?**
    Yes. Even if a clinical team knows each other they must perform an introduction stating their name and role at the first procedure of the day. They do not need to reintroduce themselves for the remaining procedures but should confirm everyone was introduced beforehand. However, if any team members change between operations, introductions must be performed again.

22. **Do the Safe Surgery Checklist components included in questions #3, #4, and #5 need to be in one document that would align with the WHO example or can they be in different documents (i.e., pre-anesthesia notes, surgeon H&P, and pre-surgical checklists, etc.)?**
    It is possible to have separate checklists for each phase of the surgical procedure (i.e., before the induction of anesthesia, before the skin incision and/or before the procedure begins, and before the patient leaves the operating or procedure room). However, each individual component included in questions #3, #4, and #5 should be listed on the checklist(s) and hospitals should document whether the components were read aloud at the appropriate time with the appropriate members of the surgical team present.

23. **How is "whole surgical team" defined?**
    "Whole surgical team" is comprised of the surgeons, anesthesia professionals, nurses, technicians, and other operating room personnel involved in surgery. This is based off the World Alliance for Patient Safety Implementation Manual Surgical Safety Checklist (First Edition).

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# *SECTION 4: MATERNITY CARE*

This section includes questions and reference information for Section 4: Maternity Care. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.


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# Section 4: Maternity Care

**Maternity Care Fact Sheet and Bibliography:**
https://ratings.leapfroggroup.org/measure/hospital/2026/maternity-care

**Hospitals that did not deliver newborns during the reporting period or did not have an open labor and delivery unit during the entire reporting period should select "no" or "yes, but unit is now closed or wasn't open for the entire reporting period" in question #2 and move on to the Affirmation of Accuracy. Your hospital's results will be displayed as "Does Not Apply" on Leapfrog's public reporting website.**

Section 4 includes questions about maternity care volume and services, cesarean birth, episiotomy, newborn bilirubin screening, and DVT prophylaxis for women undergoing cesarean delivery. The section also includes questions about high-risk deliveries, including volume and outcomes. The subsection on cesarean birth (4C) includes questions about cesarean births stratified by race/ethnicity that will not be scored or publicly reported, however, responses will be used for confidential reporting on the Hospital Details Page in 2026.

**Each hospital achieving the standard for Cesarean Birth:**
Meets or is better than the 23.6% target for performance on the nationally endorsed outcome measure.

**Each hospital achieving the standard for Episiotomy:**
Meets or is better than the 5.0% target for performance on the nationally endorsed outcome measure.

**Each hospital achieving the standard for Newborn Bilirubin Screening Prior to Discharge:**
Meets or exceeds the 90% target for the process measure of care.

**Each hospital achieving the standard for Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery:**
Meets or exceeds the 90% target for the process measure of care.

**Each hospital achieving the standard for High-Risk Deliveries:**
Achieves favorable hospital volume characteristics for high-risk deliveries by admitting 50 or more very low birth weight newborns/year to its neonatal ICU,

OR

Achieves favorable outcomes for high-risk deliveries as measured by the Vermont Oxford Network.

**Download the 2026 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.**

# 4A: Maternity Care Volume and Services

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Notes:**

Note 1: This section is only applicable to hospitals that deliver newborn babies. Hospitals that do not deliver newborn babies should select "no" or "yes, but unit is now closed or wasn't open for the entire reporting period" in question #2 in 4A and move on to the Affirmation of Accuracy. Your hospital's results will be displayed as "Does Not Apply" on Leapfrog's public reporting website.

Note 2: Hospitals must use the same 12-month reporting period for all subsections in Section 4: Maternity Care, except for Section 4A questions #4-8 and Section 4B questions #6-8.

Note 3: Maternity Care Services (questions #4-8) will not be scored but will be used in public reporting.

**Specifications:** See ***Maternity Care Volume and Services Measure Specifications*** in the Reference Information beginning on page 164.

**Reporting Period: 12 months**

- Surveys submitted prior to September 1:
  - 01/01/2025 – 12/31/2025
- Surveys (re)submitted on or after September 1:
  - 07/01/2025 – 06/30/2026

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

### *Maternity Care Volume*

| | |
|---|---|
| 1) 12-month reporting period used: | ○ 01/01/2025 – 12/31/2025<br>○ 07/01/2025 – 06/30/2026 |
| 2) Did the hospital deliver newborn babies during the reporting period?<br><br>*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."* | ○ Yes<br>○ No<br>○ Yes, but unit is now closed or wasn't open for the entire reporting period |
| 3) Total number of live births (i.e., liveborn infants) at this hospital location for the reporting period.<br><br>*If fewer than 10 cases, skip the remaining questions in Section 4, including all subsections, and go to the Affirmation of Accuracy. The hospital will be scored as "Unable to Calculate Score" or "Does Not Apply."* | _____ |


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## *Maternity Care Services*

**Reporting Period:** Answer questions #4-9 based on the practices currently in place at the time you submit this section of the Survey.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

| | |
|---|---|
| 4) Do certified nurse-midwives and/or certified midwives offer care for labor and delivery at your hospital? | ○ Yes<br>○ No |
| 5) Do doulas offer care for labor and delivery at your hospital?<br><br>*Select all that apply.* | ☐ Yes, the hospital employs or contracts with doulas<br>☐ Yes, patients can bring their own doulas<br>☐ No |
| 6) What breastfeeding/lactation support is provided in your hospital after delivery and prior to hospital discharge?<br><br>*Select all that apply.* | ☐ Clinical lactation care, education, and support provided by an International Board Certified Lactation Consultant® (IBCLC®)<br>☐ Education and counseling provided by other lactation consultants, counselors, educators, and/or specialists<br>☐ None of the above |
| 7) Which of the following does your hospital offer patients after delivery and prior to hospital discharge?<br><br>*Select all that apply.* | ☐ Tubal ligation<br>☐ Bilateral salpingectomy<br>☐ Long-acting reversible contraception (LARC) (e.g., IUDs)<br>☐ None of the above |
| 8) Has your hospital adopted a policy that prevents nonmedically indicated early elective deliveries (before 39 completed weeks gestation) that includes all the following:<br>• Written standards for when an early elective delivery is, and is not, appropriate based on ACOG and national guidelines (i.e., The Joint Commission),<br>• Written protocols for the medical director, or other designated physician, to review and approve an early elective delivery when medically indicated based on ACOG and national guidelines, and<br>• Written protocols for staff to follow when scheduling an early elective delivery if approved by the medical director or other designated physician? | ○ Yes<br>○ No |


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# 4B: Cesarean Birth

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Notes:**

Note 1: Hospitals must use the same 12-month reporting period for all subsections in Section 4: Maternity Care, except for Section 4B questions #6-8.

Note 2: Cesarean Birth Stratified by Race/Ethnicity (questions #6-8) will not be scored or publicly reported but will be used for confidential reporting on the Hospital Details Page.

**Specifications:** See ***Cesarean Birth Measure Specifications*** in the Reference Information beginning on page 165.

**Reporting Period: 12 months**
Answer questions #1-5 based on all cases (or a sufficient sample of them for questions #2-3)

- Surveys submitted prior to September 1:
  - 01/01/2025 – 12/31/2025
- Surveys (re)submitted on or after September 1:
  - 07/01/2025 – 06/30/2026

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

**Sufficient Sample:** See ***Cesarean Birth Measure Specifications*** for instructions for identifying a sufficient sample for questions #2 and #3.

| | |
|---|---|
| 1) 12-month reporting period used: | ○ 01/01/2025 – 12/31/2025<br>○ 07/01/2025 – 06/30/2026 |
| 2) Total number of nulliparous mothers (or sufficient sample of them) that delivered a live term singleton newborn in the vertex presentation with >=37 weeks of gestation completed, with **Excluded Populations** removed:<br><br>*If fewer than 10 cases met the criteria for the denominator, skip questions #3-8 and continue to the next subsection. The hospital will be scored as "Unable to Calculate Score."* | _____ |
| 3) Total number of mothers indicated in question #2 that had their newborn delivered via cesarean section: | _____ |
| 4) Do the responses in questions #2 and #3 above represent a sample of cases? | ○ Yes<br>○ No |
| 5) If "yes" to question #4, did your hospital sample using The Joint Commission's sampling algorithm or Leapfrog's sampling instructions, as provided in the Maternity Care Reference Information? | ○ The Joint Commission<br>○ The Leapfrog Group |

## *Cesarean Birth Stratified by Race/Ethnicity*

**Reporting Period: 24 months**
Answer questions #6-8 based on all cases

- Surveys submitted prior to September 1:
  - 01/01/2024 – 12/31/2025
- Surveys (re)submitted on or after September 1:
  - 07/01/2024 – 06/30/2026

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

| | |
|---|---|
| 6) 24-month reporting period used: | ○ 01/01/2024 – 12/31/2025<br>○ 07/01/2024 – 06/30/2026 |
| 7) Did your hospital stratify NTSV cesarean births by race/ethnicity for the reporting period using the measure specifications provided and do you choose to report those data to this Survey?<br><br>*If "no" to question #7, skip question #8 and continue to the next subsection.* | ○ Yes<br>○ No |

8) Enter your hospital's responses below by race/ethnicity:

*If the number of cases for a race/ethnicity is less than 10 (in column a), skip column b and then move to the next category. If zero, enter "0" in column a.*

| Race/ethnicity | a) Total number of nulliparous mothers that delivered a live term singleton newborn in the vertex presentation with >= 37 weeks of gestation completed, with ***Excluded Populations*** removed (denominator) | b) Total number of mothers indicated in question #8a that had their newborn delivered via cesarean section (numerator) |
|---|---|---|
| Non-Hispanic White | _____ | _____ |
| Non-Hispanic Black | _____ | _____ |
| Non-Hispanic American Indian or Alaska Native | _____ | _____ |
| Non-Hispanic Asian or Pacific Islander | _____ | _____ |
| Hispanic | _____ | _____ |
| Non-Hispanic Other (including two or more races) | _____ | _____ |
| Unknown | _____ | _____ |

# 4C: Episiotomy

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Note:** Hospitals must use the same 12-month reporting period for all subsections in Section 4: Maternity Care, except for Section 4B questions #6-8.

**Specifications:** See ***Episiotomy Measure Specifications*** in the Reference Information beginning on page 169.

**Reporting Period: 12 months**
Answer questions #1-3 based on all cases.

- Surveys submitted prior to September 1:
  - 01/01/2025 – 12/31/2025
- Surveys (re)submitted on or after September 1:
  - 07/01/2025 – 06/30/2026

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

| | |
|---|---|
| 1) 12-month reporting period used: | ○ 01/01/2025 – 12/31/2025<br>○ 07/01/2025 – 06/30/2026 |
| 2) Total number of vaginal deliveries, with **Excluded Populations** removed:<br><br>*If fewer than 10 cases met the criteria for the denominator, skip question #3 and continue to the next subsection. The hospital will be scored as "Unable to Calculate Score."* | _____ |
| 3) Total number of mothers indicated in question #2 that had an episiotomy procedure performed: | _____ |

# 4D: Process Measures of Quality

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Note:** Hospitals must use the same 12-month reporting period for all subsections in Section 4: Maternity Care, except for Section 4B questions #6-8.

**Specifications:** See ***Process Measures of Quality Measure Specifications*** in the Reference Information beginning on page 170.

**Reporting Period: 12 months**
Answer questions #1-9 based on all cases (or a sufficient sample of them).

- Surveys submitted prior to September 1:
  - 01/01/2025 – 12/31/2025
- Surveys (re)submitted on or after September 1:
  - 07/01/2025 – 06/30/2026

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

**Sufficient Sample:** See ***Process Measures of Quality Measure Specifications*** for instructions for identifying a sufficient sample for questions #3-4 and #7-8.

| | |
|---|---|
| 1) 12-month reporting period used: | ○ 01/01/2025 – 12/31/2025<br>○ 07/01/2025 – 06/30/2026 |

### *Newborn Bilirubin Screening Prior to Discharge*

| | |
|---|---|
| 2) Did your hospital perform a medical record audit on all cases (or a sufficient sample of them) **and** measure adherence to the newborn bilirubin screening prior to discharge clinical guideline?<br><br>*If "no" to question #2, skip questions #3-5 and continue to question #6. The hospital will be scored as "Did Not Measure."*<br><br>*If "yes, but fewer than 10 cases met the inclusion criteria for the denominator," skip questions #3-5 and continue to question #6. The hospital will be scored as "Unable to Calculate Score."* | ○ Yes<br>○ No<br>○ Yes, but fewer than 10 cases met the inclusion criteria for the denominator |
| 3) Number of cases measured against the guideline, either all cases or a sufficient sample of them (**denominator**): | _____ |
| 4) Number of cases in question #3 that adhere to the clinical process guideline (**numerator**): | _____ |
| 5) Do the responses in questions #3 and #4 represent a sample of cases? | ○ Yes<br>○ No |

***Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery***

| | |
|---|---|
| 6) Did your hospital perform a medical record audit on all cases (or a sufficient sample of them) **and** measure adherence to the appropriate DVT prophylaxis in women undergoing cesarean delivery clinical guideline?<br><br>*If "no" to question #6, skip questions #7-9 and continue to the next subsection. The hospital will be scored as "Did Not Measure."*<br><br>*If "yes, but fewer than 10 cases met the inclusion criteria for the denominator," skip questions #7-9 and continue to the next subsection. The hospital will be scored as "Unable to Calculate Score."* | ○ Yes<br>○ No<br>○ Yes, but fewer than 10 cases met the inclusion criteria for the denominator |
| 7) Number of cases measured against the guideline, either all cases or a sufficient sample of them (**denominator**): | _____ |
| 8) Number of cases in question #7 that adhere to the clinical process guideline (**numerator**): | _____ |
| 9) Do the responses in questions #7 and #8 represent a sample of cases? | ○ Yes<br>○ No |


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# 4E: High-Risk Deliveries

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Note:** Only include units that were open for the entire reporting period and that remain currently open.

| | |
|---|---|
| 1) Does your hospital admit high-risk deliveries [30]?<br><br>*If "no" or "yes, but only on an emergency basis or when a patient is too unstable for safe transfer," skip the remaining questions in Section 4E, and go to the Affirmation of Accuracy. The hospital will be scored as "Does Not Apply."* | ○ Yes<br>○ No<br>○ Yes, but only on an emergency basis or when a patient is too unstable for safe transfer |
| 2) Does your hospital operate a Level II/III, Level III, or Level IV neonatal ICU (NICU), or is it co-located [31] with a hospital that operates a NICU, that admits or accepts transfers of very low birth weight babies [32]?<br><br>*If "no" to question #2, skip the remaining questions in Section 4E, and go to the Affirmation of Accuracy. The hospital will be scored as "Limited Achievement."*<br><br>*If the NICU is co-located in another hospital and your hospital immediately transfers all complicated newborns there, answer question #3 and either questions #4-5 or #6-10 based on information pertaining to the co-located hospital's NICU.* | ○ Yes<br>○ No |
| 3) Hospitals that participate in the Vermont Oxford Network (VON) and have a recent 12-month report available may elect to report their hospital's Volume (questions #4-5)<br><br>**OR**<br><br>the VON's Death or Morbidity Measure [33] (questions #6-10).<br><br>Hospitals that do not participate in the Vermont Oxford Network should report their hospital's Volume (questions #4-5).<br><br>Please indicate which measure the hospital will report on*:*<br><br>*If you elect to report on Volume, answer questions #4-5 and skip questions #6-10.*<br><br>*If you elect to report on the VON National Performance Measure, skip questions #4-5. Please ensure that you have entered an accurate VON Transfer Code in the Hospital Profile and submitted the Data Share Authorization letter to VON. Otherwise, you will be scored as "Declined to Report."* | ○ Volume<br>○ VON National Performance Measure |

### *Neonatal Intensive Care Unit(s) – Volume*

**Important Note:** Hospitals must use the same 12-month reporting period for all subsections in Section 4: Maternity Care, except for Section 4B questions #6-8.

**Specifications:** See ***Neonatal Intensive Care Unit(s) – Volume Measure Specifications*** in the Reference Information beginning on page 1722.

**Reporting Period: 12 months**
- Surveys submitted prior to September 1:
  - 01/01/2025 – 12/31/2025
- Surveys (re)submitted on or after September 1:
  - 07/01/2025 – 06/30/2026

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

| | |
|---|---|
| 4) 12-month reporting period used: | ○ 01/01/2025 – 12/31/2025<br>○ 07/01/2025 – 06/30/2026 |
| 5) For the reporting period, how many very low birth weight babies were admitted to your hospital's neonatal intensive care unit(s)? | _____ |

### *Neonatal Intensive Care Unit(s) – National Performance Measurement*

**Important Note:** Hospitals participating in the Vermont Oxford Network (VON) may opt to report on the VON National Performance Measure. In order for Leapfrog to obtain the data from VON, the VON data must be finalized, and hospitals must complete the following steps:
1. Provide an accurate VON Transfer Code in the Hospital Profile,
2. Complete a Data Sharing Authorization letter and submit it to VON by **June 15**. Hospitals that submitted their Data Sharing Authorization letter to VON in previous Leapfrog Hospital Survey Cycles do not have to re-submit a new letter in 2026,
3. Select "VON National Performance Measure" in question #3, and
4. Submit the 2026 Leapfrog Hospital Survey by the June 30 Submission Deadline.

Hospitals that select "VON National Performance Measure" in question #3, but do not adhere to the other steps will be scored and publicly reported as "Declined to Report" for the High-Risk Deliveries measure.

**Specifications:** See ***Neonatal Intensive Care Unit(s) – National Performance Measurement Measure Specifications*** in the Reference Information beginning on page 172.

**Reporting Period: 12 months**
Responses are based on the latest **12-month** report received from the Vermont Oxford Network (VON) for the **Death or Morbidity Measure.**
- 2024 VON data
- 2025 VON data *(usually available after August 31)*

*Leapfrog will update the VON data three times per Survey Cycle for all hospitals that have completed the steps noted above. See deadlines and reporting periods in the* ***Neonatal Intensive Care Unit(s) - National Performance Measurement Measure Specifications.***

| | |
|---|---|
| 6) Most recent 12-month reporting period for which VON performance results are available: | *No response required here. Determined* |

| | |
|---|---|
| | *automatically based on VON data.* |
| 7) Hospital's volume based on VON report: | *No response required here. Determined automatically based on VON data.* |
| 8) Hospital's standardized mortality ratio (**SMR) 95% lower bound** based on VON report: | *No response required here. Determined automatically based on VON data.* |
| 9) Hospital's observed to expected ratio of morbidity or mortality (**SMR shrunken**) based on VON report: | *No response required here. Determined automatically based on VON data.* |
| 10) Hospital's **SMR 95% upper bound** based on VON report: | *No response required here. Determined automatically based on VON data.* |


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**Affirmation of Accuracy**

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Maternity Care Section at our hospital, and I hereby affirm that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this affirmation on behalf of our hospital.

The hospital and I acknowledge that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also acknowledge that analyses and ratings The Leapfrog Group derives from this information will be made public on the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade website, and/or other Leapfrog Group published works, products and services. The hospital and I acknowledge that analyses and ratings derived from this information and all intellectual property rights related to those analyses and ratings shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. I hereby affirm that this information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may license analyses and ratings derived from this information to other entities including researchers, not-for-profit entities, and for-profit entities, and the revenue from such licensure will be used solely to support The Leapfrog Group's not-for-profit mission. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
*(first name and last name)* *(title)*
on _____.
*(date)*


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# Section 4: Maternity Care Reference Information

### *What's New in the 2026 Survey*

Leapfrog is updating the measure specifications from The Joint Commission for PC-02 Cesarean Birth (Section 4B) to reflect version 2026A1 for those hospitals that do not already submit data to The Joint Commission and therefore need to retrospectively collect data. We are also continuing to accept both data for the chart-abstracted measure (PC-02) and data collected using The Joint Commission's electronic clinical quality measure (eCQM) specifications (ePC-02). Hospitals measuring this quality indicator and reporting results to The Joint Commission should continue to use that data when responding to the questions in Section 4B: Cesarean Birth.

Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may continue using the data provided in their CMQCC reports when responding to subsections 4A: Maternity Care Volume and Services (volume only), 4B: Cesarean Birth, 4C: Episiotomy, and 4D: Process Measures of Quality. Hospitals participating in the Michigan Obstetrics Initiative (OBI) may also continue to use the data provided in their OBI reports to report on Section 4B: Cesarean Birth.

### Section 4A: Maternity Care Volume and Services

**Maternity Care Volume**
Leapfrog is updating the measure specifications used to report on the total number of live births (volume) in Section 4A: Maternity Care Volume and Services to indicate that hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in CMQCC reports when reporting on their live births. As in past Surveys, hospitals can alternatively continue to either use the data reported to their state or the Z codes provided in the measure specifications.

**Maternity Care Services**
Leapfrog is updating the existing Maternity Care Services questions to provide further clarity on the services provided at hospitals offering maternity care to ensure this data can continue to be used in a meaningful and useful way by hospitals, patients and their families, employers, purchasers, and other users of Leapfrog's data. Updates include a revised question and FAQ related to the type of breastfeeding/lactation support offered after delivery and prior to hospital discharge. As a reminder, these questions are used in public reporting but are not scored.

**Request for Information**
As part of our request for public comments, Leapfrog included a request for information on the collection of data and calculation of rates for vaginal births after cesarean section (VBACs) in the 2027 Leapfrog Hospital Survey. Specifically, Leapfrog asked about the Agency for Healthcare Research and Quality (AHRQ)'s Inpatient Quality Indicator (IQI) 22: Vaginal Birth After Cesarean (VBAC) Delivery Rate, Uncomplicated measure which is currently used by both CMQCC and Cal Hospital Compare, as well as other states. Leapfrog appreciates all the comments that were received.

Several comments supported the inclusion of this measure and hospitals indicated that they are already collecting the data needed to report. A few comments explained that the exclusion criteria used in the measure does not fully account for clinically appropriate, guideline-supported indications for repeat cesarean delivery and urged Leapfrog to consider additional exclusions or other reporting metrics. One comment cautioned Leapfrog against unintentional consequences when evaluating the measure, such as encouraging inappropriate access rather than safe access. All comments will be reviewed with Leapfrog's Maternity Care Expert Panel as part of Leapfrog's regular standard review process.

While we continue to evaluate this information, we are removing the current maternity services question regarding whether hospitals offer patients the opportunity to attempt VBAC from the 2026 Leapfrog Hospital Survey


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## Section 4B: Cesarean Birth

Leapfrog is continuing to include questions on the collection of cesarean birth data (NTSV C-section measure) by race/ethnicity and is asking hospitals to provide numerators and denominators for the NTSV C-section measure for each of the following races/ethnicities, which were also used in 2024 and 2025 reporting: Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian or Alaska Native, Non-Hispanic Asian or Pacific Islander, Hispanic, and Non-Hispanic Other (including two or more races). Reporting this information requires that hospitals collect ethnicity and race, including if a patient identifies with multiple races. As in 2024 and 2025, these questions are required but will not be used in scoring or public reporting by hospital on the Survey Results website. Instead, cesarean birth rates stratified by race/ethnicity will continue to be confidentially shared with reporting hospitals on their Hospital Details Pages.

Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in their CMQCC reports and hospitals reporting to the U.S. News & World Report Maternity Services Survey may use the data provided to U.S. News & World Report when responding to these questions. Both can use the crosswalk provided in the measure specifications to aid in reporting. Otherwise, hospitals will continue to use The Joint Commission's PC-02 Cesarean Birth measure specifications (version 2026A1) and Leapfrog instructions to retrospectively review all cases and stratify by race/ethnicity.

There are no changes to the scoring algorithm for Section 4B: Cesarean Birth.

## Section 4C: Episiotomy

There are no changes to this subsection.

## Section 4D: Process Measures of Quality

### Newborn Bilirubin Screening Prior to Discharge

There are no changes to this measure.

### Appropriate DVT Prophylaxis in Women Undergoing Cesarean Section

In response to feedback and consultation with our Maternity Care Expert Panel, Leapfrog is updating the measure specifications for Appropriate Deep Vein Thrombosis (DVT) Prophylaxis in Women Undergoing Cesarean Delivery to remove credit for patients receiving heparin or heparinoid given the American College of Obstetricians and Gynecologists' clinical guidance that all patients should have pneumatic compressions devices placed prior to cesarean delivery. As such, only patients receiving pneumatic compression devices prior to surgery will be included in the numerator. However, clinical guidelines continue to recommend that patients at high- or moderaterisk for DVT should also receive appropriate pharmacological prophylaxis in addition to the placement of pneumatic compression devices. The target for this measure remains at 90%.

There are no changes to the scoring algorithms for Section 4D: Process Measures of Quality.

## Section 4E: High-Risk Deliveries

Based on a review of responses to the 2025 Leapfrog Hospital Survey, Leapfrog is updating question #1 in Section 4E: High Risk Deliveries to further clarify which hospitals are required to report on this subsection. This update will not impact reporting requirements for this subsection as the associated endnote previously indicated that hospitals must answer "yes" to electively admitting high-risk deliveries if they admit deliveries where the conditions (expected birth weight less than 1500 grams or gestational age at least 22 weeks but less than 32 weeks) are known prior to admission (e.g., not admitted on only an emergent basis).

### Neonatal Intensive Care Unit(s) – Volume

Based on feedback received from participating hospitals and in consultation with our experts, Leapfrog is updating the measure specifications used for those hospitals opting to report using their volume of very low birthweight babies (i.e., less than 1500 grams) admitted to their neonatal intensive care unit(s) by removing the following two ICD-10-CM codes:


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- P05.2: Newborn affected by fetal malnutrition not light or small for gestational age
- P05.9: Newborn affected by slow intrauterine growth, unspecified

Unlike the other codes provided, which reflect birth weights between 500 and 1500 grams, these two codes do not specify birthweight and our understanding is that newborns with very low birthweight are already captured via the other codes provided in the measure specifications. This update allows hospitals to pull the volume data using claims and without having to rely on chart review as the current criteria of excluding newborns weighing 1500 grams or more is no longer needed.

**Neonatal Intensive Care Unit(s) – National Performance Measurement**
Leapfrog is continuing to obtain data directly from the Vermont Oxford Network (VON) for those hospitals that electively admit high-risk deliveries and opt to use VON's Death or Morbidity Outcome Measure when reporting on Section 4E: High-Risk Deliveries. Hospitals will still need to complete the following steps:

1. Complete a Data Sharing Authorization letter and submit it to VON by the dates listed in the measure specifications. (Hospitals that successfully submitted a Data Sharing Authorization letter in prior years will not be required to submit another letter in 2026),
2. Select "VON National Performance Measure" in Section 4E: High-Risk Deliveries question #3,
3. Provide an accurate VON Transfer Code in the Hospital Profile of the Leapfrog Hospital Survey (this will be pre-populated if previously provided); and,
4. Submit the Leapfrog Hospital Survey by the dates listed in the measure specifications.

Hospitals that select "VON National Performance Measure" in question #3 of Section 4E: High-Risk Deliveries, but do not complete all the steps listed above will be scored and publicly reported as "Declined to Report" for the High-Risk Deliveries measure.

### *Change Summary Since Release*

None. If substantive changes are made to this section of the Survey after release on April 1, 2026, they will be documented in this Change Summary section.


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# Section 4: Maternity Care Measure Specifications

## *Maternity Care Volume Measure Specifications*

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

**Reporting Period: 12 months**

- Surveys submitted prior to September 1:
  - 01/01/2025 – 12/31/2025
- Surveys (re)submitted on or after September 1:
  - 07/01/2025 – 06/30/2026

**Question #3:** The number of live births (i.e., infants) at this hospital location (inborn cases only), reported to your state during the reporting period.

Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in CMQCC reports when responding to this question of the Survey. Download instructions for using the CMQCC reports on the Survey and CPOE Materials webpage.

Alternatively, the below list of Z codes can be used to identify live births, with the caution that these codes are coded for the newborn, not the mother; likely to be found in your hospital's birth CIS/medical record system; but often not in claims data since normal newborn care may be included in the mother's claim without baby's diagnosis coding.

Z38.00 – Z38.01: Single liveborn infant, born in hospital
Z38.30 – Z38.31: Twin liveborn infant, born in hospital
Z38.61 – Z38.69: Other multiple liveborn infant, born in hospital

Note: This data point is simply used to qualify a hospital for further reporting of the normal delivery measures.


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## *Cesarean Birth Measure Specifications*

**Important Notes:**

Note 1: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Note 2: Leapfrog uses the specifications created by The Joint Commission (TJC) for the Cesarean Births measure. As such, Leapfrog will update its instructions annually, and more frequently if appropriate, to maintain alignment with TJC. Hospitals can access the TJC's measure specifications directly using the links in the table below.

Note 3: Cesarean Births (questions #2-3) can be reported based on all eligible cases OR a sufficient sample of cases as outlined in the denominator specifications for the 12-month reporting period. Cesarean Births Stratified by Race/Ethnicity (questions #7-8) must be reported based on all eligible cases for the 24-month reporting period.

**Source:** Joint Commission PC-02 version 2026A1

**Reporting Period: 12 months**

- Surveys submitted prior to September 1:
  - 01/01/2025 – 12/31/2025
- Surveys (re)submitted on or after September 1:
  - 07/01/2025 – 06/30/2026

Note: The discharge date must be used to determine whether a case falls within the reporting period specified.

If you measured this quality indicator, reported the results to The Joint Commission (TJC), and continue to submit these data to The Joint Commission, **use those data when responding to this subsection of the Survey.** Leapfrog will accept data collected for either the chart-abstracted measure (PC-02) or the electronic clinical quality measure (ePC-02).

Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in CMQCC reports when responding to this subsection of the Survey. Download instructions for using the CMQCC reports on the Survey and CPOE Materials webpage.

Hospitals participating in the Michigan Obstetrics Initiative (OBI) may use the data provided in OBI reports when responding to this subsection of the Survey.

Otherwise, use TJC's PC-02 Cesarean Birth measure specifications (version 2026A1) to retrospectively collect and report data for this measure. The PC-02 measure specifications are outlined below. To access the measure specifications directly on The Joint Commission's website, visit https://manual.jointcommission.org/releases/TJC2026A1/MIF0167.html.

Note: Leapfrog will also accept data collected for ePC-02 using TJC's electronic clinical quality measure (eCQM) specifications for the appropriate reporting period. eCQM specifications can be found here.

**Sampling Cases:** Hospitals that report the Perinatal Care Measure Set to TJC may use the sampling methodology used by the TJC to report on questions #2-3.

Otherwise, hospitals opting to identify a sufficient sample of mothers for this measure, in lieu of full case reporting, should follow the instructions below. Hospitals may refer to the TJC Measure Algorithm flow chart at the bottom of each set of specifications linked above, for an example of how to identify cases.

Sampling instructions for 01/01/2024 – 12/31/2024 discharges:

- Review your hospital's first delivery as of **April 15, 2025** if submitting a Survey prior to September 1 (or *optionally,* **July 15, 2025** if (re)submitting a Survey on or after September 1, 2026 and sampling from 07/01/2025 – 06/30/2026 discharges).


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- Evaluate this case against the inclusion criteria; retain the case for the sample if it meets the inclusion criteria.
- Evaluate this case against the exclusion criteria; retain the case for the sample if it does not meet any of the listed exclusions.
- Move to the next delivery and evaluate for inclusion/exclusion applicability.
- Continue through cases in sequential order until **a sample of at least 30 cases** is reached or all cases discharged during the reporting period are reviewed, whichever comes first.

**Question #2 (denominator):** Nulliparous patients delivered of a live term singleton newborn in vertex presentation with ***Excluded populations*** removed.

*Note: The denominator should include both nulliparous mothers with a live term singleton newborn in vertex presentation that had their newborn delivered via cesarean section and nulliparous mothers that delivered vaginally.*

**Included Populations:**

- *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for delivery as defined in Appendix A, Table 11.01.1 Delivery.
- Nulliparous patients with *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for outcome of delivery as defined in Appendix A, Table 11.08 Outcome of Delivery and with a delivery of a newborn with 37 weeks or more of gestation completed.

**Excluded Populations:**

- *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for multiple gestations, abnormal presentations, and conditions justifying cesarean delivery as defined in Appendix A, Table 11.09 Multiple Gestations, Abnormal Presentations, and Conditions Justifying Cesarean Delivery (please see FAQs for additional coding guidance https://datacenter.cmqcc.org/support/download/c463ad71c0197fd1b1dd54db4bb09d31d8e8b35e https://datacenter.cmqcc.org/support/download/a7955e52541df8ed63aa8e884909d81caeb1f659)
- Less than 8 years of age
- Greater than or equal to 65 years of age
- *Gestational Age* < 37 weeks or Unable to Determine (UTD)

**Data Elements:** Visit https://manual.jointcommission.org/releases/TJC2026A1/MIF0167.html.

***If fewer than 10 cases during the reporting period, skip the next question.***

**Question #3 (numerator):** Patients in the denominator with cesarean births.

**Included Populations:**
*ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for cesarean birth as defined in Appendix A, Table 11.06 Cesarean Birth

**Excluded Populations:** None

**Data Elements:** Visit https://manual.jointcommission.org/releases/TJC2026A1/MIF0167.html.

## Cesarean Birth Stratified by Race/Ethnicity

**Source:** Joint Commission PC-02 version 2026A1

**Reporting Period: 24 months**

- Surveys submitted prior to September 1:
  - 01/01/2024 – 12/31/2025
- Surveys (re)submitted on or after September 1:
  - 07/01/2024 – 06/30/2026

Note: The discharge date must be used to determine whether a case falls within the reporting period specified.

When reporting on Cesarean Birth Stratified by Race/Ethnicity, hospitals must report using a 24-month reporting period as specified in question #6.

Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in CMQCC reports when responding to question #8. Download instructions for using the CMQCC reports on the Survey and CPOE Materials webpage. Hospitals reporting to the U.S. News & World Report Maternity Services Survey may use the data provided to U.S. News & World Report and the crosswalk provided below when responding to question #8.

Otherwise, hospitals should use TJC's PC-02 Cesarean Birth measure specifications (version 2026A1) to retrospectively review **all cases** and then stratify those cases by race/ethnicity. The PC-02 measure specifications are outlined below. To access the measure specifications directly on The Joint Commission's website visit https://manual.jointcommission.org/releases/TJC2026A1/MIF0167.html.

**Question #8a (denominator):** Total number of nulliparous patients delivered of a live term singleton newborn in vertex presentation with ***Excluded populations*** removed by the following races/ethnicities:

- Non-Hispanic White
- Non-Hispanic Black
- Non-Hispanic American Indian or Alaska Native
- Non-Hispanic Asian or Pacific Islander
- Hispanic
- Non-Hispanic Other (including two or more races)
- Unknown

Each patient should only be counted once and included in the appropriate race/ethnicity category based on known race/ethnicity information. If race or ethnicity is unknown, include the case in the "Unknown" category. Hispanic patients should be included in the "Hispanic" category regardless of race. If a race/ethnicity category is not used by your hospital, include the case in the "Unknown" category, i.e., if patients with more than one race are listed as "multiracial" regardless of their ethnicity, include these cases in the "Unknown" category. Hospitals that do not collect all races for patients that identify with multiple races are not able to report.

Hospitals reporting to U.S. News can use the below crosswalk when reporting to Leapfrog. Hospitals using CMQCC can use the below crosswalk or information provided directly in their Leapfrog CMQCC report:

| CMQCC Race/Ethnicity | U.S. News Race/Ethnicity | Leapfrog Race/Ethnicity |
|---|---|---|
| Hispanic-US Born | Hispanic or Latino | Hispanic |
| Hispanic Non-US Born | | |
| White | White | Non-Hispanic White |
| | Middle Eastern or North African | |
| Black | Black or African American | Non-Hispanic Black |

| | | |
|---|---|---|
| Asian | Asian | Non-Hispanic Asian or Pacific Islander |
| Pacific Islander | Native Hawaiian or Pacific Islander | |
| Native American (American Indian or Alaska Native) | American Indian or Alaska Native | Non-Hispanic American Indian or Alaska Native |
| Other | N/A | Non-Hispanic Other (including two or more races) |
| Multiracial | Multiracial and/or Multiethnic | |
| Unknown | Unknown | Unknown |

*Note: The denominator should include both nulliparous mothers with a live term singleton newborn in vertex presentation that had their newborn delivered via cesarean section and nulliparous mothers that delivered vaginally.*

**Included Populations:**

- *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for delivery as defined in Appendix A, Table 11.01.1 Delivery.
- Nulliparous patients with *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for outcome of delivery as defined in Appendix A, Table 11.08 Outcome of Delivery and with a delivery of a newborn with 37 weeks or more of gestation completed.

**Excluded Populations:**

- *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for multiple gestations, abnormal presentations, and conditions justifying cesarean delivery as defined in Appendix A, Table 11.09 Multiple Gestations, Abnormal Presentations, and Conditions Justifying Cesarean Delivery
- Less than 8 years of age
- Greater than or equal to 65 years of age
- *Gestational Age* < 37 weeks or Unable to Determine (UTD)

**Data Elements:** Visit https://manual.jointcommission.org/releases/TJC2026A1/MIF0167.html.

***If fewer than 10 cases during the reporting period for any race/ethnicity, skip the next question.***

**Question #8b (numerator):** Patients in the denominator with cesarean births by the following races/ethnicities:

- Non-Hispanic White
- Non-Hispanic Black
- Non-Hispanic American Indian or Alaska Native
- Non-Hispanic Asian or Pacific Islander
- Hispanic
- Non-Hispanic Other (including two or more races)
- Unknown

**Included Populations:**
*ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for cesarean birth as defined in Appendix A, Table 11.06 Cesarean Birth

**Excluded Populations:** None

**Data Elements:** Visit https://manual.jointcommission.org/releases/TJC2026A1/MIF0167.html.


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## *Episiotomy Measure Specifications*

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

**Source:** National Quality Forum #0470

**Reporting Period: 12 months**

- Surveys submitted prior to September 1:
  - 01/01/2025 – 12/31/2025
- Surveys (re)submitted on or after September 1:
  - 07/01/2025 – 06/30/2026

Note: The discharge date must be used to determine whether a case falls within the reporting period specified.

Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in CMQCC reports when responding to this subsection of the Survey. Download instructions for using the CMQCC reports on the Survey and CPOE Materials webpage.

**Question #2 (denominator):** Total number of vaginal deliveries during the reporting period, with Excluded Populations removed.

For the purposes of this measure, use the following MS-DRGs to identify a vaginal delivery:

- 768: Vaginal delivery with O.R. procedure except sterilization and/or D&C
- 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

The following APR-DRGs should also be used to identify a vaginal delivery if your hospital 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

The following Tricare DRGs should also be used to identify a vaginal delivery if your hospitals uses Tricare DRG coding:

- 762 Vaginal delivery with sterilization or D&C with MCC
- 763 Vaginal delivery with sterilization or D&C with CC
- 764 Vaginal delivery with sterilization or D&C without CC/MCC
- 768 Vaginal delivery with O.R. procedure except sterilization and/or D&C
- 805 Vaginal delivery without sterilization or D&C with MCC
- 806 Vaginal delivery without sterilization or D&C with CC
- 807 Vaginal delivery without sterilization or D&C without CC/MCC

**Excluded Populations:**
Exclude any cases with the following ICD-10-CM diagnostic code in any field:

- O66.0: Obstructed labor due to shoulder dystocia

**Question #3 (numerator):** Total number of mothers included in question #2 (the denominator) that had an episiotomy procedure performed.

For the purposes of this measure, the following ICD-10-PCS procedure codes should be used for identifying an episiotomy:

- 0W8NXZZ: Division of female perineum, external approach


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## *Process Measures of Quality Measure Specifications*

**Important Notes:**

Note 1: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Note 2: For Maternity Care Process Measures, hospitals with a sufficient sample size (as defined below) can randomly sample for the denominator of each indicator and measure and report adherence based on that sample. Most likely, the numerator criteria for these two measures will require medical chart review if these specific data are not already extracted or coded consistently for other purposes.

### Newborn Bilirubin Screening Prior to Discharge

**Source:** Providence Health

**Reporting Period: 12 months**

- Surveys submitted prior to September 1:
  - 01/01/2025 – 12/31/2025
- Surveys (re)submitted on or after September 1:
  - 07/01/2025 – 06/30/2026

Note: The discharge date must be used to determine whether a case falls within the reporting period specified.

Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in CMQCC reports when responding to this subsection of the Survey. Download instructions for using the CMQCC reports on the Survey and CPOE Materials webpage.

**Sampling:** If you have fewer than 30 cases that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, include ALL of these cases in measuring adherence to the process guidelines. You need NOT use more than 12 months of historical data to increase the eligible cases beyond 30; just measure and report on ALL eligible cases that you have in that reporting period.

If you have more than 30 cases that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, you may randomly sample at least 30 of them for the denominator of each guideline and measure and report adherence based on that sample.

**Question #3 (denominator):** Eligible cases include all normal newborns born at or beyond 35 completed weeks gestation that were delivered in the hospital during the reporting period (all inborns) with **Excluded Populations** removed.

**Excluded Populations:**

- admitted to a neonatal ICU, either at your hospital or another hospital; or
- with parental refusal to test; or
- prenatal documentation of severe congenital anomalies in the newborn and documentation that the newborn will receive comfort care measures only; or
- newborn died prior to discharge

**Question #4 (numerator):** Number of eligible cases included in the denominator who have a serum or transcutaneous bilirubin screen prior to discharge to identify risk of hyperbilirubinemia.

## Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery

**Source:** National Quality Forum #0473

**Reporting Period: 12 months**

- Surveys submitted prior to September 1:
  - 01/01/2025 – 12/31/2025
- Surveys (re)submitted on or after September 1:
  - 07/01/2025 – 06/30/2026

Note: The discharge date must be used to determine whether a case falls within the reporting period specified.

Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in CMQCC reports when responding to this subsection of the Survey. Download instructions for using the CMQCC reports on the Survey and CPOE Materials webpage.

**Sampling:** If you have fewer than 30 cases that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, include ALL of these cases in measuring adherence to the process guidelines. You need NOT use more than 12 months of historical data to increase the eligible cases beyond 30; just measure and report on ALL eligible cases that you have in that reporting period.

If you have more than 30 cases that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, you may randomly sample at least 30 of them for the denominator of each guideline and measure and report adherence based on that sample.

**Question #7 (denominator):** Eligible cases include all women undergoing cesarean delivery during the reporting period.

Include cases with one of the following MS-DRG codes:

- 783: Cesarean section with sterilization with MCC
- 784: Cesarean section with sterilization with CC
- 785: Cesarean section with sterilization without CC/MCC
- 786: Cesarean section without sterilization with MCC
- 787: Cesarean section without sterilization with CC
- 788: Cesarean section without sterilization without CC/MCC

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

- 539: Cesarean section with sterilization
- 540: Cesarean section without sterilization

The following Tricare DRGs should also be used to identify a cesarean delivery if your hospital uses Tricare DRG coding:

- 771 Cesarean section without sterilization with MCC
- 772 Cesarean section without sterilization with CC
- 773 Cesarean section without sterilization without CC/MCC
- 783 Cesarean section with sterilization with MCC
- 784 Cesarean section with sterilization with CC
- 785 Cesarean section with sterilization without CC/MCC

**Excluded Populations:** None.

**Question #8 (numerator)** Number of eligible cases included in the denominator who received pneumatic compression devices prior to surgery.

Note 1: Use of a pneumatic compression device may be documented in the OR log but must be placed pre-operatively to qualify for inclusion in the numerator.

Note 2: Clinical guidelines continue to recommend that patients at high or moderate risk for DVT should also receive appropriate pharmacological prophylaxis in addition to the placement of pneumatic compression devices.

For a list of approved pneumatic compression devices, see the devices listed under "Intermittent Pneumatic Compression Device (IPC)" in Table 2.1 VTE Prophylaxis Inclusion Table.

### *High-Risk Deliveries Measure Specifications*

**Important Notes:**

Note 1: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Note 2: Hospitals should report on the selection from Section 4E question #3 (**either** Volume OR the National Performance Measure (VON)).

### Neonatal Intensive Care Unit(s) – Volume

Hospitals opting to report on Volume should only use ICD-10-CM codes as indicated in the specifications below. When calculating hospital volume, count the number of patients with any one or more of the specified diagnosis codes for high-risk deliveries, subject to the other inclusion/exclusion criteria below. The diagnosis codes may be in any field. The count can include inborn as well as transfer cases.

**Source:** The Leapfrog Group

**Reporting Period: 12 months**

- Surveys submitted prior to September 1:
  - 01/01/2025 – 12/31/2025
- Surveys (re)submitted on or after September 1:
  - 07/01/2025 – 06/30/2026

Note: The discharge date must be used to determine whether a case falls within the reporting period specified.

**Question #5 (Instructions for Volume Reporting)**

**Included Populations:**
Number of newborns admitted to the neonatal ICU with the following ICD-10-CM codes:

| ICD-10-CM Code | Description |
|---|---|
| P05.02 | Newborn light for gestational age, 500-749 grams |
| P05.03 | Newborn light for gestational age, 750-999 grams |
| P05.04 | Newborn light for gestational age, 1000-1249 grams |
| P05.05 | Newborn light for gestational age, 1250-1499 grams |
| P05.12 | Newborn small for gestational age, 500-749 grams |
| P05.13 | Newborn small for gestational age, 750-999 grams |
| P05.14 | Newborn small for gestational age, 1000-1249 grams |
| P05.15 | Newborn small for gestational age, 1250-1499 grams |
| P07.02 | Extremely low birth weight newborn, 500-749 grams |
| P07.03 | Extremely low birth weight newborn, 750-999 grams |

| | |
|---|---|
| P07.14 | Other low birth weight newborn, 1000-1249 grams |
| P07.15 | Other low birth weight newborn, 1250-1499 grams |

**Excluded Populations:** Newborns admitted to the neonatal ICU weighing 1500 grams or more.

### Neonatal Intensive Care Unit(s) – National Performance Measurement

Hospitals participating in the Vermont Oxford Network (VON) may opt to report on the VON National Performance Measure. In order for Leapfrog to obtain the data from VON, the VON data must be finalized, and hospitals must complete the following steps:

1. Provide an accurate VON Transfer Code in the Hospital Profile,
2. Complete a Data Sharing Authorization letter and submit it to VON by **June 15** (Hospitals that submitted their Data Sharing Authorization letter to VON in previous Leapfrog Hospital Survey Cycles do not have to re-submit a new letter in 2026),
3. Select "VON National Performance Measure" in question #3, and
4. Submit the 2026 Leapfrog Hospital Survey by the June 30 Submission Deadline.

Hospitals that select "VON National Performance Measure" in question #3, but do not adhere to the other steps will be scored and publicly reported as "Declined to Report" for the High-Risk Deliveries measure.

Data will be available for review on the Leapfrog Hospital Survey Hospital Details Page beginning on July 12. The VON data Leapfrog obtains can be found in the Vermont Oxford Network's Nightingale Internet Reporting System. Leapfrog has provided instructions for using the VON Nightingale online tool on the Survey and CPOE Materials webpage. These instructions can be used to verify the data that Leapfrog is obtaining from VON, which includes:

| Variable | From the Vermont Oxford Network (SMR Report from Nightingale online tool) |
|---|---|
| Volume | From the latest 12-month standardized mortality or morbidity ratio (SMR) report for Death or Morbidity, the hospital's "N" for the volume of cases for the reporting period. |
| SMR 95% (lower bound) | From the same report, the hospital's "SMR 95% (lower)" for Death or Morbidity. This represents the lower value of your hospital's 95% confidence interval. |
| SMR (shrunken) | From the same report, the hospital's "SMR (shrunken)" for Death or Morbidity. This is the weighted average of the hospital value and the population (Vermont Oxford Network) mean value. |
| SMR 95% (upper bound) | From the same report, the hospital's "SMR 95% (upper)" for Death or Morbidity. This represents the upper value of your hospital's 95% confidence interval. |

#### Deadlines and Reporting Periods

Leapfrog will update the VON data three times per Survey Cycle for all hospitals that have completed the steps noted above according to the deadlines and reporting periods listed in the following table:

| VON Deadline | VON Reporting Period | Leapfrog Survey Submission Date | Review Results |
|---|---|---|---|
| *Hospitals must complete and submit their Data Sharing Authorization letter to VON before this date** | | *VON data will not be publicly reported if hospitals have not submitted by this date* | *Data received from VON will be available to review on the Hospital Details Page or Public Reporting Website by these dates* |
| June 15, 2026 | 2024 | June 30, 2026 | July 12, 2026** |
| August 14, 2026 | 2025*** | August 31, 2026 | September 10, 2026 |
| November 16, 2026 | 2025 | November 30, 2026 | December 9, 2026 |

* Hospitals that successfully submitted a Data Sharing Authorization letter in previous years are not required to submit another letter in 2026
**Data will be published on the Public Reporting Website starting on July 25, 2026.
***Anticipated release of 2025 VON data.

See FAQs for additional information about responding to the questions in this section.

# Section 4: Maternity Care Frequently Asked Questions (FAQs)

1. **Under normal circumstances our hospital does not perform newborn deliveries. However, during the reporting period we had a few emergency situations and/or transfers. Should we indicate delivering newborns during the reporting period?**
   If your hospital does not electively perform newborn deliveries (i.e., no labor/delivery unit, only admit in an emergency situation), you would respond "no" to question #2 in Section 4A, as hospitals are instructed to report inborns only.

2. **Should newborns that are delivered outside of the hospital that are brought to labor and delivery be included in the total number of live births in Section 4A?**
   When calculating the total number of live births in Section 4A question #3, refer to the measure specifications for Maternity Care Volume. Only inborns should be included in the total volume.

3. **Should hospitals use delivery date or discharge date when including births/cases for the measures reported in Section 4: Maternity Care?**
   The discharge date should be used to determine whether a case falls within the reporting period specified.

4. **For the purposes of Section 4A question #6, what qualifies for the different categories of lactation personnel?**
   The National Lactation Consultant Alliance has categories for lactation personnel, with specific qualifications based upon the extent of their education and training.

   - International Board Certified Lactation Consultants® (IBCLCs®) are individuals that are board certified by the International Board of Lactation Consultant Examiners® to provide ***clinical lactation care*** (e.g., clinical assessments, lactation management and feeding plans, referrals to other healthcare practitioners, etc.), as well as education and support to postpartum patients.

   - Lactation consultants, counselors, educators, and/or specialists are individuals that provide basic breastfeeding and lactation teaching, as well as support to postpartum patients. This would include approximately 20 different designations, with an array of lactation-specific education requirements.

   More information on the differing types of personnel can be found here.

5. **In Section 4D, what tools should hospitals use for managing patients that receive a serum or transcutaneous bilirubin screen to assess the risk of hyperbilirubinemia prior to discharge?**
   One example a hospital can use is the Bhutani Nomogram. For an example, please see:
   *American Academy of Pediatrics Clinical Practice Guidelines: Management of Hyperbilirubinemia in the Newborn Infant 35 or More Weeks of Gestation.*
   http://pediatrics.aappublications.org/content/114/1/297.full

   **Tip**: To view any Figure in the reference, click on it to open, then again to enlarge.

   Other tools may also be used if the serum or transcutaneous screen is conducted prior to discharge and risk is managed appropriately.


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6. **In Section 4D, what codes or diagnoses should be used to identify severe congenital anomalies for exclusions for newborn bilirubin screening prior to discharge?**
   Leapfrog's Maternity Care Expert Panel has opted to not overcomplicate the measure by providing ICD-codes for identifying congenital anomalies in the newborn. Instead, we would suggest that you focus on identifying the following exclusions: documentation that the newborn will receive comfort care measures only, which would accompany the prenatal documentation of severe congenital anomalies in the newborn.

   If you have concerns about the level of effort required to identify these exclusions, please note that Leapfrog allows hospitals to report on a sample of 30 cases for those facilities that opt to report on a sample instead of full case reporting. You can find those instructions in the Maternity Care Process Measure Specifications.


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# *SECTION 5: PHYSICIAN AND NURSE STAFFING*

This section includes questions and reference information for Section 5: Physician and Nurse Staffing. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.


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# Section 5: Physician and Nurse Staffing

**Adult and Pediatric ICU Physician Staffing Fact Sheet and Bibliography:**
https://ratings.leapfroggroup.org/measure/hospital/2026/specially-trained-doctors-care-critical-care-patients

**Nursing Workforce Fact Sheet and Bibliography:**
https://ratings.leapfroggroup.org/measure/hospital/2026/nursing-workforce

**Hospitals that do not admit adult critical care patients or operate an adult general medical, surgical, medical/surgical, or neuro ICU should select "No" in question #2 in Section 5A: Adult ICU Physician Staffing and move on to Section 5B: Pediatric ICU Physician Staffing. Hospitals that do not admit pediatric critical care patients or operate a pediatric general medical, surgical, medical/surgical, or neuro ICU should select "No" in question #2 in Section 5B: Pediatric ICU Physician Staffing and move on to Section 5C: Nursing Workforce.**

**Hospitals that regularly admit adult and/or pediatric critical care patients to a mixed acuity unit, should select "Yes" in question #2 in Section 5A: Adult ICU Physician Staffing and/or Section 5B: Pediatric ICU Physician Staffing and respond to all applicable questions. The standard applies to all adult and pediatric general medical, surgical, medical/surgical, and neuro critical care patients (medical and surgical), including those patients in mixed acuity units.**

**For hospitals that have more than one type of ICU that applies to either Section 5A or 5B included in the ICU Physician Staffing standard, where the ICU physician staffing structure may differ among units, hospitals are instructed to report on the ICU with the lowest level of staffing by physicians certified in critical care medicine when responding to questions #1-15 in Section 5A: Adult ICU Physician Staffing and Section 5B: Pediatric ICU Physician Staffing. For example, if the adult neuro ICU is staffed by intensivists at least 8 hours/day, 7 days/week, but the adult surgical ICU is not, the hospital would respond to questions #1-15 in Section 5A based on the adult surgical ICU.**

Section 5 includes questions about the management of critical care patients and the staffing structure of your hospital's adult and pediatric general medical, surgical, medical/surgical, and neuro ICUs, and questions about your hospital's nursing staffing.

**Each hospital achieving the standard for Adult and/or Pediatric ICU Physician Staffing assures that**:
All critical care patients [34] in its General Medical, Surgical, Medical/Surgical, and Neuro ICUs[14] are managed or co-managed [35] by physicians certified in critical care medicine [36] who:

- Are ordinarily present in the ICU [37] during daytime hours for at least 8 hours per day, 7 days per week, and during this time provide clinical care exclusively[37] in the ICU
  OR
- Are present via telemedicine [38], in combination with on-site intensivist coverage, for a total of 24 hours per day, 7 days per week; meet all of Leapfrog's ICU requirements for intensivist presence in the ICU via telemedicine; and supported by an on-site intensivist who establishes and revises the daily care plan for each ICU patient, **and**
- At other times*
  - Return more than 95% of ICU calls within 5 minutes, based on a quantified analysis [39] of notification device response time; and
  - Can rely on a physician, physician assistant, nurse practitioner[42], or an FCCS-certified nurse "effector" [40] who is in the hospital and able to reach ICU patients within 5 minutes in more than 95% of cases, based on a quantified hospital analysis of response time of the effector reaching the patient.

*Not applicable for hospitals with 24/7 intensivist coverage.

**Each hospital achieving the standard for Total Nursing Care Hours per Patient Day:**
Has a ratio of total nursing care hours per patient day that is greater than or equal to the 50th percentile (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, mixed acuity, pediatric, or critical access hospital).

**Each hospital achieving the standard for RN Hours per Patient Day:**
Has a ratio of RN hours per patient day that is greater than or equal to the 50th percentile (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, mixed acuity, pediatric, or critical access hospital).

**Each hospital achieving the standard for Percentage of RNs who are BSN-Prepared:**
Has a percentage of RNs who are BSN-prepared that is greater than or equal to 80%.

**Download the 2026 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.**


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# 5A: Adult ICU Physician Staffing

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Notes:**

Note 1: Each of the endnotes referenced in the questions below must be reviewed before responding to each question.

Note 2: Some intensivist "presence" may be accomplished via tele-intensivists per Leapfrog's specifications (More Information[38]). However, at this time hospitals cannot achieve the standard through the sole use of tele-intensivists.

Note 3: On an interim basis, other categories of physicians may be considered by Leapfrog to be "certified in Critical Care Medicine" (More Information[36]).

Note 4: The standard applies to all adult general medical, surgical, medical/surgical, and neuro critical care patients (medical and surgical), including those patients in mixed acuity units.

**Reporting Period: 3 months**
Answer questions #1-15 based on the staffing structure currently in place at the time that you submit this section of the Survey. The staffing structure should have been in place for at least the past 3 months and reflect the ordinary staffing structure for each applicable ICU.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

| | |
|---|---|
| 1) What is the latest 3-month reporting period for which your hospital is submitting responses to this section? 3 months ending: | _____<br>*Format: Month/Year* |
| 2) Does your hospital operate any adult General Medical, Surgical, Medical/Surgical, or Neuro ICUs[14]?<br><br>*If your hospital has more than one applicable adult ICU, respond to all questions in this section based on the adult ICU that has the lowest level of staffing by physicians certified in critical care medicine (More Information[14]).*<br><br>*If your hospital does not operate an applicable adult ICU but regularly admits adult critical care patients to mixed acuity units, select "yes" and respond to the remaining questions in Section 5A.*<br><br>*If "no" to question #2, skip the remaining questions in Section 5A and continue to the next subsection. The hospital will be scored as "Does Not Apply."* | ○ Yes<br>○ No |
| 3) Is the ICU staffed with physicians who are certified in critical care medicine[36] and present on-site or via telemedicine?<br><br>*If "no, the ICU is not staffed with any physicians certified in critical care medicine" to question #3, skip the remaining* | ○ Yes, the ICU is staffed with physicians certified in critical care medicine<br>○ Yes, the ICU is staffed with physicians certified in critical care medicine |

| | |
|---|---|
| *questions in Section 5A and continue to the next subsection. This hospital will be scored as "Limited Achievement."* | based on Leapfrog's expanded definition<br>○ No, the ICU is not staffed with any physicians certified in critical care medicine |
| 4) Do the physicians who are certified in critical care medicine[36] (whether present on-site or via telemedicine) manage or co-manage all critical care patients[34] in the ICU?<br><br>*If "no" to question #4, skip questions #5-11 and continue to question #12.* | ○ Yes, all patients are managed or co-managed by a physician certified in critical care medicine when the physician is present (on-site or via telemedicine)<br>○ No, not all patients are managed or co-managed by a physician certified in critical care medicine when the physician is present (on-site or via telemedicine) |

*There are currently two different options to achieve Leapfrog's ICU Physician Staffing Standard: on-site intensivist coverage for 8 hours a day/7 days per week or 24/7 tele-intensivist coverage with some daily on-site intensivist coverage. Questions #5 and #6 are meant to differentiate between these two options; however, they are both worth the same credit. Hospitals that have 24/7* ***on-site*** *intensivist coverage, and who meet all the criteria listed, should respond "yes" to question #5.*

| | |
|---|---|
| 5) Are all critical care patients[34] in the ICU managed or co-managed[35] by one or more physicians certified in critical care medicine[36] who meet **all** the following criteria:<br>• ordinarily present[37] **on-site** in the ICU during daytime hours;<br>• for at least **8 hours per day, 7 days per week**; and<br>• providing clinical care exclusively[37] in the ICU during these hours?<br><br>*If "yes" to question #5, skip question #6 and continue to question #7.* | ○ Yes<br>○ No |
| 6) Are all critical care patients[34] in the ICU managed or co-managed[35] by one or more physicians certified in critical care medicine[36] who meet **all** the following criteria:<br>• present via telemedicine, in combination with on-site intensivist coverage, for a total of **24 hours per day, 7 days per week**;<br>• meet all of Leapfrog's ICU requirements for intensivist presence in the ICU via telemedicine (More Information[38]); and<br>• supported by an on-site intensivist who establishes and revises the daily care plan for each ICU patient? | ○ Yes<br>○ No |

*If "no" to question #5 and question #6, skip questions #7-8 and continue to question #9.*

| | |
|---|---|
| 7) When the physicians (from question #3) are not present in the ICU on-site or via telemedicine, do they return more than 95% of calls/pages/texts from these units within five minutes, based on a quantified analysis[39] of notification device response time? (More information on the use of telemedicine to cover calls [41]) | ○ Yes<br>○ No<br>○ Not applicable; intensivists are present on-site 24/7 |

| | |
|---|---|
| 8) When the physicians (from question #3) are not present on-site in the ICU or not able to physically reach an ICU patient within 5 minutes, can they rely on a physician, physician assistant, nurse practitioner [42], or FCCS-certified nurse or intern "effector"[40] who is in the hospital and able to reach these ICU patients within five minutes in more than 95% of the cases, based on a quantified analysis[39] of response time of the effector reaching the patient? | ○ Yes<br>○ No<br>○ Not applicable; intensivists are present on-site 24/7 |

*If "no" to either question #7 or #8 in this section, continue to questions #9-15. If "yes" or "not applicable; intensivists are present on-site 24/7" to questions #7 and #8, skip the remaining questions in Section 5A and continue to the next subsection.*

| | |
|---|---|
| 9) Are all critical care patients[34] in the ICU managed or co-managed[35] by one or more physicians certified in critical care medicine[36] who meet **all** the following criteria:<br>• ordinarily present[37] on-site in the ICU during daytime hours;<br>• for at least **8 hours per day, 4 days per week or 4 hours per day, 7 days per week**; and<br>• providing clinical care exclusively[37] in the ICU during these hours? | ○ Yes<br>○ No |
| 10) Are all critical care patients[34] in the ICU managed or co-managed[35] by one or more physicians certified in critical care medicine[36] who meet **all** the following criteria:<br>• present via telemedicine for **24 hours per day, 7 days per week**;<br>• meet all of Leapfrog's modified ICU requirements for intensivist presence in the ICU via telemedicine (More Information [43]); and<br>• supported in the establishment and revision of daily care planning for each ICU patient by an on-site intensivist, hospitalist, anesthesiologist, or physician trained in emergency medicine? | ○ Yes<br>○ No |
| 11) Are all critical care patients[34] in the ICU managed or co-managed[35] by one or more physicians certified in critical care medicine[36] who are:<br>• on-site at least **4 days per week** to establish or revise daily care plans for each critical care patient in the ICU? | ○ Yes<br>○ No |

*If "yes" to question #9, #10, or #11, skip question #12 and continue to question #13.*

| | |
|---|---|
| 12) If not all critical care patients[34] are managed or co-managed[35] by physicians certified in critical care medicine[36], either on-site or via telemedicine[38], are **some critical care patients** managed or co-managed by these physicians who are:<br>• ordinarily present[37] on-site in the ICU during daytime hours;<br>• for at least **8 hours per day, 4 days per week or 4 hours per day, 7 days per week**; and<br>• providing clinical care exclusively[37] in the ICU during these hours? | ○ Yes<br>○ No |
| 13) Does an on-site clinical pharmacist do **all** the following:<br>• at least 5 days per week, makes daily on-site rounds on all critical care patients[34] in the ICU; and<br>• on the other 2 days per week, returns more than 95% of calls/pages/texts from the unit within 5 minutes, based on a quantified analysis[39] of notification device response time;<br>**OR**<br>• makes daily on-site rounds on all critical care patients[34] in the ICU 7 days per week? | ○ Yes<br>○ No<br>○ Clinical pharmacist rounds 7 days per week |

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| 14) Does a physician certified in critical care medicine[36] lead daily interprofessional rounds on-site on all critical care patients[34] in the ICU 7 days per week? | ○ Yes<br>○ No |
| 15) Are physicians certified in critical care medicine[36] responsible for all ICU admission and discharge decisions when they are:<br>• present on-site for at least **8 hours per day, 4 days per week or 4 hours per day, 7 days per week**? | ○ Yes<br>○ No |

# 5B: Pediatric ICU Physician Staffing

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Notes:**

Note 1: Each of the endnotes referenced in the questions below must be reviewed before responding to each question.

Note 2: Some intensivist "presence" may be accomplished via tele-intensivists per Leapfrog's specifications (More Information[38]). However, at this time hospitals cannot achieve the standard through the sole use of tele-intensivists.

Note 3: On an interim basis, other categories of physicians may be considered by Leapfrog to be "certified in Critical Care Medicine" (More Information[36]).

Note 4: The standard applies to all pediatric general medical, surgical, medical/surgical, and neuro critical care pediatric patients (medical and surgical), including those pediatric patients in mixed acuity units.

**Reporting Period: 3 months**
Answer questions #1-15 based on the staffing structure currently in place at the time that you submit this section of the Survey. The staffing structure should have been in place for at least the past 3 months and reflect the ordinary staffing structure for each applicable ICU.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

| | |
|---|---|
| 1) What is the latest 3-month reporting period for which your hospital is submitting responses to this section? 3 months ending: | _____<br>*Format: Month/Year* |
| 2) Does your hospital operate any pediatric General Medical, Surgical, Medical/Surgical, or Neuro ICUs[14]?<br><br>*If your hospital has more than one applicable pediatric ICU, respond to all questions in this section based on the pediatric ICU that has the lowest level of staffing by physicians certified in critical care medicine (More Information[14]).*<br><br>*If your hospital does not operate an applicable pediatric ICU but regularly admits critical care pediatric patients to mixed acuity units, select "yes" and respond to the remaining questions in Section 5B.*<br><br>*If "no" to question #2, skip the remaining questions in Section 5B and continue to the next subsection. The hospital will be scored as "Does Not Apply."* | ○ Yes<br>○ No |

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| 3) Is the ICU staffed with physicians who are certified in critical care medicine[36] and present on-site or via telemedicine?<br><br>*If "no, the ICU is not staffed with any physicians certified in critical care medicine" to question #3, skip the remaining questions in Section 5B and continue to the next subsection. This hospital will be scored as "Limited Achievement."* | ○ Yes, the ICU is staffed with physicians certified in critical care medicine<br>○ Yes, the ICU is staffed with physicians certified in critical care medicine based on Leapfrog's expanded definition<br>○ No, the ICU is not staffed with any physicians certified in critical care medicine |
| 4) Do the physicians who are certified in critical care medicine[36] (whether present on-site or via telemedicine) manage or co-manage all critical care patients[34] in the ICU?<br><br>*If "no" to question #4, skip questions #5-11 and continue to question #12.* | ○ Yes, all patients are managed or co-managed by a physician certified in critical care medicine when the physician is present (on-site or via telemedicine)<br>○ No, not all patients are managed or co-managed by a physician certified in critical care medicine when the physician is present (on-site or via telemedicine) |

*There are currently two different options to achieve Leapfrog's ICU Physician Staffing Standard: on-site intensivist coverage for 8 hours a day/7 days per week or 24/7 tele-intensivist coverage with some daily on-site intensivist coverage. Questions #5 and #6 are meant to differentiate between these two options; however, they are both worth the same credit. Hospitals that have 24/7* ***on-site*** *intensivist coverage, and who meet all the criteria listed, should respond "yes" to question #5.*

| | |
|---|---|
| 5) Are all critical care patients[34] in the ICU managed or co-managed[35] by one or more physicians certified in critical care medicine[36] who meet **all** the following criteria:<br>• ordinarily present[37] **on-site** in the ICU during daytime hours;<br>• for at least **8 hours per day, 7 days per week**; and<br>• providing clinical care exclusively[37] in the ICU during these hours?<br><br>*If "yes" to question #5, skip question #6 and continue to question #7.* | ○ Yes<br>○ No |
| 6) Are all critical care patients[34] in the ICU managed or co-managed[35] by one or more physicians certified in critical care medicine[36] who meet **all** the following criteria:<br>• present via telemedicine, in combination with on-site intensivist coverage, for a total of **24 hours per day, 7 days per week**;<br>• meet all of Leapfrog's ICU requirements for intensivist presence in the ICU via telemedicine (More Information[38]); and<br>• supported by an on-site intensivist who establishes and revises the daily care plan for each ICU patient? | ○ Yes<br>○ No |

*If "no" to question #5 and question #6, skip questions #7-8 and continue to question #9.*


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| 7) When the physicians (from question #3) are not present in the ICU on-site or via telemedicine, do they return more than 95% of calls/pages/texts from these units within five minutes, based on a quantified analysis[39] of notification device response time? (More information on the use of telemedicine to cover calls[41]) | ○ Yes<br>○ No<br>○ Not applicable; intensivists are present on-site 24/7 |
| 8) When the physicians (from question #3) are not present on-site in the ICU or not able to physically reach an ICU patient within 5 minutes, can they rely on a physician, physician assistant, nurse practitioner[42], or FCCS-certified nurse or intern "effector"[40] who is in the hospital and able to reach these ICU patients within five minutes in more than 95% of the cases, based on a quantified analysis[39] of response time of the effector reaching the patient? | ○ Yes<br>○ No<br>○ Not applicable; intensivists are present on-site 24/7 |

*If "no" to either question #7 or #8 in this section, continue to questions #9-15. If "yes" or "not applicable; intensivists are present on-site 24/7" to questions #7 and #8, skip the remaining questions in Section 5B and continue to the next subsection.*

| | |
|---|---|
| 9) Are all critical care patients[34] in the ICU managed or co-managed[35] by one or more physicians certified in critical care medicine[36] who meet **all** the following criteria:<br>• ordinarily present[37] on-site in the ICU during daytime hours;<br>• for at least **8 hours per day, 4 days per week or 4 hours per day, 7 days per week**; and<br>• providing clinical care exclusively[37] in the ICU during these hours? | ○ Yes<br>○ No |
| 10) Are all critical care patients[34] in the ICU managed or co-managed[35] by one or more physicians certified in critical care medicine[36] who meet **all** the following criteria:<br>• present via telemedicine for **24 hours per day, 7 days per week**;<br>• meet all of Leapfrog's modified ICU requirements for intensivist presence in the ICU via telemedicine (More Information[43]); and<br>• supported in the establishment and revision of daily care planning for each ICU patient by an on-site intensivist, hospitalist, anesthesiologist, or physician trained in emergency medicine? | ○ Yes<br>○ No |
| 11) Are all critical care patients[34] in the ICU managed or co-managed[35] by one or more physicians certified in critical care medicine[36] who are:<br>• on-site at least **4 days per week** to establish or revise daily care plans for each critical care patient in the ICU? | ○ Yes<br>○ No |

*If "yes" to question #9, #10, or #11, skip question #12 and continue to question #13.*

| | |
|---|---|
| 12) If not all critical care patients[34] are managed or co-managed[35] by physicians certified in critical care medicine[36], either on-site or via telemedicine[38], are **some critical care patients** managed or co-managed by these physicians who are:<br>• ordinarily present[37] on-site in the ICU during daytime hours;<br>• for at least **8 hours per day, 4 days per week or 4 hours per day, 7 days per week**; and<br>• providing clinical care exclusively[37] in the ICU during these hours? | ○ Yes<br>○ No |

| | |
|---|---|
| 13) Does an on-site clinical pharmacist do **all** the following:<br>• at least 5 days per week, makes daily on-site rounds on all critical care patients[34] in the ICU; and<br>• on the other 2 days per week, returns more than 95% of calls/pages/texts from the unit within 5 minutes, based on a quantified analysis[39] of notification device response time;<br>**OR**<br>• makes daily on-site rounds on all critical care patients[34] in the ICU 7 days per week? | ○ Yes<br>○ No<br>○ Clinical pharmacist rounds 7 days per week |
| 14) Does a physician certified in critical care medicine[36] lead daily interprofessional rounds on-site on all critical care patients[34] in the ICU 7 days per week? | ○ Yes<br>○ No |
| 15) Are physicians certified in critical care medicine[36] responsible for all ICU admission and discharge decisions when they are:<br>• present on-site for at least **8 hours per day, 4 days per week or 4 hours per day, 7 days per week**? | ○ Yes<br>○ No |

# 5C: Nursing Workforce

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

### *Total Nursing Care Hours per Patient Day and RN Hours per Patient Day*

**Important Notes:**

Note 1: If a hospital operates single acuity Medical, Surgical, or Med-Surg units, but all of these units had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period, then the hospital should respond "yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period" in questions #4, #6 and #8, and then report on mixed acuity Medical, Surgical and Med-Surg units, if applicable, in questions #10-12.

Note 2: Hospitals that operate at least one single acuity Medical, Surgical, or Med-Surg unit **AND** at least one mixed acuity Medical, Surgical, or Med-Surg Unit have the option to respond to question #14 to report on their mixed acuity units. Responses to these questions are optional and will not be scored or publicly reported.

**Specifications:** See ***Nursing Workforce Measure Specifications*** in the Reference Information beginning on page 198.

**Reporting Period: 12 months**

- Survey submitted prior to September 1:
  - 01/01/2025 – 12/31/2025
- Surveys submitted on or after September 1:
  - 07/01/2025 – 06/30/2026

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

| | |
|---|---|
| 1) 12-month reporting period used: | ○ 01/01/2025 – 12/31/2025<br>○ 07/01/2025 – 06/30/2026 |
| 2) Did your hospital calculate total number of patient days, total number of productive hours worked by employed and contracted nursing staff with direct patient care responsibilities (RN, LPN/LVN, and UAP), and total number of productive hours worked by RN nursing staff with direct patient care responsibilities for the reporting period in single or mixed acuity Medical, Surgical, and/or Med-Surg Units, and do you choose to report those data to this Survey?<br><br>*If "no" to question #2, skip questions #3-16 and continue to question #17. The hospital will be scored as "Did Not Measure."*<br><br>*If "does not apply; hospital does not operate applicable units," skip questions #3-16 and continue to question #17. The hospital will be scored as "Does Not Apply."* | ○ Yes<br>○ No<br>○ Does not apply; hospital does not operate applicable units |
| 3) Which method did your hospital use to calculate the total number of patient days for each single acuity Medical, Surgical, Med-Surg or mixed acuity Medical, Surgical or Med-Surg Unit? | ○ Midnight census (including observation patients)<br>○ Midnight census and patient days from actual hours for short stay patients |

| | |
|---|---|
| | ○ Patient days from actual hours<br>○ Patient days from multiple census reports |

| | |
|---|---|
| 4) Does your hospital operate any adult or pediatric single acuity Medical Units?<br><br>*A single acuity unit is defined as a unit where at least 90% of the patients receive the same level of care.*<br><br>*If "no" or "yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period" to question #4, skip question #5 and continue to question #6.* | ○ Yes<br>○ No<br>○ Yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period |

5) Enter your hospital's responses for each quarter for all adult and pediatric single acuity Medical Units for the reporting period selected in question #1:

| | **(a)** Total number of patient days: | **(b)** Total number of productive hours worked by employed and contracted **nursing staff (RN, LPN/LVN, and UAP)** with direct patient care responsibilities: | **(c)** Total number of productive hours worked by **RN nursing staff** with direct patient care responsibilities: |
|---|---|---|---|
| Quarter 1 | | | |
| Quarter 2 | | | |
| Quarter 3 | | | |
| Quarter 4 | | | |

| | |
|---|---|
| 6) Does your hospital operate any adult or pediatric single acuity Surgical Units?<br><br>*A single acuity unit is defined as a unit where at least 90% of the patients receive the same level of care.*<br><br>*If "no" or "yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period," skip question #7 and continue to question #8.* | ○ Yes<br>○ No<br>○ Yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period |

7) Enter your hospital's responses for each quarter for all adult and pediatric single acuity Surgical Units for the reporting period selected in question #1:

| | **(a)** Total number of patient days: | **(b)** Total number of productive hours worked by employed and contracted **nursing staff (RN, LPN/LVN, and UAP)** with direct patient care responsibilities: | **(c)** Total number of productive hours worked by **RN nursing staff** with direct patient care responsibilities: |
|---|---|---|---|
| Quarter 1 | | | |
| Quarter 2 | | | |
| Quarter 3 | | | |
| Quarter 4 | | | |

| | |
|---|---|
| 8) Does your hospital operate any adult or pediatric single acuity Med-Surg Units?<br><br>*A single acuity unit is defined as a unit where at least 90% of the patients receive the same level of care.*<br><br>*If "no" or "yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period," skip question #9 and continue to question #10.* | ○ Yes<br>○ No<br>○ Yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period |

9) Enter your hospital's responses for each quarter for all adult and pediatric single acuity Med-Surg Units for the reporting period selected in question #1:

| | **(a)** Total number of patient days: | **(b)** Total number of productive hours worked by employed and contracted **nursing staff (RN, LPN/LVN, and UAP)** with direct patient care responsibilities: | **(c)** Total number of productive hours worked by **RN nursing staff** with direct patient care responsibilities: |
|---|---|---|---|
| Quarter 1 | | | |
| Quarter 2 | | | |
| Quarter 3 | | | |
| Quarter 4 | | | |

| | |
|---|---|
| 10) Does your hospital operate at least one adult or pediatric mixed acuity Medical, Surgical or Med-Surg Unit?<br><br>*A mixed acuity unit is defined as a unit where more than 10% of patients receive varying levels of care.*<br><br>*If "no" or "yes, but had fewer than 15 patients days per month for all 3 months of any quarter of the reporting period," skip questions #11-12.* | ○ Yes<br>○ No<br>○ Yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period |

*If "yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period" to questions #4, #6, and #8 and "yes" to question #10, continue to questions #11-12 and report on your mixed acuity unit(s).*

*Hospitals that operate both single and mixed acuity units can optionally report on their mixed acuity units in question #14.*

| | |
|---|---|
| 11) What type(s) of adult or pediatric mixed acuity Medical, Surgical, or Med-Surg Units does your hospital operate?<br><br>*Select all that apply.*<br><br>*A High Acuity Unit is a mixed acuity unit in which 50-89% of the patients are critical care **and** the remaining 11-49% can be any other acuity level.*<br><br>*A Moderate Acuity Unit is a mixed acuity unit in which 25-49% of the patients are critical care **OR** 50-89% of the patients are step down care. The remaining percentage can be any other acuity level.* | ☐ High Acuity<br>☐ Moderate Acuity<br>☐ Blended Acuity |


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| | |
|---|---|
| *A Blended Acuity Unit is a mixed acuity acute care unit in which less than 90% of the patients receive a single acuity level of care, less than 50% receive step down care, **and** less than 25% receive critical care.* | |

12) Enter your hospital's responses for each quarter for all adult and pediatric mixed acuity Medical, Surgical, and Med-Surg Units for the reporting period selected in question #1:

| | **(a)** Total number of patient days: | **(b)** Total number of productive hours worked by employed and contracted **nursing staff (RN, LPN/LVN, and UAP)** with direct patient care responsibilities: | **(c)** Total number of productive hours worked by **RN nursing staff** with direct patient care responsibilities: |
|---|---|---|---|
| Quarter 1 | | | |
| Quarter 2 | | | |
| Quarter 3 | | | |
| Quarter 4 | | | |

***Additional Questions (Optional – Fact-Finding Only)***

| | |
|---|---|
| 13) Does your hospital currently utilize virtual nursing to perform direct patient care responsibilities in the units from questions #4-11? | ○ Yes<br>○ No |

Hospitals that operate Adult or Pediatric **Single** Acuity Medical, Surgical, or Med-Surg Units will be scored and publicly reported based on questions #4, #6, and/or #8.

Reporting on Mixed Acuity units in question #14 is optional and responses will not be scored or publicly reported in 2026; however, responses will be used to inform potential updates for 2027.

14) Enter your hospital's responses for each quarter for all adult and pediatric mixed acuity Medical, Surgical, and Med-Surg Units for the reporting period selected in question #1:

| | **(a)** Total number of patient days: | **(b)** Total number of productive hours worked by employed and contracted **nursing staff (RN, LPN/LVN, and UAP)** with direct patient care responsibilities: | **(c)** Total number of productive hours worked by **RN nursing staff** with direct patient care responsibilities: |
|---|---|---|---|
| Quarter 1 | | | |
| Quarter 2 | | | |
| Quarter 3 | | | |
| Quarter 4 | | | |


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### *NQF Safe Practice #9 – Nursing Workforce*

**Important Note:** Hyperlinks in question #16 refer to the Patient Safety Practices FAQs beginning on page 250, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

**Specifications:** See ***NQF Safe Practice Measure Specifications*** in the Reference Information beginning on page 212.

| | |
|---|---|
| 15) Is your hospital currently recognized as an American Nurses Credentialing Center (ANCC) Magnet® organization or a 2020 or 2024 Pathway to Excellence® organization?<br><br>*If "yes, our hospital is a current American Nurses Credentialing Center (ANCC) Magnet® organization" or "yes, our hospital is a 2020 or 2024 Pathway to Excellence® organization," skip question #16, and continue to question #17.*<br><br>*Pathway to Excellence® hospitals that have not received either the 2020 or 2024 designation must select "no."* | ○ Yes, our hospital is a current American Nurses Credentialing Center (ANCC) Magnet® organization<br>○ Yes, our hospital is a 2020 or 2024 Pathway to Excellence® organization<br>○ No |
| 16) Within the last 12 months, to ensure adequate and competent nursing staff service and nursing leadership at all levels, our organization has: | |
| a. held nursing leadership directly accountable for improvements in performance through performance reviews or compensation. | ○ Yes<br>○ No |
| b. included nursing leadership as part of the hospital senior administrative leadership team. | ○ Yes<br>○ No |
| c. held the board (governance) and senior administrative leadership accountable for the provision of financial resources to ensure adequate nurse staffing levels. | ○ Yes<br>○ No |
| d. budgeted financial resources for balancing staffing levels and skill levels to improve performance. | ○ Yes<br>○ No |
| e. developed a staffing plan, with input from nurses, to ensure that adequate nursing staff-to-patient ratios are achieved. | ○ Yes<br>○ No |

### *Percentage of RNs who are BSN-Prepared*

**Specifications:** See ***Nursing Workforce Measure Specifications*** in the Reference Information beginning on page 237.

**Reporting Period: 12 months**
Answer questions #17-19 based on the most recent day within the last 12-months for which you have complete data.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

| | |
|---|---|
| 17) Did your hospital calculate the Percentage of RNs who are BSN-Prepared measure for the reporting period, and do you choose to report those data to this Survey?<br><br>*If "no" to question #17, skip the remaining questions in Section 5C and go to the Affirmation of Accuracy. The hospital will be scored as "Did Not Measure."* | ○ Yes<br>○ No |
| 18) Total number of employed RN nursing staff at the hospital with direct patient care responsibilities: | _____ |
| 19) Total number of employed RN nursing staff at the hospital with direct patient care responsibilities who have a BSN degree or higher (e.g., MSN, DNP, PhD): | _____ |

**Affirmation of Accuracy:**

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Physician and Nurse Staffing Section at our hospital, and I hereby affirm that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this affirmation on behalf of our hospital.

The hospital and I acknowledge that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also acknowledge that analyses and ratings The Leapfrog Group derives from this information will be made public on the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade website, and/or other Leapfrog Group published works, products and services. The hospital and I acknowledge that analyses and ratings derived from this information and all intellectual property rights related to those analyses and ratings shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. I hereby affirm that this information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may license analyses and ratings derived from this information to other entities including researchers, not-for-profit entities, and for-profit entities, and the revenue from such licensure will be used solely to support The Leapfrog Group's not-for-profit mission. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
*(first name and last name)* *(title)*
on _____.
*(date)*

# Section 5: Physician and Nurse Staffing Reference Information

## *What's New in the 2026 Survey*

### Section 5A: Adult ICU Physician Staffing and Section 5B: Pediatric ICU Physician Staffing

There are no changes to these subsections.

### Section 5C: Nursing Workforce

There are three major changes planned for 2026 and additional clarifications to the measure specifications regarding applicable units.

First, all hospitals will be required to report on whether they operate any mixed acuity medical, surgical and/or med-surg units, and if they do, the types of mixed acuity units (high, moderate and/or blended). Hospitals that operate **both** single and mixed acuity units can then **optionally** report on nursing hours in their mixed acuity unit(s) but will continue to ONLY be scored on the **single** acuity units. An analysis of the data collected in 2026 and anticipated key informant interviews with Survey participants will help determine if additional updates to scoring and public reporting should be proposed for 2027. This change is the first step in responding to hospital requests to earn credit for their staffing of both single and mixed acuity units.

Hospitals that operate only one single acuity unit, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period will be asked to report on their mixed acuity medical, surgical and/or medsurg units (if applicable) and will be scored and publicly reported on those units.

Second, Leapfrog is temporarily pausing public reporting of the Nursing Skill Mix measure (the proportion of total nursing hours worked by registered nurses), as the Nursing Workforce Expert Panel further examines the relationship between this measure and the Total Nursing Care Hours Per Patient Day and Total RN Hours Per Patient Day measures.

Third, Leapfrog is adding a new optional fact-finding question to assess hospital's use of virtual nursing models, which will not be scored or publicly reported in 2026.

Leapfrog has also added a clarification to the measure specifications for hospitals that operate Single Acuity MedSurg Units: OB and Med-Surg Units, which are defined as combination units in which greater than 50% of the patients are obstetric and the remaining percent are adult acute med-surg such as gynecological and/or pediatric acute med-surg, should be excluded.

For the 2027 Leapfrog Hospital Survey, Leapfrog and the National Database of Nursing Quality Indicators (NDNQI) are exploring options that would allow active NDNQI clients to authorize Leapfrog to access their data directly from the NDNQI database, eliminating the need for clients to request reports from NDNQI.

There are no changes to the scoring algorithm for Section 5C: Nursing Workforce.

## *Change Summary Since Release*

None. If substantive changes are made to this section of the Survey after release on April 1, 2026, they will be documented in this Change Summary section.


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## *Nursing Workforce Measure Specifications*

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

### Total Nursing Care Hours per Patient Day and RN Hours per Patient Day Measure Specifications

**Source:** American Nurses Association (ANA) (National Quality Forum #0205)

**Reporting Period: 12 months**

- Survey submitted prior to September 1:
  - 01/01/2025 – 12/31/2025
- Surveys submitted on or after September 1:
  - 07/01/2025 – 06/30/2026

**Hospitals that report this data to NDNQI® (National Database of Nursing Quality Indicators®):**
Data for this measure can be obtained directly from NDNQI. See details below.

Hospitals that submit nursing care hours and patient days to NDNQI will be able to respond to questions #2 - 13 in Section 5C. Active NDNQI clients should email NDNQISupport@PressGaney.com or call 855-304-9788 to connect with one of NDNQI's team members and specify that they are requesting support for the purposes of Leapfrog Hospital Survey reporting on Total Nursing Care Hours per Patient Day and RN Hours per Patient Day. For 2026, additional support for these calculations for active NDNQI clients with eligible data will be provided at no additional cost.

For NDNQI units to include, please reach out directly to ndnqisupport@pressganey.com.

**Hospitals that do not report this data to NDNQI:**
Data for this measure can be obtained using the measure specifications below.

**Question #3: Which method did your hospital use to calculate the total number of patient days for each single acuity Medical, Surgical, Med-Surg or mixed acuity Medical, Surgical or Med-Surg Unit?**

- **Midnight Census (including observation patients):** The sum of the daily midnight census counts (the number of ***all*** patients on the unit at midnight each day) during the reporting period. Short stay patients (who are in and out of the unit before the census count is taken) should be included; otherwise, this method cannot be used.
- **Midnight Census and Patient Days from Actual Hours for Short Stay Patients:** A combination of Midnight Census and Patient Days from Actual Hours collected during the reporting period.
- **Patient Days from Actual Hours:** The sum of the actual hours for all patients during the reporting period divided by 24; typically obtained from an accounting system that tracks the actual time spent in the hospital by each patient.
- **Patient Days from Multiple Census Reports:** The sum of the daily average censuses collected during the reporting period; typically collected multiple times per day (e.g., every 4 hours or each shift).

Note: Patient days should be calculated to include all patients in adult and pediatric single acuity Medical, Surgical, Med-Surg or mixed acuity Medical, Surgical or Med-Surg Units. This includes patients that do not have inpatient status (i.e., observation patients).


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**Single Acuity Adult or Pediatric Medical, Surgical, or Med-Surg Units (questions #4-9)**

**Question #4: Does your hospital operate any adult or pediatric single acuity Medical Units?**

**Single Acuity Medical Unit (adult and pediatric):**
A single acuity general care unit in which at least 90% of the patients are admitted to medical services, such as internal medicine, oncology, or cardiology. Medical specialty units such as Cardiac Medical, GI Medical, Infectious Disease Medical, Neurology Medical, Hematology/Oncology Medical, Renal Medical, and Respiratory Medical, are also included.

Note: For the purposes of these measures, Leapfrog has aligned with NDNQI, which defines units based on the acuity of the patients being cared for in the unit, and not the equipment being used. Telemetry is considered a monitoring tool rather than an evaluation of a patient's level of acuity. For example, a unit that has all telemetry patients may still have a general population level of patients that would meet NDNQI's definition of a medical, surgical, or med-surg unit. Hospitals should evaluate the actual acuity of the patients in each unit to determine the appropriate unit designation.

**Excluded units:**

- Labor and Delivery
- Neonatal
- Critical Access (a unit where more than 10% of beds are for skilled nursing (swing beds))
- Rehabilitation
- Psychiatric
- Perioperative
- Critical Care
- Step Down/Progressive
- Hospice
- Mixed Acuity Units: a unit where more than 10% of the patients in the unit receive varying levels of care (e.g., general medical care and progressive care or intensive care)
- Units with fewer than 15 patient days per month for all 3 months of any quarter of the reporting period
- Units that transitioned to an excluded unit type during the reporting period (e.g., a single acuity Medical Unit transitioned to a critical care unit during the reporting period)

**Question #5: Single Acuity Medical Units**
Enter your hospital's responses for each quarter for all adult and pediatric single acuity **Medical Units** for the reporting period selected in question #1.

**Question #5(a):** Total number of patient days across all adult and pediatric single acuity **Medical Units** during each quarter of the reporting period based on your hospital's method for counting patient days.

Patient days should be calculated to include all patients in adult and pediatric single acuity Medical Units. This includes patients that do not have inpatient status (i.e., observation patients).

**Question #5(b):** Total number of productive hours worked by employed and contracted **nursing staff (RN, LPN/LVN, and UAP)** with direct patient care responsibilities in all adult and pediatric single acuity **Medical Units** during each quarter of the reporting period.

**Productive Hours**

**Include** the following hours worked by employed and contracted RNs, LPN/LVNs, and UAPs:

- Actual direct patient care hours worked by nursing staff
- Overtime spent performing direct patient care
- Orientation hours for new hires that are considered part of the unit's staffing matrix, whose work hours are charged to the unit's cost center, and who would be replaced if they called out sick
- Sitter hours authorized for both physical touch and direct patient care intervention

**Exclude** the following hours worked by employed and contracted RN, LPN/LVN, and UAP:


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- Budgeted or scheduled hours
- Vacation time, sick time, education leave, or committee time
- Orientation hours for new hires that are not considered part of the unit's staffing matrix, whose work hours are not charged to the unit's cost center, and would not be replaced if they call out sick
- Hours from when the unit was staffed but there were no patients in the unit
    - If these nursing hours cannot be removed, then the unit should not be included.
- Virtual or remote hours
- Sitter hours without authorization for both physical touch and direct patient care intervention

**Employed and Contracted Nursing Staff**

**Include** the following RN, LPN/LVN, and UAP nursing staff:

- Staff employed by the hospital
- Temporary staff who are not employed by the hospital (i.e., contracted/agency staff)
- Float staff who are assigned to a unit other than their unit of employment on an as-needed basis if they are assigned direct patient care responsibilities
- Staff who are counted in the unit's staffing matrix, are replaced if they call out sick, and whose work hours are charged to the unit's cost center

**Exclude** the following RN, LPN/LVN, and UAP nursing staff:

- Nursing staff whose primary responsibility is administrative in nature (at least 50% of their time is administrative)
- Specialty teams, patient educators, or case managers who are not assigned to a specific unit
- Unit secretaries or clerks, monitor technicians, and others with no direct patient care responsibilities
- Advanced Practice Registered Nurses (APRNs), including certified nurse-midwife (CNM), clinical nurse specialist (CNS), certified nurse practitioner (CNP), and certified registered nurse anesthetist (CRNA)

*A UAP is any unlicensed person, regardless of title, who performs tasks delegated by a nurse. This includes certified nursing aides/assistants (CNAs), patient care assistants (PCAs), patient care technicians (PCTs), state-tested nursing assistants (STNA), nursing assistants-registered (NA/Rs) or certified medication aides/assistants (MA-Cs).*

**Direct Patient Care Responsibilities**

**Direct Patient Care Responsibilities** are defined as patient centered nursing activities by hospital unit-based staff in the presence of the patient and activities that occur away from the patient that are patient related:

- Medication administration
- Nursing treatments
- Nursing rounds
- Admission, transfer, discharge activities
- Patient teaching
- Patient communication
- Coordination of patient care
- Documentation time
- Treatment planning
- Patient screening (e.g., fall risk) and assessment

**Questions #5(c):** Total number of productive hours worked by **RN nursing staff** with direct patient care responsibilities in all adult and pediatric single acuity **Medical Units** in each quarter.

**Include** the total number of productive work hours worked by employed and contracted **RN nursing staff ONLY** from question 5b.


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**Question #6: Does your hospital operate any adult or pediatric single acuity Surgical Units?**

**Single Acuity Surgical Unit (adult and pediatric):**
A single acuity general care unit in which at least 90% of the patients are admitted to surgical services, such as general surgery, neurosurgery, or orthopedics. Surgical specialty units such as Bariatric Surgery, Cardio-thoracic Surgery, Gynecologic Surgery, Neurosurgery, Orthopedic Surgery, Plastic Surgery, Transplant Surgery, and Trauma Surgery, are also included.

Note: For the purposes of these measures, Leapfrog has aligned with NDNQI, which defines units based on the acuity of the patients being cared for in the unit, and not the equipment being used. Telemetry is considered a monitoring tool rather than an evaluation of a patient's level of acuity. For example, a unit that has all telemetry patients may still have a general population level of patients that would meet NDNQI's definition of a medical, surgical, or med-surg unit. Hospitals should evaluate the actual acuity of the patients in each unit to determine the appropriate unit designation.

**Excluded units:**

- Labor and Delivery
- Neonatal
- Critical Access (a unit where more than 10% of beds are for skilled nursing (swing beds))
- Rehabilitation
- Psychiatric
- Perioperative
- Critical Care
- Step Down/Progressive
- Hospice
- Mixed Acuity Units: a unit where more than 10% of the patients in the unit receive varying levels of care (e.g., general medical care and progressive care or intensive care)
- Units with fewer than 15 patient days per month for all 3 months of any quarter of the reporting period
- Units that transitioned to an excluded unit type during the reporting period (e.g., a single acuity Medical Unit transitioned to a critical care unit during the reporting period)

**Question #7: Single Acuity Surgical Units**
Enter your hospital's responses for each quarter for all adult and pediatric single acuity **Surgical Units** for the reporting period selected in question #1.

**Question #7(a):** Total number of patient days across all adult and pediatric single acuity **Surgical Units** during each quarter of the reporting period based on your hospital's method for counting patient days.

Patient days should be calculated to include all patients in adult and pediatric single acuity Surgical Units. This includes patients that do not have inpatient status (i.e., observation patients).

**Question #7(b):** Total number of productive hours worked by employed and contracted **nursing staff (RN, LPN/LVN, and UAP)** with direct patient care responsibilities in all single acuity adult and pediatric **Surgical Units** in each quarter.

**Productive Hours**

**Include** the following hours worked by employed and contract RNs, LPN/LVNs, and UAPs:

- Actual direct patient care hours worked by nursing staff
- Overtime spent performing direct patient care
- Orientation hours for new hires that are considered part of the unit's staffing matrix, whose work hours are charged to the unit's cost center, and who would be replaced if they called out sick
- Sitter hours authorized for both physical touch and direct patient care intervention

**Exclude** the following hours worked by employed and contracted RN, LPN/LVN, and UAP:

- Budgeted or scheduled hours
- Vacation time, sick time, education leave, or committee time


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- Orientation hours for new hires that are not considered part of the unit's staffing matrix, whose work hours are not charged to the unit's cost center, and would not be replaced if they call out sick
- Hours from when the unit was staffed but there were no patients in the unit
  - If these nursing hours cannot be removed, then the unit should not be included.
- Virtual or remote hours
- Sitter hours without authorization for both physical touch and direct patient care intervention

**Employed and Contracted Nursing Staff**

**Include** the following RN, LPN/LVN, and UAP nursing staff:

- Staff employed by the hospital
- Temporary staff who are not employed by the hospital (i.e., contracted/agency staff)
- Float staff who are assigned to a unit other than their unit of employment on an as-needed basis if they are assigned direct patient care responsibilities
- Staff who are counted in the unit's staffing matrix, are replaced if they call out sick, and whose work hours are charged to the unit's cost center

**Exclude** the following RN, LPN/LVN, and UAP nursing staff:

- Nursing staff whose primary responsibility is administrative in nature (at least 50% of their time is administrative)
- Specialty teams, patient educators, or case managers who are not assigned to a specific unit
- Unit secretaries or clerks, monitor technicians, and others with no direct patient care responsibilities
- Advanced Practice Registered Nurses (APRNs), including certified nurse-midwife (CNM), clinical nurse specialist (CNS), certified nurse practitioner (CNP), and certified registered nurse anesthetist (CRNA)

*A UAP is any unlicensed person, regardless of title, who performs tasks delegated by a nurse. This includes certified nursing aides/assistants (CNAs), patient care assistants (PCAs), patient care technicians (PCTs), state-tested nursing assistants (STNA), nursing assistants-registered (NA/Rs) or certified medication aides/assistants (MA-Cs).*

**Direct Patient Care Responsibilities**

**Direct Patient Care Responsibilities** are defined as patient centered nursing activities by hospital unit-based staff in the presence of the patient and activities that occur away from the patient that are patient related:

- Medication administration
- Nursing treatments
- Nursing rounds
- Admission, transfer, discharge activities
- Patient teaching
- Patient communication
- Coordination of patient care
- Documentation time
- Treatment planning
- Patient screening (e.g., fall risk) and assessment

**Questions 7(c):** Total number of productive hours worked by **RN nursing staff** with direct patient care responsibilities in all adult and pediatric single acuity **Surgical Units** in each quarter.

**Include** the total number of productive work hours worked by employed and contracted **RN nursing staff ONLY** from question 7b.


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**Question #8: Does your hospital operate any adult or pediatric single acuity Med-Surg Units?**

**Single Acuity Med-Surg Combined Unit (adult and pediatric):**
A single acuity general care unit that cares for patients admitted for medical, surgical, or family practice services and does not meet the 90% criteria for Medical or Surgical unit type. Specialty med-surg units such as Cardiac Med-Surg, Neuro/Neurosurgery Med-Surg, and Hematology/Oncology Med-Surg, are also included.

Note: For the purposes of these measures, Leapfrog has aligned with NDNQI, which defines units based on the acuity of the patients being cared for in the unit, and not the equipment being used. Telemetry is considered a monitoring tool rather than an evaluation of a patient's level of acuity. For example, a unit that has all telemetry patients may still have a general population level of patients that would meet NDNQI's definition of a medical, surgical, or med-surg unit. Hospitals should evaluate the actual acuity of the patients in each unit to determine the appropriate unit designation.

**Excluded units:**

- Labor and Delivery
- OB and Med-Surg (a combination unit in which greater than 50% of the patients are obstetric and the remaining percent are adult acute med-surg such as gynecological and/or pediatric acute med-surg)
- Neonatal
- Critical Access (a unit where more than 10% of beds are for skilled nursing (swing beds))
- Rehabilitation
- Psychiatric
- Perioperative
- Critical Care
- Step Down/Progressive
- Hospice
- Mixed Acuity Units: a unit where more than 10% of the patients in the unit receive varying levels of care (e.g., general medical care and progressive care or intensive care)
- Units with fewer than 15 patient days per month for all 3 months of any quarter of the reporting period
- Units that transitioned to an excluded unit type during the reporting period (e.g., a single acuity Medical Unit transitioned to a critical care unit during the reporting period)

**Question #9: Single Acuity Med-Surg Units**
Enter your hospital's responses for each quarter for all adult and pediatric single acuity **Med-Surg Units** for the reporting period selected in question #1.

**Question #9(a):** Total number of patient days across all adult and pediatric single acuity **Med-Surg Units** for each quarter included in the reporting period based on your hospital's method for counting patient days.

Patient days should be calculated to include all patients in adult and pediatric single acuity Med-Surg Units. This includes patients that do not have inpatient status (i.e., observation patients).

**Question #9(b):** Total number of productive hours worked by employed and contracted **nursing staff (RN, LPN/LVN, and UAP)** with direct patient care responsibilities in all single acuity adult and pediatric **Med-Surg Units** in each quarter.

**Productive Hours**

**Include** the following hours worked by employed and contracted RNs, LPN/LVNs, and UAPs:

- Actual direct patient care hours worked by nursing staff
- Overtime spent performing direct patient care
- Orientation hours for new hires that are considered part of the unit's staffing matrix, whose work hours are charged to the unit's cost center, and who would be replaced if they called out sick
- Sitter hours authorized for both physical touch and direct patient care intervention


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**Exclude** the following hours worked by employed and contracted RN, LPN/LVN, and UAP:

- Budgeted or scheduled hours
- Vacation time, sick time, education leave, or committee time
- Orientation hours for new hires that are not considered part of the unit's staffing matrix, whose work hours are not charged to the unit's cost center, and would not be replaced if they call out sick
- Hours from when the unit was staffed but there were no patients in the unit
    - If these nursing hours cannot be removed, then the unit should not be included.
- Virtual or remote hours
- Sitter hours without authorization for both physical touch and direct patient care intervention

**Employed and Contracted Nursing Staff**

**Include** the following RN, LPN/LVN, and UAP nursing staff:

- Staff employed by the hospital
- Temporary staff who are not employed by the hospital (i.e., contracted/agency staff)
- Float staff who are assigned to a unit other than their unit of employment on an as-needed basis if they are assigned direct patient care responsibilities
- Staff who are counted in the unit's staffing matrix, are replaced if they call out sick, and whose work hours are charged to the unit's cost center

**Exclude** the following RN, LPN/LVN, and UAP nursing staff:

- Nursing staff whose primary responsibility is administrative in nature (at least 50% of their time is administrative)
- Specialty teams, patient educators, or case managers who are not assigned to a specific unit
- Unit secretaries or clerks, monitor technicians, and others with no direct patient care responsibilities
- Advanced Practice Registered Nurses (APRNs), including certified nurse-midwife (CNM), clinical nurse specialist (CNS), certified nurse practitioner (CNP), and certified registered nurse anesthetist (CRNA)

*A UAP is any unlicensed person, regardless of title, who performs tasks delegated by a nurse. This includes certified nursing aides/assistants (CNAs), patient care assistants (PCAs), patient care technicians (PCTs), state-tested nursing assistants (STNA), nursing assistants-registered (NA/Rs) or certified medication aides/assistants (MA-Cs).*

**Direct Patient Care Responsibilities**

**Direct Patient Care Responsibilities** are defined as patient centered nursing activities by hospital unit-based staff in the presence of the patient and activities that occur away from the patient that are patient related:

- Medication administration
- Nursing treatments
- Nursing rounds
- Admission, transfer, discharge activities
- Patient teaching
- Patient communication
- Coordination of patient care
- Documentation time
- Treatment planning
- Patient screening (e.g., fall risk) and assessment

**Questions #9(c):** Total number of productive hours worked by **RN nursing staff** with direct patient care responsibilities in all adult and pediatric single acuity **Med-Surg Units** in each quarter.

**Include** the total number of productive work hours worked by RN nursing staff ONLY from question 9b.


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**Mixed Acuity Adult or Pediatric Medical, Surgical, or Med-Surg Units (questions #10-12)**

**Question #10: Does your hospital operate at least one adult or pediatric mixed acuity Medical, Surgical, or Med-Surg Unit?**

Leapfrog has aligned with the National Database of Nursing Quality Indicators' (NDNQI) unit definitions below.

**Mixed Acuity Medical, Surgical and Med-Surg Units (adult and pediatric):**
A unit where more than 10% of patients receive varying levels of care.

**Excluded units:**
- Cardiac
- Neurology
- Hematology/Oncology
- Neonatal
- Critical Care
- Critical Access (a unit where more than 10% of beds are for skilled nursing (swing beds))
- Units with fewer than 15 patient days per month for all 3 months of any quarter of the reporting period
- Units that transitioned to an excluded unit type during the reporting period (e.g., a mixed acuity Medical Unit transitioned to a critical care unit during the reporting period)

**Question #11: What type(s) of adult and/or pediatric mixed acuity Medical, Surgical or Med-Surg Units does your hospital operate?**

Leapfrog has aligned with the National Database of Nursing Quality Indicators' (NDNQI) unit definitions below.

**High Acuity Medical, Surgical and Med-Surg Units:**
A mixed acuity unit in which 50-89% of the patients are critical care and the remaining 11-49% can be any other acuity level.

**Moderate Acuity Medical, Surgical and Med-Surg Units:**
A mixed acuity unit in which 25-49% of the patients are critical care OR 50-89% of the patients are step down care. The remaining percentage can be any other acuity level.

**Blended Acuity Medical, Surgical and Med-Surg Units:**
A mixed acuity acute care unit in which less than 90% of the patients receive a single acuity level of care, less than 50% receive step down care, and less than 25% receive critical care.

**Question #12 or Question #14: Mixed Acuity Medical, Surgical and Med-Surg Units**
Enter your hospital's responses for each quarter for all adult and pediatric mixed acuity Medical, Surgical and Med-Surg Units for the reporting period selected in question #1.

**Question #12(a) or Question #14(a):** Total number of patient days across all adult and pediatric **mixed acuity Medical, Surgical and Med-Surg Units** for each quarter included in the reporting period based on your hospital's method for counting patient days.

Patient days should be calculated to include all patients in all adult and pediatric mixed acuity Medical, Surgical or Med-Surg Units. This includes patients that do not have inpatient status (i.e., observation patients).

**Question #12(b) or Question #14(b):** Total number of productive hours worked by employed and contracted **nursing staff (RN, LPN/LVN, and UAP)** with direct patient care responsibilities in all adult and pediatric **mixed acuity Medical, Surgical, and Med-Surg Units** in each quarter.

**Productive Hours**

**Include** the following hours worked by employed and contracted RNs, LPN/LVNs, and UAPs:
- Actual direct patient care hours worked by nursing staff
- Overtime spent performing direct patient care


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- Orientation hours for new hires that are considered part of the unit's staffing matrix, whose work hours are charged to the unit's cost center, and who would be replaced if they called out sick
- Sitter hours authorized for both physical touch and direct patient care intervention

**Exclude** the following hours worked by employed and contracted RN, LPN/LVN, and UAP:

- Budgeted or scheduled hours
- Vacation time, sick time, education leave, or committee time
- Orientation hours for new hires that are not considered part of the unit's staffing matrix, whose work hours are not charged to the unit's cost center, and would not be replaced if they call out sick
- Hours from when the unit was staffed but there were no patients in the unit
    - If these nursing hours cannot be removed, then the unit should not be included.
- Virtual or remote hours
- Sitter hours without authorization for both physical touch and direct patient care intervention

**Employed and Contracted Nursing Staff**

**Include** the following RN, LPN/LVN, and UAP nursing staff:

- Staff employed by the hospital
- Temporary staff who are not employed by the hospital (i.e., contracted/agency staff)
- Float staff who are assigned to a unit other than their unit of employment on an as-needed basis if they are assigned direct patient care responsibilities
- Staff who are counted in the unit's staffing matrix, are replaced if they call out sick, and whose work hours are charged to the unit's cost center

**Exclude** the following RN, LPN/LVN, and UAP nursing staff:

- Nursing staff whose primary responsibility is administrative in nature (at least 50% of their time is administrative)
- Specialty teams, patient educators, or case managers who are not assigned to a specific unit
- Unit secretaries or clerks, monitor technicians, and others with no direct patient care responsibilities
- Advanced Practice Registered Nurses (APRNs), including certified nurse-midwife (CNM), clinical nurse specialist (CNS), certified nurse practitioner (CNP), and certified registered nurse anesthetist (CRNA)

*A UAP is any unlicensed person, regardless of title, who performs tasks delegated by a nurse. This includes certified nursing aides/assistants (CNAs), patient care assistants (PCAs), patient care technicians (PCTs), state-tested nursing assistants (STNA), nursing assistants-registered (NA/Rs) or certified medication aides/assistants (MA-Cs).*

**Direct Patient Care Responsibilities**

**Direct Patient Care Responsibilities** are defined as patient centered nursing activities by hospital unit-based staff in the presence of the patient and activities that occur away from the patient that are patient related:

- Medication administration
- Nursing treatments
- Nursing rounds
- Admission, transfer, discharge activities
- Patient teaching
- Patient communication
- Coordination of patient care
- Documentation time
- Treatment planning
- Patient screening (e.g., fall risk) and assessment


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**Question #12(c) or Question #14(c):** Total number of productive hours worked by **RN nursing staff** with direct patient care responsibilities in all adult and pediatric **mixed acuity Medical, Surgical, and Med-Surg Units** in each quarter.

**Include** the total number of productive work hours worked by employed and contracted RN nursing staff ONLY from question 12b or question 14b.

See FAQs for additional information about responding to the questions in this section.


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## Percentage of RNs who are BSN-Prepared Specifications

**Source:** The Leapfrog Group

**Reporting Period:** Answer questions #17-19 based on the most recent day within the last 12-months for which you have complete data.

**Question #18 (denominator):** Total number of employed RN nursing staff at the hospital with direct patient care responsibilities.

Included RN Nursing Staff:

- Staff employed by the hospital in most hospital units, including observation, co-located[31] outpatient units, and emergency departments who:
  - Are counted in the unit's staffing matrix, **and**
  - Are replaced if they call in sick, **and**
  - Whose work hours are charged to the unit's cost center
- Float staff who are assigned to a unit other than their unit of employment on an as-needed basis if they are assigned direct patient care responsibilities

Excluded RN Nursing staff:

- Staff that are not employed by the hospital (i.e., contracted/agency staff)
- Staff that are exclusively assigned to skilled nursing units or mixed acuity neonatal units
- Staff that are part of specialty teams or are patient educators or case managers who are not assigned to a specific unit
- Unit secretaries or clerks or others with no direct patient care responsibilities
- Staff that are primarily responsible for administrative tasks (at least 50% of their time is administrative)
- Advanced Practice Registered Nurses (APRNs), including certified nurse-midwife (CNM), clinical nurse specialist (CNS), certified nurse practitioner (CNP), and certified registered nurse anesthetist (CRNA)

Direct Patient Care Responsibilities are defined as patient centered nursing activities by hospital unit-based staff in the presence of the patient and activities that occur away from the patient that are patient related:

- Medication administration
- Nursing treatments
- Nursing rounds
- Admission, transfer, discharge activities
- Patient teaching
- Patient communication
- Coordination of patient care
- Documentation time
- Treatment planning
- Patient screening (e.g., fall risk) and assessment

**Question #19 (numerator):** Total number of employed RN nursing staff at the hospital with direct patient care responsibilities who have a BSN degree or higher (e.g., MSN, DNP, and PhD).

Note: Hospitals can use any method to identify RN nursing staff who have a BSN degree or higher, including:

- NDNQI Annual RN Survey
- Data collected by the nurse managers at the hospital
- Information from HR or credentialing office, or
- Staff survey via SurveyMonkey or other free data collection tool.

See FAQs for additional information about responding to the questions in this section.

# Section 5: Physician and Nurse Staffing Frequently Asked Questions (FAQs)

## *Adult and Pediatric ICU Physician Staffing FAQs*

### *ICU General Questions*

1. **What is the reporting period for the ICU measure?**
   Hospitals should report on Section 5A and 5B based on their staffing structure at the time they submit this section of the Survey. The staffing structure must have been in place for at least the past 3 months and should reflect the ordinary staffing structure for the ICU.

2. **How should hospitals report if they have more than one type of qualifying ICU?**
   If your hospital has more than one applicable ICU (i.e., multiple adult ICUs or multiple pediatric ICUs), respond to all questions in each section based on the ICU that has the lowest level of staffing by physicians certified in critical care medicine. Review endnote 34 for more information.

3. **Does Leapfrog's ICU standard apply to mixed acuity units? A multi-organizational service unit (MOSU) unit?**
   The standard applies to all adult and pediatric general medical, surgical, medical/surgical, and neuro critical care patients (medical and surgical), including those patients in mixed acuity units and other non-critical care units.

4. **Are cardiac critical care patients in a general medical, surgical, and medical/surgical ICU required to be co-managed by an intensivist?**
   Cardiac critical care patients in a general medical, surgical, or medical/surgical ICU that are in beds dedicated to cardiac critical care patients and being cared for by dedicated cardiac physicians (e.g., cardiologist or cardiac surgeon) and nursing staff are not included in Leapfrog's ICU Physician Staffing standard and do not need to be managed/co-managed by the intensivist. However, cardiac critical care patients in a general medical, surgical, or medical/surgical ICU bed being cared for by general medical or surgical critical care physicians and nursing staff are included in the standard and do need to be managed/co-managed by the intensivist. Additional clarification is available here.

5. **Does Leapfrog's ICU Physician Staffing standard include cardiac critical care patients?**
   For the purposes of reporting on Section 5A and 5B, cardiac critical care patients in general medical, surgical, or medical/surgical ICU beds being cared for by general medical and/or surgical critical care physicians and nursing staff are included in the standard and need to be managed/co-managed by the intensivist. Cardiac critical care patients in a general medical, surgical, or medical/surgical ICU that are in beds dedicated to cardiac critical care patients and being cared for by dedicated cardiac physicians (e.g., cardiologist or cardiac surgeon) and nursing staff are not included in Leapfrog's ICU Physician Staffing standard and do not need to be managed/co-managed by the intensivist.

### *ICU Certification*

6. **Is there any empirical basis for specifying a minimum annual number of days of ICU experience for each board-eligible physician providing ICU care?**
   No. Accordingly, if it is added to the Leapfrog standard in the future, it will be based on newly published research and expert advice.

7. **Do all intensivists serving as tele-intensivists need to meet Leapfrog's definition of "certified in critical care medicine"?**
   Yes. All intensivists who serve as tele-intensivists do need to meet Leapfrog's definition of "certified in critical care medicine."


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8. **Is a physician who is awaiting the results of the certification test considered "certified in critical care medicine"?**
   A physician is considered certified in critical care medicine as long as the board that originally certified the physician in critical care medicine deems that physician certified. Intensivists that are close to having their certification lapse should check with the board that certified them to see how exactly that board defines a lapsed certification.

9. **Are physicians board certified in critical care medicine from the American Osteopathic Association (AOA) considered "certified in critical care medicine" for Leapfrog's ICU Physician Staffing Standard?**
   Yes. Physicians with a board certification in critical care from American Osteopathic Association (AOA) are considered "certified in critical care medicine."

10. **How should intensivists trained in critical medicine in a foreign country be treated for purposes of meeting the ICU Physician Staffing (IPS) Standard?**
    Foreign trained physicians who were certified in critical care medicine in the country in which they trained would be considered certified for the purposes of the ICU Physician Staffing (IPS) standard.

### *ICU Telemedicine*

11. **Can you clarify what you mean by combined presence of tele-intensivists and on-site intensivists, as needed, for 24 hours per day/7 days per week in question #6 for Sections 5A and 5B?**
    Hospitals can achieve Leapfrog's IPS Standard by having daily on-site intensivist coverage combined with a telemedicine service that meets all ten of the Leapfrog requirements. For example, an on-site intensivist takes two hours in the morning to establish and revise the daily care plan for each ICU patient, then a tele-intensivist picks up management or co-management of the ICU patients and is continually monitoring all critical care patients for the remaining 22 hours, for a combined total of 24 hours per day/7 days per week.

    Hospitals should minimize the number of hand-offs between the on-site intensivist and the tele-intensivist during a 24-hour period and maximize the continuous time that one type of intensivist is caring for critical care patients. **Leapfrog does not recommend more than 4 hand-offs per 24 hours.**

12. **Our hospital uses a telemedicine service to provide coverage in our ICU for 16 hours/7 days per week coverage when the on-site intensivist is not present at the hospital. Can our hospital still fully meet Leapfrog's standard?**
    Hospitals that use telemedicine to cover "call" for the on-site intensivist are able to fully meet Leapfrog's standard if: (1) the telemedicine service meets all ten of the Leapfrog requirements; and (2) the hospital has an "effector" (physician/PA/NP/FCCS-certified nurse or intern) on-site during that time period to carry out the tele-intensivist's orders and can reach the ICU patient within 5 minutes, 95% of the time.

### *ICU Response Time*

13. **Does Leapfrog specify standards for second tier calls (e.g., the initial call to a physician is not answered within 5 minutes)?**
    No. We do not intend to reach this level of detail in our specifications, absent a compelling case that the gain would offset its added complexity.

14. **Are there definitions for what constitutes high and low urgency calls/pages/texts?**
    No, and hospitals don't have to focus only on high urgency calls/pages/texts, but some notification device systems can make this differentiation, and, in these instances, low urgency calls/pages/texts can be excluded from the analysis of response times.


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15. **If my hospital has few instances where there is no intensivist coverage, how should we conduct the response time audit? Can we perform mock pages to satisfy the intent?**
    Unannounced mock pages would meet the intent. For the audit to be reliable, 20 unannounced mock pages over 90 days should be evaluated.

16. **When an intensivist is not on-site in the ICU, can hospitals use a non-FCCS-certified CRNA as the "effector?"**
    No. To serve as the "effector," CRNAs require FCCS-certification.

17. **When an intensivist is not on-site in the ICU, can hospitals use FCCS-certified interns as the "effector?"**
    Yes. An FCCS-certified intern can serve as the "effector."

### *ICU Rounding*

18. **How does Leapfrog define "makes on-site daily rounds" for clinical pharmacists in question #13 within Sections 5A and 5B?**
    A clinical pharmacist would need to make on-site daily rounds (5 or 7 days per week) on **all** critical care patients (not some or most critical care patients) in **all** applicable ICUs (adult or pediatric general medical, surgical, medical/surgical, and neuro ICUs).

    Please note that if your clinical pharmacist is rounding 5 days per week, then, during the other 2 days per week, a clinical pharmacist still needs to respond to calls/texts/pages within 5 minutes, as determined by a response time audit.

19. **Are pharmacy residents considered clinical pharmacists in question #13 within Sections 5A and 5B?**
    To be considered a clinical pharmacist, Leapfrog only requires that the pharmacist have a Doctor of Pharmacy (PharmD) degree. Therefore, a PharmD graduate completing a residency would meet Leapfrog's criterion to be considered a clinical pharmacist.

20. **What roles should be included in interprofessional rounds in question #14 within Sections 5A and 5B?**
    For rounds to be considered interprofessional, the team should include 3 or more persons. Typical personnel that would be part of the rounding team include physician, nurse, pharmacist, physical and/or occupational therapist, and nutritionist.

### *Total Nursing Care Hours per Patient Day and RN Hours per Patient Day FAQs*

21. **Why has Leapfrog aligned their unit type definitions with NDNQI?**
    Though NDNQI participation is not required to report on the Total Nursing Care Hours per Patient Day and RN Hours per Patient Day, a number of hospitals participate in NDNQI and have data available to report to the Leapfrog Hospital Survey.

22. **How is patient acuity defined?**
    Patient acuity is the level of care that patients are receiving. The three levels of care are:
    - critical care (highest level of acuity)
    - step down (lower level of acuity that patients in a critical care unit yet a higher level of acuity than is provided on a general care unit)
    - general care

    Single acuity medical, surgical and med-surg units are units where at least 90% of the patients receive general care. Mixed acuity medical, surgical and med-surg units are units where less than 90% of the patients receive a single acuity level of care (more than 10% of patients receive varying levels of care).


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**23. What is the definition of virtual nursing?**

Virtual nursing is defined using the American Nursing Association (ANA)'s definition: leveraging remote technology and tools to provide safe and quality patient care through application of the nursing process by emphasizing communication, compassion, and collaboration throughout the continuum of care. Leapfrog is specifically asking if virtual nurses are used to perform direct patient care responsibilities, which are defined as patient centered nursing activities by hospital unit-based staff in the presence of the patient and activities that occur away from the patient that are patient related:

- Medication administration
- Nursing treatments
- Nursing rounds
- Admission, transfer, discharge activities
- Patient teaching
- Patient communication
- Coordination of patient care
- Documentation time
- Treatment planning
- Patient screening (e.g., fall risk) and assessment

## *NQF Safe Practice #9 – Nursing Workforce FAQs*

**24. How do I know if my hospital is eligible to report it has a current Pathways to Excellence designation?**

Hospitals that applied for Pathway to Excellence designation beginning in January 2021 and onward were certified using the 2020 or 2024 Pathways to Excellence® criteria and are eligible to report that they have a current designation.

Hospitals can check the Designation Year or Redesignation Year on the American Nurses Credentialing Center website. If the year is 2021 or later, the hospital meets the Pathways to Excellence® criteria.

**25. 15e: If the state has set minimum nurse to patient staffing ratios, do hospitals in that state automatically meet the intent of this element?**

No. Minimum ratios do not necessarily address the "adequacy" issue, as the make-up of your hospital's patient population may require more intensive staffing than is prescribed by the state's minimum.

**26. 15e: What are the minimum requirements to qualify as a "staffing plan?"**

"A staffing plan" refers to nursing policies and procedures or a specific process used by the organization to pre-determine appropriate staffing patterns based on usual patient mix and nursing qualifications. A hospital must demonstrate full achievement of its targets.

Organizations must integrate several data sets into a staffing system that predefines and quantifies appropriate staffing targets. These data sets include:

- Historical Data (e.g., patient volumes, acuity levels, and staff volumes of direct caregivers)
- Comparative Data (e.g., comparisons between similar units internally and comparative external data from hospitals of like size and geographic location)
- Clinical Outcomes
- Skill Mix of Staff (e.g., licensing levels and educational training, years of experience, and volume of new graduates on a unit)
- Physical environment (e.g., distance staff have to travel to access support equipment, visibility of patients, locations of nursing stations to patient rooms, etc.)
- Type of patient care needs
- Support services available


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Daily monitoring should take place to determine variances between predetermined staffing patterns and actual staffing patterns. If necessary, corrective action should be taken. Regular monitoring should take place to determine the accuracy of targets established and determine adjustments as needed.

### *Percentage of RNs who are BSN-Prepared FAQs*

27. **Should RNs with direct patient care responsibilities exclusively assigned to outpatient units or hospital clinics be included when reporting on the Percentage of RNs who are BSN-Prepared measure?**
Yes. The total number of RN nursing staff employed at the hospital should include nurses with direct care responsibilities in most hospital units, including observation, co-located[31] outpatient units, and emergency departments. Only employed RNs exclusively assigned to Skilled Nursing units or Mixed Acuity Neonatal units should be excluded when reporting on the measure.

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# *SECTION 6: PATIENT SAFETY PRACTICES*

This section includes questions and reference information for Section 6: Patient Safety Practices. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.


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# Section 6: Patient Safety Practices

**NQF Safe Practices Fact Sheets:**
https://ratings.leapfroggroup.org/measure/hospital/2026/effective-leadership-prevent-errors

**Hand Hygiene Fact Sheet and Bibliography:**
https://ratings.leapfroggroup.org/measure/hospital/2026/handwashing

**Diagnostic Excellence Bibliography:**
https://ratings.leapfroggroup.org/measure/hospital/2026/whats-new-2026

**Hospital Boarding in the Emergency Department (ED) Bibliography:**
https://ratings.leapfroggroup.org/measure/hospital/2026/whats-new-2026

Section 6 includes questions about your hospital's adherence to two National Quality Forum-endorsed Safe Practices, and questions about your hospital's hand hygiene practices. It also includes a subsection on diagnostic excellence (6D) and a new subsection on Hospital Boarding in the Emergency Department (ED) (6E). Section 6D is required while Section 6E is optional. These subsections will not be scored or publicly reported.

**Each hospital achieving the standard for NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems and NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention:**
Has earned 100% of points (adopted all elements) for the NQF Safe Practice.

**Each hospital achieving the standard for Hand Hygiene:**
Has met all elements for the Monitoring domain including collecting compliance data on at least 200 hand hygiene opportunities* each month in each patient care unit. Has also met all elements for the Feedback domain, as well as **2 of the 3** remaining domains for hand hygiene:

- Training and Education Domain
- Infrastructure Domain
- Culture Domain

OR

Has met all elements for the Monitoring domain including collecting compliance data on at least 100 hand hygiene opportunities* each month in each patient care unit, as well as **all 4** remaining domains for hand hygiene:

- Feedback Domain
- Training and Education Domain
- Infrastructure Domain
- Culture Domain

**or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 1-3 or Tables 4-6.*

**Download the 2026 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.**


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# 6A: NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Notes:**

Note 1: Page numbers throughout this subsection refer to the NQF Safe Practices for Better Healthcare – 2010 Update report, which is available for download here: http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials.

Note 2: Hyperlinks throughout this subsection refer to the Patient Safety Practices FAQs beginning on page 250, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

**Specifications:** See ***NQF Safe Practice Measure Specifications*** in the Reference Information beginning on page 237.

### *Awareness*

| **1.1) Within the last 12 months, in regard to raising the awareness of key stakeholders to our organization's efforts to improve patient safety, the following actions related to the identification and mitigation of risks and hazards have been taken:** | |
|---|---|
| a. board (governance) minutes reflect regular communication regarding **all** three of the following:<br>i. risks and hazards (as defined by *NQF Safe Practice #4 – Identification and Mitigation of Risks and Hazards*);<br>ii. culture measurement (as defined by *NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention*); and<br>iii. progress towards resolution of safety and quality problems. (p.75) | ○ Yes<br>○ No |
| b. patients and/or care partners are active participants in the hospital-wide safety and quality committee that meets on a regularly scheduled basis (e.g., biannually or quarterly). (p.75) | ○ Yes<br>○ No |
| c. steps have been taken to report ongoing efforts to improve safety and quality in the organization and the results of these efforts to the community. (p.75) | ○ Yes<br>○ No |
| d. all staff and independent practitioners were made aware of ongoing efforts to reduce risks and hazards and to improve patient safety and quality in the organization. (p.75) | ○ Yes<br>○ No |

### *Accountability*

| **1.2) Within the last 12 months, in regard to holding the board, senior administrative leadership, midlevel management, nursing leadership, physician leadership, and frontline caregivers directly accountable for results related to the identification and mitigation of risks and hazards, the organization has done the following:** | |
|---|---|
| a. an integrated patient safety program has been in place for the entire reporting period, providing oversight and alignment of safe practice activities. (p.76) | ○ Yes<br>○ No |
| b. a Patient Safety Officer (PSO) has been appointed and communicates regularly with the board (governance) and senior administrative leadership; the PSO is the primary point of contact of the integrated patient safety program. (p.76) | ○ Yes<br>○ No |
| c. performance has been documented in performance reviews and/or compensation incentives for all levels of hospital management and hospital-employed caregivers noted above. (p.76) | ○ Yes<br>○ No |
| d. the interdisciplinary patient safety team communicated regularly with senior administrative leadership regarding **both** of the following and documented these communications in meeting minutes (pp. 76-77):<br>i. progress in meeting safety goals, and<br>ii. provided team training to caregivers. | ○ Yes<br>○ No |


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| | |
|---|---|
| e. the hospital reported adverse events to external mandatory or voluntary programs. (p.77) | ○ Yes<br>○ No |

### *Ability*

| **1.3) Within the last 12 months, in regard to implementation of the patient safety program, the board (governance) and senior administrative leadership have provided resources to cover the implementation, as evidenced by:** | |
|---|---|
| a. dedicated patient safety program budgets to support the program, staffing, and technology investment. (p.77) | ○ Yes<br>○ No |

### *Action*

| **1.4) Within the last 12 months, structures and systems have been in place to ensure that senior administrative leadership is taking direct action, as evidenced by:** | |
|---|---|
| a. CEO and senior administrative leadership are personally engaged in reinforcing patient safety improvements, e.g., "walk-arounds," and reporting to the board (governance). Calendars reflect allocated time. (p.78) | ○ Yes<br>○ No |
| b. CEO has actively engaged leaders from service lines, midlevel management, nursing leadership, and physician leadership in patient safety improvement actions. (p.79) | ○ Yes<br>○ No |
| c. hospital has established a structure for input into the patient safety program by licensed independent practitioners and the organized medical staff and physician leadership. Input documented in meeting minutes or materials. (p.79) | ○ Yes<br>○ No |


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

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Notes:**

Note 1: Page numbers throughout this subsection refer to the NQF Safe Practices for Better Healthcare – 2010 Update report, which is available for download here: http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials.

Note 2: Hyperlinks throughout this subsection refer to the Patient Safety Practices FAQs beginning on page 250, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

Note 3: Throughout this subsection, the culture of safety survey referenced in each practice element refers to one administered in the last 24 months as indicated in 2.1a. This means that the same culture of safety survey should be used when responding to each practice element.

**Specifications:** See ***NQF Safe Practice Measure Specifications*** in the Reference Information beginning on page 237.

### *Awareness*

| **2.1) Within the last 24 months, in regard to culture measurement, our organization has done the following:** | |
|---|---|
| a. conducted a culture of safety survey of our employees using a nationally recognized tool that has demonstrated validity, consistency, and reliability. The units surveyed account for at least 50% of the aggregated care delivered to patients within the hospital and include the high patient safety risk units or departments. (p.88)<br><br>*If "no" to question 2.1a, skip the remaining questions in Section 6B and continue to the next subsection. The hospital will be scored as "Limited Achievement."* | ○ Yes<br>○ No |
| b. portrayed the results of the culture of safety survey in a report, which reflects both hospital-wide and individual unit level results, as applicable. (p.88) | ○ Yes<br>○ No |
| c. benchmarked results of the culture of safety survey against external organizations, such as "like" hospitals or other hospitals within the same health system. | ○ Yes<br>○ No |
| d. compared results of the culture of safety surveys across roles and staff levels. | ○ Yes<br>○ No |
| e. service line, midlevel managers, or senior administrative leaders used the results of the culture of safety survey to debrief at the relevant unit level, using semi-structured approaches for the debriefings and presenting results in aggregate form to ensure the anonymity of survey respondents. | ○ Yes<br>○ No |

### *Accountability*

| **2.2) Within the last 24 months, in regard to accountability for improvements in culture measurement, our organization has done the following:** | |
|---|---|
| a. shared the results of the culture of safety survey with the board (governance) and senior administrative leadership in a formal report and discussion. (p.88) | ○ Yes<br>○ No |
| b. included in performance evaluation criteria for senior administrative leadership both the response rates to the culture of safety survey and the use of the culture of safety survey results in the improvement efforts. | ○ Yes<br>○ No |

### *Ability*

| **2.3) Within the last 12 months, in regard to culture measurement, the organization has done the following (or has had the following in place):** | |
|---|---|
| a. conducted staff education program(s) on methods to improve the culture of safety, tailored to the organization's culture of safety survey results. | ○ Yes<br>○ No |
| b. included the costs of culture measurement/follow-up activities in the patient safety program budget. | ○ Yes<br>○ No |

### *Action*

| **2.4) Within the last 12 months, in regard to accountability for improvements in culture measurement, our organization has done the following:** | |
|---|---|
| a. developed or implemented explicit, hospital-wide organizational policies and procedures for regular culture measurement. (p.88) | ○ Yes<br>○ No |
| b. disseminated the results of the culture of safety survey widely across the institution, and senior administrative leadership held follow-up meetings with the sampled units to discuss the unit's results and concerns. (p.88) | ○ Yes<br>○ No |
| c. identified performance improvement interventions based on the culture of safety survey results, which were shared with senior administrative leadership and subsequently measured and monitored. (p.88) | ○ Yes<br>○ No |


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# 6C: Hand Hygiene

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Notes:**

Note 1: Hyperlinks not followed by a superscript throughout this subsection refer to the Patient Safety Practices FAQs beginning on page 250. These hyperlinks are not included in the Online Survey Tool.

Note 2: The framework and questions in this subsection are modeled after the World Health Organization's Hand Hygiene Self-Assessment Framework.

Note 3: Hospital responses should reflect patient care units only, including all adult and pediatric medical, surgical, and medical/surgical units (including telemetry units), step-down/progressive units, obstetrical units, intensive care units (including neonatal units), pre-operative and post-anesthesia care units, observation units, and dedicated emergency department units.

Note 4: Only include units that were open for the entire reporting period (i.e., most recent month or past three months based on responses selected in monitoring questions #8-10) and that remain currently open.

**Specifications:** See ***Hand Hygiene Measure Specifications*** in the Reference Information beginning on page 238.

**Reporting Period:** Answer questions #1-21 based on the practices currently in place at the time you submit this section of the Survey.

Note: For monitoring, this means that the monthly sample size (or quarterly sample size if answering question #10) would need to be met at least once in each patient care unit the month (or quarter) preceding the time of the submission of the Survey and there must be a process in place to meet the monthly (or quarterly) sample size thereafter in each patient care unit every month/quarter.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

## *Training and Education*

| | |
|---|---|
| 1) Do individuals who touch patients or who touch items that will be used by patients [44] in your patient care units receive hand hygiene training from a professional with appropriate training and skills [45] at **both:**<br>• the time of onboarding, and<br>• annually thereafter?<br><br>*If "no" to question #1, skip questions #2-3 and continue to question #4.* | ○ Yes<br>○ No |
| 2) In order to pass the **initial** hand hygiene training, do individuals who touch patients or who touch items that will be used by patients[44] in your patient care units need to physically demonstrate proper hand hygiene with soap and water and alcohol-based hand sanitizer? | ○ Yes<br>○ No |

| | |
|---|---|
| 3) Are **all** six of the following topics included in your hospital's initial and annual hand hygiene training:<br>• Evidence linking hand hygiene and infection prevention;<br>• When individuals who touch patients or who touch items that will be used by patients[44] should perform hand hygiene (e.g., WHO's 5 Moments for Hand Hygiene, CDC's Guideline for Hand Hygiene);<br>• How individuals who touch patients or who touch items that will be used by patients[44] should clean their hands with alcohol-based hand sanitizer and soap and water as to ensure they cover all surfaces of hands and fingers, including thumbs and fingernails;<br>• When gloves should be used in addition to hand washing (e.g., caring for *C. diff.* patients) and how hand hygiene should be performed when gloves are used;<br>• The minimum time that should be spent performing hand hygiene with soap and water and alcohol-based hand sanitizer; and<br>• How hand hygiene compliance is monitored? | ○ Yes<br>○ No |

### *Infrastructure*

| | |
|---|---|
| 4) Does your hospital conduct quarterly audits on a sample of dispensers in your patient care units to ensure all the following:<br>• Paper towels, soap dispensers, and alcohol-based hand sanitizer dispensers are refilled when they are empty or near empty, and<br>• Batteries in automated paper towel dispensers, soap dispensers, and alcohol-based hand sanitizer dispensers (if automated dispensers are used in the patient care units) are replaced? | ○ Yes<br>○ No |
| 5) Do **all** rooms and bed spaces in your patient care units have:<br>• an alcohol-based hand sanitizer dispenser located at the entrance to the room or bed space, and<br>• alcohol-based hand sanitizer dispenser(s) located inside the room or bed space that are equally accessible to the location of all patients in the room or bed space? | ○ Yes<br>○ No |


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| | |
|---|---|
| 6) Does your hospital conduct audits of the volume of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated) on a sample of dispensers in your patient care units at **all** the following times:<br>• upon installation,<br>• whenever the brand of product or system changes, and<br>• whenever adjustments are made to the dispensers?<br><br>**OR**<br><br>Has your hospital conducted an audit of the volume of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated) on a sample of your hospital's existing dispensers if there have been no changes to any dispensers?<br><br>*If "no" or "does not apply, wall-mounted dispensers are not used," skip question #7 and continue to question #8.* | ○ Yes<br>○ No<br>○ Does not apply; wall-mounted dispensers are not used |
| 7) Do all the audited dispensers deliver, with one activation, 1.0 mL of alcohol-based hand sanitizer OR a volume of alcohol-based hand sanitizer that covers the hands completely and requires 15 or more seconds for hands to dry (on average)? | ○ Yes<br>○ No |

### *Monitoring*

| | |
|---|---|
| 8) Does your hospital collect hand hygiene compliance data on at least **200 hand hygiene opportunities**, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 1-3, **each month in each patient care unit**?<br><br>*If "yes" to question #8, skip questions #9-10 and continue to question #11.* | ○ Yes, using an electronic compliance monitoring system throughout all patient care units<br>○ Yes, using an electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units<br>○ Yes, using only direct observation throughout all patient care units<br>○ No |
| 9) Does your hospital collect hand hygiene compliance data on at least **100 hand hygiene opportunities**, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 4-6, **each month in each patient care unit**?<br><br>*If "yes" to question #9, skip question #10 and continue to question #11.* | ○ Yes, using an electronic compliance monitoring system throughout all patient care units<br>○ Yes, using an electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units<br>○ Yes, using only direct observation throughout all patient care units<br>○ No |


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| | |
|---|---|
| 10) Does your hospital collect hand hygiene compliance data on at least **100 hand hygiene opportunities each quarter in each patient care unit**?<br><br>*If "no" to question #10, skip questions #11-19 and continue to question #20.* | ○ Yes, using an electronic compliance monitoring system throughout all patient care units<br>○ Yes, using an electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units<br>○ Yes, using only direct observation throughout all patient care units<br>○ No |
| 11) Does your hospital use hand hygiene coaches or compliance observers to provide individuals who touch patients or who touch items that will be used by patients[44] in your patient care units with feedback on both when they are and are not compliant with performing hand hygiene? | ○ Yes<br>○ No |

## Direct Monitoring – Electronic Compliance Monitoring System

*If "yes, using an electronic compliance monitoring system throughout all patient care units" or "yes, using an electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units" to question #8, question #9, or question #10, answer questions #12-13 based on the units that use an electronic compliance monitoring system.*

| | |
|---|---|
| 12) In those patient care units where an electronic compliance monitoring system is used, does the monitoring system used meet **both** of the following criteria:<br>• The system can identify both opportunities for hand hygiene and that hand hygiene was performed, and<br>• The hospital itself has validated the accuracy of the data collected by the electronic compliance monitoring system? | ○ Yes<br>○ No |

| | |
|---|---|
| 13) In those patient care units where an electronic compliance monitoring system is used, are direct observations also conducted for coaching and intervention purposes that meet **all** the following criteria:<br>• Observers immediately intervene prior to any harm occurring to provide non-compliant individuals with immediate feedback;<br>• Observations identify both opportunities for hand hygiene and compliance with those opportunities;<br>• Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct;<br>• Observations within a unit are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of individuals who touch patients or who touch items that will be used by patients[44] on duty for that shift; and<br>• Observations capture a representative sample of the different roles of individuals who touch patients or who touch items that will be used by patients[44] (e.g., nurses, physicians, techs, environmental services workers)? | ○ Yes<br>○ No |

## Direct Monitoring – Direct Observation

*If "yes, using an electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units" or "yes, using only direct observation" to question #8, question #9, or question #10 answer questions #14-15 based on the units that do NOT use an electronic compliance monitoring system.*

| | |
|---|---|
| 14) In those patient care units where an electronic compliance monitoring system is NOT used, do the direct observations meet **all** the following criteria:<br>• Observations identify both opportunities for hand hygiene and compliance with those opportunities;<br>• Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct;<br>• Observations within a unit are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of individuals who touch patients or who touch items that will be used by patients[44] on duty for that shift; and<br>• Observations are conducted to capture a representative sample of the different roles of individuals who touch patients or who touch items that will be used by patients[44] (e.g., nurses, physicians, techs, environmental services workers)? | ○ Yes<br>○ No |
| 15) Does your hospital have a system in place for both the initial and recurrent training and validation of hand hygiene compliance observers? | ○ Yes<br>○ No |

### *Feedback*

| | |
|---|---|
| 16) Are unit-level hand hygiene compliance data fed back to individuals who touch patients or who touch items that will be used by patients[44] at least monthly for improvement work? | ○ Yes<br>○ No |
| 17) Are unit-level hand hygiene compliance data used for creating unit-level action plans? | ○ Yes<br>○ No |
| 18) Is regular (at least every 6 months) feedback of hand hygiene compliance data, with demonstration of trends over time, given to:<br>• senior administrative leadership, physician leadership, and nursing leadership,<br>• the board (governance), and<br>• the medical executive committee?<br><br>*If "no" to question #18, skip question #19 and continue to question #20.* | ○ Yes<br>○ No |
| 19) If "yes" to question #18, is senior administrative leadership, physician leadership, and nursing leadership held directly accountable for hand hygiene performance through performance reviews or compensation? | ○ Yes<br>○ No |

### *Culture*

| | |
|---|---|
| 20) Are patients and visitors invited to remind individuals who touch patients or who touch items that will be used by patients[44] to perform hand hygiene? | ○ Yes<br>○ No |
| 21) Have **all** the following individuals (or their equivalents) demonstrated a commitment to support hand hygiene improvement in the last year (e.g., a written or verbal commitment delivered to those individuals who touch patients or who touch items that will be used by patients[44]):<br>• Chief Executive Officer,<br>• Chief Medical Officer, and<br>• Chief Nursing Officer? | ○ Yes<br>○ No |


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# 6D: Diagnostic Excellence

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Notes:**

Note 1: This subsection will not be scored or publicly reported.

Note 2: An error in the diagnostic process is an event where one or both of the following occurred, with harm or high potential of harm to the patient:

- Delayed, wrong, or missed diagnosis: At least one missed opportunity to pursue or identify an accurate and timely diagnosis based on the information that existed at the time.
- Diagnosis not communicated to the patient: An accurate diagnosis was available but was not effectively communicated to the patient or family caregiver.

All references to "errors in the diagnostic process" refer to both types of events.

Note 3: Diagnosis excellence means making and communicating a correct and timely diagnosis using appropriate resources while maximizing patient experience and managing uncertainty.

**Reporting Period:** Answer questions #1-8 based on the latest **24 or 36 months** prior to Survey submission (see individual question for specific reporting period).

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

### *Convening a Multidisciplinary Team Focused on Diagnostic Excellence*

| | |
|---|---|
| 1) Does your hospital have a multidisciplinary team that meets all the following requirements:<br>• Focused on reducing harm to patients from errors in the diagnostic process;<br>• Sponsored by either the CEO or CMO;<br>• Includes, at a minimum, representatives from nursing, pharmacy, laboratory medicine, radiology, pathology, hospital medicine or inpatient care specialists, emergency medicine, and quality or risk management;<br>• Meets at least quarterly;<br>• Reports to senior leaders quarterly;<br>• Reports to the Board annually; and<br>• Includes at least one patient and/or care partner?<br><br>*The multidisciplinary team can be the established hospital-wide safety and quality committee if the committee has a dedicated agenda item at least quarterly to review efforts focused on reducing harm to patients from errors in the diagnostic process.*<br><br>*If "no" to question #1, skip questions #2-5 and continue to question #6.* | ○ Yes<br>○ No<br>○ Yes, but our multidisciplinary team does not yet include a patient and/or care partner |
| 2) As a standing agenda item of at least quarterly meetings, has the multidisciplinary team reviewed any clinical or administrative data, patient experience or patient reported data, or incident reports to identify or track errors in the diagnostic process? | ○ Yes<br>○ No |

| | |
|---|---|
| 3) In the past 24 months, has the multidisciplinary team convened the emergency medicine staff to develop or implement any initiatives aimed at improving accurate and timely diagnosis of commonly misdiagnosed conditions? | ○ Yes<br>○ No<br>○ No, but the emergency medicine staff have independently implemented at least one such initiative, and presented their initiative to the multidisciplinary team |
| 4) In the past 24 months, has the multidisciplinary team convened pathologists and radiologists to develop or implement protocols to ensure timely review and resolution of discrepancies, and timely communication of diagnoses to patients and their families? | ○ Yes<br>○ No<br>○ No, but radiologists and pathologists independently developed or implemented at least one such protocol, and presented their protocol to the multidisciplinary team |
| 5) In the past 24 months, has the multidisciplinary team encouraged all staff (verbally or in writing), including all clinicians who participate in the diagnostic process, to report errors in the diagnostic process via the hospital's incident or event reporting system? | ○ Yes<br>○ No |
| 6) In the past 36 months, has your hospital used the Safer Dx Checklist to identify at least one high-priority practice that is not currently at "Full" implementation?<br>*If "yes, but all practices are currently fully implemented," or "no" to question #6, skip question #7 and continue to question #8.* | ○ Yes, led by our multidisciplinary team<br>○ Yes, led by a different team at the hospital<br>○ Yes, but all practices are currently fully implemented<br>○ No |
| 7) What steps has your hospital taken to implement one or more practices listed in the Safer Dx Checklist?<br>*Select all that apply.* | ☐ Allocated budget<br>☐ Appointed an individual or team responsible for implementation<br>☐ Set a date for full implementation<br>☐ None of the above |

### *Training on Communication to Reduce Errors in the Diagnostic Process*

| | |
|---|---|
| 8) In the past 36 months, has your hospital trained any staff using AHRQ's TeamSTEPPS for Diagnosis Improvement program to improve communication among members of the care team (including nurses, pharmacists, and other allied health professionals), within the context of the diagnostic process or in reducing errors in the diagnostic process? | ○ Yes<br>○ No |


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# 6E: Hospital Boarding in the Emergency Department (ED) (Optional – Fact-Finding Only)

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Notes:**

Note 1: This subsection will not be scored or publicly reported.

Note 2: Only include units that were open for the entire reporting period and that remain currently open.

Note 3: When reporting on questions #4 and/or #5, pediatric patients admitted to an adult bed should be included in question #4. Pediatric patients admitted to a pediatric bed should be included in question #5. Hospitals that do not operate dedicated pediatric inpatient or observation units, but admit pediatric patients, should only respond to question #4.

**Specifications:** See ***Hospital Boarding in the Emergency Department (ED) Measure Specifications*** in the Reference Information beginning on page 246.

**Reporting Period: 12 months**

- Surveys submitted prior to September 1:
  - 01/01/2025 – 12/31/2025
- Surveys (re)submitted on or after September 1:
  - 07/01/2025 – 06/30/2026

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

| | |
|---|---|
| 1) 12-month reporting period used: | ○ 01/01/2025 – 12/31/2025<br>○ 07/01/2025 – 06/30/2026 |
| 2) Did your hospital operate a dedicated emergency department (ED) [46] during the reporting period?<br><br>*If "no" or "yes, but ED is now closed or wasn't open for the entire reporting period," skip questions #3-5 and go to the Affirmation of Accuracy.* | ○ Yes<br>○ No<br>○ Yes, but ED is now closed or wasn't open for the entire reporting period |
| 3) What type(s) of dedicated emergency department(s)[46] did your hospital operate?<br><br>*Select all that apply.* | ☐ Adult only<br>☐ Pediatric only<br>☐ Adult/Pediatric combined |

*If "Adult only" or "Adult/Pediatric combined" to question #3, answer question #4 based on the patients admitted to adult inpatient non-psychiatric and psychiatric beds (including ED visits where the patient was placed in hospital observation status).*


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4) Enter your hospital's total number of emergency department (ED) visits with an admission to an adult inpatient non-psychiatric or psychiatric bed (including ED visits where the patient was placed in hospital observation status) in column (a), the number of those ED visits indicated in column (a) with a boarding time greater than 4 hours, the total boarding time (in hours) for ED visits indicated in column (a), the median number of hours spent in the ED for ED visits indicated in column (a), and the 90th percentile of hours spent in the ED for ED visits indicated in column (a).

*If the number of visits for an adult admission type is less than 10 (in column a), skip columns b, c, d, and e and then move to the next admission type.*

*For columns c, d, and e, enter hours and minutes up to one decimal place (e.g., enter 1.5 to denote 1 hour and 30 minutes).*

| **Admission Type** | **ED Visits, Boarding Time, and Time Spent in the ED** | | | | |
|---|---|---|---|---|---|
| | **(a) Total number of ED visits with an inpatient admission or where the patient was placed in hospital observation status** | **(b) Number of ED visits indicated in column (a) with a boarding time greater than 4 hours** | **(c) Total boarding time (in hours) for ED visits indicated in column (a)** | **(d) Median number of hours spent in the ED for ED visits indicated in column (a)** | **(e) 90th percentile of hours spent in the ED for ED visits indicated in column (a)** |
| Admitted to an adult inpatient **non-psychiatric bed** | | | | | |
| Admitted to an adult inpatient **psychiatric bed** | | | | | |

*If "Pediatric only" or "Adult/Pediatric combined" to question #3, answer question #5 based on the patients admitted to pediatric inpatient non-psychiatric and psychiatric beds (including ED visits where the patient was placed in hospital observation status).*

5) Enter your hospital's total number of emergency department (ED) visits with an admission to a pediatric inpatient non-psychiatric or psychiatric bed (including ED visits where the patient was placed in hospital observation status) in column (a), the number of those ED visits indicated in column (a) with a boarding time greater than 4 hours, the total boarding time (in hours) for ED visits indicated in column (a), the median number of hours spent in the ED for ED visits indicated in column (a), and the 90th percentile of hours spent in the ED for ED visits indicated in column (a).

*If the number of visits for a pediatric admission type is less than 10 (in column a), skip columns b, c, d, and e and then move to the next admission type.*

*For columns c, d, and e, enter hours and minutes up to one decimal place (e.g., enter 1.5 to denote 1 hour and 30 minutes).*

| **Admission Type** | **ED Visits, Boarding Time, and Time Spent in the ED** | | | | |
|---|---|---|---|---|---|
| | **(a) Total number of ED visits with an inpatient admission or** | **(b) Number of ED visits indicated in column (a) with a** | **(c) Total boarding time (in hours) for ED visits** | **(d) Median number of hours spent in the ED for ED visits** | **(e) 90th percentile of hours spent in the ED for ED visits** |

| | **where the patient was placed in hospital observation status** | **boarding time greater than 4 hours** | **indicated in column (a)** | **indicated in column (a)** | **indicated in column (a)** |
|---|---|---|---|---|---|
| Admitted to a pediatric inpatient **non-psychiatric bed** | | | | | |
| Admitted to a pediatric inpatient **psychiatric bed** | | | | | |

**Affirmation of Accuracy**

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Patient Safety Practices Section at our hospital, and I hereby affirm that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this affirmation on behalf of our hospital.

The hospital and I acknowledge that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also acknowledge that analyses and ratings The Leapfrog Group derives from this information will be made public on the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade website, and/or other Leapfrog Group published works, products and services. The hospital and I acknowledge that analyses and ratings derived from this information and all intellectual property rights related to those analyses and ratings shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. I hereby affirm that this information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may license analyses and ratings derived from this information to other entities including researchers, not-for-profit entities, and for-profit entities, and the revenue from such licensure will be used solely to support The Leapfrog Group's not-for-profit mission. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
*(first name and last name)* *(title)*
on _____.
*(date)*


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# Section 6: Patient Safety Practices Reference Information

### *What's New in the 2026 Survey*

### Section 6A: NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems

In consultation with Leapfrog's Patient and Family Caregiver Expert Panel, Leapfrog is updating the term used in Safe Practice 1.1b, from "patients and/or families of patients" to "patients and/or care partners," to be inclusive of a broader population of potential active participants to consider for inclusion in the hospital-wide safety and quality committee.

Leapfrog is updating FAQ #9 in Section 1.1b to define a "patient and/or care partner" as any patient who has currently, or in the past, received care at the hospital campus, as well as their family members or other trusted individuals navigating or participating in a patient's care at the hospital (e.g., facilitate communication, participate in consent process).

Leapfrog received extensive public comments regarding a potential update to the 2027 Hospital Survey to strengthen the participation of patients and/or care partners on the hospital-wide quality and safety committee by requiring two or more patients and/or care partners on committees. Commenters across stakeholder groups consistently support incorporating patients and their care partners in quality and safety committees and specifically cite the valuable feedback they have provided to hospitals in that context and the role they've played as partners in improving clinical care delivery. However, hospitals cited obstacles to increasing the number of representative participants and recommended that Leapfrog pursue a standard to further incorporate patients' perspectives in quality and safety efforts that goes beyond participation in a specific committee, but instead reflects participation through other venues, including PFACs, structured post-care interviews, or other targeted ways to solicit patient feedback.

Finally, hospitals in a health system noted that because they convene individual hospital committees at each campus, they are already hearing from numbers of patients and families, including at network committees that already will have the benefit of multiple participating patients. All comments will be reviewed with Leapfrog's Expert Panel as part of Leapfrog's regular standard review process prior to announcing any potential changes for the 2027 Leapfrog Hospital Survey.

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

There are no changes to this subsection. As a reminder, the AHRQ Hospital Survey on Patient Safety Culture Version 1.0 can no longer be used for the purposes of reporting on the 2026 Leapfrog Hospital Survey. Only Version 2.0 may be used. Similarly, SCORE can no longer be used for the purposes of reporting on the 2026 Leapfrog Hospital Survey. Only SCORE II may be used. Please reference the Guidelines for a Culture of Safety Survey document available on our website.

### Section 6C: Hand Hygiene

There are no changes to this subsection.

**Request for Information**

As part of our request for public comments, Leapfrog included a request for information and recommendations on strengthening all elements of the Hand Hygiene standard, prompted by ongoing dialogue with the Association for Professionals in Infection Control and Epidemiology (APIC). Leapfrog appreciates the over one hundred commenters that submitted information. Some comments supported APIC's perspective that 50 observations are sufficient for monitoring. Several comments requested that Leapfrog consider alternatives to the monitoring requirements due to current burden and potential for reporting bias such as cumulative sampling and point prevalence models. Many also added that they encourage Leapfrog to maintain its current multimodal approach to hand hygiene and the five domains included while revisiting the monitoring requirements. Some commenters supported maintaining Leapfrog's standard as is. One commenter suggested that the hand hygiene measure be removed entirely given the inclusion of associated outcomes like the healthcare-associated infections.

Leapfrog and its Hand Hygiene Expert Panel continue to conclude that the current monitoring standard is necessary to ensure hospitals are using reliable data on both hand hygiene compliance and changes in


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compliance levels. This is based on a comprehensive literature review and statistical analysis. However, given the relatively limited body of literature available on this topic and the compelling comments, Leapfrog will continue working with APIC, World Health Organization, and others to test the standard and determine if changes are merited for the 2027 Leapfrog Surveys.

## Section 6D: Diagnostic Excellence

To better assess overall national performance in this emerging area of patient safety, Leapfrog is requiring hospitals to report on Section 6D: Diagnostic Excellence beginning with the 2026 Leapfrog Hospital Survey. However, responses will not be scored or publicly reported.

Leapfrog is removing several questions in this subsection to focus on the most effective evidence-based practices to reduce diagnostic errors, including convening a multidisciplinary team; leveraging that team to collect and review data, encourage data submission, assess progress on the Safer Dx Checklist; training staff using AHRQ's TeamSTEPPS for Diagnosis Improvement, and convening emergency medicine staff, radiologists, and pathologists, to develop and implement protocols to reduce the incidence of diagnostic errors..

Progress on implementing these best practices will be assessed by eight questions, compared to 22 questions from the 2025 Hospital Survey.

We removed the following questions:

- Questions #1 and #2, concerning hospital CEO or CMO commitment to reducing harm to patients due to diagnostic error and communicating specific actions as part of that commitment.
    - Note: The hospital's CEO or CMO is still required to formally sponsor the multidisciplinary team, as well as review quarterly reports from the team and facilitate a report-out to the hospital board every year. As such, the hospital CEO and CMO are still required to meaningfully and publicly engage with staff to reduce harm to patients from diagnostic error; this question is being removed to streamline reporting.
- Questions #3 and #4, concerning engaging with Patient and Family Advisory Councils (PFACs) on initiatives aimed at reducing errors in diagnosis.
    - Note: Leapfrog is adding a new requirement, that the hospital's multidisciplinary team must include at least one patient and/or care partner (for example, the patient and/or care partner currently serving on the patient safety committee). The Agency for Healthcare Research and Quality has specifically cited including patients as members of quality and safety committees as a "next step" beyond convening a patient and family advisory council, representing a progressive incremental step in patient and care partner engagement (AHRQ Working with Patients and Families as Advisors Implementation Handbook). A majority of hospitals that report to the Leapfrog Hospital Survey have incorporated patients and care partners in their hospital-wide quality and safety committees; hospitals that elect to use these committees as an opportunity to prioritize diagnosis work by dedicating specific time on their agenda to diagnosis can continue to use the same patient and/or care partners, or use this opportunity to engage additional individuals.
- Question #8, concerning whether the multidisciplinary team focused on diagnostic excellence has educated staff on their efforts to reduce errors in diagnosis.
- Question #10, concerning whether the multidisciplinary team conducted any analyses or case reviews within four weeks of a diagnostic error being identified and ensured the findings were communicated to the individuals involved in the patient's care and hospital leadership.
- Questions #12 and #14, concerning the multidisciplinary team convening emergency medicine staff to identify commonly misdiagnosed conditions in the emergency department, as well as convening radiologists and pathologists to discuss diagnosis related issues. Instead, questions #13 and #15 are updated to capture this information.
- Questions #17-22, assessing hospitals' processes for assessing whether certain cancer diagnoses were communicated to patients or the ordering provider of the diagnostic test (closing the loop on cancer diagnosis).


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In addition, Leapfrog is updating the current question #1, regarding whether a hospital has convened a multidisciplinary team focused on diagnostic excellence, in two key aspects:

- First, Leapfrog is revising the guidance embedded in the question to read: "The multidisciplinary team can be the established hospital-wide safety and quality committee if the committee has a dedicated agenda item at least quarterly to review efforts focused on reducing harm to patients from errors in the diagnostic process."

  In prior years, the guidance indicated that the multidisciplinary team should be a distinct entity and separate from the established hospital-wide safety and quality committee. However, in response to hospital feedback and in consultation with our Diagnostic Excellence Expert Panel, Leapfrog determined that a safety and quality committee with dedicated time for discussion meets the intent of the question.

- Second, Leapfrog is updating the wording of question #1 to read "does your hospital have a multidisciplinary team," a change from the previous "does your hospital convene a multidisciplinary team," to allow hospitals who belong to a system that has convened a system-level committee focused on diagnostic excellence to use that team to guide efforts at both a system level and on individual campuses.

- Third and finally, as indicated above, Leapfrog now requires that the multidisciplinary team include at least one patient and/or care partner.

Furthermore, Leapfrog is updating the response options to indicate that if a different team at the hospital met the requirements of questions #3 and #4, that team must also present their findings to the multidisciplinary team.

To clarify the current question #6 and question #7, Leapfrog is adding a response option "Yes, but all practices are currently fully implemented" to question #6, and rephrasing question #7 to read "What steps has your hospital taken to implement one or more practices listed in the Safer Dx Checklist?".

To further clarify terminology used throughout this section, Leapfrog is replacing the term "errors in diagnosis" with "errors in the diagnostic process", where applicable.

Finally, although Leapfrog is removing former questions #3, #4, and #10 in this subsection, the underlying diagnostic safety concepts associated with these questions remain important and addressable by hospitals using resources created by Leapfrog as part of our Diagnostic Excellence initiative. As such, Leapfrog is adding two new FAQs to Section 6D: Diagnostic Excellence to direct hospitals to these resources:

**Section 6E: Hospital Boarding in the Emergency Department (ED)**
In 2025, Leapfrog announced the decision to begin reporting on Emergency Department (ED) safety, recognizing the ED's essential role in patient outcomes and importance to consumers and purchasers. As the first step in that reporting, the 2025 Leapfrog Hospital Survey introduced three fact-finding measures on hospital boarding in the ED. These included: the percentage of ED patients that are admitted to the hospital or for observation that had a boarding time greater than four hours, the median length of stay in the ED for patients admitted to the hospital or for observation, and the 90th percentile length of stay in the ED for patients admitted to the hospital or for observation. These measures excluded patients that were placed in ED observation status or transferred to another hospital.

Leapfrog is making several refinements to last year's questions and measure specifications and will add one new question for the 2026 Leapfrog Hospital Survey, aimed at standardizing data collection, improving clarity, and strengthening the foundation for future benchmarking and public reporting.

First, based on feedback from Leapfrog's Emergency Department Boarding Expert Panel, we are updating questions #4 and #5 and asking hospitals to additionally report the total boarding time (in hours) for all ED visits with an inpatient admission or where the patient was placed in hospital observation status. This will allow Leapfrog to understand the average hours patients admitted to the hospital boarded in the


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ED. This information will complement the existing data collected about patients that board for four or more hours.

Second, the notes and measure specifications will be updated for clarity and to support standardized data collection. Specifically, the definitions for boarding time, guidance for hospitals operating a single general ED that are admitting pediatric patients to adult inpatient beds or adult observation beds, and guidance for hospitals admitting patients to licensed detox beds.

Finally, four new FAQs will be added to provide additional clarification regarding reporting expectations and definitions.

These questions will remain optional and will not be used in scoring or public reporting in 2026.

### *Change Summary Since Release*

June 23, 2026 – Added Psychological Safety Culture Survey as an approved Option 3 Culture of Safety Survey. All approved Culture of Safety Surveys are available in Guidelines for a Culture of Safety Survey available on the Survey and CPOE Materials webpage.


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# Section 6: Patient Safety Practices Measure Specifications

## *NQF Safe Practice Measure Specifications*

**Instructions for Reporting on NQF Safe Practices:**

1. **Prepare:**
    a. Download and review a copy of the National Quality Forum's *Safe Practices for Better Healthcare – 2010 Update* report for reporting on subsections 6A and 6B available at http://leapfroggroup.org/survey-materials/survey-and-cpoe-materials.
    b. Print and review a hard copy of (1) the Survey questions, (2) the practice-specific FAQs, and (3) the scoring algorithm.

2. **Identify Individuals to Assist:** Decide who should participate on your team to assist in collection of the documentation for assessment.

3. **Plan:** The team should be briefed and assigned duties to help capture the key information necessary for submission of this section.

4. **Collect and Maintain**: Key documentation must be collected to support answering the questions in this section of the Survey. Please refer to the Survey Binder for examples of acceptable documentation. Documentation should be maintained to ensure that your hospital can respond to Leapfrog's request for documentation should you be selected for our Monthly Documentation Requirements. Reviews are performed every month during the Survey Cycle (April 1 to November 30) and throughout the Corrections Period. In addition, the documentation can be helpful if your hospital is planning to update and resubmit this section of the Survey prior to November 30.

5. **Assess:** When all the supporting documents are assembled, it is recommended that hospitals review their final responses to Section 6 with the CEO and/or responsible leadership. Hospitals should update their answers online as they adopt additional practices throughout the Survey Cycle (April 1 to November 30). As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

6. **Submit:** Section 6 must be completed and affirmed before it can be submitted with the Survey.


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### *Hand Hygiene Measure Specifications*

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

**Source:** The framework and questions in this subsection are modeled after the World Health Organization's Hand Hygiene Self-Assessment Framework.

**Reporting Period:** Answer questions #1-21 based on the practices currently in place at the time you submit this section of the Survey.

Note: For monitoring, this means that the monthly sample size (or quarterly sample size if answering question #10) would need to be met at least once in each patient care unit the month (or quarter) preceding the time of the submission of the Survey and there must be a process in place to meet the monthly (or quarterly) sample size thereafter in each patient care unit every month/quarter.

If the monitoring sample size is not met at any point after submission, the Survey must be updated and re-submitted. More information about updating a Survey can be found at https://www.leapfroggroup.org/survey-materials/updating-your-hospital-survey.

As a reminder, Leapfrog randomly requests documentation on a monthly basis and key documentation must be collected and maintained to support responses to all questions. Hospitals are urged to regularly review their documentation, including reports supporting their monitoring of hand hygiene, and maintain copies throughout the Survey Cycle. Please refer to the Survey Binder for examples.

**Patient Care Units:** Include only the following patient care units when reporting on the questions in this subsection:

- Medical, Surgical, and Medical/Surgical Units (including telemetry units)[19] (adult and/or pediatric)
- Step-down/progressive Units[20] (adult and/or pediatric)
- Obstetrical Units (Labor and Delivery Units[21], nursery, etc., excluding procedural areas)
- General Medical, Surgical, Medical/Surgical, and Neuro ICUs[14] (adult and/or pediatric)
- Level II/III, Level III, or Level IV Neonatal ICU[17]
- Specialty ICUs (adult and/or pediatric)
- Pre-operative and Post-anesthesia Care Units[22] (adult and/or pediatric)
- Observation Units (adult and/or pediatric)
- Dedicated Emergency Departments[47] (adult and/or pediatric)

Other units that are not denoted above would be excluded for the purposes of reporting on Section 6C Hand Hygiene. The following units would be excluded:

- Behavioral Health Units
- Psychiatric Units
- Palliative Care and Hospice Units
- Rehabilitation Units
- Operating Rooms
- Procedural and Diagnostic Areas, such as Radiology, Endoscopy, Dialysis, and Radiation Units
- Admission Units that don't hold patients overnight
- Primary Care Clinics
- Units that are not currently open and/or were not open consistently throughout the entire reporting period (i.e., most recent month or past three months based on responses selected in monitoring questions #8-10)

***Infrastructure***

**Question #4:** Does your hospital have a process in place to ensure that **all** the following are done, as necessary, and quarterly audits are conducted on a sample of dispensers in your patient care units to ensure that the process is followed?

- Refill paper towels, soap dispensers, and alcohol-based hand sanitizer dispensers when they are empty or near empty
- Replace batteries in automated paper towel dispensers, soap dispensers, and alcohol-based hand sanitizer dispensers (if automated dispensers are used in the patient care units)

In order to respond "yes" to question #4, a process must be in place to ensure that paper towel, soap, and alcohol-based hand sanitizer dispensers are refilled when they are empty or near empty and batteries are replaced in automated paper towel, soap, and alcohol-based hand sanitizer dispensers (if automated dispensers are used in patient care units).

In addition, a quarterly audit must be conducted on a sample of paper towel, soap, and alcohol-based hand sanitizer dispensers to include checking that dispensers are refilled and that batteries in automated dispensers are replaced. The quarterly audit should be a supplement to a system that checks these supplies on a routine basis (e.g., environmental services check with their regular cleaning).

**Sampling Instructions:** The sample must be based on a random or systematic sampling procedure, where the sampling plan assures wide sampling (i.e., the same places would not always be monitored) and includes at least 5% of the dispensers in 20% of the patient care units.

**Question #6:** Does your hospital conduct audits of the volume of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated) on a sample of dispensers in your patient care units at **all** the following times:

- upon installation;
- whenever the brand of product or system changes; and
- whenever adjustments are made to the dispensers;

OR

Has your hospital conducted an audit of the volume of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated) on a sample of your hospital's existing dispensers if there have been no changes to any dispensers?

In order to respond "yes" to question #6, a volume audit on a sample of wall-mounted alcohol-based hand sanitizer dispensers (manual and automated) in your patient care units must be conducted **at least** once (upon installation, whenever the brand of product or system changes, and whenever adjustments are made to the dispensers) using one of the below methods. Prior volume audits are acceptable if they were conducted using the instructions in Leapfrog's 2019-2025 Surveys, documentation has been maintained, and no changes have been made to the dispensers since the audit.

**Sampling Instructions:** The sample must be based on a random or systematic sampling procedure, where the sampling plan assures wide sampling (i.e., the same places would not always be monitored) and includes at least 5% of the dispensers.

**Method #1 - Auditing Liquid Volume:** To audit the ***liquid volume*** of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated), use the following process:

1. Select a sample of dispensers based on a random or systematic sampling procedure.
2. Take a small, graduated plastic medicine cup and have the dispenser deliver 10 doses of alcohol-based hand sanitizer.
3. Divide the total volume dispensed by 10 to get an average of the amount dispensed.

NOTE: Hospitals using foam alcohol-based hand sanitizer will need to follow the steps above, but will instead need to weigh the sample, divide the results by 10 to obtain the average output of the sample, and then convert the weight in grams to milliliters by dividing the weight by the density (which can be provided by your vendor for your specific product).


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**Method #2 - Auditing Average Hand Rubbing Time:** To audit the ***average hand rubbing time*** of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated), use the following process:

1. Select a sample of dispensers based on a random or systematic sampling procedure.
2. Identify multiple individuals (at least 10) with varying hand sizes (by quick observation).
3. For each sampled dispenser, have each of the individuals identified in step #1 dispense a volume of alcohol-based hand sanitizer.
4. For each individual, have a separate individual time the amount of hand rubbing time required for hands to dry completely.
5. Repeat this process for each individual and calculate an **average** time based on the ten observations conducted.
6. Repeat this process for each sampled dispenser.

**Question #7:** Do all the audited dispensers deliver, with one activation, 1.0 mL of alcohol-based hand sanitizer OR a volume of alcohol-based hand sanitizer that covers the hands completely and requires 15 or more seconds for hands to dry (on average)?

In order to respond "yes" to question #7, the **average** liquid volume for **each** sampled dispenser needs to be at least 1.0 mL (if using method #1) or the **average** hand rubbing time for **each** sampled dispenser needs to be at least 15 seconds (if using method #2).

***Monitoring***

**Hand hygiene opportunities:** Hand hygiene opportunities are the number of times that an individual who touches patients or who touches items used by patients should have cleaned their hands given the hand hygiene framework your hospital has adopted (e.g., WHO's "5 moments," Ontario's 4 moments, CDC's guidelines, etc.). In terms of determining opportunities to monitor, this would depend on the guidelines the hospital chooses to follow.

For example, many facilities choose to audit before and after patient contact or room entry and exit because this is operationally the simplest method. Auditing opportunities before and after dirty tasks is operationally difficult. There is some evidence that measuring adherence on room entry and exit may be an acceptable stand-in for other opportunities within the patient encounter.

**Electronic compliance monitoring system:** Electronic compliance monitoring systems would include door minder or activity monitoring systems, systems that include the wearing of electronic badges, and camera-based systems that are used to monitor hand hygiene compliance.

**Question #8:** Does your hospital collect hand hygiene compliance data on at least **200 hand hygiene opportunities**, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 1-3, **each month in each patient care unit**?

In order to respond "yes" to question #8, your hospital must monitor at least **200 hand hygiene opportunities**, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 1-3, **each month in each patient care unit** using either:

- An electronic compliance monitoring system throughout all patient care units
- An electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units
- Only direct observation throughout all patient care units

Refer to the following tables to determine how many hand hygiene opportunities must be monitored in each patient care unit monthly for question #8. **Historical data** (e.g., past 3 months, 6 months, 12 months, etc.) on the monthly occupancy rates or procedure/patient volumes should be used.

Units/areas can be combined for the purposes of determining if you have met the monthly or quarterly monitoring sample size if they share a common group of staff (i.e., staff are scheduled to work in the broader area and float between units or staff may be scheduled to work either unit on any given day). Hand hygiene opportunities would still need to be monitored throughout both units/areas.


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**Table 1: Units where the monthly occupancy rate can be calculated**

| If your unit's average daily census is… | Your patient care unit needs to collect hand hygiene compliance data for at least this number of hand hygiene opportunities per month for question #8… |
|---|---|
| 13 patients or higher | 200 |
| 10-12 patients | 150 |
| 7-9 patients | 100 |
| 5-6 patients | 75 |
| 3-4 patients | 45 |
| 1-2 patients | 15 |

**Table 2: Units where the monthly occupancy rate cannot be calculated (e.g., PACU, labor and delivery, outpatient units)**

| If your unit's average number of procedures/patient volume in a month is… | Your patient care unit needs to collect hand hygiene compliance data for at least this number of hand hygiene opportunities per month for question #8… |
|---|---|
| 400 procedures/patients or greater | 200 |
| 320-399 procedures/patients | 150 |
| 240-319 procedures/patients | 100 |
| 160-239 procedures/patients | 75 |
| 120-159 procedures/patients | 50 |
| 60-119 procedures/patients | 30 |
| 30-59 procedures/patients | 15 |
| <30 procedures/patients | 5 |

**Table 3: Emergency department units**

| If your emergency department's average number of visits in a month is… | Your patient care unit needs to collect hand hygiene compliance data for at least this number of hand hygiene opportunities per month for question #8… |
|---|---|
| 2000 visits or greater | 200 |
| 1500-1999 visits | 150 |
| 1000-1499 visits | 100 |
| 750-999 visits | 75 |
| 500-749 visits | 50 |
| 250-499 visits | 25 |
| 150-249 visits | 15 |
| <150 visits | 5 |

**Question #9:** Does your hospital collect hand hygiene compliance data on at least **100 hand hygiene opportunities**, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 4-6, **each month in each patient care unit**?

In order to respond "yes" to question #9, your hospital must monitor at least **100 hand hygiene opportunities**, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 4-6, **each month in each patient care unit** using either:

- An electronic compliance monitoring system throughout all patient care units
- An electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units
- Only direct observation throughout all patient care units

Refer to the following tables to determine how many hand hygiene opportunities must be monitored in each patient care unit monthly for question #9. **Historical data** (e.g., past 3 months, 6 months, 12 months, etc.) on the monthly occupancy rates or procedure/patient volumes should be used.


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Units/areas can be combined for the purposes of determining if you have met the monthly or quarterly monitoring sample size if they share a common group of staff (i.e., staff are scheduled to work in the broader area and float between units or staff may be scheduled to work either unit on any given day). Hand hygiene opportunities would still need to be monitored throughout both units/areas.

**Table 4: Units where the monthly occupancy rate can be calculated**

| **If your unit's average daily census is…** | **Your patient care unit needs to collect hand hygiene compliance data for at least this number of hand hygiene opportunities per month for question #9…** |
|---|---|
| 13 patients or higher | 100 |
| 10-12 patients | 75 |
| 7-9 patients | 50 |
| 5-6 patients | 37 |
| 3-4 patients | 22 |
| 1-2 patients | 7 |

**Table 5: Units where the monthly occupancy rate cannot be calculated (e.g., PACU, labor and delivery, outpatient units)**

| **If your unit's average number of procedures**/patient volume **in a month is…** | **Your patient care unit needs to collect hand hygiene compliance data for at least this number of hand hygiene opportunities per month for question #9…** |
|---|---|
| 400 procedures/patients or greater | 100 |
| 320-399 procedures/patients | 75 |
| 240-319 procedures/patients | 50 |
| 160-239 procedures/patients | 37 |
| 120-159 procedures/patients | 25 |
| 60-119 procedures/patients | 15 |
| 30-59 procedures/patients | 7 |
| <30 procedures/patients | 2 |

**Table 6: Emergency department units**

| **If your emergency department's average number of visits in a month is…** | **Your patient care unit needs to collect hand hygiene compliance data for at least this number of hand hygiene opportunities per month for question #9…** |
|---|---|
| 2000 visits or greater | 100 |
| 1500-1999 visits | 75 |
| 1000-1499 visits | 50 |
| 750-999 visits | 37 |
| 500-749 visits | 25 |
| 250-499 visits | 15 |
| 150-249 visits | 7 |
| <150 visits | 2 |

**Question #10:** Does your hospital collect hand hygiene compliance data on at least **100 hand hygiene opportunities each quarter in each patient care unit**?

In order to respond "yes" to question #10, your hospital must monitor at least **100 hand hygiene opportunities each quarter in each patient care unit** using either:

- An electronic compliance monitoring system throughout all patient care units
- An electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units
- Only direct observation throughout all patient care units


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There are no alternate sample sizes for the quarterly requirement. Hospitals trying to meet the quarterly requirement in question #10 will need to monitor 100 hand hygiene opportunities a quarter.

Units/areas can be combined for the purposes of determining if you have met the monthly or quarterly monitoring sample size if they share a common group of staff (i.e., staff are scheduled to work in the broader area and float between units or staff may be scheduled to work either unit on any given day). Hand hygiene opportunities would still need to be monitored throughout both units/areas.

**Question #12:** In those patient care units where an electronic compliance monitoring system is used, does the monitoring system used meet both of the following criteria?

- The system can identify both opportunities for hand hygiene and that hand hygiene was performed
- The hospital itself has validated the accuracy of the data collected by the electronic compliance monitoring system

In order to respond "yes" to question #12, the electronic monitoring system in use must identify both opportunities and that hand hygiene was performed, which could include both group monitoring systems and badge-based systems.

For example, an electronic monitoring system that records when an individual (not identified) enters and exits a room and also records if a dispenser was used within the same time frame, would qualify as the entry and exit is used as a proxy for a hand hygiene opportunity (before and after touching a patient) and the dispenser use is used as a proxy for a hand hygiene event. This data can be adjusted to take visitors into account and used to estimate hand hygiene compliance. Another example would be a badge-based system where individuals or their roles can be identified.

In addition, validation of the accuracy of the data collected by the electronic compliance monitoring system must be performed by hospital personnel or independent third-party personnel, in addition to any validation conducted by the manufacturer. It needs to include both a "planned path" phase where the researcher(s) make timed observations of room entries and exits and use of dispensers and compare their results to data recorded by the electronic compliance monitoring system. Followed by a "behavioral path" phase where observers record the same variables when individuals who touch patients or who touch items that will be used by patients are performing their usual duties, as this tends to be more chaotic and variable. A general validation protocol that can be used for both group monitoring systems and badge-based systems has been described in a fair amount of detail in the 2016 article by Limper H et al. Similar methods for conducting validation studies of badge-based system have been described by Pineles LL, et al. in 2014, and by Doll ME et al. in 2019. The 2023 article from Parker et al. regarding sample sizes for the validation can also be referenced.

**Question #13:** In those patient care units where an electronic compliance monitoring system is used, are direct observations also conducted for coaching and intervention purposes that meet all the following criteria?

- Observers immediately intervene prior to any harm occurring to provide non-compliant individuals with immediate feedback
- Observations identify both opportunities for hand hygiene and compliance with those opportunities
- Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct
- Observations within a unit are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of individuals who touch patients or who touch items that will be used by patients[44] on duty for that shift
- Observations capture a representative sample of the different roles of individuals who touch patients or who touch items that will be used by patients[44] (e.g., nurses, physicians, techs, environmental services workers)

In order to respond "yes" to question #13, direct observations must be conducted for coaching and intervention purposes and meet the following sample sizes at a minimum:

**In units with either low hand hygiene compliance* and/or units with high infection rates**:**

- On a monthly basis, hospitals will need to perform 20 direct observations.

- If after collecting those observations, more than 50% of the observations were NOT compliant and/or did NOT demonstrate proper technique, the hospital will need to perform an additional 20 observations the following month (40 total observations per unit with low hand hygiene compliance or high infection rates).
- The hospital must continue to collect 40 observations per month until the number of observations that are NOT compliant and/or did not demonstrate proper technique is reduced to less than 50%.

Compliance and infection rates must be assessed at least quarterly and additional observations need to be collected on a monthly basis for the entire quarter if warranted based on the above rules. If a standardized infection ratio cannot be calculated for the quarter, units with 2 or more observed infections should do the additional collection of direct observations.

**Low hand hygiene compliance is defined as two or more standard deviations below the hospital's overall mean hand hygiene compliance rate.*

***High infection rates are defined as two or more standard deviations above the hospital's standardized infection ratio for any of the following healthcare-associated infection measures: CLABSI, CAUTI, MRSA, and C.diff.*

**In all other units:**

- On a quarterly basis, hospitals using ECM need to perform 10% of the observations noted in Tables 1-3 in ALL patient care units included in Leapfrog's Hand Hygiene Standard (e.g., if the unit would require 200 direct observations without ECM, then with the use of ECM, they need to collect 20 direct observations).
- Units in which direct observation data is being collected monthly (i.e., units with low hand hygiene compliance and/or high infection rates) do not require the additional quarterly data collection.

All direct observations conducted must meet the following criteria:

- Observers immediately intervene prior to any harm occurring to provide non-compliant individuals with immediate feedback
- Observations identify both opportunities for hand hygiene and compliance with those opportunities
- Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct
- Observations within a unit are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of individuals who touch patients or who touch items that will be used by patients[44] on duty for that shift
- Observations capture a representative sample of the different roles of individuals who touch patients or who touch items that will be used by patients[44] (e.g., nurses, physicians, techs, environmental services workers)

Observers must record at least the following:

- The date as well as the start and end time of the observation session (or the date and shift being observed)
- The unit where the observation session is being conducted
- The role of the individual being observed (e.g., nurse, physician, etc.)
- The indication (or moment) for performing hand hygiene (e.g., before/after touching a patient, before/after a procedure, before/after touching patient surroundings, etc.)
- Whether hand hygiene was performed or not performed based on the indication noted and if the technique was correct

**Question #14:** In those patient care units where an electronic compliance monitoring system is NOT used, do the direct observations meet all the following criteria?

- Observations identify both opportunities for hand hygiene and compliance with those opportunities
- Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct
- Observations within a unit are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of individuals who touch patients or who touch items that will be used by patients[44] on duty for that shift
- Observations capture a representative sample of the different roles of individuals who touch patients or who touch items that will be used by patients[44] (e.g., nurses, physicians, techs, environmental services workers)

In order to respond "yes" to question #14, direct observations must be conducted in patient care units that do not use an electronic compliance monitoring system and must meet the following criteria:

- Observations identify both opportunities for hand hygiene and compliance with those opportunities
- Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct
- Observations within a unit are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of individuals who touch patients or who touch items that will be used by patients[44] on duty for that shift
- Observations capture a representative sample of the different roles of individuals who touch patients or who touch items that will be used by patients[44] (e.g., nurses, physicians, techs, environmental services workers)

Observers must record at least the following:

- The date as well as the start and end time of the observation session (or the date and shift being observed)
- The unit where the observation session is being conducted
- The role of the individual being observed (e.g., nurse, physician, etc.)
- The indication (or moment) for performing hand hygiene (e.g., before/after touching a patient, before/after a procedure, before/after touching patient surroundings, etc.)
- Whether hand hygiene was performed or not performed based on the indication noted and if the technique was correct

**Question #15**: Does your hospital have a system in place for both the initial and recurrent training and validation of hand hygiene compliance observers?

In order to respond "yes" to question #15, your hospital must regularly monitor the quality and accuracy of observations that are collected by each observer through initial and recurrent validation (at least once a year) of hand hygiene compliance observers. This would include having an individual trained in infection control simultaneously collecting data with the hand hygiene compliance observers and comparing results. Alternatively, videos which include an interactive assessment and completion of an observation form, such as the WHO Hand Hygiene Training Film and Slides Accompanying the Training Films, Videos from Hand Hygiene Australia, or internally developed videos with assessment, would also be sufficient for validating hand hygiene compliance observers. Hospitals must expand the testing scenarios that are included in the videos (i.e., the videos should be expanded to include: various types of individuals who touch patients or who touch items that will be used by patients, a larger number of scenarios where individuals are adherent and non-adherent, the inclusion of all moments observed, etc.).

See FAQs for additional information about responding to the questions in this section.


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## *Hospital Boarding in the Emergency Department (ED) Boarding Measure Specifications*

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

**Source:** The Leapfrog Group

**Reporting Period: 12 months**

- Survey submitted prior to September 1:
  - 01/01/2025 – 12/31/2025
- Surveys submitted on or after September 1:
  - 07/01/2025 – 06/30/2026

**Hospital Boarding in the ED Workbook (Excel):**

To complete the data collection and respond to questions #4-5, hospitals should download the Hospital Boarding in the Emergency Department Workbook (Excel). This workbook includes five tabs: Instructions, Adult Inpatient Non-Psychiatric, Adult Psychiatric, Pediatric Inpatient Non-Psychiatric, Pediatric Psychiatric. The workbook can be used to calculate the responses to questions #4 and #5:

- (b) Number of ED visits indicated in column (a) with a boarding time greater than 4 hours
- (c) Total boarding time (in hours) for ED visits indicated in column (a)
- (d) Median number of hours spent in the ED for ED visits indicated in column (a)
- (e) 90th percentile of hours spent in the ED for ED visits indicated in column (a)

The workbook is available on the Survey Materials Webpage.

**Included Units:**

- Dedicated Emergency Department[46] (adult, pediatric, and adult/pediatric)

**Question #4, column a:** Total number of ED **visits** with an inpatient admission or where the patient was placed in hospital observation status.

Enter the total number of emergency department (ED) visits during the reporting period for each of the following admission types:

Patients admitted to an adult inpatient **non-psychiatric bed**
Patients admitted to an adult inpatient **psychiatric bed**

**Include:**

- Patients with an ED visit that were admitted to the hospital's inpatient setting or placed in hospital observation status.
- Patients with an ED visit that were admitted to the hospital's licensed detoxification beds should be included in this question's count of patients admitted to inpatient psychiatric beds
- Patients with an ED visit that were admitted to a psychiatric unit located or co-located with the hospital, even if that unit operates under a separate CCN.

**Exclude:**

- Patients with an ED visit that were placed in ED observation status.
- Patients transferred to another hospital.

Note: A patient can have multiple ED visits with a hospital admission and/or placed in hospital observation status during the performance period so each patient ED visit with an inpatient admission or placement into hospital observation status is included in the denominator (question #4a).

***If the number of visits for an adult admission type is less than 10 (in column a), skip columns b, c, d, and e and then move to the next admission type.***

**Question #4, column b:** Number of ED **visits** indicated in column (a) with a boarding time greater than 4 hours.

Enter the total number of emergency department (ED) **visits** indicated in column (a) with a boarding time greater than 4 hours for each of the following admission types:

Patients admitted to an adult inpatient **non-psychiatric bed**
Patients admitted to an adult inpatient **psychiatric bed**

**Include:**

- Patients with an ED visit that were admitted to the hospital's inpatient setting or placed in hospital observation status with an ED boarding time that was longer than 4 hours.

**Boarding time** is defined as the time from the decision to admit (e.g., admission order) to the patient's final departure from the ED."

**Question #4, column c:** Total boarding time (in hours) for ED visits indicated in column (a).

Enter the total boarding time (in hours) for ED visits indicated in column (a) for each of the following admission types:

Patients admitted to an adult inpatient **non-psychiatric bed**
Patients admitted to an adult inpatient **psychiatric bed**

**Include:**

- Total number of hours spent in the ED for patients with an ED visit that were admitted to the hospital's inpatient setting or placed in hospital observation status.

**Boarding time** is defined as the time from the decision to admit (e.g., admission order) to the patient's final departure from the ED.

**Question #4, column d:** Median number of **hours** spent in the ED for ED visits indicated in column (a).

Enter the median number of hours spent in the ED for ED visits indicated in column (a) for each of the following admission types:

Patients admitted to an adult inpatient **non-psychiatric bed**
Patients admitted to an adult inpatient **psychiatric bed**

**Include:**

- Hours spent in the ED for patients with an ED visit that were admitted to the hospital's inpatient setting or placed in hospital observation status.

**Hours spent in the ED** is defined as the difference between the "patient arrival time at the ED" to "final patient departure from the ED."

**Question #4, column e:** 90$^{th}$ percentile of **hours** spent in the ED for ED visits indicated in column (a).

Enter the 90$^{th}$ percentile of hours spent in the ED for ED visits indicated in column (a) for each of the following admission types:

Patients admitted to an adult inpatient **non-psychiatric bed**
Patients admitted to an adult inpatient **psychiatric bed**

The **90th percentile** represents the amount of time in which 90% of the patients fall below that value. For example, if your hospital's 90th percentile of hours spent in the ED is 36.5 hours, it means that 90% of your ED patients who were admitted to the hospital were in the ED for 36.5 hours or less.

**Include:**

- Hours spent in the ED for patients with an ED visit that were admitted to the hospital's inpatient setting or placed in hospital observation status.

**Hours spent in the ED** is defined as the difference between the "patient arrival time at the ED" to "final patient departure from the ED."


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**Question #5, column a:** Total number of ED **visits** with an inpatient admission or where the patient was placed in hospital observation status.

Enter the total number of emergency department (ED) visits during the reporting period for each of the following admission types:

Patients admitted to a pediatric inpatient **non-psychiatric bed**
Patients admitted to a pediatric inpatient **psychiatric bed**

**Include:**

- Patients with an ED visit that were admitted to the hospital's inpatient setting or placed in hospital observation status.
- Patients with an ED visit that were admitted to the hospital's licensed detoxification beds should be included in this question's count of patients admitted to inpatient psychiatric beds
- Patients with an ED visit that were admitted to a psychiatric unit located or co-located with the hospital, even if that unit operates under a separate CCN.

**Exclude:**

- Patients with an ED visit that were placed in ED observation status.
- Patients transferred to another hospital.

Note: A patient can have multiple ED visits with a hospital admission and/or placed in hospital observation status during the performance period so each patient ED visit with an inpatient admission or placement into hospital observation status is included in the denominator (question #5a).

***If the number of visits for a pediatric admission type is less than 10 (in column a), skip columns b, c, d, and e and then move to the next admission type.***

**Question #5, column b:** Number of ED **visits** indicated in column (a) with a boarding time greater than 4 hours.

Enter the total number of emergency department (ED) **visits** indicated in column (a) with a boarding time greater than 4 hours for each of the following admission types:

Patients admitted to a pediatric inpatient **non-psychiatric bed**
Patients admitted to a pediatric inpatient **psychiatric bed**

**Include:**

- Patients with an ED visit that were admitted to the hospital's inpatient setting or placed in hospital observation status with an ED boarding time that was longer than 4 hours.

**Boarding time** is defined as the time from the decision to admit (e.g., admission order) to the patient's final departure from the ED.

**Question #5, column c:** Total boarding time (in hours) for ED visits indicated in column (a).

Enter the total boarding time (in hours) for ED visits indicated in column (a) for each of the following admission types:

Patients admitted to a pediatric inpatient **non-psychiatric bed**
Patients admitted to a pediatric inpatient **psychiatric bed**

**Include:**

- Total number of hours spent in the ED for patients with an ED visit that were admitted to the hospital's inpatient setting or placed in hospital observation status.

**Boarding time** is defined as the time from the decision to admit (e.g., admission order) to the patient's final departure from the ED.


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**Question #5, column d:** Median number of **hours** spent in the ED for ED visits indicated in column (a).

Enter the median number of hours spent in the ED for ED visits indicated in column (a) for each of the following admission types:

Patients admitted to a pediatric inpatient **non-psychiatric bed**
Patients admitted to a pediatric inpatient **psychiatric bed**

**Include:**

- Hours spent in the ED for patients with an ED visit that were admitted to the hospital's inpatient setting or placed in hospital observation status.

**Hours spent in the ED** is defined as the difference between the "patient arrival time at the ED" to "final patient departure from the ED."

**Question #5, column e:** 90th percentile of **hours** spent in the ED for ED visits indicated in column (a).

Enter the 90th percentile of hours spent in the ED for ED visits indicated in column (a) for each of the following admission types:

Patients admitted to a pediatric inpatient **non-psychiatric bed**
Patients admitted to a pediatric inpatient **psychiatric bed**

The **90th percentile** represents the amount of time in which 90% of the patients fall below that value. For example, if your hospital's 90th percentile of hours spent in the ED is 36.5 hours, it means that 90% of your ED patients who were admitted to the hospital were in the ED for 36.5 hours or less.

**Include:**

- Hours spent in the ED for patients with an ED visit that were admitted to the hospital's inpatient setting or placed in hospital observation status.

**Hours spent in the ED** is defined as the difference between the "patient arrival time at the ED" to "final patient departure from the ED."


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# Section 6: Patient Safety Practices Frequently Asked Questions (FAQs)

## *General Questions*

1. **For the purposes of reporting on Section 6 of the Leapfrog Hospital Survey:**

   a. **Frontline caregivers** include, but are not necessarily limited to employed physicians, mid-levels (NPs, PAs), nurses, environmental services staff, allied health professionals, and occupational and physical therapists.

   b. **Service line management** refers to those who manage all functions within a specific service line (e.g., oncology, cardiac, women's, orthopedics). These individuals may be managing a departmental sub-function within a broader department (e.g., cardiac care within the Department of Medicine).

   c. **Midlevel management** includes the intermediate management of an organization that is subordinate to the executive management and responsible for at least two lower levels of staff below them. An example would include a Director of Nursing, who might oversee Nursing Managers, who oversee the nurses who care directly for patients.

   d. **Physician leadership** refers to physicians who serve in a leadership role in the organization. Titles may include positions such as Chief Medical Officer, Vice President for Medical Affairs, Medical Director, and/or Department Chair.

   e. **Nursing leadership** refers to nurses who serve in a leadership role (e.g., Chief Nursing Officer, Vice President/Assistant Vice President of Nursing, Vice President/Assistant Vice President for Clinical Operations, etc.)

   f. **Senior administrative leadership** refers to administrators who are responsible for hospital-wide departments or services (e.g., Chief Executive Officer, Chief Administrative Officer, Chief Nursing Officer, Chief Medical Officer, etc.).

   g. **Patient Safety Officer** refers to the patient safety leader (who may or may not have the title "Patient Safety Officer") who has responsibility for multiple and integrated areas of patient safety. The organization may appoint an officer who may have other assigned duties or may specifically employ a Patient Safety Officer designated with this responsibility. Multiple executives who are responsible for individual areas (i.e., risk, quality, infection prevention, etc.), but do not assess the integrated safety issues, would not qualify.

   h. **Board (governance)** refers to the individual hospital's board of directors, or the board that governs the hospital and can pass policies that impact the hospital, or a system-wide board that governs hospitals in the system, or a committee of the board (such as a board-appointed, hospital-wide Patient Safety and Quality Committee, which includes board members).

   i. **Medical executive committee** refers to a primary governance committee for medical staff. The medical executive committee makes leadership decisions related to medical staff policies, procedures, and rules, with an emphasis on quality control and quality improvement. They also adopt and implement these policies and procedures and are responsible for medical staff appointment and reappointment.

2. **Why is it necessary to continue to review a safe practice once it has been implemented?**
   All too often in the hectic pace of providing patient care in a hospital, with frequent staff turnover and lots of part-time employees, it is difficult to get a change in practice well-established. Annual review with monitoring and tracking of the safe practices will ensure that they are embedded in the operations of the hospital and not lost in the transition of new staff coming in or part-time employees coming and going.


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3. **The phrase "performance reviews or compensation" is used throughout Section 6 within many *Accountable* elements. Do performance reviews and compensation plans need to have specific language about the Safe Practice or can a set of patient safety goals related to the specific Safe Practice be attached?**
   A performance review or compensation plan should include specific language about a Safe Practice. A list of Safe Practices and related goals may be incorporated into the performance review and/or compensation plan or formalized programs whereby a measure of success of those activities or programs is tied to individual performance reviews or compensation incentive plans of executives.

   Every employee should have a patient safety component included in their annual review. Another option is to include in the employee's competency review (Ongoing Professional Practice Evaluation, Focused Professional Practice Evaluation).

4. **There are several references to hospital budgets throughout Section 6 within many *Ability* elements. How can hospitals meet the intent of these elements?**
   The intent of these elements is to verify that actions specific to the Safe Practices have been included in hospital budgets. To meet the intent of these elements, hospitals should ensure that these actions can be identified within a department budget or hospital budget. If the budget includes categories that address the Safe Practice but do not specifically name the Safe Practice, then the intent of the element is met.

   Further, if a hospital has not allocated budget dollars for activities tied to a Safe Practice but can document expenses specific to the Safe Practice during the reporting period, the intent of the element is met. Plans to allocate specific budget dollars for a Safe Practice should be incorporated into the next upcoming budget year as an ongoing process.

   Hospitals may also document training or education expenditures specific to the Safe Practice or expenditures on educational materials that are specific to the Safe Practice.

   Hospitals that have invested in in-house staff educators and who include in their job descriptions the coordination and delivery of training and education to appropriate hospital staff on specific Safe Practices meet the intent of this element. For example, if the position description for an in-house educator, such as the Quality Director, includes the coordination and delivery of in-service training and educational sessions related to improving the culture of safety based on the organization's culture of safety survey results, then the intent of this practice is met. Specific time allocations are not required as long as there is documentation of staff participation through dated meeting minutes or attendance records. Training can be in-person or virtual/ computer-based.

5. **How should staff education be measured?**
   Educational meetings should clearly address the subject matter pertinent to adverse events and performance improvement targeted by the specific Safe Practice. Hospitals should track meeting dates, frequency of training sessions provided, attendance records or completion records, and the percentage of the total staff who received the information. Training can be in-person or virtual/ computer-based.

6. **There are several references to developing or implementing Performance Improvement Programs throughout Section 6 within many *Action* elements. How can hospitals meet the intent of these elements?**
   At a minimum, performance improvement programs should include **all** the following five criteria:

   - **Education** regarding the pertinent adverse event frequency, severity, and/or impact of best practices. These expenses should be budgeted and tracked to meet the budget elements of the Safe Practices.
   - **Skill building** in use of performance improvement tools. These expenses should be budgeted and tracked to meet the budget elements of the Safe Practices.
   - **Measurement** of process measures or outcomes measures. The "Outcome, Process, Structure, and Patient-Centered Measures" section at the end of each Safe Practice in the


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NQF Safe Practices for Better Healthcare 2010 Update suggests performance measures that can be used to support measuring and monitoring quality improvement efforts. The NQF Safe Practices for Better Healthcare – 2010 Update report is available for download here: http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials.

- **Process improvement** and interventions.
- **Reporting** of performance outcomes.

A "campaign" such as an awareness campaign would not meet the intent of these elements.

### *NQF Safe Practice #1 – Leadership Structures and Systems FAQs*

7. **1.1a, 1.2b, and 1.2d: Several elements within NQF Safe Practice #1 mention that "regular communication" is required. How does Leapfrog define "regular communication"?**
   Regular communication means more than once a year. Some hospitals may discuss these items quarterly or even monthly. Hospitals can document that these communications took place through dated meeting minutes. We would urge hospitals to improve the details of their board and other meeting minutes to ensure they are able to clearly document that the issues were discussed.

   The discussion of these items can be a general note in the minutes, without specific details. However, hospitals should maintain copies of dated presentations and reports related to these agenda items in order to document adherence to these elements. Meetings can be in-person or virtual.

8. **1.1a: If NQF Safe Practice #4 – Identification and Mitigation of Risks and Hazards has been removed from the Leapfrog Hospital Survey, are hospital boards still expected to communicate regularly regarding risks and hazards?**
   Though we are not asking hospitals to report on this Safe Practice, it remains important to communicate the actions you are taking to identify and mitigate risks and hazards to patients to your board.

9. **1.1b: What is meant by "patients and/or care partners are active participants in the hospital-wide safety and quality committee?"**
   To meet the intent of this element, hospitals must have patients and/or care partners participate on the hospital-wide safety and quality committee. A patient and/or care partner can be any patient who has currently, or in the past, received care at the hospital campus, as well as their family members or other trusted individuals navigating or participating in a patient's care at the hospital (e.g., facilitate communication, participate in consent process).

   The safety and quality committee should have influence over hospital-wide quality and safety issues, not just a particular department or service line. Hospitals with a system-wide safety and quality committee must have one patient representative per campus on the system-wide safety and quality committee.

   Meetings should be formal, and minutes should be taken. Topics covered should be related to broad oversight of hospital-wide patient safety and quality issues and what is being done to effect changes. An example would be tracking and preventing adverse events.

   In most hospitals, due to the scope of issues discussed at Patient and Family Advisory Council (PFAC) meetings, having a PFAC would not meet the criteria for a safety and quality committee. If your hospital has a PFAC member on the hospital-wide patient safety and quality committee, then your hospital is meeting the intent of this safe practice.

   Patients and/or care partners can participate in these meetings in person, via conference call, or via video conference. Hospitals do not meet the intent of this element if the patients and/or care partners are invited but do not regularly attend. It is the responsibility of the hospital to ensure that patients and/or care partners can provide their perspectives to other committee members during meetings. The patient serving on that committee should have the experience, orientation or training needed to understand and effectively contribute to safety and quality committee issues.


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Hospitals should identify people who are not Board members or employees to serve on the committee so the participant can represent the views of patients and without conflict. Board members have a fiduciary responsibility to the organization, and therefore may have a potential conflict representing the views of patients and/or care partners.

Hospitals can document adherence to this element by maintaining committee rosters and meeting minutes with attendance and participation noted. Patients and/or care partners should have the opportunity to present or co-present a topic, lead or co-lead a discussion, or co-chair the committee, and this should be noted in the meeting minutes. Patients and/or care partners should have attended at least one meeting prior to Survey submission.

Hospitals in the process of adding patients/care partners to the hospital-wide safety and quality committee can refer to AHRQ's toolkit for engaging patients and families in hospital improvement work for more information at https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/index.html.

10. **1.1c: What are some examples of how a hospital can report to the community ongoing efforts and results of these efforts to improve safety and quality?**
Hospitals can utilize several communication vehicles to reach the broader community, including webpages that are prominent from the organization's homepage, electronic newsletters, mailings or annual reports, or an ad in the local paper. The communication must include **both** efforts the hospital is taking to improve safety and quality and the results of those efforts. As the sole focus of the NQF Safe Practices for Better Health Care report is reducing or preventing adverse events (refer to NQF list of adverse events at https://digitalassets.jointcommission.org/api/public/content/4534bbaaee4f4bd280c2054765f37f4b?v=a60f8f9a), patient safety and quality efforts **reported to the community** must have this focus as well. In other words, efforts the hospital is taking to improve safety and quality should be related to reducing or preventing these adverse events and the results of those efforts would be the measurable outcomes.

    Meetings where a few community members are present would not meet the intent of this practice as the intent is to reach a larger audience.

    Each hospital within the same health care system would need to report the results to the community for each hospital in the system because the results of efforts to improve safety and quality would be different at each hospital.

11. **1.2a, 1.3a, 1.4c: What are the minimum requirements to qualify as a "patient safety program?"**
As part of accreditation through The Joint Commission, hospitals are required to meet standard LD.03.09.01, which identifies the elements that must be included in an integrated patient safety program (see pages 57 – 62 in the Organization Culture and System Performance Expectations chapter of The Joint Commission E-dition). Hospitals that are not accredited by The Joint Commission can use these elements as a guide as well.

12. **1.2d: What is the role of an interdisciplinary patient safety committee?**
An interdisciplinary patient safety committee is an internal hospital committee that oversees the activities defined in the NQF Safe Practice #1 Practice Element Specifications and develops action plans to create solutions and changes in performance.

13. **1.2d: What is an example of team training that is appropriate for caregivers?**
Hospitals can utilize TeamSTEPPS, a comprehensive, evidence-based training program for health care professionals. At a minimum, the elements of basic teamwork training should be met as described on page 96 of the Safe Practices for Better Healthcare– 2010 Update, which is available for download here: http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials.


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Team training to caregivers would need to be provided and then reported to senior administrative leadership by the interdisciplinary patient safety team to meet the intent of Safe Practice 1.2d.

14. **1.2e: How can hospitals that have not had any adverse events during the reporting period earn credit for this element?**
    First, we urge your hospital to reassess its conclusion that no adverse events occurred; that would be highly unusual. Following the reassessment, if no adverse events were identified **and** the hospital can document that it has policies in place to report such events when they do occur (to a mandatory or voluntary program), the hospital would meet the intent of this element. Please see Section 7A: Never Events for a list of adverse events and components of a Never Events Policy.

15. **1.4a: What are some examples of how the CEO and senior administrative leadership can be personally engaged in reinforcing patient safety improvements?**
    Executive walk-arounds are an example of how the CEO and senior administrative leadership can be personally engaged in reinforcing patient safety improvements. The executive walk-arounds provide staff with visibility and access to senior management. They also provide the CEO and senior administrative leadership with the opportunity to address issues and concerns in various departments in real-time, rather than in monthly meetings. Monthly meetings with staff in a centralized location do not meet the intent of this Safe Practice.

    Progress on the implementation of walk-arounds can be measured by tracking the number of walk-arounds performed per unit or clinical area for designated time periods as shown in the calendars of the CEO and senior administrative leadership. Some progressive hospitals have tied incentives to regular executive walk-rounds and to reliable exchange of information on clinical unit performance. Some hospitals have established a feedback loop between the CEO and senior administrative leadership and staff to measure the implementation of performance improvement ideas that were generated during executive walk-arounds.

16. **1.4b: What are some examples of how the CEO can actively engage leaders from service lines, midlevel management, clinical leadership, and physician leadership in patient safety improvement actions?**
    Hospitals can refer to the American College of Healthcare Executives professional policy statement, which includes two evidence-based resources:

    - Leading a Culture of Safety: A Blueprint for Success
    - Safer Together: A National Plan to Advance Patient Safety

17. **1.4c: What are some examples of how hospitals can engage the medical staff as direct contributors to the patient safety program?**
    Examples may include:
    - Senior leadership requests time on Medical Staff Department standing agendas to provide patient safety updates and elicit direct feedback on specific areas as well as “what keeps the medical staff up at night.”
    - Medical staff are invited and encouraged to be active participants in clinical unit meetings where patient safety is addressed.
    - The board appoints a community-based active medical staff member to represent the organization on a regional patient safety initiative.

18. **1.4c: In a hospital where all medical staff is employed, how do we answer this question?**
    The intent of this element is to ensure that physicians and medical staff have the opportunity to provide input on the hospital’s patient safety plan because often they do not have a significant position in the hierarchal structure of an organization but carry a great deal of influence over how the organization is run. Thus, they are informal leaders who can be change agents and “accelerators or barriers for improvement.” If the organization's board and senior administrative leadership seek and document input from physicians and medical staff regarding patient safety programs, the intent of this element has been met.


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### *NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention FAQs*

19. **Why are two different reporting periods used in NQF Safe Practice #2?**
    Within the *Awareness and Accountability* elements, a 24-month reporting period is used because these elements are related to conducting the culture of safety survey, which is typically conducted every other year. Within the *Ability and Action* elements, a 12-month reporting period is used because these practices are related to follow-up activities that would be completed after the results from the culture of safety survey are available.

20. **2.1a: What are the requirements to qualify as a "culture of safety survey?"**
    Several surveys are readily available that specifically address culture, safety climate, and teamwork. These surveys incorporate all the additional specifications as outlined in NQF Safe Practice #2 (see 2010 NQF Safe Practice Report).

    Hospitals that do not use a nationally recognized culture of safety tool must ensure that their culture of safety survey meets Leapfrog's guidelines for what constitutes a valid, consistent, and reliable survey tool. These guidelines were developed in consultation with Leapfrog's Culture of Safety Expert Panel. The guidelines can be found on the Survey and CPOE Materials webpage under supporting materials for Section 6.

    As a reminder, the AHRQ Hospital Survey on Patient Safety Culture Version 1.0 can no longer be used for the purposes of reporting on the 2026 Leapfrog Hospital Survey. Only Version 2.0 may be used. Similarly, SCORE can no longer be used for the purposes of reporting on the 2026 Leapfrog Hospital Survey. Only SCORE II may be used.

    A general employee satisfaction survey that has a small component of the survey addressing organizational culture does not qualify.

21. **2.1a Can an employee engagement survey and nationally recognized culture of safety tool be conducted at the same time?**
    Yes, if the culture of safety tool is unaltered and administered in its entirety.

22. **2.1a: What does "50% of the aggregated care delivered to patients within the hospital" mean?**
    As described on page 88 of the NQF Safe Practices for Better Healthcare Report, "a census of units or service areas that in aggregate deliver care to more than 50 percent of the patients receiving care should be surveyed, service lines or units where there is a high patient safety risk should be measured, and there should be a valid sample to allow for unit-level analysis and facilitate improvement."

23. **2.1b: For reporting individual unit level results, what is the minimum number of responses a hospital should have?**
    Most major vendors use a threshold of 5 or more responses and a 40% response rate. For larger units, a lower response rate may be acceptable. If a unit does not meet these thresholds, your hospital could aggregate the results of "like" units together (e.g., medical/surgical units, ICUs, ORs). Hospitals should not combine results across "unlike" units.

24. **2.1c: What is meant by "like" hospitals? Can hospitals benchmark against those within the same network or system? How would a pediatric hospital benchmark against other pediatric hospitals?**
    Hospitals should benchmark their results against hospitals with similar demographics, such as hospital type, number of beds, number of admissions, urban/rural designation, etc. Hospitals in systems or healthcare networks should benchmark throughout the health system, but not within the same region.


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Pediatric hospitals utilizing the AHRQ Hospital Survey on Patient Safety Culture can benchmark their results using the AHRQ's User Comparative Database Report (refer to instructions starting on page 29).

25. **2.1d: What is meant by roles and staff levels?**
    Roles are job types (e.g., surgeons, nurses, hospitalists, physician assistants, or clinical and non-clinical, etc.). Staff levels are defined within the organization's hierarchy (e.g., senior administrators, directors, managers, etc.).

26. **2.2b: Does performance evaluation criteria for senior administrative leadership need to include the actual targeted response rate to the culture of safety survey?**
    Yes. The organization's targeted response rate to the culture of safety survey should be included in performance evaluation criteria for senior administrative leadership. Criteria for using the survey results in improvement efforts should also be included to meet the intent of this element.

27. **2.3a: Which employees should be included in the staff education program? Employees in all units or just those in low-performing units?**
    Staff education needs to include education for all levels of staff, from senior administrative and clinical leadership to frontline caregivers. In addition, because all units have opportunities for improvement, the staff education should include all units but can focus on deficiencies of a specific unit or department.

28. **2.1e and 2.4b: What is the difference between 2.1e and 2.4b? Both seem to focus on sharing and discussing the Culture of Safety Survey results.**
    While both elements focus on sharing and discussing Culture of Safety Survey results, these elements focus on different audiences and activities, and the result is that different kinds of feedback are collected. Safe Practice 2.1e requires local leaders (e.g., unit/department manager) to engage their unit/departments in a discussion about the survey results, while Safe Practice 2.4b requires senior administrative leadership to engage each sampled unit in a discussion about the survey results and their concerns.

## *Hand Hygiene FAQs*

### Training and Education

29. **Are online training modules acceptable for the purposes of question #1 and question #3?**
    Online training modules are acceptable for the purposes of answering question #1 and question #3 if they meet all requirements outlined in the question.

    For question #1, the online training must be done at the frequency specified and would need to be delivered and/or developed by a professional with appropriate training and skills. For question #3, the online training must meet all six topics outlined in the question.

    Physical demonstration (question #2) **cannot** be done using an online training module.

30. **Can a hospital answer "yes" to the training and education questions #1-3 if the training and education for medical/nursing/pharmacy students is done by the medical/nursing/pharmacy school?**
    Yes, you can answer "yes" to questions #1-3 if your hospital, alone, or in combination with other hospitals, has developed a standard orientation/on-boarding curriculum for students that meets all requirements outlined in the training and education questions. Your hospital will need to have continued and ongoing input into the curriculum, but the administration of the training and education for students, including physical demonstration of proper hand hygiene technique, could be conducted by the school.


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31. **What are examples of what can count as "physically demonstrating" proper hand hygiene during the initial hand hygiene training?**
    Before new individuals to your hospital have contact with patients and the patient care space, they will need to demonstrate proper hand hygiene with soap and water and alcohol-based hand sanitizer. This demonstration could be done as part of other onboarding activities, during occupational health activities as part of the TB test, during department orientations, in small groups, etc. A group "teach-back" would be acceptable, but with no more than 10 students per one trainer/monitor. An online or in-person "simulation" would not be sufficient for this purpose. Computer-based assessments of an individual's hand hygiene technique are acceptable if the assessment tracks an individual's hand motions, is done without providing instructions to the individual during the assessment, and feedback is given to them at the end.

    Hospitals that are starting to implement this component should add physical demonstration to their **initial** training for any **new** individuals who touch patients or who touch items that will be used by patients at their hospital**.** Leapfrog is not asking hospitals to retroactively train individuals.

## Infrastructure

32. **Is having an electronic system and dashboards that display low product and low battery reports which are used to ensure that the refilling and replacing of dispensers is completed in a timely manner sufficient for meeting the quarterly audit requirements in question #4?**
    Yes, if you have ongoing and reliable electronic ways of understanding when product or batteries are low, that would suffice for the audit. The goal is to make sure that supplies are available in soap, alcohol-based hand sanitizer, and paper towel dispensers.

33. **What does Leapfrog mean by "equally accessible to the location of all patients in the room or bed space" for the purposes of question #5?**
    Equally means the same distance from any patient's bed, which can be measured in steps. Leapfrog is not looking for an exact distance, but rather the goal is to ensure that hand hygiene can be easily performed regardless of the location of the patient being cared for in the room or bed space.

## Monitoring

34. **Why did Leapfrog select 200 hand hygiene opportunities for monthly monitoring in question #8?**
    200 hand hygiene opportunities were chosen as the sample size based on a study by Yin et. al which showed that 180-195 opportunities would need to be monitored to accurately observe a 10% change in hand hygiene compliance (Yin et al.). The additional sample sizes outlined in the measure specifications are for smaller patient care units where monitoring 200 opportunities may not be feasible.

    References:
    Steed C, Kelly JW, Blackhurst D, Boeker S, Diller T, Alper P, Larson E. Hospital hand hygiene opportunities: where and when (HOW2)? The HOW2 Benchmark Study. American Journal of Infection control. 2011 Feb 1;39(1):19-26.

    Jun Yin MS, Heather Schacht Reisinger PhD, Mark Vander Weg PhD, Marin L. Schweizer PhD, Andrew Jesson, Daniel J. Morgan MD MS, Graeme Forrest MD, Margaret Graham, Lisa Pineles MA and Eli N. Perencevich MD MS. Establishing evidence-based criteria for directly observed hand hygiene compliance monitoring programs: a prospective, multicenter cohort study. Infection Control and Hospital Epidemiology Vol. 35, No. 9 2014 Sep, pp. 1163-8.

35. **My hospital uses an electronic compliance monitoring system, but it does not meet all the criteria outlined in questions #12-13. Can I report on the hand hygiene compliance data we collect via direct observation instead?**


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Yes. If your hospital also uses direct observation to collect hand hygiene compliance data (not just for coaching/intervention) throughout **all** patient care units (including those with the electronic compliance monitoring system), you can select "yes, using only direct observation" in either question #8, question #9, or question #10 and report on your adherence to the direct observation criteria only. Otherwise, you will need to respond "no" to question #12.

36. **Is Leapfrog encouraging hospitals to implement electronic compliance monitoring? These systems can be costly, and the technology still needs to advance.**
The questions in the hand hygiene standard ask about a variety of strategies that can be used to monitor and improve hand hygiene. Leapfrog is encouraging hospitals to take a multimodal approach. Regarding monitoring, while hospitals can achieve the Leapfrog standard with direct observation alone, Leapfrog is communicating a strong preference for use of electronic monitoring (implemented according to evidence-based principles). In addition to literature suggesting electronic monitoring works better to pinpoint compliance issues, the difference in the sheer number of hand hygiene opportunities covered by the two monitoring strategies represent powerful evidence in favor of electronic monitoring. Electronic monitoring allows facilities to monitor virtually every patient encounter, while direct observation monitors a selection. Based on the evidence, our standard calls for monitoring 200 hand hygiene opportunities per unit per month, which is a small subset of overall hand hygiene opportunities. Even beyond capturing more encounters aligned with the evidence, electronic monitoring alleviates the ethical quandary of an observer watching patient harm without intervening.

    As with Computerized Physician Order Entry (CPOE) systems and Bar Code Medication Administration (BCMA) systems, we anticipate that electronic compliance monitoring technology will improve over time and become an important component of a comprehensive hand hygiene program. Electronic monitoring is a routine component of public safety in other industries where compliance is critical, so health care can and should achieve those standards for its patients.

    All items included in Section 6C are based on the evidence review and recommendations from Leapfrog's national Hand Hygiene Expert Panel and others. We have included in the Hand Hygiene bibliography several peer-reviewed studies that have examined the benefits of using electronic monitoring systems over direct observation. The bibliography is available at https://ratings.leapfroggroup.org/measure/hospital/2025/handwashing.

37. **How does reporting the number of hand hygiene opportunities monitored in questions #8-10 impact our hospital's scoring?**
Hospitals can earn "Achieved the Standard" by either answering "yes" to question #8 and monitoring 200 hand hygiene opportunities (or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 1-3 of the Hand Hygiene Measure Specifications) each month in each patient care unit and also meeting all other elements of the Monitoring and Feedback domains, as well as meeting all elements in 2 of the 3 remaining domains OR by answering "yes" to question #9 and monitoring at least 100 hand hygiene opportunities (or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 4-6 of the Hand Hygiene Measure Specifications) each month in each patient care unit and also meeting all other elements of the Monitoring domain and all elements in the remaining four domains. Facilities that answer "yes" to question #10 and only monitor 100 hand hygiene opportunities a quarter are only eligible to earn a maximum performance category of "Considerable Achievement" based on their adherence to the elements in the other domains. Hospitals should review the Hand Hygiene scoring algorithm in the 2025 Leapfrog Hospital Survey Scoring Algorithms document for more details.

38. **Are online training modules acceptable for the purposes of training hand hygiene compliance observers in question #15?**
Online training can be used for the initial and recurrent training of hand hygiene compliance observers. Please refer to the Hand Hygiene Measure Specifications for more information on the requirements for the validation of hand hygiene compliance observers.


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### Feedback

39. **For the purposes of responding to question #19, what are some examples of how hospital leadership can be held accountable through performance reviews or compensation?**
A performance review or compensation plan should include specific language about hand hygiene performance. A list of hand hygiene practices and related goals may be incorporated into the performance review and/or compensation plan or formalized programs whereby a measure of success of those activities or programs is tied to individual performance reviews or compensation incentive plans of executives. Examples include meeting targets for hand hygiene compliance rates, having bonuses tied to structural changes like the implementation of electronic compliance monitoring systems, etc. Language pertaining solely to infection control practices and performance would NOT be sufficient.

### Culture

40. **What are some examples of how patients and visitors can be invited to remind individuals who touch patients or who touch items that will be used by patients to perform hand hygiene?**
Patients and visitors can be invited to remind individuals who touch patients or who touch items that will be used by patients to perform hand hygiene with posters placed in patient care units, bedside placards, buttons worn by the staff, etc.

41. **What are some examples of demonstrating a commitment to hand hygiene improvement as referenced in question #21?**
Some examples of how individuals can demonstrate a commitment to support hand hygiene improvement are written or verbal commitments given during town hall meetings, videos, e-mails from the CEO, public comments to staff, etc. This needs to be a verbal or written commitment that is delivered to those individuals who touch patients or who touch items that will be used by patients.

### *Diagnostic Excellence FAQs*

42. **Can our hospital system convene a multidisciplinary team at the system level, instead of individual hospitals assembling teams at their respective facilities?**
Multidisciplinary teams convened to solely focus on reducing errors in the diagnostic process can be convened at the system level. However, each meeting must include specific discussion of each individual hospital in the system, in order to closely **oversee** case analyses, review data specific to individual sites, and be responsive to the individual hospital's leadership.

43. **As our hospital reviews clinical or administrative data, patient experience or patient reported data, or incident reports to identify or track errors in the diagnostic process, as described in question #2, what specific methodology should be used to conduct a root cause analysis of these errors in the diagnostic process?**
Together with a team of leading experts, Leapfrog has published Root Cause Analysis of Cases Involving Diagnosis: A Handbook for Healthcare Organizations. This resource offers authoritative guidance on how to modify existing approaches to conducting a RCA to study cases involving diagnosis. Guidance covers the process for finding cases of diagnostic error and how to convene an RCA team, map problems with the diagnostic process, use fishbone diagrams to consider possible domains of causes, and select appropriate interventions.

    The Agency for Healthcare Research and Quality has also published Measure Dx: A Resource to Identify, Analyze, and Learn from Diagnostic Safety Events that can be further leveraged as resource. The toolkit is open access, and includes strategies and resources (e.g. infographics, checklists, case review tools) that can be used to set a baseline for implementation, conduct a self-assessment, implement strategies, and reviewing and analyzing case data to identify actionable insights to improve patient safety and reduce diagnostic errors.


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44. **As our hospital pursues initiatives aimed at reducing harm to patients from errors in the diagnostic process, how can patients and/or care partners be engaged in that effort?**
In addition to including a patient and/or care partner on the multidisciplinary team focused on reducing harm to patients from errors in the diagnostic process, hospitals can work with their PFACs to reduce errors in the diagnostic process. Leapfrog has created a Patient and Family Advisory Council (PFAC) Toolkit for Exploring Diagnostic Quality, which offers specific guidance for hospitals and PFAC members who look to partner in designing and deploying initiatives to push for diagnostic safety. This web-based tool includes overall introductions to patient and family engagement and convening a PFAC, detailed information and educational materials on the diagnostic process aimed at a lay audience, and specific examples of model PFAC initiatives focused on diagnostic safety and quality.

45. **If our hospital is already conducting a TeamSTEPPS 3.0 training for staff, can the elements from TeamSTEPPS for Diagnosis Improvement be incorporated into the general TeamSTEPPS 3.0 training, rather than given as a standalone training?**
If your course facilitator for the TeamSTEPPS program specifically incorporates slides from the TeamSTEPPS for Diagnosis program to cover diagnosis-specific concepts and tools, that would be an acceptable approach, and is supported by the TeamSTEPPS for Diagnosis Course itself. Note that in slide 13 of the TeamSTEPPS for Dx Introduction Slide Set, facilitators are encouraged to "review all the TeamSTEPPS materials before planning your training. In this way, you can determine your site's communication needs and develop a targeted approach using the diagnosis-specific and general TeamSTEPPS tools as appropriate."

    Note that in order to document that the TeamSTEPPS for Diagnosis training was conducted, course materials should be saved and clearly indicate the TeamSTEPPS content specific to diagnosis has been incorporated, including key terms and examples used.

### *Hospital Boarding in the Emergency Department (ED) FAQs*

46. **Can hospitals use patient sampling to report data for Section 6E?**
No, hospitals are required to report on all applicable ED visits and cannot report using a sample.

47. **How should a co-located pediatric hospital within an adult hospital, sharing a single ED that treats both adult and pediatric patients, respond to this section?**
Hospitals should report on operating a pediatric emergency department in question #3 and then respond to question #5, where hospitals report on ED visits with an admission to a pediatric inpatient non-psychiatric or psychiatric bed (including ED visits where the patient was placed in hospital observation status).

48. **How should boarding time be calculated for ED patients who are admitted to the hospital but transferred from the ED to the cardiac catheterization lab or another diagnostic or procedural area before being transferred to the inpatient unit?**
Boarding time is calculated using the final departure time from the ED. If a patient leaves the ED for a test, treatment, or procedure, but then returns to the ED prior to being transferred to the inpatient bed, boarding time will continue and include the time spent in the test, treatment, or procedural area.

49. **How should boarding time be calculated for ED patients who are admitted to the hospital but transferred from the ED to an operating room for a surgical procedure before being transferred to the inpatient unit?**
Boarding time is calculated using the final departure time from the ED. If a patient leaves the ED for a surgical procedure, boarding time will end when they are transferred to the operating room if they do not return to the ED.


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# SECTION 7: MANAGING SERIOUS ERRORS

This section includes questions and reference information for Section 7: Managing Serious Errors. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

# Section 7: Managing Serious Errors

**Never Events Fact Sheet:** https://ratings.leapfroggroup.org/measure/hospital/2026/responding-never-events

Section 7 includes questions about your hospital's response to Never Events. In addition, Leapfrog collects information via its NHSN Group about five healthcare-associated infections (CLABSI, CAUTI, MRSA, *C. diff.*, and SSI: Colon). Hospitals reporting on Section 7B: Healthcare-Associated Infections are required to join Leapfrog's NHSN Group. Important information and deadlines are available on the *Review NHSN Instructions webpage*.

**Each hospital achieving the standard for Never Events:**
Has a policy that includes the nine principles of Leapfrog's Never Events policy and will implement this policy if a "never event" occurs within their hospital.

**Each hospital achieving the standards for Healthcare-Associated Infections (2015 Baseline Used for the June and August NHSN Downloads):**

1. Has a CLABSI standardized infection ratio of less than or equal to 0.413* for ICU and select ward inpatients.
2. Has a CAUTI standardized infection ratio of less than or equal to 0.427* for ICU and select ward inpatients.
3. Has a MRSA standardized infection ratio of less than or equal to 0.496* for facility-wide inpatients.
4. Has a *C. diff.* standardized infection ratio of less than or equal to 0.621* for facility-wide inpatients.
5. Has an SSI: Colon standardized infection ratio of less than or equal to 0.349* for inpatients following eligible colon procedures.

***** Once CMS begins calculating and publicly reporting HAI measures on Care Compare using the 2022 Baseline, Leapfrog will also transition to using data calculated with the 2022 Baseline in a reasonable and feasible timeframe. Following the first download of data with the 2022 Baseline, Leapfrog will reestablish cut-points used for the performance categories in Section 7B: Healthcare-Associated Infections (HAIs).

**Each hospital achieving the standards for Healthcare-Associated Infections (2022 Baseline Used for the October and December NHSN Downloads):**
Has a standardized infection ratio less than or equal to 0.333 for the applicable HAI measure (CLABSI, CAUTI, MRSA, *C. diff*, or SSI: Colon).

**Download the 2026 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.**


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# 7A: Never Events

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Note:** To earn credit for these questions, hospitals must have a policy in place that addresses the National Quality Forum's list of Serious Reportable Events. All references to "never event" or "serious reportable event" are specific to the National Quality Forum list available at https://digitalassets.jointcommission.org/api/public/content/4534bbaaee4f4bd280c2054765f37f4b?v=a60f8f9a.

**Reporting Period:**
Answer questions #1-9 based on the principles currently included in your hospital's never events policy at the time you submit this section of the Survey.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Below are the nine elements which make up The Leapfrog Group's Policy Statement regarding never events. [47] Indicate which of the following principles are included in your hospital's current never events policy.

| | |
|---|---|
| 1) We apologize to the patient [48] and/or family affected by the never event[47]. | ○ Yes<br>○ No |
| 2) We report the event to at least one of the following external agencies [49] within 15 business days of becoming aware that the never event[47] has occurred:<br>• Joint Commission, as part of its Sentinel Events policy;<br>• DNV GL Healthcare;<br>• State reporting program for medical errors; or<br>• Patient Safety Organization (as defined in The Patient Safety and Quality Improvement Act of 2005). | ○ Yes<br>○ No |
| 3) We perform a root cause analysis [50], which at a minimum, includes the elements required by the chosen external reporting agency.<br><br>*If "no," skip questions #6-7. The hospital will be scored as "Limited Achievement."* | ○ Yes<br>○ No |
| 4) We waive all costs directly related to the never event[47].<br><br>*In order to respond "yes" to this question, all costs directly related to the never event must be waived to both the patient and the payor.* | ○ Yes<br>○ No |
| 5) We make a copy of this policy available to patients, patients' family members, and payers upon request. | ○ Yes<br>○ No |
| 6) We interview patients and/or families, who are willing and able, to gather evidence for the root cause analysis[50]. | ○ Yes<br>○ No |
| 7) We inform the patient and/or the patient's family of the action(s) that our hospital will take to prevent future recurrences of similar events based on the findings from the root cause analysis[50]. | ○ Yes<br>○ No |
| 8) We have a protocol in place to provide support for caregivers involved in never events[47] and make that protocol known to all caregivers and affiliated clinicians. | ○ Yes<br>○ No |
| 9) We perform an annual review to ensure compliance with each element of Leapfrog's Never Events Policy for each never event[47] that occurred.<br><br>*If "no" to any questions #1-8, skip this question and continue to the next subsection.* | ○ Yes<br>○ No |


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# 7B: Healthcare-Associated Infections

Hospitals that share a CMS Certification Number must have a unique NHSN ID as required by NHSN. Please carefully review Leapfrog's Multi-Campus Reporting Policy on the Review NHSN Instructions webpage.

**Specifications:** See ***Healthcare-Associated Infections Measure Specifications*** in the Reference Information beginning on page 268.

**Reporting Period: 12 months**

- June and August Data Downloads: 01/01/2025 – 12/31/2025
- October and December Data Downloads: 07/01/2025 – 06/30/2026
- October and December Data Download for hospitals with 50 or fewer beds*: 07/01/2024 – 06/30/2026

**Bed size reported via the 2025 NHSN Patient Safety Component - Annual Survey's "Total Number of Beds Set Up and Staffed"*

*Leapfrog will update data four times per Survey Cycle for all members of our NHSN group that have provided an accurate NHSN ID in the Hospital Profile and submitted the 2026 Leapfrog Hospital Survey.*

*Visit the Review NHSN Instructions webpage for important information on deadlines for joining Leapfrog's NHSN Group.*

Leapfrog downloads standardized infection ratios (SIRs) directly from the CDC's National Healthcare Safety Network (NHSN) four times during the Survey Cycle for the following infection measures:

- CLABSI in ICUs and select wards;
- CAUTI in ICUs and select wards;
- Facility-wide inpatient MRSA Blood Laboratory-identified Events;
- Facility-wide inpatient C. diff. Laboratory-identified Events; and
- SSI: Colon

The measures are calculated by NHSN and will be scored and publicly reported for each hospital that joins Leapfrog's NHSN group, provides a valid NHSN ID in their Leapfrog Survey Profile, and submits a 2026 Leapfrog Hospital Survey by the published deadlines. Hospitals that have a predicted value <1 for an infection measure will be scored as "Unable to Calculate" for that measure.

| | |
|---|---|
| 1. Has your hospital joined Leapfrog's NHSN Group, reviewed Leapfrog's Data Rights Template, and provided a valid NHSN ID in the Profile? | ○ Yes<br>○ No, the hospital acknowledges that they will be publicly reported as "Declined to Report" for all five infection measures |


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**Affirmation of Accuracy**

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Managing Serious Errors Section at our hospital, and I hereby affirm that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this affirmation on behalf of our hospital.

The hospital and I acknowledge that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also acknowledge that analyses and ratings The Leapfrog Group derives from this information will be made public on the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade website, and/or other Leapfrog Group published works, products and services. The hospital and I acknowledge that analyses and ratings derived from this information and all intellectual property rights related to those analyses and ratings shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. I hereby affirm that this information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may license analyses and ratings derived from this information to other entities including researchers, not-for-profit entities, and for-profit entities, and the revenue from such licensure will be used solely to support The Leapfrog Group's not-for-profit mission. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
*(first name and last name)* *(title)*
on _____.
*(date)*


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# Section 7: Managing Serious Errors Reference Information

### *What's New in the 2026 Survey*

**Section 7A: Never Events**
There are no changes to this subsection.

**Section 7B: Healthcare-Associated Infections**
Leapfrog downloads HAI data from the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) four times during the Survey Cycle for use in the Leapfrog Hospital Survey. Both Leapfrog and CMS currently use and publicly report data that is calculated using a 2015 Baseline (i.e., Standard Population Data Year). Starting in fall 2026, CMS plans to calculate HAI measures using NHSN's new 2022 Baseline for data publicly reported on the Care Compare website. Once CMS begins calculating and publicly reporting HAI measures on Care Compare using the 2022 Baseline, Leapfrog will also transition to using data calculated with the 2022 Baseline in a reasonable and feasible timeframe.

Leapfrog anticipates using 2015 Baseline CMS IPPS Reports for scoring in the first two NHSN data downloads (June and August), then 2022 Baseline CMS IPPS Reports for scoring in the next two NHSN data downloads (October and December). However, this plan is subject to CMS' actual rollout of the new baseline on Care Compare.

In order to ensure that hospitals have adequate time to review updates to the scoring algorithm for these five measures, Leapfrog plans to download 2022 Baseline CMS IPPS Reports, with the reporting period of 01/01/2025 – 12/31/2025, in June to model a new scoring algorithm for Section 7B: Healthcare-Associated Infections (HAIs). The new scoring algorithm will be available for public comment and finalized prior to its anticipated use in October 2026.

The deadlines to join Leapfrog's NHSN Group and anticipated use of the 2022 Baseline can be found in the measure specifications.

### *Change Summary Since Release*

October 20, 2026 – Updated the reporting period used in Section 7B Healthcare-Associated Infections for the October and December NHSN Data Downloads to use a 24-month reporting period (07/01/2024 – 06/30/2026), rather than a 12-month reporting period for hospitals that reported 50 or fewer staffed beds (<=50) on their 2025 NHSN Patient Safety Component – Annual Survey. Hospitals reporting more than 50 staffed beds will continue to utilize a 12-month reporting period (07/01/2025 – 06/30/2026). Leapfrog is now also using the NHSN 2022 Baselines and updated risk-adjustment model. Please review the updated information in the Section 7B Healthcare-Associated Infections Measure Specifications and in the updated "NHSN Guidance: Join the Group, Review/Accept Data Rights Template, and Download Reports" document on the Review NHSN Instructions webpage.

Updates have also been made to the Section 7B Healthcare-Associated Infections Scoring Algorithm and can be reviewed in the updated 2026 Leapfrog Hospital Survey Scoring Algorithms document published on October 20, 2026 here.


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# Section 7B: Healthcare-Associated Infections Measure Specifications

**Important Note:** Hospitals that share a CMS Certification Number must have a unique NHSN ID as required by NHSN. Please carefully review Leapfrog's Multi-Campus Reporting Policy on the Review NHSN Instructions webpage.

### *Checklist for Joining Leapfrog's NHSN Group and Ensuring the Data are Accurate:*

☐ **Join or verify that you are in Leapfrog's NHSN Group**

- Instructions for joining or verifying that you are in Leapfrog's NHSN Group are available here in the "NHSN Guidance: Join the Group, Review/Accept Data Rights Template, and Download Reports" document.
- Hospitals must belong to Leapfrog's NHSN Group prior to the NHSN Download Dates listed in the "Deadlines and Reporting Periods" table below.

☐ **Review and accept Leapfrog's Data Rights Template within NHSN**

- **All hospitals** are required to review and accept the Data Rights Template at least annually before **June 22, 2026,** and whenever updates are made to their location mapping in NHSN.
  - Include any locations that were active during the reporting period even if they are currently inactive to ensure that Leapfrog obtains the appropriate SIR.
  - Confirm that you have given Leapfrog access to data from your most recent NHSN Patient Safety Component - Annual Hospital Survey. Surveillance data from the most recent NHSN Annual Hospital Survey is used by NHSN to risk adjust SIRs; SIRs cannot be calculated by NHSN or downloaded by Leapfrog if you restrict access to this data.
  - Failure to review and update (as needed) your Data Rights Template may result in Leapfrog pulling incorrect data for your hospital.
- Instructions for reviewing and accepting the Data Rights Template are available here in the "NHSN Guidance: Join the Group, Review/Accept Data Rights Template, and Download Reports" document.

☐ **Generate datasets and download reports within NHSN on the same day as Leapfrog**

- All hospitals are required to (a) generate datasets within NHSN, (b) download CMS IPPS reports, and (c) download a copy of your 2025 Patient Safety Component - Annual Hospital Survey from NHSN on the **same day** that Leapfrog will be downloading the data from NHSN for all current group members.
- Instructions for generating datasets and downloading these reports from NHSN are available here in the "NHSN Guidance: Join the Group, Review/Accept Data Rights Template, and Download Reports" document.
- NHSN data download dates are listed in the "Deadlines and Reporting Periods" table below (please note that there are four NHSN data download dates per Survey Cycle).
- By generating datasets and downloading reports within NHSN on the same day as Leapfrog, hospitals can confirm that their data matches the data Leapfrog has obtained.
- If hospitals do not generate datasets and download reports on the same day as Leapfrog, the Help Desk will not review any discrepancies.
- Note that Leapfrog will download and use 2015 Baseline CMS IPPS Reports in the first two NHSN data downloads (June and August), then 2022 Baseline CMS IPPS Reports in the next two NHSN data downloads (October and December). See ***Deadlines and Reporting Periods*** for updated information.

☐ **Review SIRs**

- For verification purposes, hospitals are required to download reports from NHSN on the **same day**, as described above.
- Once Leapfrog has published the healthcare-associated infection Survey Results on the Hospital Details Page, hospitals are urged to compare the Survey Results to their NHSN reports that were pulled on the same day as Leapfrog.


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- Dates on which the Survey Results will be available on the Hospital Details page are listed in the "Deadlines and Reporting Periods" table below.

☐ **Report discrepancies**
If, while comparing your NHSN reports to your Leapfrog Hospital Survey Results, you find a discrepancy, you must contact Leapfrog's Help Desk immediately. If you do not contact Leapfrog by the **end of the month** in which scored results are available on your Hospital Details Page (i.e., July, September, November, and January, respectively), the issue will not be investigated by the Help Desk.

### *Deadlines and Reporting Periods*

Highlighted section updated on October 20, 2026.

| **Join By Date**<br>*Hospitals must have joined and completed all required steps by this date* | **NHSN Download Date**<br>*Hospitals should download their reports on this date (the same date as Leapfrog)* | **NHSN Baseline**<br>*Hospitals should download reports with this baseline on the NHSN Download Date* | **HAI Reporting Period**<br>*Hospitals should download reports with this reporting period on the NHSN Download Date* | **Leapfrog Survey Submission Date**<br>*HAI data will not be publicly reported if hospitals have not submitted and provided a valid NHSN ID by this date* | **Verify Results**<br>*Data pulled by Leapfrog will be available to review on the Hospital Details Page or Public Reporting Website by these dates* |
|---|---|---|---|---|---|
| June 21 | June 22 | **2015 Baseline** | 01/01/2025 – 12/31/2025 | June 30 | July 12 |
| Aug 19 | Aug 20 | **2015 Baseline** | 01/01/2025 – 12/31/2025 | Aug 31 | Sep 10 |
| Oct 21 | Oct 22 | **2022 Baseline** | **50 or fewer beds*:** 07/01/2024 – 06/30/2026 **More than 50 beds*:** 07/01/2025 – 06/30/2026 | Oct 31 | Nov 10 |
| Dec 16 | Dec 17** | **2022 Baseline** | **50 or fewer beds*:** 07/01/2024 – 06/30/2026 **More than 50 beds*:** 07/01/2025 – 06/30/2026 | Nov 30 | Jan 12, 2027 |

*Bed size reported via the 2025 NHSN Patient Safety Component - Annual Survey's "Total Number of Beds Set Up and Staffed"

**The Leapfrog Hospital Survey closes on November 30, 2026. The last NHSN data download is on December 17, 2026, to incorporate any facilities and corrections from facilities that joined prior to this last download date.


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# Section 7A: Never Events Frequently Asked Questions (FAQs)

1. **The National Quality Forum released an updated Serious Reportable Events list in January 2026. Should our Never Events Policy refer to the 2011 Serious Reportable Events list, or the new 2025 Sentinel Events and Serious Reportable Events list?**
   To earn credit for these questions, hospitals must have a policy in place that addresses the National Quality Forum's list of Serious Reportable Events (SREs). All references to "never event" or "serious reportable event" refer specifically to the National Quality Forum SRE list. For the 2026 Leapfrog Hospital Survey, hospitals may reference either the 2011 Serious Reportable Events list or the 2025 Sentinel Events and Serious Reportable Events. Beginning with the 2027 Leapfrog Hospital Survey, only the 2025 Sentinel Events and Serious Reportable Events list will be accepted. Both SRE lists are available at https://www.qualityforum.org/en-us/key-initiatives/updating-the-serious-reportable-events-sre-list.

2. **When reporting Never Events, what "state reporting program for medical errors" applies in my state?**
   Congress has passed legislation requiring all states to develop a reporting program for medical errors. At this time, many states have already enacted or adopted some requirement that hospitals report serious medical errors or similar adverse events to a state agency. Others are still implementing legislation or regulations that define that requirement. States that have developed programs may also define reportable events differently.

3. **What if there is no "state reporting program for medical errors" in my state? Do we still have to report Never Events to meet Leapfrog principles for this policy? To whom?**
   Hospitals in states that do not have a state reporting program or requirement in effect can meet the reporting requirement of Leapfrog's principles for implementation of a Never Events policy by reporting all Never Events voluntarily to The Joint Commission, DNV GL Healthcare, or a Patient Safety Organization.

   If there is no state-required reporting program in effect, no available Patient Safety Organization to which your hospital can report, and your hospital is not Joint Commission or DNV GL Healthcare accredited, the Leapfrog requirement for reporting to an external agency is amended. Hospitals must report the Never Event to their governance board and must still perform a root-cause analysis internally of each Never Event to meet Leapfrog's principle for full implementation of its Never Events policy.

4. **The reportable adverse events defined by our state's reporting program don't include all 29 Never Events endorsed by the National Quality Forum (NQF) and adopted in the Leapfrog policy. Will reporting only the state-required reportable events to the state agency suffice for meeting Leapfrog's requirement for reporting Never Events to an external agency? Does our hospital have to report other Never Events, as defined by NQF/Leapfrog, to that state agency even though not required by our state's reporting program?**
   Hospitals should report all their state-required reportable events to the state agency. All other Never Events, as defined by NQF's list of Serious Reportable Events, which cannot be reported to the state agency, should be reported to another external agency (e.g., accreditor, Patient Safety Organization), if possible. If reporting those events to another external agency is not possible, the final option is to report those events to the hospital's governance board.

5. **Won't Leapfrog's request to have hospitals apologize to the patient put the hospital at risk for liability?**
   Not necessarily. Research indicates that malpractice suits are often the result of a failure on the hospital's part to communicate openly with the patient and apologize for its error. Patients feel the most anger when they perceive that no one is willing to take responsibility for the adverse event that has occurred. A sincere apology from the responsible hospital staff can help to heal the breach of trust between doctor/hospital and patient. (When Things Go Wrong: Responding to Adverse Events. Boston, 2006. Mass Coalition for the Prevention of Medical Errors)


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6. **How does Leapfrog define "waive cost?"**
   At its core, Leapfrog's approach to never events is about improving patient care. While the policy asks hospitals to refrain from billing either the patient or a third-party payer, such as a health plan or employer company, for any costs directly related to a serious reportable adverse event, Leapfrog understands that, due to the wide array of circumstances surrounding never events, specific details of what constitutes "waiving cost" should be handled on a case-by-case basis by the parties involved. For an example, please see "Lessons learned from implementing a principled approach to resolution following patient harm" by Smith et. al.

7. **Does Leapfrog recommend any resources for hospitals looking to adhere to Leapfrog's Never Events principles?**
   Yes, the Agency for Healthcare Research and Quality (AHRQ) has developed and tested the Communication and Optimal Resolution (CANDOR) Toolkit, which outlines a process for hospitals and practitioners to respond to unexpected events in a timely, thorough, and just way. The National Patient Safety Foundation (NPSF) has issued a report titled RCA$^2$: Improving Root Cause Analyses and Actions to Prevent Harm, which examines best practices and provides guidelines to help standardize and improve Root Cause Analysis. In addition, hospitals can download tips and tools for interviewing patients and families for the Root Cause Analysis on the Survey and CPOE Materials webpage.


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# *SECTION 8: PEDIATRIC CARE*

This section includes questions and reference information for Section 8: Pediatric Care. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.


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# Section 8: Pediatric Care

**Pediatric Care Fact Sheet:** https://ratings.leapfroggroup.org/measure/hospital/2026/pediatric-care

**Section 8 is applicable to all hospitals but is a required section for Survey submission for pediatric hospitals ONLY.**

**Hospitals that do not care for (or perform CT scans on) patients 17 years of age or younger should respond "no" to question #2 in 8A and 8B and move on to the Affirmation of Accuracy. Your hospital's results will be displayed as "Does Not Apply" on Leapfrog's public reporting website.**

Section 8 includes questions about patient experience (CAHPS Child Hospital Survey) and Computed Tomography (CT) radiation dose for pediatric patients. For 2026, this section is required for submission for pediatric hospitals.

**Each hospital achieving the standard for Patient Experience (CAHPS Child Hospital Survey):**
Performed in the top quartile for at least 4 of the 5 CAHPS Child Hospital Survey domains (a subset of the 18 total domains), listed below:

- Communication with Parent – Communication about your child's medicines
- Communication with Parent – Keeping you informed about your child's care
- Communication with Child – How well nurses communicate with your child
- Communication with Child – How well doctors communicate with your child
- Attention to Safety and Comfort – Preventing mistakes and helping you report concerns

**Each hospital achieving the standard for Pediatric Computed Tomography (CT) Dose:**
Received 75% or more of the possible points based on comparing CT radiation doses across two anatomic areas (head and abdomen/pelvis) and five age strata to national benchmarks.

**Download the 2026 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.**


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# 8A: Patient Experience (CAHPS Child Hospital Survey)

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Notes:**

Note 1: This subsection is only applicable to hospitals that care for patients 17 years of age or younger. Hospitals that do not care for patients 17 years of age or younger should respond "no" to question #2 in 8A and move on to 8B. Your hospital's results will be displayed as "Does Not Apply" on Leapfrog's public reporting website.

Note 2: To help ensure that the Top Box Scores[51] represent an appropriate sample of patients, hospitals must have at least 100 pediatric acute-care admissions to inpatient units other than a neonatal ICU (NICU). Otherwise, they should respond "Yes, but fewer than 100 pediatric admissions were for non-NICU patients" to question #2 and skip the remaining questions in Section 8A. The hospital will be scored as "Does Not Apply." For example, if your hospital had 600 pediatric acute-care admissions, and 550 of those admissions were to a neonatal ICU, you should respond "Yes, but fewer than 100 pediatric admissions were for non-NICU patients" to question #2 as your hospital only has 50 admissions to inpatient units other than a neonatal ICU.

**Specifications:** See ***Patient Experience (CAHPS Child Hospital Survey) Measure Specifications*** in the Reference Information beginning on page 281.

**Reporting Period: 12 months**
Answer questions #1-12 for the latest 12-month period prior to the submission of this section of the Survey.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

| | |
|---|---|
| 1) What is the latest 12-month reporting period for which your hospital is submitting responses to this section? 12-month reporting period ending: | _____<br>*Format: Month/Year* |
| 2) Did your hospital have at least 500 pediatric acute-care admissions during the 12-month period referenced in Section 1, question #5?<br><br>*Refer to your responses to questions #5 and #12 in Section 1A: Basic Hospital Information.*<br><br>*If "no" or "yes, but fewer than 100 pediatric admissions were for non-NICU patients," skip questions #3-12 and continue to the next subsection. The hospital will be scored as "Does Not Apply."* | ○ Yes<br>○ Yes, but fewer than 100 pediatric admissions were for non-NICU patients<br>○ No |
| 3) Has your hospital administered, or started to administer the CAHPS Child Hospital Survey during the reporting period?<br><br>*If "no" to question #3, skip questions #4-12 and continue to the next subsection. The hospital will be scored as "Did Not Measure."* | ○ Yes<br>○ No |
| 4) Did your hospital administer the full CAHPS Child Hospital Survey or a truncated version?<br><br>*If administering a truncated version, hospitals must follow the specifications for truncating the survey provided in the Patient Experience (CAHPS Child Hospital Survey) Measure Specifications.* | ○ Full version<br>○ Truncated version |

| | |
|---|---|
| 5) How many surveys were returned during the reporting period?<br><br>*If less than 100, skip questions #6-12 and continue to the next subsection. The hospital will be scored as "Unable to Calculate Score."* | _____ |
| 6) Which of the following modes were used to administer the survey?<br><br>*Select all that apply.* | ☐ Mail<br>☐ Phone<br>☐ Email<br>☐ Tablet |
| 7) Which of the following times were surveys administered during the reporting period?<br><br>*Select all that apply.* | ☐ Day of discharge<br>☐ After discharge |

In questions #8-12, report your hospital's Top Box Score[51] (rounded to the nearest whole number) from each of the five publicly reported patient experience measures from your 12-month vendor report that matches the reporting period that you selected in question #1.

| | |
|---|---|
| 8) Communication with Parent – Communication about your child's medicines | _____ |
| 9) Communication with Parent – Keeping you informed about your child's care | _____ |
| 10) Communication with Child – How well nurses communicate with your child | _____ |
| 11) Communication with Child – How well doctors communicate with your child | _____ |
| 12) Attention to Safety and Comfort – Preventing mistakes and helping you report concerns | _____ |


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# 8B: Pediatric Computed Tomography (CT) Radiation Dose

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Notes:**

Note 1: All pediatric patient (ages 17 years and younger) scans performed at your hospital should be included when reporting on this measure, including cases that were never admitted to an inpatient ward.

Note 2: This section is only applicable to hospitals that perform CT scans on patients 17 years of age or younger. Hospitals that do not perform CT scans on patients 17 years of age or younger should respond "no" to question #2 in 8B and move on to the Affirmation of Accuracy. Your hospital's results will be displayed as "Does Not Apply" on Leapfrog's public reporting website.

**Specifications:** See ***Pediatric Computed Tomography (CT) Radiation Dose Measure Specifications*** in the Reference Information beginning on page 282.

**Reporting Period: 12 months**
Answer questions #1-7 based on all cases (or a sufficient sample of them)

- Surveys submitted prior to September 1:
  - 01/01/2025 – 12/31/2025
- Surveys (re)submitted on or after September 1:
  - 07/01/2025 – 06/30/2026

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

**Sufficient Sample:** See ***Pediatric Computed Tomography (CT) Radiation Dose Measure Specifications*** for instructions on identifying a sufficient sample for questions #2-7.

| | |
|---|---|
| 1) 12-month reporting period used: | ○ 01/01/2025 – 12/31/2025<br>○ 07/01/2025 – 06/30/2026 |
| 2) Does your hospital perform CT scans on pediatric patients?<br><br>*If "no" to question #2, skip the remaining questions in Section 8B, and go to the Affirmation of Accuracy. The hospital will be scored as "Does Not Apply."* | ○ Yes<br>○ No |
| 3) Did your hospital calculate its distribution of CT radiation doses for pediatric patients over the reporting period, and do you choose to report those data to this Survey?<br><br>*If "no" to question #3, skip the remaining questions in Section 8B, and go to the Affirmation of Accuracy. The hospital will be scored as "Did Not Measure."* | ○ Yes<br>○ No |
| 4) Which of the following is your hospital using to report the CT radiation dose length product (DLP)?<br><br>*If "manual data collection" is not selected, skip question #5 and continue to question #6.* | ○ Manual Data Collection<br>○ Dose Monitoring Software<br>○ ACR National Radiology Data Registry Report |

| | |
|---|---|
| 5) If using manual data collection, do the responses in questions #6 and #7 represent a sample?<br><br>*If your hospital reviewed all cases for age strata with fewer than 30 encounters and sampled for those age strata with greater than 30 encounters, select "yes."* | ○ Yes<br>○ No |

6) Enter your hospital's 25th, 50th, and 75th percentiles (rounded to the nearest whole number) for CT radiation dose length product (DLP) in **head** scans for pediatric patients for each age stratum standardized to 16cm phantoms.

*If the number of encounters for an age stratum is less than 10 (in column a), skip columns b, c, and d and then move to the next age stratum. If zero, enter "0" in column a. The hospital will be scored as "Unable to Calculate Score" if all age strata have less than 10 encounters.*

| Age Stratum | HEAD | | | |
|---|---|---|---|---|
| | **(a) Number of encounters** | **(b) 25th Percentile** | **(c) 50th Percentile** | **(d) 75th Percentile** |
| < 1 year | | | | |
| 1 - 4 | | | | |
| 5 - 9 | | | | |
| 10 - 14 | | | | |
| 15 - 17 | | | | |

7) Enter your hospital's 25th, 50th, and 75th percentiles (rounded to the nearest whole number) for CT radiation dose length product (DLP) in **abdomen/pelvis** scans for pediatric patients for each age stratum standardized to 32cm phantoms.

*If the number of encounters for an age stratum is less than 10 (in column a), skip columns b, c, and d and then move to the next age stratum. If zero, enter "0" in column a. The hospital will be scored as "Unable to Calculate Score" if all age strata have less than 10 encounters.*

| Age Stratum | ABDOMEN/PELVIS | | | |
|---|---|---|---|---|
| | **(a) Number of encounters** | **(b) 25th Percentile** | **(c) 50th Percentile** | **(d) 75th Percentile** |
| < 1 year | | | | |
| 1 - 4 | | | | |
| 5 - 9 | | | | |
| 10 - 14 | | | | |
| 15 - 17 | | | | |


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**Affirmation of Accuracy**

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Pediatric Care Section at our hospital, and I hereby affirm that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this affirmation on behalf of our hospital.

The hospital and I acknowledge that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also acknowledge that analyses and ratings The Leapfrog Group derives from this information will be made public on the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade website, and/or other Leapfrog Group published works, products and services. The hospital and I acknowledge that analyses and ratings derived from this information and all intellectual property rights related to those analyses and ratings shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. I hereby affirm that this information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may license analyses and ratings derived from this information to other entities including researchers, not-for-profit entities, and for-profit entities, and the revenue from such licensure will be used solely to support The Leapfrog Group's not-for-profit mission. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
*(first name and last name)* *(title)*
on _____.
*(date)*


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# Section 8: Pediatric Care Reference Information

### *What's New in the 2026 Survey*

Leapfrog is adding Section 8: Pediatric Care as a minimum required section for Survey submission for pediatric hospitals ONLY. Pediatric hospitals that respond in Section 8A: Patient Experience that they did not administer the CAHPS Child Hospital Survey and/or in Section 8B: Pediatric Computed Tomography (CT) Radiation Dose that they did not calculate their distribution of CT radiation doses will be publicly reported as "Did Not Measure."

There are no changes to Section 8A: Patient Experience (CAHPS Child Hospital Survey) or Section 8B: Pediatric CT Radiation Dose.

### *Change Summary Since Release*

None. If substantive changes are made to this section of the Survey after release on April 1, 2026, they will be documented in this Change Summary section.


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# Section 8: Pediatric Care Measure Specifications

## *Patient Experience (CAHPS Child Hospital Survey) Measure Specifications*

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

**Source:** Agency for Healthcare Quality and Research (AHRQ) (NQF #2548)

**Reporting Period:** The latest 12-month period prior to the submission of this section of the Survey. Hospitals can elect to use either survey return date or discharge date to pull reports for this measure.

This section of the Leapfrog Hospital Survey asks hospitals who care for pediatric patients about their results from the CAHPS Child Hospital Survey. The first several questions are designed to learn more about the current administration of the survey. The last five questions collect the "Top Box" [51] score for each of the following five domains:

- Communication with Parent – Communication about your child's medicines
- Communication with Parent – Keeping you informed about your child's care
- Communication with Child – How well nurses communicate with your child
- Communication with Child – How well doctors communicate with your child
- Attention to Safety and Comfort – Preventing mistakes and helping you report concerns

Hospitals using Press Ganey, NRC, or PRC to administer the CAHPS Child Hospital Survey can use the AHRQ CAHPS Crosswalk below to ensure they are reporting on the correct domains. The Crosswalk is designed to help translate the standard vendor report to the AHRQ Domains used in questions #8-12 of the Leapfrog Hospital Survey.

Hospitals that opt to truncate the CAHPS Child Hospital Survey after question 40, which is the last question required to report on the five domains listed above, must ensure that all questions prior to and including question 40 remain in order and unaltered. In addition, hospitals opting to truncate the survey must retain questions 50-54 and 56-57 (in order and unaltered) which ask for the child and survey participant's demographic information. Note: Hospitals that collect information captured in questions 51-52 administratively are not required to retained them.

For more information regarding which questions from the CAHPS Child Hospital Survey correspond to the five domains listed above, visit https://www.ahrq.gov/cahps/surveys-guidance/hp/about/child-survey-measures.html.

**CAHPS Child Hospital Survey Domain Crosswalk**

| AHRQ Domain Name | Press Ganey Domain Name | NRC Domain Name | PRC Domain Name |
|---|---|---|---|
| Communication with Parent – Communication about your child's medicines | **Communication Child's Med** | **Communication About Meds** | **Communication About Medicines** |
| Communication with Parent – Keeping you informed about your child's care | **Informed Child's Care** | **Keeping You Informed About Your Child's Care** | **Keeping Parent Informed** |
| Communication with Child – How well nurses communicate with your child | **Nurses Communicate Child** | **Nurse Communication With Child** | **Nurses – Child** |
| Communication with Child – How well doctors communicate with your child | **Doctors Communicate Child** | **Doctor Communication With Child** | **Doctors – Child** |
| Attention to Safety and Comfort – Preventing mistakes and helping you report concerns | **Prevent Mistakes Rpt Conc** | **Preventing Mistakes and Helping You Report Concerns** | **Preventing Mistakes** |

See FAQs for additional information about responding to the questions in this section.


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## *Pediatric Computed Tomography (CT) Radiation Dose Measure Specifications*

**Important Notes:**

Note 1: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Note 2: For purposes of this measure, an "encounter" consists of a full examination and any CT scans performed within one hour of each other involving the designated anatomic area (i.e., head or abdomen/pelvis). For example, two CT scans conducted 30-minutes apart on the same patient's head are considered one "encounter." CT scans of the same anatomic area performed with and without contrast are considered one "encounter." Scans of two different anatomic areas performed within one hour would not be considered the same "encounter." Scans of the same anatomic area performed greater than 60 minutes apart would also not be considered the same "encounter."

Note 3: This measure includes two sets of instructions in the table below: one for hospitals using dose monitoring software and one for hospitals that are not using dose monitoring software. Please be sure to use the correct set of instructions.

Note 4: Hospitals performing manual data collection must use the CT Dose Workbook provided on the Survey and CPOE Materials webpage to standardize their CT radiation dose length product (DLP) for head scans to 16cm phantoms and abdomen/pelvis scans to 32cm phantoms.

**Source:** University of California, San Francisco (NQF #2820)

**Reporting Period: 12 months**

- Surveys submitted prior to September 1:
  - 01/01/2025 – 12/31/2025
- Surveys (re)submitted on or after September 1:
  - 07/01/2025 – 06/30/2026

**Hospitals participating in the ACR National Radiology Data Registry:**
Data for this measure can be obtained directly from a special Leapfrog report. See details below.

Hospitals that report to the American College of Radiology (ACR) and receive reports through the National Radiology Data Registry (NRDR) will be able to respond to questions #6-7 in Section 8B using a specialized report that will be made available with the quarterly Dose Index Registry Executive Summary reports. This separate "Leapfrog" report will be available for download through the NRDR portal and will contain data according to the age ranges and measure specifications of the Leapfrog Hospital Survey. **Enter values from the "Leapfrog" tab using the "Table: Pediatric Exams for Leapfrog Survey" and the appropriate percentiles in the Head and Abdomen Pelvis columns rounded to the nearest whole number directly into the Online Hospital Survey Tool.** While this report should be from the most recent 12 months, it does not need to include the full 12 months.

**Hospitals using dose monitoring software:**
Data for this measure can be obtained using dose monitoring software. See instructions below.

**Question #6, column a: Total Number of Encounters**
Using your dose monitoring software, obtain the total number of encounters in **head scans** for each age stratum (<1, 1-4, 5-9, 10-14, 15-17). Enter these values into the Survey.

**Inclusions:**
CT HEAD BRN WO IVCON
CT HEAD WO IVCON
CT PEDS HEAD WO IVCON
CT HEAD
CT PEDS HEAD BRN WO IVCON
CT BRN WO IVCON
CT HEAD BRN
CT HEAD BRN W IVCON
CT HEAD W IVCON

CT HEAD WO & W IVCON
CT HEAD BRN WO & W IVCON
CT BRN WO & W IVCON
CT BRN W IVCON

**Exclusions:**

- Encounters involving facial bones or sinuses
- Encounters where the indication is for a biopsy, including prop studies and stereotactic studies and procedures
- Encounters that cross multiple anatomic areas should be excluded. For example, encounters involving both the head and neck are excluded from the "head" anatomic region.
- Encounters where the documented age is missing or listed as the date of admission (i.e., an accurate birthday could not be obtained and therefore the admission date was used), as is the case for some trauma patients

**Sampling Cases:** Hospitals using dose monitoring software must report on all encounters in the 12-month reporting period.

**Hospitals using Radimetrics Dose Monitoring Software:**

- If your hospital is using unique study instance UIDs for every scan performed, review your data to ensure that any scans performed on the same patient and same anatomic area within a one-hour timeframe are being combined into one encounter. The DLPs for all scans within the one-hour timeframe should be combined and that combined value used to calculate the percentiles reported to Leapfrog.
- If your hospital is NOT using unique study instance UIDs and is combining DLPs for all scans performed on the same patient and same anatomic area within one hour into one study instance UID, no review is required as this adheres to the definition of encounter. However, these hospitals should review any repeat or delayed scans to ensure repeat or delayed scans performed greater than 60 minutes apart are not being combined into the same study instance UID.

**Question #6, columns b, c, and d: 25$^{th}$, 50$^{th}$, and 75$^{th}$ Percentiles**
Based on the encounters identified for each age stratum (column a), use your dose monitoring software to calculate the 25$^{th}$ percentile (column b), the 50$^{th}$ percentile (column c), and the 75$^{th}$ percentile (column d) for CT radiation dose length product (DLP) in **head scans standardized to 16cm phantoms**. Enter these values into the Survey rounded to the nearest whole number.

If the number of encounters for an age stratum (i.e., <1 or 1-4, etc.) is less than 10 (column a), skip columns b, c, and d. If the number of encounters for an age stratum is zero, enter "0" in column a, and skip columns b, c, and d. You cannot leave any rows in column a blank.

**Phantom Dose Specifications:**
For head scans, use a 16 cm phantom dose value. The orange box in the screenshot below the table is an example of a Dose Report which shows the phantom dose value used. The phantom dose value is used to estimate the radiation dose to the patient.

**Scout Doses (Topograms)** should not be included when calculating the 25$^{th}$, 50$^{th}$, or 75$^{th}$ percentiles.

**Question #7 column a: Total Number of Encounters**
Using your dose monitoring software, obtain the total number of encounters in **abdomen/pelvis** for each age stratum (<1, 1-4, 5-9, 10-14, 15-17). Enter these values into the Survey.

**Inclusions:**
CT ABD PELVIS W IVCON
CT ABD/PEL W IVCON
CT PEDS ABD PELVIS
CT ABD PELVIS WO IVCON
CT ABD/PEL WO IVCON
CT ABD/PEL


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CT PEDS ABD/PEL WO IVCON
CT ABD PELVIS WO & W IVCON
CT ABD/PEL WO & W IVCON
CT ABD PELVIS
CT ABD PELVIS WO IVCON

**Exclusions:**

- Encounters where the indication is for a biopsy, including prop studies and stereotactic studies and procedures
- Encounters that cross multiple anatomic areas should be excluded. For example, encounters involving both the chest and abdomen/pelvis are excluded from the "abdomen/pelvis" anatomic region.
- Encounters where the documented age is missing or listed as the date of admission (i.e., an accurate birthday could not be obtained and therefore the admission date was used), as is the case for some trauma patients

**Sampling Cases:** Hospitals using dose monitoring software must report on all encounters in the 12-month reporting period.

**Question #7, columns b, c, and d: 25th, 50th, and 75th Percentiles**
Based on the encounters identified for each age stratum (column a), use your dose monitoring software to calculate the 25th percentile (column b), the 50th percentile (column c), and the 75th percentile (column d) for CT radiation dose length product (DLP) in **abdomen/pelvis scans standardized to 32cm phantoms**. Enter these values into the Survey rounded to the nearest whole number.

If the number of encounters for an age stratum (i.e., <1 or 1-4, etc.) is less than 10 (column a), skip columns b, c, and d. If the number of encounters for an age stratum is zero, enter "0" in column a, and skip columns b, c, and d. You cannot leave any rows in column a blank.

**Phantom Dose Specifications:**
For abdomen/pelvis scans, use a 32cm phantom dose value. The orange box in the screenshot below the table is an example of a Dose Report which shows the phantom dose value used. The phantom dose value is used to estimate the radiation dose to the patient.

**Scout Doses (Topograms)** should not be included when calculating the 25th, 50th, or 75th percentiles.

**Hospitals not using dose monitoring software:**
Data for this measure can be obtained from Dose Reports that come directly from the CT Machine and are sent along with the images to the Picture Archiving and Communications (PACS) used to review the images. See instructions below.

**CT Dose Excel Workbook**
To assist hospitals who do not use dose monitoring software in calculating the responses to questions #6 and #7, Leapfrog has developed a CT Dose Workbook to assist hospitals in standardizing their CT dose data based on these specifications. The workbook includes 12 tabs: Instructions, Summary, and 10 Data Entry tabs for each anatomic area/age stratum combination. The tabs for head scans are red and the tabs for abdomen/pelvis scans are blue. Once you enter your hospital's CT radiation dose length product (DLP) data into the appropriate tab, the workbook will automatically calculate your responses to questions #6 and #7 in the Summary tab, and those values should be entered in the Survey.

The CT Dose Workbook is available on the Survey and CPOE Materials webpage and should be used when reporting on this measure.


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**Question #6, column a: Total Number of Encounters**
To determine the total number of encounters in **head scans** for each age stratum (<1, 1-4, 5-9, 10-14, 15-17), you will need to obtain dose reports. See sampling instructions below.

**Inclusions:**
CT HEAD BRN WO IVCON
CT HEAD WO IVCON
CT PEDS HEAD WO IVCON
CT HEAD
CT PEDS HEAD BRN WO IVCON
CT BRN WO IVCON
CT HEAD BRN
CT HEAD BRN W IVCON
CT HEAD W IVCON
CT HEAD WO & W IVCON
CT HEAD BRN WO & W IVCON
CT BRN WO & W IVCON
CT BRN W IVCON

**Exclusions:**
- Encounters involving facial bones or sinuses
- Encounters where the indication is for a biopsy, including prop studies and stereotactic studies and procedures
- Encounters that cross multiple anatomic areas should be excluded. For example, encounters involving both the head and neck are excluded from the "head" anatomic region.
- Encounters where the documented age is missing or listed as the date of admission (i.e., an accurate birthday could not be obtained and therefore the admission date was used), as is the case for some trauma patients

**Sampling Cases:**
Hospitals that are using information stored in the CT Machine have the option of reporting on all encounters or a sample of encounters. Hospitals opting to identify a sample of encounters for this measure should follow these instructions:
- Review your hospital's scans starting on January 15, 2025 (or July 15, 2025 if (re)submitting a Survey on or after September 1, 2026).
- Work sequentially until **a sample of at least 30 encounters per anatomic area and age strata combination** (i.e., head <1; head 1-4, etc.) is reached, or all cases in the reporting period are reviewed, whichever comes first.

**Question #6, columns b, c, and d: 25th, 50th, and 75th Percentiles**
Using your dose reports, enter the phantom dose and **Total DLP (mGY-cm)** for each encounter into each of the 5 "Head" tabs of the CT Dose Workbook. Be sure to review the instructions tab carefully before you begin entering data. The worksheet will automatically standardize your dose data to a 16cm phantom, if necessary. The worksheet will then automatically calculate the total number of encounters, as well as the 25th, 50th, and 75th percentiles for each anatomic area and age stratum.

See the example CT Dose Report from a CT scanner at the end of this table:
- The orange box in the screenshot is an example of a Dose Report which shows the phantom dose value used. The phantom dose value is used to estimate the radiation dose to the patient.
- The red box highlights the Total DLP. Note that your CT scanner may have a differently formatted Dose Report.

**Scout Doses (Topograms)** should not be included when entering the Total DLP for each encounter into the CT Dose Workbook.

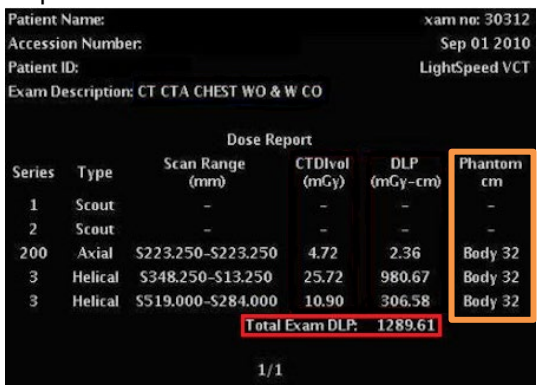
**Question #7 column a: Total Number of Encounters**
To determine the total number of encounters in **abdomen/pelvis scans** for each age stratum (<1, 1-4, 5-9, 10-14, 15-17), you will need to obtain dose reports. See sampling instructions below.

**Inclusions:**
CT ABD PELVIS W IVCON
CT ABD/PEL W IVCON
CT PEDS ABD PELVIS
CT ABD PELVIS WO IVCON
CT ABD/PEL WO IVCON
CT ABD/PEL
CT PEDS ABD/PEL WO IVCON
CT ABD PELVIS WO & W IVCON
CT ABD/PEL WO & W IVCON
CT ABD PELVIS
CT ABD PELVIS WO IVCON

**Exclusions:**
- Encounters where the indication is for a biopsy, including prop studies and stereotactic studies and procedures
- Encounters that cross multiple anatomic areas should be excluded. For example, encounters involving both the chest and abdomen/pelvis are excluded from the "abdomen/pelvis" anatomic region.
- Encounters where the documented age is missing or listed as the date of admission (i.e., an accurate birthday could not be obtained and therefore the admission date was used), as is the case for some trauma patients

**Question #7 columns b, c, and d: 25th, 50th, and 75th Percentiles**
Using your dose reports, enter the phantom dose and **Total DLP (mGY-cm)** for each encounter into each of the 5 "Abdomen Pelvis" tabs of the CT Dose Workbook. Be sure to review the instructions tab carefully before you begin entering data. The worksheet will automatically standardize your dose data to a 32cm phantom, if necessary. The worksheet will then automatically calculate the total number of encounters, as well as the 25th, 50th, and 75th percentiles for each anatomic area and age stratum.

See the example CT Dose Report from a CT scanner at the end of this table:
- The orange box in the screenshot is an example of a Dose Report which shows the phantom dose value used. The phantom dose value is used to estimate the radiation dose to the patient.
- The red box highlights the Total DLP. Note that your CT scanner may have a differently formatted Dose Report.



Patient Name: xam no: 30312
Accession Number: Sep 01 2010
Patient ID: LightSpeed VCT
Exam Description: CT CTA CHEST WO & W CO

Dose Report

| Series | Type | Scan Range (mm) | CTDIvol (mGy) | DLP (mGy-cm) | Phantom cm |
|---|---|---|---|---|---|
| 1 | Scout | - | - | - | - |
| 2 | Scout | - | - | - | - |
| 200 | Axial | S223.250-S223.250 | 4.72 | 2.36 | Body 32 |
| 3 | Helical | S348.250-S13.250 | 25.72 | 980.67 | Body 32 |
| 3 | Helical | S519.000-S284.000 | 10.90 | 306.58 | Body 32 |
| | | | Total Exam DLP: | 1289.61 | |

1/1

**Scout Doses (Topograms)** should not be included when entering the Total DLP for each encounter into the CT Dose Workbook.

See FAQs for additional information about responding to the questions in this section.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# Section 8: Pediatric Care Frequently Asked Questions (FAQs)

## *Patient Experience (CAHPS Child Hospital Survey) FAQs*

1. **Why does Leapfrog refer to two different reporting periods in Section 8A question #2: one reporting period which refers to the number of pediatric admissions during the 12 months from Section 1 and one reporting period which refers to the results of our CAHPS Child Hospital Survey?**
   These two reporting periods are different because hospitals that have not historically had 500 pediatric admissions annually may not have begun to administer the CAHPS Survey to their patients and therefore it would not be appropriate to ask these facilities to report on their current results in Section 8A.

2. **Do I need to include neonatal ICU (NICU) discharges when administering the CAHPS Child Hospital Survey and reporting those results to Leapfrog?**
   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.

   In 2026, 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, we are urging those 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 2026 should include NICU discharges in their sample per the sampling framework detailed in the manual.

3. **Can we use other lower cost modes for administering the CAHPS Child Hospital Survey? Survey administration is costly, and our hospital has low response rates.**
   Some hospitals have asked about the use of alternative, lower cost modes of survey administration, such as administering paper surveys at discharge that can then be batched and mailed to a vendor to calculate results. This approach is potentially an opportunity both to lower the cost of administration and to increase response rates.

   Leapfrog's Pediatric Expert Panel has noted that while administering the CAHPS Child Hospital Survey using paper forms at discharge is not on the list of AHRQ-approved modes, hospitals that are trying to find ways to administer the survey and increase response rate should be able to submit results to the 2026 Leapfrog Hospital Survey. That said, the Pediatric Expert Panel has expressed a desire for these different modes to be tested, and so we cannot guarantee that you will be able to submit these results for future Leapfrog Hospital Surveys.

4. **Is Interactive Voice Response (IVR) or texting a link to an online survey an acceptable mode for administering the CAHPS Child Hospital Survey?**
   Hospitals that administer the CAHPS Child Hospital Survey via IVR should select "phone" in question #6. Hospitals that administer the CAHPS Child Hospital Survey by texting a link to an online survey to the patient should select "email."

## *Pediatric Computed Tomography (CT) Radiation Dose FAQs*

5. **Is this measure only applicable to pediatric inpatients, or should all pediatric scans be included?**
   All pediatric patient (ages 17 years and younger) scans should be included when reporting on this measure, including cases that were never admitted to an inpatient ward.

6. **Should multiple phase scans be included in the reporting?**
   Yes, the intent of this measure is to capture the entire dose a patient receives, even if this radiation is received over multiple phase scans.

7. **Should any CT encounters involving anatomic areas not listed in the Survey questions (i.e., head or abdomen/pelvis) be included in the reporting?**
   No. When reporting CT encounters in the Survey, only encounters involving the head or abdomen/pelvis should be included. Encounters involving any other anatomic area should not be reported. For example, encounters involving both the head and neck are excluded from the "head" anatomic region.

8. **Are the CT doses adjusted for any factors other than age, such as height and weight?**
   No, CT doses are only stratified by age and anatomic region. The pediatric CT radiation dose measure is an NQF-endorsed measure, developed so that all hospitals in the country who do pediatric CT scans can report. Its known limitation is that it does not consider patient size (e.g., height and weight) but instead uses age as a proxy for size. Part of the reason is that unless hospitals use dose monitoring software, which not all hospitals currently do due to cost, they would not have this information readily available to them. However, to align with the American College of Radiology (ACR), head scans are standardized to 16cm phantoms and abdomen/pelvis scans are standardized to 32cm phantoms.


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# *SECTION 9: OUTPATIENT PROCEDURES*

This section includes questions and reference information for Section 9: Outpatient Procedures. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.


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# Section 9: Outpatient Procedures

**Outpatient Procedures Fact Sheet and Bibliography:**
https://ratings.leapfroggroup.org/measure/hospital/2026/care-elective-outpatient-surgery-patients

Section 9 includes questions about the volume and safety of same-day procedures performed in hospital outpatient departments. Additionally, Leapfrog downloads CMS data on unplanned hospital visits after an outpatient colonoscopy (OP-32) and the experience of patients who had a same-day surgery performed (OAS CAHPS). For 2026, reporting on Section 9C: Volume of Procedures is optional.

**Hospitals will not be able to access Section 9 until the American Medical Association's Terms of Use are completed via the CPT Code Workbook button on the Survey Dashboard, and the appropriate CPT Code Workbook is downloaded.**

**Each hospital achieving the standards for Certified Clinicians Present While Patients Are Recovering:**

1. Has an ACLS certified clinician, plus a second clinician, present at all times and immediately available in the building while adult patients are present in the hospital outpatient department.
2. Has a PALS certified clinician, plus a second clinician, present at all times and immediately available in the building while pediatric patients are present in the hospital outpatient department.

**Each hospital achieving the standard for the Safe Surgery Checklist:**

1. Uses a safe surgery checklist on **all** patients undergoing an applicable procedure (reported on in Section 9C, if applicable) that includes **all** safe surgery checklist elements; **and**
2. Verbalizes **all** safe surgery checklist elements in the presence of the appropriate personnel; **and**
3. Completes an audit on a sufficient sample of patients to document adherence to the checklist; **and**
4. Documents adherence to the checklist for at least 90% of the patients included in the audit.

**Each hospital achieving the standard for Medication Safety for Outpatient Procedures:**
Has met the 90% target for documenting all three components: home medications, visit medications, and allergies/adverse reaction(s) in the clinical record.

**Each hospital achieving the standard for Rate of Unplanned Hospital Visits After an Outpatient Colonoscopy (OP-32):**
Performs in the top quartile for OP-32, Rate of Unplanned Hospital Visits After an Outpatient Colonoscopy. Quartiles are determined using results published by CMS for both Ambulatory Surgery Centers (ASCs) and hospitals on June 30, 2026.

**Each hospital achieving the standard for Patient Experience (OAS CAHPS):**
Performs in the top quartile for four OAS CAHPS domains. Quartiles are determined using results published by CMS for both Ambulatory Surgery Centers (ASCs) and hospitals on June 30, 2026, for the four OAS CAHPS domains, listed below:

a) Facilities and Staff
b) Communication About Your Procedure
c) Patients' Rating of the Facility
d) Patients Recommending the Facility

**Download the 2026 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.**


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# 9A: Basic Outpatient Department Information

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Notes:**

Note 1: In order to access this section in the Online Survey Tool, hospitals must complete the American Medical Association's Terms of Use via the CPT Code Workbook button next to Section 9 on the Survey Dashboard and download the appropriate CPT Code Workbook. Instructions for downloading the CPT Code Workbook are available in the Volume of Procedures Measure Specifications. Each hospital must complete these steps even if they are part of a hospital system.

Note 2: This subsection will not be scored but will be used in public reporting. Your selection(s) of procedure categories in question #3 will be used in our procedure-based search tool at ratings.leapfroggroup.org.

Note 3: The term "hospital outpatient department" is used to refer to all hospital outpatient departments or areas of the hospital, including areas that are used for **both** inpatient and outpatient procedures, that perform the outpatient procedures listed in Section 9C and that share your hospital's license or CMS Certification Number (CCN). This would include, but is not limited to surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are co-located[31] with your hospital. Hospitals should only include hospital outpatient departments or areas of the hospital that perform the procedures listed in Section 9C in an operating room[52] or procedure room[53].

**Reporting Period: 12 months**

- Surveys submitted prior to September 1:
  - 01/01/2025 – 12/31/2025
- Surveys (re)submitted on or after September 1:
  - 07/01/2025 – 06/30/2026

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

| | |
|---|---|
| 1. 12-month reporting period used: | ○ 01/01/2025 – 12/31/2025<br>○ 07/01/2025 – 06/30/2026 |
| 2. Does your hospital perform any of the procedures listed in Section 9C on an outpatient basis:<br>• **in the hospital** or at a **hospital outpatient department** co-located[31] with the hospital<br>and/or<br>• at a **surgery center or free-standing hospital outpatient department** that shares your hospital's license or CMS Certification Number? | ○ Yes<br>○ No |

*If "no" to question #2, skip the remaining questions in Section 9, including all subsections, and go to the Affirmation of Accuracy.*


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| | |
|---|---|
| 3. Which of the following procedure specialties does your hospital perform on an outpatient basis?<br>*Cardiothoracic Surgery, Oral and Maxillofacial Surgery, Pain Management, Podiatry, and Vascular Surgery apply to adult patients only. All other surgical specialties apply to adult or adult/pediatric patients.*<br>*Select all that apply.* | ☐ Cardiothoracic Surgery<br>☐ Gastroenterology<br>☐ General Surgery<br>☐ Neurological Surgery<br>☐ Obstetrics and Gynecology<br>☐ Ophthalmology<br>☐ Oral and Maxillofacial Surgery<br>☐ Orthopedics<br>☐ Otolaryngology<br>☐ Pain Management<br>☐ Plastic and Reconstructive Surgery<br>☐ Podiatry<br>☐ Urology<br>☐ Vascular Surgery |
| 4. Total number of operating rooms [52] used to perform the outpatient procedures listed in Section 9C: | _____ |
| 5. Total number of endoscopic procedure rooms [53] used to perform the outpatient procedures listed in Section 9C: | _____ |

# 9B: Medical, Surgical, and Clinical Staff

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Notes:**

Note 1: The term "hospital outpatient department" is used to refer to all hospital outpatient departments or areas of the hospital, including areas that are used for **both** inpatient and outpatient procedures, that perform the outpatient procedures listed in Section 9C and that share your hospital's license or CMS Certification Number (CCN). This would include, but is not limited to surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are co-located[31] with your hospital. Hospitals should only include hospital outpatient departments or areas of the hospital that perform the procedures listed in Section 9C in an operating room[52] or procedure room[53].

Note 2: Hyperlinks throughout these questions refer to the Medical, Surgical, and Clinical Staff FAQs beginning on page 319, as well as to endnotes. FAQ hyperlinks are not included in the Online Survey Tool.

**Reporting Period: 3 months**
Answer questions #1-2 based on the staffing structure currently in place at the time that you submit this section of the Survey. The staffing structure should have been in place for at least the past 3 months and reflect the ordinary staffing structure for each applicable hospital outpatient department.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

| | |
|---|---|
| 1. Is there an Advanced Cardiovascular Life Support (ACLS) trained clinician [54], as well as a second clinician[54] (regardless of ACLS training), present at all times and immediately available in the building while an adult patient (13 years and older) is present in the hospital outpatient department?<br><br>*Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should respond based on the least intensively staffed location.*<br><br>*Hospitals should report on all hospital outpatient departments or areas of the hospital that perform the outpatient procedures listed in Section 9C and that share the hospital's license or CCN.*<br><br>*Hospitals that did not perform any applicable procedures on patients 13 years and older during the reporting period should select "not applicable; pediatric patients only." The hospital will be scored as "Does Not Apply."* | ○ Yes<br>○ No<br>○ Not applicable; pediatric patients only |

| | |
|---|---|
| 2. Is there a Pediatric Advanced Life Support (PALS) trained clinician[54], as well as a second clinician[54] (regardless of PALS training), present at all times and immediately available in the building while a pediatric patient (infant through 12 years) is present in the hospital outpatient department?<br><br>*Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should respond based on the least intensively staffed location.*<br><br>*Hospitals should report on all hospital outpatient departments or areas of the hospital that perform the outpatient procedures listed in Section 9C and that share the hospital's license or CCN.*<br><br>*Hospitals that do not care for pediatric patients should select "not applicable; adult patients only" and hospitals that only performed applicable pediatric procedures on pediatric patients 13 years and older during the reporting period should select "not applicable; pediatric patients are all aged 13-17," regardless of the presence of clinicians trained in PALS. The hospital will be scored as "Does Not Apply."* | ○ Yes<br>○ No<br>○ Not applicable; adult patients only<br>○ Not applicable; pediatric patients are all aged 13-17 |

# 9C: Volume of Procedures (Optional)

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Notes:**

Note 1: CPT Codes are provided in downloadable Excel files on the Survey Dashboard. To access the files, click the CPT Code Workbook button next to Section 9. You will be required to complete the American Medical Association's Terms of Use before downloading the Excel file and using the individual CPT codes to query your EHR or billing system. You are only required to complete the Terms of Use once per Survey Cycle (April 1 – November 30).

The CPT Code Workbooks (Excel files) are labeled for Section 3A: Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss and Section 9C: Volume of Procedures. Please note, if you are part of a hospital system, each hospital will need to complete the Terms of Use. This is a requirement of the American Medical Association.

Note 2: This subsection is optional and will not be scored but will be used in public reporting to inform purchasers and consumers about the hospital's experience with the procedure.

Note 3: The term "hospital outpatient department" is used to refer to all hospital outpatient departments or areas of the hospital, including areas that are used for **both** inpatient and outpatient procedures, that perform the outpatient procedures listed in Section 9C and that share your hospital's license or CMS Certification Number (CCN). This would include, but is not limited to surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are co-located[31] with your hospital. Hospitals should only include hospital outpatient departments or areas of the hospital that perform the procedures listed in Section 9C in an operating room[52] or procedure room[53].

Note 4: Hospitals should only report on procedures they electively perform. If your hospital does not perform the procedure on an outpatient basis or ONLY does so when a procedure is urgent, you should answer "no" and not report on those procedures.

**Specifications:** See ***Volume of Procedures Measure Specifications*** in the Reference Information beginning on page 319.

**Reporting Period: 12 months**

- 01/01/2025 – 12/31/2025

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

| | |
|---|---|
| 1) 12-month reporting period used: | *No response required here. Reporting period automatically 01/01/2025 – 12/31/2025.* |
| 2) During the reporting period, were one or more of the following **ophthalmology** procedures performed at your hospital outpatient department(s) on adult and/or pediatric patients:<br>• Anterior segment eye procedures,<br>• Posterior segment eye procedures, or<br>• Ocular adnexa and other eye procedures? | ○ Yes<br>○ Yes, but no longer performs these procedures<br>○ No |

| | |
|---|---|
| *If "no" or "yes, but no longer performs these procedures," skip questions #11-13 below.* | |
| 3) During the reporting period, were one or more of the following **orthopedic** procedures performed at your hospital outpatient department(s) on adult and/or pediatric patients:<br>• Finger, hand, wrist, forearm, and elbow procedures;<br>• Shoulder procedures;<br>• Spine procedures;<br>• Hip procedures;<br>• Knee procedures;<br>• Toe, foot, ankle, and leg procedures; or<br>• General orthopedic procedures?<br>*If "no" or "yes, but no longer performs these procedures," skip questions #14-16 below.* | ○ Yes<br>○ Yes, but no longer performs these procedures<br>○ No |
| 4) During the reporting period, were one or more of the following **otolaryngology** procedures performed at your hospital outpatient department(s) on adult and/or pediatric patients:<br>• Ear procedures;<br>• Mouth procedures;<br>• Nasal/sinus procedures; or<br>• Pharynx/adenoid/tonsil procedures?<br>*If "no" or "yes, but no longer performs these procedures," skip questions #17-19 below.* | ○ Yes<br>○ Yes, but no longer performs these procedures<br>○ No |
| 5) During the reporting period, were one or more of the following **gastroenterology** procedures performed at your hospital outpatient department(s) on adult patients:<br>• Upper GI endoscopy, or<br>• Lower GI endoscopy?<br>*If "no" or "yes, but no longer performs these procedures," skip questions #20-22 below.* | ○ Yes<br>○ Yes, but no longer performs these procedures<br>○ No |
| 6) During the reporting period, were one or more of the following **general surgery** procedures performed at your hospital outpatient department(s) on adult patients:<br>• Cholecystectomy and common duct exploration;<br>• Hemorrhoid procedures;<br>• Inguinal and femoral hernia repair;<br>• Other hernia repair;<br>• Laparoscopy;<br>• Lumpectomy or quadrantectomy of breast; or<br>• Mastectomy? | ○ Yes<br>○ Yes, but no longer performs these procedures<br>○ No |


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| | |
|---|---|
| *If "no" or "yes, but no longer performs these procedures," skip questions #23-25 below.* | |
| 7) During the reporting period, were one or more of the following **urology** procedures performed at your hospital outpatient department(s) on adult patients:<br>• Circumcision;<br>• Cystourethroscopy;<br>• Male genital procedures;<br>• Urethra procedures; or<br>• Vaginal repair procedures?<br>*If "no" or "yes, but no longer performs these procedures," skip questions #26-28 below.* | ○ Yes<br>○ Yes, but no longer performs these procedures<br>○ No |
| 8) During the reporting period, was the following **neurological surgery** procedure performed at your hospital outpatient department(s) on adult patients:<br>• Spinal fusion procedures?<br>*If "no" or "yes, but no longer performs this procedure," skip questions #29-31 below.* | ○ Yes<br>○ Yes, but no longer performs this procedure<br>○ No |
| 9) During the reporting period, were one or more of the following **obstetrics and gynecology** procedures performed at your hospital outpatient department(s) on adult patients:<br>• Cervix procedures,<br>• Hysteroscopy, or<br>• Uterus and adnexa laparoscopies?<br>*If "no" or "yes, but no longer performs these procedures," skip questions #32-34 below.* | ○ Yes<br>○ Yes, but no longer performs these procedures<br>○ No |
| 10) During the reporting period, were one or more of the following **plastic and reconstructive surgery** procedures performed at your hospital outpatient department(s) on adult patients:<br>• Breast repair or reconstruction, or<br>• Skin graft/reconstruction procedures?<br>*If "no" or "yes, but no longer performs these procedures," skip questions #35-37 below.* | ○ Yes<br>○ Yes, but no longer performs these procedures<br>○ No |

### *Ophthalmology*

11) Total adult and/or pediatric volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #2 and update your response from "yes" to "no."*

| | (a) *Adult Volume* | (b) *Pediatric Volume* |
|---|---|---|
| **Anterior segment eye procedures** | _____ | |
| **Posterior segment eye procedures** | _____ | |
| **Ocular adnexa and other eye procedures** | _____ | _____ |

| 12) Where were these **ophthalmology** procedures performed?<br><br>*Select all that apply.*<br><br>*If only "hospital" is selected, skip question #13 and continue to question #14.* | ☐ Hospital<br>☐ Surgery center or free-standing hospital outpatient department |
|---|---|

13) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **ophthalmology** procedures:

| | *Name* | *City* |
|---|---|---|
| **Surgery Center/Free-Standing Hospital Outpatient Department 1** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 2** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 3** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 4** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 5** | | |


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***Orthopedic***

14) Total adult and/or pediatric volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #3 and update your response from "yes" to "no."*

| | *(a) Adult Volume* | *(b) Pediatric Volume* |
|---|---|---|
| **Finger, hand, wrist, forearm, and elbow procedures** | _____ | _____ |
| **Shoulder procedures** | _____ | _____ |
| **Spine procedures** | _____ | |
| **Hip procedures** | _____ | |
| **Knee procedures** | _____ | _____ |
| **Toe, foot, ankle, and leg procedures** | _____ | _____ |
| **General orthopedic procedures** | _____ | _____ |

15) Where were these **orthopedic** procedures performed?

*Select all that apply.*

*If only "hospital" is selected, skip question #16 and continue to question #17.*

- ☐ Hospital
- ☐ Surgery center or free-standing hospital outpatient department

16) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **orthopedic** procedures:

| | *Name* | *City* |
|---|---|---|
| **Surgery Center/Free-Standing Hospital Outpatient Department 1** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 2** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 3** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 4** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 5** | | |


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## *Otolaryngology*

17) Total adult and/or pediatric volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #4 and update your response from "yes" to "no."*

| | *(a) Adult Volume* | *(b) Pediatric Volume* |
|---|---|---|
| **Ear procedures** | _____ | _____ |
| **Mouth procedures** | _____ | _____ |
| **Nasal/sinus procedures** | _____ | _____ |
| **Pharynx/adenoid/tonsil procedures** | | _____ |

| 18) Where were these **otolaryngology** procedures performed?<br><br>*Select all that apply.*<br><br>*If only "hospital" is selected, skip question #19 and continue to question #20.* | ☐ Hospital<br>☐ Surgery center or free-standing hospital outpatient department |
|---|---|

19) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **otolaryngology** procedures:

| | *Name* | *City* |
|---|---|---|
| **Surgery Center/Free-Standing Hospital Outpatient Department 1** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 2** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 3** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 4** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 5** | | |


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## *Gastroenterology*

20) Total adult volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #5 and update your response from "yes" to "no."*

| | *Adult Volume* |
|---|---|
| **Upper GI endoscopies** | _____ |
| **Lower GI endoscopies** | _____ |

| | |
|---|---|
| 21) Where were these **gastroenterology** procedures performed?<br><br>*Select all that apply.*<br><br>*If only "hospital" is selected, skip question #22 and continue to question #23.* | ☐ Hospital<br>☐ Surgery center or free-standing hospital outpatient department |

22) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **gastroenterology** procedures:

| | *Name* | *City* |
|---|---|---|
| **Surgery Center/Free-Standing Hospital Outpatient Department 1** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 2** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 3** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 4** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 5** | | |


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## *General Surgery*

23) Total adult volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #6 and update your response from "yes" to "no."*

| | *Adult Volume* |
|---|---|
| **Cholecystectomies and common duct explorations** | _____ |
| **Hemorrhoid procedures** | _____ |
| **Inguinal and femoral hernia repairs** | _____ |
| **Other hernia repairs** | _____ |
| **Laparoscopies** | _____ |
| **Lumpectomies or quadrantectomy of breast procedures** | _____ |
| **Mastectomies** | _____ |

| | |
|---|---|
| 24) Where were these **general surgery** procedures performed?<br><br>*Select all that apply.*<br><br>*If only "hospital" is selected, skip question #25 and continue to question #26.* | ☐ Hospital<br>☐ Surgery center or free-standing hospital outpatient department |

25) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **general surgery** procedures:

| | *Name* | *City* |
|---|---|---|
| **Surgery Center/Free-Standing Hospital Outpatient Department 1** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 2** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 3** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 4** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 5** | | |


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## *Urology*

26) Total adult volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #7 and update your response from "yes" to "no."*

| | *Adult Volume* |
|---|---|
| **Circumcisions** | _____ |
| **Cystourethroscopies** | _____ |
| **Male genital procedures** | _____ |
| **Urethra procedures** | _____ |
| **Vaginal repair procedures** | _____ |

| | |
|---|---|
| 27) Where were these **urology** procedures performed?<br><br>*Select all that apply.*<br><br>*If only "hospital" is selected, skip question #28 and continue to question #29.* | ☐ Hospital<br>☐ Surgery center or free-standing hospital outpatient department |

28) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **urology** procedures:

| | *Name* | *City* |
|---|---|---|
| **Surgery Center/Free-Standing Hospital Outpatient Department 1** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 2** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 3** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 4** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 5** | | |


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## *Neurological Surgery*

29) Total adult volume for the following procedure performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform the procedure listed below, go back to question #8 and update your response from "yes" to "no."*

| | *Adult Volume* |
|---|---|
| **Spinal fusion procedures** | _____ |

| | |
|---|---|
| 30) Where were these **neurological surgery** procedures performed?<br><br>*Select all that apply.*<br><br>*If only "hospital" is selected, skip question #31 and continue to question #32.* | □ Hospital<br>□ Surgery center or free-standing hospital outpatient department |

31) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **neurological surgery** procedures:

| | *Name* | *City* |
|---|---|---|
| **Surgery Center/Free-Standing Hospital Outpatient Department 1** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 2** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 3** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 4** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 5** | | |


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## *Obstetrics and Gynecology*

32) Total adult volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #9 and update your response from "yes" to "no."*

| | *Adult Volume* |
|---|---|
| **Cervix procedures** | _____ |
| **Hysteroscopies** | _____ |
| **Uterus and adnexa laparoscopies** | _____ |

33) Where were these **obstetrics and gynecology** procedures performed?

*Select all that apply.*

*If only "hospital" is selected, skip question #34 and continue to question #35.*

- ☐ Hospital
- ☐ Surgery center or free-standing hospital outpatient department

34) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **obstetrics and gynecology** procedures:

| | *Name* | *City* |
|---|---|---|
| **Surgery Center/Free-Standing Hospital Outpatient Department 1** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 2** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 3** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 4** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 5** | | |


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## *Plastic and Reconstructive Surgery*

35) Total adult volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #10 and update your response from "yes" to "no."*

| | *Adult Volume* |
|---|---|
| **Breast repair or reconstructive procedures** | _____ |
| **Skin graft/reconstruction procedures** | _____ |

| | |
|---|---|
| 36) Where were these **plastic and reconstructive surgery** procedures performed?<br><br>*Select all that apply.*<br><br>*If only "hospital" is selected, skip question #37 and continue to the next subsection.* | ☐ Hospital<br>☐ Surgery center or free-standing hospital outpatient department |

37) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **plastic and reconstructive surgery** procedures:

| | *Name* | *City* |
|---|---|---|
| **Surgery Center/Free-Standing Hospital Outpatient Department 1** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 2** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 3** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 4** | | |
| **Surgery Center/Free-Standing Hospital Outpatient Department 5** | | |


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# 9D: Safety of Procedures

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Notes:**

Note 1: The elements required for each stage of the safe surgery checklist in questions #5-12 are adapted from the WHO Surgical Safety Checklist and the AHRQ Endoscopy Checklist.

Note 2: Question #7 will not be used in scoring or public reporting. Hospitals that do not perform outpatient procedures on adult or pediatric patients will be scored and publicly reported as "Does Not Apply."

Note 3: Hyperlinks throughout these questions refer to the Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures FAQs beginning on page 325, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

Note 4: The term "hospital outpatient department" is used to refer to all hospital outpatient departments or areas of the hospital, including areas that are used for **both** inpatient and outpatient procedures, that perform the outpatient procedures listed in Section 9C and that share your hospital's license or CMS Certification Number (CCN). This would include, but is not limited to surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are co-located[31] with your hospital. Hospitals should only include hospital outpatient departments or areas of the hospital that perform the procedures listed in Section 9C in an operating room[52] or procedure room[53].

**Specifications:** See the ***Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures Measure Specifications*** in the Safety of Procedures Reference Information beginning on page 3268.

**Reporting Period: 12 months**
Answer questions #1-9 for the latest 12-month period prior to submission of this section of the Survey.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

**Sufficient Sample:** See ***Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures Measure Specifications*** for instructions on identifying a sufficient sample for questions #6-9.

### *Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures*

| | |
|---|---|
| 1) What is the latest 12-month reporting period for which your hospital is submitting responses to questions #2-9? 12-month reporting period ending: | _____<br>*Format: Month/Year* |
| 2) Does your hospital utilize a safe surgery checklist on every patient, every time one of the applicable procedures in Section 9C is performed?<br><br>*Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should respond based on the location with the fewest processes in place.*<br><br>*If "no" to question #2, skip the remaining questions in Section 9D and continue to the next subsection. The hospital will be scored as "Limited Achievement."* | ○ Yes<br>○ No |


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| | |
|---|---|
| 3) **Before the induction of anesthesia**, is a safe surgery checklist that includes all the following elements read aloud in the presence of the anesthesia professional and nursing personnel:<br>• Patient ID;<br>• Confirmation of procedure;<br>• Patient consent;<br>• Site marked, if applicable;<br>• Anesthesia/medication check;<br>• Allergies assessed;<br>• Difficult airway/aspiration risk;<br>• Risk of blood loss (only applicable if risk of blood loss is >500ml for adults or >7ml/kg for children); and<br>• Availability of devices (applicable to endoscopy procedures only)? | ○ Yes<br>○ No |
| 4) **Before the skin incision and/or before the procedure begins**, is a safe surgery checklist that includes all the following elements read aloud in the presence of the whole surgical team**:**<br>• Clinical team introduction;<br>• Confirmation of patient name, procedure, and, if applicable, surgical/incision site;<br>• Antibiotic prophylaxis, if applicable;<br>• Anticipated Critical Events (i.e., non-routine steps, length of procedure, blood loss, patient-specific concerns, sterility);<br>• Equipment check/concerns; and<br>• Essential imaging available, if applicable? | ○ Yes<br>○ No |
| 5) **Before the patient leaves the operating room and/or procedure room**, is a safe surgery checklist that includes all the following elements read aloud in the presence of the whole surgical team:<br>• Confirmation of procedure performed;<br>• Instrument/supply counts, if applicable;<br>• Specimen labeling, if applicable;<br>• Equipment concerns; and<br>• Patient recovery/management concerns? | ○ Yes<br>○ No |

*If "no" to question #3, #4, or #5, skip the remaining questions in Section 9D and continue to the next subsection. The hospital will be scored as "Limited Achievement."*

*Hospitals performing the audit in Section 3B question #6 and the audit in Section 9D question #6 should audit 15 cases who underwent a procedure included in Section 3A and 15 cases who underwent a procedure included in Section 9C. Hospitals only performing the audit in Section 9D question #6 and not in Section 3B question #6 should audit 30 cases who underwent a procedure included in Section 9C.*

| | |
|---|---|
| 6) Did your hospital perform an audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 9C and measure adherence to the safe surgery checklist?<br><br>*Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should select at least one case from each location.*<br><br>*If "no" to question #6, skip the remaining questions in Section 9D and continue to the next subsection. The hospital will be scored as "Limited Achievement."* | ○ Yes<br>○ No |


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| | |
|---|---|
| 7) How many cases were included in the audit from question #6? | _____<br>*Max value is 100* |
| 8) Which method was used to perform the audit on a sufficient sample in question #6? | ○ In-person observational audit<br>○ Retrospective audit of medical records or EHR data<br>○ Both |
| 9) Based on your hospital's audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 9C, what was your hospitals documented rate of adherence to the safe surgery checklist (i.e., what percentage of the sampled cases had all elements in questions #3, #4, and #5 completed)? | ○ 90%-100%<br>○ 75%-89%<br>○ 50%-74%<br>○ Less than 50% |


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# 9E: Medication Safety for Outpatient Procedures

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

**Important Note:** The term "hospital outpatient department" is used to refer to all hospital outpatient departments or areas of the hospital, including areas that are used for **both** inpatient and outpatient procedures, that perform the outpatient procedures listed in Section 9C and that share your hospital's license or CMS Certification Number (CCN). This would include, but is not limited to surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are co-located[31] with your hospital. Hospitals should only include hospital outpatient departments or areas of the hospital that perform the procedures listed in Section 9C in an operating room[52] or procedure room[53].

**Specifications:** See ***Medication Safety for Outpatient Procedures Measure Specifications*** in the Reference Information beginning on page 329.

**Reporting Period: 12 months**
Answer questions #2-7 based on all cases (or a sufficient sample of them),

- Surveys submitted prior to September 1:
  - 01/01/2025 – 12/31/2025
- Surveys (re)submitted on or after September 1:
  - 07/01/2025 – 06/30/2026

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

**Sufficient Sample:** See ***Medication Safety for Outpatient Procedures Measure Specifications*** for instructions on identifying a sufficient sample for questions #2-7.

| | |
|---|---|
| 1) 12-month reporting period used: | ○ 01/01/2025 – 12/31/2025<br>○ 07/01/2025 – 06/30/2026 |
| 2) Did your hospital perform an audit of clinical records for all patients undergoing those procedures included in Section 9C (or a sufficient sample of them) who were discharged from a hospital outpatient department for the reporting period selected **and** measure adherence to medication documentation guidelines regarding home medications, medications administered during the visit or prescribed at discharge, and medication allergies?<br><br>*If "no" to question #2, skip questions #3-7 and continue to the next subsection. The hospital will be scored as "Did Not Measure."*<br><br>*If "yes, but there were fewer than 30 outpatients discharged for the reporting period," skip questions #3-7 and continue to the next subsection. The hospital will be scored as "Unable to Calculate Score."* | ○ Yes<br>○ No<br>○ Yes, but there were fewer than 30 outpatients discharged for the reporting period |
| 3) Number of cases measured (either all cases or a sufficient sample of them): | _____ |
| 4) Number of cases in question #3 with a list of **all home medication(s),** including dose, route, and frequency, documented in the clinical record: | _____ |


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| | |
|---|---|
| 5) Number of cases in question #3 with a list of **all medication(s) administered during the visit and new medications prescribed at discharge**, including the strength, dose, route, date, and time of administration, documented in the clinical record: | _____ |
| 6) Number of cases in question #3 with a list of **all medication allergies and adverse reaction(s)** documented in the clinical record: | _____ |
| 7) Do the responses in questions #3-6 represent a sample of cases? | ○ Yes<br>○ No |

# 9F: CMS Measures

**This section is not applicable to pediatric hospitals.**

**Specifications:** See ***CMS Measures Measure Specifications*** in the Reference Information beginning on page 334.

**OP-32 Reporting Period: 24 months**

- All data downloads: 1/1/2022 - 12/31/2024

**OAS CAHPS Reporting Period: 12 months**

- June Data Download: 7/1/2024 - 6/30/2025
- August Data Download: 10/1/2024 - 9/30/2025
- November Data Download: 1/1/2025 - 12/31/2025

*Leapfrog will update data three times per Survey Cycle for hospitals that have provided an accurate CCN in the Hospital Profile and report performing outpatient procedures in Section 9A Basic Outpatient Department Information.*

Leapfrog obtains data for five Hospital Outpatient Quality Reporting (OQR) program measures directly from the CMS Provider Data Catalog:

- OP-32: Rate of Unplanned Hospital Visits After an Outpatient Colonoscopy
- Patient Experience Top Box Score[51] (OAS CAHPS)
    a) Facilities and Staff
    b) Communication About Your Procedure
    c) Patients' Rating of the Facility
    d) Patients Recommending the Facility

For Leapfrog to obtain the data, hospitals must provide a valid CMS Certification Number (CCN) in the Hospital Profile. Hospitals that report not performing outpatient procedures in Section 9A or are a pediatric hospital will be scored and publicly reported as "Does Not Apply" for all measures.

**OP-32:** Hospitals that report not performing outpatient gastroenterology procedures in Section 9A will also be scored and publicly reported as "Does Not Apply."

Data will be downloaded three times per Survey cycle: June 30, August 31, and November 30.


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**Affirmation of Accuracy**

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Outpatient Procedures Section at our hospital, and I hereby affirm that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this affirmation on behalf of our hospital.

The hospital and I acknowledge that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also acknowledge that analyses and ratings The Leapfrog Group derives from this information will be made public on the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade website, and/or other Leapfrog Group published works, products and services. The hospital and I acknowledge that analyses and ratings derived from this information and all intellectual property rights related to those analyses and ratings shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. I hereby affirm that this information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may license analyses and ratings derived from this information to other entities including researchers, not-for-profit entities, and for-profit entities, and the revenue from such licensure will be used solely to support The Leapfrog Group's not-for-profit mission. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
*(first name and last name)* *(title)*
on _____.
*(date)*


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# Section 9: Outpatient Procedures Reference Information

### *What's New in the 2026 Survey*

Leapfrog is renaming Section 9F: OAS CAHPS to Section 9F: CMS Measures and moving Patient Follow-up within Section 9D: Safety of Procedures into Section 9F.

### Section 9A: Basic Outpatient Department Information

Leapfrog is adding a new question to capture surgical specialties performed by hospitals. This information will be used to inform the search function on the Leapfrog Ratings website and will display the surgical specialties selected within the question. Leapfrog will not ask about volume for these additional surgical specialties. These questions will continue to be used in public reporting but are not scored.

### Section 9B: Medical, Surgical, and Clinical Staff

There are no changes to this subsection.

### Section 9C: Volume of Procedures

Beginning in 2026 Leapfrog is no longer requiring hospitals to report their outpatient procedure volume. Instead, this section is optional, and results will not be scored but will continue to be used in public reporting for those who submit this subsection. For those hospitals opting to report their volumes, updated CPT Codes will be provided within the Online Survey Tool when the Survey launches on April 1.

### Section 9D: Safety of Procedures

**Patient Follow-up**

Leapfrog is moving OP-32 Rate of Unplanned Hospital Visits After An Outpatient Colonoscopy to Section 9F: CMS Measures.

**Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures**

There are no changes to these questions.

### Section 9E: Medication Safety for Outpatient Procedures

There are no changes to this subsection.

### Section 9F: CMS Measures

Leapfrog is no longe asking hospitals to report their OAS CAHPS Top Box scores. Instead, Leapfrog will obtain these data directly from the CMS Provider Data Catalog:

- Patient Experience Top Box Scores (OAS CAHPS)
    e) Facilities and Staff
    f) Communication About Your Procedure
    g) Patients' Rating of the Facility
    h) Patients Recommending the Facility

Additionally, as described above, Leapfrog is also obtaining data for OP-32: Rate of Unplanned Hospital Visits After an Outpatient Colonoscopy directly from the CMS Provider Data Catalog.

For hospitals that provide a valid CMS Certification Number (CCN) in the Hospital Profile and report performing outpatient procedures in Section 9A: Basic Outpatient Department Information of the Leapfrog Hospital Survey, data will be downloaded three times per Survey cycle: June 30, August 31, and November 30.

The top quartiles used in the 9F: Patient Experience (OAS CAHPS) scoring algorithm will be calculated using results published by CMS for both Ambulatory Surgery Centers (ASCs) and hospitals on June 30, 2026.

Anticipated reporting periods and data download dates for the CMS measure and new FAQs are available in the measure specifications.

### *Change Summary Since Release*

None. If substantive changes are made to this section of the Survey after release on April 1, 2026, they will be documented in this Change Summary section.


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# Section 9A: Basic Outpatient Department Information Frequently Asked Questions (FAQs)

1. **Our hospital shares a CMS Certification Number (CCN) with other hospitals, and we have many hospital outpatient department locations (e.g., surgery centers, endoscopy centers, free-standing hospital outpatient departments, etc.) all under the same CCN. How should we report on Section 9: Outpatient Procedures?**
   As per Leapfrog's Multi-Campus Reporting Policy, all hospital campuses will need to complete their own Leapfrog Hospital Survey unless they are co-located.

   For Section 9: Outpatient Procedures, each hospital campus will need to indicate in Section 9A if they are performing the outpatient procedures listed in Section 9C at their hospital and/or at a surgery center or free-standing hospital outpatient department that shares their hospital's CMS Certification Number (CCN). You should only include those hospital outpatient departments that your hospital refers patients to. The remainder of the questions in Section 9 will need to be answered based on:
   - all hospital outpatient departments in your hospital, including any areas such as inpatient units, where outpatient procedures are performed (as reported in Section 9A question #2); and,
   - all surgery centers and free-standing hospital outpatient departments that share your hospital's CCN (as reported in Section 9A question #3)

   In Section 9C, you will be able to provide total volume across all hospital outpatient department locations (as reported in Section 9A questions #2 and #3) and information for the different outpatient locations where the specific outpatient procedures are performed. All other questions should be answered based on all outpatient locations. If you have different adherence across locations, you should answer based on the least adherent location.

   If all hospital campuses are referring patients to the same surgery centers and free-standing hospital outpatient departments, you would include the information and volume for these locations when responding to Section 9 on all their Leapfrog Hospital Surveys.

2. **How should our hospital report on the number of operating rooms and endoscopic procedure rooms in questions #4-5 if our operating/procedure rooms are used for both inpatient and outpatients? How should we report if we have multiple hospital outpatient departments?**
   Hospitals should report on the total number of adult and pediatric operating rooms or procedure rooms if these rooms are used for both inpatient and outpatient procedures. Otherwise, hospitals should only report on the number of operating/procedure rooms that are used for outpatient procedures. If your hospital has multiple hospital outpatient departments, report the total number of adult and pediatric outpatient operating rooms or procedure rooms across all locations. You should only be reporting on operating rooms and procedure rooms that are used to perform the outpatient procedures listed in Section 9C Volume of Procedures.


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# Section 9B: Medical, Surgical, and Clinical Staff Frequently Asked Questions (FAQs)

1. **How does Leapfrog define "immediately available" and "in the building" as it pertains to ACLS and/or PALS trained clinicians?**
   "Immediately available" is defined as being physically present in the building and not engaged in an activity or procedure that cannot be interrupted if hands-on intervention is needed for a patient.

   Leapfrog defines "in the building" as within the hospital outpatient department or surgery center or in an area co-located with the hospital outpatient department or surgery center. Leapfrog defines co-located as a location within "immediate physical proximity," meaning the two locations are physically connected, either by a tunnel, an enclosed bridge, or the locations abut each other so that hallways readily connect.

2. **If a hospital did not perform any outpatient pediatric procedures during the reporting period selected in Section 9C, should they still report on PALS-trained clinicians in Section 9B question #2?**
   No. If your hospital did not report any pediatric discharges for the procedures listed in Section 9C during the reporting period, then you should select "Not applicable; adult patients only" in question #2.

3. **Is the PEARS certification the equivalent of PALS certification for the purposes of responding to question #2?**
   No. PEARS is not the equivalent of or substitution for PALS certification. The PEARS curriculum is focused on recognition of and steps to mitigate pediatric respiratory emergencies, whereas the PALS curriculum informs clinicians how to manage these emergencies, with emphasis on leadership of the care team, and how to perform key air management techniques. Additionally, the PALS curriculum instructs providers on multiple ways to obtain IV access to improve circulatory issues.

4. **How should hospitals report on ACLS/PALS certification if they have more than one hospital outpatient department performing the procedures listed in Section 9C Volume of Procedures?**
   Hospitals with more than one hospital outpatient department are instructed to respond to questions #1-2 based on the location with the least intensive staffing. For example, if one hospital outpatient department has an ACLS trained clinician, as well as a second clinician present at all times and immediately available in the building when adult patients are in the hospital outpatient department, but another hospital outpatient department does not, you should answer "no" to question #1.

5. **If a free-standing pediatric hospital has clinicians trained in PALS but a small percentage of the patient population is over 13, should these clinicians also have ACLS training, or would the PALS training be sufficient?**
   If your hospital outpatient departments are performing procedures on adult and pediatric patients, there should be at least one clinician with ACLS training when adult patients (13 years and older) are recovering and one clinician with PALS training when pediatric patients (infant to 12 years) are recovering. This could mean that some clinicians maintain both certifications or some maintain ACLS, and others maintain PALS.


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# Volume of Procedures Measure Specifications

**Important Notes:**

Note 1: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Note 2: CPT Codes are provided in downloadable Excel files on the Survey Dashboard. To access the files, click the CPT Code Workbook button next to Section 9. You will be required to complete the American Medical Association's Terms of Use before downloading the Excel file and using the individual CPT codes to query your EHR or billing system. You are only required to complete the Terms of Use once per Survey Cycle (April 1 – November 30).

The CPT Code Workbooks (Excel files) are labeled for Section 3A: Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss and Section 9C: Volume of Procedures. Please note, if you are part of a hospital system, each hospital will need to complete the Terms of Use. This is a requirement of the American Medical Association.

Note 3: When counting patients for the purposes of identifying total volume in Section 9C, you should only include scheduled outpatient (i.e., admitted and discharged on the same day) procedures performed at your hospital outpatient departments within the reporting period. Include scheduled outpatient procedures with a planned observation or extended recovery stay. Exclude scheduled outpatient procedures with a planned inpatient admission. Exclude emergent/urgent cases, such as procedures for patients that come through the emergency department. To count patient discharges, use the Volume of Procedures Measure Specifications below and the CPT codes available in the Library on the Survey Dashboard.

**Source:** The Leapfrog Group, American Medical Association, The Health Care Cost Institute

**Reporting Period: 12 months**

- 01/01/2025 – 12/31/2025

**Questions #2-10:** Respond "yes" or "no" based on whether your hospital outpatient department(s) performed any of the procedures during the reporting period on adult and/or pediatric patients. The procedures fall within nine specialty areas:

***Adult Procedures***

1. Ophthalmology procedures: anterior segment eye procedures; posterior segment eye procedures; and ocular adnexa and other eye procedures
2. 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
3. Otolaryngology procedures: ear procedures; mouth procedures; and nasal/sinus procedures
4. Gastroenterology procedures: upper GI endoscopy; and lower GI endoscopy
5. General surgery procedures: cholecystectomy and common duct exploration; hemorrhoid procedures; inguinal and femoral hernia repairs; other hernia repairs; laparoscopy; lumpectomy or quadrantectomy of breast; and mastectomy
6. Urology procedures: circumcisions; cystourethroscopy; male genital procedures; urethra procedures; and vaginal repair procedures
7. Neurological surgery procedures: spinal fusion procedures
8. Obstetrics and gynecology procedures: cervix procedures; hysteroscopy; and uterus and adnexa laparoscopies
9. Plastic and reconstructive surgery procedures: breast repair or reconstructive procedures; and skin graft/reconstruction procedures

***Pediatric Procedures***

1. Ophthalmology procedures: ocular adnexa and other eye procedures
2. Orthopedic procedures: finger, hand, wrist, forearm, and elbow procedures; shoulder procedures; knee procedures; toe, foot, ankle, and leg procedures; and general orthopedic procedures


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

Respond "yes" if:
- One or more of your hospital outpatient departments performed the procedure on an outpatient basis for the entire reporting period (12 months) and continues to do so
- One or more of your hospital outpatient departments performed the procedure on an outpatient basis during part of the reporting period (less than 12 months) and continues to perform the procedure

Respond "yes, but no longer perform these procedures" if your hospital outpatient departments performed the procedure for all or some of the reporting period, but NO longer performs the procedure

Respond "no" if your hospital outpatient departments do not perform the procedure.

**Questions #11-37**: Based on your responses to questions #2-10, report on the total (a) adult and/or (b) pediatric volume for each procedure (from questions #2-10) during the reporting period:

***Adult Procedures***

1. Ophthalmology procedures: anterior segment eye procedures; posterior segment eye procedures; and ocular adnexa and other eye procedures
2. 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
3. Otolaryngology procedures: ear procedures; mouth procedures; and nasal/sinus procedures
4. Gastroenterology procedures: upper GI endoscopy; and lower GI endoscopy
5. General surgery procedures: cholecystectomy and common duct exploration; hemorrhoid procedures; inguinal and femoral hernia repairs; other hernia repairs; laparoscopy; lumpectomy or quadrantectomy of breast; and mastectomy
6. Urology procedures: circumcisions; cystourethroscopy; male genital procedures; urethra procedures; and vaginal repair procedures
7. Neurological surgery procedures: spinal fusion procedures
8. Obstetrics and gynecology procedures: cervix procedures; hysteroscopy; and uterus and adnexa laparoscopies
9. Plastic and reconstructive surgery procedures: breast repair or reconstructive procedures; and skin graft/reconstruction procedures

***Pediatric Procedures***

1. Ophthalmology procedures: ocular adnexa and other eye procedures
2. Orthopedic procedures: finger, hand, wrist, forearm, and elbow procedures; shoulder procedures; knee procedures; toe, foot, ankle, and leg procedures; and general orthopedic procedures
3. Otolaryngology procedures: ear procedures; mouth procedures; nasal/sinus procedures; pharynx/adenoid/tonsil procedures

When calculating total **hospital outpatient department volume for (a) adult and/or (b) pediatric patients** count the number of **patients** discharged from your hospital outpatient department(s) within the reporting period with any one or more of the codes specified for each procedure, subject to the criteria below:
- Only include scheduled outpatient (i.e., admitted and discharged on the same day) procedures performed at your hospital outpatient departments within the reporting period. Include scheduled outpatient procedures with a planned observation or extended recovery stay.
- Exclude scheduled outpatient procedures with a planned inpatient admission. Exclude emergent/urgent cases, such as procedures for patients that come through the emergency department.
- Only the procedure codes provided by Leapfrog should be used to report on the questions in Section 9C.


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- If a patient had more than one of the listed procedures performed on the same visit (i.e., repair of dislocating knee cap (CPT: 27422) and repair of superior labrum anterior/posterior (SLAP) lesion (CPT: 29807)), include the patient in the total volume for both procedures.

### *Ophthalmology Measure Specifications*

For ophthalmology procedures, use the CPT codes available via the Survey Dashboard to count **patients** discharged from your hospital outpatient departments who have undergone any of the 3 procedures during the reporting period.

One procedure applies to **both adult and pediatric patients**:
- Ocular adnexa and other eye procedures

Two procedures apply to **adult patients only:**
- Anterior segment eye procedures
- Posterior segment eye procedures

Using the "Ophthalmology_adult" sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Using the "Ophthalmology_ped" sheet, count the total number of pediatric (17 years of age and younger) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

### *Orthopedic Measure Specifications*

For orthopedic procedures, use the CPT codes available via the Survey Dashboard to count **patients** discharged from your hospital outpatient departments who have undergone any of the 7 procedures during the reporting period.

Five procedures apply to **both adult and pediatric patients**:
- Finger, hand, wrist, forearm, and elbow procedures
- Shoulder procedures
- Knee procedures
- Toe, foot, ankle, and leg procedures
- General orthopedic procedures

Two procedures apply to **adult patients only:**
- Spine procedures
- Hip procedures

Using the "Orthopedic_adult" sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Using the "Orthopedic_ped" sheet, count the total number of pediatric (17 years of age and younger) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

### *Otolaryngology Measure Specifications*

For otolaryngology procedures, use the CPT codes available via the Survey Dashboard to count **patients** discharged from your hospital outpatient departments who have undergone any of the 4 procedures during the reporting period.

Three procedures apply to **both adult and pediatric patients**:
- Ear procedures

- Mouth procedures
- Nasal/sinus procedures

One procedure applies to **pediatric patients only:**
- Pharynx/adenoid/tonsil procedures

Using the "Otolaryngology_adult" sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Using the "Otolaryngology_ped" sheet, count the total number of pediatric (17 years of age and younger) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

### *Gastroenterology Measure Specifications*

For gastroenterology procedures, use the CPT codes available via the Survey Dashboard to count **patients** discharged from your hospital outpatient departments who have undergone either of the 2 procedures during the reporting period.

Both procedures apply to **adult patients only:**
- Upper GI endoscopy
- Lower GI endoscopy

Using the "Gastroenterology_adult" sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

### *General Surgery Measure Specifications*

For general surgery procedures, use the CPT codes available via the Survey Dashboard to count **patients** discharged from your hospital outpatient departments who have undergone any of the 7 procedures during the reporting period.

All seven procedures apply to **adult patients only**:
- Cholecystectomy and common duct exploration
- Hemorrhoid procedure
- Laparoscopy
- Lumpectomy or quadrantectomy of breast
- Mastectomy
- Inguinal and femoral hernia repair
- Other hernia repair

Using the "General surgery_adult" sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

### *Urology Measure Specifications*

For urology procedures, use the CPT codes available via the Survey Dashboard to count **patients** discharged from your hospital outpatient departments who have undergone any of the 5 procedures during the reporting period.

All five procedures apply to **adult patients only**:
- Circumcision
- Cystourethroscopy


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- Male genital procedures
- Urethra procedures
- Vaginal repair procedures

Using the "Urology_adult" sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

### *Neurological Surgery Measure Specifications*

For neurological surgery procedures, use the CPT codes available via the Survey Dashboard to count **patients** discharged from your hospital outpatient departments who have undergone the procedure during the reporting period.

One procedure applies to **adult patients only**:
- Spinal fusion procedures

Using the "Neurological surgery_adult" sheet, count the total number of adult (18 years of age or older) patients discharged with any of the CPT codes listed. The CPT code can be in any procedure field.

### *Obstetrics and Gynecology Measure Specifications*

For obstetrics and gynecology procedures, use the CPT codes available via the Survey Dashboard to count **patients** discharged from your hospital outpatient departments who have undergone any of the 3 procedures during the reporting period.

Three procedures apply to **adult patients only**:
- Cervix procedures
- Hysteroscopy
- Uterus and adnexa laparoscopies

Using the "Obstetrics and gynecology_adult" sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

### *Plastic and Reconstructive Surgery Measure Specifications*

For plastic and reconstructive surgery procedures, use the CPT codes available via the Survey Dashboard to count **patients** discharged from your hospital outpatient departments who have undergone either of the 2 procedures during the reporting period.

Two procedures apply to **adult patients only**:
- Breast repair or reconstruction
- Skin graft/reconstruction procedures

Using the "Plastic_reconstruct surg_adult" sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

See FAQs for additional information about responding to questions in this section.


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# Section 9C: Volume of Procedures Frequently Asked Questions (FAQs)

1. **How did Leapfrog select these 9 specialties and the procedures in this section of the Survey?**
   Leapfrog worked with the Health Care Cost Institute (HCCI) to identify the most commonly billed surgical procedures in ambulatory surgery centers and hospital outpatient departments for commercially insured adult and pediatric patients. Leapfrog's technical experts then assessed the list of procedures based on their frequency and type of anesthesia used during the procedure. Those selected for the Survey represent the highest volume procedures nationally requiring moderate to general anesthesia (including nerve blocks).

   Please reach out to the Leapfrog Help Desk if you believe additional CPT Codes should be added to the Survey; Leapfrog will take these suggestions to our technical experts.

2. **Should we count patients discharged with a G code for colonoscopy?**
   No. A "G" (HCPCS II) code is used to differentiate between colonoscopies performed for screening purposes rather than for a diagnostic or therapeutic procedure. The Survey only includes major diagnostic and therapeutic procedures.


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# Safety of Procedures Measure Specifications

### *Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures*

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

**Source**: The Leapfrog Group, WHO Surgical Safety Checklist and Implementation Manual, AHRQ Endoscopy Checklist

**Reporting Period**: **12 months**
Latest 12-month period prior to submission of this section of the Survey

**Safe Surgery Checklist Workbook (Excel)**

To complete the data collection and respond to questions #6-9, hospitals should download the Safe Surgery Checklist Workbook (Excel). This workbook includes five tabs: Instructions, Section 3B (Complex Surgery), Section 3B – Data Entry, Section 9D (Outpatient Procedures), and Section 9D – Data Entry. The Section 9D tabs can be used to complete the safe surgery checklist audits for this subsection and to calculate the response for question #9.

The workbook is available on the Survey Materials Webpage.

**Sampling:**

**For hospitals with one hospital outpatient department that performs the procedures listed in Section 9C and Section 3A and submit both Section 9 and 3:** Hospitals can randomly sample 15 patients (who had one of the procedures included in Section 9C) and measure and report adherence to the safe surgery checklist based on that sample.

When sampling from a larger population of cases, hospitals that perform procedures across multiple surgical specialties (e.g., general surgery, orthopedics, urology, etc.) included in Section 9C and facilities that perform procedures for both adult and pediatric patients should obtain a representative sample (i.e., include patients who underwent procedures in different surgical specialties and include both adult and pediatric patients, if applicable).

**For hospitals with multiple hospital outpatient departments that perform the procedures listed in Section 9C and Section 3A and submit both Section 9 and 3:** Hospitals can randomly sample 15 patients (who had one of the procedures included in Section 9C) and measure and report adherence to the safe surgery checklist based on that sample. However, hospital must sample across the various locations where the procedures are being performed, including freestanding hospital outpatient departments or surgery centers, in addition to ensuring that the sample includes patients who underwent procedures in different surgical specialties and both adult and pediatric patients, if applicable.

**For hospitals with one or multiple hospital outpatient departments that ONLY perform the procedures in Section 9C or that ONLY submit Section 9**: Hospitals must randomly sample 30 patients who had one of the procedures included in Section 9C and report adherence to the safe surgery checklist on that sample. Hospitals that perform the procedures listed in Section 9C and 3A should follow the guidance above.


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**Question #6: Did your hospital perform an audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 9C and measure adherence to the safe surgery checklist?**

To respond "yes" to question #6, hospitals must measure and document whether all the elements in questions #3, #4, and #5 were verbalized in the presence of the appropriate personnel for each sampled case. Hospitals that completed the audit should respond "yes" to this question regardless of whether the adherence to the checklist was 100%. Hospitals will report on adherence to the checklist in question #9.

**Question #7: How many cases were included in the audit from question #6?**

Hospitals that perform procedures in both Section 3A and Section 9C, and submit both Section 3 and 9, can randomly sample 15 patients (who had one of the procedures included in Section 9C) and measure and report adherence to the safe surgery checklist based on that sample.

Hospitals that ONLY perform the procedures in Section 3AC, or that ONLY submit Section 9, must randomly sample 30 patients (who had one of the procedures included in Section 9C) and measure and report adherence to the safe surgery checklist based on that sample.

**Question #8: What method was used to perform the audit on a sufficient sample in question #6?**

Hospitals can only perform a retrospective audit by reviewing medical records or EHR data if adherence to the safe surgery checklist is clearly documented in the medical record or EHR and the documentation clearly demonstrates that each element was verbalized in the presence of the appropriate personnel. If hospitals cannot clearly determine whether (a) the checklist element was verbalized and (b) that the appropriate personnel were present via a retrospective audit, an in-person observational audit must be completed.

Hospitals performing in-person observational audits must do so in the latest 12 months prior to Survey submission.

Hospitals performing retrospective audits must audit cases from the latest 12 months prior to Survey submission but can also review any case from Section 9C that was performed in the latest calendar year prior to Survey submission.

**Question #9: Based on your hospital's audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 9C, what was your hospitals documented rate of adherence to the safe surgery checklist (e.g., what percentage of the sampled cases had all elements in questions #3, #4, and #5 completed)?**

Based on the audit completed for question #6, determine the total number of patient audits where **all** elements of the safe surgery checklist (included in questions #3, #4, and #5) were read aloud in the presence of the appropriate personnel 1) before the induction of anesthesia, 2) before the skin incision and/or the procedure began, and 3) before the patient left the operating and/or procedure room.

**Included cases:**

- The patient audit shows that **all** elements of the safe surgery checklist, at **all** three time points, were read aloud in the presence of the appropriate personnel.

**Excluded cases:**

- The patient audit does **not** demonstrate that all elements of the safe surgery checklist were read aloud in the presence of the appropriate personnel (i.e., one or more elements of the checklist were not read aloud, or the appropriate personnel were not present during the checklist).
- The patient audit does **not** demonstrate that the safe surgery checklist was read aloud in the presence of the appropriate personnel at all three time points (i.e., before anesthesia, before skin incision, and before the patient leaves).


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**Important Note**: If a Safe Surgery Checklist element includes the qualifier "if applicable," hospitals should determine if that element of the checklist was applicable to the patient and procedure being performed. If the element was determined to be "not applicable" to the patient and procedure, it does not count against the total adherence. For example, if your hospital performed a hernia repair, the availability of a device on-site would not be applicable. Therefore, when completing the Safe Surgery Checklist Workbook for this patient, indicate N/A for that element (device on-site) and your hospital would be able to count that case as adherent.


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# Section 9D: Safety of Procedures Frequently Asked Questions (FAQs)

## *General Questions*

1. **How should hospitals report on the processes in Section 9D Safety of Procedures if they have more than one hospital outpatient department performing the procedures listed in Section 9C Volume of Procedures?**
   Hospitals with more than one hospital outpatient department are instructed to respond to Section 9D based on the location with the fewest processes in place. For example, if one hospital outpatient department uses a safe surgery checklist on all patients, but another hospital outpatient department does not, you should answer "no" to question #6.

## *Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures FAQs*

2. **What 12-month reporting period should be used when reporting on this section?**
   When responding to the questions in Section 9D, hospitals should enter the month in which they complete their observational in-person or retrospective EHR review audits. If your hospital does not perform an audit, enter the month in which you are completing the Survey.

3. **Does the safe surgery checklist referenced in Section 9D questions #1-9 apply to all procedures, including colonoscopies, endoscopies, etc.?**
   Yes, it applies to all procedures in Section 9C questions #2-10. If your hospital outpatient department(s) do not utilize a safe surgery checklist for colonoscopy and/or endoscopy, respond "No" to question #2.

4. **Can different elements of the "Before the induction of anesthesia" checklist (question #3) be performed in different places?**
   Yes, hospitals may perform some elements of the pre-anesthesia checklist outside of the operating room. Hospitals may read aloud the following elements in a pre-procedure (preop) area: Patient ID, Confirmation of procedure, Patient consent, Site marked, if applicable, and Allergies assessed.

   Hospitals should not remove conversation prompts as it is harmful to the purpose of the checklist and should continue debriefing and requiring participation of the surgical team members in key moments.

5. **Do we need to perform a "clinical team introduction" if the team already knows each other and/or will be in the operating room together all day?**
   Yes. Even if a clinical team knows each other they must perform an introduction stating their name and role at the first procedure of the day. They do not need to reintroduce themselves for the remaining procedures but should confirm everyone was introduced beforehand. However, if any team members change between operations, introductions must be performed again.

6. **Do the Safe Surgery Checklist components included in questions #3, #4, and #5 need to be in one document that would align with the WHO example or can they be in different documents (i.e., pre-anesthesia notes, surgeon H&P, and pre-surgical checklists, etc.)?**
   It is possible to have separate checklists for each phase of the surgical procedure (i.e., before the induction of anesthesia, before the skin incision and/or before the procedure begins, and before the patient leaves the operating or procedure room). However, each individual component included in questions #3, #4, and #5 should be listed on the checklist(s) and hospitals should document whether the components were read aloud at the appropriate time with the appropriate members of the surgical team present.

7. **How is "whole surgical team" defined?**
   "Whole surgical team" is comprised of the surgeons, anesthesia professionals, nurses, technicians, and other operating room personnel involved in surgery. This is based off the World Alliance for Patient Safety Implementation Manual Surgical Safety Checklist (First Edition).

# Medication Safety for Outpatient Procedures Measure Specifications

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

**Source:** The Leapfrog Group

**Reporting Period: 12 months**

- Surveys submitted prior to September 1:
  - 01/01/2025 – 12/31/2025
- Surveys (re)submitted on or after September 1:
  - 07/01/2025 – 06/30/2026

**Medication Safety Documentation Workbook (Excel)**

To complete the data collection for this subsection and respond to questions #3-7, hospitals should download the Medication Safety Documentation Workbook (Excel). This workbook includes seven tabs: Instructions, 2025 Sampling, 2026 Sampling, Home Meds, Visit Meds, Allergies, and Data Entry and can be used to identify patients to sample in order to complete the three clinical record audits, as well as calculate the responses to enter into the Online Hospital Survey Tool for each of the audits.

This workbook is available on the Survey Materials webpage and should be used when completing this subsection.

**Sampling:**

***For hospitals with one hospital outpatient department that performs the procedures listed in Section 9C:***
If you have more than 30 cases that meet the criteria for inclusion in the denominator of the process measures during the time period of the clinical record audit, you may randomly sample 30 of them for the denominator of each documentation guideline, and measure and report adherence based on that sample. When sampling from a larger population of cases, this is the minimum number of cases needed to make a statistically reliable statement of percent adherence to the process guidelines.

***For hospitals with multiple hospital outpatient departments that perform the procedures listed in Section 9C:***
If you have more than 30 cases total (across all hospital outpatient departments) that meet the criteria for inclusion in the denominator of the process measure during the time period of the clinical record audit, you may randomly sample a minimum of 10 cases from the hospital (including any co-located hospital outpatient departments or inpatient areas performing outpatient procedures) and each free-standing hospital outpatient department or surgery center. Hospitals will need to report on a total minimum sample size of at least 30, and measure and report adherence based on that sample. When sampling from a larger population of cases, this is the minimum number of cases needed to make a statistically reliable statement of percent adherence to the process guidelines.

For example, if you are reporting on your hospital (including multiple areas where outpatient procedures are performed), as well as another hospital outpatient department that is free-standing, you could sample 15 cases from each for a total sample size of 30. If you are reporting on seven locations, you could sample 10 cases from each for a total sample size of 70.

Note: Hospitals that share a CMS Certification Number (CCN) with other hospitals may use the same sample for reporting on a shared hospital outpatient department location (e.g., surgery center, endoscopy center, free-standing hospital outpatient department, etc.). For example, Hospital A and Hospital B share a CCN and both refer patients to the same gastroenterology center. Hospital A samples 15 cases from their hospital and 15 cases from the gastroenterology center. Hospital B can use the sample of 15 cases from the gastroenterology center in addition to sampling from their hospital when reporting on their own Leapfrog Hospital Survey.

**Medications:** For the purposes of this measure, a **medication** is a substance that is taken into, or placed onto, the body of a person for one or more of the following reasons:

- as a placebo
- to prevent a disease (e.g., flu vaccine)
- to make a diagnosis (e.g., contrast dye)
- to test for the possibility of an adverse effect
- to modify a physiological, biochemical or anatomical function or abnormality (e.g., heparin/heparin flushes, statins, antihypertensives, etc.)
- to replace a missing factor (e.g., blood product)
- to ameliorate a symptom (e.g., aspirin)
- to treat a disease or condition (including topicals, nasal sprays, eye drops, compounds, inhalants, injectables, patches, etc.)
- to induce anesthesia
- to stabilize or hydrate during medical treatment or procedures (e.g., IV fluids, normal saline, lactated ringers, etc.)
- to provide nutrition (e.g., enteral nutrition products, parenteral nutrition products, breast milk [breast milk applies to BCMA measure only])
- as a supplement (e.g., iron for a patient with iron deficiency anemia or calcium/vitamin D for a patient with osteoporosis)

For the purposes of this measure, the following are **not** considered medications:

- Pre-filled saline flushes and pre-filled heparin flushes (i.e., saline and heparin flushes that come from the manufacturer already filled and are not filled by the hospital's pharmacy)
- Chlorhexidine and alcohol preparation pads
- Intra-op irrigation solutions

**Question #3 (denominator):** Number of cases measured (either all cases or a sufficient sample of them).

Your hospital should perform a clinical record audit of either all adult and/or pediatric patients undergoing those procedures included in Section 9C discharged during the reporting period or a sufficient sample of those patients discharged during the reporting period as described above.

This audit of clinical records can be done retrospectively (anytime during the Survey Cycle of April 1 – November 30).

The total number of clinical records included in your audit is reported in question #3.

**Excluded cases:** Patients discharged from the hospital outpatient departments without having one of the procedures included in Section 9C performed during the reporting period.

**Question #4 (numerator):** Number of cases in question #3 with a list of **all home medication(s),** including dose, route, and frequency, documented in the clinical record.

Determine the total number of clinical records included in the audit (in question #3), where a list of all home medication(s), including dose, route, and frequency, was documented in the clinical record either on the day of the procedure or after a pre-screening phone call (i.e., 1-2 days in advance of the procedure). Records that include documentation that the patient had no home medications should be included.

"Home medications" are defined as medications that the patient was taking prior to admission.

The following home medications may be excluded from the clinical record unless they are clinically relevant* (e.g., herbal supplement that is known to interact with anesthesia):

- as needed (PRN) medications
- topical lotions/creams
- saline nasal spray and artificial tear eye drops
- herbals and supplements and vitamins


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- medications prescribed for the purpose of operative prep prior to colonoscopy

Home medications that must be included in the clinical record include clinically relevant* PRN medications such as inhalers, nitroglycerin, analgesics (opioid and non-opioid), muscle relaxants, and sedatives.

**Clinically relevant is defined as any PRN medication that treats a medical condition on the patient's problem list and/or condition they are being treated for during the visit (i.e., reason for the hospital stay).*

**Included cases:**
- The clinical record includes documentation that the patient has no home medications.

**Excluded cases:**
- The clinical record is missing a list of all home medication(s).
- The clinical record is missing dose, route, **or** frequency for a home medication

**Question #5 (numerator):** Number of cases in question #3 with a list of **all medication(s) administered during the visit and new medications prescribed at discharge,** including the strength, dose, route, date, and time of administration, documented in the clinical record.

Determine the total number of clinical records included in the audit (question #3), where a list of all medication(s) administered during the visit and new medications prescribed at discharge, including the strength, dose, route, date, and time of administration, was documented in the clinical record on the day of the procedure.

Local, regional, and general anesthesia medications must only have **total dose, date, and time of administration** documented in the clinical record to be considered complete.

Lidocaine jelly only needs to have **strength, date, and time of administration** documented in the clinical record to be considered complete.

IV solutions must have **strength, dose, route, date, and time of administration** documented in the clinical record to be considered complete. However, if the IV solution only comes in one concentration/strength (such as the LR Injection), the strength can be entered as N/A and the start time and volume of the bag can be documented for dose in order to be considered complete.

New medications prescribed at discharge, but not administered at the hospital must only have **strength, dose, route, and date the medication was prescribed** documented in the clinical record to be considered complete.

**Excluded cases:**
- The clinical record is missing a medication that was administered or prescribed during the visit or at discharge.
- The clinical record is missing strength, dose, route, date, **or** time of administration for a medication administered or prescribed during the visit or at discharge except as described above for anesthesia medications, IV solutions, and prescribed medications.

**Question #6 (numerator):** Number of cases in question #3 with a list of **all medication allergies and adverse reaction(s)** documented in the clinical record.

Determine the total number of clinical records included in the audit (question #3), where a list of all medication allergies and adverse reaction(s) was documented in the clinical record. Hospitals should only assess medication allergies (i.e., hospitals do not need to assess food or environmental allergies).

**Included cases:**
- The clinical record includes documentation that the patient reported no known allergies.

**Excluded cases:**

- The clinical record does **not** include either a list of allergies and adverse reaction(s) **nor** documentation of no known allergies.
- The clinical record does include a list of allergies but does not include documentation of the adverse reaction(s) for each allergy.

**Important Note:** In addressing allergies and adverse reaction statuses noted as "unknown" in the clinical record, hospitals should assess if:

- "unknown" is used to indicate that the patient (or patient's family) was asked for the adverse reaction status, but they indicated it was not known, in which situation the case should be included in the numerator (question #6); or
- "unknown" is used in the clinical record to indicate that the information is not available because it was not requested or documented by the clinician, in which situation the case should be excluded from the numerator (question #6)

See FAQs for additional information about responding to questions in this section.


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# Section 9E: Medication Safety for Outpatient Procedures Frequently Asked Questions (FAQs)

1. **How often do home medications need to be updated in the clinical record for Section 9E question #4?**
   Home medications must be recorded in a pre-screening phone call 1-2 days in advance of the procedure or updated on the day of the clinical procedure (for all procedures included in Section 9C of the 2026 Leapfrog Hospital Survey).

   Patients who are returning for a second or follow-up procedure within 12 months of the initial procedure are not required to have an updated home medication list in their clinical record in order for the record to be counted in the numerator of the home medication audit (i.e., included in the count in question #4). However, in cases of frequent repeated clinical visits, the home medications list should be updated at least once every 12 months.

2. **For medications that only ever have a single route of administration (e.g., orally only), does route have to be documented in the clinical record for questions #4 and #5?**
   No. If there is a medication that can only ever be given via a single route, route does not have to be documented to count the case when responding to questions #4 and #5.

3. **We do medication reconciliation on patients for certain outpatient procedures. Will the medication reconciliation on the procedure day suffice for the "medication audits" requirement in question #4? Or does it have to be a retrospective audit after the procedure day?**
   Leapfrog specifies that, unless all medical records are audited, the clinical record audit should be conducted on a random sample of discharged patients. If your hospital does not perform medication reconciliation before all patients are discharged to ensure that the correct dose, route, and frequency are documented in the clinical record for all home medications this would not meet the requirements of Section 9E.

   Instead, your hospital should randomly sample from all clinical records of discharged outpatients (adults and children) who had the procedures included in Section 9C during the reporting period, not just those records that had medication reconciliation conducted during the same day visit. This audit may occur on the same day as the patient visit or following patient discharge.


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# CMS Measures Measure Specifications

Leapfrog obtains data for the following measures directly from the CMS Provider Data Catalog:

- OP-32: Rate of Unplanned Hospital Visits After an Outpatient Colonoscopy
- Patient Experience Top Box Score[51] (OAS CAHPS)
    a) Facilities and Staff
    b) Communication About Your Procedure
    c) Patients' Rating of the Facility
    d) Patients Recommending the Facility

The following questions from the OAS CAHPS Survey are included in each domain:

Facilities and Staff
Q3: Did the check-in process run smoothly?
Q4: Was the facility clean?
Q5: Were the clerks and receptionists at the facility as helpful as you thought they should be?
Q6: Did the clerks and receptionists at the facility treat you with courtesy and respect?
Q7: Did the doctors and nurses treat you with courtesy and respect?
Q8: Did the doctors and nurses make sure you were as comfortable as possible?

Communication About Your Procedure
Q1: Before your procedure, did your doctor or anyone from the facility give you all the information you needed about your procedure?
Q2: Before your procedure, did your doctor or anyone from the facility give you easy to understand instructions about getting ready for your procedure?
Q9: Did the doctors and nurses explain your procedure in a way that was easy to understand?
Q10: Anesthesia is something that would make you feel sleepy or go to sleep during your procedure. Were you given anesthesia?
Q11: (If "yes" to Q10) Did your doctor or anyone from the facility explain the process of giving anesthesia in a way that was easy to understand?
Q12: (If "yes" to Q10) Did your doctor or anyone from the facility explain the possible side effects of the anesthesia in a way that was easy to understand?

Patients' Rating of the Facility
Q23: Using any number from 0 to 10, where 0 is the worst facility possible and 10 is the best facility possible, what number would you use to rate this facility?

Patients Recommending the Facility
Q24: Would you recommend this facility to your friends and family?

Please note that question numbers are taken from the OAS CAHPS Survey, which you can download at https://oascahps.org/Survey-Materials.

### Review your CMS data

- Once Leapfrog has published your hospital's Survey Results on the Hospital Details Page, hospitals are urged to compare the CMS data Leapfrog has obtained with the data published on CMS' website.
- Dates on which the Survey Results will be available on the Hospital Details page are listed in the "Deadlines and Reporting Periods" table below.

If you find a discrepancy while comparing your hospital's data published on the CMS website to the data published on the Hospital Details page, contact Leapfrog's Help Desk immediately.


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**Deadlines and Reporting Periods**

| CMS Download Date | CMS Reporting Period | Review Results |
|---|---|---|
| *Leapfrog will download the dataset from the CMS Provider Data Catalog on these dates* | *These reporting periods are subject to CMS data availability on the download date and may change.* | *Data pulled by Leapfrog will be available to review on the Hospital Details Page or Public Reporting Website by these dates* |
| June 30, 2026 | OP-32: 1/1/2022 - 12/31/2024<br>OAS CAHPS: 7/1/2024 - 6/30/2025 | July 12, 2026* |
| August 31, 2026 | OP-32: 1/1/2022 - 12/31/2024<br>OAS CAHPS: 10/1/2024 - 9/30/2025 | September 10, 2026 |
| November 30, 2026 | OP-32: 1/1/2022 - 12/31/2024<br>OAS CAHPS: 1/1/2025 - 12/31/2025 | December 9, 2026 |

*Data will be published to the Public Reporting Website starting on July 25, 2026.

See FAQs for additional information about responding to questions in this section.

# Section 9F: CMS Measures Frequently Asked Questions (FAQs)

1. **We share a CMS Certification Number (CCN) with another hospital that participates in the OAS CAHPS Survey. How can we report on results from the OAS CAHPS Survey that are specific to our outpatient department?**
   Since OAS CAHPS data is now pulled on behalf of hospitals using CCNs, Leapfrog can no longer report OAS CAHPS data by individual facilities when CCNs are shared. Leapfrog has cautioned against hospitals located on separate campuses sharing CCNs since results will be aggregated and publicly reported on information tools, such as CMS Care Compare and the Leapfrog Hospital Safety Grade. While Leapfrog is committed to making differences among facilities known to patients and their families, Leapfrog made this change to minimize administrative burden associated with completing the Survey.

2. **Why does Leapfrog not publicly report the "Preparations for Discharge and Recovery" OAS CAHPS domain for hospitals?**
   Leapfrog plans to publicly report the "Preparations for Discharge and Recovery" OAS CAHPS domain for both ASCs and hospitals in future Surveys. The scores for this domain are not expected to be publicly available for ASCs until late 2026, and Leapfrog aligns with the public reporting of OAS CAHPS measures for both HOPDs and ASCs.


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# Endnotes

[1] ***Acute-Care Units***
Include units used for short-term, acute-care medical, surgical, medical/surgical (including telemetry), as well as obstetrical, intensive, and step-down/progressive care.

Exclude units used for short and long-term psychiatric care, rehabilitation, observation, or sub-acute care (e.g., skilled nursing facility, hospice extended care, sub-acute eating disorder treatment, extended care facility, or residential substance abuse treatment), and swing bed units.

[2] ***CMS Certification Number (CCN)***
A CMS Certification Number (CCN) is issued by the Centers for Medicare and Medicaid Services (CMS) to financial reporting entities, which may be individual hospitals or a group of hospitals, for the purpose of reimbursement. While Leapfrog does ask each campus of a multi-hospital system to submit an individual Survey, hospitals within the system may be assigned the same CMS Certification Number and therefore should have the same CCN reported in this field. CCNs are six digits; with the first two digits representing the state in which the hospital is located. Hospitals that do not receive Medicare reimbursement may not have a CMS Certification Number and should not have a CCN reported in this field. Leapfrog pre-populates this field in the Online Hospital Survey Tool. If the hospital's CCN is different from the one shown online, please contact the Help Desk.

[3] ***National Health Safety Network (NHSN) ID***
A NHSN ID is issued by the Centers for Disease Control and Prevention and is used as a unique identifier for facilities participating in NHSN surveillance activities. Each hospital within a system, even if they share a CCN, must report separately to NHSN and should have their own NHSN ID if they are located separately. Please see the NHSN instructions available at https://www.leapfroggroup.org/survey-materials/review-nhsn-instructions. NHSN IDs are five digits. Leapfrog pre-populates this field in the Online Hospital Survey Tool for hospitals that provided a valid NHSN ID, joined our NHSN Group, and submitted the 2025 Leapfrog Hospital Survey. If the hospital NHSN ID is different from the one shown online, please update accordingly.

In order to be scored and publicly reported for any of the five applicable infection measures and to have the hospital's teaching status represented, hospitals must: (1) provide an accurate NHSN ID in the Profile, (2) join Leapfrog's NHSN Group by the appropriate deadline, and (3) submit the 2026 Leapfrog Hospital Survey by the appropriate deadline.

[4] ***Vermont Oxford Network (VON) Transfer Code***
A Vermont Oxford Network (VON) Transfer Code is issued by the Vermont Oxford Network and is used as a unique identifier for hospitals reporting data through the VON Nightingale Internet Reporting System. Each hospital has their own VON Transfer Code, which can be found at https://public.vtoxford.org/transfer-codes/. VON Transfer Codes are four, five, or seven digits. Leapfrog pre-populates this field in the Online Hospital Survey Tool Profile for hospitals that provided a valid VON Transfer Code in 2025. If the hospital's VON Transfer Code is different from the one shown online, please update accordingly.

[5] ***Federal Tax Identification Number (TIN)***
Enter the TIN that your hospital uses for billing purposes. *The number is a nine-digit number (e.g., 098765432) and must conform precisely to this format – be sure to enter any leading 0.* If your hospital has more than one TIN, use the one that would most typically be used for UB-04 claims filed with commercial health insurance plans for inpatient hospital stays.


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[6] ***National Provider Identifier (NPI)***
The NPI is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number of covered health care providers. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or medical specialty. Leapfrog pre-populates this field in the Online Hospital Survey Tool. If the hospital's NPI is different from the one shown online, please contact the Help Desk.

[7] ***State***
Your hospital is assigned to a state based on the CMS Certification Number assigned (or identifier specially issued by the Leapfrog Help Desk) to your hospital. If your hospital is incorrectly assigned to a state, contact the Help Desk to resolve the discrepancy.

[8] ***Tips for Entering Web Addresses***
This address becomes the link attached to your hospital's name in the public release of Survey Results. Enter it exactly as you wish it to be and test it.

- Do not exit out of the Online Hospital Survey Tool to go to the Web page of interest while you are entering data into the Survey or some of your Survey entries may be lost.
- Instead, minimize (but don't close) the Survey window and any other windows that are open, then open your internet browser in a separate window. Find the Web page whose address you wish to enter and Copy/Paste the entire address into the Survey entry. **The http:// prefix needs to be included.**
- If entering the Web page address manually, be careful to type it correctly, without embedded spaces. Forward (/) or backward (\) slashes may be used. Don't forget the "www." if that is part of the address. **The http:// prefix needs to be included.**
- Make sure to use .org, rather than .com, if that's the domain for your hospital's website.
- Although many hospitals elect to enter the address for the home page of their hospital website, consider pointing it to a page specific to patient safety, the Leapfrog safety practices, or other quality improvement activities that you want to communicate to your community.

[9] ***Healthcare System or Integrated Delivery Network***
Healthcare Systems or Integrated Delivery Networks (IDN) are central organizations that own, lease, or sponsor two or more hospitals with the goal of providing coordinated patient care. Pediatric, specialty, and rehabilitation hospitals are included as hospitals in this definition. IDNs may belong to a larger parent system. Leapfrog pre-populates this field in the Online Hospital Survey Tool and only uses the field internally (e.g., it will not be shared publicly). If the IDN displayed in the Online Survey Tool is incorrect, please contact the Help Desk.

[10] ***Licensed Acute-Care Beds***
If your state does not license bed types or if acute-care beds are currently staffed higher than the number of licensed beds, enter the number of staffed beds from question #3. If the number of licensed beds has changed in the last year, indicate the average or other number most representative of your operating bed capacity over the last year.

Include short-term, acute-care medical, surgical, medical/surgical (including telemetry), obstetrical, and intensive care beds, as well as step-down/progressive care beds as licensed by your state.

Exclude beds licensed or used for short and long-term psychiatric care, rehabilitation, observation, or sub-acute care (e.g., skilled nursing facility, hospice extended care, sub-acute eating disorder treatment, extended care facility, or residential substance abuse treatment) and swing beds.


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[11] ***Staffed Acute-Care Beds***
Include licensed beds regularly in operation, whether currently occupied by a patient or not. If the number has changed over the last year, indicate the average or other number most representative of your operating bed capacity over the last year.

[12] ***Total Adult Acute-Care Admissions***
Include adult (aged 18 years and older) acute-care medical, surgical, and medical/surgical (including telemetry), obstetrical, and intensive care admissions. Include transfers from other hospitals. Include admissions directly to an ICU, even if counted in question #9. Include admissions to step-down/progressive units.

Exclude short and long-term psychiatric care, rehabilitation, observation, or sub-acute care (e.g., skilled nursing facility, hospice extended care, sub-acute eating disorder treatment, extended care facility, or residential substance abuse treatment) admissions and admissions to swing units.

[13] ***Total Pediatric Acute-Care Admissions***
Include pediatric (ages 17 years and younger) acute-care medical, surgical, medical/surgical (including telemetry), and intensive care admissions. Include transfers from other hospitals. Include admissions directly to an ICU or Level II/III, Level III, or Level IV neonatal ICU (NICU), even if counted in question #12 or #15. Include admissions to step-down/progressive units.

Exclude newborn admissions to the nursery and pediatric patients admitted for maternity care, short and long-term psychiatric care, rehabilitation, observation, or sub-acute care (e.g., skilled nursing facility, hospice extended care, sub-acute eating disorder treatment, extended care facility, or residential substance abuse treatment) and admissions to swing units. Exclude admissions for patients that were transferred to another facility.

[14] ***General Medical, Surgical, Medical/Surgical, and Neuro ICUs***
Include general medical, surgical, medical/surgical, and neuro ICUs (medical and surgical). Exclude ICUs "dedicated exclusively" to patients with specialized conditions (e.g., cardiac, burn, trauma, neonatal, etc.) unless the same ICU is used for both specialized intensive care patients as well as general medical, surgical, medical/surgical, or neuro intensive care patients. "Dedicated exclusively" means that general medical, surgical, medical/surgical, or neuro intensive care patients are not also cared for in these specialized units (except in rare overflow situations). Exclude intermediate care or telemetry/step-down/progressive units.

For the purposes of reporting on adult and pediatric ICU admissions in Section 1A: Basic Hospital Information questions #9 and #12, include admissions to general medical, surgical, medical/surgical, and neuro ICUs (medical and surgical), whether directly admitted to the unit or transferred to the unit from another area of your hospital (e.g., post-operatively). Include transfers from other hospitals as admissions to your hospital. Include the number of admissions that include an ICU stay, not the number of patient trips to the ICU.

[15] ***Licensed ICU Beds***
If your state separately designates ICU beds, indicate the number of licensed beds in adult (question #7) and pediatric (question #10) general medical, surgical, medical/surgical, and neuro ICUs (medical and surgical). If your state does not license ICU beds or if the number of staffed ICU beds is currently higher than the number of licensed ICU beds, enter the number of staffed ICU beds from question #8 in question #7 and number of staffed ICU beds from question #11 in question #10. See endnote #14 for more information.

Exclude beds "dedicated exclusively" to patients with specialized conditions (e.g., cardiac, burn, trauma, neonatal). "Dedicated exclusively" means that general medical, surgical, medical/surgical, or neuro


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intensive care patients are not also cared for in these specialized units (except in rare overflow situations). Exclude beds used for step-down/progressive care.

[16] ***Staffed ICU Beds***
Indicate the number of adult ICU beds from question #7 in question #8 and number of pediatric ICU beds from question #10 in question #11 that are regularly in operation, whether currently occupied by a patient or not. If the number has changed over the last year, indicate the average or other number most representative of your operating ICU capacity over the last year. See endnote #14 for more information.

[17] ***Neonatal ICUs***
Include Level II/III, Level III, and Level IV neonatal ICUs (NICUs). Exclude neonatal nurseries (Level I and Level II). For more information about what is considered a NICU, please refer to the CDC's definitions of Neonatal Units on p. 15-12 to 15-15 of the following document:
https://www.cdc.gov/nhsn/pdfs/pscmanual/pscmanual_current.pdf.

For the purposes of reporting on NICU admissions in Section 1A: Basic Hospital Information question #15, include admissions to Level II/III, Level III, and Level IV NICUs, even if counted in question #5. Include transfers from other hospitals as admissions to your hospital. Exclude admissions for patients that were transferred to another facility.

[18] ***CPOE Linked to Pharmacy, Laboratory, ADT Information***
The ability of a CPOE system to catch the majority of common, serious prescribing errors depends on proper identification of patients (ADT information), current and recent pharmacy orders and drug dispensing history, and access and integration of key laboratory results for the patient. CPOE systems that are not linked to those other systems or do not reflect that current information accurately about the patient are not likely to catch serious prescribing errors.

[19] ***Medical, Surgical, and Medical/Surgical Units***
An exact definition on which units would be included in general medical, surgical, or medical/surgical cannot be provided because each hospital is laid out differently. For information about what is considered a general medical, surgical, or medical/surgical unit, please refer to the CDC's definitions of Medical Ward, Medical/Surgical Ward, and Surgical Ward on p. 15-17 to 15-20 of the following document: https://www.cdc.gov/nhsn/pdfs/pscmanual/pscmanual_current.pdf. The flowchart on p. 15-3 can also be used to help define units in your hospital. Units for patients from a specific service type (e.g., burn, cardiac) and observation units must be excluded. Include telemetry units (defined on p. 15-20 of the above referenced document).

For the purposes of reporting on Sections 2C: BCMA and 6C: Hand Hygiene, include both single and mixed acuity medical, surgical, medical/surgical, and telemetry units, as well as step-down/progressive beds in a dedicated medical, surgical, or medical/surgical unit.

For the purposes of reporting on Section 5C: Nursing Workforce, hospitals must reference the unit definitions and acuity definitions in the measure specifications.

[20] ***Step-down/Progressive Units***
A single acuity unit in which at least 90% of the patients are at a lower level of acuity than patients in a critical care unit, yet at a higher level of acuity than that which is provided in a general care unit. These units may be called progressive care, intermediate care, direct observation, or transitional care units. Telemetry alone is not an indicator of acuity level. To classify as a step-down unit, the telemetry patients must require a higher level of nursing intensity than is available on medical, surgical, and medical/surgical units.

[21] ***Labor and Delivery Units***


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Include all antepartum and postpartum units. Nursery units, OR units, and procedural areas must be excluded.

[22] ***Pre-Operative or Post-Anesthesia Care Units***
For reporting on Section 2C: BCMA include all pre-operative and post-anesthesia care units (PACUs) located in or co-located with your hospital. For reporting on Section 6C: Hand Hygiene, include all pre-operative and post-anesthesia care units (PACUs) located in or co-located with your hospital, as well as those located in free-standing hospital outpatient departments that perform the outpatient procedures listed in Section 9: Outpatient Procedures and that share your hospital's license or CMS Certification Number. This includes combined pre-operative and post-anesthesia care units as well. If the hospital distinguishes between post-anesthesia phases within its PACU(s) (i.e., Phase I, Phase II, and Phase III recovery), all phases must be included when reporting.

Pre-operative units include areas where patients are prepared for an inpatient or outpatient surgical or diagnostic procedure, (i.e., where patients have their medical histories reviewed with their care team and receive physical examinations to determine risk factors and other information relevant to the surgery or procedure).

PACUs include areas where patients are watched after an inpatient or outpatient surgical or diagnostic procedure that required anesthesia or sedation and where hospital staff (e.g., nurses, anesthesiologists, and other support services) monitor patient recovery from anesthesia or sedation by keeping track of vitals and providing pain management.

[23] ***Certified Pharmacy Technician***
A certified pharmacy technician would include a pharmacy technician that has a Pharmacy Technicians Certification Board's (PTCB) Medication History Certificate.

[24] ***Sampling for Medication Reconciliation***
The sample must contain at least 30 patients from a 6-month reporting period. Sampling is limited to medical, medical/surgical units and step-down/progressive units (adult only). Patients that were discharged or expired before the Gold Standard Medication History could be obtained must be excluded from the sample. Patients that do not have discharge orders written during the reporting period must also be excluded from the sample. A sampling worksheet is available in the Medication Reconciliation Workbook for those who would like assistance in obtaining a random sample of patients.

[25] ***Gold Standard Medication History***
The Gold Standard Medication History is the list of medications that the patient was taking prior to admission. Within 24 hours after admission, a trained pharmacist, pharmacy resident, or certified pharmacy technician must interview each patient selected for the 6-month sample and obtain the Gold Standard Medication History. Note that this is in addition to, and separate from, any pre-admission medication list that was created as part of normal care. Best practices for collecting the Gold Standard Medication History can be found in the "Other Supporting Materials" for Section 2 on our website.

[26] ***Discrepancies in Gold Standard Medications***
For each Gold Standard Medication, there may be up to two unintentional discrepancies: a discrepancy in admission orders and a discrepancy in discharge orders. For example, if a medication on the Gold Standard Medication History is ordered for a patient on admission with the incorrect dose, this counts as one discrepancy. If this medication is ordered on discharge for the same incorrect dose, this counts as a second discrepancy. The number of unintentional discrepancies is a count of medication orders where an unintentional discrepancy occurred. You should not count the number of errors associated with the same medication order (e.g., a discrepancy in the dose and frequency in the same medication in admission orders counts as one discrepancy).


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[27] ***Unintentionally Ordered Additional Medications***
Count medications where a patient was not taking (and was not supposed to be taking) a certain medication, but the medical team incorrectly thought the patient was taking the medication and therefore ordered it on admission and/or discharge. Count each medication once, regardless of whether it was ordered on admission, discharge, or both.

[28] ***Discrepancies Due to Unintentionally Ordered Additional Medications***
For each unintentionally ordered additional medication, there may be up to two discrepancies: unintentionally ordered at admission, unintentionally ordered at discharge, or both. For example, if a medication is unintentionally ordered at admission, then this counts as one discrepancy. If the same medication is also ordered at discharge, then this counts as a second discrepancy.

[29] ***Data Completeness Requirement for the STS Mitral Valve Repair/Replacement (MVRR) Composite Score***
Participants are excluded from the analysis if they have fewer than 36 isolated MVRR procedures in the patient population. Please find more information in the NQF-endorsed measure specifications, available at https://www.sts.org/quality-safety/performance-measures/descriptions#MVRRComposite.

[30] ***High-Risk Deliveries Admitted***
Includes deliveries with:

- *expected* birth weight <1500 grams; or
- gestational age at least 22 weeks but <32 weeks.

Not all women at risk for delivery of babies with these conditions are known beforehand to be at risk. Therefore, hospitals should not report on high-risk deliveries in Section 4E: High Risk Deliveries if they only admit deliveries in which these high-risk conditions were unknown prior to admission or if they only admit high-risk deliveries on an emergency basis or when a patient is too unstable for safe transfer.

[31] ***Co-located***
A location within “immediate physical proximity” of the hospital would be considered a co-located location or unit, e.g., a co-located neonatal ICU (NICU) or co-located hospital outpatient location. "Immediate physical proximity” means the two locations must be physically connected, either by a tunnel, an enclosed bridge, or the locations abut each other so that the hallways readily connect.

[32] ***Very low birth weight babies***
Complicated newborns are those infants with a birth weight <1500 grams. If your hospital has a neonatal ICU (or is co-located with a hospital that has a neonatal ICU) that admits or accepts transfers of neonates with these conditions, you must answer “yes” to question #2.

[33] ***VON’s Death or Morbidity Measure***
This measure is collected and calculated by the Vermont Oxford Network and includes patients who have died or are known to have one or more of the following: severe intraventricular hemorrhage (SIVH); chronic lung disease (CLD); necrotizing enterocolitis (NEC); pneumothorax; any late infection (bacterial, fungal, or coagulase negative staph); or cystic periventricular leukomalacia (PVL).

[34] ***All Critical Care Patients***
**“All critical care patients”** means all general medical, surgical, medical/surgical, and neuro ICU patients including critical care patients in mixed acuity units.

[35] ***Managed or Co-Managed***
The intensivist, when present (whether on-site or via telemedicine), is authorized to diagnose, treat, and write orders for a patient in the ICU on the intensivist’s own authority. Examples of co-management include, but are not limited to, communication on patient status between the intensivist and hospitalist on


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a daily basis, intensivists co-develop care plans for all ICU patients, etc. Mandatory consults or daily rounds by an intensivist are not sufficient to meet the managed/co-managed requirement. However, an ICU need not be closed to meet this requirement.

[36] ***Certified in Critical Care Medicine***
A physician who is "certified in Critical Care Medicine" is a board-certified physician who is additionally certified in the subspecialty of Critical Care Medicine. Certification in Critical Care Medicine is awarded by the American Boards of Internal Medicine, Surgery, Anesthesiology, Pediatrics, and Emergency Medicine, as well as the American Osteopathic Board (AOS).

"Neurointensivists" include any physician that meets at least one of the following paths:

- Physicians who are board-certified in their primary specialty and who are additionally certified in the subspecialty of Neurocritical Care Medicine. Certification in Neurocritical Care Medicine is awarded by the United Council for Neurologic Subspecialties (UCNS) or by the American Board of Psychiatry and Neurology, Inc. (ABPN). Physicians who have not yet passed a certifying exam, either through UCNS or ABPN, are considered to be equivalent to a physician "certified in Neurocritical Care Medicine" for up to 3 years after they are eligible to take either: (1) the UCNS exam (UCNS currently offers a "grandfathering" option for their "Practice Track" for exam eligibility) or (2) the ABPN exam (ABPN currently offers a "grandfathering" or practice pathway track for exam eligibility, which will last until 2026). These options provide a 3-year grace period for clinicians to take and pass the necessary exams. To qualify for the grace period, hospitals and/or clinicians will need to provide clear documentation of what their eligibility dates were to sit for one or both of these exams.
- Physicians who are board-certified in their primary specialty and who are additionally credentialed by the American Board of Neurological Surgery (ABNS) through their Recognition of Focused Practice in Neurocritical Care. Physicians who have not yet passed the ABNS Neurocritical Care RFP exam are considered to be equivalent to a physician "certified in Neurocritical Care Medicine" for up to 3 years after they are eligible to take the exam. This provides a 3-year grace period for clinicians to take and pass the necessary exam. To qualify for the grace period, hospitals and/or clinicians will need to provide clear documentation of what their eligibility dates were to sit for the exam.

**Expanded Definition of Certified in Critical Care Medicine**
On an interim basis, three other categories of physicians are considered by Leapfrog to be equivalent to a physician "certified in Critical Care Medicine" for the purpose of meeting the standard:

- Physicians who completed training prior to availability of subspecialty certification in critical care in their specialty (1987 for Internal Medicine, Surgery, Anesthesiology, Pediatrics and 2013 for Emergency Medicine), who are board-certified in their specialty, and who have provided at least six weeks of full-time ICU care annually. (The weeks need not be consecutive weeks.)
- Physicians who have finished their fellowship in Critical Care Medicine, but have not yet passed an existing board-certifying exam, are considered to be equivalent to a physician "Certified in Critical Care Medicine" for up to three years after completion of the fellowship. This provides the physician an adequate window to take her/his boards and re-take if necessary.
- Physicians who are board-certified in their primary specialty and have completed a critical care fellowship at an ACGME-accredited program, but are ineligible to sit for a board-certifying exam in Critical Care in either their primary specialty or subspecialty because their training occurred under two separate certifying boards, are considered to be equivalent to a physician "Certified in Critical Care Medicine" if they are board-certified in their primary specialty and have provided at least six weeks of full-time ICU care annually. (The weeks need not be consecutive weeks.)


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Physicians who have let their board certification lapse are not considered to be “Certified in Critical Care Medicine.”

[37] ***Ordinarily and Exclusively Present in the ICU***
**“Ordinarily present in the ICU”** refers to direct on-site presence in the ICU of an intensivist during the 4-hour or 8-hour period. While it need not be the same intensivist for the entire 4-hour or 8-hour period, it is expected that the ICU(s) are primarily staffed by dedicated ICU intensivists who are ordinarily and exclusively present in the ICU(s). "Presence" does *not* mean staffed part-time by multiple physicians who are not ordinarily and exclusively dedicated to the ICU, *nor* does it mean the cumulative time that one or more intensivists spend in the unit visiting, rounding, consulting, or responding to pages.

The standard allows for normally expected intensivist activities outside of the ICU related to their responsibilities in the ICU (e.g., evaluating patients proposed for ICU admission), as long as intensivists are ordinarily present in the ICU and return immediately when paged. An intensivist present in one ICU immediately adjacent to another can be considered present in both units as long as they can respond to demands in both units as if they would if both units were one larger unit. For the purposes of this Survey, “adjacent” units are those units that can be reached within 5 minutes. While tele-intensivists can be used to meet the presence requirement, some on-site intensivist presence is still necessary to meet the Leapfrog specifications.

**“Exclusively”** means that when the physician is in the ICU, they have no concurrent clinical responsibilities to non-ICU patients.

[38] ***Intensivist Presence via Telemedicine***
To meet the Leapfrog ICU requirement for intensivist presence in the ICU via telemedicine, a hospital must be able to document that it fulfills **all** the following 10 key features based on a modification of the approach reported in Critical Care Medicine (Rosenfeld, B. et al. “Intensive care unit telemedicine: Alternate paradigm for providing continuous intensivist care,” *Critical Care Medicine*, Vol. 28, No. 1, pp. 3925-3931).

1. A physician certified in critical care medicine (see endnote #36) who is physically present in the ICU (“on-site intensivist”) performs a comprehensive review of each ICU patient each day and establishes and/or revises the care plan. The on-site intensivist must be available by phone to answer any questions from the tele-intensivist related to the established or revised care plan.

   The tele-intensivist, who must also be a physician certified in critical care medicine (see endnote #36), has immediate access to information regarding the on-site intensivist’s care plan at the time the management responsibility is transferred to the tele-intensivist by the on-site intensivist.

   When care is transferred back to the on-site intensivist, the tele-intensivist must communicate any changes to the care plan to the on-site intensivist. Hospitals relying on electronic hand-offs must ensure that physician sign-in and sign-out of reports is being recorded. In addition, these reports should be monitored as one way to audit compliance with the hand-off process described above.

2. When an intensivist is not on-site in the ICU managing or co-managing all ICU patients, a tele-intensivist is continuously monitoring and able to manage all ICU patients for the remaining 24 hours per day, 7 days per week. “Continuously monitoring” means the tele-intensivist has no other concurrent responsibilities, is immediately available to communicate with ICU staff, and is continuously in the physical presence of the tele-ICU’s patient monitoring and communications equipment. "Manage" means authorized to diagnose, treat, and write orders for a patient in the ICU on the intensivist’s own authority.

3. The tele-intensivist's care is proactive, with routine visualization and physiological review of all patients at a frequency appropriate to their severity of illness.

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

5. Bedside cameras are physically available in each ICU. If cameras are not mounted in each patient room within the unit, then at least one dedicated bedside camera must be available for every five beds in the ICU, plus a dedicated back-up camera in each ICU. If ICUs are located on different floors of the hospital, each ICU on each floor must have its own set of dedicated cameras if they are not mounted in every room. "Dedicated" means that the cameras are on the unit for the sole purpose of patient care. Personal devices (e.g., personal phones, tablets, etc.) would not meet this requirement.

6. The tele-intensivist must be able to turn on each bedside camera to visualize patients, with sufficient clarity to assess breathing pattern and communicate with on-site personnel at the bedside in real time.

7. Within five minutes of a request for assistance being initiated by hospital staff, the tele-intensivist's patient workload ordinarily permits the tele-intensivist to complete a comprehensive visual and physiological assessment of any patient.

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

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

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

[39] ***Quantified Analysis of Response Times***
Hospitals can monitor the response times of intensivists, "effectors," and clinical pharmacists in multiple ways, as long as the data collection process is non-biased and scientific.

As an example, hospitals can have the ICU staff maintain a response time audit log (low priority excluded) in the ICU(s) on six randomly sampled days per year. On those days, ICU nurses could record:

- For question #7, the number of calls/pages/texts made to the intensivist when they were not present in the unit (whether on-site or via telemedicine) and the number of times the intensivist's response time exceeded 5 minutes


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- For question #8, the number of calls/pages/texts made to a physician, physician assistant, nurse practitioner, or FCCS-certified nurse or intern "effector" and the number of times these individuals did not reach the patient at the bedside within 5 minutes
- For question #13, the number of calls/pages/texts made to the clinical pharmacist on days when they were not rounding on-site in the unit and the number of times the clinical pharmacist's response time exceeded 5 minutes

Hospitals can then estimate whether they meet the 95% timely response standards by dividing the total number of log exceptions by the total number of calls/pages/texts per day.

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

The six randomly selected days can be conducted over the course of a year prior to submission of Section 5 of the Survey. If resubmitting responses to Section 5, six new randomly selected days must be sampled in the three-month reporting period prior to resubmission.

Hospitals that use telemedicine to cover 'call' for the on-site intensivist should review endnote #41. Hospitals that have an effector that is dedicated 24/7 to the ICU (as defined as being within a 5 min walk to the ICU) should review endnote #42.

[40] ***FCCS-Certified Nurse or Intern "Effector"***
FCCS certificates are awarded to nurses and doctors upon their successful completion of a brief course developed by the Society for Critical Care Medicine to improve/confirm critical care knowledge and skills. For more information visit https://www.sccm.org/Education-Center/Educational-Programming/Fundamentals/Fundamental-Critical-Care-Support.

At present, this is the only such course recommended by The Leapfrog Group's expert advisory panel. Intensivists and any other physicians who are certified in critical care medicine (or eligible based on residency training or fellowship) need not also be FCCS certified.

Physicians, physician assistants, and nurse practitioners also are not required to be FCCS certified, but they must meet the criteria specified in endnote #42 to serve as the responder/"effector."

[41] ***Use of Tele-intensivists to Cover Calls***
Hospitals that use telemedicine to cover 'call' for the on-site intensivist are able to answer "yes" to question #7 if: (1) the telemedicine service meets all ten of the requirements outlined in endnote #38; and (2) the hospital has an 'effector' (physician/PA/NP/FCCS certified nurse or intern) on-site during that time period to carry out the tele-intensivist's orders and can reach the ICU patient within 5 minutes, 95% of the time.

[42] ***Physician/PA/NP serving as the Responder/"Effector"***
Physicians/PAs/NPs (includes Clinical nurse Specialists, Nurse Anesthetists, or NPs) serving as the responder in the ICU must meet the following criteria:

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 institutions internal policies (bylaws).


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3. Carry out the intensivist's orders and instructions, under the intensivist's guidance, when they are serving in a responder role.

If the effector is dedicated 24/7 to the ICU (as defined as being within a 5 min walk to the ICU), then hospitals can indicate "yes" to meeting the response time requirement (5 min response; 95% of the time) in question #8, in lieu of conducting a response time audit.

[43] ***Modified Intensivist Presence via Telemedicine***
To earn reduced credit on the Leapfrog ICU standard for intensivist presence in the ICU via telemonitoring, a hospital must affirm that its telemonitoring intensivist presence fulfills the following nine key features based on a modification of the approach reported in Critical Care Medicine (Rosenfeld, B. et al. "Intensive care unit telemedicine: Alternate paradigm for providing continuous intensivist care," *Critical Care Medicine*, Vol. 28, No. 1, pp. 3925-3931). Note that, as with other Leapfrog specifications, these features must be met under ordinary circumstances.

1. When an intensivist is not on-site in the ICU managing or co-managing all ICU patients, a tele-intensivist is continuously monitoring and able to manage all ICU patients for the remaining 24 hours per day, 7 days per week. "Continuously monitoring" means the tele-intensivist has no other concurrent responsibilities, is immediately available to communicate with ICU staff, and is continuously in the physical presence of the tele-ICU's patient monitoring and communications equipment. "Manage" means authorized to diagnose, treat, and write orders for a patient in the ICU on the intensivist's own authority.

2. The tele-intensivist's care is proactive, with routine visualization and physiological review of all patients at a frequency appropriate to their severity of illness.

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

4. Bedside cameras are physically available in each ICU. If cameras are not mounted in each patient room within the unit, then at least one dedicated bedside camera must be available for every five beds in the ICU, plus a dedicated back-up camera in each ICU. If ICUs are located on different floors of the hospital, each ICU on each floor must have its own set of dedicated cameras if they are not mounted in every room. "Dedicated" means that the cameras are on the unit for the sole purpose of patient care. Personal devices (e.g., personal phones, tablets, etc.) would not meet this requirement.

5. The tele-intensivist must be able to turn on each bedside camera to visualize patients, with sufficient clarity to assess breathing pattern and communicate with on-site personnel at the bedside in real time.

6. Within five minutes of a request for assistance being initiated by hospital staff, the tele-intensivist's patient workload ordinarily permits the tele-intensivist to complete a comprehensive visual and physiological assessment of any patient.

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

8. Written standards for remote care are established and include, at a minimum:
   a) tele-intensivists are certified by a national medical specialty board in critical care medicine;
   b) tele-intensivists are licensed to practice in the legal jurisdiction in which the ICU is located;


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c) tele-intensivists are credentialed in each hospital to which he/she provides remote care (can be special telemedicine credentialing);
d) activities of the tele-intensivist are reviewed within the hospital's quality assurance committee structure;
e) there are explicit written policies regarding roles and responsibilities of both the on-site intensivist and the tele-intensivist;
f) ICU staff are educated regarding the function, roles, and responsibilities of the tele-intensivist; and
g) there is an established written process to ensure effective communication between the ICU staff and the tele-intensivist.

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

[44] ***Individuals who touch patients or who touch items that will be used by patients***
This would include individuals who are formally engaged by the hospital to help support the patient care process. This would include both direct and indirect care providers that are likely to have contact with patients in a patient care unit, enter a patient care unit, touch items that will be used by patients in a patient care unit, or interact with patient fluids (e.g., blood, specimens) in a patient care unit, such as doctors, mid-levels, nurses, pharmacists, environmental services staff, phlebotomists, laboratory techs, etc. This would also include students and volunteers. These individuals must be trained to identify and perform proper hand hygiene for the specific indications/moments (see WHO's 5 Moments for Hand Hygiene, CDC's Guideline for Hand Hygiene) that are relevant to their work.

Administrative workers that only perform office duties and do not touch patients or touch items that will be used by patients in a patient care unit would not be included in this definition. Patients and their visitors would also not be included in this definition. While patients and their loved ones are important parts of the patient care process, they are not formally engaged by the hospital for this work. Vendors would also not be included.

[45] ***Professional with Appropriate Training and Skills***
This would include staff formally trained in Infection Control or Infectious Diseases, whose tasks include dedicated time for staff training. In some settings, this could also be medical or nursing staff involved in clinical work, with dedicated time to acquire thorough knowledge of the evidence for and correct practice of hand hygiene.

At a minimum, the trainer must have an understanding of the information and concepts presented in the WHO Guidelines on Hand Hygiene in Health Care and the Hand Hygiene Technical Reference Manual.

[46] ***Dedicated Emergency Department***
A dedicated emergency department is an area of the hospital that meets any one of the following criteria:

- Licensed by the state as an emergency department,
- Holds itself out to the public as providing emergency care, or
- During the preceding calendar year, at least one-third of its outpatient visits were for the treatment of emergency medical conditions.

For the purposes of reporting on the Survey, only include emergency departments that are located in your hospital. Exclude free-standing emergency departments.


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[47] ***Never Event***
In 2011, the National Quality Forum released a list of 29 events that they termed "serious reportable events," extremely rare medical errors that should never happen to a patient. Often termed "never events," these include errors such as surgery performed on the wrong body part or on the wrong patient, leaving a foreign object inside a patient after surgery, or discharging an infant to the wrong person. This is an update of NQF's original 2002 and 2006 reports. Please see NQF's "Never Events" list at https://digitalassets.jointcommission.org/api/public/content/4534bbaaee4f4bd280c2054765f37f4b?v=a60f8f9a. Hospitals may not earn credit for this question if they have only implemented a policy that includes the Center for Medicare and Medicaid (CMS) Never Events.

[48] ***Apology to the Patient***
While Leapfrog recognizes that on very rare occasions "never events" can occur that are not the fault of care systems or clinical care staff, given the high level of trust patients place in health care providers, Leapfrog feels it is appropriate for caregivers to apologize when a patient within their care setting suffers a serious event.

As the National Quality Forum identified in their 2002, 2006, and 2011 Serious Reportable Events Report, given the serious nature of these events, it is reasonable for hospitals to initially assume that the adverse event was due to the referenced course of care. And while further investigation and/or root cause analysis of the unplanned event may be needed to confirm or refute the presumed relationship, delaying an apology to the patient is not treating the patient with compassion and sympathy.

[49] ***Reporting Never Events to External Agencies***
If your hospital is not accredited by The Joint Commission or DNV GL Healthcare, is located in a state without a state-wide reporting program for medical errors, AND there is no available Patient Safety Organization to which your hospital can report medical errors, the hospital should report the event to the Board of Trustees. Full implementation of the Never Events policy still requires the hospital to conduct a root cause analysis of the event.

[50] ***Root Cause Analysis***
The National Patient Safety Foundation published a set of best practices and guidelines in its report "RCA$^2$ Improving Root Cause Analysis and Action to Prevent Harm." The report can be found at https://www.ihi.org/library/tools/rca2-improving-root-cause-analyses-and-actions-prevent-harm.

[51] ***Top Box Score***
The percent of survey respondents who chose the most positive score for a given item. Looking at the **top box** is an approach to understand the number of responses with a strong sentiment.

For the CAHPS Child Hospital Survey "Global Rating – Recommend hospital" domain, responses of 9 and 10 are included in the top box score. For the "Global Rating – Recommend hospital" domain, responses of "Definitely yes" are included in the top box score. For all other domains included in Section 8A, the top box score is the percent of survey respondents choosing "Always."

For the OAS CAHPS Survey "Patients' Rating of the Facility" domain, responses of 9 or 10 are included in the top box score. For the "Patients Recommending the Facility" domain, responses of "Definitely yes" are included in the top box score. For all other domains included in Section 9F, the top box score is the percent of survey respondents choosing "Yes, definitely."

[52] ***Operating Rooms***
If your state designates and licenses operating rooms, enter the number of operating rooms licensed by your state that are used to perform the outpatient procedures listed in Section 9C. If your state does not designate and license operating rooms, enter the number of operating rooms used to perform the outpatient procedures listed in Section 9C that meet the following definition from the 2018 FGI Guidelines:

a room that meets the requirements of a restricted area, is designated and equipped for performing surgical or other invasive procedures, and has the environmental controls for an OR as indicated in ASHRAE 170. An aseptic field is required for all procedures performed in an OR.

More information about the 2018 FGI Guidelines can be found at https://www.fgiguidelines.org/wp-content/uploads/2017/08/SLS17_FGI_ExamProcedureOperatingImaging_170721.pdf.

Hospitals must include the total number of operating rooms that are used to perform the outpatient procedures listed in Section 9C, including operating rooms that are used for both inpatient and outpatient procedures.

[53] ***Endoscopic Procedure Rooms***
If your state designates and licenses procedure rooms, enter the number of procedure rooms licensed by your state that are used for endoscopies listed in Section 9C. If your state does not designate and license procedure rooms, enter the number of procedure rooms that are used for endoscopies listed in Section 9C that meet the following definition from the 2018 FGI Guidelines: a room designated for the performance of patient care that requires high-level disinfection or sterile instruments and some environmental controls but is not required to be performed with the environmental controls of an operating room.

More information about the 2018 FGI Guidelines can be found at https://www.fgiguidelines.org/wp-content/uploads/2017/08/SLS17_FGI_ExamProcedureOperatingImaging_170721.pdf.

Hospitals must include the total number of procedure rooms that are used to perform the endoscopies listed in Section 9C, including procedure rooms that are used for both inpatient and outpatient procedures.

[54] ***Clinician***
A clinician refers to a physician, physician assistant (PA), nurse practitioner (NP), certified registered nurse anesthetist (CRNA), nurse (RN or MSN), or respiratory therapist.


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