LEAPFROG ASC SURVEY 2.0

PATIENT SAFETY AND QUALITY

Leapfrog ASC Survey 2.0 Binder

THELEAPFROGGROUP

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Overview

What is the Purpose of This Binder?

The Leapfrog ASC Survey 2.0 Binder is available via PDF for use by all ASCs to collect, organize, and record information during the completion of the Leapfrog ASC Survey 2.0. This document can be printed and placed in a binder. The information is helpful when completing subsequent years' Surveys, in staff and leadership transitions, and as a historical record.

How Should We Use This Binder?

This binder is meant to be used as a tool to help you collect, organize, and record information that you used to complete your Leapfrog ASC Survey 2.0. Nothing in the binder is meant to replace or substitute the information that Leapfrog provides in the hard copy of the Survey or reference materials available on the Leapfrog website (https://www.leapfroggroup.org/asc-program/asc-survey-20).

Section 1: Basic Facility Information

This section will not be scored in 2026. However, some responses will be shown on Leapfrog's public reporting website. For example, Leapfrog will display the number of operating and/or procedure rooms.

Section 2: Patient Rights and Ethics

Tips/Guidelines for Collecting, Organizing & Recording Information

- ☐ Review the reporting time periods for this section.
- ☐ Read the questions and FAQs in Section 2 of the hard copy of the Survey to ensure that you understand the criteria for each question BEFORE you respond to the questions.
- ☐ Make a note of who in your facility provided information or ran reports, obtained copies of policies or consent forms for you to respond to the questions.
- ☐ Be sure to print, date, label, and file reports that you used for this section in the binder.
- ☐ If you submitted questions on this section to the Leapfrog Help Desk, print copies of your responses (i.e., tickets) and save them in this tab for future reference.

2A: Billing Ethics

The types of documentation you should include in this binder are provided below. Only maintain documentation for those questions in which your facility responds "yes."

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**Question 1:** What pricing information is displayed on your facility's website for commonly performed procedures?	N/A	
☐	**Question 2:** Webpage URL where payer-specific negotiated charges, cash prices, or Department of Defense medical and dental reimbursement rates are displayed for consumers: *The http:// prefix needs to be included.* *Please note that the webpage URL should be a direct link to pricing information on your website and not the facility's main webpage.*	Webpage URL that displays either negotiated prices, cash prices, or Department of Defense medical and dental reimbursement rates based on response to question #1.	
☐	**Question 3:** Within 30 days of the final claims adjudication (or within 30 days from date of service for patients without insurance), does your facility 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: a) Name and address of the facility where billed services occurred; b) Date(s) of service; c) An individual line item for each service or bundle of services performed; d) Description of services billed that accompanies each line item or bundle of services performed; e) Amount of any principal, interest, or fees (e.g., late or processing fees), if applicable; f) Amount of any adjustments to the bill (e.g., health plan payment or discounts), if applicable; g) Amount of any payments already received (from the patient or any other party), if applicable; h) Instructions on how to apply for financial assistance, if applicable; i) Instructions in the patient's preferred language on how to obtain a written translation or oral interpretation of the bill; and j) Notification that physician services will be billed separately, if applicable? *If any one of the elements above are only provided upon request, select "only upon request." If any one of the elements above are not ever provided, select "no."*	1. Policy or procedure outlining the timeframe for providing the billing statement or master itemized bill. 2. Copy or sample of billing statement or master itemized bill that includes items a-j.	

☐	**Question 4:** Does your facility give patients instructions for contacting a billing representative: • Who has access to an interpretation service to communicate in the patient's preferred language, **and** • Who has the authority to do all the following within 10 business days of being contacted by the patient or patient representative: i. initiate an investigation into errors on the bill, ii. offer a price adjustment or debt forgiveness based on facility policy, and iii. offer a payment plan?	1. Copy of instructions for contacting a billing representative. 2. Policy, procedure, or position description outlining the scope of the billing representative's responsibilities, including items i-iii. 3. Evidence that billing representatives have access to an interpretation service, such as a vendor contract or service agreement.	
☐	**Question 5:** Does your facility take legal action against patients for late payment or insufficient payment of a medical bill? *This question does not include patients with whom your facility has entered into a written agreement specifying a good faith estimate for a medical service.*	1. Policy or procedure document that clearly indicates legal action is not taken against patients for late or insufficient payment of a medical bill, unless a pre-existing written agreement specifying a good faith estimate for a medical service is in place. 2. Copy of state or federal legislation that requires your facility to transfer delinquent payments to a state or federal agency (e.g., Department of Treasury, Attorney General, etc.) for action. If applicable based on response. The definition of legal action, must at a minimum, include the following: 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. Note that 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 question (e.g., filing a lien after an auto accident, or misappropriation of an insurance reimbursement).	

2B: Health Care Equity

The types of documentation you should include in this binder are provided below. Only maintain documentation for those questions in which your facility responds "yes."

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**Question 1:** Which of the following **patient self-identified** demographic data does your facility collect **directly from its patients (or patient's legal guardian)** prior to or while registering a patient for a facility visit?	1. A template registration form or screenshot of patient portal form where demographic information is collected. 2. A copy of a script that clearly demonstrates staff ask patients/legal guardians about the demographic information your facility collects.	
☐	**Question 2:** Does your facility 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: • the time of onboarding, and • annually thereafter?	1. Copy of online or in-person training curriculum. 2. Policy indicating when personnel are required to take the training.	
☐	**Question 3:** Does your facility 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? *If "no" to question #3, skip questions #4-5 and continue to question #6.*	Copy of stratified quality measure results. Note: 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.	
☐	**Question 4:** By stratifying the quality measure(s) from question #3, has your facility identified any health care disparities among its patients? *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.*	Copy of stratified quality measure results. Note: 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.	
☐	**Question 5:** In the past 12 months, has your facility used the data and information obtained through question #4 to update or revise its policies or procedures OR In the past 12 months, has your facility developed a written action plan that describes how it will address at least one of the health care disparities identified through question #4?	Copy of updated policy or procedure or written action plan based on stratified measure results from questions #3-4.	
☐	**Question 6:** Does your facility 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*?	Link (URL) to webpage that displays facility efforts to reduce health care disparities and the impact of those efforts. The webpage could include 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.	
☐	**Question 7:** Does your facility report out and discuss efforts related to identifying and addressing disparities with the facility's governance and leadership at least annually?	Copy of governance and leadership meeting minutes demonstrating discussion and updates of facility efforts to address disparities, which shows attendance of leadership.	

2C: Informed Consent

The types of documentation you should include in this binder are provided below. Only maintain documentation for those questions in which your facility responds "yes."

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
Training on Informed Consent			
☐	**Question 1:** Does your facility train employed staff on informed consent and tailor different training topics to different staff roles, including facility leaders, MD/NP/PA, nurses and other clinical staff, administrative staff and interpreters, and has your facility made the training: • a required component of onboarding for the appropriate newly hired staff, and • required for the appropriate existing staff who were not previously trained?	1. Slide deck or content from learning management system (LMS) modules used in training. 2. Policy indicating when personnel are required to take the training.	
Content of Informed Consent Forms			
☐	**Question 2:** As part of your facility's process for obtaining informed consent, does: • the clinician explain expected difficulties, recovery time, pain management and restrictions after a procedure that may be experienced by the patient either in the facility or post-discharge, if applicable; • the patient have the opportunity to ask questions; and • the consent form document that these two elements of the process have taken place?	A template consent form that includes places to document all the elements outlined in the question.	
☐	**Question 3:** Do ALL applicable consent forms used by your facility include the names(s) of the clinician(s) performing the procedure?	A template consent form that includes places to document all the elements outlined in the question.	
☐	**Question 4:** Are ALL applicable consent forms used by your facility written at a 6th grade reading level or lower? *The procedure name and description, and any words accompanied by a plain language definition can be excluded from the reading level assessment.*	Copy of consent form(s) for applicable procedures. The results of the reading level assessment, which can be performed in Microsoft Word using the following instructions: (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.	
Process for Gaining Informed Consent			
☐	**Question 5:** Prior to the informed consent discussion, does your facility: • ask what the patient/legal guardian's preferred language for medical decision-making is; • where needed, provide the patient/legal guardian access to a qualified medical interpreter, **NOT a family member or caregiver;** • 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 • have the medical interpreter sign the consent form (either in-person, electronically, or by documenting the use of an interpreter in the medical record)?	1. A template consent form that includes a space for the medical interpreter to sign or a copy/screenshot of an example medical record the use of an interpreter has been clearly documented. 2. Copy of policy or other document (such as a registration form or informed consent training curriculum) that clearly demonstrates staff always ask patients/legal guardian's about their preferred language for medical decision-making. 3. Evidence that those performing the informed consent have access to qualified medical interpreters or an interpretation service, such as a vendor contract or agreement.	

☐	**Question 6:** As part of the informed consent discussion, do clinicians at your facility 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?	Copy of policy or informed consent training curriculum that clearly demonstrates that clinicians are trained in and required to use the teach back method with patients during the informed consent process.	

2D: Taking Responsibility For Never Events

The types of documentation you should include in this binder are provided below. Only provide documentation for those questions in this section for which your facility responded "yes."

Ensure that the policy includes all **25 NQF Serious Reportable Events**. ASCs may not earn credit for any of the 9 questions if their policy does not include all 25 NQF Serious Reportable Events.

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**Question 1:** We apologize to the patient and/or family affected by the never event.	Copy of policy with relevant language highlighted.	
☐	**Question 2:** We report the event to at least one of the following external agencies within 15 business days of becoming aware that the never event has occurred: • State reporting program for medical errors • Patient Safety Organization (as defined in The Patient Safety and Quality Improvement Act of 2005) • Accreditation Organizations (i.e., JC, AAAHC, AAAASF, HFAP, etc.)	Copy of policy with relevant language highlighted.	
☐	**Question 3:** We perform a root cause analysis which at a minimum, includes the elements required by the chosen external reporting agency.	Copy of policy with relevant language highlighted.	
☐	**Question 4:** We waive all costs directly related to the never event.	Copy of policy with relevant language highlighted.	
☐	**Question 5:** We make a copy of this policy available to patients, patients' family members, and payers upon request.	Copy of policy with relevant language highlighted.	
☐	**Question 6:** We interview patients and/or families who are willing and able, to gather evidence for the root cause analysis.	Copy of policy with relevant language highlighted.	
☐	**Question 7:** We inform the patient and/or the patient's family of the action(s) that our facility will take to prevent future recurrences of similar events based on the findings from the root cause analysis.	Copy of policy with relevant language highlighted.	
☐	**Question 8:** We have a protocol in place to provide support for caregivers involved in never events and make that protocol known to all caregivers and affiliated clinicians.	Copy of policy with relevant language highlighted.	

☐	**Question 9:** We perform an annual review to ensure compliance with each element of Leapfrog's Never Events Policy for each never event that occurred.	Copy of policy with relevant language highlighted.	

Place Documentation For Section 2 After This Page

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Section 3: Patient Safety Practices

Tips/Guidelines for Collecting, Organizing & Recording Information

- ☐ Review the reporting periods for this section.
- ☐ Make a note of who in your facility provided information or ran reports, obtained copies of policies or consent forms for you to respond to the questions.
- ☐ Be sure to print, date, label, and file reports that you used for this section of the binder.
- ☐ If you submitted questions on this section to the Leapfrog Help Desk, print copies of your responses (i.e., tickets) and save them under this tab for future reference.

3A: Infection Surveillance Following Breast Surgeries, Laminectomies, Herniorrhaphies, Or Knee Prosthesis Procedures

For the NHSN OPC Module Measures (OPC Annual Facility Survey, BRST SSI, HER SSI, KPRO SSI, LAM SSI), print your NHSN reports for the reporting period using the instructions provided on the Join NHSN Group webpage and include them in this binder.

Note that Leapfrog recommends that facilities save copies of the NHSN 2025 Outpatient Procedure Component – Annual Facility Survey and SSI Reports on the same day that Leapfrog will be downloading the data from NHSN for all current group members. Download the NHSN Guidance Document on the Join NHSN Group webpage for instructions.

3B: Hand Hygiene

The types of documentation you should include in this binder are provided below. Only provide documentation for those questions in this section for which your facility responded "yes."

SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
Training and Education		
Question 1: Do individuals who touch patients or who touch items that will be used by patients in your facility receive hand hygiene training from a professional with appropriate training and skills at **both**: • the time of onboarding, and • annually thereafter?	1. Copy of hand hygiene educational document showing frequency of training (either online or in-person training curriculum. 2. Credentials of hand hygiene trainer. 3. Policy indicating when personnel are required to take the training.	
Question 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 need to physically demonstrate proper hand hygiene with soap and water and alcohol-based hand sanitizer?	Curriculum from an in-person orientation or other in-person session (e.g., occupational health session) which includes physical demonstration of hand hygiene and associated sign in sheets or description of computer-based assessment used for physical demonstration and report showing completion for new individuals.	
Question 3: Are **all** five of the following topics included in your facility's initial and annual hand hygiene training: • Evidence linking hand hygiene and infection prevention; • When individuals who touch patients or who touch items that will be used by patients should perform hand hygiene (e.g., WHO's 5 Moments for Hand Hygiene, CDC's Guideline for Hand Hygiene); • How individuals who touch patients or who touch items that will be used by patients 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; • The minimum time that should be spent performing hand hygiene with soap and water and alcohol-based hand sanitizer; and • How hand hygiene compliance is monitored?	Copy of online or in-person training curriculum for initial and annual hand hygiene training which includes all **five** topics.	

Infrastructure		
Question 4: Do **all** rooms and bed spaces in your surgical and treatment areas have • an alcohol-based hand sanitizer dispenser located at the entrance to the room or bed space, and • 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?	Would be verified via Leapfrog's on-site verification protocol.	
Monitoring		
Question 5: Does your facility collect hand hygiene compliance data on at least **200** hand hygiene opportunities, or at least the number of hang hygiene opportunities outlined in Table 1, **each month**?	1. Report showing **summary** counts of monthly opportunities monitored which shows at least 200 hand hygiene opportunities were monitored in the facility (or the number outlined based on the table in the Survey). At a minimum, the report needs to include the month preceding the time of submission of Section 3B Hand Hygiene. The facility should also have a process in place to ensure they can continue to meet the requirement moving forward. 2. For facilities where less than 200 opportunities are being monitored (refer to sample sizes in table in the Survey): - historical data used (e.g., past year, 6 months, 3 months etc.) showing the average number of procedures in a month; and - determined sample size that was used (based on sample sizes in the table in the Survey).	
Question 6: Does your facility collect hand hygiene compliance data on at least **100** hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined in Table 2, **each month**?	1. Report showing **summary** counts of monthly opportunities monitored which shows at least 100 hand hygiene opportunities were monitored in the facility (or the number outlined based on the table in the Survey). At a minimum, the report needs to include the month preceding the time of submission of Section 3B Hand Hygiene. The facility	

	should also have a process in place to ensure they can continue to meet the requirement moving forward. 2. For facilities where less than 100 opportunities are being monitored (refer to sample sizes in table in the Survey): - historical data used (e.g., past year, 6 months, 3 months etc.) showing the average number of procedures in a month; and - determined sample size that was used (based on sample sizes in the table in the Survey).	
Question 7: Does your facility collect hand hygiene compliance data on at least **100** hand hygiene opportunities **each quarter**?	1. Report showing **summary** counts of quarterly opportunities monitored which shows at least 100 hand hygiene opportunities were monitored in the facility. At a minimum, the report needs to include the quarter (or most recent 3 months) preceding the time of submission of Section 3B Hand Hygiene. The facility should also have a process in place to ensure they can continue to meet the requirement moving forward.	
Question 8: Does your facility use hand hygiene coaches or compliance observers to provide individuals who touch patients or who touch items that will be used by patients with feedback on both when they are and are not compliant with performing hand hygiene?	List of staff who serve as hand hygiene coaches/observers and the schedules they followed for observing/coaching.	
Direct Monitoring – Electronic Compliance Monitoring System		
Question 9: In those surgical or treatment areas 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, and • The facility itself has validated the accuracy of the data collected by the electronic compliance monitoring system?	Would be verified via Leapfrog's on-site verification protocol.	
Question 10: In those surgical or treatment areas where an electronic compliance monitoring system is used, are direct observations also	1. Example of direct observation template or sheet (electronic or paper copy) used by observers/coaches which shows:	

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 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 on duty for that shift; and • Observations capture a representative sample of the different roles of individuals who touch patients or who touch items that will be used by patients (e.g., nurses, physicians, techs, environmental services workers)?	- if the observer/coach intervened (observer/coach needs to intervene in all cases of noncompliance) - the date as well as the start and end time of the observation session (or the date and shift being observed) - the area 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 that is observed (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. 2. Report showing a **summary** of weekly or monthly direct observation data (or description) which shows: - observations for coaching/intervention purposes were conducted for **all** surgical or treatment areas where an electronic compliance monitoring system is used - observations within a surgical or treatment area were conducted weekly or monthly across all shifts and on all days of the week (i.e., a summary of observation counts by day of week and observation counts by shift for each unit OR a description of how this is accomplished) - observations capture a representative sample of the different roles of individuals, e.g., nurses, physicians, techs, environmental services workers (i.e., a summary of observation counts by role OR a description of how this is accomplished).	

Direct Monitoring- Direct Observation		
Question 11: In those surgical or treatment areas 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 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 on duty for that shift; and • 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 (e.g., nurses, physicians, techs, environmental services workers)?	1. Example of direct observation template or sheet (electronic or paper copy) used by observers which shows: - the date as well as the start and end time of the observation session (or the date and shift being observed) - the area 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 that is observed (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. 2. Report showing a **summary** of weekly or monthly direct observation data (or description) which shows: - observations were conducted for **all** surgical or treatment areas that do not have an electronic compliance monitoring system - observations within a surgical or treatment area were conducted weekly or monthly across all shifts and on all days of the week (i.e., a summary of observation counts by day of week and observation counts by shift for each unit OR a description of how this is accomplished) - observations capture a representative sample of the different roles of individuals, e.g., nurses, physicians, techs, environmental services workers (i.e., a summary of observation counts by role OR a description of how this is accomplished).	

Question 12: Does your facility have a system in place for both the initial and recurrent training and validation of hand hygiene compliance observers?	1. Training schedule for hand hygiene compliance observers which shows initial and recurrent training. 2. Results/documentation of regular quality monitoring of hand hygiene compliance observers (e.g., comparing results from simultaneous data collection by someone from Infection Control and a hand hygiene compliance observer, interactive video assessments, etc.).	
Feedback		
Question 13: Are hand hygiene compliance data fed back to individuals who touch patients or who touch items that will be used by patients at least monthly for improvement work?	Documentation of how hand hygiene compliance data were delivered monthly to individuals who touch patients or who touch items that will be used by patients (e.g., report, handout, e-mail, etc.).	
Question 14: Are hand hygiene compliance data used for creating action plans?	Action plans based on hand hygiene compliance data (hand hygiene compliance data should be highlighted).	
Question 15: Is regular (at least every 6 months) feedback of hand hygiene compliance data, with demonstration of trends over time, given to: • ASC leadership, and • ASC governance?	Documentation of how hand hygiene compliance data, with demonstration of trends over time, were delivered at least every 6 months to ASC leadership and ASC governance (e.g., report, handout, e-mail, etc.).	
Question 16: If "yes" to question #15, is ASC leadership held directly accountable for hand hygiene performance through performance reviews or compensation?	Performance reviews or compensation methodology for ASC leadership which include accountability for hand hygiene performance (e.g., meeting targets for hand hygiene compliance rates, bonuses tied to implementation of technology, etc.).	
Culture		
Question 17: Are patients and visitors invited to remind individuals who touch patients or who touch items that will be used by patients to perform hand hygiene?	Examples or photos of posters, bedside placards, buttons worn by staff, or other materials used to invite patients and visitors to remind individuals to perform hand hygiene.	

Question 18: Has ASC leadership 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)?	Written or verbal commitments to support hand hygiene improvement dated within the last 12 months from the leadership (e.g., e-mails, videos, minutes or talking points from town hall meetings, public comments to staff, etc.) that are addressed to individuals who touch patients or who touch items that will be used by patients.	

3C: Culture Of Safety

NQF Safe Practice #2: Culture Measurement, Feedback, And Intervention

The types of documentation you should include in this binder are provided below. Only maintain documentation for those safe practice elements that your facility checked the box for. Ensure that each document is dated according to the reporting period.

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
2.1 Does your facility currently have 20 or more employees?		N/A	
Awareness			
2.2 Within the last 24 months, in regard to culture measurement, our facility has done the following:			
☐	a. Administered one of the following culture of safety surveys to employees: • AHRQ Survey on Patient Safety (SOPS); • Glint Patient Safety Pulse; • Press Ganey Safety Culture Survey; • Safety, Communication, Organizational Reliability, Physician & Employee Burnout and Engagement (SCORE) Survey; or • Gallup Patient Safety Culture Survey	Results from culture of safety survey that show patient care or treatment areas surveyed. Be sure results are dated within past 24 months of submission date. Results should include participation rate.	
☐	b. Risk Manager, Quality Coordinator, or leadership used the results of the culture of safety survey to debrief staff using semi-structured approaches for the debriefings and presenting results in aggregate form to ensure the anonymity of survey respondents.	Meeting notes or presentation lead by local patient safety leaders that reflects semi-structured approach, with attendance reflecting units.	
Accountability			
2.3 Within the last 24 months, in regard to accountability for improvements in culture measurement, our facility has done the following:			
☐	a. shared the results of the culture of safety survey with governance and leadership in a formal report and discussion. (p.88)	Governance and leadership agenda, minutes, and/or presentation. All documentation should be dated.	
Ability			
2.4 Within the last 12 months, in regard to culture measurement, the facility 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 facility's culture of safety survey results.	Education session curriculum and sign in sheets for all staff levels.	

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
		Examples of documentation from personnel or administrative records. If using in-house staff educators to meet the intent, include job description. Highlight text from job description that 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.	
Action			
2.5 Within the last 12 months, in regard to culture measurement, feedback, and interventions, our facility has done the following (or has had the following in place):			
☐	a. developed or implemented explicit, facility-wide organizational policies and procedures for regular culture measurement. (p.88)	Policies and/or examples of strategies implemented (e.g., meetings, education, events, etc.).	
☐	b. identified performance improvement interventions based on the culture of safety survey results, which were shared with leadership and subsequently measured and monitored. (p.88)	Dashboard of metrics, progress report, etc. showing performance improvement intervention and meeting minutes showing attendance by leadership.	
Additional Question (Optional – Fact Finding Only)			
2.6 What was the response rate (i.e., rate of returned surveys) among employees that were administered the culture of safety survey within the past 36 months?		N/A	

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Section 4: Volume of Procedures

Tips/Guidelines for Collecting, Organizing & Recording Information

- ☐ Review the reporting periods for this section.
- ☐ For Section 4A: National Volume Standards for Total Knee Replacement, Total Hip Replacement, and Bariatric Surgery for Weight Loss and Section 4B: Facility Volume for Select Procedures (Optional) be sure to ***only*** use those CPT codes listed for each procedure in the Library on the ASC Dashboard.
- ☐ Make a note of who in your ASC provided information, ran reports, obtained copies of policies or consent forms for you to respond to the questions.
- ☐ If your facility queried (e.g., code or scripts) your claims or other administrative data sets or followed specific protocols to abstract data from clinical records, include a note or copy so that you can create similar reports next year.
- ☐ Be sure to print, date, label, and file reports that you used for this section of the binder.
- ☐ If you submitted questions on this section to the Leapfrog Help Desk, print copies of your responses (i.e., tickets) and save them under this tab for future reference.

4A: National Volume Standards For Total Knee Replacement, Total Hip Replacement, And Bariatric Surgery For Weight Loss

The types of documentation you should include in this binder are provided below. Ensure that each document is dated according to the reporting period in question #1. Only maintain documentation for those questions in which your facility responds "yes."

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**Question 1:** 12-month or 24-month reporting period used:	N/A	
☐	**Question 2:** Select all procedures that your facility performs: Total knee replacement Total hip replacement Bariatric surgery for weight loss None of the above	N/A	
☐	**Question 3:** Total facility 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.*	Use only those CPT and ICD-10 codes listed for each procedure in the Library on the Survey Dashboard. Maintain copies of the reports used to calculate total facility volume.	
☐	**Question 4:** Does your facility's privileging process include the surgeon meeting or exceeding the minimum annual surgeon volume standard listed below?	Copy of privileging process that includes the surgeon meeting or exceeding the minimum surgeon volume standard for each procedure. The surgeon volume standard must be explicitly stated in the document.	

4B: Facility Volume For Select Procedures (Optional)

Use ***only*** those CPT codes listed for each procedure in the Library on the ASC Dashboard. Maintain copies of the reports your facility is using to report on the volume of adult and pediatric procedures during the reporting period.

Place Documentation For Section 4 After This Page

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