PROPOSED CHANGES TO THE 2023 LEAPFROG HOSPITAL SURVEY

OPEN FOR PUBLIC COMMENT
Comments Accepted until COB on December 21, 2022

Each year, The Leapfrog Group's research team reviews the literature and convenes expert panels to ensure the Leapfrog Hospital Survey aligns with the latest science and the public reporting needs of purchasers and consumers. Once the list of proposed changes is assembled for next year's Survey, Leapfrog releases that list for public comment. The public comments received are then reviewed by Leapfrog's research team and used to refine the Survey before it is finalized.

The proposed changes to the 2023 Leapfrog Hospital Survey are outlined below. To provide a public comment, please respond by completing the public comment form **here**. Comments will be accepted until COB on **December 21, 2022**.

This year, we are requesting that commenters pay special attention to the following:

- Proposed Structural Changes
- Proposed Changes for Section 1C: Informed Consent
- Proposed Changes for Section 6C: Nursing Workforce

We are grateful to those who take the time to submit comments each year. These comments bring enormous value to Leapfrog's team and our expert panel deliberations, and help ensure the Survey is valuable to hospitals, purchasers, and consumers.

For information on the 2022 Leapfrog Hospital Survey, visit www.leapfroggroup.org/survey.

DEADLINES AND REPORTING PERIODS FOR 2023

Review the 2023 Leapfrog Hospital Survey Deadlines and anticipated reporting periods in Appendix I and II.

STRUCTURAL CHANGES

Leapfrog is implementing four structural changes to the 2023 Leapfrog Hospital Survey, including the Online Survey Tool.

First, we are combining Section 8: Medication Safety, which includes Section 8A: Bar Code Medication Administration (BCMA) and Section 8B: Medication Reconciliation, with Section 2: Medication Safety. The updated Section 2: Medication Safety will include the following subsections:

- Section 2A: Computerized Physician Order Entry (CPOE)
- Section 2B: EHR Application Information
- Section 2C: Bar Code Medication Administration (BCMA)
- Section 2D: Medication Reconciliation

Because Section 2 is required for submission, hospitals will now be required to complete subsections 2C Bar Code Medication Administration and 2D Medication Reconciliation to submit the Survey.

Second, with the change to the structure of Section 2, we will make the CPOE Evaluation Tool available immediately upon completion of the Hospital Profile. This will allow adult and general hospitals to complete a CPOE Test at their earliest convenience starting on April 1, without having to first complete and affirm Section 2. Although hospitals may now complete the Evaluation Tool early, CPOE Test results will continue to be scored and publicly reported only once the Survey has been submitted.

Third, we are proposing to score and publicly report results for the Nurse Staffing and Skill Level measures (nursing hours per patient day, RN hours per patient day, nursing skill mix, and proportion of RNs that are BSN-prepared) and we will add these measures to Section 6C Nursing Workforce. The updated Section 6: Patient Safety Practices will include the following subsections:

- Section 6A: Practice #1 - Culture of Safety Leadership Structures and Systems
- Section 6B: Practice #2 - Culture Measurement, Feedback, and Intervention
- Section 6C: Nursing Workforce (which will include Nursing Care Hours per Patient Day, RN Hours per Patient Day, Nursing Skill Mix, Proportion of RNs that are BSN-prepared, and NQF Safe Practice #9)
- Section 6D: Hand Hygiene

Finally, we are adding Section 7: Managing Serious Errors to the list of sections that are required to submit the Survey. Starting in 2023, the list of sections that are required to be completed and affirmed before the Survey can be submitted will include:

- Section 1: Basic Hospital Information
- Section 2: Medication Safety (which will include BCMA and Medication Reconciliation)
- Section 4: Maternity Care
- Section 5: ICU Physician Staffing
- Section 6: Patient Safety Practices
- Section 7: Managing Serious Errors

As always, hospitals are urged to submit all sections of the Survey and can indicate within a section if a measure does not apply.

PROPOSED CONTENT CHANGES

HOSPITAL PROFILE

There are no proposed changes to the Hospital Profile.

SECTION 1: BASIC HOSPITAL INFORMATION

SECTION 1A: BASIC HOSPITAL INFORMATION

In recognition of the published evidence and guidelines documenting the importance of environmental hygiene on infection prevention, Leapfrog is exploring the development of a new standard around environmental hygiene and will be consulting with experts in advance of the 2024 Leapfrog Hospital Survey. Environmental hygiene under consideration includes cleaning and disinfecting, as well as air-handling, ventilation, and water quality. For the 2023 Leapfrog Hospital Survey, we are proposing to add an optional, fact-finding question to 1A: Basic Hospital Information to assess how hospitals are integrating environmental services and facilities engineering into their quality and safety structures:

1) How are environmental services (EVS) and facilities engineering integrated into your hospital's quality and safety structures? *Select all that apply.*	☐ The individual responsible for EVS directly reports to, or has a dotted line, to the individual responsible for patient safety and quality ☐ The individual responsible for facilities engineering directly reports to, or has a dotted line, to the individual responsible for patient safety and quality ☐ EVS and facilities engineering staff are surveyed as part of the hospital's Culture of Safety Survey and leaders conduct debriefings with the EVS and facilities engineering staff around the team's survey results ☐ EVS and facilities engineering leaders are included in the hospital's daily patient safety huddles ☐ Other ☐ Not applicable; EVS and facilities engineering are not integrated into the hospital's quality and safety structures

This optional, fact-finding question will not be used in scoring or public reporting in 2023.

SECTION 1B: PERSON-CENTERED CARE: BILLING ETHICS AND HEALTH EQUITY

BILLING ETHICS

In response to hospital feedback, an analysis of responses submitted to the 2022 Leapfrog Hospital Survey, and feedback from researchers in the field, Leapfrog is proposing the following updates to Section 1B: Billing Ethics:

- Question #1, regarding a master itemized bill, will be updated to clarify that hospitals must provide instructions on how to obtain a written translation or oral interpretation of the bill in the patient's preferred language.
- Question #2, regarding access to billing representatives and timely resolution of billing issues, will be updated to give billing representatives 10 days, rather than 5 days, to initiate an investigation into errors on a bill, review, negotiate, and offer a price adjustment or debt forgiveness based on hospital policy, and establish a payment plan. Question #2 will also be updated to require that billing representatives have access to a translation service to help communicate information in the patient's preferred language.
- Hospitals that respond "yes" to Question #2 will be asked to report on an additional question about whether their billing representatives are resolving patient inquiries within 10 business days at least 95% of the time based on a random audit. Responses to this question will not be scored or publicly reported until 2024.

- All hospitals will be asked to report on an additional, optional fact-finding question about whether they notify patients within 30 days that an unpaid balance has been closed (e.g., due to the hospital's charity care program or the bill written off as unrecoverable debt).

Additionally, Frequently Asked Questions (FAQs) will be added regarding alternatives to legal action against patients and requirements regarding billing statements. Updates to the questions and the new FAQs for Section 1B: Billing Ethics are detailed in Appendix III. There are no proposed changes to the scoring algorithm.

HEALTH EQUITY

To date, Leapfrog has focused questions in this subsection on the collection of patient self-reported demographic information. Based on feedback from Leapfrog's national Advisory Committee and an analysis of responses submitted to the 2022 Leapfrog Hospital Survey, Leapfrog will revise the questions to focus on methods that hospitals are using to stratify measures by race, ethnicity, preferred language, sexual orientation, and gender identify. These questions will continue to be required, but responses will not be scored or publicly reported in 2023.

SECTION 1C: INFORMED CONSENT

In response to hospital feedback, an analysis of responses submitted to the 2022 Leapfrog Hospital Survey, and consultation with Leapfrog's Patient and Family Caregiver Expert Panel, Leapfrog is proposing to score and publicly report Section 1C: Informed Consent in 2023. In preparation for scoring and public reporting, we are proposing the following updates to the subsection:

First, the following six questions were identified by the expert panel as being most relevant for use in scoring and public reporting:

- One (1) question from the Policies and Training domain that focuses on staff training on the hospital's informed consent policies
- Three (3) questions from the Content of the Informed Consent Forms domain that focus on: detailing expected difficulties with the procedure; naming individuals who will be involved with the procedure, including trainees; and ensuring informed consent forms are at a 6th grade reading level
- Two (2) questions from the Processing for Gaining Informed Consent domain that focus on providing medical interpretation in the patient/legal guardian's preferred language, where needed, when discussing informed consent and using the "teach back method" with patients to ensure they understand what is being explained to them.

Updates to the questions listed above and the proposed scoring algorithm are detailed in Appendix IV.

Second, we are removing questions focused on the hospital having a written policy on informed consent, the hospital explicitly offering patients the opportunity for a care partner to participate in the informed consent process, and the use of high-quality decision aids when discussing treatment options.

Finally, we are retaining several questions from the 2022 Leapfrog Hospital Survey but making them optional for fact finding purposes only; they will not be scored or publicly reported in 2023. As we conduct additional research on these and other important, evidence-based practices related to the informed consent process, additional questions may be scored and publicly reported in the future.

The full list of optional, fact-finding questions is available in Appendix IV.

SECTION 2: MEDICATION SAFETY

As described above, we are combining Section 8: Medication Safety, which includes Section 8A: Bar Code Medication Administration (BCMA) and Section 8B: Medication Reconciliation, with Section 2: Medication Safety. The updated Section 2: Medication Safety will include the following subsections:

- Section 2A: Computerized Physician Order Entry (CPOE)
- Section 2B: EHR Application Information
- Section 2C: Bar Code Medication Administration (BCMA)
- Section 2D: Medication Reconciliation

Because Section 2 is required for submission, hospitals will now be required to complete subsections 2C: BCMA and 2D: Medication Reconciliation to submit the Survey.

SECTION 2A: COMPUTERIZED PHYSICIAN ORDER ENTRY (CPOE)

There are no proposed changes to this subsection.

SECTION 2B: EHR APPLICATION INFORMATION (FOR ADULT AND GENERAL HOSPITALS ONLY)

Leapfrog will remove questions regarding Medicare Promoting Interoperability Program scores. As a reminder, the remaining questions in this subsection are not scored or publicly reported.

CPOE EVALUATION TOOL (FOR ADULT AND GENERAL HOSPITALS ONLY)

As described above, we will make the CPOE Evaluation Tool available immediately upon completion of the Hospital Profile. This will allow adult and general hospitals to complete a CPOE Test at their earliest convenience starting on April 1, without having to first complete and affirm Section 2. As a reminder, CPOE Test results are only scored and publicly reported once the Survey has been submitted.

Additionally, Leapfrog is planning several content updates for the Adult Inpatient Test. First, the Test Order library will be reviewed and updated as appropriate based on the latest published literature. Second, the Drug Allergy Order Checking Category will be removed due to sustained high performance in this category across all hospitals over multiple years. Finally, the Drug Dose (Single) and Drug Dose (Daily) Order Checking Categories will be combined into a single Order Checking Category renamed Excessive Dose and will include both single and daily dose testing scenarios.

Although the total number of Test Orders will decrease, there are no proposed changes to the scoring algorithm for the Adult Inpatient Test.

SECTION 2C: BAR CODE MEDICATION ADMINISTRATION (BCMA)

There are no proposed changes to the questions used in scoring or the scoring algorithm for this subsection. However, based on feedback received from hospitals as well as guidance from Leapfrog's Bar Code Medication Administration Expert

Panel, Leapfrog is proposing to update the optional, fact-finding questions included in this subsection to focus on BCMA utilization and compliance in the following areas: pre-operative units, post-operative units/post anesthesia care units (PACUs), and emergency departments. These new questions, which will not be scored or publicly reported in 2023, are detailed in Appendix V.

SECTION 2D: MEDICATION RECONCILIATION (FOR ADULT AND GENERAL HOSPITALS ONLY)

There are no proposed changes to this subsection.

SECTION 3: ADULT AND PEDIATRIC COMPLEX SURGERY

SECTION 3A: HOSPITAL AND SURGEON VOLUME

Based on feedback from hospitals and under the guidance of the Complex Surgery Expert Panel, Leapfrog is proposing updates to the measure specifications that hospitals will use to calculate hospital volume and surgeon volume for the purpose of privileging for three complex surgeries.

OPEN AORTIC PROCEDURES

Leapfrog will add one ICD-10 procedure code to Open Aortic Procedures. This procedure code was added by CMS in 2022 and meets our definition of an Open Aortic Procedure: *A procedure where the surgeon exposes the aorta (thoracic or abdominal), clamps it, and sews on the aorta*.

ICD-10 Code	Description
X2RX0N7	Replacement of Thoracic Aorta, Arch using Branched Synthetic Substitute with Intraluminal Device, Open Approach, New Technology Group 7

BARIATRIC SURGERY FOR WEIGHT LOSS

Leapfrog will expand the list of procedure codes for Bariatric Surgery for Weight Loss to include outpatient procedures that will be captured using Current Procedural Terminology (CPT) codes. The CPT Codes will be available via the Online Survey Tool when the Survey opens on April 1, 2023. Due to the American Medical Association's Terms of Use, hospitals must complete the Terms of Use via the Online Survey Tool to access the CPT Codes. This procedure will also be added to Leapfrog's Ambulatory Surgery Center (ASC) Survey.

NORWOOD PROCEDURE

Leapfrog will remove questions regarding the STS Congenital Heart Surgery Database (CHSD) Participant Postoperative Length of Stay and Participant Operative Mortality measures but will continue to ask about hospital participation in the CHSD. Beginning in 2023, hospitals that perform the Norwood Procedure will be scored using three criteria: total hospital volume, incorporating Leapfrog's minimum annual surgeon volume standards into their process for privileging surgeons, and participation in the STS CHSD. The points assigned to each criterion reflects the Complex Surgery Expert Panel's opinion on its importance to patient outcomes. The updated scoring algorithm is available in Appendix VI.

SECTION 3B: SURGICAL APPROPRIATENESS

Based on feedback from hospitals and in consultation with the Complex Surgery Expert Panel, Leapfrog will remove questions regarding surgical appropriateness for Open Aortic Procedures as these procedures are performed as a part of life saving efforts.

There are no proposed changes to the public reporting of Section 3B: Surgical Appropriateness for 2023. However, the surgical appropriateness questions have been an important part of the Complex Surgery standards for several years and remain an important area of interest for Leapfrog's purchaser and employer members. As such, Leapfrog plans to incorporate these questions into scoring and public reporting beginning in 2024 for the following complex surgeries: Carotid Endarterectomy, Mitral Valve Repair and Replacement, Bariatric Surgery for Weight Loss, Total Knee Replacement, Total Hip Replacement, Lung Resection for Cancer, Esophageal Resection for Cancer, Pancreatic Resection for Cancer, and Rectal Cancer Surgery.

Additionally, in 2024, Leapfrog plans to add a new question to Section 3B to assess the extent to which a hospital's appropriateness criteria are being utilized by asking hospitals to report on their findings from the retrospective reviews completed in question #3 for the following procedures: Carotid Endarterectomy, Mitral Valve Repair and Replacement, Bariatric Surgery for Weight Loss, Total Knee Replacement, and Total Hip Replacement. The updated scoring algorithm will be published with the Proposed Changes to the 2024 Leapfrog Hospital Survey.

SECTION 3C: SAFE SURGERY CHECKLIST FOR ADULT AND PEDIATRIC COMPLEX SURGERY

Leapfrog is proposing two updates to Section 3C: Safe Surgery Checklist for Adult and Pediatric Complex Surgery. First, Leapfrog will increase the audit requirement from 15 sampled cases to 30 sampled cases for hospitals **only** submitting Section 3 and not also submitting Section 10 Outpatient Procedures. Hospitals that submit **both** Sections 3 and 10 will continue to audit 15 complex surgical cases and 15 outpatient surgical cases.

Second, for those hospitals that conducted a random sample audit to assess compliance with the Safe Surgery Checklist, Leapfrog will ask if the audit was completed by real-time observations, or a retrospective review of medical records or EHR data.

There are no proposed changes to the scoring algorithm for Section 3C: Safe Surgery Checklist for Adult and Pediatric Complex Surgery.

SECTION 4: MATERNITY CARE

Leapfrog will provide updated measure specifications from The Joint Commission (TJC) for PC-01 Elective Deliveries (Section 4B) and PC-02 Cesarean Birth (Section 4C) for those hospitals that do not already submit data to TJC and therefore need to retrospectively collect data. Hospitals measuring these quality indicators and reporting results to The Joint Commission should continue to use the data reported to TJC when responding to these subsections of the Survey. Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may continue to use the data provided in their CMQCC reports when responding to subsections 4B: Elective Deliveries, 4C: Cesarean Birth, 4D: Episiotomy, and 4E: Process Measures of Quality. Hospitals participating in the Michigan Obstetrics Initiative (OBI) may also continue to use the data provided in their OBI reports to report on Section 4C: Cesarean Birth.

SECTION 4A: MATERNITY CARE VOLUME AND SERVICES

Leapfrog will rename Section 4A: Maternity Care Volume to Section 4A: Maternity Care Volume and Services and add new questions regarding service offerings that will be used for public reporting only. The new questions will focus on the availability of midwives and doulas, breastfeeding support, vaginal delivery after cesarean section, and postpartum tubal ligation. The questions, which are detailed in Appendix VII, will not be scored, but will be required and used in public reporting.

SECTION 4B: ELECTIVE DELIVERIES

There are no proposed changes to this subsection.

SECTION 4C: CESAREAN BIRTH

Under the guidance of Leapfrog's Maternity Care Expert Panel, Leapfrog will add a set of optional fact-finding questions to this subsection to collect cesarean birth rates stratified by race and ethnicity. Hospitals will be asked to provide numerators and denominators for the NTSV C-section measure for each of the following racial and ethnic categories: 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). These fact-finding questions, detailed in Appendix VIII, will be optional and will not be used in scoring or public reporting in 2023.

Leapfrog is requesting information from hospitals on their methods for stratifying NTSV C-section rates, including sampling methodologies they are using. To respond to Leapfrog's request for information, please submit a Help Desk ticket at https://leapfroghelpdesk.zendesk.com.

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

SECTION 4D: EPISIOTOMY

There are no proposed changes to this subsection.

SECTION 4E: PROCESS MEASURES OF QUALITY

There are no proposed changes to this subsection.

SECTION 4F: HIGH-RISK DELIVERIES

There are no proposed changes to this subsection.

NEONATAL INTENSIVE CARE UNIT(S) – NATIONAL PERFORMANCE MEASUREMENT

Leapfrog will continue 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 4F: 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 Appendix IX. (Hospitals that successfully submitted a Data Sharing Authorization letter in prior years will not be required to submit another letter in 2023),
2. Select "VON National Performance Measure" in Section 4F: 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 Appendix IX.

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

SECTION 5: ICU PHYSICIAN STAFFING (IPS)

Based on feedback from hospitals, Leapfrog will update the wording of several questions in this section to increase clarity regarding the criteria to respond "yes."

First, question #3, which asks if physicians certified in critical care are managing or co-managing all critical care patients in applicable intensive care units (ICUs) will be separated into two questions.

Second, questions #11 and #14 will be updated to specify the minimum number of hours required for intensivist coverage. The revised questions are detailed in Appendix X.

Next, for hospitals that operate more than one type of ICU included in Leapfrog's standard (adult or pediatric medical and/or surgical ICU or medical and/or surgical neuro ICU) with varying staffing models, Leapfrog will add a note at the beginning of the section to remind hospitals that they should answer questions in this section based on the unit with the least intensive staffing structure as described in endnote #25. Additionally, phrasing throughout the section will be updated to reference the ICU with the least intensive staffing more clearly.

While there are no proposed changes to the scoring algorithm for Section 5: ICU Physician Staffing (IPS), question references in the scoring algorithm will be updated to reflect the updated question numbering described above. The scoring algorithm is available in Appendix X.

SECTION 6: PATIENT SAFETY PRACTICES

SECTION 6A: NQF SAFE PRACTICE #1 – CULTURE OF SAFETY LEADERSHIP STRUCTURES AND SYSTEMS

There are no proposed changes to this subsection.

SECTION 6B: NQF SAFE PRACTICE #2 – CULTURE MEASUREMENT, FEEDBACK, AND INTERVENTION

There are no proposed changes to this subsection.

SECTION 6C: NURSING WORKFORCE

As described above, Leapfrog is proposing to score and publicly report results for the Nurse Staffing and Skill Level measures (nursing hours per patient day, RN hours per patient day, nursing skill mix, and proportion of RNs that are BSN-

prepared) and will include those measures in Section 6C: Nursing Workforce. In preparation for scoring and public reporting, we will add a question regarding which method was used to calculate the total number of patient days for each inpatient medical, surgical, and/or med-surg unit.

Further, given that Leapfrog has asked hospitals to report their progress in implementing the elements of NQF Safe Practice #9 Nursing Workforce for over 15 years, moving forward, we will only ask hospitals to report on five of the seventeen practice elements not directly captured through the Nurse Staffing and Skill Level measures. The five practice elements hospitals will continue report on include:

- 9.2a: held nursing leadership directly accountable for improvements in performance through performance reviews or compensation.
- 9.2b: included nursing leadership as part of the hospital senior administrative leadership team.
- 9.2d: held the board (governance) and senior administrative leadership accountable for the provision of financial resources to ensure adequate nurse staffing levels.
- 9.3d: budgeted financial resources for balancing staffing levels and skill levels to improve performance.
- 9.4a: developed a staffing plan, with input from nurses, to ensure that adequate nursing staff-to-patient ratios are achieved.

Hospitals recognized as an American Nurses Credentialing Center (ANCC) Magnet® hospital or a 2020 Pathway to Excellence® hospital will receive full credit for the five practice elements. However, NQF Safe Practice #9 will no longer be scored and publicly reported as a stand-alone measure. Instead, the NQF Safe Practice #9 Nursing Workforce measure will only be used if the hospital scores in the bottom performance category (Limited Achievement) on the Nurse Staffing and Skill Mix measures (Total Nursing Care Hours per Patient Day, RN Hours Per Patient Day, and Nursing Skill Mix).

The proposed scoring algorithm is detailed in Appendix XI.

SECTION 6D: HAND HYGIENE

There are no proposed changes to this subsection.

SECTION 6E: NURSE STAFFING AND SKILL LEVEL

Leapfrog is proposing to score and publicly report results for the Nurse Staffing and Skill Level measures (nursing hours per patient day, RN hours per patient day, and proportion of RNs that are BSN-prepared) and we will add these measures to Section 6C Nursing Workforce.

SECTION 7: MANAGING SERIOUS ERRORS

As described above, Section 7: Managing Serious Errors will be added to the list of sections required to submit the 2023 Leapfrog Hospital Survey.

SECTION 7A: NEVER EVENTS POLICY STATEMENT

Leapfrog will update the wording to question #4, which asks if hospitals waive all costs related to all never events, to clarify that this includes costs to both the patient and the payor.

SECTION 7B: HEALTHCARE-ASSOCIATED INFECTIONS

There are no proposed changes to this subsection.

The deadlines to join Leapfrog's NHSN Group are available in Appendix XII.

SECTION 8: MEDICATION SAFETY

See Section 2: Medication Safety

SECTION 9: PEDIATRIC CARE

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

For hospitals administering the CAHPS Child Hospital Survey, we will ask an additional question to assess whether the full CAHPS Child Hospital Survey or a truncated version is being administered. Additionally, we will update the measure specifications to clarify that hospitals administering the truncated version of the CAHPS Child Hospital Survey must retain the demographic questions in order and unaltered. This requirement supports Leapfrog's efforts to have hospitals stratify quality measures for the purpose of identifying healthcare disparities.

There are no proposed changes to the scoring algorithm for Section 9A: Patient Experience (CAHPS Child Hospital Survey).

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

Based on feedback from hospitals and industry experts, Leapfrog will add a new unscored question to collect the age of the CT machine being used for pediatric CT scans. This new information will be used to analyze the relationship between machine age and dose and used to inform thresholds used in Leapfrog's data verification protocols.

There are no proposed changes to the scoring algorithm for Section 9B: Pediatric Computed Tomography (CT) Radiation Dose.

SECTION 10: OUTPATIENT PROCEDURES

SECTION 10A: BASIC OUTPATIENT DEPARTMENT INFORMATION

There are no proposed changes to this subsection.

SECTION 10B: MEDICAL, SURGICAL, AND CLINICAL STAFF

There are no proposed changes to this subsection.

SECTION 10C: VOLUME OF PROCEDURES

There are no proposed changes to this subsection.

SECTION 10D: SAFETY OF PROCEDURES

PATIENT FOLLOW-UP

Leapfrog will remove the Centers for Medicare and Medicaid Services (CMS) outcome measure OP-31 Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery since CMS has made this measure voluntary through the 2023 Hospital Outpatient Reporting (OQR) Final Rule.

Data download dates for OP-32 Rate of Unplanned Hospital Visits After Colonoscopy are available in Appendix XIII.

There are no proposed changes to the scoring algorithm for OP-32.

PATIENT SELECTION

There are no proposed changes to these questions.

SAFE SURGERY CHECKLIST FOR ADULT AND PEDIATRIC OUTPATIENT PROCEDURES

Leapfrog is proposing two updates to the Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures question set. First, Leapfrog will increase the audit requirement in question #11 from 15 sampled cases to 30 sampled cases for hospitals **only** submitting Section 10 and not also submitting Section 3: Adult and Pediatric Complex Surgery. Hospitals that submit **both** Sections 3 and 10 will continue to audit 15 complex surgical cases and 15 outpatient surgical cases.

Second, for those hospitals that conducted a random sample audit to assess compliance with the Safe Surgery Checklist, Leapfrog will ask if an observational audit or a retrospective review of medical records or EHR data was used.

There are no proposed changes to the scoring algorithm for Section 10D: Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures.

SECTION 10E: MEDICATION SAFETY FOR OUTPATIENT PROCEDURES

Leapfrog will clarify that only medications newly prescribed at discharge should be counted as medication prescribed at discharge and/or administered during the visit. We will also add intra-op irrigation solutions to the list of excluded medications and will update the measure specifications to exclude the dose requirement for lidocaine jelly.

There are no proposed changes to the scoring algorithm for Section 10E: Mediation Safety for Outpatient Procedures.

SECTION 10F: PATIENT EXPERIENCE (OAS CAHPS)

Leapfrog will clarify that hospitals must currently be administering the OAS CAHPS Survey to respond “yes” to question #3, which asks if the hospital administers, or has started to administer, the OAS CAHPS Survey.

There are no proposed changes to the scoring algorithm for Section 10F: Patient Experience (OAS CAHPS).

Thank you for your interest in the Leapfrog Hospital Survey. The Leapfrog Group and our experts will consider comments carefully in finalizing the 2023 Leapfrog Hospital Survey. Leapfrog will publish responses to public comments and a summary of changes in March 2023.

APPENDIX I

Timeline for the 2023 Leapfrog Hospital Survey

Date	Deadline
March	Summary of Changes to the 2023 Leapfrog Hospital Survey and Responses to Public Comments will be published at www.leapfroggroup.org/hospital.
April 1	**2023 LEAPFROG HOSPITAL SURVEY LAUNCH**
June 22	**FIRST NHSN GROUP DEADLINE:** Hospitals that join Leapfrog's NHSN Group by June 22, provide a valid NHSN ID in the Profile, and submit the Leapfrog Hospital Survey by June 30, will have data available prior to public reporting on their Hospital Details Page starting on July 12. Results will be publicly reported on July 25. Please see Appendix XII for instructions and other 2023 NHSN deadlines.
June 30	**SUBMISSION DEADLINE:** Hospitals that submit a Survey (and CPOE Evaluation Tool if applicable) by June 30 will have their Leapfrog Hospital Survey Results available prior to public reporting on their Hospital Details Page starting July 12. Results will be publicly reported starting on July 25. Hospitals that do not submit a Survey by June 30 will be publicly reported as "Declined to Respond" until a Survey has been submitted. Competitive Benchmarking Reports: Hospitals that would like to receive a free Summary Report must submit a Survey by June 30. The free Summary Report will be emailed to each hospital's CEO and Primary Survey Contact in September.
July 12	The first set of Leapfrog Hospital Survey Results, which reflect Surveys submitted by June 30, will be privately available for hospitals to view on July 12 via the Hospital Details Page link on the Survey Dashboard. In addition, Leapfrog will send out its first round of monthly data verification emails and documentation requests.
July 25	The first set of Leapfrog Hospital Survey Results, which reflect Surveys submitted by June 30 are published. After July, results are updated on the fifth business day of the month to reflect Surveys (re)submitted by the end of the previous month.
August 31	**TOP HOSPITAL DEADLINE:** Submission deadline for hospitals to be eligible to receive a Leapfrog Top Hospital Award. Hospitals are encouraged to submit their Survey by June 30 in order to resolve any data entry or reporting errors identified by Leapfrog through its monthly data verification and documentation requests. **DATA SNAPSHOT DATE FOR THE FALL 2023 HOSPITAL SAFETY GRADE:** Adult and general hospitals that would like Leapfrog Hospital Survey Results included in the fall 2023 Leapfrog Hospital Safety Grade must submit a Survey and CPOE Evaluation Tool by August 31. Hospitals are encouraged to submit their Survey by June 30 in order to resolve any data entry or reporting errors identified by Leapfrog through its monthly data verification and documentation requests. Find more information about the Leapfrog Hospital Safety Grade here.
November 30	**LATE SUBMISSION DEADLINE:** The 2023 Leapfrog Hospital Survey will close to new submissions at 11:59 pm ET on November 30. No new Surveys, new Survey sections, or CPOE Evaluation Tool Tests can be submitted after this deadline.

Date	Deadline
	Only hospitals that have submitted a Survey by November 30 will be able to log into the Online Survey Tool to make corrections to previously submitted sections during the months of December and January. Survey updates reflecting a change in performance must be made prior to November 30. Performance updates made after November 30 will not be scored or publicly reported. Adult and general hospitals that would like Leapfrog Hospital Survey Results included in the spring 2024 Leapfrog Hospital Safety Grade must submit a Survey and CPOE Evaluation Tool by November 30. Hospitals that submitted a Survey by August 31 are strongly urged to review their Last Submitted Survey to ensure it is accurate and complete. Find more information about the Leapfrog Hospital Safety Grade here.
January 31, 2024	**CORRECTIONS DEADLINE:** Hospitals that need to make corrections to previously submitted 2023 Leapfrog Hospital Surveys must make necessary updates and re-submit the entire Survey by January 31, 2024. Hospitals will not be able to make changes or submit their Survey after this date. Survey updates reflecting a change in performance must be made prior to November 30. Performance updates made after November 30 will not be scored or publicly reported. **DATA SNAPSHOT DATE FOR THE SPRING 2024 HOSPITAL SAFETY GRADE:** Adult and general hospitals that would like Leapfrog Hospital Survey Results included in the spring 2024 Leapfrog Hospital Safety Grade must submit a Survey and CPOE Evaluation Tool by November 30 to have Leapfrog Hospital Survey Results available for the January 31 Data Snapshot Date. Find more information about the Leapfrog Hospital Safety Grade here.

APPENDIX II

Anticipated Reporting Periods for the 2023 Leapfrog Hospital Survey

	Survey Submitted Prior to September 1	Survey (Re)Submitted on or After September 1
Survey Section	**Reporting Period**	**Reporting Period**
1A Basic Hospital Information	12 months ending 12/31/2022	12 months ending 06/30/2023
1B Person-Centered Care: Billing Ethics and Health Equity	N/A	N/A
1C Informed Consent	N/A	N/A
2A Medication Safety - Computerized Physician Order Entry (CPOE)	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
2B EHR Application Information	N/A	N/A
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: 12 months or 24 months ending 12/31/2022	Volume: 12 months or 24 months ending 06/30/2023
	STS MVRR Composite Score: Latest 36-month report	STS MVRR Composite Score: Latest 36-month report
3B Surgical Appropriateness	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission
3C Safe Surgery Checklist for Adult and Pediatric Complex Surgery	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
4A Maternity Care Volume and Services	12 months ending 12/31/2022	12 months ending 06/30/2023
4B Elective Deliveries	12 months ending 12/31/2022	12 months ending 06/30/2023
4C Cesarean Birth	12 months ending 12/31/2022	12 months ending 06/30/2023
4D Episiotomy	12 months ending 12/31/2022	12 months ending 06/30/2023
4E Process Measures of Quality	12 months ending 12/31/2022	12 months ending 06/30/2023
4F High-Risk Deliveries	Volume: 12 months ending 12/31/2022	Volume: 12 months ending 06/30/2023
	VON: 2021 report	VON: 2022 report
5 ICU Physician Staffing	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
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

	Survey Submitted Prior to September 1	Survey (Re)Submitted on or After September 1
Survey Section	**Reporting Period**	**Reporting Period**
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 Nursing Workforce	NQF Safe Practice #9: Latest 12 months prior to Survey submission	NQF Safe Practice #9: Latest 12 months prior to Survey submission
	Nursing Staffing and Skill Level: 12 months ending 12/31/2022	Nursing Staffing and Skill Level: 12 months ending 06/30/2023
6D Hand Hygiene	N/A	N/A
7A Never Events Policy	N/A	N/A
7B Healthcare-Associated Infections	June and August Data Downloads: 01/01/2022 – 12/31/2022	October and December Data Downloads: 07/01/2022 – 06/30/2023
8A 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 12/31/2022	12 months ending 06/30/2023
9A Basic Outpatient Department Information	12 months ending 12/31/2022	12 months ending 06/30/2023
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 12/31/2022	12 months ending 06/30/2023
9D Safety of Procedures	Patient Follow-up: Latest 12 or 24 months prior to Survey submission	Patient Follow-up: Latest 12 or 24 months prior to Survey submission
	Patient Selection: N/A	Patient Selection: N/A
	Safe Surgery Checklist: Latest 3 months prior to Survey submission	Safe Surgery Checklist: Latest 3 months prior to Survey submission
9E Medication Safety for Outpatient Procedures	12 months ending 12/31/2022	12 months ending 06/30/2023
9F Patient Experience (OAS CAHPS)	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission

APPENDIX III

Section 1B: Billing Ethics – Questions for 2023

Updates highlighted in yellow

New questions highlighted in blue

1) Within 30 days of the final claims adjudication, does your hospital provide **every patient**, either by mail or electronically, with a billing statement and/or master itemized bill for facility services 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 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 i. Instructions in the patient's preferred language on how to obtain a written translation or oral interpretation of the bill j. Notification that physician services will be billed separately, if applicable *If your hospital provides all the elements indicated above, but some are provided only upon request, select "Only upon request." If your hospital provides most of the elements, but at least one is not provided to patients even upon request, select "No."*	*Yes* *No* *Only upon request*
2) Does your hospital give patients instructions for contacting a billing representative who has the authority to do the following within 10 business days of being contacted by the patient or patient representative, AND can access an interpretation service to communicate in the patient's preferred language? a. Initiate an investigation into errors on a bill b. Review, negotiate, and offer a price adjustment or debt forgiveness based on hospital policy c. Establish a payment plan	*Yes* *No*
3) Based on a quantified analysis of response times, do your hospital's billing representatives meet the required timeframes outlined in	*Yes* *No*

question #2 above for each of the element's a, b, and c at least 95% of the time?	*Did not conduct a quantified analysis of response times*
4) Does your hospital take legal action against patients for late payment or insufficient payment of a medical bill? *Patients with whom your facility has entered into a written agreement specifying a set price (not a range or estimate) for a medical service are not included in this question.*	*Yes* *No*

Additional Question (Optional – Fact Finding Only)

5) Does your hospital notify patients who have had their outstanding unpaid balance closed (e.g., due to the hospital's charity care program, or the bill having been written off as unrecoverable debt), within 30 days of the balance being closed?	*Yes* *No* *Not applicable, our hospital does not close outstanding unpaid balances*

Section 1B: Billing Ethics – FAQs for 2023

Updates highlighted in yellow

1) **In answering question #1, what timeframe applies to patients that are uninsured?**
For patients that are uninsured, a billing statement and/or master itemized bill should be provided to them by the hospital within 30 days of the date of service.

2) **In answering question #1, should patients that do not have an outstanding balance be provided with a billing statement?**
Yes, every patient must be provided with a billing statement, even if the patient does not have an outstanding balance; if the balance has already been paid, this would be indicated in "item (g) Amount of any payments already received (from the patient or any other party), if applicable."

3) **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 primary 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 likely to receive care at the hospital.

4) **What does Leapfrog mean by "legal action" in question #4?**
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 the debt collection agency is prevented from taking legal action against patients by their contract with the hospital, 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 set price (not a range or estimate) for a medical service would not be 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).

5) 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 nonprofits such as RIP 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 RIP Medical Debt here: https://ripmedicaldebt.org/hospitals/.

APPENDIX IV

Section 1C: Informed Consent – Questions for 2023

Updates highlighted in yellow

Policies and Training

1) Does your hospital have a training program on informed consent that tailors 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: • a required component of onboarding for the appropriate newly hired staff, and • required for the appropriate existing staff who were not previously trained, and • required to be re-taken at least every five years for staff already trained unless there are major changes to the informed consent policy?	*Yes* *No*

Content of Informed Consent Forms

2) As part of your hospital's process for obtaining informed consent, does: • the clinician explain expected difficulties, recovery time, pain management, and restrictions after a test, treatment, or procedure, in the hospital and post-discharge, if applicable; and • the patient have the opportunity to ask questions; and • the consent form document that this element of the process has taken place?	*Yes* *No*
3) Do ALL of your hospital's consent forms include: • the name(s) of the clinician(s) performing the test, treatment, or procedure; • whether the clinician is expected to be absent from portions of the test, treatment, or procedure (e.g., opening, closing); and • if any assistants or trainees will be involved in the test, treatment, or procedure?	*Yes* *No*
4) Are ALL of your hospital's consent forms written in plain language and at a 6th grade reading level or lower?	*Yes* *No*

Process for Gaining Informed Consent

5) Prior to the informed consent discussion: • does your hospital ask what the patient/legal guardian's preferred language for medical decision-making is, and • where needed, your hospital provides the patient/legal guardian access to a qualified medical interpreter, and • your hospital's consent form captures whether a qualified medical interpreter was used to conduct the informed consent process, and	*Yes* *No*

• your hospital has the medical interpreter sign the consent form? *If anyone other than a qualified medical interpreter is ever used to translate (e.g., caregiver or family member), answer "No" to this question.*	
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 done, why it will be done, and what are the primary risks?	*Yes* *No*

Additional Questions (Optional – Fact Finding Only)

7) Does your hospital's written policy reference a list, or a defined set of guidelines, so the appropriate staff know which tests, treatments, and procedures require patient/legal guardian consent, with any exceptions noted?	*Yes* *No*
8) As part of your hospital's process for obtaining informed consent, does: • the clinician explain all of the patient's testing or treatment choices (including the choice of declining to go through with the test, treatment, or procedure), including the severity and probability of the risks and benefits of each choice, if applicable; and • the patient have the opportunity to ask questions; and • the consent form document that this element of the process has taken place?	*Yes* *No*
9) As part of your hospital's process for obtaining informed consent, does: • the clinician explain the clinical rationale (i.e., condition-specific justification) for why the test, treatment, or procedure is being performed, • the patient have the opportunity to ask questions; and • the consent form document that this element of the process has taken place?	*Yes* *No*
10) Which clinician is responsible for conducting the informed consent process at your hospital?	*The clinician primarily responsible for performing the procedure* *Another clinician on the procedure team* *Another clinician not involved with performing the procedure* *Other*
11) As part of the informed consent discussion, do clinicians at your hospital tell patients/legal guardians how many times a year they perform the test, treatment, or procedure?	*Yes* *No*
12) For tests, treatments, and procedures that are scheduled a week (i.e., seven calendar days) or more in advance, is the consent form shared with the patient at least three calendar days before the patient's test, treatment, or procedure?	*Yes* *No*
13) For tests, treatments, and procedures that are scheduled a week (i.e., seven calendar days) or more in advance, do clinicians practicing at your hospital discuss the consent form with the patient/legal guardian at least one calendar day before the patient's procedure, and is the patient/legal guardian provided with an opportunity to ask questions?	*Yes* *No*

14) At least once a year, does your hospital solicit feedback from patients/legal guardians about your hospital's informed consent process to understand how it can be improved over time?	*Yes* *No*
15) At least once a year, does your hospital complete an audit of the informed consent process to evaluate its efficacy and provide feedback to staff on opportunities for improvement?	*Yes* *No*

Section 1C: Informed Consent – Proposed Scoring Algorithm for 2023

Informed Consent Score (Performance Category)	**Meaning that…**
Achieved the Standard (4 bars)	The hospital responded "Yes" to **all** questions in the following three domains: • **Policies and Training Domain**: question #1 • **Content of Informed Consent Forms Domain**: questions #2-4 • **Process for Gaining Informed Consent Domain**: questions #5-6
Considerable Achievement (3 bars)	The hospital responded "Yes" to **5 out of 6** questions in the three domains.
Some Achievement (2 bars)	The hospital responded "Yes" to **4 out of 6** questions in the three domains.
Limited Achievement (1 bar)	The hospital responded "Yes" to **3 or fewer questions** in the three domains.

APPENDIX V

Section 2C: Bar Code Medication Administration – Additional Questions for 2023 (Optional – Fact Finding Only)

1) Does your hospital operate pre-operative units? If "no" to question #1, skip questions #2-5 and continue to question #6.	*Yes* *No*
2) If "yes," how many of this type of unit are open and staffed in the hospital?	_____
3) How many of the units in question #2 utilized the BCMA/eMAR system when administering medications at the bedside?	_____
4) The number of scannable medication administrations during the reporting period in those **pre-operative units** that utilize BCMA as indicated in questions #3 above?	_____
5) The number of medication administrations from question #4 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)?	_____
6) Does your hospital operate post anesthesia care units (PACUs)? *If "no" to question #6, skip questions #7-10 and continue to question #11.*	*Yes* *No*
7) If "yes," how many of this type of unit were open and staffed in the hospital?	_____
8) How many of the units in question #7 utilized the BCMA/eMAR system when administering medications at the bedside?	_____
9) The number of scannable medication administrations during the reporting period in those **PACUs** that utilize BCMA as indicated in questions #8 above?	_____
10) The number of medication administrations from question #9 that had both the patient and the medication scanned during administration with a BCMA system that is linked to the eMAR?	_____
11) Does your hospital operate an emergency department? *If "no" to question #11, skip questions #12-15 and continue to the next subsection.*	*Yes* *No*
12) If "yes," how many of this type of unit were open and staffed in the hospital?	_____
13) How many of the units in question #12 utilized the BCMA/eMAR system when administering medications at the bedside?	_____
14) The number of scannable medication administrations during the reporting period in those **emergency departments** that utilize BCMA as indicated in questions #13 above?	_____
15) The number of medication administrations from question #14 that had both the patient and the medication scanned during administration with a BCMA system that is linked to the eMAR?	_____

APPENDIX VI

Section 3A: Hospital and Surgeon Volume – Scoring Algorithm for Norwood Procedures for 2023

First, hospitals will be assigned points based on whether they meet each of the three (3) criteria:

Norwood Procedure Criteria	Leapfrog's Standard	Points Assigned
The hospital met the minimum hospital volume standard	Hospital has experience with 8 cases per year	• 50 points, if met • 0 points, if not met
The hospital's process for privileging surgeons includes meeting or exceeding the minimum annual surgeon volume standard	Hospital's privileging process requires a surgeon to have experience with at least 5 cases per year	• 25 points, if met • 0 points, if not met
The hospital participates in the Society of Thoracic Surgeons (STS) Congenital Heart Surgery Database (CHSD)	Hospital participates in STS CHSD	• 50 points, if participates • 0 points, if does not participate

Then points on each criterion are totaled together to assign an overall Performance Category for public reporting:

Norwood Procedure Score (Performance Category)	**Total Points**
Achieved the Standard (4 bars)	100 or more points
Considerable Achievement (3 bars)	75 points
Some Achievement (2 bars)	50 points
Limited Achievement (1 bar)	25 or fewer points
Does Not Apply	The hospital does not perform the procedure.

APPENDIX VII

Section 4A: Maternity Care Volume and Services – New Questions for 2023 (Will be Used in Public Reporting)

1) Does your hospital have certified nurse-midwives and/or certified midwives deliver newborns?	*Yes* *No*
2) Does your hospital use doulas for labor and delivery? *Select all that apply.*	☐ *Yes, hospital employs doulas* ☐ *Yes, hospital allows patients to bring their own doulas* ☐ *No*
3) Does your hospital offer breastfeeding/lactation consultants? *Select all that apply.*	☐ *Yes, in the hospital* ☐ *Yes, at home after discharge* ☐ *No*
4) Does your hospital follow the World Health Organization/UNICEF Baby-Friendly Hospital Initiative (i.e., the Ten Steps to Successful Breastfeeding)?	*Yes* *No*
5) Does your hospital routinely offer vaginal birth after cesarean section (VBAC)?	*Yes* *No*
6) Does your hospital offer postpartum tubal ligation?	*Yes* *No*

APPENDIX VIII

Section 4C: Cesarean Birth – Additional Questions (Optional – Fact Finding Only)

1) Did your hospitals stratify NTSV cesarean births by the racial and ethnic categories below for the reporting period and do you choose to report those data to this Survey? *If "no" to question #1, skip questions #2-3 and continue to the next subsection.*		*Yes* *No*
2) Enter your hospital's responses below by racial and ethnic category: If the number of cases for a racial/ethnic category 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 Category	a) 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 (denominator)	b) Total number of mothers indicated in question #2a 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	_____	_____
3) Do the responses in question #4 above represent a sample of cases?		*Yes* *No*

APPENDIX IX

VON Reporting Periods and Deadlines for 2023

Complete and submit Data Sharing Authorization to VON by*	VON data will be scored and publicly reported for hospitals that have submitted Section 4 by	VON Reporting Period	Available on Hospital Details Page and Public Reporting Website
June 15, 2023	June 30, 2023	2021	July 12, 2023 Hospital Details Page July 25, 2023 Public Reporting Website
August 15, 2023	August 31, 2023	2022**	September 8, 2023***
November 15, 2023	November 30, 2023	2022	December 7, 2023***

* Hospitals that successfully submitted a Data Sharing Authorization letter in previous years will not be required to submit another letter in 2023.
**Anticipated release of 2022 VON data.
*** Available on Hospital Details Page on the same date as public release of Survey Results

APPENDIX X

Section 5: ICU Physician Staffing (IPS) – Questions for 2023

Updates highlighted in yellow

New note highlighted in blue

Note: If your hospital has more than one type of ICU included in this standard, where the ICU physician staffing structure may differ among ICU types, report on the least restrictive ICU when responding to questions #1-15. For example, if the pediatric medical ICU is staffed by intensivists at least 8 hours/day, 7 days/week, but the adult medical ICU is not, respond to questions #1-15 based on the adult medical ICU.

1) What is the latest 3-month reporting period for which your hospital is submitting responses to this section? 3 months ending:	_____ *Format: Month/Year*
2) Does your hospital operate any adult or pediatric general medical and/or surgical ICUs and neuro ICUs? *If "no" to question #2, skip the remaining questions in Section 5, and go to the Affirmation of Accuracy. The hospital will be scored as "Does Not Apply."*	*Yes* *No*
3) Is this ICU staffed with physicians certified in critical care medicine who are present on-site or via telemedicine? *If "no" to question #3, skip the remaining questions in Section 5, and go to the Affirmation of Accuracy. The hospital will be scored as "Limited Achievement."*	*Yes, the ICU is staffed with physicians certified in critical care medicine* *Yes, the ICU is staffed with physicians certified in critical care medicine based on Leapfrog's expanded definition* *No, the ICU is not staffed with any physicians certified in critical care medicine*
4) Are **all critical care patients** in the ICU managed or co-managed by these physicians (whether present on-site or via telemedicine) who are certified in critical care medicine? *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)* *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 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 in this ICU managed or co-managed by one or more physicians certified in critical care medicine who meet **all** the following criteria: • ordinarily present **on-site** in each of these ICUs during daytime hours • for at least **8 hours per day, 7 days per week**	*Yes* *No*

• providing clinical care exclusively in one ICU during these hours	
If "yes" to question #5, skip question #6 and continue to question #7. If "no," continue to question #6.	
6) Are all critical care patients in this ICU managed or co-managed by one or more physicians certified in critical care medicine who meet **all** the following criteria: • present via telemedicine, 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 • supported by an on-site intensivist who establishes and revises the daily care plan for each ICU patient	*Yes* *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 this 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 of notification device response time?	*Yes* *No* *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, or FCCS-certified nurse or intern "effector" 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 of response time of the effector reaching the patient?	*Yes* *No* *Not applicable; intensivists are present on-site 24/7*
If "no" to either question #7 or #8 in this section, please answer 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 5, and go to the Affirmation of Accuracy.	
9) Are all critical care patients in this ICU managed or co-managed by one or more physicians certified in critical care medicine who meet all of the following criteria: • ordinarily present on-site in each of these units during daytime hours • for at least **8 hours per day, 4 days per week or 4 hours per day, 7 days per week** • providing clinical care exclusively in one ICU during these hours	*Yes* *No*
10) Are all critical care patients in this ICU managed or co-managed by one or more physicians certified in critical care medicine who meet **all** of the following criteria: • present via telemedicine for **24 hours per day, 7 days per week** • meet all of Leapfrog's modified ICU requirements for intensivist presence in the ICU via telemedicine • supported in the establishment and revision of daily care planning for each ICU patient by an on-site intensivist, hospitalist, anesthesiologist, or physician trained in emergency medicine	*Yes* *No*
11) Are all critical care patients in this ICU managed or co-managed by one or more physicians certified in critical care medicine who are: • on-site at least **4 days per week** to establish or revise daily care plans for each critical care patient in each of these ICUs	*Yes* *No*
If "yes" to question #9, #10, or #11, skip question #12 and continue to question #13.	

12) If not all critical care patients are managed or co-managed by physicians certified in critical care medicine, either on-site or via telemedicine, are **some patients** managed or co-managed by these physicians who are: • ordinarily present on-site in each of these units during daytime hours • for at least **8 hours per day, 4 days per week or 4 hours per day, 7 days per week** • providing clinical care exclusively in one ICU during these hours	*Yes* *No*
13) Does an on-site clinical pharmacist do **all** the following: • at least 5 days per week, makes daily on-site rounds on all critical care patients in each of these ICUs • on the other 2 days per week, returns more than 95% of calls/pages/texts from these units within 5 minutes, based on a quantified analysis of notification device response time **OR** makes daily on-site rounds on all critical care patients in each of these ICUs 7 days per week	*Yes* *No* *Clinical pharmacist rounds 7 days per week*
14) Does a physician certified in critical care medicine lead daily interprofessional rounds on-site on all critical care patients in each of these ICUs 7 days per week?	*Yes* *No*
15) Are physicians certified in critical care medicine responsible for all ICU admission and discharge decisions when they are: • present on-site for at least **8 hours per day, 4 days per week or 4 hours per day, 7 days per week**	*Yes* *No*

Section 5: ICU Physician Staffing (IPS) – Scoring Algorithm for 2023

Updates highlighted in yellow

IPS Score (Performance Category)	**Meaning that…**
Achieved the Standard (4 bars)	The hospital responded "Yes" or "Not applicable, intensivists are present 24/7" to **all** the following questions: • Question #3: The ICU is staffed with physicians either present on-site or via telemedicine who are either certified in critical care medicine or meet Leapfrog's expanded definition for certification in critical care • Question #4: All critical care patients are being managed or co-managed by physicians certified in critical care medicine (when present on-site or via telemedicine) • Question #5 **or** #6: One or more intensivist(s) is/are

IPS Score (Performance Category)	Meaning that…
	○ Ordinarily present on-site in each ICU during daytime hours for at least 8 hours per day, 7 days per week, providing clinical care exclusively in one ICU during these hours ○ Present via telemedicine, 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 • Question #7: When physicians (from question #3) are not present (on-site or via telemedicine) in these ICUs, one of them returns more than 95% of calls/pages/texts from these units within five minutes • Question #8: When physicians (from question #3) are not present (on-site or via telemedicine) in the ICU or not able to physically reach an ICU patient within 5 minutes, another physician, physician assistant, nurse practitioner or FCCS-certified nurse "effector" is on-site at the hospital and able to reach ICU patients within five minutes in more than 95% of the cases Note: When telemedicine is employed as a substitute for on-site intensivist coverage, it must meet all ten requirements detailed in endnote #29 (in the hard copy of the Survey), which includes some on-site intensivist time to manage the ICU patients' admissions, discharges, and care planning.
Considerable Achievement (3 bars)	The hospital responded "Yes" or "Clinical pharmacist rounds 7 days per week" to **all** the following questions: • Question #3: The ICU is staffed with physicians either present on-site or via telemedicine who are either certified in critical care medicine or meet Leapfrog's expanded definition for certification in critical care • Question #4: All critical care patients are being managed or co-managed by physicians certified in critical care medicine (when present on-site or via telemedicine) • Question #9 **or** #13: ○ One or more intensivist(s) is/are ordinarily present in each ICU during daytime hours for at least 8 hours per day, 4 days per week or 4 hours per day, 7 days per week; providing clinical care exclusively in one ICU during these hours ○ On-site clinical pharmacist makes daily rounds on all critical care patients in adult and pediatric medical and/or surgical and neuro ICUs at least 5 days/week, and on the other 2 days/week, a clinical pharmacist returns

IPS Score (Performance Category)	Meaning that…

	more than 95% of calls/pages/texts from these units within five minutes; or on-site clinical pharmacist rounds 7 days per week
	• Question #14 **or** #15:
	  ○ An intensivist leads daily, interprofessional rounds on-site on all critical care patients in adult and pediatric medical and/or surgical and neuro ICUs 7 days per week
	  ○ When intensivists are on-site in adult and pediatric medical and/or surgical and neuro ICUs, they make all admission and discharge decisions at least 8 hours per day, 4 days per week OR 4 hours per day, 7 days a week

Considerable Achievement (alternative) (3 bars)	The hospital responded "Yes" to **all** the following questions: • Question #3: The ICU is staffed with physicians either present on-site or via telemedicine who are either certified in critical care medicine or meet Leapfrog's expanded definition for certification in critical care • Question #4: All critical care patients are being managed or co-managed by physicians certified in critical care medicine (when present on-site or via telemedicine) • Question #10: One or more intensivist(s) is/are present via telemedicine 24 hours per day, 7 days per week, meet all of Leapfrog's modified ICU requirements, with on-site care planning done by an intensivist, hospitalist, anesthesiologist, or a physician trained in emergency medicine Note: When telemedicine is employed as a substitute for on-site intensivist coverage, it must meet all nine requirements detailed in endnote #34 (in the hard copy of the Survey).
Some Achievement (2 bars)	The hospital responded "Yes" to **all** the following questions: • Question #3: The ICU is staffed with physicians either present on-site or via telemedicine who are either certified in critical care medicine or meet Leapfrog's expanded definition for certification in critical care • Question #4: All critical care patients are being managed or co-managed by physicians certified in critical care medicine (when present on-site or via telemedicine) • Question #11: One or more intensivist(s) is/are present on-site at least 4 days per week to establish or revise daily care plans for all critical care patients • Question #14 **or** #15:

IPS Score (Performance Category)	Meaning that…
	○ An intensivist leads daily, interprofessional rounds on-site on all critical care patients in adult and pediatric medical and/or surgical and neuro ICUs 7 days per week ○ When intensivists are on-site in adult and pediatric medical and/or surgical and neuro ICUs, they make all admission and discharge decisions at least 8 hours per day, 4 days per week OR 4 hours per day, 7 days a week Or the hospital responded "Yes" to **all** the following questions: • Question #12: If not all, at least some critical care patients are managed or co-managed by physicians who are certified in critical care medicine (i.e., "intensivists"), either on-site or via telemedicine at least 8 hours per day, 4 days per week OR 4 hours per day, 7 days per week • Question #14 **or** #15: ○ An intensivist leads daily, interprofessional rounds on-site on all critical care patients in adult and pediatric medical and/or surgical and neuro ICUs 7 days per week ○ When intensivists are on-site in adult and pediatric medical and/or surgical and neuro ICUs, they make all admission and discharge decisions at least 8 hours per day, 4 days per week OR 4 hours per day, 7 days a week Note: When telemedicine is employed as a substitute for on-site intensivist coverage, it must meet all nine requirements detailed in endnote #34 (in the hard copy of the Survey).
Limited Achievement (1 bar)	The hospital responded to all the questions in this section, but it does not yet meet the criteria for ***Some Achievement***.
Does Not Apply	The hospital does not operate an adult or pediatric general medical or surgical intensive care unit or a neuro intensive care unit.

APPENDIX XI

Nurse Staffing and Skill Level – Proposed Scoring Algorithms for 2023

A hospital's performance on the **Total Nursing Care Hours per Patient Day** measure will be calculated by adding together the "Total number of productive hours worked by employee or contract nursing staff with direct patient care responsibilities" across all three unit types (medical, surgical, and med/surg) and all four quarters, and then dividing by the sum of the "Total number of inpatient days" across all three unit types (medical, surgical, and med/surg) and all four quarters. The result will then be divided into 24 (24 hours/day) to calculate the average number of patients per nurse. To calculate the 50th, 75th, and 90th percentiles used in scoring, Leapfrog will place hospitals into one of three cohorts – small teaching, large teaching, or non-teaching. Hospitals will only be compared to hospitals within the same cohort.

Total Nursing Care Hours per Patient Day Score (Performance Category)	**Meaning that…**
Achieved the Standard (4 bars)	The hospital's average number of patients per nurse is lower than or equal to the 50th percentile (where lower is better) for that hospital's cohort (small teaching, large teaching, or non-teaching)
Considerable Achievement (3 bars)	The hospital's average number of patients per nurse is higher than the 50th percentile but lower than or equal to the 75th percentile (where lower is better) for that's hospital cohort (small teaching, large teaching, or non-teaching)
Some Achievement (2 bars)	The hospital's average number of patients per nurse is higher than the 75th percentile but lower than or equal to the 90th percentile (where lower is better) for that's hospital cohort (small teaching, large teaching, or non-teaching) **OR** The hospital's responses did not pass Leapfrog's Extensive Monthly Data Verification Process
Some Achievement (alternative) (2 bars)	The hospital's average number of patients per nurse is higher than the 90th percentile (where lower is better) for that hospital's cohort (small teaching, large teaching, or non-teaching) **AND** The hospital achieved Leapfrog's standard for National Quality Forum (NQF) Safe Practice #9 Nursing Workforce
Limited Achievement (1 bar)	The hospital's average number of patients per nurse is higher than the 90th percentile (where lower is better) for that hospital's cohort (small teaching, large teaching, or non-teaching) **OR** The hospital did not measure

A hospital's performance on the **RN Hours per Patient Day** measure will be calculated by adding together the "Total number of productive hours worked by RN nursing staff with direct patient care responsibilities" across all three unit types (medical, surgical, and med/surg) and all four quarters and dividing by the sum of the "Total number of inpatient days"

across all three unit types (medical, surgical, and med/surg) and all four quarters. The result will then be divided into 24 (24 hours/day) to calculate the average number of patients per RN. To calculate the 50th, 75th, and 90th percentiles used in scoring, Leapfrog will place hospitals into one of three cohorts – small teaching, large teaching, or non-teaching. Hospitals will only be compared to hospitals within the same cohort.

RN Hours per Patient Day Score (Performance Category)	Meaning that…
Achieved the Standard (4 bars)	The hospital's average number of patients per RN is lower than or equal to the 50th percentile (where lower is better) for that hospital's cohort (small teaching, large teaching, or non-teaching)
Considerable Achievement (3 bars)	The hospital's average number of patients per RN is higher than the 50th percentile but lower than or equal to the 75th percentile (where lower is better) for that hospital's cohort (small teaching, large teaching, or non-teaching)
Some Achievement (2 bars)	The hospital's average number of patients per RN is higher than the 75th percentile but lower than or equal to the 90th percentile (where lower is better) for that hospital's cohort (small teaching, large teaching, or non-teaching) **OR** The hospital's responses did not pass Leapfrog's Extensive Monthly Data Verification Process
Some Achievement (alternative) (2 bars)	The hospital's average number of patients per RN is higher than the 90th percentile (where lower is better) for that hospital's cohort (small teaching, large teaching, or non-teaching) **AND** The hospital achieved Leapfrog's standard for National Quality Forum (NQF) Safe Practice #9 Nursing Workforce
Limited Achievement (1 bar)	The hospital's average number of patients per RN is higher than the 90th percentile (where lower is better) for that hospital's cohort (small teaching, large teaching, or non-teaching) **OR** The hospital did not measure

A hospital's performance on the **Nursing Skill Mix** measure will be calculated by adding together the "Total number of productive hours worked by RN nursing staff with direct patient care responsibilities" across all three unit types (medical, surgical, and med/surg) and all four quarters and dividing by the sum of the "Total number of productive hours worked by employee or contract nursing staff with direct patient care responsibilities" across all three unit types (medical, surgical, and med/surg) and all four quarters.

The result will be percentage of total productive nursing hours worked by RN (employee and contract) nursing staff with direct patient care responsibilities in all inpatient medical, surgical, or med-surgical units.

To calculate the 10th, 25th, and 50th percentiles used in scoring, Leapfrog will place hospitals into one of three cohorts – small teaching, large teaching, or non-teaching. Hospitals will only be compared to hospitals within the same cohort.

Nursing Skill Mix Score (Performance Category)	Meaning that…
Achieved the Standard (4 bars)	The hospital's percentage of total productive nursing hours worked by RN nursing staff is higher than or equal to the 50th percentile (where a higher is better) for that hospital's cohort (small teaching, large teaching, or non-teaching)
Considerable Achievement (3 bars)	The hospital's percentage of total productive nursing hours worked by RN nursing staff is lower than the 50th percentile but higher than or equal to the 25th percentile (where higher is better) for that hospital's cohort (small teaching, large teaching, or non-teaching)
Some Achievement (2 bars)	The hospital's percentage of total productive nursing hours worked by RN nursing staff is lower than the 25th percentile but higher than or equal to the 10thth percentile (where higher is better) for that hospital's cohort (small teaching, large teaching, or non-teaching) **OR** The hospital's responses did not pass Leapfrog's Extensive Monthly Data Verification Process
Some Achievement (alternative) (2 bars)	The hospital's percentage of total productive nursing hours worked by RN nursing staff is lower than the 10th percentile (where higher is better) for that hospital's cohort (small teaching, large teaching, or non-teaching) **AND** The hospital achieved Leapfrog's standard for National Quality Forum (NQF) Safe Practice #9 Nursing Workforce
Limited Achievement (1 bar)	The hospital's percentage of total productive nursing hours worked by RN nursing staff is lower than the 10th percentile (where higher is better) for that hospital's cohort (small teaching, large teaching, or non-teaching) **OR** The hospital did not measure

A hospital's performance on **Proportion of RNs that are BSN-prepared** measure will be based on the percentage of RNs that are BSN-prepared.

Proportion of RNs that are BSN-prepared Score (Performance Category)	Percentage of BSN-prepared RNs
Achieved the Standard (4 bars)	>= 80%
Considerable Achievement (3 bars)	> 50% and <= 79%
Some Achievement (2 bars)	> 20% and <= 49%
Limited Achievement (1 bar)	< 20% or the hospital did not measure

A hospital's performance on the **NQF Safe Practice #9 Nursing Workforce** measure will only be used if the hospital scores in the bottom performance category (Limited Achievement) on the Nursing Care Hours per Patient Day measure, RN Hours Per Patient Day measure, or Nursing Skill Mix measure. See above for more information.

NQF Safe Practice #9 Score (Performance Category)	**Meaning that…**
Achieved the Standard	The hospital responded "yes" to all 5 elements, or the hospital is currently recognized as an American Nurses Credentialing Center (ANCC) Magnet® organization, or the hospital is currently recognized as a 2020 Pathway to Excellence® organization

APPENDIX XII

NHSN Reporting Periods and Deadlines for 2023

The NHSN reporting periods and deadlines for the 2023 Leapfrog Hospital Survey are as follows:

Join Leapfrog's NSHN Group by	Leapfrog will download data from NHSN for all current group members	Data downloaded from NHSN will be scored and publicly reported for hospitals that have submitted Section 7 by	HAI Reporting Period	Available on Hospital Details Page and Public Reporting Website
June 22, 2023	June 23, 2023	June 30, 2023	01/01/2022 – 12/31/2022	July 12, 2023 Details Page July 25, 2023 Public Reporting Website
August 23, 2023	August 24, 2023	August 31, 2023	01/01/2022 – 12/31/2022	September 8, 2023*
October 23, 2023	October 24, 2023	October 31, 2023	07/01/2022 – 06/30/2023	November 7, 2023*
December 20, 2023	December 21, 2023**	November 30, 2023	07/01/2022 – 06/30/2023	January 9, 2024*

Leapfrog will provide step-by-step instructions for hospitals to download the same reports that Leapfrog downloads for each of the NHSN data downloads on our website by April 1.

* Available on Hospital Details Page on the same date as public release of Survey Results

** The Leapfrog Hospital Survey closes on November 30, 2023. The last NHSN data download is on December 21, 2023 to incorporate any facilities and corrections from facilities that joined by the last join date of December 20, 2023.

APPENDIX XIII

OP-32 Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy Reporting Periods and Deadlines for 2023

CMS data will be scored and publicly reported for Hospitals that have submitted Section 10 by	CMS Reporting Period	Available on Hospital Details Page	Available on the Public Reporting Website
June 30, 2023	OP-32: Most recent 24 months	July 12, 2023	July 25, 2023
August 31, 2023	OP-32: Most recent 24 months	September 8, 2023	September 8, 2023
November 30, 2023	OP-32: Most recent 24 months	December 7, 2023	December 7, 2023

END OF DOCUMENT